Group Board

Agenda

Meeting in Public on Friday, 07 July 2023, 10:00 – 13:30

Hyde Park Room, Lanesborough Wing, St George's Hospital, Tooting SW17 0QT

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:00	-	Feedback from visits to various parts of the site	Board members	-	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
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	Verbal
	1.4	Action Log and Matters Arising	Chairman	Review	Verbal
10:35	1.5	Group Chief Executive Officer's Report	GCEO	Review	Verbal

Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:45	2.1	Establishment of Infrastructure Committees	GCCAO	Approve	Report
10:55	2.2	Public Sector Equality Duty Report 2022/23	GCPO	Approve	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:05	3.1	Maternity Services Report	GCNO	Review	Report
11:20	3.2	Integrated Quality and Performance Report	GDCEO	Review	Report
11:40	3.3	Finance Report (Month 02, 2023/24)	GCFO	Review	Report
11:50	3.4	Group Strategy Oversight and Implementation	GDCEO	Review	Report

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:05	4.1	Quality Committee-in-Common Report	Committee Chair	Assure	Report
	4.2	Finance Committee-in-Common Report	Committee Chair	Assure	Verbal
	4.3	People Committee-in-Common Report	Committee Chair	Assure	Report

	4.4	SGUH Audit Committee Report	Committee Chair	Assure	Report
	4.5	ESTH Audit Committee Report	Committee Chair	Assure	Report
	4.6	ESTH Estates Assurance Committee Report	Committee Chair	Assure	Report

Items for Noting

Time	Item	Title	Presenter	Purpose	Format
12:40	5.1	Healthcare Associated Infection Report	GCNO	Note	Report
	5.2	Patient Safety Response Framework Implementation	GCNO	Note	Report
	5.3	Learning from Deaths Report Q4, 2022 /23	GCMO	Note	Report
	5.4	Medical Appraisals and Revalidation	GCMO	Note	Report
	5.5	Integrated Care Systems Update Q1, 2023 / 24	GDCEO	Note	Report

Closing items

Time	Item	Title	Presenter	Purpose	Format
13:00	6.1	New Risks and Issues Identified	Chairman	Note	Verbal
	6.2	Any Other Business	All	Note	Verbal
	6.3	Reflections on the Meeting	Chairman	Note	Verbal
13:10	6.4	Patient / Staff Story	GCNO	Review	Verbal
13:30	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

The Board will respond to written questions submitted in advance by members of the Public and from Governors of St George's University Hospitals NHS Foundation Trust.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Andrew Asbury*^	Group Chief Infrastructure, Facilities & Environment Officer	GCIFEO
Ann Beasley	Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Stephen Collier	Non-Executive Director – SGUH	SC
Chris Elliott*	Associate Non-Executive Director – ESTH	CE
Paul da Gama*^	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones^	Associate Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Derek Macallan	Non-Executive Director - ESTH	DM
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Aruna Mehta	Non-Executive Director – ESTH	AM
Andrew Murray	Non-Executive Director – SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director - ESTH	PW
Tim Wright	Non-Executive Director - SGUH	TW
In Attendance		
Deirdre LaBassiere	Deputy Director – Corporate Governance	DD-CG
Anna Macarthur	Group Director of Communications & Engagement	GDCE
Ralph Michell	Group Director of Strategy	GDOS
Apologies		
Yin Jones^	Associate Non-Executive Director – SGUH	YJ
Observers		
Sarah Forrester	Appointed Governor – Healthwatch Wandsworth	SF
Richard Mycroft	Governor – South West Lambeth	RM
Huon Snelgrove	Staff Governor – Non-Clinical	HS

Quorum:	*The quorum for the Group Board (Epsom and St Helier) is the attendance of a minimum 50% of the members of the Committee including at least two voting Non-Executive Directors and at least two voting Executive Directors.* *The quorum for the Group Board (St George's) is the attendance of a minimum 50% of the members of the Committee including at least two voting Non-Executive Directors and at least two voting Executive Directors.*

** Denotes non-voting member pf the Group Board (Epsom and St Helier)*
^ Denotes non-voting member of the Group Board (St George's)

Minutes of Trust Board Meeting (Public)

Meeting in Public on Friday, 05 May 2023

Whitehall Lecture Theatre, Education Block, St Helier Hospital, Wrythe Lane, Sutton SM5 1AA

PRESENT		
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Ann Beasley	Non-Executive Director/Vice Chairman – ESTH / SGUH	AB
James Blythe	Managing Director – ESTH	JB
Stephen Collier	Non-Executive Director - SGUH	SC
Chris Elliott	Associate Non-Executive Director - ESTH	CE
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) - SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Associate Non-Executive Director - SGUH	YJ
Peter Kane	Non-Executive Director ESTH / SGUH	PK
Martin Kirke	Non-Executive Director - ESTH	MK
Derek Macallan	Non-Executive Director	DM
James Marsh	Acting Chief Executive Officer	AGCEO
Andrew Murray	Non-Executive Director - SGUH	AM
Thirza Sawtell	Managing Director – Integrated Care	MD-IC
Kate Slemeck	Managing Director – St George's - SGUH	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham	Associate Non-Executive Director - ESTH	PW
Tim Wright	Non-Executive Director - SGUH	TW
IN ATTENDANCE		
Deirdre LaBassiere	Deputy Director – Corporate Governance	DD-CG
Anna Macarthur	Director of Communications and Engagement	DCE
Ralph Michell	Group Deputy Chief Executive Officer	GDCEO
OBSERVERS		
Richard Mycroft	Governor, South West Lambeth	RM

Afzal Ashraf	Governor, Wandsworth	AA
Jo Hunter	Director of Nursing and Governance, MedCard	DNG
APOLOGIES		
Andrew Asbury	Group Chief Infrastructure, Facilities & Environment Officer	GCIFEO
Aruna Mehta	Non-Executive Director - ESTH	AM
Jacqueline Totterdell	Group Chief Executive Officer	GCEO

** Non-voting members of the Board*

Items recorded in the order they were taken.

Feedback from Board Visits

Board members provided feedback from the visits conducted in the following areas: Maternity and Neonatal Unit, Radiology, MRI and CT, Dental POD, Renal Main Haemodialysis Unit, Endocospy, Pharmacy and Cardiac Rehab.

Maternity and Neonatal Unit – Ann Beasley, Jenny Higham and James Marsh

Maternity

The overall tone of the visit, which happened on International Day of the Midwife, was professionalism, friendliness and staff who did not appear stressed. The area was not busy.

Estates

Familiar estates issues presented, such as a poor lift that breaks down, mildew and doors being off their hinges. There is frustration that the centralised system to deal with issues arising has resulted in poor responsiveness for sometimes up to weeks with impact on service delivery. There is a lack of storage and also a lack of waiting areas which was seen in the Foetal Medicine Unit where people who may have received bad news have to leave, often in distress, via a routine antenatal clinic.

Staffing

Staffing was raised, although the number of deliveries is falling. Staff were aware of reviews, including Ockenden and the consequential suspension of the home delivery service.

Midwifery Report

There is dialogue between SGUH and other sites in connection with the CQC inspection and similar issues such as staffing rotas and triage processes have been actively addressed.

Neonatal Unit

The unit has up to 18 cots with 8 babies. Staff highlighted that flow needs to improve between the different units with better rationalisation of resources.

Radiology – Phil Wilbraham

Overall, a positive visit. The team were enthused by the Coronation and were dressing up the reception area but also exhibiting great enthusiasm for the Trust and for the radiology team; it was commented that it was a good and busy team.

Short staffing is a concern and the constant rearrangement of rotas is stressful. There are some areas for improvement in facilities but, from a flow perspective, things work well. A new scanning machine is to be introduced in three months, in collaboration with South-West London, and the department are looking forward to that. "Annalisa", a piece of AI equipment that scans chests and picks up whether there is a chance of cancer, is considered a valuable member of the team.

Dental POD including Maxillofacial Department and Plastics – Yin Jones, Derek MacCallan and James Blythe

The unit sees 15 patients a day and the management structure is very good.

Key issues highlighted were:

- There is a need for a children / family waiting area separate to the main wating area, particularly for those who have disabilities and are presenting with mental health challenges. It was confirmed that there are some potential solutions which are not expected to impact adversely on the budget.
- Managing staff was a concern, although it was acknowledged that staff morale was high and the sister who escorted them was very complimentary about her colleagues.
- Estates is a challenge as there are four procedure rooms, which are only as large as cupboards, which would present a problem if there was a crash, as there would be significant issues in getting the crash trolley into the room. There was peeling paint and windows have to kept open for proper ventilation.

Renal Dialysis Unit: - Gillian Norton, Peter Kane and Stephen Jones

This is a modern ward with capacity for 28 patients, is in good condition and there was a sense of good order. It was very busy and seemed quite crowded but in fact there were only 27 patients present, there is a lot of equipment. The ward was warm to accommodate the dialysis process.

Positive feedback from staff confirmed that they were happy, there was good team working and collegiate respect.

Key concerns highlighted:

- Transport: Patients are not always picked up and dropped off on time and the backlog created impacts negatively on patients being able to receive enough dialysis time.
- Behaviour: Dealing with challenging patients particularly those presenting with mental health issues. Security does not always provide sufficient support.
- Staffing: There is some pressure created on the ward due to sickness related staff absence.
- Capacity: A full unit means that patients cannot be moved off wards into the Dialysis Unit so beds cannot be freed. This is partly due to there being no room in the satellites and work is progressing with the satellites to consider how to free capacity.

The Chairman added that she spoke to a couple of patients and a family member and all spoke warmly of staff regarding their support and kindness to patients.

Endoscopy & Eye Surgery Unit: Martin Kirke, Tim Wright and Arlene Wellman

A very positive visit, with enough staff on both wards which were well organised. No major problems highlighted and staff were happy in their roles. The environment, within the limitations of the estate, was impressive. One of the refurbished areas looked quite agreeable with a patient commenting on its cleanliness.

The wards provided good evidence of the benefits of flexible working where staff were able to work the hours that suited them, whilst still working full time. As a result, it was relatively easy to resource those units.

Pharmacy: Chris Elliott and Paul da Gama

There was a good general mood and a number of positive conversations..

Pharmacy consists of four areas being:

- Storage – where pharmacy articles are brought in, stored and checked for the right amounts;
- Cancer – dealing specifically with cancer treatment and some special biological treatments;
- Outpatients; and
- In patient.

The area was cramped but clean.

There has been a recent move to a seven day rota which appeals to some staff but not others. The new rota has been complicated to initiate and get working. Most areas are well-staffed but there is an issue with recruitment and retention at the lower levels. Part of the problem identified is that there are increasing numbers of attractive pharmacy roles available in the community, particularly in general practice, which include flexible working and better hours. There is an overall eagerness to complete their statutory training but a member of staff stated that they do not have the time and space available to do more of the quality improvement and/or career development training because they are so busy.

The department felt under some stress, with sometimes an hour and a half wait for outpatients to collect prescriptions. The peak time of lunchtime coincides with time that staff are entitled to have off for lunch and as such, peak time for demand coincides with their weakest time for staffing. There was discussion about the potential for prescribing direct to a patient's nominated pharmacy. It was recognised that the Trust could not necessarily deliver this aspiration but there are efficiencies that could be realised, if it were an option. Staff added that they would like to receive recognition from the Board.

Cardiac Rehabilitation and Phlebotomy: Andrew Murray, Stephen Collier and Richard Jennings

On arriving at Cardiac Rehabilitation the doors were locked so the visit did not take place. Further, it eventually transpired that the Cardiac Rehabilitation department was closed on a Friday. As such, a visit to the Phlebotomy department was undertaken instead.

A very positive visit where they were made to feel extremely welcome. The assistant service manager, a phlebotomist for over 10 years, assisted them. The environment is hot and uncomfortable. It was, however, clean and tidy. The fire escape was clearly labelled, with all staff aware of who their fire wardens were and they had all been properly trained. There are 7 patient bays and the department undertakes ¼ million blood tests per year. The department serves outpatients and carries out domiciliary visits 5 days a week. They cover wards 7 days a week. They also do paediatric phlebotomy, supporting Queen Mary's Hospital (QMH) as there is a three week waiting list for phlebotomy at QMH.

There have only been 5 needle injuries in the last year. Wrong labelling of blood does occur and this tends to happen when printers go down at the places that make the blood requests. The handwritten blood requests, received as a result, can produce mistakes.

Local IT systems work well.

There was feedback about pay issues. Turnover from ESTH to SGUH was an issue, which is being reviewed through a business case.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies. The Chairman particularly welcomed Ralph Mitchell representing the GDCEO, Jo Hunter who was observing the meeting as part of her NHS Leadership Academy Nye Bevan Programme and Governors Richard Mycroft and Dr Afzal Ashraf. She commented that the meeting was an important development in the Group as it marked the first time that the Boards of each sovereign trust were meeting in common and that the report on the agenda, already agreed by the Board in private, explains the arrangement from a public accountability perspective. The Chairman added that this way of working will be a more efficient way of the board conducting its business.	
1.2	**Declarations of Interest**	
	The standing interests in relation to the shared roles 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 at ESTH on 2 March 2023 were approved as a true and accurate record. The minutes of the meeting held at SGUH on 2 March 2023 were approved as a true and correct record.	
1.4	**Action Log and Matters Arising** The Board noted the following updates on the open actions: **Transferred from SGUH Board Action Log:** • **PUBLIC220901.1:** The GCMO stated that meetings with key departments are ongoing to consider how to better support staff. A recent meeting with the ED at SGUH provided practical suggestions relating to security and the wearing of body cameras. It was agreed that the GCMO would provide a further update at the next Board meeting and	

	that someone would liaise with the Dialysis Unit to assist with an immediate response to an issue which has arisen there. • **PUBLIC220901.3:** The GCMO and the GCNO shall provide a regular report to Quality Committee as part of the Infection Prevention and Control Report. The item was proposed for closure. The Board agreed all items on Action Log proposed for closure should be closed.	
1.5	**Group Chief Executive's Officer (GCEO) Report** The Board received the report from the AGCEO, who made the following points: GCEO The Board noted that the GCEO is on an extended leave of absence due to illness but is recovering well and will be returning to work in the summer. The Board thanked the GCFO for covering as GDCEO and the GDOS for covering the GDCEO's substantive portfolio whilst he is acting as GCEO. Industrial Action Since the last board meeting both Trusts have experienced industrial action. It has been an exceptionally challenging time with impact on delivery of services. However, hard work, flexibility of staff and the changed ways of working have ensured the provision of safe services to patients. Financial Plan The challenging financial plan, which has been a significant area of focus for the Executive team, has been signed off. The GCFO's update will provide details of recent developments, next steps and working with system partners to support the ongoing financial recovery. Staff Survey Details of the staff survey are covered in the GCPO's update. The feedback is to be translated into positive action with plans for focused areas of support over all sites. National Chief Officer Visit The National Chief Officer, Ruth May was recently welcomed as part of her visit to SGUH for the National Student Nursing Congress, by the GCNO and the MD-SGUH. CMO-ESTH Resignation The CMO-ESTH, Dr Ruth Charlton is stepping down to return to clinical duties. She is replaced by Dr Rebecca Suckling, who is assuming her post at the end of May 2023. The Board noted that Dr Ruth Charlton has been a remarkable role model exemplifying calmness, professionalism, clarity of thought, compassion and dedication to quality. The AGCEO expressed his personal thanks to her commenting on how much he has enjoyed working with her and also learned from her.	

	The following comments, queries and observations were made: Phil Wilbraham queried how the new Group Strategy and the Staff Survey will come together, as ultimately the strategy will be delivered by colleagues and it is important that the strategy is communicated effectively. The AGCEO stated that the aim is to launch the group strategy, signed off by Private Board, in two weeks. The focus will be on embedding the strategy into mindsets of all employees at both Trusts. Final work is to be done with the Site Leadership Teams (SLT) which will include confirming with the SLTs how to support divisions, directorates and services to embed continuous learning and improvement at a local level that meets the needs of the divisions and the individual sites. The strategy will be launched across all staff services. There is a direct link with the Staff Survey in relation to the planned response to the Staff Survey and the ambitions within the strategy. Responding to a query from the Chairman on whether there is active engagement with staff, the AGCEO confirmed that 2000 staff have been engaged in the process of developing the strategy. Work is progressing on translating engagement into action and supporting divisions and services to use the strategy as a live document that resonates across the organisation. **The Group Board noted the Group Chief Executive's report** **The Group Board expressed their gratitude for Dr Ruth Charlton's considerable contribution to ESTH** **The Group Board confirmed that they would be prepared to undertake visits to help drive the Group Strategy forward.**	
2.0	**ITEMS FOR REVIEW**	
2.1	**Maternity Services Report** The GCNO introduced the report aimed at providing assurance on the compliance at ESTH and SGUH with Safety Action 9 of the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) and the requirement for Trusts to complete the Perinatal Quality Surveillance Report. She highlighted that staffing continues to be a challenge with achievements of 94% at SGUH and 90% at ESTH with work continuing to ensure that staffing is placed in the right areas at all times. At SGUH work has begun to focus on review of the staffing and nursing template which had previously not been updated. In addition, the initial feedback following the recent inspection of Maternity Services by the CQC at SGUH is being reviewed. She confirmed that reviews commissioned by the Board regarding data at SGUH and culture within maternity services at ESTH and SGUH are to start imminently. The following queries and observations were made: • Ann Beasley queried the timeline for outcomes of the data review. The GCNO responded that as this is a niche area the appointment timescale was slightly prolonged. However, now that appointments have been made it is expected that a report to Board will be made in July 2023, having undertaken the investigation review, reviewed the data and spoken to the teams.	**GCNO**

	• Referencing the report on the agenda from Quality Committee, Andrew Murray stated that the Committee is keen to see progress on the two reviews. • Derek Macallan requested that a line be added to the report to reflect the number of live births per year, which would highlight successes. • The MD-ESTH observed the improved fill rate at SGUH noting that there is an ongoing challenge at ESTH and queried the mitigation measures that the ESTH labour ward could take to ensure safe services. The GCNO responded that a new Director of Midwifery has been appointed who has brought a different perspective. A process for staffing of labour wards has now been implemented which involves staffing being reviewed in a huddle in the morning, with staff allocated to ensure that labour wards are adequately covered depending on how many women are presenting on the day. Also, a huddle report was provided to the Executive twice a day, which includes information such as whether birthing centres needed to be closed, any procedures cancelled or patients moved, in order to provide robust visibility across the sites on what is happening on the labour wards. **The Group Board noted the report for assurance.**	**GCNO**
2.2	**Integrated Quality and Performance Report** The Chairman opened the item by inviting the AGCEO to introduce the item and then inviting comments from the ESTH and SGUH MDs. The AGCEO highlighted the Integrated Quality and Performance Report (IQPR) is a mixed picture of success and on-going challenge. Both Trusts are operating in a challenging environment and staffs' efforts to maintain good performance and to manage impact on patients during the recent episodes of industrial action is acknowledged. General themes arising are: <u>Cancer</u> Good progress has been made over the last financial year. ESTH sustained excellent performance and SGUH has worked hard to improve performance as noted through a letter of thanks from Royal Marsden Partners who acknowledged the reduction in the number of patients who had been waiting more than 62 days for treatment from referral. <u>Urgent and emergency care</u> Good comparative performance against peers is being maintained against the key national target of patients who are waiting more than 4 hours for discharge or admission, although there is more to be done to offer a higher level of service. Good progress has been made, particularly at SGUH, on ambulance handovers but at both Trusts challenges persist in relation to patients who are waiting 12 hours or more in the EDs. <u>Planned care</u> Both Trusts have good comparative performance against peers in London and nationally and there has been a significantly improving trajectory at SGUH but there are ongoing challenges at ESTH for patients waiting 52 weeks or more. There has been a good achievement in almost entirely eliminating patients waiting 78 weeks or more. There are opportunities to improve productivity in relation to theatre utilisation and patient access to elective care.	

Quality

The Board noted the recent Never Events that occurred at both sites. There are challenges at SGUH in regard to the number of patients who continue to develop category 3 & 4 pressure ulcers. At ESTH there are challenges in relation to the mortality rate and compliance with VTE documentation.

Integrated Care

The Board noted the ongoing progress with reviewing the transfer of care, particularly at Surrey Downs Health and Care. Although it is good to see the high level of referrals for urgent community response it was noted that it does present a challenge with ability to see patients in a timely fashion.

ESTH

The MD-ESTH highlighted:

Further to falling below the 85% national standard for the cancer 62 day performance in January 2023, the Trust is now performing above target since February 2023. This will be an area of continual focus as the numbers accessing cancer pathways through the two week rule increase.

Progress has been made on diagnostic waits where a number of patients waiting more than six weeks for a diagnostic has significantly decreased, although the Trust is not yet back to the normal thresholds. This is an area of ongoing focus for the site team. A Community Diagnostic Centre scheme, based in Wallington, has not yet been secured and availability of capital is the barrier. This will continue to be pursued as accommodating increasing demands on diagnostics from the Wallington community in the hospital setting at ESTH will be extremely challenging.

There are 52 week waits in relation to gynaecology and paediatrics. The paediatric challenge is that it is a complex and interdependent service relying on other agencies and a workforce that is heavily engaged in doing work outside of the service. It is hoped that the pending meeting with the Director of Children's Services of the Local Authority will assist.

Emerging out of the winter season there is a refocus on experience, outcomes and core standards of safety in relation to urgent care. Key challenges are around paediatric A&E volumes. There has been improvement in relation to the 12 hour decision to admit metric which is key to maintaining flow through the hospital on the day. Maintaining access to the discharge lounges at both Trusts helps significantly to maintain flow. Improving identification of definite discharges for the following day is also helping with significant improvement with flow.

The GCMO referred to certain Never Events that had occurred at ESTH, the action in hand as a consequence and confirmed that there was negligible harm to the patients:

- A retained guide wire which had erroneously been left in a patient.
- In March 2023, at SWLEOC, the wrong nerves were blocked as a result of an injection with the root cause being that the site was not marked before the procedure. In addition, there was another similar event at

SWELEOC with a wrong side nerve block because the drapes concealed the marking site. This occurred despite steps having been taken immediately after the first Never Event to ensure that the site is always marked.

The Board held a thorough and robust discussion in relation to ESTH, SGUH and Integrated Care (IC) and the following observations and queries were made:

Ann Beasley queried whether the Quality Committee is reviewing the SHMI measure continuing to rise, as referenced in mortality being higher than expected at St. Helier. The GCMO responded that it is regularly reported to the Committee. There is a two-pronged approach to examine to what extent this is a data artifact rather than a quality concern and it is likely that some of the ways the data is being recorded, for same day emergency care, may artificially push up figures as other organisations do not record their data in the same way because this is national benchmarking. However, the approach is that this is not a data quality issue but a genuine quality issue which is the safer and proper assumption to make. Different patient groups are regularly reviewed where mortality appears higher than expected against quality of care. There is no evidence of an individual patient group that accounts for excess mortality. Therefore, areas where issues are identified for improvement even if they cannot be linked to the mortality figures are being deliberated. A great deal of work has been undertaken by the MD-SGUH, the outgoing CMO-ESTH and the GCMO, with feedback from Junior Doctors about the regularity with which inpatients see a senior consultant to make processes at St. Helier more robust. The MD-ESTH added that one of the planned investments, as part of the annual plan for 2023 / 24, is to extend critical care outreach for both sites. A cause and effect cannot be directly attributed to mortality but it is has been observed that similar organisations that have low mortality rates have 24 / 7 critical care outreach. In addition, some indicators around cardiac arrest numbers suggest this is the right thing to do.

Phil Wilbraham commented that there has been a significant rise in the wait lists for paediatrics and it is critical that the trend is reversed. The MD-ESTH stated that a detailed plan is being prepared, with a number of strands which include sensitive conversations with the local authorities and weekly meetings with the service.

Chris Elliott sought confirmation of measures to improve patient-initiated follow-up and virtual appointments by both Trusts in seeking to improve efficient use of outpatient resources. The MD-ESTH responded that PIFU rates need to improve. The Trusts have received considerable advice and guidance on usage however, there is a need to plan more explicitly, in particular in relation to consultant job plans. This is mainly as volumes are such that it is becoming a significant area of work on its own. There is growing maturity and understanding of which techniques work.

SGUH

The MD-SGUH highlighted:

There has been good improvement on ambulance handover and reduction of 12 hour delays in ED. Operations' focus remains on frailty, same day emergency care, internal professional standards and embedding the regularity of flow programme.

Improvement continues in relation to cancer two week wait performance driven by breast and lower gi. 62 day performance requires improvement and is partially linked to the need to reduce the backlog which despite going below 100 for the first time was affected by the industrial action.

Regarding diagnostic rates, 98% patients are being seen within two weeks, a driver being endoscopy progressing in the right direction of travel. Significant work continues regarding theatre utilisation which shows much improvement with Queen Mary improving to above 80%, uncapped at 88%.

The 78 week wait is now zero and the 52 week wait is ahead of the curve. The main challenge relates to outpatients waiting over 40 weeks for their first appointment. The patient transformation programme is progressing with a date to start rolling out the IT switch being discussed in light of competing IT pressures. It is expected that this will substantially support the recording and safe delivery of PIFU.

Martin Kirke queried the approach or measures taken by SGUH in particular, but also ESTH, to give confidence to stakeholders in relation to matters such as the effects of the industrial action on overall performance as against the matters that are within the organisation's control. He observed that it must be demotivating for those who are putting effort into making improvements. The MD-SGUH responded that there is currently work ongoing to review the industrial action, including loss of capacity, additional costs in terms of enhanced rates to cover Junior Doctor and nurses and catch-up costs which will require some difficult decisions for the future.

Responding to a query by Tim Wright on what progress has been made on increasing the impact on flow of ITU and bed capacity, the MD-SGUH responded that one of the impacts on theatre utilisation, lists starting late and inability to do some highly complex activity, is shortage of ITU capacity. The details of a new ITU unit which was due to be delivered in March 2023 are still being negotiated. The GCMO and the MD-SGUH and her team are reviewing alternative strategies to enhance capacity. Some small things have been identified The most impacted services, neurosurgery and cardiac surgery are both important services for SGUH. The MD-SGUH stated that she would bring a progress report to the Quality or Finance Committee to provide assurance to the Board.

The GCMO added that there has been a Never Event which involved a retained swab in maternity and confirmed that the mother and baby were not harmed.

IC

The MD-IC highlighted:

ESTH has the main responsibility for transfer of care hubs which provide for patients who are medically fit to leave hospital and facilitate their discharge back into the community in relation to the two community services which ESTH runs. This provides great insight, which is also being developed at SGUH, to understand where to focus attention to support discharges. In Surrey Downs the focus is on long term care needs when leaving hospital, the availability of care home beds and the effectiveness of processes to work with families, carers and the individual to ensure that the patient is transferred appropriately and in a

	timely way. Work is continuing with some improvements in palliative care. There is focus also on those requiring continuing day care in the community. In Sutton the focus is on patients who have historically been in hospital beds and how to provide care in their own homes, wrapping around the virtual ward and support within the community. Drawing on learning nationally around virtual wards that they cannot run in isolation, a more holistic package of care is being created. It is anticipated that this will result in a positive impact on flows through the hospital and also quality of care. In relation to the 2 hour urgent care response, the number of referrals in the Surrey Downs area and particularly from Epsom A&E has risen. A decision has been made to maintain a safe service but to absorb the number of referrals which results in a cost to the service. Other community service peers tend to close their books and not take the referrals. It is right to keep the service open and there is careful monitoring of safety and responsiveness Responding to a query from the Chairman the MD-IG confirmed that progress is being made with nursing homes at end of life as provided in the detailed report to Finance and Performance Committee. Delays in the pathway have been identified and work is continuing with local hospices and care homes to provide an increased level of support to enable them to feel able take patients with palliative care needs. **The Group Board noted the report and noted the operational performance.**	
2.3	**Finance Report (Month 12 2022 / 23)** The GCFO introduced the paper and highlighted that it updates the Group Board on the month 12 (year end) financial positions of both trusts. As a Group we are required to report the financial positions of both trusts separately. Summary information is provided in these reports given the demands of year end. The financial positions for both trusts are in line with forecast, ESTH a deficit of £35.0m and SGH a deficit of £30.0m. IC is not reported separately as it is embedded within the ESTH financial position. Both trusts have met submission deadlines to date and expect to continue to do that. Responding to a query from Stephen Collier on whether both trusts are where they expected to be in terms of balance sheet, the GCFO confirmed that they are better. **The Group Board:** **a. Noted the financial position for St George's as at Month 12 2022/23** **b. Noted the financial position for Epsom and St Helier as at Month 12 2022/23**	
2.4	**NHS Staff Survey Report and Action Plan** The GCPO introduced the report which provides an overview of the results of the 2022 NHS Staff Survey for SGUH and ESTH. He highlighted that there has been no significant change in results from 2021. The survey results are average as compared to other London Trusts. Key themes:	

- Pay: Arising from the cost of living crisis and industrial action
- Advocacy: Scores have reduced in relation to recommendations of the organisations as a place for friends and family to receive treatment.
- Protected Characteristics:
  - Disability scores are disappointing. A number of staff with a disability perceive the organisations as not making reasonable adjustments and steps are being taken to address this.
  - BAME staff, broadly, have better perception in many areas.
  - There are no significant differences in terms of gender.
  - In regard to sexual orientation, non-binary and LGBT staff felt less positive and preferred “not to say”.

Overall, given the pressure of the last year the survey results are as expected.

The Board noted that this item had been discussed in Private Board under embargo and the Chairman stated that it was essential that the important messages be discussed formally in Public Board.

Peter Kane queried whether there were any lessons learnt from UCLH who was performing in the top quartile.

The Chairman observed that UCLH may not have the same pressures as SGUH and ESTH as they are based in central London and provide tertiary services and queried whether other Trusts may be better comparators. The GCPO stated that more similar trusts will be reviewed as part of lessons learnt exercise.

Martin Kirke highlighted that in the discussion held in People Committee it was felt that comparisons with other organisations was not the best approach and that it would be a better exercise to breakdown the benchmarking by subject to get a more granular effect. In addition, in peer comparisons it is better to consider those that have managed improvements.

The Chairman queried whether there was a balance to be struck relating to what is done in regard to the Big 5 and what is actually done by teams, focussing on those areas that are struggling. The GCPO stated that every department has been broken down into the least and most engaged, to understand the rationale for the top 10 and bottom 10. He added that the Big 5 is the organisational work being done across the Trusts but there is also work being undertaken to put in place localised plans for every area against their staff survey results

The MD-SGUH added it is important to review internal scores of departments that are doing well and those that are doing less well. There is currently a triangulation exercise regarding leadership and appraisals. Some of it is not complicated or unsurprising and there is learning from services with positive scores and those at the other end of the spectrum.

The MD-ESTH stated that generally where low scores present in particular areas we need to understand the rationale for the dissatisfaction. There are some areas that are recognised as extremely challenging to work in, relating to volume and violence and aggression, which are supported as much as possible. In other areas we seek to hold leaders to account on specific things to be addressed such as working habits, constructive support or leadership as these impact on staff experience and therefore patient experience and outcomes. He added that it was good to hear the feedback from pharmacy, particularly as work

	had previously been done in response to previous staff surveys in relation to seven day working impacting on recruitment and retention. He stated that staff are held to account for improving their service not for improving their staff survey score as such with the expectation of improved perceptions of staff as a result.of services improving. Commenting on the negative position in relation to reasonable adjustments, Yin Jones queried whether there were any quick wins to raise the score. The GCPO responded that a paper, for approval, will be brought to the next Group Executive Management meeting about creating a centralised budget for adjustments, aimed at eliminating the barrier of lack of budget. The next steps will be clarifying processes and then communicating the plan working closely with staff and networks. The Chairman added that Martin Kirke, the GCPO, the AGCEO and herself are meeting informally with staff support groups and they are receiving direct feedback. **The Group Board:** **a. Reviewed the NHS Staff Survey 2022 results for both SGUH and ESTH, including the response rates, the most improved and most declined scores for each Trust, and benchmarking of the performance of each Trust against the NHS People Promise Themes.** **b. Reviewed the proposed Big 5 and impact priorities to respond to the feedback through the NHS Staff Survey.**	
3.0	**ITEMS FOR ASSURANCE**	
3.1	**Quality Committee-in-Common Report** Andrew Murray, Joint-Chair of the Committee, provided an update on the Quality Committee-in-Common meetings held in March and April 2023 and highlighted the following 3 key issues: <u>Industrial Action</u> The Committees reviewed the planning for and impact of industrial action by Junior Doctors at both Trusts in March and April and the preparations undertaken to maintain patient safety. The Committees were assured that there had been no known cases of patient harm as a result of the industrial action at either Trust and that learning has been shared across the Group. A key concern is the number of elective procedures that had needed to be cancelled and the Committees further recognised that while patients had been kept safe, the measures taken to ensure this could not be sustained on an indefinite basis. <u>Maternity Services</u> The Quality Committees-in-Common continue to review, on a monthly basis, the quality and safety of maternity services across the Group. The Committees sought assurance on the planned external review of quality and safety in the SGUH maternity unit, and on the commissioning of a Group-wide external review of culture in maternity services, which follows the recommendations of the Kirkup Review.	

	Major Trauma Services at SGUH The Committees received an update on the actions being taken to improve major trauma outcomes at SGUH and were assured that good progress is being made. The refurbished major trauma ward at SGUH will open in May. A substantive consultant appointee with an interest in major trauma has now started within the neurosurgery team and is leading on the neurotrauma workstream. Referencing the industrial action, Jenny Higham stated that the Committee saw no direct evidence of harm but it is acknowledged that there were consequences for individuals as a result of delayed procedures. The GCMO added that in reviewing harm there is consideration of an immediate link between cause and effect and the harm that happens in real time as a result of the industrial action. In relation to the Clinical Ethics Committee the GCMO stated that he recently met with the site medical directors and the Chair of the Committee to discuss direction of travel. In response to a query from the Chairman on whether there would be a joint ethics committee, the GCMO responded that there is appetite to form one. Tim Wright, in his capacity as the representative on the SGUH Ethics Committee, expressed his support. He pointed out that the Ethics Committee currently reports into PGCE, which is a SGUH group and there are also legal implications for providing advice to ESTH clinical groups. Derek Macallan stated that he has expressed a willingness to provide support work at ESTH around ethical advice. **The Group Board noted the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in March and April 2023.**	
3.2	**Finance Committee-in-Common Report** Ann Beasley, Joint-Chair of the Committee, provided an update on the Finance Committee-in-Common meetings held in March and April 2023, opening with an apology for a verbal report and highlighted the following: Financial Outturn The financial outturn is in line with the Committee's expectations. IQPR The Committee is paying particular attention to cancer performance and the Committee has received assurance of a plan to move to green. ITU Capacity The Committee was concerned with lack of progress at SGUH as it adversely impacts elective and non-elective activity. This has a consequence for finances in that if activities cannot be undertaken and targets reached then financial targets will be adversely impacted. Financial Plan The Committee has focussed on the financial plan 2023 / 24. The plan which has been put forward requires a significant delivery of CIPs in both Trusts. Across South-west London all the trusts have agreed that the aim is to deliver 5½% CIP which is at the top end of what has been delivered in recent years. She emphasised that it is important to ensure that those schemes deliver which is what will position the Trusts to deliver in the following years. The Committee has recognised that this requires more detailed scrutiny for of the plans and their	

	delivery particularly in the early months of the year taking into account scrutiny from the ICS and London Region and London NHS. Group Corporate Services Review Referring to the length of time to deliver against targets and that targets were not always clear, and recognising that the review is being overseen by People Committee, the Finance Committee is taking a close interest in delivery of savings. **The Group Board noted the issues escalated by the Finance Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in April 2023.**	

3.3	**People Committee-in-Common Report**
	
	Martin Kirke, Joint-Chair of the Committees, provided an update on the People Committees-in-Common meetings held in March and April 2023 and highlighted the following 3 key issues which are the highest areas of risk:
	
	Industrial Action
	
	The Committees have received assurance that robust measures are being taken to minimise risk in the context of the impact on staff, rather than the operational position. The Committee has considered and recognised stress impacts amongst staff such as for those taking on roles they are not familiar with, as in the case of consultants covering for junior doctors. The stress and the psychological impact for those taking industrial action whether they wish to or not and divisions within the workforce were also considered. The Committee also noted support from HR to line managers in regard to advice relating to ER legislation and working arrangements.
	
	Diversity and Inclusion
	
	A national issue, the staff survey provides a familiar and frustrating picture. Historically, diversity and inclusion has suffered from long action lists which become difficult to review. The Committee has been encouraging a more evidence-based approach to consider what works and the data which underpins that and a concentration on fewer actions to support that approach. The Committee has suggested that the key data, in the WRES and WDES, is produced quarterly rather than annually.
	
	Recruitment and Retention
	
	The Committee has noted the enormous hidden cost in terms of staff time to recruit and replace which has a negative impact on productivity and quality. Whilst the Committee has received assurance on the volume of work being done in this area, of benefit would be shorter action lists and a more evidence-based approach, with an improvement in data quality and triangulation of data.
	
	Stephen Collier added in relation to SGUH that:
	
	• The Covid19 pandemic adversely impacted two areas:
	  ○ The well-formed pre-pandemic programme of job planning activities for consultants which it is anticipated will take 2 – 3 years to now progress; and
	  ○ The initiative to broaden the pool of consultants who were being encouraged to apply for a Consultants Excellence Award.
	• The joint bank project is continuing well and illustrates the benefit of being a group and also the limitation of one trust providing services to another. There is a need for arms-length separation and negotiation as	

	services need to be delivered well. The Committee is receiving regular assurance on this critical issue. • The group consolidation programme is being viewed from both People and Finance Committee and the commonality of membership within both groups ensures an internal consistency of discussion recognising the focus is different as aligned to each Committee's terms of reference. Ann Beasley observed that in relation to job planning that three years was an inordinately long period of time given that it had been discussed for three years already at SGUH. Referencing the extra work that the Committee has asked for in relation to financial consequences of some of the HR processes in recruitment and retention that drives the need for agency staff, she queried what was being done to fill vacant positions arising from sickness. The GCPO stated that there has been an improvement of sickness rates, particularly at SGUH. The Committee will continue to receive reports on plans for management of sickness. **The Group Board noted the issues escalated by the People Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in March and April 2023.**	
3.4	**Audit Committee Report (SGUH)** Peter Kane, Chair of the Audit Committee, provided an update on the Audit Committee meeting held in May 2023. The Committee received a good level of assurance on the last financial year and is planning ahead for 2023 /24, to include the transition to a single Group internal auditor being RSM. The current arrangement of a single Group external auditor, Grant Thornton, is working smoothly. Highlighted were: <u>Annual Report</u> The DCE is currently developing the annual report. The Committee has noted a greater commonality across the ESTH and SGUH reports. The report provides a robust picture of the Trust's current position, achievements and future plans. <u>External Audit</u> The Committee received assurance of good collaboration by the GCFO and the Finance team. A single auditor to undertake the production of a VFM report alongside the audit, for each Trust, supports a joint approach. <u>Internal Audit</u> The 2022 / 23 plan has been completed successfully. There are some recommendations for improvements but no major issues. The Head of Internal Audit produced an annual opinion which is likely to provide moderate assurance. It is felt to be a good outcome and following up from the recommendations has been working well and there are few outstanding actions. The 2023/24 Audit plan has engendered significant discussion at group level because of the transition and the limited time to finalise the plan. There has been good progress but some further iterations are expected in order to ensure	

	a balance between getting best value from the work across the Group alongside the assurance needed for SGUH. Counter-fraud The external auditors have advised substantial assurance. Cyber The dashboard being developed is still a work-in-progress and the Group Chief Digital Officer will be reporting to the Committee and will be working closely with Tim Wright. Committee Effectiveness Report The Committee will undertake a review in six months to consider whether it needs to constitute as a Committee-in-Common next year. Chris Elliott queried the value added by both Trusts having common auditors. Peter Kane responded that both Trusts will benefit from a more consistent approach in relation to reporting including VFM reports. In addition, it is expected that the auditors will highlight good practice within the Group and that there is added value in RSM being internal auditors for most of the South-west London trusts including the ICS such that they will provide, to the Group, best practice learning and outcomes from peers. Stephen Collier observed that although the annual accounts are not for filing and they have no statutory value as a set of group accounts they would be an interesting expression of the activities of the Group. The GCFO responded that this would attract considerable resource to undertake. **The Group Board noted the issues escalated by the SGUH Audit Committee to the Group Board and the wider issues on which the Committee received assurance in May 2023.**	
3.5	**Audit Committee Report (ESTH)** Peter Kane, Chair of the Audit Committee, provided an update on the Audit Committee meeting held in May 2023. The Committee received a good level of assurance on the last financial year and is planning ahead for 2023 /24, to include the transition to a single Group internal auditor being RSM. The current arrangement of a single Group external auditor, Grant Thornton, for this year is working smoothly. Highlighted were: Annual Report The DCE is currently developing the annual report. The Committee has noted a greater commonality across the ESTH and SGUH reports. The report provides a robust picture of the Trust's current position, achievements and future plans. External Audit The Committee received assurance of good collaboration by the GCFO and the Finance team. A single auditor to undertake the production of a VFM report alongside the audit, for each Trust, supports a joined approach. Internal Audit The 2022 / 23 plan has been completed successfully. There are some recommendations for improvements but no major issues. The Head of Internal	

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3.6	**ESTH Estates Assurance Committee Report** Ann Beasley, Chair of the Committee, provided an update on the Estates Assurance Committee meeting held in March 2023 and highlighted the following: <u>Deep Dive – Medical Engineering</u> The Committee received the outcomes of a Deep Dive into Clinical Engineering Medical Devices. <u>Outstanding Areas for Deep Dive</u> The Committee has two further areas to address, namely: • Decontamination; and • High Voltage Electrical Safety	

	Summary and Forward Plan of the Committee The Committee has met six times in the last year and has reviewed a number of areas but some of the early areas require further work. Moving forward, the Committee will revisit the actions from those early areas to discuss and assess whether planned mitigations are now sufficiently established in order to hand over routine monitoring to the Finance Committees-in-Common. BYFH Delays The continued delay in the start of the new hospital is having a significant impact on the existing estate. The Committee is of the view that a robust review of how the estate will withstand the delays needs to occur in conjunction with the BYFH programme which can practically be done by holding the two meetings together. Tim Wright queried whether there was an opportunity to bring both Trusts together is a way that allowed for shared learning through the office of the GCIFEO. The MD-ESTH responded that the GCIFEO would prepare the agenda in terms of the way he structures the functions and is already actively engaging in ensuring shared learning for both Trusts, such as sharing of the learning from the recent CQC inspections. **The Group Board noted the issues escalated by the ESTH Estates Assurance Committee to the Group Board and the wider issues on which the Committee received assurance in March 2023.**	
3.7	**Sutton Health and Care and Surrey Downs Health and Care Partnership Boards Report** Chris Elliott provided an update on the Sutton Health and Care and Surrey Downs Health and Care Partnership meetings held on a monthly basis and in introducing his report, emphasised the commonality between the two alliances, their aims and methods of working. Both alliances came within their budgets for the financial year 2022 / 23 and they have progressed their calculations for meeting mandatory constraints for 2023 / 24. In addition, planning being advanced for anticipated but yet unknown dates for CQC visits. A CQC visit is planned for children with educational needs at Sutton. The staff survey for Surrey Downs is now on the Integrated Risk Register as a tool to be used to improve recruitment and retention to reduce the current high vacancy rate. **The Group Board noted the issues escalated by the Partnership to the Group Board and the wider issues on which the Partnership received assurance in their last monthly meetings.**	
4.0	**ITEMS FOR NOTING**	
4.1	**Healthcare Associated Infection Report** The GCNO introduced this report which provided a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level with a particular focus on: • Covid-19 • *Clostridioides difficile* (C diff) • MRSA Bloodstream Infections	

	• Gram Negative Bloodstream Infections • Healthcare Associated Infections • Hand Hygiene Compliance • IPC MandatoryTraining including Fit Testing The report supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts. The GCNO added that for the third year in a row ESTH have had 0 MRSA vancomycin resistant infections and that SGUH this has reduced significant to 1. The Board congratulated the hard work of the team and the effort that has been made to reduce the numbers. **The Board noted the update.**	
4.2	**Gender Pay Gap Report** The Board received the Gender Pay Gap report prepared in line with the Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 which require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is required to publish information on their website. This report captures data as at 31 March 2022 for the Group. In light of the deadline for publication, at their meetings in March 2023, the Trust Boards of SGUH and ESTH each agreed to delegate to the People Committees-in-Common authority to review and approve for publication the data. The Committees reviewed this report at their meeting on 10 March 2023 and the data for each Trust has been submitted to the Government portal and published on the respective Trust websites. **The Group Board:** **Noted the mean and median gender pay gap positions for SGUH and for ESTH as at 31 March 2023.** **Noted the trend overview in respect of the gender pay gap position for each Trust.** **Noted that the People Committees-in-Common discharged the delegation of authority from each of the two Trust Boards to approve the submission and publication of the gender pay gap data for each Trust ahead of the deadline of 31 March.**	
4.3	**Fit and Proper Person Test Compliance** The Board noted that the fit and proper person regulation (FPPR) came into force for all NHS organisations in November 2014 and requires organisations to seek assurance that all executive and non-executive Directors are suitable and fit to undertake the responsibilities of their role. The Care Quality Commission (CQC) holds NHS Trusts to account in relation to FPPR.	

	During 2022 a review was undertaken of each Trust's records to seek assurance that the Trusts were able to demonstrate compliance with the regulation. The review originally identified a small number of gaps which have been investigated further with remedial action taken. It also identified some opportunities for improving the verification of self-declaration information. This has included the collation of all relevant documentation (arising from direct liaison with relevant Board members), the centralisation of all electronic records and a review of both Trusts' procedures. Following a recent audit at both Trusts, it was concluded that there was substantial assurance in the management of this procedure. **The Group Board noted the compliance of SGUH and ESTH with the Fit and Proper Person Regulations.**	
4.4	**Group Board Arrangements** The Board received the report that set out the arrangements for the establishment of a "Group Board" between SGUH and ESTH by means of establishing a committees-in-common arrangement, which were agreed by the Board of Directors of each Trust on 6 and 28 April 2023. Under these arrangements the Trust Board of SGUH and the Trust Board of ESTH has each established a new "Group Board" committee, the "Group Board (St George's)" and the "Group Board (Epsom & St Helier)" respectively. The new Group Board committees are formally constituted as committees of the SGUH and ESTH Boards. The Committees will act under delegated authority from, and at all times remain accountable to, their respective 'parent' Trust Boards. All business conducted by each Committee will be conducted in the name of the respective Trust. In practical terms, however, the two Group Board committees will, together, effectively manage both Trusts within the Group. To give effect to these arrangements, both Trust Boards have delegated authority extensively to their respective Group Board committee. This will both empower the Group Board Committees to operate with maximum authority and discharge many of the responsibilities currently exercised by the sovereign Trust Boards. The Board noted the practical arrangements that will govern the way in which the Group Board will operate in practice, including a new Group report template already agreed and introduced. The proposals set out in the report build on previous discussions and decisions of the two Boards. In particular, the proposals reflect the commitment in the Strategic Case for the establishment of the Group that "while individual board would be retained in statute, as much decision-making as practicable would take place via either a Board meeting 'in common' or a sub-committee 'in common'. They also reflect the decision by the Boards in October 2022 to commence Group Board meetings in 2023/24. The proposals had been reviewed in detail by Capsticks, and the legal advice obtained confirmed that the arrangements proposed were appropriate and robust within the existing statutory and regulatory framework. **The Board noted the Group Board arrangements that have previously been agreed by the Board of Directors of SGUH and ESTH, which are presented here for the purposes of public transparency as to these arrangements.**	

5.0	CLOSING ITEMS	
5.1	**Any new risks or issues identified** There were no new risks or issues identified for escalation to the Corporate Risk Register.	
5.2	**Any Other Business** There was no other business.	
5.3	**Reflections on meeting** **ESTH** The MD-IC provided her reflections on the meeting and highlighted: • As the first meeting of two unitary boards meeting as a Board-in-Common the board appeared to work cohesively as one unitary board but with clear focus on the two organisations that each sovereign board is responsible for. • The Executive were clear about their roles and responsibilities. • The meeting flowed well and was assisted by good communication between Executive colleagues and the NEDs. • The Chairs of the Committees reported on their items clearly and eloquently focussing on the separation of powers between the two Trusts but also the commonality of the Group. • Timing could have better allowed room to allow for balance of conversation as there were some areas where conversation went on longer than required and other areas the meeting felt rushed. • The feedback visits created energy and enthusiasm but a clarity of focus on what the Board wants to achieve from the reporting from the visits would be helpful. **SGUH** Tim Wright provided his reflections on the meeting and highlighted: • It was good that the first Group Board meeting was held at St. Helier. • The formula of topping and tailing the meeting with visits and the patient story grounds the meeting, is a powerful construct and provides insight to NEDs who would not otherwise get those. • The room is fit for purpose and notwithstanding the outside noise and the difficulties with the PA system, the acoustics work well. • The new style of the papers works well, particularly breaking out the sections by colour and being explicit about items for noting, review and assurance. • The line on the Cover Sheet, “This paper has been considered before by:” is powerful and it aids in focussing the Board’s mind that many of the papers are already familiar and this is reflected in the depth of challenge to the Executive at Board meetings as robust challenge has usually been received at Committee. • Some of the papers were late which makes it difficult for NEDs to review all of the material.	

	• The Board appeared to be polite in their deliberations regarding the item in relation to the IQPR and the check and challenge could have been more in-depth although the Committee chairs were questioned rigorously to provide assurance around their items. • A very effective meeting.	
5.4	**Patient / Staff Story** The Group Board welcomed Lucy Botting Director of Sutton Health and Care, Sara Fenner, Head of Urgent Care and Facilitated Discharge and Robert Odes, ESTH Frailty Consultant. The story provided the Board with an insight into the Sutton Virtual Ward, the alliance partnership arrangements between Sutton Health and Care, the GP Federation and ESTH and described how the ward functions and delivers care closer to home. The story also described how the ward works in synergy with other services across Sutton Health and Care and within ESTH. The presenting team provided a narrative of the patient cohort that the team takes onto the ward (referral criteria) and evidenced the impact the virtual ward has made through activity data. The Board received a video which highlighted how professionals including GPs, pharmacists and ESTH have found care on the ward and a patient experience story evidencing further impact. **Consent** Patients featured in the video gave their consent for their stories to be shared, understanding the board meeting is public and recorded. Andrew Murray observed that the virtual ward is impressive and appears to work well for patients. He queried how the presenting team was able to engage with GPs and receive 100% buy in from PCNs and practice managers and whether there was a resource implication. Lucy Botting responded that in the first six months that the virtual wards have been in development there were challenges with engaging fully with GPs, with 30%-40% buy in. GPs have found the structure of the virtual ward easy to navigate and have appreciated the range of professionals available such as frailty consultants, nurses who deliver care and pharmacists but over time it has taken effort and goodwill. Andrew Murray also requested an insight, which could assist learning for SGUH in their journey in regard to virtual wards on how the team are ensuring GPs take responsibility for patients, whether it is avoiding admission or an early discharge and for confirmation on how that is working, particularly in relation to the priorities with discharging patients with complex needs. Robert Odes referenced a comment made in the video that the amazing thing about the virtual ward was that it provided continuity of care between hospitals and GPs and explained how that GPs have stated that they feel safer in virtual ward rounds, even with complex patients. The virtual ward also allows for ease of patient moving into the community. The MD-SGUH stated that it is important that SGUH provides an equivalent service and that the difference to people's lives made by the service was profound. She queried the balance between the risk threshold and trying to get patients discharged early. James Blythe stated that there is more work to be done in this regard, particularly in relation to patients with higher care dependency and the link into social care and reablement becomes a potential	

	constraint which requires another level of co-ordination. Lucy Botting stated that there is still more to do by building trust, going to ward rounds and driving more innovative solutions. Referencing a visit to Buttercup Ward, a short term ward run by GPs, which was also an excellent model for bridging which mirrors the virtual ward, Derek Macallan queried whether the team works with Buttercup. Lucy Botting responded that they work well with that ward providing therapy and work closely with the PCNs and staff through the in-reach virtual ward clinicians. The Chairman added that the virtual ward could be exploited more by the hospital and it seems that the hospital staff need to develop more confidence in handing patients over. James Blythe observed that during the Junior Doctor Industrial Action there were different patterns of admission to the virtual ward which raised the issue of training, as a graduate training provider. He added that the scheme at Buttercup Ward was short-term and that national funding is being pursued to extend the model. The Board thanked the team for sharing their perspectives.	
	CLOSE	
Date of next meeting: 10 am on 7 July 2023, Hyde Park Room, St. George's		

The meeting closed at 13:00

Group Board (Public) - 7 July 2023

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC220901.1 *(Transferred from SGUH Board Action Log)*	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	GCMO and GCNO to provide verbal update at meeting. **Previous update (5 May 2023):** The GCMO stated that meetings with key departments are ongoing to consider how to better support staff. A recent meeting with the ED at SGUH provided practical suggestions relating to security and the wearing of body cameras. It was agreed that the GCMO would provide a further update at the next Board meeting and that someone would liaise with the Dialysis Unit to assist with an immediate response to an issue which has arisen there.	**DUE**
PUBLIC230505.1 *(GESH Board Action Log)*	5 May 2023	2.1	Maternity Services Report	GCMO to provide a report to the Group Board further to the commissioned appointments for the investigation review regarding data at SGUH and culture within maternity services at ESTH and SGUH.	5 Jul 2023	GCNO	GCNO to provide verbal update at meeting on the progress of the external reviews into culture and data in maternity. The Maternbity Services report at item 3.1 on the Group Board agenda provides an update that the external review into the MBRRACE-UK stillbirth rate and neonatal death rate at SGUH has commenced and that the report is expected to be received in September 2023.	**DUE**
PUBLIC230505.1 *(GESH Board Action Log)*	5 May 2023	2.1	Maternity Services Report	Line to be added to the Maternity Services Report to reflect the number of live births per year, which would highlight successes.	5 Jul 2023	GCNO	GCNO to provide verbal update at meeting. Data on the number of live births per year has not yet been added to the Maternity Services Report.	**DUE**
PUBLIC220901.3 *(Transferred from SGUH Board Action Log)*	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 / GCNO	**Update on 5 May 2023:** The GCMO and the GCNO shall provide a regular report to Quality Committee as part of the Infection Prevention and Control Report. The item was proposed for closure. Initial indications as to how this reporting could work have been presented to the Quality Committee in draft. Action transferred to the Quality COmmittee action log.	**PROPOSED FOR CLOSURE**

Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	1.5	
Report Title	**CEO Report**	
Executive Lead(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Report Author(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Previously considered by	n/a	07 July 2023
Purpose	**For Noting**	

Executive Summary

A summary of key events over the past two months to update the Board on strategic and operational activity at across the St George's, Epsom and St Helier University Hospitals and Health Group, including:

- NHS 75th Anniversary celebrations;
- Operational updates, including Mental Health pressures in Emergency Departments;
- NHS Assembly Long-term Plan & NHSE Long-term Workforce Plan;
- An update on the PTC for Paediatric Cancer; and
- Events, Awards and Appointments.

Action required by Group Board
The Board is asked to note the report.

Committee Assurance	
Committee	N/A
Level of Assurance	N/A

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

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

1.0 Purpose of paper

1.1 To provide an update to the Board on Trust activity over the past two months.

2.0 Background

2.1 Regular update to the Board.

3.0 Leadership and Group Update: Introduction

3.1 Firstly, I am delighted to be back. I would like to take the opportunity to thank you all for your well wishes whilst I was off. It is great to be here with you all, and I look forward to taking you through an update on the Group today and the top priorities that I, and my Executive Team, are tackling. This is a special month as we celebrate the NHS's 75th anniversary on 5th July with a number of festivities to honour our hard-working staff, and also take stock of where we are as an organisation – and our priorities for the future.

3.2 I want to take this opportunity to thank all of our teams for everything they do. Our entire staff of 17,000 - from the cleaners and porters, to the nurses and doctors, to the administrative and corporate teams – are all working hard under continuing challenging circumstances to deliver the very best care for our patients. The NHS relies on the sheer hard work and compassion of our staff, and these moments are crucial for giving thanks and praise to the teams, and to recognise their hard work. This week the Chairman and I, as well as the rest of the Executive Team, have been out and about throughout all of our Sites to deliver cakes to staff, talk with them about their experiences, and thank them for their service. We have also got a number of celebrations planned across the organisation, including big tea parties, NHS choir performances, and planting trees to support our green plans.

4.0 Operational Update: Mental Health & Emergency Departments

4.1 Giving thanks to our staff is more important than ever. Our systems are under strain and operationally, I wanted to inform you of the particular and acute pressures that our Emergency Departments are facing at the moment, including with high attending numbers of mental health patients - both adults and children. We all recognise that an Emergency Department is often not the right place for someone experiencing a mental health crisis. Following a surge in mental health patients in June, I called a number of our system and community partners, including the Borough Police Commander and leaders of Local Authorities, to discuss ways of tackling this challenge, together. We are working on collective solutions to this complex problem urgently, and I look forward to reporting on new actions that will seek to ensure that these patients receive the right care, in the right environment.

4.2 Additionally, there has been ongoing industrial action over the past two months – with more scheduled for later this month. We continue to plan for, and mitigate against, the risks posed by these strikes to ensure all patients are treated safely. As the industrial action continues over a sustained period, it is becoming harder each time to recover from the impact on our elective activity.

5.0 Balancing Our Priorities: Finance, Quality, Performance and People

5.1 My Executive Team and I continue to balance the key goals of the Trust. Financial activity remains a key focus and additional measures are underway to ensure our budget is appropriately controlled, with more detail to come later from Chief Finance Officer, Andrew Grimshaw. Whilst we continue to prioritise our finances, we always balance this with our operational delivery, commitment to the highest quality of care and supporting our workforce throughout. Our Group Chief Nursing Officer Arlene Wellman will update us on our work with the CQC regarding their recent report on St George's maternity services, and the important work underway to address the challenges identified.

6.0 The NHS's Long-Term Plan

6.1 At the National Level, I also wanted to update you on important developments for our long-term priorities. To commemorate the 75th anniversary, the NHS has taken the chance to review priorities and the NHS Assembly published the long-term plan for the NHS, which considers where the NHS has come from, where it is now, and where it is going. As part of this, the report outlines three fundamental shifts that the NHS is experiencing, pushing it in the right direction to meet the needs of the population, which are: 1) Preventing ill health; 2) Personalisation and participation; and 3) Co-ordinated care, closer to home. This plan also outlines 'enabling conditions' for these shifts to be fully realised, including:

- A thriving workforce and better supported carers, in line with the Workforce Plan.
- Stronger partnerships with others.
- Better use of digital technology and data.
- A modernised infrastructure, particularly in primary care, supported by a long-term infrastructure plan.
- Maximising the value of care and treatment, alongside greater efficiency.
- Creating a well-led, learning, and self-improving service.

7.0 The Long-Term Workforce Plan

7.1 This long-term plan is very useful in articulating the vision for the NHS at this juncture, and the key priorities to reach our goals. As one of the first concrete actions plans to emerge from this vision, on 30th June, NHS England published its Long-term Workforce Plan. This is an important publication, which outlines the key drivers of change and the core priorities for addressing the demographic shifts in our society.

7.2 Currently, local NHS services are reporting vacancies totalling over 112,000. This reflects changes in the needs of our population, but also crucially that better public health has led to a dramatic increase in life expectancy. This development is pivotal to the overall changes required from the NHS, as by 2037 the population over 85 years old is estimated to grow by 55%. NHSE has estimated that this may lead us to a significant shortfall of staff with the right skills and experience.

7.3 The Long-term Workforce Plan talks about three overall aims: To train; retain; and reform. The plan outlines the following details underpinning these goals:

- **Train:** Significantly increasing education and training to record levels, as well as increasing apprenticeships and alternative routes into professional roles, to deliver more doctors and dentists, more nurses and midwives, and more of other professional groups, including new roles designed to better meet the changing needs of patients and support the ongoing transformation of care.

- **Retain:** Ensuring that we keep more of the staff we have within the health service by better supporting people throughout their careers, boosting the flexibilities we offer our staff to work in ways that suit them and work for patients, and continuing to improve the culture and leadership across NHS organisations.
- **Reform:** Improving productivity by working and training in different ways, building broader teams with flexible skills, changing education and training to deliver more staff in roles and services where they are needed most, and ensuring staff have the right skills to take advantage of new technology that frees up clinicians' time to care, increases flexibility in deployment, and provides the care patients need more effectively and efficiently.

8.0 Regional CEOs Meeting: Hosted at St George's

8.1 I hosted the Regional CEOs meeting here on 22nd June, it was a pleasure to have close to 50 NHS CEO's here at St George's to attend the monthly CEOs meeting chaired by Caroline Clarke, NHS England's Regional Director for London. We discussed important issues of the day, including interpreting the NHS's Workforce Plan for the London Region and discussing collaboration across Integrated Care Boards. We discussed five over-arching priorities for London, including:

- Develop one sustainable health and care workforce for London.
- Support Integrated Care Systems to deliver for their populations.
- Maximise the London People Board's influence for our workforce.
- Creating a more equitable culture in health and care.
- Advocate for London as a digital global city in a competitive world.

8.2 I will continue to keep you updated on this important work.

9.0 Group Strategy Launch: gesh CARES

9.1 As you know, on 15 May we launched our five-year Group strategy – a crucial pillar for driving forward greater collaboration across our family of hospitals and community services.

9.2 In developing this strategy, we engaged with hundreds of our patients, staff and partners about how we can provide the best possible care across the Group, and remain ready for the future as demand for our services grows.

9.3 Our vision for 2028 is to provide outstanding care, together. We have four aims – our CARE objectives – to guide us and help us achieve this: Collaboration and partnership; Affordable services, fit for the future; Right care, right place, right time; Empowered, engaged staff. Underneath our CARE objectives are corporate strategies and nine long-term strategic initiatives that will help us deliver outstanding care, together.

9.4 As well as the strategy document itself, we produced a summary, plus a short animation explaining the main aspects of our vision and priorities, and these have been widely viewed by staff and stakeholders. Our focus will now turn towards embedding the strategy and its aims across the Group via all our channels, and sharing progress by using case studies and filmed content. As part of this, implementing the strategy will form a key part of our management awayday in September, which will include approximately 100 leaders from across the Group.

10.0 Consultation for the Principle Treatment Centre for Paediatric Cancer

10.1 As we have previously discussed here at Board, the future of the Principal Treatment Centre (PTC) for children's cancer services – which we currently provide in partnership with the Royal

Marsden - is under review by NHS England. NHSE will decide between two possible outcomes after an upcoming 12-week public consultation. The options are either that St George's becomes the sole provider of paediatric services for the region, or the entire service moves to the Evelina, managed by Guy's and St Thomas'. On 29th June we hosted a staff engagement event, led by Kate Slemeck, Managing Director of St George's, and NHSE representatives. This was a lively and productive session at which staff were able to ask questions and hear from NHSE on the process, which has been delayed to consider all the input. Staff expressed concerns around the consultation process, and the fact that some factors were not being given enough importance in the scoring and evaluation that has taken place so far, particularly that St George's has been delivering the service for so long and has such deep expertise.

10.2 Our staff have been providing children's cancer services for decades and are passionate about the quality and safety of the future service. Our teams raised with NHS England the risks of patient harm which would need managing under a model where the PTC is not on the same site as neurosurgery, such as the Guy's and St Thomas' model, but which would not occur if the PTC and neurosurgery were co-located as it would be with St George's. NHS England reassured our staff that this would be considered in the consultation process.

10.3 Until a final decision is made, St George's continues to provide an outstanding service to children with cancer and continue our research collaborations by enrolling children into new studies.

10.4 More broadly, we have been making use of all of our communications channels to promote #KidsDeserveStGeorges – our campaign to keep the services at St George's which we genuinely believe is the best outcome for children and their families. We recently welcomed Cllr Simon Hogg, Leader of Wandsworth Council and Cllr Graeme Henderson, Cabinet member for Health on a tour of our paediatrics team. They visited Pinckney Ward, Paediatrics Intensive Care and the Clinical Research Facility. Kate Slemeck and Dr James Marsh led the visit, and introduced both councillors to our paediatric and research clinicians as part of our stakeholder engagement.

11.0 Group-wide Awards

11.1 We are very proud to update you that there have been a number of awards and accolades in the last two months.

- **NHS Parliamentary Awards**
- The NHS Parliamentary Awards are an opportunity for local MPs to engage with NHS Trusts in their constituency and to put forward staff who are going above and beyond for a prestigious award. We are absolutely thrilled that we have been shortlisted in 2 categories this year – congratulations to our Homelessness Inclusion Team and to Charmaine Case, who have been nominated respectively in the Urgent and Emergency Care and Lifetime Achievement categories.
- **Asian Women of Achievement Awards**
- We are delighted that Ediscyll Lorusso, Senior Thrombosis Specialist Nurse Practitioner, was recognized at the Asian Women of Achievement Awards which celebrate multicultural Britain and the contribution of diverse cultures and talents to UK society. Edi was a finalist in the "Professions" category - which recognises women who have trained and qualified in their chosen professional practise and have become a leading practitioner.
- **Patricia Yiggon receives Royal College of Nursing Award**
- Earlier in the year the Royal College of Nursing (RCN) celebrated the dedication of their outstanding RCN reps, active members and forum members who've made a significant contribution to the nursing profession. We're so proud of Patricia Yiggon, Gynaecology

Nurse, who was awarded a certificate of merit for outstanding service to members of the RCN in the London Region. Great work Patricia.

- **Mohammed Radha, Healthcare Assistant, SWLEOC, attended the King's Coronation**
- At the start of May, Mohammed Radha, one of our outstanding healthcare assistants from Oak Ward (SWLEOC), was invited to the King's Coronation Ceremony May at Westminster Abbey for this historic occasion. Last year, the late Queen Elizabeth II awarded him an Order of the British Empire Medal for his contributions to the NHS and the Covid 19 pandemic.
- **Remembering Dr Allan Seraj**
- We remembered and celebrated the late and much-missed Dr Allan Seraj in June. Friends and colleagues of Allan participated in The Seraj Stroll, from St Helier Hospital to Epsom Hospital, to raise funds for the Dr Allan Seraj Scholarship Fund. This was set up in memory of Dr Seraj and enables internationally educated nurses (IENs) to apply and bid for funding to attend conferences, courses and seminars relevant to their career development. More than £500 has already been raised.

12.0 Group-wide Events

12.1 We have held some wonderful events recently, below are a few examples.

- On 21 June we celebrated **national Estates and Facilities Day**. Events and celebrations included an open staff party at each site visited by Senior Leadership to thank and honour our staff. We also had fun events, including a visit from a Harris Hawk display from Zeus, who patrols the skies helping with pest control by deterring pigeons and seagulls. London Fire Brigade also parked up outside Ferguson House giving staff the chance to check out a fire engine and parked up alongside was one of the High Dependency Unit Vehicle. Staff could also test their your knowledge on a number of subjects such as health and safety with a "Spot the Hazard" quiz and there were hands-on experiences as well, including vintage telephone equipment, plus displays and information with the latest news on our Building Your Future Hospitals programme.

- On 22 June, Richard Meddings, Chair of NHS England, was hosted by our Chairman and our Managing Director for Integrated Care at Surrey Downs Health and Care and Surrey Heartlands, including a focus on our specialist Emergency Frailty Service.

- Councillor Ruth Dombey, Lead for Sutton Council, visited twice at the end of June:
    - The first visit was hosted by Sutton Health and Care, highlighting the work of our community teams, and also including a visit to St Helier to see some of the areas of investment.
    - The second visit was at St Helier, to mark the start of our NHS 75 celebrations. Cllr Dombey and her team were met by site Managing Director James Blythe and six of our longest-serving staff and presented 'Thank you Epsom St Helier' gratitude books, where the local community have recorded their thoughts and thanks for our staff.

- **gesh *on your bike* day:** At the start of June our hospital group hosted its first-ever active travel day. Employees at St George's, Epsom and St Helier were encouraged to travel to work by bike or their preferred choice of active travel. We hosted the Mayor of Wandsworth at St George's, and were also excited to be visited by Olympic gold medallist Joanna Rowsell. We also saw a number of stalls from local community groups in our main reception.

- **Excellence in education awards:** Our Postgraduate Medical Education team recently hosted their annual Excellence In Education awards at AfC Wimbledon, recognising colleagues' contributions to education and training. The event gave staff an opportunity to showcase their work and innovation with a poster judging competition.

13.0 Appointments

13.1 I am delighted to announce that we have recently appointed Anna Macarthur as our Group Chief Communications Officer. Anna has been leading our Group Communications function as Director of Communications since September 2021, and has done a wonderful job of drawing her team together across the Group and delivering a number of high profile campaigns for gesh. We welcome Anna to her new role, and very much look forward to working with her in her new capacity. Congratulations, Anna, from us all!

Group Board

Meeting on Friday, 23 June 2023

Agenda Item	2.2	
Report Title	**Public Sector Equality Duty (PSED) Reports**	
Executive Lead(s)	Paul da Gama, Group Chief People Officer	
Report Author(s)	Sandra Ovid (ESTH Report), Joseph Pavett-Downer (SGH Report)	
Previously considered by	N/A	
Purpose	**For Approval / Decision**	

Executive Summary

As public bodies the Trust are required to publish equality information to demonstrate how they complied with the 'general' and 'specific' duties of the public sector equality duty (PSED). The PSED Report incorporates information in relation to both Patient and Workforce equalities.

Furthermore, the Equality Act describes that meeting different needs includes (among other things) taking steps to consider the needs of those with disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups/committees. It explains that compliance with the general equality duty may involve treating some people more favourably than others or taking steps to offer specific levels of support which help some communities access services or improve health outcomes (though only if permissible otherwise under the Act).

The PSED demonstrates our compliance by using information from standalone equality reports such as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). It also includes the Gender Pay Gap data and our Equality Delivery System (EDS). In relation to Patient or Health Equalities, we are asked to spotlight any services that help to demonstrate compliance with both the general and specific duties of the PSED.

These reports provide an overview of ESTH and SGH's ongoing commitment to inclusion and the activities taking place which we hope have improved staff and patient experience. As a result of these activities, we are able to provide a demonstration of compliance with regards to the Public Sector Equality Duty. Whilst there is a significant amount of work still to be done, both trusts can show that it is linking its work with the general duties and identifying areas for improvement.

The continued focus on the Culture Development (Big 5)' priority areas (see separate report) is very supportive of ED&I Adopting a group wide approach and sharing best practice will help to provide a more equitable experience for our workforce. There are remaining challenges and areas for improvements in relation to EDI, most notably in relation to the collection of reliable and consistent patient demographic data (on protected characteristics and health outcomes). Strengthening this area will enable St George's to better understand the experience of patients from marginalized communities and introduced targeted approaches and robust governance processes.

Action required by Group Board

The Board is asked to:

a. Review the reports.
b. Approve the reports for publication on the Trust websites.

Committee Assurance	
Committee	People Committees-in-Common
Level of Assurance	Substantial Assurance: The report and discussions assured the Committee that there are robust systems of internal control operating effectively to assure that risks are managed effectively

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	ESTH PSED Report
Appendix 2	Appendix 1 PSED (ESTH) - Workforce, Recruitment and Starters & Leavers Data Analysis
Appendix 3	Appendix 2 PSED (ESTH) - Patients, Services and Health Inequalities
Appendix 4	SGUH PSED Report

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications

Legal and / or Regulatory implications

This report ensures the Trust fulfils its legal obligations in relation to public sector equality duty (PSED)

Equality, diversity and inclusion implications

This paper sent out what the trust has delivered in relation to its duties as a public sector organisation in relation to ED & I.

Environmental sustainability implications

There are no environmental sustainability implications

Public Sector Equality Duty
Group Board, 07 July 2023

1.0	**Purpose of paper**
1.1	The demonstrate the actions taken by both Trusts in relation to their Public Sector Equality Duty as set out in the Equality Act 2010.
2.0	**Background**
2.1	The report sets out a range of actions, activities and initiatives that have been delivered in 2022/23 by both Trusts in order to fulfil their legal obligations. The report will be edited to produce a publication that will be place do the Trust's websites and available for all members of the public and organisations.
2.2	The report contains both Trusts reports which will need to be published separately on the Trust websites.
2.3	The GESH Group does not have a legal obligation to publish a PSED report as it is not a legal entity in relation to the Equality Act 2010.
2.4	The reports were reviewed at the People Committees-in-Common on 23 June and approved for submission to the Group Board.
3.0	**Analysis**
3.1	The report draws upon qualitative and quantitative data on the three areas of workforce, patients and health inequalities. The data shows the reported position on a range of issues in the three areas and also provides in many cases a descriptive narrative of the actions.
3.2	There has been collaboration on the reports between Epsom and St Helier and St George's. Epsom and St Helier have previously completed and published a PSED and this experience has been helpful to St George's. In order to respect the individual Trust's separate legal status it has been considered prudent and respectful to not follow exactly the same template for the report. Consideration can be given to a common template for future publications.
4.0	**Sources of Assurance**
4.1	Workforce data
4.2	Population data
4.3	Patient data (although further work is needed in some areas)
4.4	Descriptions of activities and initiatives undertaken
5.0	**Implications**
5.1	This report captures our work in this vital area and ensures are compliant with our legal obligations. It also raises the need to make further progress particularly in relation to health inequalities across the Group.

6.0 Recommendations

6.1 The Board is asked to:

a. Review the reports.
b. Approve the reports for publication on the Trust websites.

Report 1

Draft Public Sector Equality Duty Annual Report 2022 - 2023

Other formats and languages
If you would like a copy of this report in a different language or a different format, such as large print or Braille, please contact:

Equality, Diversity and Inclusion
Department Epsom and St Helier
University Hospitals NHS Trust
Tel: 020 8296 2000

Table of Contents

Our Public Sector Equality Duty Report is dedicated to the ongoing commitment and efforts of our staff, who continue to play a vital role in delivering outstanding care, and our response to the Covid-19 pandemic. We pay a special tribute to our colleagues who died during 2019-2023 and celebrate their lives and contribution to the NHS.

First Name	Position Title
Temitope Adeshina	Senior Practice Based Clinical Pharmacist
Samuel Adu	Cleaning Assistant
Colin Bbosa	Patient Catering Assistant
Barbara Beckley	Medical Records Clerk
Bhuvneshwari Bhatt	HCA
Maureen Chung	Nurse
Ruth Cocksedge	Clinical Typist
Phillipa Constantine	Clinical Matron
Susan Debattista	Receptionist
Aldwin Domagas	Medical Equipment Librarian
Teresa Eden	Clinical Audit Assistant
Malcolm Eller	Ambulance Care Assistant
Gail Gibbs	Nurse
Ramunas Glaveckas	Cleaning Assistant
Caryl Hayward	Healthcare Assistant
George Holland	Secretary, Epsom Hospital Radio
Kimberley Jennings	Phlebotomist
Alexander Kidd	Guardian Of Safe Working Hours
David Kirvan	MLA
Anne Laurie	Lecturer & Project Manager
Theresa Mason	Senior Staff Nurse
Miew McCarthy	Patient Pathway Assistant
Gaynor Moore	Patient Pathway Coordinator
Margaret Moore	Nurse
Barbara Owens	HCA
Carina Razalan	Trainee Nursing Associate
Dorothy Russell	Clinical Services Assistant
Mae Sarabia	Senior Staff Nurse
Allan Seraj	Head of Education and Workforce Development for N&M/AHP
Simon Spencer	Emergency Medical Technician
Dawn Summers	HCA
Sarah Sutherland	Staff Nurse
Linda Udeagbala	Community Staff Nurse
Elizabeth Wellbelove	Patient Coordinator

Executive Summary

Welcome and overview from our CEO, Chief People Officer and Chairperson

We are pleased to introduce our 2022/23 Public Sector Equality Duty (PSED) Annual Report as it captures a wealth of information and evidence that demonstrates how Epsom & St Helier University Hospitals NHS Trust (ESTH) has met, and will continue to meet, its statutory duties under the Equality Act 2010.

The purpose of the report is to provide a detailed overview of the equality data relating to staff and service users of ESTH. We collect data and review it regularly to ensure that we are not inadvertently behaving in a way that disadvantages members of staff or patients with protected characteristics. Through delivering our commitment to a diverse workforce and an inclusive approach to the service that we provide, we believe ESTH will develop its capacity and capability to lead by example, to be an employer of choice for everyone, regardless of their background.

We are committed to providing first-class health care for our diverse population recognising our legal duty to eliminate unlawful discrimination and provide equality of outcomes for our population. We recognise that services need to be designed with the person at the centre of them thereby embedding the values underpinning equality, diversity, inclusion and human rights at the core of our business, which shapes and influences our decisions, policymaking, service planning and employment practices. We are committed to achieving our equality duties and obligations, to reduce avoidable health inequalities in all aspects of our roles and functions.

2020-21 was clearly different due to the unprecedented and challenging times following the unexpected arrival of the COVID-19 global pandemic. The impact it has had on people, the economy and the public service offered, has exposed inequalities within our communities and inevitably the gap has widened. As we begin our journey to rebuild from the past three years, we are committed to doing all we can to address these inequalities via our varied services.

As a Trust, we aim to proactively and positively address inequalities that affect our staff, as well as the health inequalities in the communities we serve.

Our Staff Networks have expanded their membership numbers. Their impact, their amazing efforts and collaborative work together has taken an increasingly long-term view. Our Equality, Diversity and Inclusion (EDI) team has a clear agenda to work to, and also echoes, this ongoing, all-inclusive approach to meet our challenges. We would like to take this opportunity to recognise the work of our staff, who have contributed to this comprehensive report: EDI for bringing all this work together; Staff Networks; Staff side; Freedom to Speak Up; Workforce; HR; Recruitment; Health and Well-being; Chaplaincy; Patience Experience and most of all the Business Intelligence team and Medical Services leads who provided data and progress on the Core20PLUS5. We have paid specific focus to this as it is the national NHS England and NHS Improvement approach which supports the reduction of health inequalities at both national and system level.

This report is divided into three sub-reports and should be read in conjunction with each other. It will give an overview of the Trust's commitment to Equality, Diversity and Inclusion, the workforce demographic and the services we provide for the patient and to the community.

Ms Jacqueline Totterdell
Group Chief Executive Officer
(from 16 August 2021)

Mr Paul Da Gama
Group Chief People Officer
(from 1 February 2022)

Ms Gillian Norton OBE DL
Chairman

Report 1: Public Sector Equality Duty Annual Report 2022-2023

Section 1
Examines Trust culture, provides insight from our leadership team, and reviews the challenges presented by COVID-19 and its subsequent impact. It outlines our service, community demographics, and footprint across the South West London and Surrey boroughs. It highlights our aims, vision, progress against our 2021-2025 equality objectives, key achievements, and the Trust's commitment to Equality, Diversity, and Inclusion.

Section 2
Looks at the NHS National context of Mandatory Contracts e.g.,WRES, WDES, Gender Pay Gap, Ethnicity Pay Gap, and our use of all relevant legislative frameworks, which help steer our processes and procedures. It demonstrates the clear visible leadership, sponsorship of established committees, representative networks and forums across the trust, and trust board of directors' commitments which support the Trust to be inclusive.

Section 3
Looks at the Trust culture and access to services, specific focus on prioritising the health and mental well-being of our people, and meeting the needs of the modern workforce. Gives an overview of the Freedom to Speak Up Guardian (FTSU) services, which is an impartial service offering confidential, independent, and sensitive advice and support to all staff raising concerns, It examines the outcomes from the staff survey and reviews for strategic planning, in order to action change.

It focuses on the ongoing work of our chaplaincy service for staff and patients which looks to give an insight into a person-centred outlook on life regarding religion and beliefs. Our pledge to the Armed Forces Covenant works to support veterans, patients, and their families for the trust to become a veteran-friendly hospital. With a view of our recognition of talent and supporting our staff aspirations, in accessing training and career progression. Our process regarding socialising policies for equality impact assessments (EIAs) and inclusive policies is free from barriers and adverse impacts.

Report 2: Workforce, Recruitment and Starters & Leavers Data Analysis

Section 1
Gives a brief overview of the Trust's community services in South-West London and North-East Surrey. Shows an interpretation of data on the Trust's overall workforce in comparison with the communities we serve.

Section 2
Examine data-inclusive recruitment, starters and leavers and a bird's eye view of our international workforce and insight into starters and leavers by Protected Characteristics.

Report 3: Patients, Services and Health Inequalities

Section 1

Gives an overview of our patient experience services, It lays out the activities that would be necessary to drive the reduction of health inequalities across six services. It focuses on the NHS CORE20PLUS services and gives an insight into the Trust's strategic plans for 2024 on people from the nine protected groups and the inclusion group accessing the services. Provides a snapshot of the GESH approach to Reducing Health Inequalities. It also provides a link to the six services which look to answer the service's whole system approach; engaging with the communities, or residents at risk of medical conditions, living with medical conditions, or caring for someone with medical or long-term conditions and engagement activities**.**

Section 2
Show a comparison of the data of the current and previous year of service users accessing services by Protected Characteristics.

Section 3
Provides Surrey and South West London ICB Health Inequalities Priority areas.

Section 4
Concludes with a summary of answering how the Trust is achieving its Public Sector Equality Duty.

Report 1: Public Sector Equality Duty Annual Report 2022-2023

Section 1

1. Introduction

At Epsom and St Helier University Hospitals NHS Trust (ESTH), we are proud to offer an extensive range of services, including cancer, pathology, surgery, and gynaecology to people across South West London and North East Surrey. We operate two busy general hospitals, Epsom Hospital and St Helier Hospital, and run services from other locations, including Sutton Hospital. We are also part of two innovative integrated care partnerships - Sutton Health and Care and Surrey Downs Health and Care.

St Helier Hospital is home to the South West Thames Renal and Transplantation Unit and Queen Mary's Hospital for Children, while Epsom Hospital is home to the South West London Elective Orthopaedic Centre (SWLEOC). Both Epsom and St Helier hospitals have Accident and Emergency departments (A&E) and Maternity services (Obstetrics).

We have almost 7,000 staff and 500 volunteers, who work around the clock to keep our busy hospitals running smoothly and service the needs of nearly 900,000 people, who come to our hospitals for care and treatment every year.

To effectively deliver a wide variety of clinical services, the Trust employs a diverse and multicultural workforce. See the PSED – Report 2 – Workforce, Recruitment and Starters Leavers Data Analysis.

As teaching hospitals, we play a key role in the education and training of tomorrow's doctors, nurses and other health professionals. Both sites work in partnership with St George's University Hospitals and St George's University of London, to deliver high quality education and research. Outside St George's University Hospitals, we support the education of more medical students than any other teaching hospital in South London. Further details about the Trust and its history are available on the Trust's website: www.epsom-sthelier.nhs.uk/our-story.

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

In August 2021, after years of collaboration and creating closer working ties, we announced that the Boards of Epsom and St Helier and St George's had agreed to form a hospital group.

This is an important new chapter for both organisations, which will enable us to strengthen the professional networks we have already created and ensure both Trusts provide the best possible care for our patients. The two Trusts remain separate legal entities but are now led by a single executive team, which have put in place harmonised governance arrangements enabling and supporting closer collaborative working.

1.1. Our Aim

As a proud NHS-provider, we are committed to offering a comprehensive service available to all, irrespective of gender, race, disability, age, sexual orientation, religion, belief, gender reassignment, pregnancy, and maternity, marital or civil partnership status. We also consider characteristics beyond these groups and include the inclusions groups such as Carers, Asylum Seekers and Refugees, Prisoners, Sex workers, those who are Homeless or Unemployed, have Mental Health or Domestic Abuse concerns, or issues with Drugs and Alcohol.

This report provides Trust-wide information relating to Epsom and St Helier University Hospitals' service users, staff and volunteers. It is being published in conjunction with supporting information to show service-users, carers, families, local communities and stakeholders as to how we are progressing on equality, both within national frameworks and at a local level. It has always been our aim to provide equal access to our services for all our patients and users and this report details the progress we have made in ensuring this happens.

Ultimately, the PSED report aims to help ensure that an effective approach to Equality Diversity and Inclusion becomes embedded across ESTH by highlighting, not just its achievements, but also areas where processes could be improved.

Within this report, we provide context and background to our Equality, Diversity and Inclusion journey before detailing our ongoing work and future plans in protecting the interests of both our patients and our workforce.

1.2. Our Objectives

As a Trust, we aim to proactively and positively address inequalities that affect our staff, as well as the health inequalities in the communities we serve. The Trust set six Equality objectives that cover the period from April 2021 to March 2025.

Each of these objectives is supported and strengthened by associated targets and progress made against them. The new 2022 Equality Delivery System (EDS) framework has been streamlined and condensed from four domains into three domains. NHSI has encouraged this to be implemented in April 2023.

To assist with setting our equality objectives, we talked to local interest groups and our own staff, to help us assess how we are performing against the goals of the EDS. We will use this assessment process to monitor progress between 2023-2024, (see below).

Table 1

Equality Objectives 2022-2025	Actions	Progress
Equality Objective 1 Improving data on protected characteristics of users accessing services	To improve the mapping, quality, content and extent of equality information in order to better facilitate compliance with the Public Sector Equality Duty in relation to patients, service-users and service delivery.	Recent upgrade in ESR allows ability to check when staff validate their E&D information. Plan is to target all staff who have not validated their data every year. The Workforce team will be carrying out an equality census highlighting the importance of holding accurate E&D data. We also audit all new starters on a monthly basis, ensuring our recruitment team are entering/checking E&D data.
Equality Objective 2 Roll-out De-Bias Recruitment Selection Toolkit	Launch and monitor the De-Biased Recruitment Toolkit, mapping the retention, progression, development and experience of all staff to enable the Trust to become an inclusive employer of choice.	The Trust developed a toolkit for use at ESTH as part of the Values work. A De-Bias Recruitment Selection Toolkit was based on a combination of this toolkit and the Trust recruitment process. The Trust developed a Values based approach to recruitment, which is used for all staff including Consultants. Recruiters are required to ask their interview questions using a comprehensive template, which covers a range of scenarios, situations or examples and draws on the personal interpretation to different situations. A pool of questions was developed that can be used to assess behaviour standards. This approach has been adopted by, other employers externally, as its use at ESTH has demonstrated that it worked with higher numbers of diverse candidates being successful at interview.
Equality Objective 3 Improve disclosure rate of disabled staff	To improve disabled staff representation, treatment, experience and their employment and developmental opportunities within the Trust.	Project was launched 'Why share your Diversity Data with us?' The aim was for GESH to improve data held on disabled staff A letter was designed, which contained information and guidance on how the information will be used and the importance of disclosure. This was signed-off by the Trust Chairperson and the Disabled / Enabling networks across GESH and sent to the home addresses of all of the staff
Equality Objective 4 Enhance RESPECT Programme	Continue to develop and enhance our RESPECT agenda (above all, we value respect)	The Trust has now completed the Discovery phase and is moving into the Design phase, joining up with the findings from the Staff Survey to create a coordinated approach to improving the Culture at ESTH.

Equality Objectives 2022-2025	Actions	Progress
Equality Objective 6 Quality Improvement	To develop and improve patient-centred health services which are safe, effective, timely, efficient and equitable	ESTH have proactively signed up to increasing Quality improvement methodology. The programme running "IDEAS" is part of the Trust five year strategy. This has already had an impact on sustainable changes, which stimulate creativity and is delivered via QI practitioner programme. The QI practitioner course is open to all professions and is inclusive of all trust staff. We now have over 100 QI practitioners across the Trust working in clinical and non-clinical areas and they take part is many activities such as simulation-based education and patient safety investigation

1.3. Key achievements

The Trust has clearly defined our mission and vision and in doing so has identified key priorities to strengthen our people, culture, and values. Equality, Diversity and Inclusion (EDI) are clearly embedded within these priorities. Through the organisational strategy and the EDI Annual Reporting Framework, the Trust links our overall EDI objectives and approach to the day-to-day operational objectives of the Trust. There have been significant steps forward in recent years.

This report provides Trust-wide information relating to Epsom and St Helier Hospitals' service users, staff and volunteers. It is being published, in conjunction with supporting information, to show service-users, carers, families, local communities and stakeholders how we are progressing on equality, both within national frameworks and at a local level. It has always been our aim to provide equal access to our services for all our patients and users. This report details the progress we have made in ensuring this happens. Ultimately, the PSED report aims to help ensure that an effective approach to Equality Diversity and Inclusion becomes embedded across ESTH by highlighting, not just its achievements, but also areas where processes could be improved.

Within this report we provide a context and background to our Equality, Diversity and Inclusion journey, before detailing our ongoing work and future plans, in protecting the interests of both our patients and our workforce.

1.4. Equality, diversity and inclusion

Addressing inequalities, particularly in relation to population health, is a key priority for us as we rebuild and recover following the height of the pandemic. Embedding equality, diversity and inclusion into everything we do has been an important area for the Trust over the past two years, with the Trust Board setting this as a key priority area across every part of the organisation.

We are committed to providing first -class health and care for our diverse population, recognising that services need to be designed with the person at the centre, ensuring equality, diversity; inclusion and human rights are at the centre of our business shaping and influencing our decision- making. This work is monitored by the Board.

We have four staff networks in place in order to support our people from ethnic minority backgrounds, LGBTQ+, Women, and Disabled staff; to ensure elimination of harassment, discrimination, bullying and abuse; to advance on equality of opportunity and to foster good relations. The networks are also open to others who may not share protected characteristics but wish to promote and advertise the work of the networks through allyship.

1.5. Our People's Panel

Our People's Panel – an initiative that aims to ensure future key projects and programmes are co-designed with patients and local people.

There has never been a more important time for local people to join us and have their say on our work, as we plan to build the brand new Specialist Emergency Care Hospital in Sutton and significantly improve Epsom and St Helier University Hospital. Members can get involved in a wide range of projects and programmes, from improving how the Trust communicates with patients, to having their say on new designs and layouts of our buildings, to directional signs and information shown around the hospitals.

For further information about the Trust People's Panel can be viewed at our website.

1.6. People and Organisational Development Strategy 2021-2025

The Trust People and Organisational Development Strategy was approved by the Trust Board in August 2021. It is our mission to deliver outstanding care, every day and our ambition that we have a sustainable and fulfilled diverse workforce, empowered to deliver our mission. Our workforce is crucial to help us in delivering our priorities as set out in the 5 year strategy can be viewed at our website.

Delivering these priorities will not only require us to build on what is great about working at ESTH but will require a fresh look at our workforce models to ensure the culture, values and behaviour standards of the Trust are fit for purpose and enable us to attract, develop and retain our most valuable resource – our people.

As we move forward with our refreshed Trust Strategy, it is an opportune time to review and update our workforce priorities to enable us to deliver these aims. As such we have reviewed our Trust People and Organisational Development Strategy 2021-2025.

The 2021-2025 strategy is built on our vision, with four supporting pillars, namely: providing ***outstanding care everyday*** by ***attracting***, ***developing*** and ***retaining*** exceptional people whilst nurturing an environment of **wellbeing** and **respect.**

The People Strategy sets out our people priorities until 2025, setting out the ambitions for the future of our workforce.

It will embrace the opportunities that Building Your Future Hospitals (BYFH) will bring and recognising the challenges that we faced during 2020 and early 2021 as we responded to COVID-19.

1.7. Culture

We started work on our new Culture & Leadership Programme Programme in March 2022. Its purpose is to help us transform our organisational culture and enable us to realise our mission of 'outstanding care, every day' for our patients, which was the heart of our purpose. It aligns with multiple areas of work that support our culture:-

- People plan
- Equality, Diversity and Inclusion action plans,
- Quality and service improvement strategic projects/ programmes
- Staff survey results
- Use the NHSE/I Culture and Leadership Programme as a tool to help us develop our Respect Culture and Leadership 2022-2025
- Utilise a robust dashboard of metrics to measure culture change

The Culture programme is a GESH-wide programme of work that:

- supports the Strategic Priority of 'Empoywered and Engaged Staff''
- is comprised of 5 workstreams (the 'Big 5') and
- is underpinned by 'golden threads' of EDI and Health & Wellbeing running throughout.

The 5 workstreams are:

- Civility & Psychological Safety
- Bullying & Harrassment/Keeping Staff Safe
- Inclusive Behaviours
- Compassionate & Inclusive Leaders
- High-performing Teams

We have two types of Culture board to drive and enable the success of the Culture programme::

- A GESH-wide board (meets every other month) to focus on the delivery of the GESH-wide plan and discuss/resolve any GESH-wide issues
- Local/site-based boards (also meeting every other month) to focus on local topics, including staff network updates.

1.7.1. Culture Champions

Change cannot happen without input from our staff; it is really important we get buy-in from all levels of the organisation, to make a tangible step towards embedding sustainable change, thereby improving our culture and ultimately patient care.

In 2022, the Trust launched its NHS England Improvement, Culture, and Leadership program to help us understand, our culture and how we can improve the lived experience of our staff.

17 multi-professional Culture Champions from clinical and non-clinical backgrounds were appointed to run staff focus groups, carry out local visits to the teams, and interview members of the board and the senior site leadership team, to better appreciate what it is like to work at ESTH.

The Culture Champions supported this program throughout the discovery phase and took part in the various communication activities, which enabled us to hear over 700 voices. Although their official role as Culture Champions has come to an end, they will no doubt continue in an unofficial capacity as ambassadors of culture change at ESTH.

Key highlights 2022-2023

- As the Trust has moved to the group model of working, we now have a new People Committee (PC) which is a sub-committee of the Board, that remains committed to upholding a focus on EDI as a standalone item on their agenda
- Executive Question Time launched on 17 March 2023 to hear the voices of our staff and their burning questions, led by our Group CEO Jacqueline Totterdell and the Group Executive Team. In this forum, staff have the opportunity to ask questions and are invited to submit questions in advance of the meeting
- 2021 Veterans Accreditation – co-design with veterans and reservists materials and work streams to ensure that veterans and their family members are supported when they come into the Trust, and Displaying the public pledge and covenant signing in a variety of ways across the Trust (e.g. banners, posters and press release)
- Launch of the Ask Aunty App and Programme
- Launch of Disability Advice Line
- Reverse Mentoring Programme (linked to the Ask Aunty programme for International staff)
- We marked Speak Up Month – our Freedom To Speak Up team hosted a series of awareness sessions throughout the month, including visiting many teams in person
- Babies born on World Book Day given reading gifts
- Trust commissioned Skill Boosters EDI Training Catalogue
- Charlotte Graham and Philippa Othmane were awarded Linda Udeagbala Nursing Awards for outstanding contribution to student experience.
- In the 2022 Staff Survey results, Epsom and St Helier Hospitals obtained the highest score in London for several of the EDI domains, including the response rate from BAME staff and the number of BAME staff believing that the Trust acts fairly in career progression and promotion. The score reflects an improvement on previous years' results, and evidences the positive work being undertaken across the Trust on Equality, Diversity and Inclusion
- During LGBT+ History Month celebrations we looked at the history of gay rights and what it means for LGBTQ+ communities, our LGBTQ+ Network raised awareness of domestic violence and hate crimes against the LGBTQ+ community
- Celebrating Ramadan Mubarak. We have 362 Muslim staff members, celebrating a blessed Ramadan. The holy month started 22 March 2023, and Muslims globally recognise the holiday in many ways, including daily fasting and reciting the Quran during special prayers. Since 2020

and as a result of the pandemic, Dr Ziyad Abubacker (Renal Doctor) and his sister provided Trust staff and patients with sponsored free meals for Efitar (breaking of Fast). We thank them for their kind generosity over the last three years

- International Women's Day events this year included an online celebration by the Health and Care Women Leaders Network, an on-site event at St George's Hospital, and an online ESTH virtual event
- We held our first ever, all staff engagement event alongside St George's colleagues. All 17,000 staff across Epsom, St Helier, St George's, and Surrey Downs and Sutton Health and Care were invited to hear from our Group CEO Jacqueline Totterdell and meet all our Group Executives.
- Our Head of Security, Paul Grzegorzek, headed to the Ukraine to deliver aid to the people there, working in refugee centres along the border, as well as transporting orphaned children as part of the official refugee placement efforts
- We signed a contract with Cerner to provide a shared electronic patient record system with St George's, which will enable us to deliver more streamlined, contemporaneous, comprehensive records. Having greater access and oversight of a person's current and past health, means that plans can be formulated with different members of the multi-disciplinary team, which will enable us to better meet the holistic, individualised patient care required
- The Trust has representation on the South West London and Surrey Heartland ICS EDI Networks
- The Trust has mandatory training relating to EDI, that addresses legislative frameworks and expected behaviours at the Trust and in addition our Women's Health & Children's Division have run mandatory cultural competence training for the past 2 years
- The Trust commissioned a Skill Boosters video-based training platform, which is designed to address meaningful workplace challenges in areas such as equality, diversity and inclusion, leadership and teamwork
- In October 2022, the Trust held its second Workforce Race Equality Standard (WRES) Workshop and staff had an opportunity to have their say on how the Trust approaches race equality at work. The aim of these workshop sessions were to listen to Trust members
- Trust is hosting Project Search (DFC) Programme for 16-24 years old with learning disabilities
- WRES conference 2022 Speakers (Race Observatory, Dr Habib Navqui, Maria Gabriel, Dr Joan Mayer, Dr Stacy Johnson)
- WDES Conference 2022 , NHS WDES Team, DWP, Project Search
- The maternity and obstetric team have formed a maternity cultural transformation group, which has a programme of work, which has looked at embedding changes in practice and service to reduce the inequalities in maternal health. As a result of this work, the team were shortlisted for an RCN award in 2021 and the HSJ in 2022

1.8. How we ensure easy access to our information online

Our website helps us to ensure that our patients, staff and stakeholders have easy access to information about our services. We therefore have stringent policies relating to the provision of online information to ensure that it is written and presented in an accessible way to meet the Access Information Standard (AIS). The website contains RECITE software, which enables the translation of any pages embedded on the website. Viewers can translate the text into a variety of different languages, select an audio version or enable a hearing loop if required.

1.9. Our accessibility statement

The Trust has ensured that it has remained compliant with the Accessible Information Standard, by supporting patients to receive information in a format that meets their needs. Furthermore, the Trust maximises opportunities for patients to access interpretation services, where English was not identified as a first language, they required support for BSL or other advocacy services. Hearing loops are available for outpatient clinics across our sites, and through regular internal reviews of the environment, the Trust commissioned an accessibility audit and has taken on board the recommendations.

1.10. Stakeholders engagement and partners

The Trust works with Surrey Heartlands and SWL ICSs to ensure a system wide approach to the wider EDI agenda.

Epsom and St Helier University Hospital dedicated Communications and Engagement team works closely with the EDI team, supporting the organisation to meet its EDI objectives, deliverables and activities for

the year. This may include support for activities through internal bulletins and events, the Trust's external stakeholder newsletter, social media and events.

September 2021 employed a dedicated Senior Engagement Officer, and in October 2021 launched its first-ever patient and public involvement network, called the People's Panel. For details of the panel and other recent activities, see below.

Engagement activities include

- The Trust launched its first-ever People's Panel in October 2021 and to date has 257 members of which 151 joined in 2022/23
- We have a dedicated People's Panel page on our website
- We use our social media platforms and attend community events to boost membership

Of the 257 members, Nine represented someone else i.e. carer, parent or husband
Three represented a group of local people and Twenty-five represented organisations:

Citizens Advice Epsom and Ewell, Stakeholder Surrey Heartlands ICS, BAME Voice, Sutton African and Caribbean Cultural Organisation, Alzheimer's Society, Belmont and South Cheam Residents Association, Central Surrey Voluntary Action, The Chi Clinic, Xyla Health and Wellbeing, Age Concern Epsom and Ewell, Care101, CAB Epsom and Ewell, Community Action Surrey, Healthwatch Sutton, NESCOT College, Leatherhead and Shanklin Village Resident Associations, Surrey County Council, Surrey Coalition of Disabled People, Surrey Heartlands ICS, the Labour Party, Ewell Liberal Democrats, Merton Centre for Independent Living.

Section 2

2. Statutory and Mandatory Frameworks

As a Trust, we are committed to using all relevant legislative frameworks to help steer our processes and procedures. There are numerous national regulations in place to protect the interests of both our patients and staff, and this influences our choices and drives our strategies.

The Public Sector Equality Duty (PSED) is one such regulation. It came into effect in 2011, was developed to harmonise the equality duties and recognise the protected characteristics.

The PSED forms an intrinsic part of the Equality Act 2010 (Section 149). It applies to public sector bodies, including the NHS, and others who undertake public functions. It requires these organisations to publish specific information to evidence compliance with the PSED, including their equality objectives. The Trust also needs to meet its obligations under the Human Rights Act, which means that as a public body we must, at all times, act in a manner compatible with the rights protected in this Act and safeguard these for patients and staff in our care and employment.

Human rights principles are also core to the rights of patients as set out in the NHS Constitution:
"You have the right to be treated with dignity and respect and in accordance with your human rights" (Section 2a: NHS Constitution)

The Health Inequalities Duty - NHS Act 2006 is another national consideration. It was introduced by the Lansley reforms in the Health and Social Care Act 2012 and shapes how NHS England can lawfully make decisions about its functions and identifies how significant breaches of the duties can invalidate decisions.

Specific Duties Regulations (SDR) requires NHS organisations including Epsom and St Helier NHS Hospitals, as public sector organisations, to publish information to demonstrate our compliance with the general equality duty.

This report seeks to demonstrate compliance to the specific duties and aims to meet the monitoring and publishing requirements set out in the specific duty regulations.

2.1. Equality Delivery System (EDS)

The NHS Equality Delivery System 2022 (EDS 2022), as its predecessors were before, is a tool designed to help NHS organisations, in partnership with local stakeholders, to review and improve their performance for people with characteristics protected by the Equality Act 2010, and to support them in meeting the Public Sector Equality Duty (PSED).

The EDS is structured to generate regional and local conversations about what is working well and what is not working so well, enabling organisations to make necessary improvements, with lessons being learnt more widely. It assists local NHS organisations, in discussion with local partners including local populations, in reviewing and improving their performance for patients, service users and the broader public. It supports organisations in keeping 'Everyone Counts' as the key principle that applies to everyone served by the NHS in line with the NHS Constitution. The EDS provides a ready-made way for the NHS to respond to requirements of the PSED.

The EDS is still a requirement of the NHS Standard Contract (SC13.5 Equity of Access, Equality and Non-Discrimination), and aligns with the Leadership and Capability and People themes within the NHS oversight framework 2022/23. All NHS organisations are expected to use the EDS 2022 to help them improve their equality performance for patients, communities and staff.

The EDS provides a focus for organisations to assess the physical impact of discrimination, stress, and inequality, providing an opportunity for organisations to support a healthier and happier workforce, which will in turn increases the quality of care provided for patients and service users.

The EDS comprises eleven outcomes spread across three Domains, which are: (1) Commissioned or provided services (2) Workforce health and well-being (3) Inclusive leadership (please see Table 2 below).

The outcomes are evaluated, scored, and rated using available evidence and insight. It is these ratings that provide assurance or point to the need for improvement. Please note, the EDS 2022-2023 report will be available October 2023.

Table 2

EDS Domain 1: Commissioned or provided services:
Outcome 1A: Patients (service users) have required levels of access to the service.
Outcome 1B: Individual patients (service users) health needs are met.
Outcome 1C: When patients (service users) use the service, they are free from harm.
Outcome 1D: Patients (service users) report positive experiences of the service.

EDS Domain 2: Workforce health and well-being:
Outcome 2A: When at work, staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions.
Outcome 2B: When at work, staff are free from abuse, harassment, bullying and physical violence from any source.
Outcome 2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source.
Outcome 2D: Staff recommend the organisation as a place to work and receive treatment.

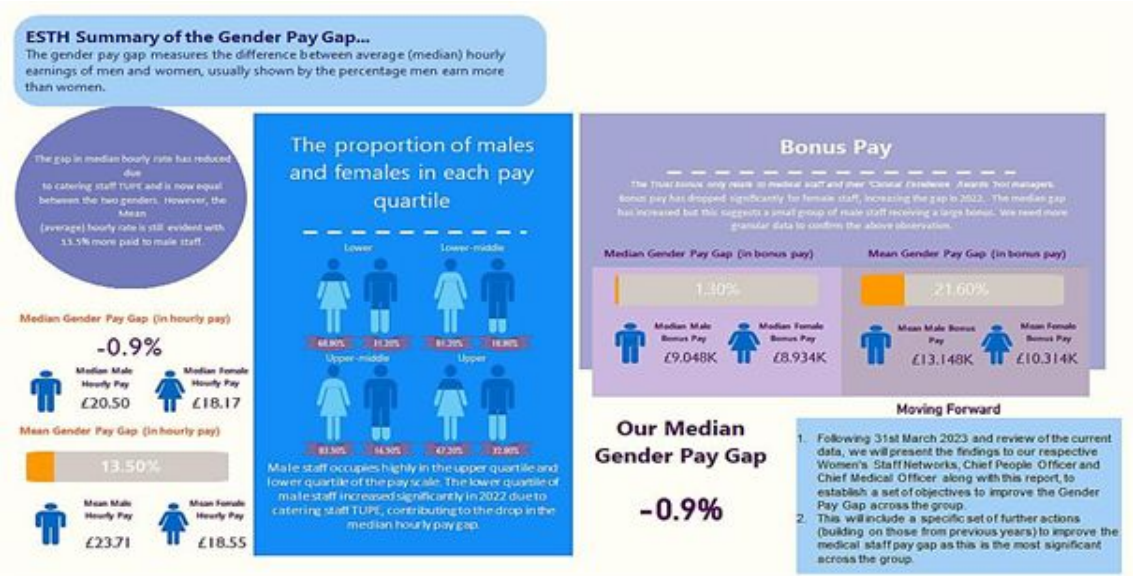
EDS Domain 3: Inclusive leadership:
Outcome 3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities.
Outcome 3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed.
Outcome 3C: Board members, system and senior leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients.

2.2. Gender Pay Gap Report 2022

The Gender Pay Gap (GPG) describes the difference between the average earnings of all the women in an organisation compared to the average earnings of all the men in that organisation. This is not the same as equal pay, which is about ensuring men and women doing the same or comparable jobs are paid the same. Our GPG Report was published in 2023 (the data is a snapshot taken at 31 March 2022) which provides an analysis of pay by gender. It also provides information regarding the areas of focus and the progress made against them.

ESTH GPG 2022 shows our mean hourly pay for males is £3.21 higher than that of females, which is a gap of 13.5%. Male median pay is 16p lower than females, which is a gap of 0.9%.The Trust's GPG 2023 report can be viewed at our website.

Table 3



2.2a Appendix 1 - ESTH PSED Draft finish HV7 13062023

2.3. Workforce Race Equality Standard (WRES)

The NHS Equality and Diversity Council have agreed action to ensure employees from black and minority ethnic (BAME) backgrounds have equal access to career opportunities and receive fair treatment in the workplace. NHS Trusts are expected to show progress against a number of indicators of workforce equality, which include recruitment opportunities, the likelihood of entering the disciplinary process, and accessing non-mandatory training. As part of the Trust's PSED annual report covering 1 April 2022 – 31 March 2023, the Trust assessed itself against the Workforce Race Equality Standard (WRES nine) indicators.

We have made progress against some indicators but less progress against other indicators such as: indicator 2 the recruitment likelihood ratio was 1.04; not significantly different from "1.0" or equity. Specifically, 85 out of 2514 white candidates were appointed from shortlisting (3.4% of white candidates) compared to 84 out of 2573 BME candidates (3.3% of BME candidates).

A maximum of three high priority areas for improvement have been identified for the Trust such as indicators 1 to 3 and 9. For further information on the Trust's WRES report 2021-22 and accompanying Action Plan can be viewed at our website.

Table 4: Summary for the 2021/22 reporting year

Indicator number and description			
Indicator 1: ESTH BME representation in the workforce overall			38.3%
Pay band at which BME under-representation first occurs	**Non-clinical**	Band 4 - Band 5 +	Band 3 Band 8D
	Clinical	Band 4 - Band 5 +	Band 3 Band 7
	Medical		**Consultant**
Race disparity ratios	**Non-clinical**	Lower:middle	1.08
		Middle:upper	0.81
		Lower:upper	0.88
	Clinical	Lower:middle	1.47
		Middle:upper	1.51
		Lower:upper	2.23
Indicator 2: likelihood of appointment from shortlisting			
likelihood ratio White / BME			1.04
Indicator 3: likelihood of entering formal disciplinary proceedings			
likelihood ratio BME / White			1.20
Indicator 4: likelihood of undertaking non-mandatory training			
likelihood ratio White / BME			1.07
Indicator 5: harassment, bullying or abuse from patients, relatives or the public in last 12 months			
		BME	27.5%
		White	26.6%
Indicator 6: harassment, bullying or abuse from staff in last 12 months			
		BME	26.2%
		White	24.6%
Indicator 7: belief that the trust provides equal opportunities for career progression or promotion			
		BME	44.8%
		White	54.2%
Indicator 8: discrimination from a manager/team leader or other colleagues in last 12 months			
		BME	15.8%
		White	9.0%
Indicator 9: BME representation on the board minus BME representation in the workforce			
		Overall	-26.5%.
		Voting members	-18.3%.
		Executive members	-27.1%.

2.4. Workforce Disability Equality Standard (WDES)

The WDES came into force on 1st April 2019. It is mandated through the NHS Standard Contract and the Trust completed its first WDES report in the summer of 2019. This is the fourth year completing the WDES.

The WDES is a set of ten specific metrics that enable NHS organisations to compare the experiences of Disabled and Non-disabled staff. This information is then used to develop local action plans and enable the Trust to demonstrate progress against the indicators for disability equality.

As part of the Trust's PSED annual report covering 1 April 2022 – 31 March 2023, the Trust assessed itself against the WDES ten metrics. We have made progress against some metrics such as the relative likelihood of recruitment which shows a significant drop on the previous year.

Our disclosure rates have increased slightly, showing staff are feeling more confident to disclose and our disabled voices metric demonstrating disabled staff have a platform where they are being heard has increased. The results that are shown on the NHS Staff survey disclosing a disability (17 %) however do not align with the results shown on ESR (4.3%). Some of the key findings from 2022 report can be viewed in the table below. For further information of our WDES 2021-22 Report and Action Plan can be viewed at our website.

Table 5: Summary for the 2021/22 reporting year

Metric	Label	2022	
1	Declaration Rate	4.0%	
2	Recruitment	2.32	
3	Capability	16.62	
9b	Disabled voices	6.5	
10	Board membership	-4.0%	
Metric	**Label**	**Category**	**2021**
4a	Harassment, bullying or abuse Public	Disabled	32.09%
		Non-disabled	28.02%
		Difference	4.07%
4b	Harassment, bullying or abuse Manager	Disabled	20.09%
		Non-disabled	14.00%
		Difference	6.09%
4c	Harassment, bullying or abuse Colleagues	Disabled	25.07%
		Non-disabled	17.07%
		Difference	8.00%
4d	Harassment, bullying or abuse Reporting	Disabled	49.03%
		Non-disabled	50.08%
		Difference	1.77%
Metric	**Label**	**Category**	**2021**
5	Career Development	Disabled	46.03%
		Non-disabled	51.08%
		Difference	-5.05%
6	Presenteeism	Disabled	32.01%
		Non-disabled	26.02%
		Difference	5.99%
7	Feeling Valued	Disabled	32.21%
		Non-disabled	49.90%
		Difference	-16.88%
8	Workplace Adjustments	Disabled	74.40%
		Non-disabled	49.90%
		Difference	-16.88%
9a	Staff Engagement	Disabled	6.50%
		Non-disabled	7.00%
		Difference	-0.50%

2.5. Trust commitment and visible leadership

There is clear visible leadership, sponsorship of established committees, representative networks and forums across the Trust. The Board made personal commitments to support the Trust's inclusivity pledge, along with many of the staff.

