Group Board

Agenda

Meeting in Public on Friday, 08 September 2023, 09:45 – 13:10

Conference Room 1, Wells Wing, Epsom Hospital, Dorking Road, Epsom KT18 7EG

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:45	-	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 Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:45	2.1	Maternity Services Report	GCNO	Review	Report
11:15	2.2	Integrated Quality and Performance Report	GDCEO	Review	Report
11:40	2.3	Finance Report (Month 4, 2023/24)	CFO-ESTH	Review	Report

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:50	3.1	Quality Committee-in-Common Report	Committee Chair	Assure	Report
	3.2	Finance Committee-in-Common Report	Committee Chair	Assure	Verbal
	3.3	People Committee-in-Common Report	Committee Chair	Assure	Report
	3.4	SGUH Audit Committee Report	Committee Chair	Assure	Report
	3.5	ESTH Audit Committee Report	Committee Chair	Assure	Report

Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:25	4.1	South West London Acute Provider Collaborative Memorandum of Understanding	GCEO	Approve	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
	5.1	Healthcare Associated Infection Report	GCNO	Note	Report
	5.2	Fit and Proper Persons Test: National Changes to Requirements	GCCAO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:35	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
12:50	6.4	Patient / Staff Story	GCNO	Review	Verbal
13:10	-	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
Lizzie Alabaster	Site Chief Finance Officer – ESTH (*deputising for GCFO)*	SCFO-ESTH
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
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
Nicole Porter-Garthford	Deputy Chief People Officer *(deputising for GCPO)*	NPG
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 Chief Communications & Engagement Officer	GCCEO
Apologies		
Paul da Gama*^	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Observers		
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	ABen
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 Group Board Meeting

Meeting in Public on Friday, 07 July 2023, 10:00 – 12:50

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

PRESENT		
Gillian Norton	Chairman – ESTH and SGUH	Chairman
Andrew Asbury*^	Group Chief Infrastructure, Facilities & Environment Officer	GCIFEO
Ann Beasley	Non-Executive Director – 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 - SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
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*^	Group Deputy Chief Executive Officer	GDCEO
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
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director - ESTH	PW
IN ATTENDANCE		
Deirdre LaBassiere	Deputy Director – Corporate Governance	DD-CG
Anna Macarthur	Director of Communications and Engagement	DCE
Carolyn Cullen	Interim Corporate Governance Manager (Minutes)	CC
APOLOGIES		
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Aruna Mehta	Non-Executive Director - ESTH	AM
Tim Wright	Non-Executive Director - SGUH	TW

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

Feedback from Board Visits

The Chairman addressed the Board ahead of the feedback stating it had been a difficult 24 hours for the Trust with the tragedy in Wimbledon which had affected the whole hospital.

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

Maternity (Delivery Suite, Triage, HDU and Gwillam Ward): Phil Wilbraham, Jenny Higham and Andrew Asbury

Overall, a positive visit with a ward that had very professional staff.

At the time of the visit there were less patients than normally would be expected. The ward appeared calm, very tidy, and clean with very dedicated staff. Staff suggested that more could be done regarding the patient journey and patient experience and shift patterns could be an issue.

Keate Ward and Gunning Ward: Martin Kirke, James Blythe and Kate Slemeck

The ward had an air of calm professionalism and strong team working.

Martin Kirke expressed surprised that the step down ward was empty, but it was explained by staff that there was currently a major configuration of space, and a newly designed major trauma ward was about to open. Staff stated that one of the issues faced was access to the Cerner system, which was caused by intermittent Wi-Fi. The visit team were struck by the massive trolleys that computer terminals were on. They also noted that Keate Ward which was first into Covid and was last to come out was re-orientating to its new role and finding its feet, although the ward had stable staffing. The visit team were impressed by the newly refurbished ward, which was of a very high standard as it showed what can be achieved when refurbishing old estate.

Outpatients (Clinic 1and Freddie Hewitt Ward): Ann Beasley, Arlene Wellman and Thirza Sitwell

The team were impressed that children with mental health conditions were in their own bays with one-to-one nursing but noted that it was a hugely challenging environment for our staff who were not mental health nurses. There are recruitment issues and vacancies, staff are having to cover vacant shifts. The range of children that were in the ward were from 7 months to 17 years old but staff assured the team that this was a standard age range for a children's ward. In the Outpatients area there was a lack of storage with equipment piled in the corridor. A complaint made by staff about a malfunctioning sluice had taken a long time to be rectified and staff reported feeling demoralised by this and they feel the reporting system is not working, as they file the same issue several times. This presents a danger that staff will give up reporting and infection control issues may emerge.

Haematology (Ruth Myles Ward, Day Unit and Mctee Ward): Stephen Collier, Andrew Grimshaw

The team visited the Haematology Day Unit and Ruth Myles Ward. The team were impressed by the busy but happy unit. The dedication of staff was evident. There was low staff turnover and low usage of agency staff. An agency staff member did however comment about how welcomed they had been. Issues that staff raised included length of stay because of full wards; however, the visit team were assured that a clinical review was taking place to make flow improvements. Another issue raised was a lack of isolation space which is important for this patient group. The team were impressed that staff had given up locker space to have sufficient side room space. However, the Chairman commented that the importance of staff welfare needed to be considered and it happened too often that because of space constraints staff areas were turned into ones for patients.

Theatres and Recovery: Chris Elliott and Paul Da Gama

Although the area was very clean and tidy, space is taken up by machinery. Staff have raised this on the risk register as a potential fire escape issue. The team noted that staff were appropriately dressed

for theatre; and were struck by the team ethos which was aided by coffee debrief sessions. Complexity of flow through this area was also highlighted as a concern, particularly moving patients into intensive care beds. The GCPO commented that it was good to hear staff positive about training. A known issue regarding access to taxis for staff working on late shifts was also raised by staff and this is being progressed.

Neuro and Cardiology: Andrew Murray and Richard Jennings

Overall, a very positive culture and well ordered.

Issues highlighted by staff included:

- More space to store equipment and the recruitment and retention of nursing staff.
- Flow was an issue and staff commented that intermediate beds are required as difficult to refer patients on to wards.
- Shift patterns where staff began shifts at 8 am but operations began at 10 am.

Senior health: Yin Jones and James Marsh

Senior Health is the new term for older people's care. This term arose out of consultation with patients. Staff referred to strong multi-disciplinary working. Flow was an issue; almost half the patients were delayed discharges. The visit team were impressed at how much pride the staff took in maintaining a calm environment; but as reflected in other visits, Wi-Fi was raised as an issue.

Paediatric Intensive Care, Nicholls ward, General Intensive Care and ED: Gillian Norton and Jacqueline Totterdell

The Chairman and the GCEO visited staff who had treated patients arising from the Serious Incident. They Chairman had thanked the staff on behalf of the Board. The GCEO informed the Board that she had received many texts and emails from both the community and from staff regarding their shock at the incident. Follow up support will be made available to staff, and it was recognised that staff had been extremely professional in their response to the incident.

The Chairman thanked Board members for the feedback and stated that the time for this session should be extended as it is a valuable insight into the work of the Trust, gives context to the consideration of matters on the agenda and should not be rushed.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies.	
1.2	**Declarations of Interest**	
	There were no new declarations of interest	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 5 May 2023 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	

	The Board noted the following updates on the open actions: • **PUBLIC220901.1**: The GCMO gave an update saying that they are developing a "You said/we did" response to staff who log that they have faced bullying and abuse. The GCPO stated that a comprehensive report on abuse will go to the People Committee in the Autumn. Item closed. • **PUBLIC230505.1**: Andrew Murray stated that the tendering for the culture review was in progress. Interim findings are expected in the Autumn which will go in the first instance to the Quality Committee and then to Group Board. Item closed. • **PUBLIC230505.1**: The GCNO stated that data on the number of live births per year had been added to the Maternity Services Report. Item closed. • **PUBLIC220901.3**: The GCNO stated that an infection Control Report will be going to Quality Committee quarterly. Item closed. **The Board reviewed all items on the Action Log and proposed that indicated items should be closed.**	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The Chairman welcomed the GCEO back following her recent illness. The Board received the report from Jacqueline Totterdell (GCEO), who made the following points: <u>NHS 75th Anniversary celebrations</u> Staff had welcomed the celebrations, which are important for recognising their work and raising morale. <u>Operational updates, including Mental Health pressures in Emergency Departments</u> High numbers of mental health patients, both adults and children, are presenting in ED. It is recognised that the ED is often not the right place for someone experiencing a mental health crisis. The GCEO has raised this with system and community partners, including the Borough Police Commander and leaders of Local Authorities, to discuss ways of tackling this challenge. Collective solutions to this complex problem are urgently being sought, and these will be reported back to the Board. <u>NHS Assembly Long-term Plan & NHSE Long-term Workforce Plan</u> To commemorate the 75th anniversary, the NHS has taken the chance to review priorities. The NHS Assembly has published a report outlining three fundamental shifts in the role of the NHS: preventing ill health; personalisation and participation; and 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, stronger partnerships with others, better use of digital technology and data. The NHSE has published a long-term workforce plan which has three overall aims: to train; retain; and reform.	**GCEO**

	An update on the PTC for Paediatric Cancer The future of the Principal Treatment Centre (PTC) for children's cancer services currently provided in partnership with the Royal Marsden is under review by NHS England (NHSE). NHSE will decide between two possible outcomes after a 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's. On 29th June the Group hosted a staff engagement event, led by the MD-SGUH at which staff were able to ask questions and hear from NHSE on the process. Staff expressed concerns around the consultation process, and 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 a long time and as such has deep expertise and also provides neurosurgery. The engagement campaign to keep services at St George's is proceeding at pace. The Trust welcomed Cllr Simon Hogg, Leader of Wandsworth Council and Cllr Graeme Henderson, Cabinet member for Health on a tour of our paediatrics team. Until a final decision is made, St George's continues to provide an outstanding service to children with cancer and the Trust continues with research collaborations by enrolling children into new studies. Events, Awards and Appointments Staff were shortlisted in two categories for the NHS Parliamentary Awards; the Homelessness Inclusion Team from Urgent and Emergency Care and Charmaine Case, Breast Clinical Nurse Specialist. Particular congratulations go to Charmaine who was the winner in the Lifetime Achievement category. Ediscyll Lorusso, Senior Thrombosis Specialist Nurse Practitioner, was recognized at the Asian Women of Achievement Awards. Edi was a finalist in the "Professions" category - which recognises women who have become leading practitioners. Patricia Yiggon from Gynaecology also received the Royal College of Nursing Award. Anna Macarthur has been appointed Group Director of Communications and Engagement. The following comments and observations were made: Peter Kane welcomed the long term aims of the NHS workforce plan but asked what is being done to improve recruitment and retention now. The GCEO stated that the Trust is working with 25 other trusts to identify good practice that can be adopted quickly. Local leadership is key and the GCEO is actively working with local universities and apprenticeship schemes to grow our workforce. **The Board noted the Group Chief Executive's report**	
2.0	**ITEMS FOR DECISION**	
2.1	**Establishment of Infrastructure Committee-in-Common**	

	The GCIFEO presented the terms of reference for the proposed Infrastructure Committee. The GCIFEO stated that this Committee will take forward the Group Estate's Strategy, its green plan and give more focus to health and safety assurance. The Chairman informed the Board that Ann Beasley will be chairing this bi-monthly committee. Peter Kane asked that there be a review of committee effectiveness after 12 months to see if the Committee is achieving the goals set out in the terms of reference. This is our usual practice. The MD-ESTH, welcomed the proposal for this Committee. The MD-ESTH hoped it would develop co-ordinated working between clinical divisions, IT and estates staff. The GCIFEO clarified that the work plan for the Committee would include undertaking a six facets survey and working through any findings. **The Group Board approved the terms of reference for the establishment of an Infrastructure Committee-in-Common**	**GCIFEO**
2.1	**Public Sector Equality Duty Report 2022/23**	
	The GCPO introduced the two reports (one for each Trust) and informed the Board that all trusts are required to publish equality information to demonstrate how they have 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. The PSED demonstrates compliance by using information from other standalone equality reports such as the Workforce Race Equality Standard report (WRES) and the Workforce Disability Equality Standard (WDES) and includes Gender Pay Gap data and information from our Equality Delivery System (EDS). The reports set 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 reports were reviewed at the People Committees-in-Common on 23 June and approved for submission to the Group Board. Martin Kirke welcomed the reports and stated that there were achievements of note but suggested that the focus be on a smaller number of initiatives, done in depth, in 2023/24. **The Group Board:** **1. Reviewed both the reports** 2. **Approved the reports for publication on Trust websites**	
3.0	**ITEMS FOR REVIEW**	
3.1	**Maternity Services Report**	
	The GCNO introduced the report to provide assurance regarding compliance at ESTH and SGUH with the Maternity Incentive Scheme Year 5 (CNST). GCNO highlighted that both Trusts need to demonstrate compliance with standards and the technical guidance, in order to be eligible to reclaim the 10% incentive element of the maternity CNST contributions.	

	The safety of maternity services is monitored from an internal and external perspective and has seen increased scrutiny at both national and local level in response to the Ockenden enquiry. **For ESTH**: Annual figures published in May 2023 by MBRRACE-UK indicate that in 2021 extended perinatal mortality is comparable to similar Trusts and the neonatal death rate was more than 5% lower than similar Trusts. **For SGUH**: Annual figures published by MBRRACE-UK indicate that the stillbirth rate and the neonatal death rate is 'more than 5% higher than average for type of hospital' category. An external review has commenced, and the findings are expected in September 2023. Chris Elliot asked whether our Trusts are socio-economic outliers compared to the group of trusts we were measured against. The GCNO responded that our outcomes are reflective of similar populations. Jenny Higham queried how training is facilitated, bearing in mind it is difficult to organise multi-agency training. The GCNO stated that options for how training is delivered are being reviewed. **The Group Board reviewed the report**	
3.2	**Integrated Quality and Performance Report**	
	The GDCEO introduced the report that 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. The GDCEO drew the Board's attention to the following: • **Infection control**: **In SGUH** there were seven Clostridium Difficile infections during May 2023, this is up from April 2023 (2) and March 2023 (4) A multifaceted Trust level Clostridium Difficile infection action plan is in place and work has commenced. There were also 10 cases of E. coli bacteraemia during May 2023, this is up from April 2023 (8). A working group has been formed and a Trust level action plan is in the process of being developed. • **Never Events and Serious Incidents:** SGUH declared two Never Event (Serious Incidents) in May 2023. 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. • **Cancer Services:** Cancer performance is comparatively good for both Trusts against London peers, but the service remains challenged, operationally. However, both Trusts are achieving the Faster Diagnostic Standard (FDS) with sustained improvement at SGUH, who have previously struggled to meet this standard. • **A&E:** Both Trusts are achieving the national target of discharging patients within four 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 remains significant flow issues at both Trusts impacting on the ability to reduce the numbers of patients waiting more than 12 hours in the ED. This remains a key area of focus.	

	• **Integrated Care:** Two-hour urgent care response is being maintained above the national standard within Sutton and Surrey Health and Care but there is a rising trend of referrals in Sutton. Discharges on Pathway 3 remains challenged. The MD-SGUH stated that the junior doctor industrial action, the consultant industrial action and industrial action by radiographers will impact adversely on performance. Martin Kirke stated that senior nurses stepping up during the junior doctors' dispute deserve great credit. The Chairman stated that enormous effort has been put in by the Executive, senior managers and staff across the Trusts to maintain services. The MD-IC, asked the Board to note that aps are being developed for patients with MSK conditions which will improve self-care. However, of concern is that care homes in the Sutton and Sutton Downs area regularly ask for additional nursing support to admit patients with complex needs which is costly. The Chairman observed that whilst she recognised the difficulties, it is a local authority responsibility to ensure a sufficient provision of differing types of care and nursing home provision and that the Group is actively lobbying and working with local authorities to address this. **The Group Board noted the report**	
3.3	**Finance Report (Month 2 2023/24)**	
	The GCFO introduced the Month 2 2023/24 finance report. The financial outlook for 2023/24 remains very challenging. At SGUH, the Trust is reporting a deficit of £12.2m at the end of May, which is £1.8m adverse to plan. At ESTH, the Trust is reporting a deficit of £11.4m at the end of May, which is £0.8m adverse against plan. Both Trusts have agreed deficit plans with NHSE as part of the SWL ICS deficit plan. After two months both Trusts are on plan but that is excluding the impact of overspends as a result of industrial action. The GCFO emphasised that continued focus on cost control and the development and delivery of CIPs through site management meetings which are a priority. **The Group Board considered the finance report and noted the Month 2 financial position.**	
3.3	**Group Strategy Oversight and Implementation**	
	The GDCEO presented the Group Strategy update: Launch and mobilisation plan. It is now two months on from launching the Group Strategy. 4,300 staff have read the email launching the strategy, and 2,024 have downloaded the strategy document. 500 staff watched May's Executive Question Time, which focussed on the strategy launch. Externally the announcement of the strategy launch was viewed 750 times on our external websites and 75 individuals and stakeholders have emailed our Trusts. The GDCEO highlighted that work will now focus on driving outcomes and delivery, there will be a governance review of the implementation framework and a road map will be introduced to track progress. Phil Wilbraham welcomed the importance given to communication, stating that it is important that all levels of staff are engaged. However, more work should be done	

	to sharpen the “lift conversation” messaging to make it stick. The GDCEO stated that one-page posters will be put up shortly to address this. Peter Kane welcomed the RAG rating to monitor implementation. The GDCEO stated that the emphasis must be on improving the quality of services. **The Group Board noted the update and approved the approach to developing corporate enabling strategies**	
4.0	**ITEMS FOR ASSURANCE**	
4.1	**Quality Committee-in-Common Report**	
	Andrew Murray, Joint-Chair of the Committee, provided an update on the Quality Committee-in-Common meetings held in May and June 2023 and highlighted the following 3 key issues: <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 governance, the first phase of which will focus on the Group’s maternity services. The tendering process for the quality governance review is underway. The report from the first of the two phases of this review will be received three months after it begins but the Committees have asked to receive a progress update in September. 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. <u>Patients with mental health needs presenting in Emergency Departments</u> At the June meeting of the Committee a detailed discussion on the impact of the number of patients with mental health conditions attending the Group’s Emergency Departments was held. The GCEO confirmed that she had convened an urgent system-wide meeting to discuss this issue. <u>Haemodialysis Serious Incidents</u> At the June meeting it was highlighted that there had been two separate Serious Incidents in which haemodialysis patients under the care of the ESTH renal service had sadly died after venous disconnection, in June 2022 and March 2023. 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. A new system of deep dives has been instituted by the Committees. However, the Committees will ensure focus is given to implementing already agreed action plans. **The Board noted the update.**	
4.2	**Finance Committee-in-Common Report**	

	Ann Beasley, Joint-Chair of the Committee, provided an update on the Finance Committees-in-Common meetings held in May and June 2023 and highlighted the following: Agency rate cards The SGUH and ESTH Medical Directors had 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. Mental Health patient attendances at ED The SGUH and ESTH Chief Operating Officers noted the challenge of the increase in mental health patients presenting in the ED. Committee members reflected on how this would need system-level support. Finances adverse to plan in Month 2 SGUH and ESTH are £1.8m and £0.7m adverse to plan respectively at Month 2, owing to the impact of industrial action. The pressure of escalating medical pay rates was highlighted at both Trusts, which had been exacerbated by the recent industrial action. The Committee had discussed how this risk could be mitigated; but noted that it will require a London-wide response. The impending consultants' industrial action in July is a particular risk to both activity and financial plans. Delivery of 2023/24 Cost Improvement Plans (CIPs) The GCFO stated that SGUH has £10.6m of CIP plans against a target of £62.1m and ESTH £9.7m of CIP against a target of £37.3m. Chief Operating Officers at both sites have emphasised that pressure on general managers to deal with industrial action, performance metrics and CIP delivery is considerable. **The Board noted the update**	
4.3	**People Committee-in-Common Report**	
	Stephen Collier, Joint-Chair of the Committees, and Martin Kirke, Joint-Chair of the Committees presented the report which set out the key issues considered by the People Committees-in-Common at their meetings in May and June 2023. The key issues highlighted: Industrial Action The industrial action by staff continues to be a risk and a concern. The BMA are re-balloting junior doctors 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. Public Sector Equality Duty (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. 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.	

	There was concern about the length of time some investigations took in both Trusts and a need for concerted action to speed these up. Martin Kirke observed that many of the Trusts' HR policies are out of date, are convoluted and consultation is resource intensive. He asked that information on how other trusts update their policies should be sought so that the process can be streamlined. **The Board noted the update**	**GCPO**
4.4	**Audit Committee Report (SGUH)**	
	Peter Kane, Chair of the Audit Committee, introduced the report that set out the key issues discussed and agreed by the Committee at its meetings on 3 May and 15 June 2023. The Audit Committee's Annual Report for 2022/23 is also put forward for Board approval. The terms of reference for the Committee have been reviewed. There are no proposed changes to the terms of reference, other than formatting changes to bring them in line with other Board Committees. The workplan for 2023/24 includes a review of the Group Board Assurance Framework, a review of the new Group-wide Risk Management Policy and Process, a review of the new Group-wide approach to the management of Group, a review of Trust-wide policies, and internal controls in relation to raising concerns. St Georges had submitted its set of accounts and received a clean audit opinion. **The SGUH Board:** **1. Noted the report of the Committee's meetings held on 3 May and 15 June 2023** **2. Approved the Audit Committee Annual Report for 2022/23** **3. Approved the proposed changes to the Committee's Terms of Reference** **4. Approved the Committee's proposed work plan for 2023/24**	
4.5	**Audit Committee Report (ESTH)**	
	Peter Kane, Chair of the Audit Committee, outlined the report which 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. The terms of reference for the Committee have been reviewed. There are no proposed changes to the terms of reference, other than formatting changes to bring them in line with other Board Committees. The Committee workplan for 2023/24 includes a 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 a review of Trust-wide policies, and internal controls in relation to raising concerns.	

	The ESTH accounts had not yet been signed off. An Audit Committee will be held on 14 July 2023 if a clean set of accounts is approved. The Auditor's Report and the Opinion will then be considered by the Board later on 14 July 2023. The GCFO added that the incoming auditors had required a higher level of testing, and there was learning for the audit due in May next year. **The ESTH Board:** **1. Noted the report of the Committee's meetings held on 4 May and 15 June 2023** **2. Approved the Audit Committee Annual Report for 2022/23** **3. Approved the proposed changes to the Committee's Terms of Reference** **4. Approved the Committee's proposed work plan for 2023/24**	
4.6	**ESTH Estates Assurance Committee Report**	
	The MD-ESTH and the GCIFEO introduced the report. The ESTH Estates Assurance Committee met on 31 May 2023 and 28 June 2023. Key topics at the May meeting were the High Voltage Electricity Services and Decontamination Services. At the meeting held at the end of June, the Committee considered its closing report for the Trust Board. The Board is reminded that the Committee was established with a time limited remit: "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." The Committee has concluded that its journey has ended, and the Board has approved the terms of references for the new Infrastructure Committee and as such, this Committee has now closed. **The Group Board:** **1. Noted the report from the ESTH Estates Assurance Committee on its meetings held in May and June 2023 along with the closing report.**	
5.0	**ITEMS FOR NOTING**	
5.1	**Healthcare Associated Infection Report**	
	The GCNO stated that the paper provides a monthly update on Healthcare Associated Infections (HCAIs) and key issues/ concerns arising in Infection Prevention and Control (IPC) at site level for May 2023. The year-to-date position for infections monitored is: • C-difficile ESTH is below the national threshold and SGUH is above • MRSA blood stream infection ESTH is below the national threshold and SGUH is above	

	• Pseudomonas Aeruginosa ESTH is above the national threshold and SGUH is below • E-Coli both ESTH and SGUH are above the national threshold. There were 12 Covid-19 related deaths in May 2023. **The Group Board received the Healthcare Associated Infection (Infection Control) Report**
5.2	**Patient Safety Response Framework Implementation**
	The GCNO introduced the report which provided a progress update on the implementation of the Patient Safety Response Framework (PSIRF) across the Group. Organisations have been 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 how these methods will be applied to different patient safety incidents. The PSIRFs were approved at the Board meeting on 9 June 2023 and will be launched across the Group on 7 August 2023. Prior to the launch a SWL ICB stakeholder event is being held today 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). **The Group Board noted the report**
5.3	**Learning from Deaths Report Q4, 2022/23**
	The GCMO highlighted that all trusts are required to collect and publish specified information on deaths on a quarterly basis. This report summarises our Trusts' policy and approach to learning from deaths, 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. 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. **SGUH** - The total number of deaths in Q4 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 avoidable death. This case was escalated. 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. **The Group Board noted the report**
5.4	**Medical Appraisals and Revalidation SGUH and ESTH**

	Introducing the report, the GCMO highlighted that the Responsible Officer (RO) reports to the Board annually report on progress on medical appraisal and revalidation of licensed doctors. Since the last Board review Dr Elizabeth Rhodes has been appointed as the Responsible Officer for St George's starting March 2023. • The number of doctors connected to St George's continues to increase • The compliance rate for appraisal is 84% against the 95% target. This remains an area of focus for the Appraisal and Revalidation Group • No referrals for non-engagement have been made to the GMC in the last 12 months • The number of revalidation deferrals has fallen in 2022/23 • A small number of doctors are more than six months overdue on their appraisal; intensive work is underway to ensure they comply with annual appraisal requirements. The report contains the Designated Body Annual Board Report which has been 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 2022/23. The annual Statement of Compliance will be submitted to NHSE in September 2023 and be signed by the Chief Executive. **The SGUH Board:** **1. Noted the designated body annual board report** **2. Noted the planned actions for the upcoming year** **3. Agreed to progress with signing the Statement of Compliance for 2023 for SGUH.**	
5.4	**Responsible Officer Report on Medical Appraisal and Revalidation -ESTH**	
	Introducing the report, the GCMO highlighted that this is the Trust Responsible Officer's Annual Report for ESTH. It covers the progress made in medical revalidation and the developments during the reporting year 1st April 2022 to 31st March 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 total number of appraisals for the period was 525. 175 appraisals were not undertaken, all of which were approved by the RO. During the reporting period there were 202 scheduled revalidations: 194 were submitted and 8 deferred. The annual Statement of Compliance is due to be submitted to NHSE in September 2023 with a Statement of Compliance signed by the Chief Executive or Chairman.	

	The ESTH Board: **1. Noted the designated body annual board report** **2. Noted the planned actions for the upcoming year** 3. **Agreed to progress with signing the Statement of Compliance for 2023 for ESTH**	
5.5	**Integrated Care System Update: South West London and Surrey Heartlands Q1 2023-24**	
	The GDCEO introduced the Integrated Care System (ICS) update report which 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. **The Group Board noted the update**	
6.0	**CLOSING ITEMS**	
6.1	**Any new risks and issues identified**	
	There were no new risks or issues identified for escalation to the Corporate Risk Register.	
6.2	**Any other business**	
	There was no other business.	
6.3	**Reflections on meeting**	
	Phil Wilbraham provided his reflections on the meeting and highlighted that: • The ward visits and feedback is valued by Board members and more time should be given to this at the Board meeting. Discussion of other items was richer having seen life on the “shop floor”. • Industrial action is a concern for the Board and for staff and carefully supporting staff through this challenging time was important. Equally, there is a recognition that the industrial action is having a severe impact on delivery, finances and on our patients. • Development of the Group Strategy is welcomed. It seemed that the Group was visibly coming together at the joint Board. • More emphasis could have been given to integrated care at this meeting.	
6.4	**Patient / Staff Story**	
	The Group Board welcomed Dave Woodruff, Project Manager and Co-chair of the Bike User Group at SGUH. Dave Woodruff explained that there is an active and successful Bike User Group at SGUH which promotes and encourages staff to consider cycling to work. SGUH has invested in facilities for cyclists. The User Group is also liaising with other active transport groups, and working closely with the travel and transport team at ESTH. Dave Woodruff emphasised that there is still more SGUH could be doing, but a lack of finance sometimes prevents this. An Active Travel Day, held on 6 June	

2023 was very successful. The MD-SGUH had hosted the day and Juliana Annan, Wandsworth Mayor and Olympic gold medallist Joanna Rowsell MBE (now retired from the Great Britain Cycling Team) had attended.

Dave Woodruff stated that the key issues coming out of the active travel day were:

- Recognition that active travel is an ideal way to boost health and wellbeing both for staff and people visiting our hospitals. Active travel will reduce the number of people suffering from diseases linked to sedentary lifestyles.
- Local community groups are looking for SGUH to put its weight behind petitions to TFL/Council/ other organisations to improve the local area to make active travel more accessible and improve air quality.
- Our workforce can be role models for the community and as the number of staff who use active travel increases, so does influence.

Andrew Murray stated that he was a keen cyclist and supported this initiative. However, he had been knocked off his bike recently and he wished to raise safety concerns regarding the local cycle route network. The GCEO stated that she had contacted local councils in the past regarding cycle route network issues but had been counselled not to support specific schemes or campaigns. The Chairman added that general support by the Group for active travel, with our local decision makers, was the way to go.

Phil Wilbraham asked whether financial incentives could be given to staff. The GCFO stated that there is a scheme for staff to purchase bikes. Dave Woodruff added that Dr Bike is a service by a local repairer that is offered free to staff, which also donates renovated bikes.

The Chairman thanked Dave Woodruff for all his work in promoting active travel and for attending the Group Board meeting to explain what was being done. The Board was keen to show its support.

CLOSE

The meeting closed at 13.22.

QUESTIONS FROM MEMBER OF THE PUBLIC AND GOVERNORS

There were no questions from the public or from Governors

Date of next meeting:

10 am on 8 September 2023 Conference Room 1, Wells Wing, Epsom Hospital

Group Board (Public) - 8 September 2023

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC230707.1 *(GESH Board Action Log)*	7 Jul 2023	1.5	Group Chief Executive Officer Report	GCEO to give update on discussions with system partners, including the Borough Commander, on ways of tackling the challenge of patients with mental health concerns presenting in ED	8 Sep 2023	GCEO	Completed	PROPOSED FOR CLOSURE
PUBLIC230707.2 *(GESH Board Action Log)*	7 Jul 2023	2.1	Establishment of Infrastructure Committee-in-Common	GCIFEO to commission a review of committee effectiveness after 12 months of the committee being operational to assess if the goals set out in the terms of reference are being achieved.	12 Sep 2024	GCIFEO		NOT YET DUE
PUBLIC230707.3 *(GESH Board Action Log)*	7 Jul 2023	4.3	People Committee-in-Common Report	GCPO to review and give an update on how other trusts update their HR policies so that updating policies can be streamlined.	8 Sep 2023	GCPO	Completed.	PROPOSED FOR CLOSURE

Group Board

Meeting in Public on Friday, 08 September 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	-
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:

- Reflections on the Lucy Letby trial and verdict;
- An update on NHS England's implementation of the new Patient Incident Safety Response Framework;
- An update on NHS England's call to trusts to ensure systems and processes to support staff to speak up are in place and robust;
- An update on operational challenges, including industrial action and finances;
- An update on the PTC for Paediatric Cancer;
- An update on the Group's position in relation to Reinforced Aerated Autoclaved Concrete (RAAC) and NHS England's new requirements for Boards to seek additional assurance; and
- Group Events and Awards.

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

Chief Executive's Report
Group Board, 8 September 2023

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 Reflections on Recent Events

3.1 The past two months have brought challenging times for our organisation, and for the NHS. As ever I want to start by thanking our staff for all their enduring hard work under difficult circumstances and in a continued challenging operational environment. We continue to strive to meet all of our patient's needs, support each other as colleagues, and provide the best possible care in the best possible way.

3.2 The Lucy Letby trial will undoubtedly have a profound impact on the NHS now, and for years to come. We are all shocked by this horrific criminal act, which was an appalling betrayal of the trust that is placed in our institution. My thoughts go out to all families affected.

3.3 Going forward, we welcome the public inquiry, and will support all our NHS colleagues in learning every possible lesson from this terrible case. We will work proactively to ensure that all appropriate mechanisms are put in place to ensure the highest levels of safety and security throughout our operations.

4.0 NHS England's New Patient Safety Incident Response Framework

4.1 We will be implementing NHS England's new Patient Safety Incident Response Framework (PSIRF) across our Group in September. This new framework seeks to increase opportunities to learn and improve, and will underpin a culture of continuous improvement.

4.2 The PSIRF represents a new approach to patient safety and is being rolled out across the NHS this autumn. The PSIRF puts all those involved in the patient safety incident at the heart of the evaluation. By involving all participants and reviewing all contributing factors, it supports the development and maintenance of an effective patient safety incident response system. The PSIRF integrates four key aims:

- Compassionate engagement and involvement of those affected by patient safety incidents
- Application of a range of system-based approached to learning from patient safety incidents
- Considered and proportionate responses to patient safety incidents

- Supportive oversight focused on strengthening response system functioning and improvement

4.3 PSIRF will strengthen our responses to patient safety incidents and provide a framework for us to continue to foster continuous improvement throughout our organisation.

4.4 A key aspect of PSIRF, and our new Group strategy, is establishing a patient safety culture and an environment in which staff feel psychologically safe and supported to raise concerns. We are absolutely committed to supporting our staff to speak up. As an Executive team, and as a Board, we are committed to supporting our staff to feel confident in speaking up, really listening to those concerns, and taking action to respond to them in the right way – and making this a central part of how we work and support each other. Staff can raise concerns through a number of different routes, including to their line managers and lead directors. Staff can also raise concerns with our Freedom to Speak Up (FTSU) Guardians, who play a key role in supporting staff and contributing the development of a strong safety and learning culture. But we know we have more to do which is why we are taking steps to further strengthen our approach to raising and responding to concerns. A robust system for raising concerns is critical to supporting continuous improvement.

4.5 Both the Chairman and I have sent out communications to all staff recently on the importance of speaking up, the systems that are in place to support those raising concerns, and our commitment to listening and responding in the right way to concerns.

4.6 Leading and nurturing a culture of openness, continuous learning, and improvement has always been a critical part of the NHS, and it will be a priority for all NHS organisations in the light of the Letby trial.

4.7 NHS England has written to all Trusts to ensure that the following systems and mechanisms are in place with appropriate oversight:

- All staff have easy access to information on how to speak up.
- Relevant departments, such as Human Resources, and Freedom to Speak Up Guardians are aware of the national Speaking Up Support Scheme and actively refer individuals to the scheme.
- Approaches or mechanisms are put in place to support those members of staff who may have cultural barriers to speaking up or who are in lower paid roles and may be less confident to do so, and also those who work unsociable hours and may not always be aware of or have access to the policy or processes supporting speaking up. Methods for communicating with staff to build healthy and supporting cultures where everyone feels safe to speak up should also be put in place.
- Boards seek assurance that staff can speak up with confidence and those raising concerns are treated well.
- Boards are regularly reporting, reviewing and acting upon available data.

4.8 I look forward to driving this important work forward, and keeping you updated.

5.0 Regulatory Update: CQC Maternity Services Report

5.1 As you know, as part of the Quality Commission (CQC) National Maternity Review programme, the CQC is inspecting all NHS acute hospital maternity services they have not inspected and rated since April 2021.

5.2 As part of the focused inspections, St George's maternity services were inspected against the domains of well-led and safe in March this year.

5.3 In August, we received a CQC report based on the inspection. Disappointingly, the CQC assigned an overall rating of "inadequate" for the maternity service, based on a number of factors identified, including safe staffing, triage processes, the estate and quality governance processes.

5.4 Needless to say, this was a difficult report for us all to receive, and we have conducted a number of focused, and all-staff, briefing sessions in order to speak with our staff and discuss what this means for us. We take this report with the utmost seriousness.

5.5 I would also like to reiterate my assurance that the maternity unit continues to be a safe and positive environment to give birth in, which has been recognised by the CQC national patient experience maternity survey, which rated St George's as receiving the fourth highest patient satisfaction levels nationally in 2022 as well as being rated in the top three performing Trusts in London for antenatal care.

5.6 That said, it is evident that although progress has been made, there is much more to do. This is a report that is relevant to all of us, as we all share the responsibility to continuously improve our services – not only in maternity but across our entire organisation.

5.7 Since receiving the report from the CQC, our teams have worked immensely hard to address all immediate concerns. We also have a longer-term, comprehensive action plan to address the factors that have contributed to this rating. We will all – as a leadership team and as the service – together, work to improve our performance. I know how hard our midwives and obstetricians work, and I want to thank them for all their passion and dedication to the women and birthing individuals who come to St George's.

5.8 The Group Board will consider the actions arising from the CQC inspection of maternity services at St George's as a separate agenda item, and will maintain close oversight of the improvement actions we are taking.

6.0 Operational Update: Finances & Industrial Action

6.1 My Executive Team and I continue to balance the key goals of the Trust. The broader financial context for the NHS continues to be highly challenging and we remain focused on tackling our budget deficit through a number of mechanisms to drive forward efficiency. The Group Board has a focused item on financial performance as a separate item on the agenda and the Group Board will have an opportunity to discuss this in detail. As ever, we work as an Executive Team to continually balance finance, quality, performance and people.

6.2 Industrial action continues across our Sites and we work hard to ensure patient safety is protected despite operational challenges. In the coming weeks, we will face continued industrial action, including junior doctors strikes on 20-22nd September; consultant strikes on 19-20 September, and joint industrial action from both junior doctors and consultants on 2-5 October. Preparing for, and mitigating the risks of, these events is at the forefront of my team's mind and planning is underway at Group- and Site-level.

7.0 Consultation for the Principal Treatment Centre for Paediatric Cancer

7.1 As mentioned in my last update to the Board, the future of children's cancer services is changing as NHS England is deciding where a Principal Treatment Centre for children's cancer services should be located. This follows a national service specification in 2021, which sets out how children's cancer services should be on the same site as a Paediatric Intensive Care Unit (PICU) and other specialised children's services.

7.2 St George's has been part of the current Principal Treatment Centre, alongside the Royal Marsden Hospital, for more than 25 years and our children's services are rated Outstanding by the CQC. We already provide most of the specialist paediatric services that really matter for children with cancer, including paediatric intensive care, neurosurgery and much more. We will be sharing details of the NHS England consultation on our website and other channels and encouraging as many people as possible to have their say. The consultation is expected to launch on 21 September 2023.

7.3 Having a child who is ill with cancer is of course an extremely difficult and stressful time for parents and families. Families want to be reassured that their child is receiving the best possible care in the best way. We believe that St George's offers the best option for a future Principal Treatment Centre on one site. We our ready and looking forward to implementing our vision for a new state-of-the-art children's cancer centre that delivers cutting edge treatments and therapies at St George's.

8.0 Media Reports of St George's Chaplain

8.1 The Board will have seen media reports of a Chaplain at St George's, Suliman Gani, visiting Afghanistan and meeting with Taliban officials while on annual leave. I wanted to assure the Board that I have taken all action available to me in response to this situation. I know I speak on behalf of the Board when I say that we wholeheartedly condemn the actions and human rights abuses perpetrated by the Taliban, and their treatment of women is abhorrent.

8.2 As soon as we became aware of Mr Gani's visit - and some of his reported views - we took immediate action and also sought advice from the police, Prevent and relevant local authorities.

8.3 We met with Mr Gani on his return to the UK who said his visit was part of a charity delegation to deliver humanitarian aid. At this meeting we reinforced our expectations that our patients and staff must be treated in line with the Trust's values. Disciplinary action can only be considered if personal or political views impact upon conduct in the workplace or if any policies are breached.

8.4 Should any breach of our Trust policies take place, appropriate action will be taken. I hope this assures the Board.

9.0 Reinforced Aerated Autoclaved Concrete

9.1 The Board will have seen media coverage regarding the use of Reinforced Aerated Autoclaved Concrete (RAAC) and guidance published last week by the Department of Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate.

9.2 On 5 September 2023, NHS England wrote to all NHS trust chairs, chief executives and estates directors regarding the identification, monitoring and remediation of RAAC across the NHS estate (attached at appendix 1). As the letter explains, following an alert issued by the Standing Committee on Structural Safety in 2019, the NHS in England put in place a programme to identify RAAC, support providers to put in place appropriate mitigations, and plan for eradication.

9.3 All trusts were asked to assess their estate to identify the presence of RAAC. Across all sites in our hospital group, at both St George's University Hospitals and Epsom and St Helier University Hospitals, a number of surveys have been undertaken and we have established that there is no RAAC present anywhere on our estate. However, further checks will be carried out.

9.4 The NHS England letter of 5 September 2023 asks the Boards of NHS trusts are asked to review the returns that have been provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on their estates. This information will be collated and will be submitted to the Board for review at the earliest opportunity.

10.0 Group-wide Awards

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

10.2 **Anthony Nolan Supporter Awards**: In July Dr Jenna Love, Anthony Nolan Clinical Psychologist within the St George's Cancer Psychological Support (CaPS team), made the final shortlist in the Anthony Nolan Supporter Awards. Dr Love was nominated in the 'Clinical Supporter of the Year' category. Jenna was recruited into post two years ago to support patients undergoing stem cell transplants at St George's (both cancerous and non-cancerous conditions), and has already made an enormous difference to patients, carers and the wider stem cell transplant Multi-disciplinary team here.

10.3 **Cavell Star Awards:** The Cavell Star Awards are given to nurses, midwives, nursing associates and healthcare assistants who show exceptional care to colleagues, patients and families, and in July we were very pleased to award two 'Stars' at ESTH. Firstly, very well done to Juliet Kimpa-oy, manager of Swift ward, with a Cavell Star Award for her contribution to Planned Care. Juliet's colleagues agree she is committed and dedicated to her colleagues and patients, making sure high quality of care is always provided. And secondly many congratulations to A5 ward manager Ann Gell Bunoy. Gell was nominated because she has shown such engagement with our falls initiatives and is always happy to take on new challenges, showing good leadership qualities, a great work ethic and doing everything with a smile.

10.4 **Chief Allied Health Professions Officer (CAHPO) Awards:** Congratulations to Ben Wanless, Consultant MSK Physiotherapist at St George's, who was shortlisted for a Chief Allied Health Professions Officer (CAHPO) Award.Ben was shortlisted for the AHP Digital Practice Award, awarded by NHS England. This category recognises Allied Health Professionals who have led the way in digital developments. Ben's submission revolved around a digital self-management technology for all common musculoskeletal injuries and conditions across an entire Integrated Care System.

10.5 **WellChild Doctor Award:** Congratulations to Dr Richard Chavasse, Paediatric Respiratory Consultant at St George's, who has won a prestigious WellChild Doctor Award. Colleagues and families of children in his care jumped at the chance to nominate him, describing him as an outstanding doctor who works relentlessly to provide the best possible care for children needing long-term ventilation and support with respiratory problems. WellChild Nurse Alex McClements who works with Richard, said: "He is truly an inspiration to work with. His passion for the service is apparent in all his work."

11.0 Group-wide Events

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

11.2 **NHS 75:** On 5 July we celebrated 75 years of the NHS across our Group. There was a huge amount going on throughout the day, including staff and visitors signing a giant birthday card, a film of 75 members of staff describing the NHS in 75 words, and the executive team getting out and about to deliver cupcakes to wards. BBC London was on site at St George's to film some of the celebrations, and MP for Tooting Rosena Allin-Khan joined in the fun at our Big Tea Party. It was a really special day, topped off by our staff choir performing a song written especially for the occasion. At Epsom and at St Helier hospitals, Sutton Council Lead Councillor Ruth Dombey and her team visited St Helier, to present 'Thank you Epsom St Helier' gratitude books. On 5 July itself, the day saw tea parties at both acute sites, with entertainment from a local singer and a local school choir. Celebration 'thank you' packs including cakes were also sent out to all the community sites. We also planted the first two of 75 trees as part of our Green Plan commitments, and announced plans to hold 75 recruitment events in our local community settings.

11.3 **London Pride:** Fifty members of the St George's LGBTQ+ Staff Network joined the Pride in London parade on 1 July. They represented St George's as being a proud provider of healthcare for all**.**

11.4 **National Medical Examiner**: At the start of July, Dr Alan Fletcher, National Medical Examiner, visited the Wandsworth and Merton Medical Examiner Service which is hosted by St George's. He congratulated the team on the successful implementation of the service locally and reflected on exceptional feedback from doctors and families.

11.5 **Civility and Psychological Safety:** This has been the current 'Big 5' theme from our staff survey at the Group across the summer, with many activities taking place, including the second of two well-attended virtual event on 11 July. On a lighter but no less important tack, August was Kindness Month at gesh, with many initiatives including an online Kindness Wall, where staff could recognise each other's daily acts of kindness.

11.6 **Black Leaders Awareness Day:** This annual awareness day is a chance to hear about the experience of Black leaders. To recognise the day across our hospital Group, we spoke to Group Chief Nursing Officer, Arlene Wellman, who imparted some of her wisdom about what being a Black leader means to her, and the challenges she has experienced on her pathway from a newly qualified nurse to Group Chief Nursing Officer.

11.7 **South Asian Heritage Month:** This was an opportunity to celebrate and honour South Asian history and culture. This year's theme was 'Stories to Tell' and at St George's we shared

stories across our channels from members of our staff on their experience of being of South Asian heritage and living in Britain.

11.8 **Electronic Patient Records (EPR):** EPR is coming to ESTH next spring in the form of the Cerner system, and the pre-launch activities have continued apace. In August, three in-person Documentation Amnesty events were held to help staff understand new EPR processes, prepare to move across to the new system and sign up for training.

11.9 **World Hepatitis Day**: The theme for this year's World Hepatitis Day was 'Hep Can't Wait' and the Trust's Viral Hepatitis and Community Liver Health Team got out and about on the St George's Liver Health Bus to raise awareness of the disease including symptoms and testing.

11.10 **Channel 4's Emergency**: St George's is one of the four major trauma centres in London, and our teams at St George's had a starring role in Channel 4's 'Emergency', which was back in August for its second series. Filmed last summer in an incredibly busy month for trauma departments, the series followed the minute-by-minute decisions made by teams at St George's and the other Major Trauma Network teams in London, as they treat the most critically injured patients.

Classification: Official

NHS England

To:
- All NHS trusts:
  - chairs
  - chief executive officers
  - estates leads

cc.
- Integrated care boards:
  - chairs
  - chief executive officers
  - estates leads
- Regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

5 September 2023

Dear Colleagues,

Reinforced aerated autoclaved concrete (RAAC)

Last week new guidance was published by the Department for Education regarding the approach to the presence of RAAC in the school estate. This has generated heightened public interest in the presence of RAAC in the NHS estate, and a number of questions from colleagues.

You are all aware of the risks associated with RAAC as part of the extensive programme of work undertaken over recent years. We are writing to reiterate the position in the NHS estate, and to outline actions you should be taking to assure yourselves as far as possible that RAAC is identified and appropriately mitigated, to keep patients, staff and visitors safe.

To provide co-ordination to these actions, we will be communicating via regional operations centres. **Please therefore ensure that appropriate arrangements are made within your organisation to be able to respond to communication from your regional operations centre (ROC) on this subject.**

Guidance on RAAC identification, monitoring and remediation

All guidelines on RAAC are based and driven by expert advice from the Institute for Structural Engineers (IStructE). There has been no change in IStructE guidance, which government has confirmed continues to be the basis of action to manage the situation in the NHS and wider public sector. We continue to work closely with government departments and technical advisory groups and have asked to be made aware of any changes to the guidance so that we can share these with you immediately.

Publication reference: PRN00777

Following an alert issued by The Standing Committee on Structural Safety (SCOSS) in 2019, the NHS in England put in place a now well-established programme to identify RAAC, support providers to put appropriate mitigations in place, and plan for eradication. We have worked closely with the trusts managing the 27 previously identified sites, including securing funding for investigative, safety/remedial and replacement work, with three of those sites now having eradicated RAAC.

As part of this ongoing work, in May 2023 NHS England sent out additional guidance to organisations including all provider trusts (including mental health, community and ambulance) following updated national guidance from IStructE on RAAC identification, management and remediation and Further Guidance on Investigation and Assessment (April 2023).

Identification of RAAC

We asked trusts to assess their estate again based on this updated guidance. Initial assessments of additional sites identified through this process are already being undertaken and are expected to be completed by the end of this week. The national RAAC programme team are collating information from these assessments, including where appropriate mitigation plans and the steps necessary to remove this material from use.

Given the importance of this work, we ask that – in any instances where this has not already been the case – boards ensure they support their estates teams and review the returns they provided to assure themselves that the assessments made were sufficiently thorough and covered all buildings and areas on your estate (including plant/works, education and other non-clinical areas/buildings).

ICBs will want assurance about the primary care estate and should work with their local primary practices and PCNs to ensure you have confirmation that no RAAC has been identified or, where it has, on the identification and management of RAAC. Guidance for the primary care estate was circulated in January of this year, which ROCs can reshare.

Management of identified RAAC

Trusts which have previously identified RAAC will have put in place management plans in line with the IStructE guidance.

In light of the need to maintain both the safety and confidence of staff, patients and visitors, **we recommend that in those organisations where the presence of RAAC has been confirmed and is being managed, boards take steps now to assure themselves that the management plans in place for each incidence – and particularly where panels are currently subject to monitoring only – are sufficiently robust and being implemented.**

Where you think you require assistance in completing this work, please contact: england.estatesandfacilities@nhs.net.

Planning for RAAC incidents

Effective management of RAAC significantly reduces associated risks; but does not completely eliminate them. Planning for RAAC failure, including the decant of patients and services where RAAC panels are present in clinical areas, is therefore part of business continuity planning for trusts where RAAC is known to be present, or is potentially present.

A regional evacuation plan was created and tested in the East of England. Learnings from this exercise have been cascaded to the other regions.

We would recommend that all boards ensure that they are familiar with the learning from this exercise and that they are being incorporated into standard business continuity planning as a matter of good practice.

This exercise is, however, essential for those organisations with known RAAC, and should be done as a matter of priority if it has not already been completed.

Thank you to you and your teams for the work on this to date, particularly in those organisations where RAAC has been found and management/remediation plans have been enacted. As mentioned above we will communicate further information through ROCs.

Yours sincerely,

Jacqui Rock
Chief Commercial Officer

Dr Mike Prentice
National Director for Emergency Planning and Incident Response

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	2.1	
Report Title	**Group Maternity Services Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	**Bene Agbagwara-Osuji, Director of Midwifery and Gynaecology Nursing, Epsom and St Helier University Hospitals NHS Trust (ESTH)** **Laura Rowe, Lead Midwife for Clinical Governance and Risk (ESTH)** **Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH)** **Alison Benincasa, Group Director of Compliance**	
Previously considered by	Quality Committee in Common	27 July 2023
Purpose	**For Assurance**	

Executive Summary

The purpose of the report is to inform the Board of:

- The progress against the required actions following the CQC's unannounced inspection of St George's Maternity Services on 22 and 23 March 2023 and the Section 29A Warning Notice issued by the Care Quality Commission (CQC)
- The development of the new CQC Maternity Services Action Plan for St George's Maternity Services following the publication of the CQC Inspection Report in August 2023 and in response to the revised CQC rating of Inadequate (see Appendix 1)
- The progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns; and activity to ensure safety within maternity units across the Group including a status update against the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5. Training compliance and safe staffing levels continue to be a risk for ESTH and SGH.

Action required by Group Board

The Board is asked to:

a) Note the compliance status against the CNST year 5 MIS

b) Note that the Quality Committee in Common and Board will receive regular updates regarding progress against the MIS
c) Note the formal closure of the Section 29A Warning Notice Action Plan and the development of the new CQC maternity services action plan to address the 15 'Must Do' recommendations and 6 'Should Do' recommendations
d) Receive the report for assurance
e) Make recommendations for any further action

Committee	Quality Committees-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	**New CQC maternity Services Action Plan**
Appendix 2	**Maternity Services Monthly Report**
Appendix 3	**ESTH and SGUH PMRT Case Detail**
Appendix 4	**MBBRACE-UK Report 2021 – LMNS Review 2023**

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.

There is a reputational risk to St George's Maternity Services on publication of the CQC inspection 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

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
• National research recognises that there are protected characteristics which are at a greater risk of maternal and neonatal complications. The report presents the ethnicity for mortality data • Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups is important and will continue to be considered. This model of care requires appropriate staffing levels to be implemented safely
Environmental sustainability implications
No issues to consider

Group Maternity Services Report
Group Board, 08 September 2023

1.0 Purpose of paper

1.1 The purpose of the report is to inform the Board of:

- The progress against the required actions following the CQC's unannounced inspection of St George's Maternity Services on 22 and 23 March 2023 and the Section 29A Warning Notice issued by the Care Quality Commission (CQC)
- The development of the new CQC Maternity Services Action Plan for St George's Maternity Services following the publication of the CQC Inspection Report in August 2023 and in response to the revised CQC rating of Inadequate (see Appendix 1)
- The progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns and activity to ensure safety within maternity units across the Group including a status update against the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5.

2.0 Background

2.1 The learning from the recent CQC inspection of Maternity Services at St George's Hospital identified the need to strengthen the assurance provided to Quality Committee and the Board.

2.2 In response, the assurance set out in table 1, section 5 below is included to strengthen the Site and Group level reporting and oversight of Maternity Services for reporting and assurance at QCIC and Trust Board.

2.3 NHS Resolution released the technical details for the Maternity Incentive Scheme (MIS) Year 5 on 31 May 2023. The MIS supports the delivery of safer maternity care by incentivising an element of Trust contributions to the Clinical Negligence Scheme for Trusts (CNST). MIS rewards Trusts that meet 10 safety actions designed to improve the delivery of best practice in maternity and neonatal services.

2.4 Much of the CNST technical guidance is time bound, the first deadlines being Safety Action 2, MSDS (Maternity Services Data Set) and Safety Action 5, which requires that a midwifery workforce review is undertaken 6 monthly and reported to Board. This work is underway and will be reported at a future meeting.

2.5 NHS England set out a national ambition to halve the rates of stillbirth, neonatal deaths, maternal deaths, and brain injuries during birth by 2025, (from a 2010 baseline). Aligned with the Perinatal Quality Surveillance Model (PQSM), maternity and neonatal services are required to report monthly against an agreed data set which is included at Appendix 2 and covers the period June 2023.

3.0 Section 29A Warning Notice Action Plan: Closed 28 June 2023

3.1 The Section 29A Warning Notice Action Plan was developed after the Trust received the Warning Notice from the Care Quality Commission (CQC) on 28 March 2023, following the CQC's unannounced inspection of SGUH's Maternity services on 22 and 23 March 2023.

3.2 The Section 29A Warning Notice Action Plan contained 21 Action Areas which responded to 23 points within the Warning Notice across four themes: Safe staffing; triage; governance and leadership; and estates.

3.3 The progress made was summarised in the Trust's formal Section 29A Warning Notice Response letter which was submitted to the CQC on 28 June 2023 following sign off by Group Executive Board on 27 June 2023 and received at Group Board (Private) on 7 July 2023.

3.4 One Action Area, the finalisation of the Maternity Services Establishment, is included in the new CQC Maternity Services Action Plan and is currently being worked through.

4.0 New CQC Maternity Services Action Plan

4.1 A new CQC maternity services action plan has been developed to respond to the 15 'Must Do' recommendations and 6 'Should Do' recommendations published in the CQC Maternity Services Inspection Report August 2023 (see Appendix 1).

4.2 One Action Area related to the Section 29A Warning Notice as identified above, the finalisation of the Maternity Services Establishment, is included in the new CQC Maternity Services Action Plan and is currently being worked through.

4.3 The monitoring and oversight of the new CQC maternity services action plan is undertaken by the CQC Maternity Services Steering Group, chaired by the Group Chief Nurse.

5.0 Maternity Services: Progress summary of actions against local and national requirements

Table 1: Assurance

Assurance	Report Published	Status	Evidence
Review of MBRRACE cases in 2022 report			
MBBRACE-UK Audit Report	2022	• SGUH was identified as an outlier: over 5% higher than the average for comparable Trusts in the 2020 audit report. The recently published 2021 MBRACE-UK report confirms SGUH is no longer an outlier and is now within 5% of the average for comparable Trusts • ESTH was identified as within 5% of the average for comparable Trusts • A review of the 74 cases at SGUH in 2020 has been commissioned and is in progress • There has been a challenge in the collection of the case notes, this has been prioritised by the site leadership team with the maternity Senior Team	MBBRACE-UK 2020 Report: previously received at Quality Committee in Common (QCiC) Terms of Reference: previously received at QCiC

<table>
<tr><td></td><td></td><td></td><td>PMRT Quarterly Report Appendix 3</td></tr>
<tr><td>MBBRACE- UK Audit Report</td><td>2023</td><td colspan="3">The findings of the 2023 report is that both ESTH and SGUH were within the category of the 5% average for comparable Trusts
Local review undertaken by maternity teams in collaboration with local LMNS
SGUH 36 stillbirth case reviews identified care and service delivery issues which potentially contributed to the outcome in 8 cases. Actions progressed in relation to staffing, escalation, triage, risk assessment and fetal monitoring
SGUH 22 neonatal death case reviews identified no concerns with care or service delivery issues
ESTH 13 stillbirth case reviews identified care and service delivery issues which potentially contributed to the outcome in 4 cases. Actions completed in relation to escalation for review, care planning and review of women reporting reduced fetal movements
ESTH 1 neonatal death case review identified no concerns with care or service delivery issues</td><td>MBBRACE-UK 2021 Report: Summary of findings Appendix 4

PMRT Quarterly Report Appendix 3</td></tr>
<tr><td colspan="6">Midwifery workforce is reported and monitored Monthly with local twice daily SITREPS to the Site and Group Nursing teams. There is a focus on Midwifery staffing levels as part of ongoing work.</td></tr>
<tr><td rowspan="4">Midwifery Workforce Planning</td><td></td><td></td><td>Fill Rate (>94%)</td><td>Band 7 Supervisory midwife (100%)</td><td>Triage, 2.0 wte per shift (100%)</td><td rowspan="4">Maternity Services Monthly Report Appendix 2</td></tr>
<tr><td>June 2023</td><td>ESTH STH</td><td>95%</td><td>100%</td><td rowspan="2">Commence reporting in next period</td></tr>
<tr><td>June 2023</td><td>ESTH EGH</td><td>91%</td><td>100%</td></tr>
<tr><td>June 2023</td><td>SGUH</td><td>90%</td><td>98%</td><td>93.3%</td></tr>
<tr><td colspan="6">Compliance with CNST year 5 Maternity Incentive Scheme</td></tr>
<tr><td rowspan="2">10 Safety Actions Maternity Incentive Scheme Year 5 (CNST)</td><td></td><td colspan="2">ESTH</td><td colspan="2">SGUH</td><td rowspan="2">Maternity Services Monthly Report Appendix 2</td></tr>
<tr><td></td><td colspan="4">Risk of non-compliance:
Safety Action 3: Transitional Care
Safety Action 5: Midwifery Workforce Planning
Safety Action 6: Saving babies Lives Bundle</td></tr>
<tr><td colspan="6">Training compliance in midwifery units have been identified as an on-going risk</td></tr>
<tr><td>Multidisciplinary Training</td><td></td><td colspan="3">Risk of non-compliance Safety Action 8: Multidisciplinary Training
ESTH: Performance across all staff groups range from 50% to 96% in June 2023 with the most progress in Anaesthetics (44% in May to 50% in June) but still below the required targets</td><td>Maternity Services Monthly Report Appendix 2</td></tr>
</table>

		• SGUH: Performance across all staff groups from 55% to 95.5% in June 2023. • Training for Obstetricians in both Trusts fell by 12 % • A training plan to recover training compliance is being worked through	
Culture: Maternity Services			
Culture review: Maternity Services		Governance review has been commissioned and Phase 1 will include culture review of maternity services	Terms of Reference previously received at QCiC

5.0 Recommendations

5.1 The Board is asked to:

a. Note the compliance status against the CNST year 5 MIS
b. Note that the Quality Committee in Common and Board will receive regular updates regarding progress against the MIS
c. Note the formal closure of the Section 29A Warning Notice Action Plan and the development of the new CQC maternity services action plan to address the 15 'Must Do' recommendations and 6 'Should Do' recommendations
d. Receive the report for assurance
e. Make recommendations for any further action

MUST DO	CQC Wording	Alignment with Action Areas in Section 29 Warning Notice Action Plan	Comments and actions
1	The service must ensure staffing levels are safe and there are effective processes in place to escalate and mitigate safe staffing concerns. (Regulation 12	AA1, AA2, AA3, AA4, AA5, AA10	Establishment still not signed off. Once signed off this 'Must Do' will be COMPLETE
2	The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))	AA6	COMPLETE
3	The service must ensure adequate and up-to-date policies, pathways and guidance are in place, including implementation of a standard operating procedure in maternity triage and clear, effective escalation pathways to mitigate for risks of short staffing on women, birthing people, babies and staff. (Regulation 12)	AA6, AA7, AA8, AA9, A10, AA12, AA13, AA14, AA15, AA16, AA17, AA18	COMPLETE
4	The service must ensure safe care of women in labour especially in relation to fetal monitoring. (Regulation 12 (2) (a) (b)	AA6	COMPLETE
5	The service must ensure that all staff groups complete mandatory training in a timely way. (Regulation 12)	AA5	New HROD workstream created to include this 'Must Do'
6	The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))	AA16, AA17, AA18	Awaiting final Audit Plan from Emily, then COMPLETE. This will be monitored therough the new 'Ongoing Audit' workstream created in Phase 2 Action Plan.
7	The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments. (Regulation 12 (2) (g))	Not referenced in Section 29A Warning Notice	Create a new 'Medicines Management' workstream.
8	The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))	AA13, AA14, AA15, AA17	COMPLETE
9	The service must ensure clinical areas are clean, fit for purpose and equipment is properly serviced and maintained in a timely way, including but not limited to emergency trolleys, resuscitaires and appropriate, timely portable appliance testing. (Regulation 15 (1) (a) (c) (d))	AA6, AA7, AA8, AA9	Final estates job (widening doorway in Triage Area) being completed by end of July. Once finished this 'Must Do' will be COMPLETE.
10	The service must ensure governance processes are effective including but not limited to communication between staff, service leaders and trust executives, clear and up-to-date guidelines in place, acting on audit results, and appropriate incident management. (Regulation 17 (1))	AA1, AA2, AA3, AA4, AA5, AA6, AA7, AA12, AA13, AA14, AA15, AA17, AA18	New Sitrep in operation but final changes still not completed and signed off. Once Sit Rep signed off this 'Must Do' will be COMPLETE.
11	The service must ensure all staff are provided with annual developmental appraisals. (Regulation 12	Not referenced in Section 29A Warning Notice	New HROD workstream created.
12	The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))	AA1 - AA18 inclusive	Awaiting final Audit Plan from Emily. Once finished this 'Must Do' will be COMPLETE. Checking this documentation and compliance will be included in new 'Ongoing Audit' workstream created in Phase 2 Action Plan.
13	The service must ensure maternity safeguarding processes are strengthened, including timely staff training, consideration of a maternity safeguarding policy, adequate availability of staff trained in safeguarding concerns, and timely actions to implement safe measures to reduce the potential for baby abduction. (Regulation 13	AA6, AA7	Maternity Safeguarding Policy to go to MGM. Once finished this 'Must Do' will be COMPLETE.
14	The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12)	AA6, AA9	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).
15	The service must ensure that documentation in the bereavement suite is completed contemporaneously and in full. (Regulation 17 (2) (c))	Not referenced in Section 29A Warning Notice	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).
SHOULD DO	**CQC Wording**		**Comments and actions**
16	The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies. (Regulation 12	Not referenced in Section 29A Warning Notice	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).
17	The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way. (Regulation 12)	Not referenced in Section 29A Warning Notice	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).
18	The service should ensure it takes account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups. (Regulation 17 (2) (d) (e)	Not referenced in Section 29A Warning Notice	New HROD workstream created.
19	The service should formalise a second consultant ward round on the labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations. (Regulation 12)	Not referenced in Section 29A Warning Notice	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).
20	The service should examine its culture and involve staff in improving it, including staff members with protected characteristics under the Equality Act 2010.	Not referenced in Section 29A Warning Notice	New HROD workstream created.
21	The service should improve executive knowledge of and involvement in maternity services, including but not limited to growth of the maternity safety champion role, and health inequalities for women and birthing people who use the service.	AA1, AA2, AA3, AA4, AA5, AA18	COMPLETE - part of CNST compliance.