Committees, networks and forums have documented terms of reference that are aligned to the organisation's governance structures. These provide sufficient empowerment to escalate issues to the appropriate relevant senior staff for action and/or resolution.

The Trust as part of the gesh group launched its new five-year strategy in May 2023, which sets out its priorities over the next five-year period. This is linked to the Trust's revised mission statement which informed the Trust's six equality objectives (see Table 1):

"Outstanding Care, Everyday"

2020, the Trust's revised mission is to deliver 'Outstanding care, every day', building on the progress that has been made over the past five years, and setting ourselves an aspiring goal.
To deliver this, the Trust recognises that it needs to strengthen its people, culture, and value. This recognises the contribution our people make to delivering outstanding care and responding to what matters to those who access our services and also our role in our local communities, including providing equity of service and reducing health inequalities.
The People Strategy is still in place and the Culture work we are doing supports this plus the GESH Group Strategy 2023-28.

What do we want to achieve?

Our vision for 2028 is to provide outstanding care, together.
With the help of our patients, staff, and partners, we have chosen four overall aims for 2028 – our CARE objectives. These are the things we care about the most and will be central to achieving our vision.

- **C**ollaboration and partnership
- **A**ffordable services, fit for the future
- **R**ight care, right place, right time
- **E**mpowered, engaged staff

In all this, everything we do will be driven by our patients.

How will we get there?
The answer is – together. 17,000 people work at St George's and Epsom and St Helier, and every one of us will have a part to play in making our vision a reality.
We will deliver our vision through:

1. **Local improvement**: continuous improvement, pursued by teams of staff at every level in our organisations, from Board to ward, against a common framework of annual improvement priorities.

2. **Corporate enablers**: action led by individual corporate departments, working with clinical teams, to deliver against a range of corporate strategies: quality and safety, people, IT, estates, research and innovation, our green plans.

and

3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work:

    - The Building Your Future Hospitals programme
    - Supporting a continuous improvement approach throughout organisations, through high-performing teams and leaders
    - Implementing a shared system for electronic patient records across our Group
    - Transforming our outpatient services
    - Collaborating with other hospitals across South West London
    - Transforming our culture, and making our workplaces more diverse and inclusive
    - Pursuing collaboration across our GESH Group
    - Collaborating with local partners in Surrey Downs, Sutton, Merton, and Wandsworth
    - Strengthening our specialised services

You can read more detail about our CARE objectives in our strategy summary document or in our full strategy. We have also produced a short animation explaining the key points of our strategy, which you can view here.

The Trust has a dedicated EDI team including a Head of EDI, a dedicated People's Committee (PC) and Culture Inclusion Equity Board (CIE) reporting to the Trust Board. This work has been developed as a result of the awareness of the disproportionate impact of COVID-19 on Black, Asian, and Minority Ethnic (BAME) people becoming evident in the last two years. Also relevant were concerns highlighted by the Black Lives Matter (BLM) movement and the need for everyone connected to ESTH to strive to be anti-racist in everything done within the Trust.

2.6. Governance - People Equality Culture Committee

Development of a new People Strategy will commence in June 2023 and will be aligned with a new Group Strategy. The People Strategy includes the 'Big 5' Culture programme (referenced earlier) which will focus on 5 key themes all designed to improve the working environments at ESTH and SGUH.

The Equality Impact Assessment Tool (EIA) was updated and implemented in January 2020, to ensure there is an inclusive approach and adherence to further additions to the EIA process. Saw Equality Health Impact Assessment (EHIA) was included into the process from January 2022.

The Trust also has a formal and structured procurement process to ensure that outsourced providers are aware of the procedures, contracting arrangements and supplier contracts, ensuring they are aligned to the Trust EDI requirements. These are taken into consideration in the Procurement process by observance of the Public Contract Regulations 2015; adherence to non-discrimination and equality of treatment. Procurement is led by the South West London (SWL) Procurement team, based at St George's Hospital.

The Trust has in place formal terms of reference (TOR) for:

- A Group-wide People Committee in Common
- People Management Groups (PMG) at each site
- A Group-wide Culture Board (which feeds into PMG)
- Site-based/local Culture boards (that feed into the Group-wide Culture Board)
-
-

People's Committee is chaired by a non-executive director (NED) and is comprised of other NEDs and the executive board members. From a review of minutes from the last three meetings in 2022-23 there has been good attendance from senior representatives at the named committee meetings.

2.7. Executive Question Time

Executive Question Time launched on 17 March 2023 to hear the voices of our staff on burning questions, led by our Group CEO Jacqueline Todderdell and the Executive Team – where staff can ask questions. Staff are invited to submit questions in advance of the meeting**.**

The executive team have been listening to staff feedback and questions and spotted some recurring themes, which they would like to support such as remote working, career development, and pay.

Section 3

3. NHS Staff Survey 2022

One of the key ways that we can support our people is by listening to what they say and acting on their feedback. The survey provides vital insight into staff views around what we do well, and where improvements could be made. This enables us to develop strategic plans and enact change for next year.

Our 2022 results were published in March 2023, and showed that 3,464 people responded (50% of our eligible workforce), compared to 60% last year. We have seen improvements, but much remains to be done.

The 'Big 5' priority areas listed below in many ways are a refined version from the themes identified from the previous year (2021) and are shared between ourselves and St George's.

- Civility and psychological safety
- Bullying and harassment/keeping staff safe (violence and aggression)
- Inclusive behaviour within teams
- Compassionate and inclusive leadership
- High-performing teams

In addition, we will be working with STGH over the 18 month joint programme of work supported by actions at a local level.

The Trust has seen a slight reduction in the number of staff experiencing violence, aggression and bullying and harassment in the workplace, but we need to continue our focus on this.

We have also seen small improvements in line managers giving clear feedback and asking for the opinion of staff before making decisions. Appraisals (including quality and completion rates) have shown improvement. However, we will continue to focus on this area as we are still below our planned target.

While it is heartening to see some positive shifts, some of the results are more disappointing, including the decline in the number of staff feeling valued and supported to do their job properly.

In terms of our NHS Staff Survey results, we are average compared to the national average in 6 People Promise Themes and below average (but not significantly) in one - 'We are always learning'.

We are average in 13 of the 16 People Promise subgroups and below average in the following areas:

- Diversity and Equality – fairness in career progression and discrimination from managers and colleagues
- Development – opportunities and access to development

The Trust looks to obtain a positive score around reasonable adjustments, where 74.4% of staff with a

long-lasting health condition or illness say the Trust has made adequate adjustment(s) to enable them to carry out their work.

This compares favourably with the national comparator. This also represents a 2% increase on the 2021 figure of 72.4%.

3.1. Freedom To Speak Up

Freedom To Speak up Guardians (FTSU) are employed across the NHS. This role was created as a result of the recommendations published in 2015 by Sir Robert Francis following his review of the Mid Staffordshire Hospital Trust. See the full report here.

FTSU Guardians were originally recruited for secondary healthcare settings, but this is now evolving and the role is widening so we now see Guardians in primary care settings, hospices, private hospitals and more recently in the private sector as organisations recognise the value of FTSU. There are currently 961 Freedom to Speak Up Guardians in 575 organisations.

Guardians offer an impartial service offering confidential, independent and sensitive advice and support to all workers raising concerns.

The benefits that organisations see coming from a positive speaking up culture include better patient outcomes, improved staff wellbeing and improved management practices.

Nationally, year upon year data shared with the NGO from Guardians show that there is an increase in workers raising concerns directly to their Guardian. FTSU Guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017.

At ESTH, we are committed to supporting a culture of learning, openness, and transparency throughout our whole organisation. We want to ensure that our staff are empowered to speak up, if they have any concerns about patient care.

Since 2016, the FTSU service at the Trust has expanded and now consists of a Guardian and two Deputy Guardians. They work across our acute sites and with our integrated care partnerships; Sutton Health and Care and Surrey Downs Health and Care.

Guardians meet with staff in confidence providing confidential impartial independent advice, help, and support. There is no limit to the concerns that staff can raise, and no criteria that concerns have to meet in order to be addressed. The fundamental purpose of the service is to take forward patient safety issues, and it is recognised that there is a strong link between confident, happy staff and improved patient safety. This means staff are free to raise concerns of any kind with the FTSU service.

Staff data and information is confidential. The Guardians provide feedback directly to those raising concerns on actions taken and keep staff up to date with anything relating to the concern they have raised. The service also provides feedback to all staff through a quarterly newsletter and encourages the Trust to learn from concerns raised. From 1 April 2022 to 31 March 2023 there were 350 cases raised.

The staff groups which raised the highest number of concerns over the past year are: nursing and midwifery, administrative and clerical staff.

The main types of concern raised over the past year, which has been broadly consistent with the previous year, have been concerns around 'management conduct', bullying and harassment. Concerns with an element of patient safety have also been more prominent over the past year.

Beyond these areas, a number of concerns have related to:

- Discrimination
- Staffing levels
- Pay

- HR policy and process
- Transformation

Common themes relate to concerns around Trust infrastructure and process, racism, together with health and wellbeing. We have also seen increased concerns about the cost of living increases and some feel that a few of the basic mechanisms do not work as well as they should relating to pay, staff support, and policies being followed.

The team continued to proactively raise awareness of the advice and support available to staff throughout the year, including during Speak Up month in October. This is an initiative organised annually by the National Guardian's Office, raising awareness of Freedom to Speak Up and the work which is being done to make speaking up business as usual. The team organised a local initiative with a similar month of activities earlier in the year, in May, in order to keep the profile of the service high. During both periods, the team met with many colleagues across our sites.

The service also has a team of FTSU Champions across the Trust who help to raise awareness of FTSU particularly within their own teams and across the Trust during our awareness raising campaigns.

3.2. Volunteering and Voluntary Services

- Cancer Information and Support Centre (including the Macmillan Butterfly Centre at Epsom Hospital)
- Epsom Hospital Radio
- Epsom Medical Equipment Fund
- Friends of Epsom and West Park Hospitals
- League of Friends for St Helier Hospital
- Chaplaincy volunteers
- Radio St Helier
- Momentum Children's Charity
- Emerge Advocacy
- Breastfeeding Network
- Stroke Surrey
- The Kidney Fund - St Helier

The Trust Corporate Volunteers make up the largest number of volunteers. Between April 2021 - March 2022 due to the restrictions required at the height of the COVID-19 to preserve the safety of our volunteer team there were only 8 Emerge advocates visiting Paediatric ED, 17 working remotely running the radio stations and all other volunteers were stood down.

In April 2022 - March 2023 there were 181 Volunteers working across ESTH sites.

Further information on the Trust's Voluntary Services can be view at our website.

3.3. Health and Wellbeing

The Trust launched its People and Organisational Development Strategy. This has a specific focus on prioritising the health and mental well-being of our people, meeting the needs of the modern workforce (including flexible working and supporting work/life balance), and prioritising the safety of our staff. We want everyone who works at ESTH to feel supported with their physical health and mental wellbeing.

In order to take into consideration the significant impact that COVID-19 can have on Black, Asian, and Minority Ethnic community groups, and those with underlying, long-term conditions, such as diabetes; the EDS now supports the outcomes of the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) by encouraging NHS organisations to understand the connection between those outcomes and the health and wellbeing of staff members. The EDS provides a focus for Trusts to assess the physical impact of discrimination, stress and inequality. It provides an opportunity for Trusts to support a healthier and happier workforce, which will in turn increase the quality of care provided for patients and service users.

The Trust has promoted a range of national offers and other health and wellbeing resources in 2021/22, including:

- Digital weight management programme
- Osteopathy clinic discounts
- Work Perks (WPA)and Eden Red benefits, discounts, and offers
- Webinars to support menopause, mood and food, mindfulness teaching session, managing stress
- Smoking cessation support
- Free online health and well-being talks
- Activities and classes; Outdoor yoga
- Schwartz Rounds, which promotes open safe discussions and supports staff wellbeing
- Free financial advice offers and will writing service

As previously mentioned, we are aware that our staff have faced a variety of challenges as we have all navigated our way through the different barriers, and challenges presented by COVID-19. We continue to work towards meeting the needs of our modern workforce so as to achieve a better work/life balance. Staff health and well-being will remain our priority in the year ahead as we continue our journey in making ESTH a great place to work, putting staff well-being at the forefront of everything we do.

We have a number of measures in place to achieve this, including regularly reviewing and improving our well-being offer. We are continuing to work collaboratively with Surrey Heartlands and Southwest London ICS on a number of initiatives, which include providing ongoing monitoring and support for vulnerable staff, continuing to provide Covid-19 and flu vaccination support, supporting flexible working, acting on feedback from the annual staff survey and much more.

3.4. Staff Networks

There are four active staff networks at the Trust: The Enabling Network; LGBTQ+ Network; Women's Network; and the REACH Network (formally known as the BAME Staff Network). Some of the networks had struggled to maintain momentum during the pandemic but all have plans going forward to recruit new interest and to develop action plans including supporting the Gender Pay Gap, WRES and WDES work taking place within ESTH. The group leadership team has agreed for executives sponsors to be allocated to each network across the group with potential site sponsors.

3.4.1. Women's Staff Network

The Women's network was formed in 2020 and is one of the matured networks. It is a self-organised staff group addressing issues and feeding into the Trust's Culture Inclusion Equity Committee. The network's aim is to give a voice to our female colleagues through a group that is currently under-represented at senior levels across the NHS. The network sometimes collaborates on women's initiatives and events within St George's Hospital. On 16th March 2023, the network presented its annual celebration of International Women's Day with a guest speaker. There were over seventy members of staff in attendance including men. For further information on the women's network and current events see presentation link can be viewed at our website.

3.4.2. REACH Staff Network

The REACH Network (which stands for Race Equality and Cultural Heritage) was formed in 2019 and is one of the matured networks. It is a self-organised staff group addressing issues and feeding into the Trust's Culture Inclusion Equity Committee. The network looks to improve the working lives of ethnic minority staff by informing and empowering them and ensuring their rights are respected. The network has remained very successful and has continued to offer regular events for its members. For further information on the REACH network and current events see presentation can be viewed at our website.

3.4.3. Enabling Staff Network

South West London Integrated Care System

Disability Advice Line

The Enabling network was formed in 2019 and is one of the matured networks. It is a self-organised staff group addressing issues and feeding into the Trust's Culture Inclusion Equity Committee. The network has a new management team consisting of new co-chairs. It has a senior sponsor, who is the chairperson for GESH. The network had a very busy year in 2022. The network focus is building managers' capacity by giving them the tools to support disabled and long term medical conditions. To attract recruit and retain disabled people in the workplace. In 2023, the SWL ICS funded a Disability Advice Line for the Trust. For further information on the Enabling's network and current events can be viewed at our website.

3.4.4. LGBTQ+ Staff Network

The LGBTQ+ network was formed in 2019 and is one of the less matured networks. It is a self-organised staff group addressing issues and feeding into the Trust's Culture Inclusion Equity Committee. The network held an awareness webinar on LGBT+ Health Inequalities and Non binary. The event was attended by Trust staff, who participated in breakout rooms and some completed the poll responding to the question 'Where do you think ESTH are on LGBTQ+ equality'. For further information on the LGBTQ+'s network and current events see presentation can be viewed at our website**.**

3.4.5. Chaplaincy

The Chaplaincy department provides professional pastoral, spiritual and religious care by being alongside patients, their loved ones and staff, to enable them to find meaning and purpose in their situation. The service is person centred and is guided by the person's values, perceptions and outlook on life, which may not involve believing in a higher power or following a specific religion. The department also provides diverse rites and rituals to mark important transitions in life such as death, marriage or the birth of a baby.

The team also provides one-to-one/group staff support, staff training around faith and cultural issues and also acts as a resource for different religious and cultural information and needs. For further information on the Trust Chaplaincy service can be viewed at our website.

3.5. Armed Forces and Veterans

The Armed Forces Covenant is our public pledge to support patients and staff who have or who are still serving in the military. The work to support veterans, patients and their families is marked by the commencement of a project aimed at gaining accreditation for the Trust to become as a veteran-friendly

hospital.

In April 2021, the Patient Experience Team began engagement with the Veteran Covenant Healthcare Alliance (VCHA) to start working towards gaining accreditation to become a veteran-friendly hospital. We were very proud to sign the Armed Forces Covenant on 10 November 2021, making our public pledge to ensure that the armed forces community face no disadvantage when accessing our services.

To help celebrate the signing and commemorate Armistice Day we asked the public to send in their knitted poppies. We received over 500 poppies and were able to decorate the outside of Epsom and St Helier hospitals. To help raise awareness of why it is so important to support the armed forces community, we produced a veteran's digital story. Our Security Operations Manager very kindly shared his armed forces experience and his transition back into civilian life which we captured and made available via the Trust's YouTube channel (https://www.youtube.com/watch?v=672WhJpPnTo).

This digital story has now been adopted by a number of other trusts and organisations including Ashford and St Peters Hospital, Surrey and Borders Partnership Trust and Hampshire Police which are sharing with their staff to illustrate the importance of identifying and supporting the armed forces community.

3.6. Staff–Side

Epsom and St Helier Staff side is a collective of unions who have the aim of achieving the best working conditions for our staff. It is made up of unions that represent different staffing groups across the Trust. The Staff side meets with Trust management once a month to discuss and negotiate on matters that affect staff. This may include negotiating for policies that provide staff with better working conditions and support; discussing consultations on changes to staff contracts and working patterns, to achieve the best outcome for staff members, and highlighting any inequalities caused by these changes.

The Staff side uses the Partnership forum to

- Raise concerns about inequalities that unions have been informed of or witnessed
- Negotiate for staff health and well-being improvements
- Voice the need for the Trust to support staff education and training
- Raise issues from around the Trust
- Challenge managers and make suggestions on changes that could assist with improving staff morale, staff support and reduce bullying and harassment

The Trust Partnership Forum (TPF) meets monthly with Trust management and Staff side representatives to discuss and address matters of concern raised by management and staff.

3.7. Policies, procedures

All policies are accessible via Victor (intranet site). The Trust no longer issues paper copies to prevent version control issues. Everything on Victor has accessibility features built-in for ease of use. The Trust holds a vast amount of policies, guidelines, SOP's and patient information leaflets.

The Trust has a Flexible Working Policy and Special Leave Policy to support employees in continuing in employment and managing work life balance.

3.8. Staff training and development

We take the learning and development of our team very seriously. We have hundreds of learning opportunities for all of our staff that will meet developmental needs for those from different backgrounds, roles or professions. Our training programme offers an extensive range of courses, from first aid at work through clinical systems training to presentation skills and leadership development. We also offer our staff the opportunity to gain accreditation with a QCF (Quality Care Framework) award while at work.

We also pride ourselves on recognising talent and supporting people's aspirations. We sponsor a number of healthcare assistants every year to undertake their nursing degrees or to become an assistant practitioner. We have numerous opportunities for medical staff as well, which are run by our two postgraduate medical centres. Our postgraduate medical centre provides training for doctors at all stages of their career, as well as a stimulating lecture programme.

Similarly, the Trust offers an EDI e-learning (Equality & Diversity & Human Rights) as a statutory/mandatory requirement, which at year-end shows the following compliance:-

- 2022 - 78.3% of people accessed the mandatory training
- 2023 - 87.88 % of people accessed the same course

There was an increase in 10% in compliance rates which is in-line with the Trust target.

The Trust has an Appraisal Policy with an appraisal 'window' which is reviewed on a rolling monthly basis. The appraisal documentation (along with the supplementary resources and training) places emphasis on the importance of carrying out as a minimum, an annual health and well-being conversation as part of the appraisal review.

We have Equality and Diversity e-learning resource materials produced by Skills boosters. The resource material was developed with consultants from Pearn Kandola. Managers can access over 300 learning materials and videos (short and long presentations) on the Trust training platform.

Our Deputy Chief People Officer is holding regular workshops, during 2023 and future topics will include:

- Staff induction and helping them settle in
- How to deal with bullying and harassment
- Being an inclusive and compassionate leader and colleague
- Manager and employee self-service on ESR
- How to have an effective appraisal
- How to provide and receive feedback
- Encouraging civility and psychological safety
- How to avoid payroll issues

3.9. Equality Impact Assessments (EIA's)

All policies that affect the workforce are subject to an Equality Impact Assessment (EIA). The Trust Partnership Forum through Staff-Side is involved in the development of both new and revised policies, as part of the cross-over approach to embedding EDI into service delivery.

The Trust has an EIA Scrutiny panel which consists of staff networks currently being consulted as a mechanism for participation in workforce policy development, which has representation from the Enabling; REACH; Women's, LGBTQ+ staff networks, and the Chaplaincy team.

As a Trust we are aspiring to update our business cases, policies, procedures, processes and upskill our staff in how to properly carry out Equality Impact Assessments (EIA) to support Equality Diversity and Inclusion (EDI) considerations and make better decisions, when considering all service re-designs and workforce change. We have carried out collaborative training for staff, which covers health inequality impact assessments from a clinical or operational or service perspective. This means that staff can formulate an EIA that addresses the needs of their area.

All policies must be socialised, at the relevant committees, before going to the Trust's Policy Review Group (PRG). The EIA must be completed before the policy approval group can sign off and issue the policy to all staff. A policy going to PRG must be received by the Deputy Head of Corporate Governance at least one week before the meeting takes place. At that time, it must have been approved by all relevant stakeholders, submitted to the library for reference checking, and have a completed and approved EIA.

The EIA form contains a detailed appendix outlining the Equality Act 2010 and Public Sector Equality Duty 2011. The appendix highlights key considerations as they relate to protected characteristics and inclusion groups (as defined by NHS England Health Inequalities Duty 2006). The EIA provides a framework of questions to guide the impact assessor in considering the Human Rights Act. It also provides information and key statistics to highlight health inequalities, which includes mental health inequalities.

During 2022-23 there have been over sixty EIAs carried out. The EIA process has taken up traction across services in 2021 with more policies being submitted with a completed EIA. The EDI Team in collaboration with NHSEI and Surrey Heartland ICS has delivered and scheduled EIA and EHIA training for staff and policy leads. The program has run from January 2021 and will continue to September 2023. We continue to deliver the EIA training with the ICS, Consultant midwife and Head of EDI to expand the number of staff who are able to complete EIAs across the service.

Conclusion

This report has provided an overview of the Trust work towards meeting the Public Sector Equality Duty with respect to both the general duties (in the form of narrative) and the specific duties (with respect to the trust equality data which can be found in reports 1 and 2.

Whilst there is work to be done, the Trust can show that it is linking its work into meeting the general duties and identifying areas for improvement.

The past year has seen a number of successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including the launch of the trust's first Culture Equity and Inclusion Board, and GESH co-production of a new strategic plan for equalities and strengthening the Trust governance structure to equality, diversity and inclusion.

Celebrating differences which showcased Ramadan, South Asian History Month, Black History Month, International Women's Day, LGBTQ+ Health inequalities, Disability Advice Line, WRES and WDES conferences.

However there remain some challenges for the Trust, most notably in relation, the Workforce Race Equality Standard and Workforce Disability Equality Standard, and the 'Big 5' priority areas listed below in many ways are a refined version from the themes identified from the previous year (2021) and are shared between ourselves and St George's.

- Civility and psychological safety
- Bullying and harassment/keeping staff safe (violence and aggression)
- Inclusive behaviour within teams
- Compassionate and inclusive leadership
- High performance teams

Targeted work in June 2022-2023 has begun to yield results of our staff survey results around some of this and the Workforce Disability Equality Standard (WDES) and Workforce Race Equality Standard (WRES) will mean a need to consolidate learning for all NHS equality standards into one place to ensure due regard is paid to each.

Throughout 2022/2023 there are a number of projects planned including the Ask Aunty program, mobile phone app and the Disability Advice Line.

With respect to the new EDS 2022 the result will be published in October 2023 which will review some aspect of the trust work not in its entirety but some areas such as patients, workforce, and leadership.

In 2023 the trust published its first baseline data for the Ethnicity Pay Gap, but we are not legally obliged to produce or publish one. This is in line with other employers who are calculating and reporting their gaps already. Legislation should not be the motivation behind this as we should go beyond legal duties and move towards greater transparency becoming the norm. We will keep it on our list of things we ought to do.

However there remain issues concerning the consistency of delivery and the quality of the demographic data that should inform improvement actions to ensure that all demographic groups are receiving equally good treatment from the Trust.

Report 2

PSED

Workforce, Recruitment and Starters & Leavers Data Analysis

Other formats and languages

If you would like a copy of this report in a different language or a different format, such as large print or Braille, please contact:

Equality, Diversity and Inclusion
Department Epsom and St Helier
University Hospitals NHS Trust

Tel: 020 8296 2000

Table of Contents

Section 1- Epsom and St Helier University Hospitals NHS Trust (ESTH) Workforce as 31st March 2023

1.1 Introduction

ESTH provides general hospital and community services to over 490,000 people in south-west London and north-east Surrey.
We operate in a complex environment, with overlapping geographies and places. This includes:

- **Two systems**: South West London Health and Care Partnership and Surrey Heartlands Integrated Care System
- **Two places:** Surrey Downs Health and Care and Sutton Health and Care
- **Bilateral joint working:** with St George's University Hospitals NHS Foundation Trust as part of GESH Hospitals Group
- **Collaboration:** South West London Acute Provider Collaborative (St George's University Hospitals NHS Foundation Trust, Croydon Health Services NHS Trust and Kingston Hospital NHS Foundation Trust). ESTH's Strategy 2020 – 2025.

The Trust's People Strategy 2020-2025

2020, the Trusts revised mission is to deliver 'Outstanding care, every day', building on the progress that has been made over the past five years, and setting ourselves an aspiring goal.

To deliver this, the Trust recognises that it needs to strengthen its people, culture and value. This recognises the contribution our people make to delivering outstanding care and responding to what matters to those who access our services and also our role in our local communities, including providing equity of service and reducing health inequalities.

The People Strategy is still in place and the Culture work we are doing supports this plus the GESH Group Strategy 2023-28.

What do we want to achieve?

Our vision for 2028 is to provide outstanding care, together.

With the help of our patients, staff and partners, we have chosen four overall aims for 2028 – our CARE objectives. These are the things we care about the most and will be central to achieving our vision.

- **C**ollaboration and partnership
- **A**ffordable services, fit for the future
- **R**ight care, right place, right time
- **E**mpowered, engaged staff

In all this, everything we do will be driven by our patients.

How will we get there?

The answer is – together. 17,000 people work at St George's and Epsom and St Helier, and every one of us will have a part to play in making our vision a reality.

We will deliver our vision through:

1. **Local improvement**: continuous improvement, pursued by teams of staff at every level in our organisations, from Board to ward, against a common framework of annual improvement priorities.

2. **Corporate enablers**: action led by individual corporate departments, working with clinical teams, to deliver against a range of corporate strategies: quality and safety, people, IT, estates, research and innovation, our green plans.

3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work:

- The Building Your Future Hospitals programme
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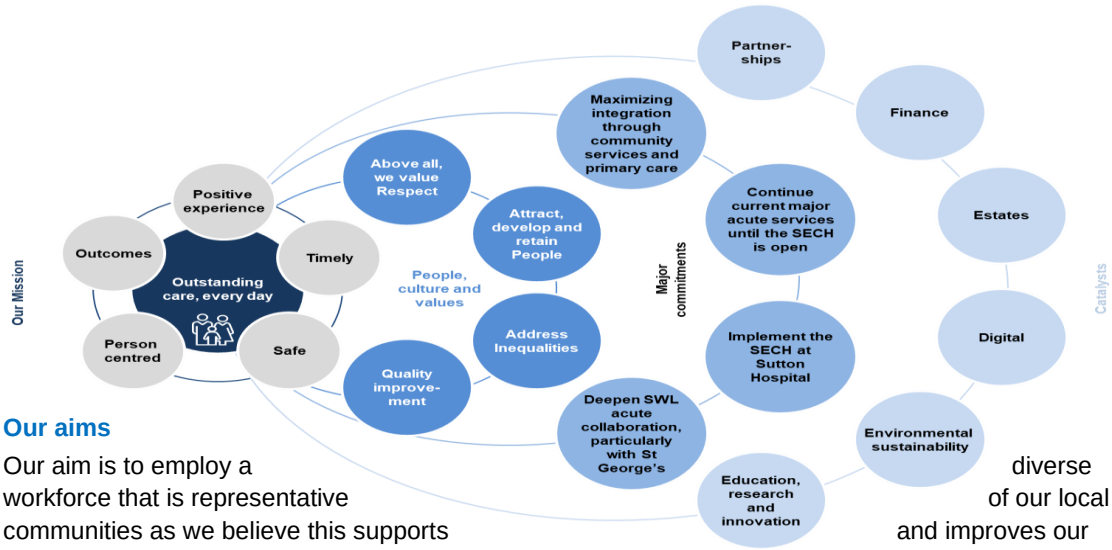
- Strengthening our specialised services

You can read more detail about our CARE objectives in our strategy summary document or in our full strategy. We have also produced a short animation explaining the key points of our strategy, which you can view here.

Figure 1:



Our aims

Our aim is to employ a diverse workforce that is representative of our local communities as we believe this supports and improves our decision-making in the development of health care services. This section of the report illustrates the demographics of Surrey and South West London and the Trust's workforce as of 31 March 2023.

1.2 Workforce

The figure 2 tables below shows the comparison of how the trust footprint straddles SWL and Surrey boroughs, by protected characteristics and looks to highlight whether the trust workforce reflects the community it serves.

Key Highlights - Figure 2

Protected Characteristic	Narrative
Age	
	Epsom and St Helier' Trust 2023 shows the age ranges between 31-40,(28.5%), 41.50 (24.2%) 51-60 (24.7),and under 31 (17%) have no significant gaps in percentages they remained static over the last 12 months. 61+ age group (10.6%), increased by 0.6% compared to the previous year which was (10%). **South West London population** Ages 30-39 (20.7%) make up the largest proportion of the population in South West London, which is not significantly different from the trust age demography. The following age ranges are, 20-29 (17.5%), and 40-49 (14.2%) the trust is over-representative of these age ranges. Notably, South West London's Average Age is 35.7%. ESTH Staff are positively representative of the population we serve. **Surrey Population** Across Surrey, less than a quarter of residents were aged 19 or under (23.8%), with roughly 6 in 10 of 'working age' (20-64 years, 57.3%), and just under a fifth (18.9%) being 'older people' (aged 65 or above). Overall, ESTH age demography is positively representative of the population we serve.
Disability	

	Epsom and St Helier' Trust In 2023 shows 4.28 % of the workforce disclosed they have a disability this is a slight increase of 0.28% on the previous year which was (4%). **South West London population** South West London 2021 census reports in the following categories 59.2% reported they have very good health. 28.7% good health. 8.6% average health. 2.6% poor health and 0.8% very poor health. **Surrey Population** The day-to-day activities of 13.5% of Surrey's population are limited by a long-term health problem or disability. This proportion is unchanged since 2001 The activities of 88,600 (5.7%) are limited to "a lot". 86% of Surrey residents are in good or very good health, with just 3.5% suffering bad or very bad health 108,400 (9.6%). **Overall findings** Overall, ESTH disability demography doesn't represent the population we serve.
Gender - Re-assignment	
	Epsom and St Helier' Trust There is a Data Gap. Data is not collected for this characteristic. No national agreement on the collection of data or what question/s to ask. **South West London population** There were no data on this group for SWL. **Surrey Population** A total of 3,628 residents (0.37%) in Surrey answered "No", indicating that their gender identity was different from their sex registered at birth. Within this group: • 1,361 (0.14%) answered "No" but did not provide a write-in response • 731 (0.08%) identified as a trans man • 756 (0.08%) identified as a trans woman • 495 (0.05%) identified as non-binary • 287 (0.03%) wrote in a different gender identity **Overall findings** Overall, it's hard to make meaningful analysis of this group; ESTH does not capture enough data to confirm whether the trust is representative of the community it serves.
Marriage & Civil Partnership relationships	
	Epsom and St Helier' Trust 2023 Staff reported their marital status 51.1% disclosed they were married slight decrease by 0.9% from the previous year which was (52%). Single, shows 33.2% a decrease of 3.2%; divorce, civil partnership and legally separated have remained static over the last 12 months. Notably, the not disclosed 7.6% has increased by 4.6% compared to the previous year which was (3%). **South West London population** South West London partnership population constitutes 43% who are single. 43% are married and in a civil partnership. 2% are separated and still legally married. 7% are divorced and 4% are widowed**.**

	Surrey Population Census data relating to Civil Partnerships shows that 665 people (0.35% of the population in the borough) responded as being in a registered same-sex civil partnership. **Overall findings** Overall, ESTH age demography shows no significant difference to the population it serves.
Pregnancy and Maternity.	
	The number of maternities represents the number of women giving birth **Epsom and St Helier' Trust** Data is not currently collected on ESR this is held by HR separately. Workforce to provide data **South West London population** South west London 2022, 2,492 babies delivered **Surrey Population** Office for National Statistics data shows there were 12,451 live births in Surrey in 2021 – 571 more than the previous year. **Overall findings** Overall, it's hard to make meaningful analysis on this group, ESTH, does not capture enough data to confirm whether the trust is representative of the community it serves.
Race	
	Epsom and St Helier' Trust 2023 shows 50.4% of the workforce identified as White, this is a decrease of -6.6% on the previous year which was (57%). 40.9% are from Black Asian Minority backgrounds this is an increase of 2.7% from the previous year which was (38%). 7.64% chose not to disclose this has increased by 2.64% on the previous year which was (5%). **South West London population** South West London is home to an ethnically diverse population and several ethnic groups across boroughs. The White population represents 68%. Black Asian and Other minority ethnic constitute 32% of the population. **Surrey Population** According to the latest 2021 census, the population in Surrey is predominantly white (85.5%), with non-white minorities representing the remaining 14.5% of the population. Asian people were the largest minority group in Surrey accounting for 7.7% of the population. 20,834 or 2% of the Surrey population are black according to the latest 2021 census. **Overall findings** Overall, ESTH, Black Asian Minority Ethnic staff are positively represented by the populations we serve.
Religion and Belief	

	Epsom and St Helier' Trust Staff who identify as Christian is 47.8 % a slight increase of 1.8% from the previous year which was 46%. Non-disclosure among staff is 23.5 % overall, a decrease of -2.5% compared to the previous year which was (26%). Islam, Hinduism, Sikhism, Buddhism, and other religious group represent 18.26% collectively of the workforce these groups has remained fairly static over the last 12 months. **South West London Population** 75% of the SWL population identified as Christian, not much of a significant difference in comparison to the trust's workforce. Islam, Hinduism, Sikhism, Buddhism, and other religious group make up 26% of the community. **Surrey Population** 51% of the Surrey population identify as Christians. 36.6% have disclosed they have no religion. Islam, Hinduism, Sikhism, Buddhism, and other religious groups represent 6.4% of the community. **Overall findings** Overall, ESTH, religion or belief of staff isn't representative of the population we serve.
Gender	
	Epsom and St Helier' Trust When we compare the NHS National workforce figure of 76.7% female and 23.3% male% this is similar to the ESTH staff figure of 75%female and 24% male. Women have decreased by -2% compared to the previous year which was 77%. Males have increased slightly by 1% compared to the previous year. **South West London population** Males account for 48% of South West London population, while females made up 52% **Surrey Population** Males account for 48.8% of Surrey's 1,205,616 populations, while females made up 51.2% of the total. **Overall findings** Overall, ESTH gender demography for females is positively represented of the population we serve. However, males are underrepresented in our workforce compared to the communities we serve.
Sexual Orientation	
	Epsom and St Helier' Trust In 2022-23 a total of 76.5 % of staff identified as heterosexual or straight an increase of 2.5% on the previous year (74%). A total of 21.1% were asked but declined to provide their sexual orientation status, a decrease of 2.9% from the previous year which was (24%). Lesbian (0.46%), Gay men (2%) Bi-sexual (0.87%), and other sexual orientation not listed (0.14%). **South West London population** 1.31% described themselves as gay and lesbian. 0.87% as bisexual. 0.14% selected "Other sexual orientation" **Surrey Population** 881,673 people (90.66% of the Surrey population aged 16 years and over) identified as straight or heterosexual. 11,355 (1.17%), described

	themselves as gay or lesbian. 10,232 (1.05%) described themselves as bisexual. 2,535 (0.26%) selected “Other sexual orientation.” Overall, ESTH gender demography for sexual orientation was not significantly different to the communities we serve. **Overall findings** Overall, ESTH sexual orientation demography is positively representative of the population we serve
Source	https://www.varbes.com/demographics/surrey-demographics https://www.plumplot.co.uk/South-West-London-census-2021.html https://uk.news.yahoo.com/number-pregnant-smokers-south-london-050000363.html

1.3 ESTH Workforce Profile as of March 2023

Table 1

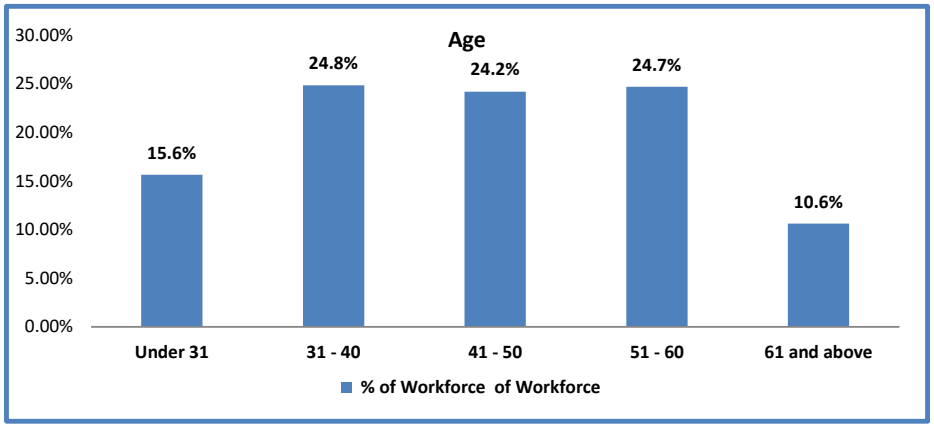


Table 2

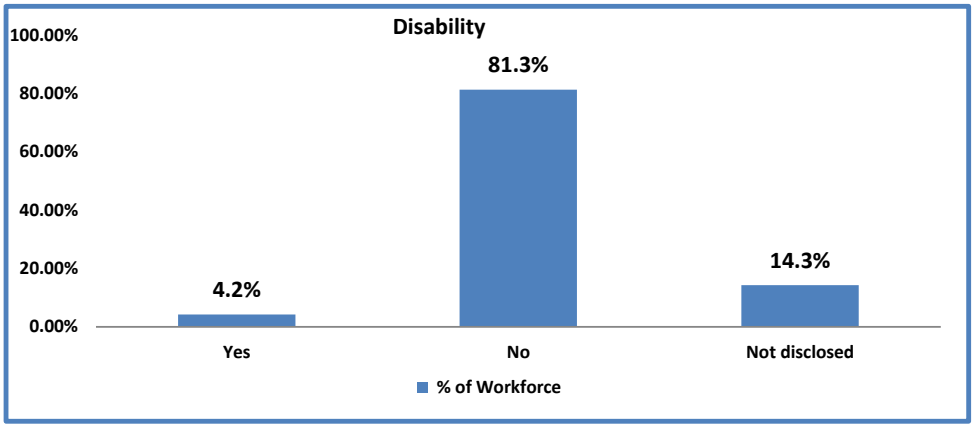


Table 3

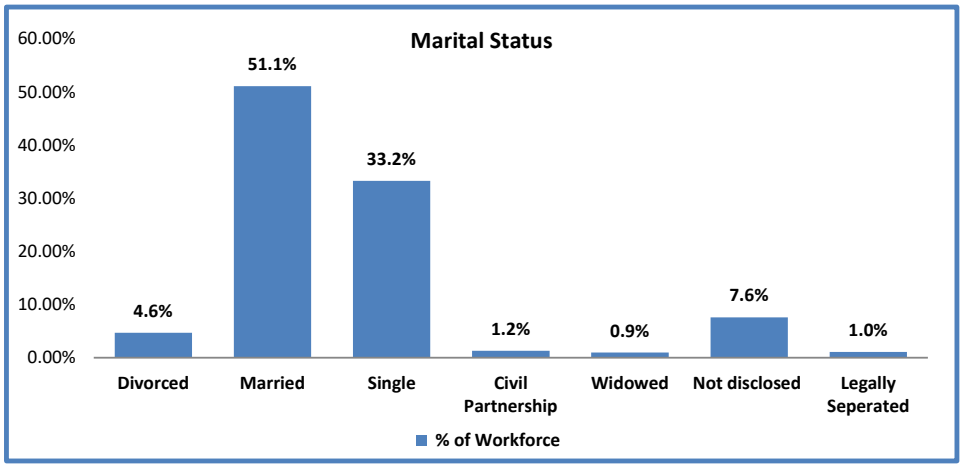


Table 4

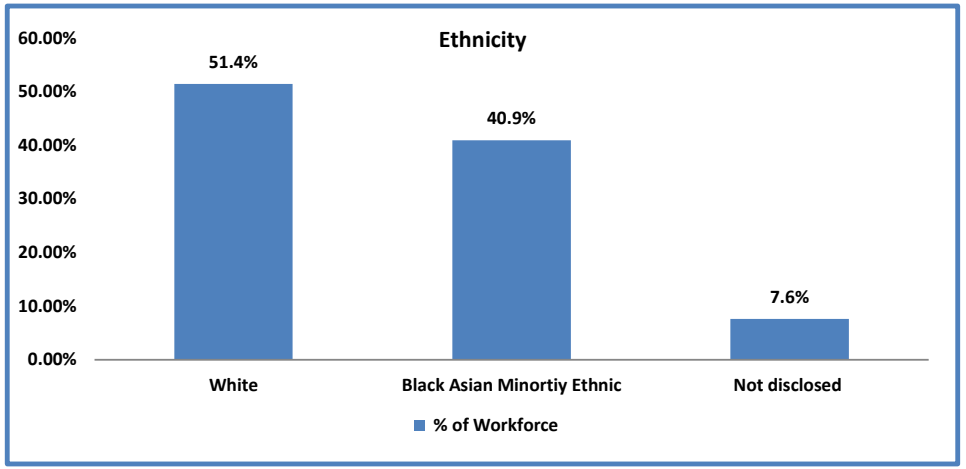


Table 5

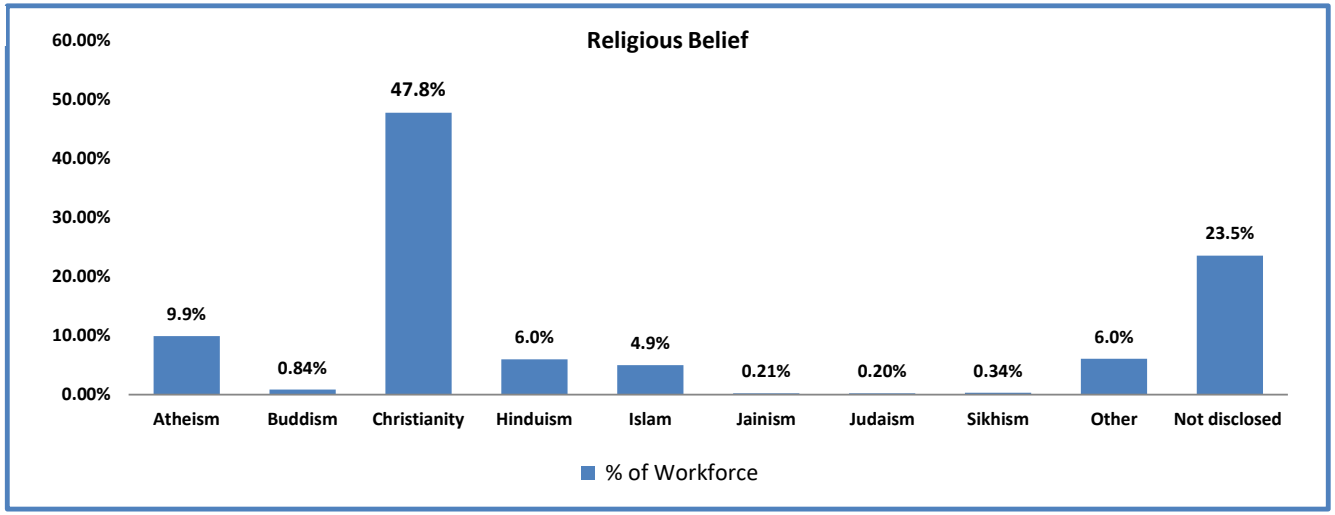


Table 6

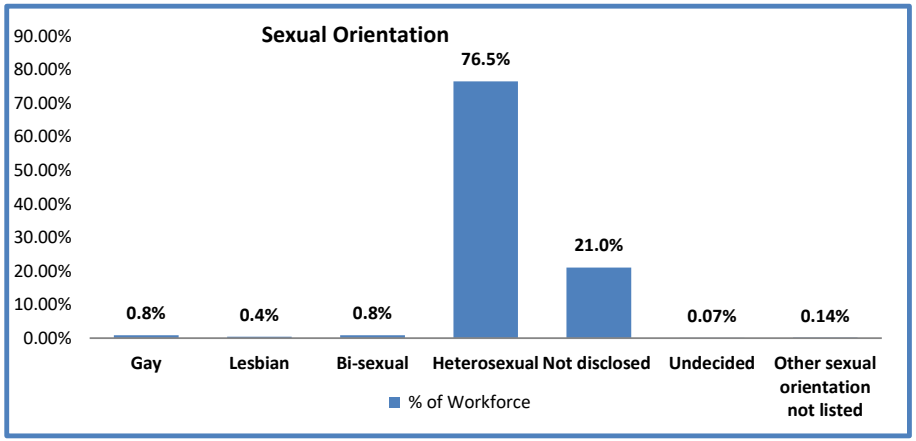
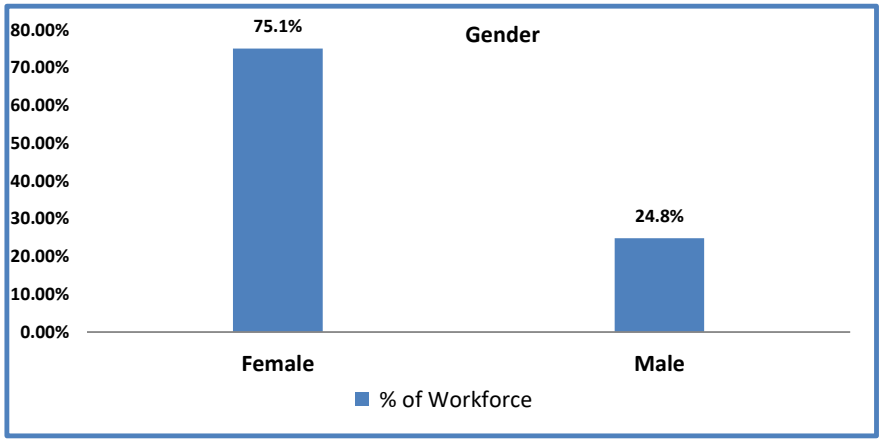


Table 7



Section 2 – Recruitment

2.1 Recruitment and Selection as of 31 March 2023

Recruitment and retention remain one of the highest priorities for the Trust. Our workforce has faced some of the most difficult challenges during the pandemic, and has continuously worked above and beyond. We are grateful to all of our staff who supported us during this time including those who deferred their retirement or returned to work, and to those staff who were redeployed into the most critical services. Over this period, we have required additional support from our bank, agency and support workers who have been an essential part of our workforce and contributed significantly during this time. Despite the pandemic having been officially declared as over, the subsequent pressures on staff to deal with backlogs of treatment remain high.

The establishment of the new South West London Recruitment Hub has enabled the Trust to address recruitment issues across the region more collaboratively. By working more collaboratively we have achieved a reduction in time to hire and, as a result, our vacancy rates as well as our reliance on the use of temporary staffing have reduced. We have also seen an increase in our new starters in comparison to previous years. While there is more to do to address our recruitment challenges, we have recorded important progress.

2.2 Recruitment Process Data by Protected Characteristics

The Trust collects recruitment data on the Protected Characteristics. Data shown on pages 14 -17 is display in a chart and is analysed by protected characteristics on an annual basis by the SWL Recruitment Hub Team. The information provides a breakdown of applicants by protected characteristics and how they fared well within the recruitment process. We will use the data as a baseline for identifying any future trends where potential disparities between certain protected groups may exist during the recruitment process, and where any such disparities be mitigated or rationalised.

To highlight this issue, we looked at data on people applying and being shortlisted and appointed to ESTH jobs. Covering 12 months from April 2022- March 2023, the data are vast, including some 24546 applications, 6252 shortlisted, 3940 attended interviews, and 622 appointed.

The way our recruitment system, TRAC, moves applicants through the system is they are only completely moved to ‘appointed’ status once the entirety of the vacancy has been closed and all applicants moved to appointed in the flow. Please note a few points based on the data from TRAC and the EDI reporting data numbers:

- All data is supplied from a full-year cycle and includes all applicants that have applied at any stage throughout the requested year.
- All numbers supplied are as submitted applicants and are corrected in the stages of Applications, Shortlisted and Interview attended
- At the appointed stage the numbers seem lower due to the nature of the way TRAC is structured and moved into the appointed stages in comparison to the actual starters within the Trust itself.

2.3 Data on the recruitment and selection profile: Key highlights

Ethnicity

The data shows that individuals with White ethnicity were more frequently selected from the shortlist, compared to those from ethnic minorities. Despite this, Black British Africans submitted the highest number of applications (9418), with (917) being shortlisted, 586 attending interviews, and 81 being appointed. It is important to note that success rates varied greatly among different ethnic groups, with mixed heritage individuals such as White & Black African, Indian, White Asian, Bangladeshi, or other ethnicities experiencing lower success rates.

Age

Age ranges 30-35, and 36-39 were the highest (120 and 105 respectively) made applications and were appointed from shortlisting. Notably, as the age increased there were fewer appointments, in particular in the age ranges of 60-65+.

Disability

879 disabled applicants applied 407 were shortlisted from that figure only 231 attended interviews and 36 were appointed.

Transgender

One Trans person applied, none shortlisted and no appointment

Marital Status

The civil partnership cohort saw 366 applicants in total.153 were shortlisted and 19 appointed.

Gender

Out of 4274 shortlisted candidates, 514 women were appointed after 2769 attended interviews. Similarly, out of 1773 shortlisted candidates, 106 males were appointed after 1054 attended interviews.

Religion or Belief

Those of a Christian faith had the most applicants and appointments (350) from shortlisting (3229), followed by Atheists who had fewer appointments (90) from shortlisting (715). Although Hindus had a substantial number of applicants (2237), only a small percentage were appointed (40) from shortlisting (565).

Sexual orientation

Out of a total of 5453 shortlisted applicants, the highest number of appointments (561) went to heterosexual individuals. The second highest number of appointments (29) from shortlisted (278) went to individuals who did not disclose their sexual orientation. Gay and lesbian individuals were the third largest group of applicants (299) and received (19) appointments from a shortlist of (112).

2.3.1 International workforce

International nurses make a significant contribution to our healthcare system. However, they often face challenges that can hinder their successful integration into the workforce. According to the NHS People Strategy 2021 A number of joint working opportunities have already been identified and established and further collaborative working will be essential if we are to maximise the workforce opportunities that we have across our region, particularly as we move towards an Integrated Care System.

Over the past year, our recruitment efforts have yielded impressive results, particularly in attracting specialized nurses, healthcare support workers, and newly qualified nurses. We have also opened up opportunities for trainee nurse associates through apprenticeships, further expanding our team. Despite the challenges posed by the pandemic, we have persevered and maintained our overseas recruitment efforts, which continue to be a crucial part of our nursing pipeline. Between May 2022 and March 2023, we were able to successfully recruit 82 overseas nurses to join our team and fill various roles across the trust, including adult nurses, children's nurses, and midwives. We are proud of our accomplishments and look forward to continuing to provide quality care to our patients with our dedicated and skilled nursing staff.

For international nurse/midwifery recruitment we have welcomed the following:

Table 9

International Nurse/Midwifery Recruitment:			
May 2022 - March 2023			
	Total	**Women**	**Men**
Adult Nurses	75	89%	11%
Children's Nurses	5	100%	0
Midwife	2	100%	0
Total	82	90%	10%

Table 10 summarises Epsom & St Helier's international workforce. The headcount for Feb 2022-Feb 2023 is (2029) corresponding to WTE 1829.

Key highlights

The whole time equivalent (WTE) report of 2023 provides crucial data on staff categories. Children are nursing accounts for 9%, while community nursing (excluding health visitors and district nurses) is 12%. Registered midwives make up 10% of the workforce, but there were no applicants for district nursing or school nursing positions.

The bands range from 5 to 8 and above, and the largest group, at 33%, Band 6, Band 7 makes up 24% of the workforce, while 10% are at Band 8 or above. It's worth noting that the age range of workers is between 44 -55 (17.2%).

However, there are notable numbers of workers between the ages of 20 and 45. Nevertheless, the number of WTEs starts to decrease significantly between the ages of 45 and 55, and the data is not available after age 65. Further investigation may be necessary.

The ethnicity breakdown shows that 42% of workers are white, 30% are Asian, 19% are Black African Caribbean, 3% are of mixed ethnicities, and 4% did not disclose their ethnicity. This data is essential for helping us to ensure diversity and inclusion in the workplace.

Table 10


Workforce Profile : Feb-2023
NHS
Health Education England
WTE:
1,829.0
Headcount:
2,029
Avg WTE:
0.90
Organisation Locations - WTE
Staff in Post
Feb-2022 to Feb-2023
Headcount
WTE
Region
London
ICS
NHS South West London Inte..
Organisation Type
Trust - Acute
Organisation Name
EPSOM AND ST HELIER UN..
Grade Band
All
Staff Group
Nursing & Midwifery
Profession
All
Job Role
All
Start Date
Feb-2022
End Date
Feb-2023
Reset Filters
(Except Region & Dates)
Staff Group
Adult Nursing 69%
Children's Nursing 9%
Community Nursing exc HV and DN 12%
District Nurses 0%
Registered Midwives 10%
School Nursing 0%
Grade Band
Age Distribution
Avg Age 44
Age > 55
17.2%
Ethnicity
Nationality
UK
EU/EEA (ex. UK)
ROW

Table 11

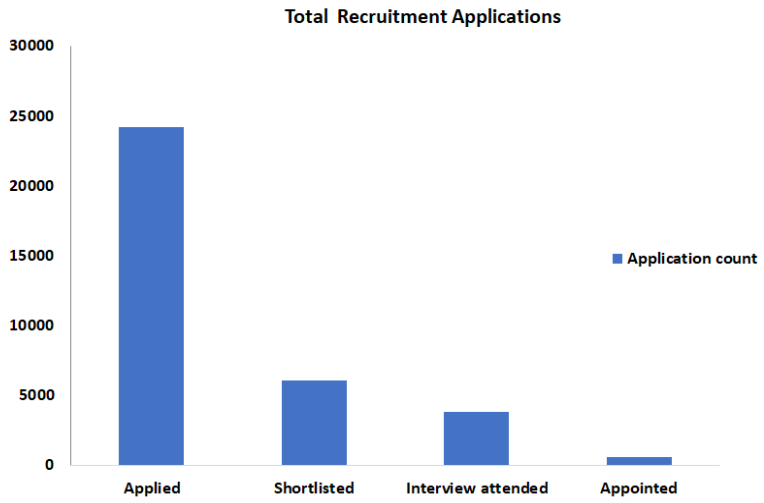


Table 12

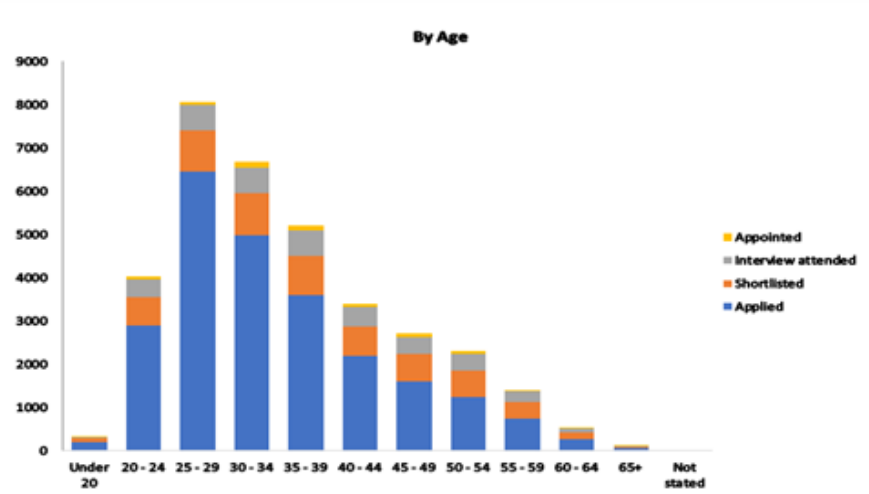


Table 13

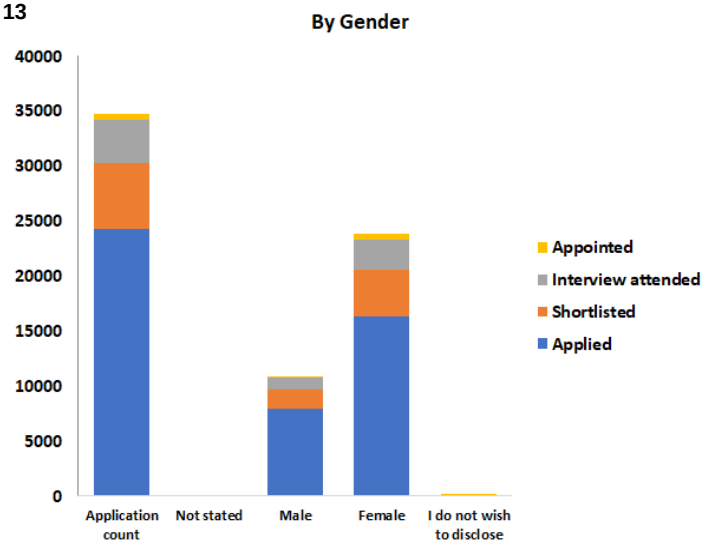
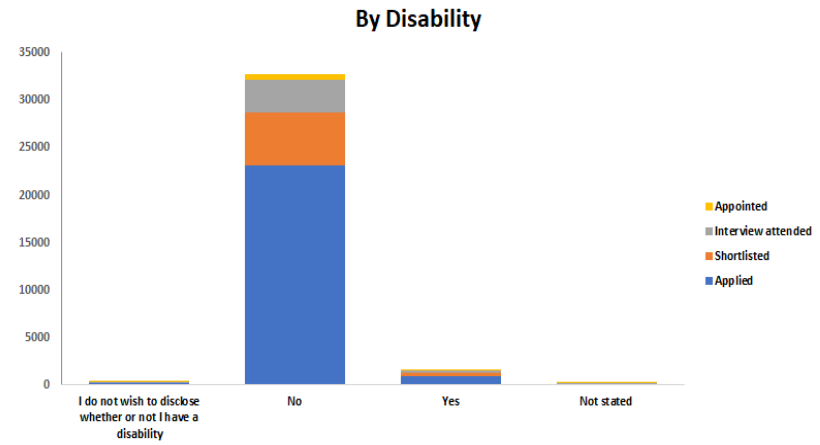


Table 14



17

Table 15

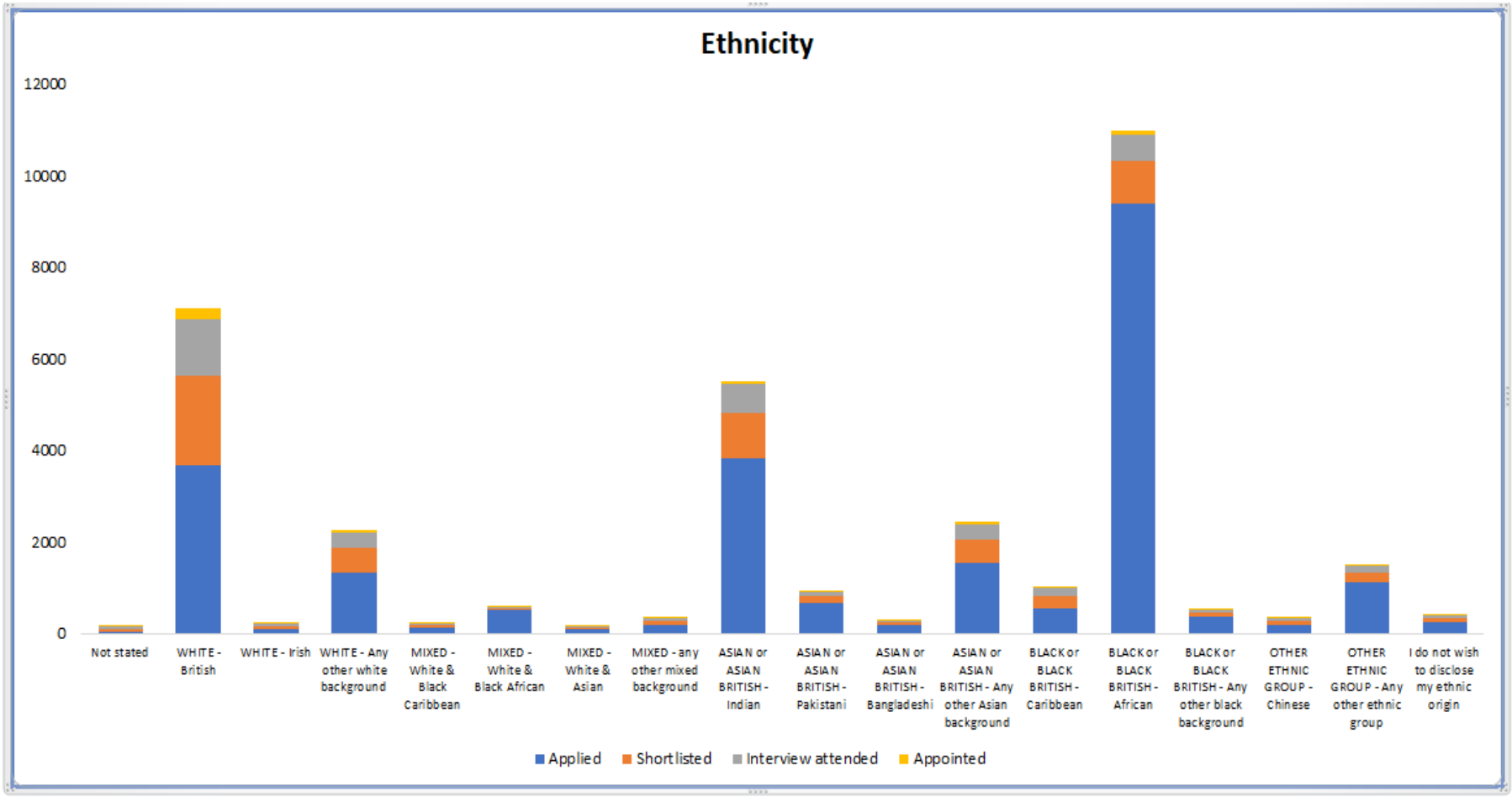

Ethnicity
12000
10000
8000
6000
4000
2000
0
Not stated
WHITE - British
WHITE - Irish
WHITE - Any other white background
MIXED - White & Black Caribbean
MIXED - White & Black African
MIXED - White & Asian
MIXED - any other mixed background
ASIAN or ASIAN BRITISH - Indian
ASIAN or ASIAN BRITISH - Pakistani
ASIAN or ASIAN BRITISH - Bangladeshi
ASIAN or ASIAN BRITISH - Any other Asian background
BLACK or BLACK BRITISH - Caribbean
BLACK or BLACK BRITISH - African
BLACK or BLACK BRITISH - Any other black background
OTHER ETHNIC GROUP - Chinese
OTHER ETHNIC GROUP - Any other ethnic group
I do not wish to disclose my ethnic origin
Applied
Shortlisted
Interview attended
Appointed

Table 16

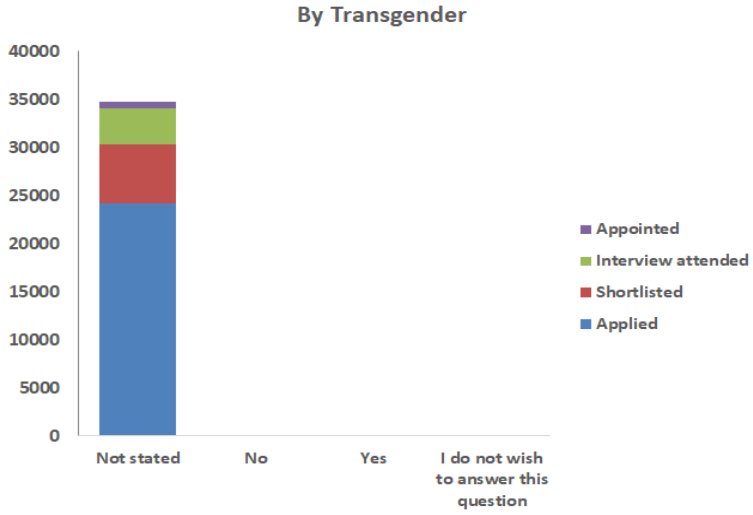


Table 17

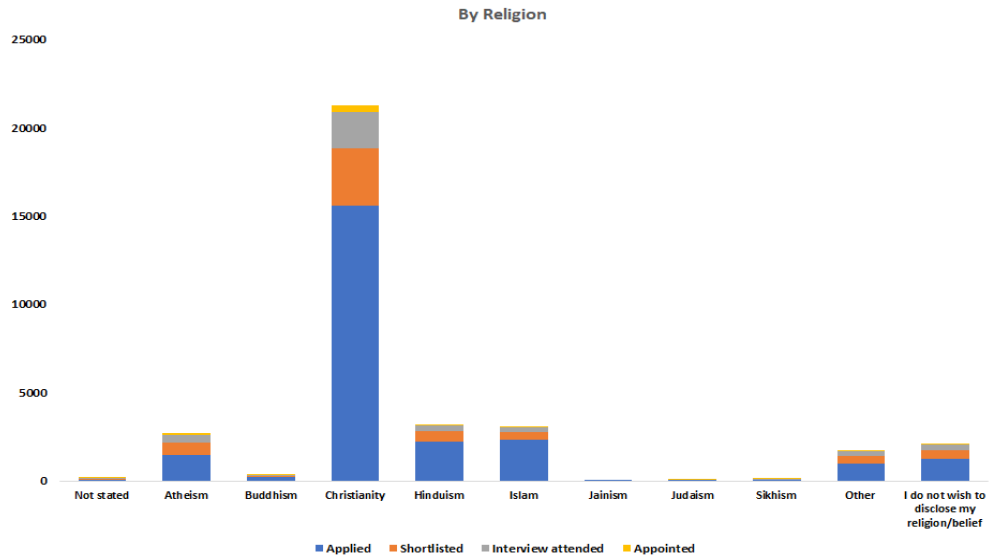


Table 18

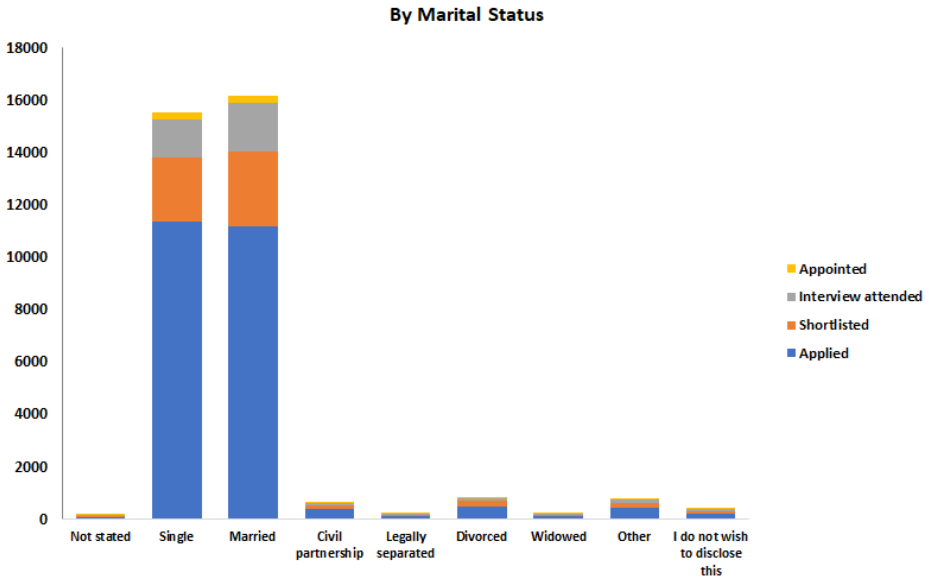
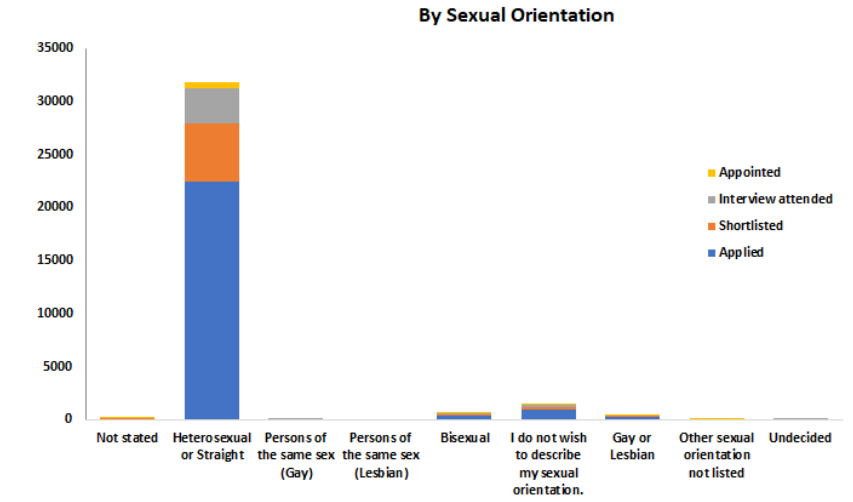


Table 19



Section 3 – Starters and Leavers

3.1 Starters and Leavers by Protected Characteristics as of March 2023

The work that the NHS does would not be possible without the critical contribution of a broad diversity of people, covering different genders, ethnicities, disabilities, religions, national origins, sexual orientations, ages and other characteristics.

However, there appears to be scope for the NHS to become a more inclusive, diverse and equitable workforce at every level. Across an array of characteristics – including ethnicity, disability, gender and religion – some groups are under-represented in certain NHS careers. Despite efforts to improve equality and inclusion in the workforce and some improvements around diversity – in terms of minority ethnic representation in very senior roles – progress has been limited. Overall, within the NHS the most commonly site reasons for leaving were relocation, health, lack of opportunities, promotion outside the trust, further education, training ,work-life balance and retirement.

Table (fig3) breaks down staff at ESTH by their staff group and compares starters with leavers. The table highlights trends within particular staff groups. From the table it can be deduced that the Trust is losing more staff than are starting across all of the staff groups, with the exception of additional clinical services, where we've retained more than we've lost.

Fig 3

.

ESTH	Starters WTE	Leavers WTE	Variance
Add Prof Scientific and Technic	23.44	46.91	- 23.47
Additional Clinical Services	291.21	220.20	71.01
Administrative and Clerical	143.89	183.26	- 39.37
Allied Health Professionals	90.43	97.05	- 6.62
Estates and Ancillary	75.33	76.17	- 0.83
Healthcare Scientists	6.43	11.40	- 4.97
Nursing and Midwifery Registered	182.18	272.41	- 90.23
Total	812.91	907.40	- 94.49

Key highlights

Our data reveals an exact count of 1327 new starters and 1429 leavers during the period of 2022-2023. The data clearly indicates a difference between the number of new employees and departures.

Ethnicity: In 2022-23, 53% of Black Asian Minority Ethnicity individuals reported starting with the Trust, while 40% of White staff left the Trust. **Workforce will validate this number**

Age: according to the data, an overwhelming 61% of staff left their positions before reaching the age of 41. Interestingly, new hires were predominantly younger, with those under 31 representing a higher percentage. However, the age range of 51-60+ experienced a significant contrast, with 23% of staff leaving compared to only 14% of new hires in that same age range. This disparity is noteworthy and deserves attention.

Disability: the data shows that 4% of new employees and 5% of those who left their jobs have disabilities, highlighting the challenges that disabled workers face. This trust recogniges the significance of promoting inclusivity and accessibility to ensure equity of opportunities for all.

Sexual orientation: In terms of sexual orientation, there were no noteworthy variations in the ratios of those starting and leaving among those who recognised themselves as homosexual, gay men, lesbian, or bisexual.

Religion or Belief: the available data indicates that there is no discernible contrast between Christian and atheists in terms of starting or leaving.

Pregnancy: in terms of pregnancy the available data indicates that there were no starters disclosed they were pregnant. However, 11(1%) of staff were reported as leavers were pregnant.

Starters and Leavers data

Table 20

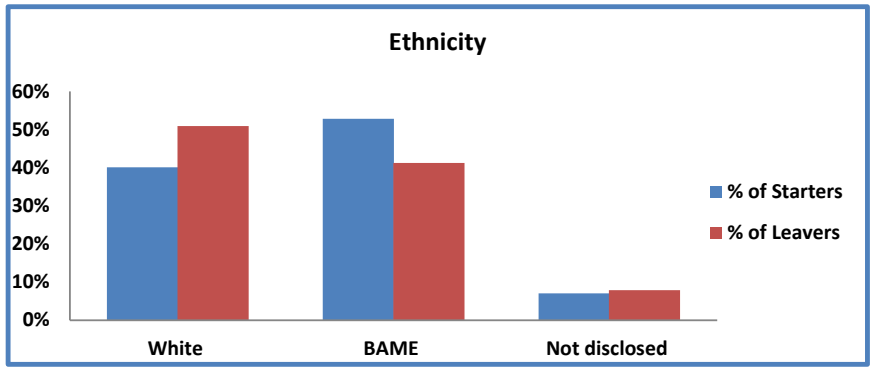
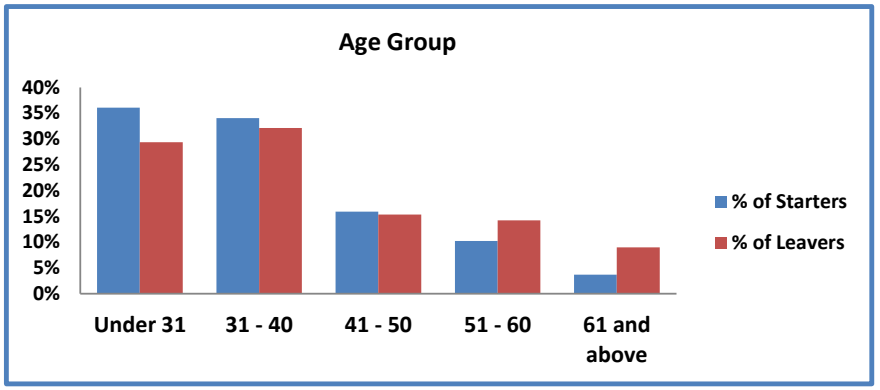


Table 21



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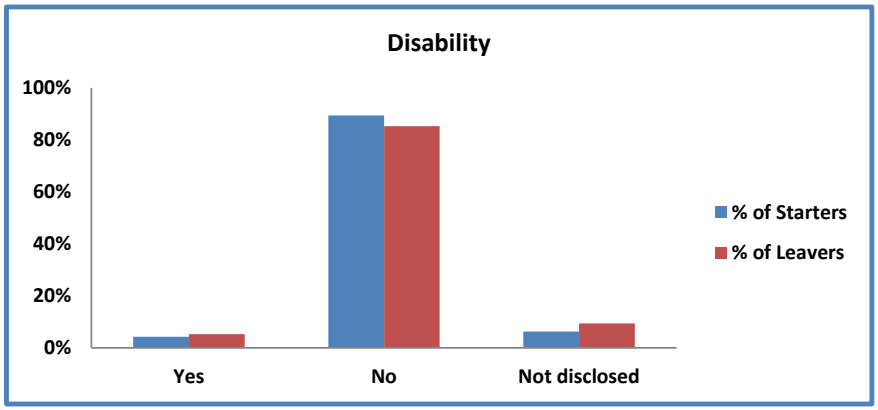

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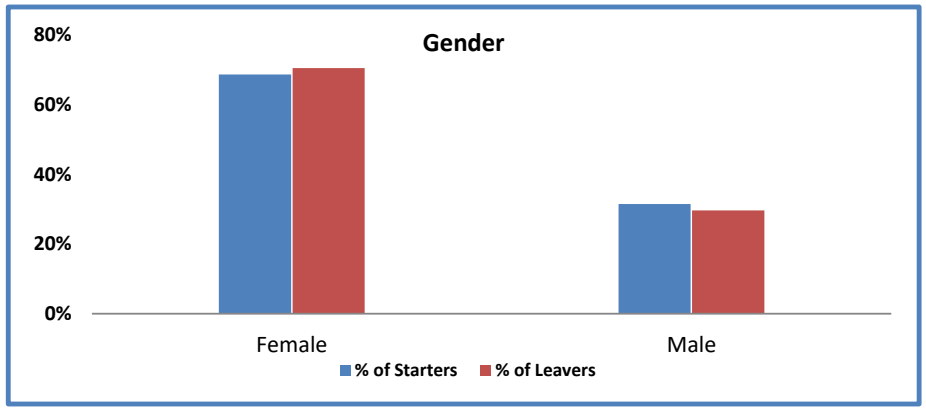

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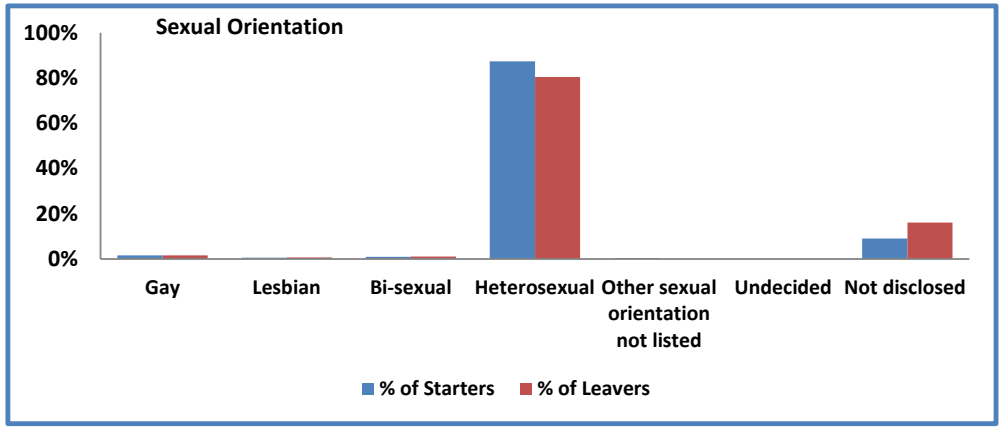

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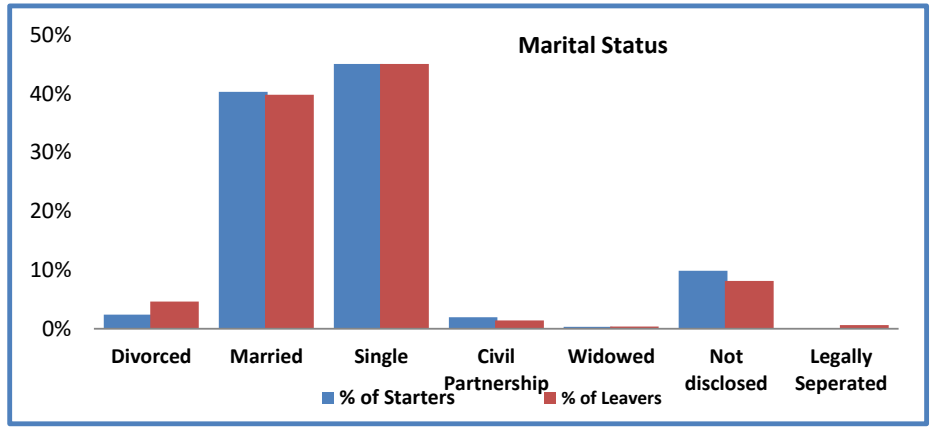

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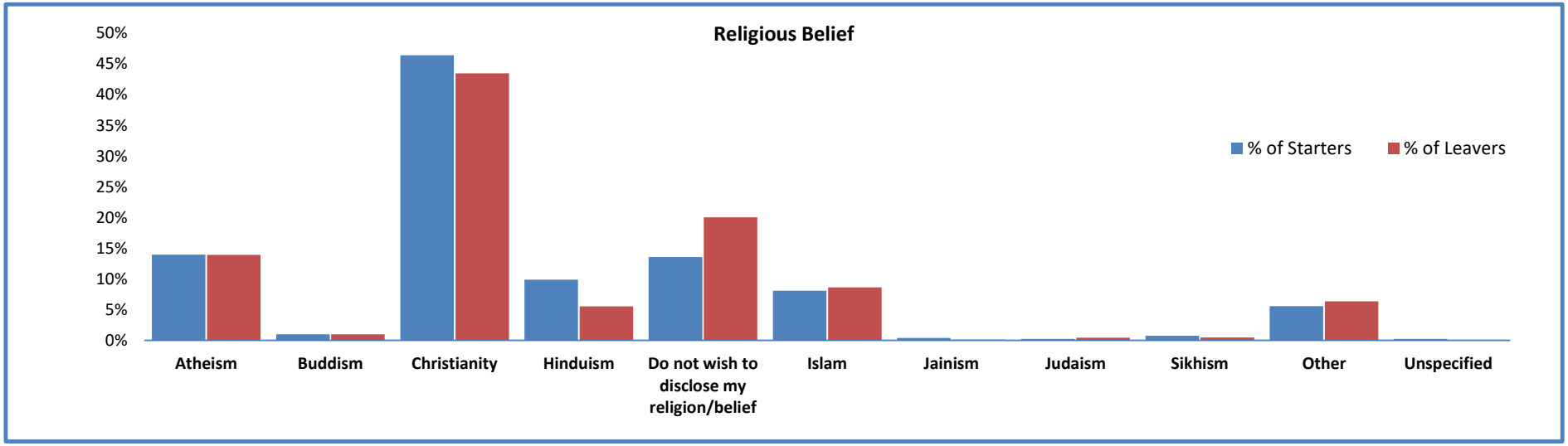

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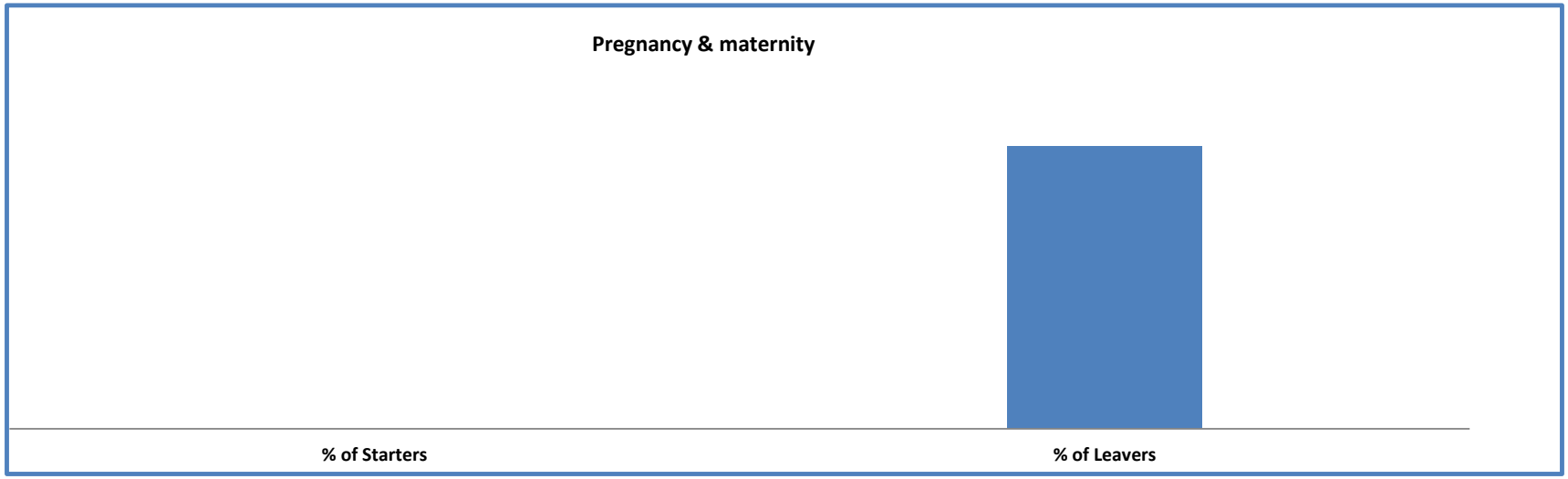

4.0 Conclusion

ESTH remains committed to advancing equality, promoting human rights, and reducing health inequalities. This annual report highlights our key achievements during 2022/23 to ensure that our services reflect and respond to the needs of our people and that we comply with our statutory equality duty.

The Workforce PSED report aims to show how we continue to work to ensure that equality; diversity and inclusion are mainstreamed and fully embedded in the planning and delivery of our services both now and to meet the future needs of the population and our workforce across Surrey and South West London. The report provided a thorough account of the work undertaken by the Trust to promote equality, equity, and diversity and create an inclusive culture for staff.

A substantial amount of work has been carried out in order to develop our new Culture Equity and Improvement Programme in March 2022. Its purpose was to help us transform our organisational culture and enable us to realise our mission of 'outstanding care, every day' for our patients, which was the heart of our purpose. It has helped to align multiple areas of work that support our culture. Further information on our Culture work can be viewed on our website.

Overall, 2022-2023 revealed an exact count of 24247 applications received from this number. 6069 were shortlisted, 3836 attended interviews, and 622 were appointed.

Our data reveals an exact count of 1327 new starters and 1429 leavers during the period of 2022-2023. The data clearly indicates a difference of between the number of new employees and departures.

SWL Recruitment Hub manages six trust recruitment activities remains high with a sustained upward trend for 2022/23 and an increase in the month between December 2022 to January 2023. Many campaigns are multiple hires so the number of applicants in the pipeline is high and additional pressure remains due to continued high levels of turnover in all Trusts.

- Overall, ESTH recruitment activity remains high with 506 active live campaigns, many with multiple hires.
- As in previous months 2023, the highest levels of activity are within Nursing & Midwifery Registered and Administrative and Clerical (the two largest staff groups).
- The number of live campaigns has increased in all staff groups except Estates and Ancillary, Add Prof Scientific and Technic, and Additional Clinical Services.
- Overall, Trust is losing more staff than are starting across all of the staff groups, with the exception of additional clinical services, where we've retained more than we've lost.

We have seen year on year improvement in the last six years in completing our WRES. The WRES provides a framework for NHS trusts to report, demonstrate and monitor progress against a number of indicators of workforce equality objectives, and to ensure that employees from ethnic minority backgrounds receive fair treatment in the workplace and have equal access to career opportunities. These indicators are a combination of workforce data and results from the NHS Staff Survey.

The overall performance of our WRES data comparing 2021 and 2022 is set out in the Trust's WRES Report and WRES Action Plan on the Trust website: https://www.epsom-sthelier.nhs.uk/equality-and-diversity

We have seen small improvement over the last four years in completing the WDES. The WDES is a set of ten specific measures (metrics) that enable NHS organisations to compare the experiences of disabled and non-disabled staff. This information will then be used to develop local action plans and enable the Trust to demonstrate progress against the indicators for disability equality. WDES Report and WDES Action Plan on the Trust website: https://www.epsom-sthelier.nhs.uk/equality-and-diversity

During 2022/23 we have further developed and strengthened our Staff Networks and continued to work with our Culture Equity Inclusion board. This ongoing engagement is invaluable in helping us maintain an understanding of the barriers experienced by some groups and by working together to identify improvements.

2020-21 was clearly different due to the unprecedented and challenging times following the unexpected arrival of the COVID-19 global pandemic. The impact it has had on people, the economy, and the public service

offered, has exposed inequalities within our communities and inevitably the gap has widened. Will continue to highlight and may exacerbate existing health inequalities. As we begin our journey to rebuild from the past three years, we are committed to doing all we can to address these inequalities via our varied services. As such it is important as ever to plan and deliver our services from the founding principle of equality, human rights, and inclusion.

Our Equality Objectives demonstrate the Trust's commitment to working towards creating an inclusive environment in support of the Trust Values, which show how we value the identity of all of our staff. We look forward to refreshing our four-year Equality Objectives 2023-2027.

Finally, we conclude this report by acknowledging the significant challenges everyone has faced during 2022-2023 and sincerely thank and note our appreciation for all our networks chairs, allies, staff, and partners who have contributed to our PSED workforce annual report.

Report 3

PUBLIC SECTOR EQUALITY DUTY REPORT

2022 – 2023

Patients, Services and Health Inequalities

Table of Contents

1 Introduction

Improving the patient and carer experience is one of the Trust's key objectives and forms a central part of our mission to provide outstanding care to every patient, every day. The views of the people who use our services are important to us. We want to know when things have gone well, but also when we don't get things right, so we can learn and improve. We welcome all feedback and seek to take a proactive approach to helping with any questions or concerns raised.

This report provides Trust-wide information relating to the Trust's service users, volunteers, and members. It should be read in conjunction with our Public Sector Equality Duty (PSED) 2023 Report One 'Meeting the Public Sector Equality Duty at Epsom and St Helier's University Hospital' and is being published in concurrence with information to demonstrate to our service users, carers, families, local communities, and stakeholders how we are progressing on equality. You can access the PSED report and other equality information on our website.

1.1 Our People's Panel

Our People's Panel is an initiative that aims to ensure future key projects and programmes are co-designed with patients and local people. Patients and the public are engaged through a range of forums including the new People's Panel and a number of associated patient groups.

There has never been a more important time for local people to join us and have their say on our work, as plans progress on the build of the new Specialist Emergency Care Hospital in Sutton, which will significantly improve Epsom and St Helier hospitals.

Members are invited to get involved in a wide range of projects and programmes, from improving how the Trust communicates with patients, to having their say on the new design and layout of our buildings, and the directional signage and information displays around the hospitals. Further information about the Trust's People Panel can be found is available via our website.

1.2 Equality headlines for access to services 2022-23

- The Trust-wide diversity profile of service users has increased significantly compared to the previous year.
- Sexual orientation is not currently captured on IPM
- Gender Reassignment is a new field in IPM with a small number flagged as "Yes", but numbers are very low (<1%) showing as a consistent zero score.
- Pregnancy & Maternity are not currently recorded on IPM.

- Disability has alerts for patients with a disability, but does not yet have a way of distinguishing those without - whether they have a disability or have chosen not to disclose, and therefore the result is defaulted to "no".

This limits the Trust's ability to analyse access to services by these protected characteristics groups.

1.3 Patient Services

Improving patient and carer experience is one of Epsom and St Helier University Hospitals key objectives, and it forms a central part of our mission to provide outstanding care to every patient, every day. The views of the people who use our services are important to us. We want to know when things have gone well, but also when we don't get things right, so we can learn and improve.

Our patients are at the very heart of our services. It is essential that we not only listen to their feedback but that we act on it effectively and provide a service that acknowledges our service user demographics.

There are core channels for feedback that are monitored and managed by the Patient Experience Team, and the feedback received is used to recognise and share good practice, and to identify and act upon opportunities for transformation and improvement.

Through undertaking analysis and review of our patient profile by protected characteristics we can determine which groups are accessing our services. This process enables us to look at patterns of service uptake and patient flow, which informs us of areas in need of attention and any potential inequalities of access.
From a position of heightened awareness we can take a more proactive approach in ensuring equity of access is fairly distributed across all the protected characteristic groups in our services.

A particular focus for 2021-22 is to re-energise the carers project. This involves the creating and launching a carers policy for staff alongside a carers guideline for carers, with an additional supporting ward pack of information available for patients on admission to our hospitals.

The Patient Experience Team are creating a mechanism for capturing carers coming into the Trust to enable the Patient Experience Team to:

- carry out audits to ensure carers are being supported.
- carry out regular 'Carer Awareness Training' sessions for staff.
- raise the profile of carers and support available to carers and young carers by carrying out initiatives for the national awareness days; and
- advertise the 'Carers Forum' to ensure the Trust have direct access to hear the views of carers from across the nine protected groups.

For further information on the patient experience service see the presentation link (page 17).

1.3.1 Carers

We continue to make progress with our Carers project. We began collaborating with the Service Improvement Team on a discharge project to ensure that carers are embedded in the process. This follows a change in legislation that came into effect on July 1st 2022 - Section 91 of the Health and Care Act 2022 introduces a new duty of care for NHS trusts and foundation trusts to involve carers (including young carers) in discharge planning.

Our Carers Forum continues to run quarterly, giving carers a voice to share their experiences and help us shape the work we are doing here at the Trust. We continue to promote this to recruit more members and ran an advert on our hospital radio station. The Trust continues to commit to supporting the needs of unpaid carers of our patients.

Carers Ward Packs continue to be refreshed. These contain all the information required to support a Carer when they have been identified the on a ward and work alongside the Carers alert and Carers tab in our Patient Administration System where carers details can be captured.

We celebrate Carers week between the 6th and 12th June. This event is an annual awareness campaign organised by the charity **Carers UK** to celebrate and recognise the vital contribution made by some 6.5 million unpaid carers across the UK. This year's theme was: "Making caring Visible, Valued and Supported". This included creating an information pack and quiz which were taken out to staff at acute and community sites, engaging with them to highlight the important work that unpaid carers do. A stand at both acute sites, to share information with the public and inform them of the project here at the Trust was a success. This really helped people to identify themselves as carers, which is critical to enable us to support them whilst they are on our wards and also helps us to connect them with supporting organisations in the community.

'We Care About Carers, merchandise was launched throughout the summer, which included tote bags, coasters and pens to promote our project and they have been a great success. They have instigated conversations and questions about how we support carers in our Trust. You may see our staff sporting these around our sites
Carers awareness training continues on a monthly basis, and we have also arranged bespoke sessions for the departments and community sites to tailor the information to their needs and ensure they are equipped to identify, record and support unpaid carers.

1.3.2 Patient Advice and Liaison Service (PALS)

Our Patient Advice and Liaison Service (PALS) is available to provide patients, families and carers with confidential, on-the-spot help and advice. PALS can be an effective accessible port-of-call for support for patients and visitors, and also provide important information about our services.

1.3.3 PALS aim to:

- resolve problems quickly on your behalf
- listen to your concerns, suggestions and queries
- act on your comments to improve the patient experience in our hospitals.
- advise and support patients, their families and carers; and

- supply information about the services our hospitals provide

Further information on the trust's PALS service is available via our website.

1.3.4 Communication and information support services

It is our aim to ensure every person using our services has the best possible treatment whilst in our care. The Trust offer a range of services to support anyone with additional communication or information needs, regardless of whether English is their first language or not, or they have a disability or long term health condition or not.

1.3.5 Language support services

Ensuring that patients understand their treatment and care plan options is fundamental to clinical care, as is the equality of access to health services. The Language Support service provides access to resources to help to ease communications and open channels to access interpreters, translation services and additional information. The aim is to avoid indirectly discriminating against someone who does not speak English as a first language or who requires any other type of communication support. Provision of our translation and interpreting services is overseen and facilitated by the PALS staff, who act as the key point of contact for all enquiries or requests relating to language and communication support.

1.3.6 DATIX Incident Reporting System

The Trust uses Datix (a risk management information system) to collect and manage data on reported adverse events and potential adverse events (as well as information and data on incidents, complaints, claims, PALS and risks). The purpose of collecting the data on Datix is to have an effective platform protected by Information Governance policies to collate reported activity, identify risks, allocate a line of investigation, engage a system of assessment and learning, and implement improvements. The Datix data captures four of the nine protected groups: age, gender ethnicity religion or belief.

1.3.7 Complaints

The Trust believes that good quality complaints handling is vital to ensuring continuous improvement in the quality and safety of care and provides a tangible and measurable reflection of commitment to an open and responsive safety culture. The effective handling of complaints therefore remains key for patient experience at the Trust.
There are several avenues for patients and service users to raise concerns regarding their experience of care. The Complaints Team supports the review of complaints as set out in the NHS Social Care and Health Regulations 2009. The aim of the complaints function is to address concerns raised, as well as learn and review the services we offer to continually improve the patient journey and experience.

During 2022/2023 a total of 511 complaints were received (excluding those cases that were re-opened). This compares to 447 complaints received in 2021/2022.

2022/2023 saw the largest total number of formal complaints received over the previous three financial year periods.

During 2022-2023, the months of highest activity included May, June and October, with a peak in activity being August 2022 (63 complaints). Adversely, the month of lowest activity was February 2023 when only 29 complaints were reported. The last time when this was previously seen was in June 2020.

For further information on the Patient Experience Services, you can view our website.

2 Volunteering and Voluntary Services

In 2022 the volunteering and voluntary service carried out a large recruitment drive which included:

- reaching out to the nine protected characteristics networks, forums, and faith groups - giving talks to promote volunteering, and the benefits of being a volunteer with the Trust,
- continuing visits to schools and colleges, and giving the same opportunities to all students,
- supplying a volunteer uniform to promote unity and visually promote the service,
- targeted advertising in multiple public spaces in the communities, and
- advertising in the top five languages, where required.

Our Volunteering and Voluntary Services work closely with the Cancer Information and Support Centre (including the Macmillan Butterfly Centre at Epsom Hospital) together with:

- Epsom Hospital Radio
- Epsom Medical Equipment Fund
- Friends of Epsom and West Park Hospitals
- League of Friends for St Helier Hospital
- Chaplaincy volunteers
- Radio St Helier
- Momentum Children's Charity
- Emerge Advocacy
- Breastfeeding Network
- Stroke Surrey
- The Kidney Fund - St Helier

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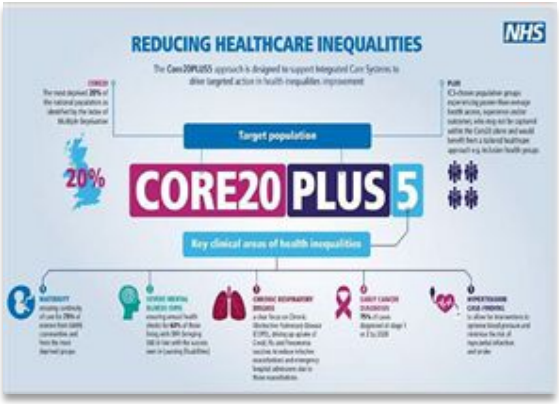
From April 2022 - March 2023 there were 181 Volunteers working across ESTH sites. Further information about the Trust's Voluntary Services can be found on our website

3 NHS CORE20PLUS5

As we continue to ease out of the COVID-19 pandemic and the latest wave of the Omicron variant, it is important we look forward, taking with us the learning gained and turning our focus to finding a way to live with the virus whilst reducing its impact on people - and on the NHS - as it shifts from a pandemic to a endemic.



Core20PLUS5 is a national NHS England approach to inform action to reduce healthcare inequalities at both national and system level. The approach defines a target population – the 'Core20PLUS' – and identifies '5' focussed clinical areas requiring accelerated improvement.

The approach, which initially focussed on healthcare inequalities experienced by adults, has now been adapted to apply to children and young people. The information below outlines the Core20PLUS5 approach for adults.

3.1 Core20

The most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD). The IMD has seven domains with indicators accounting for a wide range of social determinants of health.

3.2 PLUS

PLUS population groups should be identified at a local level. Population groups we would expect to see identified are ethnic minority communities, people with a learning disability and those on the autistic spectrum. In addition to people with multiple long-term health conditions, other groups that share protected characteristics as defined by the Equality Act 2010 and groups experiencing social exclusion, known as inclusion health groups coastal communities (where there may be small areas of high deprivation hidden amongst relative affluence).

4 Inclusion health

Inclusion health groups include people experiencing homelessness, drug and alcohol dependence, vulnerable migrants, Gypsy, Roma and traveller communities, sex workers, people in contact with the justice system, victims of modern slavery and other socially excluded groups. There are five clinical areas of focus which require accelerated improvement. Governance for these five focus areas sits with national programmes where national and regional teams coordinate activity across local systems to achieve national aims.

4.1 Maternity

Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups. This model of care requires appropriate staffing levels to be implemented safely.

4.2 Severe Mental Illness (SMI)

Ensuring annual health checks for 60% of those living with SMI (bringing SMI in line with the success

seen in learning disabilities).

4.3 Chronic Respiratory Disease

A clear focus on Chronic Obstructive Pulmonary Disease (COPD) driving the uptake of COVID, flu and pneumonia vaccines to reduce infective exacerbations and emergency hospital admissions due to those exacerbations.

4.4 Early Cancer Diagnosis

To meet the target of 75% of cases diagnosed at stage 1 or 2 by 2028.

4.5 Hypertension

Hypertension case-finding and optimal management and lipid optimal management will allow for the provision of interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke.

5 GESH Approach to Reducing Health Inequalities

St Georges, Epsom and St Helier (GESH) have identified health inequalities as part of one of nine major strategic initiatives. This high level approach aims to:

- Proactively outreach into communities that are disproportionately impacted by poor health and those who engage less with the Health Sector.
- Create reasonable adjustments for patients who encounter our services; and
- Develop the group as an 'anchor institution' ensuring that our workforce is reflective of the local population and that we are able to attract employees from all spectrums of SWL society.

This programme of work, sponsored by a member of the executive team, will initially work with Public Health in South West (SWL) to help target the group's approaches to each of the three areas listed above.

6 Proactive outreach

What opportunities exist for GESH to tackle health inequalities, where proactive outreach for prevention/ health promotion and emergency pathway usage would be effective?

6.1.1 Reasonable adjustments

What opportunities exist for GESH to make reasonable adjustments in care provision to ensure health inequalities are not further deepened? e.g. Link between deprivation and Did Not Attend (DNA) rate.

6.1.2 Anchor Institution

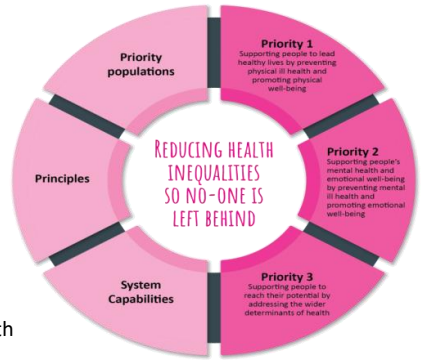
What opportunities are there for GESH to increase as an 'anchor institution' in SWL e.g. exploiting the benefits we can bring to the local economy by attracting employees from our local communities

This section gives a bird's eye view of the Epsom and St Helier University Hospitals (ESTH) service users' data CORE20PLUS services by protected characteristics groups.

6.1.3 ESTH Health Inequities

May 2023, our EDS Task and Finish Group met with our Health Inequality leads across our footprint, SWL and Surrey ICB. An insight of our community health inequalities gave the trust a clear direction of the priority areas which we need to consider when applying our EDS 2022.

6.1.4 Surrey ICB Health Inequalities



Priority 1

- People have a healthy weight and are active
- Substance misuse is low (drugs/alcohol/smoking)
- The needs of those experiencing multiple disadvantage are met
- Serious conditions and diseases are prevented
- People are supported to live well independently for as long as possible

Priority 2

- Adult, children and young people at risk of and with depression, anxiety and other mental health issues access the right early help and resources
- The emotional well-being of parents and caregivers, babies and children is supported
- Isolation is prevented and those that experience isolation are supported
- Environments and communities in which people live, work and learn build good mental health

Priority 3

- People's basic needs are met e.g., food security, poverty, housing strategy.
- Children, young people and adults are empowered in their communities
- People access training and employment opportunities in a sustainable economy
- People are safe and feel safe incl. domestic abuse and safeguarding
- The benefits of healthy environments for people are valued and maximised

6.1.5 South West London ICB Health Inequalities

- 50% of our 'Core20' population live in Croydon
- People in our 'Core20' population have a six-year difference in their healthy life expectancy, and a two-year difference in their life expectancy
- Our 'Core20 population are disproportionately represented by those from Black, Asian and minority ethnic backgrounds
- 29.5% of our'Core20' population have a diagnosed long-term condition

We have selected six services which include an additional service COVID-19 which aligns with chronic respiratory disease conditions highlighted in the Health Inequalities section of this report detailing ESTH plans for reducing health inequalities.

Total of service users accessing services in 2022-2023, 239144, compared to 2021-2022, 596369.
We recognise that we are not currently capturing data on all protected characteristic groups, and we suggest the following caveat should be considered when reviewing our patient data section (pages 9-11) regarding who is accessing the services being reporting on follows:

1. Percentage values are rounded, therefore some will not result in a 100% outcome.
2. Age and Gender categories were straight forward to map to.
3. Marital status in IPM does not offer Civil Partnership or Legally Separated as options; hence these are "N/A".
4. Disability - we have alerts for patients with a disability but have no way of distinguishing those without this flagged, whether they have a disability one or have chosen not to disclose, so have defaulted to "no".
5. Sexual orientation - captured on the Patient Administration System PAS system - this is defaulted to "not disclosed
6. Gender Reassignment - this is a new field in PAS and we have a small number flagged as "Yes", but very low numbers and not even 1%, hence why this is consistently zero
7. Pregnancy and Maternity - we do not record this on PAS.

The categories below in the table have been determined by using the following criteria:

Table A: shows a summary of services

Total Service	2022-2023 Overall, 239144 patients accessed ESTH services. A count of unique patients using any of the ED / Inpatient / Outpatient services.
1. Maternity	Taken from the Badgernet system which records births - this is a unique count of mothers (regardless of number of births or number of babies)
2. Respiratory	A unique count of patients attending a COPD or Asthma Outpatient clinic or had COPD diagnosed as an inpatient
3. COVID-19	A unique count of patients who had a positive COVID test result returned whilst as an inpatient
4. Cancer	A unique count of patients on a cancer pathway
5. Hypertension	A unique count of patients attending a Hypertension clinic in Outpatients or had Hypertension diagnosed as an inpatient https://www.aafp.org/pubs/fpm/issues/2014/0300/p5.html
6. Psychiatry Liaison (MH)	A unique count of patients referred to the Psych Liaison service via iCM

7 Service User Data Comparisons

The following tables show data comparisons for service users accessing services between 2021-2020 – 2022-2023 by Protected Characteristics

Table 1 **2021-2022**

Age	Cancer	Respiratory	COVID-19	Psychiatry Liaison (MH)	Maternity
Under 31	6%	3.62%	19%	44%	69%
31 - 40	7%	5.26%	13%	14%	29%
41 - 50	12%	9.38%	9%	13%	2%
51 - 60	20%	16.24%	13%	10%	0%
61+	55%	65.50%	46%	19%	0%
Total Service Users	**14979**	**9805**	**27594**	**55**	**8840**

Table 2 **2022-2023**

Age	Total service	Maternity	Respiratory	COVID-19	Cancer	Hyper-tension	Psychiatry Liaison (MH)
Under 31	34%	37%	3%	9%	5%	1%	30%
31 - 40	12%	59%	2%	6%	6%	2%	13%
41 - 50	11%	4%	4%	6%	11%	4%	12%
51 - 60	12%	0%	11%	12%	20%	11%	15%
61+	30%	0%	81%	67%	58%	81%	30%
Total Service Users	**239144**	**3816**	**17545**	**6385**	**21739**	**17421**	**1424**

Tables **1 and 2** shows the age profile comparison of service users between 2021-22 and 2022-2023 and reveals changing numbers from the previous year.
It is important to note, 2022-2023 data includes additional services from CORE20PLUS.

Key highlights

- An increase in the COVID-19 age range for 60+ (81%) compared to 46% from the previous year.
- An increase the Psychiatry service 60+ to 30% compared to 19% from the previous year.

Table 3 **2021-2022**

Marital Status	Cancer	Respiratory	COVID-19	Psychiatry Liaison (MH)	Maternity
Divorced	5%	6%	4%	20%	0%
Married	48%	52%	39%	18%	28%
Single	16%	13%	23%	49%	67%
Civil Partnership	0%	0%	0%	0%	0%
Widowed	7%	9%	6%	0%	0%
Not disclosed	24%	20%	28%	13%	5%
Legally separated	0%	0%	0%	0%	0%
Total Service Users	**14979**	**9805**	**27594**	**55**	**8840**

Table 4 **2022-2023**

Marital Status	Total	Maternity	Respiratory	COVID-19	Cancer	Hyper-tension	Psychiatry Liaison (MH)
Divorced	3%	0%	6%	6%	5%	6%	5%
Married	28%	54%	47%	45%	49%	48%	22%
Single	30%	39%	10%	20%	15%	9%	45%
Civil Partnership	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Widowed	3%	0%	11%	11%	7%	11%	4%
Not disclosed	36%	7%	26%	18%	24%	26%	25%
Legally separated	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Total Service Users	**239144**	**3816**	**17545**	**6385**	**21739**	**17421**	**1424**

Tables **3 and 4** show a comparison of the Marital status profile of service users between 2021-22 and 2022-2023. Overall access to services has increased. However, there are no significant changes from the year before. It is important to note, 2022-2023 have additional services from the CORE20PLUS service.

Table 5 **2021-2022**

Disability	Cancer	Respiratory	COVID-19	Psychiatry Liaison (MH)	Maternity
Yes	0%	0%	0%	0%	0%
No	0%	0%	0%	0%	0%
Not disclosed	100%	100%	100%	100%	100%
Total Service Users	**14979**	**9805**	**27594**	**55**	**8840**

Table 6 **2022-2023**

Disability	Total services	Maternity	Respiratory	Hyper-tension	COVID 19	Cancer	Psychiatry Liaison (MH)
Yes	1%	0%	2%	2%	3%	1%	2%
No	99%	100%	98%	98%	97%	99%	98%
Not disclosed	0%	0%	0%	0%	0%	0%	0%
Total Service Users	**239144**	**3816**	**17545**	**17421**	**6385**	**21739**	**1424**

Tables **5 and 6** shows a comparison of the Disability profile of service users between 2021-22 and 2022-2023. Overall access to services has increased, for those patients declaring a disability compared to the previous year. It is important to note, 2022-2023 have additional services from the CORE20PLUS service.

Table 7 **2021-2022**

Sexual orientation	Cancer	Respiratory	COVID-19	Psychiatry Liaison (MH)	Maternity
Gay	0%	0%	0%	0%	0%
Lesbian	0%	0%	0%	0%	0%
Bi-sexual	0%	0%	0%	0%	0%
Heterosexual	0%	0%	0%	0%	0%
Not disclosed	100%	100%	100%	100%	100%
Undecided	0%	0%	0%	0%	0%
Other/not listed	0%	0%	0%	0%	0%
Total Service Users	**14979**	**9805**	**27594**	**55**	**8840**

Table 8 **2022-2023**

Sexual orientation	Total service	Maternity	Respiratory	COVID-19	Cancer	Hyper-tension	Psychiatry Liaison (MH)
Gay	0%	0%	0%	0%	0%	0%	0%
Lesbian	0%	0%	0%	0%	0%	0%	0%
Bi-sexual	0%	0%	0%	0%	0%	0%	0%
Heterosexual	0%	0%	0%	0%	0%	0%	0%
Other sexual orientation not listed	0%	0%	0%	0%	0%	0%	0%
Not disclosed	0%	100%	100%	100%	100%	100%	0%
Total Service Users	**239144**	**3816**	**17545**	**6385**	**21739**	**17421**	**1424**

Tables 7 and 8 shows a comparison of the Sexual Orientation profile of service users between 2021-22 and 2022-2023. It's important to note Sexual orientation is not captured on iPM so this group has defaulted to "not disclosed. Overall access to services has increased, but there are no significant changes within the services from the year before. It is important to note, 2022-2023 has additional services from the CORE20PLUS service.

Table 9 2021-2022

Ethnicity	Maternity	Respiratory	COVID-19	Cancer	Psychiatry Liaison (MH)
White	**69%**	81%	73%	78%	82%
BME	30%	18%	27%	21%	18%
Not disclosed	0%	0%	0%	0%	0%
Total Service Users	**8840**	**9805**	**27594**	**14979**	**55**

Table 10 2022-2023

Ethnicity	Total service	Maternity	Respiratory	COVID-19	Cancer	Hyper-tension	Psychiatry Liaison (MH)
White	65%	67%	77%	78%	80%	77%	84%
BME	17%	27%	13%	15%	11%	13%	6%
Not disclosed	18%	5%	16%	8%	9%	16%	10%
Total Service Users	**239144**	**3816**	**17545**	**6385**	**21739**	**17421**	**1424**

Tables 8 and 9 shows a comparison of the ethnicity profile of service users between 2021-22 and 2022-2023. Overall access to services has increased; there are some changes within the services from the year before. It is important to note, 2022-2023 have additional services from the CORE20PLUS service.

Key highlights:

The table shows a decrease in BME patients accessing psychiatry services. A decrease of BME patients accessing cancer services and an increase of white patients accessing cancer services. Significant decrease of BME patients accessing COVID-19 services in 2022-2023.

Table 11 2021-2022

Religion or Belief	Cancer	Respiratory	COVID-19	Psychiatric liaison (MH)	Maternity
Atheism	0%	0%	0%	4%	0%
Buddhism	0%	0%	0%	0%	0%
Christianity	54%	56%	42%	31%	17%
Hinduism	2%	2%	2%	0%	2%
Islam	2%	2%	3%	0%	3%
Jainism	0%	0%	0%	0%	0%
Judaism	0%	0%	0%	0%	0%
Sikhism	0%	0%	0%	0%	0%
Other	21%	15%	4%	31%	1%
Not disclosed	21%	24%	49%	35%	76%
Total Service Users	**14979**	**9805**	**27594**	**55**	**8840**

Table 12 2022-2023

Religion or Belief	Total service	Maternity	Respiratory	COVID-19	Cancer	Hyper-tension	Psychiatry Liaison (MH)
Atheism	18%	13%	13%	14%	18%	13%	23%
Buddhism	0%	0%	0%	0%	0%	0%	1%
Christianity	36%	26%	58%	58%	57%	58%	40%
Hinduism	2%	4%	2%	3%	2%	3%	1%
Islam	3%	7%	2%	4%	2%	2%	0%
Jainism	0%	0%	0%	0%	0%	0%	0%
Judaism	0%	0%	0%	0%	0%	0%	0%
Sikhism	0%	0%	0%	0%	0%	0%	0%
Other	1%	1%	1%	1%	1%	1%	1%
Not disclosed	40%	49%	22%	20%	19%	22%	34%
Total Service Users	**239144**	**3816**	**17545**	**6385**	**21739**	**17421**	**1424**

Tables 10 and 11 shows a comparison of profile of Religion or belief service users between 2021-22 and 2022-2023. Overall access to services has increased;

there are some changes within the services from the year before. It is important to note, 2022-2023 have additional services from the CORE20PLUS service.

Key highlight

- The category Other has decreased significantly compared to the previous year.

Table 13 2022-2023

Gender Reassignment	Total services	Maternity	Respiratory	Hyper-tension	COVID-19	Cancer	Psychiatry Liaison (MH)
Yes	0%	0%	0%	0%	0%	0%	0%
No	100%	100%	100%	100%	100%	100%	100%
Chose not to disclosed	0%	0%	0%	0%	0%	0%	0%
Total Service Users	**239144**	**3816**	**17545**	**17421**	**6385**	**21739**	**1424**

Tables 13 shows a comparison of profile of Gender Reassignment service users between 2022-2023. Gender Reassignment - this is a new field in iPM and we have a small number flagged as "Yes", but very low numbers and not even 1%, hence why this is consistently zero.

8 Services

8.1 CORE20PLUS Services

This section looks at Epsom and St Helier University Hospital's services by providing a service overview and insight into the service strategy, together with a breakdown of health inequalities and engagement with protected groups'. Further information on each of the services below can be viewed by clicking on the links.

8.2 COVID-19 services

Epsom & St Helier University Hospitals Trust along with community partners Sutton Health & Care and Surrey Downs Health & Care have developed an Integrated Post COVID Model of Care which brings together secondary care and community rehabilitation to support patients experiencing the ongoing symptoms of COVID-19.
This service is delivered by a multidisciplinary team spanning Sutton and Surrey localities and includes doctors, nurses, psychologists, physiotherapists and occupational therapists. The service offers medical, physical and psychological assessment, MDT discussion and onward referral to the most appropriate specialist treatment pathway or rehabilitation services. It is worth noting that this information is regarding the long- covid service. It is not regarding patients admitted to ESTH with covid. Further information on long-covid can be viewed on our website.

8.3 Respiratory service

The Trust provides services for most respiratory conditions and a range of diagnostic services. It maintains close links with other specialties including allergy/immunology, thoracic surgery, oncology, and national reference centres at the Royal Brompton , St George's, and Guy's and St Thomas Hospitals. Further information on the service overview, which offers an insight into the service strategy, reducing health inequalities, and the whole system approach to engaging with protected groups. The communities or residents who are at risk, living, with or caring for someone with respiratory disease. Further information on our Respiratory service can be viewed on our website .

8.4 Cancer services

Our cancer services department works closely with other teams and services across our hospitals, providing advice and support. This includes: Colorectal, Upper Gastrointestinal, Lung, Urology, Gynaecology, Haematology, Dermatology, Head and Neck, Neurology and "other" cancers. The Trust does not have a Breast Cancer or sarcoma units. Suspected Breast Cancer patients are typically referred to the Royal Marsden Hospital (RMH), or if identified at ESTH to have suspicion of Breast Cancer are referred internally to RMH. For Sarcoma patients, patients are referred to either RMH or the Royal National Orthopaedic Hospital (RNOH).

The department plays a key role in ensuring that patients referred to our hospitals with a suspicion of cancer are offered their first appointment within 14 days, and progress along their care pathway in a timely way, ensuring first treatment starts within 62 days of the referral received.

The Trust works in close partnership with Macmillan Cancer Support and has a support centre at Epsom

General Hospital for patients, families and carers.

As alluded to above, the Trust works in partnership with RMH and RNOH. In addition, it also works with St George's Healthcare NHS Trust and Epsom Medical. Collectively with our partners, we provide and support cancer services for Merton, Sutton and Surrey locality patients. Further information on our cancer service can be viewed at our website.

8.5 Maternity Service

Epsom and St Helier University Hospitals maternity services provide a full range of maternity care for around 3,800 mothers and their babies every year. Maternity services are provided at both Epsom and St Helier Hospital. Both hospitals have inpatient antenatal, postnatal facilities along with midwifery-led birth centres and obstetric-led labour wards; and a homebirth team providing the full range of care to women who choose to have their baby at home. Our integrated teams are inspiring to provide continuity of carer to all women, but especially those women from a global majority and those living in the lowest decile areas of deprivation. Further information on the maternity service can be viewed at our website.

8.6 Psychiatry Liaison Services (Severe mental illness (SMI)

- Epsom and St Helier University Hospitals' Liaison Psychiatry Service assesses and manages adults with mental health problems at St Helier Hospital. This includes people staying on our wards and those in our Emergency Department.

Patients referred to the Service have a wide range of mental health problems, such as:

- self-harm
- mental health problems in the context of physical illness
- states of confusion such as, delirium and dementia
- eating disorders
- and medically unexplained physical symptoms.

Lucy to provide further information

8.7 Hypertension

Intro needed

Further information on the service overview, which offers an insight into the management for interventions to optimise blood pressure and minimise the risk of myocardial infarction and stroke, the service strategy, reducing health inequalities, and the whole system approach to engaging with protected groups. The communities or residents who are, living, with, or caring for someone with hypertension. Further information can be viewed at our website.

8.8 The Patient Experience Team

Improving patient and carer experience is one of the Trust's key objectives and forms a central part of our mission to provide outstanding care to every patient, every day. The views of the people who use

the Trust services are very important to us. As a Trust we want to know when things have gone well, but also when our services or staff don't get things right, so that we can learn and improve. All feedback is welcomed to support a proactive approach to helping with any questions or concerns.
To assess and better understand the experience of our patients, their loved ones, and carers, we actively seek feedback from people using our services. The core channels for feedback that are monitored and managed by the Patient Experience Team are: Patient Experience Surveys (FFT: Friends and Family Test, National surveys required by the Care Quality Commission (CQC), local surveys; Patient Experience membership (via Patient First, our designated mailing list); Carers forum (a forum of current or past carers who have accessed our services with those they care for); Veterans (raising awareness within the Trust through training and using feedback from Veterans to improve services); Patient Advice and Liaison Service (PALS); Complaints; and formal gratitude (e.g. letters to the Chief Executive). Feedback received is used to recognise and share good practice and to identify and act on opportunities for improvement. We also have the invaluable services of our Volunteers who help within designated areas of the Trust. Further information can be viewed at our website

8.9 Chaplaincy Services

The Chaplaincy department provides professional pastoral, spiritual and religious care by being alongside patients, their loved ones and staff, to enable them to find meaning and purpose in their situation. The service is person centred and is guided by the person's values, perceptions and outlook on life, which may not involve believing in a higher power or following a specific religion. The department also provides diverse rites and rituals to mark important transitions in life such as death, marriage or the birth of a baby. Further information can be viewed at our website.

9 Conclusion

This report provides information about how we meet our obligations under the Public Sector Equality Duty. It includes our activity in relation to equality, diversity and inclusion during 2022/23.

The Public Sector Equality Duty (PSED) specifies the core Equality Diversity and Inclusion aims for NHS trusts – to eliminate unlawful discrimination,
advance equality of opportunity and
foster good relationships between those that have a protected characteristic and those who do not.

Listening to and working with patients is vital if we are to build an NHS that is both sustainable and works for everyone. We have very active patient groups and have carried out a number of listening events on a range of subjects from reviewing of services.

The Equality Delivery System (EDS) provides us with a comprehensive assessment process to grade our health outcomes, patient experience, diversity of our workforce, and inclusive leadership. The EDS toolkit relies very much on the insight and evidence of patient, community and staff engagement in the setting, and delivery of equality objectives.

In May 2023, our EDS Task and Finish Group met with our Health Inequality leads across our footprint, SWL, and Surrey ICB. An insight into our community health inequalities gave the trust a clear direction of the priority areas which we need to consider when applying our EDS.

NHS
St George's University Hospitals
NHS Foundation Trust

St George's

Public Sector Equality Duty (PSED) Annual Report 2022 - 2023

Other formats and languages
If you would like a copy of this report in a different language or a different format, such as large print or Braille, please email Diversity.Inclusion@stgeorges.nhs.uk

Report Author; Joseph Pavett-Downer, June 2023

St George's University Hospitals NHS Foundation Trust

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Welcome and overview from our Chief Executive Officer, Chief People Officer, and Chairperson

We are pleased to introduce our 2022/23 Public Sector Equality Duty (PSED) Annual Report as it captures a wealth of information and evidence that demonstrates how St George's University Hospitals (SGH) has met, and will continue to meet, its statutory duties under the Equality Act 2010.

These reports provide an overview of the Trust's commitment to Equality, Diversity, and Inclusion (EDI), EDI related activities over the last 18 months and our workforce and patient demographics. The purpose of the report is to provide an overview of activities and equality data relating to staff and service users of St Georges. We collect data and review it regularly to ensure that we are not inadvertently behaving in a way that disadvantages members of staff or patients with protected characteristics. Through delivering our commitment to a diverse workforce and an inclusive approach to the service that we provide, we believe St George's will develop its capacity and capability to lead by example and to be an employer of choice for everyone, regardless of their background.

We are committed to providing first-class health care for our diverse population recognising our legal duty to eliminate unlawful discrimination and provide equality of outcomes for our population. We recognise that services need to be designed with the person at the centre of them thereby embedding the values underpinning equality, diversity, inclusion, and human rights at the core of our business, which shapes and influences our decisions, policymaking, service planning and employment practices. We are committed to achieving our equality duties and obligations, to reduce avoidable health inequalities in all aspects of our roles and functions.

The last few years have been particularly challenging due to the unprecedented impact of the COVID-19 pandemic. The pandemic highlighted significant inequalities and unfortunately resulted in further inequality which has increase the gap further. It is vital we maintain focus on EDI and continue to rebuild and improve the experience and treatment of those with protected characteristics. We are committed to doing all we can to address these inequalities and will work to proactively address inequalities that affect our staff, as well as the health inequalities in the communities we serve.

We would like to take this opportunity to recognise the work of our staff and the teams who have contributed to this comprehensive report, this includes our EDI Team, Staff Networks, Workforce and Business Intelligence teams, Staff Side, Freedom to Speak Up, HR, Health and Well-being, Staff Support, Patient Experience, and the Clinical Services featured.

Ms Jacqueline Totterdell
Group CEO

Mr Paul Da Gama
Group CPO

Ms Gillian Norton OBE DL
Chairman

Section 1 – Background and Introduction

Introduction to the PSED

Each year public bodies, subject to section 149 of the Equality Act 2010, are required to publish equality information. This summary of equality information should demonstrate how they (St George's) complied with the '*general'* and '*specific'* duties of the public sector equality duty (PSED). The PSED Report incorporates information in relation to both Patient and Workforce equalities.

What are the *general* duties?

In the exercise of its functions, St George's, must have due regard to the need to:

1. Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Act.
2. Advance equality of opportunity between people who share a protected characteristic and those who do not.
3. Foster good relations between people who share a protected characteristic and those who do not.

The second aim mentioned above (*advancing equality of opportunity*) involves having due regard to the need to:

- Removing or minimising disadvantages suffered by people due to their protected characteristics.
- Taking steps to meet the needs of people from protected groups where these are different from the needs of other people.
- Encouraging people from protected groups to participate in public life or in other activities where their participation is disproportionately low.

Furthermore, the Equality Act describes that meeting different needs includes (among other things) taking steps to consider the needs of those with disabilities. It describes fostering good relations as tackling prejudice and promoting understanding between people from different groups/committees. It explains that compliance with the general equality duty may involve treating some people more favourably than others or taking steps to offer specific levels of support which help some communities access services or improve health outcomes (though only if permissible otherwise under the Act).

The equality duty covers the nine protected characteristics: age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. Public authorities also need to have due regard to the need to eliminate unlawful discrimination against someone because of their marriage or civil partnership status. This means that the first aim of the duty applies to this characteristic but that the other aims (advancing equality and fostering good relations) do not apply.

How do we demonstrate compliance?

Along with other local data, the PSED uses information from standalone equality reports such as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). It also includes the Gender Pay Gap data and our Equality Delivery System (EDS). In relation to Patient or Health Equalities, we are asked to spotlight any services that help to demonstrate compliance with both the general and specific duties of the PSED.

Our Hospitals and Services

Since the opening of the original St George's Hospital on Hyde Park Corner in 1733, St George's has built an international reputation for quality of care, education, research and medical advances. We share our main hospital site in Tooting with St George's, University of London, and together we train future generations of the NHS workforce.

Our organisation is large – with more than 9,000 staff – but retains a strong sense of community. We have strong links with the local populations we serve but are also recognised nationally and internationally for being a leader in research and innovation. This enables us to attract staff from all corners of the globe.

In February 2015, St George's became an NHS Foundation Trust. As the largest healthcare provider in south west London, our two hospital sites at St George's Hospital and Queen Mary's Hospital in Roehampton serve a population of 1.3 million across south west London. As a provider of many tertiary services, such as neurosciences and paediatric medicine, we also offer care for significant populations in Surrey, Sussex, Hampshire and beyond, totalling around 3.5 million people. Even further afield, we provide care for patients from across the south west of England in specialties such as complex pelvic trauma. Other services are even more specialist, and our family HIV care service and expertise in bone marrow transplantation for non-cancer diseases mean we treat people from across the country.

St George's is one of the four major trauma centres for London, and home to hyper acute stroke and heart attack centres. We operate one of London's four helipads, which means we treat some of the most unwell and severely injured patients from across the south of England. We are a major centre for cancer services: St George's is one of only two designated children's cancer centres in London, and the seventh largest centre for cancer surgery/chemotherapy in London. We are one of London's largest children's hospitals, with one of only four paediatric trauma units in London, and our children's services are rated Outstanding by the CQC. St George's Hospital also hosts the only paediatric intensive care unit in south west London.

St George's is a major centre for neurosciences, and the third largest provider in London for neurosurgery. We also offer many innovative treatments for patients – for example, we were the first centre in the country to provide a 24/7 mechanical thrombectomy service, which involves surgically removing blood clots from the brain for patients who have had a stroke.
Many of our services are also part of established clinical networks, which bring together clinicians and support staff from a range of healthcare providers to improve the quality of services for patients.

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

In August 2021, after years of collaboration and creating closer working ties, we announced that the Boards of Epsom and St Helier and St George's had agreed to form a hospital group. This is an important new chapter for both organisations, which will enable us to strengthen the professional networks we have already created and ensure both Trusts provide the best possible care for our patients. The two Trusts remain separate legal entities but are now led by a single executive team, which have put in place harmonised governance arrangements enabling and supporting closer collaborative working.

St George's University Hospitals NHS Foundation Trust

Section 2 – Organisational Commitment and Strategy

Our Commitment to Inclusion

St George's is committed to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued. As well as being well-represented across all levels, we must ensure that people from marginalised groups, are actively and always included, and that this inclusion is felt authentically at a personal level.

For our patients and visitors, we are committed to offering a comprehensive service available to all, irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief; sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. Nine of these characteristics are known as protected characteristics under the Equality Act 2010 (see opposite). We also consider characteristics beyond these groups and include inclusions groups such as Carers, Asylum Seekers and Refugees, Prisoners, Sex workers, those who are Homeless or Unemployed, have Mental Health or Domestic Abuse concerns, or concerns with Drugs and Alcohol use.

Taking a holistic approach, that starts with how we treat our staff, helps to create an inclusive culture at St George's which has significant benefits for our service users. A number of these benefits are noted below:

- Staff who feel included, engaged, and supported have greater personal resources and resilience to offer thorough and compassionate care.
- Staff who are differently-abled may offer enhanced empathy and support to patients due to their lived-experiences.
- Stronger team performance by maximising our blend of skills, talents, knowledge, and professional experience.
- Improved staff retention and consistency of care.
- A reduction in bullying, harassment, discrimination, and other forms of exclusion by building greater understanding, appreciation and respect.
- Supports our organisational journey towards adopting a more compassionate and inclusive culture.

"Our ambition is to create an organisation - and a reinforcing culture - that not only offers equality and a positive experience for all our colleagues, but one that actively nurtures and celebrates our differences. We strive for this in the certainty that our rich diversity and a universal sense of belonging will be integral to our success as a healthcare organisation."

St George's University Hospitals NHS Foundation Trust

Our Strategy for 2023-2028

As a Trust, we aim to proactively and positively address inequalities that affect our staff, as well as the health inequalities in the communities we serve. Our organisations have seen major change in recent years – such as the COVID pandemic, a new legal framework for the NHS, and St George's, Epsom and St Helier coming together to form a Group. In that context, over the course of 2022, we spoke to hundreds of our patients, staff and partners about what they want the future to look like for our organisations. This strategy, based on those discussions, sets out our direction of travel for the coming five years.

What do we want our role to be in 2028?

Working as a group gives us the opportunity to think about the role we'll play in our local communities and across the wider NHS. We want to provide local services for the people of Surrey Downs, Sutton, Merton and Wandsworth, and be a major tertiary centre for south west London – particularly known for our specialist major trauma, renal, neuroscience, paediatric and cancer services.

As university hospitals, we'll focus on research and education, working closely with St George's, University of London.

While our Trusts will have distinct identities, we'll work as one family to maximise the benefits of being a group, and work with partners to join up care around patients' needs. We will act as anchor institutions – this means we'll have a positive impact on our local communities beyond healthcare.

What do we want to achieve?

Our vision for 2028 is to provide outstanding care, together. With the help of our patients, staff and partners, we have chosen four overall aims for 2028 – our **CARE** objectives.

These are the things we care about the most and will be central to achieving our vision:

- **C**ollaboration and partnership
- **A**ffordable services, fit for the future
- **R**ight care, right place, right time
- **E**mpowered, engaged staff

In all this, everything we do will be driven by our patients.

How will we get there?
The answer is – together. 17,000 people work at St George's and Epsom and St Helier, and every one of us will have a part to play in making our vision a reality.
We will deliver our vision through:

1. **Local improvement**: continuous improvement, pursued by teams of staff at every level in our organisations, from Board to ward, against a common framework of annual improvement priorities.

2. **Corporate enablers**: action led by individual corporate departments, working with clinical teams, to deliver against a range of corporate strategies: quality and safety, people, IT, estates, research and innovation, our green plans.

3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work:

    - The Building Your Future Hospitals programme
    - Supporting a continuous improvement approach throughout organisations, through high-performing teams and leaders
    - Implementing a shared system for electronic patient records across our Group
    - Transforming our outpatient services
    - Collaborating with other hospitals across South West London
    - Transforming our culture, and making our workplaces more diverse and inclusive
    - Pursuing collaboration across our GESH Group
    - Collaborating with local partners in Surrey Downs, Sutton, Merton and Wandsworth
    - Strengthening our specialised services

You can read more detail about our CARE objectives in our strategy summary document (PDF) or in the full strategy (PDF). We have also produced a short animation explaining the key points of our strategy, which you can view here.

"Our vision for 2028 is simple but powerful – we will offer outstanding care, together."

Our Governance Structure

Our Head of Equality Diversity and Inclusion is part of our People Function, within our Education, Culture and Organisational Development Team. They report directly to our Group Deputy Chief People Officer and are a member of several stakeholder and governance committees, including our Culture, Equity and Inclusion Programme Board, Patient Partnership and Experience Group, Partnership Forum, People Management Group and our People Committee in Common – which is a sub-committee of our Board.

These groups/committees receive regular reports and updates which allow for effective communication to our senior leadership teams and oversight of progress, and also enables our EDI team to seek support and highlight concerns directly to our Executive Leadership team. As well as progress against our equality objectives and action plans these reports include Staff Network updates, Pay Gap reports, WRES, WDES and PSED.

In addition, our Group Chief Executive, Group Chief People Officer and Chairperson meet quarterly with each of our Staff Network Chairs to discuss progress and support with any areas of concern or barriers. Our Staff Networks also have a named Group and Site Executive Sponsor that will champion and advocate on their network's behalf.

Section 3 - Workforce

This section provides an overview of programmes of work in relation to workforce inclusion.

This section spotlights specific teams and initiatives that have been introduced throughout 2022 and 2023 to improve the experience of staff and provide a demonstration of how St George's has had due regard for the general and specific duties of the PSED.

Whilst many of these examples help to improve the experience of everyone that works at St George's they were developed with inclusion as a key principle. This has ensured specific consideration has been given to improving the experience, and amplify the voices of, staff with one or more protected characteristics.

Overview of Key Achievements / Activities

- Awarded Gold by the British Armed Forces, naming St George's as one of the most supportive organisations for Veterans, Reserves, Cadet Force Adult Volunteers and Spouses and Partners of those serving in the Armed Forces. Further information on the steps taken to achieve this accolade can be found here.
- Developed two bespoke e-learning modules - Disability Awareness (for all staff) and a Workplace Adjustments module for line managers. These modules achieved over 70% compliance across the workforce within 4 months of launching.
- Developed a bespoke LGBTQIA Awareness Module which aims to build a greater understanding of the challenges and barriers that the LGBTQIA+ community face when accessing health and care services, and how support can be improved to positively impact patient care and experience.
- Active Bystander Training delivered to over 300 members of staff across the organisation. To reinforce this learning, our EDI Team also developed a bitesize online training session which is available to staff as part the Trust Management Fundamentals.
- We continue to support the DFN Project Search Programme which is now in its 11th year at St George's. Over 70% of St George's Project Search graduates have gone on to secure permanent employment - 14 of which with St George's.
- Introduction of a menopause policy and monthly menopause cafés to support individuals experiencing menopause. These sessions provide a free, safe and inclusive space to learn more about menopause, its impact on staff and to share experiences.

- Increased numbers of staff accessing health and wellbeing interventions. For example, almost 300 staff members participated in our Health and Wellbeing Challenge - an increase of 185% compared to the previous year. This event saw staff record their daily exercise or healthy habit, sign up to daily challenges and compete with colleagues.
- Health and Wellbeing led a Cost-of-Living Group and provided a range of tools and resources for staff to build financial resilience and receive support. This included webinars, national and local resources, and partnership with a local foodbank that delivered food onsite to help staff who are unable to visit the foodbank due to their working hours.
- Trained additional Health and Wellbeing Champions and Mental Health First Aiders across the Trust. These trained colleagues provide staff with a level of peer support who can help in a crisis and signpost to available resources.
- Trained over 150 Recruitment Inclusion Specialists who have supported almost 500 interviews panels across the organisation.
- Co-designed the SWL Inclusive Recruitment Module in partnership with the SWL Recruitment Hub
- Improved collaboration and shared best practice across Southwest London Trusts and the ICS. This includes membership and attendance at our SW London EDI Leaders Network. This work included our St George's EDI Team delivering several *Train the Trainer* Sessions for our Recruitment Inclusion Specialist Training. These Train the Trainer sessions support colleagues at other trusts to understand the RIS initiative and begin work embedding the process within their own organisations.
- Announced the official opening of our new breastfeeding room for staff - kindly funded by our St George's Hospital Charity. The room aims to provide a comfortable space for staff who choose to breastfeed. The idea for the room emerged from discussions at our Women's Staff Network meetings, which provide an opportunity to parents to share thoughts on how to make St Georges a more inclusive workplace for women.

- The LGBTQ+ Network hosted activities to raise awareness of issues face by the Trans community, particularly within health care. This included talks by UK charity TransActual as well as interviews with staff and promotion of resources.
- Introduction of a centralised Reasonable Adjustments budget which will improve staff access to adjustments, ensuring requests are managed in a timely and supportive manner.
- To close our Black History Month 2022, we invited staff to enter a reflective writing competition with a focus on *'Reclaiming Your Time; self care when facing repeated racial injustice'.* The aim of the competition was to celebrate the resilience of people of colour, who often grow up being taught they'll need to "work harder" than their white peers in order to be seen. #RestAsResistance promotes healing from burnout caused by ideologies like this and challenges the status quo stemming from racial injustice.
- We marked Speak Up Month – our Freedom To Speak Up team hosted a series of awareness sessions throughout the month, including visiting many teams in person.

- Our Learning and Development and EDI Team co-designed and delivered Career Conversations Webinars and drop-in sessions hosted for staff. These sessions featured talks and information stands from professional leads, providing practical information and training on career planning and pathways in the NHS and interview training. Topics include; Strategic Career Planning, Writing Applications for Success and Interview Preparation and Networking.
- Part of South West London's Disability Advice Line (DAL) service – an innovative support service that gives confidential independent disability advice.
- Commissioned Suzy's Charter for workplace Safety via the Suzy Lamplugh Trust.
- Introduction of monthly *Executive Question Time; a forum* to hear the voices of our staff and their burning questions, led by our Group CEO Jacqueline Totterdell and the Group Executive Team. All 17,000 staff members across the group are invited to attend these online forums and submit question in advance, and anonymously if preferred.
- Our Bi-monthly *Ally Movie Nights* continue to grow in success with our EDI Team selecting a film that builds understanding of the experiences of those from marginalised communities and encourages discussion about important issues these communities face. These informal viewings allow staff to attend a social educational evening with colleagues, sharing experience, views on the movies and pizza.

Culture Programme

Our Culture Programme launched in 2020 and is based on the NHS E/I's Culture and Leadership Programme. Guided by NHS E/I methodology, our programme consisted of three main phases:

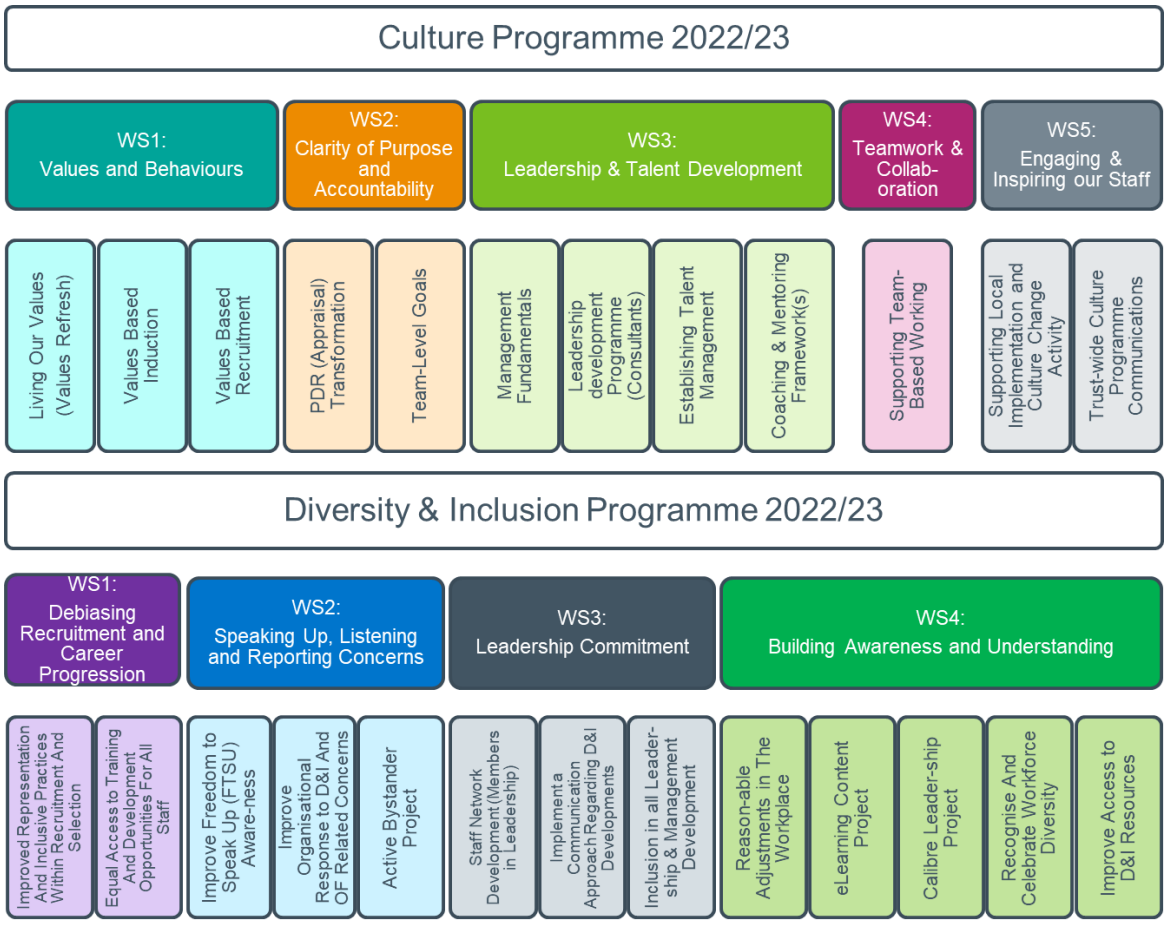
- Discover (diagnostic phase); March 2020 – November 2020.
- Design; January 2021 – March 2021
- Deliver; April 2021 onwards

<u>Key elements of the programme delivered:</u>

- Senior Clinical Leaders Development Programme – delivered for ~40 Clinical Directors and Care Group Leaders. A modular programme delivered in partnership with the King's Fund, sponsored by Site CMO Luci Etheridge. This is part 1 of a wider programme to deliver an overarching leadership framework for GESH. Part 2 (2023-2024) is planned be informed by evaluation of Part 1 – and delivered as a multi-professional programme across GESH.
- Talent management priorities agreed – 1. Retention, 2. Employer of Choice and 3. Succession planning for key positions. The first phase of this is to provide a 4-phase onboarding approach to enhance new joiners experience at each stage in their onboarding journey (See, Start, Support, Sustain).

- Launch of SGUH values-based behaviours to the Trust: guides; managers toolkit; workshops; e-learning and team digitask; embedding into recruitment training for managers and appraisals.
- Launch of Management Fundamentals toolkit, which supports managers at each point of the employee lifecycle.
- Developing continual improvement action plans with Divisional Teams, to respond directly to findings of the 2022 Staff Survey, with implementation plans over 18 months. HRBP/OD teams will support teams to implement improvements at local level and report progress on delivery to Site Executives.
- Development of a framework to address behaviours experienced by Junior Doctors and Medical Students, comprising leadership development specifically in creating psychological safety in clinical teams, training in forums for Junior Doctors to enable and encourage them to speak up and enhanced induction for Students on placement.
- Ongoing focused support to areas to support culture development and address conflict, for example supporting theatres facilitating a range of interventions for theatre staff and coordinating roll out of the scenario-based pre-surgery training for theatres across the organisation.

Figure 1: An overview of the Culture Programme and EDI Workstreams for 2022/23.



Values Based Behaviours

As part of our Culture Programme and following extensive collaboration with teams across the organisation we launched our Values-Based Behaviours Framework across the Trust.

This framework launched in July 2022 and included: guides; managers toolkit; workshops; e-learning and team digitask; embedding into recruitment training for managers and appraisals. A fundamental part of this work was the focus of key definitions and examples of the type of behaviours we expect and love to see, and importantly clearing defining the types of unacceptable behaviours and how this can be addressed.

In addition to the resource packs, we published a video which coincided with the launch of the Behaviours Framework. This video features colleagues from across the organisation speaking to the real-life experiences and impact of poor behaviours at work.

The video aims to emphasise the importance of our day-to-day behaviour, and the real and personal impact our behaviour has on others – both positive and negative

Project Search

Project Search is a supported internship for local young adults with a learning disability and/or autism. The Project Search Tutors and Job Coaches work closely with hospital staff to provide on-site support, with the aim of developing a young people's employability skills through total immersion in the workplace: the internships run from September to August with interns attending the Trust every day, Monday to Friday, for a mix of classroom-based teaching and work experience placements across the trust.

As the year progresses the interns spend less time in the classroom and more in the departments hosting the work experience placement (hours in the final term are from 9.30am to 3.30pm). The interns undertake real work, rather than shadowing, and they learn these work skills from staff and managers hosting a placement. These trust members of staff are called Project SEARCH mentors and they take on this role on a voluntary basis.

This initiative was launched at St George's in 2012 and in this time over 70% of St George's Project Search graduates have gone on to secured permanent employment - 14 of which with St George's. This includes three interns securing full time employment within Theatre Porters, two interns in Catering and one intern in each of the following: General Porters, Sterile Services, Outpatients, Medical Records, Student Union Shop, Marks and Spencer's. One intern secured an apprenticeship with the St Georges Advanced Patient Simulation Centre (GAPS).

Project SEARCH at St Georges has been assessed by external inspectors twice and at our last assessment rated as 'outstanding'.

The Project Search Internship is a partnership we are deeply proud of and committed to continuing. The programme has received much support from teams across the organisation including the Emergency Department, Pharmacy Pre-Pack, Medical Staffing, HR Recruitment, the Education Centre: Haematology Services, Atkinson Morley Reception, the Playroom, the University Library, Macmillan Cancer Support Services and Gardening Team.

Menopause Café

In addition to development of our Menopause policy, our Health and Wellbeing service hosts monthly menopause cafés to support individuals experiencing the menopause. These sessions provide a free, safe and inclusive space to learn more about menopause, it's impact on staff and allows staff to share experiences. In the last year we have had roughly 45 members of staff regularly accessing the cafes which are promoted to all staff, regardless of gender or age with the aim of breaking down the stigma surrounding menopause and normalising this stage of life. We also recognise not only women go through the menopause and this recognition fosters inclusion amongst our transgender and non-binary communities. The cafés have received a positive response, with members commenting "It is nice to have a place to talk openly" and "it's really good the Trust is doing this, not all Trusts are so open and proactive". The range of topics covered this year have included mental health and the menopause, empowering self-advocacy with GPs/health professionals to secure referrals to menopause specialists, as well as highlighting the experiences of staff when it comes to premature ovarian insufficiency.

Mandatory e-Learning Modules (Disability Awareness and Essential Workplace Adjustments)

To support the delivery of our 2020/21 objectives, we developed, piloted and launched new e-learning modules. The Disability Awareness and Essential Workplace Adjustments modules were introduced via the Trust's online learning platform. These were launched alongside new

guidance packs which were developed in collaboration with our Disability Staff Network, Calibre graduates and other key stakeholders such as Health and Wellbeing, Employee Relations, and Occupational Health.

The Disability Awareness module is a mandatory requirement for all staff and is aimed at helping staff to understand more about disability and long-term health conditions, and the issues that sufferers can face in everyday life and the workplace. It also looks at how staff across the organisation can be more inclusive with small steps like improving written and verbal communication to ensure that services are accessible to all.

The Essential Workplace Adjustments module is a mandatory requirement for line managers and explores our legal responsibility to make workplace adjustments and how to support staff through this process.

These modules also guide managers through the 'working environment' more broadly and helps them consider what can be done to enable staff with a disability or long-term health condition to achieve their goals, fulfil the responsibilities within their job description and contribute to the successful delivery of the team's objectives.

Health and Wellbeing

Health and Wellbeing service provides a range of resources and interventions to support mental, physical, social and financial wellbeing of staff and provides training and toolkits for managers to ensure that staff are supported in the workplace.

The provision includes:

- Mental health training (Mental Health First Aid, Mental Health for Managers, Suicide Prevention)
- Health promotion campaigns (including wellbeing challenges, exercise classes, active transport, lunchtime walks, mindfulness, menopause cafes and training, 'take a break; campaign)
- Online resources on a variety of health and wellbeing topics (including healthy eating, exercise, mental health, and financial wellbeing tools)
- Promotion of support resources available to staff (occupational health, staff support counselling and mediation service, cancer support, foodbank partnership, bicycle user group)
- Cost-of-Living Crisis and supporting staff through access to financial perks / saving schemes, such as Eden Red, Health Service Discounts, Blue Light Card, Discounted Café Menus and other offers through local businesses.

One of the key priorities for the Health and Wellbeing service is to ensure that our staff are aware of and utilise the resources available to them, helping them to improve their health and wellbeing, reducing sickness absence and turnover, and improving service to the patients.

Two of the primary challenges in meeting these priorities is digital exclusion / equality of access to online information and time to participate in health and wellbeing interventions during the working day. Our priority for reducing this inequality is to improve access to communications and design new interventions with these groups in mind. We must ensure

that there are multiple ways for staff to access information and resources and that we consider how to increase engagement and support staff to attend events, within their working day, whilst balancing other work commitments.

Looking forward, the health and wellbeing team will continue to deliver a comprehensive programme of wellbeing support which addresses staff mental, physical, social and financial wellbeing, taking into consideration the needs of different staff groups. Areas of focus will include improving accessibility and developing communication channels to reach underrepresented groups. Other areas of focus will include:

- Protected characteristics are considered at the design stage of interventions.
- Targeted interventions to address challenges of specific demographics (e.g. access to mental health interventions for men, help with managing menopause symptoms)
- Work closely with our EDI networks
- A continued focus on the Cost-of-Living Crisis and Financial Wellbeing.

Freedom To Speak Up

Freedom To Speak Up Guardians (FTSU) are employed across the NHS. This role was created as a result of the recommendations published in 2015 by Sir Robert Francis following his review of the Mid Staffordshire Hospital Trust. See the full report here.

There are currently 961 Freedom to Speak Up Guardians across 575 organisations, offering an impartial and confidential advice and support service for staff raising concerns. This innovative service helps to promote and build a positive speaking up culture which can support improving patient outcomes, staff wellbeing and management practices.

Lead Freedom to Speak Up Guardian
Karyn Richards-Wright
07775-020-247 / 0208-725-4001

Deputy Freedom to Speak Up Guardian
Community Lead Guardian
Tasheka Wilson
07721-584-612 / 0208-725-5033

Nationally, year upon year data shared with the NGO show that there is an increase in workers raising concerns directly to their Guardian. FTSU Guardians have handled over 75,000 cases since the National Guardian's Office first started collecting data in 2017.

At St George's, we are committed to supporting a culture of learning, openness, and transparency throughout our whole organisation. We want to ensure that our staff are empowered to speak up if they have any concerns about patient care.

Since 2016, the FTSU service at the Trust has expanded and now consists of a Guardian and one Deputy Guardian, who work across all St George's sites and community areas.

Guardians meet with staff in confidence providing confidential impartial independent advice, help, and support. There is no limit to the concerns that staff can raise, and no criteria that concerns must meet in order to be addressed. The fundamental purpose of the service is to take forward patient safety issues, and it is recognised that there is a strong link between confident, happy staff and improved patient safety. This means staff are free to raise concerns of any kind with the FTSU service.

Staff data and information is confidential. The Guardians provide feedback directly to those raising concerns on actions taken and keep staff up to date with anything relating to the

concern they have raised. The service also provides feedback to all staff through a quarterly newsletter and encourages the Trust to learn from concerns raised. From 1 April 2022 to 31 March 2023 there were 143 cases raised.

The staff groups which raised the highest number of concerns over the past year are: nursing and midwifery, administrative and clerical staff and doctors.

The main types of concern raised over the past year, which has been broadly consistent with the previous year, have been concerns around systems and processes (which included an increase in concerns relating to fair recruitment), staff safety and leadership '. Beyond these areas, several concerns have related to:

- Cultural issues
- Behavioural relationships
- Bullying & Harassment

The team continued to proactively raise awareness of the advice and support available to staff throughout the year, including during Speak Up month in October. This is an initiative organised annually by the National Guardian's Office, raising awareness of Freedom to Speak Up and the work which is being done to make speaking up business as usual.

The service also has a team of FTSU Champions across the Trust who help to raise awareness of FTSU particularly within their own teams and across the Trust during our awareness raising campaigns.

The lead Guardian at St George's is also the Network Chair for London and Guardian mentor and as such works closely with the National Guardians Office and other Trusts across the country.

Staff Support Counselling & Mediation Service

The Staff Support Counselling & Mediation Service is an in-house confidential service for staff which seeks to promote the mental health and psychological resilience of Trust Staff. We have excellent insight, knowledge and understanding of the diverse challenges staff may experience in relation to their mental health and wellbeing. Staff have quick and easy access to professional and experienced counsellors and mediators and the service falls into three broad categories:

- Individual counselling and support: drawing on a range of evidenced based interventions at NICE Level 3 of psychological support with the option, as appropriate, to refer to the teams Psychiatrist for assessment at Level 4.
- Mediation & Conflict resolution: this includes manager support sessions.
- Preventative and restorative interventions: Teaching and offering a variety of groups, including, mindfulness, reflective practice, debriefs, burnout and resilience workshops.

During the last twelve months a priority has been to respond to the challenges to the mental health of staff in relation to Trauma and Burnout following the pandemic, as well as supporting staff in relation to a variety of mental health and wellbeing challenges through one-to-one support, Reflective Practice, Training etc, including interventions to promote psychological resilience. Part of this work has included seeking to breaking down barriers to accessing mental health support and as a team we seek to attend and be active participants and support the various networks and groups which the Trust has available for Staff. For example, LGBTQI+, DaWN, Diversity & Inclusion networks and Overseas Nurses Induction etc.

Our mediation service has facilitated 1:1 mediation for staff in conflict arising out of a variety

of challenges, including cultural differences. Mediations are handled very sensitively by trained mediators to enable exploratory processes to develop empathic understanding between parties around difference.

Some of the services key achievements / activities in the last year include:

- Reducing stigma in relation to mental health across the Trust to both Clinical and non-clinical staff.
- Supporting World Mental Health Day
- Fortnightly reflective practice session, focusing on working with dying, death & loss.
- Promotion and provision of Management Support Sessions.
- Introduction of a service Risk Register
- Continued regular attendance and raising awareness of the Staff Support service, includes via Junior Doctor Forums, Staff Networks, and other staff forums.
- Continuing to embed Pragmatic Tracker, the reporting system into the service.
- Welcoming a new Staff Counsellor on an 18-month FTC to support in meeting the increasing demands on the service.

Looking forward our strategic plans and areas of focus include:

- To further develop and enhance the provision of NICE recommended guidelines in relation to being a Trauma Informed Service.
- To embed the enhanced pathway of support, from point of contact with the service, through triage, referral, assessment and intervention.
- To review, update and develop resources, including those on the Trust Intranet.
- To continue to offer enhanced provision of support to the Emergency Department.
- To develop and offer a range of groups on presentations to mental health and wellbeing, for example, stress, anxiety, conflict, bereavement, depression & burnout.
- Collaborating with Occupational Health re. Drug and Alcohol addiction.
- To continue to seek to reduce mental health social stigma, including communicating the message to all that, 'It is okay, not to be okay.'
- Improve representation and diversity within the staff support team.

Staff Networks

St George's has four active staff networks, which were all formed in 2019;

- Black, Asian and Minority Ethnic (BAME) Staff Network
- LGBTQ+ Staff Network
- Disability and Wellness (DAWN) Staff Network
- The Womens Staff Network

These mature networks and their Network Leadership Committees (NLCs) have been actively engaging with staff, consulting on key policy and process changes, organising key celebratory and awareness events. Our Network Chairs are also members of our Culture, Equity and Inclusion Programme Board which is chaired by our Chief Executive Officer and allows an

opportunity to influence key decisions at an organisational level. Each of our four recognized Staff Network have access to a personalized Charity Grant as well as an allocated budget for network related activities and development.

BAME Network

The BAME Network has a membership of over 300 people. The network supports the organisational culture programme, driving change through the CEI (Culture, Equality, Inclusion) board through various events and initiatives. The network introduced the 'See ME first' initiative in 2022 which aims to promote Equality, Diversity and Inclusivity and to say that we are an open, non-judgmental NHS organisation that will all Black, Asian and Minority Ethnic staff with dignity and respect.

By wearing the See ME First Badge, the wearer, is showing their commitment to the Values of the Organisation: to be Excellent, Kind Responsible and Respectful and are echoing the sentiment of Dr Martin Luther King Jr that people should 'not be judged by the colour of their skin, but by the content of their character'.

The network have also hosted celebration events for key cultural days: Black history month, Eid, Diwali and Chinese. For the coming year they will be rolling out 'Hear Me Now' Sessions – to provide staff with a safe space express personal and professional difficulties they are going through.

DAWN Network

The DAWN Network has a membership of 108 people. The network supports the organisational culture programme, driving change through the CEI (Culture, Equality, Inclusion) board through various events and initiatives. They have celebrated Sign language awareness week, supporting over 30 staff to complete a BSL taster course.

Throughout the year they run staff engagement events around health conditions/ disabilities and how to disclose this on ESR. Including celebrating UK Disability Month hosting activities throughout the month: weekly virtual talks from staff 'Me and My Disability', virtual BSL sessions, virtual mindfulness sessions and promoting best practice and resources. The network was pivotal in developing and reviewing the Disability Awareness and Essential Workplace Adjustments mandatory training modules. Launching the Calibre Leadership Programme, a talent development and leadership programme for staff who identify as neurodiverse or disabled, or who have a long term physical or mental health condition. With the aim of empowering staff with the necessary techniques and knowledge to overcome barriers within the workplace.

LGBTQ+ Network

The LGBTQ+ Network has a membership of 175 people. The network supports the organisational culture programme, driving change through the CEI (Culture, Equality, Inclusion) board through various events and initiatives. The network has hosted events throughout the year including Pride celebrations, Trans Awareness week, with speakers from TransActual discussing trans rights and best practice and barriers in healthcare.

The network continues to promote the NHS Rainbow Badge Scheme, with over 500 staff members pledging support. By choosing to wear a Rainbow Badge, individuals are sending a message that says: "you can talk to me". These staff members are not subject matter experts but will provide a safe space and know how to signpost people to the support.

Womens Network

The Womens Network has a membership of 200 people. The aim of the network is to provide a voice and shine a light on the experience of female colleagues, who are currently underrepresented at senior levels. They have led on the implementation of the breastfeeding/ chest feeding room on site. They continue to support the Menopause café, for staff that are pre-menopausal, menopausal or seeking help for a friend/loved one.

The network have also supported Imposter Syndrome sessions have been hosted virtually to help tackle self-doubt and feelings of fraudulence about one's own abilities. Looking ahead to the rest of the year they hope to coordinate joining the London Women's Night Safety Charter, in addition to continuing their current events.

Section 4 – Patients and Service Users

This section provides an overview of programmes of work in relation to health inclusion.

This section spotlights specific teams and initiatives that have been introduced throughout 2022 and 2023 to improve the experience of patients and provide a demonstration of how St George's has had due regard for the general and specific duties of the PSED.

Overview of Key Achievements / Activities

- Improved shared access to our electronic patient record system between ESTH and STG. Enabling access to more consistent and comprehensive records and reports. Furthermore, having greater access and oversight of a person's current and past health, means that plans can be formulated with different members of the multi-disciplinary team, which will

enable us to better meet the holistic, individualised patient care required.

- Introduction of our first Transgender Health Records Standard Operating Policy (SOP) which aims to improve the experience of our transgender patients. This SOP was developed by our Health Records service in consultation with our EDI Team and members of our LGBTQ+ Staff Network. This policy will help to ensure patients health records are accurate, consistent, and up-to-date which will enable staff to treat transgender patients with the dignity, respect, and the equality they are entitled to.
- Introduced an LGBTQIA Awareness Module which aims to build a greater understanding of the challenges and barriers that the LGBTQIA+ community face when accessing health and care services, and how support can be improved to positively impact patient care and experience.
- Relaunched our Patient Partnership and Experience Group (PPEG) and increased numbers of volunteers, including patient partners and patient representatives, ensuring the diverse voices of patients/carers are welcomed, heard and involved.
- Diverse and topical patient stories at the St George's Trust Board, bringing patient experience to the Executive team, raising awareness of areas for improvement or those currently affected by transformation projects/events in progress, demonstrating patient involvement.
- Launch of a new Patient Experience intranet site and blog providing a platform to raise awareness of key information for staff.
- A patient engagement event took place in September and October with an in-person and virtual events welcoming patient/carer feedback on service priorities following the acute stage of the pandemic.
- A volunteer recruitment event took place in February to meet our aim of recruiting 100 new volunteers by 31 March 2023 to return volunteer numbers to pre-pandemic levels.
- Partnership working improved through new, and refreshed links with partner agencies including carers agencies, Healthwatch, volunteer groups, charities and local organisations.
- St George's is working with the Integrated Care Board, part of the new South-West London patient engagement group sharing learning and best practice across the sector.
- St George's successfully ran national surveys including Maternity, Inpatients, Emergency and Urgent Care and Adult and Children's Cancer surveys, engaging with patients to identify areas of good practice and where improvements could be made. Action plans were presented at the Patient Safety and Quality Group (PSQG) to detail planned service improvements arising from these surveys.
- The Patient-Led assessments of the care environment (PLACE) restarted with good patient engagement and representation across both St George's and Queen Mary's.
- A new patient support group launched for adult ITU survivors.
- Several events took place recognising the efforts and achievements of St George's volunteers.
- Launch of the online mandatory Oliver McGowen Training for all staff. This national training packages package aims to save lives by ensuring the health and social care workforce have the right skills and knowledge to provide safe, compassionate and informed care to autistic people and people with a learning disability.
- The Learning Disabilities Patient Partnership and Experience Group launched in September welcoming patient representatives and discussing key issues where patient experience can be improved.
- Increased patient representation on groups and committees to ensure the voice of the patients is heard, recognised and valued, capturing insights, experience and knowledge of service use.
- A veteran event took place, the first since prior to the pandemic, welcoming local officers and related organisations to an event commemorating Armistice Day.
- The Children's and Young People's council (patient user group) undertook the 15 steps challenge.
- Maternity Voice Partnership (MVP) continued to work with patients to identify, improve and capture experience to improve women and partners experience of the unit.

- The Trust launched *You said, We did* to capture learning from feedback and to demonstrate to patients/ carers our commitment to improving through listening to our patients.
- Inclusion of patients with a learning disability on our Tableau report.
- Relaunching the Learning Disability Patient Participation and Engagement Group post Covid-19.
- The Learning Disability Liaison Team (LDLT) have been working with Bowel Screening Programme clinicians to manage reasonable adjustments for people with a learning disability (LD) from their first point of access.
- The LDLT have introduced Learning Disability (LD) training to teams across the organisation, highlighting fundamental aspects of LD care including Hospital Passports and reasonable adjustments to consider.
- Introduction of a new LDLT patient leaflet which features Makaton signs to support communication.
- Learning Disability Patient Participation Group relaunched post Covid. Due to evidence highlighting barriers to accessing technology it was not possible to move to virtual meetings and the decision was made to wait until face to face was possible. The format has been refreshed and a new Terms of Reference approved.
- NHS Benchmarking Survey has been completed.
- Attending local LD forums including those hosted by the ICB, Wandsworth Clinical Reference Group, Mencap forum and engaging with Trust Governors with interest in LD.

Chaplaincy and Spiritual Care

The Chaplaincy and Spiritual Care Team are a multi-faith, multi-denominational team who offer spiritual and religious care to patients, staff, visitors, and volunteers. Based within our Spiritual Care Centre in Grosvenor Wing, the team provide:

- Support for patients, their relatives, or friends.
- Time and space to explore thoughts and feelings.
- A caring, sensitive, and non-judgmental ear for all.
- Religious care in response to your individual needs.
- Support for staff and volunteers.

The team host a number of weekly events and services, including Muslim Friday Prayers (both male and female prayers rooms are available), 'Refresh' a time of Christian worship and reflection (an inclusive service for all), Roman Catholic Mass, meet with a Chaplain for private prayer, Christian Service with communion.

Charity Partners

St George's is very fortunate to be supported by a number of charities. These charities help by providing support to our patients and their families, friends and carers, and by making fundraising to help us to improve our facilities, making sure that our patients are treated in the best possible environment.

These charities include; St George's Hospital Charity, First Touch, The Limbless Association Country Air Ambulance, Headway, Friends of Queen Marys, The Douglas Bader Foundation, Full Circle, Ronald McDonald House, Friends of St George's, The Neurosciences Research Foundation, The Wolfson Foundation and St George's Kidney Patients Association.

Complaints and Patient Advice and Liaison Service (PALS)

The **Complaints** team at St Georges are responsible for the management of formal complaints received by the Trust from patients, relatives or third parties. The team is also responsible for responding to all queries raised by the Parliamentary and Health Service

Ombudsman (PSHO), who may investigate a complaint once it has been fully investigated through the local complaints process. Our aim is to provide a timely response to the complaints raised in the agreed timeline and in an accessible and preferred format, requested by the complaint as per the process. The team provides written responses to all complaints received including verbal resolutions and works collaboratively with each division to improve patient experience, identify themes and work on early resolutions.

The **PALS** Team provides support for patients, relatives and third parties who have a query about anything related to care delivered by the Trust. This could involve issues such as appointment queries, not being able to get through to a department or providing feedback without wanting to receive a formal written response.

Complaints and PALS work to four key priorities:

- Ensuring complaints or queries are responded to in an unbiased, timely and supportive manner.
- Ensure thematic analysis and learning from complaints, compliments, or other feedback.
- Review of data and feedback through an EDI and Culture lens.
- Raise awareness and share information at divisional level as well as an organisational level through the appropriate governance channels.

As part of our collaborative group model the Complaints and PALS team have been working to share best practice across the group and ensure consistency of approach. The improvements include a named case officer speaking directly with complainants to build a relationship, understand the key issues, how these are currently impacting the complainant and seeking to ensure all parties understand the resolution we hope to achieve. This change has helped to build trust and confidence that may have been impacted following a poor experience. Furthermore, it helps the division to respond to complainants thoroughly, ensuring all key concerns are recognised and addressed. These improvements have helped to rebuild positive relationships, provide further insights / learning opportunities and have been welcomed by teams across the organisation.

Currently there are several limitations with data collection in relation to protected characteristics, therefore we are not able to establish clear themes or whether some communities are disproportionately impacted in terms of reporting poor experience using services at St George's. Limited data is available in regard to Age, Ethnicity and Sex, we do not have data on any other protected characteristic.

Further information and demographics, including our Complaints and PALs Annual Reports can be found here.

Health and Safety

The Health and Safety (H&S) Team's role is to ensure compliance with H&S legislation and prevent accidents, injuries, and work-related illnesses to staff, patients, visitors and contractors in the workplace. The H&S Team undertake audits, inspections, and investigations to ensure we keep our staff and patients safe, and that compliance is achieved and maintained by the Trust. Key activities this year include:

- Partnership working with the Metropolitan Police under Operation Cavell. This agreement helps to ensure that the Metropolitan Police and Crown Prosecution Service support all Trust staff reporting incidents of assaults and hate crime, through the prosecution process. This has involved work with witness support and is subject to

regular meetings to review incidents and performance of the law enforcement/CPS actions against assurances given.

- Introduction and implementation of Trauma Risk Management (TRiM) Programme. This programme reinforces and compliments our existing Staff Support provision, providing initial response/review in relation to traumatic incidents experienced by staff.
- Working with the charity *Words4Weapons* to install a knife bin on our Tooting site which we hope will reduce the incidents of offensive weapon/bladed article/ firearms on the trust site.
- Introduction of our Violence Prevention and Reduction Group, which is responsible for monitoring, overseeing, and ensuring Trust compliance against the NHS Violence Prevention and Reduction Standard. The Group also provides a forum to review and discuss any violent incidents and/or trends seeking to ensure sustainable remedial action is taken, to mitigate the risks of violence and aggression towards staff, patients, contractors and service users. The group includes representation from our Head of EDI and our Staff Networks.

Learning Disability Liaison Team

The Learning Disability Liaison Team (LDLT) supports adults (18+) with a diagnosis of Learning Disability. The LDLT has 781 referrals in 2022/23.

The core aim of the service is to ensure that adults with a learning disability have access to supplementary support if required. As well as providing support to the person at the centre of care, the team provides support to their families, carers, community health teams and our statutory partners. The team provide admission support to individuals and the clinical teams, pathway planning, discharge input, reasonable adjustments, education and teaching, liaison and navigation and participate in clinical reference groups, LeDeR and NHS Benchmarking. For 2022/23, the service activities and priorities have included:

- Inclusion of patients with a learning disability on the Tableau TEP report.
- Relaunching the LD Patient Participation and Engagement Group post Covid-19.
- Delivering training to staff highlighting fundamental aspects of LD care including Hospital Passports and reasonable adjustments to consider.
- Work in partnership with other professionals and agencies to ensure that the patient remains safe along the pathway of care from point of admission to discharge.
- Facilitate discussion and guidance around best interests' decision making in accordance with the Mental Capacity Act (2005).
- Coordinate and implement reasonable adjustments where appropriate as required in accordance with Equality Act 2010.
- Monitoring use of DNACPRs to ensure communication, effective consideration of all aspects of the individual and reduce risk of diagnostic overshadowing.
- Learning Disability Patient Participation Group relaunched post Covid.
- NHS Benchmarking Survey has been completed.
- Building networks and exploring opportunities for sharing best practice, including attending local LD forums hosted by the ICB, Wandsworth Clinical Reference Group, Mencap forum.

Looking forward the LDLT priorities include:

- Creating an externally facing webpage for the LDLT. This will host easy to read information, details on navigating the hospital, introduction to the team and contact details. In partnership with clinical services this will include accessible videos that offer a guide or 'welcome to' the department, showing what the buildings or waiting rooms look like which helps to prepare those visiting our hospital.

- Formalising our LD Policy and/or Strategy, highlighting roles, responsibilities and how we can improve access.
- Working with the Head of EDI, Learning and Development Team, Patient Experience and wider Trust partners to ensure Oliver McGowan's Mandatory Training (Tier 1 and 2 face to face) is available and staff are support to gain compliance.
- Working with the screening programmes to improve parity of access, and with community partners to facilitate discussions on necessity. Strategic input is required via the ICB to look at how the system can support all aspects of this work.
- Recruitment of an additional full-time HCA, who will support further social inclusion for our inpatients with an LD. This will also include supporting outpatient appointments and reasonable adjustments (i.e. fast track) for outpatients.
- Work with Outpatients, Patient experience and clinical systems to contribute to accessible information appointment letters.

Patient Experience

The Patient Experience service is a wide-reaching service with numerous feedback loops aiming to capture patient experience through patient engagement and involvement, ensuring that patients are involved, and their views considered via a variety of means.

The service encourages feedback via many methods, including:

- National and Local surveys
- Listening to patients through listening events and focus groups.
- Patient user groups and Patient Support Groups
- Maternity Voice Partnership
- Learning from feedback and sharing learning
- Working with volunteers
- Involving patients and carers in planning service improvements/transformation
- Community partnerships
- Friends and Family test

This service aims to improve patient experience by involving patients/carers in service improvement projects and engaging patients in areas to improve patient experience. Service users are experts in receiving care and Trust staff experts in delivering care therefore by listening and working collaboratively with service users, the Trust strives to make improvement in standards of care, linking in with partnership agencies to triangulate community wide improvements.

The service has particularly focused on improving and identifying ways to welcome feedback, improving the accessibility of engagement events to increase knowledge of experience from users with protected characteristics. Many of the activities and achievements listed above welcomed a diverse range of users to share their experience and learn from their stories. Specific examples of activities as follows:

- St George's runs the Project Search programme, helping young people with learning disabilities and autism to find jobs.
- Patients that took part in the PLACE audits this year included patients with disabilities, cultural diversity, and a parent volunteer with a disabled child. This contributed greatly

to our assessments, supporting improvements being made to benefit service users, enabling the viewing of departments through the lens of a diverse patient group.

- Engagement events that took place this year were advertised both within the Trust and through Healthwatch Wandsworth to encourage patients/carers representing the diversity of our community to take part.
- LD PPEG relaunched following a pause due to the pandemic, welcoming the group back to the Trust in person.
- The Children's and Young People council continues to run with the children contributing to the running of the paediatric service with suggestions for improvement through food and environmental decoration and by their involvement in recruiting staff.
- Maternity services continue to work with parents to improve services through the Maternity Voices Partnership, welcoming stories and feedback from all parents who had had their babies at St George's to help shape services.

Looking forward the service priorities include:

- Create and embed a new GESH patient experience strategy, to follow the new GESH Quality Priorities embedding the expectations of inclusion, co-design and co-production as business as usual.
- Benchmark the Trust against the new Working in Partnership with People and Communities document, highlighting areas for improvement against this statutory guidance.
- Implement the new Carers and Hospital Discharge toolkit, supporting teams to embrace this toolkit consistently and transparently across the Trust.
- Ascertain formal compliance of the Accessible Information Standard at St George's as this remains on the risk register.
- Become a Veteran Aware accredited organisation.
- Work with chaplaincy staff to build relationships with community groups underrepresented in local and national surveys.
- Continue to raise the profile of patient partners and partnership working with service users/transformation projects.
- Increase volunteer numbers.

Equality Reporting

Accessible Information Standard

All NHS Providers must follow the Accessible Information Standard (AIS). The Standard sets out a specific, consistent approach to identifying, recording, flagging, sharing and meeting the information and communication support needs of patients, service users, carers and parents with a disability, impairment or sensory loss.

AIS applies to people who use a service and have information or communication needs because of a disability, impairment, or sensory loss. This includes interpretation or translation for people whose first language is British Sign Language. It can also be used to support people who have aphasia, autism or a mental health condition which affects their ability to communicate. The AIS consists of five steps;

- **Identify** - How does the service assess for information or communication needs

and plan to meet these needs?
- **Record** – What systems are in place to record these needs clearly?
- **Flag** - How does the service highlight or flag people's information and communication needs in their records? The chosen method must make it possible for all staff to quickly and easily be aware of (and work to meet) those needs.
- **Share** – Where required and with consent, how does a service share details of people's information and communication needs with other health and social care services?
- **Meet** - How does the service make sure it meets people's needs, ensuring people receive information which they can access and understand?

Work has taken place since the introduction of the AIS and many services across St George's are now able to provide a more inclusive and accessible patient experience. These improvements include:

- Correspondent formats including easy read, large text, braille and other languages.
- Communication alerts within our electronic patient records system (Cerner)
- Access to services/systems such as; Language Line- offering British Sign Language and Interpretation services
- Access to Relay UK and Hearing Loop
- Detailed accessibility information via AccessAble

As there is limited evidence available to provide assurance that we are consistently meeting the requirements of the AIS, we are introducing an AIS Steering Group which will be responsible for identifying areas of best practice across the organisation, exploring areas for collaboration with ESTH and identifying priority workstreams, staff training needs and system barriers.

This group will be overseen by a named Executive Sponsor and consist of key leaders which will be vital to the success and sustainability of this programme of work. The group will monitor and report progress to the Senior Responsible Officer for Health Inequalities.

How we ensure easy access to our information online

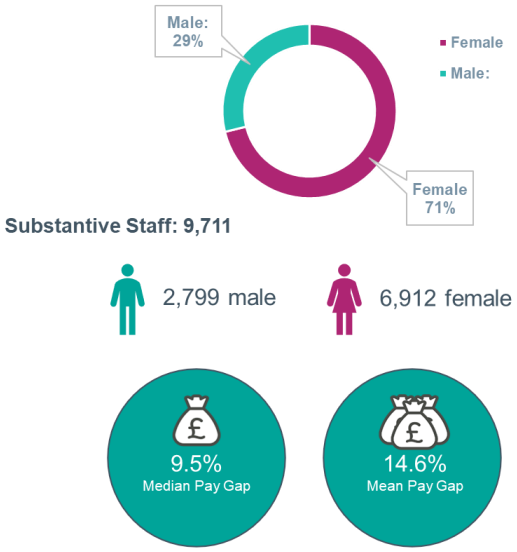
Our website helps us to ensure that our patients, staff, and stakeholders have easy access to information about our hospitals and services. We want as many people as possible to be able to use our website and access information about us. For example, that means users are able to:

- Change the appearance of this site, including font size and colours
- Use a "plain layout"
- Translate the page into over 50 languages using Google Translate. Note: Google Translate is a free service to help non-English speakers to understand the basic site information. However, we cannot guarantee that translations are 100% accurate. For this reason, we do not recommend that patients rely on translated text to make medical decisions.
- Access only using a keyboard, including skipping from link to link using the TAB.

Our full accessibility statement can be found here

Gender Pay Gap Report 2022

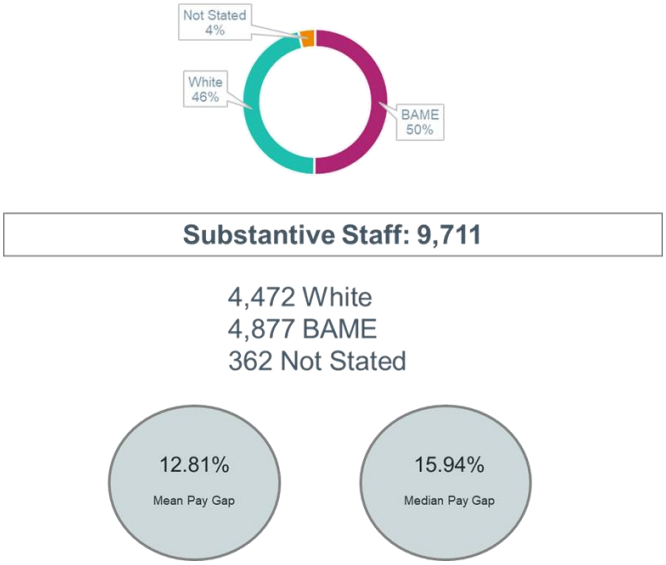
The Gender Pay Gap (GPG) is a mathematical calculation based on the difference between the average (or 'mean') hourly earnings of women compared to the average hourly earnings of men. The Gender Pay Gap highlights any imbalance of average pay across an organisation.



For example, if an organisation's workforce is predominantly female yet the majority of higher paid roles are held by men, the average female salary would be lower than the average male salary. The Gender Pay Gap is not the same as equal pay which is focused on men and women earning equal pay for the same / similar jobs or for work of equal value. It is unlawful to pay people unequally because of their gender. On 31st March 2022 St George's employed 9,711 staff - 6,912 were female and 2,799 were male. The mean hourly pay for males is £3.87 higher than that of females, which is a gap of **14.6%.** Male median pay is £2.20 higher than females, which is a gap of **9.5%.** If Medical Staff were removed from STG's overall total, the gender pay gap would be 0.37% in favour of females. Further information, including next steps can be found here.

Ethnicity Pay Gap Report 2022

The Ethnicity Pay Gap is a mathematical calculation based on the difference between: The **mean** is the difference between the average pay of all white employees and the average pay of all BAME employees. The **median is** the difference between the pay of the middle white and middle BAME when all white employees and then all BAME employees are listed from the highest to the lowest paid.



On 31st March St George's employed 9,711 staff – 4,877 were BAME, 4,472 were white, and 362 not stated. The mean hourly pay for white staff is £3.25 higher than that of BAME staff, which is a gap of **12.81%**. White median pay is £3.76 higher than that of BAME staff, which is a gap of **15.94%**. Further information, including next steps can be found here.

Workforce Disability Equality Standard (WDES)

All NHS providers are required to complete an annual Workforce Disability Equality Standard Report (WDES). The report is based on a snapshot of data from 31st March each year and aims to highlight progress against several key indicators of workforce equality for staff with a disability. The key findings and metrics for this report submission

are outlined below - each point is compared to the previous reporting period in 2021:

Workforce Numbers and Declaration

- There is an 1% increase in the number of staff that have declared a disability (+65 staff members), this group makes up 3% of the workforce.
- There is a higher number of staff with a disability in lower bands however the headcount percentage remains consistent across all bands.
- There is a reduction in the number of staff with a disability status recorded as 'unknown', from 769 in 2020 to 754 in 2021.
- Staff with a declared disability within the medical workforce remains very low, particularly the Consultant grade (0.30%) and the Non-Consultant Career grade (0%).
- Whilst staff with a disability are under-represented at Executive and Board level within non-voting, they are positively represented in voting.

Recruitment

Applicants without a disability are 1.21 times more likely to be appointed compared to applicants with a disability, this has increased from 1.08 in 2021.

Capability

Staff with a disability are 4.44 times more likely to enter the capability process compared to non-disabled staff.

Harassment, Bullying and Abuse (HBA)

- The gap between the experience of staff with a disability and staff without a disability has increased in indicators 4a, 4b and 4c of the Staff Survey. However, the rates of staff with a disability experiencing these negative behaviours have reduced. Compared to 2020, HBA, towards staff with a disability, from:
    - Patients/service users (4a) is down -1.0% (-3.6% since 2019)
    - Managers (4b) is down -2.4% (-7.2% since 2019)
    - Colleagues (4c) is down -3.1% (-5.2% since 2019)

- The number of staff with a disability who felt able to report harassment, bulling or abuse has reduced by -1.5% compared to 2019.
- Reporting rates at St George's, for staff with a disability, is higher than the average nationally for the second year in a row.

Beliefs about equal opportunities, career progression and promotion

- Staff with a disability felt less confident about the Trust providing equal opportunities with regards to career progression and promotion. This dropped from 42.7% in 2020 to 40.1% in 2021.
- The confidence of staff without a disability has also dropped from 50.1% to 48.4%, due to this reduction the gap between the experience of staff with a disability and staff without a disability has remained consistent at around 8% for the second year.

Feeling pressure to go to work when unwell

- A higher number of staff with a disability reported feeling pressure to come into work despite not feeling able to carry out their duties.
- Whilst this was also reported in years 2018, 2019 and 2020, this year the gap between staff with a disability and staff without a disability is at its highest (11.3%).
- Staff without a disability report feeling slightly less pressured compared 2020.

Feeling that work is undervalued

- Whilst both groups report lower rates of feeling valued by the organisation, staff with a disability are still much less likely to feel that their work is valued.

Adjustments in the workplace
Only 63% of staff with a disability felt that adequate adjustments had been made to enable them to carry out their work. A notable decrease of 8.5% points compared to 71.5% in 2020.

Further information, including our WDES Key Activities and Action Plans (figure can be found here.

Workforce Race Equality Standard (WRES)

All NHS providers are required to complete an annual Workforce Race Equality Standard (WRES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality, including a specific indicator to address the low numbers of Black, Asian and Minority Ethnic board members across NHS organisations. Data for WRES indicators 5 to 8 are drawn from questions in the NHS staff survey.

The key findings and metrics for this report submission are outlined below. Unless indicated, each point is compared to the previous reporting period:

Improved Indicators

- Overall, the BAME staff population at St George's continues to increase year on year (50%)
- The relative likelihood of white applicants being appointed from shortlisting compared to BAME applicants has reduced from 1.47 to 1.26.
- The relative likelihood of BAME staff entering the formal disciplinary process compared to white staff has reduced for the third year, from 2.54 in 2020 to 1.26 in 2022
- The number of BAME staff reporting they have experienced bullying, harassment or abuse (HBA) has reduced across all 3 indicator groups.
- Compared to 2021, HBA, towards BAME staff, from:
    - *Patients/service users* is down -4.0%
    - *Other Staff* is down -4.2%
    - *Managers* is down -1.4%

Reduced / Static Indicators

- BAME staff are over-represented in lower bands
- BAME staff are under-represented in higher bands, particularly in Band 8d, 9 and VSM.
- BAME staff are under-represented at Executive and Board level, both in voting and non-voting (-31.4%).

Our D&I Action Plan, which was introduced in late 2020, has driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the deliverables set out in our 2020 action plan have now been delivered, there are still a number to be implemented, including introduction of divisional D&I action plans and further improvements within ER case management.

The WRES and WDES 2022 findings provide an opportunity to review progress against current organisational needs and allow for further engagement with stakeholder groups, including our staff networks, to establish the areas of priority for 2022/23. The new group model with Epsom and St Helier also offers opportunities to align our actions to deliver improvements across both organisations. These findings were presented to key stakeholder groups in late 2022 and our updated action plan (developed in collaboration with ESTH) published here.

St George's University Hospitals NHS Foundation Trust

NHS Staff Survey 2022

One of the key ways that we can support our people is by listening to what they say and acting on their feedback. The survey provides vital insight into staff views around what we do well, and where improvements could be made. This enables us to develop strategic plans and enact change for next year.

The national NHS Staff Survey is conducted annually and provides a highly valuable insight into what our staff think about the Trust and how they are treated. The feedback we receive is carefully analysed and is used to inform our staff engagement plans and our ongoing work to improve the culture at St George's.

In October 2022, staff survey questionnaires were sent to 9,141 eligible members of Trust staff and of those, 4,401 were returned. This was a 48.0% response rate, which is 2% higher than the average response rate for Acute and Acute & Community Trusts nationally (46%). A high response rate ensures we can be more confident in understanding what our staff think is working well, and areas for improvement.

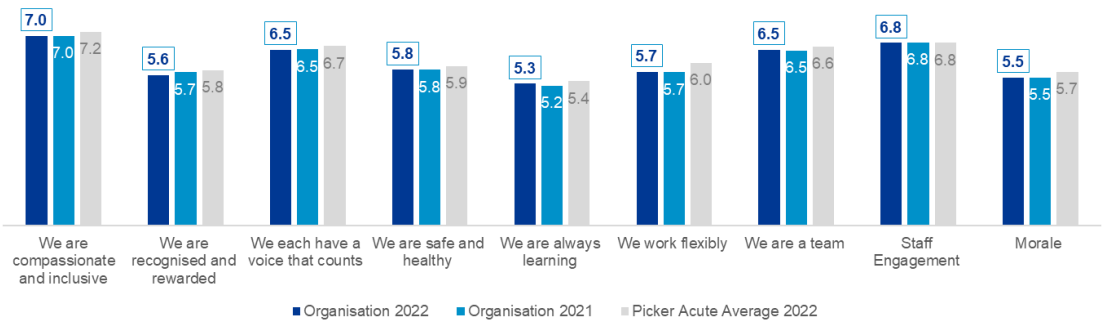
9510	9141	48%	46%	55%
Invited to complete the survey	Eligible at the end of survey	Completed the survey (4401)	Average response rate for similar organisations	Your previous response rate

58%	q23c. Would recommend organisation as place to work
67%	q23d. If friend/relative needed treatment would be happy with standard of care provided by organisation
73%	q23a. Care of patients/service users is organisation's top priority

*Bank worker survey results are presented via separate reports for those organisations who took part
**Chart shows the number of questions that are better, worse, or show no significant difference

Results were grouped into the seven People Promises. Scores for the People Promise themes remain largely the same as 2021, except for *We are recognised and rewarded* (which has seen a 0.1 decline) and *We are always learning* (which has seen a 0.1 increase). Our staff engagement score remains in line with the Picker Acute average, and also in line with our engagement score last year

Most themes perform below the Picker Acute average, except for *We are a team* (which is 0.1 above). *We work flexibly*, sees the biggest difference from the average (being 0.3 lower).



Comparing our results to benchmark average, we can see that we are slightly below the average in most indicators, with the exception of Staff Engagement, where we are in line. However, positive takeaways from our results are that:

- The majority of questions about the experience of our line managers has seen an improvement year on year.
- The largest increase year on year has been the question 'My immediate manager asks for my opinion before making decisions that affect my work', which has seen a 3.4% increase.
- Views on appraisals and learning opportunities have also seen an improvement:
  - 52.4% said they have access to the right learning and development opportunities when needed to (improvement from 49.7% in 2021)
  - The majority of respondents had received an appraisal in the last 12 months and the views on the quality of appraisals have seen a slight improvement since 2021
- 58.5% of respondents recommend the organisation as a place to work and 67.6% of respondents would recommend us as a place for treatment or care.

Performance against priority areas, monitoring arrangements, and how future priorities will be measured

Following extensive engagement, including with our Site Executive Team, CEI Programme Board and Divisions we produced our 2023 *Big Five*. These build on our top 5 from the previous year, providing more focus in areas that require momentum and improvement.

These five areas are:

1. Civility and psychological safety
2. Bullying and harassment/keeping staff safe (violence and aggression)
3. Inclusive behaviour within teams
4. Compassionate and inclusive leadership
5. High performance teams

Each of our five areas has subthemes and measures that we will closely measure in future staff surveys. Progress in these areas will be monitored these through our People Management Group, CEI Programme Board and People Committee for governance and assurance:

Theme	Sub themes
Bullying and harassment & keeping staff safe	• Tackling violence and aggression • Bullying & Harassment (and all forms of verbal abuse) as a serious safety issue impacting mental health and the quality of care that can be provided when staff feel unsafe. • Clarity on processes and support for staff • Sharing local action and best practice (e.g. ED) • Anti-racism
Civility and psychological safety	• Civility and respect • Psychological safety and speaking up • Values based behaviours • Team openness to admit to and learn from mistakes and be curious about what leads to mistakes happening. • Speaking up about concerns regarding behaviour • Speaking up about patient safety
High performance teams	• Health and wellbeing is central to high performance and prioritised. • Causes of stress and burnout to be well understood and addressing these prioritised • Managers tools to support staff to work together effectively • Conflict management
Compassionate and inclusive leadership	• Values based appraisal processes • Taking the lead in creating an inclusive team culture and holding team members to account

Theme	Sub themes
	• Continued development and promotion of management and leadership development offer
Inclusive behaviour within teams	Spotlight on work in WRES/WDES, emphasis on local action to achieve change in: • antidiscrimination, • de-biasing recruitment, • increasing representation at senior levels, • Reasonable adjustments and career progression • A continual improvement approach to implementing change

Conclusion

This report has provided an overview of St George's ongoing commitment to inclusion and the activities taking place which we hope have improved staff and patient experience. As a result of these activities, we are able to provide a demonstration of compliance with regards to the Public Sector Equality Duty.

Whilst there is a significant amount of work still to be done, St George's can show that it is linking its work with the general duties and identifying areas for improvement.

The past year has seen several successes for the Trust in relation to advancing the Equality, Diversity and Inclusion agenda, including the introduction of mandatory awareness modules, active bystander training, the launch of the trust's first Culture Equity and Inclusion Board, and the introduction of a comprehensive, and collaborative group strategy for 2023 – 2025, which includes a focus on Culture, Equity and Inclusion.

In addition, St George's has demonstrated compliance with other equality related requirements for public section organisations i.e., WRES, WDES and Gender Pay Gap. St George's has also recently published its first Ethnicity Pay Gap which demonstrates going beyond it's legal duties and moving towards greater transparency.

Next Steps

There are many remaining challenges and areas for improvements in relation to EDI, most notably in relation to the collection of reliable and consistent patient demographic data (on protected characteristics and health outcomes). Strengthening this area will enable St George's to better understand the experience of patients from marginalized communities and introduced targeted approaches and robust governance processes.

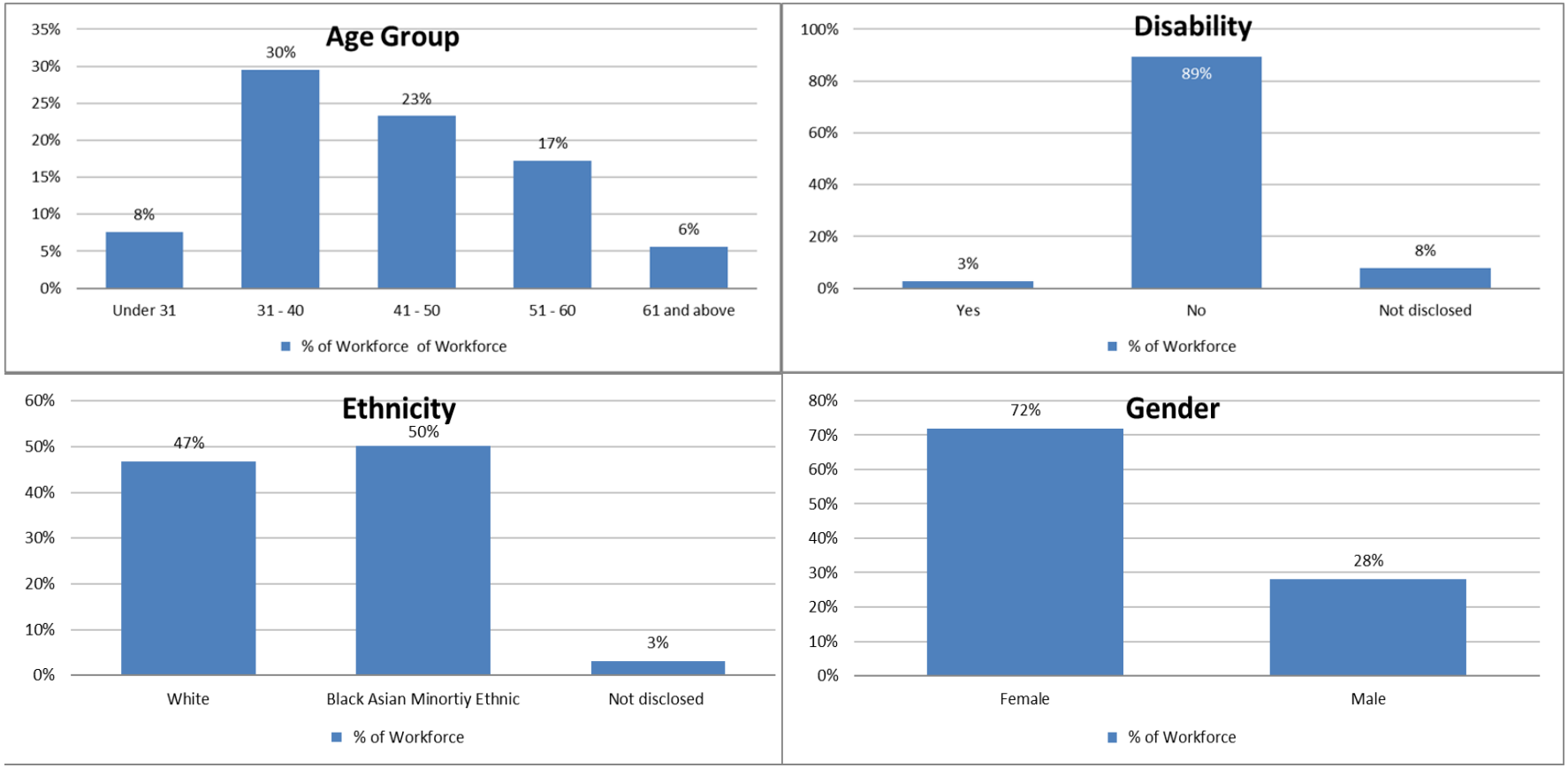
The continued focus on the 'Big 5' priority areas (listed below) is in many ways a refined approach to themes identified in the previous reporting year (2021). Adopting a group wide approach and sharing best practice will help to provide a more equitable experience for patients and our workforce.

Big Five Priority Areas;

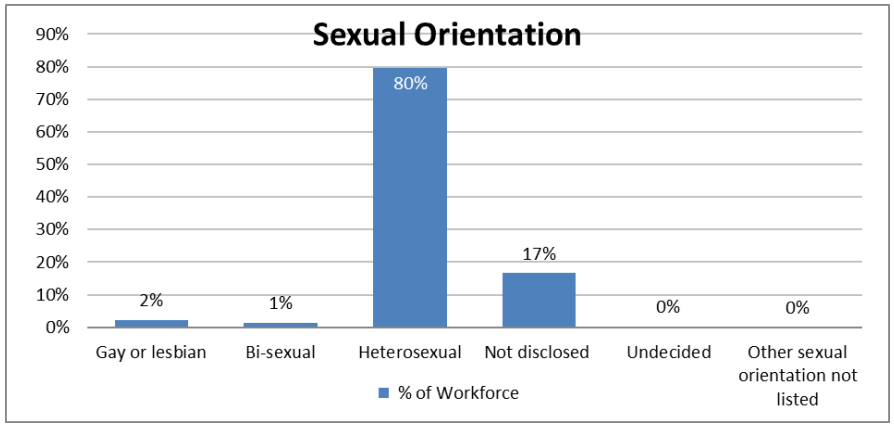
1. Civility and psychological safety
2. Bullying and harassment/keeping staff safe (violence and aggression)
3. Inclusive behaviour within teams
4. Compassionate and inclusive leadership
5. High performance teams

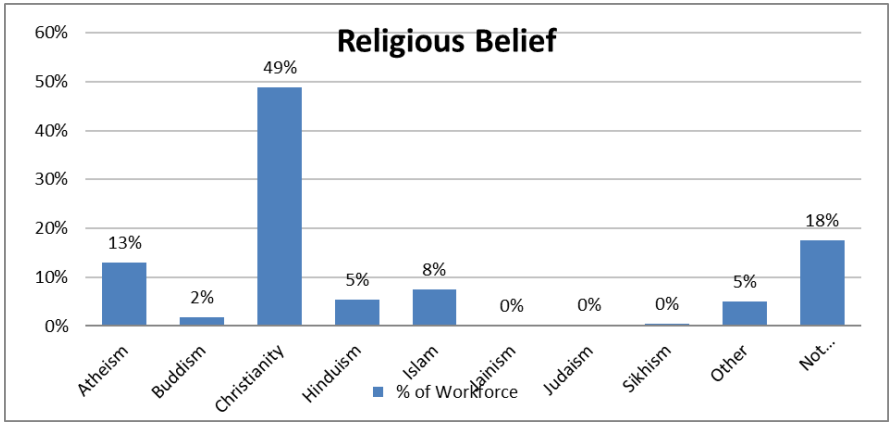
St George's University Hospitals NHS Foundation Trust

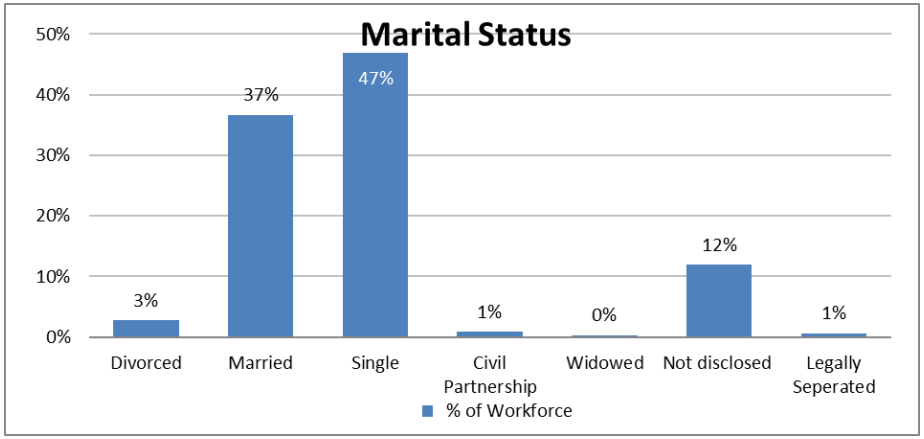
Appendix 1: Workforce Metrics by Protected Characteristic (2022-23)



SGH PSED Draft v0.05

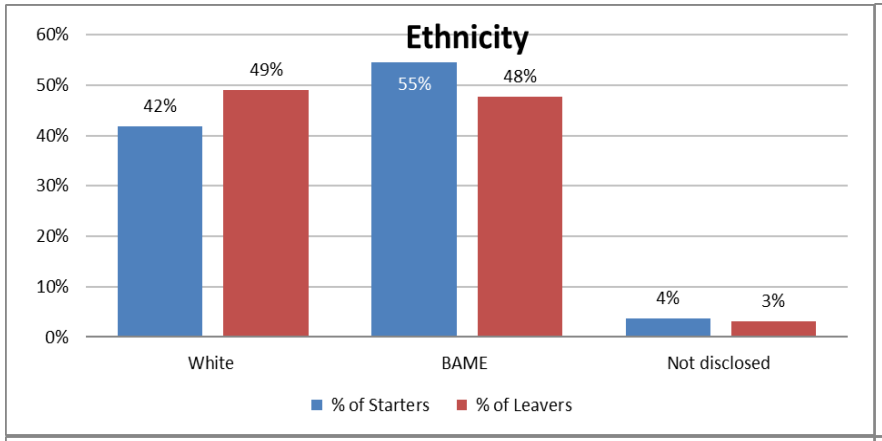

Sexual Orientation
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
2%
1%
80%
17%
0%
0%
Gay or lesbian
Bi-sexual
Heterosexual
Not disclosed
Undecided
Other sexual orientation not listed
% of Workforce

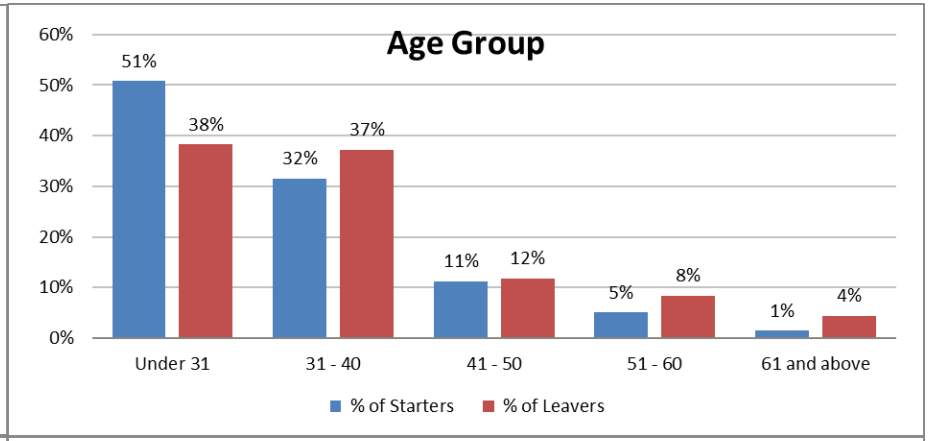

Religious Belief
60%
50%
40%
30%
20%
10%
0%
13%
2%
49%
5%
8%
0%
0%
0%
5%
18%
Atheism
Buddism
Christianity
Hinduism
Islam
Jainism
Judaism
Sikhism
Other
Not...
% of Workforce

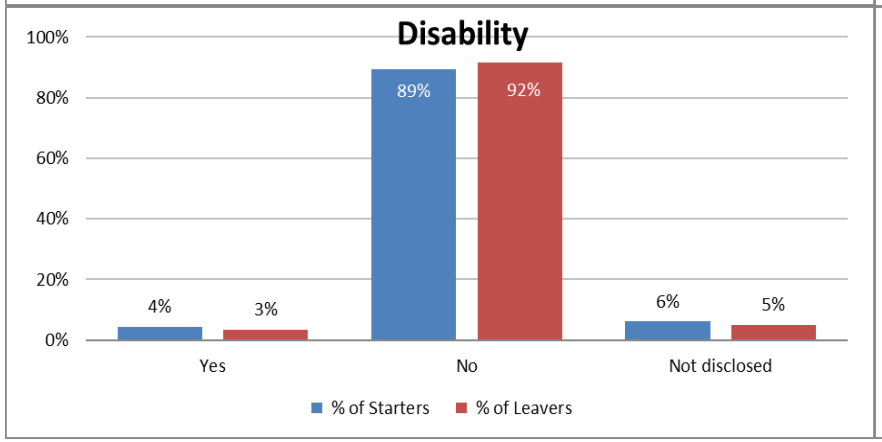

Marital Status
50%
40%
30%
20%
10%
0%
3%
37%
47%
1%
0%
12%
1%
Divorced
Married
Single
Civil Partnership
Widowed
Not disclosed
Legally Seperated
% of Workforce

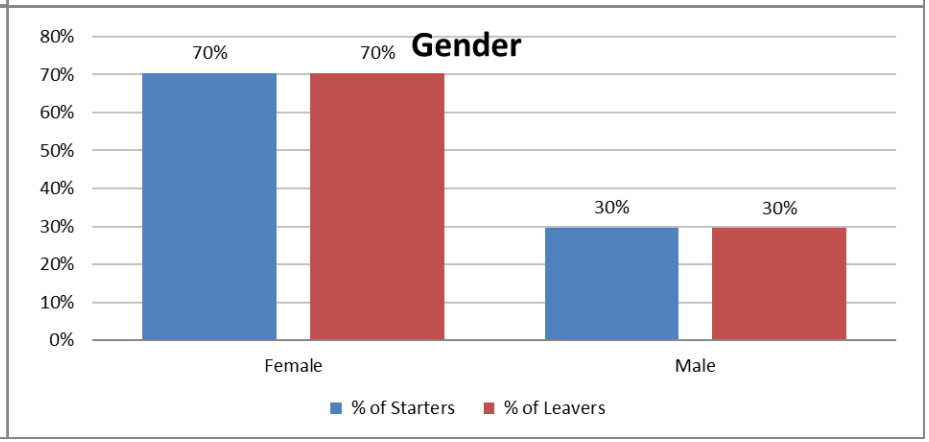
St George's University Hospitals NHS Foundation Trust

Appendix 2: Starters and Leavers by Protected Characteristic (2022-23)









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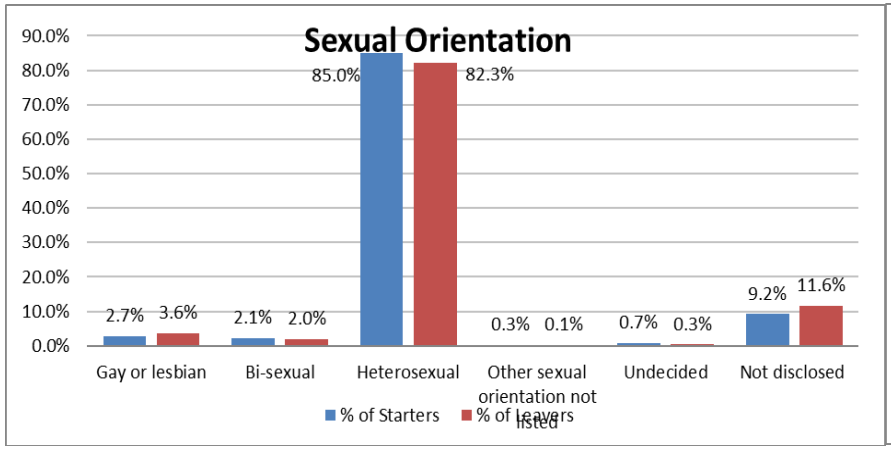
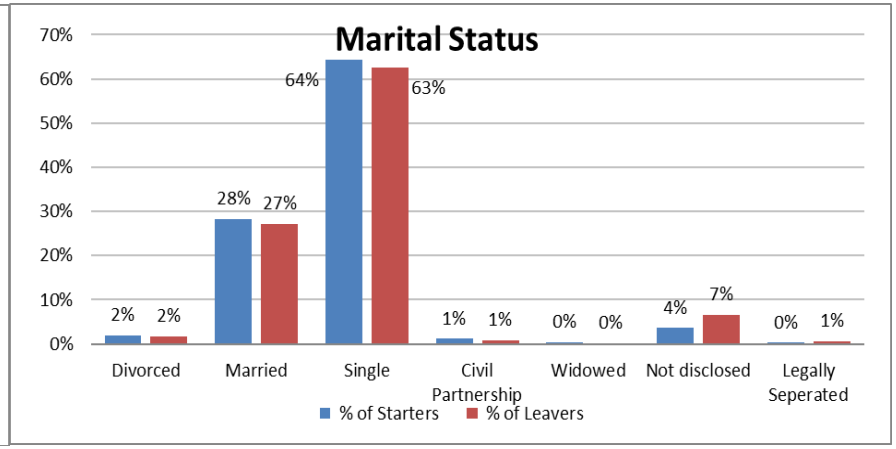
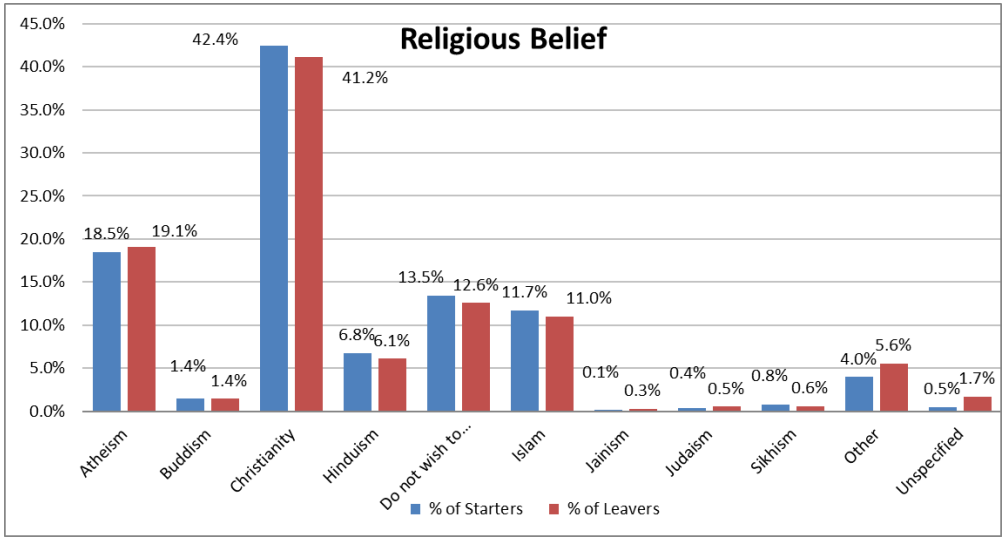

Sexual Orientation
90.0%
80.0%
70.0%
60.0%
50.0%
40.0%
30.0%
20.0%
10.0%
0.0%
2.7%
3.6%
2.1%
2.0%
85.0%
82.3%
0.3%
0.1%
0.7%
0.3%
9.2%
11.6%
Gay or lesbian
Bi-sexual
Heterosexual
Other sexual orientation not listed
Undecided
Not disclosed
% of Starters
% of Leavers


Marital Status
70%
60%
50%
40%
30%
20%
10%
0%
2%
2%
28%
27%
64%
63%
1%
1%
0%
0%
4%
7%
0%
1%
Divorced
Married
Single
Civil Partnership
Widowed
Not disclosed
Legally Seperated
% of Starters
% of Leavers


Religious Belief
45.0%
40.0%
35.0%
30.0%
25.0%
20.0%
15.0%
10.0%
5.0%
0.0%
18.5%
19.1%
1.4%
1.4%
42.4%
41.2%
6.8%
6.1%
13.5%
12.6%
11.7%
11.0%
0.1%
0.3%
0.4%
0.5%
0.8%
0.6%
4.0%
5.6%
0.5%
1.7%
Atheism
Buddism
Christianity
Hinduism
Do not wish to...
Islam
Jainism
Judaism
Sikhism
Other
Unspecified
% of Starters
% of Leavers

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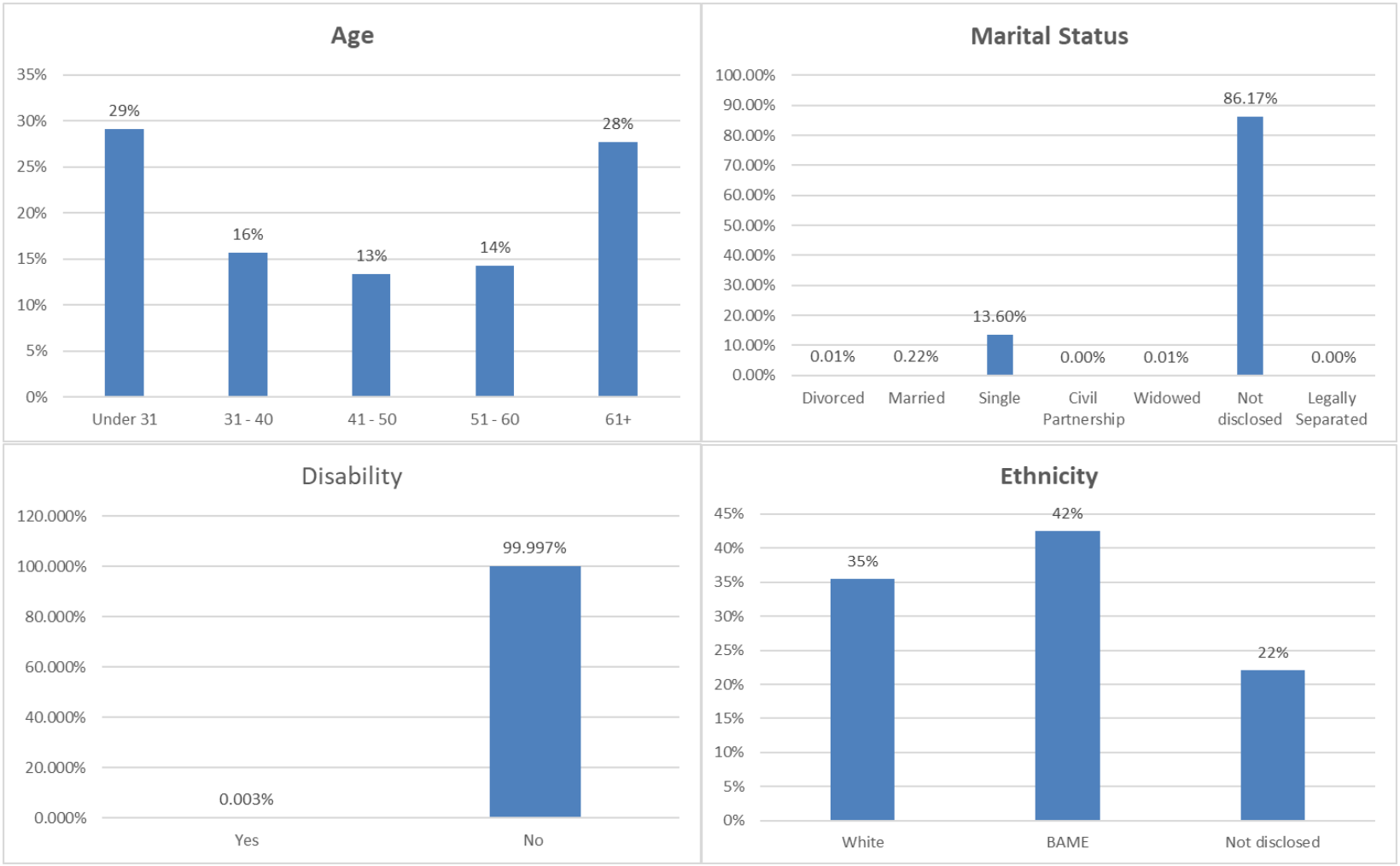
Appendix 3: Service Users by Protected Characteristic (2022-23)



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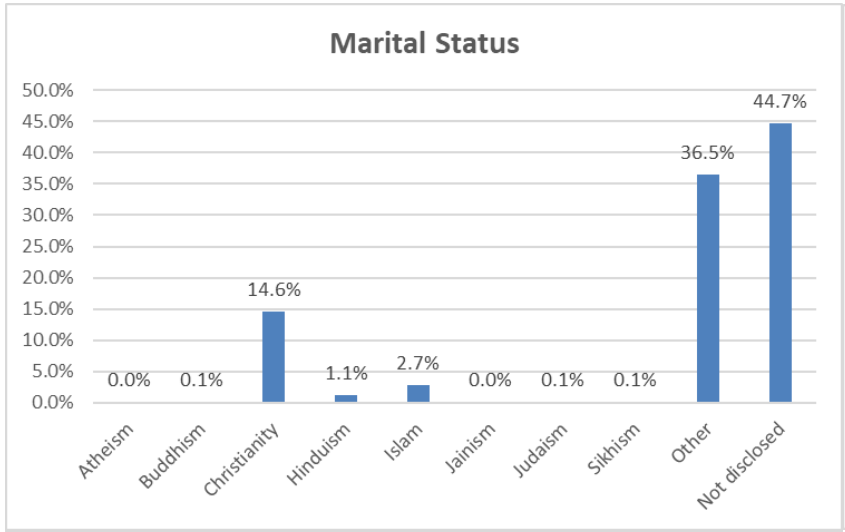

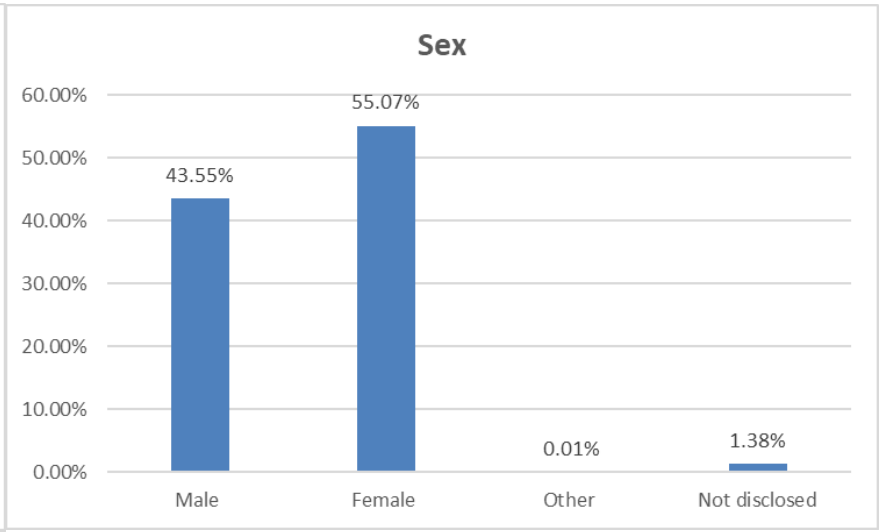

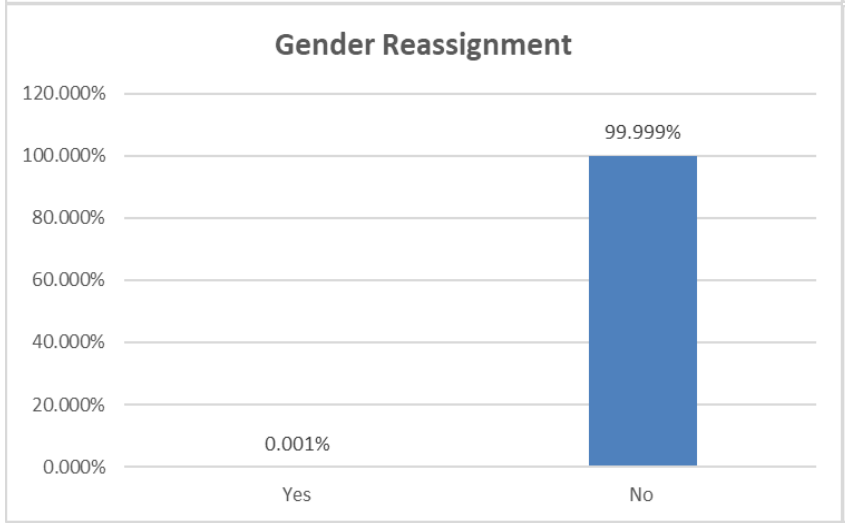

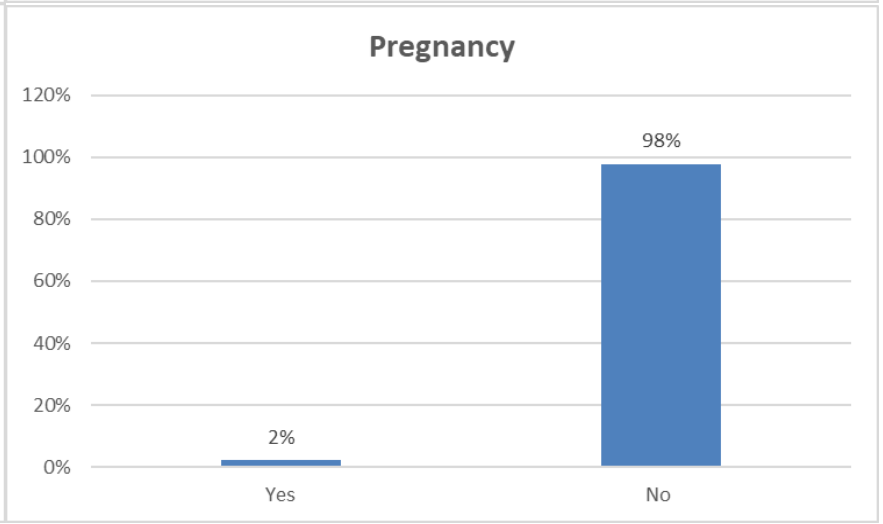

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Appendix 4: CORE20PLUS 5 Service Users by Protected Characteristic (2022-23)

		2021 - 2022					2022 - 2023				
		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
Age	Under 31	10%	29%	17%	32%	1%	8%	30%	11%	33%	1%
	31 - 40	10%	3%	11%	63%	3%	9%	4%	8%	62%	3%
	41 - 50	11%	5%	12%	5%	7%	10%	5%	7%	4%	7%
	51 - 60	18%	11%	14%	0%	16%	17%	11%	12%	0%	16%
	61+	50%	52%	46%	0%	73%	55%	50%	62%	0%	73%
	Total No. of Patients	**3,699**	**5,092**	**2,837**	**4,479**	**19,171**	**4,722**	**5,384**	**3,000**	**4,129**	**19,137**
		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
Marital Status	Divorced	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Married	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Single	1%	25%	7%	0%	0%	1%	26%	6%	0%	0%
	Civil Partnership	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Widowed	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Not disclosed	99%	75%	93%	100%	100%	99%	74%	94%	100%	100%
	Legally Separated	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**
		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
Disability	Yes	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	No	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Not disclosed	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**
		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
Ethnicity	White	41%	47%	42%	46%	41%	38%	47%	46%	44%	42%
	BAME	26%	39%	42%	39%	42%	28%	40%	39%	45%	41%
	Not disclosed	33%	13%	16%	14%	16%	35%	13%	15%	11%	17%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**

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		2021 - 2022					2022 - 2023				
		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
Marital Status	Atheism	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Buddhism	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Christianity	21%	29%	25%	10%	33%	20%	28%	29%	8%	31%
	Hinduism	1%	2%	2%	1%	3%	1%	1%	2%	1%	3%
	Islam	2%	3%	4%	5%	5%	2%	3%	4%	5%	5%
	Jainism	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Judaism	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Sikhism	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Other	57%	48%	52%	84%	47%	58%	46%	49%	86%	48%
	Not disclosed	19%	19%	18%	1%	13%	19%	22%	16%	0%	13%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**
Sex		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
	Male	47%	53%	49%	0%	54%	50%	53%	49%	0%	55%
	Female	52%	47%	51%	100%	46%	49%	47%	51%	100%	45%
	Other	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Not disclosed	1%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**
Gender Reassignment		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
	Yes	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	No	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Not disclosed	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**
Pregnancy		Cancer	Respiratory	COVID-19	Maternity	Hypertension	Cancer	Respiratory	COVID-19	Maternity	Hypertension
		%	%	%	%	%	%	%	%	%	%
	Yes	0%	0%	4%	56%	0%	0%	0%	2%	58%	0%
	No	100%	100%	96%	44%	100%	100%	100%	98%	42%	100%
	Not disclosed	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
	Total No. of Patients	**3,699**	**5,093**	**2,838**	**4,480**	**19,172**	**4,722**	**5,385**	**3,001**	**4,130**	**19,138**

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Group Board

Meeting on Friday, 07 July 2023

Agenda Item	3.1	
Report Title	**Maternity Services Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	**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)**	
Previously considered by	Quality Committees-in-Common	29 June 2023
Purpose	**For Review**	

Executive Summary

The purpose of this report is to provide assurance regarding the compliance at ESTH and SGUH with the Maternity Incentive Scheme Year 5 (CNST).