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

CQC Directive / Issue Reference	CQC Directive / Issue detail	ACTION AREA Number (see worksheet tabs)	ACTION AREA Name (see worksheet tabs)	ACTION AREA Owner	Target Completion Date	Summary Delivery Status (BRAG)
NA- Internal SGH Action	**Proactive closure of the birthing centre to mobilise staff to delivery suite**	**1**	**Proactive closure of the birthing centre**	Jan Bradley, DoM	Ongoing	**Blue**
NA- Internal SGH Action	**Pause Continuity of Care (CoC) to mobilise staff to delivery suite**	**2**	**Pause Continuity of Care (CoC)**	Jan Bradley, DoM	Ongoing	**Blue**
NA- Internal SGH Action	**Suspend home births to mobilise staff to delivery suite**	**3**	**Suspend home births**	Jan Bradley, DoM	Ongoing	**Blue**
NA- Internal SGH Action	**Non-patient facing midwives in the numbers to mobilise staff to delivery suite**	**4**	**Non-patient facing midwives in the numbers**	Annabelle Keegan, Deputy DoM	Ongoing	**Blue**
NA- Internal SGH Action	**Cancel training to mobilise staff to delivery suite**	**5**	**Cancel training**	Annabelle Keegan, Deputy DoM	Ongoing	**Blue**
1.1	1.1 **Staff we spoke to were not aware of a standard operating procedure for maternity triage and did not know how to access it.**	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.2	1.2 **Women and pregnant people attending triage were not formally risk-rated** and we found that midwives were not following the processes outlined within the standard operating procedure document.	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.3	1.3 There was **no formal prioritisation tool** to assist staff in providing timely care to those in most clinical need.	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.4	1.4 During the focussed, short-notice announced inspection on 21 st March 2023, we observed a woman in triage who was awaiting medical review for more than 4 hours and had a pain score of 8 out of 10. She was in an open environment with no way to call for assistance and no offer of analgesia.	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.5	1.5 During the inspection on 21 March 2023, we saw evidence that a woman attended triage overnight and **did not receive appropriate or timely care for her clinical situation**, including waiting for 4 hours for fetal heart auscultation to take place.	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**

1.6a	1.6 During November 2022 there were 21 incidents reported associated with the triage process without subsequent evidence of learning or improvement, including: 1.6a. Local ID 241465: a woman gave birth in the 'triage unit' which meant there was **a lack of appropriate transfer, monitoring, care, and available equipment.**	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.6b	1.6b. Local ID 248493: due to delay a high-risk woman was waiting for a review for over 7 hours and discharged herself without being seen. The impact of this was missed opportunity for safe care. This was not identified by the trust until several weeks later and the outcome for the woman and baby is unknown. **It is unclear how the service safely manages women and pregnant people who discharge themselves from care.**	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
1.6c	1.6c. Local ID 242320: due to a **lack of effective triage process and enough midwifery staff**, a woman in labour was left for 3 hours without the care of a midwife or adequate analgesia.	**6**	**Standard Operating Procedures (SOP) for Maternity Triage including risk rating and prioritisation**	Chrissy Coroyannakis, Obs Consultant	28/06/23	**Blue**
2.1	2.1 **Baby abduction drills** were performed in July 2022 and an action plan for improvements was devised. During the inspection on 21 and 22 March 2023, leaders told us the action plan was not completed, and this left babies at risk of abduction.	**7**	**Baby Anti-Abduction Action Plan**	Annabelle Keegan, Deputy DoM	28/06/23	**Blue**
2.2	2.2 During the inspection on 21 and 22 March 2023, we observed **cluttered environments across the maternity unit that posed a health and safety risk to staff and patients**. For example: we saw boxes stored in corridors that obstructed emergency equipment and access doors, and patient milk fridges that were not secure, stored in corridors. This caused trip hazards, evacuation risks and delay in administering emergency care.	**8**	**Declutter environment and unblock emergency access doors**	Cheryl Stewart, DGM Obs	28/06/23	**Blue**
2.3	2.3 From November 2022 to March 2023, maternity services reported 401 incidents to the estates department, 45% of which were resolved within 7 days. **There are currently 69 open incidents awaiting estates management, including blocked sinks and toilets, broken and mouldy bathrooms, broken light sources, leaking birth pools, incomplete portable appliance testing, no hot water supply, damaged walls, broken panic alarms, broken medical gas supply panels, and unsafe temperature maintenance in clinical rooms some of which recorded temperatures of 16 degrees celsius.** Slow response to incidents meant women, pregnant people and babies were cared for in an environment that was not sufficiently maintained to keep them safe.	**9**	**Complete outstanding Estates works**	Jenni Doman, Site Director, Estates and Facilities Division	28/06/23	**Green**
3.1	3.1 During November 2022 and February 2023, the shift fill rate on the acute wards was an average of 81%. Staffing acuity data for February 2023 showed **adequate staffing on labour ward** 60% of the time. The required number of FTE midwives to safely run labour ward was 61.48 (staffing template review performed May 2021). However, we found 13 FTE **staff contracted and trained to work on labour ward on the rota system.**	**10**	**Ensuring adequate staffing levels, with establishment reflected on Healthroster and appropriate triggers and monitoring in place**	Jan Bradley, DoM	28/06/23	**Amber**
3.2	**3.2 Escalation processes in place on labour ward were not always utilised properly or completed in full**. For example, acuity and escalation processes were not repeated or documented throughout the shift according to hospital guidance to give leaders accurate oversight of unit activity. There was no framework to identify high-risk patients in the escalation process. Once the escalation meeting had been carried out, there was not always documented evidence of relevant escalation to service leaders taking place, and it was not clear that leaders escalated staffing concerns outside of maternity when necessary. This meant escalation processes were not effective at mitigating the risk of low staffing. This impacted the safety of women, pregnant people and babies on the unit.	**12**	**Clearer Site escalation processes (OPEL status, attendance at bed meetings)**	Jan Bradley, DoM	28/06/23	**Green**

3.3	3.3.**Escalation from the maternity service into trust-wide situation meetings used terminology that was not clearly indicative of the risk posed and therefore ineffective.**	**12**	**Clearer Site escalation processes (OPEL status, attendance at bed meetings)**	Jan Bradley, DoM	28/06/23	**Green**
3.4	3.4. **Acuity tools and monitoring of maternity staffing 'red flags' were not embedded into practice.** There was no senior midwifery supernumerary oversight on labour ward, or of maternity services overall. This means women, birthing people and babies are at risk of harm due to **low staffing levels.**	**10**	**Ensuring adequate staffing levels, with establishment reflected on Healthroster and appropriate triggers and monitoring in place**	Jan Bradley, DoM	28/06/23	**Amber**
3.5	3.5. During the 2-day inspection we found the **Day Assessment Unit was staffed** by one midwife who had not been able to take a meal break on either day. The staffing template for safe management of the day assessment unit was 3 midwives and a support worker. This impacted on safe and timely care of women and pregnant people attending the unit.	**10**	**Ensuring adequate staffing levels, with establishment reflected on Healthroster and appropriate triggers and monitoring in place**	Jan Bradley, DoM	28/06/23	**Amber**
3.6	3.6. In November 2022, there were 68 incidents of delayed care or **unsafe conditions raised due to short staffing, which is ongoing and remains a risk to safe care and treatment.** For example, local ID 249453 describes high acuity, poor staffing, and an inability to provide one to one care for a woman in premature labour, as well as another patient having antibiotic administration delayed.	**10**	**Ensuring adequate staffing levels, with establishment reflected on Healthroster and appropriate triggers and monitoring in place**	Jan Bradley, DoM	28/06/23	**Amber**
4.1	4.1. Staffing was on the risk register and scored at 16 out of 25 which falls in the 'urgent action' category. **The risk register stated a gap in fulfilment of 14 FTE midwives across maternity services however this is not representative of acuity, staff rosters seen on inspection, or the staffing template review completed in May 2021. Mitigating factors documented on the risk register were not implemented**, for example: additional escalation meetings during times of high acuity, oversight of the unit by a supernumerary bleep holder, staff allocated breaks, adequate and effective assurance from the escalation pathway, adequate and effective recruitment. Acuity was not being monitored and recorded effectively and maternity staffing 'red flags' were not consistently recorded. The impact of this was there was not adequate oversight and risk management to keep women, pregnant people and babies safe.	**13**	**Improved monitoring of risk register**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**
4.2	4.2.**Incidents were not always categorised, and harm rated appropriately in order to effectively manage the service, give an accurate representation of risk, and improve safety.** We found persistent themes of obstetric haemorrhage and obstetric anal sphincter injury categorised at a less severe harm rating than appropriate. There was a pattern of incidents within the service that were consistently rated as low harm inappropriately, for example: a. Local ID 248824: a woman required several medical interventions, intensive care unit admission and a subsequent postnatal readmission b. Local ID 248282: a woman had an unexpected admission to theatre c. Local ID 249673: a woman experienced major obstetric haemorrhage and a return to theatre.	**14**	**Incidents to be classified using NICE classification**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**

4.3	4.3**. Maternity safety champions were not visible to staff on the wards** and did not have a comprehensive understanding of issues faced by maternity services. The impact of this was a lack of support for maternity service leaders and poor oversight of risks within maternity services.	**15**	**Clear visibility and increased effectiveness of safety champions**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**
4.4	4.4.**Maternity service leaders were not always able to describe audit programmes or audit results**, the impact of which was poor knowledge of service provision and lack of adequate identification of areas for learning and improvement.	**16**	**Training on audit programmes and results**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**
4.5	4.5.**Shared learning from incidents was not disseminated effectively throughout the workforce**. Staff were not aware of any recent shared safety learning and were not aware that a 'never event' had taken place within the 2 weeks preceding the inspection.	**17**	**Review of dissemination of learning from incidents, and associated processes and monitoring**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**
4.6	4.6.We reviewed maternity guidelines and found many had been updated on 20 March 2023 and did not always contain up-to-date guidance such as COVID and vaccination recommendations	**18**	**Creation of a rota of regular review of guidelines**	Emily Kaliwoh, Senior Governance Manager	28/06/23	**Blue**
NA- Internal SGH Action	**Comms workstream**	**19**	**Comms workstream**	Paul Sheringham		**Blue**
NA- Internal SGH Action	**Programme management - Maternity post-CQC Inspection Ops Group - Action Log**	**20**		Will Reynolds		**Green**
NA- Internal SGH Action	**Programme management - Maternity CQC Steering Group - Action Log**	**21**		Will Reynolds		**Amber**

Proactive closure of the birthing centre

01/09/2023 *Last*

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
1.1	***Safe Staffing***	***Current***	22.03.23	Agree escalation triggers for closing the Birth Centre	Maternity CQC Ops Group	Jan Bradley, DoM	22.03.23	Blue	**02.05.23:** Triggers SOP complete (decision Tree being added) for review at Steering Group on 05.05.23 and then OMG ratification. **Closed, being managed through Action 21.38 (copied below)**	See Evidence folder - Action 1.23 (Various versions of BC Triggers paper)		
1.2	***Safe Staffing***	***Current***	22.03.23	Agree process for including of COO and site leadership team in decision-making process around whether and when the BC opens / closes.	Maternity CQC Ops Group	Jan Bradley, DoM	22.03.23	Blue	**02.05.23:** Triggers SOP complete (decision Tree being added) for review at Steering Group on 05.05.23 and then OMG ratification. **Closed, being managed through Action 21.38**			
1.3	***Safe Staffing***	***Current***	22.03.23	Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Ops Group	Jan Bradley, DoM	22.03.23	Blue	22.03.23 - BC paused, women informed, comms out Ongoing dynamic review (see below for evidence)	See below dynamic review updates for Evidence		
1.4	***Safe Staffing***	***Current***	22.03.23	Complete risk assessment to understand and mitigate risk of closing Birthing Centre	Maternity CQC Ops Group	Dee Kapfunde, DDNG, CWDT	17.04.23	Blue		See Evidence folder - Action 1.4		
1.5	***Safe Staffing***	***Current***	30.03.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Ops Group	Jan Bradley, DoM	30.03.23	Blue	30.03.23 - action above continued	**WTE contributions in MARCH/APRIL**		
1.6	***Safe Staffing***	***Current***	11.04.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Ops Group	Jan Bradley, DoM	11.04.23	Blue	11.04.23 - staffing review to determine criteria for BC re-opening	See below dynamic review updates for Evidence		
1.7	***Safe Staffing***	***Current***	17.04.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Steering Group	Jan Bradley, DoM	17.04.23	Blue	Remains predominantly closed but responsive to staffing availability (Escalation triggers driving decisions), Reviewed in Steering Group (20th April). Dynamic review continuing - the team will continue to open the BC when staffing permits.	See below dynamic review updates for Evidence		
1.8	***Safe Staffing***	***Current***	27.04.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Steering Group	Jan Bradley, DoM	27.04.23	Blue	Mostly closed due to Estates works so far this week (wc 24th April). Open approximately 50% of the week so far. Agreement at Steering Group on 27.04.23 to continue dynamic risk assessment with triggers used to open and close based on staffing. Triggers being reviewed at the Maternity Ops meeting for review on 02/05/23	See below dynamic review updates for Evidence		
21.31	***Safe Staffing***	***Current***	27.04.23	Agreement to include in weekly updates at Steering Group the % of time the Birth Centre has been closed.	Maternity CQC Steering Group	Jan Bradley, DoM	04.05.23	Blue	**04/05/23:** Ongoing as part of dynamic review.			
1.9	***Safe Staffing***	***Current***	04.05.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Steering Group	Jan Bradley, DoM	04.05.23	Blue	Agreement to continue dynamic review and respond to staffing issues where required. Currently staffing allows for the Birth Centre to be open (wc 02.05.23). Birth Centre was closed for 4 of 7 days last week (wc 24.04.23) due to planned estates works.	See below dynamic review updates for Evidence		
1.21	***Safe Staffing***	***Current***	27.04.23	Develop a template for a letter to patients to be given to them at booking clarifying the position around the Birth Centre * Copied from to Action Area (Action 21.29)	Maternity CQC Steering Group	Jan Bradley / Paul Sheringham	04.05.23	Blue	**04/05/23**: WIP - propose deferring to next Steering Group. **18/05/23:** Work underway, to be finalised by COP 19/05/23. **22/05/23**: Completed and to be added to Maternity Pack - PS sent to WR for the Evidence locker.	See Evidence folder - Action 1.9		
1.22	***Safe Staffing***	***Current***	18.05.23	Dynamic review of Proactive closure of the midwifery led birth centre redeploying WTE midwives to the acute inpatient setting	Maternity CQC Steering Group	Jan Bradley, DoM	18.05.23	Blue	Agreement to continue dynamic review and respond to staffing issues where required. Currently staffing allows for the Birth Centre to be open (18.05.23) although significant staffing challenges (sickness) this week have led to the BC being closed earlier this week.	See below dynamic review updates for Evidence		
1.23/ 21.38	***Safe Staffing***	***Current***	04.05.23	Further tweaks to be provided to Birth Centre Triggers paper following feedback from Arlene and Alison. Then updated by Jan accordingly and will then be signed off by Steering Group - after which it will go to MGM (week after) and OMG, TMG.		Alison, Arlene and Jan Bradley	11.05.25	Blue	**04/05/23:** Comes back to Steering Group on 11/05/23 (rearranged to 18.05.23). **18/05/23:** Re-circulated by Jan for any final comments from Arlene or Alison. Feedback to be provided by AW and AB ASAP. **25/05/23:** Birth Centre Triggers paper re-circulated by Jan. 04/05/23: Comes back to Steering Group on 11/05/23 (rearranged to 18.05.23). 18/05/23: Re-circulated by Jan for any final comments from Arlene or Alison. Feedback to be provided by AW and AB ASAP. 25/05/23: Birth Centre Triggers paper re-circulated by Jan; Birth centre usage paper circulated for Board as requested. 25/05/23 (SG): Further work on this is required - feels repetitive of the Escalation paper. Needs to be briefer and more directive. 30/05/23: Following agreement at SG to strip this back considerably a simpler flow chart with key staffing numbers and activity to be built in and submitted for SG on Thursday 01/06/23. 01/06/23: Paper has been circulated - a further iteration may be required. Jan and Will to work up decision tree. 05/06/23: Circulated to Ops Group for comments and agreement on whether further refinement is required. 08/06/23: Jan to circulate to SWL colleagues (Manjit) for second opinion. 11/08/23: Manjit feedback provided - Jan to review comments and circulate latest draft. 15/06/23: Final version to be completed today. Once complete it will be included as an addendum to the Escalation Policy. 20/06/23: Now complete and will be included in the Escalation Policy. Closed	See Evidence folder - Action 1.23 (Various versions of BC Triggers paper including latest, complete version: v8)		
1.24 / 21.43	***Safe Staffing***	***Current***	04.05.24	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy to keep Home Births open in July (agreement to open in May and June on 04.05.23).		Jan Bradley	25.05.23	Blue	**18/05/23:** Plan in place to review July numbers at beginning of June. **25/05/23:** Birth centre usage paper circulated to SG for consideration.	See Evidence folder - Action 1.24 (BC usage figures to support decision about July opening)		
1.25 / 21.29	***Safe Staffing***	***Current***	27.04.23	Develop a template for a letter to patients to be given to them at booking clarifying the position around the Birth Centre * Copied to Action Area 1		Jan Bradley / Paul Sheringham	04.05.23	Blue	**04/05/23**: WIP - propose deferring to next Steering Group. **18/05/23:** Work underway, to be finalised by COP 19/05/23. **22/05/23**: Completed and to be added to Maternity Pack - PS has sent to WR for the Evidence locker.	See Evidence folder - Action 1.25 (letter template)		

1.26	***Safe Staffing***	***Current***	25.05.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	01.06.23	**Blue**	Agreement at 25/05/23 SG to continue dynamic review and respond to staffing issues where required. Reiteration at Steering Group that Triage must always have 2 members of staff every shift (Midwife plus HCA or 2 x Midwives).	**See below dynamic review updates for Evidence**		
1.27	***Safe Staffing***	***Current***	01.06.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	01.06.23	**Blue**	Agreement at 01/06/23 SG to continue dynamic review and respond to staffing issues where required. Some closures this week. Reiteration at Steering Group that Triage must always have 2 members of staff every shift (Midwife plus HCA or 2 x Midwives).	**See below dynamic review updates for Evidence**		
1.28	***Safe Staffing***	***Current***	08.06.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	08.06.23	**Blue**	Agreement at 08/06/23 SG to continue dynamic review and respond to staffing issues where required. Some closures this week due to high activity on Delivery Suite.	**See below dynamic review updates for Evidence**		
1.29	***Safe Staffing***	***Current***	15.06.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	15.06.23	**Blue**	Agreement at 15/06/23 SG to continue dynamic review and respond to staffing issues where required. Some closures this week (80% open this week) due to high activity on Delivery Suite.	**See below dynamic review updates for Evidence**		
1.31	***Safe Staffing***	***Current***	22.06.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	22.06.23	**Blue**	Agreement at 22/06/23 SG to continue dynamic review and respond to staffing issues where required. Some closures this week (60% open this week) due to high activity on Delivery Suite.	**See below dynamic review updates for Evidence**		
1.32	***Safe Staffing***	***Current***	29.06.23	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	29.06.23	**Blue**	Agreement at 29/06/23 SG to continue dynamic review and respond to staffing issues where required. Delivery Suite has been 45% open and 55% closed so far this week (up until 27th June). Last week it was 65% open and 35% closed.	**See below dynamic review updates for Evidence**		
1.33	***Safe Staffing***	***Current***	17/08/2023	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	17/08/2023	**Blue**	Agreement at 29/06/23 SG to continue dynamic review and respond to staffing issues where required. Delivery Suite has been 60% open and 40% closed so far this week (up until 17th August). Last week it was 65% open and 35% closed.	**See below dynamic review updates for Evidence**		
1.34	***Safe Staffing***	***Current***	31/08/2023	Dynamic review: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy that Home Birth centre is safe.		Jan Bradley / Paul Sheringham	31/08/2023	**Blue**	Agreement at 29/06/23 SG to continue dynamic review and respond to staffing issues where required. Week of 15th - Open 86% and closed 14%. Last week 64% and closed 36% (two shifts every 24 hours - 14 shifts per week) - only counting a period of more than four hours for a closure.	**See below dynamic review updates for Evidence**		

END

Pause Continuity of Care

01/09/2023 *Last*

Blue = Executive confirmation of evidence shows action fully

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
2.1	***Staffing***	***Current***	22.03.23	Complete risk assessment to understand and mitigate risk of pausing CoC	Maternity CQC Ops Group	Dee Kapfunde, DDNG CWDT	17.04.23	**Blue**		**See Evidence folder - Action 2.1**		
2.2	***Staffing***	***Current***	22.03.23	Pause on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Ops Group	Jan Bradley, DoM	22.03.23	**Blue**	22.03.23 - Willow CoC on call paused - shifts added to roster			
2.3	***Staffing***	***Current***	30.03.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Ops Group	Jan Bradley, DoM	30.03.23	**Blue**	30.03.23 - action above continued	**See below dynamic review updates for Evidence**		
2.4	***Staffing***	***Current***	11.04.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Ops Group	Jan Bradley, DoM	11.04.23	**Blue**	11.04.23 - staffing review to determine criteria for CoC re-opening	**See below dynamic review updates for Evidence**		
2.5	***Staffing***	***Current***	17.04.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	17.04.23	**Blue**	Remains paused - Agreement on 20th April to continue this approach.	**See below dynamic review updates for Evidence**		
2.6	***Staffing***	***Current***	27.04.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	27.04.23	**Blue**	Remains paused - Agreement at Steering Group on 27.04.23 to continue this approach.	**See below dynamic review updates for Evidence**		
2.7	***Staffing***	***Current***	04.05.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	04.05.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU.	**See below dynamic review updates for Evidence**		
2.8	***Staffing***	***Current***	18.05.24	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	18.05.24	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU.	**See below dynamic review updates for Evidence**		
2.9	***Staffing***	***Current***	25.05.24	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	25.05.24	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 25/05/23). Review of CoC to see whether CoC midwives can be pulled into the occasional shift to help if staffing short.	**See below dynamic review updates for Evidence**		
2.11	***Staffing***	***Current***	01.06.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	01.06.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 01/06/23). Looking to revert back to pausing in July and August to support staffing.	**See below dynamic review updates for Evidence**		
2.12	***Staffing***	***Current***	08.06.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	08.06.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 08/06/23). Still looking to revert back to pausing in July and August to support wider staffing and the Home Birth team.	**See below dynamic review updates for Evidence**		
2.13	***Staffing***	***Current***	15.06.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	15.06.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 15/06/23). Still looking to revert back to pausing in July and August to support wider staffing and the Home Birth team.	**See below dynamic review updates for Evidence**		

2.14	***Staffing***	***Current***	22.06.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	22.06.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 22/06/23). These plans remains in place. Still looking to revert back to pausing in July and August to support wider staffing and the Home Birth team.	**See below dynamic review updates for Evidence**		
2.15	***Staffing***	***Current***	29.06.23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	29.06.23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 29/06/23). These plans remains in place. Still looking to revert back to pausing in July and August to support wider staffing and the Home Birth team.	**See below dynamic review updates for Evidence**		
2.16	***Staffing***	***Current***	17/08/23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	17/08/23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 17/0823). Partial pause in July and August as planned to support wider staffing and the Home Birth team.	**See below dynamic review updates for Evidence**		
2.17	***Staffing***	***Current***	31/08/23	Dynamic review of the pause of on-call Willow CoC service and float shifts into DS to support staffing. Continue ANC appointments.	Maternity CQC Steering Group	Jan Bradley, DoM	31/08/23	**Blue**	Steering Group (SG) assured that Willow can now be maintained. Staff can now be released back into CoC to return to normal BAU (remains in place 31/0823). Partial pause in July and August as planned to support wider staffing and the Home Birth team. On call team have plotted shifts rather than being on call. Next step is looking timings for FU and bookings to ensure the efficient use of that resource.	**See below dynamic review updates for Evidence**		

Suspend home births

01/09/2023 *Last updated*

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual
Green = On target with evidence of progress supplied

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by	On-going monitoring
3.1		**22.03.23**	Complete risk assessment to understand and mitigate risk of suspending home births	Maternity CQC Steering Group	Dee Kapfunde, DDNG CWDT	17.04.23	**Blue**		**See Evidence folder - Action 3.1**		
3.2	***Staffing***	**22.03.23**	Suspend Home births	Maternity CQC Ops Group	Jan Bradley, DoM	06.04.23	**Blue**	22.03.23 - HB paused, women informed, comms out			
3.3	***Staffing***	**30.03.23**	Dynamic review of suspension of Home births	Maternity CQC Ops Group	Jan Bradley, DoM	30.03.23	**Blue**	30.03.23 - Reviewed and HB reinstated - no additonal or new women to be referred to HB team. Women informed, comms requested	**See below dynamic review updates for Evidence**		
3.4	***Staffing***	**31.03.23**	Dynamic review of suspension of Home births	Maternity CQC Ops Group	Jan Bradley, DoM	31.03.23	**Blue**	31.04.23 - HB MW off sick - sporadic service	**See below dynamic review updates for Evidence**		
3.5	***Staffing***	**06.04.23**	Dynamic review of suspension of Home births	Maternity CQC Ops Group	Jan Bradley, DoM	06.04.23	**Blue**	06.04.23 - staffing review determined HB open	**See below dynamic review updates for Evidence**		
3.6	***Staffing***	**11.04.23**	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	11.04.23	**Blue**	Home births reinstated for women booked to date (1 woman left to deliver from the 6 booked in April; a total of 13 women booked/ due to deliver in May) subject to safe staffing daily review. No new homebirth bookings to be taken. Agreement on 11th April to continue this approach.	**See below dynamic review updates for Evidence**		
3.7	***Staffing***	**17.04.23**	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	17.04.23	**Blue**	Home births reinstated for women booked to date (1 woman left to deliver from the 6 booked in April; a total of 13 women booked/ due to deliver in May) subject to safe staffing daily review. No new homebirth bookings to be taken. Agreement on 20th April to continue this approach.	**See below dynamic review updates for Evidence**		
3.8	***Staffing***	**24/04/2023**	Develop clear plan for what happens with the Home Births from May onwards	Maternity CQC Ops Group	Jan Bradley, DoM	02.05.23	**Blue**	02.05.23: * Staffing concerns excel completed which shows a positive staffing position. * Jan will also summarise this in a few paragraphs which explains this position. * Paper to go to Thursday's Steering Group (04.05.23).	**See Evidence folder - Action 3.8 (Excel Showing asssessment of staffing numbers in May - which are positive, enabling reopening of Home Births)**		
3.9	***Staffing***	**27.04.23**	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	27.04.23	**Blue**	Home births planned for women booked to date (1 woman left to deliver from the 6 booked in April; a total of 13 women booked/ due to deliver in May) subject to safe staffing daily review. No new homebirth bookings to be taken. Agreement at Steering Group on 27.04.23 to continue this approach. Proposal setting out options for the approach post-May to be discussed at next week's Maternity CQC Ops meeting (02.05.23) and to be reported back at Steering Group (05.05.23).	**See below dynamic review updates for Evidence**		
3.9	***Staffing***	04.05.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	04.05.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June, on the proviso that this will continue to be dynamically reviewed. A decision will be taken by the Steering Group at the end of May, for July.	**See below dynamic review updates for Evidence**		
3.11	***Staffing***	18.05.24	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	18.05.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June, on the proviso that this will continue to be dynamically reviewed. A decision will be taken by the Steering Group at the end of May, for July.	**See below dynamic review updates for Evidence**		
3.11	***Staffing***	25.05.24	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	25.05.24	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. Further assurance required around staffing in July to enable Home Births to continue in July.	**See below dynamic review updates for Evidence**		
21.43 / 3.12	***Staffing***	04.05.24	Copied from SG Action Log: Provide an update on Home Birth staffing status for the SG to review whether they are assured and happy to keep Home Births open in July (agreement to open in May and June on 04.05.23).	Maternity CQC Steering Group	Jan Bradley	25.05.23	**Blue**	**18/05/23:** Plan in place to review July numbers at beginning of June. **25/05/23:** Further assurance required around staffing in July to enable Home Births to continue in July. For discussion at SG. **01/06/23:** Hybrid proposal to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Agreed in principle by SG, for final discussion and approval at site meeting. Copied to AA3 **05/06/23:** Agreed at site meeting, with review again at the end of June for the Home Births in August.			
3.13	***Staffing***	01.06.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	01.06.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. For July, a hybrid approach has been proposed at SG to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Women would give birth in the Birthing Centre. Agreed in principle by SG, for final discussion and approval at site meeting.	**See below dynamic review updates for Evidence**		
3.14	***Staffing***	08.06.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	08.06.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. For July, a hybrid approach has been proposed at SG to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Women would give birth in the Birthing Centre.	**See below dynamic review updates for Evidence**		
3.15	***Staffing***	15.06.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	15.06.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. For July, a hybrid approach has been proposed at SG to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Women would give birth in the Birthing Centre. Confirmation of continuation of this approach on 15/06/23.	**See below dynamic review updates for Evidence**		

3.16	***Staffing***	22.06.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	22.06.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. For July, a hybrid approach has been proposed at SG to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Women would give birth in the Birthing Centre. Confirmation of continuation of this approach on 22/06/23.	**See below dynamic review updates for Evidence**		
3.17	***Staffing***	29.06.23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	29.06.23	**Blue**	Agreement by SG that Home Births can go ahead until the end of June. For July, a hybrid approach has been proposed at SG to maintain antenatal support for women in July, with the midwives coming in for planned shifts for the additional time to provide a buffer for staffing. Women would give birth in the Birthing Centre. Confirmation of continuation of this approach on 29/06/23.	**See below dynamic review updates for Evidence**		
3.18	***Staffing***	17/08/23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	17/08/23	**Blue**	Home Births paused over summer months, as planned. Women deliver within the Birthing Centre during this period. Plan to revert back to HBs needs to be reviewed given that there is only 1 HB nurse left within that team.	**See below dynamic review updates for Evidence**		
3.19	***Staffing***	31/08/23	Dynamic review of suspension of Home births	Maternity CQC Steering Group	Jan Bradley, DoM	31/08/23	**Blue**	Home Births paused over summer months, as planned. Women deliver within the Birthing Centre during this period. Plan to revert back to HBs needs to be reviewed given that there is only 1 HB nurse left within that team. Review of September's plotted Home Births for review by SG and will be discussed at next meeting (07/09/23)	**See below dynamic review updates for Evidence**		

Non-patient facing midwives in the numbers

01/09/2023 *Last*

Blue = Executive confirmation of evidence shows action fully complete,

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
4.1	***Staffing***	***Current***	22.03.23	Complete risk assessment to understand and mitigate risk of adding non-patient facing midwives into the numbers	Maternity CQC Steering Group	Dee Kapfunde, DDNG CWDT	17.04.23	Blue		See Evidence folder - Action 4.1		
4.2	***Staffing***	***Current***	22.03.23	Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	22.03.23	Blue	22.03.23 - non-patient facing clinical staff in numbers 50% of the time.			
4.3	***Staffing***	***Current***	30.03.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	30.03.23	Blue	30.03.23 - reviewed and continues	See below dynamic review updates for Evidence		
4.4	***Staffing***	***Current***	03.04.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	03.04.23	Blue	03.04.23 - reviewed and continues	See below dynamic review updates for Evidence		
4.5	***Staffing***	***Current***	11.04.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	11.04.23	Blue	11.04.23 - staffing review to determine criteria for non clinical staff to return to fulltime role	See below dynamic review updates for Evidence		
4.5	***Staffing***	***Current***	17.04.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Steering Group	Jan Bradley, DoM	17.04.23	Blue	17.04.23 - Arrangement remains in place - Agreement on 20th April to continue this approach.	See below dynamic review updates for Evidence		
4.5	***Staffing***	***Current***	27.04.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	27.04.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 27.04.23 to continue this approach.	See below dynamic review updates for Evidence		
4.5	***Staffing***	***Current***	27.04.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	27.04.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 27.04.23 to continue this approach.	See below dynamic review updates for Evidence		
4.6	***Staffing***	***Current***	04.05.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	04.05.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 04.05.23 to continue this approach.	See below dynamic review updates for Evidence		
4.7	***Staffing***	***Current***	18.05.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	18.05.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 18.05.23 to continue this approach.	See below dynamic review updates for Evidence		
4.8	***Staffing***	***Current***	25.05.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	25.05.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 25.05.23 to continue this approach.	See below dynamic review updates for Evidence		
4.9	***Staffing***	***Current***	01.06.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	01.06.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 01.06.23 to continue this approach.	See below dynamic review updates for Evidence		
4.11	***Staffing***	***Current***	08.06.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	08.06.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 08.06.23 to continue this approach.	See below dynamic review updates for Evidence		
4.12	***Staffing***	***Current***	15.06.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	15.06.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 15.06.23 to continue this approach.	See below dynamic review updates for Evidence		
4.13	***Staffing***	***Current***	22.06.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	22.06.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 22/06/23 to continue this approach.	See below dynamic review updates for Evidence		
4.14	***Staffing***	***Current***	29.06.23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	29.06.23	Blue	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 29/06/23 to continue this approach.	See below dynamic review updates for Evidence		

4.15	***Staffing***	***Current***	17/08/23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	17/08/23	**Blue**	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 17/08/23 to continue this approach. There has been a slight increase in this 50% figure over the summer to help with annual leave absences.	**See below dynamic review updates for Evidence**		
4.16	***Staffing***	***Current***	17/08/23	Dynamic review: Non-patient facing midwives in the clinical numbers for 50% of their time	Maternity CQC Ops Group	Jan Bradley, DoM	17/08/23	**Blue**	Arrangement remains in place (around 50% of the time of 4 x NP-Facing midwives is being used for DCC time) - Agreement at Steering Group on 31/08/23 to continue this approach. There has been a slight increase in this 50% figure over the summer to help with annual leave absences which has continued over the last period. New joiners from mid-September - following orientation this recruitment will enable this intervention to be stepped down.	**See below dynamic review updates for Evidence**		

Cancel training

01/09/2023 *Last*

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
5.1	***Staffing***	***Current***	22.03.23	Complete risk assessment to understand and mitigate risk of cancelling training	Maternity CQC Steering Group	Dee Kapfunde, DDNG CWDT	17.04.23	**Blue**		**See Evidence folder - Action 5.1**		
5.2	***Staffing***	***Current***	30.03.23	Review cancelled training	Maternity CQC Ops Group	Jan Bradley, HoM	30.03.23	**Blue**	30.03.23 - reviewed and continues up to ?? Date	WTE contributions in MARCH/APRIL		
5.3	***Staffing***	***Current***	04.04.23	Review cancelled training	Maternity CQC Ops Group	Jan Bradley, HoM	04.04.23	**Blue**	04.04.23 - Training week commencing 17.04.23 under review by matrons	WTE contributions in MARCH/APRIL		
5.4	***Staffing***	***Current***	11.04.23	Review cancelled training	Maternity CQC Ops Group	Jan Bradley, HoM	11.04.23	**Blue**	11.04.23 - staffing review determined PROMPT, Fetal Monitoring and Resus training can be supported to run W/C 17th April.	WTE contributions in MARCH/APRIL		
5.5	***Staffing***	***Current***	17.04.23	Review cancelled training and circulate rescheduling plan	Maternity CQC Steering Group	Jan Bradley, HoM	17.04.23	**Blue**	17.04.23 - Need to prioritise provision of PROMPT subject to staffing available on the day. If staffing is sufficient then reinstate CTG training, and again subject to staffing review reinstate Resus. Agreement on 20th April to continue this approach.	**See Evidence folder - Action 5.5 (Details of regular review of Training cancellations and impact)**		
5.5	***Staffing***	***Current***	27.04.23	Review cancelled training and circulate rescheduling plan	Maternity CQC Steering Group	Jan Bradley, HoM	27.04.23	**Blue**	CTG, PROMPT, Resus went ahead this week (wc 24.04.23) CTG and Resus next week (wc 01.05.23) and PROMPT training planned for the week after (wc 08.05.23). Agreement at Steering Group on 27.04.23 to continue to prioritise provision of essential training subject to staffing available on the day and continue to look forward two weeks ahead at each Steering Group.	**See below dynamic review updates for Evidence**		
5.6	***Staffing***	***Current***	02.05.23	**Training schedule dynamic review process:** Provide evidence of Training schedule and process being followed to dynamically review staffing to ensure that training can take place safely.	Maternity CQC Steering Group	Jan Bradley, HoM	02.05.23	**Blue**	**04/05.23:** Dynamic review now include review of split of staff training by five areas Obs, Anaesthetists, Midwives, MSWs, ODPs) to show training compliance in more granularity. Additional Training date added in September and October in Sims Lab (PROMPT) to mitigate anhy lost training.	**See Evidence folder - Action 5.6 (Training schedule and process being followed to dynamically review staffing)**		
5.7	***Staffing***	***Current***	27.04.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	27.04.23	**Blue**	27/05/23: Agreement at Steering Group with this proposal. This information has also been shared last year via the Perinatal Quality Surveillance Tool Dynamic review each wekk will now include review of split of staff training by five areas Obs, Anaesthetists, Midwives, MSWs, ODPs) to show training compliance in more granularity. Additional Training date added in September and October in Sims Lab (PROMPT) to mitigate anhy lost training.	**See below dynamic review updates for Evidence**		
5.8	***Staffing***	***Current***	04.05.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	04.05.23	**Blue**	Training ongoing. No need to suspend at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed.	**See below dynamic review updates for Evidence**		
5.9	***Staffing***	***Current***	18.05.24	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	18.05.24	**Blue**	Training ongoing. Dynamic review of rosters continue and the team have managed to successfully minimise training cancellations. No need to suspend at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed.	**See below dynamic review updates for Evidence**		
5.11	***Staffing***	***Current***	25.05.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	25.05.23	**Blue**	Training ongoing. Dynamic review of rosters continue and the team have managed to successfully minimise training cancellations. No need to suspend at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed.	**See below dynamic review updates for Evidence**		
5.12	***Staffing***	***Current***	01.06.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	01.06.23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No need to suspend at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed.	**See below dynamic review updates for Evidence**		
5.13	***Staffing***	***Current***	08.06.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	08.06.23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed.	**See below dynamic review updates for Evidence**		
5.14	***Staffing***	***Current***	15.06.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	15.06.23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed. Confirmation of continuation of this approach on 15/06/23.	**See below dynamic review updates for Evidence**		
5.15	***Staffing***	***Current***	22.06.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	22.06.23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed. Confirmation of continuation of this approach on 22/06/23.	**See below dynamic review updates for Evidence**		
5.16	***Staffing***	***Current***	29.06.23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	29.06.23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed. Confirmation of continuation of this approach on 29/06/23. Consultant strikes fall on the planned day of PROMPT but mitigations are being put in place to manage this.	**Dynamic review updates for Evidence**		

5.17	***Staffing***	***Current***	17/08/23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	17/08/23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed. Confirmation of continuation of this approach on 17/08/23.	**Dynamic review updates for Evidence**		
5.18	***Staffing***	***Current***	31/08/23	**Training schedule dynamic review process:** Agreement to keep the breakdown of training records on the local drive but not continuously updating the breakdown on the risk register.	Maternity CQC Steering Group	Jan Bradley, DoM	31/08/23	**Blue**	Training ongoing. Dynamic review of rosters continues and the team have managed to successfully minimise training cancellations. No training suspended at this time due to satisfactory staffing numbers/ training has been built into the numbers. Additional PROMPT sessions in the Sim lab in September and October booked to mitigate any cancellations if needed. Confirmation of continuation of this approach on 31/08/23. No training cancelled since March and April 2023.	**Dynamic review updates for Evidence**		

Standard Operating Procedure for Maternity Triage (SOP) development

01/09/2023 Last updated

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual
Green = On target with evidence of progress supplied

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
6.1	**Safe Triage**	**Standardising practice Reducing risk**	**22.03.23**	Standard operating procedure for maternity triage	**Maternity CQC Ops Group**	**DoM Jan Bradley**	**06.04.23**	**Blue**	**22.03.23 - SOP revised and circulated for DS and DAU** **23.03.23 - Service redesign to ensure all walk in patients attend DS for initial review** **31.03.23 - working group designed education programme and roll out across MDT** **04.04.23 - SOP signed off in Maternity Governance Meeting 04.04.23**	**See 6.1 Evidence folder (SOP, MGM minutes)**		
6.2	**Triage**	**Standardising practice Reducing risk**	**22.03.23**	Access standard operating procedure for Admission and Transfer of Maternity Patients	**Maternity CQC Ops Group**	**DoM Jan Bradley**	**06.04.23**	**Blue**	**23.04.23 -** SOP signed off in Maternity Audit and Guidelines Meeting (see minutes 23/03/23) and Maternity Governance Meeting 04.04.23 **02.05.23:** Green until Assurance has been provided to Steering Group. At which point action will be signed off as Complete / Blue. **23.05.23:** MGM minutes provided confirming governance route.	**See 6.2 Evidence folder (SOP; MAGM minutes; MGM minutes)**		
6.3	**Triage**	**Standardising practice Reducing risk**	**22.03.23**	Formally risk assess women attending Triage using a prioritisation tool	**Maternity CQC Ops Group**	**DoM Jan Bradley**	**06.04.23**	**Blue**	**31.03.23:** as above **06.04.23:** Communication to MW's re reposnsiblities for documentaion of time of arrivla and initial review times **11.04.23:** PDM and Matron to lead training for receptionist/MSW re documentation **02.05.23:** Green until Assurance has been provided to Steering Group. At which point action will be signed off as Complete / Blue. 23.05.23: MGM minutes provided confirming governance route.	**See 6.3 Evidence folder (comms to team around new Triage process)**		
6.4	**Triage**	**Standardising practice Reducing risk**	**22.03.23**	MDT education Package for Triage process	**Maternity CQC Ops Group**	**DS CGL Ana Pinas**	**06.04.23**	**Blue**	**28.04.23 - EOI for clinical support** **30.03.23 - responses from EC and JG Band 7 Traige EOI** **31.04.23 - working group met to map out training** **04.04.23 - underway by PDM team** **11.04.23:** DDoM to chase programme development and implementation **02.05.23:** Green until Assurance has been provided to Steering Group. At which point action will be signed off as Complete / Blue. **23.05.23:** MGM minutes provided confirming governance route (see Action 6.1 - Evidence folder)	**See 6.4 Evidence folder (Education package distributed to teams)**		
6.5	**Triage**	**Standardising practice Reducing risk**	**22.03.23**	PDSA cycle of impact of changes to flow and standardistion	**DIV TRI Maternity CQC Ops Group**	**DoM Jan Bradley**	**06.04.23**	**Blue**	**31.03.23 - as above** **04.04.23 - Trust QI Team supporting** **02.05.23:** Green until Assurance has been provided to Steering Group. At which point action will be signed off as Complete / Blue. **23.05.23:** MGM minutes provided confirming governance route (see Action 6.1 - Evidence folder)	**See 6.5 Evidence folder (Maternity Triage Process PDSA Planning)**		
6.6	**Triage**	**Standardising practice Reducing risk**	**22.03.23**	Completion of outstanding estates works to support flow for Triage across 1st and 4th floors	**DIV TRI Maternity CQC Ops Group**	**DoE Jenni Doman**	**06.04.23**	**Green**	The Infrastructure project team add the following changes to the existing assessment room : •t Med gas points on the window wall. 0-2 weeks •t Nurse call system. 0-2 weeks •t privacy curtain. 0-2 weeks •t WHB. 4-6 weeks Khodr Hawchar will be the project manager for this job. **02.05.23:** Dean Gornall to provide written update on this item. **09/05/23:** Medical gas works completed. However, Entonox has been capped off due to the need to ensure we have the relevant air changes within that environment. **18/05/23** •Med Gas points complete. Entonox has been capped off as we need to review the air changes in room – (duplicate of above - no ventilation in that room at all – under review with Khodr) •Nurse call system – Quote receive – £9k, works approved, PO to be raised. Works usually commence two weeks after PO has been received – Scheduled completion end of May •Privacy curtains – proposed install today – 17/05/23 – Curtains for "forget me not" – two weeks. •WHB – Order was placed last week, and Estates are saying a two-week lead time (IPS panels and Basin are on order pending delivery). Install should happen WC 22nd May (update supplier being chased to ensure still on schedule) **01/06/23: All jobs will be completed before the CQC response is required** •Med Gas - complete (Entonox isolated) •Nurse call system – works start 02/06/23 (outside controller), 09/06/23 (internal works) •Privacy curtains – 01/06/23 •HWB – complete **22/06/23:** All completed bar the door frame-widening: Confirmed by Dean Gornall (Dep Director Estates). **07/07/23:** One outstanding job remains - widening the door in the triage area. Due to be completed by end of July.	**See 6.6 Evidence folder (Estates log and email trails)**		
6.7	**Triage**	**Standardising practice Reducing risk**	**02.05.23**	Spot check audit by Governance lead to ensure that the Triage process is working.	**DIV TRI Maternity CQC Ops Group**	**Emily Kaliwoh**	**05.05.23**	**Blue**		**See 6.7 Evidence folder (Midwife audit; Midwife DS audit)**		
6.8	**Triage**	**Standardising practice Reducing risk**	**10.05.23**	Spot check audit by Governance lead to ensure that the Triage process is working.	**DIV TRI Maternity CQC Ops Group**	**Emily Kaliwoh**	**17.05.23**	**Blue**	Emily to provide evidence of audit log by COP Friday 5th May. **09/05/23:** Update provided and stored in evidnec locker. Repeat walkaround planned for 17th May (Action 6.8). Please see the Triage audit findings for the second half of April. **01/06/23:** Using our revised NICE Safer Staffing framework 96% of women are seen within the 30 minute target. We will explore the remaining 6% of cases to understand how we can improve this further.	**See 6.8 Evidence folder (DS Triage Snapshot audit)**		

Baby Anti-abduction plan drills - Improvement Plan

01/09/2023 *Last update*

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Green = On target with evidence of progress supplied

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
7.1		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Security Incidents not recorded consistently** **Actions:** * Staff to Datix any identified security breaches * Educate all staff * Support from Governance team * Face to face walk round discussions with Governance Team in clinical areas promoting best practice	**Maternity CQC Ops Group**	**Karen Ramdass**	**16.12.22**	**Blue**	**Completed Datixes:** - DW181520 - DW181519 **15.05.23:** No recent incidents. **20/06/23:** No Serious Incidents - ongoing monitoring via standard governance processes.	**See Evidence folder - Action 7.1 (Report for last month's Datixes)**		
7.2		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**The ward do not have 12 hour receptionist cover which impacts on oversight of people entering and leaving the ward:** **Action:** Recruit into the receptionist vacancy	**Maternity CQC Ops Group**	**Karen Ramdass**	**01.07.23**	**Blue**	Successfully recruited into vacancy candidate awaiting DBS check. 17/4/23 - no current vacancies 27.04.23: Current service: Gwillim establishment budget for receptionist is 1.73wte which does not facilitate 7/7 (08:00-20:00) receptionist cover. Recruitment: Interview into the current vacancy of 0.77wte took place on the 09/02/24, the proposed start date is 09/05/23. Vacant receptionist shifts are released to staff bank, but these mostly remain unfilled. Gaps in service: •To ensure there is 7/7 long day receptionist staffing the budget requires an additional 0.79wte. •To support 24-hour reception cover the establishment budget will require an additional 3.35wte. 15.05.23: Proposed start date is 12/06. Agreed plan (Bank or allocation of HCA to cover receptionist continues). **14/06/23: Receptionist now in post - CLOSED**	**See Evidence folder - Action 7.2**		
7.3		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**The ward do not have 12 hour receptionist cover which impacts on oversight of people entering and leaving the ward:** **Action:** Release vacant reception shift to bank	**Maternity CQC Ops Group**	**Karen Ramdass**	**03.01.23**	**Blue**	Covered when Bank staff filled.			
7.4		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**The ward do not have 12 hour receptionist cover which impacts on oversight of people entering and leaving the ward** **Action:** HCA or named staff to cover answering door access during day shift.	**Maternity CQC Ops Group**	**Karen Ramdass**	**03.01.23**	**Blue**	In the absence of a receptionist, if no bank staff available HCA or Housekeeper is allocated this task. **27.04.23:** In the absence of receptionist, it's the responsibility of the ward manager or midwife in charge to allocate a support worker to oversee visiting on the ward. Allocation of this staff member is done at the start of the shift, this is currently recorded in the midwife in charge handbook. If there is a shortfall of support staff due to short term sickness the ward housekeeper assists with monitoring of visitors onto the ward Monday -to Friday between 13:00 and 15:30. A note will be entered onto the shift of the person identified to undertake this role for audit purposes 15.05.23: As above.	**See Evidence folder - Action 7.4 (Roster to show allocation of taks - also included in escalation book on the ward)**		
7.5		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Visiting policy difficult to enforce due to staffing and inconsistent visiting information for patients.** **Action: Check and refine if needed Gwillim Visiting Policy for visitors to the ward, including:** * Request families name two visitors that they are expecting daily * Visitors to sign ward register to include time in and out of ward * Yellow wrist band for visitors and partners staying overnight * Midwife responsible for care on each shift to confirm partners staying on the ward is wearing a yellow wrist band * Staff to stop and challenge everyone entering the ward * New roles for HCAs to help with this process	**Maternity CQC Ops Group**	**Robyn Lofting**	~~**03.02.23**~~ **Revised deadline of 02.05.23**	**Blue**	**03.01.23:** New amended policy implemented from 03/01/23. Visiting book implemented **27.04.23:** SOP going to Maternity Ops Group on 02/05/23. Seeking clarification from Jan around where the Visiting SOP was discussed and signed off in the minutes. **04/05/23:** Approved at Maternity CQC Ops group following sign off by Maternity Governance Group (Jan to send evidence of meeting minutes). Now needs to be added to Trust Visiting policy as an addendum - evidence required (Paul to pick this up). **15.05.23:** Annabelle to chase MGM actions and minutes. **23.05.23:** MGM Minutes provided, confirming governance route. **15/06/23:** Paul has added to Trust website - COMPLETE.	**See Evidence folder - Action 7.5 (including MGM minutes and confirmation that policy is on the Trust website)**		
7.6		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Visiting policy difficult to enforce due to staffing and inconsistent visiting information for patients.** **Action:** Audit effectiveness of the new SOP after one month	**Maternity CQC Ops Group**	**Robyn Lofting**	**03.01.23**	**Blue**	27.04.23: The midwife in charge will undertake daily random checks of 5 patients to monitor compliance with partners wearing yellow wrist band. The ward manager will include auditing of partners wrist band and the visitors register for assurance purpose this will commence at the beginning of May. assure compliance by including this during her monthly ward audits. **10.05.23**: Evidence of visiting policy reminder during weekly audit provided - see evidence folder. **15.05.23:** Weekly audits taking place until the end of May - so far very positive, only two visitors who did not have a full understanding of the visiting policy. At the end of May Karen will amalgamate and come up with a formalised action plan as required. **17.05.23:** Annabelle to send over further evidence of audit today (action can then be closed).	**See Evidence folder - Action 7.6 (Evidence of Abduction SOP and Visiting policy comms and compliance; details of visiting audit - May)**		
7.7a		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Visiting policy difficult to enforce due to staffing and inconsistent visiting information for patients.** **Action: Awareness raising and comms around the new SOP and processes related to safely managing visitors to the ward, including:** * Staff training and education for the wider team, including HCA team on these new processes	**Maternity CQC Ops Group**	**Robyn Lofting**	**03.01.23**	**Blue**	**27.04.23:** There is no formal training regarding the visiting policy, changes to this policy have been discussed at ward hand over and daily huddle for the staff working on Gwillim.	**See Evidence folder - Action 7.6 (Audit completed to ensure staff understand and are complying)**		
7.7b		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Visiting policy difficult to enforce due to staffing and inconsistent visiting information for patients.** **Action: Awareness raising and comms around the new SOP and processes related to safely managing visitors to the ward, including:** *Comms to staff to advise around the new policies and SOP.	**Maternity CQC Ops Group**	**Robyn Lofting**	**03.01.23**	**Blue**	**27.04.23:** All staff were informed of the changes to the visiting policy via an email sent to all midwives 23/12/23 with new visiting guidance. Updated information was included in the "maternity communication" bulletin 12/01/23. The maternity website was updated 28/12/23 and Instagram update went live on the 10/01/23. The new policy was implemented on the 03/01/23. The ward manager and matron attended the community team leaders on the 25/04/23 to discuss changes to the visiting on Gwillim. **15.05.23:** Karen recirculated this wc 8th May and is still discussed at every huddle.	**See Evidence folder - Action 7.7b (Multiple comms via a range of different channels)**		
7.8		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Visiting policy difficult to enforce due to staffing and inconsistent visiting information for patients.** **Action: Training and comms around the new SOP and processes related to safely managing visitors to the ward, including:** * Patient Comms and Poster to advise why we are challenging visitors	**Maternity CQC Ops Group**	**Robyn Lofting**	**03.01.23**	**Blue**	* Visiting poster updated and displayed outside the ward * Website & social media updated with visiting information 27.04.23: instagram post provided and saved in evidence folder. 04.05.23: Signed off by MGM, Maternity Ops Group and CQC Steering Group. 15.05.23: QI Matron (with Comms) are designing a big banner with QR code to enable translation into different languages.	**See Evidence folder - Action 7.8 Gwillim Visiting Policy Poster**		

7.9		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Staff working in maternity currently wear scrubs - Staff to be clearly identifiable. All staff working on both wards to be in uniform.** **Action: Clarify uniform policy to staff** * Email reminder to be sent to staff re uniform policy and request with everyone to be in uniform when on duty * Send uniform request forms out to all staff	**Maternity CQC Ops Group**	**Robyn Lofting**	**31.05.23**	**Blue**	17.04.23: Discussed at ward meeting and daily ward huddle. Band 4 staff uniform are on order. Uniform poster displayed on the patient information board. Band 3/ B4 / B5 staff uniforms order has been placed with the Trust sewing room. 14/4/23 - review of compliance required for week 17/4/23. 17/4/23 - Matron reminded all staff to comply with uniform policy, order form attached to email. Aim for compliance by end May 2023. 27.04.23: Email sent to all Carmen and Gwillim staff requesting that everyone should start wearing uniform across the inpatient areas in March and October and November 2022. A reminder email was sent on the 17/04/23 Plan: Matron and Ward Manager to review compliance daily and ensure staff compliance by end June. **15.05.23:** All psters on display. Some issue around limited stock of uniforms but this being worked through by Karen.	**See Evidence folder - Action 7.9 (Uniform policy; Staff Comms)**		
7.11		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Staff working in maternity currently wear scrubs - Staff to be clearly identifiable.** **Action: Comms to patients on expectations around uniform** Source patient information poster of different uniforms	**Maternity CQC Ops Group**	**Robyn Lofting**	**06.04.23**	**Blue**	**04.05.23:** Evidence saved in evidence folder. **17.05.23:** Uniform compliance to be tested through ongoing monitoring.	**See Evidence folder - Action 7.11 (Uniform poster; Instagram post to patients)**		
7.12		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Source Tailgating poster from Comms and put up in appropriate areas.**	**Maternity CQC Ops Group**	**Robyn Lofting**	**01/03/23**	**Blue**	**27.04.23:** Evidence provided and saved.	**See Evidence folder - Action 7.12**		
7.13		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Staff from elsewhere using swipe access to enter ward outside of their work role.** **ACTIONS:** * Trust wide communications via Comms regarding staff accessing the maternity unit * Revise access to ward with Estates team	**Maternity CQC Ops Group**	**Dean Gornall**	**30/03/23**	**Blue**	30/03/23 ward entry doors has been changed to proximity card. Names of staff with authorised entry to the ward has been reviewed and finalised. Requests for access to clinical areas reviewed by DoM and Deputy DoM. **09/05/23:** Evidence provided by Dean Gornall and Chris Doherty and saved in evidence folder.	**See Evidence folder - Action 7.13 (Evidence of reset and new authorisation approach with authorisers)**		
7.14		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Antenatal education classes updated with the information on visiting times and rules** **ACTION:** Attend CMW meeting and meet with ANC staff**.**	**Maternity CQC Ops Group**	**Robyn Lofting**	**30/03/23**	**Blue**	Robyn Lofting to attend next CMW meeting to discuss changes to the ward visiting times 19/04/23 15.05.23: Met Band 7 Midwives in May and Karen is going back in June to meet B7s again.	**See Evidence folder - Action 7.14 (CMW meeting agenda)**		
7.15		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Add panic button on Carmen BC and antenatal ward with direct access to security**	**Maternity CQC Ops Group**	**Dean Gornall**	**01/02/23**	**Blue**	Not yet completed. 17/4/23 - Gwillim has an installed and working panic alarm on reception desk. Carmen request has been completed 25/04/23: Alarms fitted and tested - working.	**See Evidence folder - Action 7.15**		
7.16		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Share the key points of concern with the staff on the ward:** * Discuss the abduction drill findings at ward meeting and huddle staff handover * Develop a flow chart and an action list for staff reference in an emergency * Discuss visiting policy and abduction policy with all new members of staff plus bank and agency staff	**Maternity CQC Ops Group**	**Karen Ramdass**	**16.01.23**	**Blue**	27.04.23: Multiple briefings have taken place throughout wc 17th April and 24th April. 15.05.23: Meetings have taken place and briefing forms part of induction (being included in New Starters handbook) by Karen Ramdass. 28/06/23: Evidence provided of Gwillim ward manual for all new staff (this includes bank and agency staff). The manual is printed by media services.that all New starters evidence to be provided and details anti-abduction mitigations and processes for security. Closed.	**See Evidence folder - Action 7.16 (Ward meeting minutes; New starters manual/ handbook)**		
7.17		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Security presence everyday** **ACTION:** Identify funding (this would be a cost pressure for additional funding of 1.3WTE band 3/4 security staff) to ensure full security cover.	**Maternity CQC Ops Group**	**Cheryl Stewart, Maternity Improvement Lead**	**16.01.23**	**Amber**	**FUTURE SERVICE DEVELOPMENT - NOT LINKED TO CQC SECTION 29 RESPONSE** Funding was not agreed at OMG. Evidence of OMG discussion requested from Rachael B. Baby tagging approach to be explored first and then the need for security can then be reassessed. This will only be considered if Baby tagging not possible.			
7.18		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Security tags for babies** **ACTION:** Feasibility and Financial scoping assessment / options appraisal required - to review baby tags as potential security arrangement if needed.	**Maternity CQC Ops Group**	**Cheryl Stewart, Maternity Improvement Lead**	**16.01.23 (revised completion date of 09.04.23)**	**Amber**	**FUTURE SERVICE DEVELOPMENT - NOT LINKED TO CQC SECTION 29 RESPONSE** 13/4/23 - discussed at CQC review meeting. Financial assessment required - to review baby tags as potential security arrangement if needed. 24/04/23: Requires IT support for the system to be installed. 27.04.23: Whilst medical physics are starting to review, this needs joint work and support to progress and get costs and put a programme together – Jonathan Silver (Head of Clinical Engineering) is working on this and has asked for further information from the maternity team and I have sent to Cheryl as we may need support from the team. This is not likely to be able to be implemented for a few months so will need some focus if intended to be in for the end of June. 04/05/23: Still with Jonathan Silver - Cheryl to chase. 17/05/23: Jenni is working with Jonathan as this is more complex. 25/05/23: Three suppliers contacted so far (cost ranges from £37k and others £150k) - proposal by wc 5th June. 26/05/23: Further updates provided by Dean on Friday 26th - provisional report coming to SG on 8th June. 07/06/23: Outline paper circulated by dean G for discussion at SG. 08/06/23: Emily to carry out a reassessment of the Risk Assessment to establishment what the best option might be. Cheryl to brief Emily on options and dependencies (security guard, reception, baby tagging etc.). 12/06/23: Jan to arrange a meeting between Emily and Dean to discuss whether the interventions to date affect the Risk Assessment. 20/06/23: Initial meeting took place, further follow-up meeting taking place on 21st June with an update coming to SG on Thursday 22nd June. 22/06/23: Meeting this afternoon will determine whether a reduction in risk rating is appropriate given the other mitigations already put in place by this Action Plan. Options Appraisal to come back to Arlene by COP Monday balancing Baby-tagging and staffing interventions, to inform agreement about the way forward and what (if anything) needs to be included on this topic in the CQC letter. 28/06/23: Options Appraisal circulated last week. Finance input required to fully cost up options. Suggest re-allocation of this action to Cheryl and Joe and closing this action. 29/06/23: A number of mitigations have been put in place to mitigate the risk, so an Options Appraisal has been developed and circulated to Arlene regarding whether Baby Tagging is still required. The mitigations put in place are: • Panic button is installed and tested working – links direct to the Security office. Chris has also trained the staff on how to use • Estates have upgraded the CCTV and the door entry system, so they have much more visibility on who they are letting in and out • Estates have added additional access control on the outer doors (not live yet) and this will act as a triage area • Estates have removed access to anyone that is not linked to the Women's and Children's group • Additional lighting added into the lobby area **06/07/23:** New Risk Assessment completed by Emily and submitted to Divisional Governance (on the risk register (Maternity Unit Security Risk) under new risks waiting for approval). Updated Baby tagging Options Apprisal completed. The Risk Assessment will now be added to the Options Appraisal to further strengthen this paper.	**See Evidence folder - Action 7.18 (Baby tagging options appraisal; new Risk Assessment; updated Baby Tagging Options Appraisal.)**		
7.19b		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**ACTION:** Move the milk kitchen (from Fourth floor to Paeds) and use this space as reception area for both wards	**Maternity CQC Ops Group**	**Cheryl Stewart, Maternity Improvement Lead**	**30.04.23**	**Amber**	**FUTURE SERVICE DEVELOPMENT - NOT LINKED TO CQC SECTION 29 RESPONSE** Current item on the risk register for both Carmen and Gwillim maternity wards Current item on risk register for paediatric services due to distance between mixing feeds and to recipient 04/05/23: Not happened yet. Milk kitchen is still in situ and has not been moved. Action sitting with operational team to develop a BC to request money to make this move. **15.05.23:** Space needs to be identified upstairs on fifth floor to accommodate. No resolution so far. **17.05.23:** Cheryl to investigate whether the blocker is space or money, as well as explore alternatives with Estates. **05/06/23:** Cheryl and Jenni to check in to seek resolution and agree a plan moving forward.			

7.21		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Improved CCTV in the ward foyer** and along the corridor to both wards with upgraded VDU - 360 CCTV for improved coverage and visualisation to areas outside the ward	**Maternity CQC Ops Group**	**Dean Gornall, Deputy Director of Estates and Facilities (interim)**	**15.05.23**	**Blue**	**24.04.23:** Part of works already agreed and funded for completion in May 23 -see quotes and programme already submitted **09/05/23:** Estates team will be setting up a project group (meeting Wednesday) to undertake these works and will engage with clinical once a plan of action has been agreed. We are pressing for this to be completed by the end of May, very early June. **17.05.23:** Work started on 16th May and on target for first week of June completion. **01/06/23:** AA7.21 and 7.22 - Improved CCTV in the ward foyer and along the corridor to both wards with upgraded VDU - 360 CCTV for improved coverage and visualisation to areas outside the ward The CCTV and Access control has been installed and will be live by Monday. VLAN and IP address required **16/06/23:** Improved CCTV in the ward foyer and along the corridor to both wards with upgraded VDU - 360 CCTV for improved coverage and visualisation to areas outside the ward •CCTV cameras are working and visible by Security but not locally. The local monitoring PC's need to be setup differently by IT . They need: oSt Georges Login (service desk) oAvigilon installed on St Georges account (Desktop Team) oCyber Security lockdown (Desktop Team) •All the above need to be implemented by different departments within IT. Estates have started the process of getting these implemented **22/06/23:** Monitors now installed. Confirmed by Dean Gornall (Deputy Director of Estates and Facilities (interim))- COMPLETE.	**See Evidence folder - Action 7.21**		
7.22		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Ward doors not visible from reception desk therefore unable to clearly visualise who is entering the ward** **ACTION:** Replace the current desk with a curved desk that facilitates the visualisation of the main door into and out of Gwillim ward, increasing and enhancing safety of women and babies. This meets the requirements of one element of reducing risk as outlined in the Abduction action plan. In addition it aligns with IG requirements for protecting patient data.	**Maternity CQC Ops Group**	**Dean Gornall, Deputy Director of Estates and Facilities (interim)**	**24.06.23**	**Blue**	**24.04.23:** Gwillim Ward - proposals now received - PO to be raised w/c 24th April - Facilities linking with IT to support - lead time maybe 6-8 weeks however then works can begin - quote and drawing submitted already to programme lead as evidence. **04/05/23:** Work ongoing and estates update is that this work is on time. **09/05/23:** Estates team given a four-week lead time last week - pressing for this to come in before the end of May (further evidence saved). **17.05.23:** Due to be installed on 27th May. **01/06/23:** AA7.21 and 7.22 - Improved CCTV in the ward foyer and along the corridor to both wards with upgraded VDU - 360 CCTV for improved coverage and visualisation to areas outside the ward The CCTV and Access control has been installed and will be live by Monday. VLAN and IP address required. **16/06/23:** Ward doors not visible from reception desk therefore unable to clearly visualise who is entering the ward The new reception desk has been installed however we have had some challenges with the wiring. Pole had to be removed and data and power need to be fully relocated. Works due to be completed today. DG to send regular updates to the teams). **22/06/23:** Reception desk now fitted. Confirmed by Dean Gornall (Deputy Director of Estates and Facilities (interim))- COMPLETE.	**See Evidence folder - Action 7.22**		
7.23		***Completion of recommendations from Abduction Drill***	**15.11.2022**	**Inadequate lighting along the corridor onto the ward and in the ward foyer**	**Maternity CQC Ops Group**	**Dean Gornall, Deputy Director of Estates and Facilities (interim)**	**30.04.23**	**Blue**	**24.04.23:** Lighting that was not working has now been fixed and put back in use. Review of ceiling tiles and changes in lighting to be carried out and then funding agreed for changes to be made - programme and approvals to be updated once review has been carried out. **09/05/23:** Update from Estates - Whilst this action sits with Estates it needs to be assigned to Infrastructure Projects. We have requested a quotation and schedule of works as this will disrupt the area. (3 days work). This will need to be stripped out and there will be drilling into the ceiling to have the ceiling grid. This was a 'nice to have' so a discussion point on whether this needs to go ahead would be useful. **15.05.23:** Sensor light now installed which enables staff to identify who is at the door at night. Agreement that this is a lower priority than other actions. **17.05.23:** Wider plan to link all lights to a sensor - Dean to further explore this option and report back. **01/06/23:** The lighting is fine however, on the main circuit for the whole ward. A new sensor light has been installed in the area so in theory the job can be closed. I do, however, still want the foyer lights to have their own sensor so will progress with this. **16/06/23:** The lighting is fine and a new sensor light installed however it would be beneficial to have the lobby on its own circuit with a sensor - Job pending with Infrastructure Projects but this in theory can be closed because this is an optional extra and not a requirement. Closing.			
7.24		***Completion of recommendations from Abduction Drill***	**15.11.2022**	Additional Magnet locks to external double doors into glass corridor to create additonal secure point of entry and exit	**Maternity CQC Ops Group**	**Dean Gornall, Deputy Director of Estates and Facilities (interim)**	**15.05.23**	**Blue**	**24.03.23:** This is part of the overarching works as submitted already for the areas identified. Works to be completed in May 23 depending on Procurement lead times. **04/05/23:** Procurement delays mean that installation date has been pushed back to end of first week in June. **15.05.23:** CCTV (Action 7.21) is required at the same time otherwise the mag locks are pointless as there will be no way to visualise the person buzzing. **17.05.23:** Started yesterday, on track for start of June completion. **01/06/23:** To be installed WC the 5th. **16/06/23:** Works completed however, we cannot liven up the system due to 7.19b. Still no contact made despite numerous requests to meet. •Access Control is in and working on Gwillem Entrance , Carmen Entrance and unlocked on Main Lobby as requested •Intercoms are working fully , old inte.rcom in the process of being removed **26/06/23:** Mag locks fitted– Complete –staff names required for milk kitchen. Will go live on Monday 26th June	**See Evidence folder - Action 7.24 (Programme of works)**		
7.25		***Completion of recommendations from Abduction Drill***	**17.05.23**	Uniform compliance spot check to tested compliance with uniform policy.	**Maternity CQC Ops Group**	**Cheryl Stewart, Maternity Improvement Lead**	**01.08.23**					
7.26		***Completion of recommendations from Abduction Drill***										
7.27		***Completion of recommendations from Abduction Drill***										
7.28		***Completion of recommendations from Abduction Drill***										
7.29		***Completion of recommendations from Abduction Drill***										
7.31		***Completion of recommendations from Abduction Drill***										
7.32		***Completion of recommendations from Abduction Drill***										

Complete outstanding Estates works

01/09/2023 Last

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Must/Should Do	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
9.1	*Estates*	*Electrical safety*	*22.03.23*	*Section 29A*	**PAT testing**	**Maternity CQC Ops Group**	**DoE Jenni Doman**	**06.04.23**	**Blue**	**Contract had expired** **Contract renewed and process re-instated** **11.04.23 Teams undertaking PAT testing across maternity** **14.4.23 PAT Testing complete in all areas that were accessible to the testing teams** **w/c 17.04.23 Certificates issued - back-up log of all equipment tested to be issued w/c 17.4.23** **26.04.23 - Comms to seek opening of remaining offices to enable final PAT testing to be completed.** **27.04.23 - 99% of items have been tested (986 items and evidence provided) there are 8 rooms that could not be accessed so we have amended the tracker to reflect this and the maternity team have been asked to contact a specific estates manager to action these remaining areas and evidence will then be updated and tracker amended.** **28.04.23 - All PAT testing completed bar one room.** **09/05/23:** This is 99% complete except room LNS 1.094. I have asked the Electrical team manager to get involved and get access and sort this out. **10/05/23:** Final room now complete.	* See Action 9.1 Evidence folder		As per Electrical Safety Policy: Electrical Safety Group and updated PAT testing process - part of annual Premises Assurance Model (PAM)
9.1b	*Estates*	*Electrical safety*	*10.05.23*	*Section 29A*	**New PAT testing process rhythm to be developed for Maternity**	**Maternity CQC Ops Group**	**Dean Gornall**	**17.05.23**	**Blue**	**01/06/23:** Feedback from Dean Gornall - We do have a new PAT test policy that hasn't been ratified by any groups. I am not satisfied with the content and is not realistic in terms of user checks. I will develop a one pager for user checks that can be circulated and documented as evidence. Simple visual inspection of condition, label in date etc. I don't believe this is a requirement for the CQC to have this as this discussion came later. I will review the PAT testing policy with Jenni. **16/06/23:** To be complete by the end of this week. **27/06/23:** Final version saved in evidence folder.	* See Action 9.1b Evidence folder (Draft SOP for PAT Testing going forward)		
9.2	*Estates*	*Backlog of estates jobs*	*22.03.23*	*Section 29A*	**Determine outstanding jobs and prioritise those remaining**	**Maternity CQC Ops Group**	**DoE Jenni Doman**	~~06.04.23~~ 30/07/23	**Blue**	**24.3.23 All outstanding logs reviewed and actions taken to rectify and update - sent to Divisional Tri weekly updates issued with progress - all logs except new works due to be completed by 21.4.23** **11.04.23 - New works to be prioritised with Senior Midwifery team meeting to be held w/c 17.4.23** **09/05/23:** 406 jobs completed, 19 jobs remain outstanding, 15 could be completed before the end of June if all goes to plan, four jobs will surpass June. **10/05/23:** Current status is 15 of 19 outstanding jobs are planned to be completed by 16th June - 4 jobs that are longer term or delayed to be escalated to the Steering Group for action / deliberation. Further update from Bharat requested. **18/05/23** •5 x job completed – Entonox capped off (no ventilation at all within that room – under review with Khodr) •11 x jobs on track to be completed before the 16th June • Shower refurbishment – each unit will take 4 weeks once agreed. • Wall removal – not approved • Birthing pool (4 weeks) • Hand dryers – not approved by IPC - sent to Arlene for further consideration. **01/06/23:** •5 x jobs completed •Forget me not facility has been handed over. Khodr has mentioned a shower screen has been requested and is on order but does not impact on service Jobs that will be completed prior to the 24th June are: • Reception Desk – next week • Birthing pool – kick off install on the 07/06/23 and hopefully completed by the 13/06/23 • Blinds in visitor room – 01/06/23 The jobs that will still be outstanding before the QCQ response will be •LNS-4.119, Gwillim WC/ Shower - leakage thru to other underneath ward. (Flooring is not the issues, shower tray needs replacing) – End of June •Refurbish shower rooms & toilet – (scope of works is being completed - £7k per unit and 4 weeks completion so 6 x 6 = £42k and 28 weeks) this will need financial approval. •Benching needed to create more space and desks to be removed LNS-4.022 FETAL MEDICINE Cardiac Research (Programme of work will be issue w/c 29/05 and work expected to complete by end of June) •Wall removal - LNS-4.018 FETAL MED DAY ASSESMENT RM - Wall between reception and FMU office to be removed (Structural report will be issued w/c 29/05) - If this can be done and approved then can be done by the end of June. Severe disruption to services. Suggest we remove from the list completely **05/06/23:** Hand dryers now signed off by IPC and being installed. Birthing Pool to be progressed over the next week.	Weekly updates sent to all senior divisional team, CNO, MD - finalised log to be issued once completed for evidence See Evidence Folder Action 9.2		KPI's and reporting are being reviewed and Estates Assurance group being reset to oversee reporting; challenges with age of estate and lack of resources being reviewed for additional support in delivery of all estates maintenance rectifications to reactive maintenance logs
9.3	*Triage*	*Standardising practice* *Reducing risk*	*22.03.23*	*Section 29A*	**Completion of outstanding estates works to support flow for Triage across 1st and 4th floors**	**DIV TRI** **Maternity CQC Ops Group**	**DoE Jenni Doman**	**06.04.23**	**Blue**	**The Infrastructure project team add the following changes to the existing assessment room : initial programme as below** **•4 Med gas points on the window wall. 0-2 weeks** **•1 Nurse call system. 0-2 weeks** **•1 privacy curtain. 0-2 weeks** **•1 WHB. 4-6 weeks** **There has been some delay due to constraints with contractor and also the room design - further programme to follow w/c 17.4.23** **26.06.23 - Updated works programme recieved and added to evidence folder.** **09/05/23:** Medical gas works completed. However, Entonox has been capped off due to the need to ensure we have the relevant air changes within that environment. **18/05/23** •Med Gas points complete. Entonox has been capped off as we need to review the air changes in room – (duplicate of above - no ventilation in that room at all – under review with Khodr) •Nurse call system – Quote receive – £9k, works approved, PO to be raised. Works usually commence two weeks after PO has been received – Scheduled completion end of May •Privacy curtains – proposed install today – 17/05/23 – Curtains for "forget me not" – two weeks. •WHB – Order was placed last week, and Estates are saying a two-week lead time (IPS panels and Basin are on order pending delivery). Install should happen WC 22nd May (update supplier being chased to ensure still on schedule) **01/06/23: All jobs will be completed before the CQC response is required** •Med Gas - complete (Entonox isolated) •Nurse call system – works start 02/06/23 (outside controller), 09/06/23 (internal works) •Privacy curtains – 01/06/23 •WHB – complete **05/06/23:** Need to check with Dean and Jenni that the door frame is large enough to enable access in the event of an emergency. WR to chase up (Done). **16/06/23:** Works outstanding - Nurse call – starting 21st and to be completed by the 23rd. **22/06/23:** All complete apart from Door Frame which needs Assessing. This is not an essential piece of work so can be marked closed. •Med gas complete •Nurse call system complete	Completion of room changes and sign off following commissioning. See Evidence folder Action 9.3		This will be built into the normal Estates Maintenance processes - midwifery team to report any concerns as per procedures already in place.
9.4	*Estates*	*Standardising practice* *Reducing risk*	*14/08/2023*	*CQC Report 17/08/23 - Must Do*	**Completion of AC work in Mortuary Suite.** This was not in the original plan but is a new task which is important for patient and staff experience.	**DIV TRI** **Maternity CQC Ops Group**	**Dean Gornall**	**30.08.23**	**Green**		Completion of room changes and sign off following commissioning. See Evidence folder Action 9.3		This will be built into the normal Estates Maintenance processes - midwifery team to report any concerns as per procedures already in place.
9.5	*Estates*	*Backlog of estates jobs*	*14/08/2023*	*CQC Report 17/08/23 - Must Do*	**46 outstanding jobs on the overall Estates log, some date from April.** **Action:** Dean to review and report back where there are any concerns about delivery.	**DIV TRI** **Maternity CQC Ops Group**	**Dean Gornall**	**21.08.23**	**Green**	**Estates team is currently 7 engineers down.**			

END

Safe staffing: Ensuring adequate staffing levels, with establishment reflected on Healthroster and appropriate triggers and monitoring in place

01/09/2023 *Last updated*

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual
Green = On target with evidence of progress supplied

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
10.1	***Staffing***	***Current & Recruitment***	***22.03.23***	Review new starters to identify when WTEs come onboard	Maternity CQC Ops Group	Jan Bradley	06.04.23	**Blue**	**15.05.23:** Staffing onboarding profile has been built into staffing tracker (10.2). New starters come on board in September. Dynamically reviewed each week and updated with any changes. **Recommend closing (and 10.2).** **27/06/23:** Latest version saved.	*** See AA10.2 Evidence folder**		
10.2	***Staffing***	***Current & Recruitment***	***22.03.24***	Create Recruitment Pipeline tracker to keep visibily of staffing inflows and outflows	Maternity CQC Ops Group	Jan Bradley	03.04.23	**Green**	The tracker will be reviewed and updated on a weekly basis by local team (Annabelle, Jan and Finance). **22/06/23:** Establishment still being reviewed, once finalised the trackler will launch.	*** See AA10.2 Evidence folder**		
10.3	***Staffing***	***Current***	***22.03.23***	Request RN support from the Trust to work in HDU and Gwillim postnatal ward to cover 24/7 service	Maternity CQC Ops Group	Jan Bradley	06.04.23	**Blue**	22.03.23 - request sent out to Bank/Agency/Trust 30.03.23 - request sent out to Bank/Agency/Trust 11.04.23 - limited success 15.05.23: Occurs on daily sit rep. 3 x RNs already recruited, and 3 Irs being onboarded for their PIN.			
10.4	***Staffing***	***Current***	***22.03.23***	Live adverts and rolling recruitment for Band 6 MW's to be continued – Preceptorship Band 5's going out in April	Maternity CQC Ops Group	Jan Bradley	06.04.23	**Blue**	22.03.23 - confirmed recruitment live 30.03.23 - JB to chase incentives suggested to support recruitment; JL drafting figures 11.04.23 - interviews set for 20th April HB - 1 applicant Band 5 - 51 applicants Band 6 - 2 applicants	**Adverts live on NHS jobs** *** See AA10.4 Evidence folder**		
10.5	***Staffing***	***Current***	***22.03.23***	Birth Rate Plus Safer Staffing tool, 4 hourly reporting outcomes to be shared across the unit.	Maternity CQC Ops Group	Annabelle Keegan	06.04.23	**Blue**	22.03.23 - JH Matron to lead and circulate data 30.03.23 - JH to lead and drive 11.04.23 - BR plus red flags reported; liasied with Ass Director for Beds and Flow re escaltion across Trust	*** See AA10.5 Evidence folder (Red flags communication)**		
10.6	***Staffing***	***Current***	***22.03.23***	Work completed to finalise the revised and corrected E-roster templates across maternity separating blended areas	DIV TRI Maternity CQC Ops Group	Annabelle Keegand and Sian Weller	06.04.23	**Green**	22.03.23 - underway and confirmation from HoF JL required to offer assurance. 30.03.23 - JL to meet with AK W/C 11.03.23 to review work done to date 11.04.23 - DDoM - revisiting work with E-roster team 15.05.23: Half has been completed with Sian. Further meeting next week (23rd May - PM) to finalise second half. 30/05/23: Annabelle completed roster with Sian on Tuesday 30th May. 01/06/23: Final step is revised Establishment approval from Natilla and Finance. This can then go live in October. 22/06/23: Establishment still being reviewed, once finalised Healthroster will be updated.			
10.7	***Staffing***	***Current***	***22.03.23***	Confirm WTE for DS	DIv TRI Maternity CQC Ops Group	Annabelle Keegan	06.04.23	**Blue**	31.03.23 - Review and confirm DS establishment as displayed on E roster 11.04.23 - DDoM to action as above 15.05.23: Linked to Action 10.6. Should be completed by COP Friday 2nd June. 22/06/23: Establishment still being reviewed, once finalised Healthroster will be updated - being managed through Action 10.6 and 21.25 (copied below from SG) - CLOSING.			
10.8	***Staffing***	***Recruitment***	***22.03.23***	Consider recruiting into vacant Band 5 at midpoint to match RRP offerd by Kingston and ESTH.	DIV TRI Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Lead	06.04.23	**Blue**	30.03.23 -HoF Joseph Lewis mapping figures **15.05.23:** Need feedback from Joe Lewis. **17.05.23:** Initially considered but now outside the remit of this group so closing. Being picked up at a Trust level.	**See Action 10.8 - evidence folder**		
10.9	***Staffing***	***Recruitment***		Request to over recruit Band 5 cohort in April by 10 to allow for further 7% attrition and additional vacancies by onboarding in Oct/Nov 2023	DIv TRI Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Lead	06.04.23	**Blue**	30.03.23 - HoF Joseph Lewis mapping figures 06.04.23 - G Execs agreed to offer 15TWE in April interviews Complete recommend closing.	**See Action 10.9 - evidence folder**		
10.11	***Staffing***	***Recruitment***	***22.03.23***	Consider offering RRP for Band 6 midwives (as hard to recruit staff) to improve skill mix and get staff in immediately	DIv TRI Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Lead	06.04.23	**Blue**	Risk - affect of having to uplift other band 6 staff De-stabilise SWL 15.05.23: See Action 10.14 **17.05.23:** Initially considered but now outside the remit of this group so closing. Being picked up at a Trust level.			
10.12	***Staffing***	***Recruitment***	***22.03.23***	Consider an alternative to above - recruit substantive Band 7 R&R Lead	DIV TRI Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Lead	06.04.23	**Blue**	£70K cost pressure - business case **15.05.23:** Need an update from Tayo/ Cheryl on BC. **17.05.23:** Initially considered but now outside the remit of this group so closing. Being picked up at a Trust level. Full establishment review ongoing.			
10.13	***Staffing***	***Recruitment***	***22.03.23***	Consider approval of cost pressure of an additional 2.0 WTE Band 7 DS coordinators to support Supernumerary status – Ockenden requirement – keep Fetal Monitoring and HDU leads ringfenced and out of DS numbers - CNST requirement and safety - HSIB	SITE LEADERSHIP TEAM DIV TRI Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Lead	06.04.23	**Blue**	£140K cost pressure - business case 15.05.23: Need an update from Tayo/ Cheryl on BC. 22/06/23: Establishment still being reviewed. Latest analysis shows that sufficient numbers of B7s exist, but there are shortfalls in other bandings. Closing as per Action 21.53.	**See Evidence folder - Action 10.13 (B7 Business Case: Short and Long Form - now paused following further Establishment review)**		
10.14	***Staffing***	***Escalation***	***22.03.23***	Rapid Response Bank team costings	Maternity CQC Ops Group	George Harford	~~15.05.23~~ 21.07.23	**Green**	06.04.23 - request by DoM to finance to model figures 11.04.23 - Finance JL - generated figures for Rapid Response - DoM to map out logistics of actioning 08/06/23: Cheryl to include in the Future Service Improvement section within the CQC letter. Rationale is that B7 BC and CQC response takes priority with RRT in phase 2. 20/06/23: Cheryl has included reference to this work in the CQC letter.	**See Evidence folder - Action 10.14**		

21.24			27.04.23	Develop an Options Appraisal for Rapid Response Team.		Cheryl Stewart, Maternity Improvement Manager	~~15.05.23~~ 21.07.23	Green	04/05/23: On track. Due week after next. 17.05.23: Still being worked on but due to capacity this has not yet been completed. 25/05/23: Further discussions required around phasing of this work to take place at Maternity Ops Group on Tuesday 30/05/23.. 30/05/23: Working up this week using Divisional costings and taking to Divisional Tri at the end of this week (02/06/23). Speaking to East Sussex for transferable knowledge / concepts. Rachael to look into ESH examples as well. 05/06/23: Agreed in Ops Group that this will form part of Phase 2 of the staffing response (i.e. commencing after Section 29 response). Recommend closing and adding to 'Safe Staffing' (AA10) as a follow-up action. 08/06/23: Cheryl to include in the Future Service Improvement section within the CQC letter. Rationale is that B7 BC and CQC response takes priority with RRT in phase 2. 20/06/23: Cheryl has included reference to this work in the CQC letter.			
21.25			27.04.23	**Establishment Review:** Update next Steering Group about the Staffing Roster template (4th May) including Tableau triggers.		Jan Bradley	04.05.23	Amber	**04/05/23:** All areas completed apart from Community and maternal medicine. Expected to be completed 18th May. Once complete this will come to the Steering Group. **15.05.23:** Half has been completed with Sian. Further meeting next week (23rd May - PM) to finalise second half. **25/05/23:** A further meeting is required to complete this work. Estimated delivery date - 02/06/23. **30/05/23:** Annabelle completed roster with Sian on Tuesday 30th May. **01/06/23:** Final step is approval from Natilla and Finance. This can then go live in October. **08/06/23:** Final step is approval from Arlene in terms of establishment templates (Establishment templates completed in draft form - will be submitted COP Monday 12th June- see Action 21.54). Final approval then required from site - Natilla and Finance - once completed this can then go live in October. **15/06/23:** Anomalies identified around finances. Further work required to finalise the templates next week. **20/06/23:** Jan had a further meeting with Joe and Annabelle Tuesday AM. Now confident that the templates are correct. Joe will work through any anomalies around the background formula update and then circulate to Arlene and Steph for final sign off. Healthroster will then be updated. This will then feed into B7 BC completion (Action 21.53). **22/06/23:** Final run through with Jan, Arlene and Steph (aiming for final approval) on Friday 23/06/23. 29/06/23: Meeting next week to resolve. 06/07/23: Outcome pending.			

Clearer Site escalation processes (OPEL status, attendance at bed meetings)

01/09/2023 *Last updated*

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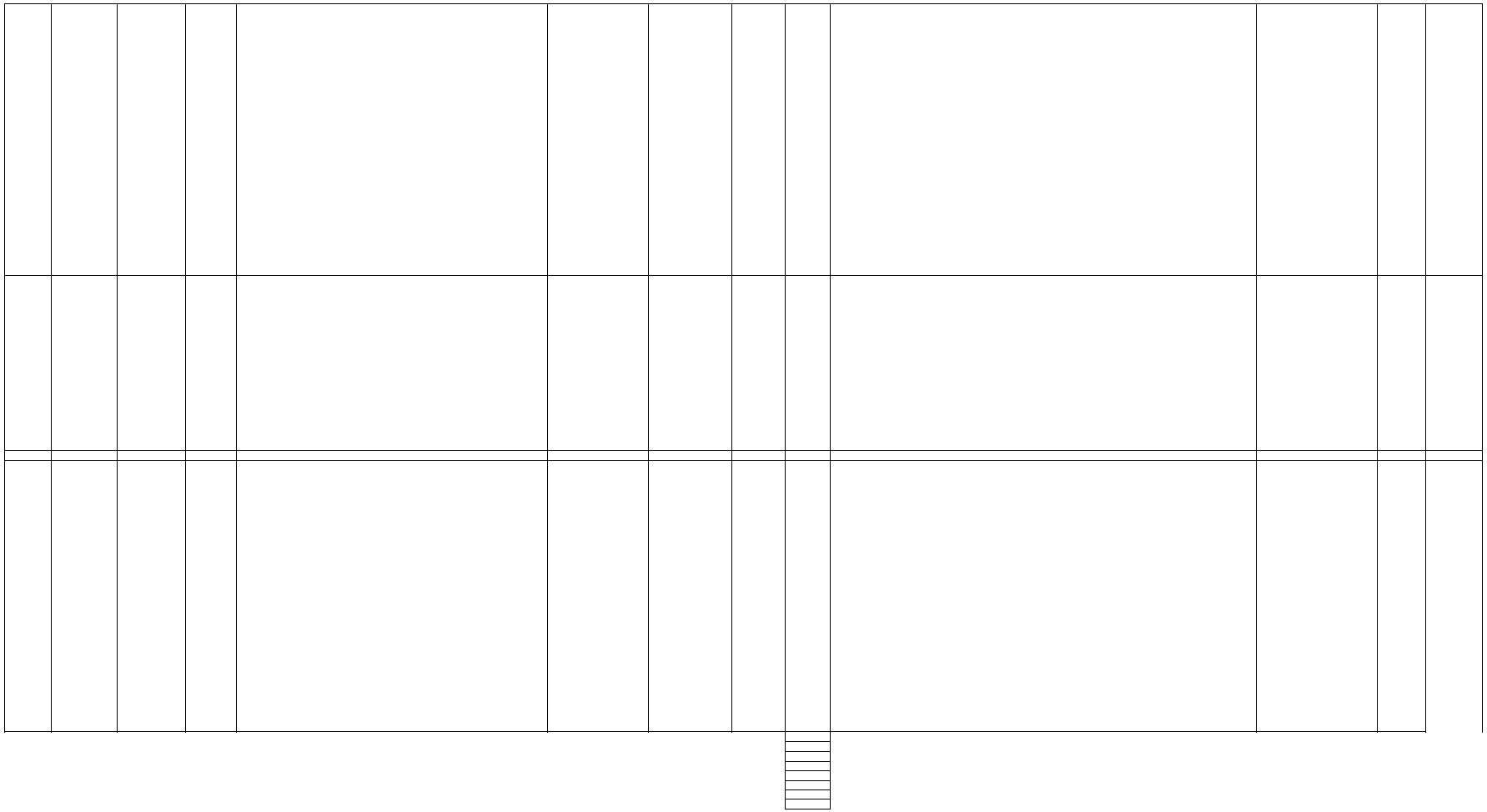
Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
12.1	*Staffing*	*Escalation*	04.04.23	Develop and circulate Draft SGH Maternity Sit Rep report for review, comment and decision about sign off.	MGM DIV TRI Weekly Assurance	Rachael Benson	11.04.23	Blue	04.04.23 - Maternity team devised local Sit Rep form 11.04.23 - Sit rep completed and circulated			
12.2	*Staffing*	*Escalation*	22.03.23	Determine what is required on the maternity sit-rep report with Tara/Natilla	Maternity CQC Ops Group	Jan Bradley, HoM	10/04/2023	Blue	24/04/23: Jan to meet with Arlene, agree Sit Rep structure and produce a single paper that summarises the triggers and actions. 26/04/23: Meeting on 27th April before Steering Group meeting 02.05.23: Conversation with Arlene focused on ensurring that each trigger was well understood and explained. Closed - see Action 21.21 below			
12.3	*Staffing*	*Escalation*	22.03.23	**Sit Rep** Design the format for the sit-rep which includes the OPEL status	Maternity CQC Ops Group	Jan Bradley, HoM	10/04/2023	Blue	Uses ESTH approach. 04/05/23: Sit rep form to be picked up again at the next Maternity Ops Group. 17/05/23: Agreement with Tom McGill to refine Sit rep approach. 26/05/23: new Site Rep form finalised and succesfully launched. 30/05/23: Compliance at the weekend - new Sit Rep launched and process is embedding. Evidence provided. 01/06/23: Further refinement made to the Sit Rep following request from Arlene. Awaiting confirmation from Arlene that she is happy. 11/06/23: Awaiting feedback - revised, streamlined version with Arlene for final approval. 15/06/23: Arlene has requested further changes and will come back to the next SG. 20/06/23: Awaiting further Sit Rep feedback from Arlene. 22/06/23: Meeting to be set up between Arlene and Jan to discuss latest version and seek agreement on a final draft. 28/06/23: Catch up hasn't taken place yet. 06/07/23: Meeting next week to resolve (to incorporate staffing template). **17/08/23:** Updated Sit Rep form circulated by Jan on evening of 17th August.	**See Evidence folder - Action 12.3 (New Sit rep form being used in practice; further refined version; latest version - v4 saved 17/08/23)**		
12.4	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities:** Agree approach for escalation of acuity and staffing to be effectively communicated up to senior leaders	Maternity CQC Ops Group	DoM Jan Bradley	06.04.23	Green	31.03.23 - SIT REP revised 03.04.23 - Staffing update circulated out to DDNG's, & CNO following site staffing meeting 06.04.23 - OPEL status of maternity to be communicated at Daily Staffing meeting and Bed Meeting 06.04.23 - DoM sought support and feedback from AD for Beds and Flow - Paul Cloves 11.04.23 - DDoM liaised with Assistant Director for Beds and Flow re automated fill and escalation across Trust 15.05.23: Further work ongoing with Paul Cloves to amalgamate and align approach with site team. 31/05/23: 4th draft of the Escalation Policy received from Paul and Tom today. Jan also linking in with ESTH around proposal for local diverts within GESH before we ask for sector help. Deadline end of next week agreed - 9th June. 06/06/23: New version circulated by Jan for comments - see AA21 - Action 21.11 11/06/23: Paul Cloves Associate Director for Flow has now confirmed he is happy with the policy so Jan will now circulate to her team for wider input, once ready it will go to MGM and then through to Divisional Board for noting. That version will then will be incorporated into the Trust Escalation Policy. Jan to confirm final deadline. 20/06/23: Final draft complete. Awaiting final feedback from B7 colleagues and will then progress to MGM. 27/06/23: Progressing to MGM.	**See Evidence folder - Action 12.4 (Draft Escalation Policy) - and final version which is now progressing to MGM).**		
12.5	*Staffing*	*Escalation*	22.03.23	**Sit Rep** **Roles and Responsibilities:** Determine who is going to receive the sit-rep and intervals with Tara/Natilla	Maternity CQC Ops Group	Tara Argent, COO	10/04/2023	Blue	24/04: 0930 and 1530 sit rep completion agreed each day. **02/05/23:** Approach to be reviewed next week as currently quite arduous / time-consuming for the team. 26/05/23: new Site Rep form finalised and succesfully launched, including who receives sit rep.	**See Evidence folder - Action 12.3 (New Sit rep form being used in practice)**		
12.6	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities:** Attendance at all Trust Site meetings by maternity representative	Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Manager	11/04/2023	Blue	**04.05.23:** Cheryl Stewart is attending for Maternity at every site meeting. **26/05/23:** Rota agreed sharing the responsibilities between Maternity Ops team. **22/06/23:** Regular attendance at site meeting confirmed.	**See Evidence folder - Action 12.3 (New Sit rep form being used in practice)**		
12.7	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy:** Ensure the OPEL status for Maternity are in line with National Guidance with Trust EPRR Manager	Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Manager	12/04/2023	Blue	15.04.23: Need to align approach with new national approach to OPEL which splits out: - Site - Maternity - Paeds Embed approach in revised Sit rep form following conversation with Paul Cloves and Arlene. **26/05/23:** Embedded in the sit rep. Ongoing work by Paul Cloves and Tom McGill to update Escalation Policy (see Action 12.4). **11/06/23:** Paul Cloves Associate Director for Flow and Site Team has now confirmed he is happy with the policy	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul Cloves, Director Flow and Site Team**		
12.8	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy:** Actions on OPEL triggers to be signed off by Site Flow Director (Paul Cloves).	Maternity CQC Ops Group	Michael Laing, EPRR Lead	12/04/2023	Blue	**26/05/23:** Ongoing work by Paul Cloves and Tom McGill to update Escalation Policy (see Action 12.4). **11/06/23:** Paul Cloves Associate Director for Flow and Site Team has now confirmed he is happy with the policy	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul**		
12.9	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities (Training):** OPEL status training for all Maternity staffing groups including triggers/ actions/ de-escalations	Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Manager	12/04/2023	Blue	**26/05/23:** Embedded in the sit rep. Awaiting completion of Escalation Policy (see Action 12.4). See Action 12.16 - CLOSED **11/06/23:** Paul Cloves Associate Director for Flow and Site Team has now confirmed he is happy with the policy	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul Cloves, Director Flow and Site Team**		
12.11	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Comms:** Determine and communicate Daily Rhythm of OPEL status to staff and site team	Maternity CQC Ops Group	Jan Bradley	10/04/2023	Blue	**26/05/23:** Embedded in the sit rep. Awaiting completion of Escalation Policy (see Action 12.4). **11/06/23:** Paul Cloves Associate Director for Flow and Site Team has now confirmed he is happy with the policy See Action 12.16 - CLOSED	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul Cloves, Director Flow and Site Team**		
12.12	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities:** Determine which member of staff on each shift is going to ensure all actions at each OPEL status are carried out and assurance these have been done	Maternity CQC Ops Group	Jan Bradley	10/04/2023	Blue	**26/05/23:** Embedded in the sit rep. Awaiting completion of Escalation Policy (see Action 12.4). **11/06/23:** Paul Cloves Associate Director for Flow and Site Team has now confirmed he is happy with the policy See Action 12.16 - CLOSED	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul Cloves, Director Flow and Site Team**		
12.13	*Staffing*	*Escalation*	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities:** Escalation and De-escalation protocol to be determined and communicated to staff	Maternity CQC Ops Group	Jan Bradley	12/04/2023	Blue	See Action 12.16 - CLOSED	**See Evidence folder - Action 12.7 (Agreed Escalation Policy and confirmation email from Paul Cloves, Director Flow and Site Team**		

12.14	***Staffing***	***Escalation***	22.03.23	**Develop Escalation Policy** **Roles and Responsibilities:** Embed Red Flags into practice and through escalation	Maternity CQC Ops Group	Emily Kaliwoh	06.04.23	**Blue**	06.04.23 - circulate Birth Rate out every four hrs 06.04.23 - cascade of completed SIT REP to CNO group 11.04.23 - BR plus and redflags report generated. **31/05/23:** Action re-assigned to Emily. **27/06/23:** Evidence provided, action closed.	**See Evidence folder - Action 12.14 (Birth rate red flags report; evidence of changes to practice to ensure red flags are discussed daily and embedded in practice)**		
21.22	***Staffing***	***Escalation***	20.01.23	**Site team engagement:** Annabelle to meet with Paul Cloves to discuss: - Setting Tableau triggers linked to staffing levels - Clarifying escalation policy and roles and responsibilities between Maternity and site teams (Copied from Steering group AA21)	Maternity CQC Ops Group	Annabelle Keegan	27.04	**Blue**	**26/04/23:** Confirmation that meeting is on 27th April at 20th April meeting. Feed back at next week's meeting. **04/05/23:** Paul postponed the meeting to next week (Friday 12th May). **15/05/23:** Annabelle and Jan have chased. Meeting with Tom McGill on 17th May to discuss merging the local escalation policy and sit rep. Tom is working on this (estimated completion date of first draft - 19/05/23). **22/05/23:** Tom draft received. Meeting with Paul will take place on Wednesday 24/05/23 to discuss Tom McGill's draft. Natilla to prompt Paul and Tom to support fast turnaround of the Escalation Policy. **25/05/23:** Third meeting took place on Sit Rep on 24th - a few adjustments required and will then be cascaded out. Meeting with Paul to discuss Maternity alignment with new London Plan, new Trust policy and site team approach. Revised Sit rep (ready next week). Escalation policy (aiming for end of June). **31/05/23:** 4th draft of the Escalation Policy received from Paul and Tom today. Jan also linking in with ESTH around proposal for local diverts within GESH before we ask for sector help. Deadine end of next week agreed - 9th June. **11/06/23:** Paul Cloves Associate Director for Flow has now confirmed he is happy with the policy	**See Action 21.11 (including confirmation email from Paul Cloves, Director Flow and Site Team)**		
21.21	***Staffing***	***Escalation***	20.01.23	**Sitrep form:** Jan and Arlene to sit down and go through the Sit rep form and agree a plan to make it clearer and more aligned within GESH (Copied from Steering group AA21)		Arlene Wellman / Jan Bradley	27.04.23	**Blue**	**26/04/23:** Meeting on 27th April before Steering Group meeting**.**	**See Evidence folder - Action 12.3 (New Sit rep form being used in practice)**		
21.22	***Staffing***	***Escalation***	20.01.23	**Sit rep compliance:** B7s need to be doing the Sit Reps consistently over the weekend – Jan to pick this up to ensure that this is happening – added to AA12.		Jan Bradley	27.04.23	**Green**	**26/04/23:** Request by Jan (DoM) that this is implemented this weekend (28th April-1st May) **-** to be checked and update at next Steering Group. **18/05/23:** Needs further work as over the weekend the B7s don't have capacity to complete in full. Included in work around adjusting Maternity Manager on Call approach. **30/05/23:** Compliance at the weekend - new Sit Rep launched and process is embedding. Evidence provided. **01/06/23:** Further refinement made to the Sit Rep following request from Arlene. Awaiting confirmation from Arlene that she is happy. **11/06/23:** Awaiting feedback - revised, streamlined version with Arlene for final approval. **15/06/23:** Arlene has requested further changes and will come back to the next SG. **20/06/23:** Awaiting further Sit Rep feedback from Arlene. **22/06/23:** Meeting to be set up between Arlene and Jan to discuss latest version and seek agreement on a final draft. **28/06/23:** Catch up hasn't taken place yet. **06/07/23:** Meeting next week to resolve (to incorporate staffing template).	**See Evidence folder - Action 12.3 (New Sit rep form being used in practice)**		
12.18	***Staffing***	***Escalation***	24.01.23	**Sit rep compliance:** Monitor compliance with plan to complete the Sit rep every day at 0930 and 1530 each day	Maternity CQC Ops Group	Cheryl Stewart, Maternity Improvement Manager	24.04.23	**Blue**		**See Evidence folder - Action 12.3 (New Sit rep form being used in practice)**		



Communications

01/09/2023

Blue = Executive confirmation of evidence shows

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
19.1		21/04/23	Jan to hold Comms meetings with staff to convey the message around the CQC's findings		Jan Bradley, HoM	21/04/23	**Blue**	Ongoing - due for completion wc 24th April. **02.05.23:** Two held so far - third postponed due to site pressures. Third re-scheduled for 17th May (4-5pm). **10/05/23:** Remains open until confirmed completed and evidence provided. **17/05/23:** Evidence of briefings held to be included in the GEM update paper.	**See Evidence folder - Action 19.1**		

END

Programme management - Maternity CQC Ops Group: Action log

01/09/2023 Last updated

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Theme	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
20.54	Governance		The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12). There is a small amount of informatin and a process within the Triage SOP, but the Ops group has deemed this insufficient to effectively respond to this **Action:** Review existing antenatal and intrapartum guidelines to ensure that the guidelines are clear on the process and that this is included in both relevant guidelines.	Ops Group; Steering Group	Emily Kaliwoh	30/09/23	Green				
20.55			**Cheryl to explore with Tom McGill the use of RATE to support matrons intentional rounding.** Cheryl not around next week so she will ask Tom to report back to Jan and Will for further discussion next week.	Ops Group; Steering Group	Cheryl Stewart	21/08/23	Amber	**21/08/23:** Will to chase up Tom to see whether progress has been made. Linked to ward accreditation to ensure appropriate training has taken place.			
20.56			**Will and Emily to run through Ongoing audit plan approved at SG on 3rd August and transfer it into the AA2 Ongoing Audit plan**	Ops Group; Steering Group	Will Reynolds, Emily Kaliwoh	21/08/23	Amber	**21/08/23:** Awaiting Emily's return from leave.			
20.57			**Baby tagging** Joe and Cheryl have reviewed the finances and Options Appraisal has been updated. Capital investment required. No additional value added in security or prevention of risk by introducing Baby Tagging. As a result, it is recommended this action is closed and existing work on bolstering security continues (estates adaptations, new protocls around challenging, visibility of doors using CCTV and by moving the reception desk). **Action:** Additional plan to increase in security to be worked up and brought o the Ops Group. New action created.	Ops Group; Steering Group	Cheryl Stewart	30/09/23					
20.58	***CQC Report 17/08/23 - Must Do (3)***	18/08/2023	**Escalation Policy** Re-working the escalation policy in line with full CQC report.	Ops Group; Steering Group	Jan Bradley	31/10/2023		**21/08/23:** Lorraine Cleghorn will start working on this refined version from 22/08/23, working with Paul Cloves and Paul Smith to shorten and make it tighter. Action reflects timeline to get the new policy signed off and through governance.			
20.59	***CQC Report 17/08/23 - Must Do (X)***	21/08/2023	**Health and Wellbeing team engagement** Jan and Will to meet with the Health and Wellbeing team to discuss the next steps coming out of the COC report.	Ops Group; Steering Group	Jan Bradley / Will Reynolds	31/08/2023					

Steering Group - Action log

01/09/2023

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Action number	Action date	Action detail	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments
21.24	27.04.23	Develop an Options Appraisal for Rapid Response Team.	Cheryl Stewart, Maternity Improvement Manager	~~15.05.23~~ 16.11.23	Green	**04/05/23:** On track. Due week after next. **17.05.23:** Still being worked on but due to capacity this has not yet been completed. **25/05/23:** Further discussions required around phasing of this work to take place at Maternity Ops Group on Tuesday 30/05/23.. **30/05/23:** Working up this week using Divisional costings and taking to Divisional Tri at the end of this week (02/06/23). Speaking to East Sussex for transferable knowledge / concepts. Rachael to look into ESH examples as well. **05/06/23:** Agreed in Ops Group that this will form part of Phase 2 of the staffing response (i.e. commencing after Section 29 response). Recommend closing and adding to 'Safe Staffing' (AA10) as a follow-up action. **08/06/23:** Cheryl to include in the Future Service Improvement section within the CQC letter. Rationale is that B7 BC and CQC response takes priority with RRT in phase 2. **20/06/23:** Cheryl has included reference to this work in the CQC letter. **06/07/23:** On track. **16/08/23:** Discussion required at SG following publishing of the final report about whether this is still required. **17/08/23:** Taking a decision to pause this as it does not feel like an immediate priority - review in three months.
21.25	27.04.23	**Establishment Review:** Update next Steering Group about the Staffing Roster template (4th May) including Tableau triggers.	Jan Bradley	04.05.23	Amber	**04/05/23:** All areas completed apart from Community and maternal medicine. Expected to be completed 18th May. Once complete this will come to the Steering Group. **15.05.23:** Half has been completed with Sian. Further meeting next week (23rd May - PM) to finalise second half. **25/05/23:** A further meeting is required to complete this work. Estimated delivery date - 02/06/23. **30/05/23:** Annabelle completed roster with Sian on Tuesday 30th May. **01/06/23:** Final step is approval from Natilla and Finance. This can then go live in October. **08/06/23:** Final step is approval from Arlene in terms of establishment templates (Establishment templates completed in draft form - will be submitted COP Monday 12th June- see Action 21.54). Final approval then required from site - Natilla and Finance - once completed this can then go live in October. **15/06/23:** Anomalies identified around finances. Further work required to finalise the templates next week. **20/06/23:** Jan had a further meeting with Joe and Annabelle Tuesday AM. Now confident that the templates are correct. Joe will work through any anomalies around the background formula update and then circulate to Arlene and Steph for final sign off. Healthroster will then be updated. This will then feed into B7 BC completion (Action 21.53). **22/06/23:** Final run through with Jan, Arlene and Steph (aiming for final approval) on Friday 23/06/23. **28/06/23:** Final review hasn't taken place yet. **29/06/23:** Meeting next week to resolve. **06/07/23:** Outcome pending. **14/07/23:** Jan and Arlene liaising to set up a meeting to finalise Establishment. **16/08/23:** Meetings have taken place on 19/07/23, 21/07/23 and 24/07/23. Sign off still pending. **17/08/23:** Agreement to schedule a further meeting. **30/08/23:** All matrons and clinical area ward managers (B7s) to be included in discussions around Establishment review. Introductory meeting on 31st August to progress this.
21.64	15/06/2023	**Safeguarding policy:** Maternity do not have a specific safeguarding policy. The safeguarding policy that is currently used is the trust-wide. It was agreed that a matemity-specific policy was required. One has already been drafted and ready to go to MGM.	Jan Bradley	22/06/2023	Amber	**20/06/23:** Going to next MGM (next Monday 26th June). **22/06/23:** Completed - remains open until MGM has reviewed. **28/06/23**: Date for MGM to be confirmed by Jan. **06/07/23:** Safeguarding Policy did not go to MGM on Monday 3rd July due to a full agenda. It will go to the next MGM meeting. **11/07/23:** Next MGM is 17th July which this policy is going to. **16/08/23:** Policy is with Adult Safeguarding lead for the Trust for review. Once signed off, next steps is the policy will progress to the Audit and Guidelines meeting first (20th September), then MGM. **30/08/23:** Policy is progressing through the governance structure. Comms with Safeguarding designate (Janet Edwards) on Tuesday 29th August to confirm the work being undertaken to address the lack of a maternity-specific safeguarding policy at St George's (as mentioned within the CQC Report).
21.79	29/06/2023	**Maternity KPIs:** Emily to lead on pulling all maternity KPIs into a single place based on the nursing heat map (to be shared by Janice) on Tableau.	Emily Kaliwoh and Laura Wells	~~15/08/2023~~ 18/09/23	Green	**06/07/23**: Emily has spoken to Janice who will email HEAT map templates. Emily to arrange a meeting to discuss the HEAT map that they use. **11/07/23:** IQPR Heat map approach used by team shared by Janice with Jan. **16/08/23:** Emily met with Laura Wells and agreed that Maternity KPIs would be added onto RATE where they pull the nursing HEATMAP data from. Laura has paused this action for now though, until the final CQC report comes out, at which point all metrics can be reviewed amd confirmed in light of that report. **17/08/23:** Happy to proceed with existing set of KPIs. Remains open until built on RATE (due mid-September). Red flags to be included.
21.83	03/08/2023	**General Manager role:** AK raised need to continue with the current arrangements for GM support and that this needed to be extended for a further period whilst a substantive solution was identified. Action for Kate: To speak to Tara re GM support	Kate Slemeck	11/08/2023	Amber	**16/08/23:** Update required at SG. **17/08/23**: Luci to discuss with Arlene offline. 30/09/23: For resolution.
21.84	03/08/2023	**Governance role:** AK raised the issue of governance support and the need for a substantive solution Action for Dee to continue with recruitment for governance role	Dee Kapfunde	11/08/2023	Amber	**16/08/23:** Candidate withdrewfrom interview. Re-advertising post. **17/08/23:** Further discussions required. **30/08/23:** Going back out to advert for a secondment.
21.86	03/08/2023	**Euroking** •Kate Brinkworth, Chief Midwifery Officer for England, has contacted the Trust about issues with contemporaneous record keeping in Euroking. Concern identified that a lot of information held in Euroking about the previous visit/ attendance is deleted at the next attendance, and on-going. Badgernet is used at ESTH, so no risk. Action for Annabelle to identify a solution (not based on Euroking) which provides a full set of notes for all episodes of care	Annabelle Keegan	18/08/2023	Amber	**14/08/23:** Natilla has asked Annabelle/ Emily to review the Euroking risk. Emily has confirmed that risk is on the risk register and updated and the score on the Risk Register sits at 12. Ongoing NHSEI investigation taking place to better understand which fields have been affected, which will then enable a more thorough re-scoring of the risk internally. Site IT colleagues (AG Clinical Safety Officer for IT) engaged and central to the discussions. Meeting on 23rd August (National) with all Trusts using Euroking to seek resolution. **17/08/23:** Awaiting outcome of Euroking meeting. **30/08/23:** Meeting with Euroking still pending. In spite of the Euroking challenges, the Trust's MSDS (Maternity Services Dataset) - linked to CNST - was found to be compliant following first round checks. However, Euroking remains a risk.
21.87	03/08/2023	**MBRRACE 2020 external review** •AB confirmed 20 stillbirth cases of 34 had been submitted. The 38 neonatal cases to be submitted when called for by reviewer. Action for Alison to request reviewers to provide immediate feedback on any issues identified for the Trust to take appropriate corrective action.	Alison Benicasa	11/08/2023	Green	**16/08/23:** All maternity and neonatal case notes uploaded for the external review are now in the folder to be submitted. **17/08/23:** Awaiting report so remains open until then. **30/08/23:** Report still awaited so remains open.
25.6 / 21.89	16/08/2023	**Review of maternity incidents** Peer review and critically examine the decsions made at SIDM in relation to maternity incidents that are brought before the panel. This will then be fed back through the Maternity CQC Steering Group to Board (including feeding into whether we require additional KPIs to be added to RATE).	Luci Etheridge	30/09/2023	Green	**16/08/23:** ToR to be produced by Jenny Miles.
25.7 / 21.91	16/08/2023	**Review of SI/AI policies against standards** Reviewing how we make decisions at SIDM, and reviewing a number of incidents I have identified from the last year where we did not declare an SI but would appear to come within these categories of stillbirth, massive haemorrhage and uterine rupture. This will then be fed back through the Maternity CQC Steering Group to Board.	Luci Etheridge	30/09/2023	Green	
21.92	17/08/2023	**Third and Fourth degree tears (67 up to July - rate increasing)** Review of this year's Third and Fourth degree tears to understand what more we can do to reduce these incidents.	Manjit Roseghini (ICB)	30/09/2023	Green	**21/08/23:** Manjit to come on site to review these 67 cases (supported by Emily where needed). Manjit to schedule a meeting with Arlene by Wednesday this week, after which point Arlene is on leave at which point delivery date will be confirmed. **30/08/23:** Arlene and Manjit to discuss ToR for Manjit's role over the next week
21.93	17/08/2023	**Estates** Action for Dean to cover general update on Trust-wide Estates update to gain assurance that there are not any similar threats across other services related to regulatory compliance.	Dean Gornall	24/08/2023	Blue	**21/08/23:** Plan on track, to be completed by Thursday 24th. **30/08/23:** Draft prepared - to be presented and discussed at SG on 31st August.
21.94	17/08/2023	**Grievance policy** Understand implications of recent update to the Grievance policy. Discussion required around the implications of the Grievance policy on the findings of the CQC Report and vice versa? **Ask John to attend next week.**	John Kitching	24/08/2023	Blue	**18/08/23:** John K invited to next Thursday's SG by WR. **21/08/23:** Will to clarify with John that part of the ask relates to NMC element. **30/08/23:** John has circulated (via Will) the updated disciplinary policy (para 10.2 – Investigation) relating to the need for all investigations of NMC-registered staff to have a PIN number. **31/08/23:** John attended the meeting and briefing the SG. Timescales have been added into the disciplinary policy which applies across the board. Flexible working policy has been re-written using the NHSE/I toolkit. The policy has been updated to adopt the principle that the startig point should be considering requests including annualised hours, compressed hours etc. balanced against the needs of the service in question etc.
21.95	17/08/2023	**Datix review approach** Emily provide a briefing on how datixes are then reviewed and processed.	Emily Kaliwoh	05/10/2023	Green	

21.96	17/08/2023	**Improved development training for Matrons and B7** Induction pack. Six month induction approach Having difficlut conversations. QI Complaints management Practicalities of HR processes Build on EDI work / module and external resource to include in training programme Focus on fair career-development pathways **Action:** Initial meeting to develop the plan.	Janice Minter	15/10/2023	Green	
21.97	31/08/2023	Review of September's plotted Home Births for review by SG and will be discussed at next meeting (07/09/23)	Jan Bradley	07/09/2023		
21.98	31/08/2023	Reconvene a meeting to review assessment and downgrading of Moderate Harm.	Emily Kaliwoh	15/09/2023		

Ongoing Audit

01/09/2023 *Last updated*

Blue = Executive confirmation of evidence shows action fully

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)
Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action number	Theme	CQC Recommendation	Action date	Action detail	1. Sources of Assurance / 2. Monitoring group	Action owner	Target Completion Date	Delivery Status (BRAG)	Progress / Comments	Evidence of expected outcome	Closed Date (i.e. Blue - signed off as closed by Exec)	On-going monitoring
22.1	*Governance*	The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies. (Regulation 12)	*11.07.23*	New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).		Jan Bradley / Emily Kaliwoh	TBD					
22.2	*Governance*	The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way. (Regulation 12)		New 'Governance' workstream including finalised PPH/ Tears, updated guidleines around delayed induction escalation, new SIDM approach and Mortuary process compliance, CNST monitoring and compliance (SBLCB).		Annabelle Keegan / Emily Kaliwoh	TBD					
22.3	*Governance*											

END

Human Resources and Organisational Development (HROD)

01/09/2023 Last updated

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Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

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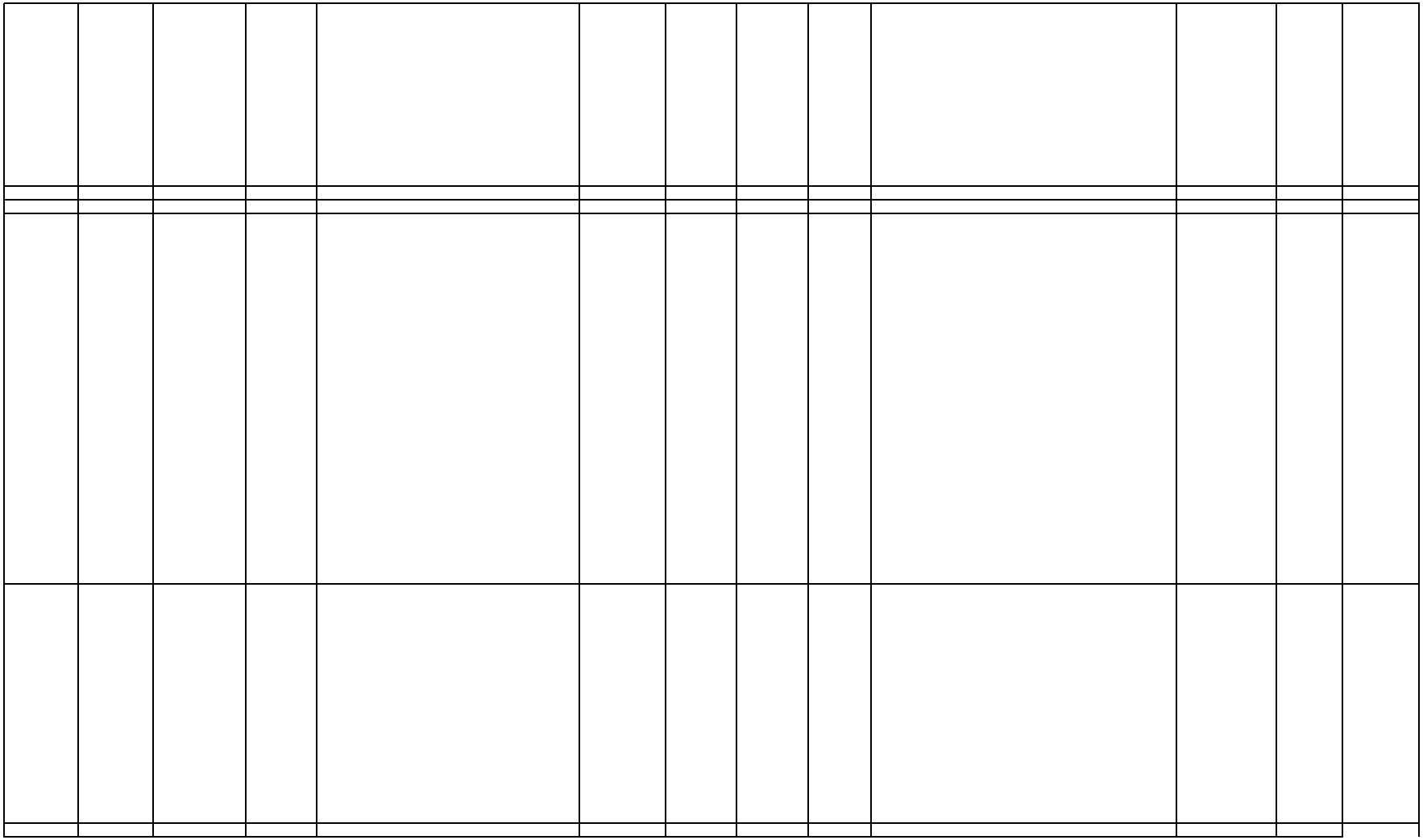
24.1	HR	The service should ensure it takes account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups. (Regulation 17 (2) (d) (e)	11.07.23	Using the WRES and working with HR to identify any areas that need additonal attention and or investigation to ensure equity and equality across alll groups		Cheryl Stewart / Jan Bradley / Jessica Moore	TBD					
	HR	The service should examine its culture and involve staff in improving it, including staff members with protected characteristics under the Equality Act 2010.	11.07.23	Using the WRES and working with HR to identify any areas that need additonal attention and or investigation to ensure equity and equality across alll groups		Cheryl Stewart / Jan Bradley / Jessica Moore	TBD					



END

Governance

01/09/2023 Last updated

Blue = Executive confirmation of evidence shows action

Maternity Services Action Plan March 2023 (in response to CQC Inspection March 2023)

Actions developed from the Final CQC Inspection reports of 'must dos' and 'should dos'

Action	Theme	CQC	Action date	Action detail	1. Sources of	Action owner	Target	Delivery	Progress / Comments	Evidence of expected	Closed Date	On-going monitoring
25.1	**Governance**			The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12). There is a small amount of informatin and a process within the TRiage SOP, but the Ops group has deemed this insufficient to effectively respond to this **Action:** Review existing antenatal and intrapurtum guidelines to ensure that the guidelines are clear on the process and that this is included in both relevant guidlines.	Ops Group; Steering Group	Emily Kaliwoh	30/09/23					
25.2 / 21.85	**Governance**		03/08/2023	**Complaints: Breached and re-opened** AW raised the issues of outstanding complaints and how these are monitored within the service. **Action:** Annabelle to provide a short briefing paper on all outstanding complaints and the plans to resolve them, together with the governance process for how to ensure timely investigation and response		Annabelle Keegan	11/08/2023	**Amber**	**14/08/23:** Annabelle has provided a complaints flow chart. Cheryl is pulling a list of all complaints but Complaints team are having to disaggregate this (splitting Obs and Gynae - the majority of complaints are Gynae). Once done, Cheryl will review and report back to SG on Thursday (along with a plan to create a sustainable process where these are regularly reviewed).	**See Evidence folder - Action 25.2**		
25.3	**Governance**			**Comms around logging incidents** **Action:** Better comms around logging incidents to staff required					**15/08/23:** Evidence saved of Five Facts communication by Jan (DoM) on 14th August around Maternity Red Flags and the improtance of and process for logging incidents. A previous Five Facts (also saved) covers Escalation.	**See Evidence folder - Action 25.3 (FIVE FACTS x 2 - Incident logging; Escalation)**		
21.72 / 25.4	**Governance**		29/06/2023	**Third and Fourth tears and PPH** should be reported in the Maternity monthly report. It's currently reported in the IQPR so this information will now be included each month in the Maternity monthly report from now on.		Jan Bradley	~~06/07/2023~~ 13/07/23	**Green**	**29/06/23:** Date of next report tbc by Jan so provisional Target Completion date can be updated. **06/07/23:** Monthly report date tbc. Jan on leave so delivery timeline adjusted, awaiting update on Monday. **16/08/23:** Confirmation that this has been included in the Maternity monthly report and IQPR. Recommend closing.	**See Evidence folder - Action 25.4: Evidence recorded of inclusion of this information in the Maternity Monthly Report**		
21.87 / 25.5	**Governance**		03/08/2023	**MBRRACE 2020 external review** •AB confirmed 20 stillbirth cases of 34 had been submitted. The 38 neonatal cases to be submitted when called for by reviewer. Action for Alison to request reviewers to provide immediate feedback on any issues identified for the Trust to take appropriate corrective action.		Alison Benicasa	11/08/2023	**Green**	**16/08/23:** All maternity and neonatal case notes uploaded for the external review are now in the folder to be submitted.	**See Evidence folder - Action 25.5: Email confirming upload**		
25.6 / 21.89	**Governance**		16/08/2023	**Review of maternity incidents** Peer review and critically examine the decsions made at SIDM in relation to maternity incidents that are brought before the panel. This will then be fed back through the Maternity CQC Steering Group to Board.		Luci Etheridge	tbc		**16/08/23:** ToR to be produced by Jenny Miles.			
25.7 / 21.91	**Governance**		16/08/2023	**Review of SI/AI policies against standards** Reviewing how we make decisions at SIDM, and reviewing a number of incidents I have identified from the last year where we did not declare an SI but would appear to come within these categories of stillbirth, massive haemorrhage and uterine rupture. This will then be fed back through the Maternity CQC Steering Group to Board.		Luci Etheridge	tbc					

Blue = Executive confirmation of evidence shows action fully complete, action closed and returned to business as usual

Green = On target with evidence of progress supplied

Amber = Deadline missed with mitigation for delivery in place and with evidence of progress supplied

Red = Deadline missed with no mitigation plan in place

Blue

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

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Appendix 2

Maternity Services Monthly Report Group Board

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

8 September 2023

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

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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 Monthly 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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1. NHS England set out a national ambition to halve the rates of stillbirth, neonatal deaths, maternal deaths, and brain injuries during birth by 2025, (from a 2010 baseline). Aligned with the Perinatal Quality Surveillance Model (PQSM), maternity and neonatal services are required to report monthly against an agreed data set which is included in this report which covers the period June 2023.
2. Neither SGUH nor ESTH achieved full compliance with Year 4 of the CNST MIS. Year 5 of the scheme was launched in May 2023 with further revisions to the technical guidance published in July 2023.
3. The following slides provide a summary of the current rag-rated status for each trust against each of the 10 Safety Action

   Currently the ratings are

SITE	Ontrack	Currently non-compliant	Safety Action with associated RISK
ESTH	6	2	2
SGH	5	1	4

The update on the review of 2021 MBRRACE-UK audit cases and findings of the MBRRACE-UK 2022 audit are presented on slide 7

The required PMRT data is presented on slides 9-11

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CNST Year 5: Status position July 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
1. PMRT	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes and on track	Yes and on track	Monthly updates to QCiC and Group Board as part of Maternity Services Report Q1 PMRT report shared at QCiC on 29 June 2023 and Group Board on 7 July 2023 7 December 2023
2. MSDS	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes and on track	There are current delays associated with the Digital Transformation work • EUROKING SYSTEM EPR platform: Multiple errors have been identified and escalated to the National teams from all sites who use it • VIEWPOINT 6 FMU Obstetric Scanning Implementation: Suboptimal scheduling system and delay in presenting appropriate alternative to Clinical teams. There is a workstream dedicated to resolving this issue with a possible solution being demonstrated on 29th July 2023.	7 December 2023
3. Transitional Care	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Transitional care cannot be delivered from current establishment. A service improvement proposal is being developed Joint NNU and Maternity task and finish group working on clear JD's and leadership for this service.	Transitional care cannot be delivered from current establishment. A service improvement proposal is being developed. Some funding has been secured from CNST – year 4 to support staffing	The ATAIN (avoiding term admission to the neonatal unit) report was shared at QCiC on 29 June 2023 and Group Board on 7 July 2023

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CNST Year 5: Status position July 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
4. Clinical Workforce Planning	Can you demonstrate an effective system of medical workforce planning to the required standard?	On track	On track	7 December 2023
5. Midwifery Workforce Planning	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Current establishment does not meet Birth-rate plus recommendations. Staffing paper to be submitted alongside business case to increase establishment to include B5 RN to run elective theatre services. Not meeting BR+ staffing recommendations also impacts on the ability to meet 100% supernumerary status of the Band 7 labour ward coordinator. Whilst business case moves through internal process staff have been moved from CoC to prioritise inpatient rotas.	Birth rate plus planned for Nov/Dec 2023 and work ongoing internally on Establishment reviews and rostering templates within maternity services	7 December 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
6. Saving Babies Care Bundle	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	Risk due to training compliance re element 4: effective fetal monitoring during labour. Current training data, shows that midwives and obstetric consultants are compliant and obstetric trainees are non-compliant. Extra training as part of divisional induction scheduled.	There are current delays associated with Digital Transformation, mitigations are currently being worked through by the teams to negate this delay • EUROKING SYSTEM EPR platform: Multiple errors identified and raised to the National teams from all sites who use it • VIEWPOINT 6 FMU Obstetric Scanning Implementation: Suboptimal scheduling system and delay in presenting appropriate alternative to Clinical teams. There is a workstream dedicated to resolving this issue with a possible solution being demonstrated on 29th July 2023	Monthly updates to QCiC and Group Board as part of Maternity Services Report and mandatory training improvement plan From 30 May 2023 – 7 December 2023
7. MVP	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Yes and on track	Yes and on track	Monthly updates to QCiC and Group Board as part of Maternity Services Report 7 December 2023
8. Multidisciplinary Training	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? • Fetal surveillance training. • Maternity emergencies and multi professional training? • Neonatal basic life support.	Mandatory training improvement plan in place and monthly monitoring of performance against trajectory	Mandatory training improvement plan in place and monthly monitoring of performance against trajectory	Anaesthetic staff booked to attend training with trajectory to meet compliance by 7 December 2023 Monthly updates to QCiC and Group Board as part of Maternity Services Report

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
9. Safety Champion	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes and on track	Yes and on track	The Maternity Services Claims Scorecard for 2022 was received at Board on 7 July 2023
10. NHS Resolution	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	Yes and on track	Yes and on track	All qualifying cases reported to date Monthly updates to QCiC and Group Board as part of Maternity Services Report

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MBRRACE & PMRT

(Perinatal Mortality Reporting Tool)
CNST Safety Action 1

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MBRRACE-UK January 2021 to December 2021

Mothers and Babies: Reducing risk through Audit and Confidential Enquires across the UK

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MBRRACE - UK is a national audit programme (commissioned by all UK governments) to collect information about all late foetal losses, stillbirths, neonatal deaths and maternal deaths across the UK. **SGUH was an outlier in the 2020 audit due to the numbers of deaths being 5% higher than the average for comparable trusts. All cases had been reviewed internally and reported through the Trusts internal governance processes and no issues identified.**

The Group Board commissioned an external review of all stillbirth and neonatal deaths in SGUH in 2020 to seek additional assurance and identification of any missed opportunities for learning. The review has commenced and the report is expected in September 2023, There has been a challenge in the collection of the case notes, this has been prioritised by the site leadership.

Annual figures for 2021 were published in May 2023
ESTH: The data shows an improved position for Neonatal deaths at ESTH when compared with the average for comparable Trusts.
SGUH: The stabilised and adjusted rate for extended perinatal death (4.61) is the same as 2020 while the rate of stillbirths per 1000 live births is 4.21 which is worse than 2020. However there is an improved position overall for SGUH when compared with the average for comparable Trusts.
A detailed analysis of the ESTH and SGUH reports is currently being undertaken in partnership with the LMNSs.

Report for each trust is included as Appendix 1 in the READING ROOM

	ESTH		SGUH	
Year	**2020**	**2021**	**2020**	**2021**
Total number of births	**3,991**	**3,904**	**4,679**	**4,666**
Extended perinatal death (stillbirth and neonatal death together) per 1000 live births	4.16	4.16	6.41	6.41
Stillbirth per 1000 live births	2.95	3.26	3.92	4.21
Neonatal Death per 1000 live births	1.21	0.91	2.52	2.26

Key	
	5 to 15% lower than the average for comparable Trusts
	within 5% of the average for comparable Trusts
	Over 5% higher than the average for comparable Trusts

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Perinatal Mortality

This data reflects antepartum stillbirths, intrapartum stillbirths and neonatal deaths.

		ESTH				SGUH			
		July 2022 – June 2023		June 2023		July 2022 – June 2023		June 2023	
		Total number of Births	Total number of Deaths	Total number of Births	Total number of Deaths	Total number of Births	Total Number of Deaths	Total number of Births	Total number of Deaths
			15		**1**		**50**		**3**
Type of Mortality	Antepartum Stillbirths	**3720**	9	**293**	1	**4342**	21	**354**	1
	Intrapartum Stillbirths		3				4		1
	Stillbirth of unknown timing						1		
	Neonatal Deaths		3				24		1
Gestational Age	22 -23+6 weeks		4				14		1
	24 - 27+6 weeks		3				11		
	28 - 31+6weeks		0				6		
	32 - 36+6weeks		3				7		
	37 - 41+6 weeks		5				10		2
	≥ 42 weeks								

*Note: Rate of Death per **1000 births at THAT GESTATION**

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Perinatal Mortality by ethnic group

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Ethnic Groups		ESTH						SGUH					
		July 2022 – June 2023			June 2023			July 2022 – June 2023			June 2023		
		Total number of Births	% of total number of births	% of total number of deaths	Total number of Births	% of total number of births	% of total number of deaths	Total number of Births	% of total number of births	% of total number of deaths	Total number of Births	% of total number of births	% of total number of deaths
Asian or Asian British	Indian	3720	0.03 (1)	6.67	293			4342	3	6 (3)	354		
	Pakistani		0.03 (1)	6.67					5	10 (5)		7 (1)	33.3
	Bangladeshi								0.6				
	Chinese		0.03 (1)	6.67					0.7				
	Any other Asian background		0.03 (1)	6.67					9	8 (4)			
Black, Black British, Caribbean or African	Caribbean		0.05 (2)	13.33					3	6 (3)		5 (7)	33.3
	African								7	8 (4)		7 (1)	33.3
	Any other Black, Black British, or Caribbean background								3	2 (1)			
Mixed or multiple ethnic groups	White and Black Caribbean								1	6 (3)			
	White and Black African								0.5	2 (1)			
	White and Asian								0.7				
	Any other Mixed or multiple ethnic background		0.05 (2)	13.33					2	4 (2)			
White	English, Welsh, Scottish, Northern Irish or British		0.16 (6)	40		1	0.34		26	24 (12)			
	Irish								0.7				
	Gypsy or Irish Traveller									2 (1)			
	Roma												
	Any other white background								18	20 (10)			
Other ethnic group	Arab												
	Any other ethnic group		0.03 (1)	6.67					10	8 (4)			
Not known									11	22 (11)			

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Perinatal Mortality Reviews

See READING ROOM Appendix 2 for further details of reviews and learning

PMRT Panel	Cases reviewed June 2023	Emerging Themes June 2023	Open Actions from previous reviews, year to date	
ESTH: 1 panel meeting	3	No new clear emerging themes identified to date	INC-121804	1. Neonatal Specialty to report post neonatal deaths to MBBRACE-UK by 31 August 2023. Action in progress. Bereavement nurse now trained on MBBRACE reporting. The process is on track for implementation by the due date. 2. Consider if pre-term grab bags on both acute maternity units are required. Action in progress and will be completed by 31 July 2023.
SGUH: 1 panel meetings	2	No new clear emerging themes identified to date	X258448	1. Ratification of Maternity Safeguarding Guidelines by 31 October 2023 – In progress
			DW186845	Revise local guidelines to reflect clear plan of care for patients who do not have ASPRE screening by 31 October 2023 – In progress

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Safety Action Updates

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Safety Action 2	Maternity Data set evidence to be included in September 2023 paper onwards
Safety Action 3	Update on Transitional Care to be included in September 2023 paper onwards
Safety Action 4	Medical Workforce planning update to be included from September 2023 onwards

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Midwifery Workforce Planning
CNST Safety Action 5

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Safe Staffing

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Staff group	Measure	April 23			May 23			June 2023		
		ESTH ST H	ESTH EGH	SGUH	ESTH ST H	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH
Midwifery	Fill Rate (target >94%)	95%	85.5%	94%	95%	87%	95.6%	95%	91%	90%
Obstetric	Expected vs fill	100%	100%	100%	100%	100%	100%	100%	100%	100%
Band 7 supervisory midwife, 1.0 wte per shift	Shift allocation 100%	100%	100%	91.7%	100%	100%	98.4%	100%	100%	98%
Triage staff, 2.0 wte per shift	Shift allocation 100%	To commence next reporting period		86.71%	To commence next reporting period		85.5%	To commence next reporting period		93.3%

Red Flag Category	ESTH St Helier	ESTH Epsom	SGUH
Coordinator not supervisory	7	20	5
Delay in time critical activity	1	0	13
Delayed induction of labour	5	0	4
Delayed pain relief	0	0	0
Delayed or cancelled care	1	0	2
Number of clinical incidents related to red flags	0	0	2

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Actions to Support Safe Staffing

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ESTH

- The overall fill rate in June 2023 was 93% (95% at STH and 91% at EGH due to sickness and maternity leave) against the target of 94%
- High cost agency was approved where staffing was at risk of being 30% lower than planned
- During the day shift, specialist midwives are utilised to support the clinical areas
- Continuity of Carer: Scoping has begun to reduce the number of continuity teams across both sites in order to meet staffing demands. One team on the Epsom site relocated to core inpatients from May 2023. This has mitigated immediate pressure until the project to review other teams is completed
- 3.9 wte midwives were redeployed from community services at St Helier to inpatient services, to protect the supernumerary status of the Band 7 midwife. Workload will be absorbed by community team leaders who previously had reduced clinical responsibility
- Current establishment does not meet Birth-rate plus recommendations- currently we are 12 Midwives short of the Birth Rate plus recommendations. A staffing paper has been submitted to the Senior Leadership Team, alongside a business case, to increase establishment to include Band 5 registered nurses to support the running of elective theatre services. This will free up midwifery staff to support delivery of midwifery care

SGUH

- Proactive closure of the birthing centre continues in order to mobilise staff to delivery suite
- Continuity of Carer: No new bookings were made into CoC teams, in order to mobilise staff to delivery suite
- Weekly review of actions to support safe staffing are undertaken as part of the on-going work to maintain safe staffing levels across the maternity services
- Provision of the home birth service is also reviewed weekly to reallocate staff to delivery suite if required
- Specialist midwives work on the delivery suite when required, to maintain safe staffing levels
- Training is cancelled and reschedule if required so that staff can be deployed to delivery suite
- All staffing templates are currently being reviewed

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Saving Babies' lives version 3
CNST Safety Action 6

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Safety Action 6 Elements – June 2023

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Elements	Indicator	Threshold	ESTH Performance	SGUH Performance
1	CO2 monitoring at booking	95%	93.8% (May)*	93%(May) 96% (June)
2	CO2 monitoring at 36/40	95%	79.9% (May)*	29% (May) 50% (June)

ESTH: CO2 monitoring at 36/40 is audited monthly to identify individual areas for support. The matrons are following up with individual midwives to explore the reasons that the intervention has not been offered. This approach has resulted in an improvement since last year. All NNU term admissions undergo an ATAIN review and safety and improvement actions are identified for implementation.

** June 2023 data for ESTH unavailable at the time of writing this report*

SGUH:There continues to be a challenge with contemporaneous data collection for CO2 monitoring with performance of 50% against the 95% target. However, this is an improvement on the performance reported in May 2023 (29.7%). In order to improve performance, whilst awaiting the solution to be provided via the Digital transformation project, real time data collection of CO2 monitoring at 36/40 is be undertaken by the antenatal clinic administrative staff and Community midwifery teams and collated on a monthly basis.

NOTE: Reporting on all other elements of safety action 6 will be included in future reports

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Maternity Voices Partnership
CNST Safety Action 7- Activity will be included from September 2023

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Multidisciplinary Training
CNST Safety Action 8

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Mandatory training compliance

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Type of Training and % compliance	Staff Group	May 23		June 23		In month performance	
		ESTH	SGUH	ESTH	SGUH	ESTH	SGUH
PROMPT 90%	Midwifery Staff	89%	77.83%	88%	79.05%	-1%	+1.22%
	Maternity Support Workers	89%	88.89%	91%	77.78%	+2%	-11.11%
	Consultant Obstetricians	92%	82.61%	80%	65.22%	-12%	-17.39%
	Trainee and Staff Grade Obstetricians	92%	87.88%	80%	86.67%	-12%	-1.21%
	Anaesthetics	44%	71.66%	50%	71.66%	+6%	<>
CTG Training 90%	Midwifery Staff	94%	88.94	96%	87.92%	+2%	-1.02%
	Obstetricians	92%	82%	82%	55%	-10%	-27%
NLS (Newborn Life Support) 90%		89%	94.53%	88%	95.5%	-1%	+1.03%

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Mandatory training Improvement plan 2023-24

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Reason for negative performance against trajectory		Mandatory training improvement plan	By when
ESTH	There are multiple factors impacting on training performance including: • Sickness for midwifery staff • Rotation of junior doctors • Junior doctors strikes requiring staff to be pulled to work clinically • Previous poor anaesthetic attendance due to staffing issues • Previously depleted PDM team	• Database has been cross checked to ensure all staff are booked ahead of time • Monthly checks of staff off on long term sickness and maternity leave to ensure training is prioritised on their return • Robust DNA policy in place • Agreement with the HOM and DOM re. escalation plan for managers pulling staff from Mandatory training to cover clinical work • Involvement of MDT faculty to ensure all staff groups are engaged and booked to attend • Liaison with Anaesthetic and Obstetric roster co-ordinators • Facilitating an extra PROMPT training day in August to ensure junior doctors are attending training at the start of their rotations. This will include full MDT so will increase all current compliance percentages • Request for further training hours submitted	Continuous improvement plan ongoing. Predicted to meet all targets with current booked attendees by November 2023 for all staff groups.
SGUH	• Two PROMPT sessions cancelled (March & April 2023) in response to staffing challenges affecting attendance • Consultant attendance restricted due to rosters • New anaesthetic trainees starting affecting denominator	• PROMPT – new anaesthetic trainees scheduled this month and two additional sessions planned – one in July and one in October • CTG – Obs Consultant attendance escalated to educational lead to plan attendance • NLS – two sessions per month until December to ensure compliance by year end	December 2023

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Maternity and Neonatal Safety and Quality Issues
CNST Safety Action 9

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HSIB/NHSR/CQC/Regulation 29 and/or other concerns

ESTH	SGUH
There has been no inspection visit as yet from the CQC maternity services inspection team. Preparations for the inspection continue and the following risks should be noted: • Training compliance • Staffing • Environment • Entonox safety Mitigations are in place with senior leadership weekly CQC meeting to monitor progress.	**Regulatory** Following a CQC inspection across SGH Maternity services in March 2023 a warning notice was served under Section 29A of the Health and Social Care Act 2008. The reasons for this are as follows: • Staffing: levels of staff available to ensure mothers and babies were not 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 implemented to address the requirements of the S29A and a final response was sent to the CQC on 28 June 2023. The draft full inspection report has been reviewed by the Trust for factual accuracy and the response was submitted to the CQC on 28 June 2023. The final inspection report is awaited. A CQC maternity services action plan is in development to address the MUST and SHOULD Do's within the inspection report. **Concerns - Digital Transformation** • EUROKING SYSTEM EPR platform: Multiple errors identified and raised to National teams from all sites who use it. This could have significant impact on CNST safety action 1 • VIEWPOINT 6 FMU Obstetric Scanning Implementation: Delay in launch due to suboptimal scheduling system and delay in presenting appropriate alternative to Clinical teams

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ESTH Incidents graded at moderate harm and above

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MODERATE HARM - Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
SEVERE HARM - Any patient safety incident that appears to have resulted in permanent harm

ESTH	Moderate / Severe Harm	Incident detail and immediate safety actions
	Moderate	**INC-134325:** Woman readmitted to hospital with possible retained products of conception seen on speculum vaginal examination. Histology results awaited. This incident has been graded as moderate harm initially as it was a readmission, but will be reviewed once histology is available.
	Moderate	**INC-134863:** Unexpected admission to ITU following delivery. Duty of Candour has been enacted. The case was discussed at the Maternity Incident Review Panel and there were no immediate care and service delivery issues identified that contributed to ITU admission. This incident has been graded as moderate harm until it has been established whether the ITU admission was avoidable or unavoidable. If the ITU admission was unavoidable the incident will be downgraded to low harm.
	Moderate	**INC-135614:** Woman presented in Triage following delivery and discharge with suture material protruding from her anus. On investigation it was confirmed that the vaginal wall was sutured and following delivery the vaginal wall can be very thin and friable; in this case initial findings suggest that the suture went through the vaginal wall into the anus; this should have been identified on rectal examination following suturing.

Investigations and case reviews are in progress for all incidents
See next slide for 3rd and 4th degree tears and Appendix 3 in the READING ROOM for incident report

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SGUH Incidents graded at moderate harm and above

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MODERATE HARM - Any patient safety incident that resulted in a moderate increase in treatment and which caused significant but not permanent harm
SEVERE HARM - Any patient safety incident that appears to have resulted in permanent harm

SGUH	Moderate / Severe Harm	Incident detail and immediate safety actions: June 2023
	Moderate	There were 20 incidents relating to post partum haemorrhages of 1.5 litres and above. There were no immediate related improvement actions
	Moderate	**DW190568:** IUD at 40 weeks. This case has been referred to HSIB and will be discussed at PMRT.
	Moderate	**DW191656:** Unexpected admission to NNU 40+6 weeks: cooling. This case has been referred to HSIB
	Moderate	**DW191004:** Maternity unit divert from 19:30-07:30 due to maternity staffing. No harm identified to birthing women and women attending Triage during this timeframe .
	Moderate	**DW191017:** Maternity unit divert: hospitals did not accept patients as agreed by SWL surge hub.
	Moderate	**DW191962:** Patient was identified as high risk ASPRE at 12 week scan (risk factors for developing pre-term pre-eclampsia). A 28 week scan was not booked. At the 36 week growth was directed to day assessment unit to discuss induction of labour (IOL) in view of being high risk ASPRE. IOL was booked at 40 weeks however, patient called later wanting to discuss an ELCS. Patient delivered by LSCS. Missed opportunity for earlier intervention and possible avoidance of unplanned LSCS. Investigation is ongoing. Baby is doing well, and no impact noted from delayed assessment

Investigations and case reviews are in progress for all incidents
See next slide for 3rd and 4th degree tears and Appendix 3 in the READING ROOM for incident report

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Contributory Factors and Root Cause for Completed Serious Incident Reports

Trust	Number of serious incidents closed in month (June 2023)	Root cause and learning
ESTH	1	This related to the HSIB case closed in June. HSIB did not make any safety recommendation is respect of the care received. There were some learning points not associated with the outcome and the case will be presented at the next Quality Half Day for learning.
SGUH	0	N/A

Overdue Serious Incident Action Plans Progress update

Trust	INC/ Datix number	Progress update and timeline for delivery
ESTH	N/A	There are no overdue actions.
SGUH	N/A	There are no overdue actions.

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Service User feedback/ Patient Voice

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ESTH			SGUH		
Feedback	**Action**	**By when**	**Feedback**	**Action**	**By when**
1. Woman was informed that there would be an investigation report sent regarding her care.	1.1 Message shared at huddle to check with the risk team regarding the level of incident review.	31/7/23 Completed	1. A family were frustrated at delays in care due to high levels of activity - elective CS	1.1 Discussion between the Ward manager and Consultant to apologise for the delay and describe the need to and ensure safety by clinically prioritising with a plan made to proceed with their delivery when safe and appropriate to do so.	COMPLETED – June 23
2. Lack of referral (physio) and de-brief appointment.	2.1 Staff have been reminded how to request a referral via iCM.	31/7/23 Completed	2. A family from Margate were supported on Gwillim with a postnatal check for their 10 day old baby. Their first child has a chronic health condition and was transferred from Margate to PICU requiring ventilation due to a chest infection. The family have historically been transferred to the Evelina Children's but will be requesting to return to SGH if and as necessary due to the exceptional care they have received since birth for their eldest child and during the puerperium.	2.1 Provided compassionate postnatal and pastoral care to the whole family.	COMPLETED – June 23
3. Lack of interpreter during an outpatient appointment.	3.1 A reminder has been sent to all clinicians regarding the use of Language Line.	31/7/23 Completed			
4. Comments around the décor in labour rooms.	4.1 Ambient lighting projectors have been purchased to improve the 'feel' of the rooms and make the less clinical.	31/7/23 Completed			
5. Lack of breastmilk storage fridge on the Labour Ward for those women who require extended HDU care before transfer to the postnatal ward	5.1 A fridge has now been purchased.	31/7/23 Completed			

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Staff feedback to Maternity Safety Champions

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ESTH (as for last month as last session held in May 2023)			SGUH		
Issue	**Action to be taken and by when**	**Progress update**	**Issue**	**Action to be taken and by when**	**Progress update**
1. Community KPIs were raised by the executive safety champion and 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.	Maternity Service KPI's: Q4 (Jan-March 2023) was shared with the Executive Safety Champion by email 2/06/23 A process has been agreed that Director of Midwifery will share quarterly screening KPI with Group Chief Nurse prior to National submission (NHS England).	1. Ensuring clinical staff get breaks during peaks of high activity. 2. Trust Values Award for Community Team who supported and advocated for a previous service user who was victim of significant DV. Woman3/12 postnatal presented in distressed state to her former Community Midwives during their antenatal clinic as she knew it would be a place of safety – emergency action taken/police and social services involved and family's safety secured.	Proactive assignment at formal escalation meeting of nominated colleague to relieve B7 Coordinator for break. 2. External stakeholder escalated commendation to DoM and Trust Values Award presented	Completed

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Feedback from ward and departmental visits and emerging themes and risks

Placeholder for future reporting:

- **In June 2023 there were several visits to the Units by Executive and Non-Executive Board Safety Champions. Feedback has been provided to the teams and any immediate actions identified have been communicated**

- **A plan is being developed to create a small group with core membership consisting of Board safety champions to review feedback from unit visits (formal and informal) and triangulate with feedback from other sources e.g Complaints, FFT, FTSU, and PALs**

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Referrals to HSIB
CNST Safety Action 10

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Cases referred to HSIB (Healthcare Safety Investigation Branch)

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HSIB are mandated to focus on human factors and 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.

** Prior to June 2023 there had been no cases at SGUH that met the criteria for referral to HSIB since December 2022.

	ESTH June 2023	**SGUH June 2023**
HSIB cases open and under review	1 case: INC-127456/127458	2 cases: MI-029193 – June (HSIB rejected – MRI normal) MI-028170 - June (HSIB to investigate)
HSIB cases closed in month	1 case: INC-122564/122525	0
HSIB open actions from previous cases	0	0
Actions based on recommendations	To be included in next reporting period	

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Appendix 3

PMRT – Case Detail June 2023

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Perinatal Mortality Reviews
Details of reviews and learning from PMRT

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PMRT Panel	Cases reviewed	Brief Case Summary and Learning/ Actions Arising	Care and delivery issues contributing to outcome	Expected/ unavoidable/ unexpected
ESTH: 1 panel meeting	3	**Case 1: INC-132008** Stillbirth at full term after an intrauterine death was identified at the booking hospital (Birmingham). Mother was transferred to St Helier for delivery to be near family members (reporting is required according to the place of birth)	N/A – in-utero hospital transfer	Expected
		Case 2: INC-131991 An intrauterine death at 22+4/40. At post-mortem examination, the placenta showed signs of chorioamnionitis.	Grade A: no care issues identified in the care of the mother after the death of the baby	Unexpected and Unavoidable
		Case 3: INC-132062 This related to and intrauterine death at 27/40. At post-mortem examination, the placenta showed necrotising chorioanmionitis, necrotising funisitis and acute villitis.	Grade A: no care issues identified in the care of the mother after the death of the baby	Unexpected and Unavoidable

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Perinatal Mortality Reviews
Details of reviews and learning from PMRT

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PMRT Panel	Cases reviewed	Brief Case Summary and Learning/ Actions Arising	Care and delivery issues contributing to outcome	Expected/ unavoidable/ unexpected
SGUH: 1 panel meetings	2 (1 SGUH case, 1 involving another care provider)	**Case 1: DW86404:** Intrauterine death at 34/40. Late booker, asylum seeker from Uganda. Reported victim of domestic violence by a family member. Missed early screening for preeclampsia and was not commenced on Aspirin at booking. Referred to Safeguarding team. Referral was accepted but not contacted by the safeguarding team. Did not attend some antenatal appointments and these were rescheduled. There may have been an opportunity to facilitate extra support from the safeguarding team but it is unknown if this would have altered the outcome for the baby. The post mortem could not identify a cause for this fetal demise. It was agreed that not taking aspirin did not affect the outcome. **Actions** Escalated to safeguarding team, system to triage and prioritise cases needed clarification. Awaiting ratification of safeguarding guideline. Implementation of NICE guidelines risk assessment for prevention of preeclampsia on women who booked over 14 weeks.	Grade C (Care issues that may have a difference to the outcome for baby) Issues around actioning safeguarding referrals. Graded A (no care issues identified in the care of the mother after the death of the baby)	Unexpected and avoidable
		Case 2: DW86809: Intrapartum IUD at 25 weeks. Booked at another health care provider. Attended SGUH with bleeding and abdominal pain as visiting London. Small for age gestational baby with reduced liquor volume. Threatened preterm labour managed as per national guidelines. Case reviewed by Specialist consultant and in view of clinical picture, offered augmentation of labour. Baby born with no signs of life, attempted resuscitation but baby did not respond to it. The post mortem showed severe acute necrotising chorioamnionitis. Grading and action plan pending.	Grade pending: There are ongoing discussions between the Clinical Director and Perinatal loss Specialist Consultant	Unexpected and avoidable

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Appendix 4

MBRRACE-UK January 2021 to December 2021

Mothers and Babies: Reducing risk through Audit and Confidential Enquires across the UK

ESTH Review of the 2021 MBRRACE Report

NB: All cases are reported to QCiC monthly on a rolling year basis and a quarterly report is submitted regarding the reviews undertaken in line with CNST MIS Year 5 requirements, therefore action plans and progress have been detailed at the time in these reports.