There are 10 Safety Actions; trusts need to demonstrate compliance with all 10 standards and the 74 page technical guidance outlining the minimum evidence requirements, in order to be eligible to reclaim the 10% incentive element of the maternity CNST contributions. The Year 5 CNST scheme runs from 30 May 2023 to 7 December 2023 for evidence purposes.

The following information is provided within this report in line with CNST requirements:

- A monthly report at Appendix 1 which covers all elements of the Perinatal Quality Surveillance Model: Required for Safety Action 9
- The quarterly report of cases that have been reviewed using the Perinatal Mortality Review Tool (PMRT) at Appendix 2: Required for Safety Action 1
- The Maternity Services Claims Scorecard for 2022 is at Appendix 3: Required for Safety Action 9. Further analysis of the triangulation of claims, incidents and complaints will be provided in subsequent reports.
- The ATAIN (avoiding term admission to the neonatal unit) at Appendix 4: Required for Safety Action 3

NOTE: In March 2023 Maternity Services at SGUH reviewed the process for the reporting and grading of 3rd and 4th degree tears and post-partum haemorrhage (PPH). It has been agreed that these incidents will be grated as moderate harm in the first instance. Each case will then be reviewed by a MDT and a final grading. Any incidents in which potential care lapses have been identified will be escalated through to SIDM for review. This change will be reflected in the next monthly Perinatal Quality Surveillance Measures Report.

Action required by Group Board
The Board is asked to: a. Receive the report for review b. Make suggestions for any further action

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Perinatal Quality Surveillance Measures May 2023 for ESTH and SGUH
Appendix 2	Perinatal Mortality Review Tool (PMRT) Quarterly Report December 2022 – March 2023
Appendix 3	Maternity Services Claims Report 2022
Appendix 4	ATAIN Action Plan (avoiding term admission to the neonatal unit)

Implications

Group Strategic Objectives

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

Risks

There is a risk that ESTH and SGUH will not be able to demonstrate full compliance with all 10 CNST Safety Actions.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

If ESTH and SGUH cannot demonstrate full compliance with all 10 CNST Safety Actions the Trusts will not be able to reclaim the 10% incentive element of the Maternity CNST contributions.

Legal and / or Regulatory implications

Enforcement undertakings applicable to ESTH and SGH

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

Equality, diversity and inclusion implications

No issues to consider

Environmental sustainability implications
N/A

Maternity Services: Perinatal Quality Surveillance Measures
Quality Committees-in-Common, 16 June 2023

1.0 Purpose of paper

1.1 The purpose of this report is to provide 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 (see Appendix 1).

2.0 CNST MIS Safety Action 9 – Monthly Summary

2.1 Table 1 below details the CNST MIS safety action 9 reporting measures for both ESTH and SGUH and provides a comparison on the quantitative data provided for both Trusts for May 2023.

Safety Action 9 reporting measure (Quantitative information only)	**ESTH**	**SGUH**
1.Perinatal Mortality: Total number of deaths (rolling report year)	16	54
2. Perinatal Mortality reviews held	3	6
3. Cases referred to HSIB for review	2 open cases 0 closed	1 open case 0 closed
4. Incidents graded at moderate harm and above	5	5
5. Serious incidents completed	0	0
6. Overdue serious incident report actions	2	0
7.Mandatory training compliance	Performance across staff groups from 44% to 92%	Performance across staff groups from 71.6% to 94.5%
8. Minimum safe staffing	STH 95% EGH 87%	90%
9. Transitional Care ATAIN	Action plan for learning and cases described	NNU and Maternity are revising the current system to review all cases – action plan under development for next month.
Bid to NHS Resolution for CNST funding – final outcome awaited	£500K	£800K
Funding Awarded following submission of action plan to meet compliance	TBC	£336K (received 11.06.23)

3.0 Recommendations

3.1 Board is asked to:

a. Receive the report for review
b. Make suggestions for any further action

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Maternity Services

Perinatal Quality Surveillance Measures May 2023

(CNST Maternity Incentive Scheme: Safety Action 9)

Group Board

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

7 July 2023

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Internal and External Assurance Processes For Both Trusts

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 at 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
- Quarterly PMRT case report and actions submitted to the Quality Committee

External Governance and Monitoring

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

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Perinatal Mortality

This data reflects late miscarriages, antepartum stillbirths and neonatal deaths.

Rolling Report - Time Period		May 2022 – May 2023	May 2022 – May 2023
		ESTH	SGUH
Total Number of Deaths		16	54
Type of Mortality	Antepartum Stillbirths	10	25
	Intrapartum Stillbirths	2	3
	Neonatal Deaths	4	24
Gestational Age	<24 weeks	3	14
	24-27 weeks	3	15
	28 - 31 weeks	0	6
	32 - 36 weeks	4	10
	37-41 weeks	6	9
	≥ 42 weeks	0	0
Ethnicity	5 White British 2 Indian 2 Black Caribbean 1 Bangladeshi 1 Other Asian 2 White/mixed 1 Other 1 Chinese 1 Pakistani		22 White 9 Asian/Asian British 5 Mixed 8 Black/black British 7 Missing or declined 3 Other

For ESTH: Annual figures published in May 2023 by MBRRACE-UK indicate that the 2021 extended perinatal mortality is **comparable to similar Trusts**. The neonatal death rate was more than 5% **lower** than similar Trusts. A detail analysis of the report in partnership with the LMNS is currently being undertaken.

For SGUH: 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). **An external review has commenced. The report is expected in September 2023.**

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**.**

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Perinatal Mortality Reviews

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

PMRT Panel	Number of cases reviewed	Care and delivery issues contributing to outcome	Brief Case Summary and Learning/ Actions Arising
ESTH: 1 panel meeting	3 (2 ESTH cases and 1 SGUH case)	INC-129066; and INC-130134 Care was graded as A (no care or service delivery issues) INC-130134. For INC-129066, there were no care or service delivery issues which directly contributed to the incident, but issues around communication and correct terminology in cases of placenta praevia where identified.	**Case 1:** An intrauterine death at 24/40. There were no identified risk factors and there were no care or service delivery issues identified. The Post Mortem report identified a small placenta showing diffuse chorionic haemosiderosis and chronic deciduitis. **Case 2:** An intrauterine death at 24/40 due to placental abruption. There were risk factors present of placenta praevia and where managed appropriately up to the point the IUD was identified. There were no care or service delivery issues identified which directly contributed to the outcome but learning in respect of communication was identified. **Case 3:** This related to pre-term twins who died at SGUH. The panel discussed and completed the tool in respect of some aspects of antenatal care.
SGUH: 2 panel meetings	6	4 cases had SGUH care only. In 2 cases other Trusts were also involved in the care.	**Case 1:** Involved care at SGUH only. This case was an antenatal stillbirth at 26+4 weeks the placental histopathology showed maternal and fetal vascular malperfusion. There were no care issues identified for this case. **Case 2:** Involved care at SGUH only. This case was the antepartum stillbirth of a set of twins at 26 weeks. The placental histopathology found high grade fetal malperfusion and on examination was noted complex cord entanglement. There were no care issues identified for this case. **Case 3:** This case was an antepartum stillbirth of a lady who presented unbooked with reduced fetal movements at 32+6. She was seen in Neurology for chronic health issues at SGUH. Sadly, there was no consent for a post-mortem examination and the placenta histopathology did not found a cause for this demise. There were issues identified as this lady did not access maternity services, feedback to the GP and Neurology was given in regards to referring patients for maternity care in an appropriate manner.

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Perinatal Mortality Reviews

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

PMRT Panel	Number of cases reviewed	Care and delivery issues contributing to outcome	Brief Case Summary and Learning/ Actions Arising
SGUH: 2 panel meetings (cont.)	6	4 cases had SGUH care only. In 2 cases other Trusts were also involved in the care.	**Case 4**: Involved care at SGUH only. This was a neonatal death of a term baby following abnormal CTG in labour. An action plan for this case has been presented to SIDM. **Case 5:** This case involved care at other Trust. This was a ex-utero neonatal death at term following an uterine rupture. This case was investigated by HSIB at the other care provider and safety actions and an action plan was developed at this ither Trust. **Case 6:** This case involved care at another Trust. This case was a neonatal death at 32+6 weeks. Baby was known to have anomalies. There were issues identified with the care of the baby following delivery and actions have been proposed by the neonatal unit to improve this issues in the future.

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Perinatal Mortality Reviews

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

PMRT Review: Emerging Themes	Open actions from previous PMRT reviews	
ESTH: No clear themes identified to date	INC-112387 INC-121804 N/A	1. ***Overdue:*** There is an open action for ED to ensure that there is a pathway in place for referral to the chaplaincy. This is being taken forward by paediatrics and the maternity risk team asked for an update in May 2023. 2. The Fetal Medicine team to ensure a critical alert is added to BadgerNet when fetal anomalies are identified on scan. This action is due by 30 June 2023. 3. Action relating to the need for the Neonatal Specialty to report post neonatal deaths to MBBRACE-UK (due 31st July 2023). 4. Action relating to the implementation of pre-term grab bags on both acute maternity units (due 31st July 2023).
SGUH: No clear themes identified to date	All PMRT actions completed	

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Cases referred to HSIB (Healthcare Safety Investigation Branch)

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

Trust	Number of cases closed in month	Number of open cases under review	Number of open actions from previous cases	Action detail and date for completion	Top 5 recommendation themes from HSIB reviews
ESTH	0	2	0	N/A	1. Staffing 2. Holistic review and management of women 3. CTG interpretation 4. Escalation 5. Communication
SGUH	0	1	0	**Open case under review:** maternal death; multiple co-morbidities HSIB report in the draft report returned by Trust awaiting family review. No concerns raised and no safety recommendations were made regarding this case**.**	1. Staffing 2. Holistic overview and management of women 3. CTG Interpretation 4. Escalation 5. Communication

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Incidents graded at moderate harm and above

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Trust	Number of incidents graded at moderate harm or above	**Incident detail and immediate safety actions:** Investigations and case reviews are in progress for all incidents.
ESTH	5	• **INC-132938:** Stillbirth at 33/40. This case will be subject to review by the PMRT panel and is also subject to an internal investigation. • **INC-133281:** PPH 2000mls; this incident will be downgraded to low harm following review if there are no contributory factors. The review is due to be completed by 16th June 2023. • **INC-133363:** PPH 2000mls; this incident will be downgraded to low harm following review if there are no contributory factors. The review is due to be completed by 19th June 2023. • **INC-133985:** PPH 1500mls; this incident will be downgraded to low harm following review if there are no contributory factors. The review is due to be completed by 28th June 2023.
SGUH	5	• **DW189068:** PPH 3 litres Uterine rupture and urology involvement. Case reviewed by Obstetric risk lead and to be discussed at CTG meeting for learning • **DW189013:** Shoulder dystocia - reviewed and all procedures followed. This incident will be downgraded as there were no contributory factors. • **DW188805:** 35/40 IUD confirmed on USS this incident is under review with maternal medicine lead. • **DW190052:** PE case to be discussed at MGM cases on 19th June. Team learning to be shared re: VTE risk assessment and re-assessment and prescribing of LMWH for women with high BMIs. • **DW189986:** Neonatal death following category 1 EMCS. Suspected fetal anaemia at 30 weeks. Baby born in poor condition, resuscitated and admitted to NICU, care later withdrawn. AAR completed for staff involved. It was agreed to report this incident as a Serious Incident. Full investigation will be taken.

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Contributory Factors and Root Cause for Completed Serious Incident Reports

Trust	Number of serious incidents closed in month	Root cause and learning
ESTH	0	N/A
SGUH	0	N/A

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Progress against Overdue Serious Incident Action Plans

Trust	Datix number	Progress update and timeline for delivery
ESTH	INC-118946	• An audit is to be completed by 31/07/2023 to demonstrate that all babies who require a transcutaneous bilimeter check have this completed by the time of discharge. • The jaundice guidance to be updated; this has been finalised and is due to be presented to the Maternity Guideline Group on 15th June 2023.
SGUH	N/A	All current Serious Incident actions have all been completed

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Maternity/GMC Survey

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ESTH		SGUH	
59%	**81%**	**52.1%**	**Awaiting Percentage Result**
Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment	**Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours**	**Proportion of midwives responding with 'Agree' or 'Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment**	**Proportion of specialty trainees in Obstetrics and Gynaecology responding with 'excellent or good' on how would they rate the quality of clinical supervision out of hours**
Actions		**ACTIONS**	
Surveys of all staff on preferred place of work have been undertaken and results are currently being collated. We are also reviewing the COC provision to ensure our inpatient areas are fully Staffed 2022 Maternity staffing survey results are due for publications immanently	Action plan is currently been pulled together.	The directorate quad enrolled and participated in the NHSE Culture and Leadership course in 2022/2023. This has included a SCORE survey for the Maternity teams which is currently under review and action plan built and implemented accordingly. The service also welcomed an enquiry and visit by NHSE Health and Wellbeing Team – full report recently received following significant delays at NHSE (restructure and consultation underway). To be reviewed and action plan built and implemented accordingly.	Obs and Gynae trainees Work during 2022, in conjunction with HEE, has resulted in an improved response and satisfaction rate for SGH GMC members. This includes a dedicated space to work, protected training opportunities, promotion of civility during clinical learning forums.

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HSIB/NHSR/CQC/Regulation 29 and/or other concerns

ESTH	SGUH
N/A	Following a CQC inspection across SGH Maternity services in March 2023 notice was served under Section 29A of the Health and Social Care Act 2008. The reasons for this are as follows – Staffing - surrounding levels of staff available to ensure mothers and babies were safe Estates - the service does not have effective processes in place to maintain its environment and equipment to the required standards to keep women, pregnant people and babies safe. Governance - Leaders do not have effective or clear oversight and governance of maternity services Triage - The service is not operating effective and timely triage processes to ensure the safety of women, pregnant people and babies. Immediate actions have been put in place to address the requirements of the S29A and a final response will be sent to the CQC describing these on the 28th June. The draft full report was received on the 15th June and the service, division, SLT and Group are reviewing this for factual accuracies and then embed the MUST and SHOULD do's into business as usual.

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Mandatory training compliance

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Type of Training and % compliance	Staff Group	April 23		May 23		In month performance	
		ESTH	SGUH	ESTH	SGUH	ESTH	SGUH
PROMPT 90%	Midwifery Staff	91%	78.85%	89%	77.83%	-2%	-1.02%
	Maternity Support Workers	85%	83.72%	89%	88.89%	+4%	+5.17%
	Consultant Obstetricians	89%	82.61%	92%	82.61%	+3%	<>
	Trainee and Staff Grade Obstetricians	76%	86.11%	92%	87.88%	+16%	+1.77%
	Anaesthetics	40%	68.2%	44%	71.66%	+4%	+3.46%
CTG Training 90%	Midwifery Staff	93%	87.80%	94%	88.94	+1%	+1.14%
	Obstetricians	89%	96%	92%	82%	+3%	-14%
NLS (Newborn Life Support) 90%		91%	95.95%	89%	94.53%	-2%	-1.42%

ESTH: If staff are required to be pulled from training to work clinically this must be agreed by either the Director of Midwifery or Head of Midwifery in advance.
An obstetric lead for training has been appointed who will follow up with those medical staff who are not booked.
The PDM (Practice Development Midwife) team is working with anaesthetists to support identifying training datesthem dates.

For SGUH: In line with the immediate safety action required by the Section 29a Warning Notice there is a weekly review of training needs versus current staffing availability to determine and prioritise mandatory training needs. This weekly review is reported as part of the CQC response with the CNOs for Site and Group. New anaesthetic trainees have been scheduled to attend PROMPT. Two additional PROMPT study days are planned in July and October. This will support achievement of safe training levels by year end to recover the position from the sessions lost due to cancelation of two sessions earlier this year in response to staffing challenges. Obstetric attendance on CTG training has been escalated to the Educational Lead

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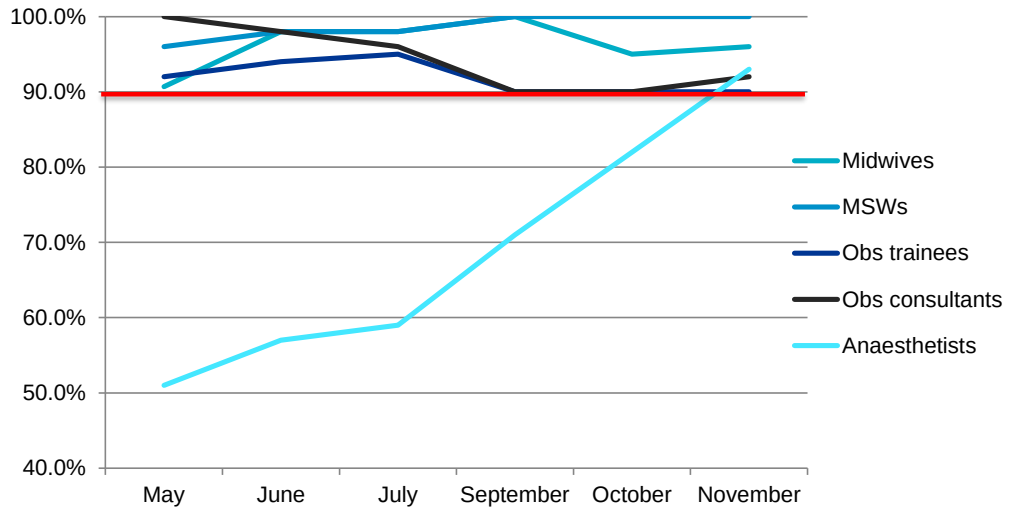
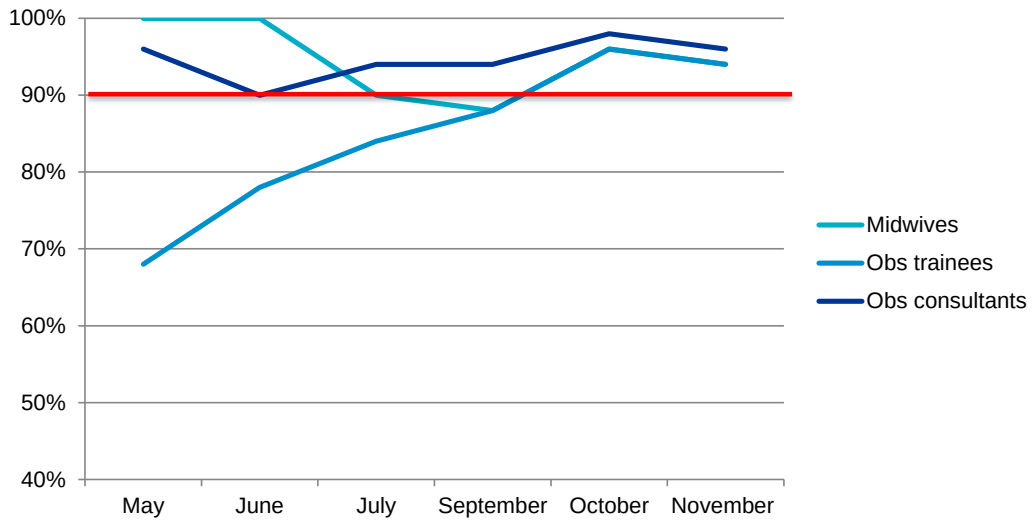
Mandatory training – planned trajectory for compliance ESTH

PROMPT/NLS data – target >90%



Fetal monitoring data – target >90%



NOTE: Please note that these figures are the expected figures for those staff who are currently booked to attend their study days. It does not take into account; sickness, DNA, new staff etc. Also please note that some of the later dates from September onwards are not yet fully booked to capacity

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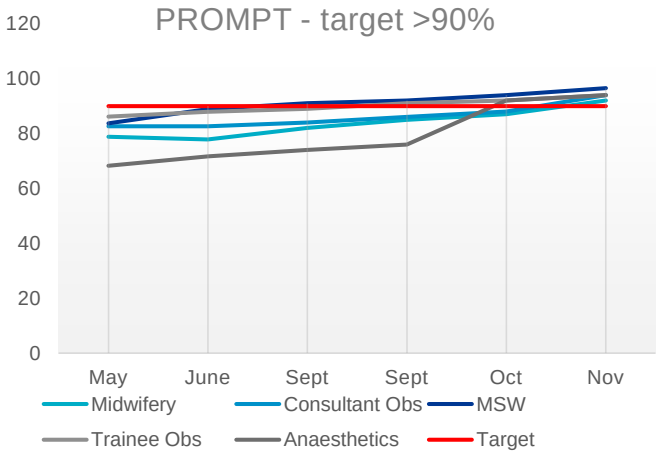
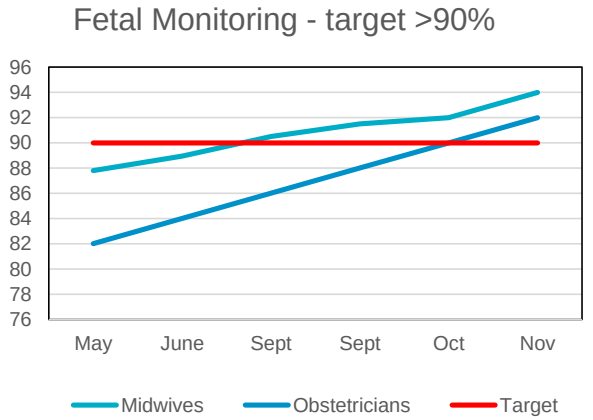
Mandatory training – planned trajectory for compliance – SGUH





NOTE: The denominator shifts every month and compliance is calculated accordingly. The denominator is dependant upon recruitment start dates for new joiners and rolling annual training needs of the existing MDT.

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Minimum safe staffing

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Staff group	Measure	Mar 23			Apr 23			May 2023		
		ESTH ST H	ESTH EGH	SGUH	ESTH ST H	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH
Midwifery	Fill Rate (target >94%)	90%	82%	94%	95%	85.5%	95.6%	95%	87%	90%
Obstetric	Expected vs fill	100%	100%	100%	100%	100%	100%	100%	100%	100%
	Number of step downs/pull across	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

ESTH:

- The fill rate in May 2023 was 91% (95% at STH and 87% at EGH due to sickness and maternity leave) against the target of 94%. High cost agency has been approved where staffing falls 30% lower than planned. During the day shift, specialist midwives are utilised to support the clinical area
- Continuity of Carer – Scoping has begun to reduce the number of continuity teams across both sites in order to support staffing demands. One team on the Epsom site has relocated to core inpatients commencing May 2023 while the project is completed.

SGUH:

- The fill rate in May was 90%%. The Birth Centre was used dynamically and Homebirth service was provided for booked women only. This position continues to be reviewed on a weekly basis with Birth Centre closed 43% in May 2023.
- Continuity of Carer – women were accepted into CoC Teams within current team establishment. This position will continue to be reviewed on a weekly basis reflective of current staffing position
- Work is underway to ensure consistent application of criteria when Band 7 record BirthRate plus data.
- Sit Rep now used twice daily to escalate and share staffing and acuity across Site and Group.

Number of Red Flags: BirthRate+ Acuity Tool

Red Flag Category	ESTH St Helier	ESTH Epsom	SGUH
Coordinator not supervisory	38	10	12
Delay in time critical activity	1	1	11
Delayed induction of labour	2	7	10
Delayed pain relief	0	0	0
Delayed or cancelled care	0	0	3
Number of clinical incidents related to red flags	0	0	0

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Maternity Dashboard

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Indicator	Threshold	ESTH Performance	SGUH Performance
CO monitoring at booking	95%	93.5% (May)	93.2%
CO monitoring at 36/40	95%	79.9% (May)	29.7% (increased by 8.1%)
3rd/4th degree tear	<5%	1.03% (Apr)	3.3%
PPH >1500mls	<3%	3.09% (Apr)	4.4%
PPH>2000mls		0.69% (Apr)	3.0%
Term NNU admissions		4.98% (Apr)	4.25%
Stillbirths (rate per 1000 births)	2.6 per 1000 live births (quaterly)	3.26 (latest is 2021 published annually by MBRRACE)	2.5 per 1000 (adjusted rate - 1 stillbirth in May) • 35+6 – IUD, type 1 Diabetes
NND (rate per 1000 births)	1.5 per 1000 live births (quarterly)	0.91	2 in month • 30+3 Fetal anaemia planned for in-utero transfusion but converted to Cat 1 LSCS. Care withdrawn in NNU. • 31+4 Fetal hydrops and Noonan's syndrome. Referred to FMU from East Surrey
HIE rate (per 1000 births)	2.2 per 1000 live births (quaterly)	0	0

For ESTH: CO2 monitoring at 36/40 is audited monthly to identify individual areas for support. The matrons are following up with individuals to explore the reasons they have not offered the intervention and this approach has resulted in an improvement since last year. All NNU term admission undergo an ATAIN review and safety and improvement actions are identified for implementation

For SGUH : There has not been a case of HIE 2/3 – cooled baby since Dec 22.

Contemporaneous data collection of CO2 monitoring remains a challenge with only 29.7% achieved, although slightly improved from April (21.6%). This is a process issue with Delivery Suite Midwives required to check the handheld paper notes and retrospectively document the CO2 reading at 36 weeks. Whilst a Digital solution is awaited real time data collection of CO2 monitoring at 36/40 will be undertaken by the ANC and Community midwifery teams and collated on a monthly basis.

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Service user feedback

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ESTH		SGUH	
Feedback	**Action**	**Feedback**	**Action**
1. A woman was informed that there would be an investigation report sent regarding her care. 2. Lack of referral (physio) and de-brief appointment. 3. Lack of interpreter during an outpatient appointment. 4. Comments around the décor in labour rooms. 5. Lack of breastmilk storage fridge on the Labour Ward for those women who require extended HDU care before transfer to the postnatal ward.	1.1 Message shared at huddle to check with the risk team regarding the level of incident review. 2.1 Staff have been reminded how to request a referral via iCM. 3.1 A reminder has been sent to all clinicians regarding the use of Language Line. 4.1 Ambient lighting projectors have been purchased to improve the 'feel' of the rooms and make the less clinical. 5.1 A fridge has now been purchased.	1. Concerns remain around the dynamic operation of the Birth Centre due to staffing pressures and immediate actions required for the CQC to support safe staffing. 2. Positive aspects related to caring and compassionate staff 3. Access to food if women are away in NNU at meal times	1.1 Regular updates via communications team to ensure website and social media is current and reflective of the dynamic operational approach to service provision 1.2 Weekly review of staffing capacity to dynamically support Birthing Centre as and when we can – this is discussed and agreed at the Maternity Services CQC Steering Group 1.3 Work has commenced to fit static birthing pool on DS 1.4 Discussion and involvement of the Maternity Voice Partnership to support ongoing communication to women and their families. 3. Discussion with Mitie and hostess to keep meals and make available

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Staff feedback to Maternity Safety Champions

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ESTH		SGUH	
Issue	**Action to be taken/ Progress update**	**Issue**	**Action to be taken/ Progress update**
1. Community KPIs were discussed, as there was no mechanism for sharing this data with the Senior Leadership Team.	1. Community KPI data to be shared with the Board Level Safety Champion (BLSC). A process will be agreed for sharing data.	1. Challenges regarding inconsistencies in facilities across our community settings – children are not allowed to accompany women going to the Nelson Midwifery Clinic but can if the are seeing the GP there. 2. New Triage service in DS – the additional space is a welcome addition. 3. Delay in any digital access for staff working in the community settings 4. New VCP process has caused significant delays in recruiting critical staff – confusion with clinical teams vs admin requiring VCP sign off	1.Working group being implemented at the Nelson to discuss issues such as this with the landlords. 2. All aspects of the internal refurbishment now complete – final element is to widen the door frame 3. Pilot for laptops with dongles to be launched in June 4. VCP process now not required for clinicians although some clinical roles need to be included - sonographers

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Appendix 2

Perinatal Mortality Review Tool (PMRT) Quarterly Report December 2022 – March 2023
CNST Safety Action 1

Perinatal Mortality Review

A review of 95% of all deaths of eligible babies from 30 May 2023 will have been started (and families informed) within two months of each death and at least 60% will have been reviewed by a multidisciplinary team and a PMRT draft report has generated within four months of each death and the report published within six months of each death.

Perinatal Mortality Reviews - ESTH quarterly report

Epsom and St Helier University Hospitals NHS Trust

CNST Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

- ***All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days and the surveillance information must be completed within one month of the death.***

Since the last report in March 2023 there have been 8 eligible cases and all have been reported to MBRRACE-UK in accordance with the MIS Year 5 requirements.

Case ID	Date of Death/Stillbirth	Date Reported	Surveillance Completed
86456/1	12/03/2023	13/03/2023	13/03/2023
86535/1	15/03/2023	16/03/2023	16/03/2023
86743/1	30/03/2023	31/03/2023	31/03/2023
87066/1	19/04/2023	20/04/2023	24/04/2023
87098/1	20/04/2023	21/04/2023	27/04/2023
87235/1	28/04/2023	02/05/2023	02/05/2023
87280/1	28/04/2023	02/05/2023	02/05/2023
87401/1	09/05/2023	11/05/2023	11/05/2023

Perinatal Mortality Reviews - ESTH

Epsom and St Helier University Hospitals NHS Trust

Case ID	Date of Death	Review Started	Review Completed	Parents Informed	Notes
79655	25/01/2022 (intrapartum stillbirth at 40+3/40)	09/03/2022	Y	Y	***HSIB***
81925	07/06/2022 (Neonatal death at 35+2/40.)	10/06/2022	Y	Y	Unbooked
82062	15/06/2022 (Intrapartum stillbirth on admission at 40+5/40.)	20/06/2022	Y	Y	HSIB
83923	09/10/2022 (Stillbirth at 35+6/40)	12/10/2022	Y	Y	Known abnormalities
84216	24/10/2022 (Stillbirth at 27+3/40)	27/10/2023	Y	Y	Booked elsewhere
85599	19/01/2023 (Stillbirth at 38+6/40)	27/01/2023	N	Y	HSIB
86413	19/02/2023 (Stillbirth at 24+4/40)	21/02/2023	N	Y	Placental abruption
86456	12/03/2023 (Stillbirth at 24+4/40)	16/03/2023	N	Y	Placental abnormalities
86535	15/03/2023 (Stillbirth at 37+6/40)	21/03/2023	Y	N	Concealed pregnancy therefore parents not informed
86743	30/03/2023 (Stillbirth at 27/40)	21/04/2023	N	Y	
87066	19/04/2023 (Stillbirth at 22+4/40)	19/05/2023	N	Y	
87098	20/04/2023 (Stillbirth at 39+3/40)	15/05/2023	N	Y	Booked and IUD confirmed at another Trust – transferred for family support
87235	28/04/2023 (Neonatal death at 37/40)	19/05/2023	N	Y	
87280	28/04/2023 (Neonatal death at 36+6/40)	N	N	Y	
87401	09/05/2023 (Stillbirth at 33/40)	22/05/2023	N	Y	

Perinatal Mortality Reviews – SGUH quarterly report

St George's University Hospitals NHS Foundation Trust

CNST Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

- ***All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days and the surveillance information must be completed within one month of the death.***

Since March 2023 there have been 12 eligible cases and all have been reported to MBRRACE-UK in accordance with the MIS Year 5 requirements.

Case ID	Date of Death/Stillbirth	Date Reported	Surveillance Completed
86404/1	05/03/2023	07/03/2023	07/03/2023
86809/1	29/03/2023	03/04/2023	Started
86875/1	06/04/2023	06/04/2023	11/04/2023
87035/1	14/04/2023	18/04/2023	18/04/2023
87039/1	16/04/2023	18/04/2023	18/04/2023
87154/2	19/04/2023	25/04/2023	Started
87253/1	26/04/2023	02/05/2023	02/05/2023
87359/1	07/05/2023	09/05/2023	09/05/2023
87434/1	12/05/2023	12/05/2023	12/06/2023
87496/1	15/05/2023	17/05/2023	Not set
87690/1	27/05/2023	30/05/2023	Started
87713/1	25/05/2023	31/05/2023	Not set

Perinatal Mortality Reviews - SGH

St George's University Hospitals NHS Foundation Trust

Case ID	Gestation	Date of death	Type of death	Review Started	Review completed	Parents informed	Additional information
84804	23/40	04/12/2022	NND	05/12/2022	Drafting report	Yes	Ex utero transfer from another healthcare provider
84903	32/40	05/12/2022	NND	28/02/2023	Drafting report	Yes	Ex utero transfer from another healthcare provider
85044	23+4/40	17/12/2022	NND	23/12/2022	04/04/2023	Yes	In utero transfer from another healthcare provider
85222	26+4/40	25/12/2022	IUD antepartum	29/12/2022	16/05/2023	Yes	
85675/1	25+6/40	18/01/2023	IUD antepartum	01/02/2023	10/05/2023	Yes	
85675/2	25+6/40	18/01/2023	IUD antepartum	01/02/2023	10/05/2023	Yes	
86068	22+3/40	03/02/2023	IUD intrapartum	22/02/2023	04/04/2023	Yes	
86404	34+2/40	05/03/2023	IUD antepartum	05/03/2023	Reviewing	Yes	
86809	25+2/40	29/03/2023	IUD intrapartum	03/04/2023	Reviewing	Yes	Booked at another Trust. Attended SGUH as visiting her family in London

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Appendix 3

Maternity Services Claims Report 2022

(CNST Maternity Incentive Scheme: Safety Action 9)

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ESTH Maternity 2022 Claims Score card

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ESTH

Red claims (High Value (over 1 million) and High Volume (3 or over)
There were 5 red claims which cost around £58,210,000, which are all open.

Blue claims (Low Value (<1 million) and High Volume (3 or over)
There were 57 blue claims which cost around £3,944.000.

- 31 claims were settled with damages paid
- 19 claims were closed with nil damages paid
- 7 of those claims are currently open

Red claims relate(d) to:

- Injudicious use of Syntocinon (reported and investigated as an SI by the Trust with learning identified and actioned).
- Wrongful birth due to failure to diagnose a congenital abnormality.
- Undetected breech presentation which resulted in a brain injury (2 cases which were both referred to HSIB for investigation). All women now have a 36/40 presentation scan.
- CTG interpretation alleged to be linked to a brain injury.

Blue claim themes

There are no clear themes emerging from review of these claims. In 10 of the cases the basis of claim was psychological trauma. The following areas were identified:

- Failure of antenatal screening to detect abnormalities
- Failure to respect women's choice/birth plans
- Failure to adequately explain risks
- Perineal trauma (failure of repair)
- Retained products of conception
- CTG monitoring

Correlation with complaints and incidents

There is an on-going theme surrounding the interpretation of CTGs and failure to act on concerns in a timely manner. We now have a dedicated fetal surveillance midwife in post who supports the Practice Development Team with multi-disciplinary training; all staff are required to complete and pass a competence assessment annually.

There are regular informal CTG review sessions and a regular fetal surveillance newsletter is produced.

Complaints

All complaints are triaged against the incident reporting system and are linked if there is an investigation on-going.

Following receipt of the above scorecard the themes from complaints were analysed:

Communication (Risk Newsletter article and incidents shared with the team)
Pain management
Lack of information leaflets 3rd/4th degree tears (now sending RCOG leaflet)
Lack of physiotherapy appointments (vacant post now filled)
Lack of de-brief appointments (being discussed through the MVP and options have been put forward e.g. pregnancy circles/mini de-briefs with CMW)
Women needing to be diverted due to capacity/staffing
Positive comments included infant feeding support, vaccination service, individual pregnancy planning, friendly and supportive staff

The failure to explain risks/benefits was identified through analysis of the blue claims on the scorecard. We are now able to provide electronic leaflet information through BadgerNet.

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SGH Maternity 2022 Claims Score card

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SGH
Total CNST claims with an Incident Date between 1/4/12 – 31/3/22 = 499 Total value of these claims = £234,355,063 (as at 30/6/22) – this includes damages and legal costs, and estimated value of any open claims 4 quadrants of scorecard: Red Zone: High Value (≥ £1m), High Volume (≥ 3claims) Yellow Zone: High Value (≥ £1m), Low Volume (< 3claims) Blue Zone: Low Value (< £1m), High Volume (≥ 3claims) Green Zone: Low Value (< £1m), Low Volume (< 3claims)
<u>Maternity</u> 9 claims in Red zone (total value = £93,943,637): All 9 are open (on-going) claims – relating to brain damage/ cerebral palsy • 6 of the 9 have a linked Incident • of the 9 has a linked complaint 32 claims in Blue Zone (total value = £3,892,615): 7 open, 25 closed claims Of the 25 closed claims, 10 were closed with nil damages. Of the 32 Blue Zone claims, 18 have a linked incident only, 1 has a linked complaint only and 6 have both linked incident AND complaint

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Appendix 4

ATAIN Action Plan (avoiding term admission to the neonatal unit)

CNST Safety Action 3

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ESTH ATAIN Action Plan as at Q4 2022/2023

Point	Recommendation	Action plan	Lead	Date completion
EGH Babies admitted as ward attenders for screen and treat	Screen and treat to be undertaken on TC or LW to minimise separation of mothers and babies	Action for NNU staff to document the reason that this could not be performed on LW or TC	SR – Neonatal SpR	31/07/2023
EGH Some babies admitted to SCBU could potentially be admitted to TC with a different staffing model	To minimise avoidable admissions to SCBU	Task and finish group to review the TC model of care	NM – Director of Nursing	Completed – working group establish
EGH There were a number of SGA babies which were undetected antenatally	Screen and treat is often being undertaken as a ward attendance to SCBU	On-going SGA audit to identify learning	AJ – Obstetric Consultant and DW – Lead for SBLCB	On-going
EGH Babies being readmitted to SCBU from the ED	Following review in the ED, eligible babies to be readmitted directly to TC	To revise existing SOP	MW – Maternity Matron	31/08/2023
EGH It was not always possible to see the rationale for ward attendances from the notes	There needs to be a clear rationale	Clinicians to document the reason for admission/ward attendance as opposed to TC in the notes	SR – Neonatal SpR	31/07/2023
STH The review highlighted the need to expedite delivery in the presence of a pathological CTG	Education and training to recognise when to expedite delivery in the presence of a pathological CTG and SROM	CTG to be used as part of training	RV – Labour Ward Lead Consultant SP - Matron	31/05/2023 ***(Completed)***

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

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SGH ATAIN Action Plan as at Q4 2022/2023

First ATAIN MDT meeting 05.06.23

Three cases discussed but no data obtained.

Discussed structure of meetings moving forward.

Meeting with ATAIN Lead NNU Consultant & Risk Team

12.06.23

- Form designed to collect data on reason for NNU admission.

- Key members of MDT identified to attend, aiming to enhance focus and clarity on review of each case.

Next ATAIN meeting

03.07.23

NNU Consultant

Obstetric Consultant

Risk & Governance Midwife

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	3.2
Report Title	**Integrated Quality and Performance Report**
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer
Report Author(s)	James Marsh
Previously considered by	Quality Committees-in-Common 29 June 2023 Finance Committees-in-Common 30 June 2023
Purpose	**For Review**

Executive Summary

This report consolidates the latest operational management and quality information and improvement actions across both St George's Hospital and Epsom and St Helier Hospitals for the month of May 2023.

Action required by People Committees-in-Common

The Committee is asked to review the report and note the operational and quality information for the Group at May 2023

Committee Assurance

Committee	Quality Committees-in-Common
	Finance Committees-in-Common

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Integrated Quality and Peformance Report

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
As set out in the report.				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☐ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
Legal and / or Regulatory implications				
• Enforcement undertakings applicable to St George's and Epsom and St Helier Hospitals • Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations				
Equality, diversity and inclusion implications				
No EDI issues to consider.				
Environmental sustainability implications				
No environmental sustainability issues to consider.				

Group Board, 07 July 2023

1.0 Purpose of paper

This report consolidates the latest operational management and quality information and improvement actions across both St George's Hospital and Epsom and St Helier Hospitals for the month of May 2023.

2.0 Quality

2.1 SAFE HIGH QUALITY CARE: SGH – MAY 2023

Successes:

- **Falls**: The number of falls per 1000 bed days remains close to or below the lower process limit for the fourth consecutive month.
- **Pressure Ulcers**: The Trust reported 5 category 3, 4 and unstageable pressure ulcers in May 2023. This is down from 8 in April and 13 in March 2023.
- Infection Control: The Trust has had zero MRSA bloodstream infections and the overall reduction in the number of Influenza cases continued in May 2023.
- **MCA/ DoLs**: Level 1 training compliance continues to be over target with 92% for May 2023.
- **Mortality**: Latest HSMR shows our mortality to be lower than expected. For emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend.
- **Maternity** – 3rd and 4th degree tears and PPH grading. We have revised our grading and review system across the datix system to rate each event as moderate harm in the first instance. Each case will be reviewed by an MDT in full and final grading then determined accordingly

Challenges:

- **Infection Control:**
  - There were 7 Clostridium Difficile infections during May 2023, this is up from April 2023 (2) and March (4) 2023. A multifaceted Trust level Clostridium Difficile infection action plan is in place and work commenced.
  - There were 10 cases of E. coli bacteremia during May 2023, this up from April 2023 (8). A working group has been formed and Trust level action plan in the process of being developed.
- **MCA & DoLS**: Mental Capacity Act level 2 compliance overall has shown a slight improvement (80%), however this remains below target. The new Practice Educator for Safeguarding & MCA has reviewed and shortened the MCA Level 1 & 2 training, hopefully this condensed content with help improve completion rates.
- Maternity: Carbon Monoxide Smoking Cessation Monitoring at antenatal booking at 36/40 weeks is low. Concerns with data collection so work is underway to capture real time as an interim measure prior to the completion of digital transformation.

Never Events and Serious Incidents

- **Never Events**: The Trust declared 2 Never Event (Serious Incidents) in May 2023. The Never Events both occurred within Surgery, consisting of 'wrong site block' and wrong site surgery

(wrong patient). Both patients have been spoken to and the duty of candour process followed, they are now recovering.

- Serious Incidents: The Trust also declared a third Serious Incident relating to a medication error, omission.
- The outcomes of these investigations are awaited and will be reviewed along with their action plans as part of the Trust's Serious Incident Decision Meeting.
-

2.2 SAFE HIGH QUALITY CARE: ESTH – MAY 2023

Successes

Mortality

- Latest HSMR, for the 12 months from March 2022 to February 2023 remains above expected level but no longer increasing since September 2022. As per previous months, elective HSMR is significantly lower than expected and non-elective HSMR dominates the trend.
- There is a slight difference in HMSR, for those patients admitted during the week over those admitted on weekends, but both cohorts remain above expected level.
- The 12 months rolling SHMI has stabilised but still high at ESTH according to the latest available data up to Dec-22 (published May-23). There is a slight difference between the two sites.
- The Trust is one of the SDEC pilot Trusts whose mortality ratios have been affected by the SDEC recordings. This has been acknowledged by NHS England on their mortality website.

Falls:

- There were 74 falls reported across the Acute Services in May, equating to 3.8 falls per 1000 bed days which is a 0.8 reduction from April data and 1.3 per 1000 OBDs reduction from May 2022 which reported rates of 5.1. Unwitnessed falls have also seen a downward trend over the past 3 months.
- There has been continued engagement to support bank staff to utilise available training. Focused work has commenced with Epsom ED to support falls reduction. In addition, phase 2 Champions Programme has been launched.

Pressure Ulcers:

- 9 hospital acquired pressure ulcers were reported in May 2023 which was a decrease from 14 reported last month. There has been Improvement noted in the completion of investigating time for local learning. Specific work on device-related pressure ulcers with Critical Care and Leg matters awareness week as part of the national campaign has begun.

Challenges

VTE:

- There has been a further decline in VTE risk assessments in May 2023. Some of the issues identified include the use of paper documentation with the results not always updated on the iCM system and a reliance on doctors to conduct the assessments. Improvement plan in place includes training and support for the nursing staff to support risk assessment as is the case in well performing areas e.g., Maternity and SWLEOC.

- National Thrombosis Week (1st-7th May 2023) was well publicised and advertised throughout the Trust through Posters, Topic of the Week, Screen saver, Ward visits and a stand to raise awareness for staff and the public.

Infection Control:

- There was one Trust MRSA bacteraemia reported in May 2023. Post infection review did not identify lapse in care but there were a few contributory factors including co-morbidities in a patient receiving treatment in STH ITU.
- There were 4 Trust attributed C diff cases, (9 YTD). The Cdiff Trust objective for 2023/24 is 38.

Complaints:

- Response within 25 days remain a challenge, although there has been an improvement from last month achieving 69% from 45%.
- Weekly meetings have been launched to maintain traction in addressing the outstanding complaints supported by GCNO.

Never Events and Serious incidents

Never Event: One Never Event was reported in SWLEOC related to wrong side nerve block. Mitigation put in place included a review of LoCSSIPs and an introduction of 'mock before you block protocol.

Serious incidents:

- There were four Serious Incidents reported in May (One Maternity/Obstetric Incident, One Pressure Ulcer, One Never Event and one fall resulting in a fractured neck of Femur).
- Fifteen of the serious incidents closed during the month of May which met the criteria for closure after the agreement with the Integrated Care Board that the lessons learned from these incidents would be addressed as part of the Trust wide Recovery plan. The Trust has 3 Trust wide action plans for inpatient falls prevention, pressure ulcer prevention and nosocomial Covid-19 infections. The actions from the Trust wide plans will be monitored through the Trust SI panel.

- Fifteen Serious Incidents were closed as part of the Recovery Work undertaken at site level, and the submission of the Trust recovery plans to ICB for pressure ulcers, falls and nosocomial covid-19 infections. There are 12 outstanding investigations overdue which will be closed by the end of June.

2.3.1 SURREY HEALTH AND CARE

Community Hospital Bedded Units (Surrey)

Successes

- Recent MUST audit for Community highlights Molesey bedded unit has been outstanding (CQUIN '23)
- Falls in the Community Hospitals are trending down. The teams have worked together with the Trust Falls team reviewing the equipment, resource utilisation and updating training. There has been focus on cognitive assessments being completed on patients as indicated and enhanced care bundles were updated.
- Hand Hygiene Audit – 100%

- Cardiac Arrest Trolley Audit – 100%

Challenges

- Safe transfers of care – 1x death under review
- Working with wards to ensure all documentation and medication are available on transfer
- Particular focus on Respect/DNACPR documentation
- Infection control at NEECH – ongoing monitoring following April issues (Norovirus/Covid) – improvements seen.

SDHC Community Services

Successes

- MSK has rolled out the get u better app. It is a free self-management resource for patients who need support with musculoskeletal issues including joint and muscle pain, is now available across the whole of Surrey Downs.
- Hand Hygiene Audit – 100%

Challenges

- Obtaining patient feedback remains a challenge
- Relocation of services from West Park site to Langley Wing – due July 2023
- Safeguarding – increase of neglect or below required level of care – complex issue involving multiple agencies and patient choice
- Open incidents – action to close.
-

2.3.2 SUTTON COMMUNITY SERVICES

Successes

- 4x places secured for September – District Nurse Specialist Qualification
- Wound Care MDT's
- Complex Patient MDT's
- Hand Hygiene Audit – 100%

Challenges

- Safe storage of notes – MSK
- Following a CQC peer review processes and reviews now in place to tighten. No IG breaches
- Single source record for patient care delivery
- Incidents occur as result of home notes, paper notes and electronic systems. EMIS implementation in progress
- Omissions of medication from third parties
- Safeguarding – increase of neglect or below required level of care – complex issue involving multiple agencies and patient choice

Never Events and Serious incidents

- All SI's for Integrated Care are either closed or on track with timelines
- There have not been any never events
- One serious incident involving a historic shared inbox has been investigated and all patients' referrals triaged and assessed

3.0 Operational Performance

3.1 ELECTIVE CARE

Outpatients

Despite progress being made on outpatient transformation and activity, the PTL continues to rise at both trusts. ESTH is an exemplar across London for developing patient initiated follow up (PIFU) and continue to make progress towards increasing numbers of patients accessing PIFU. SGH has been constrained by the slow implementation of a digital solution to support effective capture of PIFU activity.

Long-waiting patients

SGH has made good progress in reducing the numbers of patients waiting for a long time (>52, 65 and 78 weeks) for definitive treatment, but pressures are beginning to appear in 52 week waiters. Recent industrial action has impacted on maintaining the continued downward trend. ESTH has seen mounting pressure on long waiting patients with increasing referrals in gynaecology and capacity challenges in community paediatrics and gastroenterology being a predominant driving factor. There is an emerging risk in community paediatrics and gynaecology that this will impact on 65 week waits.

Diagnostics

Diagnostic performance has improved at both trusts with SGH achieving 99.02% patients receiving their diagnostic test within 6 weeks (DMO1 performance). This is the best performance in London. The position at ESTH has stabilised, and 91.3% patients received their test within 6 weeks against the national standard of 95%. Challenges remain within non-obstetric ultrasound, MRI and echocardiography.

Theatres

Both trusts have set up theatre utilisation groups and have more work to improve theatre utilisation (currently achieving 74% capped utilisation at both trusts against a target of 85%).

3.2 CANCER

Cancer performance is comparatively good for both trusts against London peers, but remains challenging operationally. However, both trusts are achieving the Faster Diagnostic Standard (FDS) with sustained improvement at SGH, having previously struggled to meet the standard. Breast services have maintained good performance. Whilst SGH have not met the 14 day referral to be seen and 62 day standard, the trust is still one of the top performers in London. ESTH have maintained delivery of the key national standards with the exception of the two week referral appointment. Industrial action as well as increasing referrals in key specialties (skin and gynaecology) have contributed to challenges. Both trusts are close to the trajectory for the numbers of patients waiting more than 62 days for definitive treatment.

3.3 NON-ELECTIVE CARE

Both trusts are achieving the national target of discharging patients within 4 hours of arrival in the ED and are sustaining progress on the numbers of patients waiting more than 30 and 60 minutes for ambulance handover. However, there remain significant flow issues at both sites impacting on the ability to reduce the numbers of patients waiting more than 12 hours in the ED back to baseline levels. This remains a key area of focus.

3.4 INTEGRATED CARE

2 hour urgent care response is being maintained above the national standard within Sutton and Surrey Health and Care, and there is a rising trend of referrals in Sutton. Discharges on Pathway 3 remains challenged for both services.

4.0 Sources of Assurance

4.1 Quality Committees-in-Common

Reasonable Assurance. The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance.

4.2 Finance Committees-in-Common

Reasonable Assurance. The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance.

6.0 Recommendations

6.1 The Board is asked to note the report and make suggestions for any further action.

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

Group Integrated Quality & Performance Report

May 2023

Presented by: James Marsh Group Deputy Chief Executive Officer
May 2023

Executive Summary
Safe, high-quality care

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

St George's Hospital

Successes

Falls: The number of falls per 1,000 bed days remains close to or below the lower process limit for the fourth consecutive month.
Pressure Ulcers: The Trust reported 5 category 3 and 4 unstageable pressure ulcers in May 2023. This is down from 8 in April and 13 in March 2023.
Infection control: The Trust has had zero MRSA bloodstream infections and the overall reduction in the number of Influenza cases continued in May 2023.
MCA/ DoLs: Level 1 training compliance continues to be over target with 92% for May 2023.
Mortality: Latest HSMR shows our mortality to be lower than expected. For emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. St Georges' SHMI performance was 0.94 and is as expected. 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.

Maternity – 3rd and 4th degree tears and PPH grading . We have revised our grading and review system across the datix system to rate each event as moderate harm in the first instance. Each case will be reviewed by an MDT in full and final grading then determined accordingly.

Challenges

Incidents: The Trust declared 2 Never Events (Serious Incidents) in May 2023.
Infection control: There were 7 Clostridium Difficile infections during May 2023, this is up from April 2023 (2) and March (4) 2023. So far the Trust is over the NHSE trajectory for 2023/24.
There were 10 cases of E. coli bacteremia during May 2023, this up from April 2023 (8). So far the Trust is over the NHSE trajectory 2023/24. An Infection Prevention and Control 'back to basics' working group has been formed with senior nursing and medical leadership
MCA & DoLS: Mental Capacity Act level 2 compliance overall has shown a slight improvement (80%), however this remains below target. The new Practice Educator for Safeguarding & MCA has reviewed and shortened the MCA Level 1 & 2 training, hopefully this condensed content with help improve completion rates.
Maternity-CO Monitoring @ antenatal booking and 36/40 (part of the SBLCB requirements) – currently reflecting as poorly performing at 36/40 antenatal appointment due to challenges with data pull (hand -held records). Work is underway to capture compliance in real time as an interim measure prior to the completion of digital transformation.

Epsom & St Helier

Successes

Nutrition: eMUST has now been rolled out to all areas (with the exemption of critical care)

TPN nursing competencies are now complete.

Successful trial of GripLok Naso-Gastric tube fixation devices on ward C4 with Trust wide implementation planned - this is a quality and safety improvement in addition to a possible cost saving.

Community MUST snap shot audit completed with results/themes disseminated.

Bespoke Nursing Service Level Agreement with Nutricia Danone has been successful at reducing enterally nourished patient A&E admissions.

VTE:

National Thrombosis Week (1st-7th May 2023) was well publicised and advertised throughout the trust through Posters, Topic of the Week, Screen saver, Ward visits and a stand to raise awareness for staff and the general public.

Falls Prevention and Management: The updated and merged Slips, Trips, Falls and Bedrails policy has been signed off and the Falls CNS is currently planning a dissemination plan to share the recent policy changes with all staff groups. The Falls CNS has commenced a quality improvement project in the Emergency Department having observed an increase in both the falls rates and incidences with harm over the past 4 months; this project focuses on increasing patient visibility and provision of call bells through a dedicated poster campaign, committed support, and education with ongoing audit to monitor improvement rates.

Further funding for crash mats was secured and this equipment has now been ordered.

Pressure Ulcers: 9 hospital acquired pressure ulcers in May; which is the lowest for several months. Training for 47 new starters. Reduction in Device related devices this month

Challenges

Pressure Ulcers: Increase in patients requiring Negative Pressure Wound therapy but there is a need to increase the skills and knowledge of ward staff .

Nutrition: Appropriate pathways for enterally fed patients remain outstanding.

Infection Control: There was one Trust MRSA bacteraemia in May. Post infection review identified that this was unavoidable due to a few contributory factors including co-morbidities in a patient receiving treatment in STH ITU. Details in separate IPC report.

Mortality: Latest published SHMI shows a decrease at 102.0. Details in separate report.

Executive Summary Elective Care

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

St George's Hospital

Successes

- Outpatient performance for May is expected to be above plan at 107%.
- First outpatient attendances is expected to be above plan at 118%.
- Outpatient focus on uncashed activity improved to 0.68% uncashed for April 23, against 1.3% March 23.
- Elective and Daycase performance is ahead of plan with a percentage of 105% submitted for May.
- Continued progress against long waiting patients continues to be made with the number of patients waiting over 65 weeks reducing from 70 in Mar 23 to 57 in Apr 23, May >65
- At the end of May, the Trust reported a further improvement in our diagnostic performance with 99.02% of patients waiting less than 6 weeks for their diagnostic test ***returning to the national 99% requirement and performing top against London Peers.***
- Planning meetings are underway to start providing surgical services at QMH site for Epsom patients from July.
- The first phase of the Theatre templates review has been completed. This is a key step to improve efficiency and access to robot.
- Cancer Faster Diagnostic Standard was achieved for a third consecutive month reporting a performance of 77.2%. Breast continued in a compliant position increasing performance to 90%.

Challenges

- There are 795 patients with a projected wait of over 40 weeks for a first appointment. A recovery plan is being put in place and managed through Elective Access.
- Challenges related to patient flow remained a significant bottleneck in May, impacting recovery and PACU.
- In May, capped theatre utilisation capped was 74% which was marginally below the previous month and below our aim of 85%, this is in part due to industrial action.
- Cancer TWW Performance A number of services were impacted by the strikes and public holidays. Particular challenges were seen within Gynae, Haematology and Lower GI.
- Cancer 62 Day Performance - Challenges, were seen in H&N and urology due to theatre capacity and late inter trust transfers from Kingston, Croydon and Epsom & St Helier.

Epsom & St Helier

Successes

- Outpatient first activity remains significantly above BAU levels with 109% in Apr23.
- Patients waiting over 65 weeks for treatment reduced from 18 in Mar23 to 16 in Apr23.
- DM01 (diagnostics) continues to be pressured, but patients waiting more than 6 weeks in Apr23 has remained quite static at 1318, a very slight increase compared to 1285 in Mar23. The modalities with the highest volume of patients waiting over 6 weeks are MR, NOUS and ECHO.
- Specialist advice increased from 15% in Mar23 to 16% in Apr23.

Cancer:
Acquisition of an outpatient TPPB machine to reduce wait times for the early pathway in prostate and support the overall performance of cancer targets and CQUINs.

- Cancer CQUIN target was met by the trust in Q4 22/23, owing to great support from endoscopy, TWR booking office, and TAC nurses.
- TAC wait times are closing towards the 3-day target, with most tumour sites booking at least 60% of patients within 3 days of referral.
- Mutual aid for Lung CT guided biopsy has been negotiated with StG which is reducing the number of patients waiting.
- .

Challenges

- 52 week waits continue on an upward trend each month. A further increase is expected in May23 due to the knock on impact of the junior doctor strikes. Community Paediatrics remains the most pressured speciality, followed by Gynaecology, Cardiology and Gastroenterology.
- The Admitted PTL (excluding diagnostics) continues to increase each month. P1, P2 and P3 cases remain stable with the increase mainly in P4s (non-urgent cases).

Cancer:

- Lack of first seen capacity in Gynae due to staff consultant leave and admin/management sickness. ESTH failed the TWR performance in April and is likely to fail in May due to lack of capacity in both Gynae and Dermatology. Cancer team is working with Gynaecology team on recovery plan for Gynae TWRs and also working with the Dermatology Team to provide extra capacity
- Increased number of referrals, over 15% compared to last year, pushing service capacity to challenging limits. EUS capacity at RMH still has a wait time of 3-5 weeks, patient dependent, leading to a negative impact on cancer targets. EBUS capacity at UCLH remains a challenge with a wait of 3-4 weeks.

Executive Summary Non-Elective Care

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

St George's Hospital

Successes

- May's 4 hour month end performance was 81.70%, which is a 7% improvement on May 2022. Performance is still strong compared to peers, SGH 13th nationally and 3rd in London.
- Type 1 attendances are below the planning numbers for May 2023 by 1.4%.
- With the support of two on site SGH LAS assigned HALOs there has been a decline in LAS requiring to cohort at SGH. May's LAS handover performance continues to be strong, with 93% of LAS offloads <15 minutes and 95% < 30 mins.
- The Homelessness and inclusion Team (HIT) and Emergency Department have been nominated for NHS Parliamentary Awards 2023. Awards ceremony 5th July, 5 representative across teams will attend.

Challenges

- The ability of the department to admit patients to downstream wards was challenged in May which in turn increased the number of 12 hour trolley waits seen. High numbers of Mental Health patients in ED continued to be challenging however working groups between Police and key SGH stakeholders have begun.
- Non-Elective length of stay remains higher than the mean of 2021/22 and across May the number of stranded and super stranded increased.
- Increasingly high number of patients not meeting the criteria to reside (NCTR).In addition to the high number of patients awaiting Pathway 2A (Merton + Wandsworth) and Pathway 3, over the last two months, the Trust has had an increasing number of Pathway 1 patients awaiting equipment.
- SGH continues to have a number of closed bays and closed & lost beds due to infection and required E&F upgrades in both SGH/QMH.
- MADE events are occurring every 2 weeks, rotating between internal & external. Work ongoing to maximise effectiveness.

Epsom & St Helier

Successes

- Mean daily Super Stranded numbers are below the locally agreed ambition of 123, the first time in 16 months.
- Type 1 attendances are below the planning numbers for April and May 2023
- The 4-hour standard is now above the (locally agreed) ambition of 76% at 76.61% for May 2023.

Challenges

- Non-elective admissions in May 2023 (2,139) have risen above the ambition (2,046) for the first time in 5 months.
- Time to initial assessment for May 2023 was 103 minutes, an improvement compared to April 2023, but still well above the ambition of 60 mins.
- 60-minute ambulance handovers improving month on month, although still high at 42 for May 2023.

Executive Summary
Our People

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

St George's Hospital

Successes

The Workforce KPIs have been incrementally improving month and month. Although turnover and appraisal still remain an issue and are below trust target. The overall compliance picture shows some improvement.

The Big 5 Staff Survey Launch took place with a Civility Workshop being held across the trust which was well attended. Leads have been identified for each month and a sustainable approach is being built in to ensure that initiatives look beyond 12 month and weave into the wider trust culture programme.

ER Risk Profile workshops have been held with 2 out of the 3 clinical divisions to identify and ring fence the back log of high risk cases and work through a line by line plan to agree actions plotted against timescales for improvement. Significant progress has been made.

Workforce Improvement Plan programme is underway and several meetings have been held with Finance and CIP teams to ensure that the work is aligned and targeted.

Challenges

The capacity challenge continues in terms of time to complete to keep focussed on MAST and Appraisal compliance rates. HRBPS are working with divisions 'action appraisal' to keep the focus on driving up appraisal numbers.

Supporting high volume complex and legacy ER cases requiring significant support from HRBP Team to plug gaps in vacancies in ER Team. This continues to be a challenge in terms of workload and priorities.

Meeting KPI's, Medical/Nursing spend.

Industrial Action, staff planning, A&C staff additional pressures.

Increase in FTSU cases.
The length of time to resolve pay issues still an area of concern.
Unfair recruitment practices across the trust regularly flagged as an issue of concern
.

Epsom & St Helier

Successes

Workforce KPIs are all trending in the right direction, but only minor improvements month on month.

Estates & Facilities vacancies have fallen from their 22% high in December 22 to 19% in May. The communications on the forthcoming changes to the pay structure for non-Agenda for Change staff began and coupled with an increase in recruitment activity we anticipate that vacancies will continue their downward move.

Turnover in Planned Care and Renal stands at a creditable 11% and 10% respectively.

Planned Care and Women's & Children's are doing reasonably well with Appraisal levels at 75% albeit against a 90% target.

Challenges

Turnover in Clinical Services Division has climbed to 21% and Appraisal levels have fallen to 51%

A general monthly jump in vacancy rates occurred during the month.

Vacancies for Nursing & Midwifery have been in a range hovering around 14.8% for 12 months with no clear improvement. (14.7% in May 23) This is broadly the picture across London.

Sickness rates for our 1,400 Additional Clinical Staff (largely B2-B4 unqualified N&M workforce) remain stubbornly high at 7.5%

Executive Summary Integrated Care

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

Sutton Health & Care (SHC)

Successes

SHC vacancy rate – decreased from 14.6 to 12.8%.

E-allocate (scheduling workforce tool). Implemented in community nursing. Go live- June 2023. This tool enables planning and predictive workforce requirements.

SHC within 3.7% agency cap in first two months of the year.

Cardiac Rehabilitation step down pilot. ESTH with SHC have received 1 years funding from NHSE for a step down MSK pilot to maximise cardiac health

SHC Discharge to Assess Team- finalists at the LGC (Local Government Chronicle) awards. Team shortlisted with LBS (London Borough of Sutton) for the Digital Impact and Innovation Award.

HSJ nomination: Learning Disability Health Facilitation Project shortlisted for the HSJ Patient Safety Learning Disabilities Initiative of the Year award.

Challenges

Community nursing vacancy rate remains high at 22%.

Waiting lists for Childrens Therapy (routine). Speech and Language (SALT) increased to 19.64 (weeks) ; Occupational Therapy (OT) increased to 29.43 (weeks).

Surrey Downs Health & Care(SDHC)

Successes

Vacancy rate reduced in April -17.19% down 0.46%

High levels od MAST (89.4%) and Appraisal rate (90.4%) maintained

Reduction in temporary staffing usage to 8.9% in M2

Care Home conference- conducted in June: Further work on admission avoidance and supported discharge to care homes

D2A- Recovery @ Home established, Huddle Review and implementation of electronic forms

West Park Relocation- Relocation of services to new bases . To be completed by July19th

Staff engagement sessions has launched and will continue to July

Dementia awareness week- Dementia bus visited community bases

Challenges

Community Nursing vacancy rates remain high at 27.44%. Golden Hello scheme to launch in June to improve recruitment

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

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

Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target / Threshold	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
Never Events	0	1	1	2	0	3		0	2	0	1	0	1	
Serious Incidents	TBC	3	3	3	TBC	6		TBC	2	1	4	TBC	5	
Number of Falls With Harm (Moderate and Above)	TBC	2	2	3	TBC	5		TBC	1	2	1	TBC	3	
Pressure Ulcers - Acquired catergory 3&4	0	13	8	5	0	13		0	2	1	3	0	4	
Dementia - Assessment & Investigation of Patients at risk of Dementia		NA	NA	NA	NA	NA		90%	61%	65%	64%	90%	65%	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	91%	92%	92%	90%	92%			NA	NA	NA	NA	NA	
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	76%	78%	80%	85%	79%			NA	NA	NA	NA	NA	
Infection Control - Number of Cdiff - Hospital & Community	TBC	4	2	7	TBC	9		TBC	3	5	4	TBC	9	
Infection Control - Number of MRSA	0	0	0	0	0	0		0	0	0	1	0	1	
Infection Control - Number of E-Coli	TBC	9	8	6	TBC	14		TBC	21	14	19	TBC	33	
VTE Risk Assessment	95%	96.8%	95.6%	95.5%	95%	95.6%		95%	86.4%	85.2%	83.8%	95%	85%	
Mortality - HSMR	<100	89.1	89.6	90.2	<100	90.2		<100	111.70	111.70	111.80	<100	111.80	
Mortality - SHMI	<1	0.93	0.94	0.94	<1	0.94		<1	1.18	1.18	1.14	<1	1.14	
Number of Complaints Received	TBC	41	53	65	TBC	118		TBC	33	34	41	TBC	75	
Complaints responded to in 25 days	85%	93%	100%	100%	85%	100%		85%	64%	45%	69%	85%	57%	

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

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

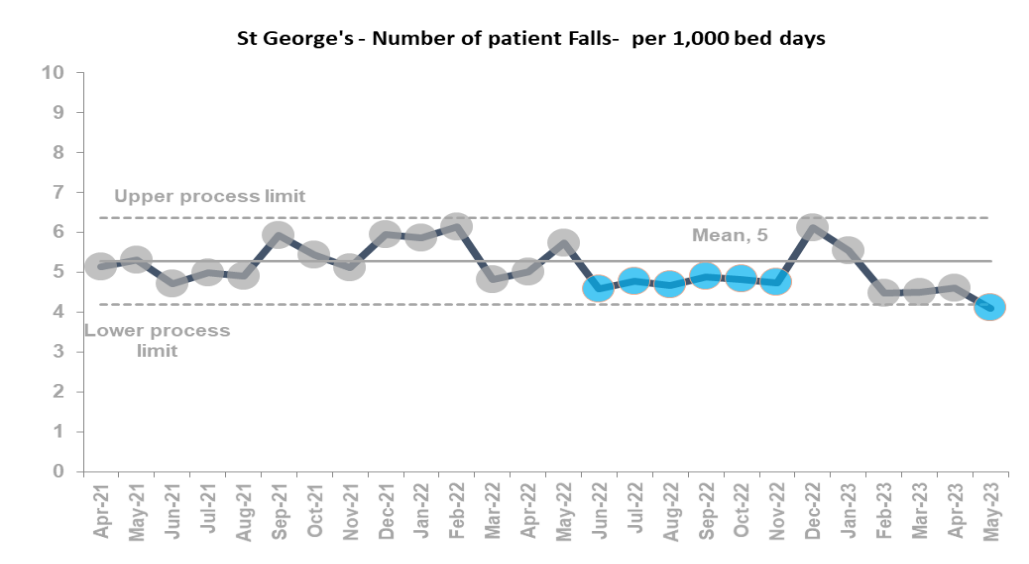
Maternity	St George's							Epsom and St. Helier						
	Monthly Target / Threashold	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
Caesarean Section Rate	N/A	34.3%	32.0%	35.1%		33.6%		N/A	39.8%	38.5%	38.6%		38.6%	
% Births with 3rd or 4th degree tear	<5%	1.4%	3.7%	3.3%	<5%	3.5%		<3%	1.7%	1.7%	4.1%	<3%	2.9%	
% Births Post Partum Haemorrhage >1.5 L	<4%	2.6%	3.4%	4.4%	<4%	3.9%		<4%	2.0%	3.1%	2.9%	<3%	3.0%	
Total Births	>433	350	326	390	5000	716			301	295	321		616	
Birth Rate - Vaginal	>60%	59.1%	54.5%	55.4%	>60%	55.0%			50.8%	47.8%	49.1%		48.4%	
Birth Rate - Instrumental	<14%	13.7%	17.5%	14.6%	<14%	16.1%			9.4%	13.8%	12.0%		12.9%	
Screening - booked before 9+6 weeks	>90%	51.1%	52.4%	49.9%	>90%	51.2%		>90%	85.6%	86.1%	86.2%	>90%	86.1%	
Screening - booked before 12+6 weeks	>90%	91.5%	93.0%	92.0%	>90%	92.5%		>90%	98.5%	98.6%	99.1%	>90%	98.8%	
1:1 support in labour	>80%	96.0%	99.0%	96.1%	>80%	97.6%		>95%	98.0%	98.6%	98.4%	>95%	98.5%	
Continuity of Care*		26.5%	23.7%	10.5%		10.5%			80.5%	80.9%	80.5%		80.7%	
Still births per 1000 births	<2.6	8.6	15.4	2.5	<2.6	9.0			10.00	3.40	3.10		3.3	
Neonatal deaths per 1000 births	<1.5	0.00	0.00	2.0	<1.5	1.00			0.00	6.80	0.00		3.4	
HIE (Hypoxic ischaemic encephalopathy rate	<2.2	0.00	0.00	0.00	<2.2	0.0			0.00	0.00	0.00		0.0	
Band 7 supernumerary status – rate	100%	96.8%	91.7%	98.4%	100%	95.1%				87%	81%		84.0%	
MDT training compliance – rate	90%	84.0%	80.0%	80.6%	90%	80.3%				76%	84%		79.6%	
Vacancy rate	<=10%	-1.6%	-6.0%	-3.8%	<=10%	-4.9%				5.6%	5.6%		5.6%	
MDT handovers Rate	100%	100.0%	100.0%	53.0%	100%	76.5%				100%	100%		100.0%	

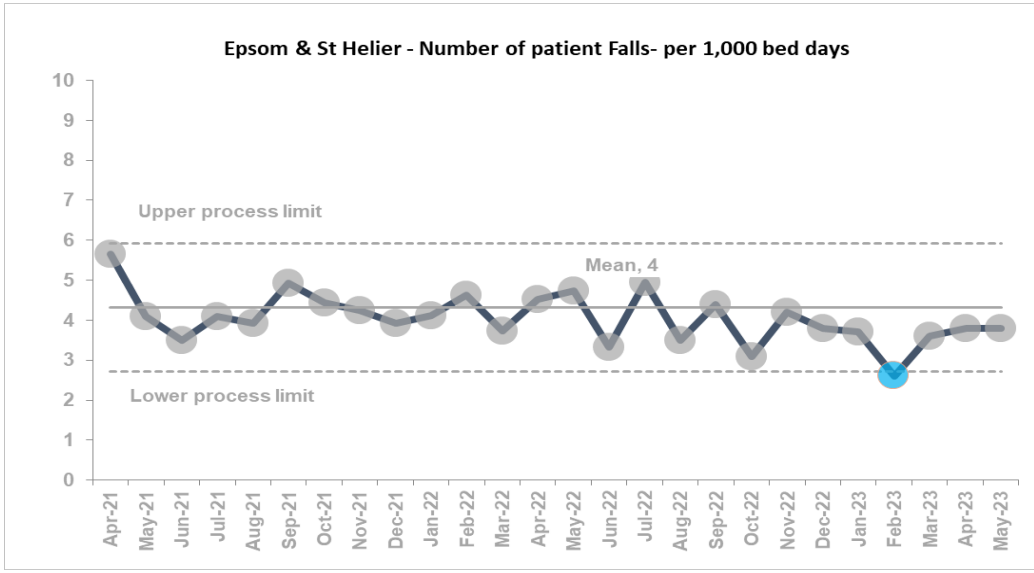
* Please note that CoC metrics have changed from May 2023 data to reflect NHS England requirements based on their definition. Data changes will be backdated to reflect NHS England reporting requirements as advised by NHS England.

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

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

Target: TBC	SGH: 4.1	ESTH: 3.1





SGH updates since last month

There were a total of 104 falls across all services in May 2023. Rates per 1,000 Occupied Bed Days were 4.1 in May 2023, with performance below the lower process limit and showing special cause variation with an improving position. The vast majority were low or no harm falls, however the Trust recorded 1 high harm fall (?collapse) in May 2023 with a medical inpatient area and 2 moderate harm falls; 1 in a medical inpatient area and the other in the radiology department. All 3 patients have now been discharged. A Trust level action plan is in place and monitored by the falls steering Group.

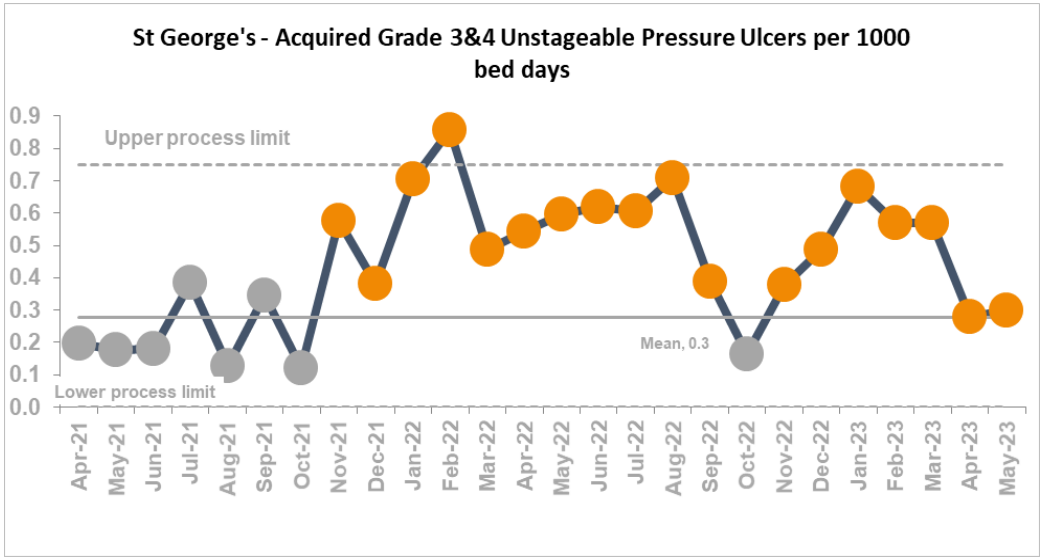
ESTH updates since last month

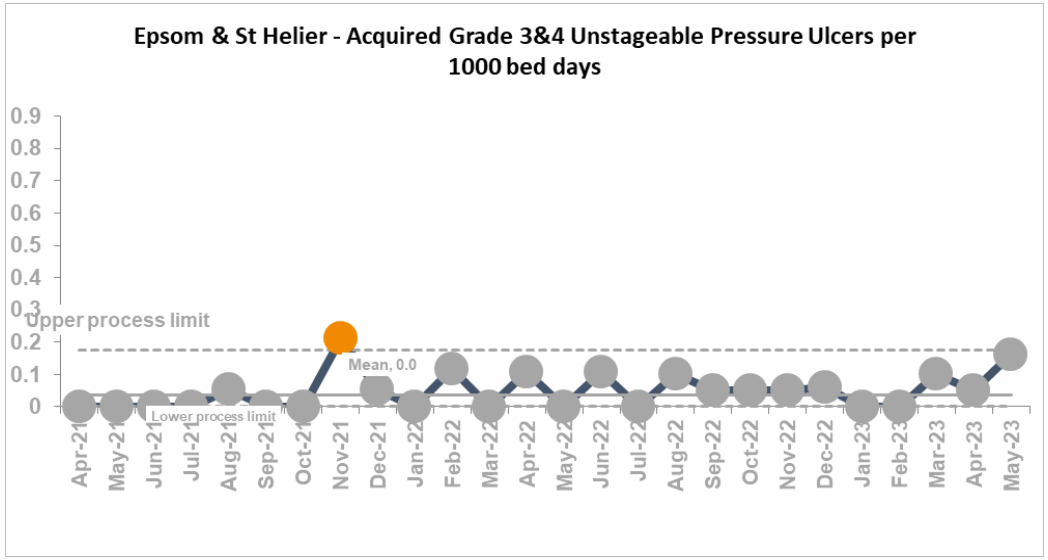
There were a total of 74 falls reported across the Acute Services in May, equating to 3.8 falls per 1000 OBDs, this is a 0.8 reduction from April data and 1.3 per 1000 OBDs reduction from May 2022 which reported rates of 5.1. Adult inpatient falls also saw a reduction with 57 incidences reported (2.9 per 1000 OBDs) compared to April which reported 69 falls or 3.7 per 1000 OBDs. Unwitnessed falls have seen a downward trend over the past 3 months, with May reporting 70% of the total number of falls reported being unwitnessed.

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

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

Target: TBC	SGH: 0.30	ESTH: 0.16





SGH updates since last month

There were a total of 5 category 3, 4 and unstageable pressure ulcers in April 2023 [3, category 3 and 2 unstageable], this is down from 7 in April 2023. Rates per 1000 bed days have been stable since March 2023 (around 0.3) and down from quarter 4 2022/23. The total number of pressure ulcers caused by medical devices in May 2023 was 21, this number continues to fluctuate with 16 in April 2023 and 28 in March 2023, only 1 out of the 21 recorded in May 2023 was as category 3, 4 or unstageable. A Trust level action place is in place and actions are on-going.

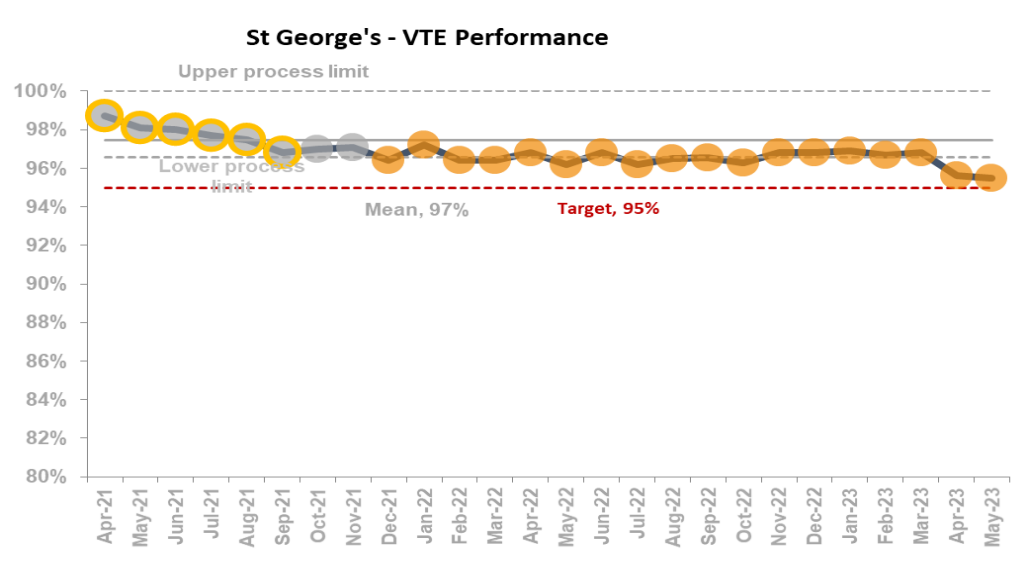
ESTH updates since last month

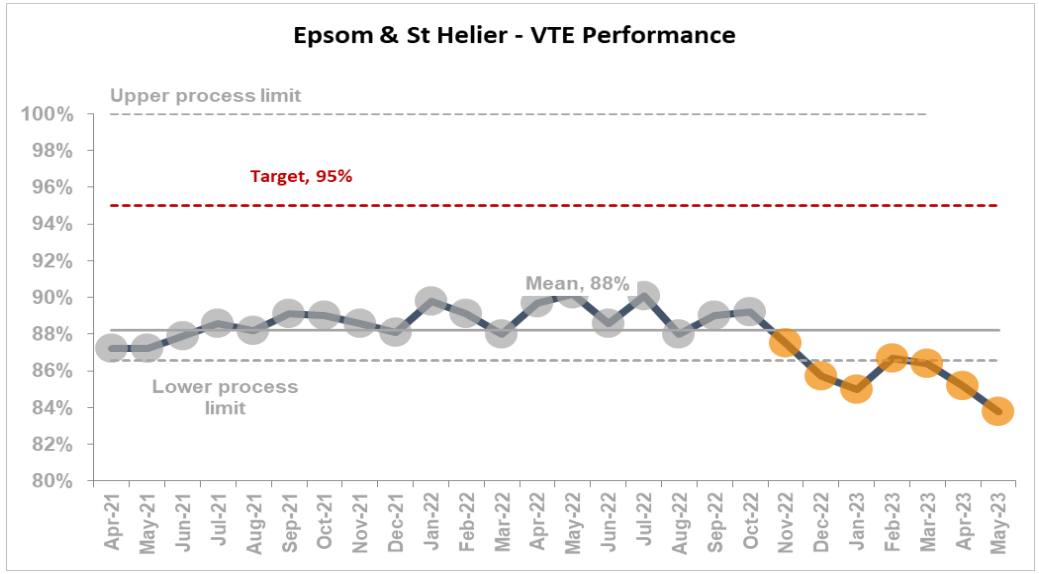
9 acquired pressure damage cases were reported in May, a decrease from last month5 category 2, 2 category 3, 2 deep tissue injuries. There has been Improvement noted in the completion of investigating time for local learning by the Ward manager/ matron.

VTE Risk Assessment

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

Target: 95%	SGH: 95.5%	ESTH: 83.8%





SGH updates since last month

Performance against VTE Risk Assessment continues to shows special cause variation with a deteriorating position. Deputy CMO and corporate nursing to meet to support Trusts HAT group and delivery of action plan.

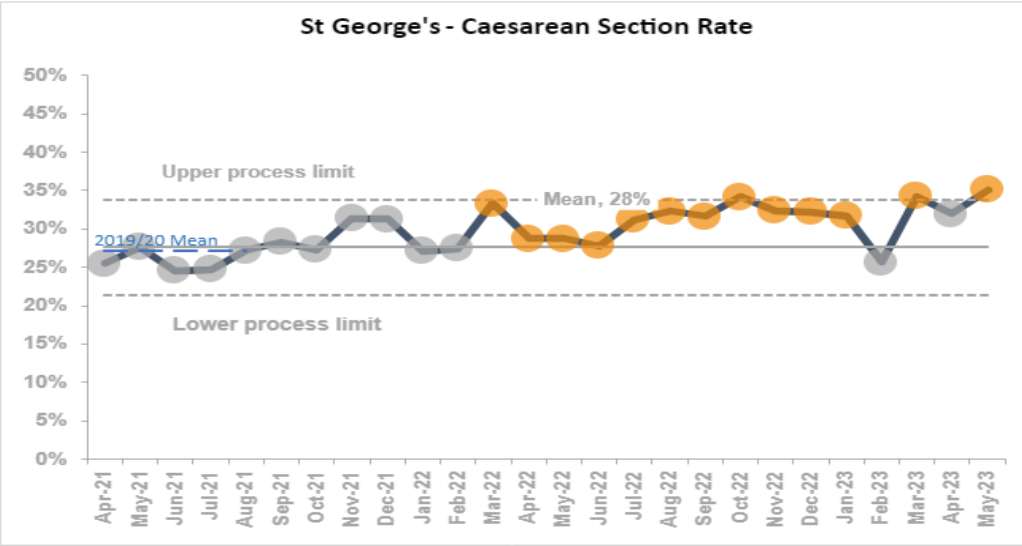
ESTH updates since last month

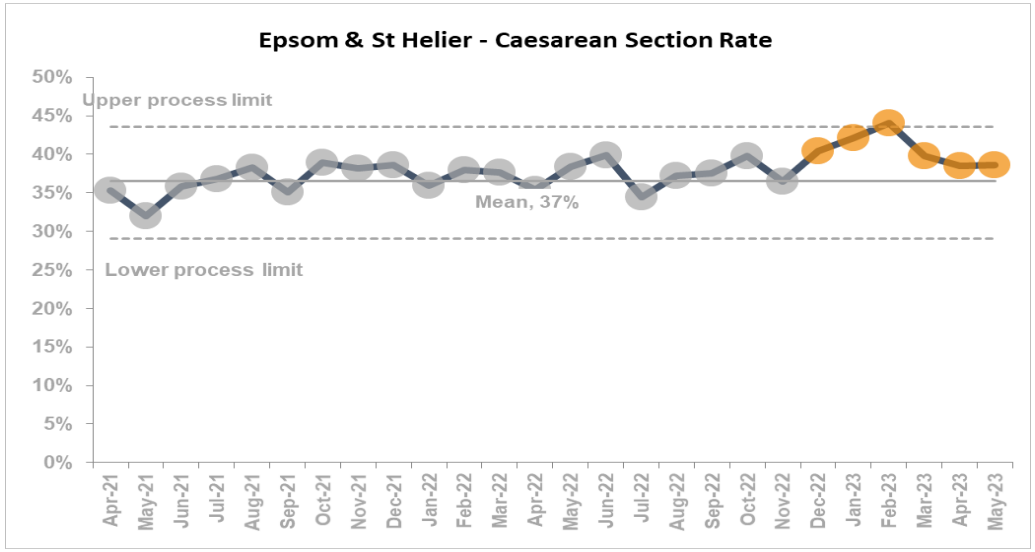
There is a further decline in VTE risk assessment. Some of this is due to the use of paper documentation which isn't always updated on the system. Improvement plan to support risk assessments, use of prophylaxes and HAT investigations.

Caesarean Section Rate

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

Target: NA	SGH: 35.1%	ESTH: 38.6%





SGH updates since last month

Total Caesarean section rates were 35.1% for May (split as 17.2% for emergency cases and 17.9% for elective cases).
There were no admissions to NNU (term baby) for active cooling in May and no HIE (hypoxic ischaemic encephalopathy) cases. The service has not had an HIE case in eight months.

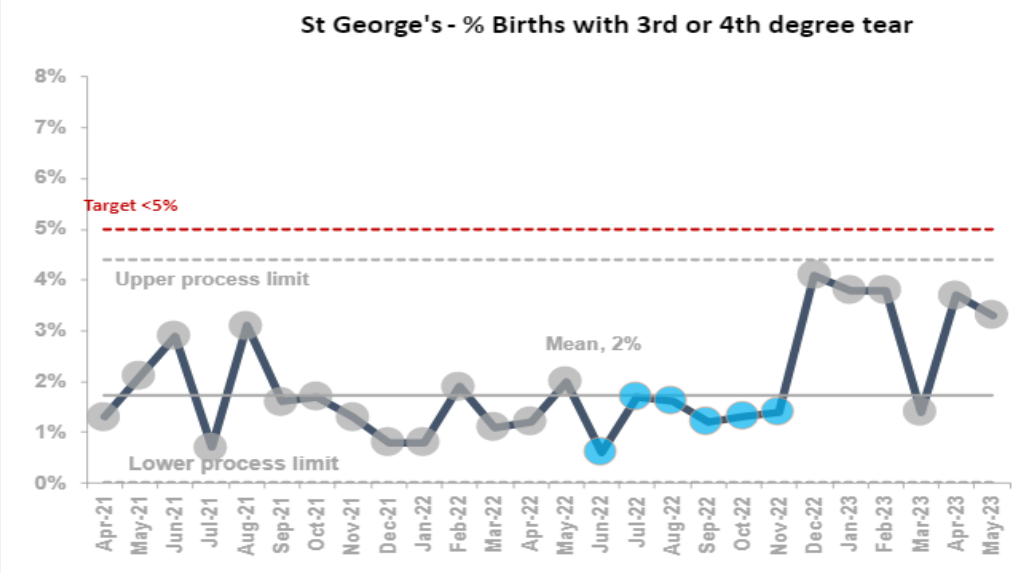
ESTH updates since last month

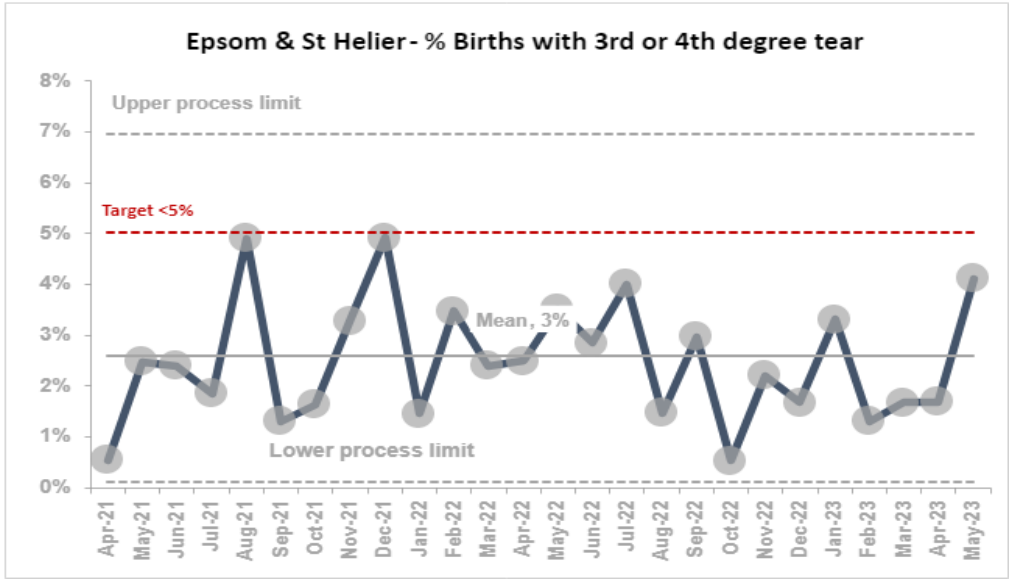
The total caesarean section rate in May 2023 was 38.6%, similar trend to last month. with a rate breakdown 21.2% unplanned and 17.4% planned. No cases of HIE (hypoxic ischaemic encephalopathy).

% Births with 3rd or 4th degree tear

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

SGH Target: <5%	SGH: 3.3%	ESTH Target: N/A	ESTH: 4.1%





SGH updates since last month

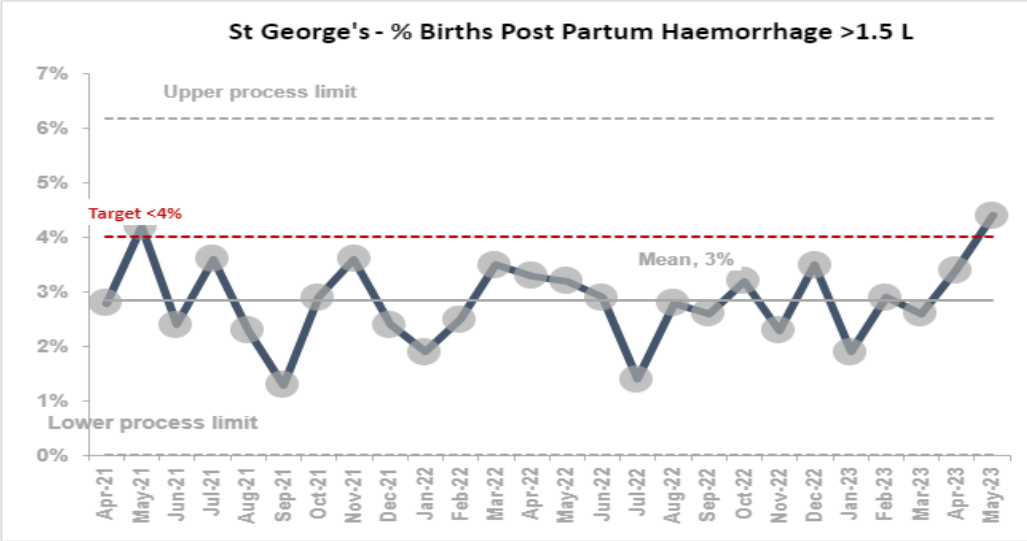
The number of 3rd or 4th degree tears shows a steady but persistent performance over the last few months, May's rate was 3.3%. Incidents of perineal trauma are not wholly preventable however we audit against recommended practice of 'hands on' and outcomes remain below the national average. Perineal protection at delivery is an area of focus and point of discussion and education across the MDT groups. We are recruiting for an additional Midwife (fixed term) to support Pelvic Health with monies from a pilot with SWL LMNS.

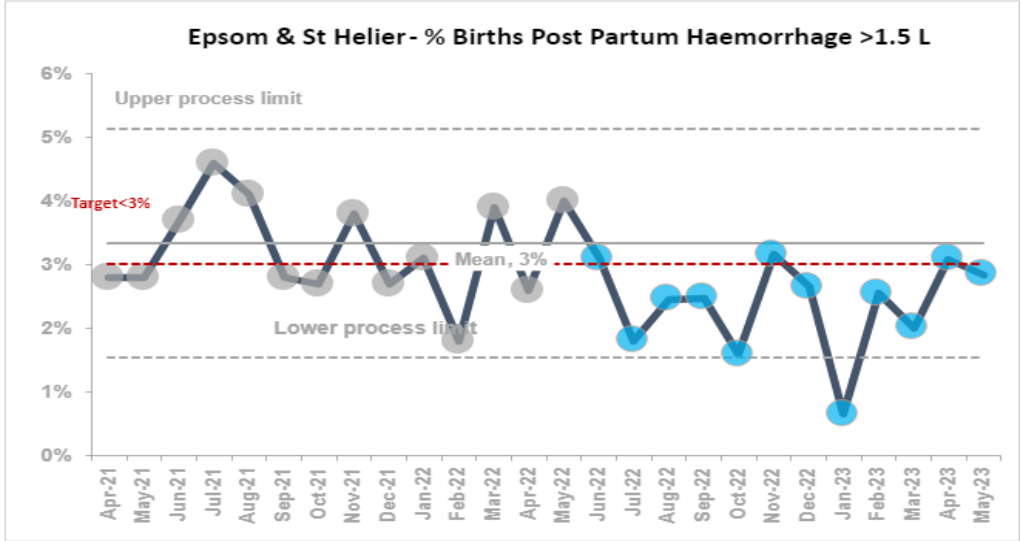
ESTH updates since last month

There was an increase in 3rd/4th degree tear rate. Whilst these tears cannot be predicted or prevented each case is reviewed to ensure that care at delivery was appropriate (e.g that an episiotomy was performed for forceps delivery). All cases but one have been reviewed and there were no contributory factors.

% Births Post-Partum Haemorrhage >1.5 L

SGH Target: <4%	SGH: 4.4%	ESTH Target: <3%	ESTH: 2.9%





SGH updates since last month

There has been a slightly increased rate for PPH >1.5L in May of 4.4% which is driven by the complexity of the women and high number of cases with an anticipated higher rate of blood loss. SGH is continuing an MDT QI project spanning the intrapartum areas to reach and sustain a reduced blood loss for our women.
Each case is reviewed on an individual basis and in line with Patient Safety Incident Response Framework principles. We will also stratify cases of PPH according to mode of delivery and intrapartum pathway.

ESTH updates since last month

Our PPH rates remain stable (>1500mls 2.01% and >2000mls 1%). All cases are reviewed by the Labour Ward Lead consultant who also audits this data periodically.

Quality - Analysis and Action

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

SGH current issues –

Infection Control: A total of 91 Covid-19 infections were detected in May 2023, of these 43 were nosocomial infections, this is up from 23 in April 2023. During May 2023 6 ward areas had Covid-19 outbreaks across the Trust. Across the Trust there were 3 Hospital Onset Healthcare Associated (HOHA) Covid-19 related deaths, 1 patient had this listed in part 2 of their death certificate and the other 2 patients are awaiting a Coroner's Inquest.

There were 7 Clostridium Difficile infections during May 2023, this is up from April 2023 (2). Of these 7, 2 were classified as HOHA, with other 5 classified as Community Onset Healthcare Associated (COHA). The Trust is over this trajectory of an average of 3.5 cases per month. All of these cases have been or are currently subject to review to identify potential learning from lapses in care.

There were 10 cases of E. coli bacteremia during May 2023: 7 have been classified as HOHA; 3 have been classified COHA. The Trust is currently over NHSE set trajectory.

Never Event: The Trust declared 2 Never Events (Serious Incidents) in May 2023. The Never Events both occurred within Surgery, consisting of 'wrong site block' and wrong site surgery (wrong patient). Both patients have been spoken to and the duty of candour process followed, they are now recovering. A third Serious Incident was also declared related to a Medication: omission.

MCA/ DoLS : Mental Capacity Act level 2 compliance for medical and dental has slightly improved at 68% for May 2023 compared to 65% in April 2023, however this is still below target. Compliance for Medical Scientists and technicians also remains an areas for improvement with a 77% completion rate for May 2023

Maternity:-May birth rate was 390 with high levels of obstetric and medical high complexity throughout.

SGH future action -

Infection Control: Infection Prevention and Control 'back to basics' working group has been formed with senior nursing and medical leadership. Workstreams and task and finish groups have been agreed to cover: Environmental and clinical cleaning, urinary catheters, venous access devices and antimicrobial prescribing.

Never Event: The outcomes of these investigations are awaited and will be reviewed along with their action plans as part of the Trust's Serious Incident Decision Meeting.

MCA/ DoLS: The MCA teams is launching a MCA Level 3 & train the trainer programme in July 2023. Those clinicians involved will be the first to receive Level 3 MCA training and be able to deliver the training within their areas with supervision and support from the MCA team.

Maternity-The response to the CQC inspection continues. Retention and Recruitment is ongoing. It has been six weeks since the last resignation in the midwifery staffing cohort. Recruitment is up to establishment with a pipeline of 15 WTE preceptorship Midwives (over establishment, as agreed by SLT) joining from Oct 2023 once NMC registrants.

ESTH current issues –

Infection Control: There was one Trust MRSA bacteraemia in May. Post infection review identified that this was unavoidable due to a few contributory factors including co-morbidities in a patient receiving treatment in STH ITU. MRSA-A post infection review (PIR) meeting has been undertaken and due to the following contributing factors, the source of the infection is unknown and it is thought it may have been from the central line or chest. An action plan is in place addressing the contributory factors identified. More details in separate IPC report.

In May there were 4 Trust attributed C diff cases, (4 Healthcare Onset Healthcare Associated and 0 Community Onset Healthcare Associated). The IPC teams have collaborated with clinical staff to complete and review RCAs within 5 days of result. The Cdiff Trust objective for 2023/24 is 38.

There were 20 Covid-19 clusters in May 2023. Combined, these clusters generated a total of 98 contacts. The IPC team continues to monitor and follow up contacts up to day 5 following the exposure date.

Never Event: One never event in SWLEOC related to wrong side Navblock. Patient was injected with steroid on the left side in error. Once this was realised she was injected on the correct right side.

VTE: Backlog in Hospital Acquired Thrombosis reviews and performance remains low due to loss of key resource and use of paper records.

Complaints: Response within 25 days remain a challenge, although there has been an improvement from last month achieving 69%.

ESTH future action –

The first **Fundamentals of Care** Study Day in June 2023 was well attended. This incorporated Falls, Nutrition, Sepsis, VTE, and Continence.

VTE: A review of service and job plans are in progress. Reduce backlogs in reviews so that learning can take place and review governance arrangements for Thrombosis Committee. Ongoing work include reviewing the backlog of incidents related to hospital acquired thrombosis to support learning through Thrombosis Committee.

Falls Prevention: There has been continued engagement to support bank staff to utilise available training. Focused work has commenced with Epsom ED to support falls reduction. In addition, phase 2 Champions Programme has been launched.

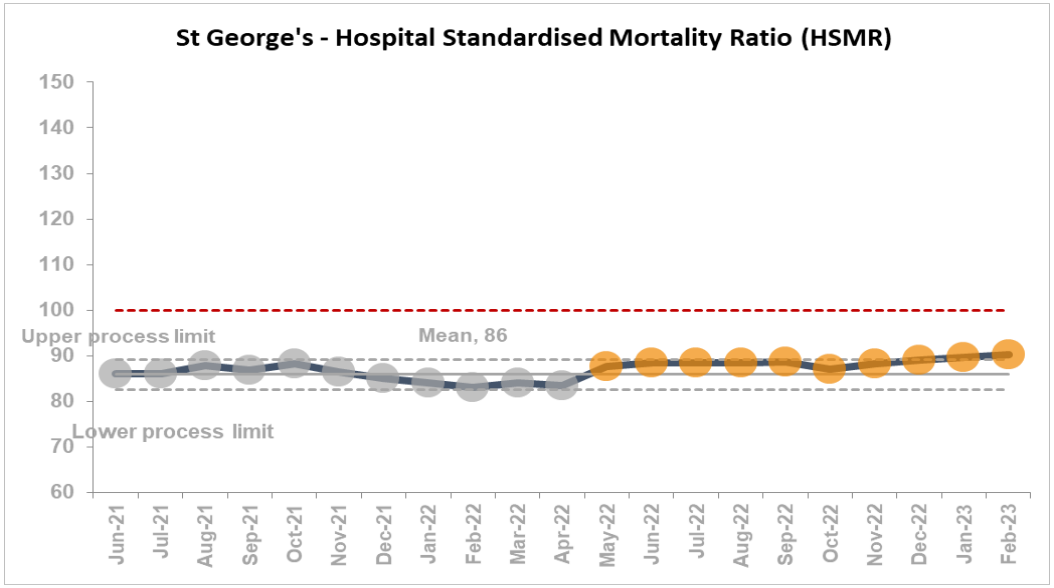
Ward Accreditation: There has been a change review of current process jointly with SGH which has incorporated learning from national approach.

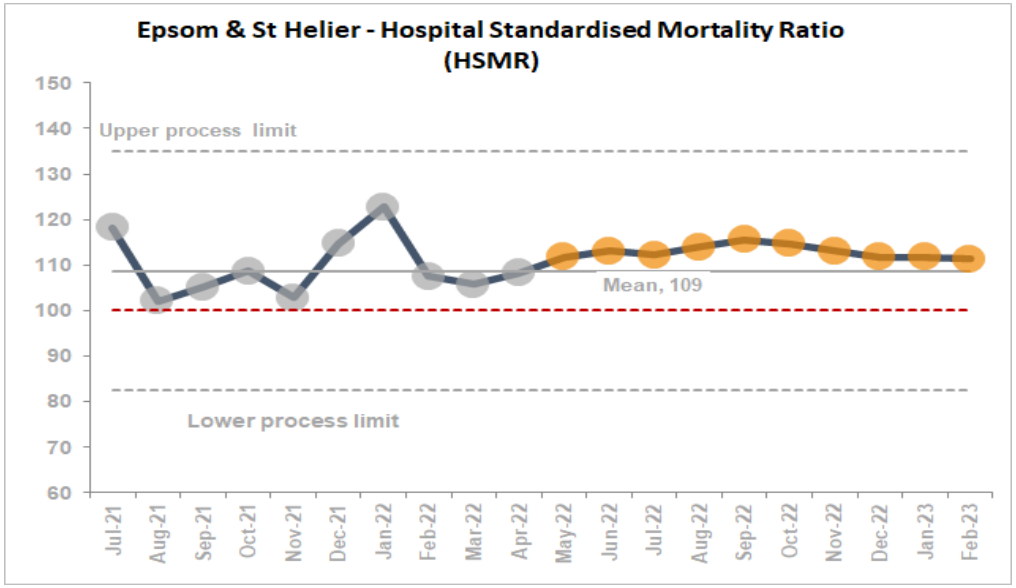
Pressure Ulcers : Specific work on device-related pressure ulcers with Critical Care and Leg maters awareness week as part of the national campaign has began.

Mortality – HSMR

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

Target: <100	SGH: 90.2	ESTH: 111.4





SGH updates since last month

Latest HSMR, for the 12 months from March 2022 to February 2023 shows our mortality remains 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 March 2022 to February 2023 remains above expected level but no longer increasing since September 2023. As per previous months, elective HSMR is significantly lower than expected and non-elective HSMR dominates the trend.

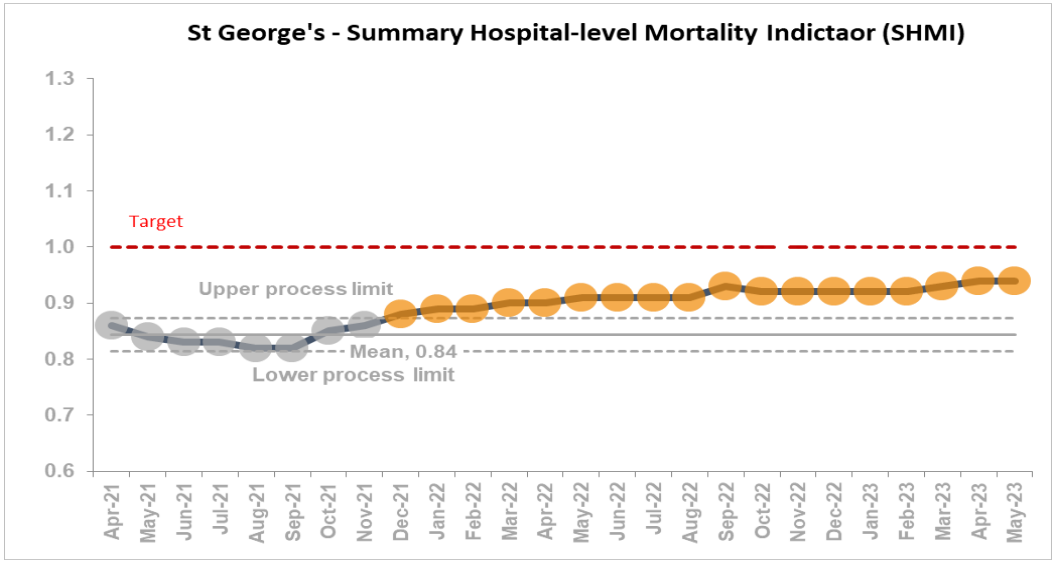
There is little difference in HMSR or those patients admitted during the week and those over the weekend, but both cohorts remain above expected level.

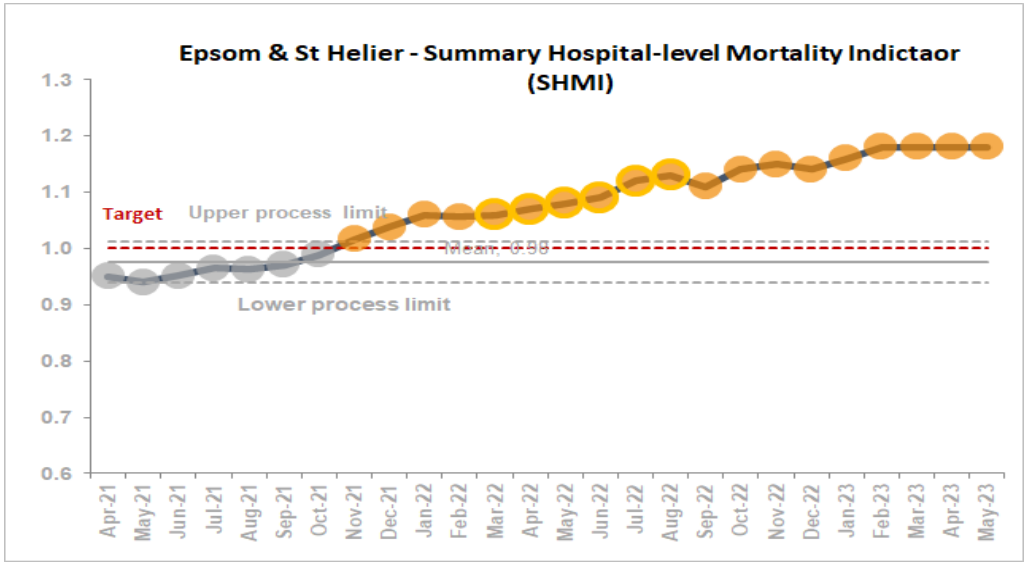
Data source: HED

Mortality – SHMI

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

Target: <1	SGH: 0.94	ESTH: 1.18





SHMI data based on rolling 12 months- January 2022 to December 2022

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 remains as expected at 0.94, reflective of the 12month period January 2022 to December 2022 (published 11 May 23).
NHS Digital has delayed the publication of the February 2022 to January 2023 data by 1 week, to 15th June; therefore, no update to the data reported previously is available.

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.