STILLBIRTH (13 cases):

- 5 stillbirths were at <30 weeks' gestation
- 5 stillbirths were between 30 and 37 week's gestation
- 3 stillbirth were at full term

CAUSE OF DEATH:

- There were 5 cases where maternal and/or fetal vascular malfperfusion was identified as a causative factor
- There was 1 case of fetal thrombotic vasculopathy
- In 5 cases there was no cause found/no post-mortem
- One case was secondary to an indirect maternal death (splenic artery rupture)
- There was one case where chorioamnionitis was identified as a causative factor

REVIEW:

- All case underwent a review; 2 cases were reviewed by HSIB and 6 cases underwent local investigation panel in addition to the PMRT panel review.
- There were care and service delivery issues identified which potentially contributed to the outcome in 4 cases and actions have been completed relating to escalation for review, care planning and review of women reporting reduced fetal movements. All improvement actions from 2021 have been completed.

ESTH Review of the 2021 MBRRACE Report
NB: All cases are reported to QCiC monthly on a rolling year basis and a quarterly report is submitted regarding the reviews undertaken in line with CNST MIS Year 5 requirements, therefore action plans and progress have been detailed at the time in these reports.

NND (1 case):
- 1 neonatal death at 27 weeks' gestation; microcephaly was suspected from scan and the death was attributed to prematurity and abruption. There were no care or service delivery issues identified which directly contributed to the death

HSIB:
- The maternal death HSIB review contained no safety recommendations.
- The intrapartum stillbirth review by HSIB contained 2 safety recommendation with reference to

    - review and monitoring of women with reduced fetal movements in the latent phase of labour. All actions have been completed and related to amended guidance for monitoring women in the latent phase of labour.

SGUH Review of the 2021 MBRRACE Report

NB: All cases are reported to QCiC monthly on a rolling year basis and a quarterly report is submitted regarding the reviews undertaken in line with CNST MIS Year 5 requirements.

STILLBIRTH (36 cases)

CAUSE OF DEATH:

- Inconclusive 1 case
- Chorioamnionitis 5 cases
- Maternal and fetal vascular mal-perfusion 6 cases
- Genetic anomalies with associated complications 2 cases
- Cord anomalies 1 case
- Delayed villous maturation 2 cases
- Abruption 1 case
- 20 cases parents did not consent to post mortem
- Ethnicity:

REVIEW:

- All cases were reviewed.
- 4 cases were referred to HSIB and six cases had an internal investigation in addition to PMRT.
- There were care and service delivery issues identified which potentially contributed to the outcome in 8 cases and actions have been progressed in relation to staffing, escalation, triage, risk assessment and fetal monitoring.

SGUH Review of the 2021 MBRRACE Report

NB: All cases are reported to QCiC monthly on a rolling year basis and a quarterly report is submitted regarding the reviews undertaken in line with CNST MIS Year 5 requirements.

NND (22 cases)

REVIEW:

- All cases reviewed.
- Two cases were referred to HSIB: one was rejected for lack of parental consent, this was investigated internally and the other was investigated by HSIB and no concerns were identified with care.

HSIB ACTIONS:

- Undertake a review of entire triage assessment process and guidelines. Ongoing PDSA cycle as per CQC programme - **completed**
- Review of fetal monitoring guidelines**.** Dec 2022 - **completed**
- Review of CTG training and assessment for midwifery and medical staff. Aug 2022 – **To be further revised following receipt of final CQC inspection report**
- Review the process of escalation of for staffing and acuity issues Aug 2022 – **completed**
- Reminder to all consultants that handover between day and night consultant must include delays in management such as Induction of labour. Aug 2022 - **completed**

Ethnicity: Review of the 2021 MBRRACE Report

Ethnicity	ESTH Still births	ESTH Neonatal Deaths	SGUH Still births	SGUH Neonatal Deaths
Any other Asian background			5	
Any other Black background			3	
Any other Ethnical group			6	
Bangladeshi			1	
Black African	2		10	3
Black Caribbean				1
Chinese			1	
Indian				2
Pakistani	1		1	1
White British	5	1	6	5
White Other			8	6
Mixed: White and Caribbean			1	1
Other/ mixed	5			
Not known			2	3
Total	**13**	**1**	**36**	**22**

Group Board

Meeting on Friday, 08 September 2023

Agenda Item	2.2
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	
Purpose	**For Assurance**

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 June 2023.

Action required by Group Board

The Board is asked to review the report and note the operational and quality information for the Group at June 2023

Committee Assurance

Committee	Quality and 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

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Integrated Quality and Performance 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, 08 September 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 June 2023.

2.0 Quality

2.1 SAFE HIGH QUALITY CARE: SGH – JUNE 2023

Successes:

- **Pressure Ulcers:** The Trust reported zero medical device related category 3, 4 and unstageable pressure ulcers in June 2023. Incidents of these pressure ulcers has remained below or the same as the mean for the 4th consecutive month.
- **Falls:** The number of falls per 1,000 bed days remains close to or below the lower process limit for the fourth consecutive month.
- **MCA**: Mental Capacity Act level 2 compliance for Nursing remains steady at 92%. Allied Health Professional compliance continues to improve with an increase from 82% to 86% since last month.
- **Mental Health:** Children's and Women's division have the highest 'We can talk' completion rate. 1 Band 7 RMN and 11 permanent Mental Health Support Worker posts have been confirmed for the Emergency Department.

Challenges:

- **Pressure Ulcers:** The Trust reported 9 category 3, 4 and unstageable pressure ulcers in June 2023. This is slightly up from 5 in May and 8 in April 2023 and will be reviewed and areas of learning shared.
- **Falls:** 4 moderate harm falls, focused work plan for July with audit results and inclusion at Back to the Floor.
- **MCA:** Mental Capacity Act level 2 compliance for medical and dental has slightly improved at 71% for June 2023 compared to 68% in May 2023, however this is still below target. The MCA teams is launching a MCA Level 3 & train the trainer programme in July 2023
- **Mental Health:** Ongoing pressure of Paediatric Emergency and Inpatient services due to patients with complex mental health needs. 4 week programme of support in place from July 2023.

Never Events and Serious Incidents

- **Never Events:** The Trust declared zero Never Events in June 2023
- **Serious Incidents:** The Trust also declared 3 Serious Incidents in June 2023. 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 – JUNE 2023

Successes:

- **Mortality:** Similar to previous months, the HSMR for elective cases remains lower than expected, while non-elective cases dominate the overall trend. However, the monthly individual HSMR values for this quarter show promising signs of decline.
- There is minimal disparity in HSMR between patients admitted during the week and those admitted over the weekend, but both cohorts remain above the expected level.
- The rise in 12 months rolling SHMI continues to be high above the upper process limit looking at the latest available data up to Jan-23 (published 15th June 2023). There is little difference between the two sites.
- Work continues to provide assurance for safe patient care, including a deep dive into clinical outliers with the help of the mortality review committee and medical examiner's office.
- **Falls:** In June there were a total of 74 falls reported Trust wide (acute services), this is a 10% reduction from the previous month and equates to 3.9 falls per 1000 occupied bed days (OBDs). Epsom Hospital saw a 43% reduction in falls compared to January while St. Helier Hospital saw a 26% reduction.
- 4 incidents reported resulted in moderate or above harm within the Acute wards and 1 incident related to Estates where a patient fell in visitors car park. Of the 4 falls, 2 resulted in severe harm (both hip fractures) occurring on Mary Moore Ward and A5 Ward and 2 moderate harms (ankle, proximal humerus, and shoulder fracture) occurring on Gloucester Ward.

- **Pressure Ulcers:** 12 hospital acquired pressure ulcers were reported in June which was a slight decrease from the 14 reported last month. (n4 category 2, n1 category 3, n6 deep tissue injuries and 1 unstageable).
- The Deep Tissue Injuries were minor skin damage which are reported to be improving.
- There were no new/ emerging themes identified therefore mitigation and learning is being supported through the overarching Trust's recovery plans related to pressure ulcers management
- **Complaints**: 40 formal complaints were received during the reporting period which is a similar trend over the year. 82% of these met the 25 days response timeframe which is remarkable improvement from last month's performance; supported by interim Complaint's manager. Weekly review meetings chaired by GCNO have been successful in reducing of outstanding complaints dated back to last year.

- **FFT r**esponse rates remain low across all areas, similar to local Trusts across the system although positive responses have remained above 86%.

Challenges

- **VTE:** There continues to be a variation in assessment within 24 hours of admission across sites with a reported compliance of 76.5% in June 2023 which is lower than 83.7% reported last month. Performance data is expected to change post validation procedures. The Business Intelligence (BI) teams are creating a VTE Dashboard which will support data quality. A review of patients will commence in outpatients to ensure

that patients not meeting the criteria for VTE assessments are not included in the numbers.

- There were 7 HAT incidents including those incidents reported from other hospitals and the coroner which is a positive decline from 24 reported in May. The incidence of HAT VTE is highest among medical patients due to their level of frailty, acuity and long hospital stay.
- A QI workshop was held in June 2023 which was well attended and in which 33 VTE champions were identified who will proactively support the clinical areas using the established QI programmes.
- Additionally, Corporate staff Induction Training, which included VTE prevention, started on June 26, 2023, with on-going dates rolled out until July 2024.
- **Serious incidents:** Three serious incidents were reported in June 2023 related to Treatment delay meeting SI criteria, a Surgical complication resulting in significant harm to the patient and a fall resulting in a fractured neck of Femur.
- There are no active Prevention of Future Deaths reports at present for Epsom and St Helier.

2.3 SURREY HEALTH AND CARE

Community Hospital Bedded Units (Surrey) June

Successes

- Improved vacancy rate in Community Hospitals thanks to the recruitment of 11 international nurses. All have passed their OSCEs and only one is awaiting their PIN.
- We are rolling out monthly 15 steps reviews in our Community Hospitals.
- NEECH ward staff have been working to adopt the Trust IT and documentation in preparation for their amalgamation with Alex ward 1st floor Langley.
- Hand Hygiene Audit – 100%
- Cardiac Arrest Trolley Audit – 100%

Challenges

- Variety of food in our Community Hospitals is inconsistent-working with NHSPs regarding this.
- OT cover in our Community Hospitals is challenged due to sickness and vacancies which affects flow.
- Direct admissions from A&E where patients do not have their medication and TTOs. Community Hospitals do not have a weekend or out of hours pharmacy service. Individual transfers are being managed locally by the teams.

SDHC Community Services

Successes

- East Elmbridge Community Nursing team entered the Nursing times Awards 2023 and have been shortlisted as finalist.
- Improvement in the open incident closure.

- Hand Hygiene Audit – 100%

Challenges

- Obtaining patient feedback remains a challenge.
- Relocation of services from West Park site to Langley Wing – due July 2023.

SHC Community Services

Successes

- No complaints
- Reduction in open incidents on Datix
- Hand Hygiene audit – 100%
- Head of Children's Services and Deputy Director Sutton Health and Care in post
- Local Councillor visits
- Learning Disabilities Health Facilitation Team shortlisted for HSJ Award

Challenges

- Supply of insulin safety needles
- Temperature of storage of medication in clinic
- Estates space

Shared issues

- Safeguarding – increase of neglect or below required level of care – complex issue involving multiple agencies and patient choice.
- District nursing vacancies, particularly Band 5
- Lone working audit in progress for June 2023

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

In line with other trusts in London, the PTL has been rising again at both trusts with a significant impact from industrial action. SGH PTL remains on plan, but ESTH is above the planned level. It is anticipated that this position will remain challenged in the foreseeable future. ESTH continues to focus on outpatient transformation with good utilisation of Patient Initiated Follow Up (PIFU) pathways and increasing uptake of advice and guidance. SGH has

been working through digital solutions to support the coding of advice and guidance, and the phased implementation of digital clinic cashing up between October 2023 and March 2024 to support a gradual increase in PIFU in the individual specialties. 18-week breaches have reduced at both trusts.

Long-waiting patients

There is a trend of rising numbers of patients waiting for a long time for definitive treatment (>52 and 65 weeks) at both trusts with more impact on performance at ESTH. The rising numbers of patients waiting for a first appointment in the most challenged specialties is starting to impact on 65 week waits. Challenged specialties remain Community Paediatrics, Gynaecology, Gastroenterology and Cardiology at ESTH, and Cardiology and Paediatric ENT at SGH. Drivers remain industrial action impacting on both trusts with increasing referral rates at ESTH impacting on Gynaecology waits and capacity issues in Community Paediatrics as additional factors. Activity levels for June are broadly on track in non-admitted pathways.

Diagnostics

Diagnostic performance has shown steady improvement at both trusts. SGH have maintained excellent performance for the proportion of patients receiving their diagnostic tests within six weeks (DM01 performance) achieving 98.8%% against the national standard of 95%. There are some challenges in some of the low volume diagnostic tests (sleep studies and urodynamics). ESTH are still below the national standard at 92.5% but are approaching the target of 95%. There are reducing numbers of patients waiting for more than six weeks in high volume diagnostic tests (endoscopy, ultrasound 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 SGH and 73.3% at ESTH against a target of 85%). Both trusts have agreed a trajectory to return to 85% capped theatre utilisation by the end of March 2024. A broad range of actions are being taken at both trusts, but a clear focus is needed to improve delayed starting times and numbers of cases scheduled, particularly in Day Case Theatres, SWLEOC and Queen Mary's Hospital theatres. SGH have provided targeted support to increase activity in low volume complex theatre activity such as Cardiac Surgery and Neurosurgery.

3.2 CANCER

Whilst cancer performance is comparatively good for both trusts against London peers, it remains fragile. Good results should be noted at both trusts for achieving the Faster Diagnostic Standard (FDS) and the 62-day target for definitive treatment at ESTH. The excellent performance at ESTH should be noted. However, industrial action and capacity issues have impacted on the 14-day first appointment target at both trusts with ongoing challenges in Gynaecology and Dermatology at ESTH, and a broad range of specialties at SGH. There is close focus and monitoring via the cancer access teams. The numbers of patients waiting for more than 62 days without definitive treatment have been impacted by

industrial action, but both trusts are focusing on this cohort of patients in recovery planning. SGH have more patients than planned with 134 patients still waiting for more than 62 days without definitive treatment. ESTH remain on plan.

3.3 NON-ELECTIVE CARE

Both trusts did not achieve the national standard of discharging >76% within 4 hours of arrival in the Emergency Department (ED). High volumes of patients, higher ambulance conveyancing rates, significant numbers and complexity of mental health patients and significant flow challenges within and out of the hospital have contributed to challenges in the delivery of this standard, along with other metrics such as ambulance handover delays and patients waiting for more than 12 hours in the department. The sustained improvement in ambulance handover delays at SGH should be noted.

3.4 INTEGRATED CARE

2-hour urgent care response is being maintained above the national standard (70%) within Sutton and Surrey Health and Care, and there is a rising trend of referrals in Sutton. Discharges on Pathway 3 (patients requiring 24-hour nursing care) 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
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Group Integrated Quality & Performance Report

June 2023

Presented by: James Marsh Group Deputy Chief Executive Officer
June 2023

Executive Summary
Safe, high-quality care

NHS
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. The first Trust wide falls audit took place in June 2023, this will inform an update of the current falls Trust action plan.

Pressure Ulcers: The Trust reported zero medical device related category 3, 4 and unstageable pressure ulcers in June 2023. Incidents of these pressure ulcers has remained below or the same as the mean for the 4th consecutive month

Infection control: The Trust has had zero MRSA bloodstream infections and the overall reduction in the number of Influenza cases continued in June 2023

MCA/ DoLs: Mental Capacity Act level 2 compliance for Nursing remains steady at 92%. Allied Health Professional compliance continues to improve with an increase from 82% to 86% since last month.

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 – Significant focus on sustaining the supernumerary status of the Co-Ordinator on Delivery Suite with a sustained rate of 98.5%.. Maternity Triage staffing prioritised to ensure effective and safe care at the point of entry to the unit with the latest audit showing 95% of women are seen within 30 mins of arrival. Ongoing low rate of hypoxic incidents in our neonatal population. Q1 for 22/23 had 0 HIE incidents in our inborn population. Very low perineal trauma rate at 1.7% of all vaginal births.

Challenges

Pressure Ulcers: : The Trust reported 9 category 3, 4 and unstageable pressure ulcers in June 2023. This is slightly up from 5 in May2023 and 8 in April 2023 and will be reviewed and areas of learning shared.

Falls: 4 moderate harm falls, focused work plan for July with audit results and inclusion at the Back to the Floor meeting.

MCA: : Mental Capacity Act level 2 compliance for medical and dental has slightly improved at 71% for June 2023 compared to 68% in May 2023, however this is still below target. The MCA teams is launching a MCA Level 3 & train the trainer programme in July 2023

Mental Health: Ongoing pressure of Paediatric Emergency and Inpatient services due to patients with complex mental health needs. 4 week programme of support in place from July 2023.

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: Healthy Eating Week- Good participation with the Healthy Eating Quiz as an educational tool.

Novice NG training began this month with good engagement. Update training continues alongside.

Nutrition Champion's programme to commence in September 2023 for the appropriate areas invited.

Complaints: Significant improvement in response times from 64% to 82%, attributed to appointment of interim complaints manager and weekly review of outstanding backlog.

Pressure Ulcers: 12 hospital acquired pressure ulcers were reported in June which was a slight decrease from the 14 reported last month.

Dementia Screening: Improved trajectory from 64% to 80% in June. Traction is required to sustain improvement.

Falls Prevention and Management : The number of falls have continued to show an improved trajectory with the lowest numbers of falls per 1000 beddays since last year.

Infection Control: Zero Trust MRSA bacteraemia for June.

Challenges

Infection Control: There were 2 cases of C.Diff in June (year to date 11). Common themes included are recent and/or frequent hospitalisations.

VTE: Risk Assessment Screening remains a challenge, despite targeted training and support by use of VTE champions. Worth noting that data validation is yet to take place and a review of patients meeting the criteria for assessment in outpatients will commence.

Mortality:

Although there has been an improved trajectory in HSMR, we have recorded increasing ED mortality rate. ED audit plan in place to identify the specifics of the pathways mostly attributed to delays in waits in DTA patients.

Maternity: CQC inspection preparations are ongoing supported by adaptable action plan. Entonox monitoring devices have been ordered but yet to be received. This remains a risk.

Executive Summary Elective Care

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St George's Hospital

Successes

- Outpatient performance is expected to be 112% after catch-up for June, which is ahead of plan. Outpatient focus on uncashed has launched and working very closely with all services to increase compliance within clinics on the day – ended on 0.58% uncashed for May'23.Significant improvement from 1.3% for March, the June position is part of the Trusts Perfect Week and the aim is to drive down the number of cashing up errors.
- 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 is in the planning phase to commence in October 23.
- The number of patients waiting over 65 weeks remains ahead of trajectory and is on track to achieve year end targets.
- At the end of June, the Trust reported 98.8% of patients waiting less than six weeks for a diagnostic test, continuing to meet the recovery target of 95% and ahead of internal trajectories. Endoscopy continue to reduce their backlog.
- Cancer Faster to Diagnosis Standard performance continued to exceed target of 75%
- Successful recruitment in cardiac anaesthesia with five new consultants starting between May-October. Planning is underway to increase the provision of cardiac surgery in line with recent appointments.
- NECU (Neurosurgery Enhanced Care Unit) opened in July, with ongoing work to embed the pathway in daily elective work, reducing demand for Neuro ITU beds.

Challenges

- Incomplete non-admitted pathways continue to rise with 680 patients with a projected wait of over 40 weeks for a first appointment . 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. Recovery plans are actively managed through Elective Access.
- Junior doctor and consultant strike impact - has been significant on the OP booking team who have supported manually cancelling and rescheduling +600 appointments within one week.
- Two week wait cancer performance in May decreased to 81.6%, a number of tumour groups were impacted by strikes and public holidays. 62 day performance decreased to 68.9%**,** challenges seen in urology due to access to prostate and later inter trust transfers Tumour specific recovery plans in place.
- Challenges related to patient flow continued in June, impacting recovery and PACU. Elective and Day Case activity across the Trust was inadvertently impacted by the bank holidays and industrial actions.

Epsom & St Helier

Successes

- Outpatient and elective activity is expected to be on plan once data catch up / coding is completed.
- DM01 (diagnostics) continues to be pressured, but patients waiting more than 6 weeks in Jun23 has reduced to 931 from 1101 in May23. The modalities with the highest volume of patients waiting over 6 weeks are NOUS, ECHO, Audiology and Urodynamics (Gynae).
- The Admitted PTL (excluding diagnostics) has begun to stabilise with the end of Jun23, a slight increase from previous month.
- PIFU rates have remained above 3% for the 5th consecutive month.

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.
- 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.
- Lung CT guided biopsy waiting list has significantly reduce in part due to mutual aid support with St George's. However, Radiology team have worked hard to increase IR capacity and the endoscopy unit has been detrimental in providing recovery beds.
- EBUS capacity at St George's has improved with St George's providing a weekly list of available capacity.
- Outpatient and elective activity is slightly below plan, but expected to remain above the mean and is slightly below plan for June. This is expected to increase with data catch up / coding.

Challenges

- 52 week waits continue on an upward trend each month. A slight reduction is expected in Jun23 due to **no** industrial action or additional bank holidays, but for Jul23 it's expected to increase due to IA. The most pressured specialities for 52wk waits are Community Paediatrics, Gynaecology, Cardiology and Gastroenterology.
- Patients waiting over 65 weeks for treatment increased in May23 (18 Gynae, 12 Comm Paeds, 5 Gastro, 5 GenSurg and 12 scattered across other specs)
- Total PTL volume has seen a further increase from 50032 in Apr23 to 50124 in May23.

Cancer:

- The 14day standard has not been met in May. This was largely due to Gynaecology and Dermatology service unable to meet the GP TWR demand. Various work streams are being worked on to mitigate capacity issue including providing extra clinics and converting routine appointments to TWR slots, exploring different models of provision of care.
- 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 however St George's is assisting with capacity.

Executive Summary Non-Elective Care

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

St George's Hospital

Successes

- June's LAS handover performance continues to be strong, with 93.44% of LAS offloads <15 minutes.
- The BI team are developing a "Live" performance dashboard for UEC performance that will be on the screens throughout the department and key areas.
- The Homelessness and inclusion Team (HIT) and Emergency Department were been nominated for NHS Parliamentary Awards 2023. Awards ceremony took place early July, although we didn't win nationally were are delighted to be selected for regional nominees.

Challenges

- Overall 4 hour performance (all Types) in June faced significant challenges throughout the month, closing the month at 71.5%. This places SGH 10th in London and 62nd nationally. Multifactorial operational pressures contributed to this performance.
- On 12th June ED had a record breaking number of attendances in 24 hours, that being 580.
- ED's overall sickness rate was 4.4%, but particular challenges can be seen within the Nursing workforce.
- Significantly complexed Mental Health presentations to ED and ongoing Industrial Action impacting workforce resilience have also been contributing factors to lower performance.
- The ability of the department to admit patients to downstream wards was challenged further challenged due to two wards in the Trust closed for refurbishment works, which in turn increased the number of 12 hour trolley waits seen. Non-Elective admissions were higher than plan.
- 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 three months, the Trust has had an increasing number of Pathway 1 patients awaiting equipment.
- 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.

Epsom & St Helier

Successes

The mean daily Super Stranded numbers remain below the locally agreed ambition of 123 for the second month in a row, and the first time for 16 months.

Time to triage remains below the ambition of 15-minutes at 13-minutes in June 2023.

NEL admissions remains below our target for June at 2,042.

Challenges

We narrowly missed delivery of the 76% 4-hour standard in June 2023, reporting 75.06% performance.

Time to initial assessment for May 2023 was 127 minutes, a deterioration compared to April 2023.

There was a significant increase in > 60-minute ambulance handovers in June 2023, reporting 130 compared to 42 in May 2023.

Executive Summary
Our People

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

St George's Hospital

Epsom & St Helier

Successes

Sickness (Target 3.8%): •Rates are drifting slowly down to sit at 4.4% as at the end of June with stress and anxiety remaining the largest cause.

Vacancy (Target 10%): •Hovered around 12-13% for the past 2 years, sitting at 12.4% as at 30 June, the lowest in 12 months.

Challenges

Sickness (Target 3.8%):• Additional Clinical Services (largely HCAs at B2 and B3) were 7.2% with N&M at 5% .
•Estates & Facilities staff sickness is on a 6-month upward trajectory currently standing at 5.1%

Vacancy (Target 10%): N&M vacancies steadily climbing month on month from the Nov '22 low of 12% to 13.6% at the end of June.

Turnover (Target 12%): •The rolling 12-month figure is 14.7% with Clinical Services division at 21%, Medicine at 14%, W&C 13%, Renal 12% and Planned Care 11%.
•E&F is turning over 20% of its workforce.
•We lost almost 1 in 7 of our N&M workforce over the past year.

Appraisal ***(Target 90%)***
•Rates for non-medical staff remain depressed at 62% with particularly low rates for Estates & Facilities staff (25%) and Allied Health Professional (52%).
•Medical appraisals dropped to 74%.

Executive Summary Integrated Care

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

Sutton Health & Care (SHC)

Successes

SHC community nursing rate reduced to 18%.

SHC within 3.7% agency cap in first three months of the year.

2 hour community response remains above trajectory set at 70%. Month 3 - 86.4%.

Length of stay within Virtual Ward decreased. Month 3 - 10 days.

Challenges

Waiting lists for Children's Therapy (routine).

Speech and Language (SALT) increased to 28.57 (weeks) ; Occupational Therapy (OT) increased to 43.95 (weeks).

Surrey Downs Health & Care(SDHC)

Successes

High levels of MAST (92%) and Appraisal rate (83.1) maintained.

Further reduction in temporary staffing usage to 7.3% in M3.
Improvement in waiting lists across all services.
Improvement in discharge flow with a median of 3 days for referral to discharge.

West Park Relocation- Relocation of services to new bases. All completed except Mary Seacole unit due 3rd of August. A leaving get together event was organised on the 14th of July .

Staff engagement sessions completed with implementation of action plan in progress.

Challenges

Community Nursing vacancy rates remain high at 27% Golden Hello scheme launched with good initial response.

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	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Never Events	0	1	2	0	0	3		0	0	1	0	0	1	
Serious Incidents	TBC	3	3	3	TBC	9		TBC	1	4	3	TBC	8	
Number of Falls With Harm (Moderate and Above)	TBC	2	3	4	TBC	9		TBC	2	1	4	TBC	7	
Pressure Ulcers - Acquired catergory 3&4	0	8	5	9	0	22		0	1	3	1	0	5	
Dementia - Assessment & Investigation of Patients at risk of Dementia		NA	NA	NA	NA	NA		90%	65%	64%	80%	90%	70%	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	92%	92%	92%	90%	92%			NA	NA	NA	NA	NA	
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	78%	80%	82%	85%	80%			NA	NA	NA	NA	NA	
Infection Control - Number of Cdiff - Hospital & Community	4	2	7	5	12	14		4	5	4	2	16	11	
Infection Control - Number of MRSA	0	0	0	0	0	0		0	0	1	0	0	1	
Infection Control - Number of E-Coli	7	8	6	5	21	19		5	3	6	9	15	18	
VTE Risk Assessment	95%	95.6%	95.5%	96.8%	95%	96.0%		95%	85.2%	85.4%	78.6%	95%	83%	
Mortality - HSMR	<100	89.6	90.2	89.9	<100	89.9		<100	111.70	111.80	111.83	<100	111.78	
Mortality - SHMI	<1	0.94	0.94	0.94	<1	0.94		<1	1.18	1.14	1.19	<1	1.17	
Number of Complaints Received	TBC	53	65	62	TBC	180		TBC	34	41	40	TBC	115	
Complaints responded to in 25 days	85%	100%	100%	100%	85%	100%		85%	45%	69%	82%	85%	65%	

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

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

Maternity	St George's							Epsom and St. Helier						
	Monthly Target / Threashold	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Caesarean Section Rate	N/A	32.0%	35.1%	35.8%		34.3%		N/A	38.5%	38.6%	40.7%		39.3%	
% Births with 3rd or 4th degree tear	<5%	3.7%	3.3%	1.7%	<5%	2.9%		<3%	1.7%	4.1%	0.6%	<3%	2.1%	
% Births Post Partum Haemorrhage >1.5 L	<4%	3.4%	4.4%	3.2%	<4%	3.7%		<4%	3.1%	2.9%	3.1%	<3%	3.0%	
Total Births	>433	326	390	345	5000	1061			295	321	293		909	
Birth Rate - Vaginal	>60%	54.5%	55.4%	63.0%	>60%	57.6%			47.8%	49.1%	50.3%		49.1%	
Birth Rate - Instrumental	<14%	17.5%	14.6%	9.5%	<14%	13.9%			13.8%	12.0%	9.0%		11.6%	
Screening - booked before 9+6 weeks	>90%	52.4%	50.2%	45.7%	>90%	49.4%		>90%	86.1%	86.2%	86.7%	>90%	86.3%	
Screening - booked before 12+6 weeks	>90%	93.4%	91.7%	88.1%	>90%	91.1%		>90%	98.6%	99.1%	98.0%	>90%	98.6%	
1:1 support in labour	>80%	99.0%	96.1%	97.1%	>80%	97.4%		>95%	98.6%	98.4%	99.7%	>95%	98.9%	
Continuity of Care*		23.7%	10.5%	14.7%		16.3%			80.9%	80.5%			80.7%	
Still births per 1000 births	<2.6	15.4	2.5	2.7	<2.6	6.9			3.40	3.10			3.3	
Neonatal deaths per 1000 births	<1.5	0.00	2.0	0.0	<1.5	0.67			6.80	0.00			3.4	
HIE (Hypoxic ischaemic encephalopathy rate	<2.2	0.00	0.00	2.89	<2.2	0.96			0.00	0.00			0.0	
Band 7 supernumerary status – rate	100%	91.7%	98.4%	99.0%	100%	96.4%			87%	81%	92%		86.7%	
MDT training compliance – rate	90%	80.0%	80.6%	77.98%	90%	79.5%			76%	84%			79.6%	
Vacancy rate	<=10%	-6.0%	-8.3%	-6.58%	<=10%	-6.9%			5.6%	5.6%	5.8%		5.7%	
MDT handovers Rate	100%	100.0%	53.0%	100.0%	100%	84.3%			100%	100%	100%		100.0%	

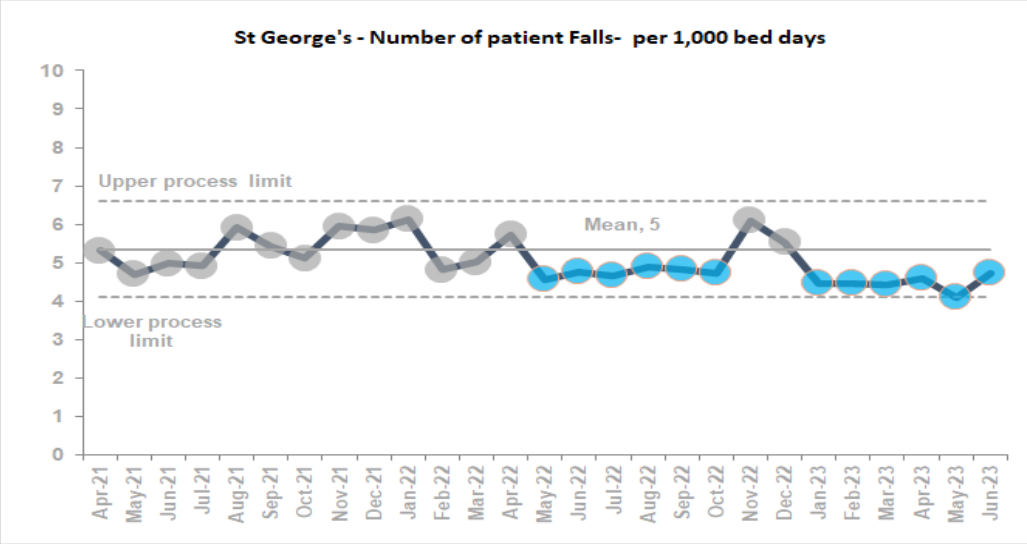
Blanks spaces indicate no data received

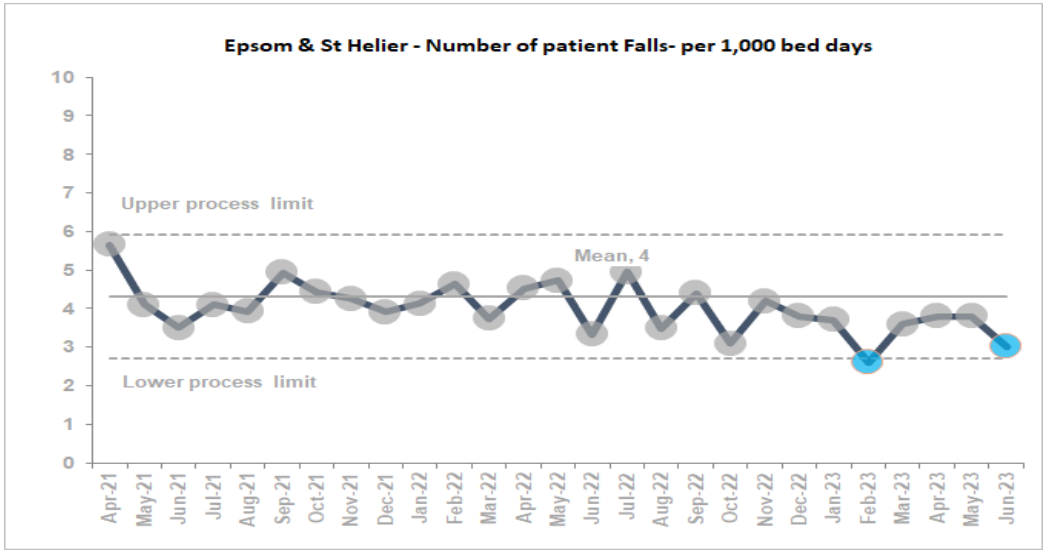
* Please note that CoC metrics have changed from May 2023 data to reflect NHS England requirements based on their definition. Data changes will be backdated to reflect NHS England reporting requirements as advised by NHS England.

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

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

Target: TBC	SGH: 4.7	ESTH: 3.0





SGH updates since last month

There were a total of 115 falls across all services in June 2023. Rates per 1,000 Occupied Bed Days were 4.7 in June 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 4 moderate harm fall in June 2023 all within a medical inpatient area.- 1 patient has been discharged, 2 remain inpatients and 1 has sadly passed away but this was not related to the fall. A Trust level action plan is in place and monitored by the falls steering Group.

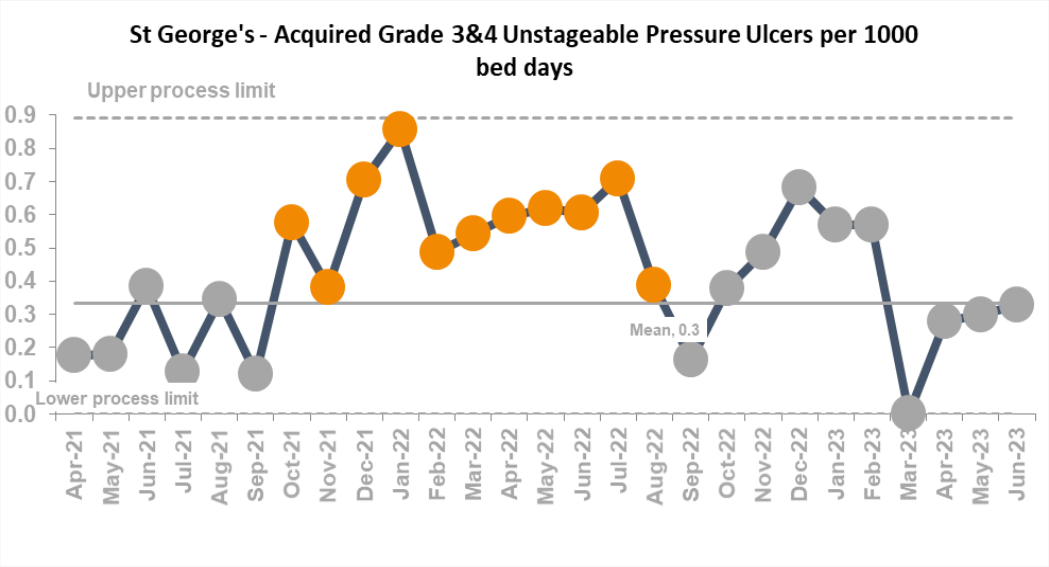
ESTH updates since last month

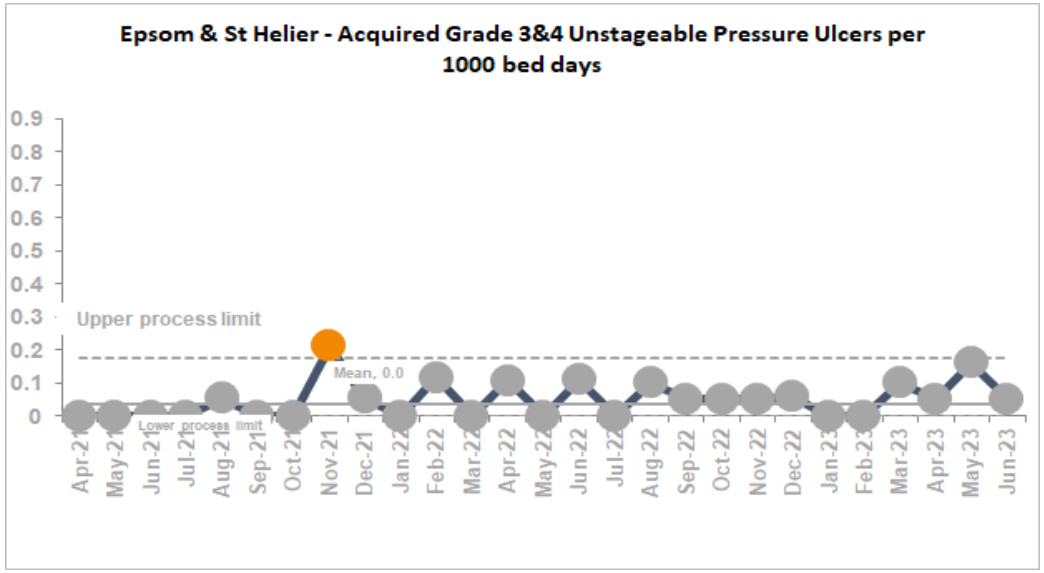
In June there were a total of 74 falls reported Trust wide, this is a 10% reduction from the previous month and equates to 3.9 falls per 1000 occupied bed days (OBDs). Epsom Acute Hospital saw a 43% reduction in falls compared to January while St. Helier Acute Hospital saw a 26% reduction.4 incidents reported resulted in moderate or above harm within the Acute wards and 1 incident related to Estates where a patient fell in visitors car park. Of the 4 falls, 2 resulted in severe harm (both hip fractures) occurring on Mary Moore Ward and A5 Ward and 2 moderate harm (ankle, proximal humerus and shoulder fracture) occurring on Gloucester Ward. There were no new/ emerging themes identified therefore mitigation and learning is being supported through the overarching Trusts recovery plans.

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: 0.33	ESTH: 0.05





SGH updates since last month

There were a total of 9 category 3, 4 and unstageable pressure ulcers in June 2023 [6 category 3 and 3 unstageable], There were no category 3, 4 and unstageable medical device related pressure ulcers which is an improvement compared to May (1) and April (2.) Rates per 1000 bed days have been stable since March 2023 (around 0.3) and down from quarter 4 2022/23.

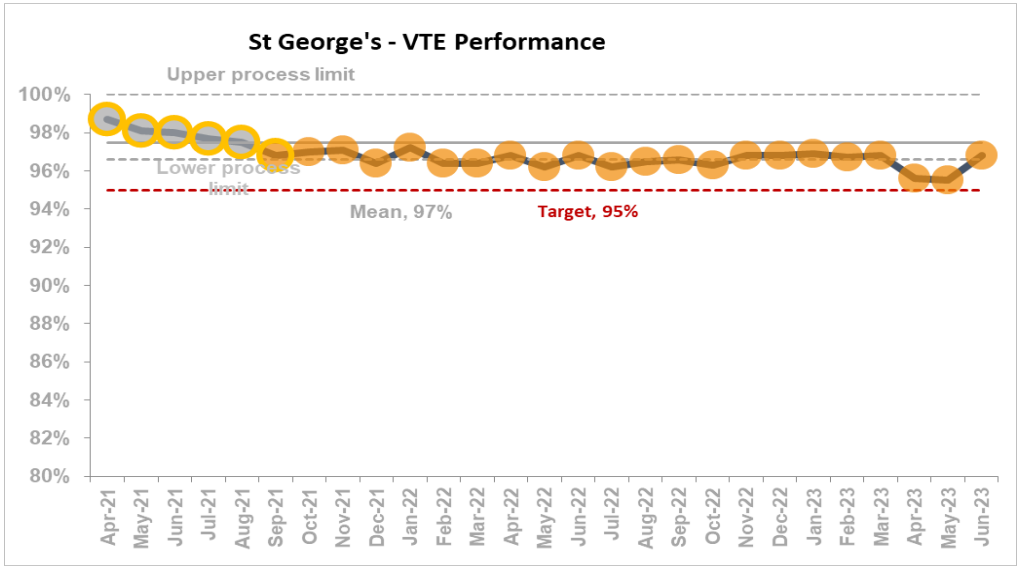
ESTH updates since last month

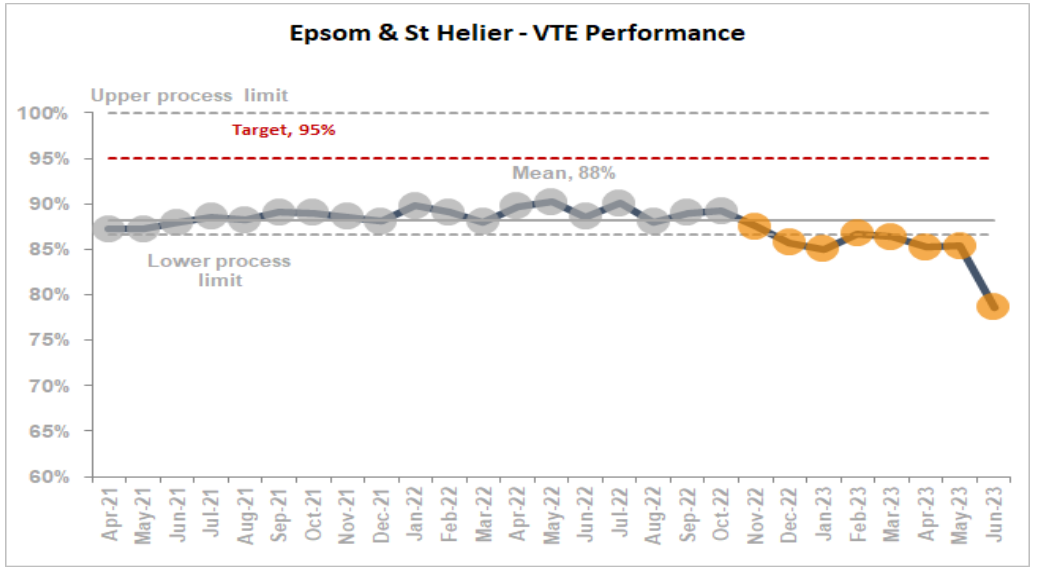
12 hospital acquired pressure ulcers were reported in June which was a slight decrease from the 14 reported last month. (n4 category 2, n1 category 3, n6 deep tissue injuries and 1 unstageable).The category 3 pressure ulcers were small ulcers. Prevention strategies for pressure ulcers were in place for both patients. The Deep Tissue Injuries were minor skin damage which are reported to be improving.

VTE Risk Assessment

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

Target: 95%	SGH: 96.8%	ESTH: 78.6%





SGH updates since last month

Performance against VTE Risk Assessment continues to shows special cause variation with a deteriorating position, with performance returning to level seen two month prior. Deputy CMO and corporate nursing to meet to support Trusts HAT group and delivery of action plan.

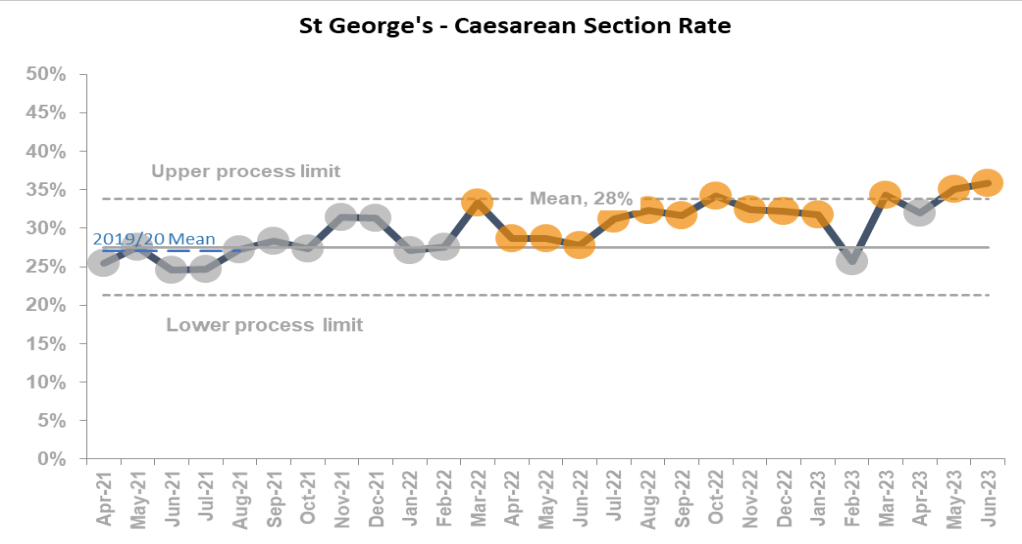
ESTH updates since last month

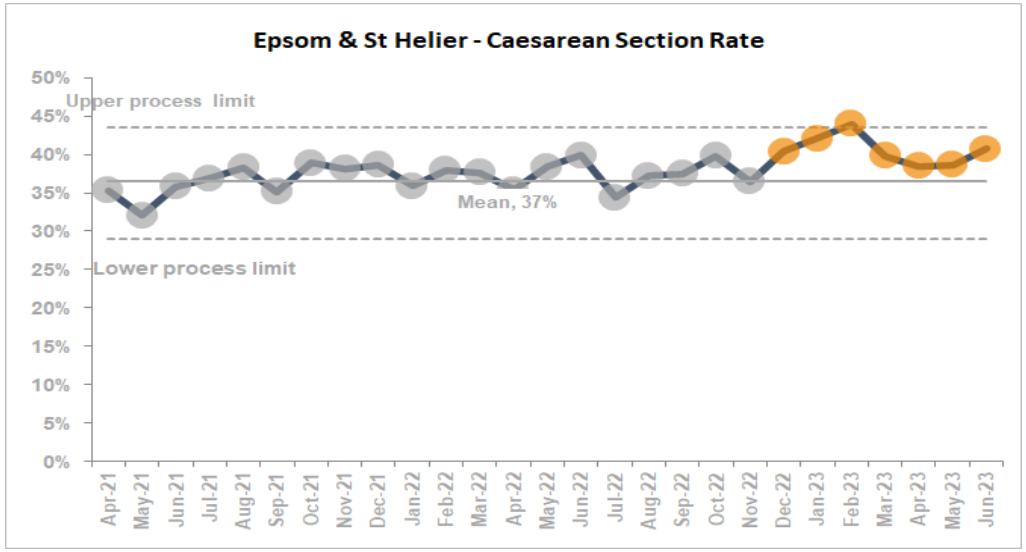
There continues to be a variation in assessment within 24 hours of admission across sites with a reported compliance of 76.5% which is lower than 83.7% reported last month. performance data is expected to change post validation procedures. VTE Dashboard is now ready for use which will support data quality. There were 7 HAT incidents including those incidents reported from other hospitals and the coroner which is a positive decrease from 24 reported in May. The incidence of HAT VTE is highest among medical patients due to their level of frailty, acuity and long hospital stay. A QI workshop was held in June which was well attended an in which 33 VTE champions were identified who will proactively support the clinical areas using the established QI programmes.

Caesarean Section Rate

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

Target: NA	SGH: 35.8%	ESTH: 40.7%





SGH updates since last month

Total Caesarean section rates were 35.8% for June (split as 19% for emergency cases and 16.8% for elective cases).
There was one admissions to NNU (term baby) for active cooling in June with a normal MRI noted – working diagnosis of potential sepsis.

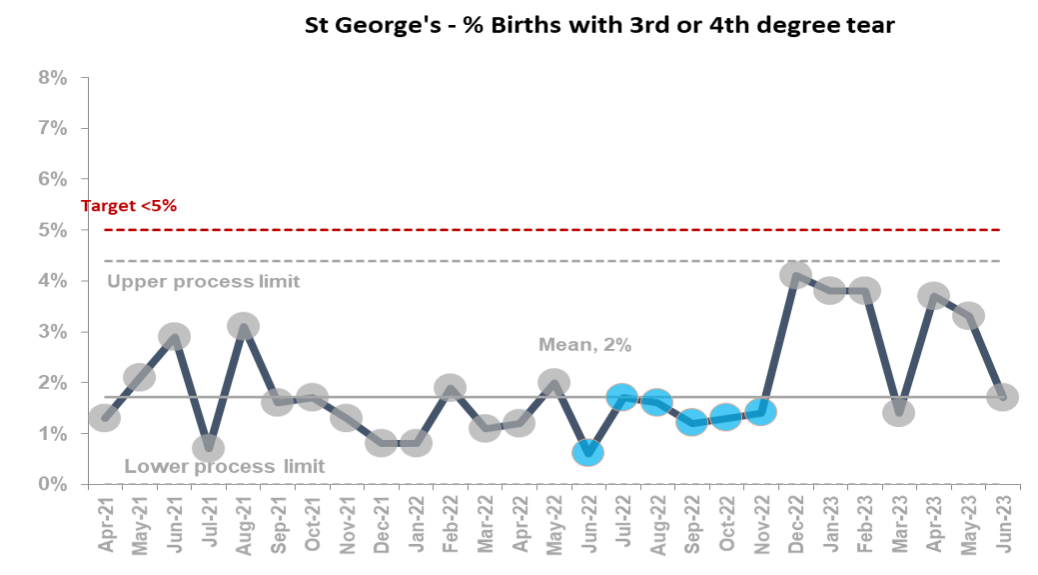
ESTH updates since last month

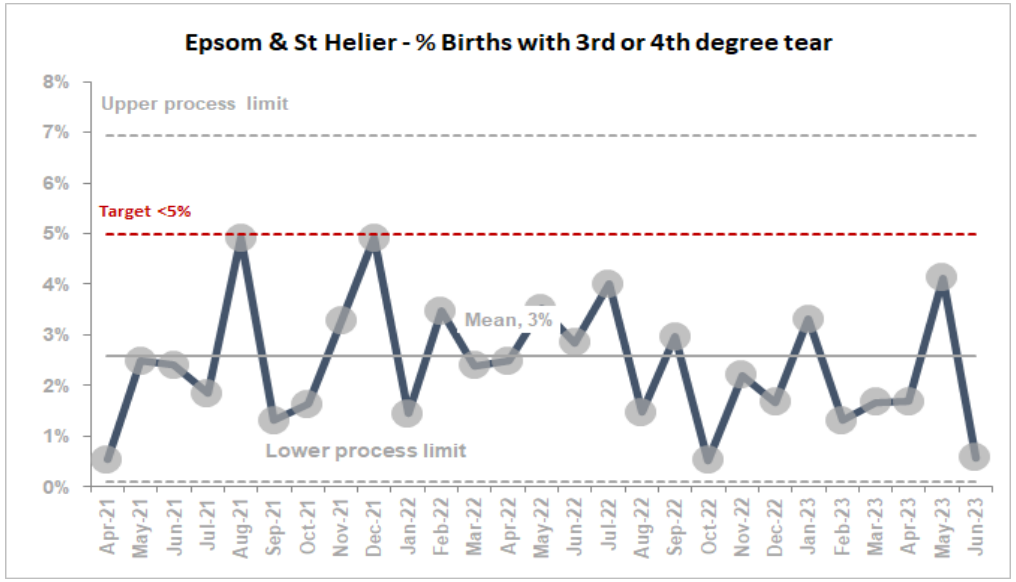
The total caesarean section rate in June 2023 was 40.7%, similar trend to last month. with a rate breakdown 21.2% unplanned and 17.4% planned. No cases of HIE (hypoxic ischaemic encephalopathy).

% Births with 3rd or 4th degree tear

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

SGH Target: <5%	SGH: 1.7%	ESTH Target: N/A	ESTH: 0.58%





SGH updates since last month

The number of 3rd or 4th degree tears shows a decline for June at 1.7%. Incidents of perineal trauma are not wholly preventable however we audit against recommended practice of 'hands on' and outcomes remain well below the national average. Perineal protection at delivery is an area of focus and point of discussion and education across the MDT groups. We have now recruited an additional Pelvic Health Midwife (fixed term – SWL funding) to support a national pilot.

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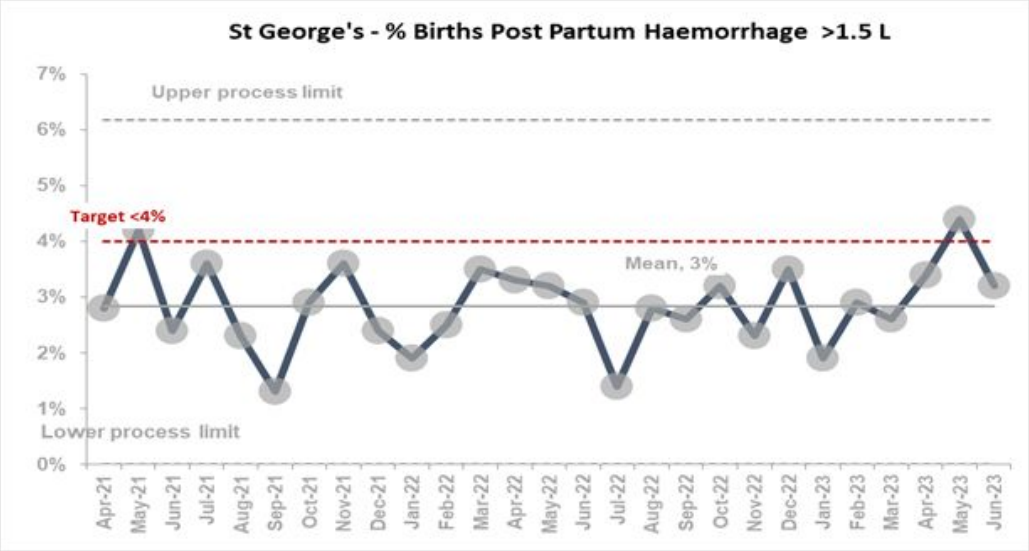
ESTH updates since last month

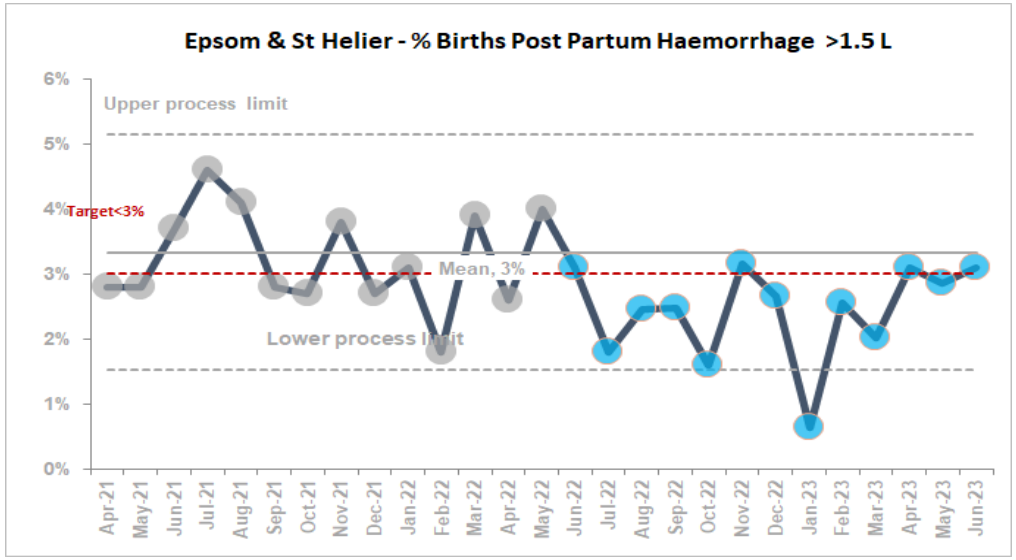
Only one 3rd /4th degree tear recorded for June. Appropriate action was taken at delivery and an episiotomy was performed which unfortunately extended into a 3rd degree tear.

% Births Post-Partum Haemorrhage >1.5 L

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

SGH Target: <4%	SGH: 3.2%	ESTH Target: <3%	ESTH: 3.1%





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: C. difficile Infection (CDI) and E. Coli Bacteraemia continue to be over NHSI/E set trajectories for the 2023-24 financial year. This is the situation nationally. Actions taken include IPC review of all E Coli and C Diff cases with learning shared

Never Event: The Trust had no never events and 3 declared serious incidents in June 2023

MCA: Mental Capacity Act level 2 compliance for medical and dental has improved at 71% for June 2023 compared to 68% in May 2023, however this is still below target.

In response to incidents involving patients that lack capacity absconding an environmental audit was completed and findings presented at the Back to the Floor meeting in June 2023, a Trust level action plan is currently in development for completion in July 2023.

Mental Health: Temporary closure of local mental health unit led to increased numbers of child adolescent and mental health admissions. Senior leaders debrief meeting held. Unit reopened and patients were transferred. No incidents of harm occurred. Ongoing pressure of Paediatric Emergency and Inpatient services due to patients with complex mental health needs.

Maternity:-June birth rate was 345 with high levels of obstetric complexity throughout with good clinical outcomes as reflected in the associated KPI's. Core Connector Walk Round by SWL LMNS reported 6/8 women in the antenatal settings graded their level of satisfaction as 10/10 and 100% of the women spoken to in the postnatal setting graded their level of satisfaction as 10/10.

SGH future action -

Infection Control: A Trust level Clostridium Difficile infection action plan is in place including:

An increased focus on 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 re-commence and Rapid response of C Diff to be discussed in local Mortality and Morbidity reviews. Key priorities to reduce Ecoli bacteraemia for 2023/24 are:

Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch and IPC team to work closely with the Urology CNS team to support education and awareness across Trust, E. coli focus week

MCA: -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.

Mental Health: Mental Health Support Workers have been authorised for 4 weeks to support patients and regular debrief sessions are being offered to staff.

Maternity-The response to the CQC inspection continues with high focus moving to MUST and SHOULD do's. Retention and Recruitment ongoing - 11 weeks since the last resignation in the midwifery staffing cohort. Recruitment is almost up to establishment with a pipeline of 4.8 Band 6 MW's and 15 WTE preceptorship Midwives (over establishment, as agreed by SLT) joining between now and Oct 2023 following NMC registration

ESTH current issues –

Pressure Ulcers: Increase in clinical demands for Tissue viability for face to face patients contact remain a challenge. Care delivery is being delayed for wound complex cases requiring expert opinion in ITU and Theatres and for wound debridement. Outstanding ward level investigation remains a concern as this is causing delay for local learning to improve practice.

Infection Control: There were 2 cases of C.Diff in June (year to date 11). Common themes included are recent and/or frequent hospitalisations.

VTE: Risk Assessment Screening remains a challenge, despite targeted training and support by use of VTE champions. Worth noting that data validation is yet to take place and a review of patients meeting the criteria for assessment in outpatients will commence.

Maternity: CQC inspection preparations are ongoing supported by adaptable action plan. Entonox monitoring devices have been ordered but yet to be received. This remains a risk.

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: Improvement on data validation and review of patients not meeting the criteria for assessment otherwise included and might be attributing to the low overall figures. Targeted training and support continues across all areas supported by VTE champions and outputs from a recent QI event.

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.

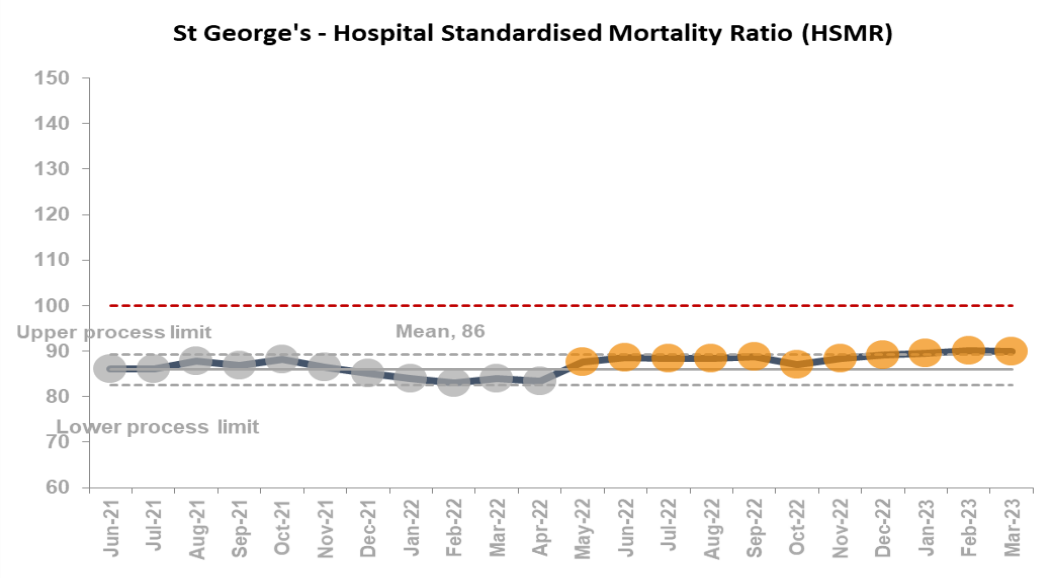
Pressure Ulcers : There were no new/ emerging themes identified therefore mitigation and learning is being supported through the overarching Trusts recovery plans related to pressure ulcers management.

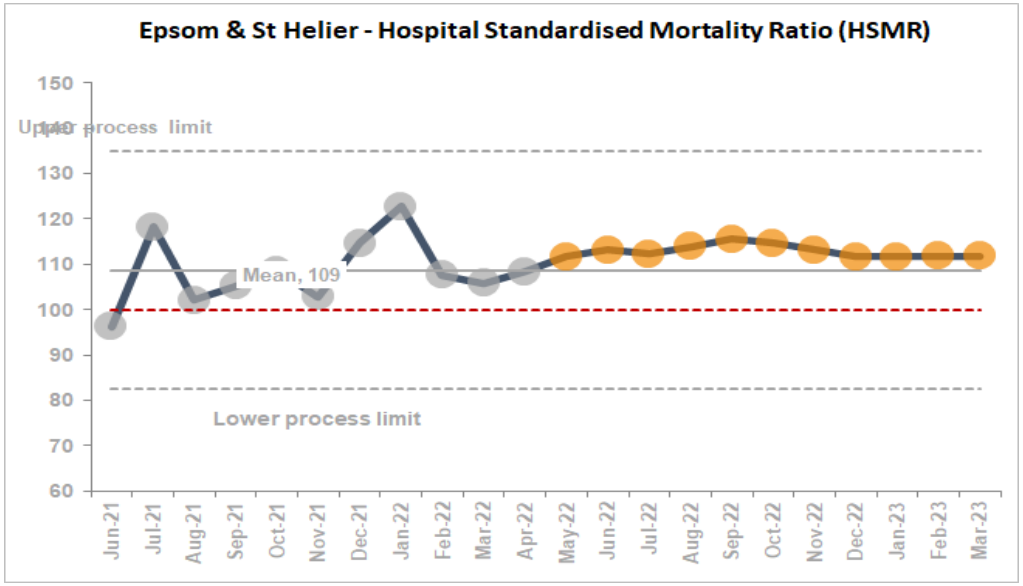
Maternity: 3rd/ 4th Degree tears-All 3rd / 4th degree tears are reviewed by a specialist midwife and any learning point identified are shared. Following an observed spike last year, all the 3rd and 4th degree notes were reviewed which found no themes or trends. In addition, the following changes have been made as part of the OASI trial: introduction of Epi- scissors; all midwives and junior/ middle grade doctors receive training on OASI care bundle.

Mortality – HSMR

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

Target: <100	SGH: 89.9	ESTH: 111.8





SGH updates since last month

Latest HSMR, for the 12 months from April 2022 to March 2023 shows our mortality remains lower than expected. Looking specifically at emergency admissions, mortality remains 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

The latest HSMR for the 12-month period from April 2022 to March 2023 continues to exceed the expected level; however, it has shown a flattening trend since September 2022. Similar to previous months, the HSMR for elective cases remains lower than expected, while non-elective cases dominate the overall trend. However, the monthly individual HSMR values for this quarter show promising signs of decline.

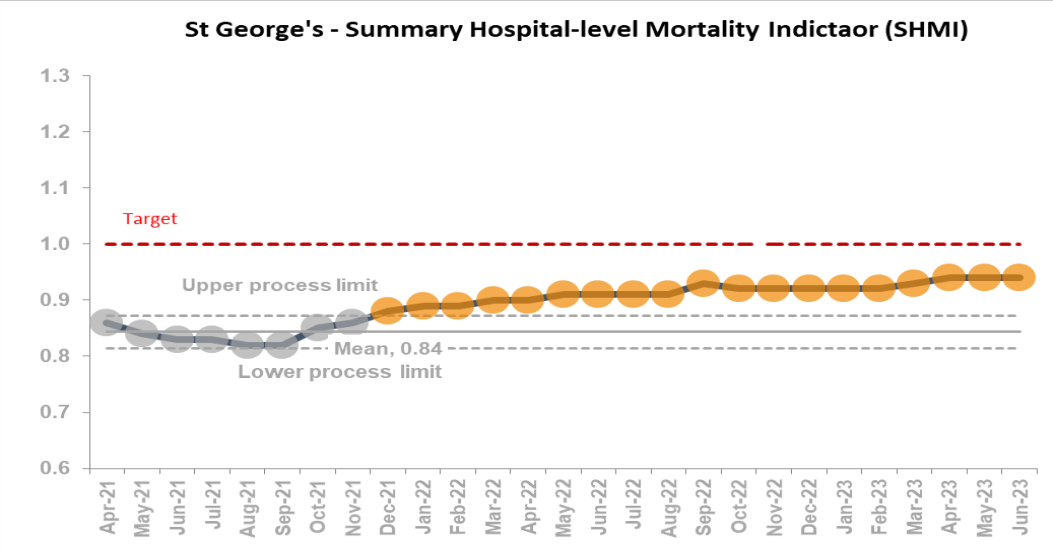
There is minimal disparity in HSMR between patients admitted during the week and those admitted over the weekend, but both cohorts remain above the expected level.

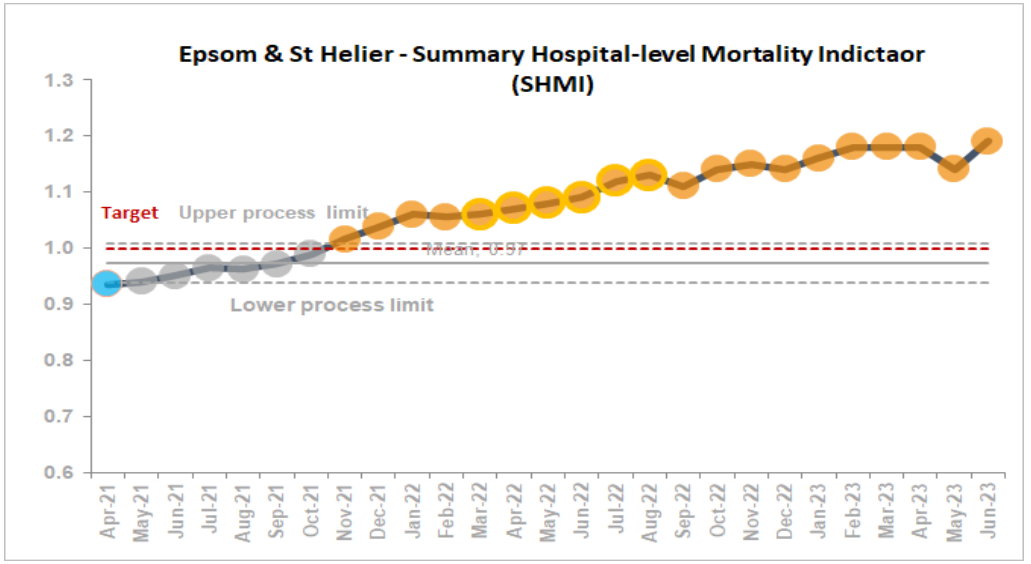
Data source: HED

Mortality – SHMI

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

Target: <1	SGH: 0.94	ESTH: 1.19





SHMI data based on rolling 12 months- February 2022 to January 2023

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.
SHMI data is based on a rolling 12 month period and reflective of period February 2022 to January 2023 (published 15th June 23).

Source NHS Digital

ESTH updates since last month

SHMI includes all inpatient mortalities that occur within a hospital. The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged. Deaths related to COVID-19 are excluded from the SHMI.

The rise in 12 month rolling SHMI continues to be high above the upper process limit looking at the latest available data up to Jan-23 (published 15th June 2023). 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).
As previously reported the April publication of SHMI data showed a run of more deaths than expected in December 2022 related to sepsis. Following initial investigation as reported previously, the Trust lead for sepsis completed a detailed investigation which was shared with MMG in June. This showed that the increase was an unusual event due to a high number of patients with significant comorbidities attending with a high severity of illness. Examples of excellent care were observed; however, for a few patient some aspects of care could have been improved. Although these are unlikely to have made a difference to the outcome these aspects of care have been highlighted for discussion at local morbidity and mortality meetings.

SGH future action -

Cardiology outcomes continue to flag in both Dr Foster data and SHMI. Higher than expected mortality is seen in coronary angioplasty and acute myocardial infarction. An internal deep dive is being undertaken including benchmarking with other major heart attack centres to better understand the current issues. The orthogeriatric team will also lead an enquiry into our recent hip fracture mortality as a recent signal has been observed there.

ESTH current issues –

The monthly Reducing Avoidable Death and Harm (RADAH) Committee reviews diagnosis-level mortality data along with crude mortality rates. The increase in HSMR rates seen since Summer 2021 has adopted a flattening trend in recent published data. However, this is above the expected limit. SHMI overall mortality for this quarter covering discharges from February 22 to January 23 was categorised as 'higher than expected' at a value of 1.193. The HSMR mortality ratio showed a similar trend to the SHMI, but observed deaths have decreased compared to expected deaths, and the current value for the month of March is 102.1, a 5.0 decrease from February. The crude mortality rate further decreased to 1.5%, showing a promising trend. Although it's lower than June 22/23 (1.7%), it's still above the June 21/22 value (1.2%).

Work continues to provide assurance for safe patient care, including a deep dive into clinical outliers with the help of the mortality review committee and medical examiner's office.

Structured Judgement Reviews (SJR) were completed for 108 deaths. 2 deaths had an overall 'poor' score 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 caused by a wide range of issues that need to be assessed. A review of SJR's 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.

ESTH future action –

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.

An audit will be conducted to further investigate A&E deaths. A readmission mortality audit is also planned to probe more deeply into the causes of death in patients who have been readmitted within seven days of discharge. Critical Care Outreach will be improved with planned staff recruitment. A pathway for managing the deteriorating surgical patient at EGH has been formulated and to be implemented. More focus is given to improving surgical pathways and reducing related deaths.