The rise in 12 month rolling SHMI stopped but still high at ESTH. Latest available data up to Dec-22 (published May-23). There is little difference between the two sites.

Source NHS Digital

Mortality - Analysis and Action

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

SGH current issues –

The Mortality Monitoring Group (MMG) consider mortality at diagnosis and procedure group level, examining HSMR data (via Dr Foster) and SHMI data (NHS Digital).
The diagnosis group 'Crushing injury or internal injury' continues to be monitored. In May high-level analysis of this group was refreshed and it was confirmed that all deaths related to trauma. This information was shared with the Clinical Lead for Major Trauma to enable triangulation with ongoing monitoring of outcomes and TARN data.
At MMG in April it was noted that SHMI data showed in December 2022 there was a run of more deaths than expected related to sepsis. This was investigated by the Trust lead for sepsis and a review of coding confirmed that there was a greater number of deaths than normally observed. An initial review of the cases showed that care appeared to be appropriate with TEP/DNACPR completed appropriately. A more detailed analysis is underway to ensure opportunities for learning are realised. This will be reported to MMG

SGH future action -

SHMI data continues to show mortality is higher than expected for fractured neck of femur. A meeting has been held with the clinical lead and a methodology for preliminary investigation was approved by MMG in May. The service believe that the flag is indicative of a pathway issue and this should be the primary focus of the work. The detail of this will be considered across the services involved in the care of this cohort and will be discussed at MMG in July. A number of immediate actions are underway including benchmarking against major trauma centres and validation of coding of comorbidities.
Cardiology outcomes continue to flag in both Dr Foster data and SHMI. Higher than expected mortality is seen in coronary angioplasty (Mar 22 – Feb 23) and acute myocardial infarction (Jan 22 – Dec 22). The clinical governance lead is reviewing deaths that have contributed to these signals. Work is ongoing to examine the impact of the shock team on outcomes which may not be fully reflected in the periods examined. A review of coding practices when patients are admitted through AMU is also in progress. The clinical governance lead and care group lead will be attending MMG in June for an in-depth review of the signals and agreement of investigation steps and timescales.

ESTH current issues –

The monthly Reducing Avoidable Death & Harm (RADAH) Committee reviews diagnosis level along with crude mortality rates. The increase in the HSMR and SHMI rates seen since Summer 2021 have stopped in recent published data. Work continues to provide assurance to safe patient care, including deep dive into clinical outliers.

Structured Judgement Reviews (SJR) were completed for 101 (25.96%) deaths. 6 deaths had an overall poor and 1 had a very poor score and these had Datix completed for learning for improvement. Any concerns identified through the SJR process were assessed as minor, moderate or major, and covered a wide range of issues. All major concerns had a Datix completed. A review of SJRs major concerns across Q1-Q4 2022-23 is being undertaken by the MR team to see whether there are any clear themes over time for learning improvements.

Overall mortality for this quarter (SHMI) covering discharges from Jan-22 to Dec-22 was categorised as 'higher than expected' at 1.188. The HSMR mortality ratio showed a similar trend to SHMI but observed deaths have reduced compared to expected deaths and the current value is 102.02, a 5.0 decrease from February.

Crude Mortality Rate shows a move away from the variance to a 7 month period (Oct 22 to April 23) where the rate stayed above the mean, returning to a regular variation pattern in May 2023, which is encouraging picture.

ESTH future action –

Clinician/Coding collaboration was on hold in May due to industrial action and will commence in June. Areas include End of Life Care team and Renal team. Divisional clinical quality leads will also be reviewing areas and develop actions to provide assurance.

The Mortality Reviewers contribute to the weekly SI/RRR panel and also have roles as Lead Investigators for Sis as part of their remit. Trust wide learning from these incidents has been done through Topic of the Week, Quality Half-Days, Safety Flashes and other fora. The Trust continues to review all unexpected deaths via mortality review and SJR processes. Details are in the separate Learning from Deaths report.

Monthly Overview – Elective Care (1)

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

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	60,612	59,466	54,118	68,034	116,033	122,152		48,987	56,274	45,004	53,080	93,075	98,084	
Patient Initiated follow ups	TBC	43	59	34	TBC	93		TBC	1,708	1,549	1,852	TBC	5,109	
Advice and Guidance	TBC	1,030	856		TBC			TBC	1,767	1,475	2,241	TBC	5,483	
Outpatient DNA rates	8%	10.0%	12.1%	13.3%	8%	12.7%		TBC	4.7%	4.8%	5.0%	TBC	4.9%	
New to follow up outpatient ratios	TBC	1.93	1.99	1.95	TBC	1.95		TBC	2.54	2.80	2.82	TBC	2.81	
Elective and day case activity	5,272	5,331	4,410	5,187	10,064	9,597		3,580	3,760	3,092	3,621	6,801	6,713	
Elective LOS	TBC	3.8	4.6	3.6	TBC	4.1		TBC	5.8	6.1	5.6	TBC	5.8	
Elective Day case rates	78%	80.0%	78.0%	79.0%	78%	79%		82%	83.3%	83.8%	83.0%	83%	83.4%	
Theatre Utilisation (Uncapped)	85%	82%	82%	82%	85.0%	82%		85%	76%	76%	77%	85%	76.5%	
Theatre Utilisation (Capped)	85%	76%	77%	74%	85.0%	76%		85%	74%	74%	74%	85%	73.8%	
Theatre Average Cases per Session	TBC	1.65	1.67	1.64	TBC	1.65		TBC	3.68	3.70	3.65	TBC	3.68	
On the day cancellations for Non Clinical Reasons	TBC	39	34	20	TBC	54		TBC	134	62	88	TBC	54	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	92.3%	82.4%	75.0%	100%	75%								

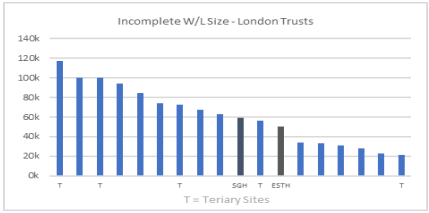
Monthly Overview – Elective Care (2)

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

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Feb-23	Mar-23	Apr-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Feb-23	Mar-23	Apr-23	YTD Target	YTD Actual	13-Month Trend
RTT – total size of waiting list*	59,445	57,437	58,966	59,271				41,400	47,214	48,852	50,032			
RTT -Incomplete Median Waiting Times		12.1	10.4	11.4					12.1	12.0	10.7			
RTT - Waits over 52 weeks*	600	481	517	549				160	385	517	586			
RTT - Waits over 65 weeks*	168	101	70	57				TBC	28	18	16			
RTT – Performance	92%	67.4%	67.9%	67.4%				92%	66.7%	67.1%	67.4%			
Cancer 14 Day Standard	93%	84.2%	87.0%	82.6%				93%	95.9%	96.0%	85.7%			
Cancer 14 Day Standard Breast Symptomatic	93%	47.8%	95.0%	92.2%										
Cancer 31 Day Diagnosis to Treatment	96%	91.8%	90.0%	92.2%				96%	100%	99%	100%			
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	77.6%	94.0%	83.0%				94%	100%	100%	100%			
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%				98%	100%	100%	100%			
Cancer 62 Day Referral to Treatment Screening	90%	50.0%	71.0%	75.6%				90%	100%	100%	100%			
Cancer 62 Day Referral to Treatment Standard	85%	53.8%	66.0%	69.5%				85%	86.0%	87.0%	86.4%			
No. of patients over 62 days	105	91	91	116				59	45	34	49			
Cancer – 28 day Faster Diagnosis Standard	75%	82.2%	78.9%	77.2%				75%	82.0%	79.8%	80.3%			
	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
Diagnostic activity	TBC	19,364	16,857	18,937	TBC	35,794		TBC	17,887	15,487	15,487		30,974	
Diagnostic performance	5%	1.8%	1.3%	0.98%				5%	10.0%	10.7%	8.7%			

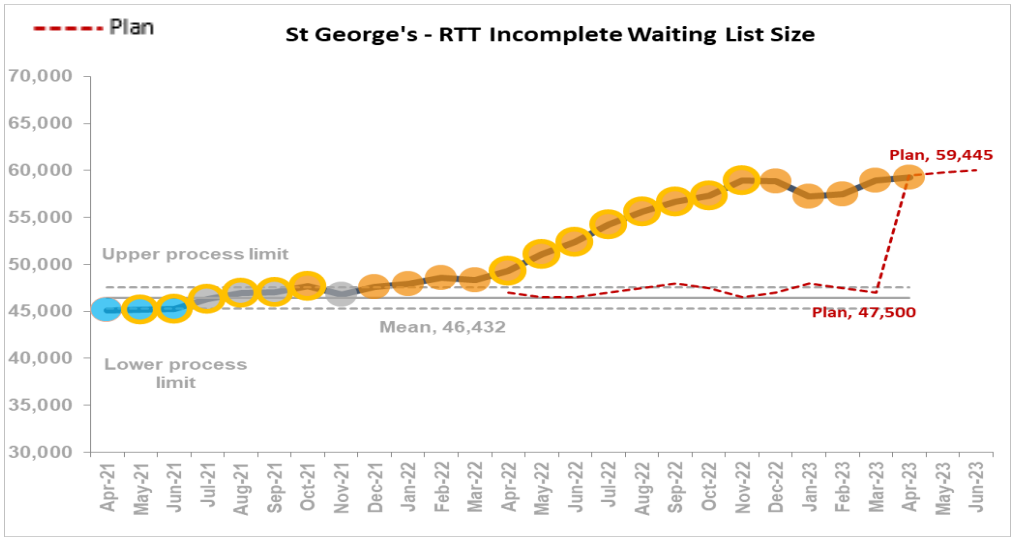
RTT – Total Waiting List Size

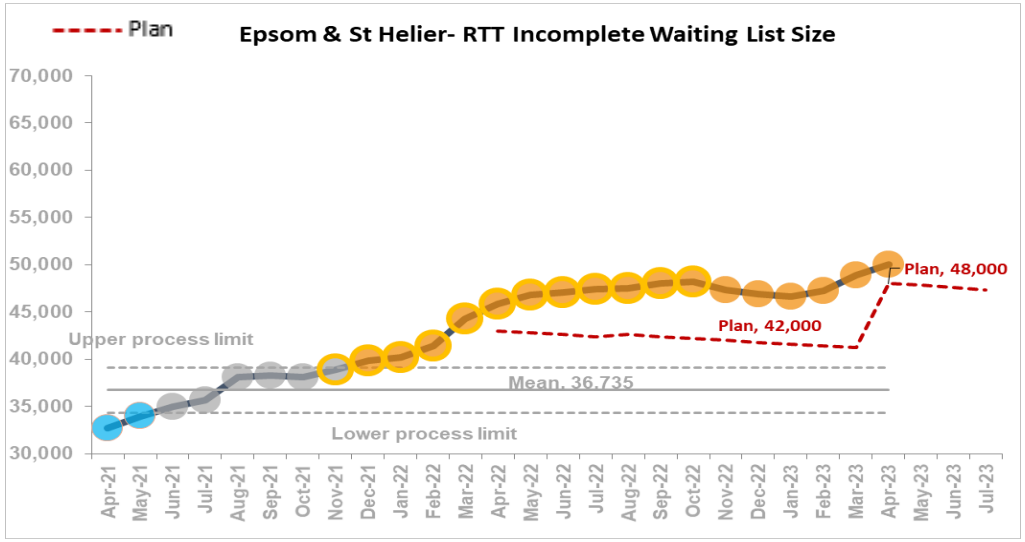
St George's, Epsom and St Helier University Hospitals and Health Group



Apr-23

SGH Plan: 59,742	SGH: 59,271	ESTH Plan: 48,000	ESTH: 50,032





SGH updates since last month

PTL volume has increased by 0.7% compared to the previous month however 0.8% better than plan, with 18w breach numbers increasing (by 396 pathways, 2.1%).
The total number of patients on the non-admitted PTL has risen slightly by 0.5% (305 pathways), with the largest proportion of 18w waits being within ENT and Cardiology.
The total number of patients waiting on the admitted PTL decreased by 76 pathways compared to March with a 0.8% reduction in 18w waits, this was driven by Cardiology and Gastroenterology. Recovery plans are being worked up. However, our >65wk trajectory is delivering, with further validation we expect an improvement in the position.

ESTH updates since last month

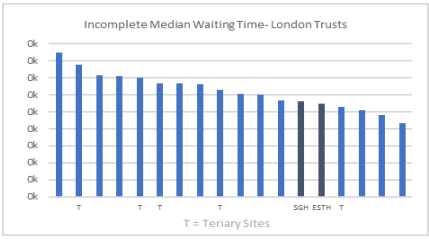
PTL volume has increased again (2.4% higher than the end of the previous month), with (18w) breach numbers also increasing (by 236 pathways, 1.5%). As with the previous month, the breach numbers increasing at a slightly lower rate than the PTL means that 18w performance has gone up slightly from last month (from 67.1% to 67.4%).

Of the total patients waiting for more than 18w for treatment, 78.7% are on the non-admitted PTL with the largest proportion within Gynae, Dermatology and Gastroenterology.

RTT – Median Waiting Times

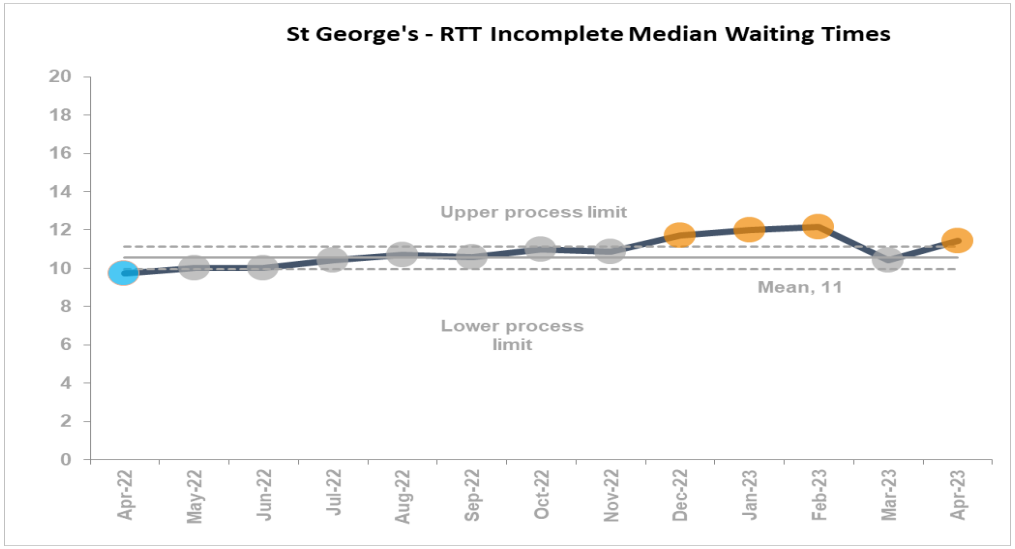
St George's, Epsom and St Helier University Hospitals and Health Group

Average (median) waiting time (in weeks)
This is the mid-point of the RTT waiting times distribution. The median is the 50th percentile. It's the time that 50% of patients waited less than, e.g. the waiting time of the middle patient if you lined them up from shortest wait to longest wait.



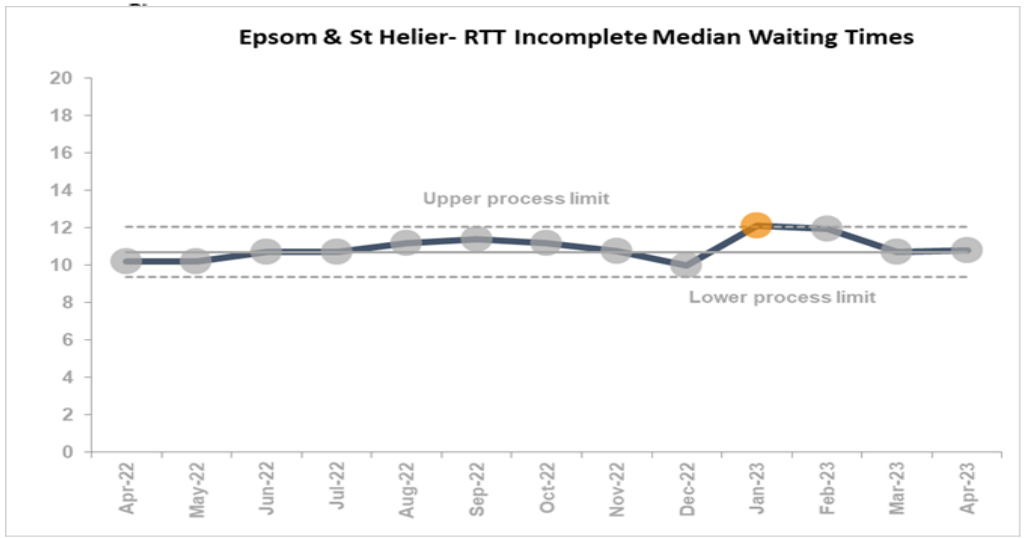
Apr-23

SGH: 11.4 Wks



SGH updates since last month
The median waiting times on the RTT incomplete PTL has been shown an increase over the past five month period, with an average waiting time of 11 weeks. The highest median waiting times are within Neurosurgical Service (17 weeks) and ENT (15 weeks). A recovery plan for Neurosurgery is being developed.

ESTH: 10.8Wks

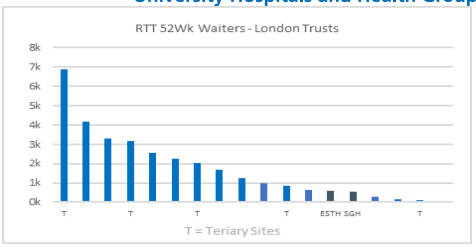


ESTH updates since last month

The median waiting times on the RTT incomplete PTL has been consistent over the last 12 month period, with an average waiting time of 11 weeks. The highest median waits are for Cardiology and Dermatology (+16 weeks)

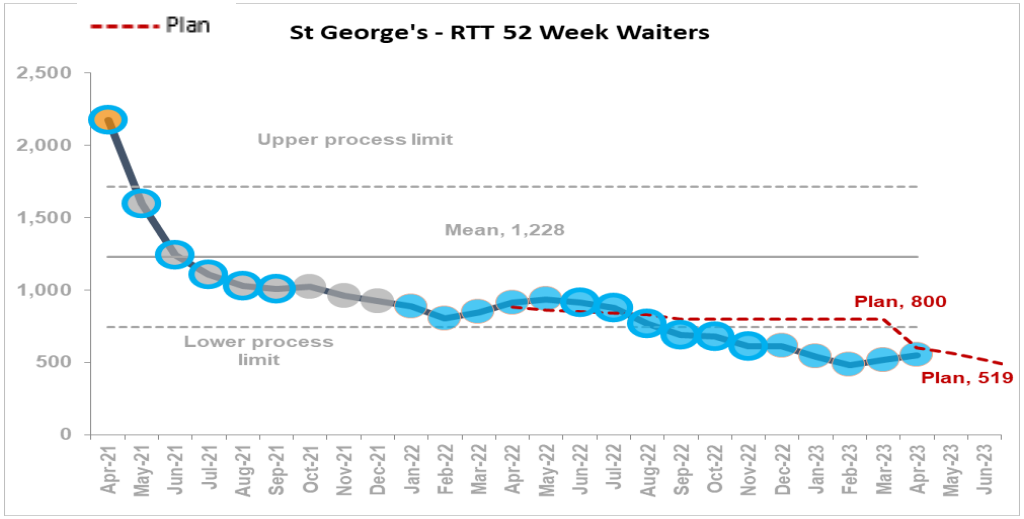
RTT – 52 Week Waiters

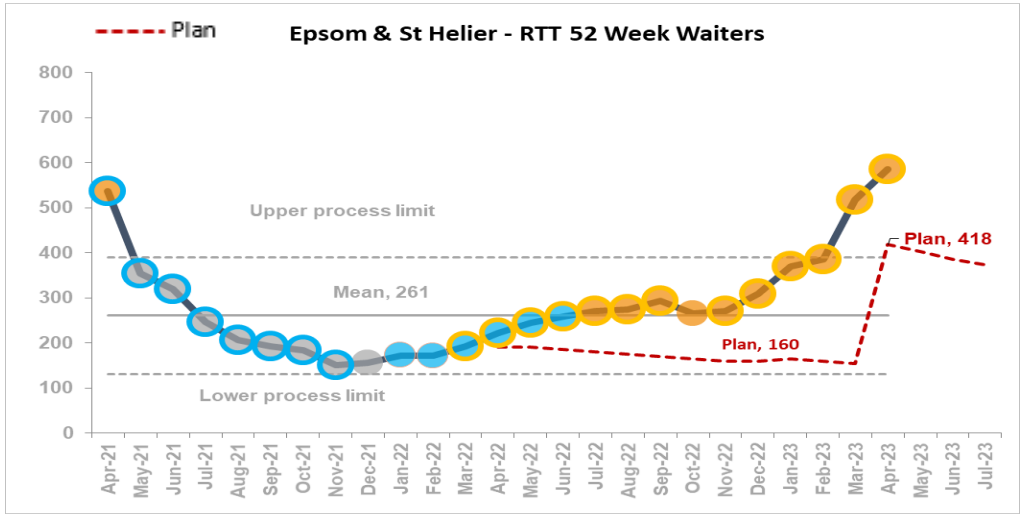
St George's, Epsom and St Helier University Hospitals and Health Group



Apr-23

SGH Plan: 566	SGH: 549	ESTH Plan: 418	ESTH: 586





SGH updates since last month

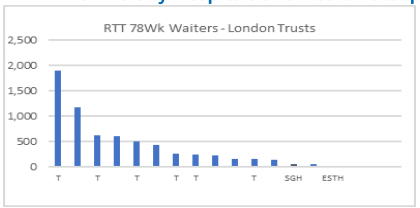
At the end of April, there were 549 incomplete pathways over 52 weeks, this is better than plan however this is an increase of 6.2% (32 pathways) compared to March. The largest increases are within ENT on the admitted PTL. Cardiology continue to hold the largest proportion of 52 week breaches overall. Cardiology have developed a recovery plan, but the Post COVID increase in referrals (seen across London) has contributed to this position.

ESTH updates since last month

The month-end 52-week waits have increased fairly significantly (by 69 pathways, 13.3%), The largest increases have been seen within Paediatric specialties and Cardiology.

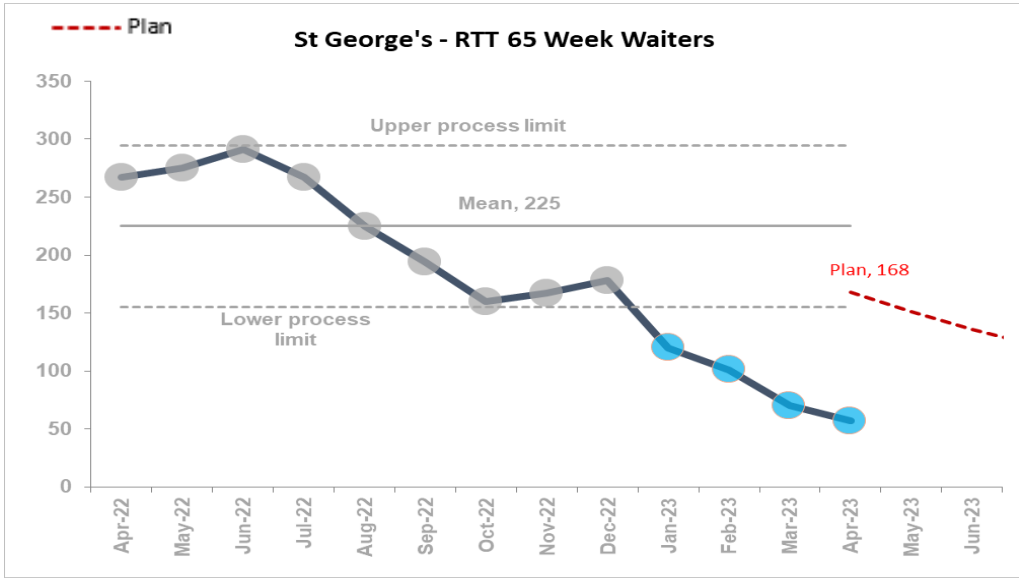
RTT – 65 Week Waiters

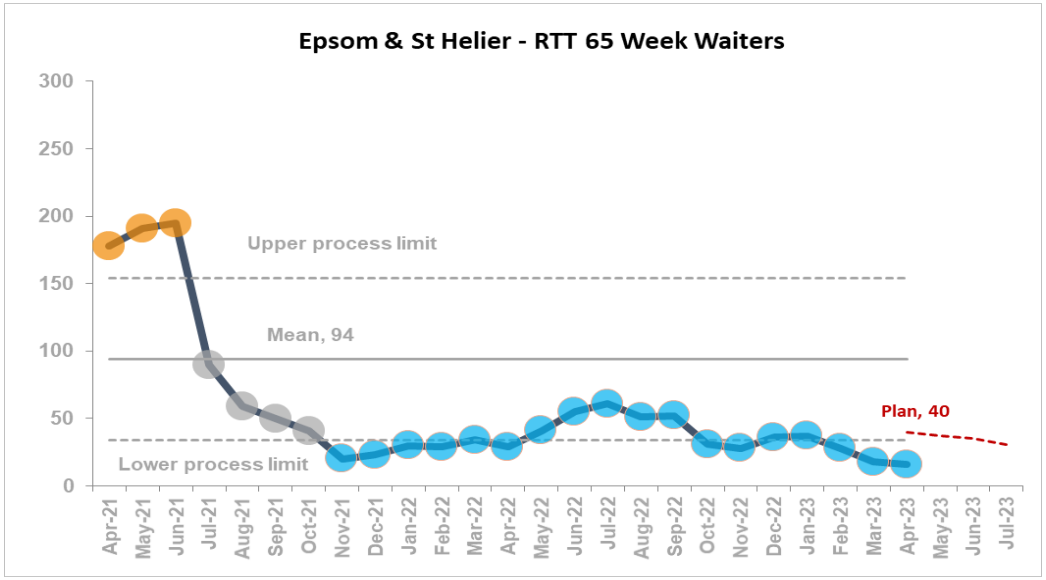
St George's, Epsom and St Helier University Hospitals and Health Group



Apr-23

SGH Plan: 168	SGH: 57	ESTH Plan: 40	ESTH: 16





SGH updates since last month

The number of patients waiting over 65 weeks continues on a downward trend and remains below plan.

ESTH updates since last month

At the end of April, 16 patients were waiting for more than 65 weeks for treatment, this is below plan of 40. The largest proportion of waits are on the non-admitted PTL (12 pathways)

Elective / RTT Analysis and Action

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

SGH current issues –

At the end of April there were 52,478 incomplete non-admitted pathways, up from 52,097 in March.

There are 795 patients with a projected wait of over 40 weeks for a first appointment. The largest numbers are in Neurosurgery; a recovery plan is being put in place and managed through Elective Access. The meeting is continuing to focus on bringing appointments forward to reduce waits, ensuring that the PTLs are validated, and the access policy is being appropriately applied.

There have been improvements in cashing up, with 386 attendances not cashed up for April, compared to over 800 in March 23.

The number of patients waiting over 65 weeks and continues on a downward trajectory and is on track to achieve year end targets. The number of 52 week incomplete pathways are beginning to rise, with increases seen within paediatric ENT. The service is clinically reviewing all these patients as part of the recovery plan and working with the network to identify suitable capacity.

SGH future action -

Focus on reducing the volume of outpatient data quality issues that may be artificially inflating the PTL size. DQ has improved to 8.3% against an upper limit of 10%

The OP transformation group is beginning the roll out of 'orders to schedule' which will support the recording of PIFU, reduce follow-ups and improve OP coding and Waiting List management.

The Trust has developed a series of FU PTLs, including PIFU and a Cancer FU PTL which will support management of patients on non-RTT pathways, which will inform capacity management and reduce the risk of patients being lost to follow-up. These are currently at the User Acceptance phase of testing, with a go-live in July.

A Children & Young Persons elective access meeting is being implemented to support the delivery and oversight of the national CYP improvement.

ESTH current issues –

- GP referrals remain above BAU levels. GP referrals for Apr23 were 5% higher than the volume received in Apr19:

Referrals	Jul-22	Aug-22	Sep-22	Oct-22	Nov-22	Dec-22	Jan-23	Feb-23	Mar-23	Apr-23
Vs BAU 19/20	100%	119%	118%	109%	119%	110%	103%	117%	138%	105%

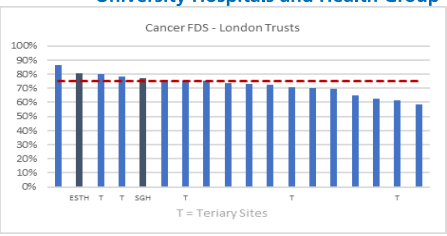
- 52 week waits continue on an upward trend each month with an increase from 517 in Mar23 to 586 in Apr23. A further increase is expected in May23 for 52 week waits due to the knock on impact of the junior doctor strikes. Community Paediatrics remains the most pressured speciality, followed by Gynaecology, Cardiology and Gastroenterology.
- The Admitted PTL (excluding diagnostics) continues to increase each month with 7769 at the end of May23, up from 7713 at the end of Apr23. P1, P2 and P3 cases remain stable with the increase mainly in P4s (non-urgent cases).
- Total PTL volume has seen a further increase from 48852 in Mar23 to 50032 in Apr23 and a further increase is expected in May23 due to the knock on impact of the junior doctor strikes.

ESTH future action –

- Further referral optimisation work being undertaken by the outpatient transformation leads, as well continuing with insourcing throughout Q1 23/24 to support with the mitigation of referrals continuing to be above BAU levels.
- Divisions and performance team continue to work in collaboration to micro-manage 52WWs on a daily basis and expedite next steps. Updates being provided to SWL on a weekly basis for patients 60weeks+.
- Community Paediatrics recovery meetings commenced on 22nd March 2023 and are ongoing.
- Opening of additional theatre to increase IP/DC activity by approx 2k and reduce the Admitted waiting list. To come online in July

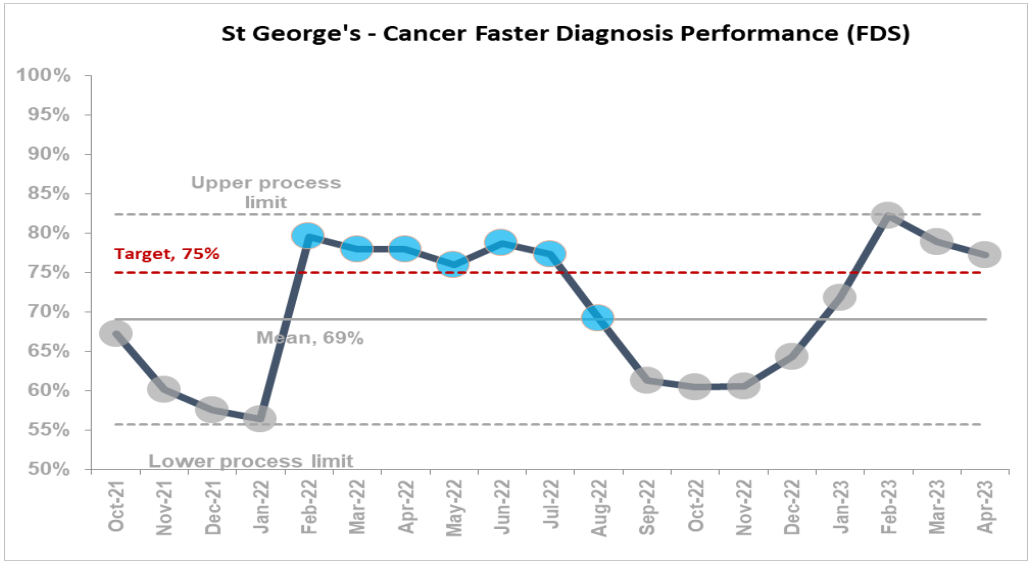
Cancer – Faster Diagnosis Standard

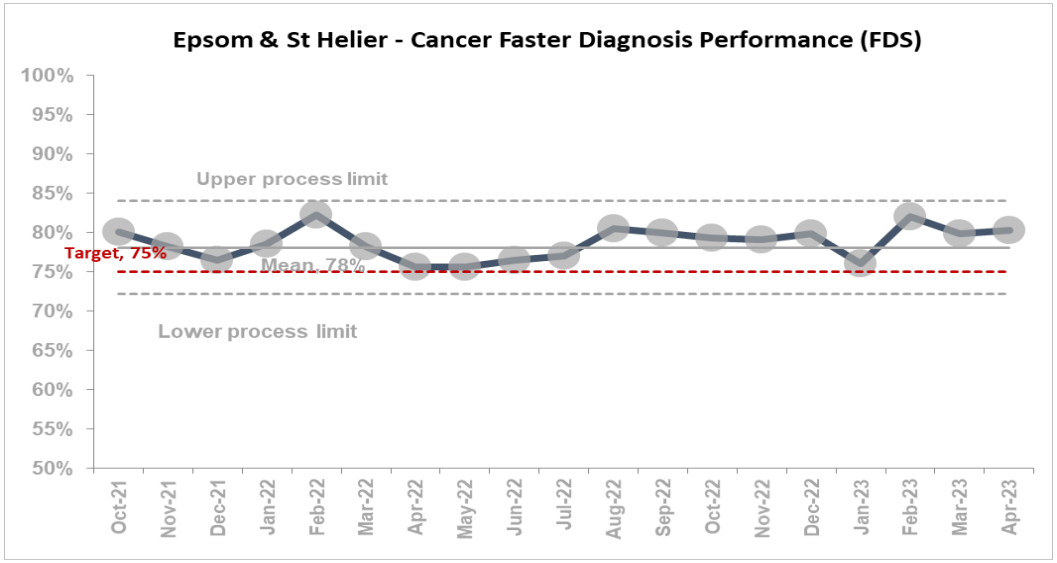
St George's, Epsom and St Helier University Hospitals and Health Group



Apr-23

Target: 75%	SGH: 77.2%	ESTH: 80.3%





SGH updates since last month

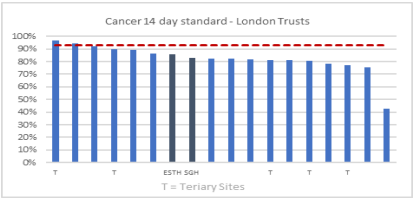
April, performance against the Faster Diagnosis Standard was 77.2% meeting the required target of 75%. Breast continued in a compliant position raising performance to 90% and Skin, with the largest cohort of patients continue to perform above target achieving 93%. Continued challenges remain within Head and Neck (60%), Lower GI (41%) and Upper GI (62%).

ESTH updates since last month

Performance against FDS remains complaint achieving 80.3% in April. All tumour groups with the exception of Head & Neck (74.6%) and Upper GI (66.2%) are compliant. The Trust expects to continue delivering FDS performance throughout the year despite the significant increase in GP referrals in specialities such as Skin. In the coming months, there will be targeted focus on improving FDS in specific areas (H&N, Gynae and Upper GI and Lung).

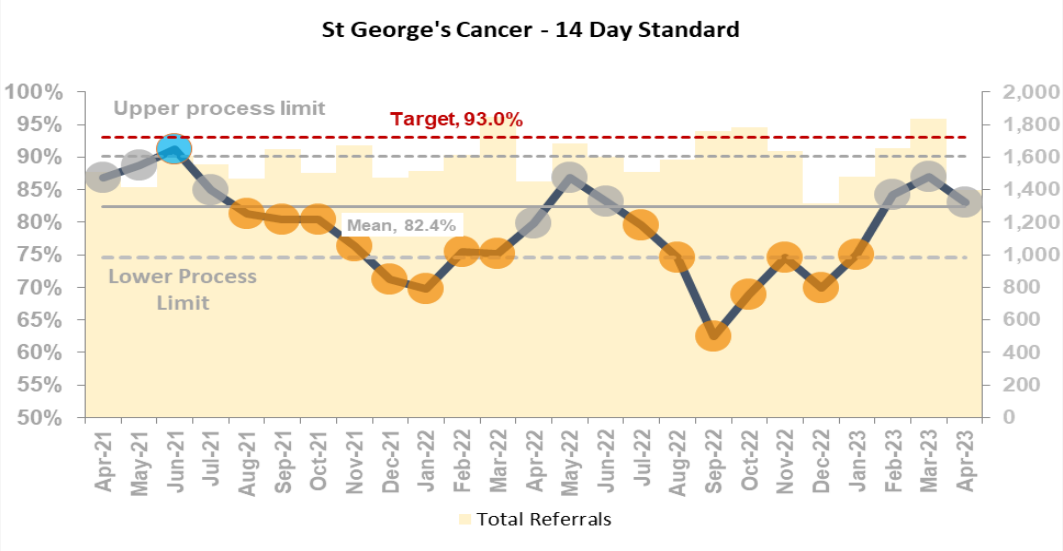
Cancer – 14 Day Referral to Seen Standard

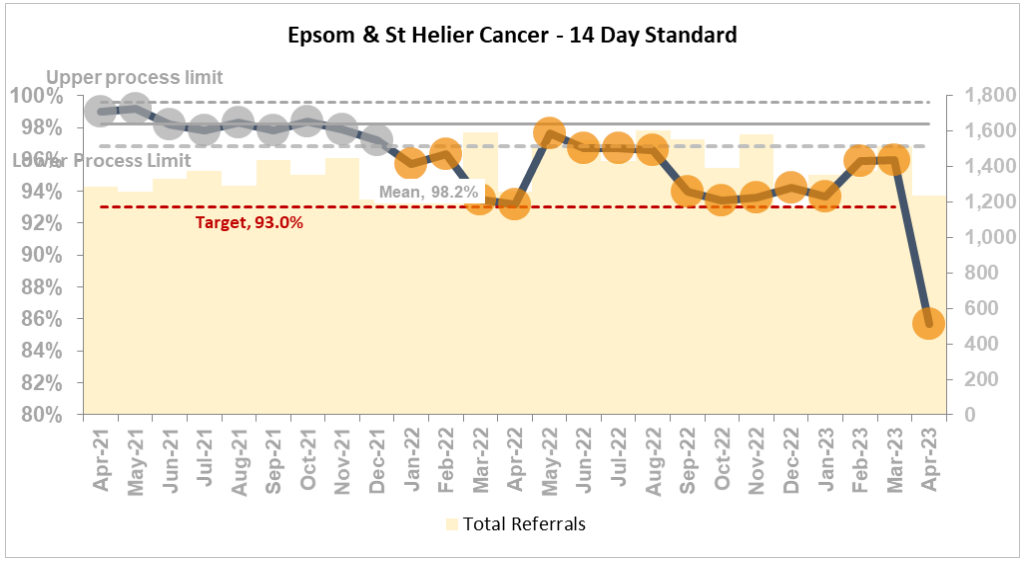
St George's, Epsom and St Helier University Hospitals and Health Group



Apr-23

Target: 93%	SGH: 82.6%	ESTH: 85.7%





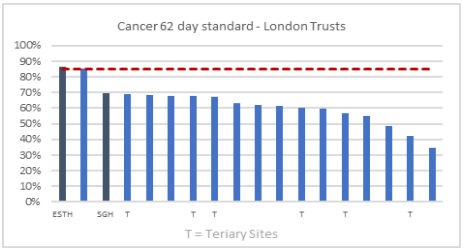
SGH updates since last month

Performance against the 14 day standard remains above the mean reporting 82.6% in April, however this is a decrease from 86.7% seen in March with capacity impacted by bank holidays and Junior Doctors Strike. With the exception of Lung and Upper GI all tumour groups are not meeting the national target of 93%. All services have trajectories in place and this is being monitored closely via cancer access with a focussed cancer week chaired by the Chief Operating Officer in June 23.

ESTH updates since last month: Performance against the 14 day standard fell considerably in April reporting 85.7% against a target of 93% which, previous to this month, has been continuously achieved. The decrease has been impacted by Gynae and Skin capacity issues. Mitigations for Gynae consist of creating extra capacity by converting routine to TWR slots, additional clinics and insourcing (short term); reviewing new care models involving nurse triage of referrals and one stop clinics with ANP support (medium term); increasing clinical workforce to deliver both cancer & non-cancer activity (long term). Mitigations for Skin include recruitment of Band 5 nurse (funded by Cancer Services for 6 months while business case is submitted) to free up consultant and ANP.

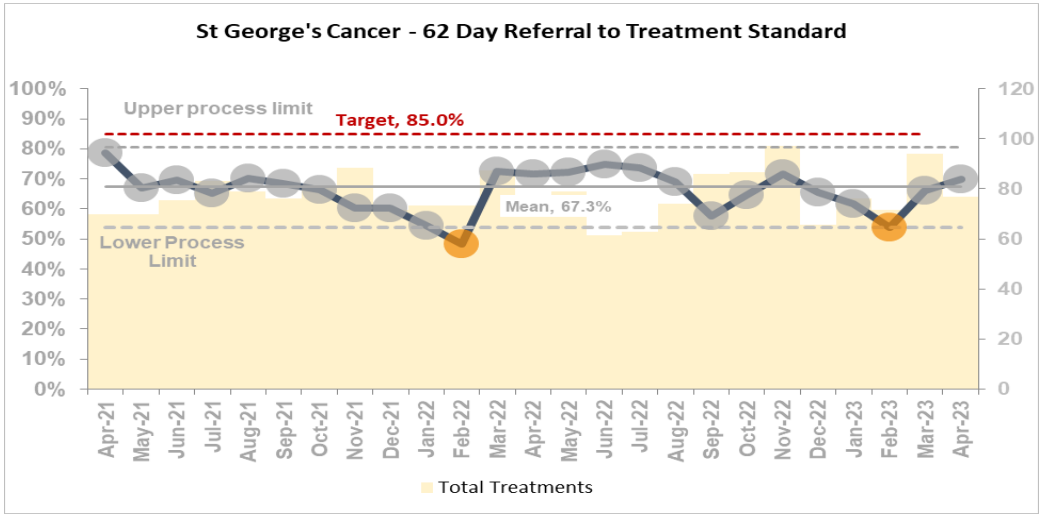
Cancer –62 Day Referral to Treatment Standard

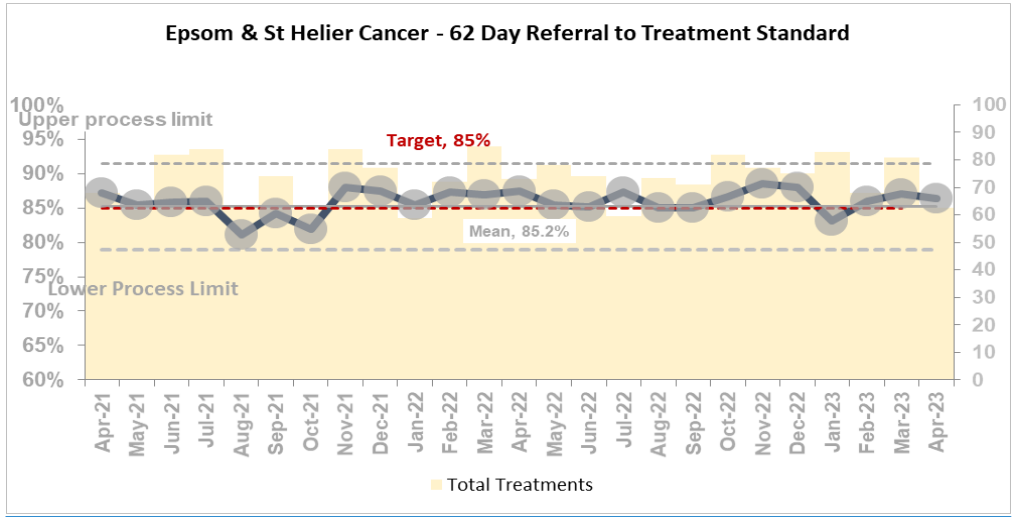
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group



Apr-23

Target: 85%	SGH: 70%	ESTH: 86.4%





SGH updates since last month

62 day performance has increased for a consecutive month reporting 70% and although below target is performing above the mean. All tumour groups, except for Head & Neck and Lung, are in a non-compliant position. We are seeing a high number of ITT (InterTrust Transfers) above 38 days.

ESTH updates since last month

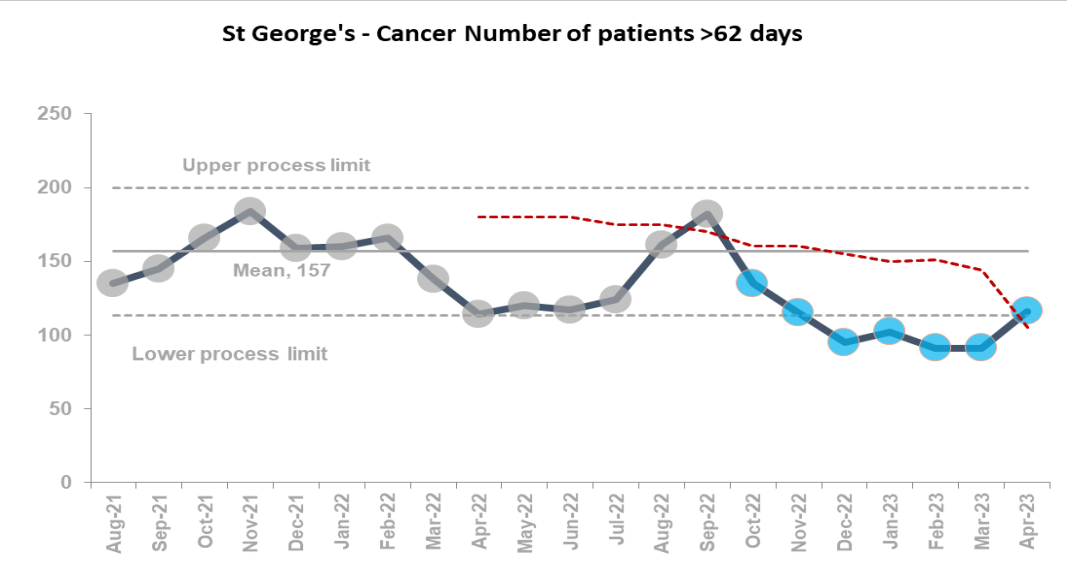
Performance against the 62 day standard continues to be met achieving 86.4% in April with 8.5 breaches despite internal challenges. The objective is to sustain this remarkable level of performance in the coming months.

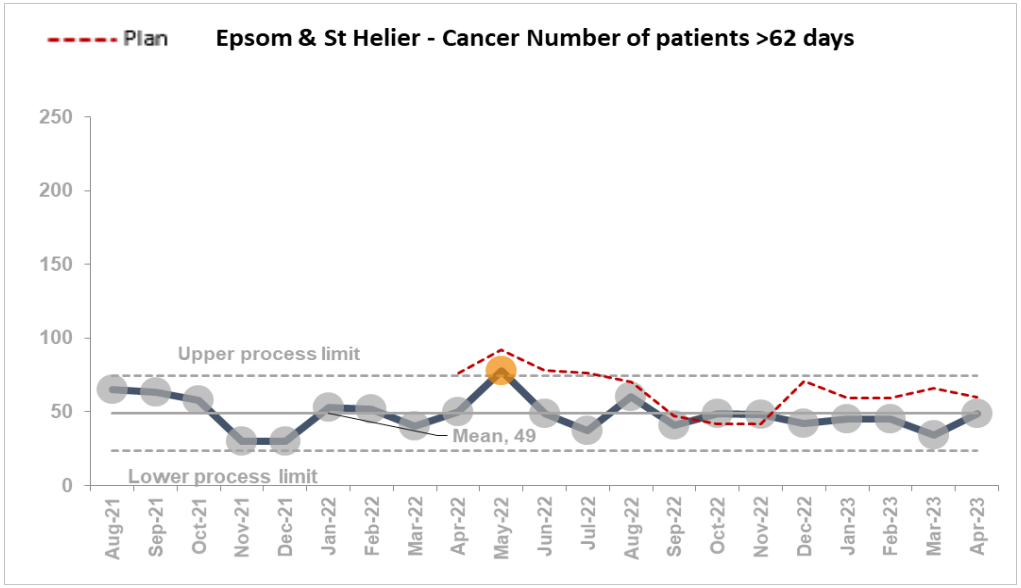
All tumour groups, with the exception of Haematology and Upper GI, were reporting a compliant position of above 85%.

Cancer – Number of patients > 62 days

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

Apr-23			
Plan: 105	SGH:116	Plan: 59	ESTH: 49





SGH updates since last month

The number of patients in our backlog increased through April and is slightly above our plan, however considerable effort is being made to reduce long-waits and ensure all patients are tracked correctly. A focused cancer week reviewing all PTLs is planned for June 23 to improve the position.

ESTH updates since last month

The Trust has consistently maintained below the expected trajectory. To ensure the provision of optimal patient healthcare, the Trust ensures clinical impact review is frequently carried out on those patients by the clinical leads for cancer in the relevant tumour site.

Cancer Performance Analysis and Action

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

SGH current issues –

TWW: Lung and UGI were compliant whilst all other areas were behind target. A number of services were impacted by the strikes and public holidays. Particular challenges were seen in the areas below:
•Gynaecology access to one stop scans and timely triage and workforce gaps, expected recovery in June 23
•Haematology with a booking profile of 20+ for TWW Lymphoma clinics a recovery plan is in progress.
•Lower GI access to TAC clinic due to workforce gaps.
FDS: FDS Performance was compliant in April 23. Similarly, Breast, Gynae, Lung and Skin achieved the standard. Challenges were seen in the areas below that are behind in-month trajectory:
•Haematology- front end challenges and impact of strikes
•H&N - Diagnostic capacity and theatre capacity for panendoscopy/diagnostics
•Urology – delays seen in the prostate pathway
62-day GP Performance: A high volume of breaches seen in H&N (7.5), Urology (5), breast (4) and Haematology (3). Challenges, were seen in H&N and urology due to theatre capacity and late inter trust transfers from the periphery.
62 Day Backlog: The back log was behind trajectory in April 23 at 133.
Good news: The Lung Service is complaint against all standards in April 23.

SGH future action -

Cancer Trajectories 23/24 Summary:
•Faster Diagnosis to be compliant **(75%)** by April 2023. **Trajectory met in April 23**.
•62 Day GP to Treatment to be compliant **(85%)** by September 2023 – **Trajectory not due for delivery until September.**
•62-day backlog to achieve 105 patients by March 2024. **Trajectory not met in April 23**
Cancer week with a focussed PTL review of all patients across all tumour streams to take place.
Tumour specific actions:
Gynaecology: Demand and Capacity review in progress and MDT lead consultant in post.
Haematology: QIA submitted for additional Lymphoma consultant support. Additional WLIs explored to support short-term capacity.
Lower GI: New locum consultant with an assigned (one) PA/session p/w to support the CNS team with complex triaging/decision making from July 23.
H&N : RMP has funded 0.8 WTE nurse to support risk stratified triage. Scoping of the triage model is under way and recruitment is in progress.
UGI: Saturday endoscopy lists are in place to support diagnostic wait times.
Skin: On-going review of tele-dermatology in progress.
Breast: Weekend insourcing is in place every Saturday. A business case has been submitted and reviewed by the Divisional Triumvirate. RMP have agreed to fund 18 months of Breast Care Nursing to support re-opening of PSFU. The recruitment process has been started with a view to have staff in place and PSFU open by Q3

ESTH current issues –

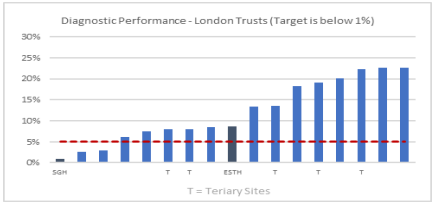
Endoscopic Ultrasound (EUS) at Royal Marsden Hospital (RMH) capacity continues to be challenging – current wait is up to 3-4 weeks.
Endobronchial Ultrasound (EBUS) capacity is challenging throughout the network, currently our lung patients are referred to UCLH where the average wait is 4-5 weeks turn around. RMP led project has increased capacity at St George's
IR diagnostics are challenged. However, mutual aid with StG is successfully improving the TWR waiting list. A successful appointment of a consultant Radiologist with IR experience would help.
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 Trust capital programme bid for additional equipment.
14-day first seen performance fell considerably in April due to capacity issues with Gynaecology and Dermatology. Gynaecology in particular is dealing with both current demand and backlog generated by April Doctors strike and high annual leave in April.

ESTH future action –

Women & Children's team are converting routine to TWR OPA slots, organising additional clinics and insourcing to create extra first seen capacity (short term solution); reviewing new care models involving nurse triage of referrals and one stop clinics with ANP support (medium term solution); increasing clinical workforce to deliver both cancer & non-cancer activity (long term solution).
Dermatology to recruit a Band 5 nurse (funded by Cancer Services for 6 months while business case is submitted) to free up consultant and ANP for cancer work.
RMH EUS capacity is under focus at group meetings and additional lists have been added. It is hoped that the capacity will double once the RMH Oak Centre opens in September.
Ongoing work with RM Partners to provide EBUS service within the network with weekly meetings having resumed in March.
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. Finalising Reporting TAT KPIs within Radiology to expedite patient pathways.

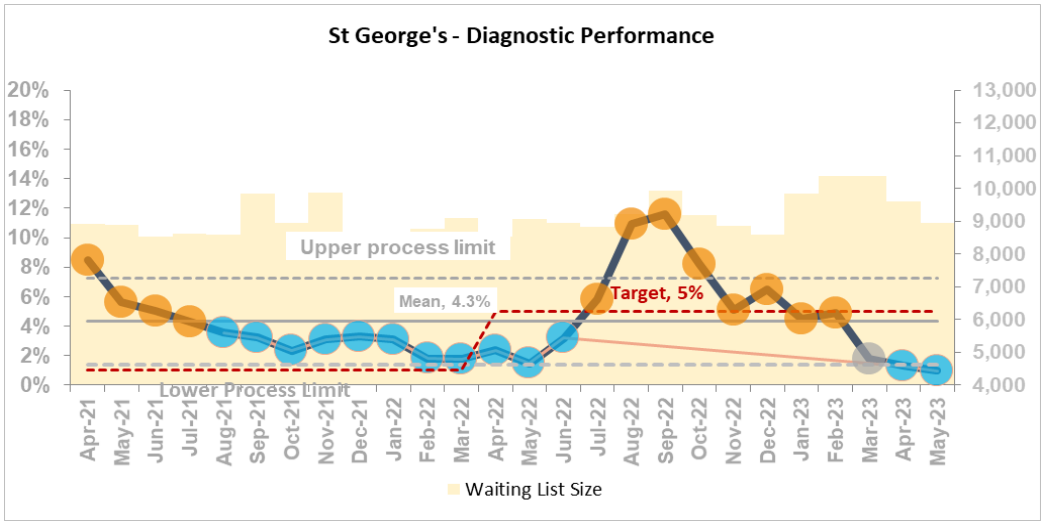
Diagnostic Performance

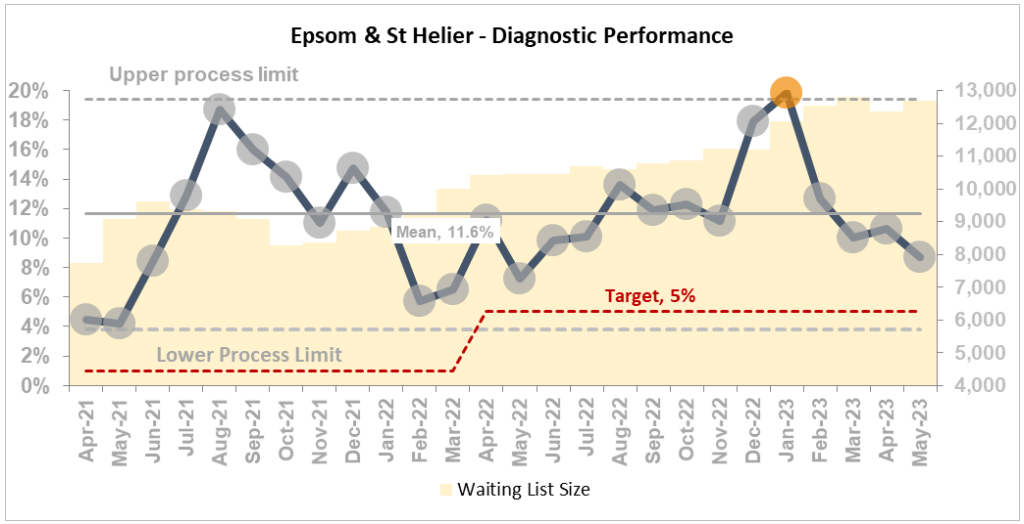
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

Target: 5%	SGH: 0.98%	ESTH: 8.7%





SGH updates since last month

At the end of May, the Trust reported a further improvement in performance with 99.02% of patients waiting less than 6 weeks for their diagnostic test ***returning to the national 99% requirement and performing top against London Peers***. Further improvement was seen within Endoscopy modalities exceeding internal trajectories. The total waiting list size decreased by 6.7% with activity levels increasing by 12% compared to April.

ESTH updates since last month

At the end of May we are reporting one 1,101 breaches, which is a significant decrease from the volume of breaches at the end of April. The PTL size has increased slightly since the end of April, with the two of these factors combining to result in a significant increase in performance to 91.3%, which is the highest level since last May 2022.

Diagnostic Performance Analysis and Action

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

SGH current issues –

Endoscopy - Endoscopy modalities are not currently meeting the national target of 1% with a total of 39 patients waiting for more than 6 weeks for a diagnostic test (a proportion of these are patient choice). The service is seeing continued improvement and are ahead of their internal trajectories. There is now a proportion of patients requiring specialist lists including GA and varicocele which have been more challenging to accommodate within six weeks.

Sleep Studies -SGH continue to see an increase in referrals impacted by challenges across SWL and capacity is not meeting demand leading to increased waits and an increase in the backlog. The services continue to provide additional sessions where possible and in addition there has been extra capacity put on through CDC to mitigate this as much as possible.

Capacity across many modalities has been impacted by industrial strikes, increase in emergency demand, sickness and annual leave, many services have relied on ad-hoc sessions across the month.

SGH future action –

Endoscopy - Additional Saturday lists running twice per month where there has been uptake from nursing and medical staff. These lists create capacity for the less complex cases, which should start to release BAU capacity for the more complex lists. The service is still trying to recruit an experienced nurse endoscopist post to address the ongoing workforce issues and have also established a trainee nurse endoscopist post. The service continues to reduce the backlog and are continuing to use doctor doctor to validate and contact patients

Sleep Studies - The service is continue to monitor demand and discussions with commissioners and SWL Diagnostics team has begun to ensure patients are going to local hospitals as a first option. Additional capacity through CDC funding to mitigate this as much as possible however low uptake.

Echocardiography

- Implemented new triage process and strengthening booking processes for Stress Echo where capacity can be challenged. Additional capacity was booked throughout the month to ensure all patients are seen within 6 weeks.

Weekly performance meetings continue to be in place to monitor and escalate any performance / capacity issues.

ESTH current issues –

Imaging: Total diagnostics DM01 performance breaches for imaging in May were 359 in total. The breakdown is 79 for MRI, 197 for Ultrasound, 46 for CT Scan and 37 for DEXA. Compared to preceding month, there was a significant reduction in breaches for all modalities.
Epsom MRI scanner had multiple breakdowns previously but this has improved in May. The team is continuing work to maintain the performance however there is a high number of vacancies arising within the radiology scheduling team during June.

ESTH future action –

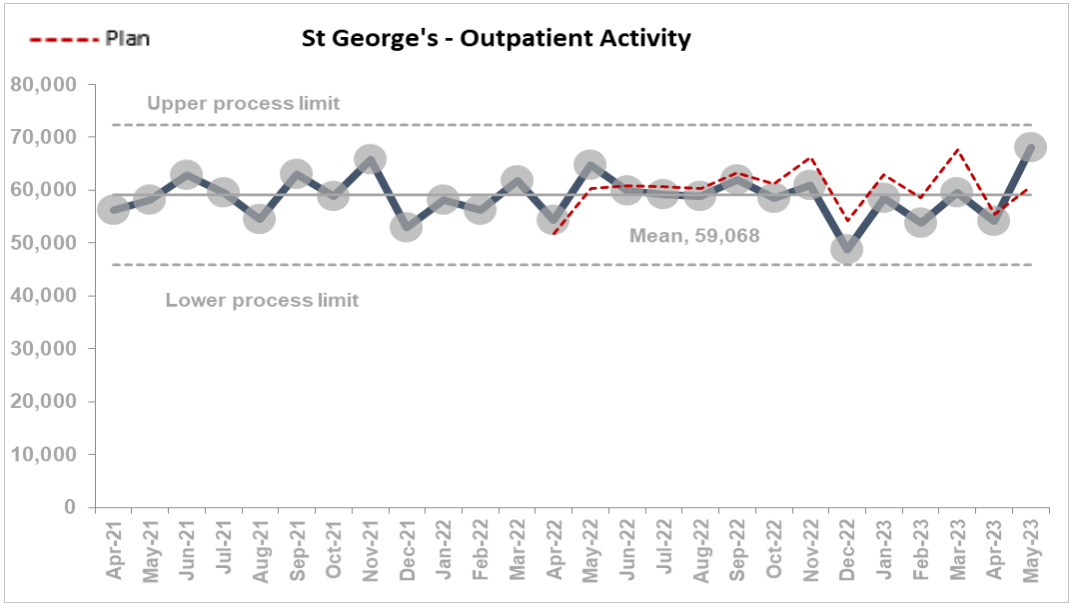
- Increase booking staff using bank staff and utilising weekend lists for all modalities
- Increase breach validation resource and process
- Focus on booking backlog and minimising 4+ weeks waiting patients;
- Use of bank and agency staff to increase capacity to reduce the backlog .
- Continue daily 15 minutes huddle with booking team and superintendents to monitor progress and resolve any bottlenecks in real time.
- Developing a 6-day working rota for CT and MRI which will to go live in June and be a precursor to future 7-day working plans.

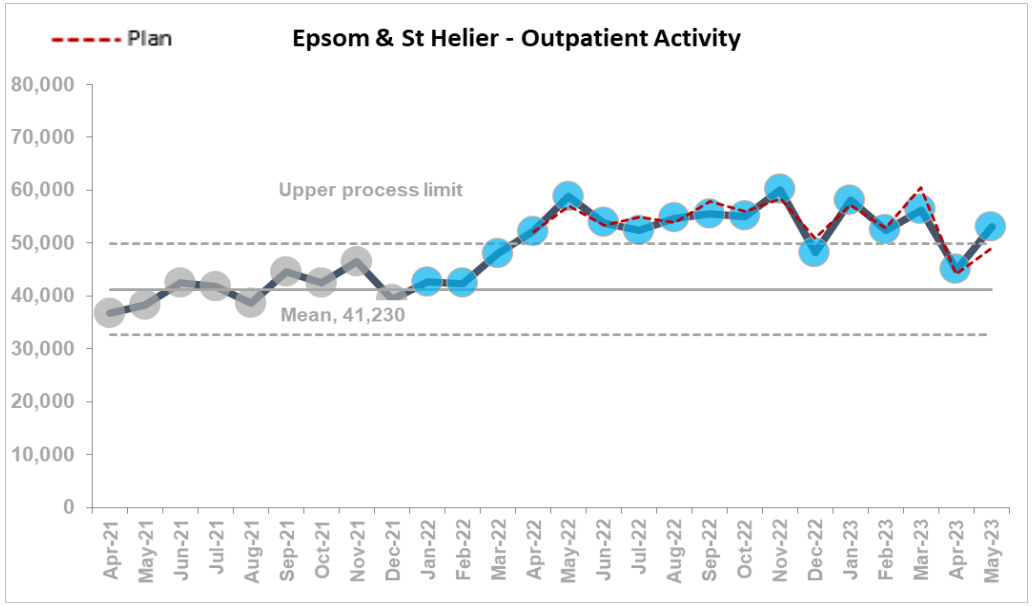
Outpatient Activity

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

May-23

Plan: 60,612	SGH: 68,034	Plan: 48,987	ESTH: 53,080





SGH updates since last month

Outpatient performance is expected to be 107% after catch-up for May, which is ahead of plan. First outpatient attendances is expected to be 118% of 2019/20 performance.
Outpatient performance is expected to be 103% after catch-up YTD, which is ahead of the 98% plan. Catch up estimates include recodes between first attendance and procedure which has led to a reduction in attendances. The impact of the Junior Doctor strikes is estimated to have decreased outpatient activity by 1,945 YTD or deteriorated variance to plan by 3%.

ESTH updates since last month

Outpatient activity performance remains above the mean and ahead of plan for May. Outpatient first activity remains significantly above BAU levels.

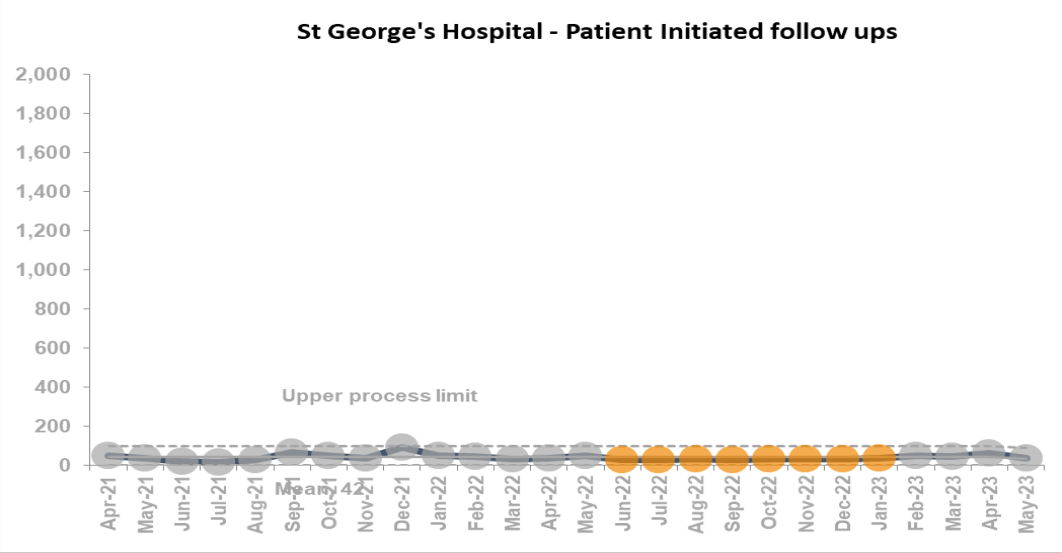
Patient Initiated Follow-up (PIFU)

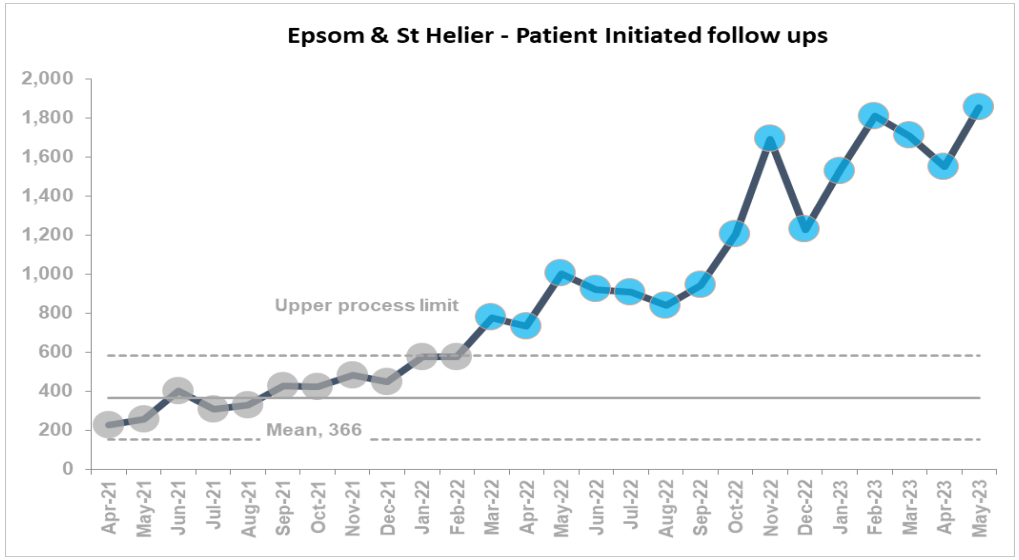
St George's, Epsom and St Helier University Hospitals and Health Group

May-23

Target: TBC	SGH: 34

Target: TBC	ESTH: 1,852





SGH updates since last month

The recording of patients continue to be an issue, this is being addressed as part of the outpatient back to basics programme.

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ESTH updates since last month

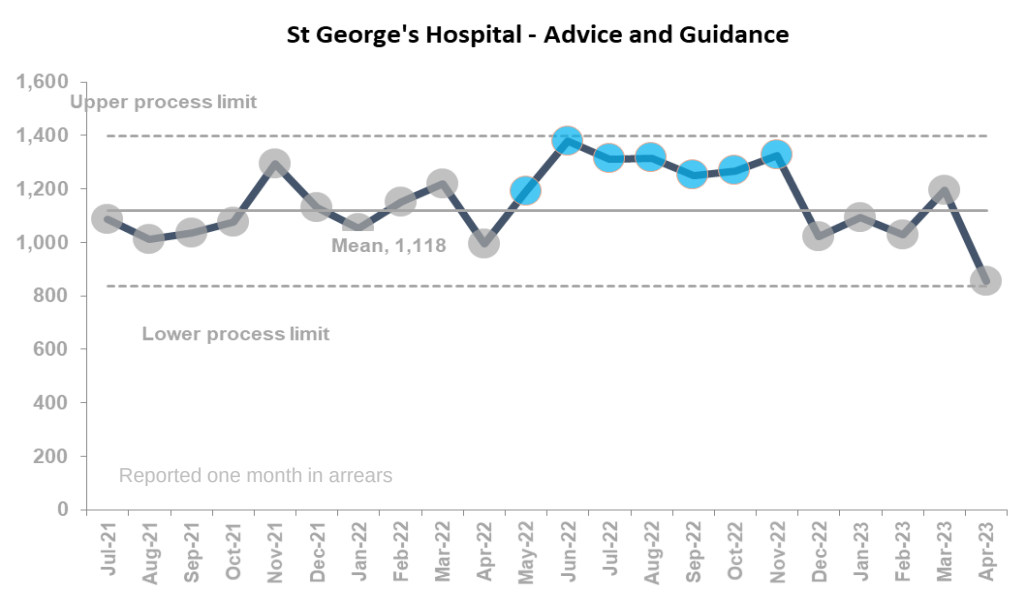
The number of patient initiated follow ups are as expected and in line with overall outpatient activity with 1,852 patients.

Advice & Guidance

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

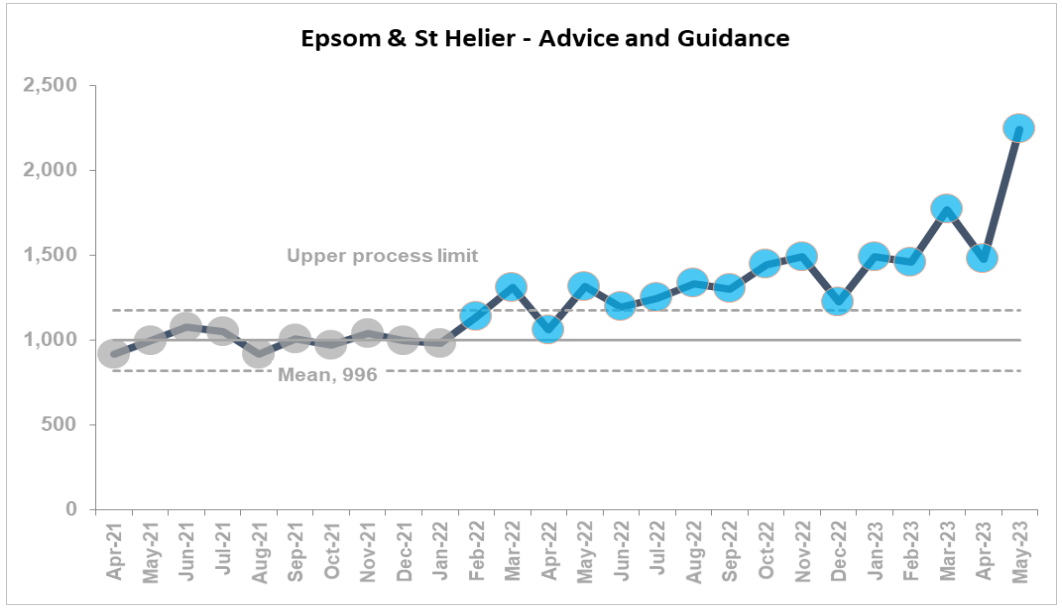
Apr-23

Target: TBC | **SGH: 856**



May-23

Target: TBC | **ESTH: 2,241**



SGH updates since last month

Recording of data continues to be worked on this will improve the position.

ESTH updates since last month

A&G utilisation continues to grow. This is likely linked to the schemes being delivered in the Outpatient Planned Care Transformation programme and is in line with expected trajectories.

Outpatient Activity - Analysis and Action

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

SGH current issues –

The service have set a clear direction via our Outpatient Transformation Board for the next 12 months and beyond and identified the following key workstreams:

1.**Outpatient 'MOT'** – Check information and configuration of all services is accurate, uses optimal resources and is peer group competitive in 1 year. T&O(80% completed)m Gynae(40% completed), Resp (30% completed) and Urology (10%completed) - progressing well
2.**Orders to schedule** – (IT project) Roll out new robust and efficient cashing up process and recording procedures in outpatients (QPOPE). Weekly project calls have commented, high level plan completed and QPOPE added to the Cert Domain
3.**Upskilling and modernising outpatients -** Running training programme for internal outpatient staff to ensure everyone is working to high standard. 5 key objectives set and plans started including launching internal OP intranet page and working through improving digital governance via Cerner worklists for appointment escalation processes
4.**Optimising referral management –** [This is an ongoing workstream] – Have now transitioned off kinesis into eRS A&G.A&G figures do not include RAS or CAS currently but progressing ability to report this
5.**Enabler workstream** – Two elements that sit outside of OP but key stakeholders - 'New OP IT strategy' and 'New OP Estates Strategy' – covering Trust strategies for ownership, accountability and ways of working between Estates and IT

SGH future action –

Outpatient Transformation Board – Key actions include: Ensuring A&G reporting change is updated in the next month, QPPOPE PIFU design build meeting to start and roll out of Advice and Refer priority services to begin as pilots to start

Outpatient focus on uncashed has launched and working very closely with all services to increase compliance within clinics on the day – ended on 0.68% uncashed for April 23.Significant improvement from 1.3% for March

Outpatient Patient Involvement – Now have patient partner as part of transformation board who has competed a 'secret shopper' exercise across 5 different clinics and reviewed waiting times, communication between staff and patients and review of reception team interaction. Presented to OP Transformation Steering Group on 15/06 and improvement plan to be developed.

Significant progress made on cashing up performance but work is ongoing.

ESTH current issues –

PIFU – Where industrial action occurs, the tendency to stand down some routine appointments (where the majority of PIFU appointments would be offered) may impact the overall PIFU rate. Despite this, we have managed to sustained a PIFU rate over 3% (May 3.1% Trustwide).

A&G – The review of the A&G data and the national methodology has led to a revised methodology to more accurately reflect current use and processes for A&G. As an indicative figure, when the revised methodology is used, A&G utilisation increases to 59% (May 2023). This figure includes the CAS for which NHSE have provisionally approved, however as a next step, it requires SWL to formalise.

ESTH future action –

PIFU – focussed PIFU engagement in Respiratory, Cardiology and Neurology supported by NHSE Action on Outpatients PIFU drive.

PIFU alongside clinical validation of un-booked overdue follow up lists now being explored in Cardiology and Gynaecology, and continues in Gastroenterology.

Continue to monitor and review PIFU uptake by speciality, to troubleshoot and offer further support and shared learning.

A&G / Pathway review / Referral Forms

Deep dive audits in to Gynaecology, Dermatology and Neurology have identified the most common reasons for referral, A&G request and diversions. From these, key themes have been identified and these are being used to target actions to optimise referrals in to the trusts and support the continued growth of A&G.

One of these targeted actions is the further expansion of the suite of editable standard texts to provide consistent, high quality, equitable and efficient responses to A&G and Referral requests from primary care.

In addition the referral support tools, known as Quick Views, continue to be implemented (Neurology, Urology, and Dermatology). The next Quick View in the rollout is for Gastroeneterology.

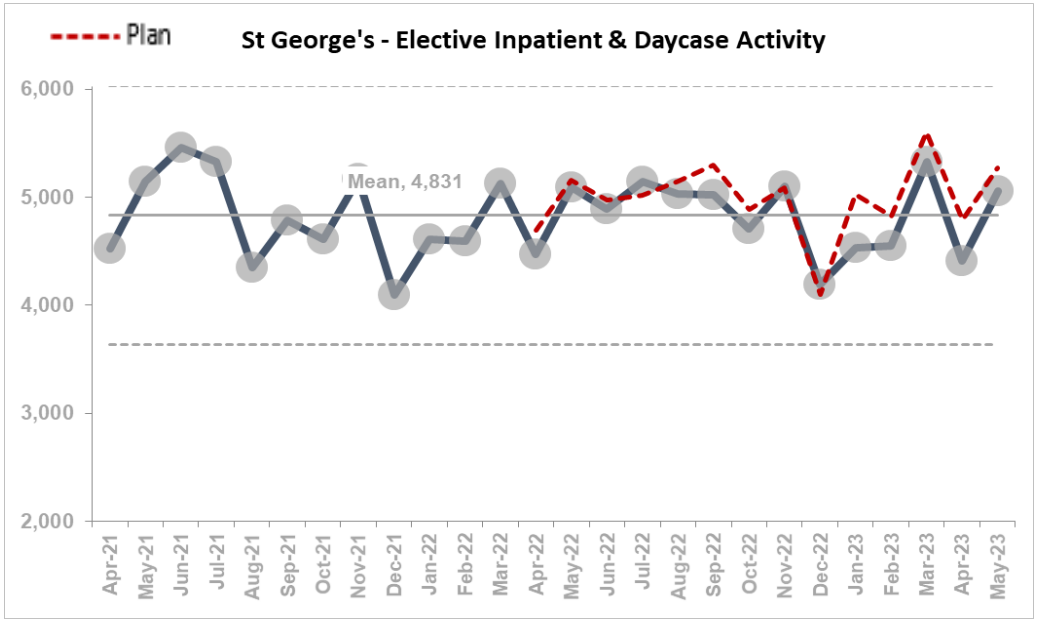
Specialty specific conversations regarding triage standardisation and peer to peer learning, including e-RS myth busting continue.

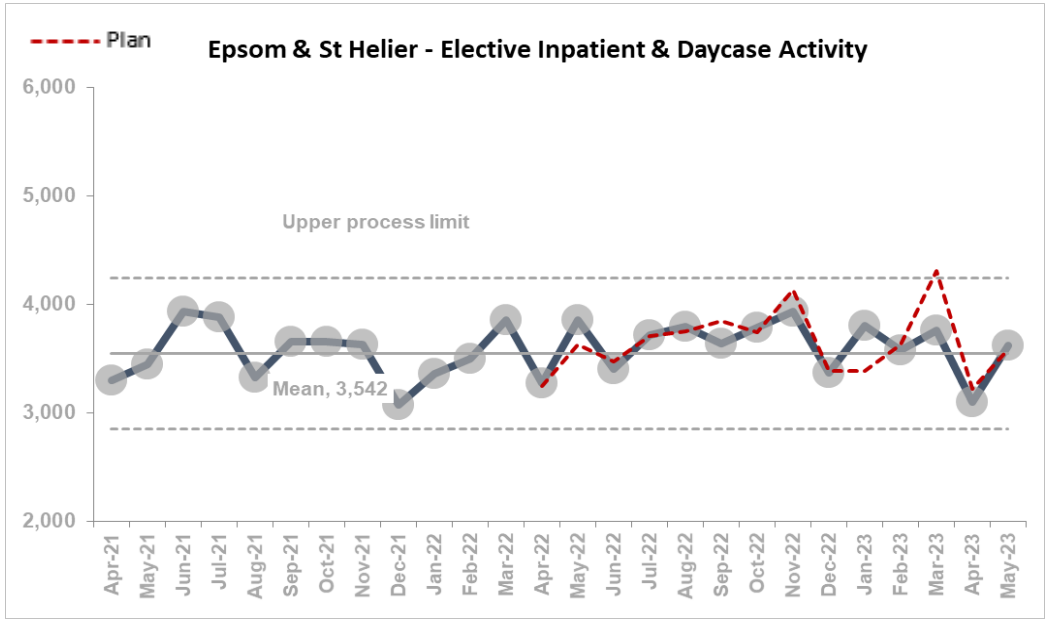
Elective Inpatient & Daycase Activity

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

May-23

SGH Plan: 5,272	SGH: 5,187	ESTH Plan: 3,580	ESTH: 3,621





SGH updates since last month

Elective and Daycase performance is ahead of plan (after estimated catch up), with a percentage of 105% submitted for May.

Elective and Daycase performance is 101% YTD (after estimated catch up) which is behind the 104% plan. The impact of the Junior Doctor strikes is estimated to have decreased activity volume by 248 which would have been on plan.

ESTH updates since last month

For the month of May elective activity was above plan. This is expected to increase once data catch up / coding is completed.

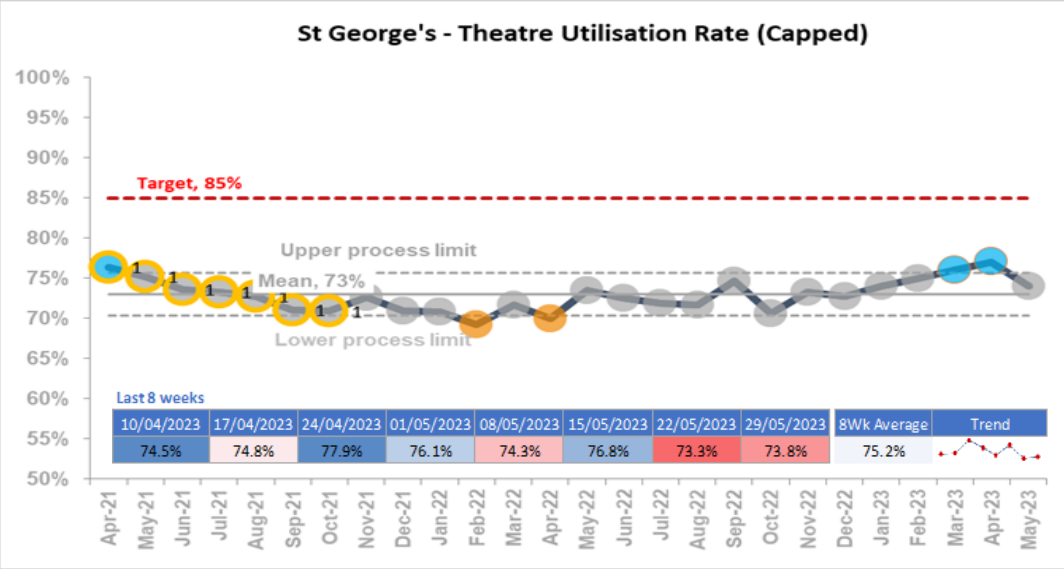
Theatre Productivity – Capped Utilisation

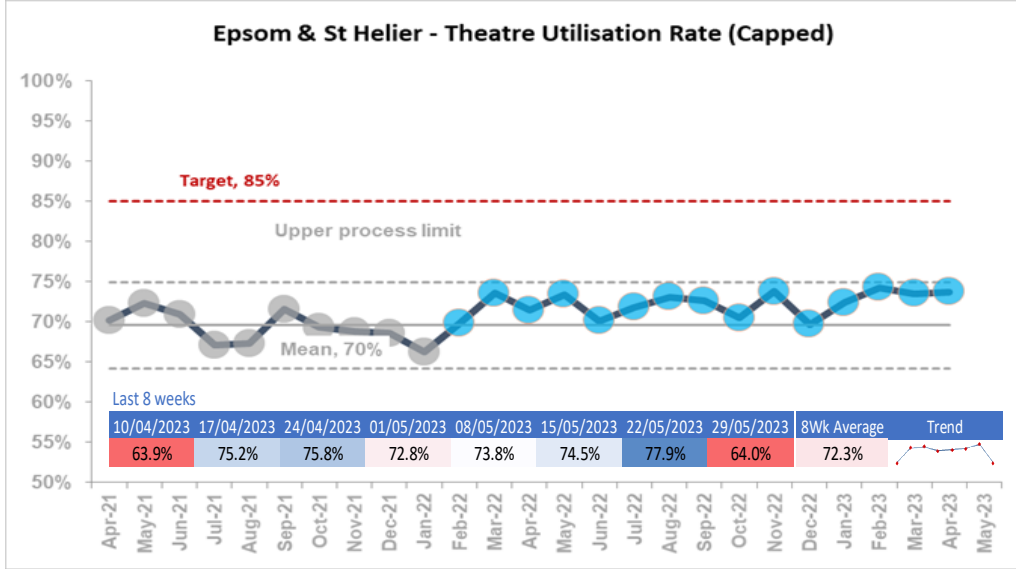
The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time. High capped utilisation signifies that the allocated planned session time has been well utilised.

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

May-23

Target: 85%	SGH: 74%	Target: 85%	ESTH: 73.72%





SGH updates since last month

Capped theatre utilisation rates remain above the mean at 74% in May with plans to improve further to deliver 85%.

Uncapped utilisation rates are currently at 82%.

ESTH updates since last month

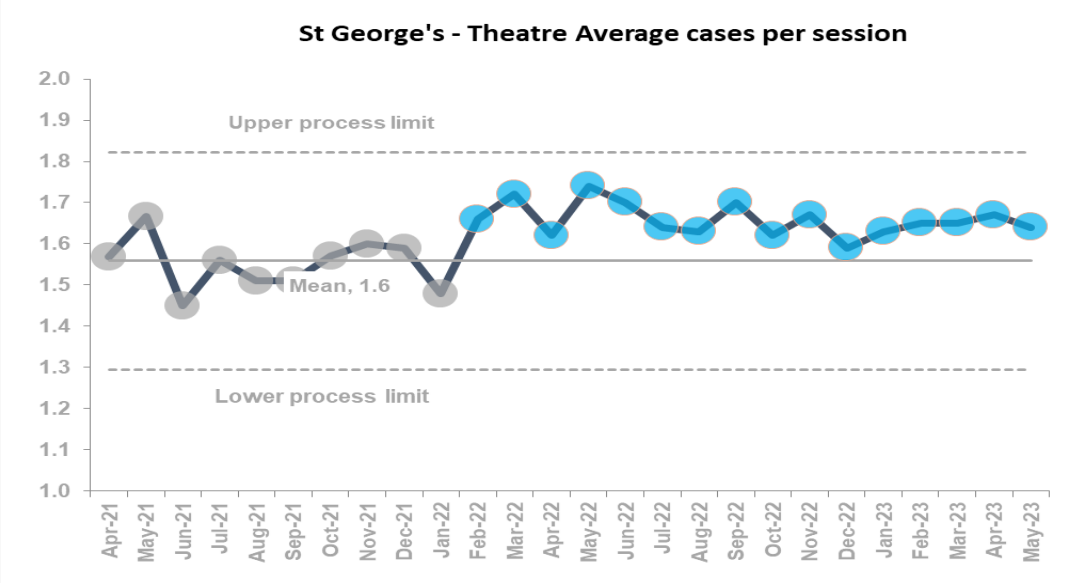
Capped utilisation figures remain positively above the mean however is not meeting our aim of 85%.

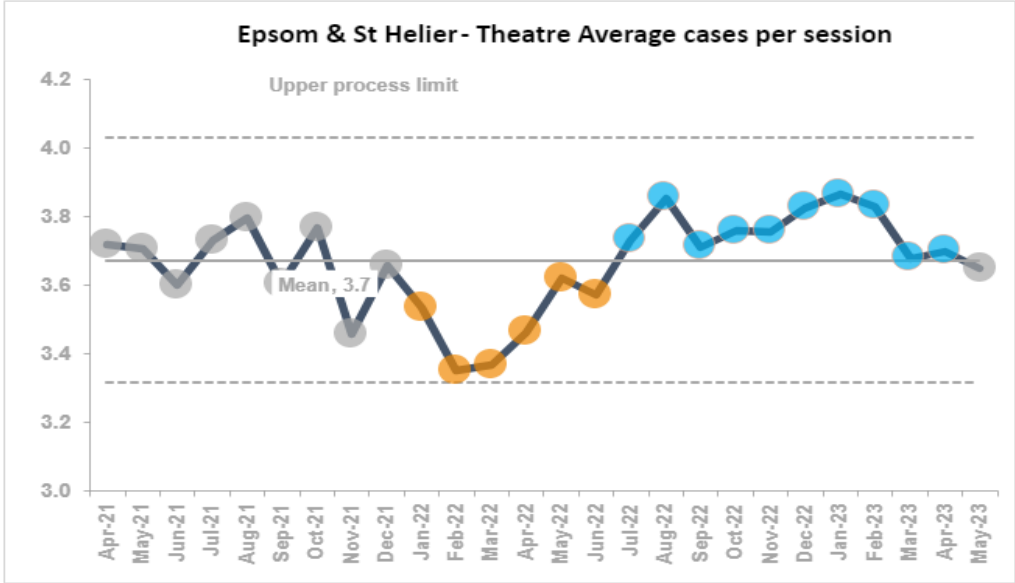
Theatre Productivity – Average Cases per Session

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

May-23

Target: TBC	SGH: 1.64	Target: TBC	ESTH: 3.65





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline, with on average through May 1.64 average cases per session.

ESTH updates since last month

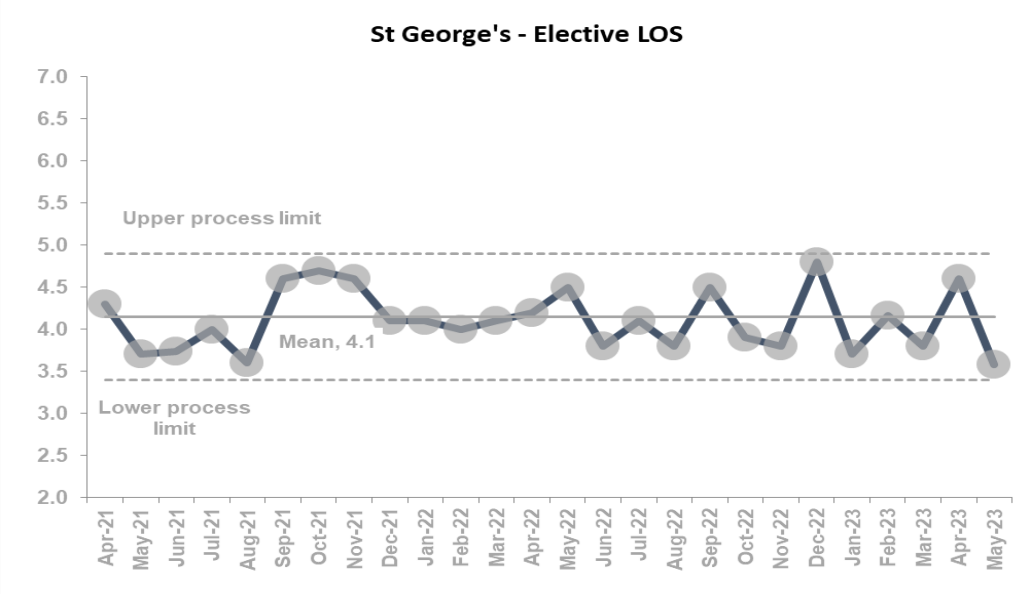
Average case per session continues within the upper and lower control limits however, a slight dip in performance across May.

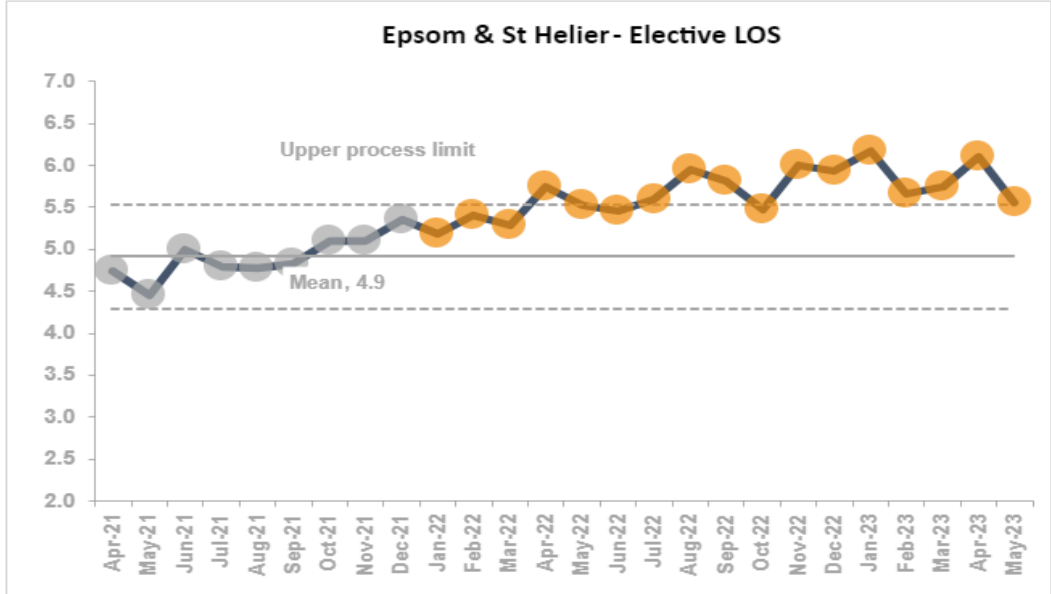
Elective Length of Stay

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

May-23

Target: N/A	SGH: 3.58	ESTH: 5.56





SGH updates since last month

Elective length of stay continues within the upper and lower control limits showing only common cause variation.

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ESTH updates since last month

Average length of stay for patients admitted on an elective pathway continues above the upper control limit, across May the average length of stay was 5.6 days.

Theatre Productivity - Analysis and Action

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

SGH current issues –

Challenges related to patient flow continued in May, impacting recovery and PACU with patients remaining in these areas longer than planned.

Elective and Day Case activity across the Trust was inadvertently impacted by the bank holidays and recent industrial actions.

We currently have consultant anaesthetist vacancies due to resignations and maternity leave with cardiac anaesthesia being an area of concern. However, 3 new consultants were appointed in May with starting dates between August and September. International recruitment is also being explored.

ESTH current issues –

Theatre admissions and flow remain a key challenge to start on time, due to capacity and room availability this is linked to scheduling of operating lists but there is an improvement of cases completed in May 2023 along with mean cases per session at 3.75.

Theatre staff have been recruited which will support increased activity within the unit Nursing and Anaesthetic practitioners with start dates in August and September. Exploring continuation of apprenticeship schemes for Anaesthetic Practitioners.

SGH future action -

In May, capped theatre utilisation capped was 74% which was marginally below the previous month. The average case per session continues above the 2019/20 baseline at 1.64.

In April, a clinically driven audit of late starts was launched. The results of this audit will be used to support future Theatre improvement initiatives.

The first phase of the Theatre templates review has been completed. This is a key step to improve efficiency and access to robot.

To support the reduction of Xyla requirements, the ops team continue to focus on medical recruitment and job planning.

Planning meetings are underway to start providing surgical services at QMH site for Epsom patients from July.

ESTH future action –

Plans are in place to expand the availability of accessible rooms for AM admissions to support on time which will further enable additional cases to be added to lists, this will commence in July 2023.

Opening of theatre B4B at St Hellier in July 2023 will provide additional theatre sessions across the organisation.

The Theatre Transformation Group is being relaunched in July 2023 with 2 'rapid action' Task and Finish Groups to support elective recovery trajectory.

Continued support of the ASA 1 pilot and increase of nurse telephone POA clinics will support patient access onto theatres additional anaesthetist sessions are being built into job planning to support POA activity.

May 2023 capped Theatre touchtime utilisation was 74%

Monthly Overview – Non Elective Care

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

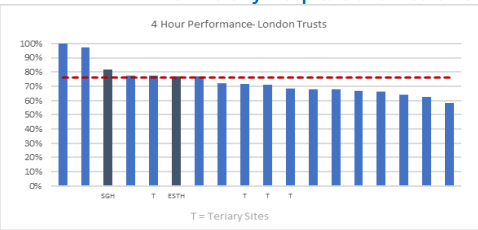
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	76%	78.3%	83.5%	81.7%	76%	82.6%		76%	73.7%	75.4%	77.1%	76%	76.2%	
12 Hour Trolley Waits	0	596	331	591	0	922		0	379	332	293	0	625	
Ambulance handover Performance 30 minutes	0	28	25	30	0	55		0	277	224	232	0	456	
Ambulance handover Performance 60 minutes	0	86	22	76	0	98		0	126	73	42	0	115	
Non elective length of stay	TBC	7.5	6.8	7.0	TBC	6.90		TBC	7.7	8.0	7.2	TBC	7.58	
Mental health delays 4 Hour Breaches	TBC	115	113	138	TBC	251								
Redamission Rate - Non Elective	TBC	8.0%	9.2%	9.7%	TBC	9.5%		TBC	5.5%	4.9%	5.7%		5.3%	
Length of stay > 7 days (stranded)	TBC	388	381	406	TBC	394		TBC	305	304	284	TBC	294	
Length of stay > 21 days (super stranded)	172	163	164	180	172	172		123	121	132	121	114	127	
Overnight G&A beds occupancy - Adults	92.0%	95.1%	95.9%	97.3%	92.0%	96.6%		92.0%	91.8%	90.6%	89.3%	92.0%	90.0%	
Number of patients not meeting criteria to reside	TBC	149	139	99					150	166	165			

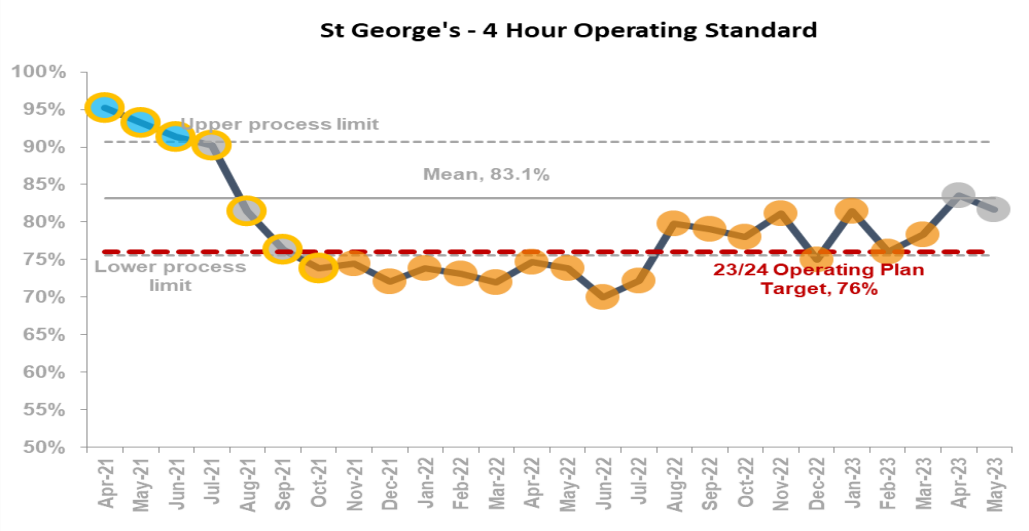
4 Hour Operating Standard

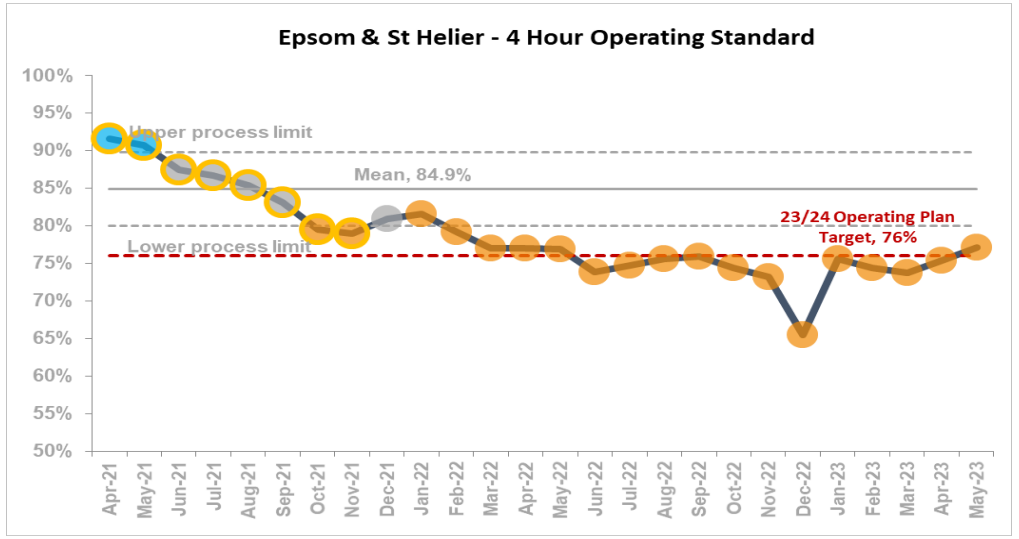
St George's, Epsom and St Helier University Hospitals and Health Group

May-23

Target: 76%	SGH: 81.7%	ESTH: 77.06%







SGH updates since last month

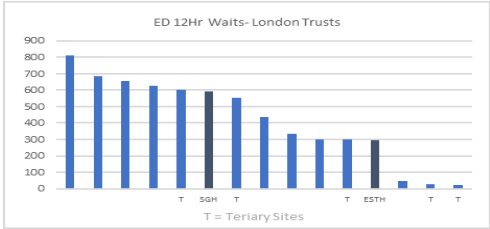
4 hour performance in May was 81.7%, continuing above the ambition of 76%. Compared to April the number of daily attendances increased by approx. 24 patients per day however trend remains comparable over time. Ambulance conveyances remain consistent with on average 78 arrivals per day and the proportion of attendances requiring admission remains on average approx. 25% daily. The majority of patients that wait for more than four hours is driven by ED capacity linked to available beds and flow across the Trust.

ESTH updates since last month

In May, 77.06% of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival seeing an increase of 1.66% compared to April.

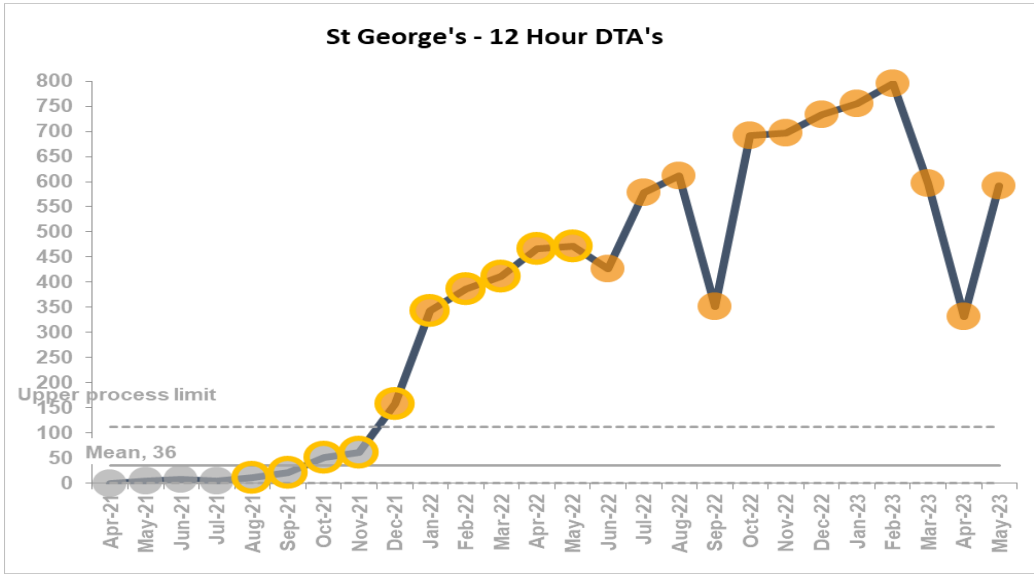
12 Hour DTA's

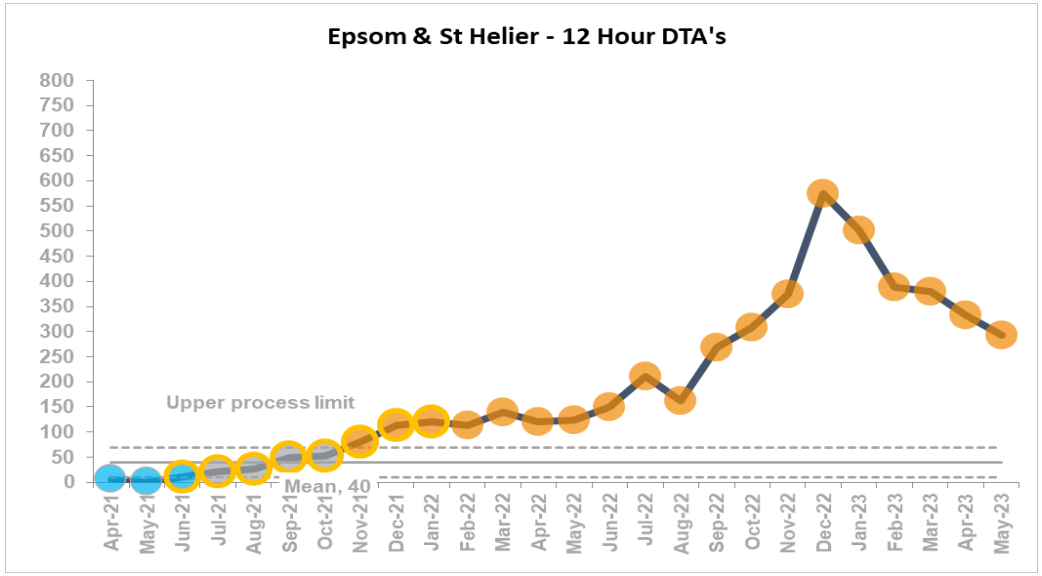
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

Target: 0	SGH: 591	ESTH: 293





SGH updates since last month

Across May the department saw a large rise in the number of 12 hour trolley wait breaches following decision to admit. This is impacted by increased length of stay and bed occupancy through May with lower than planned discharge profile. There are a number of actions being undertaken with system partners to improve the reduction in admission and increase in discharge numbers.

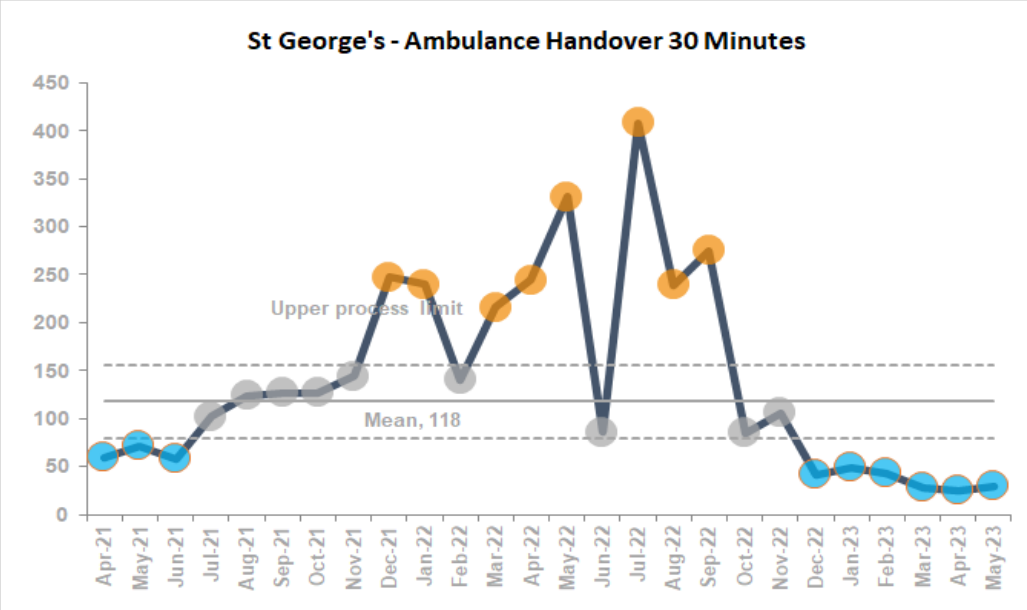
ESTH updates since last month

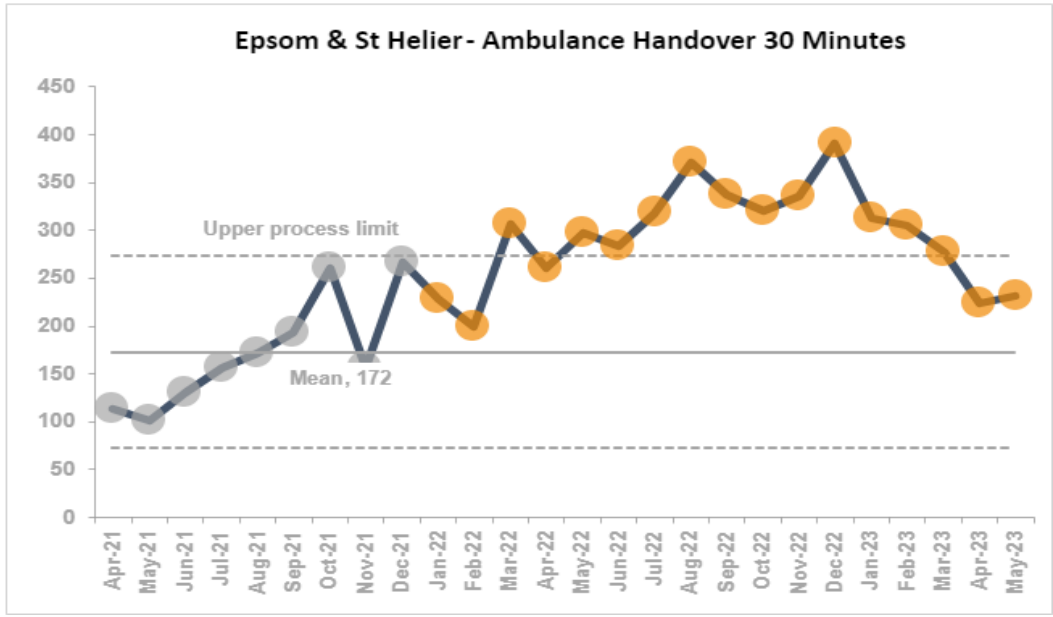
We are reporting 594 four hour trolley waits and 293 twelve hour breaches (a slight shift from 12-hrs to 4-hrs compared to last month), showing continued improvement.

Ambulance Handover Delays 30-60 minutes

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

May 23		
Target: 0	SGH: 30	ESTH: 232





SGH updates since last month

30 minute handover performance has been below the lower control limit for five consecutive months. Continue to see improved and sustained performance against continued challenges.

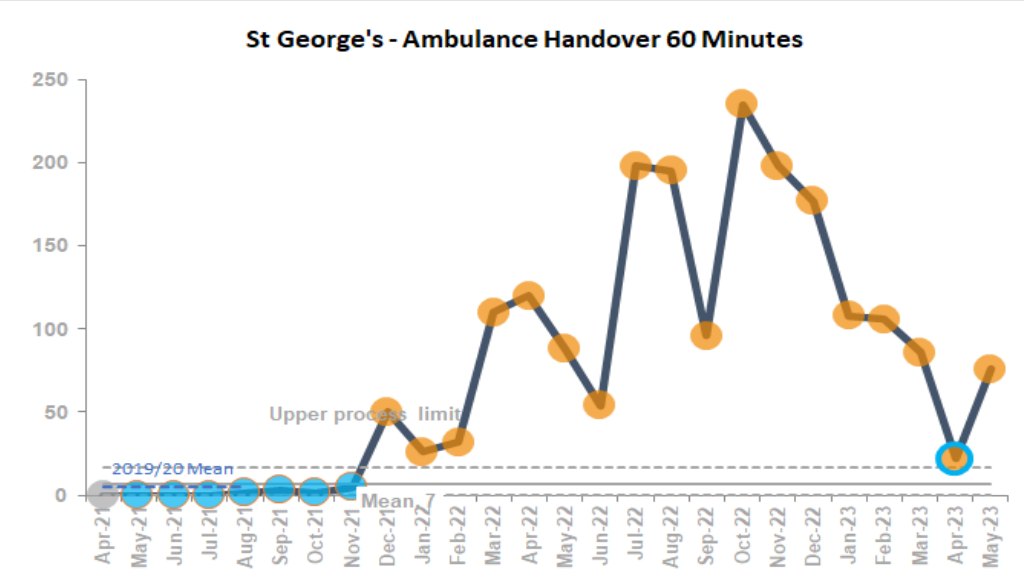
ESTH updates since last month

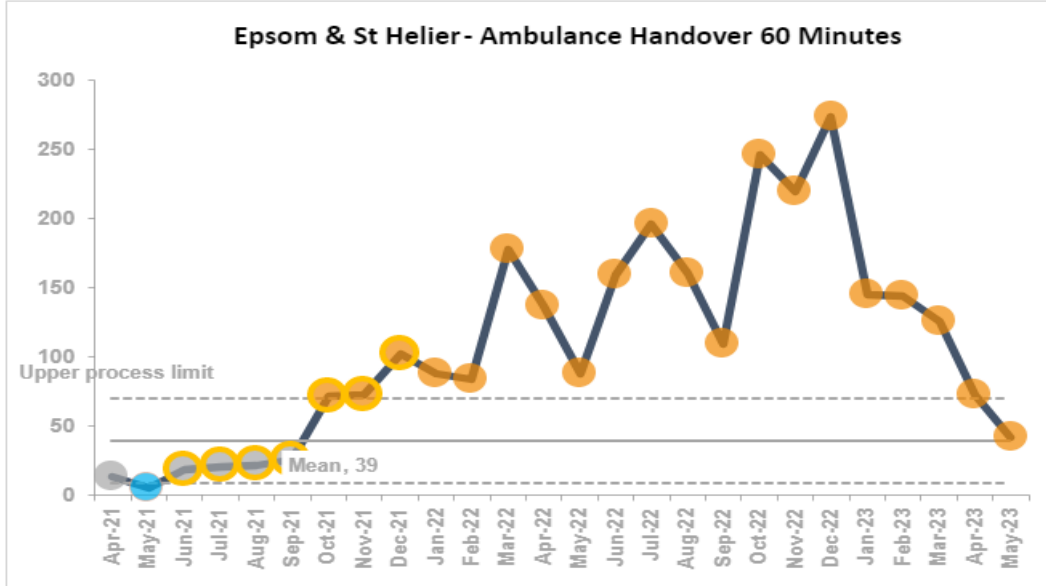
Performance against 30 minute handover delays remains above the mean. The daily average of delays across May remains the same as April (average 8 handover delays per day)

Ambulance Handover Delays 60 minutes

May 23

Target: 0	SGH: 76	ESTH: 42





SGH updates since last month

Across May, the number of ambulance conveyances waiting over 60 minutes for handover, increased by on average 2 cases per day compared to April.

ESTH updates since last month

The Trust continues to see a positive improvement in the number of 60 minute ambulance handover delays.

Emergency Performance

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

SGH current issues –

Overall 4 hour performance (all Types) in May is still strong compared to peers, SGH 13th nationally and 3rd in London.

Attendances were higher in May than April. May's 4 hour month end performance was 81.70%, which is a 7% improvement on May 2022 like-for-like performance

The ability of the department to admit patients to downstream wards was challenged in May which in turn increased the number of 12 hour trolley waits seen. High numbers of Mental Health patients in ED continued to be challenging however working groups between Police and key SGH stakeholders have begun.

With the support of two on site SGH LAS assigned HALOs there has been a decline in LAS requiring to cohort at SGH. May's LAS handover performance continues to be strong, with 93% of LAS offloads <15 minutes and 95% < 30 mins.

SGH future action –

The Homelessness and inclusion Team (HIT) and Emergency Department have been nominated for NHS Parliamentary Awards 2023. Awards ceremony 5th July, 5 representative across teams will attend.

The internal ECDB is continuing to focus on Frailty, Same Day Emergency Care, Internal Professional Standards, as well as UTC workstreams.

ED Staff Wellbeing – extensive focus has been given to ED estates over the last few months. The refurbishment of the male and female toilets and changing rooms is near completion. This work has been funded by the SGH charity

The Trust continues to embed the regularising flow programmes which supports admitted performance, to support exit from the Emergency Department and enable timely ambulance handovers. Boarding on the wards against daily predicted discharge numbers is supporting downstream capacity greatly. In relation to non-admitted performance, ED senior team are reviewing the 32 UTC standards in line with where SGH is currently performance and areas for development / opportunities.

ESTH current issues –

Our 4-hour ED performance was 77.06% in May-23 which is an improvement compared to April-23 where we delivered 75.3%. Our time to triage remains within the 15-minute standard, reporting 12 minutes in May-23, providing assurance that patients are seen soon after arrival in the department.

4-hour performance for admitted patients remains challenging, particularly on the Epsom Hospital site with onward flow from ED occurring during the late afternoon/evening period.

We have seen a slight decrease in > 7-day, > 14-day, and > 21-day LOS patients when compared to April-23.

The number of patients spending over 12 hours in the emergency department has shown an improvement in May-23 at 6.5%. This compares to just over 8% in April-23 and just over 10% in Mar-23.

Whilst over 60-minute ambulance handover delays remain high we continue to report a month-on-month improvement reporting 145 in January 2023, 144 in Feb-23, 126 in Mar-23, 73 in April-23, and 42 in May-23 .

ESTH future action –

Our weekly hospital flow meeting is now well-established and includes a comprehensive performance data pack.

The meeting includes divisional feedback on key issues impacting performance with a focus on specialty response to ED and an increase in the number of patients bypassing ED for speciality assessment. We have also reviewed our urgent care/hospital flow work programme and prioritised those workstreams that will have the biggest impact on urgent care safety, quality, and performance

We have reviewed our internal professional standards (IPS) and developed IPS for our speciality assessment units.

We are in the process of reviewing our boarding policy which will include refreshed triggers for implementation based on key learning over recent months.

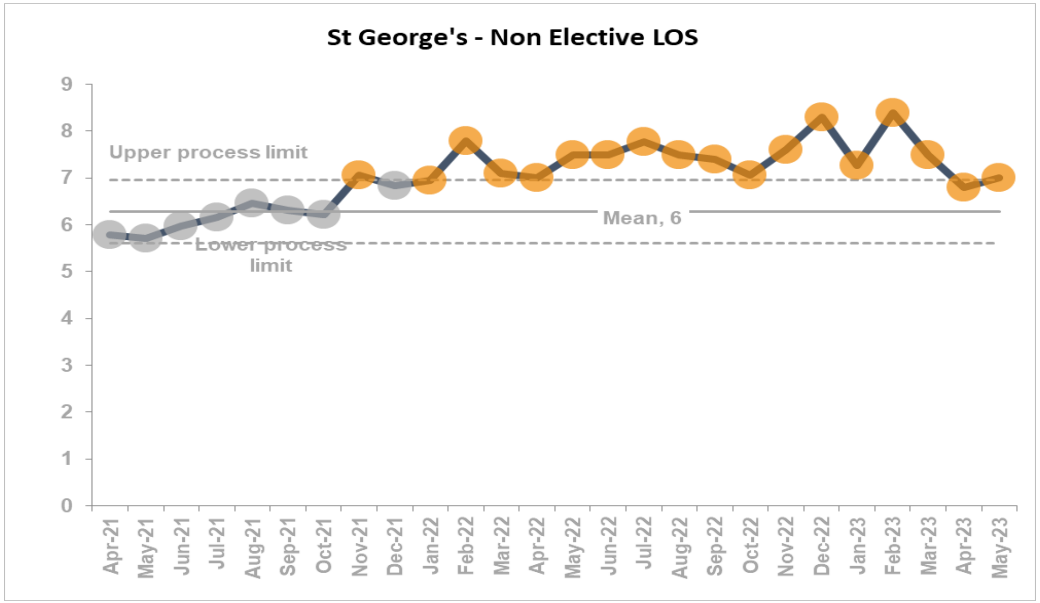
We have successfully de-escalated from Buckley escalation ward at Epsom which has enabled us to provide a stretcher discharge lounge facility on the Epsom Hospital site. This will assist in supporting early flow from ED for patients requiring admission to an inpatient bed.

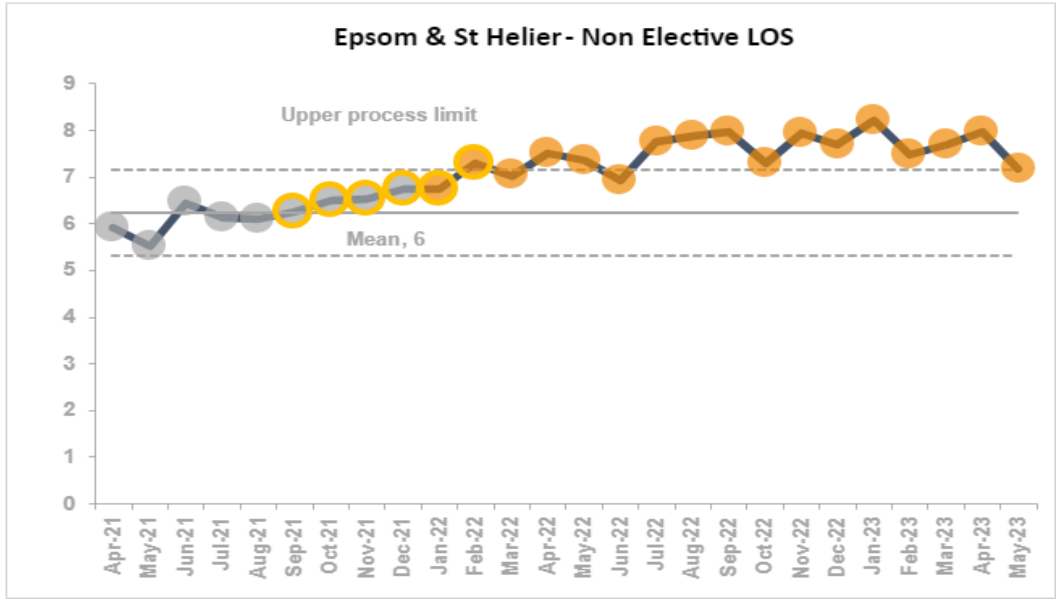
Non Elective Length of Stay

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

Apr-23

Target: TBC	SGH: 7.0	ESTH: 7.18





SGH updates since last month

Compared to the previous month, May has seen an increase in non-elective length of stay with, on average patients staying in a hospital bed for 7 days. The Trust saw an increase in super and super stranded patients along with rising occupancy rates. This is due to the reduction in onward care/D2A capacity across SWL. The number of patients waiting to be discharged due to external delay has seen a recent increase (as of 7th June 100 patients), impacting occupancy rates and flow across our wards.

ESTH updates since last month

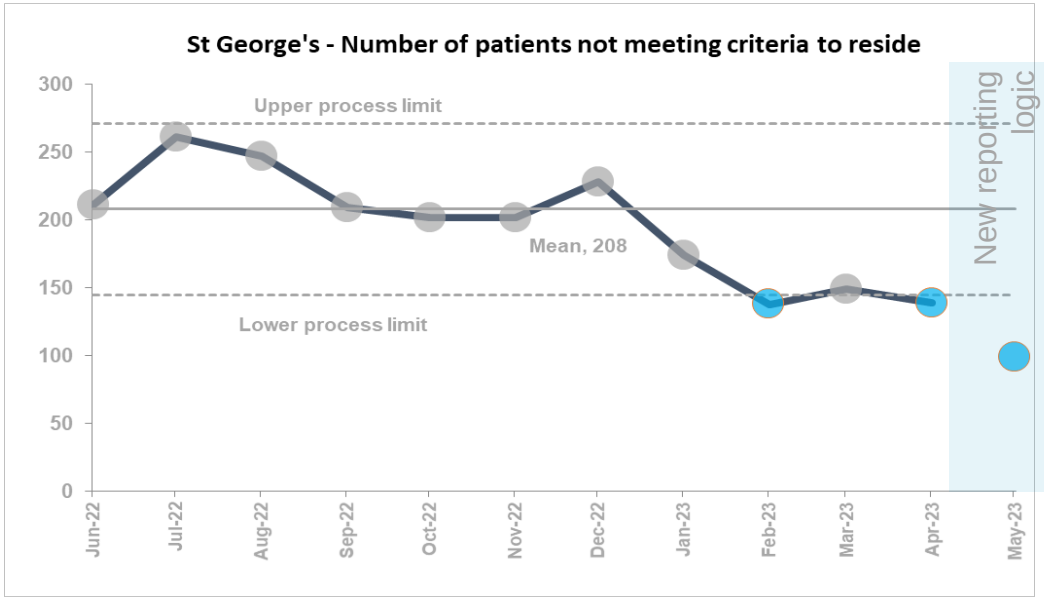
Non Elective length of stay remains above the upper control limit. On average across May patients admitted on a non-elective pathways stayed for 7.18 days, seeing a decrease compared to April. The number stranded and super stranded patients decreased also.

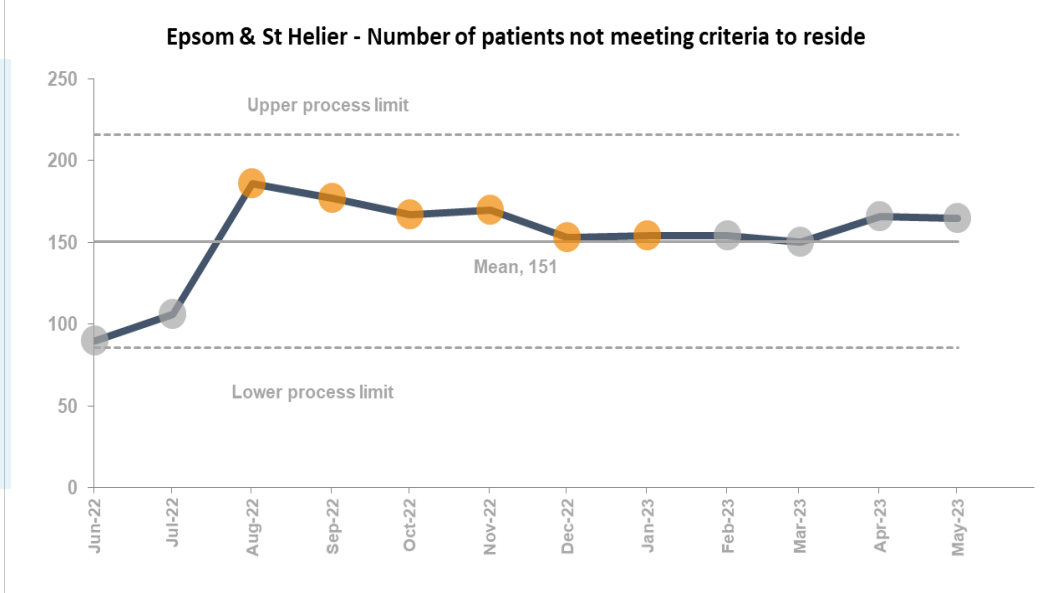
Patients not meeting criteria to reside

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

May-23

Target: TBC	SGH: 99	ESTH: 165





SGH updates since last month

Methodology and reporting of this data has been reviewed and revised following executive sign off to ensure accurate view of the numbers. Reporting logic has been implemented from 5th May 2023.

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ESTH updates since last month

The number of patients not meeting criteria reside remains predominantly within the upper and lower control limits however in recent weeks above the mean.

Length of Stay Performance - Analysis and Action

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

SGH current issues –

On the main hospital site, there are an increasingly high number of patients not meeting the criteria to reside (NCTR).In addition to the high number of patients awaiting Pathway 2A (Merton + Wandsworth) and Pathway 3, over the last two months, the Trust has had an increasing number of Pathway 1 patients awaiting equipment. This has been escalated through CSMT and Executive teams, as the root cause is the change in equipment supplier in Wandsworth and Lambeth **(NRS) –** the impact is increasing LoS and delay in POC start. It has improved over last 4 weeks and will continue to be monitored.

Ongoing industrial has impacted performance and we continue to plan/respond to the industrial action.

SGH future action -

MADE events are occurring every 2 weeks, rotating between internal & external. Work ongoing to maximise effectiveness. Need to identify clinical leadership following retirement Karen Daly, Deputy CMO.

The Trust is preparing for implementation of new IT Capacity Management software and the Trust is soon to be launching Early Notification process for Social Workers to aid expedited discharge. Renewed focus on supporting early discharge from ED and AMU via CLCH H@H. Aim in June/July to engage also with surgical front door.

The Trust's Regularising Flow SOP is in place with the implementation of boarding of inpatients as BAU irrespective of OPEL status or to only implement boarding when certain inpatient, operational triggers are met (OPEL status / Number of DTA's etc.)

Discussions with SWL ICS and NHS England about allocation of potential Winter funding for 2023/24 have begun to aid effectiveness of non-elective pathways.

In line with every team, as part of the Trust's requirement to reduce the forecasted financial deficit for 2023/24, the effectiveness of ToC/discharge teams being reviewed.

ESTH current issues –

We have seen a slight decrease in patients with a > 7day, > 14 day, and > 21-day length of stay in May 2023 compared to the previous month.

Our 4-hour ED performance for admitted patients is extremely challenged with a requirement to focus on improvements across our admitted pathway and better utilisation of our assessment units through the development of assessment area internal professional standards.

We are also focussing on improved flow across our sites and are undertaking a bed reconfiguration exercise on the Epsom Hospital site to ensure that we are making best use of the available bed base. This is alongside a review of our acute medicine model of care and bed management processes

Our on-going focus is ensuring the effectiveness of the discharge huddle on both hospital sites, improving earlier in the day discharge, and improving the number of patients who are discharged on a Saturday and Sunday.

ESTH future action –

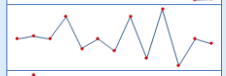
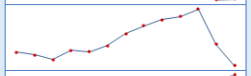
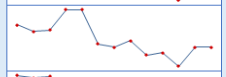
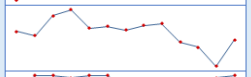
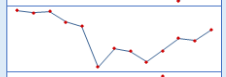
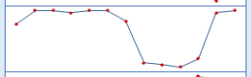
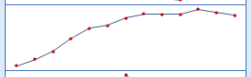
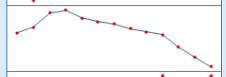
We are currently working with Sutton locality colleagues to implement a therapy led ward in the old PCN ward footprint. There have been some delays in finalising the staffing model, however, we anticipate the ward opening within the next 2 months. This will provide 18 additional beds to support those patients who are medically fit but require on-going therapy prior to discharge.

We have recently made changes to the discharge huddle on the Epsom hospital site which has moved to a face-to-face meeting like the process that is in place at St Helier. We are also undertaking a focussed piece of work to ensure more efficient processes and a shorter length of stay for patients on a fast-track pathway.

We continue to provide stretcher discharge lounge facilities on the St Helier Hospital site and have recently established stretcher discharge lounge facilities at Epsom following successful de-escalation from an inpatient area

Monthly Overview – Our People

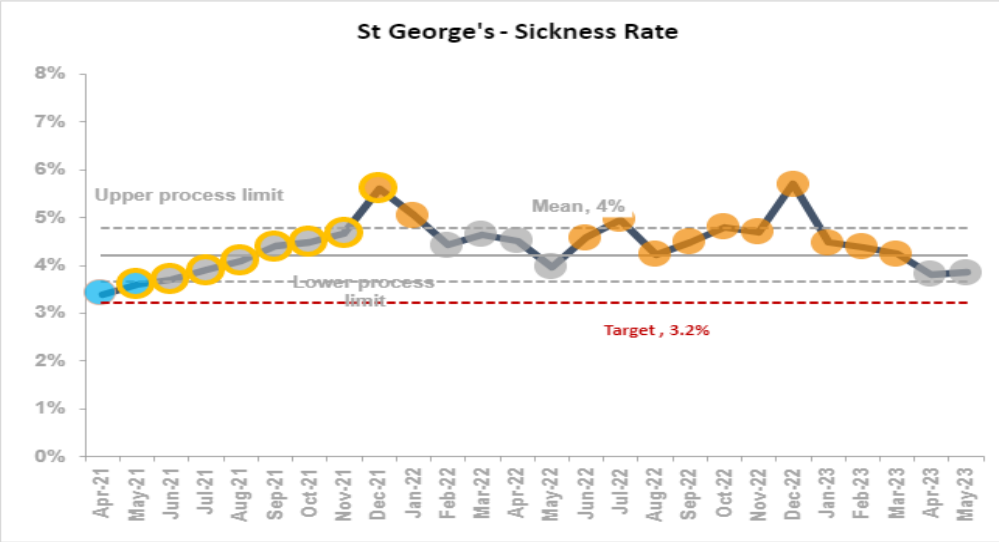
St George's, Epsom and St Helier University Hospitals and Health Group

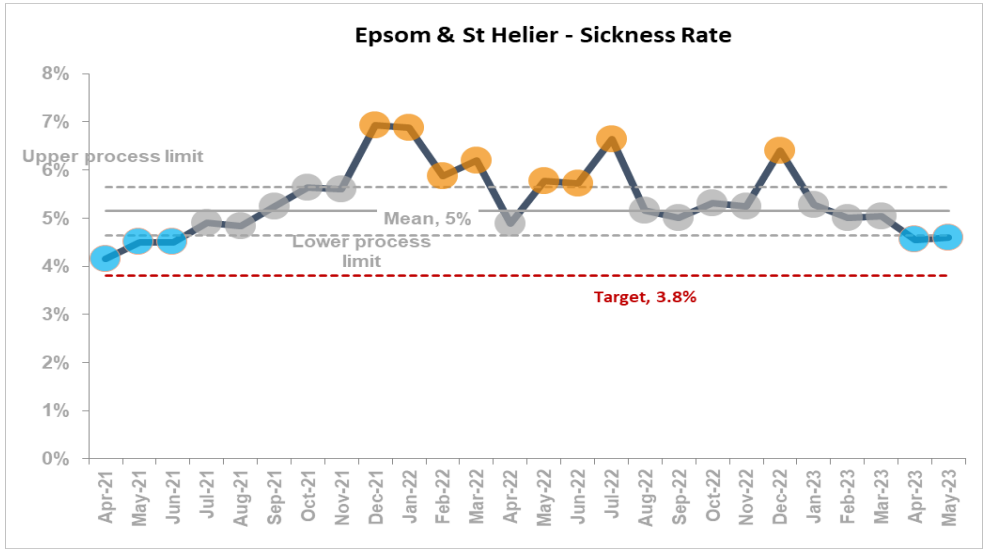
	St Georges							Epsom and St. Helier						
Our People	**Monthly Target**	**Mar-23**	**Apr-23**	**May-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Mar-23**	**Apr-23**	**May-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Sickness Rate	3.2%	4.2%	3.8%	3.9%	3.2%	3.8%		3.8%	5.0%	4.6%	4.6%	3.8%	4.6%	
Agency rates	TBC	2.0%	3.1%	2.9%	TBC	3.0%		TBC	7.0%	4.7%	3.3%	TBC	4.0%	
MAST	85%	88.2%	88.8%	89.2%	85%	89.0%		85%	81.4%	81.4%	82.1%	85%	81.7%	
Vacancy	10%	7.9%	8.5%	8.5%	10%	8.5%		10%	13.3%	12.7%	13.5%	10%	13.1%	
Appraisal Rate Medical	90%	78.9%	78.6%	79.8%	90%	79.2%		90%	71.5%	88.0%	89.0%	90%	88.5%	
Appraisal Rate Non Medical	90%	71.6%	69.8%	69.9%	90%	69.8%		90%	69.4%	68.0%	67.0%	90%	67.5%	
Turnover	13%	15.6%	15.3%	15.0%	13%	15.2%		12%	15.5%	15.6%	15.2%	12%	15.4%	
Percentage BAME staff band 6 and above	TBC	44.3%	44.4%	44.7%	TBC	44.6%		TBC	37.5%	37.1%	38.9%	TBC	38.9%	

Sickness Rate

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

SGH Target: 3.2%	3.9%	ESTH Target: 3.8%	4.6%





SGH updates since last month

The Trust's sickness rate is in line with performance achieved last month and continues to show a downward trend. The Sickness rate now at 3.9% is slightly above the target of 3.2%.

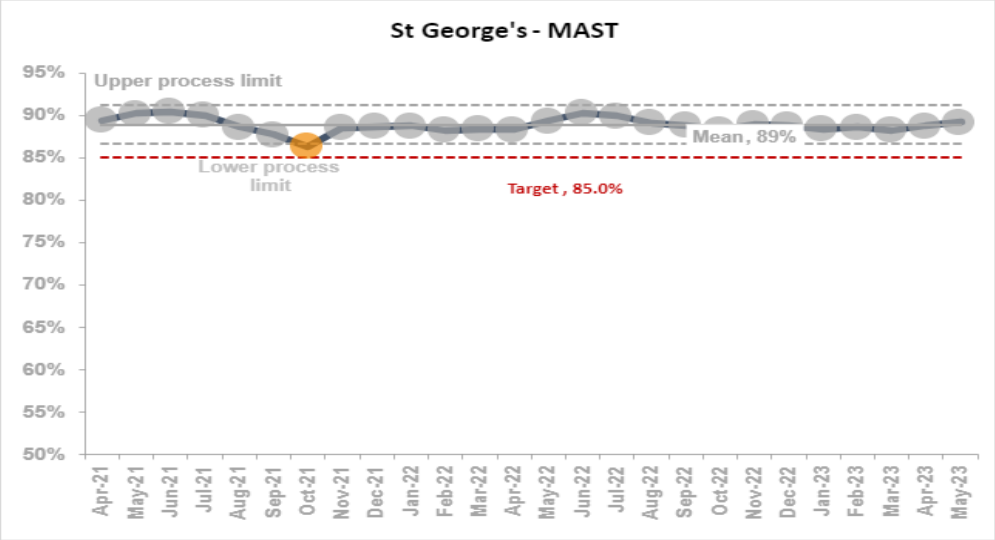
ESTH updates since last month

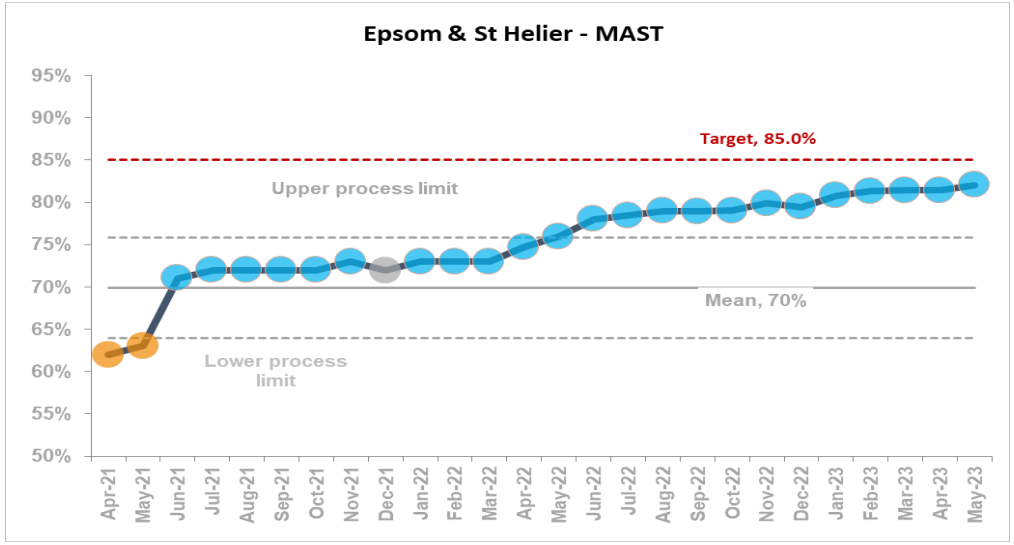
Sickness absence at ESTH was 4.6% and remains significantly above the threshold target of 3.80%. Cold, Cough, Flu-Influenza and Infectious diseases problems were the top 3 reasons for sickness absence.

MAST

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

SGH Target: 85%	89.2%	ESTH Target: 85%	82.1%





SGH updates since last month

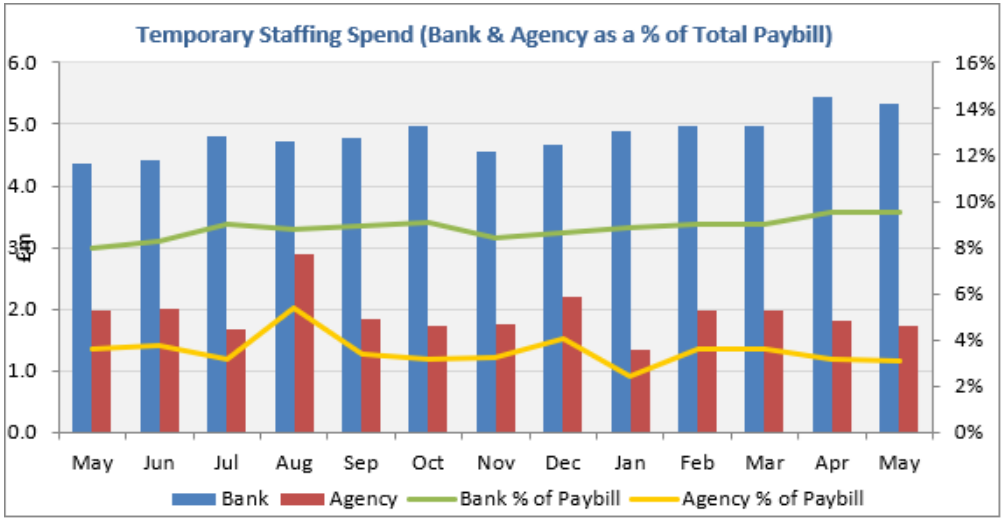
Mandatory and Statutory Training (MAST) was 89.2% in May and continues to show common cause variation over the period.

ESTH updates since last month

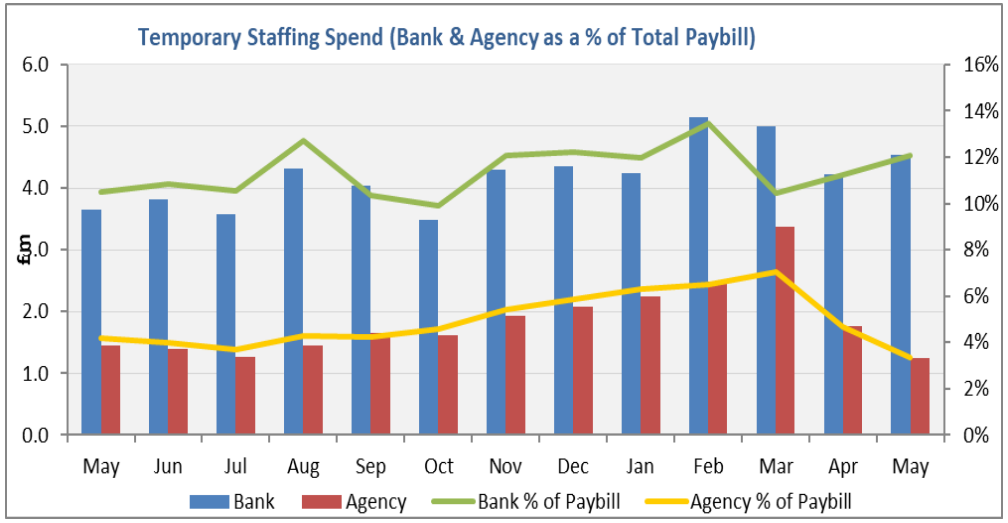
Performance against the MAST indicator is regularly discussed as part of the Divisions HR performance however achievement remains challenged. Performance in May was 82.1%. Managers can keep abreast of their performance via ESR. It allows managers to track of their trajectory by comparing their current percentage with their previous percentage to enable them to see clearly their rate of improvement or otherwise.

Agency and Bank Spend

St George's



Epsom & St Helier



Monthly Overview – Integrated Care

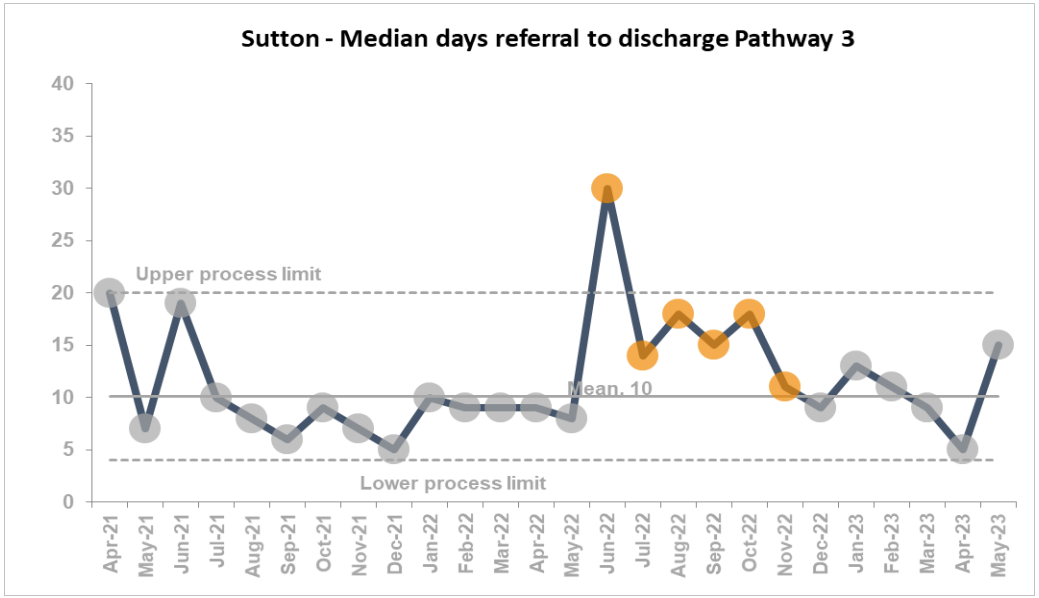
St George's, Epsom and St Helier University Hospitals and Health Group

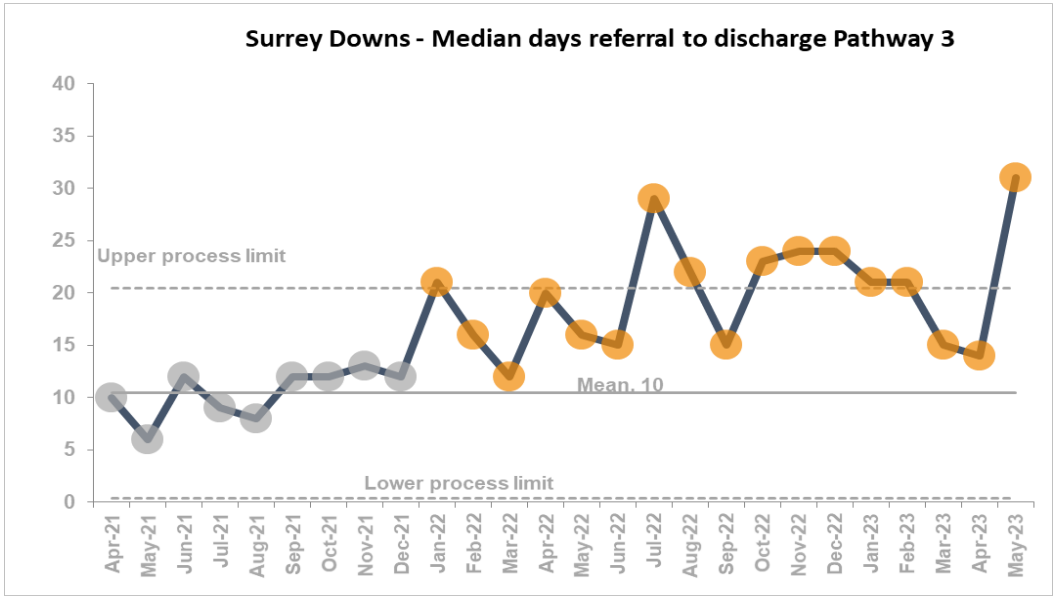
Responsive and Productive Services - Integrated Care	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Feb-23	Mar-23	Apr-23	YTD Target	YTD Actual	13-Month Trend
Median days referral to discharge Pathway 1		4	3	6		5			3	3	3		3	
Median days referral to discharge Pathway 2		4	4	4		4			1	1	1		1	
Median days referral to discharge Pathway 3		9	5	15		10			15	14	31		23	
Two hour UCR performance	70%	79.2%	81.8%	86.4%	70%	84%		70%	71.0%	79.0%	79.8%	70%	79.4%	
Two hour UCR referrals received		182	144	185		329			529	425	391		816	
Community hospitals bed occupancy									89%	86%	88%		87%	
Community hospitals LoS									21	22	19		21	
Virtual ward - Admissions		76	59	53		56			350	319	236		555	
Virtual ward LoS	14	8	14	10		12		14	7	11	19		15	
Total RTT Waiting List Size		1,288	1,458	1,615					424	535	506			
Total number of RTT patients waiting over 18 weeks		13	4	5					11	7	9			

Median days referral to discharge Pathway 3

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

Target: TBC	Sutton: 15	Surrey Downs: 31





Sutton Health & Care updates since last month

Pathway 3 – There has been a life changing event. Home is not an option at point of discharge from acute care.
Median days between referral discharge has seen an increase through May with median days increasing to 15.

Surrey Downs Health & Care updates since last month

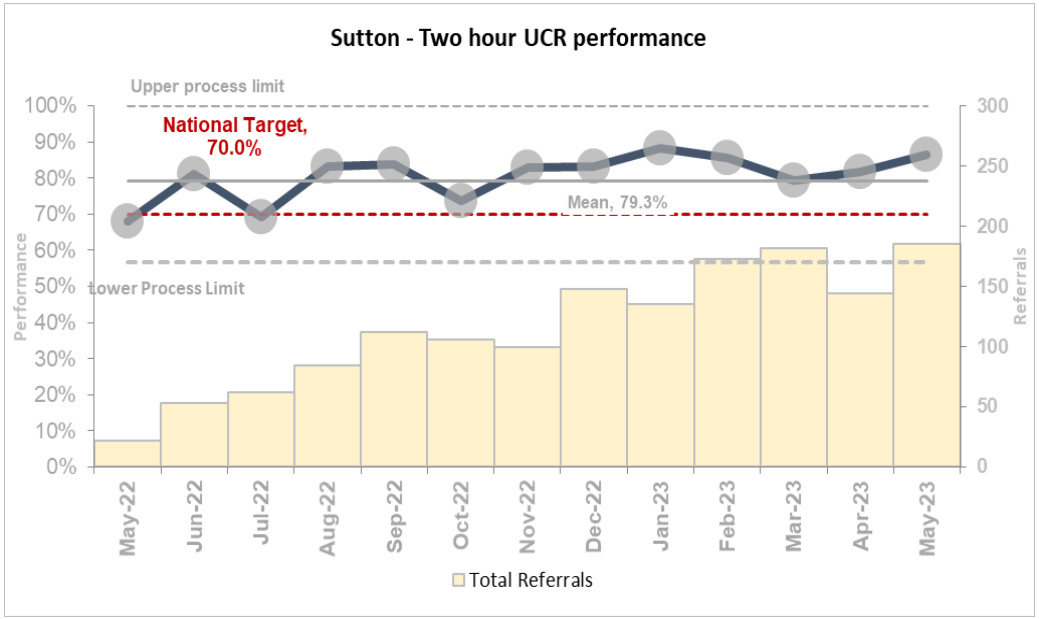
Pathway 3 – Requires on-going 24-hour nursing care, often in bedded settings.
Long term care likely to be required. Median days between referral to discharge, although within the upper and lower control limits suggesting common cause variation has been above the mean of 10 days since Jan 22.

Ageing Well

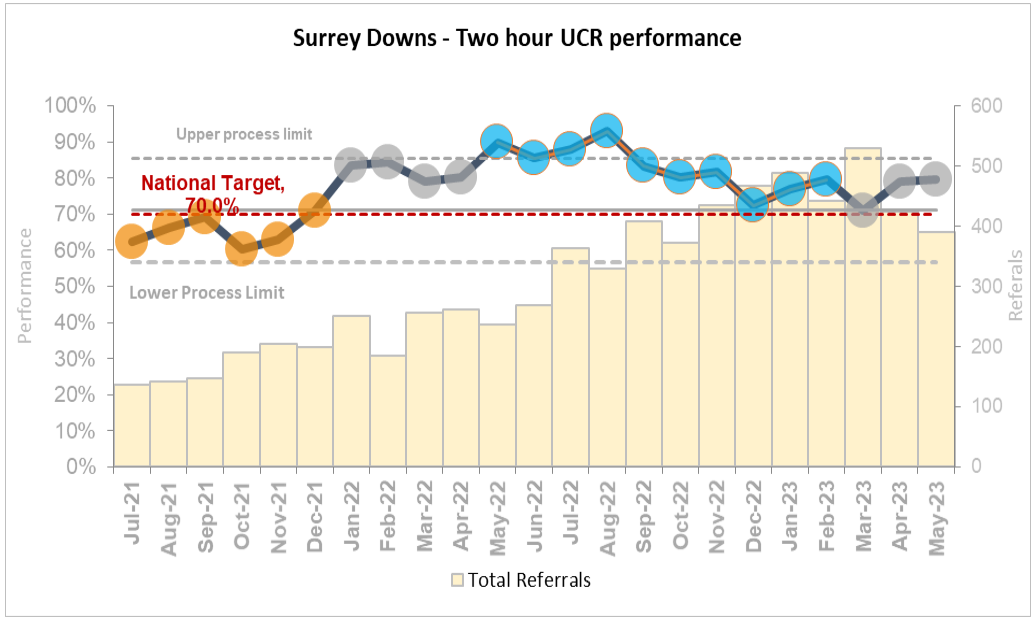
2 hour urgent community response

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

Sutton Target: 70% | **Actual: 86.41%**



Surrey Downs Target: 70% | **Actual: 79%**



Sutton Health & Care updates since last month

Providing urgent care within 2 hours of referral has a national target set by NHSE/NHSI of 70%. Patients are often experiencing a medical crisis, the aim is to keep people independent preventing an avoidable hospital admission. The service started in May 22. The service continues to perform above target.

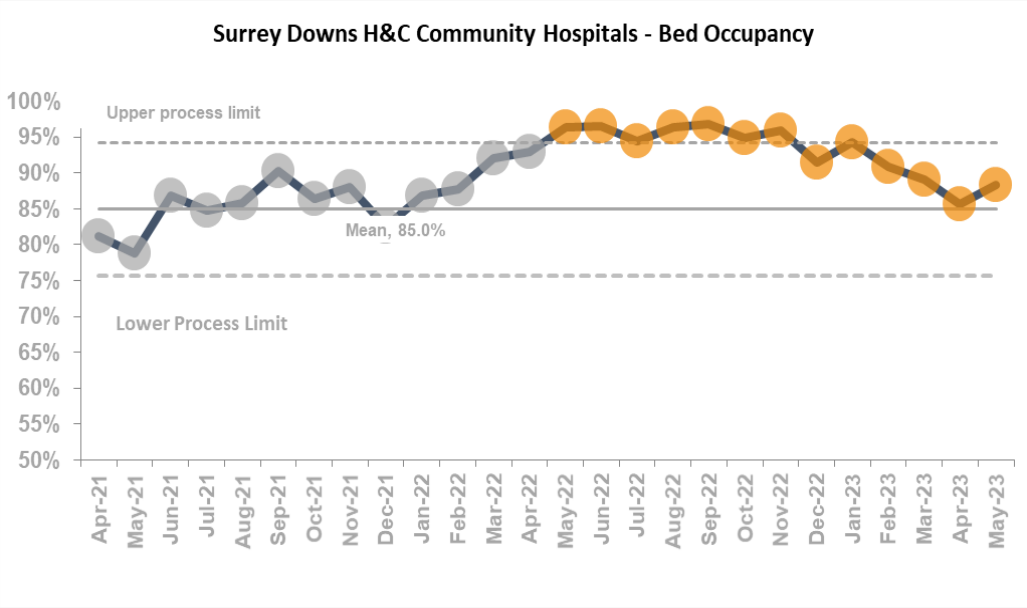
Surrey Downs Health & Care updates since last month

Providing urgent care within 2 hours of referral has a national target set by NHSE/NHSI of 70% designed to prevent hospital admission. The service started in Jul 21. Performance continues to exceed the target reporting 77% in May.

Surrey Downs Health & Care Community Hospitals

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

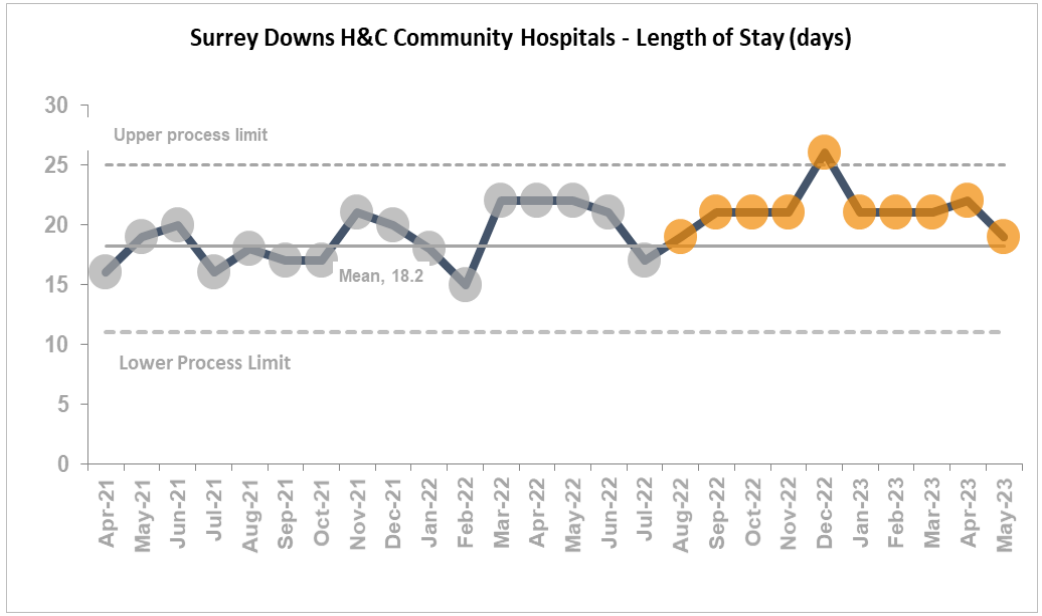
Bed Occupancy	Actual: 88.4%



Surrey Downs Health & Care updates since last month

SDHC runs 3 community hospitals and Alex Frailty on the Epsom site. Bed occupancy remaining above the mean when compared to May last year..

Length of Stay	Actual: 19 days



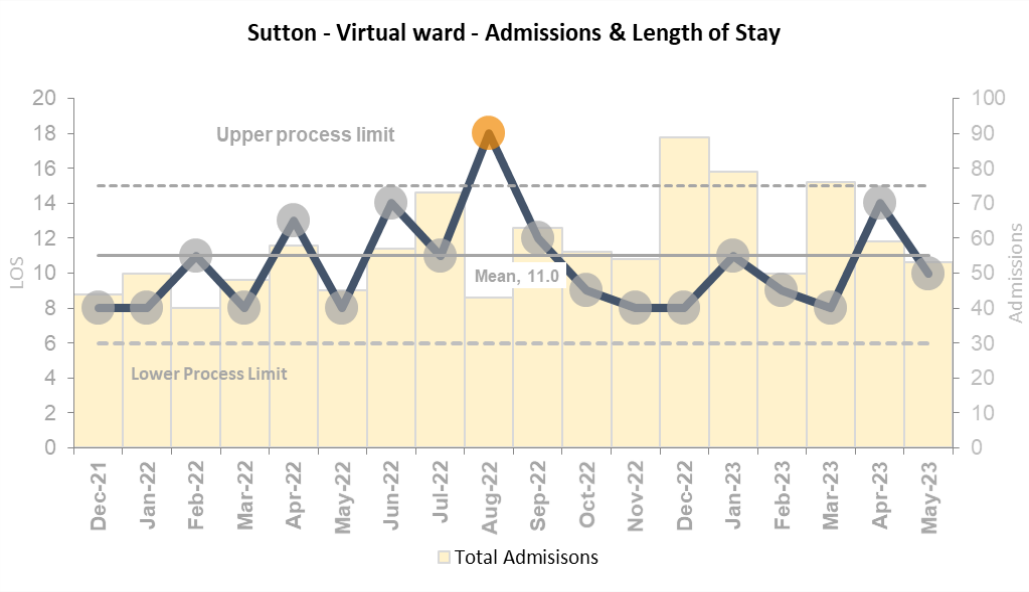
Surrey Downs Health & Care updates since last month

Length of stay in May was 19.3 days , this is consistent with previous months however above the mean.

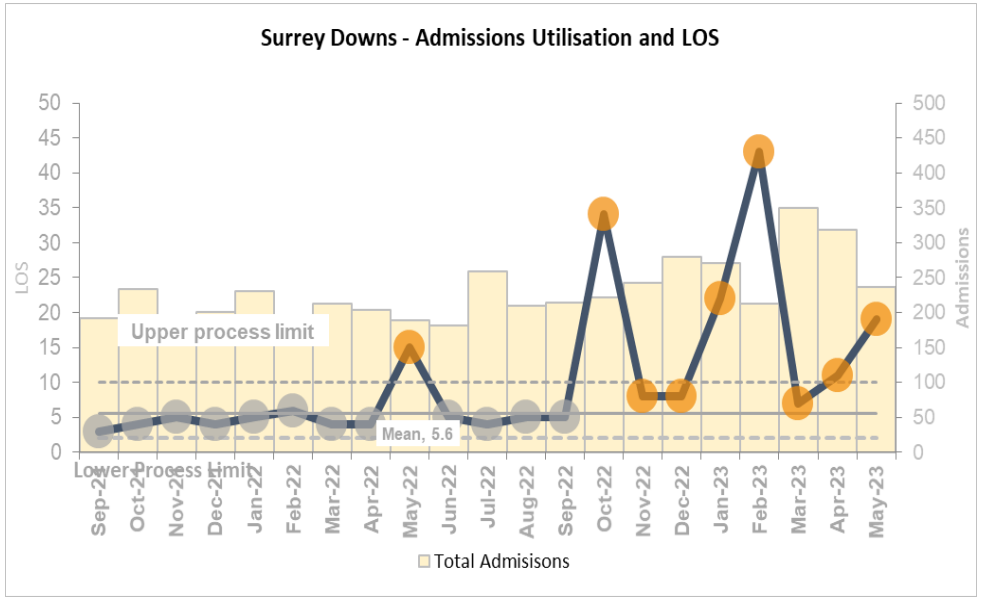
Virtual Ward
Admissions and length of stay

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

Sutton Target: TBC	Actual: 10 days



Surrey Downs Target: TBC	Actual: 19 days



Sutton Health & Care updates since last month

Service stated on Dec 21. Average LOS is 11 days, in May this dropped back to 10 days still performing within the upper and lower control limits showing only common cause variation.

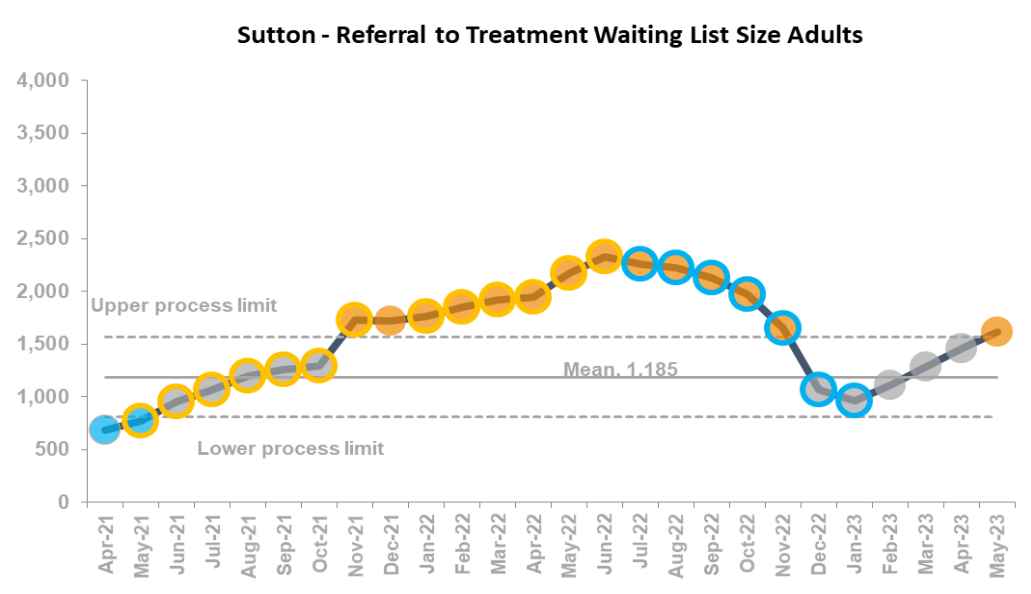
Surrey Downs Health & Care updates since last month

Service started Sep 21. LOS has seen significant variability over the past seven months and currently is above the mean of six days. Admissions over the past two months has increased and higher compared to the same period last year.

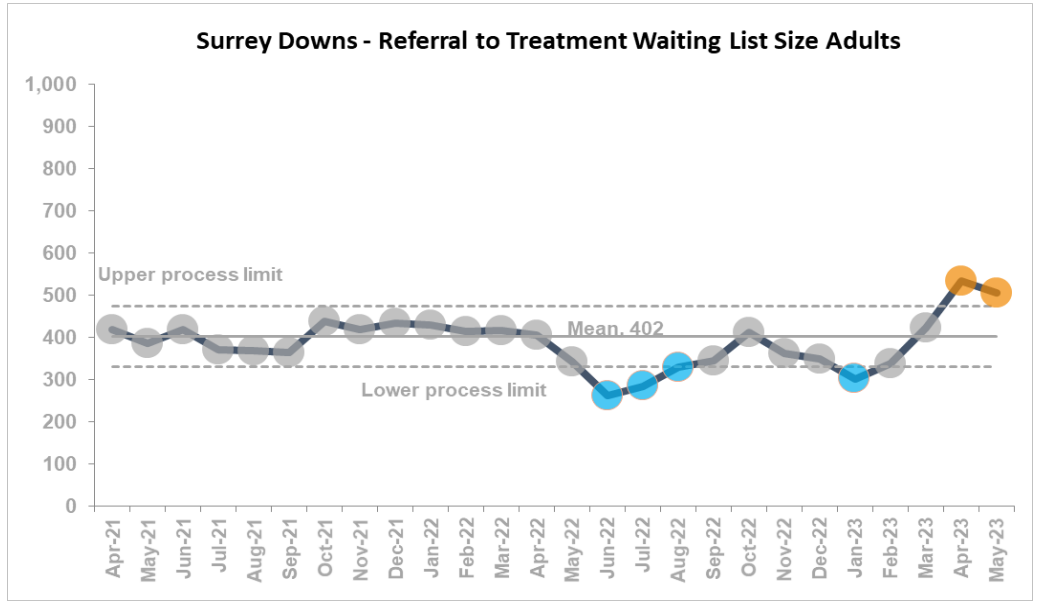
Referral to Treatment Waiting List Size

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

Sutton	Actual: 1,615



Surrey Downs	Actual: 506



Sutton Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal (MSK) pathways. After seeing a downward trend between Jul 22 and Jan 23 the RTT waiting list size has increased over the past four month period. The increase is driven by MSK pathway.

Surrey Downs Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal Clinical Assessment and Triage Service (MSK CATS) pathways. The number of pathways on the RTT waiting list has increased over the past three months. This is driven by MSK pathways. Diabetes waiting list size remains on a downward trend.

Integrated Care – Our People

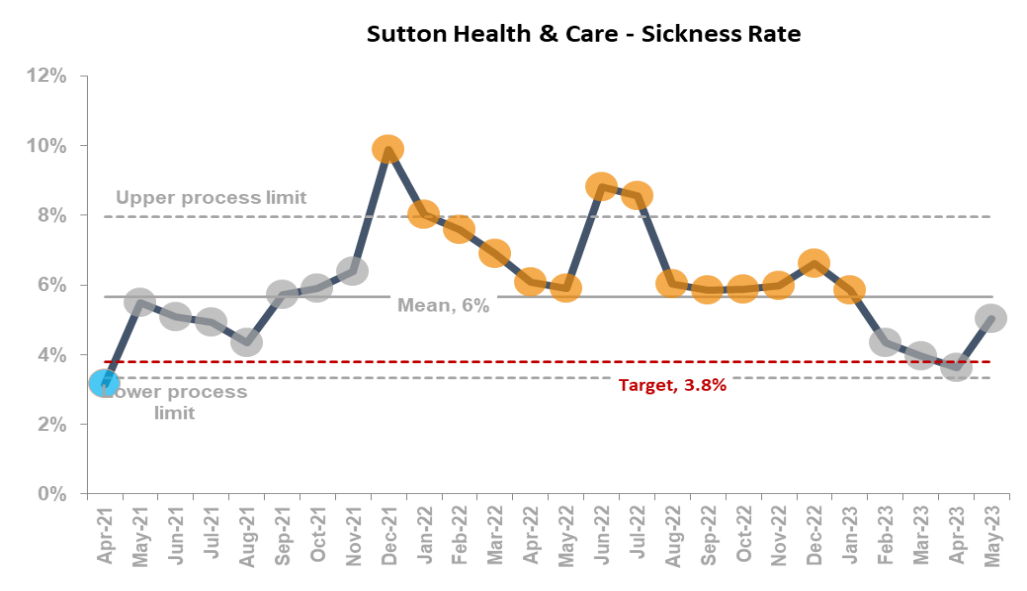
St George's, Epsom and St Helier University Hospitals and Health Group

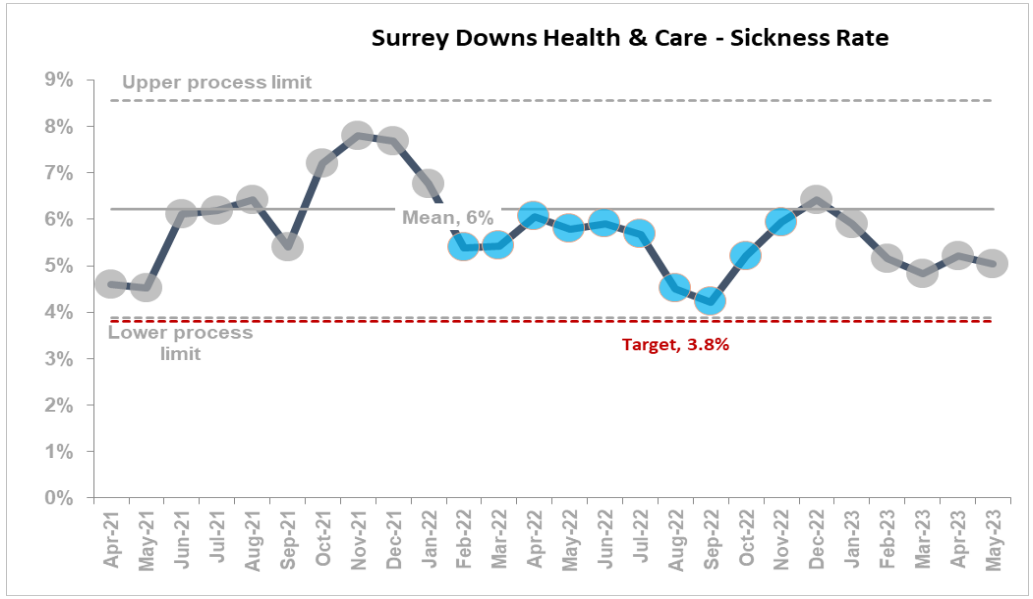
	Sutton Health & Care							Surrey Downs Health & Care						
Our People	**Monthly Target**	**Mar-23**	**Apr-23**	**May-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Mar-23**	**Apr-23**	**May-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Sickness Rate	3.2%	3.9%	3.6%	5.0%	3.2%	4.3%		3.8%	4.8%	5.2%	5.0%	3.8%	5.1%	
Agency rates		4.7%	3.2%	2.9%		3.1%			16.6%	13.0%	8.9%		11.0%	
MAST	85%	86.4%	87.7%	87.7%	85%	87.7%		85%	89.6%	89.4%	89.3%	85%	89.3%	
Vacancy	10%	14.7%	10.3%	15.4%	10%	12.8%		10%	17.6%	14.8%	20.4%	10%	17.6%	
Appraisal Rate Medical	90%		100.0%	100.0%	90%	100.0%		90%		50.0%	100.0%	90%	75.0%	
Appraisal Rate Non Medical	90%	67.1%	68.6%	70.6%	90%	69.6%		90%	91.7%	90.2%	86.2%	90%	88.2%	
Turnover	13%	1.5%	2.3%	1.0%	13%	1.6%		12%	0.6%	0.8%	0.2%	12%	0.5%	
Percentage BAME staff band 6 and above		33.6%	37.1%	38.1%		37.6%			17.3%	20.0%	19.6%		19.8%	

Sickness

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

Target: 3.8%	Sutton Health & Care: 5.0%	Surrey Downs Health & Care: 5.0%





Sutton Health & Care updates since last month

Sutton sickness rate increased in May 2023 and above the ceiling target of 3.8%. Work continues with HR/OH to improve our short and long term sickness rates providing support to staff to enable them to return to work when able.

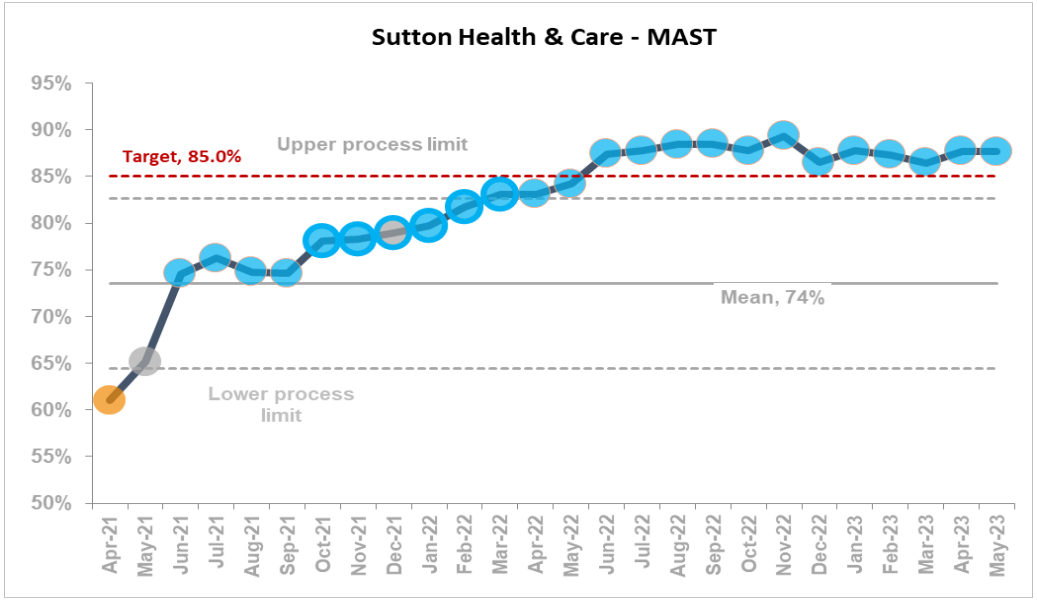
Surrey Downs Health & Care updates since last month

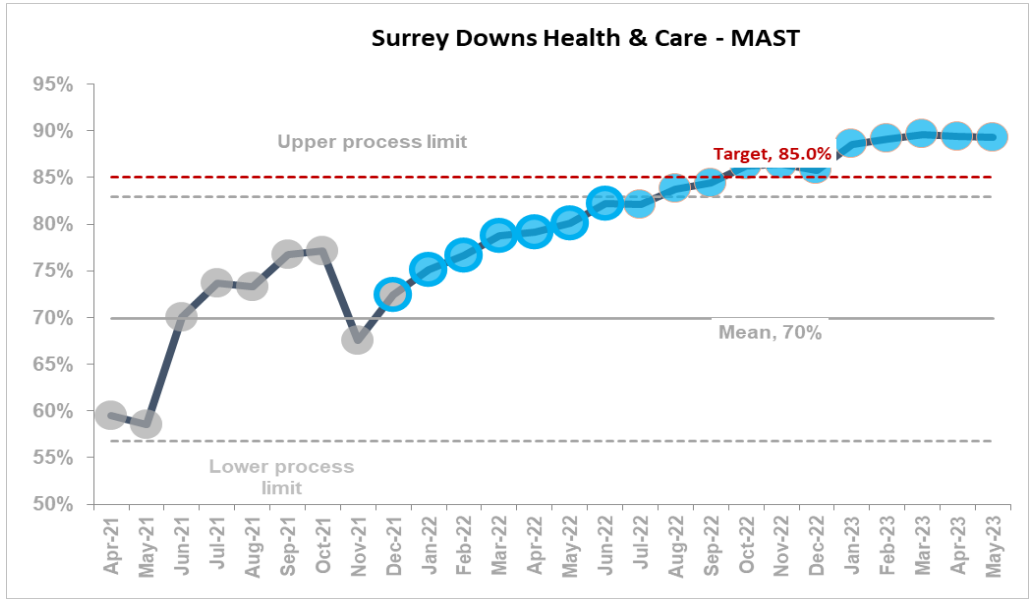
SDHC sickness absence has increased by 0.39% to 5.22% and remains significantly over the KPI of 3.8%. Anxiety/stress/depressions/other psychiatric illnesses is the highest reason for absence at 24.69% followed by 'other know causes' at 21.83%. Long term sickness absence (episodes lasting 28 days or more) accounted for 15.8% of all absence (17 occurrences). The Additional Clinical Services (health support workers) staff group reported the highest sickness absence at 36.02%

MAST

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

Target: 85%	Sutton Health & Care: 87.7%	Surrey Downs Health & Care: 89.3%





Sutton Health & Care updates since last month

The figures remain consistent, but can be improved upon and there is a robust monthly process in place to monitor MAST within SHC.

Surrey Downs Health & Care updates since last month

MAST compliance is 89.4%. This remains stable above KPI since October 2022.

Integrated Care - Analysis and Action

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

Sutton Health & Care current issues –

Virtual Ward (VW): VW occupancy rates- lower than expected (bed capacity 100). A partnership action plan is in place for 2023/24 which focuses on capacity increase.

Community nursing workforce vacancies, remain high. Recruitment plan in place.

Childrens Therapy waiting lists for routine care . An action plan is in place with LBS who provide therapy via education and social care.

Surrey Downs Health & Care current issues –

Staff survey results indicate lower percentage of people recommending the organisation than previous year

Community nursing workforce vacancies, particularly in district nursing and community matron teams

Grievance in relation to west park relocation

Sutton Health & Care future action –

1. Virtual Ward: action plan 23/24: continued implementation.
2. Childrens Therapy: collaboration with LBS to determine resolution of increased waiting lists across the borough and across all services.
3. Productivity / workforce: continued focus on safer staffing and reductions in agency and bank spend.
4. Staff engagement and listening events planned – staff survey.

Surrey Downs Health & Care future action –

Staff engagement and listening events programme in collaboration with community board

Introduction of Welcome Payment for band 5 & 6 community nurses

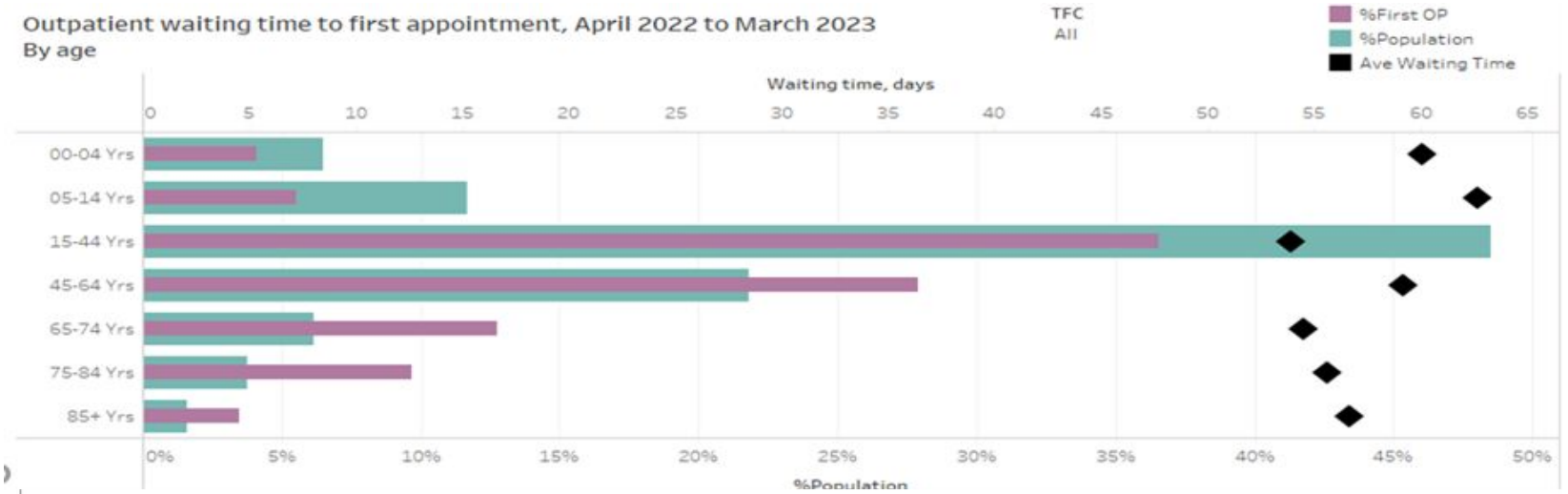
Productivity / workforce: continued focus on safer staffing and reductions in agency and bank spend.

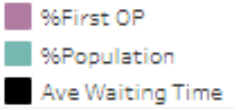
Outpatient waiting time to first appointment

St George's

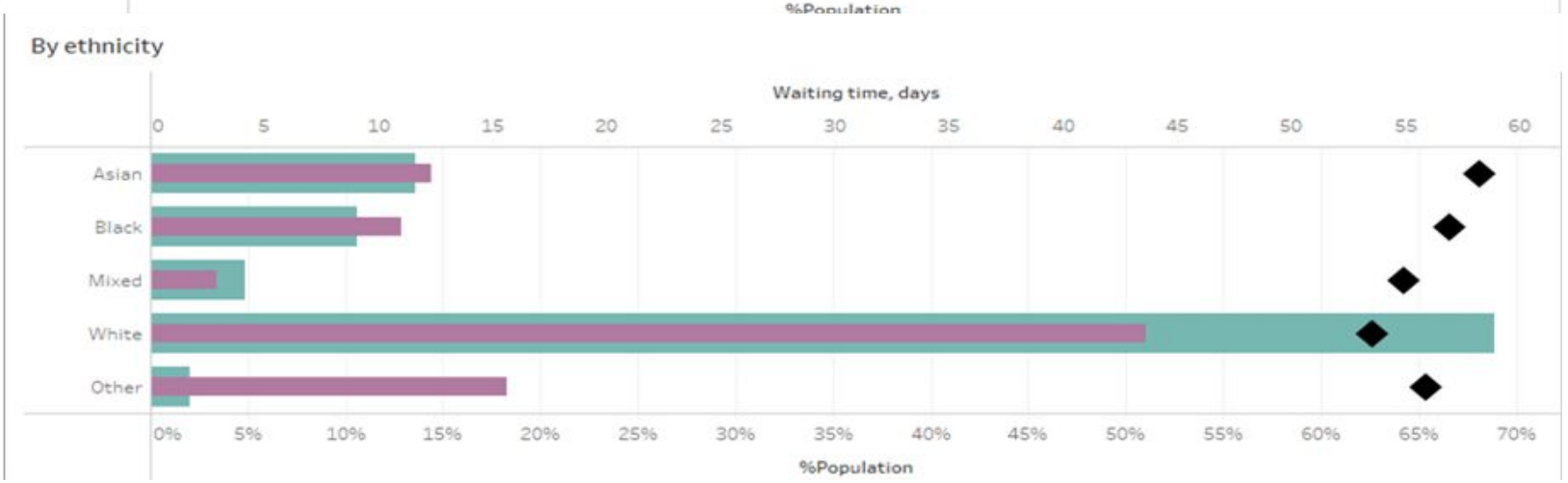
St George's, Epsom and St Helier University Hospitals and Health Group

Period – April 22 March 23 – By age





Period – April 22 to March 23 – By ethnicity



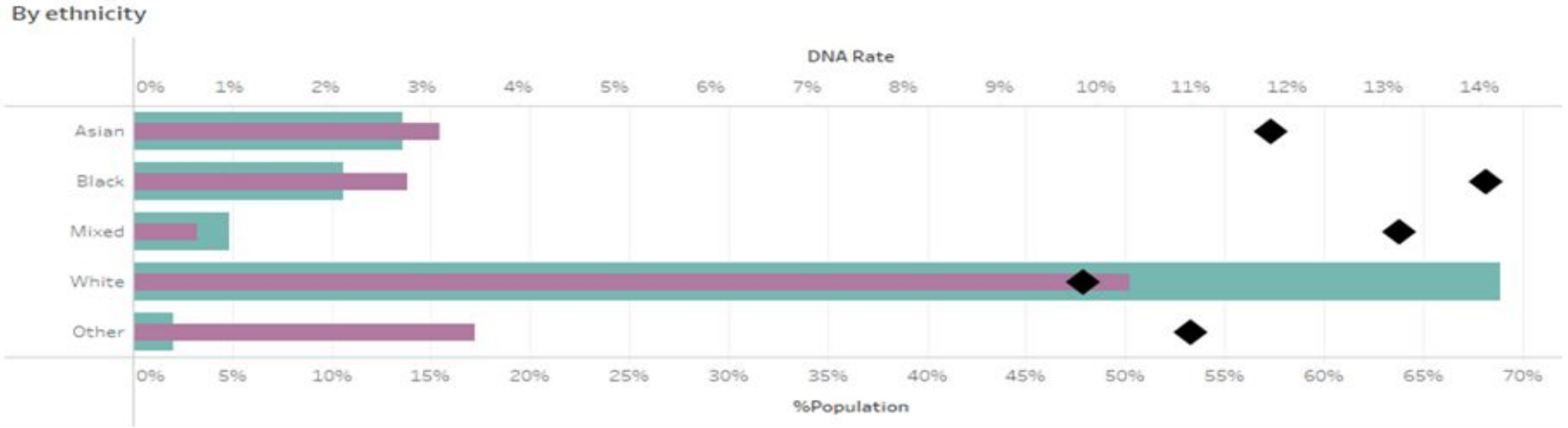
DNA Rate

St George's

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

Period – April 22 to March 23 – By age

Period – April 22 to March 23 – By ethnicity

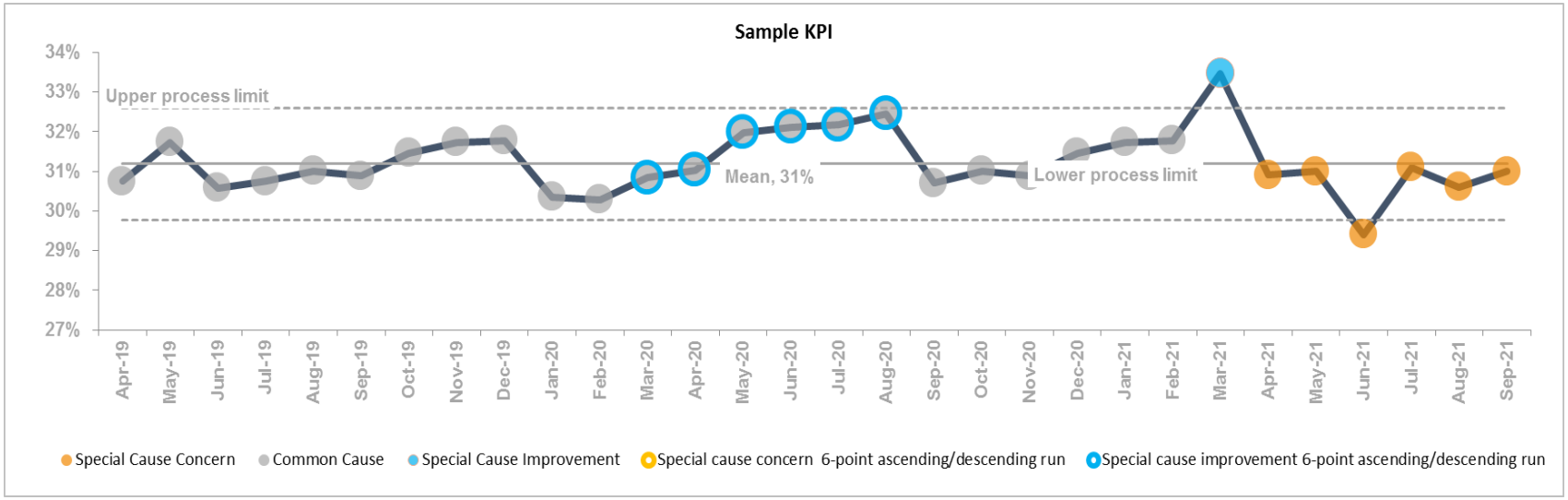


Appendix

- Guide on interpreting statistical process control charts
- ESTH Integrated Care Dashboard
- SGH Ward Heatmap

Interpreting (Statistical Process Control) Charts

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



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

Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	3.3	
Report Title	**Finance Report Month 02 (May)**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	A Grimshaw, L Alabaster & G Harford	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

The financial outlook for 2023/24 remains very challenging. Both Trusts have agreed deficit plans with NHSE as part of thee SWL ICS deficit plan.

After two months both Trusts are on plan excluding the impact of industrial action and ERF£1.2m SGH, £0.4m ESTH.

The key areas of action are continued focus on cost control and the development and delivery of CIPs through site management meetings

Action required by Group Board

The Board is requested to note this paper.

Assurance	
Committee	Finance Committee-in-Common
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Appendices

Appendix No.	Appendix Name
Appendix 1	NA

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

Implications

Group Strategic Objectives

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

Risks

Failure to deliver the agreed financial plan could see further oversight and intervention by NHSE.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

Equality, diversity and inclusion implications

Environmental sustainability implications

Trust Board (Public): 07th July 2023
2023/24 M2 Financial Performance

GCFO, SGH DFP, ESTH Site CFO

Financial month 02 (May)
Group summary

	Issue	Action
Summary I&E	Both Trusts are on plan excluding the impact of industrial action. In M1, both Trusts shown the expenditure impact (£0.6m SGH, £0.3m ESTH) and then in M2 both showed income (ERF variance) (£1.2m SGH, £0.4m ESTH).	Continued focus on cost control and the development and delivery of CIPs through site management meetings.
Pay expenditure	Pay expenditure is **overspent against budget in both trusts**,	Increased focus on grip and control actions
CIP delivery	**On plan in both Trusts in M2,** with timing adjustment at SGH.	Focus on the development and delivery of CIPs.
Capital	**Largely on plan**. The overall position is challenging at both trusts.	Careful monitoring and forecasting of capital will be required in both trusts across the year.
Cash	**Cash update outlines ESTH requirement to drawdown cash in Q2, SGH expected in Q3.**	See cash update

St Georges Hospitals

Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £12.2m at the end of May, which is £1.8m adverse to plan. The shortfall is mainly due to ERF shortfall and impact of junior doctor industrial action.	£1.8m Adv to Plan	£0.6m Adv to Plan
Income	Excluding ERF, income is reported at £0.8m favourable to plan at Month 2. This is due to additional income to cover increased centralised costs.	£0.8m Fav to plan	£0.5m Fav to plan
Expenditure	Expenditure is reported at £1.4m adverse to plan at Month 2, mainly due to premium temporary medical staffing costs to cover the junior doctor industrial action and premium temporary nursing costs across wards.	£1.4m Adv to plan	£1.1m Adv to plan
Cost Improvement Programme	CIPs are reported as £2.5m, in line with plan, albeit with a timing adjustment of £1.6m	On plan	N/A
Capital	Capital is on plan at M2	On plan	On plan
Cash	At the end of Month 2, the Trust's cash balance was £60.8m.	£60.8m £2.3m higher than Y/E	N/A

St Georges Hospitals

Month 2 Financial Performance

Table 1 - Trust Total

			Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	883.1	75.6	76.0	0.3	150.1	150.9	0.8
		Other Income	145.9	10.1	10.0	(0.1)	21.3	21.2	(0.1)
	Income Total		1,029.0	85.7	85.9	0.2	171.4	172.1	0.8
	Expenditure	Pay	(644.2)	(55.2)	(56.1)	(0.8)	(112.0)	(113.5)	(1.5)
		Non Pay	(352.5)	(31.0)	(30.4)	0.6	(63.0)	(62.9)	0.1
	Expenditure Total		(996.6)	(86.3)	(86.5)	(0.2)	(175.1)	(176.4)	(1.4)
	Post Ebitda		(71.7)	(5.3)	(5.3)	(0.0)	(10.7)	(10.7)	(0.0)
	Grand Total		(39.3)	(5.9)	(5.9)	(0.0)	(14.3)	(14.9)	(0.6)
ERF	Income		23.6	2.0	0.8	(1.2)	3.9	2.7	(1.2)
	Reported Position		(15.7)	(3.9)	(5.2)	(1.2)	(10.4)	(12.2)	(1.8)

Table 2- Acute Total

			Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	882.2	75.6	75.8	0.2	149.9	150.5	0.6
		Other Income	122.4	8.0	8.0	(0.0)	17.4	17.4	(0.0)
	Income Total		1,004.7	83.6	83.8	0.2	167.3	167.9	0.5
	Expenditure	Pay	(567.3)	(48.6)	(49.7)	(1.0)	(98.7)	(100.5)	(1.9)
		Non Pay	(207.5)	(18.6)	(17.7)	0.9	(38.5)	(37.7)	0.8
	Expenditure Total		(774.8)	(67.3)	(67.4)	(0.1)	(137.2)	(138.2)	(1.0)
	Post Ebitda		(71.7)	(5.3)	(5.3)	0.0	(10.7)	(10.7)	0.0
	Grand Total		158.2	11.0	11.1	0.1	19.5	19.0	(0.5)
ERF	Income		23.6	2.0	0.8	(1.2)	3.9	2.7	(1.2)
	Reported Position		181.8	12.9	11.8	(1.1)	23.4	21.8	(1.7)

Table 3 - Corporate Total

			Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	0.9	0.1	0.2	0.1	0.1	0.4	0.3
		Other Income	23.5	2.1	1.9	(0.1)	3.9	3.9	(0.0)
	Income Total		24.4	2.1	2.1	0.0	4.1	4.3	0.2
	Expenditure	Pay	(76.9)	(6.6)	(6.4)	0.2	(13.4)	(13.0)	0.4
		Non Pay	(145.0)	(12.4)	(12.7)	(0.3)	(24.5)	(25.3)	(0.7)
	Expenditure Total		(221.9)	(19.0)	(19.1)	(0.1)	(37.9)	(38.2)	(0.3)
	Post Ebitda		(0.0)	0.0	(0.0)	(0.0)	0.0	(0.0)	(0.0)
	Grand Total		(197.5)	(16.9)	(17.0)	(0.1)	(33.8)	(34.0)	(0.1)
ERF	Income		0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Reported Position		(197.5)	(16.9)	(17.0)	(0.1)	(33.8)	(34.0)	(0.1)

Commentary

The Trust is reporting a £12.2m deficit in M2, which is £1.8m adverse to plan. The overall adverse variance to plan is due to ERF shortfall and junior doctor industrial action.

The Trust has received £2.7m of ERF income, which is £1.2m under plan. This is due to the Trust not meeting its ERF target.

Excluding ERF income:

Income

- Income is £0.8m above plan, with additional income to cover increased centralised costs

Pay

- Pay is £1.5m overspent mainly due to premium temporary medical staffing costs to cover the junior doctor industrial action and premium temporary nursing costs across wards

Non-Pay

- Non Pay is £0.1m underspent due to release of central provisions

Corporate Services

- Corporate Services are £0.1m overspent with small variances across various areas

Epsom & St Helier Hospitals
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £11.4m at the end of May, which is £0.8m adverse against plan with Acute Services being £0.8m adverse; Integrated Care and Corporate Services are on plan. The deficit is due to the net costs of the industiral action in April of £0.3m, and a £0.4m shortfall of ERF income as a result of the industrial action.	£0.7m Adv to plan	£0.3m Adv to plan
Income	Overall income is £0.4m adverse to plan. Patinent Care income is £0.5m adverse of which £0.4m is the ERF shortfall, this is offset by Other Operating Income which is £0.1m favourable. The ICB are holding the ERF shortfall favourable variance at the system position in M2.	£0.4m Adv to Plan	£0.1m Fav to Plan
Expenditure	Expenditure is £0.5m adverse year to date, of this £0.3m is due to the net costs of the industrial action in April.	£0.5m Adv to Plan	£0.7m Adv to Plan
Cost Improvement Plans	The CIP plan has delivered £1.5m to date, however there was no savings target in April and the target increases sharply in July.	On Plan	On plan
Capital	At the end of May, the Trust's has spent £2.0m against at plan of £6.7m	£4.7m Fav to plan	£2.3m Fav to plan
Cash	The Trust has a cash balance of £7.5m against the plan of £17.8m at the end of May. The Trust is applying to NHSE for cash support.	£10.3m Adv to plan	£6.0m Adv to plan

Epsom and St Helier University Hospitals NHS Trust

Epsom & St Helier Hospitals
Month 2 Financial Performance

Table 1 - Trust Total

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	577.3	48.6	48.1	(0.5)	95.3	94.8	(0.5)
	Other Op. Income	36.1	3.4	3.4	0.0	6.7	6.7	0.1
Income Total		**613.4**	**52.0**	**51.5**	**(0.5)**	**102.0**	**101.6**	**(0.4)**
Expenditure	Pay	(435.7)	(37.9)	(37.5)	0.4	(74.8)	(75.1)	(0.3)
	Non Pay	(187.8)	(16.2)	(16.5)	(0.2)	(33.2)	(33.4)	(0.1)
Expenditure Total		**(623.5)**	**(54.2)**	**(54.0)**	**0.2**	**(108.0)**	**(108.5)**	**(0.5)**
Post Ebitda		(27.8)	(2.3)	(2.5)	(0.2)	(4.6)	(4.5)	0.1
Grand Total		**(37.9)**	**(4.5)**	**(5.0)**	**(0.4)**	**(10.7)**	**(11.4)**	**(0.8)**

Table 2 - Acute Services

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	514.1	43.1	42.8	(0.3)	84.8	84.3	(0.5)
	Other Op. Income	24.9	2.4	2.2	(0.2)	4.8	4.3	(0.5)
Income Total		**539.1**	**45.5**	**44.9**	**(0.6)**	**89.6**	**88.7**	**(0.9)**
Expenditure	Pay	(331.4)	(29.0)	(28.7)	0.3	(57.2)	(57.6)	(0.4)
	Non Pay	(119.5)	(10.2)	(10.3)	(0.0)	(21.5)	(21.1)	0.4
Expenditure Total		**(450.9)**	**(39.3)**	**(39.0)**	**0.3**	**(78.7)**	**(78.7)**	**(0.0)**
Post Ebitda		(27.8)	(2.3)	(2.5)	(0.1)	(4.6)	(4.4)	0.2
Grand Total		60.4	4.0	3.5	**(0.5)**	6.2	5.5	**(0.7)**

Table 3 - Integrated Care Services

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	63.1	5.5	5.3	(0.2)	10.5	10.4	(0.1)
	Other Op. Income	2.3	0.2	0.3	0.0	0.4	0.4	0.1
Income Total		**65.4**	**5.7**	**5.5**	**(0.2)**	**10.9**	**10.9**	**(0.0)**
Expenditure	Pay	(51.0)	(4.4)	(4.2)	0.2	(8.5)	(8.4)	0.1
	Non Pay	(14.6)	(1.3)	(1.2)	0.1	(2.5)	(2.5)	0.0
Expenditure Total		**(65.6)**	**(5.7)**	**(5.4)**	**0.3**	**(11.0)**	**(10.9)**	**0.1**
Post Ebitda		0.0	0.0	(0.0)	(0.0)	0.0	(0.1)	(0.1)
Grand Total		**(0.2)**	0.0	0.1	0.1	**(0.1)**	**(0.1)**	0.0

Table 4 - Corporate Services

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	0.1	0.0	0.0	(0.0)	0.0	0.1	0.0
	Other Op. Income	8.9	0.7	1.0	0.3	1.5	2.0	0.5
Income Total		**9.0**	**0.7**	**1.0**	**0.3**	**1.5**	**2.0**	**0.5**
Expenditure	Pay	(53.3)	(4.5)	(4.6)	(0.1)	(9.1)	(9.1)	(0.0)
	Non Pay	(53.8)	(4.7)	(5.0)	(0.3)	(9.2)	(9.7)	(0.6)
Expenditure Total		**(107.0)**	**(9.2)**	**(9.6)**	**(0.3)**	**(18.3)**	**(18.9)**	**(0.6)**
Post Ebitda		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total		**(98.1)**	**(8.5)**	**(8.5)**	**(0.1)**	**(16.8)**	**(16.8)**	**(0.0)**

- Table 1 shows the overall Trust position while tables 2 and 3 report the acute and community positions respectively.
- These have been shown to reflect the statutory need to report the whole organisation but also the need to provide reports to the Board on the two segments within the Trust. ESTH corporate services have been included within the Trust total (table 1) and acute services (table 2) position.

Summary

- **YTD £0.8m adverse to plan due to the net costs of industrial action costs and ERF (Elective Recovery Fund) income shortfall as a result of cancelled activity during industrial action. A summary of the net costs and income shortfall was presented to the M1 Finance Committee.**

The Trust position (table 1)

- The Trust has a YTD deficit of £11.4m which is £0.8m adverse to plan, the overspend is wholly related to net costs incurred due to industrial action £0.3m and ERF income lost as a result of the industrial action £0.4m. Acute services are £0.7m adverse, Integrated Care and Corporate Services are both on plan at the end of May.
- Income is £0.4m adverse in month as £0.4m ERF income loss has been recognised.
- Patient Care is £0.5m adverse in month due to the ERF income lost as a result of industrial action.
- Other operating income is on plan in month and £0.1m favourable year to date due to delivery of unplanned income CIP.
- Pay expenditure is £0.4m favourable in month due to a reduction in agency usage across the Trust. Year to date the position is £0.3m adverse due to the net costs of the industrial action in April
- Other operating expenditure is £0.2m adverse in month and £0.1m adverse Year to date as overspends on drugs are partially offset by underspends on clinical supplies.
- **Acute services (table 2).** Industrial action costs are the main issue to date.
- **Integrated care (table 3)**. £0.1m favourable in month bringing it back to break even year to date.
- **Corporate Services (table 4)**. £0.1m adverse in month and on plan year to date. Estates and Facilities are £0.2m adverse but offset by underspends in Chief Nurse and Digital.

Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	3.4	
Report Title	Group Strategy update: Launch and Mobilisation	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Kath Brook, Strategy and Planning Manager Emily Sands, Head of Communications Carl Phillips, Head of PMO	
Previously considered by	Group Executive Board	27th June 2023
Purpose	**For Noting**	**And Review**

Executive Summary

The Group Strategy update: Launch and Mobilisation report provides **an update on the GESH Group Strategy (2023-2028) launch, mobilisation progress and proposed next steps** against the following areas outlined in the strategy:

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

Action required by Group Board

The Board is asked to

- Note the update.
- Review the proposed approach to developing corporate enabling strategies.

Committee Assurance	
Committee	NA
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy update: Launch and Mobilisation report

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

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Group Strategy update:
Launch and mobilisation

Group Board

James Marsh
Group Deputy Chief Executive Officer

Report Authors:
Kath Brook, Strategy and Planning Manager
Emily Sands, Head of Communications
Carl Phillips, Head of PMO

7th July 2023

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Overview

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We are now two months on from launching the Group Strategy.

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

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

This report provides an update on the strategy launch, mobilisation progress and proposed next steps against the above delivery areas.

Board is asked to:

- Note the update
- Review the proposed approach to developing corporate enabling strategies

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Launch update

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Launch

- The Group strategy was launched on 15 May 2023.
- Staff across the Group received an email with links to the full strategy document, summary document, and animation.
- Leadership teams were briefed in advance on 11 May 2023.
- A key set of stakeholders received the strategy in advance, with our wider stakeholders receiving it on the day of launch.
- For our patients and public, we used social media, a press release to local media, and news stories on our websites.

Next steps

- Dissemination of the strategy continues across all our communication channels.
- Distribution of hard copy materials including the summary documents and posters across all our sites.
- Development of materials to support embedding the strategy from Board to ward across the organisation for example, wipeable posters where teams can fill in their contributions to our CARE objectives.
- We will also aim to bring the strategy to life and share progress by using case studies and filmed content.
- We plan to run a survey after 18 months to gauge staff understanding and ownership of the strategy's aims and objectives.

One month on: Strategy launch in numbers

Internal: St George's

ESTH analytics not available

4300 people read the all staff email from Gillian and James launching our strategy.

450 views of our internal news story launching the strategy.

600 views of our dedicated strategy intranet hub.

2,024 staff have downloaded our full strategy document.

And **980** have downloaded the strategy summary.

Internal: Across the Group

500 staff watched May's Executive Question Time, which focussed on our strategy launch.

External: Group coverage

News stories about our strategy launch on our public facing websites read **750** times.

Social media reach

Facebook	**5,597** impressions (views)	**1,224** engagements (interactions)
Twitter	**12,630** impressions (views)	**269** engagements (interactions)
LinkedIn	**4,891** impressions (views)	**208** engagements (interactions)

75 individual emails sent from Gillian and James to our key stakeholders.

500 views of our strategy animation on YouTube.

Press release on the publication of our new strategy was reported by

London Post · newsie Tooling · BBC Radio Surrey

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Mobilising to deliver – overview

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Delivering our 5-year vision

Local improvement

A range of work is underway to embed the CARE framework across the organisations, and to support staff to pursue improvement against it (see slide 7)

Strategic initiatives

Each of our 9 strategic initiatives has an exec SRO, and work is underway to ensure there is a robust programme approach to delivery (see slides 8-12)

Corporate enablers

In April, the Board agreed that corporate enabling strategies should be developed for IT, estates, sustainability, research and innovation, quality and safety, and people. Lead executive directors have developed a proposed approach for developing these strategies, set out here for Board review (see slides 13-14)

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Local improvement

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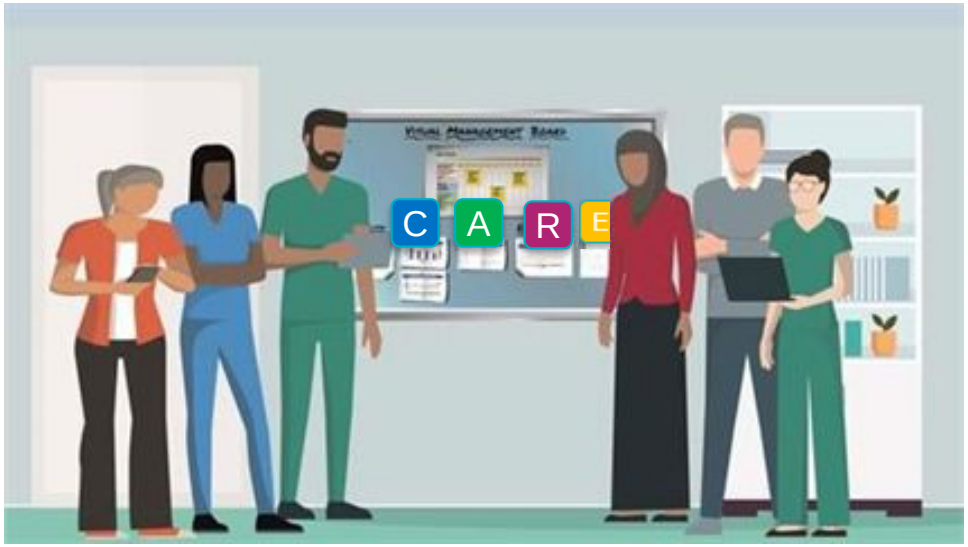
To support teams across the organisation to pursue local improvement against the CARE framework:



- Work is underway to strengthen our approach to continuous improvement, aligned to the CARE framework (see later slides on mobilisation of strategic initiatives, particularly "high performing teams")
- Annual improvement priorities against the CARE framework agreed by the Board in April have been cascaded
- Monthly Group/Site Interface meetings are now structured around the new CARE framework, and conversations have started at Group/Site interface meetings to support identification of site-specific priorities aligned to CARE objectives
- Work underway by site COOs to develop site/divisional dashboards based around CARE objectives
- Communications/BI teams to support in developing supporting visual management materials to enable the above (incl. at ward level)
- Offer of facilitated sessions at Directorate and Divisional level to support identification of local priorities and approach to embedding

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Mobilising strategic initiatives (1)

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What We Have Done

- Executive SRO assigned to each strategic initiative
- Aligned lead resources to help mobilise each initiative (from Strategy and PMO/Transformation teams)
- Started to work with SROs and key stakeholders on identifying scope and breadth of each initiative
- Set up centralised working areas for each initiative (to act as single version of truth), or linked to existing structures where programmes of work are already established and in flight
- Started to identify enabling projects and programmes sitting under initiatives that will drive outcomes and realise benefits (existing 'work in flight' plus work that needs accelerating)
- Explore and identify shared working opportunities (cross-sites; cross-functions) for economies in effort/scale

Progress in mobilising a robust programme approach to each initiative (PID, programme plan, risk management, benefits management etc.) is set out in the following slides. Progress has been assessed by the Group PMO.

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Mobilising strategic initiatives (2)

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Initiative / Programme	Executive SRO	Mobilisation RAG	Plan	PID on Page	Gov Framework setup?	Workbook (inc Scope, Governance structure, Key Benefits, RAID)	Status Overview
Building Your Future Hospitals	James Blythe	Green	Y	Y	Y	Y	• Programme in flight with established team • Governance, plans, regular reporting established
High Performing Teams & Leaders *(C|I)*	Paul Da Gama	Amber	Y	N	Y	N – requires further meeting with workstream leads	• Governance, stakeholder planning and high-level milestone plan all taking shape (inc designated workstreams and leads) • Workstream leads coming together to formalise plan and identify key risks/issues/challenges and associated benefits and outcomes
Shared EPR	Andrew Grimshaw	Green	Y	Y	Y	Y	• Programme in flight with established team • Governance, plans, regular reporting established • Programme is comprised of 5 key stages: Plan / Align / Engage / Activate and Measure. Now midway through 'Engage' phase • Gateways and key milestones are indicated in detailed programme plan
Transforming Outpatients	Richard Jennings	Amber	Y	Y	At site level	Y	• Independent programmes at site level established with dedicated teams, separate steering groups and reporting. • Direction of both programmes being set by CMO, COO and ICS. • Programmes learning from each other and ESTH inputting to SGH decisions re: Cerner builds

Mobilisation RAG Key:
Green – Work/programme well defined, plans, structure, Governance and teams in place
Amber – Work in progress to better define plan/structure/outcomes/shape
Red – Significant delays and lack of progress to define plan/structure/outcomes/shape

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Mobilising strategic initiatives (3)

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Initiative / Programme	Exec SRO	Mobilisation RAG	Plan	Gov Framework / PID on Page	Workbook (inc Scope, Governance structure, Scope and Key Benefits, RAID)	Status Overview
SWL Collaboration	James Marsh	Amber	Y	Y	In progress	• APC Programme engages with Group individuals (i.e. CEO, COO, DCEO, HRD, etc) • Plans and supporting documentation in progress • GESH Governance to be established that includes Group Executive Meetings, Clinical Board for Surgery (Elective Care), etc.
Transforming Our Culture (Diversity & Inclusion)	Arlene Wellman	Red	In progress	• Governance to be refined • PID – not started	N	• High level view of current culture initiatives drawn together. Further work required to amalgamate historic culture work at StG and RESPECT campaign at ESTH to shape future work. • Close link with high performing teams established • Need to accelerate progress in planning. Workshop chaired by SRO planned for w/c 17 July to address.
Collaboration with Local Partners (Surrey, Sutton, Merton & Wandsworth)	Thirza Sawtell	Amber	In Progress	• Governance structure in draft • PID drafted	Y	• Six key workstreams identified. • Meetings have taken place with key stakeholders Sutton, Surrey Downs, Merton & Wandsworth. • Proposed governance drafted, which will feed into integration board. • Plans in place to hold collaborative frailty workshop in September with key stakeholders across place and neighbourhood to share good practice and future vision.

Mobilisation RAG Key:
Green – Work/programme well defined, plans, structure, Governance and teams in place
Amber – Work in progress to better define plan/structure/outcomes/shape
Red – Significant delays and lack of progress to define plan/structure/outcomes/shape

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Mobilising strategic initiatives (4)

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Initiative / Programme	Exec SRO	Mobilisation RAG	Plan	Gov Framework / PID on Page	Workbook (inc Scope, Governance structure, Scope and Key Benefits, RAID)	Status Overview
Collaboration across GESH	James Marsh	Amber	In progress	Y	Y	• Integration Oversight group established and functioning • Outline programme plan in place but further work needed to scope some areas / set clear milestones in others • Work in progress to integrate corporate services, and 'pathfinder projects' underway to progress integration in clinical services (e.g. renal, urology)
Strengthening our Specialist Services	Kate Slemeck	Amber	In progress	PID – in progress further service meetings to take place	Y	• Specialist Services steering group established, engaging with identified strategic pieces of work in five key priority areas identified; Cancer, Renal, Trauma, Neurosciences and Paediatrics. Cardiac Surgery have also been identified as a key area and work is currently underway in collaboration with King's College Hospital. • Clinical lead successfully appointed • Identification of risks that impact our ability to strengthen specialist services – under review

Mobilisation RAG Key:
Green – Work/programme well defined, plans, structure, Governance and teams in place
Amber – Work in progress to better define plan/structure/outcomes/shape
Red – Significant delays and lack of progress to define plan/structure/outcomes/shape

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Mobilising strategic initiatives (5)

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What's Next? - Forward Plan

The Next Quarter's Focus:

- Better define all themes (bring amber and red mobilisation status to green for all)
- Identify enabling projects and programmes sitting under initiatives that will drive outcomes and realise benefits (existing 'work in flight' plus work that needs accelerating)
- Refine Governance framework sitting around initiative delivery (right-size effort to avoid duplication)
- Continue to explore and develop shared working opportunities (cross-sites; cross-functions) for economies in effort/scale
- Establish regular Communications heartbeat (via intranet) across initiatives
- Begin 'Programme Spotlight' deeper dives at Group Executive
- Over-arching Roadmap/plan (inc all initiatives) to track progress at high level
- Scope; Key Benefits; Critical Path; RAID log; Stakeholder Map; Governance Model – for each initiative
- More granular plans (per initiative) to track and manage key activity
- Touchpoints and Governance for supporting work

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Corporate enabling strategies

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Corporate enabling strategies will underpin delivery of our Group Strategy vision.

Boards agreed enabling strategies should be developed over the coming year.

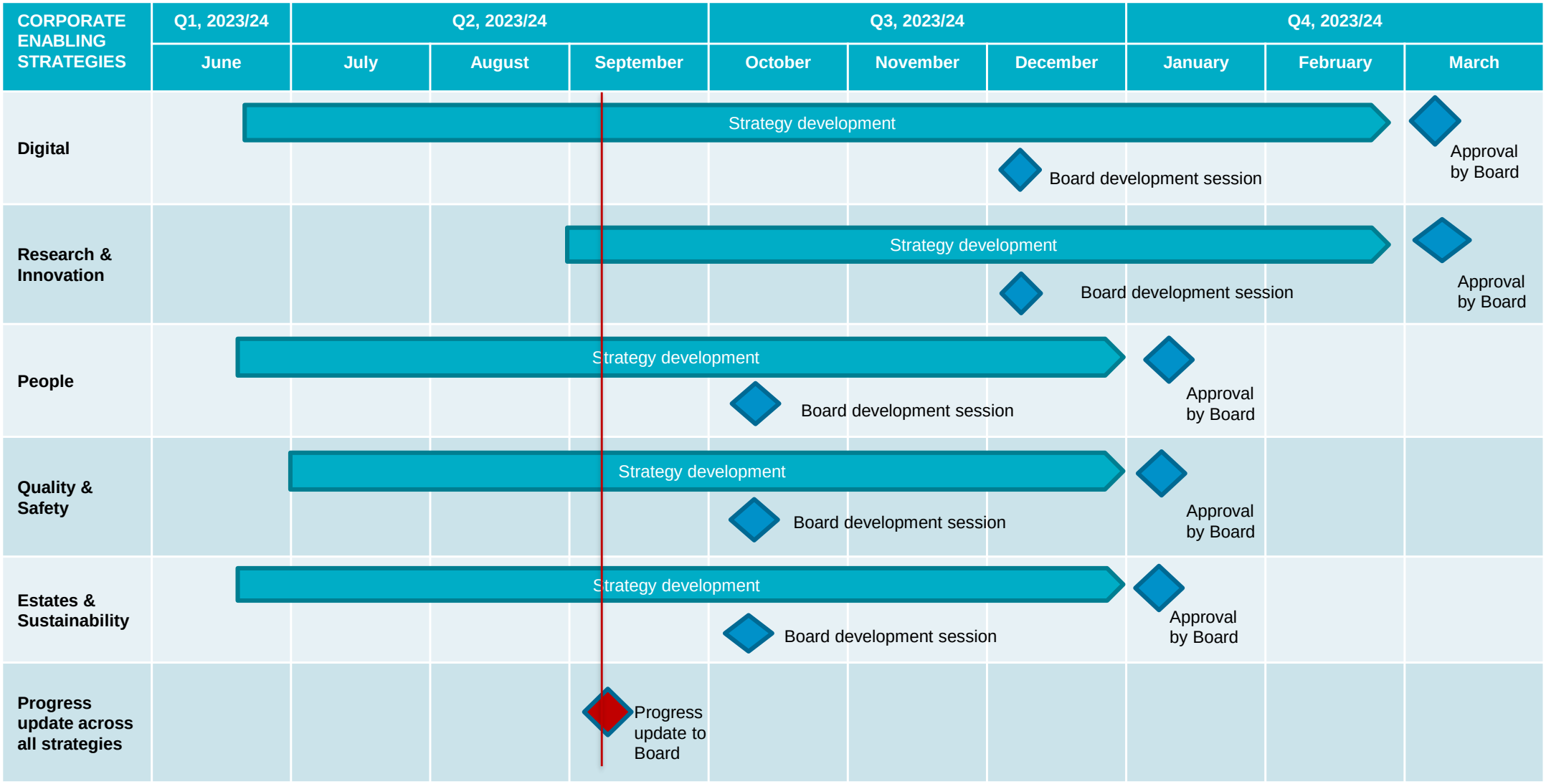
The following slides outline the **proposed approach and timeline for enabling strategy development-** Digital, Estates, Sustainability, Quality and Safety, Research & Innovation, and People.

Corporate strategies: what are we seeking to achieve?

See annex for further details on proposed scope, engagement plan, governance arrangements

Strategy	Purpose: what will success look like?
Digital	Given the need for difficult choices about how we use our resources, the Digital Strategy will set out what investments we will and won't prioritise in digital over the coming years: in the immediate term, medium term (~2-3 years), and long-term (2026 onwards). It will also meet NHSEI requirements to progress BYFH.
Research and Innovation	The strategy will articulate how the Group vision for research will be delivered, including defining the relationship between SGUH, ESTH and SGUL going forward. It will also give us a more systematic approach to fostering innovation.
People	The People Plan will give us a clear, resourced 5-year plan setting out what action we will prioritise each year to deliver our vision
Quality and Safety	The strategy will give us a: • clear approach to building a patient safety culture / culture of psychological safety • clear approach on playing our part to tackle health inequalities • better approach to setting annual quality priorities, such that they resonate and have an impact throughout the organisation (board to ward) • plan for better embedding patient voice / co-production with patients into everything we do
Estates	• Confirmed delivery approach for SECH, Renal and PTC projects • Six-facet reviews of all existing buildings and long term condition planning • Refreshed view on post-SECH DGH works, including potential to use St George's vacant sites • Revised view on use of St George's land, including fall back position for PTC work if unsuccessful • Review of disposal of St George's OPE site • Group workplace strategy • Group community estates strategy • Collaboration with partners (SGUH, MEH, etc.) • Long term view of QMH / PFI • Estate right-sizing to hit CIP targets • Group strategy for E&F team development (including insourcing / outsourcing) based on above requirements
Sustainability	Plan for delivering on our sustainability ambitions, allowing flexibility for individual sites with overarching strategic themes

Corporate strategies: proposed timeline



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Risk and reporting

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- BAF has been revised to support the management of risks to delivering the Group's strategic objectives, and is being presented to Board for approval (see separate report)

- The Board previously agreed that it should receive a progress update on delivery of the strategy as a whole every 6 months.
- This first report has focused on mobilisation. The next, due January 2024, is intended to align with business planning for 2024/25.

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Recommendations

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The Board is asked to:

- Note the update
- Review the proposed approach to developing corporate enabling strategies

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Annex – approach to corporate strategies

Group Digital Strategy proposal

Why? What will success look like when we've finished?	• Given the need for difficult choices about how we use our resources, we will have a plan setting out what investments we will and won't prioritise in digital over the coming years: in the immediate term, medium term (~2-3 years), and long-term (2026 onwards). • We will have a digital strategy that meets NHSEI requirements to progress BYFH
Scope	Covering full scope of IT/informatics (digital technology, infrastructure, clinical & non-clinical systems, BI, cyber security etc)
Time period	• 5-year strategy
Governance	• Approval by Board, following review at Infrastructure Committee • Executive steering group to give the work strategic steer & receive assurance on progress (incl. CFO, GCIO, senior site reps, DOS) • Working group to ensure the work is delivered to time/scope etc (incl. GCIO, site CIOs, site DOFs/nominees, strategy officer)
Development process:	
Timeline	Board approval March 2024.
Roles	Andrew Grimshaw as executive sponsor. Peter Davies as responsible director. Strategy team support with coordination/drafting from September.
Engagement	Given extensive engagement to date on vision for the future, proposal is to focus engagement primarily on leadership community across the Group (e.g., site leadership teams) on the question of prioritisation.