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	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	65,773	57,661	69,335	68,941	181,807	195,937		53,886	45,104	53,371	52,987	146,961	151,462	
Patient Initiated follow ups	TBC	59	34	21	TBC	114		TBC	1,551	1,854	1,809	TBC	5,214	
Advice and Guidance	TBC	856	TBC	TBC	TBC	856		TBC	1,998	2,241	2,377	TBC	6,616	
Outpatient DNA rates	8%	12.1%	13.3%	12.9%	8%	12.8%		TBC	4.8%	5.0%	6.1%	TBC	5.3%	
New to follow up outpatient ratios	TBC	1.99	1.95	0.00	TBC	1.31		TBC	2.80	2.85	2.73	TBC	2.79	
Elective and day case activity	5,739	4,419	5,313	5,190	15,803	14,922		3,938	3,092	3,621	3,870	10,740	10,583	
Elective LOS	TBC	4.6	3.6	4.7	TBC	4.3		TBC	6.1	5.6	5.5	TBC	5.7	
Elective Day case rates	78%	78.0%	79.0%	78.4%	78%	78%		82%	83.8%	83.0%	83.5%	83%	83.4%	
Theatre Utilisation (Uncapped)	85%	82%	82%	82%	85.0%	82%		85%	76%	77%	76%	85%	76.4%	
Theatre Utilisation (Capped)	85%	77%	74%	74%	85.0%	75%		85%	74%	74%	73%	85%	73.5%	
Theatre Average Cases per Session	TBC	1.67	1.64	1.63	TBC	1.65		TBC	3.70	3.65	3.75	TBC	3.70	
On the day cancellations for Non Clinical Reasons	TBC	34	20	37	TBC	91		TBC	84	116	104	TBC	91	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	82.4%	75.0%	94.6%	100%	84%								

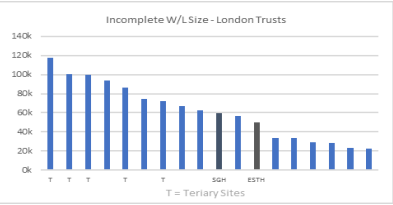
Monthly Overview – Elective Care (2)

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

Responsive and Productive Services - Elective Care	St George's Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend	Epsom and St. Helier Monthly Target	Mar-23	Apr-23	May-23	YTD Target	YTD Actual	13-Month Trend
RTT – total size of waiting list*	59,445	58,966	59,271	59,647				41,400	48,852	50,032	50,124			
RTT -Incomplete Median Waiting Times		10.4	11.4	11.1					12.0	10.7	11.0			
RTT - Waits over 52 weeks*	600	517	549	600				160	517	586	755			
RTT - Waits over 65 weeks*	168	70	57	63				TBC	18	16	52			
RTT – Performance	92%	67.9%	67.4%	69.3%				92%	67.1%	67.4%	68.1%			
Cancer 14 Day Standard	93%	87.0%	82.6%	81.6%				93%	96.0%	85.7%	89.7%			
Cancer 14 Day Standard Breast Symptomatic	93%	95.0%	92.2%	79.1%										
Cancer 31 Day Diagnosis to Treatment	96%	90.0%	92.2%	91.7%				96%	99%	100%	99%			
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.0%	83.0%	90.3%				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%	71.0%	75.6%	64.7%				90%	100%	100%	100%			
Cancer 62 Day Referral to Treatment Standard	85%	66.0%	69.5%	68.9%				85%	87.0%	86.4%	92.6%			
No. of patients over 62 days	105	91	116	134				59	34	49	34			
Cancer – 28 day Faster Diagnosis Standard	75%	78.9%	77.2%	77.4%				75%	79.8%	80.3%	79.6%			
	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Diagnostic activity	TBC	16,857	18,937	19,048	TBC	54,842		TBC	15,487	15,487	17,854		48,828	
Diagnostic performance	5%	1.3%	0.98%	1.1%				5%	10.7%	8.7%	7.5%			

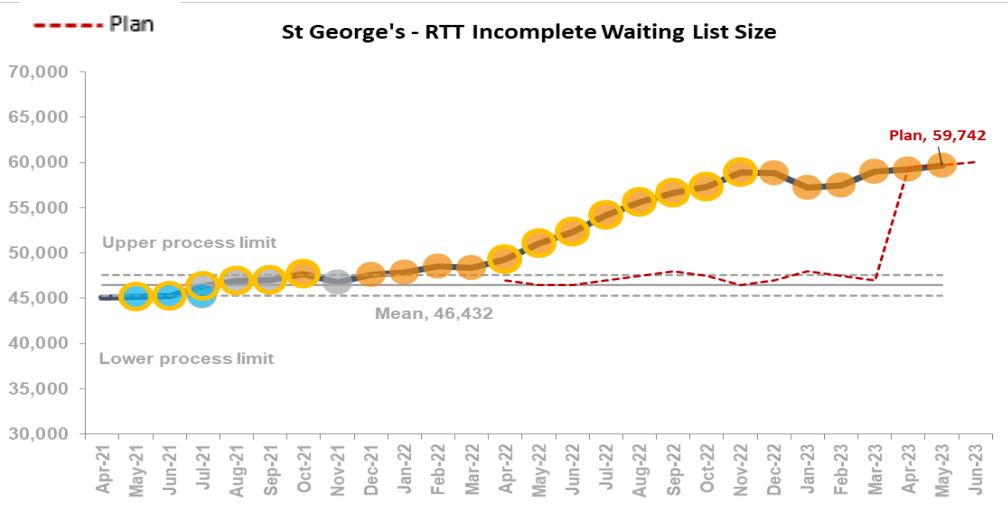
RTT – Total Waiting List Size

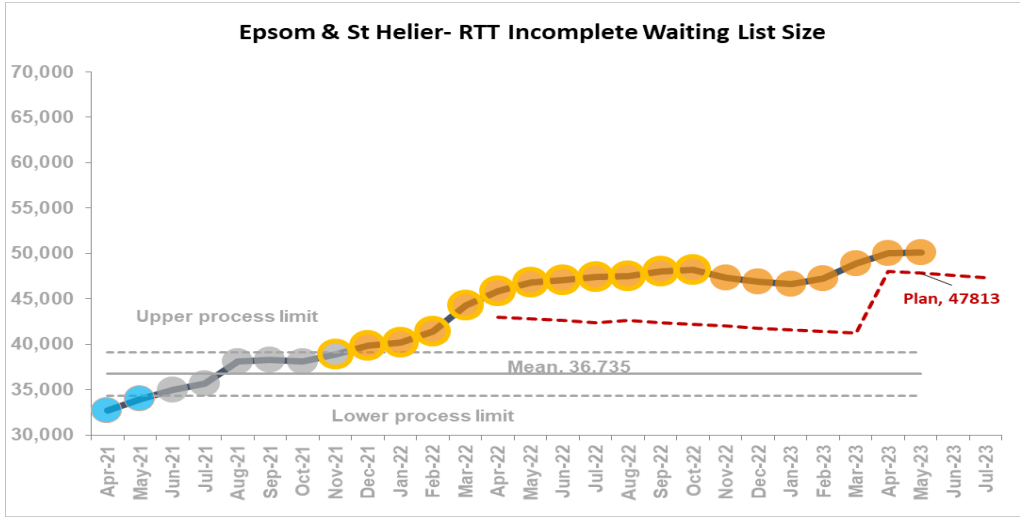
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

SGH Plan: 59,742	SGH: 59,647	ESTH Plan: 47,813	ESTH: 50,124





SGH updates since last month

PTL Volume size has increased by 0.6% compared to the previous month, however, remains within plan. Positively, 18wk breach numbers have reduced by 5% (1,043 pathways) meaning that 18wk performance has improved from last month (from 67.4% to 69.3%), this has been driven by Cardiology and Neurology. The largest proportion of 18wk breaches are within ENT however the service reported positive improvements over the month. The total number of clock stops through May increased by 33% (3,665 pathways) and continues to meet trajectory. Our >65wk trajectory continues to deliver and recovery plans have been agreed and monitored through Elective Access Committee.

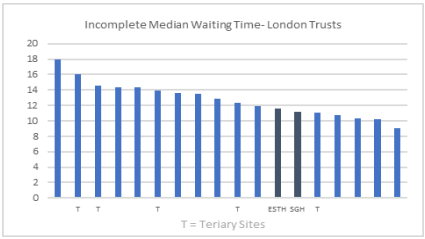
ESTH updates since last month

PTL volume has increased (albeit only by less than 0.2%), with (18w) breach numbers dropping (by 314 pathways, 1.9%), this has been driven by Gastroenterology with a reduction of 182 pathways. The combination of these two factors means that 18w performance has gone up from last month (from 67.4% to 68.1%). The largest proportion of 18wk breaches are within Gynaecology followed by Trauma & Orthopaedics.

RTT – Median Waiting Times

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

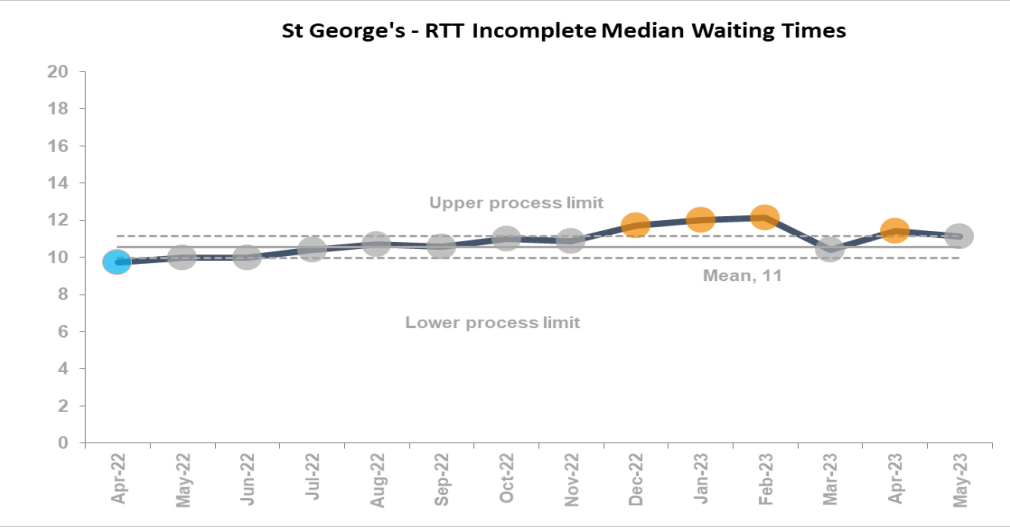
Average (median) waiting time (in weeks)
This is the mid-point of the RTT waiting times distribution. The median is the 50th percentile. It's the time that 50% of patients waited less than, e.g. the waiting time of the middle patient if you lined them up from shortest wait to longest wait.

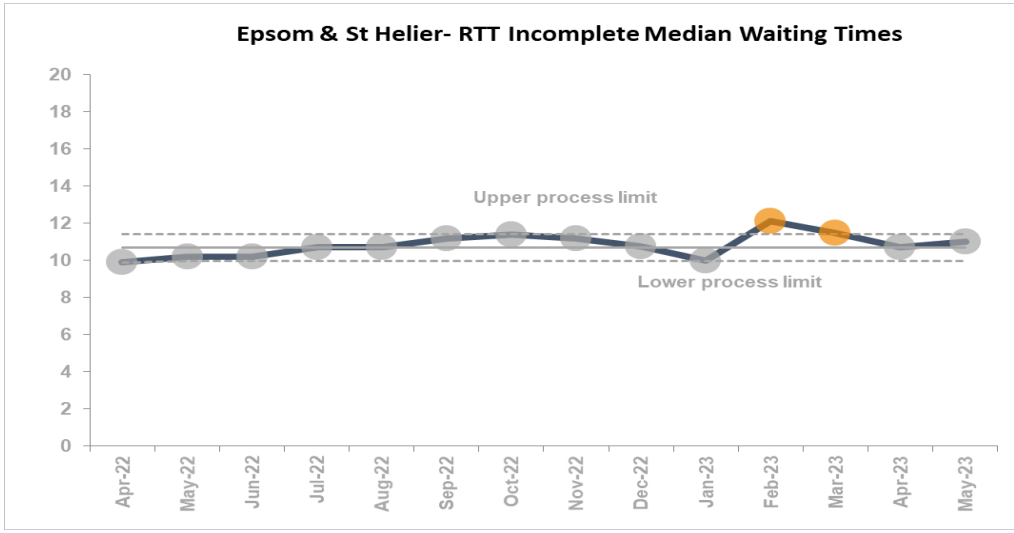


May-23

SGH: 11.1 Wks

ESTH: 11 Wks





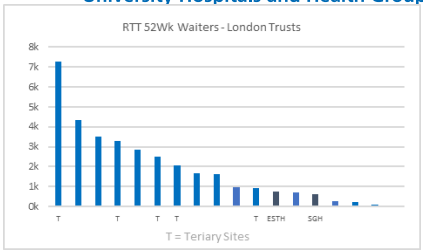
SGH updates since last month
The median waiting time on the RTT incomplete PTL has decreased slightly in May with an average waiting time of 11 weeks. The highest median waiting times are within Neurosurgical Service and ENT. A recovery plan for Neurosurgery has been developed.

ESTH updates since last month

The median waiting times on the RTT incomplete PTL has been relatively consistent over the last 12 month period, with an average waiting time of 11 weeks. The highest median waits are for Cardiology and Dermatology (+15 weeks). Neurology Service has the shortest median wait at an average of 7.8Wks.

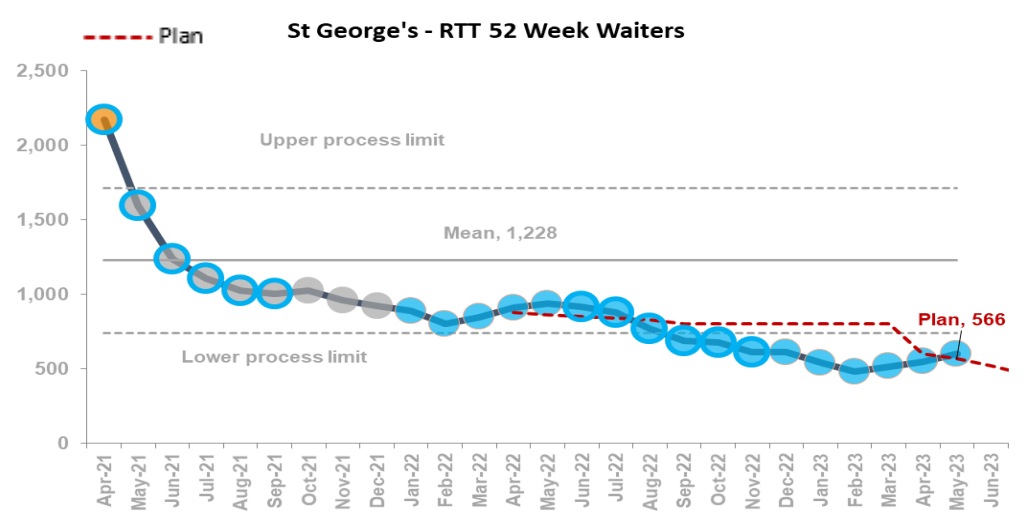
RTT – 52 Week Waiters

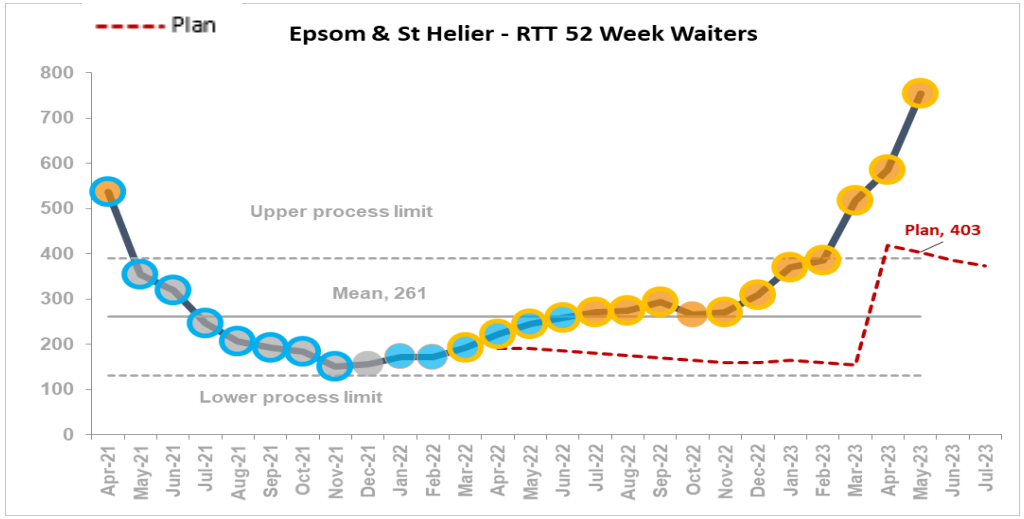
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

SGH Plan: 566	SGH: 600	ESTH Plan: 403	ESTH: 755





SGH updates since last month

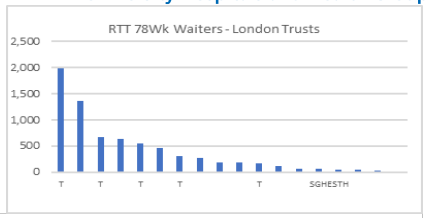
The number of 52-week incomplete pathways are beginning to rise with a total of 600 at the end of May, an increase of 51 pathways. The increase is predominantly seen within Cardiology, who have the largest proportion of 52-week breaches followed by Paediatric ENT. Cardiology have developed a recovery plan, but the Post COVID increase in referrals (seen across London) has contributed to this position. Increases in Paediatric ENT where the service are clinically reviewing all patients as part of the recovery plan and working with the network to identify suitable capacity.

ESTH updates since last month

The month-end 52-week waits have increased significantly (by 169 pathways, 28.8%). The increase has been seen within Gynaecology (increasing by 102 pathways) The most pressured services in relation to 52 week breaches are Paediatric Specialties, Gynaecology and Cardiology. Divisions and performance team continue to work in collaboration to micro-manage 52WWs on a daily basis and expedite next steps.

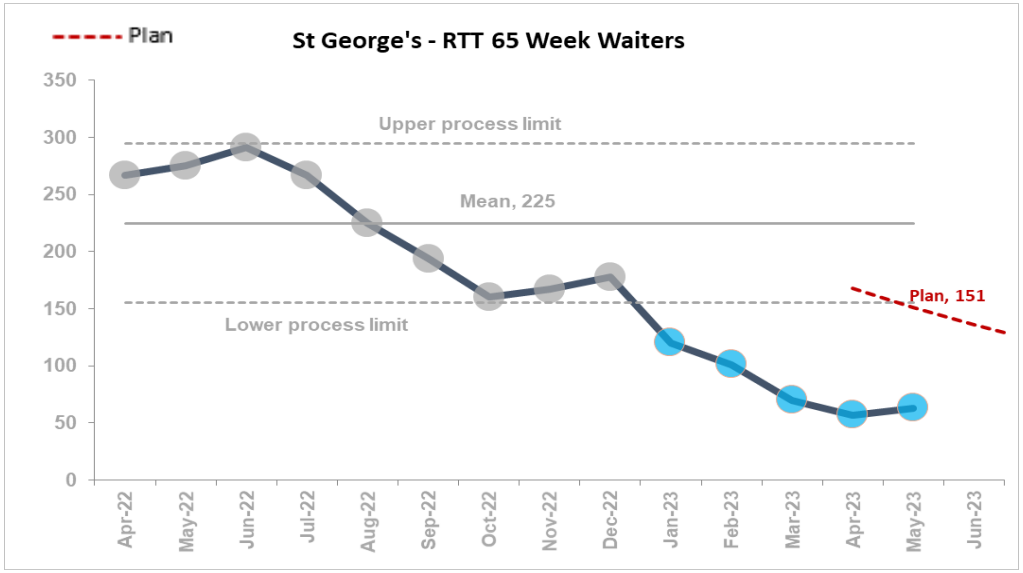
RTT – 65 Week Waiters

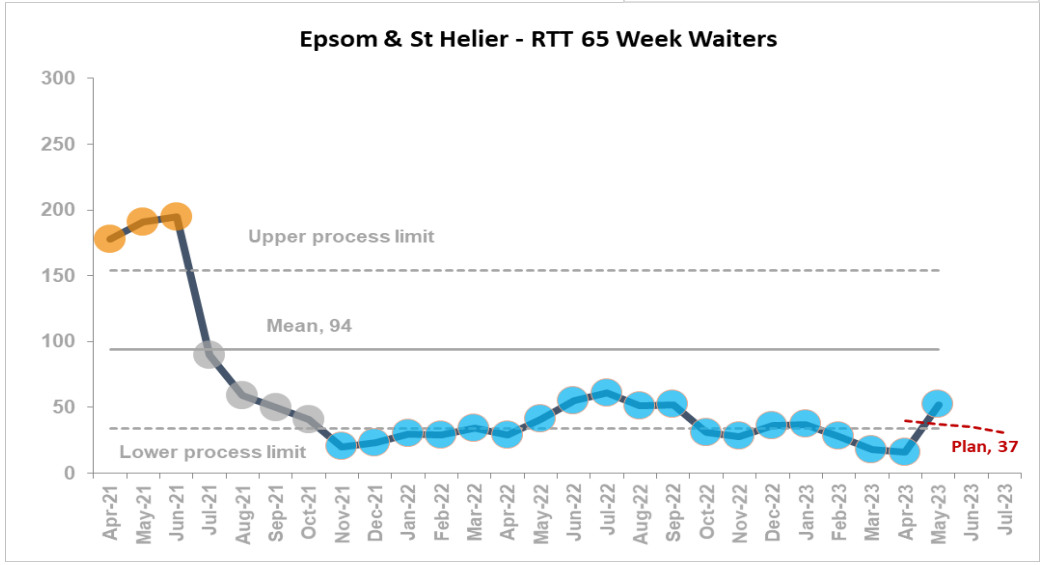
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

SGH Plan: 151	SGH: 63	ESTH Plan: 37	ESTH: 52





SGH updates since last month

The number of patients waiting over 65 weeks continues to deliver against plan, however seeing a slight increase in May. Neurology, General Surgery and Cardiology have the largest proportion of 65 week waits. Recovery plans are being worked up and will be monitored and managed through Elective Access.

ESTH updates since last month

At the end of May, 52 patients were waiting for more than 65 weeks for treatment (increase of 36 pathways) , against a plan of 37.
The majority of 65 week breaches are within Gynaecology who reported a significant increase of 15 pathways in May, followed by Community Paediatrics.

Elective / RTT Analysis and Action

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

SGH current issues –

At the end of May there were 52,842 incomplete non-admitted pathways, up from 52,478 in April seeing the fifth consecutive monthly increase.

There are 680 patients with a projected wait of over 40 weeks for a first appointment. The largest numbers are in Neurosurgery with 202 patients waiting; 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. This is also a focus area for the planned perfect week in July.

There have been further improvements in cashing up, with 337 attendances not cashed up for May.

The number of patients waiting over 65 weeks is ahead of plan and 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 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 –

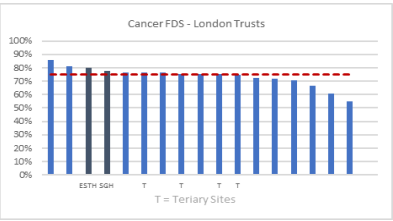
- Referrals remain significantly above BAU levels within a number of specialities, especially Gynaecology, Respiratory and Gastroenterology.
- 52 week waits continue on an upward trend each month with an increase from 586 in Apr23 to 755 in May23. A slight reduction is expected in Jun23 due to **no** industrial action or additional bank holidays, but for Jul23 it's expected to increase due to IA. The most pressured specialities for 52wk waits are Community Paediatrics (211), Gynaecology (207), Cardiology (105) and Gastroenterology (76).
- Patients waiting over 65 weeks for treatment increased from 16 in Apr23 to 52 in May23 (18 Gynae, 12 Comm Paeds, 5 Gastro, 5 GenSurg and 12 scattered across other specs)
- Total PTL volume has seen a further increase from 50032 in Apr23 to 50124 in May23.

ESTH future action –

- To mitigate the ongoing high volume of referrals in a number of specialties above BAU levels, further referral optimisation work is being undertaken by the outpatient transformation leads and insourcing also continues within several specialities.
- 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+.
- Local action/recovery plans in place for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology.
- Opening of additional theatre to increase IP/DC activity by approx 2k per year in order to reduce the Admitted waiting list commenced at the beginning of July.

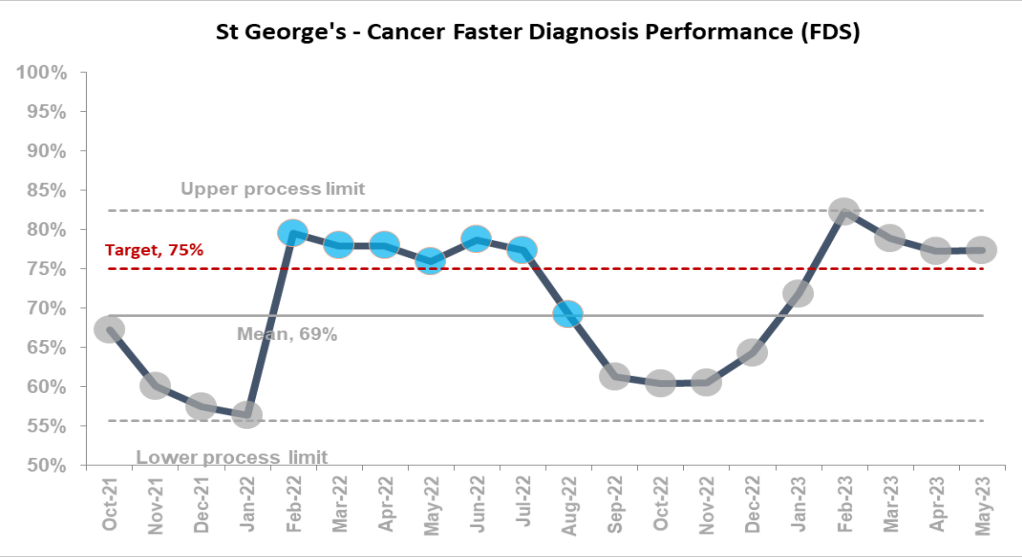
Cancer – Faster Diagnosis Standard

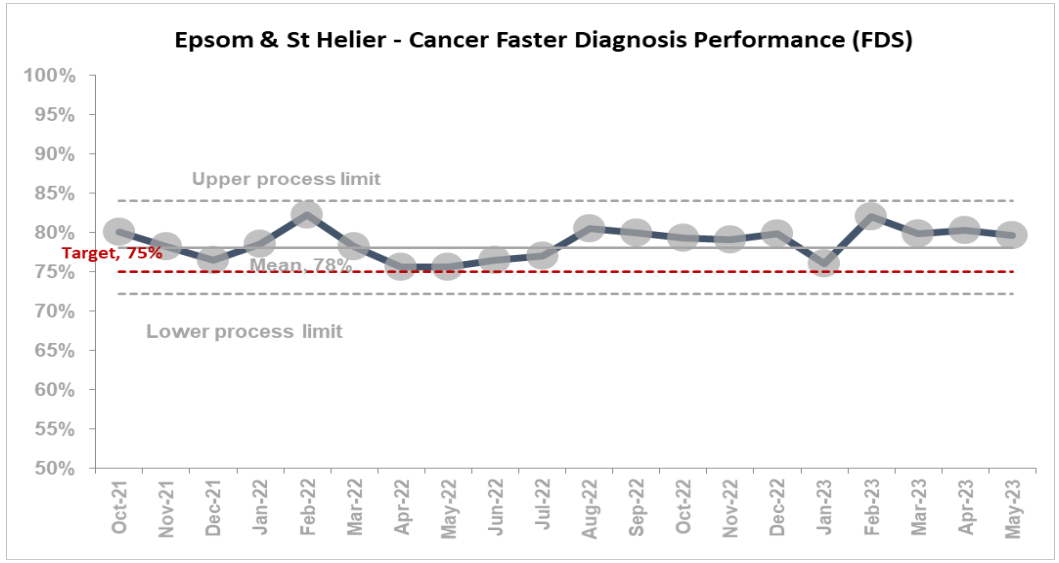
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group



May-23

Target: 75%	SGH: 77.4%	ESTH: 79.6%





SGH updates since last month

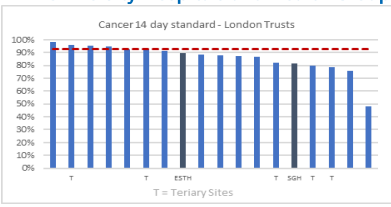
May performance against the Faster Diagnosis Standard was 77.4% against the required target of 75%. Breast, Gynae, Head & Neck and Skin are meeting target, however there are continued challenges within Haematology, Lower GI, Lung, Upper GI and Urology. There are tumour group specific actions plans that are being monitored and managed through Access Meetings.

ESTH updates since last month

Overall FDS performance is compliant in May. Tumours who were non-compliant were Lung (66.7%), Gynaecology (62.2%) and Brain (50.0%).
The Trust expects to maintain overall performance whilst addressing FDS non-compliance drivers where possible.

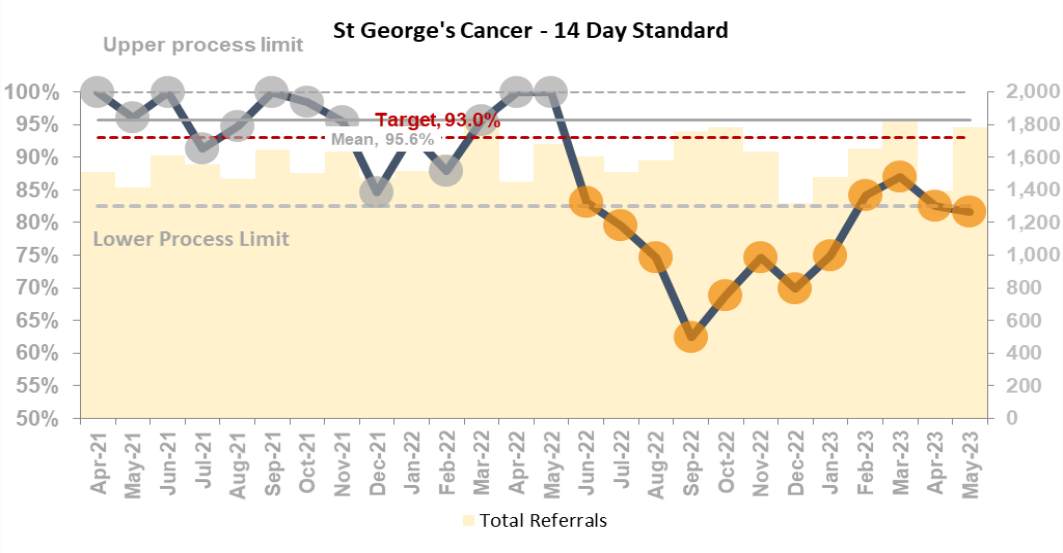
Cancer – 14 Day Referral to Seen Standard

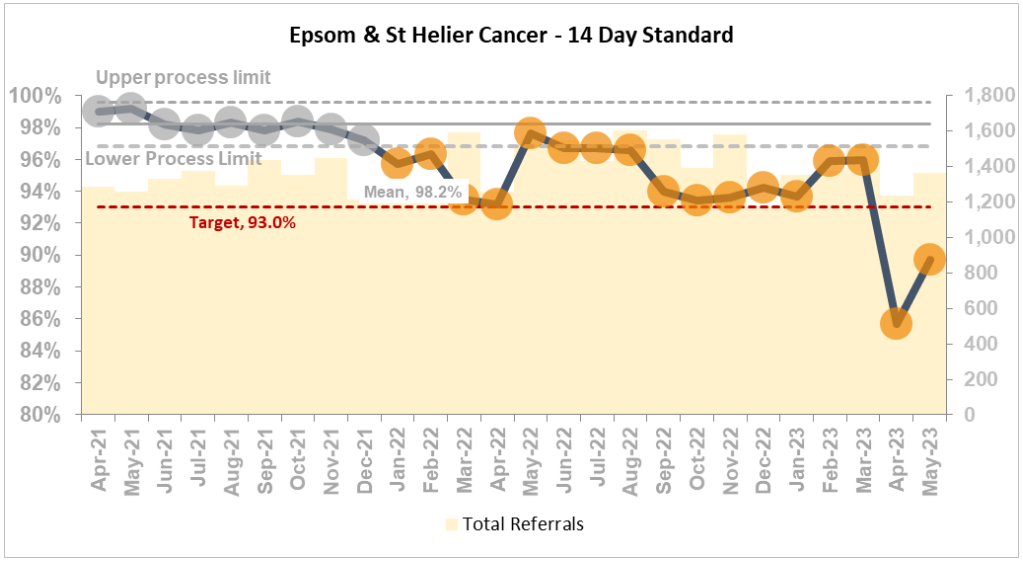
St George's, Epsom and St Helier University Hospitals and Health Group



May-23

Target: 93%	SGH: 81.6%	ESTH: 89.7%





SGH updates since last month

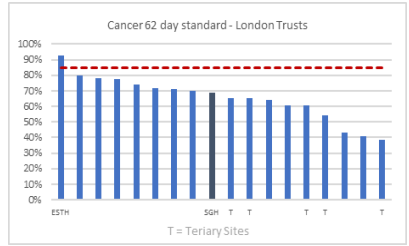
Performance against the 14 day standard remains challenged with a performance of 81.6% in May, however an improved position has been maintained. With the exception of Head & Neck and Upper GI, all other tumour groups are currently not meeting the required target of 93% (noting that Gyane and Urology both improved on April performance). The booking profile at Trust level is improving with an increase in the number of patients seen within 7 days.
All services have trajectories in place and this is being monitored closely via cancer access.

ESTH updates since last month:

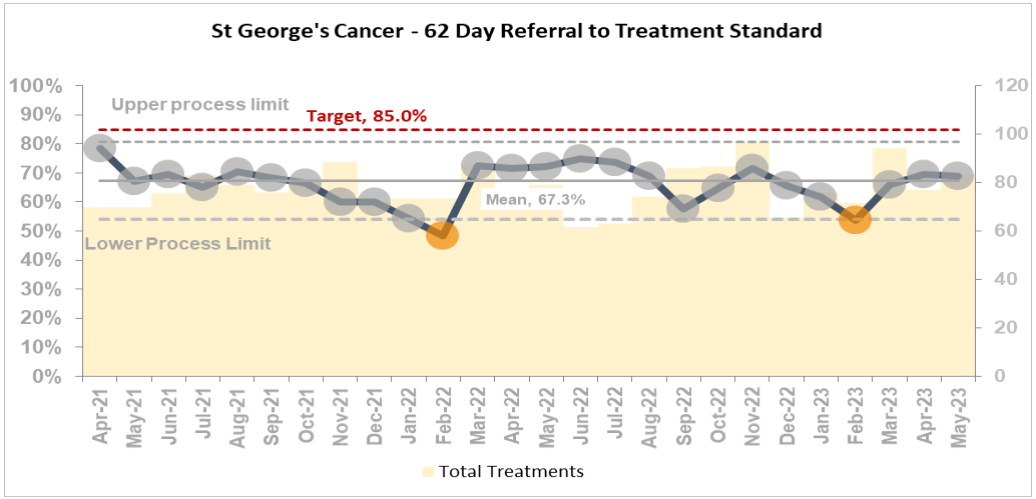
Performance against 14day standard fell once again in May reporting, but slightly improved on April (85.7%) despite an increase in overall TWW demand from 1235 to 1363. The dip in performance is due to capacity challenges in Gynaecology and Dermatology. Mitigations for both tumour groups consist of providing extra clinics and converting routine appointments to TWR slots. In addition, Cancer Department continued the funding of a Band 5 Dermatology nurse pending the service submitting a successful Business Case to fund this position substantively. The role of the Band 5 nurse is freeing up consultant and ANP time to create more TWW and minor op capacity.
Gynaecology has also started exploring different models of care for providing first encounter to Gynae TWW and CUPG patients.

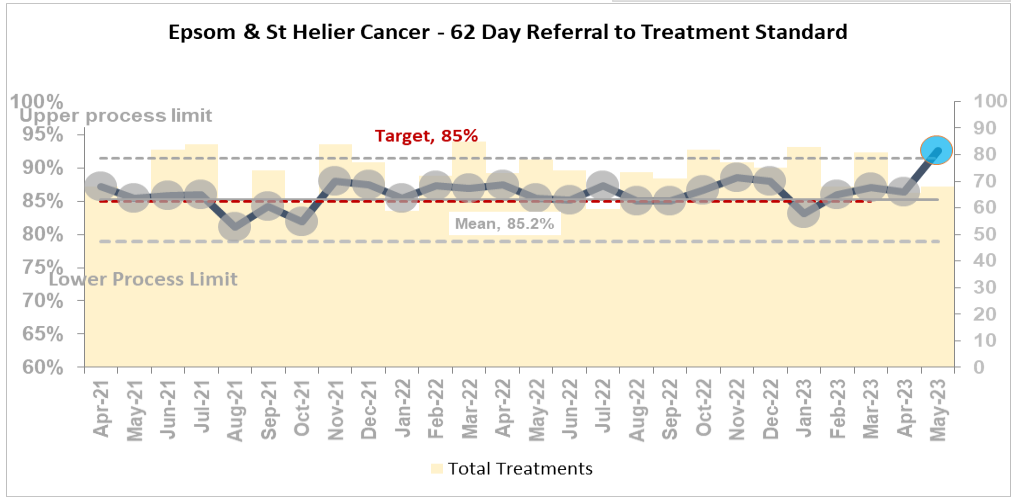
Cancer –62 Day Referral to Treatment Standard

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



May-23		
Target: 85%	**SGH: 68.9%**	**ESTH: 92.6%**





SGH updates since last month

In May the Trust reported a performance of 68.9% against the 62 day standard. Our Trust trajectory expects performance to be compliant **(85%)** by September 2023, however this is now under threat as a result of the Consultant and Radiographer Industrial action.
With the exception of Head & Neck all tumour groups are currently below 85%. Challenges with theatre capacity and late inter trust transfers from the periphery have impacted delivery. There are specific actions across all tumour groups, with additional focus via a week long COO led cancer week, performance and challenges will continue to be monitored through Cancer Access.

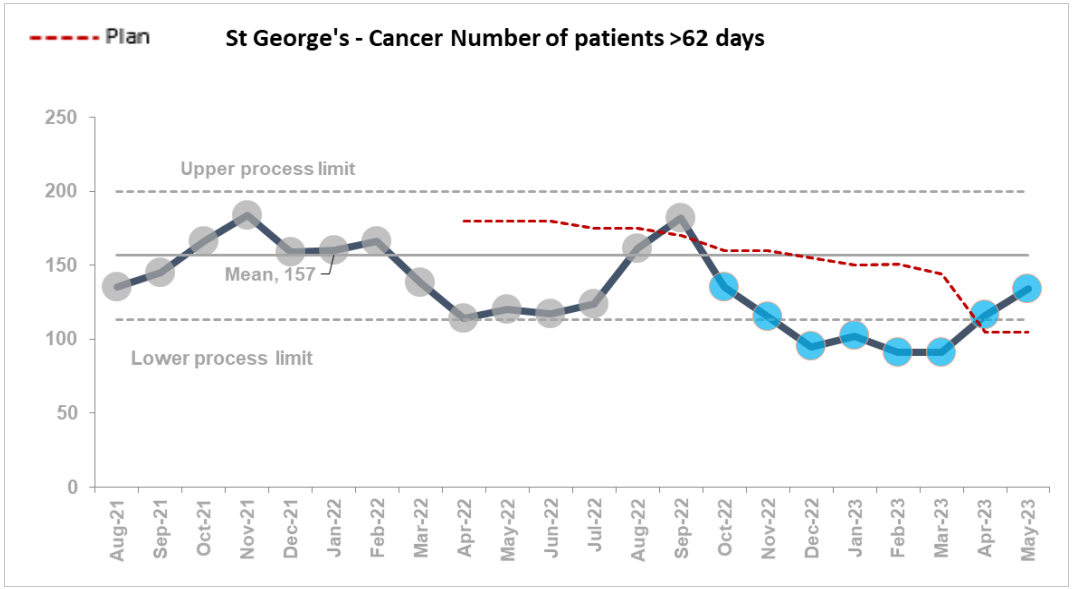
ESTH updates since last month

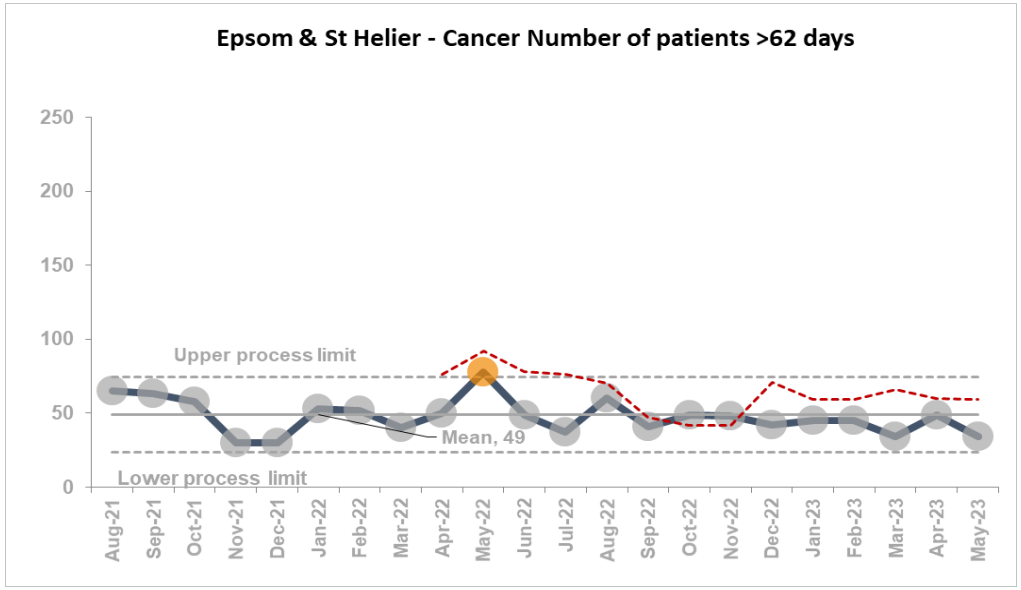
Performance against 62 day standard continues to be achieved at 92.6% in May with 5 breaches despite internal challenges. There is genuine concern around performance due to the doctors/consultant strikes and the natural dip in capacity during the summer months. Nevertheless, the services will be contacted in due course to provide the summer months plans.

Cancer – Number of patients > 62 days

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

May-23			
Plan: 105	SGH:134	Plan: 59	ESTH: 34





SGH updates since last month

The number of patients in our backlog increased through May and is above our plan with the largest proportion of waits within Lower GI, Gynae and Head & Neck. Considerable effort is being made to reduce long-waits and ensure all patients are tracked correctly.

ESTH updates since last month

Trust has consistently maintained below the expected trajectory. The Trust ensures clinical impact review is frequently carried out on those patients by the clinical leads for cancer in the relevant tumour sites to ensure optimal patient healthcare.

Cancer Performance Analysis and Action

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

SGH current issues

TWW: H&N and UGI were compliant whilst all other areas were behind target. A number of services were in recovery from the strikes and public holidays. Challenges were seen in the areas below:

- Skin experienced a high volume of seasonal referrals.
- 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 May 23. Similarly, Breast, Gynae, Lung and Skin achieved the standard.

62-day GP Performance: A high volume of breaches seen in Urology (6), and lung (8)
Challenges, were seen in urology due to access to prostate and later inter trust transfers alongside theatres, Lung due to complex pathways and late inter trust transfers not treated within 24 days,

62 Day Backlog: The back log was behind trajectory in May 23 at 134.

Good news:A Forward view into June shows compliance in Gynaecology TWW performance for the first time in 12 months.

SGH future action -

Cancer Trajectories 23/24 Summary:

•Faster Diagnosis to be compliant **(75%)** by April 2023. **Trajectory met in May 23**.
•62 Day GP to Treatment to be compliant **(85%)** by September 2023 – **Trajectory behind target in May 23 – at further risk.**
•62-day backlog to achieve 105 patients by March 2024. **Trajectory not met in May 23**
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Tumour specific actions:

Haematology: QIA approved for additional Lymphoma consultant support for 3 months.
Gynaecology: 2nd Hysto suite trialed in June
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: Xyla insourcing funding secured till September 23 to support WLIs. 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. A case for how the service will sustainably maintain performance is in progress.

ESTH current issues –

EUS capacity at RMH remains a challenge - current wait is 3-4 weeks.

Endobronchial capacity remains challenging throughout the network. Currently our lung patients are referred to UCLH where the average wait is 4 weeks. RMP led project has increased capacity at St George's.

The wait for GA diagnostic is also challenged with average wait of 3-4 weeks across all areas. ESTH has quality and capacity projects to address some of those issues. For example, creation of weekend lists in Endoscopy, introducing outpatient TPPB and improving the conversion of LA procedures to GA procedures in Gynaecology.

14day first seen performance fell in April and May due to capacity issues with Gynaecology and Dermatology. However, gynaecology has provided additional slots by converting routine to TWR and creation of ad hoc capacity. This has improved their capacity. Dermatology remains a challenge despite providing additional clinics.

ESTH future action –

Recommendations for Dermatology to take up the gynaecology model of converting routine appointments to TWR to provide more capacity. Dermatology to convert the Band 5 nurse into a substantive post.

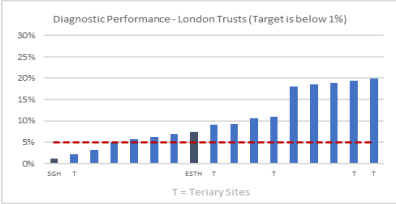
RMH EUS capacity is under focus at group meetings and additional lists have been added. It is hoped that the capacity will double once the RMH Oak Centre opens in September.

Ongoing work with RM Partners to provide EBUS service within the network with weekly meetings having resumed in March. St George's notifies ESTH weekly of available capacity for EBUS patients.

Template biopsy (TPPB) service provision is planned to change from clinician led GA to Nurse led LA. This will bring ESTH in line with other hospital

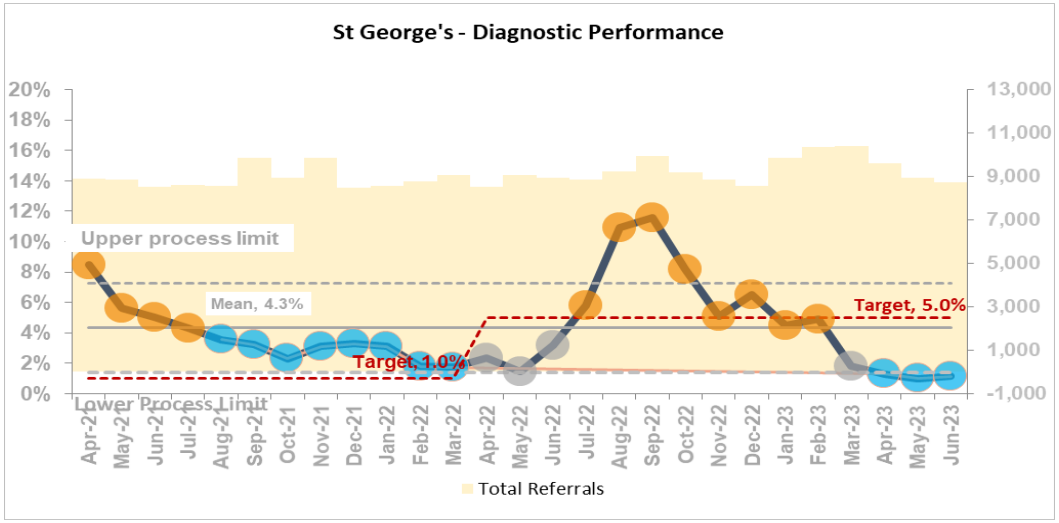
Diagnostic Performance

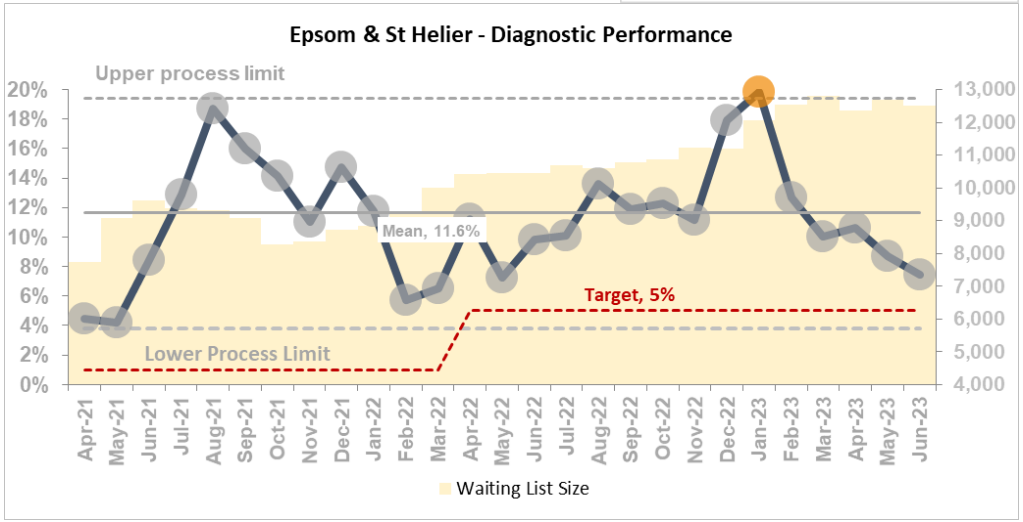
St George's, Epsom and St Helier University Hospitals and Health Group



June-23

Target: 5%	SGH: 1.2%	ESTH: 7.5%





SGH updates since last month

At the end of June, the Trust reported 107 patients waiting for more than six weeks, a performance of 98.8%. The total waiting list size reduced by 2.5% compared to May. The largest proportion of breaches remain within Sleep Studies where the Trust continues to see increased demand and Endoscopy where the service continue to see a reduction in their backlog and meeting trajectory. There were a proportion of unexpected breaches in the later part of the month due to equipment failure that led to cancelled clinics within Urodynamics.

ESTH updates since last month

At the end of June we are reporting 931 patients waiting for more than six weeks, which is a significant decrease from the volume of breaches at the end of May (and the second consecutive significant drop). The PTL size has decreased slightly since the end of May, but at a much lower rate than the breach drop, resulting in a fairly significant increase in performance to 92.6%, which is the highest level since last May. The largest proportion of breaches are within Ultrasound and Echocardiography.

Diagnostic Performance Analysis and Action

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

SGH current issues –

Endoscopy - In total Endoscopy reported 41 patients waiting for more than six weeks, this is a further decrease of the backlog, and the service 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.

Echo – The service continue to see pressures within Echo where reliance is locum cover. Over the month sessions were lost due to sickness and junior doctors strikes which meant the backlog increased.

SGH future action –

Endoscopy - Additional Saturday lists continue 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. The service continues to reduce the backlog and are continuing to use doctor doctor to validate and contact patients.

Sleep Studies - The service continues to monitor referrals and discussions with commissioners and SWL Diagnostics team has begun to ensure patients are going to local hospitals as a first option. Croydon capacity should increase through July meaning that there is less demand on SGH. There is additional capacity through CDC funding to mitigate this as much as possible and Saturday clinics through July accommodating up to 20 patients per list.

Echocardiography (echos)

- Implemented new triage process and strengthening booking processes for Stress Echo where capacity can be challenged. Organising extra capacity for evenings and Saturdays. Advertising substantive recruitment of a fellow to support stress echos.

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 June were 298 in total. The breakdown is 35 for MRI, 212 for Ultrasound, 44 for CT Scan, 5 for DEXA and 2 for Barium Enemas Compared to preceding month, there was a reduction of 61 breaches across all modalities and overall Imaging performance is above the 96.9% for June.

The team is continuing work to maintain the performance however there is a high number of vacancies arising within the radiology scheduling team. Interviewing for three scheduling posts on 13th July. Radiology Service Manager leaves on 14th July however post has been filled with the new Radiology Service Manager commencing in August.

The demand for MRI paediatric GA procedures has increased recently which is causing a bottleneck as extra capacity is restricted due to limited paediatric recovery space. Mitigation plans are in development.

There are currently 3 vacancies within the radiologist workforce which is impacting specialist lists such as biopsies and CT cardiac procedures.

ESTH future action –

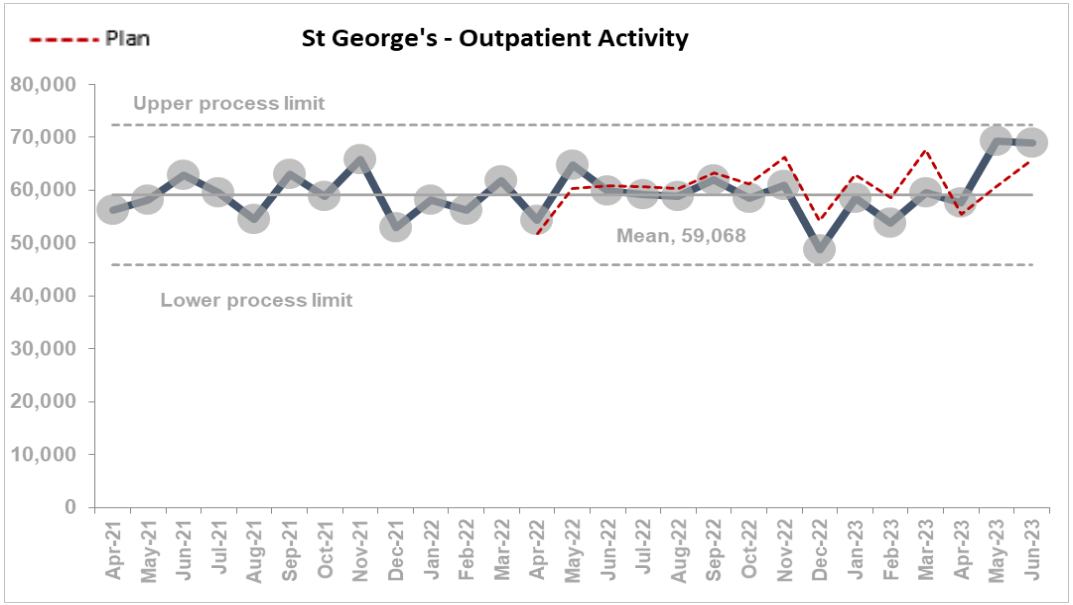
- Radiologist locum and specialist grade radiologist both commencing on 5th October. Interviews for chest consultant radiologist being held on 15th September.
- Increase scheduling staff using bank staff and utilising weekend lists for all modalities and continued use of bank and agency staff to increase scanning capacity in order to maintain performance
- Continue daily 30 minute huddles with booking team and superintendents to monitor progress, validation and resolve any bottlenecks in real time.
- 6-day working rota for CT and MRI went live in June. Is a precursor to future 7-day working plans.
- Ensuring that non-key 15 and Interventional Radiology waiting lists receive the same level of validation and monitoring as the main DMO1 key-15 procedures.

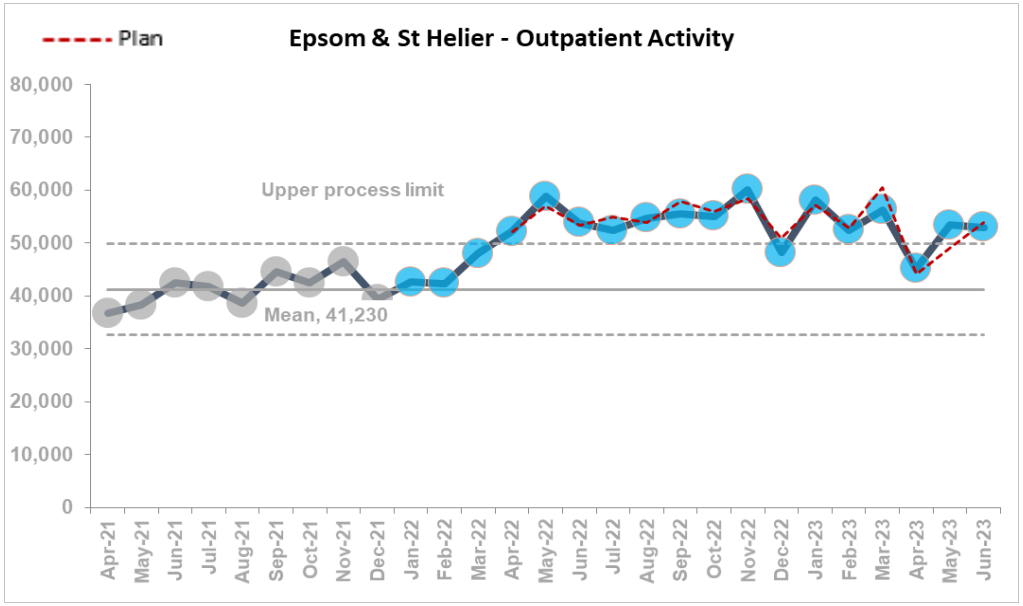
Outpatient Activity

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

Jun-23

Plan: 65,773	SGH: 68,941	Plan: 53,886	ESTH: 52,987





SGH updates since last month

Outpatient performance continues above plan.

ESTH updates since last month

Outpatient activity performance remains above the mean and is slightly below plan for June. This is expected to increase with data catch up / coding.

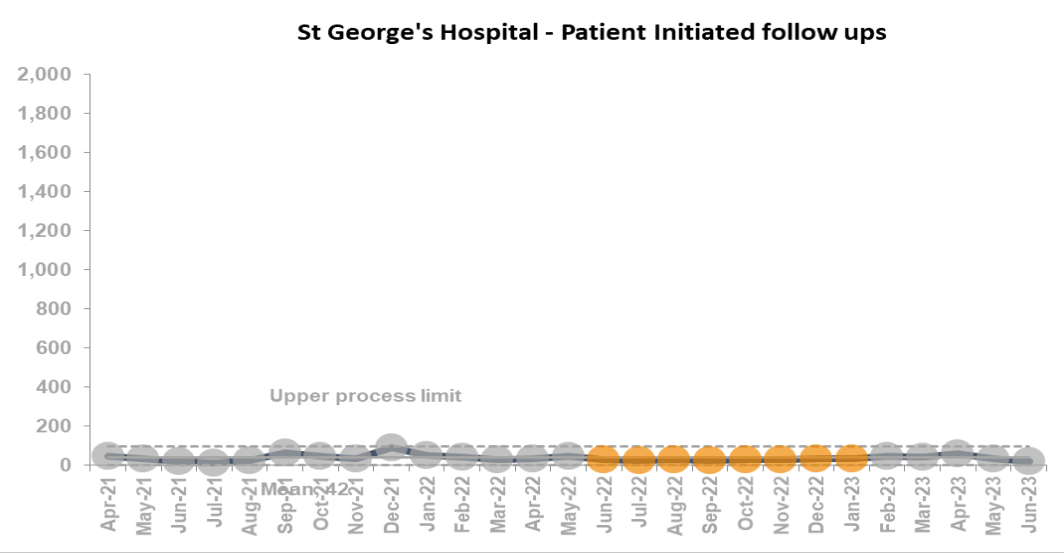
Patient Initiated Follow-up (PIFU)

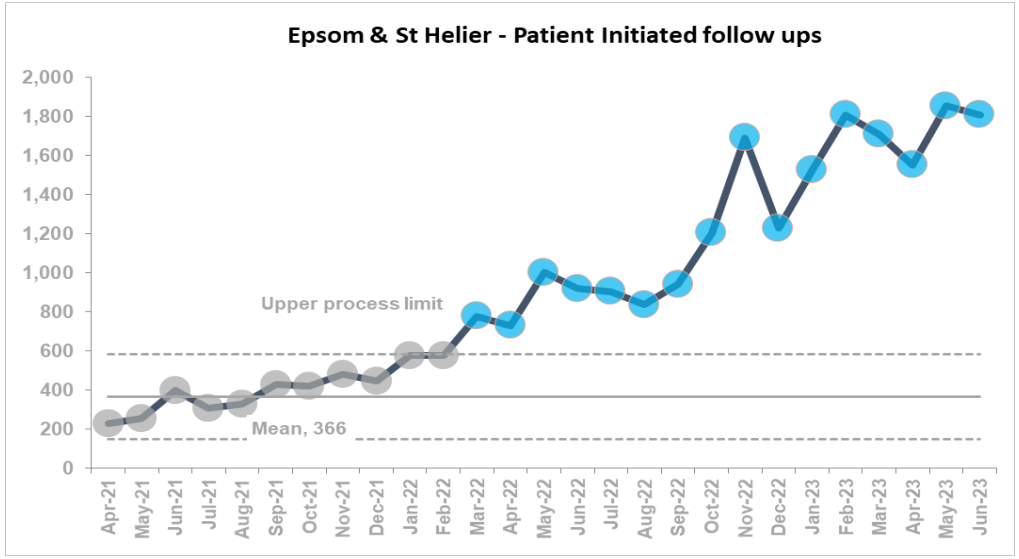
St George's, Epsom and St Helier University Hospitals and Health Group

Jun-23

Target: TBC	SGH: 21

Target: TBC	ESTH: 1,809





SGH updates since last month

Work is underway to design and build the PIFU solution as part of the orders to schedule roll out. Technical teams have been engaging with subject matter experts to ensure it is a simple, resilient and scalable solution. Patient information leaflets and letters have been drafted. SGH teams have joined speciality specific NHSE calls to learn from peers.
ESTH team are involved in SGH PIFU design as it is a process they will inherit.

ESTH updates since last month

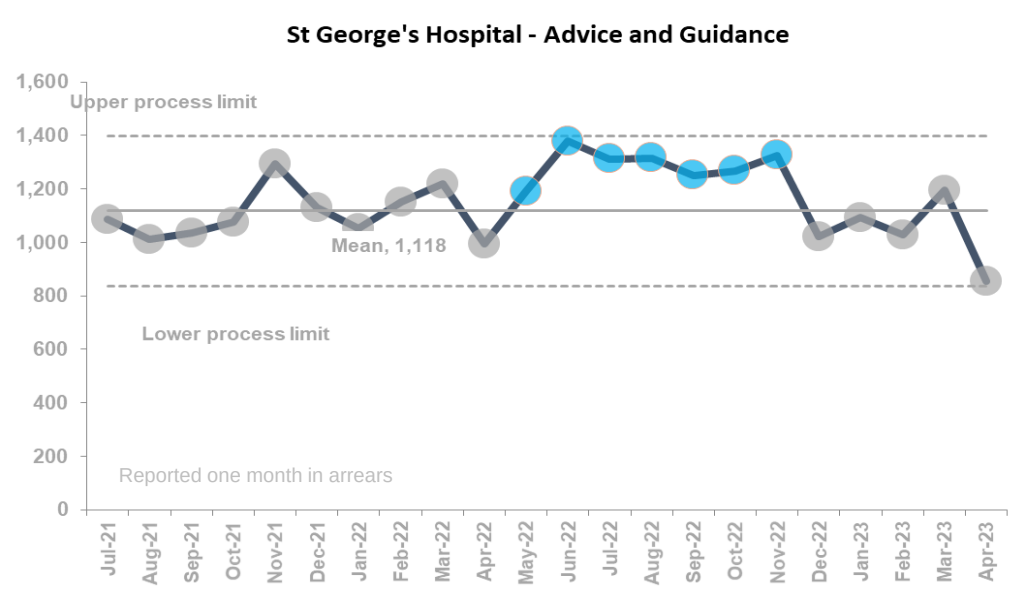
The number of patient initiated follow ups are as expected and in line with overall outpatient activity with 1,809 patients and continuing above the upper control limit.

Advice & Guidance

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

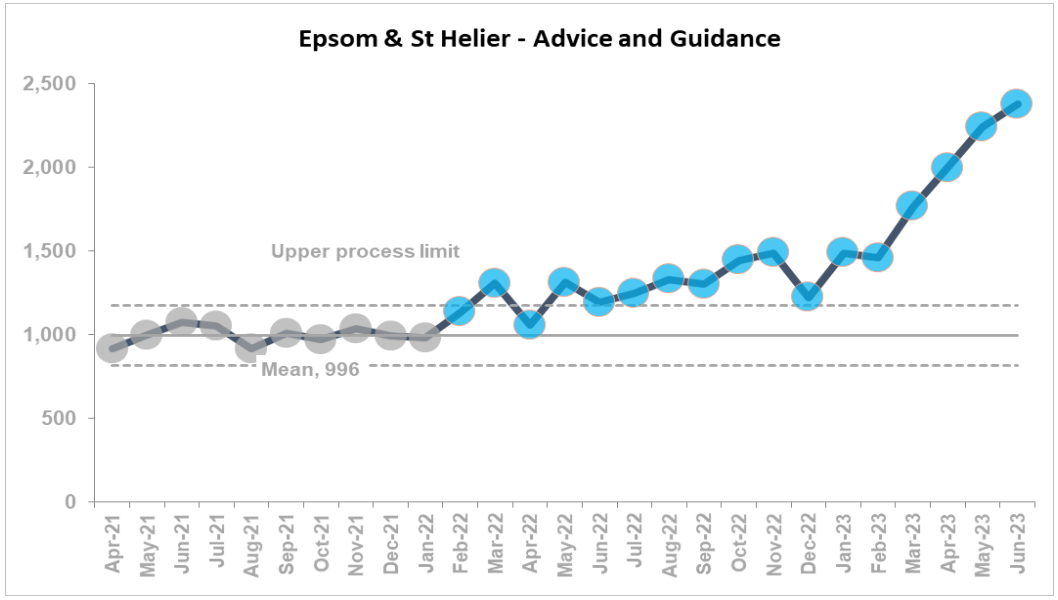
Apr-23

Target: TBC	SGH: 856



Jun-23

Target: TBC	ESTH: 2,377



SGH updates since last month

Continually working for M&W primary care leads to improve the quality and timeliness of eRS A&G responses.
Cerner are working on the solution to provide A&G type functionality. Latest estimate is availability to test Jan-24. This will enable SGH clinicians to perform A&G to referrals received on RAS queues (~5k month).

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 –

Junior doctor and consultant strike impact - has been significant on the OP booking team who have supported manually cancelling and rescheduling +600 appointments within one week

Outpatient Transformation Board 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) Gynae(20% completed), Resp (60% completed) and Urology (50%completed) - progressing well. Next services will be ENT, Dermatology, Cardiology and Gastroenterology.
2.**Orders to schedule** – (IT project) Roll out new robust and efficient cashing up process and recording procedures in outpatients (QPOPE). Project team begun work – scene setting with seniors leaders meeting to be held on 19th July
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.

SGH future action –

Outpatient Transformation Board – Key actions include: Ensuring A&G reporting change is updated in the next month.

Outpatient focus on uncashed has launched and working very closely with all services to increase compliance within clinics on the day – ended on 0.58% uncashed for May'23.Significant improvement from 1.3% for March

Outpatient Patient Involvement – Updated maps to be added to letters which includes recent layout changes, and mirror descriptions on signage throughout the hospital.

ESTH current issues –

PIFU – NHSE have calculated that across the major PIFU specialities, there is scope to increase our PIFU rate to 4.5%, based on achieving a PIFU rate in line with the 85th percentile for all 17 major specialties. Therefore the data pack is suggesting, if we were to achieve a PIFU rate in line with the national best performing specialities, our optimal PIFU rate would fall below the 5% national target (4.5%). Therefore it is unlikely a 5% national target would be achievable for the Trust. An internal trajectory has been set based on achieving a 4% PIFU rate, which we will continue to strive to achieve.

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 64%% (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 – NHSE have launched a national 4 week sprint to improve access to PIFU. Focussed PIFU engagement events are being held during July for Respiratory, Cardiology, Dermatology, Paediatrics and Neurology.

PIFU alongside clinical validation of un-booked overdue follow-up lists now being explored in Cardiology and Gynaecology, and continues in Gastroenterology. To date a total of 340 non-admitted un-booked, overdue patients reviewed of which 101 offered PIFU and 32 discharged. 39% of patients removed from the waiting list (29% PIFU'd).

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 targeted actions implemented to optimise referrals.

Editable standard texts responses to common referral themes implemented to support provide consistent, high quality, equitable and efficient responses to A&G and Referral requests from primary care.

Referral support tools, known as Quick Views, continue to be implemented (Neurology, Urology, and Dermatology). The next Quick View in the rollout is for Gastroenterology and Cardiology.

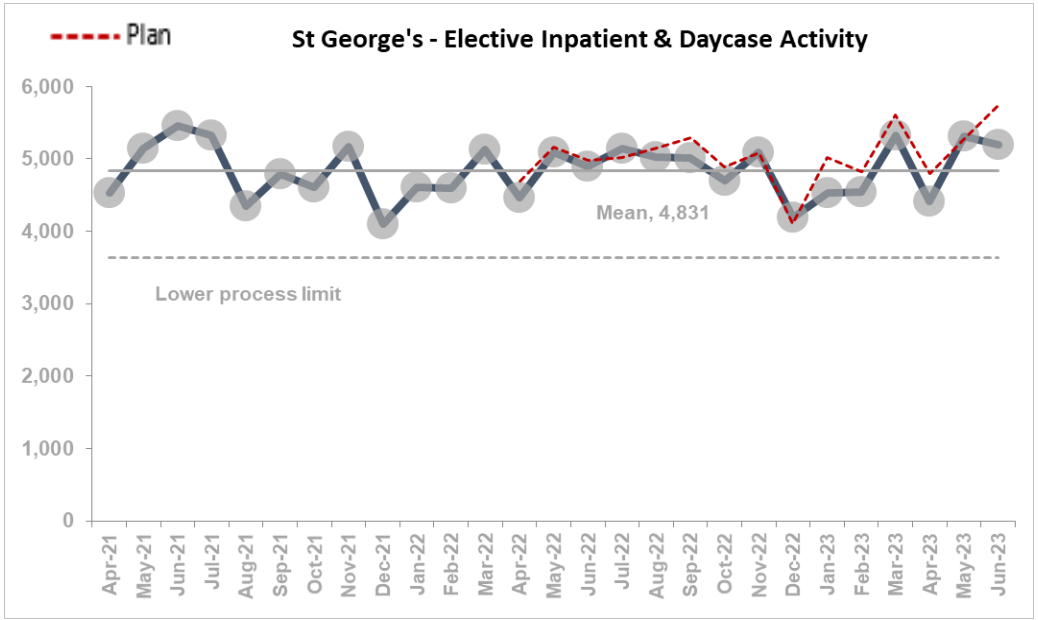
Specialty specific conversations regarding triage standardisation and peer to peer learning, including e-RS myth busting continue.

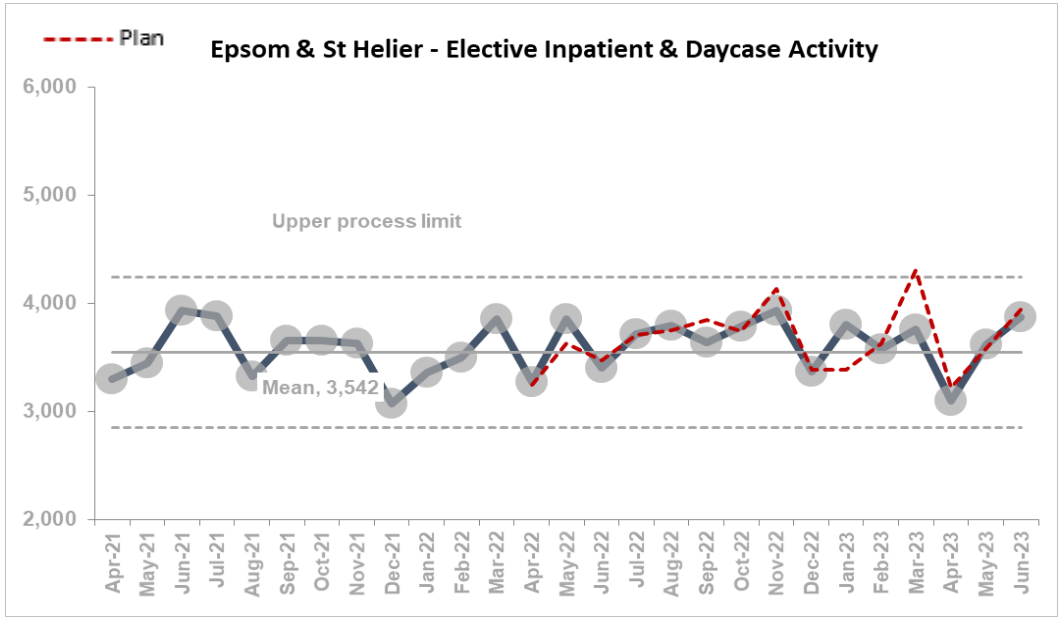
Elective Inpatient & Daycase Activity

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

Jun-23

SGH Plan: 5,739	SGH: 5,190	ESTH Plan: 3,938	ESTH: 3,870





SGH updates since last month

Elective and Daycase performance is behind (after estimated catch up), with a percentage of 108% submitted for June (plan 115%). The impact of the Junior Doctor strikes is estimated to have decreased Elective and Daycase activity by 329 or deteriorated variance to plan by 7%.