Group Research and Innovation Strategy proposal

Why? What will success look like when we've finished?	• We will have a clear, financially realistic approach to how will achieve the Group vision for research and innovation articulated in the gesh strategy. • We will be clear on how we want the relationship to work between SGUH, ESTH and the University in the context of the Group.
What does it build on / what is already there?	• Strategy will build on the existing SGUH and ESTH research programmes of work / strategies – refreshing and adding to, rather than replacing. • Limited activity by Trusts in the field of formal innovation programmes of work.
Scope	• Strategy will not be joint with SGUL but SGUL will be a key collaborator/partner • Innovation will be included as part of the research strategy (noting distinction between innovation in research and clinical/ corporate innovations including devices, digital innovation, innovative practices and personalised/ precision medicine). • Innovation in workforce is out of scope and will be included in the People Strategy.
Time period	• 5-year strategy
Governance	• In line with existing Group structure- development oversight, implementation and monitoring via Quality Committee in Common. • Wider governance- JRES and JBS consulted to support proposal.
Development process:	
Timeline	Commence early Autumn – assuming group director of research in place 6 months to develop- with proposed Group Board approval March 2024
Process	• Awaiting appointment of new Group Research Director to lead this work
Engagement	• Group wide engagement process proposed to develop the strategy • Engagement as appropriate with SGUL partners

Group People Plan proposal

Why? What will success look like when we've finished?	We will have a clear, resourced 5-year plan (more detailed in early years, more outline in later years) setting out what action we will prioritise each year to deliver our people vision.
What does it build on / what is already there?	Vision for 2028, and a set of strategic objectives based on the four domains of the national NHS People Plan and adapted to gesh context – as set out in the Group strategy. Proposal is that the Group People plan builds on this by articulating how we get there.
Scope	Education (including our strategic approach to partnership with SGUL) will be part of the strategy and not sit separately .
Time period	5-year strategy
Governance	• In line with existing Group structure- development oversight, implementation and monitoring via People Committee in Common • Strategy development steering group to be established: Chair Paul Da Gama, membership representative of corporate and clinical teams
Development process:	
Timescale	• 6 months to develop: June to August 23- development of draft , September-November 23- test strategy with wider audience and refine. • Board Development session: October 23 • Group Board approval: January 24 Board meeting
Process	• Strategy team to support development phase through to approval, HR team accountable for strategy development and implementation • Series of workshop to develop and refine an outline strategy before wider testing
Engagement	Given extensive engagement already done to date to understand where we are now and where we want to get to (e.g. culture diagnostics, staff survey, engagement on Group strategy) the proposal is to focus engagement on the question of what work we prioritise, with what phasing over the coming 5 years, and to focus this engagement on senior leaders in the organisations rather than wide-ranging front-line engagement.

Group Quality and Safety Strategy proposal

Why? What will success look like when we've finished?	Have a clear approach to building a patient safety culture / culture of psychological safety Have a clear approach on playing our part to tackle health inequalities Have a better approach to setting annual quality priorities, such that they resonate and have an impact throughout the organisation (board to ward) Have a plan for better embedding patient voice / co-production with patients into everything we do
What does it build on / what is already there?	National Quality Themes 2023/24 Quality Priorities
Scope	3-4 High-level Strategic Programmes/ Themes to complement the existing GESH Quality Priorities: Annual Quality and Safety Priorities (Board to Ward) that are clear and focused (i.e. 3 Max) and owned by Staff. Communications and a Culture that fosters continuous Quality Improvement, Learning (PSIRF) and Psychological Safety e.g. exemplars such as East London Foundation Trust (ELFT), Frimley, etc. Health Inequalities Projects are focused and fully linked to outcomes re Quality and Safety Patient Voice is embedded in the Organisation
Time period	• 3- 5 year Quality and Safety Strategy
Governance	• Core Group Meetings (Group Director of Compliance, Group Director of Nursing Governance Quality and Safety, Group Chief Nursing Officer, Group Chief Medical Officer, Strategy Team)- Monthly • Core Group+ Meetings (including CNs and MDs from Site Teams)- Monthly • Group Executives Meeting and Group Quality and Safety Committee
Development process:	
Timeline	• 6-9 Months • Completion end March 2024 - informing Quality and Safety Priorities for 2024/25
Process	• Board Development Session October 23 • Engagement with Staff re 'Communication and a Culture that fosters continuous Quality Improvement, Learning (PSIRF) and Psychological Safety' • Health Inequalities Workshop
Engagement	• As above

Group Estates strategy / Sustainability strategy

Why? What will success look like when we've finished?	Having received the outcomes for the New Hospital Programme submissions for the Group, the time is now right to develop a Group Estate Strategy as well as a plan for delivering on our sustainability ambitions, allowing flexibility for individual sites with overarching strategic themes.
What does it build on / what is already there?	The inputs for this strategy will include: • Our new Group Strategy • Group Sustainability Strategy and other enabling strategies • The BYFH OBC / Emerging Hospital 2.0 Design • ESTH / STG Existing Estate Strategies • St George's SOC for Blackshaw Site • St George's OPE Strategic Case • St George's Renal Design • St George's PTC Submission
Scope	Some of the answers that the Estate Strategy should provide are: • Confirmed delivery approach for SECH, Renal and PTC projects • Six-facet reviews of all existing buildings and long-term condition planning • Refreshed view on post-SECH DGH works, including potential to use St George's vacant sites • Revised view on use of St George's land, including fall-back position for PTC work if unsuccessful • Review of disposal of St George's OPE site • Group workplace strategy • Group community estates strategy • Collaboration with partners (SGUH, MEH, etc.) • Long term view of QMH / PFI • Estate right-sizing to hit CIP targets • Group strategy for E&F team development (including insourcing / outsourcing) based on above requirements
Time period	10 year Estates Strategy/ Sustainability Strategy
Development process:	
Timeline	To achieve the timescales needed for the BYFH business cases, this work would need to be completed by December 2023
Process	The work will be led by Andrew Asbury, Group Director of Estates, supported by Tim Wilkins, Associate Director of Estates Strategy. Existing team members across the group will be used wherever possible, there may be a need for some professional input for master planning / spatial exercises but this will be minimised to keep costs down.

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NHS
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University Hospitals and Health Group

○ Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	4.1	
Report Title	**Quality Committees-in-Common Report to Group Board**	
Non-Executive Lead	Aruna Mehta, Quality Committee Chair, ESTH Andrew Murray, Quality Committee Chair, SGUH	
Report Author(s)	Aruna Mehta, Quality Committee Chair, ESTH Andrew Murray, Quality Committee Chair, SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees-in-Common at its meetings in May and June 2023 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

1. Maternity Services, including the governance review
2. Patients with Mental Health needs presenting to Emergency Departments
3. Haemodialysis Significant Incidents.

Action required by Group Board

The Group Board is asked to note the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in May and June 2023.

Committee Assurance

Committee	Quality Committees-in-Common
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

Implications

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

Risks
As set out in paper.

CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

Financial implications
As set out in paper.

Legal and / or Regulatory implications
N/A

Equality, diversity and inclusion implications
As set out in paper.

Environmental sustainability implications
N/A

Quality Committees-in-Common Report
Group Board, 07 July 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees-in-Common at its meetings in May and June 2023 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 25 May and 28 June 2023, the Committee considered the following items of business:

May 2023	June 2023
• Quality Performance Report (M1) • Serious Incidents Report • Maternity Services Report* • Group Infection Prevention and Control Update* • Fundamentals of Care Deep Dive (Dementia Screening) • Board Assurance Framework – Quarter 4 2022/23 • Implementation of Patient Safety Incident Response Framework • Group wide review of dealing with Complaints Process • SGUH Cardiac Surgery Update • Quality Accounts 2022/23 and Quality Priorities 2023/24 • Annual Report from the Quality Committee to the Group Board	• Quality Performance Report (M2)* • Serious Incidents Report • Maternity Services Report* • Group Infection Prevention and Control Update* • Learning from Deaths Report – Quarter 4 2022/23 • Mental Health Patients within the Group's EDs • Pharmacy Update • Clinical Audit and Effectiveness Annual Report 2022/23 • Clinical Audit Priorities 2023/24

** Items marked with an asterisk are on the Group Board agenda as stand alone items in July 2023.*

2.2 The Committees were quorate for both meetings.

3.0 Key issues for escalation to the Group Board

3.1 The Committees wish to highlight the following matters for the attention of the Group Board:

a) Maternity Services

The Quality Committees-in-Common continue to review, on a monthly basis, the quality and safety of maternity services across the Group. The report considered by the Committees is also on the Group Board agenda, but the Committees wish to highlight certain issues to the Group Board.

The Committees has been pressing for a clear timeframe for the commencement of the external clinical review of SGUH maternity services in response to SGUH MBBRACE data showing outlier status in still birth and neonatal mortality rates. This review has been commissioned and is due to start imminently.

The Committees also sought assurance on the planned external review of quality governance, the first phase of which will focus on the Group's maternity services. The Committees received assurance that the Tendering process for the quality governance review is underway (see section e below regarding the Terms of Reference discussion), and understands that the report from the first of the two phases of this review will be received three months after it begins; the Committees asked to receive a progress update in September. While this review has not yet started, this is a key priority and the Committees are keen this progresses promptly and to see the analysis and consider any recommendations arising.

The Committees discussed the recent CQC inspection of maternity services at SGUH and sought assurance that the learning from this was being identified and factored into the planning for a similar inspection at ESTH, which was expected during the summer. SGUH had received the draft report from CQC and responded with factual accuracy and representations.

Assurance for maternity services at SGUH is currently limited and for ESH is reasonable. The Committees hope that the two external reviews will increase assurance levels.

b) Mental Health Patients being cared for within the Group's Emergency Departments

At the June meeting of the Committee a detailed discussion regarding the impact of the number of patients with Mental Health concerns attending the Group's Emergency Departments was held. Details of the issues with the number of these patients being cared for within the departments at both trusts over the past weekend were shared. There are delays in assessing patients with mental health need. Often, many ED Majors bays were occupied by patients with mental illness who were awaiting specialist mental health support rather than requiring treatment for physical illness. Also, at times there were a considerable number of police and security within the departments as well. There were safety concerns for patients and staff and it was widely recognised that caring for people with urgent mental health needs in Emergency Department facilities was not ideal.

The Group CEO confirmed that she had convened an urgent system wide meeting to discuss the issues. All services were in agreement that there needed to be alternative arrangements for people in crisis so that they could be cared for away from acute A&E's. This would be with appropriately trained staffing. Partners had agreed to go away and see if there was any existing space which could be used for providing these facilities on trust sites. Clearly there would be staffing costs to be met, but it may be that these could be in

part mitigated by a reduction in additional “specialling” staff who currently look after mental health patients in the EDs and on the wards.

The Teams from both trusts also outlined the continuing number of children and young people with very complex mental health and behavioural needs which were having to be cared for on the wards pending a specialist placement.

Concern was also raised regarding the recent announcement from the Metropolitan Police that they would be scaling back their support for patients in mental health distress. This would clearly have an impact within the local community and the acute trusts. Representation was being made to the Police and discussions are ongoing.

c) Serious Incidents

The Committee continues to receive monthly reporting on Serious Incidents, with commentary about immediate actions taken or relevant information about planned investigations, and learning from completed SI investigations. While the details of individual SIs are always of importance and concern, the Committee is assured that the Group has in place robust processes for identifying, investigating and reporting on SIs.

The Committees had previously discussed and have expressed concern regarding the number of overdue SI investigations at ESTH. The Group Chief Medical Officer, Group Chief Nursing Officer along with the Site Chief Medical Officer regularly review these plans and ensure appropriate mitigations are in place if there are any risks considered. The progress of the open SI investigations are monitored at the weekly serious incident meetings. The Committees will continue to seek assurance that the overdue investigations have been completed, necessary actions taken and implemented effectively, and the SI process is strengthened to prevent a reoccurrence of a backlog. It was noted that there had been a small reduction in the number of open outstanding action plans between the May and June meetings.

At the June meeting it was highlighted that there had been two separate Serious Incidents in which patients on haemodialysis under the care of the ESTH renal service had very sadly died after venous disconnection, in June 2022 and March 2023. Venous needle dislodgement or line disconnection is a well-recognised complication that can occur during haemodialysis, but the Committees were particularly concerned that two such incidents had occurred within ten months. There was an extensive and detailed discussion around the steps being taken to strengthen safety processes within the service and to minimise the risk of a recurrence. The Committees were satisfied that these incidents had been taken extremely seriously by the renal service and that appropriate improvement actions were being taken. The Committees require regular updates, however, on the implementation of the ongoing actions, and until further notice will continue to seek an enhanced level of assurance that safety concerns have been fully addressed.

d) Infection Prevention and Control

The Committees received a monthly report on infection prevention and control. As this report is also submitted to the Board in full (see agenda item 5.1), the Committees would highlight to the Board the updates received in relation to *Clostridioides difficile* (C diff). For ESTH**,** a total of 4 Hospital Onset Healthcare Associated (HOHA) C diff cases had been recorded in May 2023, taking the total number of cases for 2023/24 to 10 cases against a

nationally determined annual threshold for the Trust of 38 cases. For SGUH, a total of 7 hospital acquired C diff cases had been recorded in May 2023, five of which had been classified as HOHA and two as Community Onset Healthcare Associated (COHA). SGUH had recorded a total of 9 C diff cases for 2023/24 as a whole against a nationally determined annual threshold for the Trust of 42 cases.

Concern was raised by the Committee that the figures for C Diff were already above trajectory for both trusts.

The Committees were informed that IPC mandatory training compliance continued to be on an improving trajectory for all areas for both clinical and non-clinical staff but is not yet to target.

Therefore assurance was limited at this point in time.

There were other infections tracking above the expected trajectory and the Committees will continue to monitor IPC closely.

e) Governance Review

The Committee has received and approved the proposed Terms of Reference for the external quality governance review (as referenced above in section a). The Group Board had agreed that this review needed to be undertaken following the March 2023 Care Quality Commission (CQC) "focused short-notice inspection" of maternity and midwifery services at St George's University Hospitals NHS Foundation Trust (SGUH). This inspection identified a number of areas which required significant improvements were needed to be made to maintain safe services to patients. In the light of these findings, the Group Board decided that this raised questions as to whether the arrangements for quality governance and oversight, which were evidently not as effective as they should have been in SGUH Maternity, were as robust as they should be in general across the Group. In considering whether the shortcomings were specific to maternity services at SGUH, or whether they might indicate broader weaknesses in quality governance structures, systems, processes and controls more widely, the Board decided that this review of quality governance was required across the St George's, Epsom and St Helier University Hospitals and Health Group (the Group).

The review will initially focus on considering quality governance with the Maternity Services, and then will move on to considering other services within the Group.

4.0 Key Issues on which the Committees received assurance

4.1 The Committees wish to report to the Group Board the following matters on which they received assurance:

a) 'Fundamentals of Care' Deep Dive – Dementia Screening

The Committee received a deep dive into Dementia/ Delirium Screening activity taking place across the Group. The deep dive reviewed current practice with reference to the screening and assessment of patients with dementia and or delirium at both Trusts between April 2020 and February 2023.

Dementia screening was introduced by the Department of Health as a mandatory policy for all hospitals across England. The expected target screening rate is 90% of all patents 75 years and over within 72 hours of an emergency admission. At present this target was not being achieved at either trust.

In respect of Training

- Tier 1: 94% of staff at SGUH and 87.88% of staff at ESTH had participated in the mandatory dementia awareness training (performance target 85%).

The following areas of concern had been identified and improvement actions included in the Group Dementia and Delirium Improvement Action Plan

- Delirium screening assessments (not consistently completed)
- Low level use of Delirium Prevention plans
- Poor patient and carer experience
- Undertaking the assessments were part of basic clinical care. Not completing them had implications for Patient Safety.

The recommendation was made that there should be focused work on increasing dementia and delirium assessment in some key areas within the trust such as the AMUs – as well as engaging clinicians to fully understand the need for the reviews to be undertaken. It was confirmed that across the trusts there were Dementia Champions at a ward level. The assessment of a patient's mental health was as important as reviewing their physical health. Areas of focus such as the acute wards within the trust would be a good way to start to improve completion of assessments. This was particularly important as these patients tended to have poorer outcomes than when on medical wards.

The Committees have asked to see a progress report in due course.

b) PSIRF

At its meeting in May 2023, the Committee received an update on the new national initiative the Patient Safety Incident Response Framework (PSIRF) which promotes a range of system-based approaches for learning from patient safety incidents.

The Groups plans for implementing PSIRF had been developed in conjunction with the local Integrated Care Board (ICB) and would include changes to how investigations of incidents were undertaken. This would be to focus on learning from incidents. PSIRF was seen to be a real opportunity to make improvements in patient safety.

c) Cardiac Surgery Update (SGUH)

At the May 2023 meeting the Quality Committees-in-Common received an update on Cardiac Surgery at SGUH.

It was highlighted that London-wide, there were considerable concerns regarding the P2 patients (those whose surgery should take place within one month) waiting list which now had over 800 people on it. This length of waiting list was not sustainable and a review of services across the whole of London needed to take place.

Historically the SGUH Quality Committee had regularly reviewed outcomes within Cardiac Surgery where there previously had been some concerns. More recently there had been a shift in emphasis to different areas of concern which were included in the report:

- Patient Flow
- Availability of specialist Cardiac anaesthetists
- Availability of ITU beds

A new Cardiac Anaesthetist had been appointed to the team the previous day. Consideration as to the future of the service and what it would be able to provide, as part of London-wide need was key. This would need to include closer working with other local Cardiac Services Units and in particular that provided by Kings.

5.0 Other issues considered by the Committees

5.1 During this period, the Committee also received the following reports:

a) Clinical Audit and Effectiveness Annual Reports 2022/23 and Clinical Audit Plans for 2023/24

The Committee received the Clinical Audit and Effectiveness Annual Reports for 2022/23 from both trusts.

The Clinical Audit Plans for 2023/24 for both SGUH and ESTH were presented to the Committee and approved.

b) Pharmacy Update

At its June 23 meeting the Quality Committee in Common received the biannual update from the governance and assurance reporting frameworks within the Pharmacy Department at St George's and Epsom and St Helier hospitals. This was the first Group wide report and focused on system working and innovation and provided data-based assurance on quality and outcomes. As part of the update the Committee also received the Controlled Drug Annual Reports for both organisations.

Successes outlined in the report included:

SGUH
- MHRA inspection, de-escalation of monitoring requirements

ESTH
- Improving recruitment position as at June 2023; clinical restructure complete with senior pharmacy leadership posts at Band 8b recruited.
- Recruitment of lead community services pharmacists for Sutton Health & Care and Surrey Downs Health & Care to support greater integration of pharmacy services across the place.
- Formalisation of progression pathways for junior pharmacy staff groups

Challenges within the period included:
Both Trusts
- Providing additional support to clinical areas during the recent Junior Doctors and Nurses Strikes, including AMU and ED.

For ESTH
- Recruitment into junior pharmacist (Band 6 and Band 7) posts

The Committees discussed the challenges inherent in maintaining a relatively small pharmacy service at ESTH, which has difficulties in some areas with recruitment and retention. The move to seven day working was commended by the Committees as a significant improvement, but the impact of this on

staff was recognised as a potential factor in retention issues. The potential opportunities in closer working between the ESTH and SGUH pharmacies were discussed.

6.0 Review of risks

6.1 The Committees hold regular reviews of the quality and safety-focused strategic risks on the Board Assurance Framework (BAF) and on each Trusts' Corporate Risk Register.

The GCCAO presented the updates on the Q4 2022/23 position on the quality aspects the Board Assurance Frameworks for SGUH and ESTH. A new Group BAF, based on the recently approved Group Strategy, was being developed and the draft strategic risks were scheduled for consideration by the Group Board at its next meeting.

An overview of the strategic quality risks on the St George's Board Assurance Framework at the end of Q4 2022/23, were outlined and the following material updates were made to the following areas:

- SR1 (safe and effective care): No changes to the overall risk score or assurance rating of 16 were proposed at Q4.
- SR2 (clinical governance): In the context of the issues identified in the recent CQC inspection of maternity services at SGUH, and the wider issues around clinical governance that the inspection gave rise to, an increase in the risk score was proposed from 8 to 12,
- SR10 (research): No changes were proposed to this risk at the end of Q4. The risk score remained at 9 and the assurance rating at 'good'.

The Committee also received the updated BAF for ESTH, at the end of Quarter 4 2022/23. This included the RAG-rated progress updates. The ESTH BAF, which historically took a different approach from the BAF at SGUH, was structured to align with the Trust's annual corporate objectives and reflected the range of indicators agreed by the Board in November 2022.. The majority of the indicators remained at amber.

The importance of the new Group BAF for 2023/24 having clear, crisp measures which would enable the Board to make informed judgements on risk scores and assurance ratings was emphasised.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in May and June 2023.

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	4.2	
Report Title	**Report from Finance Committee-in-Common**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance Committee at its meetings in May and June 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

Action required by Group Board

The Board is asked to:

a. Note the paper

Committee Assurance

Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	Add Appendix Name – delete line if not needed
Appendix 2	Add Appendix Name – delete line if not needed
Appendix 3	Add Appendix Name – delete line if not needed

Implications

Group Strategic Objectives

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

Risks

[Summarise the key risks on the Corporate Risk Register and Board Assurance Framework to which this paper relates. Also set out any risks relevant to the content of the paper – set out further detail in the main body of the paper.]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

[Set out briefly any financial implications relevant to the issues described in the paper]

Legal and / or Regulatory implications

[Set out any legal and / or regulatory issues relevant to the issues described in this paper]

Equality, diversity and inclusion implications

[Set out any equality, diversity and inclusion issues relevant to the issues described in this paper]

Environmental sustainability implications

[Set out any environmental sustainability issues relevant to the issues described in this paper]

Finance Committee-in-Common Report
Group Board, 07 July 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in May and June 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 26th May 2023 and 30th June 2023, the Committee considered the following items of business:

May 2023	June 2023
• Finance Report (M1) • CIP Update • Cash Update • Industrial Action • Planning update 23/24 • Productivity Update • Business cases update • IQPR • Estates update • Range and Quality of information • Annual Committee Report • SWLP Update	• Finance Report (M2)* • CIP Update • Cash Update • Productivity Update • IQPR • EPR and Network update • Estates update • SGH Business Expenses policy • SGH Petty Cash policy

**items marked with an asterisk are on the Trust Board agenda as stand alone items in July 2023*

2.2 The Committee was quorate for both meetings.

3.0 Analysis

3.1 The Committee wishes to highlight the following matters for the attention of the Group Board:

a) Agency rate cards

The SGH and ESTH MDs highlighted the pressure of escalated medical pay rates exacerbated by the recent and proposed industrial action. The Committee discussed how the Trust could mitigate this risk, although it would require system and London-wide action.

b) Pressure on General Managers

The SGH and ESTH COOs emphasised the pressure put on general managers at both organisations with respect to CIP delivery, industrial action, and delivering performance metrics. Committee members recognised their dedication and commitment, and discussed ways of showing support and appreciation to these members of staff.

c) Mental Health patient attendances at ED

The SGH and ESTH COOs noted the challenge of the increase in mental health patient attendances in ED. Committee members reflected on how this would again need system-level support.

d) Industrial Action

Non-Executive Directors highlighted the impending Consultant industrial action in July that follows a third longer junior doctor strike for 2023/24 as evidence that this was becoming a bigger risk to operational and financial plans.

4.0 Sources of Assurance

4.1 a) Finance Report M2

The GCFO noted that SGH and ESTH are £1.8m and £0.7m adverse to plan at M2 respectively, which is wholly owing to the impact of industrial action. This includes both an expenditure impact and an impact from loss of Elective Recovery Fund income with the expenditure impact at £0.6m SGH and £0.3m ESTH and the income (ERF) variance at £1.2m SGH and £0.4m ESTH. Committee members discussed the risk to capital plans with many critical schemes not affordable at present.

b) CIP Update

The GCFO highlighted that both Trusts were on their CIP plans in M2, albeit with slightly more non-recurrent savings than originally planned. SGH now has £10.6m and ESTH £9.7m Fully Developed CIP, against their £62.1m and £37.3m targets. Committee members discussed the implications of being behind plan on grip and control requirements from NHSE, and recognised that these would continuing focus.

c) Cash update

At the June Committee, ESTH noted the submission of documentation for the requirement of external cash support in Q2 (July-September 2023).

d) IQPR

The SGH COO noted performance against key metrics in the June meeting, where **ED performance in May** is 3rd in London with 81.7%, and the number of **RTT** patients waiting over 65 and 52 weeks is on track to achieve year end targets. In May 99.02% of patients against a target of 99% were waiting for less than 6 weeks for their **diagnostic test. Cancer performance** remains challenged against two week and 62-day targets, although progress is being made.

The ESTH COO noted performance against key metrics in the June meeting, where **ED performance** in May showed 77.06% of patients either admitted, discharged or transferred within four hours of arrival. 52 week **RTT** waits continue on an upward trend each month with an increase to 586 pathways, adverse to the April Plan. Diagnostic performance of 91.3% is the best performance since May 2022. **Cancer** 14 day performance dipped in April to 85.7% against the national target of 93%, but there is consistent achievement of the other key cancer indicators.

e) Industrial Action

Committee members noted the detail of the cost impact of industrial action in April, reported to the May Committee.

f) Planning update

At the May Committee, members were informed of the final versions of the financial plan submitted for each Trust. SGH has a planned deficit in 23/24 of £15.7m, with ESTH at £37.9m

4.2 During this period, the Committee also received the following reports:

a) Productivity update

At both committees papers were produced on productivity metrics. Members noted the confusing picture on ERF and value weighted activity, and how industrial action further complicates matters.

b) Business Cases update

In May the committee received an update on big projects following latest capital planning assumptions being made available.

c) Estates update

The GCIFEO updated the committee on key E&F issues at both meetings.

d) Range and Quality of Financial information

The GCFO noted some options for how to progress reporting as Trusts and a Group at future committees in May. Committee members agreed with the proposed approach.

e) Annual Committee update

The Committee received and approved the annual report of the committee.

f) SWLP update

The Committee noted the financial outturn 2022/23 for SWLP

g) EPR and Network update

The Committee welcomed the update on EPR and the Network from the GCDO.

h) Policy update

Committee members approved the updated Petty Cash and Business Expenses policy from SGH and welcomed the intention to provide commonality with ESTH.

5.0 Implications

5.1	The Committee considered the finance, operational, IDT and estates risk on the SGH Corporate Risk Register by exception in May and June and the strategic risks within the Committee's remit on the Board Assurance Framework at the same meeting.
5.2	On the SGH Board Assurance Framework, the Committee reviewed the risks within its remit: Strategic Risk (SR) 3 (Operational and IDT Risk), SR5 (Financial Sustainability), SR6 (Financial investment), SR7 (Estates Risk). The Committee agreed no changes to risk scores or assurance ratings were appropriate at the Q1 2023/24 position.
5.3	The ESTH risk scores in finance, operations, IDT and estates also remain unchanged.

6.0 Recommendations

6.1	The Group Board is asked to note the issues escalated to the Board and the wider issues on which the Committee received assurance in May and June 2023.

Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	4.3	
Report Title	**People Committees-in-Common Report to Group Board**	
Non-Executive Lead	Stephen Collier, People Committee Chair, SGUH Martin Kirke, People Committee Chair, ESTH	
Report Author(s)	Stephen Collier, People Committee Chair, SGUH Martin Kirke, People Committee Chair, ESTH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees-in-Common at its meetings in May and June 2023 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- Industrial Action: The industrial action by staff continues to be a risk and a concern. The BMA Junior Doctors were re-balloting from 19th June to 31st August. The BMA ballot for industrial action by Consultants closed on 27th June and the first round of industrial action was due to take place on 20th and 21st July. Strike action by Consultants will have a significant impact on the Trusts.

- PSED: The Committees reviewed and approved the PSED 2022/23 report for both Trusts, for onward submission to the Group Board for approval and publication on the Trust websites by 31st July 2023. It was the first time SGUH had publishing a PSED report and learning was shared from ESTH, as staff worked collaboratively. The Trusts are required to achieve compliance in 3 areas – workforce; patient services and care; and health inequalities. The PSED demonstrates the Trusts' compliance by using information from standalone equality reports such as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). They also include the Gender Pay Gap data and the Equality Delivery System (EDS).

- Freedom To Speak Up (FTSU) 2022/23 Report: The Committees received the FTSU 2022/23 reports for each Trust. The FTSU Guardians reported increases in concerns raised, compared to the previous year, with the majority of concerns raised by nursing and midwifery, followed by administrative and clerical staff. At SGUH, the main area of concern raised was Trust systems and processes which included recruitment. At ESTH, it was management conduct, bullying and harassment. The ESTH Guardian reported a significant increase in concerns raised by staff in Estates and Facilities. The number of concerns which included an element of patient safety had increased. The areas of concern that had increased in 2022/23 were nepotism and reporting an element of detriment for raising concerns. Both Guardians reported ongoing issues of timeliness and delay in investigative processes and responsiveness to enquiries. The development of the proposed case management system and alignment of FTSU processes across the Group will help in reducing delays.

Action required by Group Board

The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in May and June 2023.

Committee Assurance	
Committee	People Committees-in-Common
Level of Assurance	Not Applicable

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committees-in-Common Report
Group Board, 07 July 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meetings in May and June 2023 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

1.2 The role of the Committee, as set out in its terms of reference, is to provide assurance on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care.

2.0 Items considered by the Committees

2.1 At its meetings on 19 May and 23 June 2023, the Committee considered the following items of business:

May 2023	June 2023
• Industrial Action update • Group Chief People Officer Update Report • Joint Bank Service Update • Group Workforce Key Performance Indicators Report with metrics • Deep Dive – Turnover / Recruitment and Retention • Workforce Improvement Plan and FY24 Budget – productivity • Payroll Dashboard – inc. SBS performance • Development of Education – SGUH Undergraduate MBBS Quality Assurance Visit Summary Report • Medical Revalidation Responsible Officer Quarterly Update • Ethnicity Pay Gap Report • Facility Time Reporting • People Management Group Report	• Group Chief People Officer's Report – including Industrial Action Update and Joint bank service update • Corporate Risk Register • GESH CEI Board update including GESH wide programme • Learning and Development - Apprenticeships • Public Sector Equality Duty* • Freedom To Speak Up (FTSU) Q4 2022/23 Report • Guardian of Safe Working Q4 Report • People Management Group Report

** Items marked with an asterisk are on the Group Board agenda as standalone items in July 2023.*

2.2 The Committees meet on a monthly basis, and the focus of meetings alternates between workforce operations in one month and culture, diversity, inclusion and organisational development the next. The chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH. The SGUH Committee Chair chaired the meeting in May and the ESTH Committee Chair chaired the meeting in June 2023.

3.0 Key issues for escalation to the Group Board

3.1 The Committees wish to highlight the following matters for the attention of the Group Board:

a) Industrial Action: The industrial action by staff continues to be a risk and a concern. The BMA Junior Doctors were re-balloting from 19th June to 31st August. The BMA ballot for industrial action by Consultants closed on 27th June and the first round of industrial action was due to take place on 20th and 21st July. Strike action by Consultants will have a significant impact on the Trusts.

b) PSED: The Committees reviewed and approved the PSED 2022/23 report for both Trusts, for onward submission to the Group Board for approval and publication on the Trust websites by 31st July 2023. It was the first time SGUH had publishing a PSED report and learning was shared from ESTH, as staff worked collaboratively. The Trusts are required to achieve compliance in 3 areas – workforce; patient services and care; and health inequalities. The PSED demonstrates the Trusts' compliance by using information from standalone equality reports such as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). They also include the Gender Pay Gap data and the Equality Delivery System (EDS).

c) Freedom To Speak Up (FTSU) 2022/23 Report: The Committees received the FTSU 2022/23 reports for each Trust. The FTSU Guardians reported increases in concerns raised, compared to the previous year, with the majority of concerns raised by nursing and midwifery, followed by administrative and clerical staff. At SGUH, the main area of concern raised was Trust systems and processes which included recruitment. At ESTH, it was management conduct, bullying and harassment. The ESTH Guardian reported a significant increase in concerns raised by staff in Estates and Facilities. The number of concerns which included an element of patient safety had increased. The areas of concern that had increased in 2022/23 were nepotism and reporting an element of detriment for raising concerns. Both Guardians reported ongoing issues of timeliness and delay in investigative processes and responsiveness to enquiries. The development of the proposed case management system and alignment of FTSU processes across the Group will help in reducing delays

4.0 Key Issues on which the Committees received assurance

4.1 The Committees wish to report to the Group Board the following matters on which they received assurance:

a) Group Workforce Key Performance Indicators Report with metrics

The KPI metrics data for March 2023 was presented, by exception, in May. Both Trusts reported similar positions to the last previous reports. At ESTH, the vacancy hotspots were still in Estates and Facilities and Healthcare Scientists. The sickness rate was still high at 5.04%. There had been a positive shift in the appraisal rate which had increased by 5% in month and was at 81%. A deep dive was being conducted into understanding the specific factors that had driven this. At SGUH, turnover had fallen for the ninth consecutive month to 15.59%, though still higher than the target of 12%. The sickness rate was still high at 4.24%. The vacancy rate at 7.92% was within target.

Benchmarking the metrics with 8 London Trusts for February was provided for the first time. It was highlighted that the SGUH vacancy rate was the second lowest compared to other London Trusts. The turnover rate was slightly higher than other London Trusts. The appraisal rate was good when compared to other London Trusts.

The Committees discussed the highest vacancy rate of 20% in integrated care community at ESTH and was assured that work was being conducted to understand the vacancies and a number of actions were being implemented.

The Committees received reasonable assurance on the Group Workforce Key Performance Indicators Report with metrics.

b) Deep Dive – Turnover / Recruitment and Retention

A high-level summary and concerns were presented to the Committees. A similar paper had been presented to the Committees in June 2022. The data for both Trusts was similar to the previous year. At ESTH, the turnover rate had increased by 0.25%. The turnover in Estates and Facilities had not improved since last year and was still a concern. This may be improved with the pay award. There was a higher turnover amongst AHPs, band 2 and 3 HCAs and Band 5 staff nurses. At SGUH, although turnover had reduced consecutively over the last 9 months, it was still slightly higher than last year by 0.03%. The main area of concern was the tenure of leavers, with 43% of new staff leaving within the first 2 years in admin and clerical; AHPs; Estates; Healthcare scientists; nursing and midwifery. 70% of new Band 2 HCAs left within 2 years, mainly to undertake further education and training. 58% of newly appointed Band 5 nurses left within 2 years. This was being addressed in the Workforce Improvement Plan. NHS England (NHSE) was working with SGUH to improve nurse retention at band 5 and HCAs. SGUH had been partnered with an organisation which was performing better on nurse retention.

The Committees received reasonable assurance on turnover, recruitment and retention.

c) Workforce Improvement Plan and FY24 Budget – productivity

The Workforce Improvement Plan (WIP) will contribute to the financial recovery of the Trust. The basis of the plan was to reduce reliance and spend on contingent staffing. The WIP includes controlling sickness absence, rostering and good annual leave practice. ESTH WIP was more progressed than SGUH, mainly due to the earlier work conducted by Kingsgate at ESTH. The team was working with PA Consulting who had made recommendations. The team was identifying SWL system CIPs and Trust CIPs. The savings on the in-housing of the bank service at ESTH needed to be included within the WIP.

ESTH had engaged with the discovery phase with divisions for the last 12 weeks, to review all contingent spend data, identifying behaviours and address, with cleaner data to understand where pinch points were and make reporting easier.

HR and Finance were working together to align the WIP to the financial recovery planning on a formal basis. The Committees agreed that the oversight on the progress of the WIP would remain with the People Committee.

d) Payroll Dashboard – inc. SBS performance

SGUH reported a consistent position on the level of manual payments caused by late new starters or incorrect bank details. The main reasons for overpayments were late leaver forms and late change forms by managers. The majority of the discussion was focused on

ESTH, as there had been deeper issues with the performance of SBS. The overall experience with SBS in the last 5 months had been positive. Pay query escalations to the team had reduced considerably from approx. 30-40 queries a month 6 months ago, to the current 2-3 queries a month. Some of the recommendations around late new starters had been implemented. Full onboarding for the medical workforce was now managed by Medical HR and had seen an improvement in pay accuracy for medical staff. ESTH was meeting regularly with SBS and providing support via a hotline and providing a lot of notice for complex pay arrangements.

Performance against the operational metrics fluctuated each month for both Trusts and had reduced slightly more recently. The aim was to minimise manual payments and overpayments at both Trusts, by ensuring the timeliness and accuracy of managers informing SBS when staff left the organisation or when contractual arrangements changed. The implementation of a manager self-service accesss portal would streamline the process and prevent delays. It was agreed that a project plan with timelines would be produced and circulated to the Committee.

The Committees received reasonable assurance on the payroll dashboard and on SBS performance.

e) <u>Development of Education – SGUH Undergraduate MBBS Quality Assurance Visit Summary Report</u>

This report was for SGUH only. The Committee was presented with the outcome of the quality assurance visit on 1st March 2023 by St George's University of London (SGUL) to the Trust Undergraduate Medical Education Team. The Trust has an ongoing relationship with SGUL. Positive feedback from the inspection team was received on the preparation work for the inspection, based on the information provided in the submission. This was apparent when the majority of the actions identified were already reflected in the information provided by the Trust, notably around ongoing initiatives.

The main actions identified were around:

- challenges in estates. The team was working with the estates team to deliver a programme of work. There had been an agreement with SGUL to share resources and facilities.

- Consistency in the quality of clinical teaching fellows and admin support across teaching areas. The capacity had been increased.

- Greater transparency in the capacity of Consultants to provide education. The Trust needed to understand the amount of time allocated for Consultants to deliver education, and ensure this was captured through the job planning process.

The SGUH Committee received reasonable assurance on the inspection and actions being taken forward.

f) <u>Medical Revalidation - Responsible Officer Quarter 4 Update</u>

The Responsible Officers (ROs) for each Trust highlighted the trends and issues in Q4.

The new RO for SGUH had been in post since March 2023 and highlighted:
- There were 1,062 connected doctors at SGUH in Q4, compared to 1016 in Q3.
- The appraisal compliance rate was 84.18%, against a target of 95%.

- Two Doctors were at risk of being discussed for non-engagement. Both Doctors had personalised bespoke plans with the RO and appraisal leads.
- More appraisers were trained in the spring and increased the appraiser body to 1:6 ratio.
- Ensured those with overdue or missing appraisals, particularly locally employed Doctors (LEDs) or Doctors from overseas were supported through the process.

The RO for ESTH reported:

- The difficulty in getting LEDs appraised. The proposal was to increase the number of appraisers by utilising educational supervisors, who would be offered training. Also, potential new appraisers would be asked if they would be interested in mentoring Doctors. This would go some way to resolving the issue.
- The number of deferrals had increased. Doctors were finding it difficult to obtain patient feedback, due to remote clinics. Therefore, appraisal dates were extended.
- All doctors had engaged with the process.
- Focus was on decreasing deferrals and increasing appraisals.

The Committees received reasonable assurance on the quarter 4 medical revalidation RO reports.

g) Ethnicity Pay Gap Report

The Committees received the ethnicity pay gap report, noting that there was no legal requirement to publish the report. The data provided in the report was captured as at 31st March 2022 ('the snapshot date') for both Trusts. The scope of the data was for all substantive and bank staff working on the snapshot date. The data did not include staff who had not disclosed their ethnicity. Further analyses were required to identify where the specific challenges were located, in order to take action.

There was a considerable difference in the mean and median pay gap between the Trusts. This was due to the demographics of the local communities of the Trusts. Although SGUH had more black, Asian and minority ethnic (BAME) staff (50%), than ESTH (38%), these were likely to be in the lower banded roles.

The mean pay gap at SGUH was 12.81% and the median was 15.94%. At ESTH, the mean pay gap was in favour of BAME staff at -6.20 and the median at -6.31%. The bonuses position for medical staff (clinical excellence awards) at SGUH was a 12.81% difference in the mean bonus pay and 33.3% difference in the median, both in favour of white staff. At ESTH, the mean bonus pay gap was 30.57% in favour of white staff, whereas the median difference was 50% in favour of BAME staff. The team would need to conduct further analysis on the recruitment and retention premiums to ascertain whether this was having an impact on the data. There were national and local premiums, based on how difficult roles were to fill. Spotlight on senior staff identified a trend at both Trusts of significantly less BAME staff in senior roles and reflected the position at both a London and a national level.

The next stage would be to get to the next level of detail to identify hotspots. There was no stand-alone action plan, as the Workforce Race Equality Standard (WRES) follow-on action plan would identify the actions required.

The Committees received partial assurance, given that further analysis was required to understand the issues and identify actions. A report would come to the September meeting with the actions reflected in the WRES.

h) Facility Time Reporting

The Committees noted the annual report and the combined Group cost of facility time for 2022/23 of £35k.

i) GESH CEI Board update including GESH wide programme

The Committees received a combined paper on the approach to developing culture across the Group over the next 2-3 years. Both Trusts had spent time reviewing the staff survey results and undertaken cultural diagnostics, culminating in the definition of the Big 5 areas of focus. The common themes across the Trusts had been identified and a group-wide culture development programme had been developed, whilst maintaining focus on the previous Big 5. The key areas will be business-critical culture and areas that have a high impact on staff on a day to day basis. The actions would be based on data and evidence. The 5 workstreams identified were:

1. Civility and Psychological Safety
2. Bullying and Harassment/Keeping staff safe (violence and aggression)
3. Compassionate and inclusive leadership
4. Inclusive behaviour
5. High-Performing Teams

The 5 workstreams contribute to the 9 strategic priorities, recently published in the Group Strategy. All work undertaken will need to contribute to Equality, Diversity and Inclusion (EDI) and Health and Wellbeing.

The 5 workstreams will be promoted to staff and bring in new interventions. Over the next 2 years, the infrastructure will be developed to embed the 5 workstreams within key people management processes which staff will be able to see.

The feedback from the Committees was that the development of a learning culture could be strengthened and responsiveness when people raised concerns could be included within psychological safety and leadership work. The Committees felt that overall productivity and high-performing teams should have more of an emphasis.

The Committees received reasonable assurance on the GESH CEI Board update including GESH wide programme.

j) Public Sector Equality Duty

The Committees reviewed and approved the PSED 2022/23 report for both Trusts, for onward submission to the Group Board for approval and publication on the Trust websites by 31st July 2023. The Trusts were required to achieve compliance in 3 areas – workforce; patient services and care; and health inequalities. The PSED demonstrates the Trusts' compliance by using information from standalone equality reports such as Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). They also include the Gender Pay Gap data and the Equality Delivery System (EDS).

It was the first time SGUH had publishing a PSED report and learning was shared from ESTH, as staff worked collaboratively. In future, the aim would be to have aconsistent format for the reports and a streamlined process.

k) Freedom To Speak Up (FTSU) 2022/23 Report

The FTSU Guardians for each Trust presented their 2022/23 reports.

The SGUH FTSU Guardian highlighted that 143 concerns had been raised in 2022/23, which was a 7% increase on the previous year (134). The staff groups that have raised the highest number of concerns over the 2022/23 financial year are nursing and midwifery staff (56) and administrative and clerical staff (29). There was also a collective concern raised by the Maternity service. The Children's Women's Diagnostics and Therapies Division, which is the largest Division, recorded the highest number of concerns with 64 (45%) of concerns being raised, MedCard with 34 concerns (24%), SNCT with 26 (18%), Corporate 12 (8%), Estates and Facilities 5 (3%) and 2 anonymous concerns. The dominant types of concern raised were around Trust systems and processes with 53 concerns being raised which included recruitment processes, followed by staff safety with 39, leadership 33, patient safety 30, behavioural relationships 28, cultural 23, bullying and harassment 23, Infrastructure and environment 3, and fraud 1.

Of the 143 concerns raised, 79% had been resolved. Timely resolution of concerns and effective communication with the Guardian remained an issue. The Guardian is meeting regularly with the site Leadership Team to progress concerns, and a new case management approach was being developed by the Guardian and Executive Lead.

A total of 44.8% of workers have undertaken the Speak Up training to date, which represents a significant increase in the number of workers trained since the introduction of Speak Up training as part of the MAST programme.

The priorities for the SGUH Guardian were to support the Group Strategy; set up triangulation meetings; implement the recommendations from the internal audit; and align the FTSU processes across the Group.

The ESTH FTSU Guardian reported a 10% increase in concerns raised in 2022/23, which was 350 cases. Of the 350 concerns, 30 were from Sutton Health and Care and 37 were from Surrey Downs Community. The staff groups which raised the highest number of concerns over the past year were similar to SGUH, with nursing and midwifery and administrative and clerical staff. The significant increase in staff raising concerns was from Estates and Facilities with 36 in 2022/23 and 8 the previous year. The main types of concern raised over the past year were consistent with the previous year and were around 'management conduct' and bullying and harassment. The number concerns with an element of patient safety increased from 14 in 2021/22 to 42 in 2022/23. A number of concerns had elements related to discrimination, pay, HR policy and processes. There was also an increase in concerns around nepotism. There had been a significant increase in colleagues reporting an element of detriment for raising concerns and with colleagues reporting concerns on behalf of others. There was a decrease in concerns regarding transformation and reorganisation; HR policies; and short staffing.

The ESTH Guardian highlighted a similar issue to SGUH around the ongoing issues of timeliness of investigation processes and responsiveness to enquiries. The delays were not always due to complexity of case, as even the more straightforward cases were taking a long time to resolve. Policies needed to be up to date and managers empowered to respond to enquiries. Priorities for ESTH were to continue to engage with staff; promote FTSU and confidence in staff to raise concerns; strengthen the service; triangulation of concerns; and develop the proposed case management system. Bring ESTH in line with SGUH by making the FTSU training part of the mandatory and statutory training.

The Committees received reasonable assurance on the FTSU 2022/23 reports.

l) Guardian of Safe Working Q4 Report

The Committees received the Q4 reports from the Guardians of Safe Working ('GoSW') at each Trust.

For SGUH, it was reported that Q4 was challenging due to winter pressures, staff sickness and industrial action. The Guardian reported the highest number of exception reports ever received for a Q4. Medicine remained the highest area for exception reporting, with immediate concerns around staff shortages. The SGUH Guardian was working with the service on escalations for agency and bank shift cover. Trainees reported feeling supported by their seniors. The pilot in Medicine to utilise Physicians Associates was being reviewed to cover out of hours. There had been a rise in exception reports from Cardiology. Locally employed doctors (LEDs) had started exception reporting and there was increased engagement by the Junior Doctor Forum. Funding from the Fatigue and Facilities charter had been used to redecorate the mess.

For ESTH, the GoSW reported that there were 177 exception reports in Q4. Similar to SGUH, the majority were received from general medicine. Of the reports, 75% were made by Specialist training 1 and Foundation Year 1 and 2 doctors. All exception reports were resolved, except for 3 which were cancelled. Gaps in Junior Doctor rotas were anticipated and the Guardian had worked with general medicine, who now had the lowest number of rota gaps. One fine was issued this year. Concern remained around the possible suppression of reporting. The Junior Doctors had been provided with unbiased advice on the industrial action.

The Committees received reasonable assurance on the Q4 GOSW reports.

m) Development of Group Corporate Services

The Committees continues to oversee the Group Corporate Services programme and receive updates in the private session of the Committee, for assurance. There is a substantial amount of work to be undertaken to be able to deliver this programme, including reviewing form and functions of corporate services, enabling agreements between the Trusts, benchmarking of functions against the NHS model hospital and similarly sized NHS providers.

5.0 Other issues considered by the Committees

5.1 During this period, the Committee also received the following reports:

a) Learning and Development – Apprenticeships

The Committees received the progress to date on apprenticeships, including the number of apprenticeships and varieties, comparative data with other NHS organisations and other sectors, the barriers in bringing in apprenticeships and the actions to be taken forward. There was now an Apprenticeships Lead in SGUH, although both Trusts had small teams.

Both Trusts are significantly underspending against their apprenticeship levy and if improved, it may contribute to improving the financial position of the Trusts. The total levy spend in 2022 for SGUH was £760,833 and for ESTH it was £535,729. The levy fund as at May 2023 for SGUH was c.£3.4m and c.£5.5m for ESTH. The estimated planned spending for 2023 was £745,041 (SGUH) and £583,074 (ESTH). The Trusts were in the 80% of NHS Trust with 100 or more staff on apprenticeships with 155 at SGUH and 157 at ESTH. Only 4% of public sector organisations use their full levy (data from City and Guilds).

There had been good successes at both Trusts to build capacity and capability in some specific and specialist areas. One of the issues highlighted was that backfill was a challenge in areas of nursing because the levy cannot be used to backfill posts. The aspiration was to become an anchor institution. The Trusts were exploring more local opportunities and the possibility of creating a hub and links with schools and universities. There will be a collaborative approach to apprenticeships across the Group, to realise opportunities. There were also opportunities to be explored at an SWL system level.

The Committees noted the report on Apprenticeships and agreed an update report would come back to the Committees in January 2024.

b) Group Chief People Officer Update Report, including the In-housing Bank Service and Industrial Action Updates

In-housing Bank Service - the Committees received regular updates on the progress of the implementation of bringing the bank service at ESTH in-house, for assurance and oversight. The current in-house arrangement at SGUH will be extended to ESTH and will be a joint management of the service, managed internally. The project was due to 'go live' on 1 July 2023. The Group Executive had agreed to extend the date by a month, to 1st August, in order to implement the necessary IT. TUPE of staff was progressing well, with 16 people transferring through from Bank Partners (the current service provider) to ESTH. Further recruitment would be required. The project would result in a significant saving.

A significant number of outstanding invoices, mainly due to non-compliant bookings of shifts with agencies, had been reported in May. By June, Bank Partners had reduced the backlog of invoices. The Trusts would continue to monitor the progress here.

Industrial Action update – the Committees received regular updates on industrial action. In May, it was reported that the majority of the unions had agreed to the pay deal. The four unions that had not agreed to the pay deal were the Royal College of Nursing (RCN), Unite, Society of Radiographers and the Royal College of Podiatry (RCOP). Of the 4 unions, 3 (except RCOP) were balloting members on strike action. RCOP had written to the Secretary of State concerning their rejection of the offer and requesting the introduction of a recruitment and retention allowance for the podiatry profession.

The pay offer would be paid to all staff in June 2023 and staff were given the option to receive the payment in instalments, rather than a single payment, so that it did not affect staff on Universal Credit. The position in relation to bank staff was that they would not receive the one-off Covid bonus, as they had been excluded in the agreement reached. Bank rates would however be uplifted to reflect the pay% award.

The BMA Junior Doctors were re-balloting from 19th June to 31st August. The BMA ballot for industrial action by Consultants closed on 27th June. The first round of industrial action is planned for 20th and 21st July. The impact of the strike action by Consultants will be significant.

NHS Staff Survey results by Protected Characteristics – progress had been made on communicating the results and actions to staff. A breakdown on protected characteristics of staff responding to the survey had been provided to the Committees. The results showed that older workers had a more positive experience than younger staff. There was not a big difference in gender, with a small number of trans staff reporting a less positive experience. It was noted that responses were negative from staff who had preferred not to disclose some characteristics. Asian and black staff reported a higher proportion of

positive results than white colleagues. For disability, staff experiences were less positive. For sexual orientation, the experience for non-straight staff at SGUH was slightly less positive than at ESTH. There were slight differences in religion.

The Committees agreed that a paper would come back to the Committee on what the data was telling us and the actions being taken forward, particularly around disability. The data was essential to understand whether the cultural changes being implemented were applicable to all staff. The WRES and WDES; the culture programme and local initiatives were significant pieces of work to address the issues for staff.

SWL Occupational Health – SWL was in the process of procuring a new occupational health system across SWL. Learning would be gained from the SWL Recruitment Hub.

Estates and Facilities - progress was being made on Estates and Facilities at ESTH. Back payments from April 2022 would be made in July, so that it did not coincide with the national pay award in June.

Pension Contribution Switching Scheme – allows qualifying staff who were nearing either their Lifetime Allowance (LTA) or the Annual Allowance (AA) thresholds to come out of the pension scheme and instead to receive the NHS Pension Scheme employer contribution (14.38% of pensionable pay, offset by reduced Employer NI contributions and administration costs (10-12%))as an additional payment in their salaries. The 2023/24 Budget had removed the maximum lifetime allowance and increased the annual allowance from £40,000 to £60,000. The scheme may have had a potentially indirectly discriminatory impact (favouring older people with long services and high paid roles), this was justified as a reasonable business necessity, whereas recent tax changes mean that the Trusts can no longer rely upon this justification. Following a discussion at Remuneration Committee it was agreed that the Trusts would look to close the scheme both to new and existing participants, by the end of this financial year (so March 2024). Sufficient notice and support will be given to allow current participants to make alternative arrangements.

c) People Management Group Report
The Committees received regular reports on PMG from both Trusts.

6.0 Review of risks

6.1 The People Committees-in-Common reviewed the People related Corporate Risk Register in June.

a) Corporate Risk Registers
The Committees were informed that an interim Group Risk Manager had been recruited. Over the summer, the Risk Team will be reviewing all the people-related risks at both Trusts, ensuring they are refreshed and up to date.

At SGUH, there were 14 people related risks. The proposal was to capture the risk of staff burnout within other existing risks as it is a consequence of other factors, rather than have it as a standalone risk. This was for both Trusts. For SGUH, the MAST training compliance risk had been open since May 2010 and had had a risk rating of 16 for 13 years. The mandatory and statutory training (MAST) compliance levels were on target (except for medical and dental) and the proposal was to reduce the likelihood score from 4 to 3, which would bring the overall risk rating to 12. Therefore, the MAST risk would come off the SGUH CRR. The MAST compliance will be monitored by local teams and the

Learning and Development Team. The risk will be escalated to the CRR, if there is non-compliance across the Trust. The SGUH Committee endorsed this proposal.

The Committees noted the existing people-related risks on the SGUH and ESTH CRR and relevant progress made in mitigating these risks; considered the closure of the Staff Burnout risk from SGUH and ESTH risk registers and the identified mitigations to be incorporated within existing risks; re-assessed the risk score for the SGUH CRR 882 (MAST training compliance levels) in view of the current Trust compliance levels; reviewed the new draft risk for industrial action for escalation to the Corporate Risk Registers of both Trusts, provided any further approach to treating the risk where needed, and agree the risk score; and noted and supported the proposed thorough review of the people-related risks on the SGUH and ESTH Corporate Risk Registers.

A comprehensive CRR for each Trust will be presented to the Committees in September and will reflect how staff burnout has been incorporated into other risks.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in May and June 2023.

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	4.4	
Report Title	**Audit Committee report of the meetings held on 3 May & 15 June 2023**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	SGUH Audit Committee	3 May & 15 June 2023
Purpose	**For Approval / Decision**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meetings on 3 May and 15 June 2023.

This report includes the draft Audit Committee report to the Group Board and sets out a proposed forward plan of business for the Audit Committee in 2023/24.

The terms of reference for the Committee have been reviewed. There are no proposed changes to the terms of reference, other than inserting – where appropriate – references to the Committee providing reports on its meetings to the Group Board, and formatting changes to bring the terms of reference into line with other Board Committees.

While no changes to the terms of reference are proposed, the Committee workplan for 2023/24 draws out elements of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year

gesh

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

Action required by the Board

The Board is asked to:

a) Note the report of the Committee's meetings held on 3 May and 15 June 2023;
b) Approve the Audit Committee Annual Report for 2022/23
c) Approve the proposed changes to the Committee's Terms of Reference;
d) Approve the Committee's proposed work plan for 2023/24

Committee Assurance	
Committee	SGUH Audit Committee
Level of Assurance	Not applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	Audit Committee Annual Report 2022/23
Appendix 2	Proposed Committee Terms of Reference
Appendix 3	Proposed Committee Forward Workplan 2023/24

Implications

Group Strategic Objectives

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

Risks

There are no specific risks relevant to this report, beyond those set out in the individual reports to the Board.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

Equality, diversity and inclusion implications

Environmental sustainability implications

Report of the SGUH Audit Committee

SGUH Trust Board, 07 July 2023

1.0 Purpose of paper

1.1 The Audit Committee met on 3 May and 15 June 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 **Year-end and Annual Report and Accounts 2022/23**

2.2 In May, the Committee was updated on the progress of the production of the 2022-23 Annual Report and Accounts at the May meeting and were pleased to be informed that work was on track to present a final draft at the Audit Committee on 15 June for recommendation to the Trust Board before submission to NHS England by 30 June 2023. The Committee was informed members would have the opportunity to provide comments on the report ahead of its presentation at the June meeting. The Committee received the report on preparations for the annual audit of the Trust's accounts which sets out the management responses to the auditors enquires.

2.3 At the meeting on 15 June, the Committee reviewed the Trust's accounts as well as the external audit findings report and the value for money report. The Committee was pleased to note the final unqualified position and was reassured that no material issues had been identified. The Committee noted that there were some minor outstanding actions arising from the external audit that would be addressed between the Audit Committee meeting and the review of the accounts by the Board.

2.4 The Committee noted that the Value for Money report flagged that financial sustainability will remain a challenge in 2023/24 and that the Trust will be engaging with system partners on developing plans to return the South West London system to a balanced financial position in 2024/25. The recommendations that were aligned to current plans had been endorsed by management.

2.5 At the June meeting the Committee reviewed the final draft Annual Report and agreed to recommend it to the Trust Board, noting the report was a fair reflection of the Trust's achievements and challenges in 2022/23.

2.6 The Committee also received the draft 2022/23 Quality Account at the June meeting and agreed to recommend its submission to the Trust Board.

2.7 **Head of Internal Audit Opinion**

2.8 The Head of Internal Audit Opinion was also presented which provided "reasonable assurance" to the Committee that there is a generally sound system of internal control, designed to meet the organisation's objectives, and that controls are generally being applied consistently.

2.9 **Internal Audit Progress Report and final Internal Audit Reports**

The Committee received five final internal audit reports and the first part of the review of the Data Security and Protection Toolkit:

- Data Security and Protection Toolkit Part One – **Advisory**
- Core Finance – **Reasonable Assurance**
- Estates and Facilities – **Reasonable Assurance**
- Divisional Governance – **Reasonable Assurance**
- Board Assurance Framework and Risk Management – **Reasonable Assurance**
- Fit and Proper Person – **Substantial Assurance**

2.10 The Committee noted the advisory opinion on the work undertaken to date on the annual submission of the Trust's Date Security and Protection toolkit which is on track for completion and submission by 30 June.

2.11 The Committee noted the reasonable rating for the Core Finance review and were reassured that once the accepted recommendations are implemented the Trust will be in a strong position to achieve substantial assurance in future.

2.12 The Committee was pleased to receive the reasonable opinion for Estates and Facilities, noting the improved trajectory since the previous limited assurance rating in this area. All recommendations have been accepted by management and are expected to be implemented by the end of 2023/24.

2.13 Divisional Governance received a reasonable assurance rating, and the Committee was reassured that the recommendations from the review aligned with the Trust's views on its quality governance needs.

2.14 The Committee noted the annual review of the Board Assurance Framework and Trust Corporate Risk Register had provided a reasonable assurance rating and that the recommendations from the review were already planned as part of the work to develop a Group-wide BAF and single risk management framework.

2.15 The Committee welcomed the substantial assurance opinion for the Fit and Proper Person review and noted the rating demonstrated the work to address retention and storage of files as well ensuring effective verification processes and annual checks.

2.16 The Committee was pleased to note the successful completion of the 2022/23 internal audit plan and that the outstanding actions and recommendations will be followed up by the new internal audit provider.

2.17 The Chair thanked TIAA on behalf of the Committee for all their work as the Trust's outgoing internal auditors and for supporting a successful transition to RSM as the incoming internal auditors.

2.18 **Internal Audit Workplan 2023/24**

2.19 At its meeting in May the Committee received the first draft of the internal audit workplan for 2023/24. The Committee requested revisions to the planned timings of some of the audits and asked for the scopes of the productivity and cybersecurity audits to be developed further. At the 15 June meeting, the Committee was pleased to recommend the approval of the plan to the Board. The Committee welcomed the inclusion of the reviews for productivity and cybersecurity noting their importance as local and national priorities. Work has now commenced on the delivery of that plan. In order to maximise learning from internal audits at a Group level, a high level framework was presented to the Committee setting out how audit

reviews undertaken at one Trust within the Group will be shared with the other, and how the learning from those audits will be shared across the Group.

2.20 **Counter Fraud Update**

2.21 The Committee approved the new counter fraud provider's 2023/24 workplan and received the progress report on ongoing investigations at the Trust and delivery of counter fraud training for staff.

2.22 The Committee also received the Counter Fraud 2022/23 Annual Report from the previous providers and were informed that the Trust had self-assessed itself as fully compliant with ten of the 12 Government Functional Standards. The Committee noted the 2022/23 self-assessment return would need to be signed off by the Chair and GCFO by the deadline of 30 May.

2.23 **Breaches and waivers report**

2.24 The Committee was told that the usage of waivers in Q4 had increased to 29 up from eight, along with an overall value to £2m. There was also an increase in the instances of breaches rising to 13. The Committee noted the spike in usage had been expected due to year-end and welcomed the work undertaken in 2022/23 at the Trust and across SWL to reduce use.

2.25 **Standing Orders, Scheme of Delegation and Standing Financial Instructions**

2.26 The Committee received the approach and timeline for developing and agreeing a new corporate governance manual for the Trust comprising of a revised set of Standing Orders, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions which will provide a consistent framework across the Group. The new framework will acknowledge the two Trusts as separate sovereign legal entities with separate corporate governance documents.

2.27 **Managing Conflicts of Interest Group-wide policy**

2.28 The Committee was informed that SGUH had achieved 69% compliance for decision-making staff making declarations of interest in 2022/23. A report outlining recommendations on how to increase compliance and engagement with staff in 2023/24 will be presented to the August Committee.

2.29 **Annual Review of Audit Committee effectiveness 2022/23**

2.30 The Committee received the results from the annual review of its effectiveness noting scoring had been positive although low engagement with the survey meant it limited learning from the results.

2.31 **Committee governance**

2.32 The Committee reviewed its terms of reference and annual work plan for 2023/24. Minor amendments were proposed to the terms of reference, which the Committee endorsed and proposes that the Board approve. These related to inserting references to the Committee providing reports on its meetings to the Group Board, and formatting changes.

3.0 Recommendations

3.1 The Board is asked to:

- Note the report of the Committee's meetings held on 3 May and 15 June 2023;
- Approve the Audit Committee Annual Report for 2022/23
- Approve the proposed changes to the Committee's Terms of Reference;
- Approve the Committee's proposed work plan for 2023/24

Peter Kane
Audit Committee Chair, NED
July 2023

NHS
St George's University Hospitals
NHS Foundation Trust

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

Audit Committee
Annual Report 2022/23

1 April 2022 – 31 March 2023

St George's University Hospitals NHS Foundation Trust

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

Contents

St George's University Hospitals NHS Foundation Trust

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

Audit Committee Annual Report 2022/23

1. Introduction

This report sets out the work of the Audit Committee of St George's University Hospitals NHS Foundation Trust during the reporting period 1 April 2022 to 31 March 2023. It provides a high level overview of the Committee's work over the past year and sets out how the Committee has discharged its responsibilities as set out in its terms of reference over the past year, in line with good corporate governance practice.

2. Committee purpose and duties

The Audit Committee has been established to ensure that that the Trust has in place effective mechanisms and systems of internal control and to provide the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee's purpose and duties are set out in its terms of reference as approved by the Trust Board on 7 July 2022. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Provide appropriate challenge and support whilst living the Trust's values.
- Play a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2022 to March 2023), the following were members or regular attendees of the Audit Committee:

St George's Audit Committee			
Name	Role	Designation	Period
Peter Kane	Member	Committee Chair, Non-Executive Director	1 April 2022 – 31 March 2023
Ann Beasley	Member	Non-Executive Director	1 April 2022 – 31 March 2023
Tim Wright	Member	Non-Executive Director	1 April 2022 – 31 March 2023
Yin Jones	Member	Associate Non-Executive Director	2 March 2023 – 31 March 2023
Andrew Grimshaw	Attendee	Group Chief Finance Officer	1 April 2022 – 31 March 2023
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2022 – 31 March 2023
Tom Shearer	Attendee	Deputy Chief Financial Officer	1 April 2022 – 31 March 2023

Other executive directors and senior leaders including the Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Group Chief Digital Officer, Director of Procurement, and the local counter fraud specialist also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews. In addition, internal auditors and external auditors attended each of the meetings.

3.2 Committee meeting attendance

In 2022/23 the quorum for each meeting of the Committee was two members. For avoidance of doubt only non-executive directors are members of the Committee.

The Committee held a total of 5 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committee were quorate.

Name	Role	Attendance
Peter Kane	Committee Chair	5/5
Ann Beasley	Member	5/5
Tim Wright	Member	5/5
Pui-Ling Li*	Member	1/4

** until 12 January 2023*

In line with the requirements that the Committee should only comprise non-executive directors as members, the following individuals were not members of the Committee and did not form part of the quorum but regularly attended the Committee during 2022/23:

Name	Role	Attendance
Andrew Grimshaw	Group Chief Finance Officer	4/5
Stephen Jones	Group Chief Corporate Affairs Officer	5/5
Tom Shearer	Deputy Chief Financial Officer	4/5

4. Committee activity and focus

4.1 External Audit

During the period the Committee received regular progress updates at each meeting from the external auditors, Grant Thornton LLP, on the preparations for and completion of the external audit of the Trust year-end financial statements, the annual report and the quality accounts during the period. The Committee supported the completion of a successful audit process of the 2021/22 financial year. The Committee reviewed the plans for conducting the 2022/23 audit and agreed to recommend to the Board the audit fee for the 2022/23 audit.

The Committee reintroduced holding private meetings with the external auditors at the close of meetings in late 2022/23 and during these meetings there were no issues of material concern raised. This is a practice the Committee plans to continue in 2023/24.

4.2 Internal Audit

During the period internal auditors carried out 15 reviews, including cybersecurity for which the draft report was still to be issued at the time of this report:

Assurance Assessments	2022/23	2021/22
Substantial Assurance	2	2
Reasonable Assurance	7	12
Limited Assurance	4	2
No Assurance	0	0
Advisory	2	1

The Committee was pleased that no reviews received a 'no assurance' rating, two were rated 'substantial assurance'. There was a high proportion of reviews rated 'reasonable assurance', but it was disappointing that four reviews had a 'limited assurance' rating, an increase of two from the previous year. These included the audits of the Trust's Payroll processes; Procurement; IT systems not supported by central IT; and the cybersecurity review which had not yet been issued. Recommendations have been made to further strengthen the controls in these areas and management have accepted and implemented the recommendations which should result in improved assurance in future. The Committee welcomed the assurances of Executive leads that future audits will see service areas engage fully with internal reviews and provide timely responses to recommendations as well as strengthened processes for signing-off on final reports. The Committee also noted the value of 'limited assurance' ratings in assisting the Trust to identify gaps, areas of concerns and improve its internal controls.

The Committee's scrutiny of the internal audit recommendation tracker, with the support of Executive leads, resulted in the outstanding recommendations being proactively progressed, with the result that the number of outstanding actions had been significantly reduced compared with previous years. However, a number of internal audit actions remained open at year end and the Committee will continue to monitor the implementation of these over the coming year.

The Committee also commended the leads for audits which received a substantial assurance rating, which included Fit and Proper Persons and ICT Programme and Project Management. It also commended leads for audits which received a reasonable assurance rating, including rostering of medical staff, temporary staffing (which had focus on rostering of AHPs), core finance, divisional governance, data quality (outpatients outcoming process) and the Board Assurance Framework and risk management.

In July 2022, the Audit Committee agreed to undertake a Group-wide tender for a new internal audit and counter fraud provider. Subsequently, following further discussions across the South West London system, at its October 2022 meeting the Committee agreed that the Trust should participate in a South West London-wide tender for both internal audit and counter fraud services including St Helier and Epsom University Hospitals and Health Group, Croydon Health Services NHS Trust, Kingston Hospital NSH Foundation Trust and

Hounslow and Richmond Community Healthcare NHS Trust. The Committee also agreed the composition of a review panel to review tenders to comprise of the Audit Committee Chairs of each of the Trusts involved. A procurement panel was convened in December 2022 to consider the tenders received. Unfortunately, the panel was unable to reach a unanimous decision, and the Trust – along with Epsom and St Helier University Hospitals and Croydon Health Services – decided to make a direct contract award to RSM, which was considered to offer the best value for money and quality of service. At the Audit Committee in January 2023, the Committee approved the recommendation. Although a SWL-wide contract award was not ultimately made, the chairs of the SWL Audit Committees expressed interest in convening a SWL Audit Chairs Forum to foster collaboration and encourage sharing of best practice particularly, though not exclusively in relation to internal audit.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditors, a core element of the Committee's focus in 2022/23 was monitoring the Trust's corporate governance, compliance and systems for internal control. To this end the Committee reviewed and endorsed the annual self-certification with the Foundation Trust Licence for 2021/22.

The Committee considered how the financial limits within the Trust's Scheme of Delegation should be interpreted in the context of the new Group structure, and noted some pragmatic changes to the existing delegations ahead of a more comprehensive review of the Trust Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions in 2023/24, about which the Committee received an update at its May 2023 meeting.

The Committee focused in particular on the management of conflicts of interest acoss the Trust, and noted a significant improvement in compliance of decision-making staff in making declarations of interest in 2022/23, achieving a year end compliance total of 69% as opposed to 54% in 2021/22. The Committee welcomed this improvement and the work of the Corporate Governance team in working with staff across the Trust to secure increased engagement. The Committee also received and endorsed the new Group-wide policy for managing conflicts of interest at its meeting in January 2023, and further noted that the Trust's system for managing conflicts of interest had been extended to Epsom and St Helier University Hospitals NHS Trust during the year which provided a means of ensuring consistency in the way in which declarations of interest are managed across the Group.

As well as regularly reviewing the use of waivers, write-offs and special payments, the Committee also reviewed counter fraud arrangements and considered issues and themes raised by the Local Counter Fraud Specialist.

There were also discussions about how to realise the benefits of the new Group model, including how the Committee might meet as a Committee-in-Common with the Epsom and St Helier Audit Committee at a future point in time.

4.4 Trust Annual Report and Accounts

In June 2022, the Committee endorsed the final draft annual report, annual accounts and quality accounts for 2021/22 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2021/22. The report was prepared in line with NHS Foundation Trust Annual Reporting Manual. A full report was prepared as the exemptions previously put in place due to the Covid-19 pandemic had been removed. The Annual Report and Accounts were received by the Trust Board on 21 June and were subsequently submitted to NHS England.

The Value for Money (VfM) Report for 2021/22 did not require the external auditors to provide a qualified or unqualified VfM opinion and the report concluded there were no significant weaknesses in the Trust's financial governance and sustainability, wider governance arrangements, and in relation to economy, efficiency and effectiveness. The report noted the challenges faced by the Trust in delivering a deficit budget with unidentified cost improvement programmes and pressures on cash balances.

In January 2023, the Committee reviewed and agreed plans for the production of the 2022/23 annual report and accounts and also agreed both the accounting policies and the external audit plan and fees for 2022/23.

4.5 Cybersecurity

The Committee received regular reports on the Trust's cybersecurity resilience and how well the Trust is prepared to respond to potential cybersecurity threats. The Committee also received updates on the work to move to a Group-wide approach and the development of a cybersecurity dashboard. The Committee also received updates on the work underlying the annual submission of its Data Security and Protection Toolkit.

5. Committee Effectiveness

The Audit Committee conducted a review of its effectiveness in 2022/23, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. Overall, albeit on a low response rate, respondents to the survey scored the performance and effectiveness of the Committee as either very effective or somewhat effective. Two areas for consideration for improving the Committee's effectiveness were the opportunity to use the South West London Audit Chairs Forum to identify and disseminate learning from audit work across SWL, and the opportunity to move in future to a committees-in-common approach, with appropriate provision for Trust-specific reporting and testing of controls.

6. Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2023/24 is attached (see Appendix 3). The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2023/24 reflects the principles set out in the NHS Audit Committee Handbook and reflects the required matters for the Committee's review.

The Committee's terms of reference have been reviewed. There are no proposed changes to the terms of reference, other than inserting – where appropriate – references to the Committee providing reports on its meetings to the Group Board, and formatting changes to bring the terms of reference into line with other Board Committees. While no changes to the terms of reference are proposed, the proposed Committee workplan for 2023/24 draws out elements of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year.

7. Conclusion

During 2023/24, the Committee worked hard to deliver its duties as set out in its terms of reference. Its overall effectiveness is reflected in the Committee effectiveness review for 2022/23. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give a reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

Audit Committee

Terms of Reference

1. Name

The Committee shall be known as the “Audit Committee”.

2. Establishment and Authority

The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

The Audit Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. Purpose

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust’s activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust’s arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust’s Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

(a) Governance, Internal Control and Risk Management: The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality and Safety Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.
vii. Oversee and provide assurance to the Board on the robustness of the Trust's governance, internal control and risk management arrangements in relation to the Trust's participation in the St George's, Epsom and St Helier University Hospitals and Health Group.

(b) Internal audit: The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.

(c) External audit: The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also work with the Council of Governors on the appointment or retention of the external auditors.

(d) Financial reporting and accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

(f) Raising concerns: The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

(g) General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.
v. Review the Trust's governance, internal control and risk management arrangements in the context of the St George's, Epsom and St Helier University Hospitals and Health Group.

(h) Management: The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

(i) Annual work plan and Committee effectiveness: Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Membership and Attendance

A Non-Executive Director will chair the Audit Committee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Corporate Affairs Officer and Chief Financial Officer are the Executive Leads for the Audit Committee.

The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair, and one Associate Non-Executive Director.

Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

The following are regular attendees at the Committee:

- Group Chief Financial Officer
- Group Chief Corporate Affairs Officer
- Managing Director – SGUH
- Site Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that director's portfolio. At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Counter Fraud Lead
- Head of Technical Accounting – for the Annual Accounts
- Group Chief Nursing Officer and/or the Group Director of Compliance – for the Quality Account
- Group Chief Communications and Engagement Officer – for the Annual Report

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

6. Quorum

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

7. Declarations of Interest

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion.

8. Meeting Frequency

Meetings of the Committee shall be held quarterly.

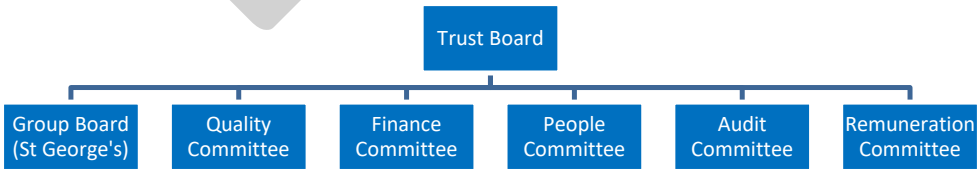
An additional extraordinary meeting will be held to review the external auditor's report and recommend the adoption of the annual report and accounts to the Trust Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

9. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The Group Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than five working days ahead of the meeting.

10. Relationship with other groups and committees

The Committee will report to the Trust Board as shown below.



11. Report to Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to

which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

12. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

13. Annual cycle of business

An annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

14. Review of Committee Effectiveness and Terms of Reference review

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Trust Board.

Document Control

Profile	
Document name	Audit Committee Terms of Reference
Version	XX
Executive Sponsor	Group Chief Corporate Affairs Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	TBC – 15 June 2023
Date of Trust Board approval	TBC – 7 July 2023
Date for next review	April 2024

St George's University Hospitals NHS Foundation Trust

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

SGUH Audit Committee Forward Plan 2023/24 - DRAFT

Items	3 May 2023	15 June 2023	3 August 2023	October 2023	January 2024
Standing items	Minutes Action log New risks/escalation to Board	Minutes Action log	Minutes Action log New risks/escalation to Board	Minutes Action log New risks/escalation to Board	Minutes Action log New risks/escalation to Board
External Audit	Informing the audit risk assessment 22-23	External Auditor's Report on the Annual Report and Accounts Letter of Representation Independent Auditor's Report to the Council of Governors Value for Money Audit Report	External Audit Progress Updates External Audit Tender (Private Session)	External Audit Progress Updates	External Audit Progress Updates External Audit Plan and Fees
Internal Audit	Internal Audit Progress Update Internal Audit Recommendations Tracker Draft Internal Audit Annual Report, including Draft Head of Internal Audit Opinion Internal Audit 2023-24 plan (inc. Internal Audit five-year workplan)	Internal Audit Workplan 2023/24 Head of Internal Audit Opinion	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. New starters – onboarding 2. IT systems by central IT 3. Cybersecurity	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. Discharge Management 2. Pressure ulcers 3. Rostering 4. Data Quality	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. Productivity 2. Procurement 3. Medical Devices 4. Key Financial Controls 5. Cybersecurity Draft Internal Audit Plan 2024/25
Counter Fraud	Counter Fraud Progress Report Counter Fraud Annual Report, Self-Assessment and 2023/24 Workplan Counter Fraud Update Quarterly Reports including updating on invoicing action Counter-Fraud Quarterly Updates		Counter-Fraud Quarterly Updates	Counter-Fraud Quarterly Updates	Counter-Fraud Quarterly Updates
Governance, Internal Control and Risk	Review of Committee Effectiveness 2022/23 Annual Review of Conflicts of Interest Compliance Review of Board Assurance Framework Internal Controls and Governance Mechanisms Standing Orders, Scheme of Delegation and Standing Financial Instructions	Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan Annual Self-Assessment of Compliance with Foundation Trust Licence	Managing Conflicts of Interest: Update on Compliance Clinical Audit Programme Developing the Group Board Assurance Framework Developing Group-wide policies: Policy on the development of Group and Trust Policies	Standing Orders, Scheme of Delegation and Standing Financial Instructions Group Risk Management Strategy and Policy Freedom to Speak Up: Internal Controls and Governance	Annual Review of Risk Management Review of Board Assurance Framework Internal Controls and Governance Mechanisms Compliance with Trust Constitution and Code of Governance for NHS Provider Trusts Review of Internal Auditors Effectiveness Review of Committee Effectiveness (plan for 2023/24)

					Use of Trust Seal
Financial Reporting	Breaches and Waivers report		Breaches and Waivers report	Breaches and Waivers report Losses & Compensation Payments Aged Debt Update	Annual Report High Level Themes Accounting Policies Breaches and Waivers report
Annual Report and Accounts	Annual Report 2022/23: Key Themes	Draft Annual Report 2022/23 Draft Annual Accounts 2022/23 and Going Concern Statement Draft Quality Accounts 2022/23			Annual Report 2023/24: Plan
IG/Cybersecurity	Information Governance / Cybersecurity update		Information Governance / Cybersecurity update inc. Cybersecurity Dashboard Information Governance Compliance Update and Annual Report	Information Governance / Cybersecurity update	Information Governance / Cybersecurity update

ESTH Trust Board

Meeting on Friday, 07 July 2023

Agenda Item	4.5	
Report Title	**Audit Committee report of the meetings held on 4 May and 15 June 2023**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	ESTH Audit Committee	04 May 2023 & 15 June 2023
Purpose	**For Approval / Decision**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meetings on 4 May and 15 June 2023.

This report includes the draft Audit Committee report to the Group Board and sets out a proposed forward plan of business for the Audit Committee in 2023/24. An update on the Annual Accounts will be provided at the Board.

The terms of reference for the Committee have been reviewed. There are no proposed changes to the terms of reference, other than inserting – where appropriate – references to the Committee providing reports on its meetings to the Group Board, and formatting changes to bring the terms of reference into line with other Board Committees.

While no changes to the terms of reference are proposed, the Committee workplan for 2023/24 draws out elements of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year.

Action required by the Board

The Board is asked to:

a) Note the report of the Committee's meetings held on 4 May and 15 June 2023;
b) Approve the Audit Committee Annual Report for 2022/23
c) Approve the proposed changes to the Committee's Terms of Reference;
d) Approve the Committee's proposed work plan for 2023/24

Committee Assurance	
Committee	ESTH Audit Committee
Level of Assurance	Not applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Audit Committee Annual Report 2022/23
Appendix 2	Proposed Committee Terms of Reference
Appendix 3	Proposed Committee Forward Workplan 2023/24

Implications

Group Strategic Objectives

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

Risks

There are no specific risks relevant to this report, beyond those set out in the individual reports to the Board.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

.

Equality, diversity and inclusion implications

.

Environmental sustainability implications

Report of the ESTH Audit Committee

Group Board, 07 July 2023

1.0 Purpose of paper

1.1 The Audit Committee met on 4 May and 15 June 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 **Year-end and Annual Report and Accounts 2022/23**

2.2 In May, the Committee was updated on the progress of the production of the 2022-23 Annual Report and Accounts at the May meeting and were pleased to be informed that work was on track to present a final draft at the Audit Committee on 15 June for recommendation to the Trust Board before submission to NHS England by 30 June 2023. The Committee was informed members would have the opportunity to provide comments on the report ahead of its presentation at the June meeting.

2.3 At the meeting on 15 June, the Committee was informed that the final external audit findings report would be delayed which meant the draft annual accounts could not be recommended to the Trust Board. The Committee were told that management and finance colleagues continue to work with external audit on resolving the delay and producing a final report.

2.4 At the June meeting the Committee reviewed the final draft Annual Report and agreed to recommend it to the Trust Board, noting the report was a fair reflection of the Trust's achievements and challenges in 2022/23.

2.5 The Committee also received the draft 2022/23 Quality Account at the June meeting and agreed to recommend its submission to the Trust Board.

2.6 **Head of Internal Audit Opinion**

2.7 The Committee was informed the Trust had been given a Head of Internal Audit Opinion of moderate assurance, based on the audits undertaken throughout 2022/23 which had demonstrated good overall levels of assurance of the Trust's controls and processes.

2.8 **Internal Audit Progress Report and final Internal Audit Reports**

2.9 The Committee received four final internal audit reports and the first part of the review of the Data Security and Protection Toolkit:

- Data Quality – Criteria to Reside – **Moderate Assurance**
- Key Financial Systems – **Substantial/Moderate Assurance**
- Freedom to Speak Up – **Moderate Assurance**
- Fit and Proper Person – **Substantial Assurance**
- Data Security and Protection Toolkit Part One – **Moderate Assurance**

2.10 The Committee received the Data Quality – Criteria to Reside review welcoming the moderate opinion and accompanying recommendations to improve on accurate data collection going forward and support the forthcoming rollout of Cerner at the Trust.

2.11 The Trust's key financial systems received substantial assurance for design and a moderate opinion for operational effectiveness. The Trust accepted the recommendations which will support more effective recovery of debt going forward and minimise risk of potential lost income.

2.12 The Committed noted the moderate assurance rating for Freedom to Speak Up audit which was flagged as an area of importance for the Committee, noting the recommendations from the audit needed to be positioned in the wider context of raising concerns and grievance as well as the overlap with Serious Incident reporting and complaints.

2.13 The Committee welcomed the substantial assurance opinion for the Fit and Proper Person review and noted the rating demonstrated the work to address retention and storage of files as well ensuring effecting verification processes.

2.14 The Committee also noted the work to date on the annual submission of the Trust's Data Security and Protection toolkit which is on track for completion and submission by 30 June.

2.15 The Chair thanked BDO on behalf of the Committee for their work as the Trust's outgoing internal auditors and for supporting a successful transition to RSM as the incoming internal auditors.

2.16 **Internal Audit Workplan 2023/24**

2.17 At its meeting in May the Committee received the first draft of the internal audit workplan for 2023/24. The Committee requested revisions to the planned timings of some of the audits and asked for the scopes of the productivity and cybersecurity audits to be developed further. At the 15 June meeting, the Committee was pleased to recommend the approval of the plan to the Board. The Committee welcomed the inclusion of the reviews for productivity and cybersecurity noting their importance as local and national priorities. Work has now commenced on the delivery of that plan. In order to maximise learning from internal audits at a Group level, a high level framework was presented to the Committee setting out how audit reviews undertaken at one Trust within the Group will be shared with the other, and how the learning from those audits will be shared across the Group.

2.18 **Counter Fraud Update**

2.19 The Committee approved the new counter fraud provider's 2023/24 workplan and received their Q1 report on ongoing investigations at the Trust and delivery of counter fraud training for staff.

2.20 The Committee also received the Counter Fraud 2022/23 Annual Report from the previous providers and were informed that the Trust had self-assessed itself as Green for 11 of the 12 Government Functional Standards, which was an improvement on the previous year.

2.21 **Breaches and waivers report**

2.22 The Committee was told that the usage of waivers in Q4 had increased to eight, up from three, with an overall value to £4532k. There was also an increase in the instances of breaches rising to three. The Committee noted the spike had been expected due to end-of-year and was a reasonably low number in both volume and value. Work would nonetheless continue to bear down on both waivers and breaches.

2.23 **Cyber Security and Information Governance**

2.24 The Committee heard work continues to develop a Group wise cybersecurity dashboard which would provide a separate Trust-level view and a Group-wide view. Work also continues to complete the annual Data Security and Protection toolkit in readiness for submission on 30 June.

2.25 **Standing Orders, Scheme of Delegation and Standing Financial Instructions**

2.26 The Committee received the approach and timeline for developing and agreeing a new corporate governance manual for the Trust comprising of a revised set of Standing Orders, Scheme of Reservation and Delegation of Powers, and Standing Financial Instructions which will provide a consistent framework across the Group. Although seeking greater standardisation, the new framework will acknowledge the two Trusts as separate sovereign legal entities.

2.27 **Managing Conflicts of Interest Group-wide policy**

2.28 The Committee was informed that at year-end ESTH had achieved 73% compliance for decision-making staff making declarations of interest. The Committee will receive recommendations on how to increase compliance further in 2023/24.

2.29 **Annual Review of Audit Committee effectiveness 2022/23**

2.30 The Committee received the results from the annual review of its effectiveness noting scoring had been positive although low engagement with the survey meant meaningful learning from the results was limited. In response to comments made in the survey, the GCCAO and GCFO were asked to develop proposals for moving to an Audit Committees-in-Common for discussion at future meeting.

2.31 **Committee governance**

2.32 The Committee reviewed its terms of reference and annual work plan for 2023/24. Minor amendments were proposed to the terms of reference, which the Committee endorsed and proposes that the Board approve. These related to inserting references to the Committee providing reports on its meetings to the Group Board, and formatting changes.

3.0 Recommendations

3.1 The Board is asked to:

a) Note the update from the Audit Committee meetings held on 4 May and 15 June 2023.
b) Note the update on the Trust's Annual Report and Accounts, including Quality Report, 2022/23. Update to be provided at the Board;
c) Approve the Audit Committee Annual Report for 2022/23;
d) Approve the proposed changes to the Committee's Terms of Reference;
e) Approve the Committee's proposed work plan for 2023/24.

Epsom and St Helier University Hospitals NHS Trust

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

Audit Committee Annual Report 2022/23

1 April 2022 – 31 March 2023

Epsom and St Helier University Hospitals NHS Trust

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

Contents

Epsom and St Helier University Hospitals NHS Trust

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

Audit Committee Annual Report 2022/23

1. Introduction

This report sets out the work of the Audit Committee of Epsom and St Helier University Hospitals NHS Foundation Trust during the reporting period 1 April 2022 to 31 March 2023. It provides a high level overview of the Committee's work over the past year and sets out how the Committee has discharged its responsibilities as set out in its terms of reference over the past year, in line with good corporate governance practice.

2. Committee purpose and duties

The Audit Committee has been established to ensure that that the Trust has in place effective mechanisms and systems of internal control and to provide the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee's purpose and duties are set out in its terms of reference as approved by the Trust Board on 7 July 2022. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Provide appropriate challenge and support whilst living the Trust's values.
- Play a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2022 to March 2023), the following were members or regular attendees of the Audit Committee:

St George's Audit Committee			
Name	Role	Designation	Period
Peter Kane	Member	Committee Chair, Non-Executive Director	1 April 2022 – 31 March 2023
Ann Beasley	Member	Non-Executive Director	1 April 2022 – 31 March 2023
Aruna Mehta	Member	Non-Executive Director	1 April 2022 – 31 March 2023
Andrew Grimshaw	Attendee	Group Chief Finance Officer	1 April 2022 – 31 March 2023
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2022 – 31 March 2023
Lizzie Alabaster	Attendee	Site Chief Financial Officer	June 2022 – 31 March 2023

Other executive directors and senior leaders including the Epsom and St Helier Site Managing Director, Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Group Chief Digital Officer, Director of Procurement, Financial Controller and the local counter fraud specialist also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews. In addition, internal auditors and external auditors attended each of the meetings.

3.2 Committee meeting attendance

In 2022/23 the quorum for each meeting of the Committee was two members. For avoidance of doubt only non-executive directors are members of the Committee.

The Committee held a total of 5 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committee were quorate.

Name	Role	Attendance
Peter Kane	Committee Chair	5/5
Ann Beasley	Member	4/5
Aruna Mehta	Member	5/5

In line with the requirements that the Committee should only comprise non-executive directors as members, these individuals were not members of the Committee and did not form part of the quorum.

Name	Role	Attendance
Andrew Grimshaw	Group Chief Finance Officer	4/5
Stephen Jones	Group Chief Corporate Affairs Officer	5/5
Lizzie Alabaster	Site Chief Financial Officer	4/4

4. Committee activity and focus

4.1 External Audit

The Committee supported the completion of a successful audit process of the 2021/22 financial year and reviewed the final external audit reports and value for money report for 2021/22 of the outgoing external auditors, KPMG.

In the latter part of the year, following the appointment of Grant Thornton LLP as the new external auditors for the Trust, reviewed the plans for conducting the 2022/23 audit and agreed to recommend to the Board the audit fee for the 2022/23 audit.

The Committee reintroduced holding private meetings with the external auditors at the close of meetings in late 2022/23 and during these meetings there were no issues of material concern raised. This is a practice the Committee plans to continue in 2023/24.

4.2 Internal Audit

During the period internal auditors carried out 10 reviews, including Medical Staffing – Guardian of Safe Working for which the draft report was still to be issued at the time of this report. Internal auditor also issued 29 recommendations for strengthening controls in 2022/23:

Audit Area	Audit Lead	Planning	Fieldwork	Reporting	Opinion Design	Opinion Effectiveness
1. Infection, Prevention & Control	Chief Nurse	✓	✓	Jan 2023	Moderate	Moderate
2. Medicines Management- Controlled Drugs	Chief Nurse	✓	✓	Jan 2023	Moderate	Moderate
3. Patient Experience- Complaints	Chief Nurse	✓	✓	July 2022	Moderate	Moderate
4. Fit and Proper Person	Chief Operating Officer	✓	✓	May 2023	Substantial	Substantial
5. HFMA-Financial Sustainability (Replaces Capital planning)	Chief Financial Officer	✓	✓	Jan 2023	Not applicable	Not applicable
6. Key Financial Systems	Chief Financial Officer	✓	✓	May 2023	Substantial	Moderate
7. Data Quality - Criteria to Reside	Director of Corporate Services	✓	✓	May 2023	Moderate	Moderate
8. Data Security & Protection Toolkit	Director of Corporate Services	✓	✓	May 2023	Not applicable	Not applicable
9. Freedom to Speak Up	Chief Corporate Affairs Officer	✓	✓	May 2023	Moderate	Moderate
10. Medical Staffing	Medical Director	✓	✓	Draft	Moderate	Moderate

The Committee was pleased that no reviews received a 'no assurance' or 'limited assurance' rating. The Fit and Proper Person review provided substantial assurance in both the design of the controls and operational effectiveness, while the Key Financial Systems audit provided substantial assurance over the design. The remaining six audits had a moderate assurance rating for both sections. The Trust was found to have good management and governance structures in place, and systems and processes and related policies and procedures were found to be well designed.

There were no high-level recommendations made in 2022/23, an improvement from the previous year which the Committee welcomed as a demonstration of improved operational controls at the Trust. The implementation of the recommendations will further enable the Trust to demonstrate a maturity level of continual improvement along with the areas that can be strengthened and actions taken for in 2023/24.

In July 2022, the Audit Committee agreed to undertake a Group-wide tender for a new internal audit and counter fraud provider. Subsequently, following further discussions across

the South West London system, at its October 2022 meeting the Committee agreed that the Trust should participate in a South West London-wide tender for both internal audit and counter fraud services including St Helier and Epsom University Hospitals and Health Group, Croydon Health Services NHS Trust, Kingston Hospital NSH Foundation Trust and Hounslow and Richmond Community Healthcare NHS Trust. The Committee also agreed the composition of a review panel to review tenders to comprise of the Audit Committee Chairs of each of the Trusts involved. A procurement panel was convened in December 2022 to consider the tenders received. Unfortunately, the panel was unable to reach a unanimous decision, and the Trust – along with Epsom and St Helier University Hospitals and Croydon Health Services – decided to make a direct contract award to RSM, which was considered to offer the best value for money and quality of service. At the Audit Committee in January 2023, the Committee approved the recommendation. Although a SWL-wide contract award was not ultimately made, the chairs of the SWL Audit Committees expressed interest in convening a SWL Audit Chairs Forum to foster collaboration and encourage sharing of best practice particularly, though not exclusively in relation to internal audit.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditors, a core element of the Committee's focus in 2022/23 was monitoring the Trust's corporate governance, compliance and systems for internal control. To this end the Committee reviewed and endorsed the annual self-certification with the Foundation Trust Licence. The Committee also undertook its annual review of the Board Assurance Framework internal controls and governance mechanisms.

In 2022/23 the Trust was required to undertake a financial sustainability self-assessment against eight areas and have this audited by their Internal Auditors. The Committee welcomed the report as showing the Trust having a robust set of controls and governance.

The Committee considered how the financial limits within the Trust's Scheme of Delegation should be interpreted in the context of the new Group structure, and noted some pragmatic changes to the existing delegations ahead of a more comprehensive review of the Trust Standing Orders, Reservation and Delegation of Powers and Standing Financial Instructions in 2023/24, about which the Committee received an update at its May 2023 meeting.

The Committee also noted the improvement in 2022/23 in the Trust's compliance with declarations of interests following the introduction of the Declare system in December 2022 to increase declarations. The Trust achieved 73% compliance for decision-making staff making declarations and will be looking to improve upon the total in 2023/24. The Committee also received and endorsed the new Group-wide policy for managing conflicts of interest at its meeting in January.

As well as regularly reviewing the use of waivers, write-offs and special payments, the Committee also reviewed counter fraud arrangements and considered issues and themes raised by the Local Counter Fraud Specialist.

There were also discussions about how to realise the benefits of the new Group model, including how the Committee might meet as a Committee-in-Common with the St George's Audit Committee at a future point in time.

4.4 Trust Annual Report and Accounts

In June 2022, the Committee endorsed the final draft annual report, annual accounts and quality accounts for 2021/22 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2021/22. A full report was prepared as the exemptions put in place due to the Covid-19 pandemic had been removed, alongside additional reporting requirements, such as fair pay disclosures. The Annual Report and Accounts were received by the Trust Board on 21 June and submitted to NHS England & Improvement by 24 June.

The value for money (VfM) report found that long term financial planning for the Trust was an area of risk for ESTH as was the significant financial challenge ESTH was continuing to face. The report noted the challenges faced by the Trust in delivering a deficit budget with unidentified cost improvement programmes.

In January 2023, the Committee reviewed and agreed plans for the production of the 2022/23 annual report and accounts.

4.5 Cybersecurity

The Committee received regular reports on the Trust's cybersecurity resilience and how well the Trust is prepared to respond to potential cybersecurity threats. The Committee also received updates on the work to move to a Group-wide approach and the development of a cybersecurity dashboard. The Committee also received updates on the work underlying the annual submission of its Data Security and Protection Toolkit.

5. Committee Effectiveness

The Audit Committee conducted a review of its effectiveness in 2022/23, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. Overall, albeit on a low response rate, respondents to the survey scored the performance and effectiveness of the Committee as either very effective or somewhat effective. Two areas for consideration for improving the Committee's effectiveness were the opportunity to use the South West London Audit Chairs Forum to identify and disseminate learning from audit work across SWL, and the opportunity to move in future to a committees-in-common approach, with appropriate provision for Trust-specific reporting and testing of controls.

6. Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2023/24 is attached (see Appendix 3). The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2023/24 reflects the principles set out in the NHS Audit Committee Handbook and reflects the required matters for the Committee's review.

The Committee's terms of reference have been reviewed. There are no proposed changes to the terms of reference, other than inserting – where appropriate – references to the Committee providing reports on its meetings to the Group Board, and formatting changes to bring the terms of reference into line with other Board Committees. While no changes to the terms of reference are proposed, the proposed Committee workplan for 2023/24 draws out elements

of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year.

7. Conclusion

During 2023/24, the Committee worked hard to deliver its duties as set out in its terms of reference. Its overall effectiveness is reflected in the Committee effectiveness review for 2022/23. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give a reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

Audit Committee

Terms of Reference

1. Name

The Committee shall be known as the “Audit Committee”.

2. Establishment and Authority

The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

The Audit Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. Purpose

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust’s activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust’s arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust’s Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

(a) Governance, Internal Control and Risk Management: The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.
vii. Oversee and provide assurance to the Board on the robustness of the Trust's governance, internal control and risk management arrangements in relation to the Trust's participation in the St George's, Epsom and St Helier University Hospitals and Health Group.

(b) Internal audit: The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.

(c) External audit: The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also make recommendations to the Board on the appointment or retention of the external auditors.

(d) Annual Report and Accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation, the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

(f) Raising concerns: The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

(g) Cybersecurity and information governance: The Committee shall review the adequacy and effectiveness of:

i. Structures, systems, processes and controls in place in relation to information governance in the Trust and approve the submission of the annual Information Governance Toolkit submission on behalf of the Board of Directors.

ii. Structures, systems, processes and controls in relation to cybersecurity.

(h) General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.
v. Review the Trust's governance, internal control and risk management arrangements in the context of the St George's, Epsom and St Helier University Hospitals and Health Group.

(i) Management: The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

(j) Annual work plan and Committee effectiveness: Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Membership and Attendance

A Non-Executive Director will chair the Audit Committee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Corporate Affairs Officer and Chief Financial Officer are the Executive Leads for the Audit Committee.

The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair.

Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

The following are regular attendees at the Committee:

- Group Chief Financial Officer
- Group Chief Corporate Affairs Officer
- Managing Director – ESTH
- Site Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that director's portfolio. At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Counter Fraud Lead
- Head of Technical Accounting – for the Annual Accounts
- Group Chief Nursing Officer and/or the Group Director of Compliance – for the Quality Account
- Group Chief Communications and Engagement Officer – for the Annual Report

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

6. Quorum

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

7. Declarations of Interest

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion.

8. Meeting Frequency

Meetings of the Committee shall be held quarterly.

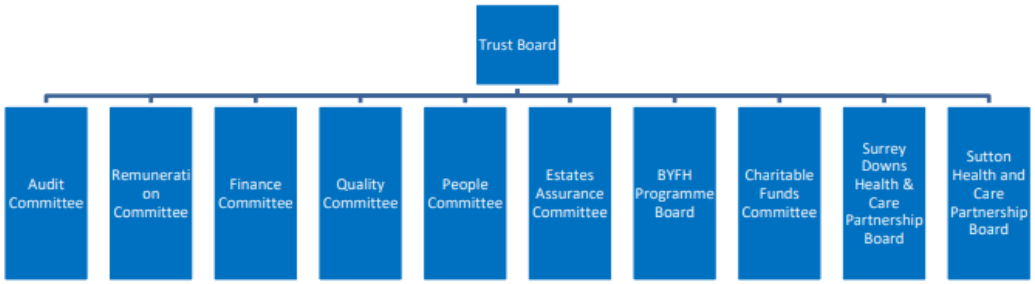
An additional extraordinary meeting will be held to review the external auditor's report and recommend the adoption of the annual report and accounts to the Trust Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

9. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The Group Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than five working days ahead of the meeting.

10. Relationship with other groups and committees

The Committee will report to the Trust Board as shown below:



11. Report to Board

The Committee Chair will prepare a report for the Trust Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance.

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

12. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

13. Annual cycle of business

An annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

14. Review of Committee Effectiveness and Terms of Reference review

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Trust Board.

Document Control

Profile	
Document name	Audit Committee Terms of Reference
Version	XX
Executive Sponsor	Group Chief Corporate Affairs Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	TBC – 15 June 2023
Date of Trust Board approval	TBC – 7 July 2023
Date for next review	April 2024

Epsom and St Helier University Hospitals NHS Trust

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

ESTH Audit Committee in Common Forward Plan 2023/24 - DRAFT

Items	3 May 2023	15 June 2023	3 August 2023	October 2023	January 2024
Standing items	Minutes Action log New risks/escalation to Board	Minutes Action log	Minutes Action log New risks/escalation to Board	Minutes Action log New risks/escalation to Board	Minutes Action log New risks/escalation to Board
External Audit	Informing the audit risk assessment 22-23	External Auditor's Report on the Annual Report and Accounts Letter of Representation	External Audit Progress Updates Value for Money Audit Report External Audit Tender (Private Session)	External Audit Progress Updates	External Audit Progress Updates External Audit Plan and Fees
Internal Audit	Internal Audit Progress Update Internal Audit Recommendations Tracker Draft Internal Audit Annual Report, including Draft Head of Internal Audit Opinion Internal Audit 2023-24 plan (inc. Internal Audit five-year workplan)	Internal Audit Workplan 2023/24 Head of Internal Audit Opinion	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. New starters – onboarding 2. Medical Staffing – Guardian of Safe Working (from 2022/23)	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. Job planning 2. Data quality 3. Sickness absence	Internal Audit Progress Update Internal Audit Recommendations Tracker Final Internal Audit Review Report 1. Surry Downs and Sutton Health and Care Alliance 2. VTE 3. Productivity 4. Cost Improvement Programme 5. Key Financial Controls 6. Cyber Security Draft Internal Audit Plan 2024/25
Counter Fraud	Counter Fraud Progress Report Counter Fraud Annual Report, Self-Assessment and 2023/24 Workplan Counter Fraud Update Quarterly Reports including updating on invoicing action Counter-Fraud Quarterly Updates		Counter-Fraud Quarterly Updates	Counter-Fraud Quarterly Updates	Counter-Fraud Quarterly Updates
Governance, Internal Control and Risk	Review of Committee Effectiveness 2022/23 Annual Review of Conflicts of Interest Compliance Review of Board Assurance Framework Internal Controls and Governance Mechanisms Standing Orders, Scheme of Delegation and Standing Financial Instructions	Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan Annual Self-Assessment of Compliance with Provider Licence	Managing Conflicts of Interest: Update on Compliance Clinical Audit Programme Developing the Group Board Assurance Framework Developing Group-wide policies: Policy on the development of Group and Trust Policies	Standing Orders, Scheme of Delegation and Standing Financial Instructions Group Risk Management Strategy and Policy Freedom to Speak Up: Internal Controls and Governance	Annual Review of Risk Management Review of Board Assurance Framework Internal Controls and Governance Mechanisms Compliance with Code of Governance for NHS Provider Trusts Review of Internal Auditors Effectiveness Review of Committee Effectiveness (plan for 2023/24) Use of Trust Seal

Financial Reporting	Breaches and Waivers report		Breaches and Waivers report	Breaches and Waivers report Losses & Compensation Payments Aged Debt Update	Annual Report High Level Themes Accounting Policies Breaches and Waivers report
Annual Report and Accounts	Annual Report 2022/23: Key Themes	Draft Annual Report 2022/23 Draft Annual Accounts 2022/23 and Going Concern Statement Draft Quality Accounts 2022/23			Annual Report 2023/24: Plan
IG/Cybersecurity	Information Governance / Cybersecurity update		Information Governance / Cybersecurity update inc. Cybersecurity Dashboard Information Governance Compliance Update and Annual Report	Information Governance / Cybersecurity update	Information Governance / Cybersecurity update

Group Board

Meeting in Public on Friday, 07 July 2023

Agenda Item	4.6	
Report Title	**Update from the Estates Assurance Committee meetings, held on 31 May 2023 and 28 June 2023**	
Executive Lead(s)	James Blythe, Managing Director - Epsom and St Helier and Andrew Asbury, Group Chief Officer, Facilities, Infrastructure and Environment	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

The ESTH Estates Assurance Committee met on 31 May 2023 and 28 June 2023.

At the meeting in May updates were received by the Committee on the High Voltage Electricity Services and Decontamination Services operating with ESTH at the current time.

At the meeting held at the end of June the Committee considered its closing report for the Trust Board (See Appendix 1)

The Board are reminded that the Committee was established with a time limited remit – in February 2022 :-

"*The Estates Assurance Committee has been established as a time-limited Committee of the Trust Board with the purpose of providing assurance to the Board on the safe operation and performance of the Trust's estates. The Committee will consider estates issues, risks and plans in the round, recognising that the challenges with the Trust's estates and significant backlog maintenance position*."

Action required by Group Board

The Board is asked to note this report from the ESTH Estates Assurance Committee meetings held in May and June 2023, along with the closing report (See Appendix 1)

Committee Assurance	
Committee	
Level of Assurance	

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Closing Report for Trust Board

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

Update from the ESTH Estates Assurance Committee meetings, held on 31 May 2023 and 28 June 2023

Group Board, 07 July 2023

1.0	Purpose of paper

1.1 This paper provides an update to the Board of the ESTH, Estates Assurance Committee meeting held on 31 May 2023 and 28 June 2023

2.0	Analysis

2.1 **Deep Dive – High Voltage Electricity**

The Committee received and noted a briefing on how High Voltage (HV) Electricity is managed within ESTH . The following key points were noted : -

- HV is managed and delivered by the National Grid. The Trust works in partnership with the National Grid to ensure that the correct systems and assurance are in place, but ultimately NG is responsible for the delivery, maintenance, safety etc.
- The internal staff team had recently been strengthened with additional staff in order to be able to provide assurance that systems were being looked after at all times and any issues quickly resolved.
- Further assurance was gained through maintaining the protocol list for all of the major disciplines along with details of authorised persons, competent persons, proof of competencies, and public liability insurance. This was so that the trust had appropriate assurance that even when the work is commissioned from external sources, the ESTH teams know that they're operating in line with protocols and regulations.
- There were a number of legacy issues with the Breathe Energy Plant at Epsom. They were nearly resolved and the trust would soon be updating the plans with the National Grid. It should only be two or three weeks until the final issues were concluded. In the meantime there was assurance that the current switch gear was in date and the systems remained safe.
- Members of the Committee had raised the point that if National Grid was managing the high voltage electricity coming into the hospitals how did the trust know how much resilience there was in the system and what happens when it goes down? It was noted St Helier was close to the Croydon substation, which during the summer months did get overdrawn and there are peaks and troughs in supply. If this happens, there is an automatic switch to the generators onsite; which are quite new. At Epsom the generators are also fairly new due to the recent Breathe Energy project. All equipment is well within date and the generators are well within their lifespan. The circuit breakers have recently been updated on both sites, so the only known deficiency is at St Helier and related to load shedding. Between A and B blocks there are two substations but there is no ability to couple them. This would have to be done manually, and is on the backlog maintenance scheme with a high priority action so that there could be more synchronisation load sharing and

as necessary coupling automatically. The same action is also required at Epsom in order to reduce the risk of any issues.

- It was confirmed that the generators on site could keep all systems running in an emergency as required.

- Both offload and on load tests in line with the statutory requirements are undertaken on both sites' generators on a monthly basis.

2.2 **Deep Dive – Decontamination Services**

The Committee received and noted a briefing on how Decontamination Services are managed within ESTH . The following key points were noted : -

- Overall there had been good improvements made in the services over the past couple of years
- The Decontamination Group had been re-established on a bimonthly basis, was well attended, and had appropriate representation from service areas. It received regular reports on the decontamination of instruments from the outsourced services
- The current Decontamination Policy was in the process of being updated.
- A Decontamination Lead for the Trust had been recently appointed. There was also an internally appointed authorised engineer. They report to the Group Chief Officer, Facilities, Infrastructure and Environment who has the overall responsibility for the service.
- The governance relating to Endoscopy Decontamination, part of which was in house, had been reviewed and updated to ensure that it was robust.
- Decontamination and supply of most equipment used with procedures and theatres was outsourced to Steris. The service was managed in house until the summer of 2021, when it moved to the external location.
- Since early 2023 there had been some issues with the cleanliness of instruments and items missing from kits. Information on these incidents had been collated and improvement notices issued to the Company.
- It was reported that the company was now struggling to deliver the services within the scope of the contract. This was due to inflation, high energy costs, increase in wages etc. The trust was carefully monitoring this concern and considering alternatives.
- The service was continuing to be monitored and it was confirmed that improvements had been seen within the previous couple of months, with less incidents being reported.

3.0 Sources of Assurance

3.1 The Committee felt there was good assurance relating to High Value Electricity Supplies to the Trust .

3.2 The Committee felt that there was reasonable assurance relating to Decontamination Services for ESTH

4.0 Summary and future work of the Committee

4.1 The Committee reflected that it had been established as a time limited committee and had been running for 18 months.

4.2 A closing report for the Trust Board would be produced (Appendix 1). This summarises the work undertaken by the Committee.

4.3 The Committee discussed the expected timescale of building the planned new SECH which now had an expected completion date before 2030. The committee recognised that an essential part of the future operating model was that the facilities at both Epsom and St Helier acute hospitals would continue to deliver 85% of the trust's services and would need to be in an appropriate condition to do that.

4.4 The Committee felt that it had largely completed its initial task and that ongoing monitoring of services would be achieved through reviewing the results in the Premises Assurance Model under another Board Committee. Work to assess the condition of the fabric of the buildings and ensuring that those which would not be required once the SECH was built were appropriately maintained until that time, whilst those that were part of the future model were appropriately updated would be better considered as part of a wider Infrastructure Committee to report to the Board on Estates, Facilities and IT issues.

5.0 Recommendations

5.1 The Board is asked to note this report from the Estate Assurance Committee meeting.

a. Note this report of the meeting held on the 31 May 2023 relating to:
   - High Value Electricity
   - Decontamination Services
b. Note the work of the Estates Assurance Committee as outlined in Appendix one and its conclusions of reasonable assurance from the deep dives it undertook
c. Note the remaining issues requiring further assurance as described in Section 3.0
d. Support the forming of a new Infrastructure Committee to report to the Board on Estates, Facilities and IT issues.

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	4.6	
Report Title	**ESTH Estates Assurance Committee Closing Report**	
Executive Lead(s)	James Blythe, Managing Director - Epsom and St Helier Andrew Asbury, Group Chief Infrastructure Facilities & Environment Officer	
Report Author(s)	Ann Beaseley, Chair	
Previously considered by	ESTH Estates Assurance Group	-
Purpose	**For Approval / Decision**	

Executive Summary

This report provides an overview of the ESTH Estates Assurance Committee since its inception in February 2022 and makes recommendations for how the assurance activities undertaken can be taken forward.