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ESTH updates since last month

For the month of June elective activity is currently slightly below plan. This is expected to increase once data catch up / coding is completed.

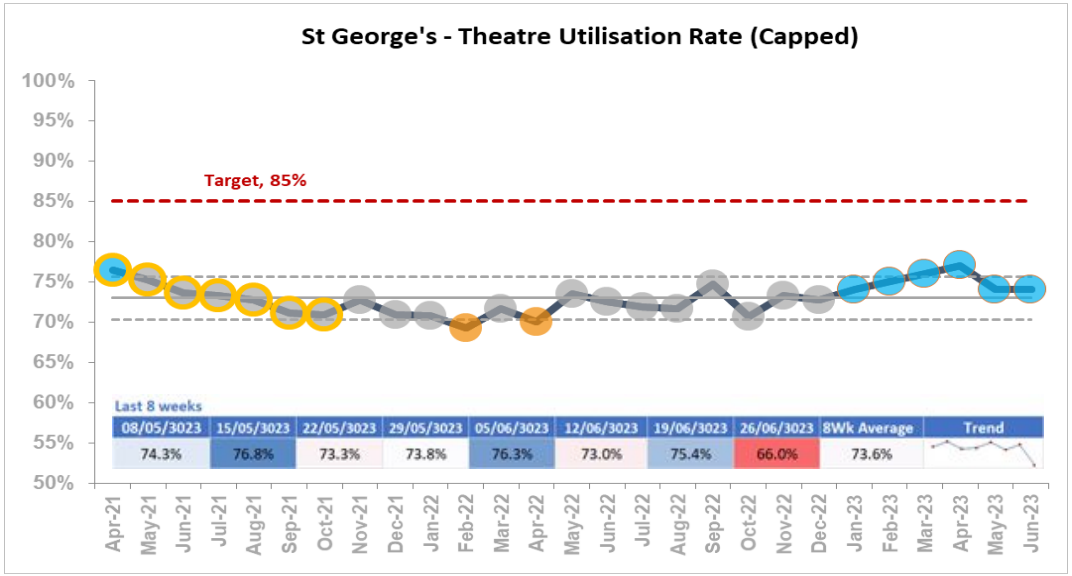
Theatre Productivity – Capped Utilisation

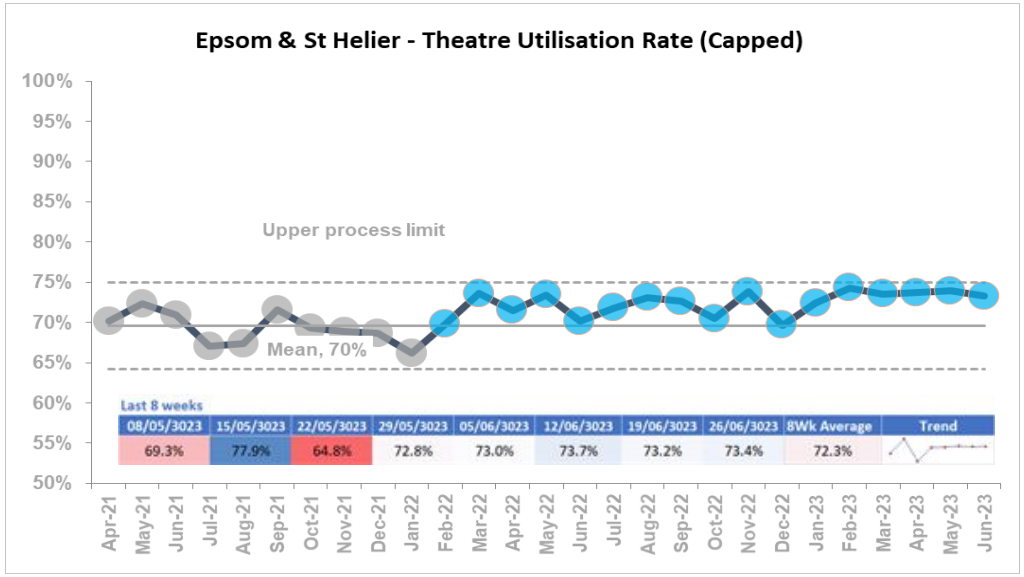
The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time. High capped utilisation signifies that the allocated planned session time has been well utilised.

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

Jun-23

Target: 85%	SGH: 74%	Target: 85%	ESTH: 73.28%





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 83%.

ESTH updates since last month

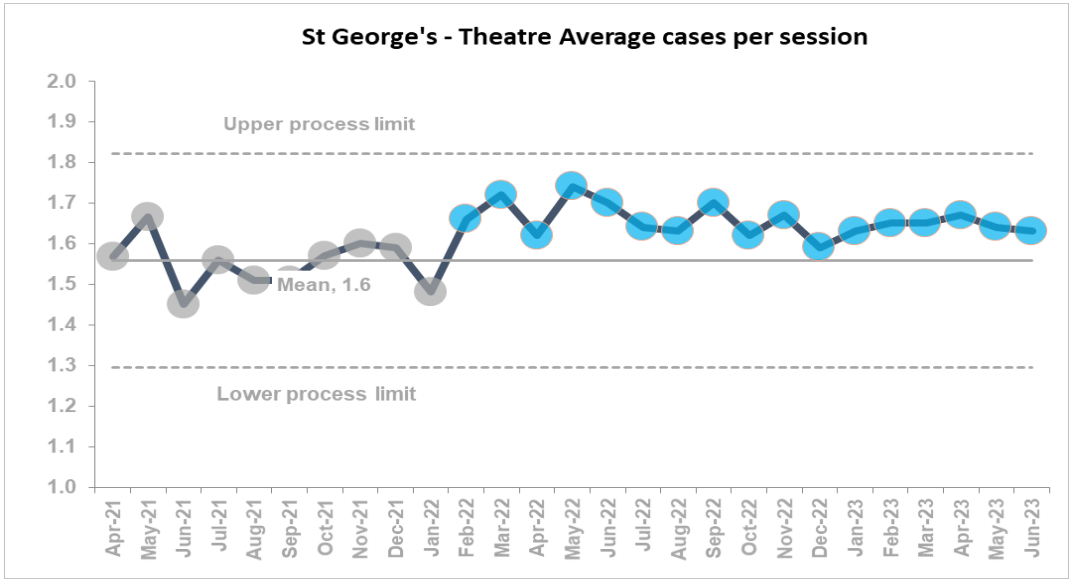
Capped utilisation figures remain positively above the mean however is not meeting our aim of 85%.

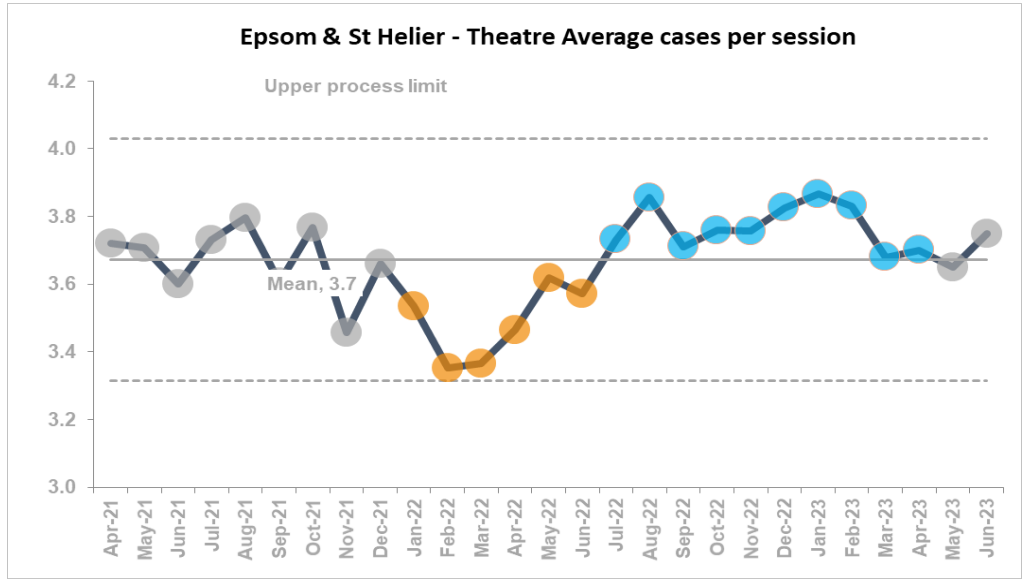
Theatre Productivity – Average Cases per Session

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

Jun-23

Target: TBC	SGH: 1.63	Target: TBC	ESTH: 3.75





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline, with on average through June 1.63 average cases per session.

ESTH updates since last month

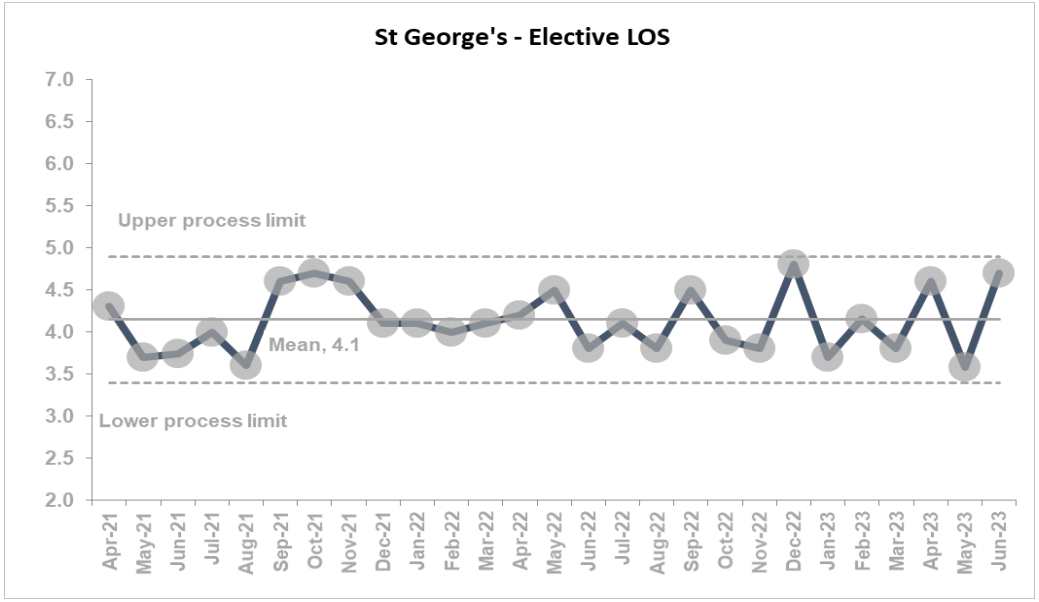
Average case per session improved above the mean throughout June with on average 3.75 cases.

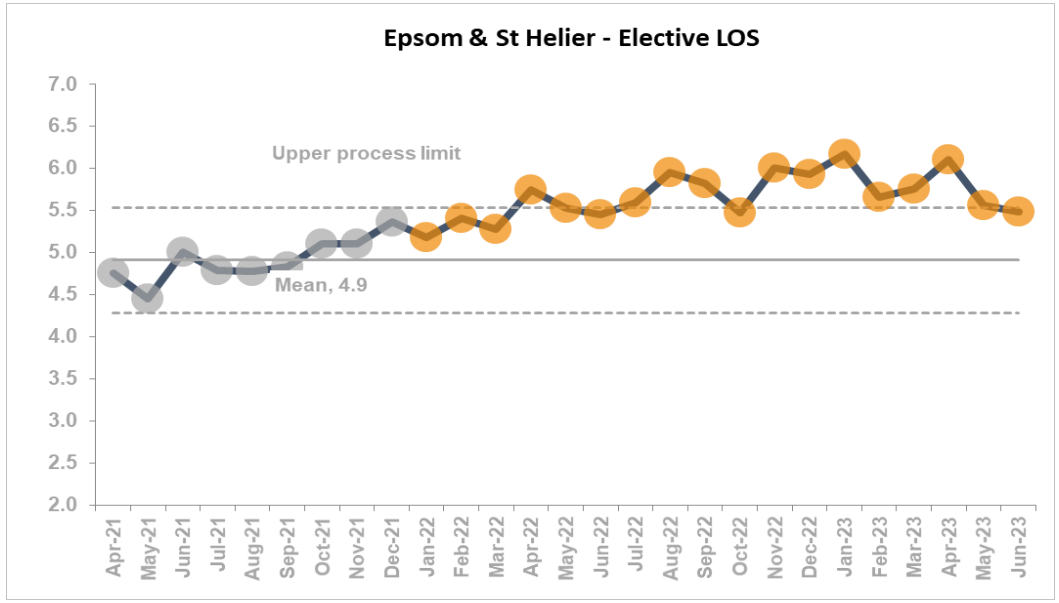
Elective Length of Stay

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

Jun-23

Target: N/A	SGH: 4.7	ESTH: 5.48





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 June the average length of stay was 5.5 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 June, impacting recovery and PACU with patients remaining in these areas longer than planned. NECU (Neurosurgery Enhanced Care Unit) opened in July, with ongoing work to embed the pathway in daily elective work, reducing demand for Neuro ITU beds.

Elective and Day Case activity across the Trust was inadvertently impacted by the bank holidays and recent industrial actions.

Successful recruitment in cardiac anaesthesia with five new consultants starting between May- October. Planning is underway to increase the provision of cardiac surgery in line with recent appointments.

SGH future action -

In June, capped theatre utilisation capped was 74% which was similar to the previous month. The average case per session continues above the 2019/20 baseline at 1.63.

In April, a clinically driven audit of late starts was launched. Data shows that the top 3 reasons for late starts are anaesthetists seeing patients before team briefing, surgeons being late and ITU/HDU bed issues. In light of these results, a new operational meeting structure is being implemented to address operational matters and theatre efficiency with all different surgical specialities.

The first phase of the Theatre template review has been completed, aimed at increasing the provision of robotic surgery.

To support the reduction of Xyla requirements, the ops team continue to focus on medical recruitment and job planning.

ESTH started operating at QMH Surgical Centre on the 17th of July.

ESTH current issues –

Challenges related to Theatre and ward flow continue to impact on elective recovery. Despite the industrial action, productivity increased slightly in June with slight increases in mean cases per sessions and total cases performed along with a positive decrease in the number of short notice and on the day cancellations.

Despite this the capped utilisation remains at 73% for the month.

Theatre staffing remains a challenge which is reflected nationally particularly for anaesthetic practitioners for both substantive and agency staff.

ESTH future action –

Further work is being completed for the ASA 1 profile and the overall ASA profile for the trust for pathway redesign in line with the new contracts.

Updated processes for cancelled on the day of surgery are being implemented to support a sustained reduction.

Utilisation of QMH Roehampton in July and increased use of the B4B vacated sessions in DSU EGH will support the capped utilisation trajectory.

Speciality specific focus group to unblock some of the operational challenges for outlying services will commence in July.

Monthly Overview – Non Elective Care

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

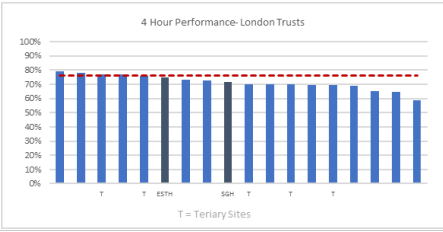
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	76%	83.5%	81.7%	71.3%	76%	78.8%		76%	75.4%	77.1%	75.6%	76%	76.0%	
12 Hour Trolley Waits	0	331	591	589	0	1511		0	332	293	366	0	991	
Ambulance handover Performance 30 minutes	0	25	30	27	0	82		0	224	232	288	0	744	
Ambulance handover Performance 60 minutes	0	22	76	81	0	179		0	73	42	130	0	245	
Non elective length of stay	TBC	6.8	7.1	7.2	TBC	7.03		TBC	8.0	7.2	7.3	TBC	7.47	
Mental health delays 4 Hour Breaches	TBC	113	138	116	TBC	367								
Redamission Rate - Non Elective	TBC	11.9%	12.1%	9.7%	TBC	11.2%		TBC	4.9%	5.7%	5.6%		5.4%	
Length of stay > 7 days (stranded)	TBC	381	406	397	TBC	395		TBC	304	284	292	TBC	293	
Length of stay > 21 days (super stranded)	172	164	180	183	172	176		123	132	121	123	114	125	
Overnight G&A beds occupancy - Adults	92.0%	95.9%	97.3%	96.9%	92.0%	96.7%		92.0%	90.6%	89.3%	91.3%	92.0%	90.4%	
Number of patients not meeting criteria to reside	TBC	139	99	110					166	165	106			

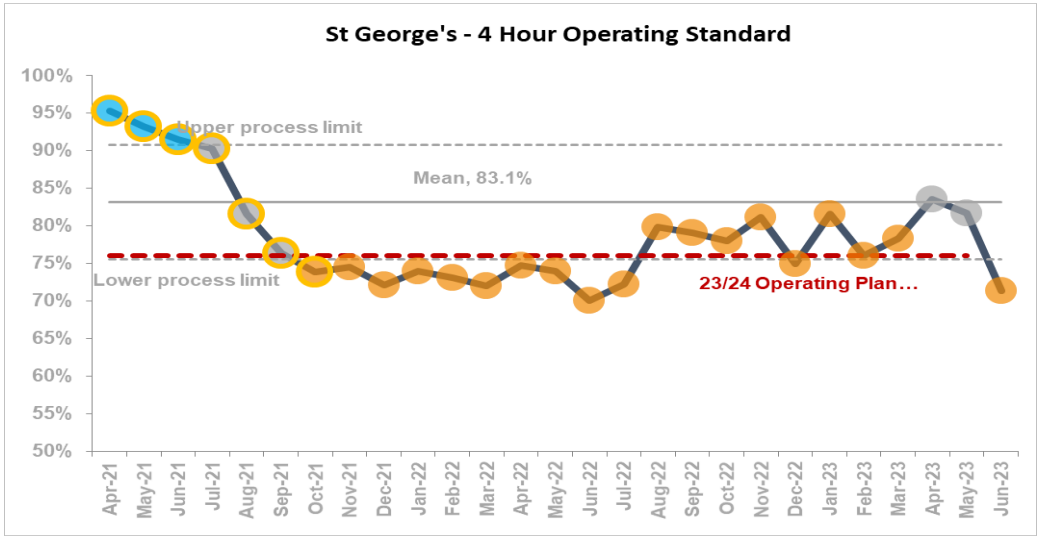
4 Hour Operating Standard

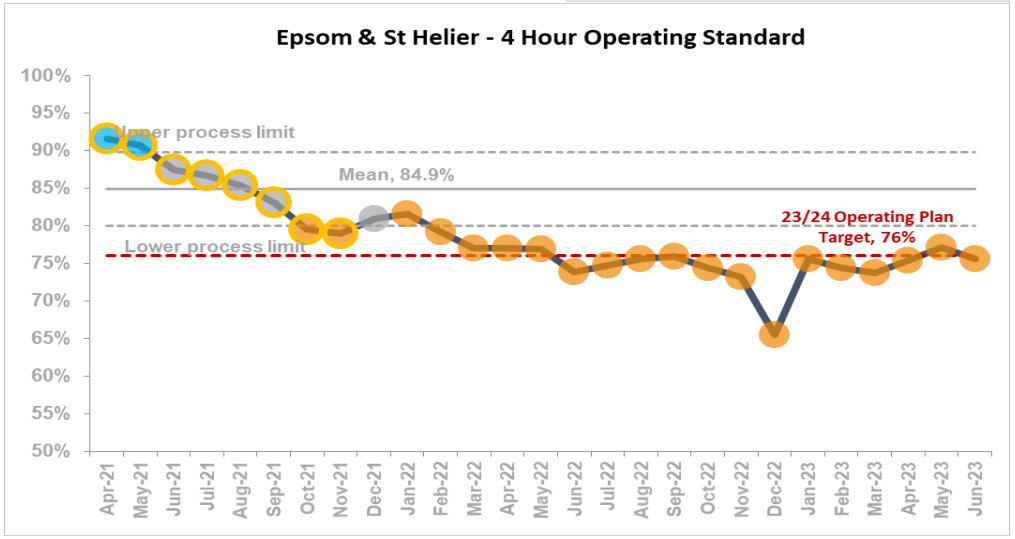
St George's, Epsom and St Helier University Hospitals and Health Group

June-23

Target: 76%	SGH: 71.5%	ESTH: 75.6%







SGH updates since last month

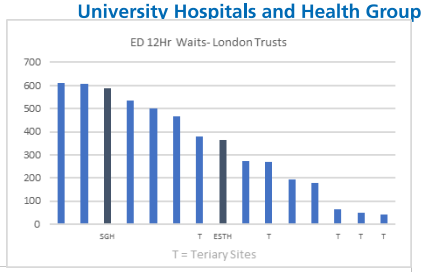
4 hour performance deteriorated in June to 71.5% compared to 81.7% in May. Capacity and flow across ED and the hospital was extremely challenged in a month where we saw the highest attendance day ever reported with 580 patients. Ambulance conveyances increased as well as acuity and non-elective admissions. The department was also impacted by high numbers of mental health patients, some with extremely challenging behaviours needing specialist care and treatment.

ESTH updates since last month

In June, 75.6% of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival seeing a decrease of 1.46% compared to May. On average across the month daily attendances increased by 30 patients per day compared to May.

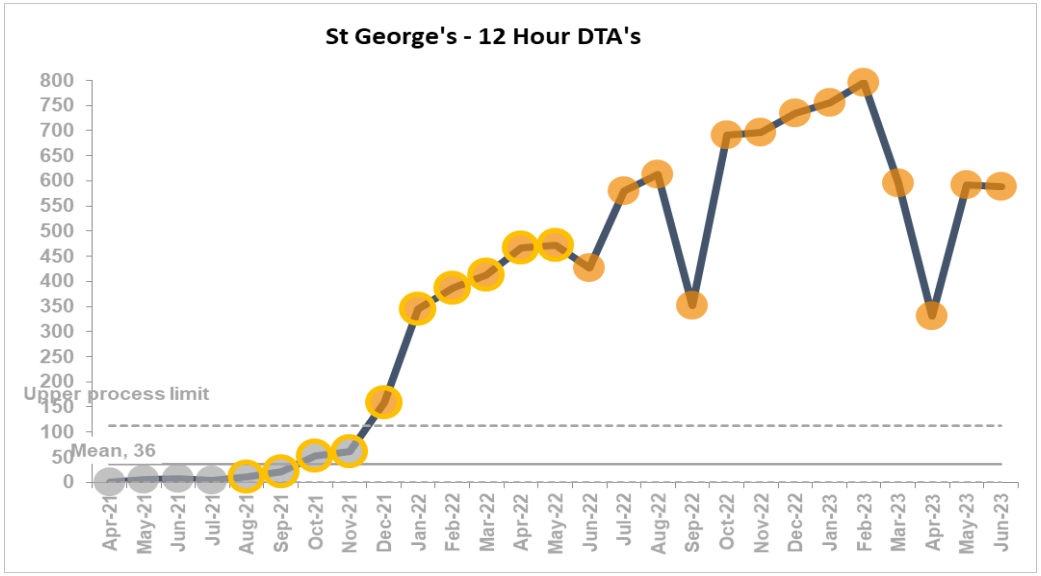
12 Hour DTA's

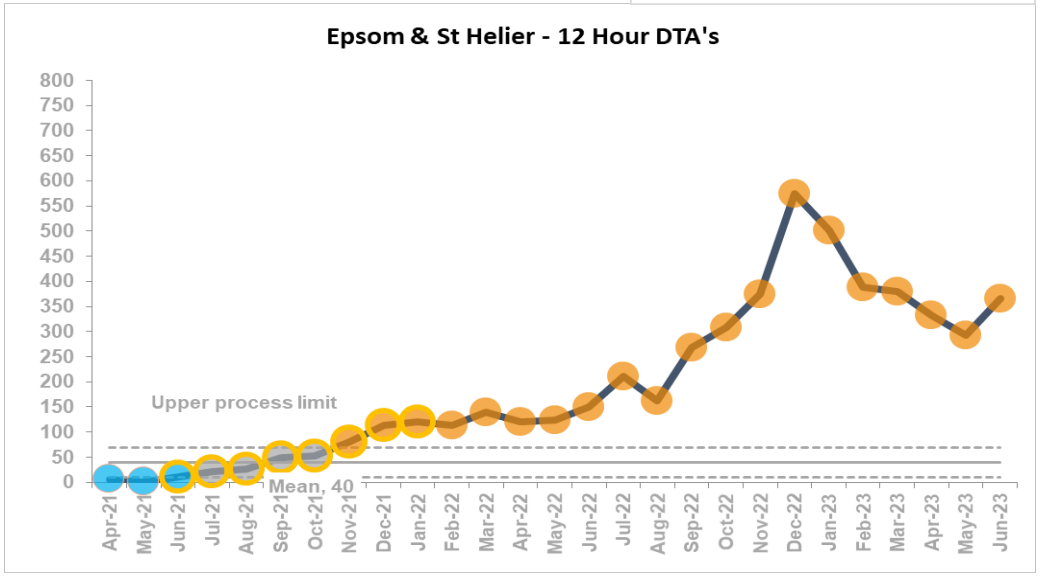
St George's, Epsom and St Helier University Hospitals and Health Group



Jun-23

Target: 0	SGH: 589	ESTH: 366





SGH updates since last month

The number of 12 hour trolley wait breaches following decision to admit remained high throughout June. This is impacted by increased attendance to our emergency department and high length of stay and bed occupancy through the month. 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

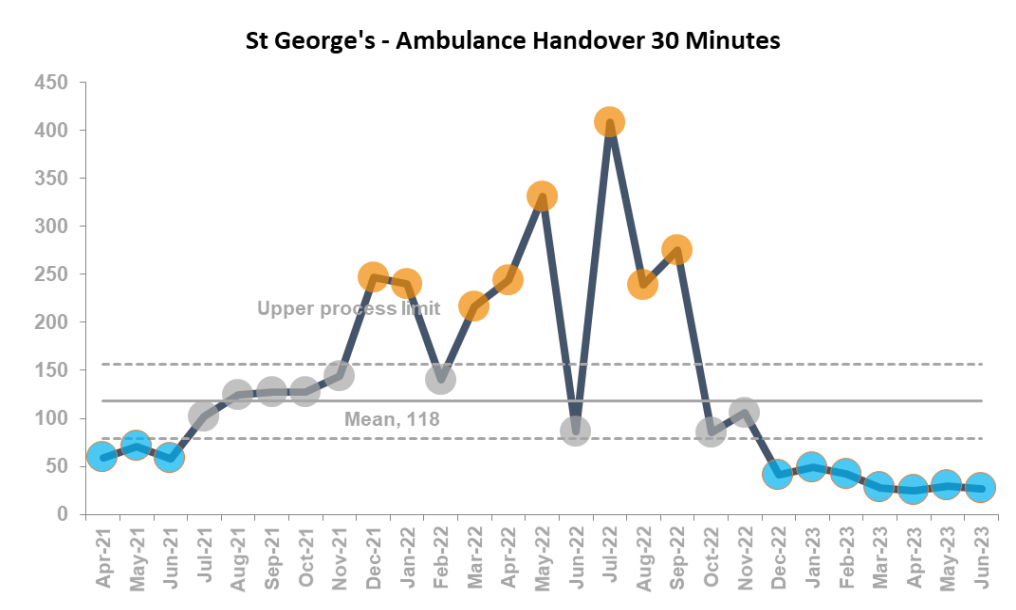
We are reporting 599 four hour trolley waits and 366 twelve hour breaches (a 25% increase of 12-hr waits compared to last month).

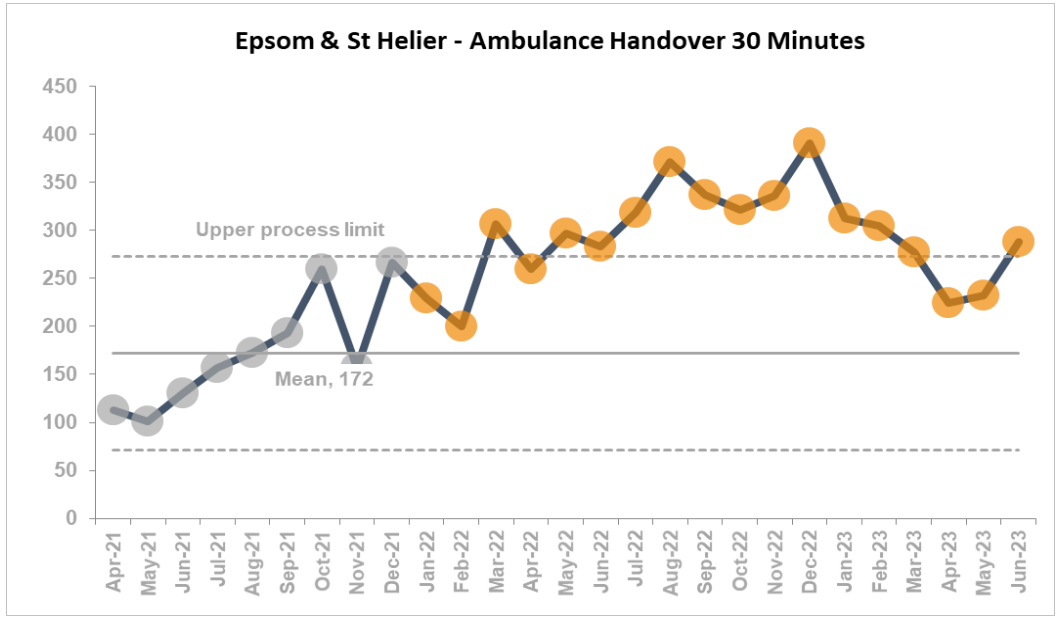
Ambulance Handover Delays 30-60 minutes

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

Jun 23

Target: 0	SGH: 27	ESTH: 288





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

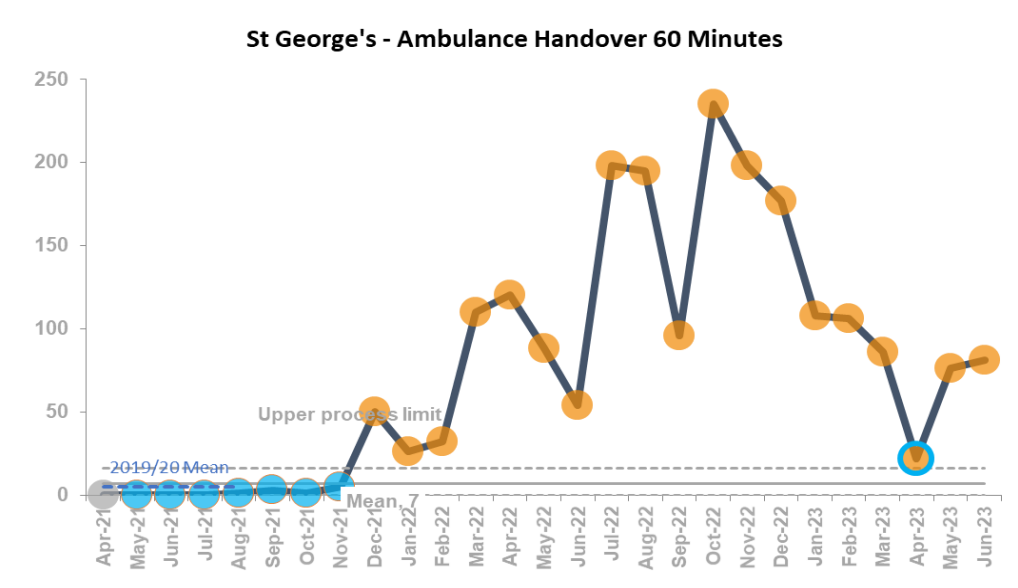
Performance against 30 minute handover delays remains above the mean. Across June on average there were 10 30 minute delays per day compared to 8 across May.

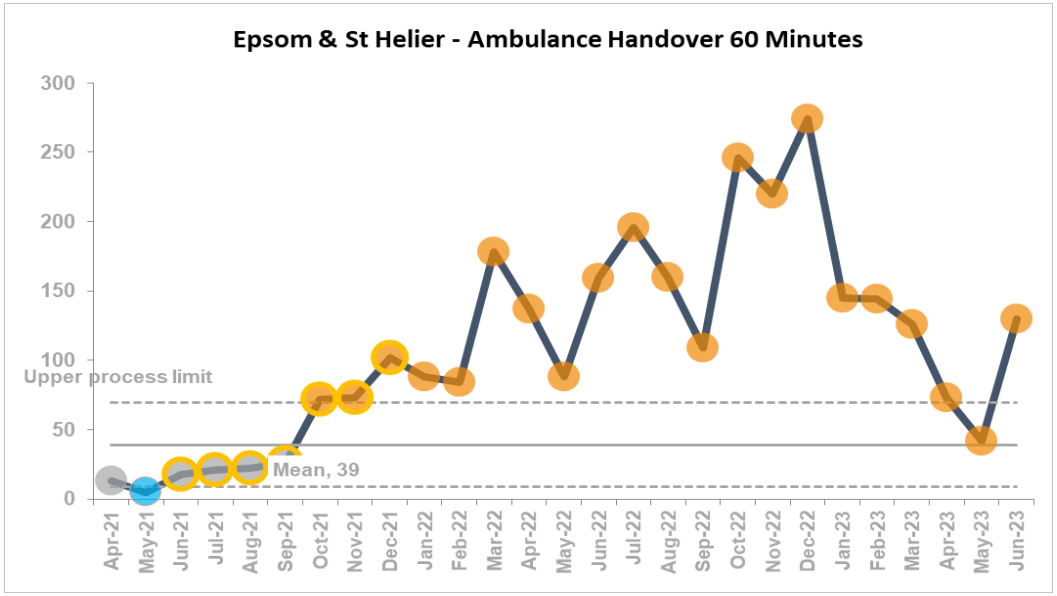
Ambulance Handover Delays 60 minutes

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

Jun 23

Target: 0	SGH: 81	ESTH: 130





SGH updates since last month

Across June, the number of ambulance conveyances waiting over 60 minutes per day for handover stayed consistent with May.

ESTH updates since last month

After a positive improvement, across June we saw an increase in 60 minute handover delay with on average four 60 minute delays per day – this was impacted by capacity challenges across the department with increased attendances seen.

Emergency Performance

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

SGH current issues –

Overall 4 hour performance (all Types) in June faced significant challenges throughout the month, closing the month at 71.5%. This places SGH 10th in London and 62nd nationally.

Multifactorial operational pressures contributed to this performance. On 12th June ED had a record breaking number of attendances in 24 hours, that being 580. High number of these attendances related to 'Thunderstorm asthma' and subsequently we received ITV coverage regarding this.
The 3rd week in June was our most challenged week for performance, we saw 3,117 patients in the week. There was an increased rate of on the day staff sickness in June. ED's overall sickness rate was 4.4%, but particular challenges can be seen within the Nursing workforce.
Ambulances conveying to SGH was high through June, a total of 6 days in June ED received 90+ ambulances each day.
Lastly, significantly complexed Mental Health presentations to ED and ongoing Industrial Action impacting workforce resilience have also been contributing factors to lower performance.

The ability of the department to admit patients to downstream wards was challenged in June due to the step down of beds for refurbishment works, and the Major Trauma Ward reopening delay.

Admitted performance in June fluctuated, there were 14 days were admitted performance was below 35% performance which impacts ED's ability to assessment patients in a timely manner.

June's LAS handover performance continues to be strong, with 93.44% of LAS offloads <15 minutes.

SGH future action –

The Homelessness and inclusion Team (HIT) and Emergency Department were been nominated for NHS Parliamentary Awards 2023. Awards ceremony took place early July, although we didn't win nationally were are delighted to be selected for regional nominees.

The internal ECDB is continuing to focus on Frailty, Same Day Emergency Care, Internal Professional Standards, as well as UTC workstreams.

High numbers of Mental Health patients in ED continues to be challenging however the ongoing support we are receiving from our CEO is much appreciated.

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.

ESTH current issues –

The trust saw an impact of the heat health alert in June-23 resulting in increased activity and acuity presenting to both hospital sites. Because of increased pressure and large numbers of unplaced patients in ED we declared a business continuity incident on Wednesday 21st June until Friday 23rd June.

We narrowly missed the 4-hour ED performance in June 23 reporting 75.06%, a deterioration compared to the previous month. Our time to triage remains within the 15-minute standard, reporting 13 minutes in June-23, providing assurance that patients are seen soon after arrival in the department.

4-hour performance for admitted patients remains challenging with onward flow from ED occurring during the late afternoon/evening period. However, we have seen recent improvement on the Epsom Hospital site following the introduction of a stretcher discharge lounge facility.

The number of patients spending over 12 hours in the emergency department has increased in June-23 at just over 8%. This compares to 6.5% in May-23, however, is an improvement compared to March-23 where we were reporting just over 10%.

June-23 saw a significant increase in > 60-minute ambulance handover delays at 130. This follows a month-on-month improvement since January-23.

ESTH future action –

Our weekly hospital flow meeting is now well-established and includes a comprehensive performance data pack. The performance pack has been further developed to drill down into individual days in order to understand factors influencing performance.

We are progressing several key actions, including:

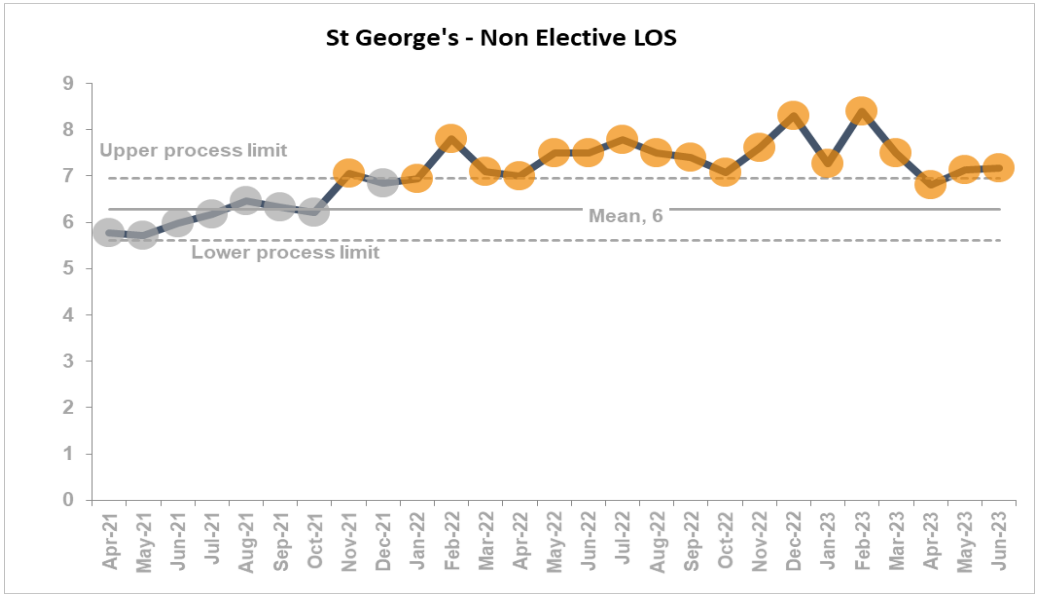
- A review of our internal professional standards (IPS), including the development of IPS for our acute gynae unit and SACU
- Review of our bed management/booking process and a plan to implement a revised process effective from 1st September. This will include increased ownership from our AMU team regarding inter ward transfers.
- Ongoing use of the stretcher discharge lounge facility on both hospital sites and newly developed triggers to support the implementation of boarding.
- A re-fresh of our daily conference call schedule to include increased divisional involvement in addressing non-elective operational flow.

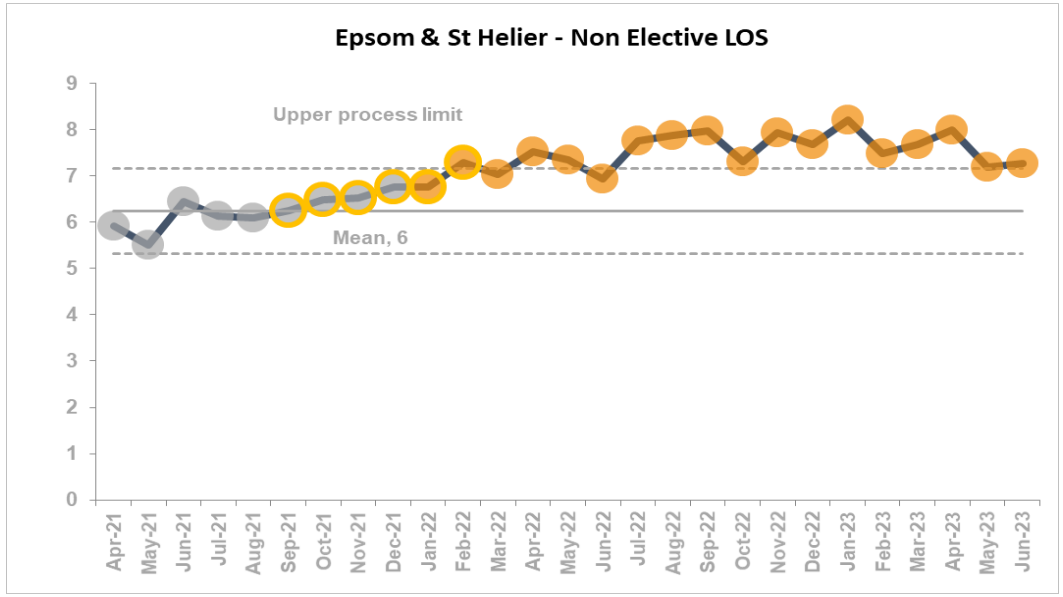
Non Elective Length of Stay

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

Jun-23

Target: TBC	SGH: 7.2	ESTH: 7.26





SGH updates since last month

Non-Elective length of stay remains above the mean however comparable to previous months with on average a length of stay of 7.2 days through June. The Trust continues to see high occupancy rates with G&A occupancy at 97.1%, the number of stranded patients (>7 days LOS) has seen an increase with super stranded (+21 days LOS) remaining stable however above mean.

ESTH updates since last month

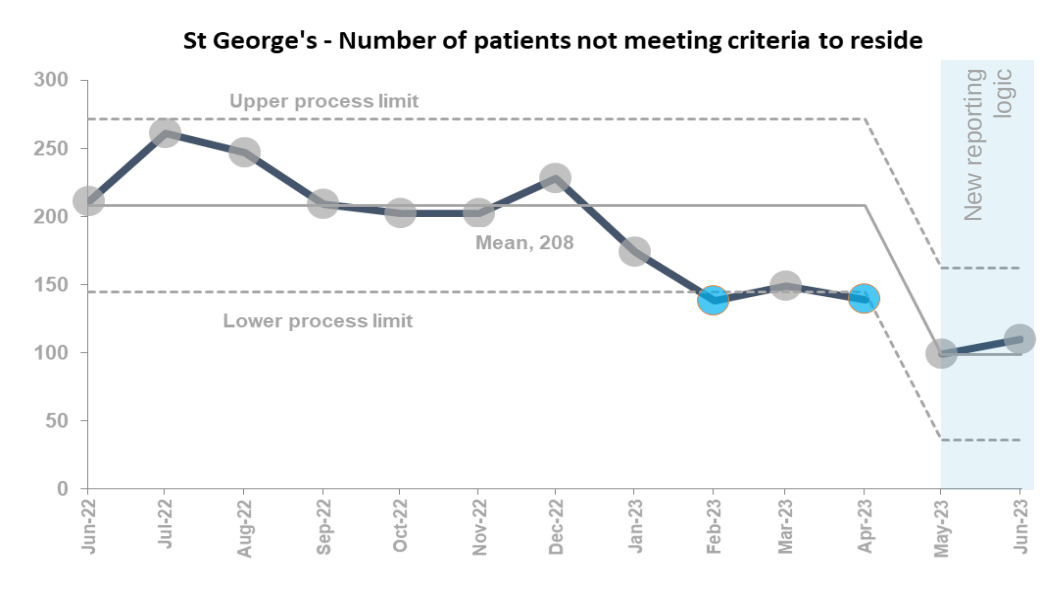
Non Elective length of stay remains above the upper control limit. On average across June patients admitted on a non-elective pathways stayed for 7.26 days. Both the daily stranded (7 day LOS) and super stranded patients (21 day LOS) saw an increase.

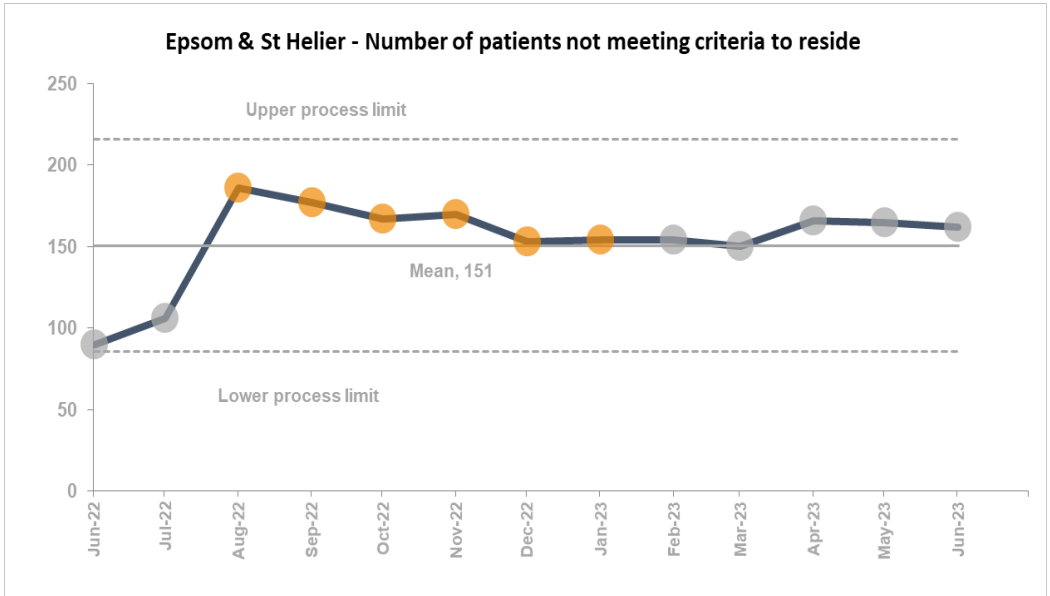
Patients not meeting criteria to reside

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

Jun-23

Target: TBC	SGH: 110	ESTH: 162





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.

June shows an increase in the number of patients not meeting the criteria to reside with on average 110 patients daily across the month.

ESTH updates since last month

The number of patients not meeting criteria reside remains predominantly within the upper and lower control limits with a slight decrease seen across June.

Length of Stay Performance - Analysis and Action

NHS
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 three months, the Trust has had an increasing number of Pathway 1 patients awaiting equipment.

Ongoing industrial action has impacted performance and we continue to plan/respond to each wave of industrial action. At time of writing, it is unknown what the impact will be on inpatient LoS due to the Society of Radiographers strike (i.e. through delayed access to dependant diagnostic tests) and whether there will be a delay in specialty input as a result of the BMA Consultant strike action, both planned for July 2023. Further consultant strike action provisionally scheduled for August 2023 leading straight into August Bank Holiday weekend will need additional planning if no movement in negotiations.

Amyand Ward is closed for planned refurbishment, leading to reduction to medical G&A beds, however we are working with local partners to reduce delays in onward care to mitigate this reduction.

SGH future action -

MADE events are occurring every 2 weeks, rotating between internal & external. Work ongoing to maximise effectiveness.

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 June 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. We have now developed internal professional standards to support improved patient flow/access to specialty areas.

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 have made good progress regarding arrangements for the therapy led unit at St Helier and have now agreed the associated staffing model/governance. We will now look to progress recruitment to support the unit opening in September 2023.

We are working closely with Surrey Downs colleagues regarding the fast-track discharge pathway and discharge to care homes with a view to reducing hospital length of stay for these patient cohorts.

SWL ICB have recently signed off a revised system wide patient choice protocol and we will be working to ensure that this is implemented for appropriate patients over the coming months.

We continue to provide stretcher discharge lounge facilities on both hospital sites and have seen an increase in the number of patients who access the discharge lounge earlier in the day..

We have also established a patient transport task and finish group to ensure that we are making appropriate use of hospital transport and are following agreed criteria for patients who are eligible for transport provision.

We continue to plan for and respond to junior doctor/consultant industrial action.

Monthly Overview – Our People

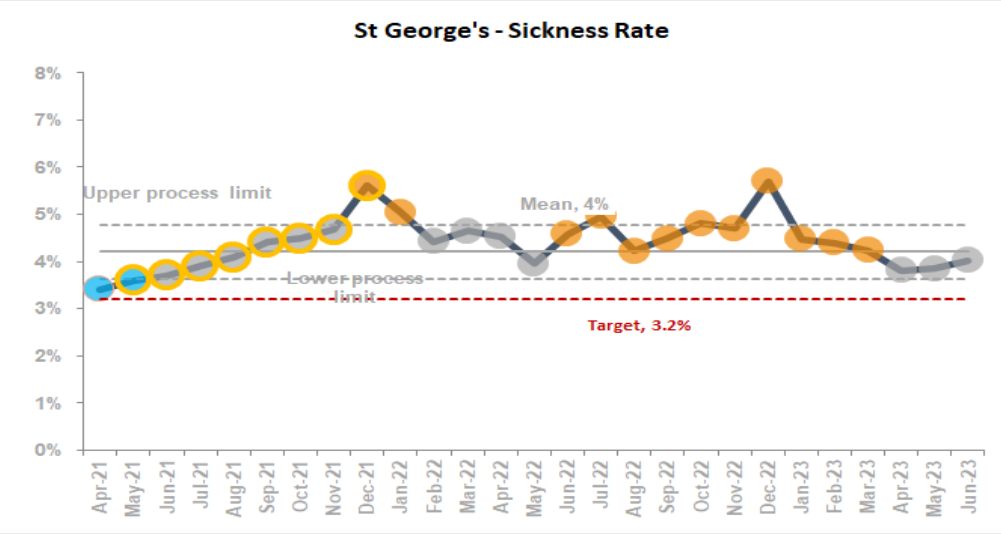
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

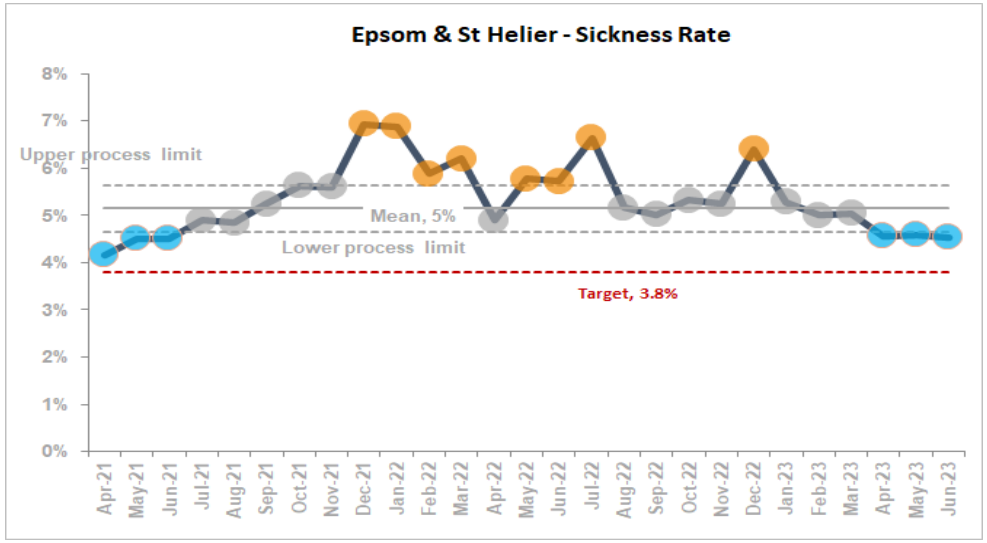
Our People	St Georges							Epsom and St. Helier						
	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	3.8%	3.9%	4.0%	3.2%	3.9%		3.8%	4.6%	4.6%	4.5%	3.8%	4.6%	
Agency rates		3.1%	2.9%	3.8%	TBC	3.3%		TBC	4.7%	3.3%	2.1%	TBC	3.4%	
MAST	85%	88.8%	89.2%	90.4%	85%	89.5%		85%	81.4%	82.1%	83.9%	85%	82.5%	
Vacancy	10%	8.5%	8.5%	9.3%	10%	8.8%		10%	12.7%	13.5%	13.2%	10%	13.1%	
Appraisal Rate Medical	90%	78.6%	79.8%	78.0%	90%	78.8%		90%	88.0%	89.0%	74.0%	90%	83.7%	
Appraisal Rate Non Medical	90%	69.8%	69.9%	69.7%	90%	69.8%		90%	68.0%	67.0%	65.2%	90%	66.7%	
Turnover	13%	15.3%	15.0%	15.0%	13%	15.1%		12%	15.6%	15.2%	14.9%	12%	15.2%	
Percentage BAME staff band 6 and above	TBC	44.4%	44.7%	44.5%	TBC	44.5%		TBC	37.1%	37.1%	37.3%	TBC	37.3%	

Sickness Rate

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

SGH Target: 3.2%	4.0%	ESTH Target: 3.8%	4.5%





SGH updates since last month

The Trust's sickness rate is in line with performance achieved last month and shows an upward trend. The Sickness rate at 4.0% is above the target of 3.2%.

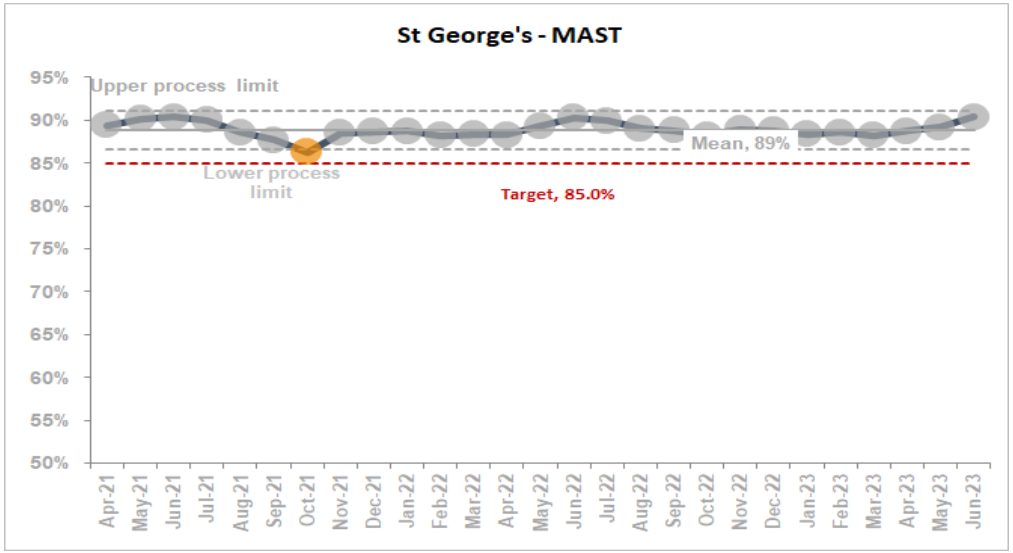
ESTH updates since last month

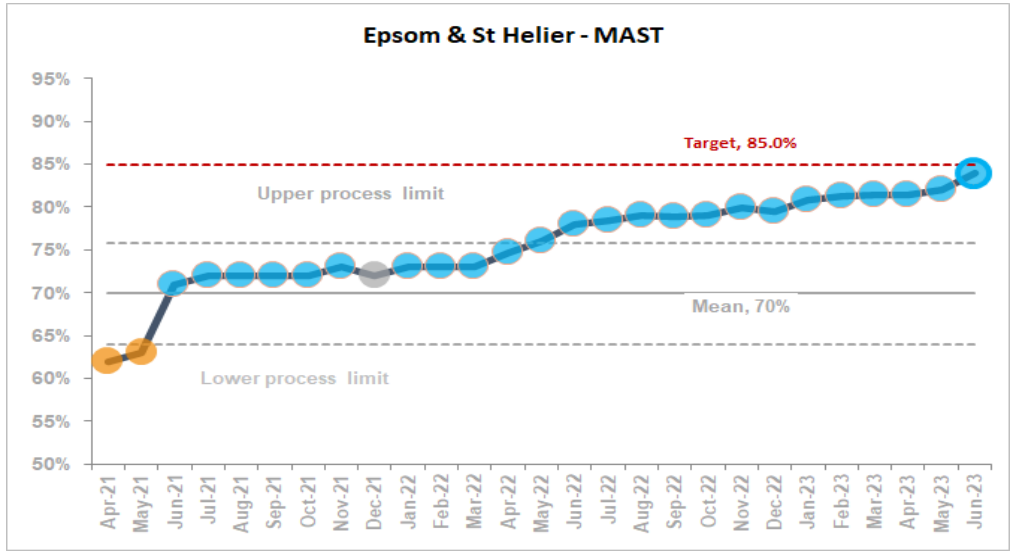
Sickness absence at ESTH was 4.5%, a slight reduction on last month's performance however remains significantly above the threshold target of 3.80%. Cold, Cough, Flu-Influenza, Other know causes and Gastrointestinal problems were the top 3 reasons for sickness absence.

MAST

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

SGH Target: 85%	90.4%	ESTH Target: 85%	83.9%





SGH updates since last month

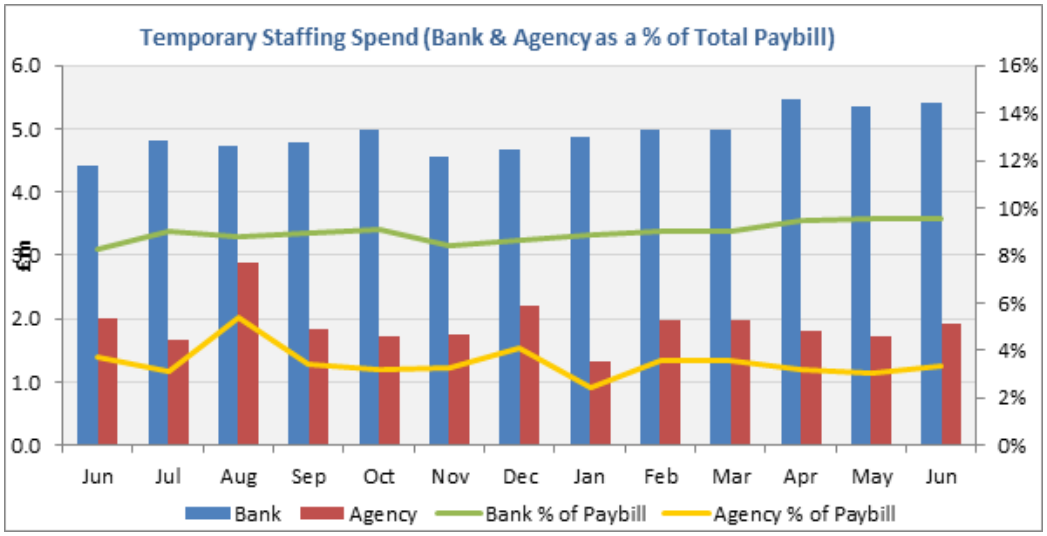
Mandatory and Statutory Training (MAST) was 90.4% in June. The compliance rate continues to hold steady and has done so for the last year showing common cause variation.

ESTH updates since last month

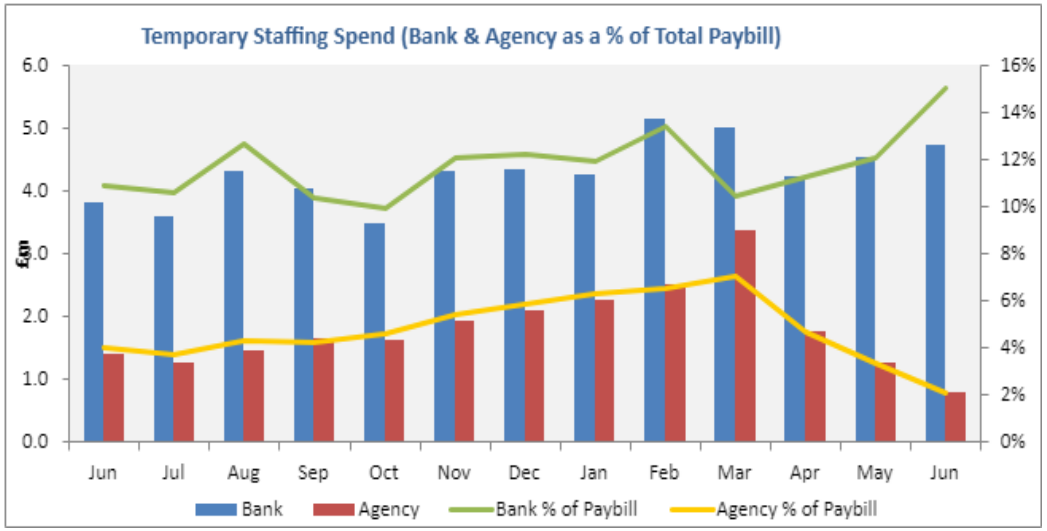
Performance in June was 83.9%. As part of the Divisional HR meetings, performance against the MAST indicator is regularly discussed. Managers are able to track their trajectory and performance on ESR where they can compare their current and previous percentage to enable them to see clearly their rate of improvement or otherwise.

Agency and Bank Spend

St George's



Epsom & St Helier



Monthly Overview – Integrated Care

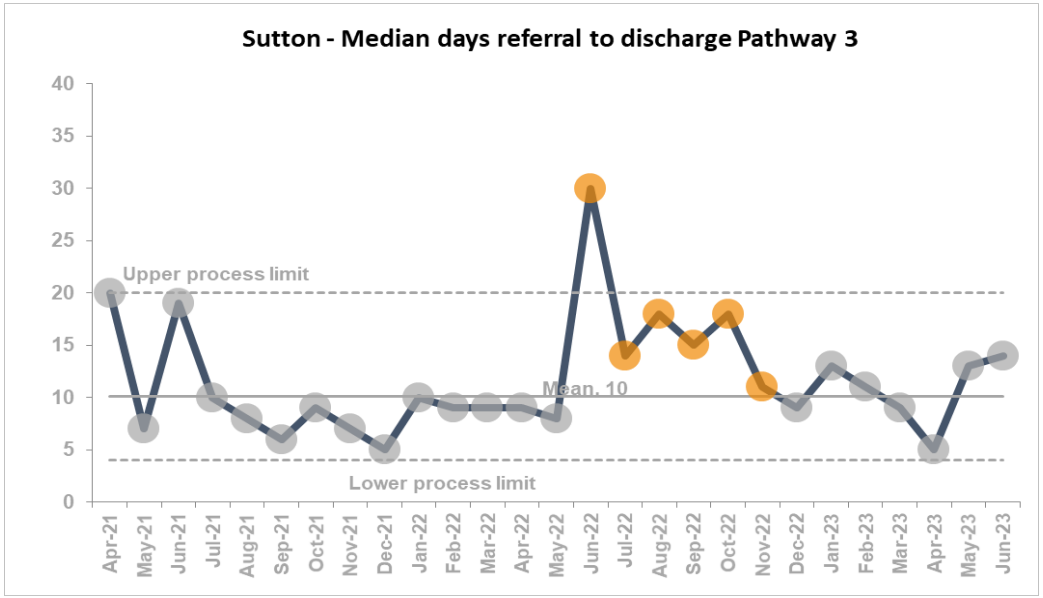
St George's, Epsom and St Helier University Hospitals and Health Group

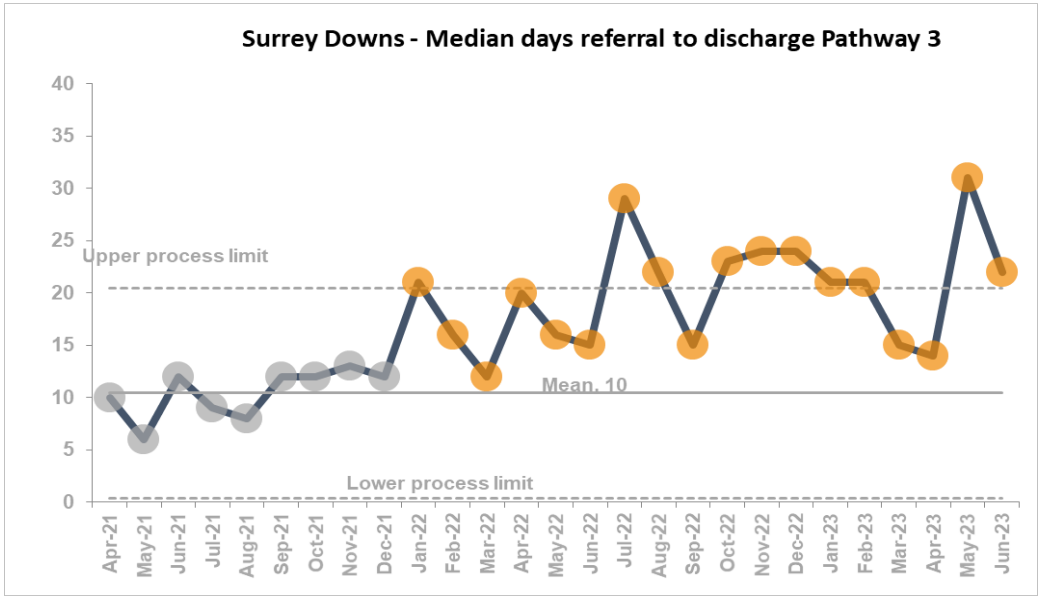
Responsive and Productive Services - Integrated Care	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Median days referral to discharge Pathway 1		3	4	7		5			3	3	2		3	
Median days referral to discharge Pathway 2		4	4	27		12			1	1	2		1	
Median days referral to discharge Pathway 3		5	13	14		11			14	31	22		22	
Two hour UCR performance	70%	81.8%	86.4%	82.7%	70%	84%		70%	79.0%	79.8%	82.6%	70%	80.5%	
Two hour UCR referrals received		144	185	197		526			429	425	436		1290	
Community hospitals bed occupancy									86%	88%	95%		90%	
Community hospitals LoS									22	19	17		19	
Virtual ward - Admissions		185	177	215		577			309	296	142		747	
Virtual ward LoS	14	2	2	2		2		14	11	19	8		13	
Total RTT Waiting List Size		1,458	1,615	1,480					535	506	580			
Total number of RTT patients waiting over 18 weeks		4	5	1					7	9	11			

Median days referral to discharge Pathway 3

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

Target: TBC	Sutton: 14	Surrey Downs: 22





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 June with median days increasing to 14.

Surrey Downs Health & Care updates since last month

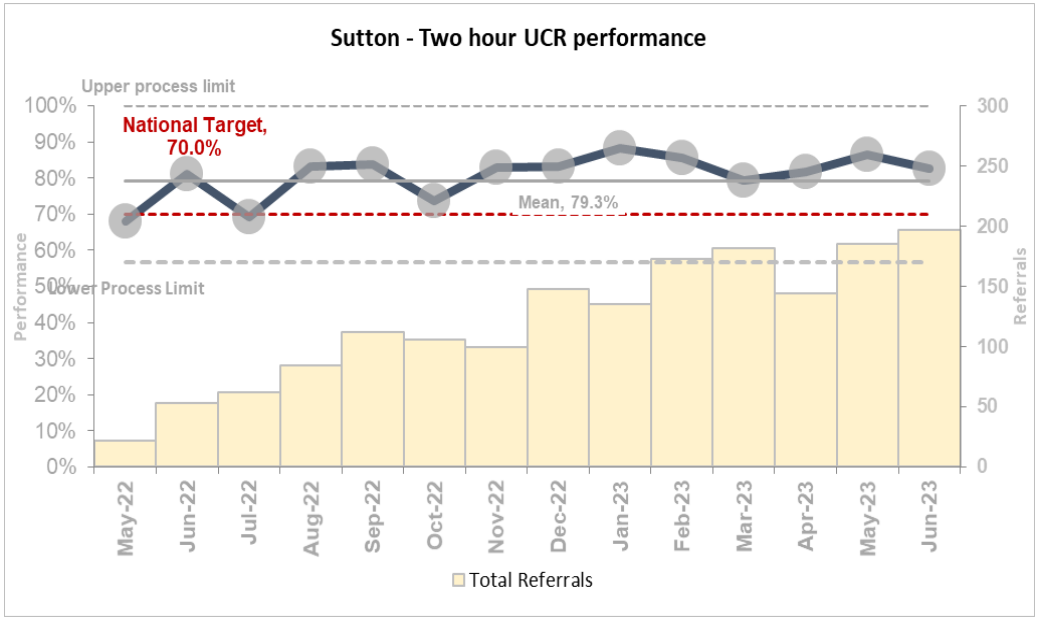
Pathway 3 – Requires on-going 24-hour nursing care, often in bedded settings.
Long term care likely to be required. Median days between referral to discharge has been above the upper control limit for the last two months. In June the median days were 22 days.

Ageing Well

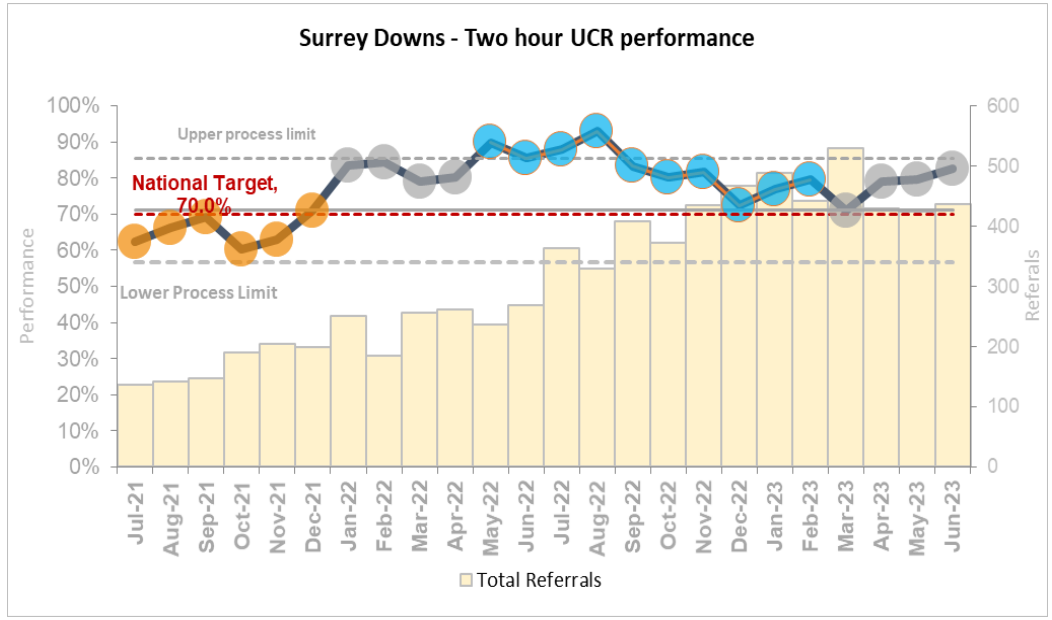
2 hour urgent community response

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

Sutton Target: 70% | **Actual: 82.74%**



Surrey Downs Target: 70% | **Actual: 82.56%**



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 achieving 82.74% in June.

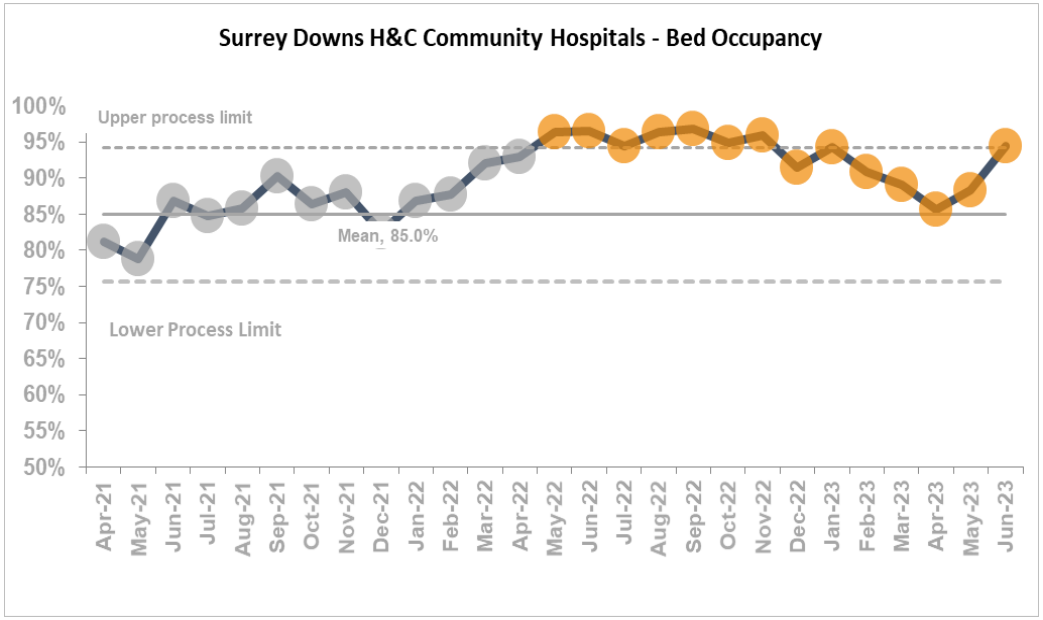
Surrey Downs Health & Care updates since last month

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 82.56% in June.

Surrey Downs Health & Care Community Hospitals

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

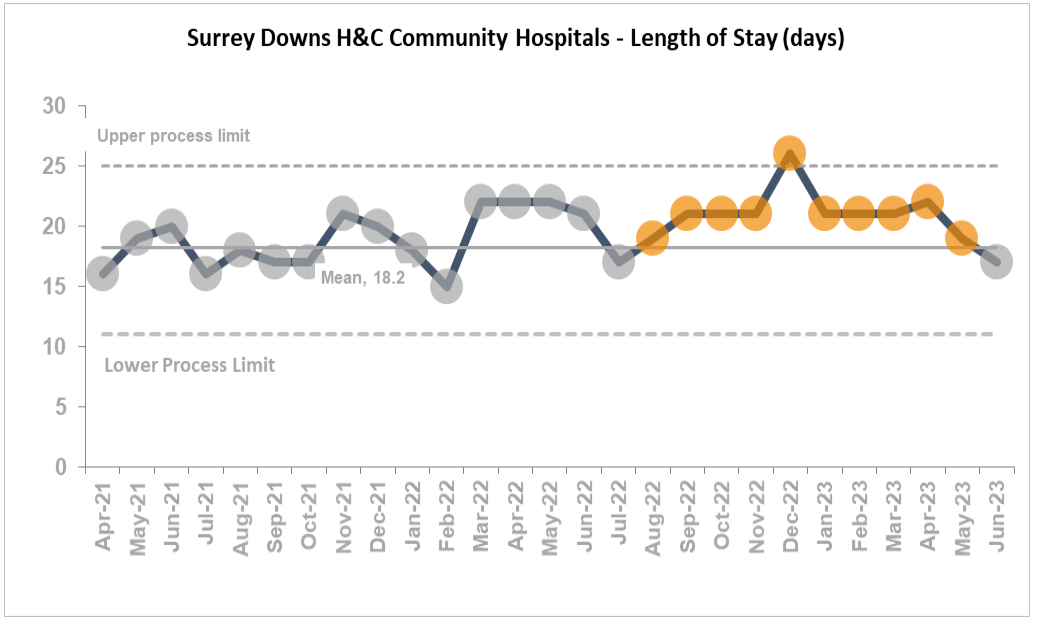
Bed Occupancy	Actual: 94.5%



Surrey Downs Health & Care updates since last month

SDHC runs 3 community hospitals and Alex Frailty on the Epsom site. Bed occupancy increased to 94.5% in June and remains above the mean.

Length of Stay	Actual: 17 days



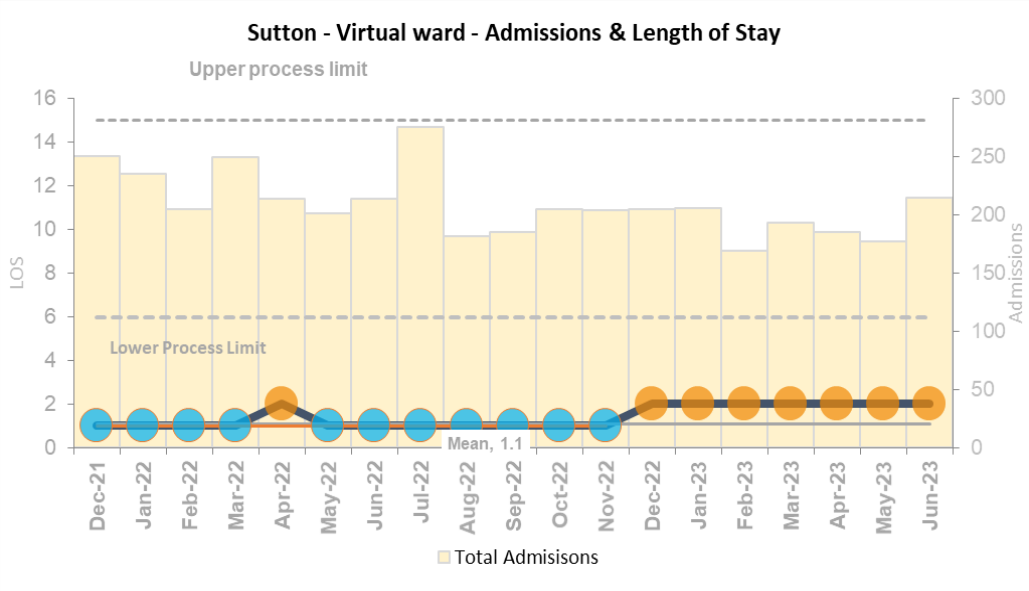
Surrey Downs Health & Care updates since last month

Length of stay in June was 17 days compared to 19.3 days through May, falling below the mean for the first time in eleven months.

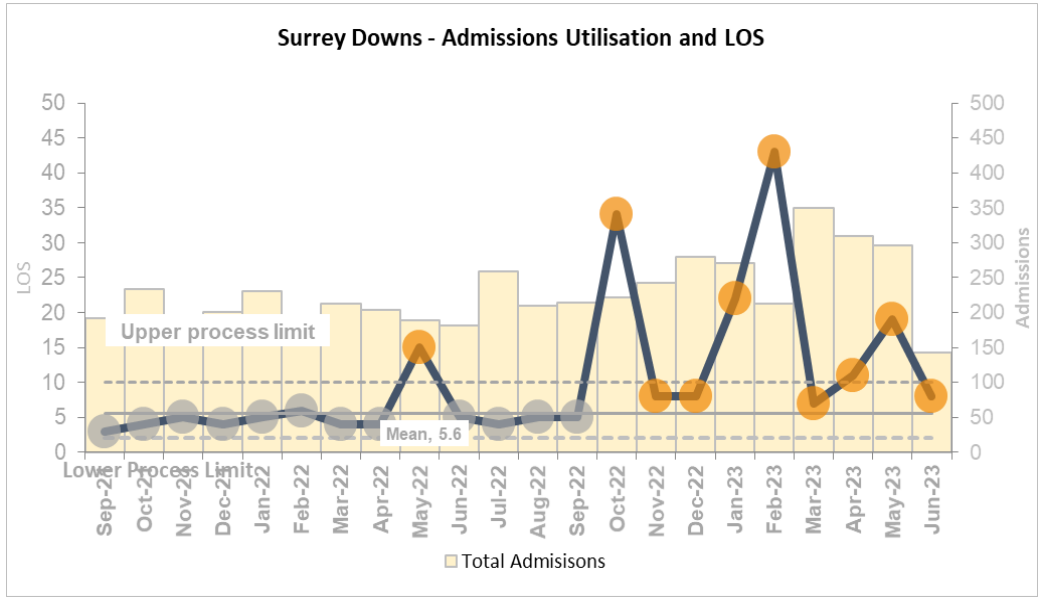
Virtual Ward
Admissions and length of stay

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

Sutton Target: TBC | **Actual: 2 days**



Surrey Downs Target: TBC | **Actual: 8 days**



Sutton Health & Care updates since last month

Service stated on Dec 21. Average LOS is currently at 2 days remaining consistent. Referrals increased throughout June, however comparable to June 2022. To note, there has recently been a change in the way virtual ward data is submitted which has meant a change to the number of referrals and length of stay.

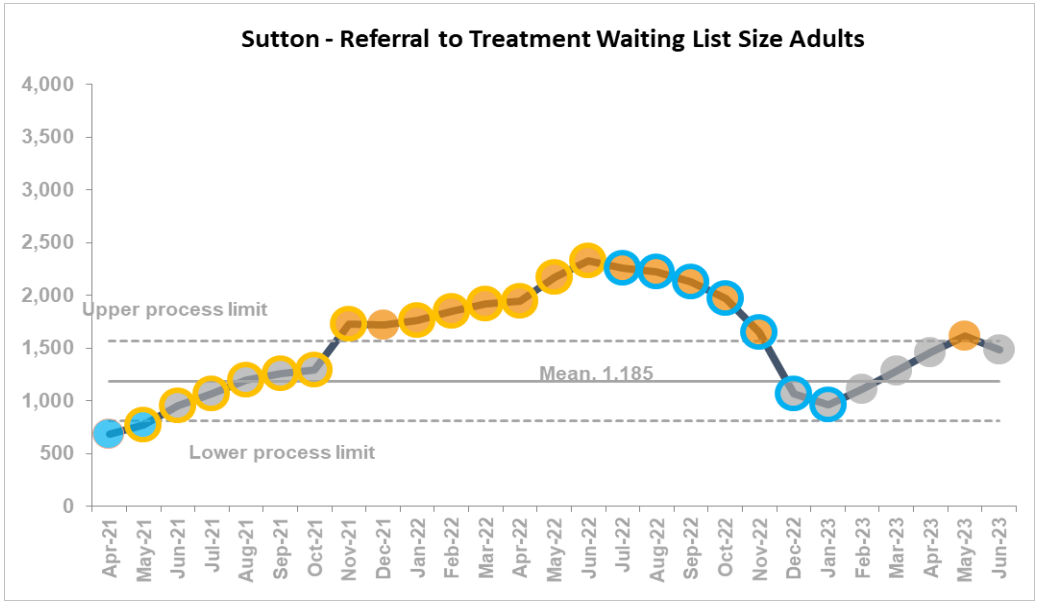
Surrey Downs Health & Care updates since last month

Service started Sep 21. There continues to be monthly variation in length of stay with on average through June a patient staying for 8 days. The number of admissions reduced by 52% compared to May-23.

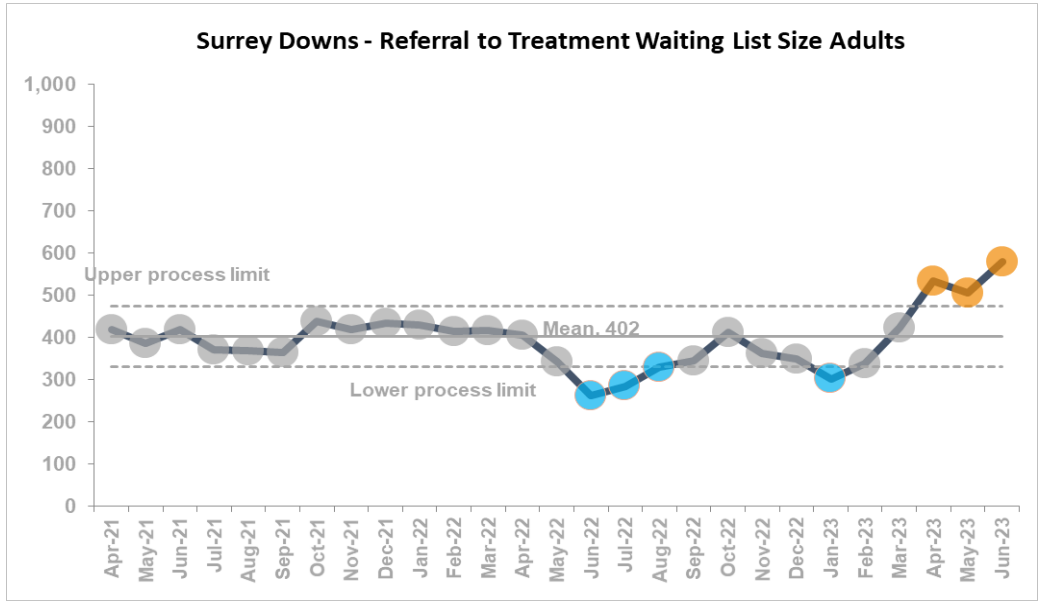
Referral to Treatment Waiting List Size

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

Sutton	Actual: 1,480



Surrey Downs	Actual: 580



Sutton Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal (MSK) pathways. At the end of June the number of patients on a RTT pathway reduced by 8.4% compared to May (-135 pathways). In total one patients was waiting for more than 18 weeks for treatment.

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 throughout June (+14.6%).

Integrated Care – Our People

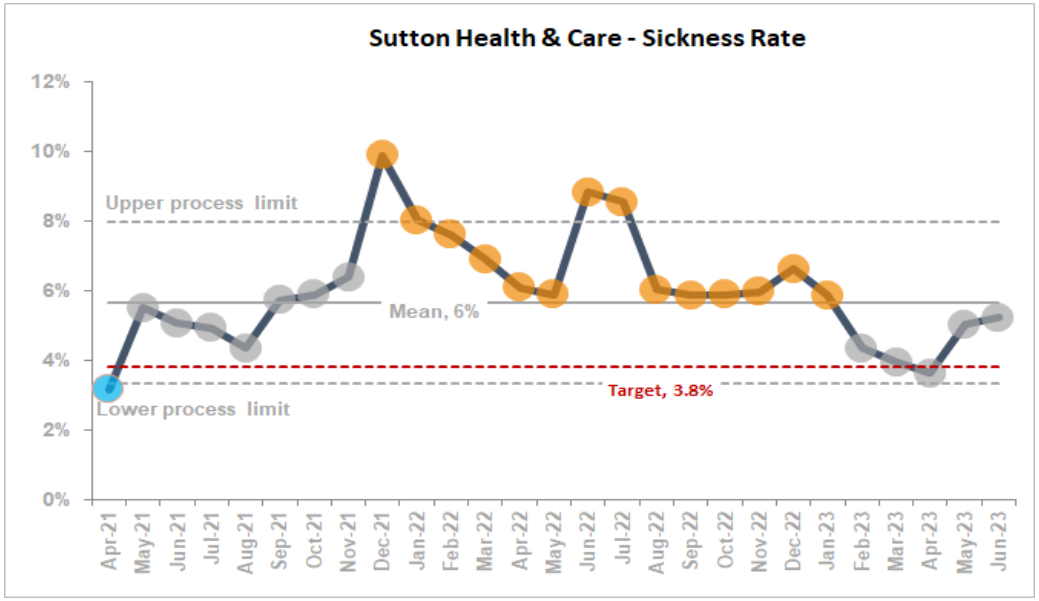
St George's, Epsom and St Helier University Hospitals and Health Group

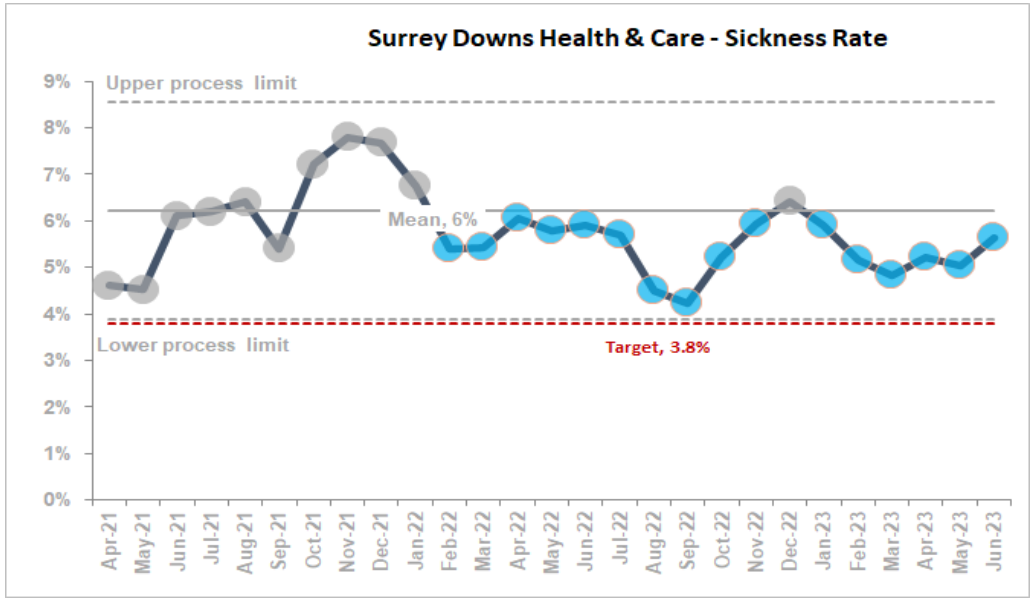
Our People	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Apr-23	May-23	Jun-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	3.6%	5.0%	5.2%	3.2%	4.6%		3.8%	5.2%	5.0%	5.6%	3.8%	5.3%	
Agency rates		3.2%	2.9%	3.5%		3.2%			13.0%	8.9%	7.3%		9.7%	
MAST	85%	87.7%	87.7%	88.5%	85%	88.0%		85%	89.4%	89.3%	92.0%	85%	90.2%	
Vacancy	10%	10.3%	15.4%	15.7%	10%	13.8%		10%	14.8%	20.4%	21.0%	10%	18.7%	
Appraisal Rate Medical	90%		100.0%	100.0%	90%	100.0%		90%	50.0%	100.0%	100.0%	90%	83.3%	
Appraisal Rate Non Medical	90%	68.6%	70.6%	70.5%	90%	69.9%		90%	90.2%	86.2%	83.1%	90%	86.5%	
Turnover	13%	2.3%	1.0%	1.9%	13%	1.7%		12%	0.8%	0.2%	1.0%	12%	0.7%	
Percentage BAME staff band 6 and above		37.1%	35.0%	35.8%		35.9%			20.0%	17.7%	17.7%		18.4%	

Sickness

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

Target: 3.8%	Sutton Health & Care: 5.2%	Surrey Downs Health & Care: 5.6%





Sutton Health & Care updates since last month

Sutton sickness rate further increased in June 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.

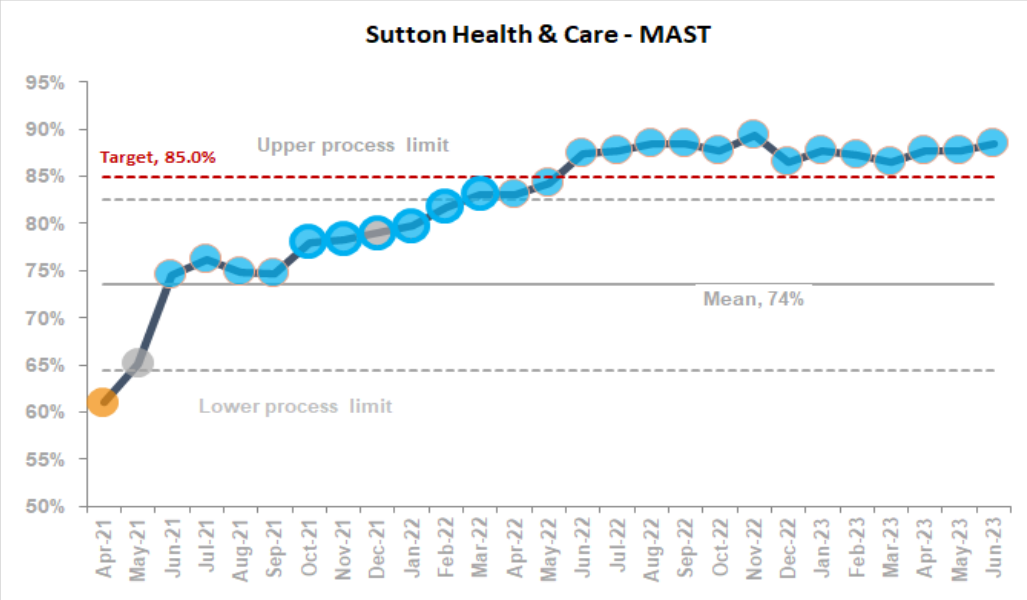
Surrey Downs Health & Care updates since last month

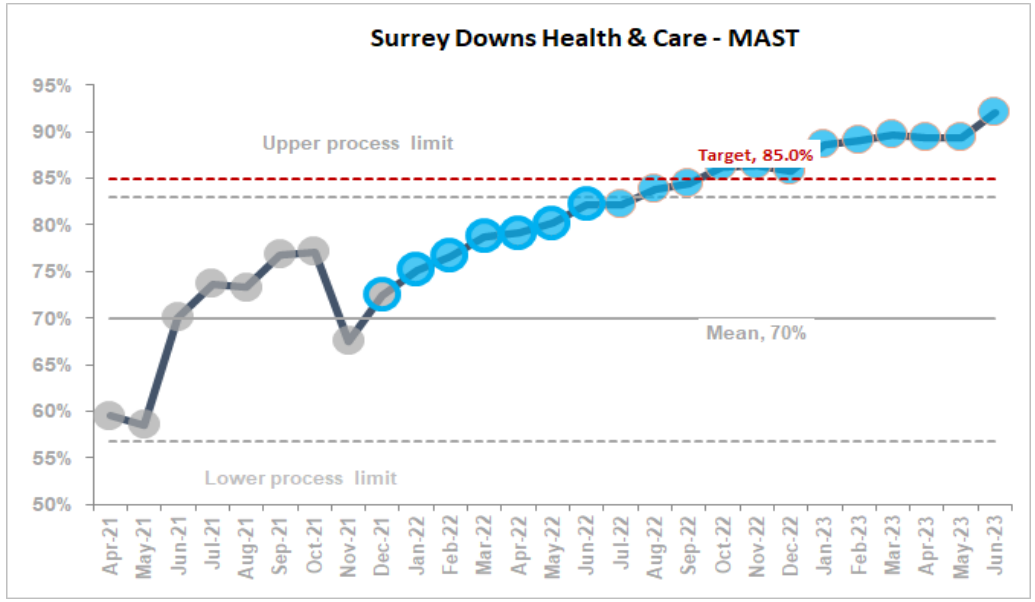
SDHC sickness absence rate has increased further and remains significantly over the KPI of 3.8%. Anxiety/stress/depressions/other psychiatric illnesses is the highest reason for absence at 24.69% followed by 'other know causes' at 21.83%. Long term sickness absence (episodes lasting 28 days or more) 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: 88.5%	Surrey Downs Health & Care: 92.0%





Sutton Health & Care updates since last month

Gradual increase but can be improved further and there is a robust monthly process in place to monitor MAST within SHC.

Surrey Downs Health & Care updates since last month

MAST compliance continues to improve. This remains 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 –

Children's Therapy waiting lists for routine care . An action plan is in place with LBS who provide therapy via education and social care.

Children's Services (special school nursing) and Education. Additional classroom capacity created at Sherwood Park from September 2023. Ongoing discussion with commissioners re provision.

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 nursing.

Sutton Health & Care future action –

1. Children's Therapy: collaboration with LBS to determine resolution of increased waiting lists across the borough and across all services.
2. Sherwood Park Special Schools discussion with Sutton PLACE and ICB.
3. Productivity / workforce: continued focus on safer staffing and reductions in agency and bank spend.

Surrey Downs Health & Care future action –

Implement the action plan from Staff engagement and listening events

Introduction of Welcome Payment for band 5 & 6 community nurses

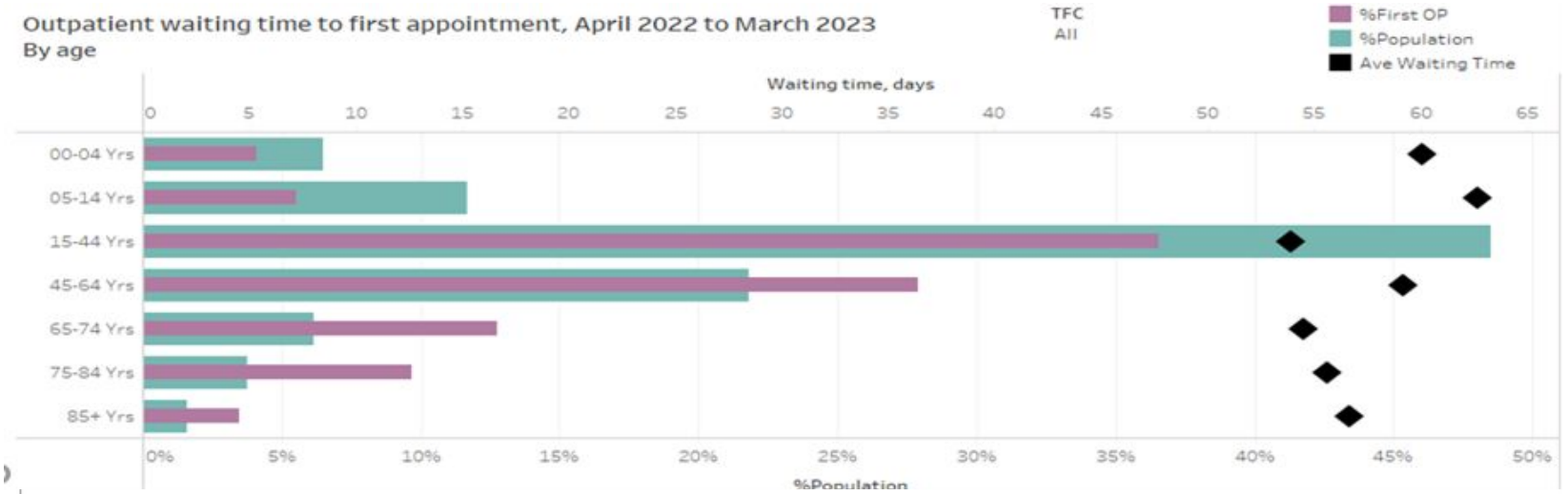
Productivity / workforce: continued focus on safer staffing and reductions in agency and bank spend.

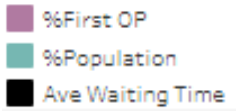
Outpatient waiting time to first appointment

St George's

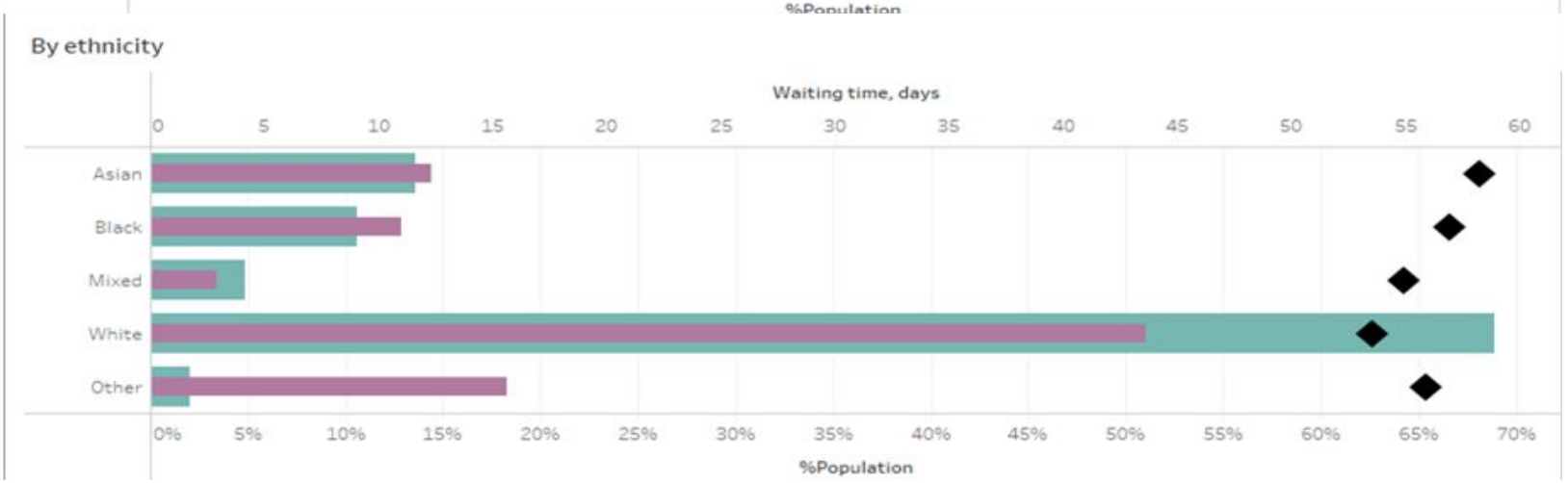
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Period – April 22 March 23 – By age





Period – April 22 to March 23 – By ethnicity



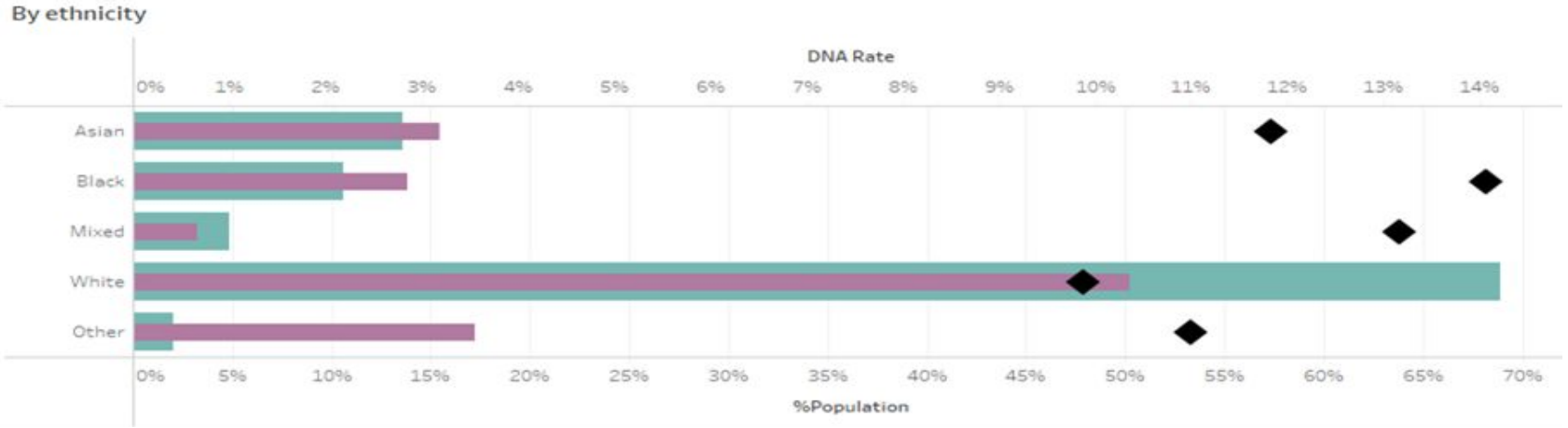
DNA Rate

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

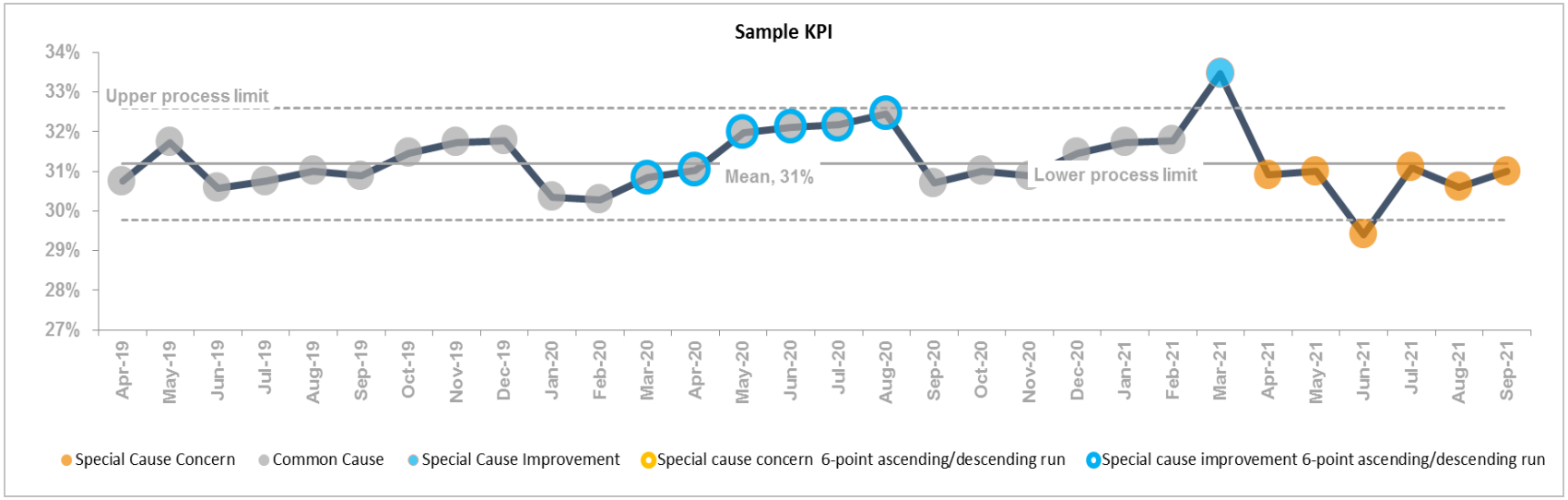


Appendix

- Guide on interpreting statistical process control charts

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

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

GESH Ward Heatmaps

June 2023

gesh

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

SGH Ward Heatmap

June 2023

gesh

Service	Quality Observatory (Issues)	Safe and Secure Medicines Management (Issues)	EWS Audit (Issues)	FFT Score	Inpatient Survey (Issues)	Compassion	Bed rails audit - assessment form completed	Saving Lives - Hand Hygiene	Saving Lives - Cleaning and Decontamination	MRSA - Acquisitions	MRSA - Bacteraemias	cDiff	MSSA	eColi	Acquired Category 3 Pressure Ulcers	Acquired Category 2 Pressure Ulcers	Medication Related SIs	SIs	Moderate and above Falls
Allingham	83.8	91.3	77.9	100	95.2	100	100	100	100	0	0	0	1	0	2	0	0	0	0
Amyand AMU	No data	95	100	100	95.3	100	100	95	90.2	0	0	0	0	0	0	0	0	1	0
Belgrave	97	100	91.5	100	99.4	100	95.8	100	90.9	1	0	0	0	0	0	0	0	0	0
Benjamin Weir	No data	No data	98.4	100	97.5	98.8	100	100	90	0	0	0	0	0	0	0	0	0	0
Caesar Hawkins Respiratory	No data	95.7	76.8		No data		100	87.1	35	0	0	1	0	0	0	0	0	0	0
Caroline	No data	100	95.6	95	95.2	99.2	100	95.2	100	0	0	0	0	0	0	1	0	0	0
Cavell	93.7	85.7	86.9	100	82.7	100	100	95	100	0	0	0	0	0	1	0	0	0	0
CCU	No data	No data	87.5	100	88.6	100	100	100	100	0	0	0	0	0	0	0	0	0	0
Champneys	No data	No data	90.7	100	91.7	100	100	100	100	0	0	0	0	0	0	0	0	0	0
Charles Pumphrey Unit	100	85	100	100	97.3	100	100	100	100	0	0	0	0	0	0	0	0	0	0
Cheselden	No data	No data	95.7	100	92	100	100	92	100	0	0	0	0	0	0	0	0	0	0
Dalby	100	100	84.3	75	87.5	100	100	86.4	94.4	1	0	1	0	0	1	0	0	0	0
Gordon Smith	99.5	No data	67.6	100	88.6	100	100	100	100	0	0	0	0	0	0	1	0	0	0
Heart Failure Unit	100	95	100	100	88.1	94.4	100	100	100	0	0	0	0	0	0	0	0	0	0
Heberden	99.4	100	100	100	86.7	92.9	100	100	95	0	0	0	0	0	0	0	0	0	0
Marnham ASHU	95.8	100	100	100	79.2	84.2	100	100	100	0	0	0	1	0	1	1	0	0	0
Mary Seacole	96	No data	100	91	77.6	96.8	100	100	100	0	0	0	0	1	0	0	0	0	1
McEntee	92.3	100	100	93	90.2	92.9	83.3	98.9	100	0	0	1	0	0	0	0	0	0	0
Richmond AMU	85.6	95	87.5	97	88.3	97.1	89.6	86.7	60	0	0	0	0	0	0	0	0	0	2
Rodney Smith	95.8	No data	79.6	75	67	83.3	100	85	81.8	0	0	0	0	2	0	0	0	0	1
Ruth Myles	No data	92	No data	100	93.2	100	No data	100	No data	0	0	0	0	0	0	0	0	0	0
Trevor Howell	93.6	84.8	96.3	0	60	50	100	100	100	0	0	0	0	0	0	0	0	0	0

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

SGH Ward Heatmap

June 2023

gesh

Surgery Anaesthetics and Neuro

Service	Quality Observatory (Issues)	Safe and Secure Medicines Management (Issues)	EWS Audit (Issues)	FFT Score	Inpatient Survey (Issues)	Compassion	Bed rails audit - assessment form completed	Saving Lives - Hand Hygiene	Saving Lives - Cleaning and Decontamination	MRSA - Acquisitions	MRSA - Bacteraemias	cDiff	MSSA	eColi	Acquired Category 3 Pressure Ulcers	Acquired Category 2 Pressure Ulcers	Medication Related SIs	SIs	Moderate and above Falls
Brodie	100	95.2	81	97	93.3	98.5	100	98.7	88	0	0	0	0	0	0	0	0	0	0
Florence Nightingale	97.9	100	92.5	95	92.9	95.8	100	100	100	0	0	0	0	0	0	0	0	0	0
Gray	93.6	100	98.8	86	85.7	89.1	96.9	100	100	0	0	1	0	1	1	1	0	0	0
Gunning	94.1	100	100	96	98.5	100	100	94.9	95	0	0	0	0	0	1	1	0	0	0
Gwynne Holford	100	100	100	100	96.4	100	100	100	100	0	0	0	0	0	0	0	0	0	0
Keate	97.7	100	94.7	100	98.6	100	100	95.1	100	0	0	0	1	0	0	0	0	0	0
Kent	96.9	81.8	100	94	88.2	93.8	100	98.9	98.9	0	0	0	0	0	0	0	0	0	0
Major Trauma Ward	No data	No data	No data		No data		No data	No data	No data	0	0	0	0	0	0	0	0	0	0
McKissock	100	100	100	99	95.8	98.8	100	100	100	0	0	0	0	0	0	0	0	0	0
Nye Bevan Unit	90	95	98.7	99	No data	99	100	100	100	0	0	0	0	0	0	0	0	0	0
Vernon	97.6	100	100	100	97	99.1	100	100	100	0	0	0	0	0	0	0	0	0	0
William Drummond	99.5	100	99	100	90.4	100	100	100	100	0	0	0	0	0	0	0	0	0	0
Wolfson / Thomas Young	99.2	100	100	71	78.2	87.5	100	97.1	97.8	0	0	1	0	0	0	0	0	0	0

Women and Children, Diagnostic and Therapy Services

Freddie Hewitt	No data	100	No data	100	88.6	97.2	100	100	100	0	0	0	0	0	0	0	0	0	0
Nicholls	76.9	100	No data	90	87.3	96.4	100	98	100	0	0	0	0	0	0	0	0	0	0
Pinckney	84.9	95	No data	100	95	100	No data	100	100	0	0	0	0	0	0	0	0	0	0

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

SGH Ward Heatmap

June 2023

St George's Heat Map - Service Spot-Light

gesh

Ward Name: Richmond
Division (Speciality): Medicine and Cardiovascular (Acute Medicine)
Flags:
- Moderate harm Falls - 2
- Quality Observatory audit 85.6% compliant
- Bedrails audit: 89.6% compliant
- Saving Lives compliance:
  - Cleaning and decontamination 60%

Accreditation: Silver (8th September 2022)
Comments: Service due re-inspection for accreditation. 2 moderate harm falls. Med Card Falls audit and action plan to be shared at PSQG and divisional level.

Ward Name: Dalby
Division (Speciality): Medicine and Cardiovascular (General Medicine)
Flags:
- Category 3, 4 & Unstageable pressure ulcers: 1
- Clostridium Difficile:1
- EWS Audit : 84.3%
- MRSA Acquisitions: 1

Accreditation: Silver (6th June 2023)
Comments: Category 3 or above pressure ulcer investigation reports to be presented and discussed with Head of Nursing for Quality and Tissue Viability Nurse to ensure lessons learnt and appropriate action plan put in place. Increased surveillance and support in place from Infection Prevention and Control Team.

Ward Name: Mary Seacole
Division (Speciality): Medicine and Cardiovascular (General Medicine)
Flags:
- E Coli: 1
- Category 3, 4 & Unstageable pressure ulcers: 1
- Friends and Family: 91%

Accreditation: Silver (6th June 2023)
Comments: Increased surveillance and support in place from Infection Prevention and Control Team and local pharmacist. Action plan to be developed at a local level where audit have identified underperformance.

Ward Name: Gray
Division (Speciality): Surgery, Neuro, Cancer and Theatres (Trauma and Orthopaedics)
Flags:
- EWS audit compliance: 72.1% compliant
- Category 3, 4 & Unstageable pressure ulcers: 1
- Category 2 pressure ulcers: 1
- E Coli: 1
- C Diff:1
- Friends and Family score: 86%

Accreditation: Silver (4th July 2023)
Comments: Category 2 pressure ulcer to be investigated by service leaders. Awaiting Rapid Response for Category 3 pressure ulcer to be reviewed by the Head of Nursing for Quality Action plan to be developed at a local level where audit have identified underperformance. Increased surveillance and support in place from Infection Prevention and Control Team.

Ward Name: Rodney Smith
Division (Speciality): Medicine and Cardiovascular (General Medicine)
Flags:
- E-coli: 2
- EWS audit compliance: 79.6% compliant
- Quality Observatory audit: 85.6% compliant
- Friends and Family score: 75
- Saving Lives compliance:
  - Cleaning and decontamination 81.8%

Accreditation: Silver (24th May 2023)
Comments: Increased surveillance and support in place from Infection Prevention and Control Team. Action plan to be developed at a local level where audit have identified underperformance.

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

ESTH Ward Heatmap
June 2023

gesh

Ward Heat Map
June 2023

Site	Occupied Bed Number	Falls Number	Falls Per 1000 beddays	Moderate Harm or Above Falls	Pressure Ulcer (During Our Care)	Unstageable/DTI Pressure Ulcers	Pressure Ulcer (3,4,DTI,U)	Moderate or Above Incidents	Transfers At Night	C.difficile	MRSA	Hand Hygiene Score	Crash Trolley Audit
Epsom General Hospital													
SWLEOC													
PACU - SWLEOC	126	2	15.9	0	0	0	0	0	1	0	0	100.00%	100.00%
Derby Ward - SWLEOC	506	4	7.9	0	0	0	0	0	0	0	0	90.00%	100.00%
Oaks Ward - SWLEOC	9	0	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Medicine													
Croft Stroke Ward	593	5	8.4	0	0	0	0	0	0	0	0	100.00%	100.00%
Buckley Gastro/GenMed	983	4	4.1	0	2	1	1	0	1	0	0	100.00%	100.00%
Gloucester Respiratory Unit	494	2	4.0	1	0	0	0	1	3	0	0	100.00%	0.00%
Britten Ward	536	2	3.7	0	1	0	0	0	3	0	0	100.00%	95.65%
Chuter Ede Ward - AMU	950	3	3.2	0	0	0	0	1	0	0	0	100.00%	100.00%
Buckley Escalation Ward - EGH	0	0	0.0	0	0	0	0	0	0	0	0	n/a	0.00%
Coronary Care Unit (CCU)	397	0	0.0	0	0	0	0	1	1	0	0	85.00%	97.92%
Critical Care													
High Dependency Unit	112	0	0.0	0	0	0	0	0	2	0	0	100.00%	93.62%
Emergency													
Emergency Department (EGH)		3	0.0	0	0	0	0	0	0	0	0	n/a	0.00%
Same Day Emergency Care EGH		1	0.0	0	0	0	0	0	0	0	0	n/a	0.00%
Surgery													
Swift Surgical Electives	0	0	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Women & Children													
Casey Paeds Ward	273	0	0.0	0	0	0	0	0	1	0	0	100.00%	100.00%
EGH Special Care Baby Unit	55	0	0.0	0	0	0	0	0	0	0	0	100.00%	97.48%
Simon Stewart Ward	240	0	0.0	0	0	0	0	0	0	0	0	0.00%	94.42%

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

ESTH Ward Heatmap
June 2023

gesh

Ward Heat Map
June 2023

Site	Occupied Bed Number	Falls Number	Falls Per 1000 beddays	Moderate Harm or Above Falls	Pressure Ulcer (During Our Care)	Unstageable/DTI Pressure Ulcers	Pressure Ulcer (3,4,DTI,U)	Moderate or Above Incidents	Transfers At Night	C.difficile	MRSA	Hand Hygiene Score	Crash Trolley Audit
St Helier Hospital													
Renal													
A6 Harry Secombe Ward (Renal)	685	2	2.9	0	0	0	0	0	0	0	0	97.62%	100.00%
B6 Richard Bright Ward (Step Closer)	0	1	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Renal Acute Care Unit		0	0.0	0	0	0	0	0	0	0	0	100.00%	98.58%
Surgery													
Mary Moore General Surgery	1079	5	4.6	1	0	0	0	1	5	0	0	96.67%	0.00%
A3 Ward (Hip fracture)	654	2	3.1	0	2	1	2	0	0	0	0	0.00%	100.00%
B3 Ward Trauma & Orthopaedics	470	0	0.0	0	1	0	0	1	1	0	0	100.00%	98.58%
Medicine													
C3 Ward GenMed	706	4	5.7	0	2	1	2	1	0	0	0	95.93%	100.00%
C1 Respiratory Ward	479	2	4.2	0	0	0	0	0	2	0	0	100.00%	100.00%
AMU (A1 Ward) - St Helier	788	3	3.8	0	1	0	0	0	0	0	0	92.96%	0.00%
Frank Deas GenMed	650	2	3.1	0	0	0	0	0	2	0	0	82.41%	0.00%
A5 Ward CotE	680	2	2.9	1	0	0	0	1	2	0	0	90.48%	100.00%
C4 Gastro	550	1	1.8	0	0	0	0	0	1	0	0	100.00%	100.00%
B5 Frailty Unit	624	1	1.6	0	0	0	0	0	1	0	0	100.00%	100.00%
C5 Ward CotE	653	1	1.5	0	2	2	2	0	0	0	0	93.33%	100.00%
A1 Coronary Care Unit - STH	320	0	0.0	0	0	0	0	0	6	0	0	100.00%	100.00%
B1 Medical Ward	360	0	0.0	0	0	0	0	0	5	0	0	100.00%	100.00%
Harry Secombe Escalation	0	0	0.0	0	0	0	0	0	0	0	0	n/a	0.00%
Rapid Assessment Hub - STH		2	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Clinical Services													
C6 Haematology Ward	270	0	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Critical Care													
B2 Ward (ICU/HDU)		0	0.0	0	0	0	0	1	0	0	0	100.00%	99.53%
Emergency													
Emergency Department (STH)		5	0.0	0	0	0	0	2	0	0	0	n/a	0.00%
Same Day Emergency Care STH		0	0.0	0	0	0	0	0	0	0	0	100.00%	100.00%
Women & Children													
Gynaecology Ward M2	203	0	0.0	0	0	0	0	1	0	0	0	100.00%	0.00%
Neonatal Unit	202	0	0.0	0	0	0	0	0	0	0	0	0.00%	97.38%
QM2 (Childrens Ward)	229	0	0.0	0	0	0	0	0	0	0	0	100.00%	94.74%
STH Maternity Ward	430	0	0.0	0	0	0	0	0	0	0	0	0.00%	0.00%

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

ESTH Ward Heatmap

June 2023

gesh

Emergency Department Heat Map

June 2023

Ward Name	Falls Number	Moderate Harm or Above Falls	Moderate or Above Incidents	Hand Hygiene Score
Emergency Department (EGH)	3	0	0	n/a
Emergency Department (STH)	5	0	2	n/a
Same Day Emergency Care EGH	1	0	0	n/a
Same Day Emergency Care STH	0	0	0	100.00%

Private Ward Heat Map

June 2023

Ward Name	Occupied Bed Number	Falls Number	Falls Per 1000 beddays	Moderate Harm or Above Falls	Pressure Ulcer (During Our Care)	Pressure Ulcer (3,4,DTI,U)	Unstageable/DTI Pressure Ulcers	Moderate or Above Incidents	Transfers At Night	C.difficile	MRSA	Hand Hygiene Score	Crash Trolley Audit
Northey Suite	237	3	12.7	0	0	0	0	0	0	0	0	100.00%	100.00%

Community Ward Heat Map (in development)

June 2023

Ward Name	Occupied Bed Number	Falls Number	Falls Per 1000 beddays	Moderate Harm or Above Falls	Pressure Ulcer (During Our Care)	Unstageable/DTI Pressure Ulcers	Moderate or Above Incidents	Transfers At Night	C.difficile	MRSA	Hand Hygiene Score	Crash Trolley Audit
Alexandra Ward Community	714	1	1.4	0	1	0	0	0	0	0	96.67%	0.00%

Community Ward	Occupied Beds	Falls Number	Falls Per 1000 beddays	Moderate Harm or Above Falls	Pressure Ulcer (During Our Care)	Unstageable/DTI Pressure Ulcers	Moderate or Above Incidents	Hand Hygiene Score	Crash Trolley Audit
Dorking Inpatient Ward	0	0.00	0	1	0	0	96.79%	98.72%	
Molesey Inpatient Ward	1	0.00	0	0	0	0	96.79%	98.72%	
NEECH Inpatient Ward	3	0.00	0	1	0	0	96.79%	98.72%	

Community Heat Map (in development)

June 2023

Location_type	Falls	Falls With Moderate Harm or Above	Pressure Ulcers During Our Care (C2+)	Pressure Ulcers During Our Care Unstageable	Moderate or Above Medication Incidents	Hand Hygeine	Safeguarding alerts (attributable to our care)
Community - Sutton Health and Care	79	4	34	6	1		
Community - Surrey Downs Health and Care	79	4	34	6	1		

SDHC Quality Dashboard

SHC Quality Dashboard

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	2.3	
Report Title	**Group- Financial Performance M4**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO, SGH DFP, ESTH Site CFO	
Previously considered by	Finance Committees-in-Common	23 August 2023
Purpose	**For Review**	

Executive Summary

This paper sets out the financial performance YTD for each Trust and the risks to delivering the full year plan. Both Trusts are on plan excluding the impact of Industrial Action on income and costs.

Action required by Finance Committees-in-Common

The Committee is asked to: Note the financial performance in M4

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

n/a

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

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

Financial implications
n/a

Legal and / or Regulatory implications
n/a

Equality, diversity and inclusion implications
n/a

Environmental sustainability implications
n/a

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

Trust Board (Public): 08th September 2023
23/24 M4 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

Year to Date Financial Information
Key actions

	Issue	Action
Summary I&E	Both Trusts are on plan excluding the impact of industrial action.	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 M4,** 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 and Q3, SGH expected in Q3.**	See cash update

ESTH
Executive summary

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £20.1m at the end of July, which is £2.2m adverse against plan with Acute Services being £2.0m adverse; Integrated Care is £0.1m favourable and Corporate Services is £0.4m adverse. The deficit is due to the net costs of the industrial action to date, £1.1m, and a £1.1m shortfall of ERF income as a result of the industrial action.	£2.2m Adv to plan	£1.2m Adv to plan
Income	Overall income is £0.5m adverse to plan. Patient Care income is £0.6m adverse of which £1.1m is the ERF shortfall. Other Operating Income which is £0.1m favourable.	£0.4m Adv to Plan	£1.0m Adv to Plan
Expenditure	Expenditure is £2.8m adverse year to date, of this £1.1m is due to the net costs of the industrial action to the end of July and CIP delivery is £2.4m less than plan.	£0.5m Adv to Plan	£1.0m Adv to Plan
Cost Improvement Plans	The CIP plan has delivered £4.5m to date, however in month the achievement is £2.4m less than plan as the efficency ask increased in month.	£2.4m Adv to plan	On Plan
Capital	At the end of July, the Trust's has spent £6.7m against at plan of £12.2m	£5.7m Fav to plan	£8.1m Fav to plan
Cash	The Trust has a cash balance of £21.7m against the plan of £19.6m at the end of July. The Trust has been granted access to cash support by NHSE.	£2.6m Fav to plan	£13.5m Adv to plan

Epsom and St Helier University Hospitals NHS Trust

ESTH
Income and expenditure

Table 1 - Trust Total

		Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	577.4	47.8	48.2	0.4	190.9	190.3	(0.6)
	Other Op. Income	37.1	3.1	3.3	0.2	13.2	13.3	0.1
Income Total		**614.5**	**50.9**	**51.4**	**0.5**	**204.1**	**203.6**	**(0.5)**
Expenditure	Pay	(436.1)	(35.7)	(36.2)	(0.5)	(147.5)	(148.2)	(0.6)
	Non Pay	(188.7)	(15.8)	(17.0)	(1.2)	(65.3)	(67.4)	(2.1)
Expenditure Total		**(624.8)**	**(51.5)**	**(53.2)**	**(1.7)**	**(212.8)**	**(215.6)**	**(2.8)**
Post Ebitda		(27.6)	(2.2)	(2.0)	0.1	(9.1)	(8.1)	1.0
Grand Total		**(37.9)**	**(2.8)**	**(3.8)**	**(1.1)**	**(17.9)**	**(20.1)**	**(2.2)**

Table 2 - Acute Services

		Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	513.3	42.5	42.8	0.3	169.6	169.0	(0.6)
	Other Op. Income	25.6	2.1	1.8	(0.2)	9.4	8.2	(1.2)
Income Total		**538.9**	**44.6**	**44.6**	**0.0**	**178.9**	**177.1**	**(1.8)**
Expenditure	Pay	(328.5)	(26.8)	(27.2)	(0.4)	(111.2)	(112.1)	(0.9)
	Non Pay	(119.7)	(9.8)	(10.4)	(0.6)	(41.8)	(42.3)	(0.5)
Expenditure Total		**(448.2)**	**(36.6)**	**(37.6)**	**(1.0)**	**(153.0)**	**(154.4)**	**(1.4)**
Post Ebitda		(27.6)	(2.2)	(2.0)	0.2	(9.1)	(7.9)	1.2
Grand Total		**63.1**	**5.8**	**5.0**	**(0.7)**	**16.7**	**14.8**	**(2.0)**

Table 3 - Integrated Care Services

		Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	64.0	5.3	5.4	0.1	21.3	21.3	(0.0)
	Other Op. Income	2.5	0.2	0.3	0.1	0.9	1.0	0.1
Income Total		**66.6**	**5.6**	**5.7**	**0.1**	**22.2**	**22.3**	**0.1**
Expenditure	Pay	(52.8)	(4.4)	(4.4)	0.0	(17.8)	(17.4)	0.3
	Non Pay	(14.6)	(1.2)	(1.3)	(0.1)	(5.0)	(5.1)	(0.1)
Expenditure Total		**(67.4)**	**(5.6)**	**(5.7)**	**(0.1)**	**(22.7)**	**(22.5)**	**0.2**
Post Ebitda		0.0	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)
Grand Total		**(0.8)**	**(0.0)**	**(0.0)**	**0.0**	**(0.5)**	**(0.4)**	**0.1**

Table 4 - Corporate Services

		Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 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	0.1
	Other Op. Income	9.0	0.8	1.1	0.3	3.0	4.1	1.1
Income Total		**9.0**	**0.8**	**1.1**	**0.3**	**3.0**	**4.2**	**1.2**
Expenditure	Pay	(54.8)	(4.5)	(4.7)	(0.1)	(18.6)	(18.7)	(0.1)
	Non Pay	(54.3)	(4.7)	(5.3)	(0.6)	(18.5)	(20.0)	(1.5)
Expenditure Total		**(109.2)**	**(9.3)**	**(9.9)**	**(0.7)**	**(37.1)**	**(38.7)**	**(1.6)**
Post Ebitda		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total		**(100.1)**	**(8.5)**	**(8.8)**	**(0.3)**	**(34.1)**	**(34.5)**	**(0.4)**

- 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 £2.2m adverse to plan due to industrial action costs and ERF (Elective Recovery Fund) income shortfall**

The Trust position (table 1)

- The Trust has a deficit of £20.1m which is £2.2m adverse to plan, the overspend is wholly related to costs incurred due to industrial action £1.1m and ERF income lost as a result of the industrial action £1.1m. Acute services are £2.0m adverse, Integrated Care is £0.1m favourable and Corporate Services are £0.4m adverse at the end of July. The Trust is £2.4m behind its efficiency target in month this has been covered by non-recurrent actions.
- Income is £0.5m favourable in month as £0.5m adverse YTD. YTD ERF income is £1.1m adverse.
- Patient Care is £0.4m favourable in month and £0.6m adverse YTD due to the £1.1m ERF income lost as a result of industrial action; High-cost drugs income is £0.3m favourable in month and £1.0m favourable YTD but this is offset by increased drugs expenditure.
- Other operating income is £0.2m favourable in month and £0.1m favourable YTD as staff recharge income and car parking income are above plan.
- Pay expenditure is £0.5m adverse in month and £0.6m adverse YTD. The net costs of industrial action are £0.6m in month and £1.1m YTD. From mid-July there is a patient requiring 5:1 supervision (RN, RMN and security).
- Other operating expenditure is £1.2m adverse in month and £2.1m adverse YTD. Drugs are £0.5m adverse in month and £1.5m adverse YTD this is partially offset by additional patient care income. Cardiology is overspent by £0.3m in month and £0.6m YTD as activity and case-mix have changed since the expansion of the catheter lab.
- **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)**. £0.3m adverse in month and £0.4m adverse YTD. Estates and Facilities are £0.4m adverse YTD with £0.1m on Energy and £0.1m on patient transport.

SGH
Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £21.6m at the end of July, which is £7.1m adverse to plan. The shortfall is due to ERF shortfall and impact of industrial action.	£7.1m Adv to Plan	£3.3m Adv to Plan
Income	Excluding ERF, income is reported at £1.0m favourable to plan at Month 3. This is due to additional income to cover increased centralised costs.	£1.0m Fav to plan	£0.5m Fav to plan
Expenditure	Expenditure is reported at £3.8m adverse to plan at Month 4, mainly due to premium temporary medical staffing costs to cover industrial action and premium temporary nursing costs across wards. Underlying non-pay is experiencing inflationary pressures currently mitigated in the position.	£3.8m Adv to plan	£1.7m Adv to plan
Cost Improvement Programme	CIPs are reported as £11.5m, in line with plan, albeit with a timing adjustment of £7.6m	On plan including timing adjustment	On plan including timing adjustment
Capital	Capital is £1.3m underspent at M4	£1.3m underspent	£2m underspent
Cash	At the end of Month 4, the Trust's cash balance was £27.0m.	£27.0m which is £31.5m lower than Y/E	£26.3m which is £32.3m lower than Y/E

Month 4 Financial Performance

SGH

Table 1 - Trust Total

			Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	901.8	75.0	75.2	0.2	303.6	304.7	1.1
		Other Income	127.2	10.4	10.7	0.3	39.3	39.2	(0.1)
	Income Total		1,029.0	85.4	85.9	0.5	342.9	343.9	1.0
	Expenditure	Pay	(644.1)	(53.0)	(57.3)	(4.3)	(220.3)	(227.7)	(7.5)
		Non Pay	(352.5)	(29.5)	(27.4)	2.2	(123.6)	(120.0)	3.7
	Expenditure Total		(996.6)	(82.5)	(84.6)	(2.1)	(343.9)	(347.7)	(3.8)
	Post Ebitda		(71.7)	(5.3)	(5.3)	0.0	(21.3)	(21.3)	0.0
	Grand Total		(39.3)	(2.4)	(4.0)	(1.6)	(22.3)	(25.1)	(2.8)
ERF	Income		23.6	2.2	0.0	(2.2)	7.9	3.5	(4.4)
	Reported Position		(15.7)	(0.2)	(4.0)	(3.8)	(14.5)	(21.6)	(7.1)

Table 2- Acute Total

			Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	900.9	74.9	75.1	0.1	303.3	304.1	0.8
		Other Income	103.7	8.5	8.5	0.1	31.4	31.1	(0.3)
	Income Total		1,004.6	83.4	83.6	0.2	334.8	335.2	0.5
	Expenditure	Pay	(564.4)	(46.5)	(50.6)	(4.1)	(193.1)	(200.8)	(7.7)
		Non Pay	(207.3)	(17.4)	(14.4)	3.0	(74.5)	(69.2)	5.3
	Expenditure Total		(771.7)	(63.9)	(65.0)	(1.1)	(267.6)	(270.0)	(2.4)
	Post Ebitda		(71.7)	(5.3)	(5.3)	0.0	(21.3)	(21.3)	0.0
	Grand Total		161.3	14.2	13.3	(0.9)	45.8	43.9	(1.9)
ERF	Income		23.6	2.2	0.0	(2.2)	7.9	3.5	(4.4)
	Reported Position		184.9	16.4	13.3	(3.1)	53.7	47.4	(6.3)

Table 3 - Corporate Total

			Full Year Budget (£m)	M4 Budget (£m)	M4 Actual (£m)	M4 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	0.9	0.1	0.2	0.1	0.3	0.6	0.3
		Other Income	23.5	2.0	2.2	0.2	7.8	8.1	0.3
	Income Total		24.4	2.0	2.4	0.3	8.1	8.7	0.6
	Expenditure	Pay	(79.7)	(6.5)	(6.7)	(0.1)	(27.2)	(27.0)	0.2
		Non Pay	(145.2)	(12.1)	(13.0)	(0.9)	(49.1)	(50.7)	(1.6)
	Expenditure Total		(225.0)	(18.6)	(19.6)	(1.0)	(76.3)	(77.7)	(1.4)
	Post Ebitda		(0.0)	0.0	0.0	0.0	0.0	0.0	0.0
	Grand Total		(200.6)	(16.6)	(17.3)	(0.7)	(68.1)	(69.0)	(0.9)
ERF	Income		0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Reported Position		(200.6)	(16.6)	(17.3)	(0.7)	(68.1)	(69.0)	(0.9)

Commentary

The Trust is reporting a £21.6m deficit in M4, which is £7.1m adverse to plan. The overall adverse variance to plan is due to ERF shortfall and the impact of industrial action.

The Trust has received £3.5m of ERF income, which is £4.4m under plan. This is due to the Trust not meeting its ERF target.

Excluding ERF income:

Income

- Income is £1.0m above plan, with additional income to cover increased centralised costs

Pay

- Pay is £7.5m overspent mainly due to premium temporary medical staffing costs to cover the industrial action and premium temporary nursing costs across wards

Non-Pay

- Non Pay is £3.7m underspent due to release of central provisions

Corporate Services

- Corporate Services are £0.9m overspent within Non-pay, partially driven by inflation

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	3.1	
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 meeting in July 2023 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committee wished to highlight to the Board are:

- Maternity Services: This was a key area of focus for the Committee at its July meeting, with a particular focus on seeking assurance on the progress of: the external clinical review of St George's (SGUH) MBBRACE data showing outlier status for still birth and neonatal mortality in 2020; the implementation of actions to address the CQC's Section 29A Warning Notice to SGUH had been implemented and that there was a clear plan for implementing 'must do' and should do'; and the commencement of an external review of quality governance.

- Patients with mental health concerns presenting to Emergency Departments: The Committee reviewed the challenges for patients presenting at ED where the primary treatment need is for mental illness. The Committee heard about the scale of the increase in attendances for both adults and children and young people over the past six years and the increases in the acuity of these patients. The Committee sought assurance on the actions being taken by the Trusts, but recognised that solutions lay at system level.

- Quality Impact Assessment of the Cost Improvement Programmes: The Committee considered the processes by which the quality impact of efficiency plans were reviewed. It heard that a process, at both Site and Group level, was being established, that an escalation process had been developed, and that these processes provided for rejecting plans where they posed unacceptable risks to quality. The Committee asked for further detail at the next meeting (including QIAs completed to date) and quarterly reports going forward on QIAs undertaken in order that it can receive assurance on the operation of the process and the outcomes.

Action required by Group Board

The Group Board is asked to note the issues escalated to by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in July 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, 08 September 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees-in-Common at its meeting in July 2023 and includes the matters the Committee specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meeting on 27 July 2023, the Committee considered the following items of business:

July 2023
• Maternity Services Report*
• Serious Incidents Report
• Deep Dive Never Events at SWLEOC
• Implementation of Patient Safety Incident Response Framework
• Integrated Quality and Performance Report (M3)*
• Group Infection Prevention and Control Update*
• Mental Health Patients being cared for in the Emergency Department
• Impact of Industrial Action on Quality and Patient Safety
• Patient Experience and Engagement Report
• Safeguarding Annual Reports
• Quality Impact Assessment of the Cost Improvement Programme

** Items marked with an asterisk are on the Group Board agenda as stand alone items in September 2023.*

2.2 The Committee was quorate for the meeting.

3.0 Key issues for escalation to the Group Board

3.1 The Committee wish to highlight the following matters for the attention of the Group Board:

a) Maternity Services

There is a separate item on maternity services on the agenda for the Group Board meeting on 8 September 2023. However, the Committee would like to highlight a number of aspects of its ongoing focus in seeking assurance regarding the safety, quality, culture and governance of maternity services across the Group.

At the Group Board meeting on 7 July, the Committee reported that it had been pressing for a clear timeline for the commencement of the external clinical review of all stillbirth and neonatal deaths at SGUH in 2020 in response to SGUH MBBRACE data showing outlier status in still birth and neonatal mortality rates. At its meeting on 27 July, the Committee received assurance that this review had now commenced, and while there had been some challenges in the collection of case notes this was being prioritised and the review was scheduled to conclude in September 2023. A local review of cases had determined that there were no areas of concern identified and the external review will provide independent assurance around this. Understanding the factors contributing to the MBBRACE outlier status is a key priority for the Committee, which will review the findings in detail upon its conclusion.

The Committee has also been focused on the issues identified by the Care Quality Commission (CQC) following its inspection of maternity services at SGUH in March 2023. The Committee's discussions at its meeting on 27 July 2023 took place in the context of these findings but ahead of the receipt and publication of the final CQC report into maternity services at SGUH, which were later published on 17 August. The Committee, which has been scrutinising the actions being taken to address the CQC's concerns since the inspection in March, received assurance that the actions necessary to address the issue highlighted in the Section 29A Warning Notice had been taken, and that a an action plan to address the further 'must do' and 'should do' actions identified by the CQC had been developed. The Committee probed the robustness of the plans and sought assurance that these would fully address the CQC's concerns. These are on the Group Board agenda for the September meeting, and the Committee will be monitoring the implementation and embedding of these actions on an ongoing basis. The Committee also sought and received assurance that the learning from the CQC's inspection of maternity services at SGUH had been identified and shared with the maternity service and Site leadership team ESTH, given an inspection of maternity services at ESTH was imminent. The Committee heard that a new forum was being established by management to receive, review and action feedback regarding maternity, and that this would involve those necessary to triangulate issues effectively.

More broadly, the Group Board has commissioned a two-part independent external quality governance review, the first looking at governance in maternity services at both SGUH and ESTH following the issues identified in the SGUH inspection, and the second looking more broadly at the robustness of quality governance more widely across the Group. This is a critical piece of work and will provide independent assurance on quality governance and make recommendations for actions to strengthen this. As the Group Board will recall, the Trusts had planned a review of culture some months ago, following the publication of the Kirkup report. The Committee endorsed the view of the Executives that undertaking this review of culture as part of the governance review was appropriate given the inherent interrelationship between structures, processes and behaviours, and sought assurance that both aspects of the review would receive appropriate focus. In terms of process, the Committee was informed that tenders for the appointment of an external reviewer were scheduled to take place the day after our July Committee meeting. We understand that a preferred lead has been identified and that the review will commence shortly, following confirmation of the costs of the review and approval by South West London Integrated Care Board and NHS England.

The Committee also received its regular report on work being undertaken in relation to the Maternity Incentive Scheme (MIS). Year 5 of the scheme had been launched in May 2023 and further revisions to the technical guidance had been published in July 2023. The Committee reviewed the current RAG-rated status for each Trust against each of the 10 Safety Actions. Six of the 10 safety actions were on track at ESTH and 5 at SGUH, with

actions scheduled for completion by December 2023 to ensure both Trusts could demonstrate compliance. The Committee sought assurance that the necessary actions would be taken to be able to submit a fully compliant position against the MIS, and were reassured that good progress was being made.

The Committee agreed that it could take limited assurance in relation to the St George's maternity services report, given the CQC's findings and the need to implement fully the action plan to achieve 'must and should do' actions, as well as the need for the Committee to see the findings of the external review of the MBBRACE data and the quality governance review. In relation to ESTH maternity services, the Committee agreed it could take reasonable assurance from the information provided.

b) Mental Health Patients being cared for within the Group's Emergency Departments

In its previous report to the Group Board in July, the Committee highlighted the impact of the number of patients with mental health needs being cared for in the Group's emergency departments (EDs). This is in the context of healthcare systems across the country struggling to meet the rising demand and the known quality, safety, operational and patient experience issues associated with treating patients with mental health needs in an emergency department. In July, the Committee considered detailed reports from each Trust setting out the scale of the increase in ED admissions for both adults and children and young people where the primary treatment need is for mental illness over the past six years, and the increase in the acuity of mental health patients attending EDs. The Committee heard that the incidences of violence and aggression towards staff involving patients with mental health conditions were increasing year-on-year and that a number of patients absconded which put them at increased risk of harm. While the Trusts had taken mitigating actions to try to cope with the increase in the number of patients presenting with mental health conditions, for example through the creation of additional side rooms and the removal of ligature risks, ED was not an appropriate environment for their needs. Long lengths of stay in ED, given the difficulties of discharging to more appropriate settings, carried significant risks both to the patients themselves, such as hospital associated distress and increased use of psychotropic medication, and on other patients and staff. The Committee also considered the health inequalities aspects, noting that often it is those patients who are most unwell and vulnerable who wait the longest. The Committee sought assurance on the actions being taken by the Trusts to ensure appropriate support for staff, review of escalation triggers and triage pathways, and – crucially – engagement to promote system-wide working to address the issue and recognised that a number of actions within the Trusts' control were being actively progressed, and that, fundamentally, the solution lay at system level. The Committee noted that consideration was being given to escalating the risks on the Corporate Risk Registers.

The Committee also discussed the recent announcement that the Metropolitan Police would be stepping back support for people in mental distress in EDs unless there was a risk to life. This would compound some of the issues, particularly in terms of support available to staff. At SGUH, it was noted that they had recently appointed a Head of Nursing for Mental Health and part of their role was to build a strategy which would support both patients and staff. Collaboration across SW London was continuing with partner organisations, but the Committee expressed concern that the need for improvements in service provision were pressing, particularly ahead of the winter period where the pressures on EDs, and other acute services, would be magnified.

c) Quality Impact Assessment of the Cost Improvement Programme

This year, given the scale of the financial challenges facing the two Trusts, the Committee took a decision earlier in the year to review the processes by which the Group was undertaking Quality Impact Assessments (QIA) of Cost Improvement Programmes (CIP). Seeking assurance that efficiency savings are being planned and implemented in a way that ensures an appropriate focus on quality and safety, and that CIP actions that present unacceptable quality risks can be reviewed and ultimately stopped, is a key role for this Committee. The Committee was, therefore, pleased to review the QIA processes being implemented, both Group-wide and at Site level. The Committee heard that criteria had been developed to determine the Site level QIAs that required scrutiny through the Group-wide QIA process. The processes enabled QIAs to be: approved with no caveats; approved with caveats such as amendments to the proposals or the inclusion of further risk mitigating measures; not approved, with a requirement to re-work and re-submit proposals; and, not approved.