Action required by Group Board

The Board is asked to:

a. Note the work of the Estates Assurance Committee and its conclusions of reasonable assurance from the deep dives it undertook
b. Note the remaining issues requiring further assurance as described in Section 3.0
c. Support the forming of a new Infrastructure Committee to report to the Board on Estates, Facilities and IT issues (Terms of Reference to be agreed)

Committee Assurance

Committee	ESTH Estates Assurance Committee
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

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

Estates Assurance Committee Report
Group Board, 07 July 2023

1.0 Purpose of paper

The purpose of this paper is to appraise the Board of the assurance activities undertaken by the ESTH Estates Assurance Committee since its inception in February 2022, together with making recommendations on how to continue to assure the Board that Estates and Facilities operations remain safe and compliant with relevant regulations and legal requirements.

2.0 Background

The Estates Assurance Committee was formed in February 2022 with the following purpose:

The Estates Assurance Committee has been established as a time-limited Committee of the Trust Board with the purpose of providing assurance to the Board on the safe operation and performance of the Trust's estates. The Committee will consider estates issues, risks and plans in the round, recognising the challenges with the Trust's estates and significant backlog maintenance position.

The Committee has now held nine meetings, with the key assurance and discussion topics at each meeting being the following:

22nd February 2022	Estate Condition Survey Backlog Maintenance and Critical Infrastructure Risk Estate Strategy Premises Assurance Model Authorised Engineer Appointments
5th April 2022	Sustainability & Green Plan Water Management Deep Dive Group Operating Model Integration of Estates Risks into emerging BAF
26th May 2022	Estates &Facilities working with IPC Ventilation Deep Dive
25th July 2022	Fire compliance Deep Dive Impacts from delay of SECH
26th September 2022	Electrical Safety Deep Dive Green Plan Development
11th November 2022	Lift Safety Deep Dive Annual Fire Safety Report
27th January 2023	Alignment of work with BYFH Programme Board Medical Gases Deep Dive IPC / Ventilation Coordination
17th March 2023	Medical Engineering Deep Dive Impacts from delay of SECH
31st May 2023	HV Electricity Deep Dive Decontamination Deep Dive Impacts from delay of SECH

3.0 Outcomes

The Committee was able to take reasonable assurance from each deep dive it undertook. Where actions were taken to give the committee further assurance, these actions were completed and recorded in the Committee minutes.

However, there were a number of strategic matters discussed at the Committee that formed recurring areas of concern that require further ongoing discussions, namely:

- The need to have a clear assurance in the future for items such as AE reports
- How Estates risks coordinate with the Board Assurance Framework
- The mechanism for prioritising capital
- How delays to the BYFH programme may impact estates operations

It is now proposed that a new Infrastructure Committee be formed to consider both Estates and IT issues. This committee would seek assurance on Estates and Facilities management together with reviewing any specific infrastructure risks on the BAF and report to the Board. To provide assurance on E&F activities, it is proposed that the new committee is given regular updates on our Premises Assurance Model, together with undertaking 'deep dives' as per the work of the Estates Assurance Committee.

Capital prioritisation would remain within the remit of the Finance Committee, albeit the Finance Committee and the proposed Infrastructure Committee would need to work closely on balancing capital expenditure with risk.

It is being proposed to undertake new six-facet surveys at both the Epsom St Helier and St George's sites. Both sites' surveys were delayed due to COVID. The ESTH survey will provide an updated view on the level of backlog maintenance and risk which will enable the coordination of backlog maintenance with the BYFH programme, particularly the latter phases of work planned on the existing sites.

With the BYFH programme now having a much higher level of delivery certainty, the prolongation risk can be managed and work on the existing sites reviewed as part of the wider OBC refresh. As the BYFH Programme Board is now likely to be consumed with managing the programme, we will review whether it is best for the BYFH Board or the Infrastructure Committee to continue to review the coordination of BYFH and maintenance activities.

4.0 Sources of Assurance

Typical sources of assurance that were examined by the Committee during their deep dives were:

- Applicable policy and procedures being in place
- Appropriately qualified people with clear roles and responsibilities
- Independent Authorised Engineer reports
- Risk Assessments
- Adequacy of maintenance regimes

- Processes for reviewing compliance
- Capital investment requirements

These sources of assurance align almost exactly with the standard questionnaire that each technical area must undertake under the Premises Assurance Model, which are:

- Policy and Procedures
- Roles and Responsibilities
- Risk Assessment
- Maintenance
- Training and Development
- Resilience, Emergency and Business Continuity Plans
- Review Process
- Costed Action Plans

By transitioning to using the Premises Assurance Model within the proposed Infrastructure Committee, this will ensure that the assurance sought by the EAC will be continued and expanded.

5.0 Recommendations

The Board is asked to:

d. Note the work of the Estates Assurance Committee and its conclusions of reasonable assurance from the deep dives it undertook.
e. Note the remaining issues requiring further assurance as described in Section 3.0
f. Support the forming of a new Infrastructure Committee to report to the Board on Estates, Facilities and IT issues (Terms of Reference to be agreed)

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	5.1	
Report Title	**Healthcare Associated Infection Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Director of Nursing/ Deputy Director of Infection Prevention and Control (ESTH)**	
Previously considered by	Quality Committees-in-Common	29 June 2023
Purpose	**For Noting**	

Executive Summary

This paper provides a monthly update on Healthcare Associated Infections (HCAIs) and key issues/ concerns arising in Infection Prevention and Control (IPC) at site level. The table below summaries the monthly HCAI position at site level for May 2023.

HCAI	ESTH	SGUH
C. *difficile* infection	Apr: 3 HOHA, 2 COHA May: 4 HOHA, 0 COHA **YTD: 10** **National threshold: 38** **Total cases 2022/23: 38**	Apr: 2 HOHA May: 5 HOHA, 2 COHA **YTD: 9** **National threshold: 42** **Total cases 2022/23: 60**
MRSA bloodstream infection	Apr: 0 May: 1 **YTD: 1** **National threshold: 0** **Total cases 2022/23: 0**	Apr: 0 May: 0 **YTD: 0** **National threshold: 0** **Total cases 2022/23: 1**
Pseudomonas aeruginosa	April: 0 May: 0 **YTD: 0** **National Threshold: 6** **Total cases 2022/23: 12**	Apr: 1 May: 4 HOHA, 2 COHA **YTD: 7** **National Threshold: 25** **Total cases 2022/23: 23**
E-coli	April: 2 HOHA, 1 COHA	April: 8 HOHA, 7 COHA

	May: 3 HOHA, 3 COHA **YTD: 9** **National Threshold: 52** **Total cases 2022/23: 55**	May: 7 HOHA, 3 COHA **YTD: 25** **National Threshold: 88** **Total cases 2022/23: 105**
Klebsiella spp.	April: 1 HOHA May: 2 HOHA **YTD: 3** **National Threshold: 24** **Total cases 2022/23: 28**	April: 4 HOHA May: 6 HOHA **YTD: 10** **National Threshold: 58** **Total cases 2022/23: 23**
Covid-19 Update		
May	Covid-19 positive cases: 59 Covid-19 deaths: 12 Nosocomial infections: 19 Nosocomial deaths: 1 **YTD positive cases: 194** **YTD nosocomial deaths: 1** **Total cases 2022/23: 2368** **Total deaths 2022/23: 276**	Covid-19 positive cases: 91 Covid-19 deaths: 12 Nosocomial infections: 43 Nosocomial deaths: 3 **YTD positive cases: 221** **YTD nosocomial deaths: 6** **Total cases 2022/23: 2461** **Total deaths 2022/23: 206**

Action required by Group Board

To receive the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective for noting and make any necessary recommendations.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Infection Prevention and Control Report – May 2023
Appendix 2	READING ROOM: ESTH IPC Report May 2023
Appendix 3	READING ROOM: SGUH IPC Report May 2023

Implications

Group Strategic Objectives

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

Risks

N/A

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

[Set out briefly any financial implications relevant to the issues described in the paper]

Legal and / or Regulatory implications

The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2023) 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

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Infection Prevention & Control Monthly Report
Quality Committees-in-Common, 25 May 2023

1.0 Purpose of paper

1.1 This paper provides a monthly update on HCAIs and key issues/ concerns arising in Infection Prevention and Control (IPC) at site level summarised in Table 1 below.

HCAI	ESTH	SGUH
C. *difficile* infection	Apr: 3 HOHA, 2 COHA May: 4 HOHA, 0 COHA **YTD: 10** **National threshold: 38** **Total cases 2022/23: 38**	Apr: 2 HOHA May: 5 HOHA, 2 COHA **YTD: 9** **National threshold: 42** **Total cases 2022/23: 60**
MRSA bloodstream infection	Apr: 0 May: 1 **YTD: 1** **National threshold: 0** **Total cases 2022/23: 0**	Apr: 0 May: 0 **YTD: 0** **National threshold: 0** **Total cases 2022/23: 1**
Pseudomonas aeruginosa	April: 0 May: 0 **YTD: 0** **National Threshold: 6** **Total cases 2022/23: 12**	Apr: 1 May: 4 HOHA, 2 COHA **YTD: 7** **National Threshold: 25** **Total cases 2022/23: 23**
E-coli	April: 2 HOHA, 1 COHA May: 3 HOHA, 3 COHA **YTD: 9** **National Threshold: 52** **Total cases 2022/23: 55**	April: 8 HOHA, 7 COHA May: 7 HOHA, 3 COHA **YTD: 25** **National Threshold: 88** **Total cases 2022/23: 105**
Klebsiella spp.	April: 1 HOHA May: 2 HOHA **YTD: 3** **National Threshold: 24** **Total cases 2022/23: 28**	April: 4 HOHA May: 6 HOHA **YTD: 10** **National Threshold: 58** **Total cases 2022/23: 23**
Covid-19 Update		
	Covid-19 positive cases: 59 Covid-19 deaths: 12 Nosocomial infections: 19	Covid-19 positive cases: 91 Covid-19 deaths: 12

May	Nosocomial deaths: 1 **YTD positive cases: 194** **YTD nosocomial deaths: 1** **Total cases 2022/23: 2368** **Total deaths 2022/23: 276**	Nosocomial infections: 43 Nosocomial deaths: 3 **YTD positive cases: 221** **YTD nosocomial deaths: 6** **Total cases 2022/23: 2461** **Total deaths 2022/23: 206**

2.0 Summary of key performance measures

2.1 The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts.

3.0 COVID-19 NHS Response:

3.1 On the 5th of May 2023, World Health Organisation (WHO) declared that Covid-19 no longer constitutes a public health emergency of international concern following the continued decrease in Covid related hospital admissions and intensive care admissions.

Following on from this, on 18 May, NHS England issued a letter outlining the transition and next steps in NHS response to Covid-19 pandemic. It is acknowledged that new waves and variants may emerge in the future, therefore will continue to monitor the situation and adapt as necessary.

The national response to Covid -19 has been stepped down from NHS level 4 incident down to a level 3 incident. In addition to downgrading the incident level, outbreak reporting is being reviewed and as of 30 June, collection of data on patients who have died with Covid-19 via the COVID-19 Patient Notification System (CPNS) system will cease and death certification will follow the same process as any other infectious disease.

The Group DIPC asked each site IPC lead to liaise with the bereavement and business intelligence teams to ensure this is reflected in future reporting.

4.0 NHS Standard Contract 2023/24

4.1 The NHS Standard Contract 2023/24 includes quality requirements for NHS Trusts to minimise rates of both Clostridioides difficile (C. diff) and of Gram negative bloodstream infections to threshold levels set by NHS England.

The exposure groups for *C diff, P. aeruginosa, and E.coli and Klebsiella spp.* are as below:

Hospital-onset healthcare associated (HOHA)	Specimen date is ≥3 days after the current admission date **(where day of admission is day 1)**

Community-onset healthcare associated (COHA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date **(where day 1 is the specimen date)**
Community-onset, indeterminate association (COIA)	Is not categorised HOHA and the patient was most recently discharged from the same reporting trust between 29 and 84 days prior to the specimen date **(where day 1 is the specimen date)**
Community-onset, community associated (COCA)*	Is not categorised HOHA and the patient has not been discharged from the same reporting organisation in the 84 days prior to the specimen date **(where day 1 is the specimen date)**

Please note COCA only applies to C diff infections.

The thresholds below comprise of total healthcare-associated cases i.e. HOHA and COHA.

	C diff	***E.coli***	***P. aeruginosa***	***Klebsiella spp.***
ESTH	38	52	6	24
SGH	42	88	25	58

Please note, MRSA's threshold remains at zero avoidable cases and there no national threshold on MSSA bacteraemia.

5.0 Key Issues

5.1 ESTH – Trust acquired MRSA bacteraemia isolated from blood cultures taken from a central line. This was from central line blood cultures from a 38 year old lady with several comorbidities admitted into ITU with sepsis/ invasive Group A Streptococcus infection since February 2023.

A post infection review (PIR) meeting has been undertaken and due to the following contributing factors, the source of the infection is unknown and it is thought it may have been from the central line or chest.

- Multiple wounds requiring dressing changes every 24hrs which meant that the patient was not suitable for chlorhexidine skin suppression.
- High numbers of multi-disciplinary staff input required which can inadvertently lead to a breakdown of IPC practices.
- Difficult and complicated central venous access.
- Bedbound bariatric patient (repositioning and wound care required 6-7 staff for up to 1 hour at any given time).
- colonisation with several multi drug resistant pathogens
- prolonged ITU stay
- exposure to multiple and long courses of antimicrobials

All of the factors listed above contributed to the patient becoming very high risk of developing healthcare associated infections. At the time of writing this report, the patient is self-ventilating and completed antimicrobial therapy. Repeat blood cultures have showed no growth and a line salvage strategy is in place to help prevent further line infection and to maintain patency of the line.

The PIR concluded that this was an unavoidable case in a patient with multiple complex co-morbidities. The main learning from this incident is management of vascular access lines in ITU. The following recommendations will be implemented in conjunction with the clinical and vascular access team:

- introduce “curos” disinfecting caps on needle free ports
- minimise use of multi ports on CVADs.
- Reintroduction of bio patch for CVAD lines.

5.2 ESTH - MRSA NICU, St Helier – MRSA was isolated in 3 babies on neonatal unit at St Helier. The index case was a baby from a set of triplets who was diagnosed 6 days into admission on the 4th of May. As a precautionary measure, the other two babies were also screened and one of them came back as MRSA positive. All 3 babies were isolated and started on treatment and including the mother.

As part of the routine weekly MRSA screening undertaken on NICU, another baby was isolated with MRSA on the 7th of May. All three isolates were sent to the reference laboratory for further molecular typing and they were genetically related suggesting cross transmission on the Unit.

An incident meeting was held with external colleagues from UK Health & Security Agency (UKHSA), unfortunately the mother was not screened as part of the elective C-section protocol, therefore it is unknown if there was vertical transmission. Weekly screening on the Unit has continued and no further cases have been detected.

All affected babies have since been discharged home.

5.3. Legionella – C Block, St Helier. Following legionella routine sampling, there were positive counts in areas on C-Block , mitigations were put into place including point of use filters and daily flushing. Results are back to normal following resampling.

5.4. SGUH - There were no major issues of concern in May.

4.0 Recommendations

6.1 The Board is asked to:

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

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Infection Prevention and Control Report

Group Board

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

7 July 2023

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Introduction and Purpose of Report

This report provides a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) at site level with a particular focus on:

- Covid-19
- *Clostridioides difficile* (C diff)
- MRSA Bloodstream Infections
- Gram Negative Bloodstream Infections
- Surgical Site Infections (SSIs)
- IPC Related Incidents
- Hand Hygiene Compliance
- IPC Mandatory Training including Fit Testing

The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts.

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Working Together at Group and Site

The site IPC teams meet weekly at the Group Infection Control meeting which is chaired by the Group Chief Nursing Officer and Director of Infection Prevention and Control. The meeting is attended by Site and Community Chief Nurses, Site Infection Prevention and Control (IPC) Lead Nurses and Site Lead Infection Control Doctors (ICDs). Agreed Terms of Reference are in place.

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 core IPC polices and standards as outlined in the Health and Social Care Act 2008. 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 at Site.

Site IPC leads continue to work collaboratively across the Health Group, with all Covid-19 guidance issued from June 2022 onwards published as guidance for the Group.

The Site IPC Leads also continue to be proactive members of the monthly South West London IPC group where all Covid-related issues and other IPC issues are discussed to ensure consistency in guidelines and practice across SW London.

Final decision making for all IPC related issues sits with the Group Chief Nursing Officer and Director of Infection Prevention and Control.

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Covid-19

	ESTH (includes SDHC and SHC)	SGUH
Total cases in May	59	91
Total deaths in month	12	12
Nosocomial infections	19	43
Nosocomial deaths	1	3
YTD positive cases	194	221
YTD nosocomial deaths	1	6
Outbreaks in month	0	6 (Belgrave, Cavell, Caesar Hawkins, Dalby, Amy and Heart Failure Unit)

IPC Practice and Prevention

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; in line with current national guidance.

There has been a significant decrease in the number of new positive cases and nosocomial infections across both sites as compared to previous months. This is reflected in the community prevalence nationally. Following the continued decrease in Covid related hospital admissions and intensive care admissions over the world, the World Health Organisation (WHO) declared that Covid-19 no longer constitutes a public health emergency of international concern.

Both sites continue to undertake root cause analysis (RCAs) for nosocomial deaths that meet the new criteria. In May, there were no cases that met the criteria for an RCA for SGH, one RCA currently being undertaken for ESTH.

Covid-19 NHS England Update: On 18 May, NHS England issued a letter outlining the transition and next steps in NHS response to Covid-19 pandemic. It is acknowledged that new waves and variants may emerge in the future, therefore will continue to monitor the situation and adapt as necessary.

The national response to Covid -19 has been stepped down from NHS level 4 incident down to a level 3 incident. In addition to downgrading the incident level, outbreak reporting is being reviewed and as of 30 June, collection of data on patients who have died with Covid-19 via the COVID-19 Patient Notification System (CPNS) system will cease and death certification will follow the same process as any other infectious disease. The changes have been communicated to all relevant teams.

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Clostridioides difficile (C diff)

	ESTH	SGUH	Integrated Care
Total cases in month	4	7	0
Lapses in care	0	1 (5 cases still awaiting review)	NA
YTD cases	10	9	NA
National threshold	38	42	NA

For ESTH: In May 2023 there were 4 Hospital Onset Healthcare Associated (HOHA) C. diff cases. All cases have been reviewed by the clinical teams and IPC and there were no cases associated with any lapses in care.

For SGUH: In May 2023 there were 5 Hospital Onset Healthcare Associated (HOHA) and 2 Community Onset Healthcare Associated (COHA) C.diff cases. One case has been associated with a lapse in care; three cases have been reviewed with no lapses in care; and five cases are awaiting final review – to be completed by end-June 2023.The following actions have also been put in place:

- An increased focused surveillance and audits on areas where positive cases are identified
- Corporate nursing and IPC team to establish task and finish group 'Getting back to Basics'
- Antimicrobial stewardship Audit process recommenced
- Consultant Microbiologist and/or Infection Control Doctor to present Cdiff cases, themes, lessons learned and any antimicrobial stewardship issues identified at Grand Round, when reviews have been completed

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MRSA Bloodstream Infections

	ESTH	SGUH
Total cases in month	1	0
YTD cases	1	0
National threshold	0	0

For ESTH: Trust acquired MRSA bacteraemia isolated from blood cultures taken from a central line in ITU on a 38 year old lady with several comorbidities. A PIR was undertaken and it was noted that patient was at very high risk of developing healthcare associated infections due to several comorbidities included prolonged ITU stay and exposure to multiple and long courses of antimicrobials. The review concluded that this was an unavoidable case in a patient with multiple complex co-morbidities. The main learning from this incident is management of vascular access lines in ITU and recommendations will be jointly implemented by the vascular access team and ITU staff.

For SGUH: In May 2023 there were no Trust attributed MRSA bloodstream infections.

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Gram negative Bloodstream Infections

	Ecoli		*Klebsilla spp*:		*Pseudomonas aeruginosa*		MSSA	
	ESTH	SGUH	ESTH	SGUH	ESTH	SGUH	ESTH	SGUH
Total Cases in month	6	10	2	6	0	6	1	2
YTD cases	9	25	3	10	0	7	4	4
National threshold	52	68	24	58	6	25	N/A	N/A

ESTH: E coli BSI surveillance and entering of risk factor data on the UKHSA data capture system continues and:

- IPC nurses review hospital acquired cases to identify source of infection
- Following review, the source of infection for the 6 cases in May are unknown (3), hepatobiliary (1) , Skin/soft tissue (1), urinary tract (1)

Community acquired BSIs are followed by the ICS IPC leads.

SGUH: There were 10 cases of E. coli bacteremia during May 2023: 7 have been classified as Hospital Onset Healthcare Associated (HOHA); 3 have been classified as Community Onset Healthcare Associated (COHA).

Following review, the source of infection for the 10 cases in May are: urine (2), unknown (3), wound (2); biliary (1)

Key priorities to reduce Ecoli bacteraemia for 2023/24 are:

- IPC team working closely with the Urology CNS team to support education and raise awareness of catheter care across Trust.
- E. coli focus week completed as part of senior nurses Back 2 the floor process in May, utilizing a QI approach
- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch
- SGUH involvement in continence service referral pathways and standards in development across Southwest London

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Surgical Site Infections

Context: NHS Trusts performing orthopaedic surgery are mandated by the Department of Health to carry out surgical site surveillance for a minimum of three consecutive months each financial year in hip replacement, knee replacement, repair of neck of femur, reduction of long bone fracture. The data is captured on the national UKHSA database. Other modules such as coronary artery bypass grafts, large bowel etc. are optional and can be undertaken to establish a local baseline.

SWLEOC at ESTH undertakes orthopaedic surveillance throughout the year.

For ESTH : An orthopedic module will be chosen and followed up in ether Quarter 4 in 2023/24 financial year.

Due to concerns raised about post op wound infections in surgery, the IPC team will be undertaking an elective large bowel surgery audit in Quarter 3.
SWLEOC: data is currently being reconciled for surveillance in Q1.

For SGUH: A module will be chosen and work undertakn in Quarter 2 2023/24 financial year.
Currently, data for the reduction of infections in long bone fracture module is being reconciled for Q4 (January-March 2023) in preparation to be submitted at the end of June 2023

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IPC Related Incidents

ESTH:

- **MRSA** was isolated in 3 babies on neonatal unit at St Helier. The index case was a baby from a set of triplets who was diagnosed 6 days into admission on the 4th of May. As a precautionary measure, the other two babies were also screened and one of them came back as MRSA positive. All 3 babies were isolated and started on treatment along with the mother of the triplets. As part of the routine weekly MRSA screening undertaken on NICU, another baby was isolated with MRSA on the 7th of May. All three isolates were sent to the reference laboratory for further molecular typing and they were genetically related suggesting cross transmission on the Unit.
- An incident meeting was held with external colleagues from UK Health & Security Agency (UKHSA). The review meeting highlighted that the mother was not screened as part of the elective C-section protocol, therefore it is unknown if there was vertical transmission. Screening for all antenatal procedures was recommenced immediately in Maternity and an audit will be undertaken to check compliance.
- Weekly screening on the Unit has continued and no further cases have been detected. All affected babies have since been discharged home.
- **Influenza**: The overall number of influenza cases has continued to decrease in May 2023 consistent with community prevalence. There were no flu clusters/outbreaks
- **Legionella:** following legionella routine sampling, there were positive counts in areas on C-Block , mitigations were put into place including point of use filters and daily flushing. Results are back to normal following resampling.

Integrated Care: There were no issues/concerns in integrated care.

SGUH:

- **CPE**: In May 2023 there was 3 CPE cases on 3 different wards causing the closure of 1 bay on each ward. One case was a previously known positive who was re-admitted to an open bay. Contacts of all cases were screened and no secondary cases identified. All cases were isolated and followed up as per policy.
- **Influenza**: The overall reduction in the number of Influenza cases continued in May with an incidence of 1 case compared to 7 cases in April**.**
- **Covid-19:** There was 1 ongoing Covid-19 outbreak on Rodney Smith which started on 28/04/2023 and a further 6 new outbreaks which commenced throughout May 2023 on Belgrave, Cavell, Caesar Hawkins, Dalby, Amy and Heart Failure Unit.

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Hand Hygiene Compliance

ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH
97%	100%	100%	98.3%

ESTH: Monthly hand hygiene compliance audits are being undertaken in all clinical areas. A total of 77 inspections across 69 areas yielded a hand hygiene compliance score of 97%. 22 areas have not had an inspection (76% completion compliance). Divisional directors of nursing are accountable to the site CNO for their compliance and action plans required as necessary.

IPC participated in the World Health Organsiation campaign on world hand hygiene day on the 5th of May with the aim of improving hand hygiene and IPC at the point of care. There were stands at key points on both sites and including the community hospitals.

SGUH: Monthly hand hygiene compliance audits are undertaken across clinical areas. This month 125 areas returned audits. These areas achieved an overall score of 98.3%. Hand hygiene audits are also carried out during Accreditation audits and any Period of Increased surveillance (PISA) audits e.g. C. diff (HAI), Norovirus, Influenza, MRSA. A focus on hand hygiene for World Hand Hygiene Day (5 May) took place with stands at both SGH and QMH and a message went out in trust comms.

Both Trusts: Areas of low compliance are followed up by the Divisional leads and the site Chief Nurses. Adhoc hand hygiene audits and spot checks are undertaken in the areas of low compliance by the IPC nurses.

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IPC Mandatory Training Compliance

	ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH CWDT	SGUH MEDCARD	SGUH SNCT
Clinical Staff	79%	86%	89%	83%	83%	84%
Non-clinical staff	87%	92%	92%	90%	87%	89%
Fit Testing	ESTH Total 2963			SGUH Total 3423		

Both Trusts: Monitoring of IPC mandatory training compliance is undertaken at directorate and divisional governance meetings, together with plans to improve performance where required. Training is scheduled during working hours as far as possible and Divisional Leads are advised to release staff to do their training during working hours.

Fit Testing: All relevant staff are required to be fit tested on at least two tight-fitting Respiratory Protective Equipment (RPE) FFP3 Masks as per Health and Safety Executive (HSE) guidance

ESTH:. As of 31st May, 2959 staff have passed fit testing, 1231 on one type/model of FFP3 mask and 1728 on two or more types
SGUH: There is no update on the plan for fit testing at the moment, however, discussions have taken place and are still ongoing.
Total number of staff fit tested on the latest mask model: 2133 (1655 passed and 478 failed).
Both Trusts The fit testing service at SGUH sits within the Health and Safety Directorate and within the Corporate Nursing Directorate at ESTH.
This service will be included in the work currently being undertaken to integrate corporate services.

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	5.2	
Report Title	**Patient Safety Incident Response Framework (PSIRF) Implementation**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Jenny Miles, Group Lead for PSIRF Implementation Maria Peries, PSIRF Programme Manager	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

The purpose of this report is to provide a progress update on the implementation of PSIRF across the Group.

As part of the Patient Safety Incident Response Framework (PSIRF) implementation programme, organisations were asked to develop a Patient Safety Incident Response Plan (PSIRP) and Policy. These documents specify the methods the Group intends to use to maximise learning and improvement and how these methods will be applied to different patient safety incidents together with the governance framework.

The PSIRFs were approved at the Board seminar on 9 June 2023 and will be launched across the Group as part of the transition to the new PSIRF on 7 August 2023. To support transition, to the new process, the following workstreams (Appendix 1) are required and are at various levels of development:

- Organisational development
- Engagement and Involvement
- Toolkits
- Training
- Governance Structure
- LFPSE (Learn from Patient Safety Events)

PSIRF training will continue to be provided to all staff in accordance with the Training Needs Analysis (TNA) at Appendix 2.

Prior to the launch a SWL ICB stakeholder event will be held on 7 July 2023 where both Trusts will provide the following:

- A summary of local priorities and response tools
- The governance structure to describe the ‘journey’ of the incident from occurrence in the Ward/service area to Board
- Confirmation of the Group formal transition date (7 August 2023)

Action required by Quality Committees-in-Common
The Board is asked to: a. Note the PSIRF progress update

Committee Assurance	
Committee	Choose an item.
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	PSIRF Implementation Workstreams
Appendix 2	Training Needs Analysis

Implications

Group Strategic Objectives

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

Risks

In the absence of adequate preparation there is a risk that both Sites will be unable to implement PSIRF in line with the new national patient strategy and commissioning intentions for 2023/24.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

No issues to consider at this stage.

Legal and / or Regulatory implications

Enforcement undertakings applicable to SGUH
Compliance with the Health & Social care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity and inclusion implications

No issues to consider.

Environmental sustainability implications

No issues to consider.

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

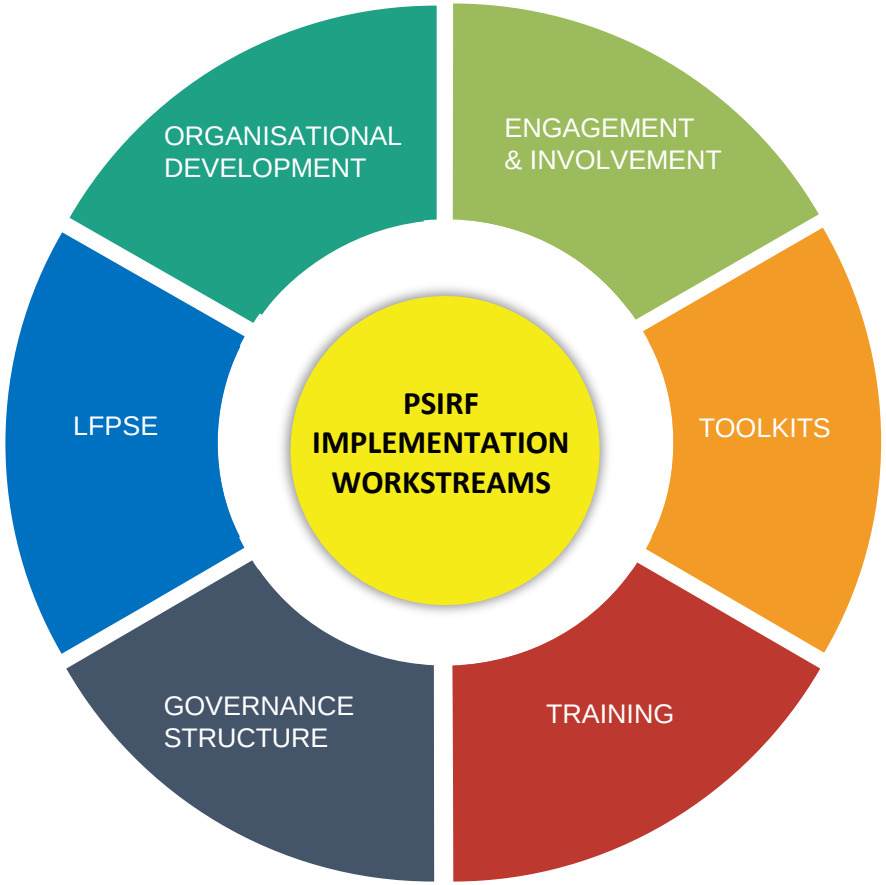
gesh

Patient Safety Incident Response Framework Implementation Workstreams

Jenny Miles, Group Lead for PSIRF Implementation (Interim)
Maria Peries, PSIRF Programme Manager

June 2023

PSIRF – Implementation Workstreams



Organisational Development Workstream priorities

- QI / Continuous Improvement
- Freedom to Speak Up
- Chaplaincy
- HR
- Staff Support / OH
- Big 5
- Pulse survey

LFPSE Workstream priorities

- Datix upgrade
- Pilot changes and live rollout
- Training
- IT support

Governance Structure Workstream priorities

- Ward to Board processes
- Group / Committee reporting
- Learning and feedback

Engagement & Involvement Workstream priorities

- PSPs
- Duty of Candour
- Processes to support staff, patients & families
- Forums for further engagement
- Intranet / Internet
- Comms strategy

Toolkits Workstream priorities

- Learning responses
- Templates
- Incident management process

Training Workstream priorities

- Training Needs Analysis
- MAST
- Induction
- Simulation
- Reporting mechanisms
- Sustainable training options

Appendix 2

PSIRF Staff Training

(Content provided by SW London Integrated Care Board)

All NHS organisation and non-NHS organisations commissioned to provide NHS services are implementing the new PSIRF. The National team recommended that all staff need to have targeted training ahead of PSIRF transition and continuous development thereafter. An NHS training and development framework has been created to assist with identifying training suppliers with the recommended training to cover:

1. Systems approach to learning from patient safety incidents (referred to Lot 4a in the national framework):

- Introduction to complex systems, systems thinking and human factors.
- Learning response methods: including interviewing, and asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews.
- Safety action development, measurement, and monitoring

2. Systems approach to learning from patient safety incidents Oversight (referred to as Lot 4b in the national framework):

- NHS PSIRF and associated documents
- Effective oversight and supporting processes
- Maintaining an open, transparent and improvement focused culture
- Importance of involvement of those affected
- PSII commissioning and planning

3. Patient and staff involvement in learning from patient safety incidents (referred to as Lot 4c in the national framework):

- Duty of Candour
- Just culture
- Being open and apologising
- Effective communication
- Effective involvement
- Sharing findings
- Signposting and support

Table1 below lists training to be provided and roles as recommended by the national patient safety team.

Table 1: training and role outline			Staff to be trained as per National Outline		
Topic	**Minimum duration**	**Content**	**Learning response leads** *(e.g. Governance /divisional / service managers, matrons, directors, medical directors, chief nurses*	**Engagement leads** *(e.g., patient liaison officers (PLO), engagements lead, senior managers involved in patient liaison after incidents*	**Those in PSIRF oversight roles** *(e.g., Board members, board subgroup members, commissioners/ICB)*
1. Systems approach to learning from patient safety incidents (LOT 4a)	2 days (12 hrs)	▪ Introduction to complex systems, systems thinking, human factors ▪ Learning response methods ▪ Safety action development, measurement, and monitoring	✓		✓
2. Oversight of learning from patient safety incidents (LOT 4b)	1 day (6 hrs)	▪ Effective oversight and supporting processes ▪ Maintaining an open, transparent and improvement focused culture ▪ PSII commissioning and planning			✓
3. Involving those affected by patient safety incidents in the learning process (LOT 4c)	1 day (6 hrs)	▪ Duty of candour; just culture, being open and apologising ▪ Effective communication and involvement ▪ Sharing findings; Signposting to support		✓	✓
4. Continuing professional development (CPD)	At least annually	▪ Stay up to date with best practice ▪ Contribute to minimum of two learning responses	✓	✓	✓
5. Patient safety syllabus level 1: (Essentials for patient safety)	eLearning	▪ Listening to patients and raising concerns ▪ Systems approach to safety ▪ Avoiding inappropriate blame; creating a just culture	✓	✓	✓
6. Patient safety syllabus level 2 (Access to practice)	eLearning	▪ Introduction to systems thinking and risk expertise ▪ Human factors ▪ Safety culture	✓	✓	✓

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	5.3	
Report Title	**GESH Learning from Deaths Quarterly Report: Q4 2022/23 (January-March 2023)**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Martine Meyer AMD for Quality, ESTH Rumiko Yonezawa Associate Director for Business Intelligence, ESTH Laura Rowe Lead Midwife for Clinical Governance and Risk ESTH Rebecca Suckling, Site CMO, ESTH Ashar Wadoodi, Learning from Deaths Lead, SGUH Kate Hutt, Head of Mortality Services, SGUH Rebecca Paulraj, Senior Business Manager, Medical Directorate, SGUH	
Previously considered by	n/a	-
Purpose	**For Noting**	

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.

ESTH - The Total number of deaths in Q4 was 389. Structured Judgement Reviews (SJR) were completed for 101 (25.96%) deaths. 6 deaths had an overall poor and 1 had a very poor score and these had Datix completed for learning for improvement. Any concerns identified through the SJR process were assessed as minor, moderate or major, and covered a wide range of issues. All major concerns had a Datix completed. A review of SJRs major concerns across Q1-Q4 2022-23 is being undertaken by the MR team to see whether there are any clear themes over time for learning improvements.

Overall mortality for this quarter (SHMI) covering discharges from January 2022 to December 2022, published in May 2023, was categorised as 'higher than expected' at 1.188. The most recent 12 months of data reported by HED covered April 2022 to March 2023. The HSMR mortality ratio showed a similar trend to SHMI but observed deaths have reduced compared to expected deaths and the current value is 102.02, a 5.0 decrease from February.

SGUH - The total number of deaths within this quarter was 430 from which 38 (8.4%) patients underwent the SJR process. There were no deaths where the care was deemed as poor. In one case the reviewer suggested there was strong evidence of avoidability of death. This case was escalated to SIDM

The latest SHMI data which covers the period December 2021 to November 2022 shows mortality was as expected at 0.93. The HSMR data from Dr Foster covers the period from February 2022 to January 2023 and is lower than expected at 89.5.

Action required by People Committees-in-Common

That the Committee 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

Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices

Implications

Group Strategic Objectives

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

Risks

Failure to achieve high standards in mortality governance presents a risk to the delivery of safe patient care.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.

Equality, diversity and inclusion implications

Environmental sustainability implications

GESH Joint Learning From Deaths Quarterly Report

(Q4 2022/23 - Jan to March 2023)

1.0 PURPOSE

1.1 The purpose of this joint paper is to provide the Quality Committee in Common 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

ESTH

2.1 There have been 389 deaths in the period Jan – March 2023 (377deaths Q4 2022)

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]

The latest SHMI data covers discharges from January 2022 to December 2022, was published in May 2023. The Trust's overall SHMI value remains categorised as 'higher than expected' at 1.188. We were one of the 10 Trusts in this category.

SHMI expected numbers of deaths are based on historical data and from similar Trusts across the country. The Trust was part of a pilot where patients in SDEC were removed from the inpatient numbers, and this cohort has lower mortality, so our expected deaths were lower. The NHS are aware of this and from April 2023, all trusts have to remove SDEC data, but because SHMI is a 12-month rolling calculation, the impact will take time to be reflected in the data.

It should be noted that NHS Digital exclude Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. SHMI does not reflect the activity categorisation changes that happened during and post pandemic, and therefore the statistical modelling used to calculate the SHMI may not be as robust.

NHS Digital provides SHMI value for ten diagnosis groups, detailed below.

Published figures for January 2022 – December 2022*

Diagnosis group description	Spells	SHMI value	SHMI banding
Acute bronchitis	490	2.0660	Higher than expected
Urinary tract infections	900	1.6226	Higher than expected
Cancer of bronchus; lung	40	1.5846	As expected
Gastrointestinal hemorrhage	305	1.5839	Higher than expected
Fluid and electrolyte disorders	295	1.3429	As expected
Pneumonia (excluding TB/STD)	1,215	1.1773	As expected
Septicaemia (except in labour), Shock	295	1.0036	As expected
Secondary malignancies	110	0.9856	As expected
Acute myocardial infarction	240	8214	As expected
Fracture of neck of femur (hip)	425	0.6586	Lower than expected

*Data published in NHSE SHMI report. Accessible here.

https://app.powerbi.com/view?r=eyJrIjoiZTAzNGIwNGEtMDNmMS00ZjU1LWExMDYtNzk4Y2I3NTViYmI4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

A sample of UTI coded deaths were subjected to a deep dive in Q2 and Q3, and it was found that only one third of the sample did the coding reflect an accurate diagnosis. A review of 19 cases of 'acute bronchitis' was undertaken. The HES code for bronchitis (J22X) is defined as 'Unspecificed Lower Respiratory Tract Infection' (LRTI), so pulls in chest infection/pneumonia where there is no information for a more specific code. In 13/19 cases it was judged that acute LRTI was the likely cause of death; possible in 4/19 and unlikely in 2/19. It is possible that a different code could have been used in these other cases.

A pilot is beginning in the Renal Division with clinician-coder collaboration to drive improvements in coding.

2.3 **Hospital Standardised Mortality Ratio (HSMR)** [source HED]

For the most recent 12 months of data reported by HED covers April 2022 to March 2023. The mortality ratio was showing a similar trend to SHMI, but observed deaths in March 2023 have reduced compared to expected deaths . The current value is 102.07, which is a 5.0 decrease from Feburary (107.12) and January (106.41). Note that HED reports can also exclude Covid-19 activity from their analysis.

Data for March 2022 – February 2023

	HSMR (basket of 56 diagnoses)	Banding
All admission methods	113.41	As expected
Elective admissions	69.08	As expected
Non elective admissions	113.90	As expected

Review of mortality analysis at diagnosis and procedure group level is considered by RADAH (Reducing Avoidable Deaths and Harm) group.

SGUH

2.4 There have been 430 deaths in the period January 2023 to March 2023.

2.5 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
The latest SHMI data covers discharges from December 2021 to November 2022, and at 0.93 our mortality is as expected.

Diagnosis group	**SHMI value**	**Banding**
Septicaemia (except in labour), Shock	0.82	Lower than expected
Cancer of bronchus; lung	0.49	Lower than expected
Secondary malignancies	0.95	As expected
Fluid and electrolyte disorders	0.67	As expected
Acute myocardial infarction	1.32	Higher than expected
Pneumonia (excluding TB/STD)	0.90	As expected
Acute bronchitis	*	*
Gastrointestinal haemorrhage	0.71	As expected
Urinary tract infections	1.13	As expected
Fracture of neck of femur (hip)	1.70	Higher than expected

* value not given due to small numbers

2.6 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
The most recent Dr Foster data covers discharges between February 2022 and January 2023. For this period our mortality is lower than expected at 89.5

	Value	Banding
HSMR	89.5	Lower than expected
HSMR weekday emergency admission	86.9	Lower than expected
HSMR weekend emergency admission	95.3	As expected

2.7 **LEARNING FROM DEATHS OBJECTIVES**

The Mortality Monitoring Group (MMG) has agreed several 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 Group, Quality Committee and ultimately Trust Board.

Priority Work Streams and Signals

Workstream	Priority area	Key updates
Mortality investigations to be concluded	Cardiology diagnosis and procedure groups, principally Acute myocardial infarction	**Clinical** The shock team is now fully functional in working hours Monday to Friday. Early audit data is showing a clear benefit to patients referred early into the pathway. Education is being provided to promote early referral into the service. **Infrastructure** The team is now working on a business plan to provide 24/7 shock team cover to further improve shock management out of hours. SW and JA are continuing to represent St Georges in Pan Thames meetings regarding shock management.
	Major trauma (TARN)	**Infrastructure**: Building of the new Trauma Ward, planned to be ready on 23rd May 23 The trauma ward is almost ready and due to be handed over from contractors at the beginning of May. The ward opening group will then finalise plans for receiving patients. The delivery of the trauma service will continue through T&O, however the consultant of the week model is now being reviewed and a

		business plan for the recruitment of major trauma fellows has been approved. The appointment of a neurosurgeon with a trauma interest is now in post and has been busy strengthening communication between emergency services and neurosurgery. Acute rehabilitation service plans are being finalised and psychological support services have now recruited a full complement of staff. **Governance:** No change reported **Clinical**: Several SOPs have now been signed off; including major haemorrhage and chest wall injury. The craniotomy and code black workstream are still to be finalised.
	Perinatal Mortality	Since the last report, further work examining the flags within perinatal mortality has been carried out. Analysis of both HSMR (includes still births) and SHMI (does not include still births) data has shown that we compare poorly with our peers. At St George's we perform late medical terminations which is not common to most trusts; however, in a direct comparison with other late termination centres, our results appear worse than expected. This data has been considered alongside national benchmarking data from MBRRACE-UK and an external review is now pending.
Mortality and Morbidity meetings development	Mortality template and TOR	We are now developing an audit template for assessing utilisation for further assessment of the mortality template and TOR. This has been planned for autumn to avoid the summer vacation period.
Learning from Deaths agenda	Reviewer team	A senior nurse has now joined the reviewer team and undergone her reviewer training. And is now a functional member of the team.
	Collaborative working with St Heliers	Quarterly Teams' meetings with Epsom & St Helier to further elucidate our different practices and eventually present a unified report to the board.

3.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

ESTH

Mortality Review Team

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 101 deaths, which represent 25.96% of all deaths. Of the 101 of those in scope to have an SJR done, 99 were completed and 2 are awaiting review.

The reasons for requesting a review include:

- Deaths where the Medical Examiner has identified a potential concern
- Deaths where bereaved families, or staff, had raised a significant concern
- Deaths of inpatients with learning disabilities
- Deaths of inpatients with severe mental illness
- Deaths where the patient was not expected to die including all deaths following elective admission
- Deaths of patients with COVID judged to be likely nosocomial

An assessment of overall care is also provided for each death reviewed.

A smaller number of deaths received an SJR in Q4 than in previous quarters (119 in Q3, 143 in Q2; 131 Q1). The percentage of overall 'poor/very poor' assessments was lower at 7.14% (13.39% Q3; 6.38% Q2; 8.4% Q1). This may reflect that the operational pressures in Q3 requiring business continuity due to ambulance service and nursing industrial action, which impacted on flow through the Trust, have resolved somewhat. We expect the numbers of deaths receiving an SJR to increase as further referrals are received.

Overall care judgement	Number	Percentage
Excellent care	4	3.96%
Good care	43	42.57%
Adequate care	45	44.55%
Poor care	6	5.94%
Very poor care	1	0.99%
Awaiting rating	2	1.98%
Total	**101**	**100%**

3.1 Areas of concern

Any concerns identified through the SJR process are assessed as minor, moderate or major. Major concerns are automatically DATIXed by the Mortality Reviewer and where appropriate a Rapid Review Report is recommended. Mortality Reviewers also liaise directly with the responsible consultant for cases where they recommend learning for improvement to be discussed at the relevant specialty-based M&M meeting. They also provide positive feedback to consultants where there is excellent care.

A review of SJRs major concerns across the whole of 2022-23 is being undertaken by the MR team to see whether there are any clear themes over time for learning tor improvement.

All SJRs assessed as overall 'poor' or 'very poor' care have a second SJR by another consultant Mortality Reviewer (MR). There is good concordance between MRs, and feedback is given to the responsible consultant or a Datix is raised, if appropriate.

3.2 Cardiac Arrests:

The MR team undertake SJRs on all Cardiac Arrests across both hospital sites to assess quality of care and support the Cardiac Arrest audit undertaken by the Resuscitation Team.

Despite having process and policies in place to support treatment escalation plans and decisions relating to resuscitation and repeated audits of CA cases and PTEP/DNACPR completion rates with recommendations there has not been a change to our CA arrest rates submitted to the National Cardiac Arrest Audit (NCAA), which stay at the higher end of the scale when compared nationally and locally

Our Resuscitation Clinical Lead has liaised with The resuscitation service manager and the chair of deteriorating patient committee at St George's Hospital regarding their NCAA results and the decline in their rates of CA to almost negligible. Factors likely to be contributing to this include a change in their management in ED of sepsis and initiating the REDS scoring system (Risk stratification of ED suspected Sepsis score) in March 2019, the launch of their 24/7 critical care outreach team in January 2020 and the initiation of electronic DNACPR/TEP forms in April 2020.

Our Trust is exploring introducing the REDS scoring system, and is due to extend the Critical Care Outreach Team service to provide 24hr cover. Initiation of electronic DNACPR/PTEP forms will be part of the CERNER roll-out to ESTH in April 2024.

This has highlighted the need for appropriate, timely discussions around appropriate escalation of care. On the St Helier site this relies on completion of Patient Treatment and Escalation Plans (PTEP) whereas at Epsom the Recommended Summary Plan for Emergency Care and Treatment (ReSPECT) is in use. A ReSPECT advance education practitioner has been appointed to embed this work

3.3 Areas of good practice:

The Mortality Review Team also identify areas of good practice, highlighted below:

- There is consistently good specialty Palliative Care Team input into end-of-life care with multi-professional involvement. There are still times when end of life is not recognised in a timely manner. The Palliative Care Team provide teaching and education but, since COVID, have had a reduction in the amount of time allocated to education and training of new nurses as part of their mandatory induction period.
- Nursing Proformas on wards are providing improved daily documentation of essential aspects of care. Medical proformas for MDT ward rounds and weekend plans are also effective. The use of such proformas is expanding within the Trust.

- There is positive impact made by the Critical Care Outreach Team (CCOT) at the St Helier Hospital site, which provides sound clinical input and support, particularly for junior doctors.

The DMD for Surgery has been successful in obtaining agreement to expand this key service to 24 hours on both sites.

The Mortality Reviewers contribute to the weekly SI/RRR panel and also have roles as Lead Investigators for SIs as part of their remit. Trust wide learning from these incidents has been done through Topic of the Week, Quality Half-Days, Safety Flashes and other fora.

3.4 Clinical Coding:

An external review of Trust coding has indicated that clinicians are not consistently documenting patient co-morbidities from previous in-patient admissions, which affects SMHI/HSMR. This issue is resolved in Trusts which have EPR. There are also missed opportunities soon after admission for increasing the accuracy of diagnostic coding.

The Trust is starting a pilot in the Renal Division for clinicians/coders to verify coding on a regular basis.

3.5 Perinatal Mortality

The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the quarterly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the safety standard, each report also detailed potential areas for learning and improvement. Over the year there were no clear themes identified.

Stillbirth and neonatal deaths are reviewed through MBRRACE-UK and reported separately to the Board. All child deaths are reviewed locally by clinical teams and presented at the monthly paediatric Divisional Management Team meeting.

SGUH

3.6 **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. We had faced some initial resistance from some care groups in adoption of the template, but we are now approaching 100% adoption and we aim to audit this process in August 2023. This builds on a recommendation from the external governance review.

3.7 **Mortality Review Team**

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 38 deaths, which represent 8.8% of all deaths. 29 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office and 9 from other sources. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel. The reasons for requesting a review are summarised below. Some reviews are triggered for more than one reason, so the triggers reported exceed the total number of reviews.

Triggers for SJR

Triggers for review	
Confirmed learning disability +/- clinical diagnosis of autism	8
Significant mental health diagnosis	12
ME or clinical team detected possible learning or potential issue with care	7
Deaths following elective admission	4
Areas subject to enhanced oversight	5
Family raised significant concerns	3

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 38 deaths reviewed this quarter problems were identified in relation to 11 deaths (28.9% of the patients reviewed).

Problems in healthcare identified

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	3	0	1	4
Medication	0	0	0	0
Treatment	1	2	0	3
Infection control	0	0	0	0
Procedure	1	0	0	1
Monitoring	1	0	0	1
Resuscitation	0	0	0	0
Communication	2	0	0	2
Other	2	1	0	3
Total	10	3	1	**14**

Overall care rating

Overall care judgement	Number	Percentage
Excellent care	6	15.8
Good care	30	78.9
Adequate care	1	2.6
Poor care	0	0
Very poor care	0	0
Unable to score	1	2.6
Total	**38**	

In one case the patient was referred for review by an external team. This patient died elsewhere having been treated at St George's solely as an outpatient; therefore, the reviewer felt unable to rate the overall quality of care.

Judgement on avoidability of death is made for all reviews

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	31	81.6
Slight evidence of avoidability	4	10.5
Possibly avoidable but not very likely (less than 50:50)	1	2.6
Probably avoidable (more than 50:50)	0	0
Strong evidence of avoidability	1	2.6
Definitely avoidable	0	0
Unable to score	1	2.6
Total	**38**	

Two of the deaths reviewed did not occur at St George's and as such the reviewers did not feel able to make a judgement about the avoidability of death.

3.8 **Learning from mortality**

There was one case out of the 38 reviews which was deemed a probably avoidable death. This was reviewed at SIDM and it was found that appropriate risk assessments were completed in a timely manner and that there were no acts or omissions that would have contributed to the incident. It was deemed not to be an AI/SI and was reviewed at a MedCard level as part of a deep dive into falls.

Learning from mortality – SIDM reviews

Datix identifier	SIDM discussion date	Outcome
DW183489	30/01/2023	Not declared SI/AI. Reviewed within MedCard as part of a deep dive into harm related to falls

3.9 **SJR Learning**

Over the last 6 months we have been communicating with Epsom & St Helier's about patients who died either at Epsom & St Helier's or St George's but have recently visited the other hospital within the group. Going forward we will develop a policy to ensure that all cases where there has been a death of a patient who has crossed both sites within 30 days will be notified to the respective site for local learning. There has been a recent case where a patient reviewed as a potential CVA at St Georges was discharged only to be admitted days later to St Helier's with a diagnosis of Guillain Barre. There were several elements of learning from this case that would have been missed were we not notified of the final diagnosis.

4.0 MEDICAL EXAMINER SERVICE

ESTH

100% of adult in-patient deaths (446) were scrutinised by the ME service in Q4

4.1 A key function of the ME service is to support the appropriate referral of deaths to the coroner. This quarter 59 (*77 in Q3)* deaths were referred. In all, 28/59 of the cases submitted were subject to further coronial investigation including PMs with the remainder felt no further investigation was required. Two child deaths were notified to the coroner with both forwarded for investigation or PM.

4.2 The number of deaths referred for an SJR by the ME service was 105. This number has steadily reduced following the significant reduction in COVID cases, the changes in working practices following action provided from previous SJR reviews plus the proportionate scrutiny undertaken by the MEs where the understanding and accuracy of review is now greater.

4.3 In addition to flagging areas where there are potential concerns the Medical Examiner (ME) service highlights cases where best practice was observed.

- Care on C4 Ward was fantastic. The Bereavement Officer, was amazing and super!
- Care was absolutely magic
- Treatment from LAS & ED was superb.
- Lack of privacy when Pt was dying, no side room available, but understand that the ward was busy.
- Palliative team 'amazing'
- Care on ITU was wonderful, staff did everything they could for the Pt
- Care was absolutely wonderful, both care and communication was perfect. Immense gratitude from the family
- Thought care was amazing. Well taken care of. Ambulance teams were fantastic too. Quick responses on three occasions.
- Fantastic care, especially the palliative team

4.4 The ESTH ME service is expanding scrutiny of deaths to the community setting, anticipating that this will become a statutory mandate at a national level. Our ME team has worked proactively with our local GPs in the Sutton locality of SWL and all 23 GP practices in Sutton catchment area now receive scrutiny from the Trust-based ME service. The service is being expanded to support a further 11 Surrey GP practices. 144 Community deaths were scrutinised in Q3 *(121 in Q3).*

We are being recognised as an exemplar at both a regional and national level for our collaborative and forward-thinking practice.

4.5 Each quarter all ME offices are required to make a return directly to the office of the National ME, as summarised below. death.

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME	
Number of in-hospital deaths scrutinised	**446**
Adult deaths	
Cases not notified to the Coroner and MCCD issued directly	387
Cases notified to the Coroner and MCCD issued following agreement by Coroner	59
Cases referred to the Coroner and taken for investigation	28
Child deaths	
Cases not notified to the Coroner and MCCD issued directly	0
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)	105
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	8
Number of cases where urgent release of body is requested and NOT achieved within requested time	0
Achieving communication with the bereaved	
Number of deaths in which communication did not take place	1
Reasons for no communication: Declined	0
No response	0
No NOK	1
Not documented	0
Detection of issues and actions	
ME referred for structured judgement review (including COVID related deaths and cardiac arrests)	105
ME referred to other clinical governance processes (includes safeguarding,nursing issues)	28
ME referred to external organisation for review (including GP practices, LAS)	6
Families referred to PALS	0

SGUH

MERTON & WANDSWORTH MEDICAL EXAMINER SERVICE

4.6 St George's hosts the Merton & Wandsworth (M&W) Medical Examiner (ME) service which is independent of the Trust and is funded centrally by the NHS. All ME offices report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each quarter all ME offices are required to make a return directly to the office of the National ME. This quarter the M&W ME service met all the required KPIs and milestones.

4.7 It had been previously stated that the ME system would become statutory in April 2023; however, on 27th April 2023 the Department for Health and Social Care published a written ministerial statement detailing the plan for deferring the statutory system to April 2024. This will put all of the ME system's obligations, duties and responsibilities on a statutory footing. It will be a legal requirement that MEs scrutinise all non-coronial deaths.

4.8 The M&W ME service has been working with community providers since July 2022 to scrutinise non-coronial deaths which occur outside of the acute setting. This quarter the service has engaged in an intensive communications programme and has been successful in on-boarding a significant number of providers. The service is now receiving referrals from 34 GP practices and specialist hospitals.

4.9 A meeting of the working group, which includes leaders from Merton and Wandsworth Primary Care Networks and the South West London Integrated Care System will be held in the following quarter. The group will evaluate progress and agree a strategy for building on current momentum so that the service continues to expand and strengthen during the non-statutory phase.

4.10 The Merton & Wandsworth ME service has been selected to host a visit from the National Medical Examiner, Dr Alan Fletcher. The Lead ME and St George's Executive team will welcome Dr Fletcher and the Regional Medical Examiner team in July. This will provide an opportunity to jointly outline the direction and work of the ME service supporting St George's and to demonstrate mutual commitment to excellent processes for the bereaved. There will also be opportunity for Dr Fletcher to observe the service in practice and to meet with the Medical Examiner Officers and Medical Examiners.

4.11 Our Lead ME contributes to both the national ME training programme and to specific training in relation to paediatric deaths involving other ME and coroner services.

4.12 The ME service remains positively engaged with Trust Learning from Deaths processes and is the presently the primary route through with deaths requiring structured judgement review are identified. This quarter the ME service flagged 29 deaths for SJR.

RECOMMENDATION

That the Committee 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 issues at both sites.

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	5.4	
Report Title	**Responsible Officer Report on Medical Appraisal and Revalidation - SGUH**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Dr Elizabeth Rhodes (Responsible Officer, SGUH) Nicola McDonald (Revalidation Support Officer)	Dr Elizabeth Rhodes (Responsible Officer, SGUH) Nicola McDonald (Revalidation Support Officer)	
Previously considered by	Choose an item.	-
Purpose	**For Assurance**	

Executive Summary

The Responsible Officer (RO) reports to the Board annually on progress in the medical appraisal and revalidation of licensed doctors including the use of the NHS England designated body annual board report.

Since the last Board review Dr Elizabeth Rhodes has ben appointed as the Responsible Officer for St George's starting in post March 2023.

- The number of doctors connected to St George's continues to increase with 1062 connections by 1/4/23.
- Appraisal compliance rate remains lower than our target of 95% at 84% for the final quarter of 2022/3 which is stable over the last 2 years. This remains a focus of work for the Appraisal and Revalidation Group (AaRG)
- No referrals to the GMC for non-engagement have been made in the last 12 months.
- The number of revalidation deferrals has fallen in 2022/3
- There is a small cohort of doctors who are more than 6 months overdue on appraisal. Intensive work is underway with individuals to ensure they comply with requirements for annual appraisal.
- Quality assurance is undertaken annually and used to inform ongoing training.
- We have trained more appraisers in Spring 2023 increasing our appraiser body to 167 (a ratio of 1:6)

The AaRG work with any doctors identified as having delayed appraisals and to identify challenges and barriers these doctors face. An area of particular focus is working to ensure our Locally Employed Doctors can access meaningful and excellent appraisals.

The AaRG continues to support appraisers to work in line with the principles of the 2022 Medical Appraisal Guide with a focus on the appraisees wellbeing.

The designated body annual board report is attached in section 3 of the report. Key action points focus on improving appraisal compliance, reaching cohorts of doctors requiring specific support and monitoring outputs and themes.

Section 3.0 of this paper contains the Designated Body Annual Board Report – this is a report filled in by the Designated Body (in this case, the Trust) using a proforma provided by NHSE. This Designated Body Annual Board Report refers to the year 2022/3. In 2020 submission of the AOA to NHSE was paused due to the pandemic and the requirement for submission has not been reinstated. Designated bodies though are encouraged to still complete and present to their boards for assurance. The annual Statement of Compliance will be submitted to NHSE in September 2023 signed by the Chief Executive or Chairman.

A glossary of abbreviations is provided at the end of the paper

Action required by Group Board

The Board is asked to:

a. Note the designated body annual board report
b. Note the planned actions for the upcoming year
c. To agree to progress with signing the Statement of Compliance for 2023 for SGUH

Committee Assurance

Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	
Appendix 2	
Appendix 3	

Implications

Group Strategic Objectives

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

Risks

Non-compliance of doctors with appraisal risks a loss of GMC licence to practise medicine

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

[Set out briefly any financial implications relevant to the issues described in the paper]

Legal and / or Regulatory implications

Medical Profession (Responsible Officer) Regulations 2010. GMC requirement for annual appraisal and a 5 yearly revalidation to maintain a licence to practise medicine

Equality, diversity and inclusion implications

Lower appraisal rates amongst locally employed doctors where there are higher proportions of doctors from a BME background or those who are International Medical Graduates
Environmental sustainability implications

Medical Appraisal and Revalidation

Group Board, 25 May 2023

1.0 Purpose of paper

1.1 The purpose of this report is to provide the Committee with timely information on the compliance of the organisation with the Medical Profession (Responsible Officer) Regulations 2010. This report contains the Designated Body Annual Report to the Board.

2.0 Background

2.1 The Responsible Officer (RO) has a statutory role in medical regulation and is accountable to the Board for the local governance processes focusing on the conduct and performance of doctors. Each RO is accountable for the performance of doctors connected to the designated body for which they act. St George's currently has 1062 connected doctors (this excludes doctors in training who are connected to HEE or agency / locum doctors connected to other designated bodies.)

2.2 Every licensed doctor who practises medicine must revalidate through the regulator, the GMC, every 5 years to maintain a licence to practise medicine. Revalidation is based on a system of annual appraisal of the whole scope of practice, based on a Good Medical Practice framework. A core responsibility of the RO is to ensure that all connected doctors have access to high quality appraisal and are supported to revalidate.

2.3 Prior to the Covid-19 Pandemic the Trust would make a self-assessment return to NHSE for the Annual Organisation Audit (AOA) but since the temporary pause of appraisals and associated activities in March 2020 formal returns of the AOA have not been reinstated but at St George's the RO has continued to report to assure the board on activities related to the revalidation of doctors. Attached is the designated body annual board report which summarises the key requirements for compliance with regulations and key national guidance enabling us to demonstrate not only basic compliance but areas of improvement and identify actions required.

3.0 Analysis

Designated Body Annual Board Report

Section 1 – General:

The board / executive management team of St George's University Hospitals NHS FT can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No action required. Comments: Dr Elizabeth Rhodes commenced as RO 20/03/2023. Training completed 03/03/2021. Action for next year: No action required.

2. The designated body provides sufficient funds, capacity, and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: No action required. Comments: 3 Divisional Appraisal Leads to support RO (1 PA each). Admin support from 1 permanent band 6 (1 wte) and 1 fixed term band 3 (0.5 wte). Action for next year: No action required.

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: No action from last year. Comments: Revalidation and Appraisal Support Team regularly cross references the GMC Connect database with new starter and leaver reports. Action for next year: No action required.

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Revalidation and Appraisal Support Team to populate medical appraisal intranet page with resources for appraisers and appraisees.

Comments: Medical Appraisal Policy to be approved in the next 6-12 months. Medical appraisal intranet page built but not yet populated due to lack of time but content plan in place.

Action for next year: To Carry Over - Revalidation and Appraisal Support Team to populate medical appraisal intranet page with resources for appraisers and appraisees.

5. A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year: No action from last year.

Comments: The Trust took part in the Higher-Level Responsible Officer Quality Review Visit (NHSEI) in March 2020.

Action for next year: No action required.

6. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: No action from last year.

Comments: All doctors with a prescribed connection are supported with appraisal and revalidation and have access to the same governance systems. On request, the Revalidation Support Officer will complete a medical practice information transfer form for those who work at St George's but are connected to another organisation i.e., for their annual appraisal.

On connecting to St George's new doctors receive a pack containing information on revalidation and appraisal and a link to joining L2P

The Appraisal and Revalidation team join the IMG induction day and will be joining the training session for IMG doctors.

Action for next year: No action required.

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for

any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes.[1]

Action from last year: Continue regular appraiser training linked to internal QA and feedback. Explore new 2022 model appraisal option.

Comments: No further refresher training/forums, but 2 new appraiser sessions run in March and April 2023.

We have continued to support and train appraisers to provide excellent appraisals.

L2P launched a 2022 appraisal form in line with what the AoMRC/GMC/NHSEI agreed, following positive feedback from the 2020 form introduced during the pandemic. Although the Trust opted not to adopt the abbreviated 2020 form and have not yet adopted the 2022 form, we encourage doctors to focus on quality and reflective discussion vs quantity of supporting information presented and to include an emphasis on health and well-being.

All doctors are required to declare their full scope of work in their appraisal and should include supporting information that proportionate to that, including information from other organisations in which they work, of any complaints and significant events they have been named in (or that they have not been named). The AaRG meet monthly and review information about doctors of concern or where additional support will be needed to ensure they meet the requirements for revalidation.

Action for next year: No further action required.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Continue annual QA exercise to sample across all appraisers over 3 years.

Comments: QA exercise led by Divisional Appraisal leads is ongoing, with sampling from each Division using the NHSEngland Appraisal Summary and PDP Audit Tool

Action for next year: Ongoing - Continue annual QA exercise to sample across all appraisers over 3 years.

[1] For organisations that have adopted the Appraisal 2020 model (recently updated aby the Academy of Medical Royal Colleges as the Medical Appraisal Guide 2022), there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet moved to the revised model may want to describe their plans in this respect.

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Publish Medical Appraisal Policy online via the Trust intranet. Comments: The policy has been reviewed by the Appraisal and Revalidation Team and will be taken to PMG for ratification within the next 6 months. Action for next year: Ratification of MAP and then publication on the Medical Appraisal and Revalidation intranet site and policy hub.

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Begin to use L2P report and review at AaRG Comments: There are sufficient trained appraisers for 6 appraisals per year at the current number of connections. The number of connections continues to rise annually. New appraisers have been training in March and April 2023 to continue to meet demand and ensure a pool of new and diverse appraisers. L2P has built a report to enable us to see when 3rd appraisals with the same appraiser are due so that we can start to actively address allocation for other doctors. Action for next year: To carry over - Begin to use L2P report and review at AaRG.

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[2] or equivalent).

Action from last year: Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing. Comments: Appraiser update training is based around QA and attendance will be monitored. Action for next year: To carry over - Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing.

[2] http://www.england.nhs.uk/revalidation/ro/app-syst/

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Report back on annual QA in the RO report to the board.
Comments: Annual Quality Assurance in line with NHSEngland Appraisal Summary and PDP audit tool continues
Action for next year: Continue annual quality assurance reviews.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation:	
Total number of doctors with a prescribed connection as at 31 March 2023	1062
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	836
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	226
Total number of agreed exceptions	76

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs

Comments: Review future recommendations through AaRG up to 3 months in advance of revalidation date.

The number of recommendations to revalidate totalled 217.

The number of recommendations to defer totalled 68.

There were no recommendations of non-engagement.

The RO has joined the SAS-LED working group and identified appraisal and revalidation as a key focus point for LED work.

The Appraisal and Revalidation Team attend the Trust IMG induction day.

Action for next year: Ongoing - Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs.

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: No action required.

Comments: The Revalidation and Appraisal Support Team will inform each doctor of what recommendation has been submitted. In most cases where a deferral is necessary, this will be communicated to the doctor beforehand with a clear action plan and timeframe to achieve by the next due date. The RO contacts the doctor directly in cases where they are deferred because they are subject to an ongoing process or where they are failing to meet the requirements of an action plan and are at risk of non-engagement.

Action for next year: No action required.

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Work with the site and Group CMO and Divisional Chairs to continue implementation of the action plan arising from the clinical governance review.

Comments: Actions from the first two parts of the governance review have been implemented. Outstanding areas from the 3rd part are mainly around the linking of care group, divisional and Trust governance:

- Insufficient support for clinical governance at care group level
- Clinical governance leads are unable to attend key meetings because of clinical commitments
- Items on the local risk registers are not escalated to divisional level.
- The Quality and Safety strategy does not drive improvement at divisional, directorate or care group level.

Action for next year: Divisional appraisal leads to continue to work with divisional governance teams to support where needs are identified. The senior leadership will continue to strive to meet areas of need.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Ensure a clear process is agreed for holding the RO to account.

Comments: Review of performance happens effectively though AaRG and The Trust Responding to Concerns group and policy supports this.

- The RO presents directly to the PCiC every quarter.
- Continue to monitor processes and outputs.

Action for next year: Continue quarterly reports to PCiC directly by the RO and annual reports to the board.

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to

concerns policy that includes arrangements for investigation and intervention for capability, conduct, health, and fitness to practise concerns.

> Action from last year: Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.
>
> Comments: The MHPS policy is still in negotiation with the LNC and meetings have occured. However, processes have been established with ER teams to support the response to concerns about doctors raised in any capacity and clinical lead development sessions have focused on this.
>
> The trust policies for ER have been revised and are subject to final approval. The new procedures are aimed to remove delays and blockages in the system and more details will be available after agreement with the LNC. Local changes will though contribute greatly to ER process efficiency.
>
> Action for next year: Finalisation of MHPS policy in discussion with the LNC, including the role of RtC and development of trackers to ensure adherence to policies.

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[3]

> Action from last year: Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.
>
> Comments: Audit completed from July 2021. Dido Harding template adopted when any decision is made about next steps. Processes have been established with ER teams to support the response to concerns about doctors raised in any capacity and clinical lead development sessions have focused on this.
>
> Action for next year: To carry over - Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your

[3] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.

organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[4]

Action from last year: No action from last year. Comments: Where a doctor works for multi-organisations, information of note is transferred from RO to RO using a MPIT form. Action for next year: No action required.

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

Action from last year: Ongoing monitoring of RtC referrals and outcomes and work with ESTH to agree shared action plan. Comments: Dido Harding template adopted when any decision is made about next steps. Action for next year: Ongoing monitoring of referrals and outcomes in conjunction with the ER team. To continue with plans to work with ESTH.

[4] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: No action from last year.
Comments: The Medical Staffing Team carry out the 6 NHS Employment Check Standards that outline the type and level of checks employers must carry out before recruiting staff into NHS positions.
Action for next year: No action required.

Section 6 – Summary of comments, and overall conclusion

Action plan 2022/3

Area of AOA	Action	Completion date	
General	Admin team to populate medical appraisal intranet page with resources for appraisers and appraisees	June 23	Ongoing – to be completed with more support in the **Revalidation and Appraisal Support Team**
Effective appraisal	Continue regular appraiser training linked to internal QA and feedback.	June 23	Completed and will continue
Effective appraisal	Continue annual QA exercise to sample across all appraisers over 3 years	June 23	Completed 2022 will continue each year
Effective appraisal	Publish MAP online via the Trust intranet	June 23	To be done when web page updated
Effective appraisal	Begin to use L2P report and review at AaRG	June 23	We have sufficient trainers but will continue to use L2P in a streamlined way
Effective appraisal	Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing.	June 23	Not completed but plan in place for 2023_4
Effective appraisal	Report back on annual QA in the RO report to the board.	June 23	
GMC	Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs	June 23	Completed but will continue
Medical governance	Work with the site and Group CMO and Divisional Chairs to continue implementation of the action plan arising from the clinical governance review.	June 23	Ongoing
Medical governance	Ensure a clear process is agreed for holding the RO to account	June 23	completed
Medical governance	Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.	June 23	Ongoing discussions. Working with ER team and LNC
Medical governance	Ongoing monitoring of RtC referrals and outcomes and work with ESTH to agree shared action plan	June 23	Ongoing monitoring of referrals and outcomes in conjunction with the ER team. To continue with plans to work with ESTH

Action plan for 2023/4

Area of AOA	Action	Completion date
General	Revalidation and Appraisal Support Team to populate medical appraisal intranet page with resources for appraisers and appraisees.	June 24
Effective appraisal	Continue annual QA exercise to sample across all appraisers over 3 years	June 24
Effective appraisal	Ratification of MAP and then publication on the Medical Appraisal and Revalidation intranet site and policy hub	June 24
Effective appraisal	Begin to use L2P report and review at AaRG	June 24
Effective appraisal	Divisional appraisal leads will implement peer support groups for appraisers to discuss difficult appraisals. A key focus for the next year will be enabling appraisers to support wellbeing.	June 24
Effective appraisal	Continue annual quality assurance reviews.	June 24
GMC	Reduce deferrals and missed appraisals further by continuing active support through AaRG and tackling at risk groups eg LEDs	June 24
Medical governance	Divisional appraisal leads to continue to work with divisional governance teams to support where needs are identified. The senior leadership will continue to strive to meet areas of need	June 24
Medical governance	Continue quarterly reports to PCiC directly by the RO and annual reports to the board.	
Medical governance	Finalisation of MHPS policy in discussion with the LNC, including the role of RtC and development of trackers to ensure adherence to policies	June 24
Medical governance	Agree MHPS policy with the LNC to include the RtC group and ensure clarity about its remit and function within the organisation.	June 24
Medical governance	Ongoing monitoring of referrals and outcomes in conjunction with the ER team. To continue with plans to work with ESTH.	June 2024

Section 7 – Statement of Compliance:

The Board / executive management team of St George's University Hospitals NHS FT has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: St George's University Hospitals NHS FT

Name: _ _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ _

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _ _

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This publication can be made available in a number of other formats on request.

Publication reference: B1844

The heading name "Analysis" can be changed to a heading relevant to the specific report. Also, where additional headings / sections are needed, please add as necessary using the format of this section.

4.0 Sources of Assurance

4.1 Appraisal and Revalidation is overseen by the RO with support of the appraisal and revalidation group (including Divisional Appraisal leads) and the Revalidation Support Officer

5.0 Implications

5.1 Legal and Regulatory Implications: GMC requirement for annual appraisal and a 5 yearly revalidation to maintain a licence to practise medicine.

6.0 Recommendations

6.1 The Board is asked to:

a. Note the designated body annual board report
b. Note the planned actions for the upcoming year
c. To agree to progress with signing the Statement of Compliance for 2023 for SGUH

.

GLOSSARY OF TERMS

AaRG: Appraisal and Revalidation Group

AOA: Annual Organisation Audit
RO: Responsible Officer
IMG: International Medical Graduate
L2P: Software name for appraisal platform used by SGUH

AoMRC: Academy of Medical Royal Colleges

PDP: Personal Development Plan:
QA: Quality Assurance
MAP: Medical Appraisal Policy
PMG: People Management Group
LED: Locally Employed Doctors
PCiC: People Committee in Common

MHPS: Maintaining High Professional Standards

LNC: Local Negotiating Committee

RtC: Responding to Concerns

ER: Employee Relations

MPIT: Medical Practice Information Transfer

Group Board

Meeting on Friday, 07 July 2023

Agenda Item	5.4	
Report Title	**Responsible Officer Report on Medical Appraisal and Revalidation**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Dr Steve Hyer (Responsible Officer) Ruby Ukoko (Revalidation Officer)	
Previously considered by	Choose an item.	-
Purpose	**For Noting**	

Executive Summary

This is the Trust Responsible Officer's Annual Report. It covers the progress made in medical revalidation and the developments during the reporting year 1st April 2022 to March 31st 2023..

The Responsible Officer remains Dr Steve Hyer, appointed in September 2019. Dr Hyer is supported by a Revalidation Officer. The number of doctors with a prescribed connection to ESTH increased in 2022/23 to 700 doctors. During the reporting period the Trust continued to provide external Responsible Officer services for a local hospice.

Appraisals and revalidation continued throughout this reporting period in line with the 'Appraisal 2020' format. The SARD appraisal system was updated to reflect this format. MS Teams/Zoom, in addition to traditional in-person appraisals, is used where permitted, to enable appraisals meetings take place to support doctors working across sites.

- Total number of appraisals for the period was 525.
- 175 appraisals were not undertaken, all of which were approved by the RO.
  Approved extensions were given on the following grounds;
  a). International doctors new to appraisal systems who need time to build evidence
  b). Doctors on sick leave due to long covid & other long-term illnesses.
  c). Doctors on maternity leave
  d). Increased work pressures from Junior doctors' strike.
- During the reporting period there were 202 scheduled revalidations; 194 were submitted, 8 deferred.
- Quarterly appraiser and revalidation forum enables appraisers to share knowledge, skills and experiences.

Section 3.0 of this paper contains the Designated Body Annual Board Report – this is a report filled in by the Designated Body (in this case, the Trust) using a proforma provided by NHSE. This Designated Body Annual Board Report refers to the year 2022/3 . In 2020 submission of the AOA to NHSE was paused due to the pandemic and the requirement for submission has not been reinstated. Designated bodies though are encouraged to still complete and present to their boards for assurance.

The annual Statement of Compliance and is due to be submitted to NHSE in September 2023 with a Statement of Compliance signed by the Chief Executive or Chairman.

Action required by Group Board

The Board is asked to:

a. Note the designated body annual board report
b. Note the planned actions for the upcoming year
c. To agree to progress with signing the Statement of Compliance for 2023 for SGUH

Committee Assurance

Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	
Appendix 2	
Appendix 3	

Implications

Group Strategic Objectives

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

Risks

N/A

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

Compliance to the GMC regulations as it relates to annual appraisals & 5 year cycle of revalidation for all doctors.

Equality, diversity and inclusion implications

The Trust has an active group of ethnic minorities and are eager to attract more of this group of doctors to train as appraisers.
Environmental sustainability implications
N/A

Responsible Officer Report on Appraisal and Revalidation
Group Board, 07 July 2023

1.0 Purpose of paper

1.1 This is the Trust Responsible Officer's Annual Report. It covers the progress made in medical revalidation and the developments during the reporting year 1st April 2022 to March 31st 2023. This report is, of itself, a required item of assurance signed off by or on behalf of the Board.

2.0 Background

2.1 As a designated body, the Trust is required to provide NHS England with an Annual Report on the revalidation of medical staff and the activities undertaken by the Responsible Officer (RO) over the previous year; this report should be presented to the Trust Board and submitted to NHS England with a statement of compliance signed on behalf of the Board. The content and format of the report is largely prescribed by NHS England.

This tenth annual report from the Responsible Officer to the Board provides an overview of the Trust's recruitment, performance, revalidation and appraisal processes in relation to medical staff working at the Trust as required by NHS England; the report comments on the Trusts compliance during 2022/23, current challenges and actions required during the next 12 months.

3.0 Analysis

[Designated Body Annual Board Report

Section 1 – General:

The board can confirm that:

1. An appropriately trained licensed medical practitioner is nominated or appointed as a responsible officer.

Action from last year: No Actions
Comments: Dr Steve Hyer remains as Responsible Officer
Action for next year: continues

2. The designated body provides sufficient funds, capacity and other resources for the responsible officer to carry out the responsibilities of the role.

Yes Action from last year: n/a Comments: Action for next year: n/a

3. An accurate record of all licensed medical practitioners with a prescribed connection to the designated body is always maintained.

Action from last year: Accurate record maintained via checks on ESR and Medical Workforce updates **Comments:** Forward look of new starters retained by the Medical Workforce Team accessible by the Revalidation Officer **Action for next year**: Ensure those doctors who have not commenced their role, do not connect to the Trust Designated Body until in post. Guidance note advising not to connect until in post, is supplied in recruitment pack

4. All policies in place to support medical revalidation are actively monitored and regularly reviewed.

Action from last year: Medical Policy revised in 2021 **Comments:** Expected revision to take place in late 2023 to take account of the 'Appraisal 2020' format that has now been adopted **Action for next year**: complete revision as above and review

A peer review has been undertaken (where possible) of this organisation's appraisal and revalidation processes.

Actions from last year HLRO visit undertaken in July 2021 **Comments**: Action Points noted in main body of Responsible Officer Report **Action for next year:** To continue ensuring action points as recommended by HLRO are undertaken and are currently ongoing: - Increase pool of appraisers - Reduce late revalidations - Increase pool of trained investigators

5. A process is in place to ensure locum or short-term placement doctors working in the organisation, including those with a prescribed connection to another organisation, are supported in their continuing professional development, appraisal, revalidation, and governance.

Action from last year: All locums, short term and Bank staff are supported in a manner equivalent to that of full-time employees **Comments:** Ongoing **Action for next year:** To ensure standards are maintained

Section 2a – Effective Appraisal

1. All doctors in this organisation have an annual appraisal that covers a doctor's whole practice, which takes account of all relevant information relating to the doctor's fitness to practice (for their work carried out in the organisation and for work carried out for any other body in the appraisal period), including information about complaints, significant events and outlying clinical outcomes. For organisations that have adopted the Appraisal 2020 model, there is a reduced requirement for preparation by the doctor and a greater emphasis on verbal reflection and discussion in appraisal meetings. Organisations might therefore choose to reflect on the impact of this change. Those organisations that have not yet used the Appraisal 2020 model may want to consider whether to adopt the model and how they will do so.

Action from last year: Appraisal 2020 model was adopted during the Covid pandemic and SARD appraisal toolkit was temporarily amended to adopt this format **Comments:** Feedback from doctors has been positive; one particular positive is the focus on well-being and pastoral care **Action for next year**: SARD our appraisal system supplier is currently working on permanent changes to the system in line with the Appraisal 2020 format.

2. Where in Question 1 this does not occur, there is full understanding of the reasons why and suitable action is taken.

Action from last year: Flexibility has been employed in allowing appraisees to complete an appraisal in a timely manner, whilst still remaining compliant **Comments**: Use of MS teams/Zoom has further enhanced appraisal completion in a timely manner; this approach has also proved to be more effective for those doctors who work cross-site. Where a doctor has not completed an appraisal on time, an explanation is sought, and a timeline for completion is given **Action for next year**: To encourage doctors to maintain appraisal completion in a timely manner

3. There is a medical appraisal policy in place that is compliant with national policy and has received the Board's approval (or by an equivalent governance or executive group).

Action from last year: Policy reviewed in 2021 **Comments**: n/a **Action for next year:** To be reviewed late 2023 to reflect new official 'Appraisal 2020' model

4. The designated body has the necessary number of trained appraisers to carry out timely annual medical appraisals for all its licensed medical practitioners.

Action from last year: Continued appraiser recruitment **Comments**: Recruitment of appraisers is ongoing. The ability for appraisers to complete training via Webinars, instead of commuting into London is seen as a positive step, allowing this training to be fitted into rotas more effectively. **Action for next year:** To recruit more appraisers

5. Medical appraisers participate in ongoing performance review and training/ development activities, to include attendance at appraisal network/development events, peer review and calibration of professional judgements (Quality Assurance of Medical Appraisers[1] or equivalent).

Action from last year: ASPAT tool is now being used to quality assure appraisals. The Responsible Officer reports back findings at the quarterly appraiser meetings. ASPAT guidance has also been added to the SARD system, this provides appraisers with a list of questions they need to consider when discussing the appraisal summary with the appraisee, enabling a concise discussion with the appraisee, prior to sign off by both parties. **Comments**: The ASPAT tool has successfully picked up on several areas of reporting in appraisal that required improvement, in particular appraiser summaries. This has been reported back at appraiser meetings. **Action for next year:** Maintain and improve further on the quality of appraisals.

6. The appraisal system in place for the doctors in your organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group.

Action from last year: Responsible Officer report to Board

[1] http://www.england.nhs.uk/revalidation/ro/app-syst/

Comments: Responsible Officer has reported to the People's Committee Board and will continue to do so on a quarterly basis

Action for next year: To continue to report to the committee.

Section 2b – Appraisal Data

1. The numbers of appraisals undertaken, not undertaken and the total number of agreed exceptions can be recorded in the table below.

Name of organisation: Epsom & St Helier NHS Trust	
Total number of doctors with a prescribed connection as at 31 March 2023	700
Total number of appraisals undertaken between 1 April 2022 and 31 March 2023	525
Total number of appraisals not undertaken between 1 April 2022 and 31 March 2023	175
Total number of agreed exceptions	175

The number of appraisals not undertaken (175) is made up of international doctors who are new to appraisals and require time to build evidence for appraisal, doctors on sick leave (including long covid), maternity leave and work-related pressures from the junior doctor's strike leading to appraisals being rescheduled.

Section 3 – Recommendations to the GMC

1. Timely recommendations are made to the GMC about the fitness to practise of all doctors with a prescribed connection to the designated body, in accordance with the GMC requirements and responsible officer protocol.

Action from last year: Maintain timely recommendations. **Comments**: All recommendations made on average one month before the revalidation due date. **Action for next year**: To continue as above

2. Revalidation recommendations made to the GMC are confirmed promptly to the doctor and the reasons for the recommendations, particularly if the recommendation is one of deferral or non-engagement, are discussed with the doctor before the recommendation is submitted.

Action from last year: Discussions with a doctor who is seeking a deferral for a revalidation are routinely undertaken to ascertain the reason for a deferral. Non-Compliance: A discussion will take place and advice is provided to ensure a doctor who is non-compliant understands the ramifications on said non-compliance. Discussion will include options available to avoid non-compliance. Responsible Officer will seek advice from Ingrid Southorn GMC Employer Liaison Advisor where necessary **Comments:** Where necessary the Revalidation Officer will work with a doctor to ensure that a potential deferral/non-compliance is mitigated and compliance maintained **Action for next year**: To reduce deferrals and maintain compliance

Section 4 – Medical governance

1. This organisation creates an environment which delivers effective clinical governance for doctors.

Action from last year: Weekly Medical Workforce Meetings with Medical Director, HR director, and Head of Medical Workforce, weekly meetings with Revalidation Officer, quarterly meetings with appraisers and appraisee feedback. **Comments**: Increasing the pool of mentors to support newly appointed Locally Employed and Overseas doctors **Action for next year**: To continue with mentorship and buddying system for doctors.

2. Effective systems are in place for monitoring the conduct and performance of all doctors working in our organisation and all relevant information is provided for doctors to include at their appraisal.

Action from last year: Serious incidents discussed at Medical Workforce Meeting (MWM) with RO in attendance. Information from MWM is used to cross-check appraisal information to ensure significant events have been recorded and reflected upon. **Comments:** Medical Practice Information Transfer information (RO to RO) is passed to the RP for new starters. **Action for next year:** Continued close working with GMC Employer Liaison Advisor

3. There is a process established for responding to concerns about any licensed medical practitioner's[1] fitness to practise, which is supported by an approved responding to concerns policy that includes arrangements for investigation and intervention for capability, conduct, health and fitness to practise concerns.

Action from last year: Responding to Concerns Policy and the Conduct and Capability Procedure required updating **Comments:** Concerns may be reported via a number of sources including the Medical Directors, the RO, the Complaints Department or Medical Workforce. The remit of the Medical Workforce Group includes discussion around ongoing cases and new issues. A decision tree is used to ascertain the seriousness of the issue, whether there is a need to escalate and the next steps to be taken. The value of 'respect' guides the approach, with conversation and mediation preferred where possible in order to achieve a timely resolution. Consideration has been given as to how best to translate this value into tangible actions, including how to support line managers to have structured conversations in terms of feedback, conflict resolution and holding difficult conversations. The Trust have noticed a recent reduction in relevant concerns, which they attribute to this new approach.

Action for next year: Divisional leads have been trained as Case Managers, and there are currently 5 trained Case Investigators within the Trust. Training was carried out via NHS Resolution. It was recommended that this be referenced within the policy documentation

4. The system for responding to concerns about a doctor in our organisation is subject to a quality assurance process and the findings are reported to the Board or equivalent governance group. Analysis includes numbers, type and outcome of concerns, as well as aspects such as consideration of protected characteristics of the doctors.[2]

Action from last year: A fitness to practise summary showing the organisation's performance benchmarked against similar NHS organisations is included in the RO report to the Board.

Comments: The summary shows numbers of doctors with undertakings, conditions, and suspensions, erased, or given warnings

Action for next year: N/A

5. There is a process for transferring information and concerns quickly and effectively between the responsible officer in our organisation and other responsible officers (or persons with appropriate governance responsibility) about a) doctors connected to your organisation and who also work in other places, and b) doctors connected elsewhere but who also work in our organisation.[3]

Action from last year: Responsible Officer Transfer of Information sought from previous employer for all new employees.

Comments: External work forms are requested to be completed for all doctors who work paid/voluntary outside of the Trust and must be included within the appraisal each year.

Action for next year: Continued governance

6. Safeguards are in place to ensure clinical governance arrangements for doctors including processes for responding to concerns about a doctor's practice, are fair and free from bias and discrimination (Ref GMC governance handbook).

[2] This question sets out the expectation that an organisation gathers high level data on the management of concerns about doctors. It is envisaged information in this important area may be requested in future AOA exercises so that the results can be reported on at a regional and national level.
[3] The Medical Profession (Responsible Officers) Regulations 2011, regulation 11: http://www.legislation.gov.uk/ukdsi/2010/9780111500286/contents

Action from last year: Policies within the Trust are subject to an equality and diversity impact assessment. **Comments:** Equality and Diversity training is mandatory for all staff in the Trust. Ensuring mandatory training is in date is part of the appraisal process. **Action for next year**: Audit tool for appraisals includes checks on mandatory training.

Section 5 – Employment Checks

1. A system is in place to ensure the appropriate pre-employment background checks are undertaken to confirm all doctors, including locum and short-term doctors, have qualifications and are suitably skilled and knowledgeable to undertake their professional duties.

Action from last year: All doctors employed by Trust are subject to the NHS mandatory pre-employment recruitment checks prior to appointment, including locum doctors. In April 2014, a new category of fitness to practise impairment 'not having the necessary knowledge of English' was introduced by the GMC, requiring Trusts to ensure that doctors have sufficient knowledge of the English language necessary for their work to be performed in a safe and competent manner. The pre-employment checks carried out on all doctors provide this assurance at the Trust.

Comments: N/A **Action for next year**: Maintain set standards

Section 6 – Summary of comments, and overall conclusion

Please use the Comments Box to detail the following: **Current Issues:** There are ongoing work pressures due to a variety of factors such as Junior Doctor's strikes, other industrial action and the ongoing recovery from the pandemic. The recruitment of international doctors who are not conversant with the appraisal & revalidation process and requiring time to build up sufficient evidence for a whole of practice appraisal is also actively being addressed. **We now run regular appraisal and revalidation lunchtime training and 1:1 sessions for new overseas doctors in the use of the SARD appraisal tool, enabling further compliance in the appraisal process. Whilst simultaneously ensuring they are aware of their responsibilities to comply with the process.** **New Actions:** Ongoing drive to recruit more appraisers and mentors including recruiting educational supervisors into appraiser roles. **Overall conclusion: All doctors in the Trust undergo yearly appraisals and 5-yearly revalidation. An appraisal may be deferred for valid reasons e.g. maternity leave or sick leave. No doctors over the year have been referred because of 'failure to engage' with the appraisal process.** **Conclusion: Over the coming year, we will continue to ensure the quality of the appraisals via the ASPAT tool and give feedback to appraisers at regular appraiser meetings.**

We hope to expand the numbers of appraisers by recruiting from the pool of educational supervisors. **In addition, we aim to recruit more mentors particularly for new consultants joining the Trust. We will continue to provide assurance to the Trust Board via quarterly reports.**

Section 7 – Statement of Compliance:

The Board / executive management team – [*delete as applicable*] of [*insert official name of DB*] has reviewed the content of this report and can confirm the organisation is compliant with The Medical Profession (Responsible Officers) Regulations 2010 (as amended in 2013).

Signed on behalf of the designated body

[(Chief executive or chairman (or executive if no board exists)]

Official name of designated body: Epsom & St. Helier University Hospitals NHS Trust

Name: _ _ _ _ _ _ _ _ _ _ _ Signed: _ _ _ _ _ _ _ _ _ _ _ **(PLEASE SIGN HERE)**

Role: _ _ _ _ _ _ _ _ _ _ _ _

Date: _ _ _ _ _ _ _ _ _ _

NHS England and NHS Improvement
Skipton House
80 London Road
London
SE1 6LH

This publication can be made available in a number of other formats on request.

3.1 Publication approval reference: PAR614

4.0 Sources of Assurance

Progress and compliance with the regulations is monitored by:

- A well-established Appraiser Group
- Weekly compliance meetings supplied to discuss action plans for those whose appraisals are overdue.
- Comprehensive dashboards within SARD to enable access and review of appraisal data and interrogate this in a number of ways to improve appraisal outcomes
- A formal audit of appraisal quality via the ASPAT Tool available on the SARD system.

4.1

5.0 Implications

- Ongoing COVID-19 recovery pressures.
- The recent junior doctor's strike caused considerable delay to the revalidation and appraisal process due to increased work pressure on appraisers and appraisees the Trust over. The decision was taken to extend appraisal due dates to allow for this.
- In an increasingly busy Trust the need for time to be allowed in job plans for appraisers remains important. Each doctor has a minimum of 1 Supporting Programmed Activity (SPA) to allow them to undertake all the things that allow them to deliver their job, including their own appraisal. Appraisers undertake a minimum of 5 appraisals and no more than 15, and it is important that this significant time requirement is acknowledged in their job plan. Each appraisal on average will take 4 hours, and in addition there are appraisers' meetings with the Responsible Officer. Few appraisers will have this as their sole additional responsibility.
- Appraiser Capacity - The single largest ongoing risk to the appraisal process remains the challenge in the recruitment and retention of appraisers. Ways of mitigating this risk are being considered.

6.0 Recommendations

6.1 The [Board Group] is asked to:

a. Note the assurance provided on medical appraisal and revalidation.
b. Note the continued progress being made in this area set against the backdrop of COVID-19 recovery & associated work pressures.
c. Confirm commitment to supporting the progress of this work.
d. Approve and sign the report.

Group Board

Meeting in Private (Confidential) on Friday, 07 July 2023

Agenda Item	5.5	
Report Title	Integrated Care System Update: South West London and Surrey Heartlands Q1 2023-24	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Kath Brook, Strategy and Planning Manager	
Previously considered by	n/a	
Purpose	**For Noting**	

Executive Summary

The Integrated Care System (ICS) update report is provided to the Group Board for information. This paper provides an update on developments across the SWL ICS and Surrey Heartlands ICS in the last quarter. In summary:

Changing environment for ICSs:
The Group continues to work with NHSE and other partners to prepare for the devolution of many specialised services from NHSE to ICSs from April 2024. ICSs will need to submit a proposal to NHSE for how they plan to manage the commissioning of specialised services (the Pre-Delegation Assessment Framework) in September. The South London 'pathfinder' (testing how to deliver contracting arrangements under devolution) is due to go live on 3 July.

SWL ICS:
SWL Integrated Care Partnership has developed a SWL Integrated Care Strategy, identifying priority areas of focus. The SWL Joint Forward Plan has also been development and describe how NHS partners across South West London will work together over the next five years to meet the needs of local people. Both strategies are due to be published imminently.

Surrey Heartlands ICS:
Surrey Heartlands' Integrated Care Strategy was launched March 2023. To oversee the delivery of this Strategy, a Delivery Oversight Committee has been set up which will have gesh representation.

Surrey Heartlands Provider Collaborative:
Surrey Heartlands Provider Collaborative continues to be developed with oversight of the Acute Provider Collaborative, a Community and Primary Care Collaborative and a Mental Health Collaborative. The Acute Providers are developing more formal arrangements for their collaborative work. Attendance by Surrey Downs Health and Care at the Surrey Heartlands Provider Collaborative was recently supported; this is being discussed and progressed by Thirza Sawtell, Group Managing Director for Integration.
A Children's and Maternity Pathways Review commenced in May 2023 with a Transformation Programme Workshop; discussion focused on opportunities, particularly in digital, infrastructure, pathways standardisation and workforce. It is expected that this will be followed by a Stroke Pathways Review. GESH has focused on ensuring these programmes treat BYFH as a fixed point.

SWL Acute Provider Collaborative:
SWL APC continues to deliver its clinical networks, diagnostics, outpatients, pathology, pharmacy, procurement, and workforce programmes and to develop its elective care, financial sustainability, diagnostics, pathology, pharmacy and workforce strategies.
The Financial Recovery Plan and Financial Sustainability Strategy will accelerate the delivery of the other programmes/ strategies in SWL, in particular collaboration, elective care and workforce.

Place- Based update:
Each Place is progressing delivery of local Health and Care Plans

Action required by Group Board

The Board is asked to:

- note the update.

Committee Assurance	
Committee	NA
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Report - Integrated Care System Update: South West London and Surrey Heartlands Q1 23-24

Implications

Group Strategic Objectives

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

Risks

NA

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

NA

Legal and / or Regulatory implications

NA

Equality, diversity and inclusion implications

NA

Environmental sustainability implications

NA

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Integrated Care System Update: South West London and Surrey Heartlands

James Marsh, GDCEO

Author: Kath Brook, Strategy & Planning Manager

July 2023

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

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Executive Summary

This paper provides an update on developments across the South West London (SWL) and Surrey Heartlands (SH) Integrated Care System (ICS) in the last quarter. In summary:

Changing environment for ICSs	The **Group continues to work with NHSE and other partners to prepare for the devolution of many specialised services** from NHSE to ICSs from April 2024. ICSs will need to submit a proposal to NHSE for how they plan to manage the commissioning of specialised services (the Pre-Delegation Assessment Framework) in September. The South London 'pathfinder' (testing how to deliver contracting arrangements under devolution) is due to go live on 3 July.
SWL ICS	SWL Integrated Care Partnership has developed a **SWL Integrated Care Strategy,** identifying priority areas of focus. The **SWL Joint Forward Plan has also been developed** and describe how NHS partners across South West London will work together over the next five years to meet the needs of local people. Both strategies are due to be published imminently.
SH ICS	Surrey Heartlands**' Integrated Care Strategy** was launched March 2023. To oversee the delivery of this Strategy a Delivery Oversight Committee has been set up which will include gesh representation.
SH Provider Collaborative (SHPC)	**SHPC continues to be developed with oversight of the Acute Provider Collaborative, a Community and Primary Care Collaborative and a Mental Health Collaborative.** Attendance by Surrey Downs Health and Care at the Surrey Heartlands Provider Collaborative was recently supported; this is being progressed by the Group MD for Integrated Care. A Children's and Maternity Pathways Review commenced in May 2023 with a Transformation Programme Workshop; discussion focused on opportunities, particularly in digital, infrastructure, pathways standardisation and workforce. It is expected that this will be followed by a Stroke Pathways Review. The Group is engaging to ensure BYFH is treated as a fixed point.
SWL Acute Provider Collaborative (APC)	**SWL APC continues to deliver its clinical networks, diagnostics, outpatients, pathology, pharmacy, procurement and workforce programmes** and to develop its elective care, financial sustainability, diagnostics, pathology, pharmacy and workforce strategies. The Financial Recovery Plan and Financial Sustainability Strategy should accelerate the delivery of the other programmes/ strategies in SWL, in particular collaboration, elective care and workforce.
Place- Based	Each Place is progressing delivery of local **Health and Care Plans**

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Changing environment for ICSs – specialised services

The Group continues to work with NHSE and other partners to prepare for the devolution of many specialised services (c. 85% of the spend) from NHSE to ICSs from April 2024.

Assurance of local systems
ICSs will need to submit a proposal to NHSE for how they plan to manage the commissioning of specialised services (the Pre-Delegation Assessment Framework, or PDAF) in September.

South London 'pathfinder'
The South London 'pathfinder' (testing how to deliver contracting arrangements under devolution) is due to go live on 3 July.

'London hub'
Discussions are ongoing between NHSE and London ICSs as to how those services which are not delegated to ICSs from April 2024 will be commissioned. Thought is being given as to whether one ICS (potentially South East London) could host the team of staff responsible for commissioning these services on behalf of the rest of London.

Transformation projects
In South London, in part to prepare for devolution, a number of pilot projects are underway, seeking to integrate care across the pathway (i.e. from primary through to specialist tertiary care). In addition to the existing pilots in cardiac, blood-borne viruses and neurosciences, NHSE have recently decided to invest in renal and sickle-cell pathways.

Implications for GESH:
The Group will need to continue working closely with partners to influence the shape of devolution. The Group will also have a key role in many of the transformation projects being prioritised (for instance, in renal pathways).

South West London ICS- key updates

SWL Joint Forward Plan
gesh provided feedback on the Joint Forward plan for SWL ICS and it is expected that this will be published imminently.

SWL ICP Integrated Care Strategy
gesh has also fed into the development of the ICS Strategy and it is expected to be published soon after the ICP board meeting on 20th July.

The six priority areas are:
1. Tackling our system-wide workforce challenges.
2. Reducing Health Inequalities.
3. Preventing ill-health, promoting self-care and supporting people to manage long term conditions.
4. Supporting the health and care needs of children and young people.
5. Positive focus on mental well-being.
6. Community-based support for older and frail people.

Across these six areas the ICP are also focussing on the following cross-cutting themes:

1. Equality, diversity and inclusion.
2. The green agenda.
3. Elevating the patient, carer and community voice

Financial Sustainability

- A 2-year Financial Recovery Plan for SWL has been forwarded to NHSE;
- It is anticipated that the delivery of the final Financial Sustainability Strategy and future governance and oversight will be discussed and reviewed at the SWL Financial Recovery Board;
- The approach to closing 'Gaps' continues, and discussions are ongoing re transformation schemes to support this;
- Areas of emphasis in the Financial Recovery Plan include:
  - Establishment, Agency and Productivity (£174m)
  - Group Estates and Corporate Functions (£89m)
  - Urgent and Emergency Care Pathways (£34m)
  - Collaboration and Elective Pathways (£26m)
  - Community, Prescribing and CHC (£11m)

2023/24 Innovation Fund Process The Board discussed the proposed process for the Innovation Fund which will be set up to support the delivery of the ICP Strategy. Members of the Board reflected on the learning from 2022/23 process, in particular the challenges of mobilising short-term projects within the required timescales. In response, there was a proposal to explore the creation of an 18-month Innovation Fund programme that would start in October 2023 and run until March 2025.

This proposal was supported by the Board and is being further developed. The Board noted that the funding for the 2023/24 Innovation Fund had yet to be agreed by the Integrated Care Board as its financial plan had not yet been finalised and therefore the creation of the innovation fund was agreed in principle at this time.

Implications for GESH: SWL Joint Forward Plan and ICP Integrated Care Strategy are broadly aligned with the gesh Group Strategy

The Group will need to engage with the SWL Innovation fund, which may provide funding opportunities for projects that services may to pilot.

Surrey Heartlands ICS- key updates

Integrated Care Strategy

Surrey Heartlands ICS launched their strategy in March 2023. The strategy has three key ambitions:

- Prevention

- Delivering care differently.

- What needs to be in place to deliver these ambitions

In order to oversee the delivery of this Strategy a Delivery Oversight Committee has been set up which has gesh representation.

Surrey Heartlands Governance:

Surrey Heartlands Delivery Oversight Group has been established- terms of reference being finalised. The Group is a subcommittee of the ICS, chaired by Chief Executive of SHICS. It is expected that the Group CEO will be invited as a member.

Implications for GESH:

The Group will need to engage via the Delivery Oversight Group in the implementation of Surrey Heartlands' strategy, given the number of Surrey patients the Group provides care for

Surrey Heartlands Provider Collaborative

The **Surrey Heartlands Provider Collaborative (SHPC)** continues to be developed with oversight of the Acute Provider Collaborative, a Community and Primary Care Collaborative and a Mental Health Collaborative. The Acute Provider Collaborative is working to develop more formal arrangements for joint working.

Attendance by Surrey Downs Health and Care at the Surrey Heartlands Provider Collaborative was recently supported; this is being discussed and progressed by Thirza Sawtell, Group Managing Director for Integrated Care.

Clinical Pathway Reviews

- a Children's and Maternity Pathways Review commenced in May 2023 with a Transformation Programme Workshop; discussion focused on opportunities, particularly in:
  - Digital (Data Standardisation)
  - Infrastructure (Affordable Housing, Beds and Estates)
  - Pathways Standardisation
  - Workforce (Education and Training, Recruitment and Retention, Rotations, Staff Passports in Surrey Heartlands).
- it is expected that this will be followed by a Stroke Pathways Review.
- The Group has engaged to ensure alignment with the BYFH Programme, providing written and oral briefings to the programme team to ensure they are sighted on the relevant BYFH clinical models, assumptions about patient flows, and financial implications

Elective Care

- collaboration continues in the Planned Care Board on PTLs
- Deep Dives are being finalised on Ophthalmology and Orthopaedics in SH, and;
- Elective Centre Programme Board is being established along with a Programme Team.

Community and Primary Care

- continued emphasis on the Fuller Stocktake.

Mental Health

- Adult Eating Disorders collaboratively being developed.
- CAHMS Tier 4 Unit being constructed at Gatwick

Implications for GESH:

There is no formal gesh representation at SHPC, however expected future representation by SDHC (which is hosted by ESTH).

GESH Group to:

- actively engage with the Children's and Maternity Pathways Review and the planned Stroke Pathways Review;
- be alert to developments in Elective Care in Surrey Heartlands and any impacts/ implications for the Group, and;
- continue to engage and look for opportunities to be proactive in programmes with SHPC.

South West London Acute Provider Collaborative 1/2

General

- 2023/24 APC priorities and financial plan in place;
- APC completed its contribution to the ICS Joint Forward Plan, and;
- APC and ICS Chairs' and CEOs' meeting scheduled for 20 July 2023.

Elective Care

- the development of the Elective Care Strategy is ongoing with discussions re a final long list of options/ opportunities being progressed and reviewed by Trusts e.g., Consolidation, Elective Hubs and/ or Spokes, Mutual Aid. Shared or Transparent Waiting Lists, Single Point of Access.
- there will be emphasis/ focus on: addressing health inequalities, approaching elective care as 'One' System, driving elective and emergency care separation, ensuring equity and reducing waiting lists/ times, establishing PTLs/ referral hubs that are shared and standardised and, optimising resources across SWL.

Main Programmes of work-key areas of focus over the last quarter:

Clinical Networks

- the appointment of an Associate Director- Clinical Networks is in progress and the approach to the contracts that end in July 2023 for the Primary Care Clinical Network Leads is being discussed with the ICS;
- the approach and case for change continues to be developed in partnership with Primary Care for Tele-dermatology, following the Dermatology Summit for SWL;
- the arrangements in place re Shared Care and a focus on issues re Medicines Management is needed in the Networks with support from Pharmacy Teams, and;
- a Clinical Network Workshop was convened in May 2023 with >50 people to discuss GIRFT and improvements to Patient Pathways.

Diagnostics

- 2023/24 Community Diagnostic Centre (CDC) plans have been resubmitted.
- 3.7m additional CDC revenue (due to over-performance) has been secured and will aid 2022/23 Backlog Recovery and 62 day Cancer Performance at Croydon. Capacity in MRI (St James Wing and the Wilson Mobile Scanners) and Endoscopy Recovery are identified risks at St George's;
- the development of a Diagnostics Strategy is being progressed in SWL,
- Direct Access for GPs is to be discussed further re Imaging in SWL.

South West London Acute Provider Collaborative 2/2

Main APC Programmes of work-key areas of focus over the last quarter:

Outpatients

- 2023/24 Operating Plan aims to deliver elective recovery for 1st outpatients of 109% with continued DNA and PIFU reductions and a focus on GIRFT Pathways;
- appointment was confirmed of Liz Ball as Outpatient Programme Director (Interim) starting in September 2023, and;
- delivery is ongoing on 3 Projects: Digital Consent (currently a Kingston Pilot which will be rolled out to SWL), Pre-habilitation and Pre-Op Assessment across SWL.

Pathology

- challenges re the courier's service are ongoing with plans being progressed to resolve these;
- challenges are ongoing with the LIMS Programme and there continues to be a delay for Epsom and St Helier's integration with LIMS;
- the development of a Pathology Strategy is in progress for SWL, and;
- Digital Investment is ongoing and will enable the maturity level of the network to progress from its rating of 'Mature' to 'Thrive' within 3-5 years.

Pharmacy

- Aseptics 'Hub and Spoke' Model continues to be developed and it is expected that a paper will be presented in July 2023; discussions re a Pan-London Strategy are being progressed and will be reviewed by SWL;
- the development of a Pharmacy Strategy is in progress for SWL, and;
- the establishment of a Pharmacy Workforce Steering Group is planned for SWL.

Procurement

- changes has been implemented to improve the SBS Help Desk and Support, and;
- the development of a Procurement Strategy is in progress for SWL.

Workforce

- it was agreed for the Applicant Tracking System (ATS) to be procured for the Recruitment Hub in SWL and an expansion to include SWL and St George's Mental Health NHS Trust was welcomed;
- there is agreement that an Investigations Service for SWL be progressed and supported (collaboration will include Croydon, Epsom and St Helier, Hounslow and Richmond Community Health, Kingston, St Georges and SWL and St George's);
- there is agreement that a Mediation Service for SWL be progressed and supported (collaboration will include Epsom and St Helier, Hounslow and Richmond Community Health, Kingston, St Georges and SWL and St George's);
- the approval of Business Cases for the consolidation of Occupational Health Services and an Occupational Health Records Management System are progressing in SWL (collaboration includes Epsom and St Helier, Hounslow and Richmond Community Health, Kingston and St Georges and later on, SWL and St George's), and;
- the development of a Workforce Strategy is planned for SWL.

Implications for GESH:

GESH Group to:

- continue to engage as a leader and partner in the SWL APC, and;
- ensure influence and representation on SWL APC Programmes.

Wandsworth, Merton, Sutton Place-Based Developments- key updates

System developments impacting Place:

SWL Primary Care Strategy- Work is underway to develop a SWL Primary Care Strategy, focusing on three main area: prevention, proactive care, and improving access. Key enablers have been identified (workforce, digital, IT, Estates) and there is a strategy development plan in place with the ICB Board in May reviewing progress. Each borough, via local governance will be responsible for implementing their own agreed actions.

Wandsworth:

- **Wandsworth Health and Care Plan 2022-2024-** priority areas of focus for 23/24 have been agreed. Of note, in relation to SGUH integration work, is the additions to 'Age Well' domain of dementia as a priority area and Frailty focus as an addition to the Falls Prevention work streams.

- Wandsworth has developed an investment prioritisation framework to support local decision-making ahead of future **SWL investment rounds, for example the 23/24 Innovation Fund and Health Inequalities Fund.** The framework has set out guiding principles for investment aligned to local priorities. Merton are also developing an investment frame-based on the Wandsworth proposal. This approach supports opportunities for investment at scale i.e., across Place boundaries.

Merton:

- **The Better Care Fund** has been agreed on a two-year basis. The conditions and objectives are similar to 22 - 23, however they have added a new Falls metric for 22 – 25. Merton plan to mirror BCF 22-25 with the Merton Health and Care Together Programme.

- **Merton Health and Care Together Committee** is streamlining its governance arrangements. Review underway with proposal to group subgroups into three themes: transformation, system enablers, system management, with quarterly reporting to Committee.

Implications for GESH: SGUH has the opportunity to pursue a more active role at place, in line with the GESH 5 years strategic ambition. It is important that SGUH remains engaged in shaping, and actively contributing to key programmes of work, for example, through active programme membership.

Surrey and Sutton Place-Based Developments- key updates

Surrey Downs:

- All partners are engaging with responses to the **Fuller Stocktake**
- A working group has been set up in response to the **ICB** Board Development and operating models, aiming to produce greater clarity on the nuances between System, Place, and Neighbourhood.
- The Surrey Downs Partnership Board held a **seminar** in April, focused on **population health and management.** This included exploring alignment with their transformation plan, for example, proactive care and place initiatives. They agreed the level of assurance with the current neighbourhood programmes and considered which place-wide priorities should be enhanced or progressed.

Sutton:

- **Sutton's Health and Care Plan - Our Health and Wellbeing Strategy.** Implementation of the strategy will be supported through the Sutton Place Delivery Plan 2022 to 2024 and the work of the Integrated Neighbourhood Teams. Key priorities for ESTH include the development of a front door frailty service, improving patient flow and discharge, establishing a community virtual ward and implementing the redesigned falls model.

Implications for GESH: ESTH continues to work closely as an active partner at Place. It is important the Trust remains engaged in shaping, and actively contributing to key programmes of work.