The Committee sought assurance that no CIPs were progressing which would impact on the underlying safety of services. The Committee was heard that the process recognised that services needed to be safe at all times and that QIAs were about ensuring that appropriate consideration had been given to the quality dimensions of efficiency plans. The Committee sought assurance that QIAs were being undertaken in full but timely way, and asked for further information at the next meeting on schemes approved and rejected and agreed to the proposal in the paper that the Committee receive a quarterly report on schemes considered through the QIA process.

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) Deep Dive – Never Events SWLEOC

Earlier in the year, the Committee had been briefed on two ‘wrong site surgery’ never events which had been declared within month at South-West London Elective Orthopaedic Centre (SWLEOC). At its July meeting, the Committee held a deep dive focused on the findings of reviews into these never events and the learning identified both for SWLEOC and the Group as a whole. Both never events had involved pain injections being administered to the wrong site. Different teams had been involved in each case. The patients involved were unharmed. The Committee heard that rapid response reviews had been undertaken at the time and initial learning had been identified and actions taken. After the second incident, delivery of the particular procedure was paused at SWLEOC while the clinical team reviewed their processes to ensure that future delivery was more robust, and the revised processes captured the actions agreed. In both cases, it was established that responsibility for site verification of the injection fell on a single individual with no further safety check to verify the site of injection. The Committee heard that a number of actions had been implemented including the introduction of mandatory marking of the injection / operation site for spinal injections, a new requirement foe all team members to be part of the World Health Organisation (WHO) checklist processes, the introduction of a new Local Safety Standard for Invasive Procedures (LocSSIP) to put in place an ‘action trigger’ for site confirmation before administration of injections, the introduction of the Faculty of Pain Medicine safety checklist for all interventional pain procedures under local anaesthesia or sedation for spinal pain injections, and requirements that there are no changes in personnel during a procedure. The Committee heard that systematic review had been undertaken, that actions had been taken, and that there had been dissemination of learning to clinicians across the Group.

The Committee noted that this report did not cover more recent wrong site and wrong patient surgery never events and is anticipating a further report detailing actions to be taken as a result of a review of these events.

a) 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 of course concerning, the Committee has previously recognised that the Group has in place robust processes for identifying, investigating and reporting on SIs.

At its July meeting, the Committee received the report of Serious Incidents which took place in May 2023 across the Group. At ESTH, 4 SIs had been recorded in May 2023. At SGUH, 3 SIs had been recorded for the same period, 2 of which had been never events. The Committee received summary reports on each of the SIs and a summary of the immediate safety actions that had been implemented for each incident. The Committee reviewed the SIs submitted for review to the Integrated Care Board and also reviewed the learning that had been identified for each case. In terms of compliance, as at 30 June 2023, there were a total of 20 open SI investigations at ESTH, 1 of which was subject to a clock stop as external investigations were being carried out and 1 was subject to an agreed extension. A total of 14 SI investigations were overdue. At SGUH, as at 30 June 2023, there were 16 open SI investigations, of which 16 were ongoing, 4 were subject to agreed extensions, 2 were being investigated by the Healthcare Safety Investigation Branch. There were no overdue SI investigations. In relation to follow-up, the Committee heard that there were 49 open SI actions, of which 48 were within the deadline established and 1 was overdue. In relation to an SI at SGUH involving venous thromboembolism (VTE), the Committee discussed the importance of undertaking appropriate VTE risk assessment in patients and administering venous thromboembolism prophylaxis. The Committee heard that a VTE risk assessment teaching session had been held in the emergency department and acute medical unit with the doctors and physician associates. This included appropriate documentation and importance of actioning risk assessment in a target timeframe.

The Committee noted that the new national Patient Safety Incident Response Framework (PSIRF) would be introduced across the Group in August 2023. This new way of investigating incidents, on which the Boards had received external training and development the previous month, would focus on learning from incidents and sharing this learning to wider groups within the organisations.

d) Impact of Industrial Action on Quality and Safety

Through the past year, the Committee has maintained close oversight of the patient safety and quality impacts of the ongoing industrial action by different groups of health professionals and has been kept informed about the steps being taken across the Group to ensure the ongoing safety of services for patients during period of industrial action and support to staff. At its July meeting, the Committee received a verbal update on the latest round of industrial action. The Committee heard that, overall, hospitals across the Group had coped well, particular in relation to maintaining patient flow. There had been no reports of safety incidents linked to the industrial action. However, the action had a significant impact on elective work, and large numbers of patients had had their appointments and procedures delayed. Cancelled activity would be rebooked as soon as possible and cancer patients would be prioritised. The growing impact of having to manage activity and ensure appropriate cover during period of industrial action meant that

management capacity was focused on this rather than other important areas such as service transformation and this too had an impact, though less immediately tangible. The Committee heard that work would be undertaken to build on the lessons learnt relating to improved flow, though noting that the level of senior consultant presence in ED during the industrial action which had facilitated prompt clinical decision-making came with other costs. The Committee asked for full details of the number of cancellations of planned care and outpatient appointments at its next meeting.

5.0 Other issues considered by the Committees

5.1 During this period, the Committee also received the following reports:

a) Infection Prevention and Control (IPC)

This report is on the Group Board agenda for September 2023. The Committee received assurance that the governance and oversight of IPC is effective across the Group. However, it noted that SGUH was over the trajectory for *C.difficile* infection set for the year by NHS England. The Committee was informed that appropriate action was being taken and that a review of all cases had been undertaken and that a report setting out plans and actions required to mitigate risks had been completed. ESTH remained within the trajectory established by NHS England for *C.difficile*. The Committee was informed that robust IPC measures are in place to identify and segregate suspected cases of Covid-19 in line with current national guidance. There had been a significant decrease in the number of new positive Covid-19 cases and in the number of nosocomial infections across both sites. This reflected the reduced community prevalence nationally. The Committee agreed it could take reasonable assurance from the report.

b) Patient Experience and Engagement Annual Report 2022/23

The Committee reviewed the Group Patient Experience and Engagement Annual Report for 2022/23 and noted the areas of achievement and good practice highlighted, including the development of a new carer and hospital discharge toolkit at SGUH, the steps to promote the involvement of carers through the Carers Forum at ESTH, the achievement by ESTH of the Veterans Covenant Healthcare Alliance accreditation in May 2023, and the recruitment of 100 new volunteers to work across the Trust at SGUH. The Committee also reviewed the priorities for patient involvement and experience over the coming year, including plans to focus on Friends and Family Test responses and other forms of patient feedback, to engage local community groups, and improve the collection and analysis of patient involvement and experience data, in particular in relation to protected characteristics. The Committee was pleased that there was a large amount of patient experience activity taking place within across the Group, which was to be celebrated, but also asked at a future meeting to receive more information and greater assurance about of how patient involvement and experience was used systematically across the Group to help drive quality improvement. The Committee approved the reports for publication.

c) Safeguarding Annual Report 2022/23

The Committee reviewed the Annual Safeguarding Reports for Adults and Children 2022/23. In terms of safeguarding activity, at SGUH there had been a 17% increase from 2021/22 to 2022/23 in the number of adult safeguarding referrals, and a 4.5% decrease in safeguarding referrals for children. At ESTH, by contrast, there had been a 2% reduction in safeguarding referrals for adults but a 26% increase in such referrals for children. The Committee recognised the achievements of the safeguarding teams at both Trusts over the past year and discussed key risks and challenges. Staffing within the safeguarding

teams was a key issue across both Trusts due to the high level of vacancies. Children's safeguarding supervision training was also highlighted as an area of challenge and there was a need for a continuing focus on ensuring staff, including medical staff, undertook the necessary training. Ensuring that correct supervision of staff was in place was also a priority for the group and this was being supported by the SW London and the wider NHS London team. The Committee recognised that there was considerable safeguarding activity for both children and adults being undertaken across the Group. It was pleased to see that the priorities for the forthcoming year had been assessed and established, and that this had captured points of learning from the previous year. The Committee approved the report for publication.

e) Implementation of the new Patient Safety Incident Response Framework

The Committee received an progress update on the implementation of the new Patient Safety Incident Response Framework (PSIRF) across the Group in advance of the scheduled transition to the new incident investigation process in August 2023. As the Group Board received dedicated training on the new framework at its development session in June, and received a report on this at its meeting in July, the Committee has not summarised the key aspects of the new framework here. The Committee was informed that plans remained on track for the roll-out of the PSIRF framework, which holds out the prospect of strengthening how we learn from incidents.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committee received assurance in July 2023.

Group Board

Meeting on Friday, 08 September 2023

Agenda Item	3.2	
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 July and extra- ordinary meeting in August 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

n/a

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance Committee-in-Common Report
Group Board, 08 September 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in July and August 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 28th July 2023 and 23rd August 2023, the Committee considered the following items of business:

July 2023	August 2023
PUBLIC MEETING • Finance Report (M3) • CIP Update • Controls Update • Industrial Action • Costing update • Productivity Update • Business cases update • IQPR • IDT risk deep dive • Estates risk deep dive • Estates monthly update • SWL Procurement Partnership Update	**PUBLIC MEETING** • Finance Report (M4)* • CIP Update

**items marked with an asterisk are on the Trust Board agenda as stand alone items in September 2023*

2.2 The Committee was quorate for both meetings.

3.0 Sources of Assurance

3.1 a) Finance Report M4

The GCFO noted that SGH and ESTH are £7.1m and £2.2m adverse to plan at M4 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 £2.7m SGH and £1.1m ESTH and the income (ERF) variance at £4.4m SGH and £1.1m ESTH. Committee members discussed the ERF risk as some of the rules have changed owing to the impact of industrial action.

b) CIP Update

The GCFO highlighted that both Trusts were on their CIP plans in M4, albeit with slightly more non-recurrent savings than originally planned. SGH now has £16.5m and ESTH £11.8m Fully Developed CIP, against their £62.1m and £37.3m targets.

Committee members discussed being more comparable on the categorisation of 'Green' schemes, with other SWL Trusts having different views on what constitutes 'Green'.

c) IQPR

Both trusts did not achieve the national standard of discharging >76% of attendees within **4 hours of arrival in the Emergency Department (ED).** Committee discussion focussed on the impact of Mental Health patients and Ambulance handover times.

In **RTT performance,** SGH incomplete non-admitted pathways continue to rise with 680 patients with a projected wait of over 40 weeks for a first appointment. The number of 52-week incomplete pathways are beginning to rise. Recovery plans are actively managed through Elective Access. **ESTH** 52 week waits continue on an upward trend each month. A slight reduction is expected in Jun23 due to no industrial action or additional bank holidays, but for Jul23 it's expected to increase due to IA. Committee members discussed theatre utilisation and delivering 85%.

Diagnostic performance - at the end of June, **SGH** reported 98.8% of patients waiting less than six weeks for a diagnostic test, continuing to meet the recovery target of 95% and ahead of internal trajectories. **ESTH** DM01 (diagnostics) continues to be pressured, but patients waiting more than 6 weeks in Jun23 have reduced to 931 from 1101 in May23.

Cancer performance is comparatively good for both trusts against London peers, it remains fragile. Good results should be noted at both trusts for achieving the Faster Diagnostic Standard (FDS) and the 62-day target for definitive treatment at **ESTH**. The excellent performance at ESTH should be noted. However, industrial action and capacity issues have impacted on the 14-day first appointment target at both trusts with ongoing challenges in Gynaecology and Dermatology at ESTH, and a broad range of specialties at SGH. There is close focus and monitoring via the cancer access teams. The numbers of patients waiting for more than 62 days without definitive treatment have been impacted by industrial action, but both trusts are focusing on this cohort of patients in recovery planning. SGH have more patients than planned with 134 patients still waiting for more than 62 days without definitive treatment. ESTH remain on plan.

d) Industrial Action

Committee members noted the detail of the impact of industrial action in June and July, reported to the July and August Committees.

3.2 During this period, the Committee also received the following reports:

a) Controls update

At the July Committee the GCFO outlined progress on controls.

b) Costing update

The committee noted the latest information on costing.

c) Productivity update

The GCFO introduced the paper on Productivity.

d) Business Cases update

In July the GCFO noted the progress being made on BYFH and Renal developments.

e) Estates update

SGH DE&F introduced the normal monthly update to committee.

f) SWL Pathology Procurement Partnership Report

Committee members noted the report and discussed Procurement CIPs.

4.0 Implications

4.1 The Committee considered the group finance, IDT and estates strategic risks as deep dives in July. Operational risk would be considered at the September meeting.

4.2 The Committee agreed changes to risk scores in finance where financial sustainability and investment risks are at 25 for both organisations. No changes to risk scores or assurance ratings were appropriate at the Q2 2023/24 position for estates and IDT at either SGH or ESTH.

5.0 Recommendations

5.1 The Group Board is asked to note the issues escalated to the Board and the wider issues on which the Committee received assurance in July and August 2023.

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	3.3	
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 meeting on 26th July 2023. No meeting was held in August. The key issues the Committees wish to highlight to the Board are:

- Industrial Action: The Committee received a regular update on industrial action and was updated on the decision of the High Court on 13 July 2023 to prohibit the supply of agency workers to cover the duties of staff taking industrial action, effective from 10 August 2023. This was not expected to have a significant impact on the Trusts' management of forthcoming action by junior doctors and consultants but would have had a much more significant impact in the event action by nurses had continued.

- Group Workforce Key Performance Indicators: The Committee sought assurance regarding the increases in staff establishment at both ESTH and SGUH and sought assurance about how these increases aligned with the delivery of each Trust's Cost Improvement Plans. Vacancy rates at ESTH continued to exceed the 10% target and sought assurance on how services were maintained in areas with particularly high vacancy rates. Sickness absence continued to present challenges at both Trusts. The Committee was pleased to see the ongoing improvements in core competency compliance and recognised the significant improvements made in reducing agency spend at ESTH over a three month period between March and May.

- Payroll Dashboard: The Committee continued to closely monitor payroll performance given ongoing challenges and concerns raised by staff through Freedom to Speak Up. The Committee was assured that progress was being made, but remained concerned at the ongoing payroll challenges, many of which were linked to timely processing of employee change requests and leaver forms.

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 July 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, 08 September 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at their meeting in July 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 meeting on 26 July 2023, the Committees considered the following items of business:

July 2023
• Group Chief People Officer's Report – including updates on industrial action and the establishment of a joint bank service • Group Workforce Key Performance Indicators • Deep Dive – Temporary Staffing at St George's • Workforce Improvement Plan • Payroll Dashboard • People Management Group Reports

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 workforce operations meeting in July. There was no meeting held in August 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 Committee has received regular updates on the industrial action taken by healthcare professionals over the past year. Responsibility for seeking assurance on the impact of the action on the quality and safety of services rests with the Quality Committee (see separate report on the agenda), but the People Committee has maintained a close interest in developments and sought assurance on support available to staff. The Committee noted that periods of industrial action were being managed actively through business continuity measures. The Committee received an update on the decision of the High Court on 13 July 2023 to prohibit the supply of agency workers to cover the duties of staff taking

industrial action effective from 10 August 2023. The Committee heard that this decision was not expected to have a significant impact on the forthcoming action by junior doctors and consultants, but would have a much more significant impact had the industrial action by nursing staff continued.

b) Group Workforce Key Performance Indicators:

The Committee regularly scrutinises a number of key performance indictors (KPIs) relevant to the Group's workforce. This supports the Committee in analysing and seeking assurance in relation to trends and patterns in our workforce data. These KPIs include: vacancy rates; turnover; sickness absence; core skills compliance; and appraisal rates. Overall, the Committee agreed that it could take reasonable assurance from the data, and wished to highlight the following key points:

- The Committee had noted and sought assurance regarding the growth in the workforce establishment at both Trusts that was evident in May, with 100 new full-time equivalent (FTE) posts added to the establishment at ESTH and a further 74 FTE posts at SGUH. The Committee heard that externally funded posts and new activity in community services along with an increase in recruitment of Band 2 healthcare assistants were the drivers for the increase in establishment at ESTH. At SGUH, 31 of the 74 additional posts were qualified nursing posts. While recognising the tension between delivering cost improvement plans and the importance of reducing waiting lists, the Committee expressed concern that the establishment was not reducing in line with efficiency plans and queried the impact of this on the delivery of the Trusts' financial plans.

- The Committee heard that vacancy rates for ESTH had increased by 0.74% in May to 13.46% and at SGUH by 0.12% to 8.39%, the former continuing to be above and the latter below the Group-wide target of 10%. The Committee discussed the vacancy rate by staff group, noting that estates and ancillary staff at both Trusts had recorded the highest vacancy rate (22.99% at ESTH and 18.13% at SGUH). The Committee sought assurance that areas that had recorded particularly high vacancy rates were safe. The Committee was told that workforce data was triangulated in a way that enabled the Trust to compare vacancies with use of temporary staffing, and this demonstrated that clinical hours were being filled. However, the Committee asked that further papers provide a fuller analysis of this in order that it could be assured.

- The Committee noted that both Trusts continued to exceed local sickness absence thresholds in May, with ESTH reporting a year-to-date sickness absence rate of 4.55% against a target of 3.8% and SGUH 3.83% against a target of 3.2%. Long term sickness absence (28 days or more) accounted for 15% of all sickness absences at ESTH and 13% at SGUH. Anxiety/stress/depression/other psychiatric illness' was the most common reason attributed to long term sickness accounting for 26% of all long-term sickness episodes at ESTH and 29% for SGUH.

- The Committee was pleased to see core competency compliance continue to exceed the Group-wide 85% target at SGUH (90% in May) and encouraged by the continuing incremental increases in compliance at ESTH, up 1% in May to 82%.

- Appraisal rates across the Group remain a key area of focus for the Committee, with performance across all staff groups continuing to be challenged. At ESTH, appraisal rates in May stood at 67% and at SGUH 70%, both against targets of 90%. Recognising that appraisal rates had improved significantly at ESTH over the previous year, the Committee was disappointed to see a fall of 0.97% at the Trust in May. However, it acknowledged that performance on appraisals was cyclical and were reassured that managers had been asked to spread out appraisal dates over the year. While marginally higher, SGUH appraisal rates had been at around the 70% mark for some time.

- The Committee was encouraged by the progress achieved at ESTH in the past three months (March to May) in reducing agency spend.

- On employee relations (ER) activity, the Committee was briefed on the number of ER cases at each Trust and was encouraged to hear that the backlog of ER cases was starting to come down. It also welcomed the appointment of a new head of ER at SGUH which would help stabilise the team. The Committee noted the very significant disparity in the ethnicity of staff subject to disciplinary processes, and sought assurance about the actions being taken to address this. It was agreed that the Committee would look in depth at this at its next meeting. The Committee welcomed steps being taken by the Trust to seek to resolve ER cases informally through mediation at early stage to prevent them needing formal resolution through the grievance process and looked forward to receiving further details about this.

c) Payroll Dashboard:

Payroll has been a continuing area of focus for the Committee over the past 18-months in the context of a sharp decline in performance at both Trusts in late 2021 and as a result of ongoing concerns raised with Freedom to Speak Up at ESTH regarding payroll errors. The Committee has received regular reporting on this in order to monitor and seek assurance regarding the steps being taken to address the payroll challenges.

The Committee received the payroll data for May 2023, noting that there had been a significant increase in manual payments for ESTH, largely as a result of missing bank details, and that both Trusts had failed to achieve the automation targets in month 2 that would demonstrate efficient and accurate payroll processing. The Committee discussed the factors contributing to this, and the importance of staff training and adherence to processes for timely updating of ESR and submission of change forms as staff moved on. The Committee agreed to refer overpayments to the Audit Committee. Notwithstanding this and the work that remained, the Committee agreed it could it was reasonably assured by the measures being taken.

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) Workforce Improvement Plan

The Committee regularly receives and seeks assurance regarding the implementation of workforce improvement plans (WIP) underway at both Trusts, which are intended to address key workforce challenges and deliver financial savings. The two Trusts have in place separate but complementary workforce improvement plans, which support their specific challenges and requirements, while ensuring a coherent Group-wide approach.

For SGUH, the Committee received updates on the priority areas for 2023/24, which included measures relating to recruitment, retention, sickness absence management, temporary staffing, medical staffing and rostering management. Many of the actions were in progress and the Committee welcomed the updates, but asked for greater assurance that defined actions on the WIP had been completed and that there was sufficient resource to implement and deliver the WIP in order to realise the anticipated cost savings and improvements. The Committee also heard that the programme had shifted slightly as a result of the new Trust-wide Cost Improvement Plans (CIPs) and that it would be for the clinical divisions to agree and deliver financial savings as they relate to workforce, with the people function helping to support this and ensure targets are achieved. As a result, the WIP in and of itself did not have a defined financial target, as the workforce savings would be realised through the delivery of the CIP programme more broadly.

For ESTH, the Committee was briefed verbally on the key initiatives underway, which included: bespoke temporary staffing review programme; weekly rostering meetings with clinical divisions; a review of acute temporary staffing which contributed to a reduction in agency spend; an automation software in the roster team to manage the data integrity on the health roster; and re-training and re-focusing managers responsible for rostering. The Committee looks forward to receiving a full report on the progress of the WIP at ESTH at its meeting in October.

Overall, the Committee agreed that it could take reasonable assurance on the workforce improvement plan at SGUH and looked forward to reviewing the WIP for ESTH at the half year point.

b) Deep Dive – Temporary Staffing – St George's

As part of its work programme for the year, the Committee holds a number of 'deep dives' on issues where it wishes to explore issues in more depth or seek further assurance. At its July meeting, the focus of the Committee's deep dive was temporary staffing at St George's. The singular focus on SGUH was in the result of the fact that at ESTH there are plans to bring the ESTH staff bank in-house in August 2023.

The Committee considered a detailed report on temporary staffing at SGUH between July 2022 and June 2023. It acknowledged the Trust's significant reliance on its temporary workforce, with around 10% of total staff hours being engaged on a contingent basis including almost 20% of nursing staff hours. The Committee heard that fill rates were good at 80%, consisting of 60% bank and 20% agency staff. Overall, the demand for bank staff was higher than vacancies and sickness absence due to the fact that SGUH went out to book bank staff early as rosters were put out and this avoided having to employ agency staff. The Committee noted that a high proportion of bank hours were provided by substantive staff working additional hours. The Committees were assured that there was a requirement for agencies to provide evidence that staff had undertaken mandatory training. When agency staff were on site, a checklist was worked through with them to ensure they were competent and had received mandatory training. When integrating corporate nursing services, there would be a role focusing on professional standards for substantive, bank and agency staff.

Overall, the Committee considered that it had received reasonable assurance on temporary staffing at St George's and would continue to monitor use of bank and agency staff through the regular reporting on workforce key performance indictors and the workforce improvement plan.

5.0 Other issues considered by the Committees

5.1 During this period, the Committee also received the following reports:

a) Group Chief People Officer Update Report

The Committee recently agreed to take a new report from the Group Chief People Officer each month to ensure the Committee is sighted on key emerging developments. The Committee has found this to be a helpful addition and a means of providing structure to these timely updates while enabling the bulk of the meeting to focus on assurance. The key items on which the Committee was briefed this month included:

- In-housing Bank Service: The Committee has previously reported on plans to bring in house the ESTH bank service. It heard that good progress had been made on the 3 main issues that had delayed the go live date from 1 July to 1 August 2023: staff would expected to transfer via TUPE to ESTH; equipment was now in place and the specification for out of hours services was also in place. There were frequent with the project team. The level of operational change was not significant, as it would be the same staff deployed, doing the same work. On track to go live 1st August 2023.

- ULEZ: The Committee was briefed on the expansion across all London boroughs of the ULEZ scheme on 29 August 2023 and the steps being taken across the Group to support staff who use their cars for work (such as community nurses) for a transitional period to help them move to alternative and more environmentally friendly transport. The Committee heard that the Trusts were encouraging staff to consider swapping to e-bikes and to explore options for purchasing electric vehicles through the salary sacrifice scheme.

- Pay award update: The Committee was briefed on the national pay award, agreed by the NHS Staff Council, to award a one off non-consolidated award on top of the 2022/23 pay award for all staff directly employed on NHS terms and conditions of service on 31 March 2023. The Committee heard that NHS Employers' guidance was clear that these awards are for staff on NHS terms and conditions only, meaning that bank staff would not qualify for the pay award.

- SWL Update: The Committee was provided with an update on the actions being taken forward to build on the work undertaken by PA Consulting, which had been engaged by South West London Integrated Care System as part of the financial recovery work across the system. The work being undertaken would concentrate on three main areas: bank rates across the trusts by rate, grade and role; agency rates, to review rates cards across the trusts and variances; and developing a range project plans to realise further workforce efficiencies. The Committee welcomed the update and looked forward to receiving further details at a future meeting.

6.0 Recommendations

6.1 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 July 2023.

Group Board

Meeting on Friday, 08 September 2023

Agenda Item	3.4	
Report Title	**SGUH Audit Committee report of the meeting held on 3 August 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 August 2023
Purpose	**For Noting**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meeting on 3 August 2023.

The items covered at the meeting were as follows:

- Internal Audit Progress Report and final Internal Audit Reports
- Information Governance and Cyber Security Update
- Information Governance Compliance Update and Annual Report
- Counter Fraud Quarterly Report
- Breaches and Waivers Report
- Managing Conflicts of Interest Update on Compliance
- Clinical Audit Programme

Action required by the Board

The Board is asked to note the report of the Committee's meeting held on 3 August 2023

Committee Assurance	
Committee	SGUH Audit Committee
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

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

Group Board, 08 September 2023

1.0 Purpose of paper

1.1 The Audit Committee met on 3 August 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 Internal Audit Progress Report and final Internal Audit Reports

The Committee received the second part of the review of the Data Security and Protection Toolkit noting it had been submitted to NHS Digital for 30 June 2023. The Committee welcomed the substantial assurance provided on the Trust's performance against the National Data Guardian's ten data security standards. The Committee noted the Trust had needed to complete 37 mandatory assertions with 103 mandatory requirements. Of these, two mandatory requirements (mandatory training of staff; server upgrades) did not fully meet the standards required and the Trust has been accredited as "Approaching Standards" rather than "Standards Met". The Trust has developed and submitted action plans to address both the mandatory training and the server issues. The Committee was informed that work to deliver the 2023/24 internal audit workplan was underway and that the review of Data Quality had commenced. Internal auditors have also initiated audit scoping meetings as well as issuing scopes for audits with proposed start dates.

2.2 Information Governance and Cyber Security Update

The Committee welcomed the latest iteration of the cyber security dashboard which provides a monthly high-level look at how the Trust is performing in managing threats and risks to its infrastructure, and Trust compliance for patching and unsupported systems. The Informatics Digital & Technology teams at SGUH and ESTH have been working to align a single approach to the dashboard as part of the ongoing Group integration work and expect further iterations in development of the dashboard. The Committee was updated on potential cyber security threats and reviewed measures implemented to ensure Trust security was updated. It was also reported that NHS England had created a new London Region Cyber Group to support its Cyber Strategy implementation and the Trust was engaging with this.

2.3 Information Governance Compliance Update and Annual Report

The Committee received the annual report for 2022/23 highlighting the Trust's compliance against the data security and protection toolkit requirements. The Committee noted the progress in recording inbound and outbound data flows following implementation of Flowz software. It was also reported the Trust had reduced the number of its information asset owners to enable a smaller group with greater understanding of their information governance responsibilities. There were 978 IG related incidents reported at the Trust in 2022/23. This represented an increase from 2021/22 and is thought to be attributable to Trust awareness campaigns led by IG team in collaboration with Cyber Security Team.

2.4 Counter Fraud Quarterly Report

The Committee considered its regular report on progress with current and new counter fraud cases under investigation and noted the work by the counter fraud team to raise awareness of emerging risks through bespoke training sessions and attendance at corporate inductions. The Committee noted the completion of the annual benchmarking of all fraud investigative work

undertaken by the service across the NHS and health sector to provide comparative data to assist the Committee in assessing Trust counter fraud arrangements and to benchmark against the performance of peers.

2.5 Breaches and Waivers Report

The Committee considered the regular breaches and waivers report for Q1 2023/24. Waiver usage had decreased in Q1 both in terms of frequency and value. However, the number of breaches had increased. It was reported as part of the ongoing work to mitigate the risk of potential breaches or waivers the Trust is committed to implementing a zero tolerance policy to the use of waivers unless there is a risk to patient safety or the Trust. The Trust is also establishing a No PO, No Pay policy. However, this will require a period of embedding the process and the Trust working with staff and suppliers to ensure a smooth transition.

2.6 Managing Conflicts of Interest: Update on Compliance

The Committee was informed that SGUH had achieved 69% compliance for decision-making staff making declarations of interest in 2022/23, an improvement of 12% over year end 2021/22. So far in 2023/24, 19% of decision-making staff had made new or revised declarations. The Committee was told an engagement programme will run over 2023/24 with the aim of increasing the compliance rate for decision-makers and will include raising awareness with line managers, ensuring declarations are made as part of induction of all new staff, communications campaigns, reminders to staff and targeted engagement with areas with low compliance and individuals without valid declarations.

2.7 Clinical Audit Programme

The Committee received the report of clinical audit activity at the Trust, with 351 clinical audit projects undertaken at the Trust in 2022/23. These were a mix of national and mandatory audits as well as locally chosen audits which align with the Trust Clinical Audit Strategy priorities. The Committee heard that the audits are a vital tool for the measurement and improvement of the quality of clinical services, raising standards to improve safety, experience, and outcomes for patients, as well as reducing unwarranted variation.

3.0 Recommendation

3.1 The Board is asked to note the report of the Committee's meetings held on 3 August 2023.

Peter Kane
Audit Committee Chair, NED
September 2023

Group Board

Meeting on Friday, 08 September 2023

Agenda Item	3.5	
Report Title	**ESTH Audit Committee report of the meetings held on 14 July and 3 August 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	14 July 2023 & 03 August 2023
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meetings held on 14 July 2023 and 3 August 2023.

The items covered at the meetings were as follows:

- External Audit findings report on 2022/23 Trust Accounts
- Internal Audit Progress Report and final Internal Audit Reports
- Information Governance and Cyber Security Update
- Information Governance Compliance Update and Annual Report
- Counter Fraud Quarterly Report
- Breaches and Waivers Report
- Managing Conflicts of Interest Update on Compliance
- Clinical Audit Programme

Action required by the Board

The Board is asked to note the report of the Committee's meetings held on 14 July and 3 August 2023

Committee Assurance	
Committee	ESTH Audit Committee
Level of Assurance	Not applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Not applicable

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

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Report of the ESTH Audit Committee

Group Board, 08 September 2023

1.0 Purpose of paper

1.1 The Audit Committee met on 14 July and 3 August 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 **External Audit Findings, Value for Money, and Annual Report and Accounts 2022/23**
A key responsibility of the Audit Committee is to review the draft annual accounts, annual report and quality account for the Trust, alongside the external auditors' report and value for money report. Unfortunately, the Committee was informed that the annual audit of the Trust's accounts had not been completed on schedule. The delays stemmed from capacity and process issues with newly appointed external auditors rather than with the timeliness of the Trust's response to the auditors requests. While the Committee devoted considerable time to reviewing draft reports, a final set of audited accounts has not yet been received and the Committee plans to hold a special meeting later this month to review the external audit findings and will then make a final recommendation to the Board, which will need to hold a special meeting to approve the annual report and accounts for 2022/23 ahead of the Trust's Annual Public Meeting. The Trust has been in close contact with NHS England throughout regarding the delays to the audit and the Committee which is fully sighted on the issues and the revised timescales for submission. In light of the delays to the receipt of audited accounts. the Committee requested a thorough review of this year's external audit process and a report outlining the lessons learnt will be presented to its next meeting.

2.2 **Internal Audit progress update and final Internal Audit reports**
The Committee received a final internal audit report undertaken by the previous auditors on *Medical Staffing – Guardian of Safe Working*, which was given a moderate assurance opinion and it noted the good controls embedded at the Trust, particularly around training during induction and encouragement of the use of exception reporting. The Committee heard that the Trust had welcomed the findings of the audit and the recommendations will be implemented over 2023/24. The Committee was informed that the work to deliver the agreed 2023/24 internal audit workplan was underway and that audit reviews have commenced alongside scoping meetings, and the internal auditors have issued scopes for audits with proposed start dates. The Committee was encouraged by the progress and looked forward to reviewing the first set of internal audits led by the new internal auditors at its next meeting.

2.3 **Information Governance / Cybersecurity Update, including Cybersecurity Dashboard**
The Committee received the update on cyber security noting the ongoing threats and risks to the Trust. It also noted the actions the Trust was taking to improve awareness of cybersecurity risks, the introduction of additional governance and improved technical solutions such as patch management of services and end-user devices. The Committee also received the latest iteration of the cyber security dashboard which has been developed in collaboration with colleagues at St George's as part of the Group integration work. The dashboard captures cyber threats to the Trust as well current compliance against managed servers, computers, and user accounts and IT devices. The Committee was updated on potential cyber security threats and reviewed measures implemented to ensure Trust security was updated. It was also reported that NHS England had created a new London Region Cyber Group to support its Cyber Strategy implementation and the Trust was engaging with this.

2.4 **Information Governance Compliance Update and Annual Report**
The Committee received the annual report for 2022/23 highlighting the Trust's compliance against the data security and protection toolkit requirements. The Committee noted the auditors had given a moderate assurance. The Committee also noted the Trust had not met the 95% target for Data Security Awareness Training and that an action plan had been implemented to address this. The Trust is currently reporting 86% compliance and is on track to achieve the 95% compliance threshold. The Committee noted the work at the Trust to meet the mandatory standard for server estate running on supported systems, with an action plan in place to ensure servers are running on supported operating systems.

2.5 **Counter Fraud Update**
The Committee considered its regular report on progress with current counter fraud cases under investigation and noted that the work by the local counter fraud service to raise awareness of emerging risks through bespoke training sessions and attendance at corporate inductions. The Committee noted the completion of the annual benchmarking of all fraud investigative work undertaken by the service across the NHS and health sector to provide comparative data to assist the Committee in assessing Trust counter fraud arrangements and to benchmark against the performance of peers.

2.6 **Breaches and waivers report**
The Committee was told that the use of waivers in Q1 had decreased from eight to three, with an accompanying decrease in value to £200k. There was also a decrease in the instances of breaches from three to two. The Committee noted the ongoing work to reduce the usage of both waivers and breaches and was told that the Trust would be implementing a zero tolerance policy on the use of waivers, unless there is a genuine risk to the Trust or to patient safety. The Trust will also be introducing a no PO no pay policy and will be talking to its suppliers ahead of implementation to ensure the process is successfully bedded in.

2.7 **Managing Conflicts of Interest: Update on Compliance**
The Committee was informed that ESTH had achieved 75% compliance for decision-making staff making declarations of interest in 2022/23, an increase of 2% on the previously reported figure in May. Currently in 2023/24, ESTH is reporting that 51% of its decision-making staff have made a declaration. The Committee welcomed the engagement of clinical staff at ESTH and noted the success in implementing the new system and achieving high levels of compliance so soon after its implementation at the end of 2022. The Committee was told an engagement programme will run over 2023/24 with the aim of increasing the compliance rate for decision-makers and will include raising awareness with line managers, ensuring declarations are made as part of induction of all new staff, communications campaigns, reminders to staff and targeted engagement with areas with low compliance and individuals without valid declarations.

2.8 **Clinical Audit Programme**
The Committee received the report of clinical audits and effectiveness at the Trust in 2022/23. The audits were a mix of national and mandatory audits as well as locally chosen audits reflecting the Trust's clinical priorities. The Committee was told the aim of the audit programme was to embed clinical quality and deliver demonstrable improvements in patient care through the development and measurement of evidence-based practice. The Committee noted there was opportunity to develop a Group programme of clinical audits particularly in non-specialised services, recognising there would be site-specific areas which would continue to necessitate single audits decided at a site level.

3.0 Recommendations

3.1 The Board is asked to note the update from the Audit Committee meeting held on 14 July and 3 August 2023.

Peter Kane
Audit Committee Chair, NED
September 2023

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	4.1	
Report Title	**SWL Acute Provider Collaborative Memorandum of Understanding**	
Executive Lead(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Report Author(s)	Nayan Tailor – SWL APC Director of Programmes	
Previously considered by	Group Executive Board	29th August 2023
Purpose	**For Approval / Decision**	

Executive Summary

The South West London Acute Provider Collaborative Memorandum of Understanding has been revised, updating the current governance provision and portfolio. The revision also incorporates discussions held with SWL Acute CEOs on the Acute Provider Collaborative in regard to the governance framework and continued principles of collaboration.

Action required by Group Board

Approve the proposed South West London Acute Provider Collaborative Memorandum of Understanding ahead of Chief Executive Officer's signature.

Assurance

Committee	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	NA
Appendix 2	NA

Implications

Group Strategic Objectives

☒ Collaboration & Partnerships

☒ Right care, right place, right time

☒ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks

No implications as the revision builds on the current Memorandum of Understanding that is in place between the acute trusts in South West London for collaborating.

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

South West London

Acute Provider Collaborative

Memorandum of Understanding

NHS
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1. Introduction

This document is the Memorandum of Understanding (MoU) between the four acute providers of South West London ("the providers"), who have agreed to collaborate under the umbrella of the South West London Acute Provider Collaborative (SWL APC). The four providers are:

- Croydon Health Services NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Kingston Hospital NHS Foundation Trust
- St George's University Hospitals NHS Foundation Trust

The parties together serve local communities across Croydon, Kingston, Merton, Richmond, Sutton and Wandsworth, which experience significant variations in health needs and outcomes. The parties believe that their collaboration activities to deliver economies of scale, closer working within clinical teams and a new approach to elective care add value to the South West London Integrated Care System (ICS). The parties also recognise the group executive structure that spans across Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust.

The parties recognise that there are many variations in the challenges they face individually, and each party has its own unique identity. Each of the parties believes that they know their own local places best and will need to continue to work individually alongside partners in other sectors (social care, primary, mental and community health services among them) to respond to the health needs of each place.

The parties recognise that they can build on the collective work to date to achieve their shared ambition of collaboration for the best outcomes in:

- Workforce
- Quality
- Performance
- Finance
- Innovation.

The parties also acknowledge that in the changing healthcare landscape – the move towards place-based population health management and the impetus towards greater partnership working and collaboration that comes with that – health providers will need to work ever more closely together.

The parties have already collaborated via their formal partnerships (currently the Elective Orthopaedic Centre, Pathology Network, Procurement Partnership, and Recruitment Hub) and through the formation of clinical networks which span primary and secondary care, along with a portfolio of programmes (Elective, Outpatients, Diagnostics, Workforce, Pharmacy).

The parties will continue to collaborate in areas where working together will give more system benefit than working individually, particularly in areas outlined within their shared ambition. The established APC Board will provide a framework for the governance of the current and future collaboration activity.

The parties acknowledge that following the enactment of the Health and Care Act 2022 there are new powers available to them to move from the model of aligned decision-making envisaged by this agreement, to different forms of governance, including a joint committee structure.

For some areas within the collaborations, the parties may choose to invite other NHS provider organisations, whether within or outside South West London, to be a part of the collaboration. Where that is the case, the arrangements for working with that external organisation will be based on the principles laid out in this MoU, as appropriate. Where specific formal partnerships are covered by legal agreements, this MoU does not supersede anything in the legal agreement. However, trusts are expected to adhere to the behaviours laid out in this MoU

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2. Status and Purpose of this MoU

2.1 The parties wish to record the basis on which they will collaborate with each other in this MoU.

2.2 The parties are working together to deliver more integrated, high quality and cost-effective care to the patients and population they serve, supporting sustainability across the NHS in South West London.

This MoU sets out:

- The key objectives for the development of the APC
- The principles of collaboration
- The governance structures in place.

2.3 While this MoU provides a framework for the parties to undertake planning and decision making in alignment with one another, the provisions of this MoU will have effect without prejudice to the autonomy or legal status of the parties, each of which retain their legal personality and functions as conferred by law, and the MoU is not intended as a step on a journey towards a merger or the creation of a new legal entity.

2.4 The parties agree that this MoU shall not be legally binding.

3. Establishment of the APC Board

3.1 The parties have established the APC Board in accordance with this MoU and, through the Board, to deliver the APC Programme.

3.2 The role of the APC Board is to oversee all elements of APC activity. This will include future strategic direction, the formal partnerships, current programmes and operational activity across the SWL system, in accordance with the Principles of Collaboration. The Board has specific legally defined responsibilities in relation to SWLEOC and SWLP, which are laid out in the Consortium Agreements and Terms of Reference for those organisations.

3.3 The APC Board replaced the Collaboration Board on the 15th of September 2022.

3.4 The APC Board is supported by programme boards and steering groups, consisting of an executive Senior Responsible Officer (SRO) and key leads from each Trust.

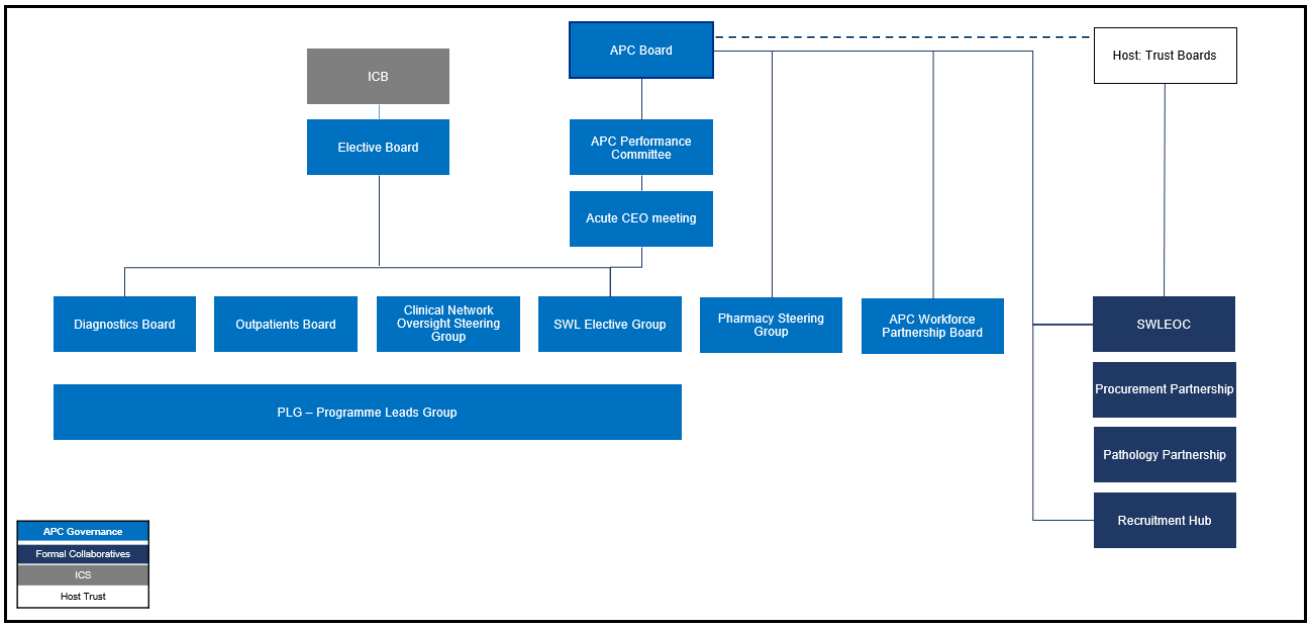
3.5 The APC Board membership consists of: The Chairs from each organisation and the Chief Executive Officers from each organisation.

3.6 In attendance (non-members) will be the APC Director and APC Director of Programmes.

3.7 The APC Board is chaired on rotation by the Chairs of each organisation. The Board is held on a bi-monthly rotation (every other month).

3.8 Any invitees, will only be present for discussions about those collaborations of which they are members, unless they are specifically invited otherwise.

3.9 The membership and purpose of the groups (within the below image) are laid out in the Terms of Reference of each group.



4. Establishment of Programme

4.1 The parties have established programmes with the responsibility for oversight of significant areas of the current collaborative portfolio.

4.2 Each Programme Group will be led by an executive SRO. The Programme Boards will in turn oversee the responsibility for and oversight of individual workstreams.

4.3 The existing formal partnerships have Steering Groups, which are chaired by the executive SRO of the collaboration. The role and membership of the Steering Groups are legally defined in the Consortium Agreements and Terms of Reference. The host Trust for each formal partnership will be responsible for monitoring the day to day running of the project; regularly reviewing performance and financial data, including at Trust Board level; and referring any concerns with performance to the APC Board.

4.4 The responsibilities of the hosts for current and future formal partnerships are laid out within the relevant consortium agreements.

4.5 For collaborations which are not supported by consortium agreements, each collaborative programme will consist of clearly defined stages. At each stage, there will be points at which trusts have to commit to the project, and clear definition of what this commitment means. There will also be clear ‘break points’ at which a Trust can choose to exit a project, and clear definition of what happens if a trust leaves at another point.

5. Principles of collaboration

As previously stated, the parties will continue to collaborate in areas where working together provides more system benefit than working individually, particularly in areas outlined within their shared ambition. The parties will develop ways for the four acute providers to work together to put the acute health sector in South West London (SWL) onto a more clinically and financially sustainable footing. The parties agree to adopt the following principles and behaviours to govern their collaboration activities (the "Principles of Collaboration"):

5.1 Principles:

- Collaboration to improve clinical outcomes, inequalities and unwarranted variation for patients.
- To improve workforce health and wellbeing, with SWL as the best place to work.
- To deliver top decile performance in quality, efficiency, and national standards.
- Deliver value for money to our populations and sustainability of our Trusts
- Use innovation and research to improve productivity (digital and technology).

5.2 Behaviours

Each party commits to giving timely, reasoned responses to any proposal for collaboration between them and to consult with the other parties before unilaterally taking any step related to, or having a significant impact on, current or planned collaborative activities.

The parties will innovate, share knowledge and trial new ways of working. Sharing any learning experiences and quickly scaling up good practice that has been shown to work well.

Recognising the significant financial challenges confronting the health service, the parties will work together to deliver efficiencies while continuing to improve quality and sustainability, and will engage constructively with other stakeholders in developing the Integrated Care System Forward Plan, shared capital plans and other system wide planning initiatives.

The parties recognise that their workforces are central to the achievement of their collaboration ambitions and will commit to allocating representatives to each of the programme groups.

The parties recognise the importance of their collaboration being underpinned by robust systems of governance and the need for compliance with the Nolan Principles.

The parties recognise the time-critical nature of the APC programmes and will respond accordingly to requests for support. The parties will ensure sufficient and appropriately qualified staff and other resources are made available to fulfil the responsibilities set out in this MoU.

The parties will also recognise the "break points" defined within a programme and ensure that any withdrawal is done so in compliance of this; to ensure that there is no impact to the other parties.

5.3 Responsibilities

Senior Responsible Officer (SRO)	• Chair the relevant Board/governance forum that they are acting as SRO for • Provide direct and hands-on leadership to the portfolio, working with other representatives on the Programme Board • Ensure that the programme is designed on the principles of collaboration, meeting the needs of the parties involved, and ensuring that parties have had the opportunity to engage in the development of the programme. • Be accountable for keeping the other Chief Executives sighted on the project, and any matters arising on quality, performance, and financial impact. This includes making recommendations to the APC Board for final approval, on behalf of the Programme Board.
Host Trust (for existing and developing formal partnerships)	• In the case of new projects, take the lead on developing the scoping and analytical phases of any new projects. The host trust will oversee and manage the work of the project team, alerting the other parties to any emerging issues. • For established projects, be accountable for the day-to-day delivery of the hosted function, against the annual plan. The host's Board will consider financial and performance information, and act based on this in the same manner as an internal function. • Undertake internal and external financial audit as required and share these with the other participating trusts on a regular basis. • Provide support services and facilities (such as accommodation, IT) unless these are provided elsewhere by mutual agreement. • Hold the employment contract on behalf of the SWL trusts for any resource who may be employed to work SWL-wide on the project or agree for the APC to do this where appropriate. The Trust will apply its own rules and regulations (such as HR rules) to the hosted function.
Member Trusts (including parties who are not part of the SWL APC, but may be involved within specific portfolios)	• Supply such Trust data as is needed for the design or management of a project, promptly and in the format requested; • Contribute resources, staff time and senior management time as required and as agreed within the scope of the individual project to ensure that the project runs smoothly and is able to deliver; • Ensure that the relevant members on the executive team are engaged on regular data on expected activity, income, financial performance, quality performance, staff absence, agency usage etc, and engage actively with this, so as to maintain clear ongoing oversight of performance; • Ensure that any withdrawal from programmes complies with the clear "break points" outlined within the programme as to not cause any impact to other participating parties.

5.4 Staff Sharing Agreement

This MoU also recognises the staff sharing agreement that is in place across South West London Acute Hospital Trusts which is aimed at giving flexibility to each party in how they collaborate in the future on a sustainable workforce plan.

6. Decision Making

6.1 The parties agree to adopt a model for aligned decision-making to support the making and taking of decisions in relation to their collaboration activities based on the following:

Formation of proposal. Meetings of the APC will act as forums in which discussion can take place, informed by the views of each of the parties as relayed through their nominated representatives. Following that discussion, the representatives of the parties in attendance at the meeting will seek to form a consensus as to the text of a resolution outlining the decision to be taken.

Adoption of proposal. Once a consensus on a proposal has been reached in a meeting of the APC, and the text of a resolution has been agreed, either

The duly authorised representatives of each of the parties in attendance at the meeting, acting in accordance with the delegated authority conferred on them, will formally agree the resolution and take the decision; or

Where the resolution is required to be adopted and a decision taken on a matter which is reserved to the Board of any of the parties, the agreed text of a resolution will be put on the agenda of the next scheduled meeting of that party's Board for determination.

6.2 Each of the parties confirms that these arrangements are in accordance with their Standing Orders, Standing Financial Instructions and Schemes of Delegation and in particular the delegation of functions to nominated representatives in their Schemes of Delegation.

6.3 In the event that the parties wish to delegate further functions to the APC in future they will seek the agreement of their respective Boards to amend their Standing Orders, SFIs and Schemes of Delegation as necessary.

6.4 In making decisions about their own organisations the parties agree to consider and promote the interests of the South West London acute sector as a whole, and not just their own organisational interests.

7. Dispute Resolution

7.1 If any party has any issues, concerns or complaints regarding the operation of this MoU or the APC Programme that party shall notify the other parties promptly and the parties will seek to resolve the issue via discussion between them.

7.2 In a case where it has not been possible or appropriate to resolve a dispute informally, the dispute shall be referred to the APC.

7.3 The APC Board will consider and reach a position on the dispute which, in the view of the APC, is the most consistent with the Key Principles in this MoU.

7.4 The parties recognise that any dispute or operation of this procedure will be without prejudice to and will not affect the statutory duties of each party.

7.5 If a party disagrees with a decision of the APC Board they may withdraw from the MoU at any point.

7.6 Disputes around the formal partnerships have defined dispute resolution processes which are laid out in their Consortium Agreements, and which will be followed for these collaborations.

8. Conflicts of Interest

8.1 The parties agree to follow the Protocol for Managing Conflicts of Interest as per their current organisation's requirements.

8.2 If one party is considered by the other parties to have committed a material breach of the Protocol for Managing Conflicts of Interest, the other parties may agree to continue with any aspect of the collaboration between them to the exclusion of the other party.

9. Compliance

9.1 The parties shall comply with:

applicable Laws and standards, including (for the avoidance of doubt) their respective Provider Licences, procurement rules, competition law, data protection, patient choice and transparency legislation; and applicable guidance issued by a Regulatory Body.

9.2 If, as a result of change in applicable laws, the parties are prevented from performing their obligations under this MoU but would be able to proceed if a variation were made to the MoU, then the parties shall consider this.

9.3 In the event that that the parties are prevented from performing their obligations under this MoU as a result of a change in applicable law and this cannot be remedied by a variation or a variation is not agreed by all parties, then the parties shall agree to terminate this MoU on immediate effect of the change in applicable law.

10. Term and Termination

10.1 This MoU shall commence on the date on which it is executed by all the parties (the "Commencement Date") and shall expire on the fifth anniversary of the Commencement Date, or sooner as required by the parties

10.2 This MoU may be terminated in whole and with immediate effect by mutual agreement in writing by all parties.

10.3 Any party may withdraw from this MoU giving at least six calendar months' notice in writing to the other parties. The MoU will remain in force between the remaining parties (unless otherwise agreed in writing between all the remaining parties) and the remaining parties will agree such amendments required to the MoU.

10.3 A withdrawing party and each remaining party shall act to ensure an orderly departure of the withdrawing party and that any disruption to the collaborative arrangements between the remaining parties is limited to what is strictly necessary.

11. Variation

11.1 This MoU may only be varied by written agreement of the parties signed by, or on behalf of, each of the parties.

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12. Charges and Liabilities

12.1 The APC operating costs shall be set with the parties within this MoU on an annual basis. The cost share shall be shared equally across all of the parties within this MoU. Additional resource requirements outside of this will be incorporated into the project initiation documents or relevant investment business cases as required.

12.2 The parties shall each bear their own costs and expenses incurred in complying with their obligations under this MoU, including in respect of any losses or liabilities incurred due to their own or their employee's actions.

12.3 No party intends that any other party shall be liable for any loss it suffers as a result of this MoU.

13. No Partnership

13.1 Nothing in this MoU is intended to, or shall be deemed to, establish any partnership or joint venture between the parties, constitute any party as the agent of another party, nor authorise any of the parties to make or enter into any commitments for or on behalf of the other parties.

14. Confidentiality

14.1 Each party shall keep the other parties' confidential information confidential and shall not:

use such confidential information except for the purpose of performing its rights and obligations under or in connection with this agreement; or

disclose such confidential information in whole or in part to any third party.

14.2 The obligation to maintain confidentiality of confidential information does not apply to any confidential information:

which another party confirms in writing is not required to be treated as confidential information;

which is obtained from a third party who is lawfully authorised to disclose such information without any obligation of confidentiality;

which a party is required to disclose by judicial, administrative, governmental or regulatory process in connection with any action, suit, proceedings or claim or otherwise by applicable law, including the FOIA or the EIR;

which is in or enters the public domain other than through any disclosure prohibited by this agreement;

which a party can demonstrate was lawfully in its possession prior to receipt from the another party; or

which is disclosed by a party on a confidential basis to any central government or regulatory body.

14.3 A party may disclose the other party's confidential information to those of its Nominated Representatives who need to know such confidential information for the purposes of performing or advising on the party's obligations under this agreement, provided that:

it informs such representatives of the confidential nature of the confidential information before disclosure; and

it procures that its representatives shall, in relation to any confidential information disclosed to them, comply with the obligations set out in this clause as if they were a party to this agreement,

and at all times, it is liable for the failure of any representatives to comply with the obligations set out in this clause.

15. Data Protection

15.1 The parties shall (and shall procure that any of their representatives involved in the performance of the parties' obligations under this MoU of the agreement) comply with any notification requirements under the Data Protection Legislation and the parties will duly observe all their obligations under the Data Protection Legislation, which arise in connection with this MoU.

15.2 The parties agree to work openly and co-operatively together, sharing information with the APC and with each other where required to support the shared work of the collaborative. This includes sharing of financial and performance data where required.

16. Freedom of Information

16.1 The parties acknowledge that each is a public authority subject to the requirements of the Freedom of Information Act 2000 ("FOIA") and the Environmental Information Regulations 2004 ("EIR").

16.2 As host trust for the APC, all FOIA requests in relations to the APC should be directed to Kingston Hospital NHS Foundation Trust.

16.3 Each party shall, in respect of any requests for information which touch on or relate to the APC and/or this MoU:

provide all necessary assistance and cooperation as reasonably requested by the other parties to enable them to comply with their obligations under FOIA and EIR;

notify the other parties of requests for information that it receives as soon as

provide to the other parties a copy of any information it holds and which is required in order to respond to a request for information within a timely manner (or such other period as the parties may reasonably specify) of any request for such Information; and

not respond directly to a request for information unless without first consulting with the other parties.

17. Governing Law and Jurisdiction

17.1 This MoU shall be governed by and construed in accordance with the laws of England and Wales.

17.2 The parties agree that the courts of England shall have exclusive jurisdiction to hear and settle any action, suit, proceeding or dispute in connection with this MoU and irrevocably submit to the jurisdiction of those courts.

18. Further Assurance

18.1 Each party shall do all things and execute all further documents necessary to give full effect to this MoU.

19. Signature Page

The parties have signed this MoU on the day and year first above written.

Signed on behalf of:	**Croydon Health Services NHS Trust**	**Epsom & St Helier University Hospitals NHS Trust**	**St George's University Hospitals NHS Foundation Trust**	**Kingston Hospital NHS Foundation Trust**
Signature:				
Name:	**Matthew Kershaw**	**Jacqueline Totterdell**		**Jo Farrar**
Title:	**Chief Executive**	**Group Chief Executive**		**Chief Executive**
Date:				

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	4.2	
Report Title	**Outpatient Transformation Self-Certification: Delegation of Authority to Finance Committees-in-Common**	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

On 4 August 2023, NHS England wrote to all NHS acute trusts about protecting and expanding elective capacity, and specifically about outpatient transformation. The NHS England letter stated that it is necessary to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis, and that achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month.

NHS England's letter asked acute trusts to:

- Revisit their plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.
- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

NHS England also asked trusts to provide assurance against a set of activities to drive outpatient recovery at pace, a process requiring a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of these priorities, NHS England has asked each acute trust to ensure that this work is discussed and challenged appropriately at Board and to undertake a Board self-certification process and have it signed off by Trust Chairs and Chief Executives by 30 September 2023. NHS England also asks that its letter be shared in full with the Board (Appendix 1).

Teams across St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust have been undertaking detailed work to complete the new requirements and self-certification ahead of the 30 September 2023 deadline. While this work is progressing, the scale of the ask from NHS England is such that it will require further work throughout September. The timing of the Group Board meeting on 8 September 2023 comes at a point where the assurance and self-certification cannot be presented at this point. As a result, the Group Board is asked to delegate authority to the Finance Committees-in-Common to review the actions, assurances and self-certification required by NHS England at its meeting on 29 September 2023. The Finance

Committees of the two Boards are the Committees charged with oversight of operational performance, including outpatient transformation and are the appropriate Committees to which to delegate authority to enable Board-level review ahead of submission to NHS England ahead of the 30 September deadline. Following review by the Finance Committees-in-Common, the submission to NHS England will need to be signed off by the Group Chairman and Group Chief Executive.

Action required by Group Board

The Board is asked to delegate authority to the Finance Committees-in-Common to review the actions and self-certifications set out in NHS England's letter *of* 4 August 2023.

Committee Assurance

Committee	Finance Committee-in-Common
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	*Protecting and Expanding Elective Capacity*, Letter from NHS England to acute trusts, 4 August 2023

Implications

Group Strategic Objectives

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

Risks

If we do not implement fully the new Fit and Proper Persons Test Framework and apply it consistently, there is a risk that directors could be appointed to the board who do not meet the required standards for appointment. This could potentially impact on patient safety and / or organisational performance and would likely trigger external regulatory intervention.

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 NHS England letter.

Legal and / or Regulatory implications

The Trusts are required to comply with the actions set out in NHS England's letter by 30 September 2023.

Equality, diversity and inclusion implications

There are no specific equality, diversity, or inclusion implications associated with the proposed delegation of authority to the Finance Committees-in-Common.

Environmental sustainability implications
There are no environmental or sustainability implications associated with the proposed delegation of authority.

Classification: Official

To:
- NHS acute trusts:
  - chairs
  - chief executives
  - medical directors
  - chief operating officers

cc.
- NHS England regional directors

NHS England
Wellington House
133-155 Waterloo Road
London
SE1 8UG

4 August 2023

Dear Colleagues,

Protecting and expanding elective capacity

In May, we wrote to you outlining the priorities for elective and cancer recovery for the year ahead. Last week, as part of the winter letter, we also asked you to maintain as far as possible ring-fenced elective and cancer capacity through winter.

We would like to thank you for your continued hard work in these areas, in the face of significant wider operational challenges, including ongoing industrial action. Thanks to the efforts put in by staff across the NHS, we have now virtually eliminated pathways waiting over 78 weeks, down by 94% since the peak of 124,000 in September 2021 (and now representing c0.1% of the total list), and significantly decreased the number of patients with urgent suspected cancer waiting longer than 62 days from a high of 34,000 to around 21,000 today.

However, one area where we know there remains more to do is outpatients. We have listened to your feedback on the support you need for this transformation and have set out the next steps below.

National support for outpatient transformation

To support outpatient transformation, we have met with royal colleges, specialist societies and patient representatives to agree a way forward, working in partnership, to champion and enable outpatient recovery and transformation. At the ‘call to arms’, colleges agreed to:

- review their guidance on outpatient follow-ups
- support new approaches to increasing wider outpatient productivity, including reducing variation in clinical templates, patient discharge, and following clinically-informed access policies.

Publication reference: PRN00673

Together with this clinical leadership, we need to build on the expectation of freeing up capacity and increasing productivity. This can be achieved through reducing follow up appointments with no procedure, fully validating RTT waiting lists, reducing variation in clinical templates, moving to patient-initiated follow-up where appropriate, following clinically-informed access policies and implementing new ways of working, such as group outpatient follow ups, reviewing clinical pathways and workforce models.

We are continuing to provide support to trusts in this area, through the following:

- Regional support
- NHS England's GIRFT outpatient guidance
- Action on Outpatients series
- The Model Health System
- Support to specific trusts via NHS England's GIRFT Further Faster programme, NHSE Tiering programme and Elective Care Improvement Support Team (IST) – learning from the Further Faster programme will be shared in the Autumn
- Access to additional capacity through the NHS Emeritus Consultant programme
- Luna weekly data quality report, which can be accessed by contacting lunadq@mbihealthcaretechnologies.com and Foundry data dashboards
- RTT rules suite
- Elective Care IST Recovery Hub - FutureNHS Collaboration Platform
- Guidance on shared decision making.

Next steps on outpatient transformation

With the majority (c80%) of patient waits ending with an outpatient appointments, we need to increase the pace in transforming outpatient services to release capacity for patients awaiting their first contact and diagnosis. This will be particularly important ahead of and during winter, when pressure on inpatient beds can be at its highest. Nationally, achieving a 25% reduction in follow up attendances without procedures would provide the equivalent to approximately 1m outpatient appointments per month**.**

This letter therefore sets out further detail on three key actions that we are asking you to take:

- Revisit your plan on outpatient follow up reduction, to identify more opportunity for transformation.
- Set an ambition that no patient in the 65-week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023.

- Maintain an accurate and validated waiting list by ensuring that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with December 2022 validation guidance) by 31 October 2023, and ensuring that RTT rules are applied in line with the RTT national rules suite and local access policies are appropriately applied.

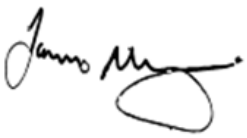
We are now asking trusts to provide assurance against a set of activities that will drive outpatient recovery at pace. This process will require a review of current annual plans, detailing the progress that can be made on outpatients transformation. As part of the above priorities, we are asking each provider to ensure that this work is discussed and challenged appropriately at board, undertake a board self-certification process and have it signed off by trust chairs and chief executives by **30 September 2023**.

The details of this self-certification can be found at Appendix A. Please share this letter with your board, key clinical and operational teams, and relevant committees.

If you are unable to complete the self-certification process then please discuss next steps with your regional team.

Thank you again for colleagues' efforts in this area, which are making a real difference to the timeliness of care we deliver to patients. We look forward to receiving your returns and, as always, if you need to discuss this in more detail, or support in conducting this exercise, please contact england.electiverecoverypmo@nhs.net.

Yours sincerely,



Sir James Mackey
National Director of Elective Recovery
NHS England

Professor Tim Briggs CBE
National Director of Clinical Improvement
Chair, Getting It Right First Time (GIRFT) Programme
NHS England

Appendix A: self-certification

About this self-certification

To deliver elective and cancer recovery ambitions, high-quality waiting list management and ambitious outpatient transformation are vital. We are now asking trusts to complete this return to provide assurance on these recovery plans.

Nationally and regionally, we will use this to identify providers requiring more support, as well as areas of good practice that can be scaled up to accelerate recovery. Please return this to NHS England by **30 September 2023**, via NHS England regional teams.

Guidance for completing the self-certification

The return asks for assurance that the board has reviewed and discussed specific outpatient operational priorities and has signed off the completed checklist. Please return this to your NHS England regional team.

Trust return: [insert trust name here]

The chair and CEO are asked to confirm that the board:

Assurance area	Assured?
1. Validation The board: a. has received a report showing current validation rates against pre-covid levels and agreed actions to improve this position, utilising available data quality (DQ) reports to target validation, with progress reported to board at monthly intervals. This should include use of the nationally available LUNA system (or similar) to address data quality errors and identify cohorts of patients that need further administrative and clinical validation. b. has plans in place to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted and validated (in line with validation guidance) by 31 October 2023, and has sufficient technical and digital resources, skills and capacity to deliver against the above or gaps identified. We are developing a range of digital support offers for providers to improve validation. c. ensures that the RTT rules and guidance and local access policies are applied and actions are properly recorded, with an increasing focus on this as a means to improve data quality. For example, Rule 5 sets out when clocks should be appropriately stopped for 'non-treatment'. Further guidance on operational implementation of the RTT rules and training can be found on the Elective Care IST FutureNHS page. A clear plan should be in place for communication with patients.	

d. has received a report on the clinical risk of patients sitting in the non RTT cohorts and has built the necessary clinical capacity into operational plans.	
2. First appointments The board: a. has signed off the trust's plan with an ambition that no patient in the 65 week 'cohort' (patients who, if not treated by 31 March 2024, will have breached 65 weeks) will be waiting for a first outpatient appointment after 31 October 2023. b. has signed off the trust's plan to ensure that Independent Sector capacity is being used where necessary to support recovery plans. To include a medium-term view using both insourcing and outsourcing, the Digital Mutual Aid System, virtual outpatient solutions and whole pathway transfers. National support and information on utilisation of the Independent Sector is available via the IS Co-ordination inbox england.iscoordination@nhs.net	
3. Outpatient follow-ups The board: a. has received a report on current performance against submitted planning return trajectory for outpatient follow-up reduction (follow-ups without procedure) and received an options analysis on going further and agreed an improvement plan. b. has reviewed plans to increase use of PIFU to achieve a minimum of 5%, with a particular focus on the trusts' high-volume specialties and those with the longest waits. PIFU should be implemented in breast, prostate, colorectal and endometrial cancers (and additional cancer types where locally agreed), all of which should be supported by your local Cancer Alliance. Pathways for PIFU should be applied consistently between clinicians in the same specialty. c. has a plan to reduce the rate of missed appointments (DNAs) by March 2024, through: engaging with patients to understand and address the root causes, making it easier for patients to change their appointments by replying to their appointment reminders, and appropriately applying trust access policies to clinically review patients who miss multiple consecutive appointments. d. has a plan to increase use of specialist advice. Many systems are exceeding the planning guidance target and achieving a level of 21 per 100 referrals. Through job planning and clinical templates, the Board understands the impact of workforce capacity to provide advice and has considered how to meet any gaps to meet min levels of specialist advice. The Trust has utilised the OPRT and GIRFT checklist, national benchmarking	

data (via the Model Health System and data packs) to identify further areas for opportunity. e. has identified transformation priorities for models such as group outpatient follow up appointments, one-stop shops, and pathway redesign focussed on maximising clinical value and minimising unnecessary touchpoints for patients, utilising the wider workforce to maximise clinical capacity.	
4. Support required The board has discussed and agreed any additional support that maybe required, including from NHS England, and raised with regional colleagues as appropriate.	

Sign off

Trust lead (name, job title and email address):	
Signed off by chair and chief executive (names, job titles and date signed off):	

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	5.1	
Report Title	**Group 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	27 July 2023
Purpose	**For Assurance**	

Executive Summary

This paper provides a monthly update on Healthcare Associated Infections (HCAIs) and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Group. The table below summaries the monthly HCAI position at site level.

HCAI	ESTH	**SGUH**
C. *difficile* infection	Apr: 3 HOHA, 2 COHA May: 4 HOHA, 0 COHA June: 2 HOHA, 0 COHA **YTD: 11** **National threshold: 38** **Total cases 2022/23: 38**	Apr: 2 HOHA May: 5 HOHA, 2 COHA June: 5 HOHA **YTD: 14** **National threshold: 42** **Total cases 2022/23: 60**
MRSA bloodstream infection	Apr: 0 May: 1 June: 0 **YTD: 1** **National threshold: 0** **Total cases 2022/23: 0**	Apr: 0 May: 0 June 0 **YTD: 0** **National threshold:0** **Total cases 2022/23: 1**
Pseudomonas aeruginosa	April: 0 May: 0 June: 0 **YTD: 0** **National Threshold: 6** **Total cases 2022/23: 12**	Apr: 1 May: 4 HOHA, 3 COHA June: 1 HOHA **YTD: 9** **National Threshold: 25** **Total cases 2022/23: 23**
E-coli	April: 2 HOHA, 1 COHA May: 3 HOHA, 3 COHA June: 5 HOHA, 4 COHA **YTD: 18** **National Threshold: 52** **Total cases 2022/23: 55**	April: 8 HOHA, 7 COHA May: 7 HOHA, 3 COHA June: 5 HOHA, 5 COHA **YTD: 35** **National Threshold: 88** **Total cases 2022/23: 105**

Klebsiella spp.	April: 0 HOHA, 1 COHA May: 2 HOHA, 0 COHA June: 4 HOHA, 1 COHA **YTD: 8** **National Threshold: 24** **Total cases 2022/23: 28**	April: 4 HOHA May: 6 HOHA June: 4 HOHA, 1 COHA **YTD: 15** **National Threshold: 58** **Total cases 2022/23: 23**
Covid-19 Update		
June	Covid-19 positive cases: 30 Covid-19 deaths: 21 Nosocomial infections: 5 Nosocomial deaths: 0 **YTD positive cases: 224** **YTD nosocomial deaths:1** **Total cases 2022/23: 2368** **Total deaths 2022/23: 276**	Covid-19 positive cases: 21 Covid-19 deaths: 6 Nosocomial infections: 4 Nosocomial deaths: 4 **YTD positive cases: 242** **YTD nosocomial deaths: 10** **Total cases 2022/23: 2461** **Total deaths 2022/23: 206**

Action required by Quality Committees-in-Common

The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective for assurance and make any necessary recommendations
- See Appendices 2 for additional information with reference to the management of C. *difficile* infection and E-coli

Committee Assurance

Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

Appendices

Appendix No.	Appendix Name
Appendix 1	Infection Prevention and Control Report – June 2023
Appendix 2	ESTH and SGUH C. *difficile* infection and E-coli – Root Cause Analysis

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 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

N/A

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

No issues to consider

Environmental sustainability implications

No issues to consider

Group Healthcare Associated Infection Report
Group Board, 08 September 2023

1.0 Purpose of paper

This paper provides a monthly update on HCAIs and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Group summarised in Table 1 below.

2.0 Summary of key performance measures

The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts.

3.0 COVID-19 Update:

Following the publication of the new screening guidance, there continues to be a high usage of PCR testing across both sites (and across the sector). This is despite implementation of the new policy and recommendations published in April 2023 for targeted screening and use of lateral flow tests for most situations.

Weekly data circulated via SW London Pathology Services is reviewed and shared with areas with high usage/noncompliance. Non-compliant areas are required to attend gesh weekly IPC meeting to discuss reasons for use of PCR tests outside of national guidance. Divisional operational leads are responsible to ensure their Divisions are complaint with recommendations.

4.0 Healthcare Associated Infections

In Quarter 1, there has been an increased number of Trust acquired *C. difficile* infections and *E. coli* bloodstream infections. As of 30 June 2023, SGH had 14 *C. difficile* infections and 35 E.coli bacteremias and ESTH has had 11 *C.difficile* infections and 18 E.coli bacteremias.

5.0 Key Issues

5. 1 *C .difficile* infections

5.1.1 For ESTH: In Quarter 1 (April-June) 2023, there were 11 cases apportioned to the Trust compared with the same period last year when there were 17 CDI cases. Although the local cumulative trajectory was breached in April/May, by the end of June 2023 the position had recovered to the threshold of 11 cases.

To enable a greater understanding of the causes of individual cases and to determine whether there were any lapses in the quality of care provided in each case, a comprehensive review of all 11 cases was undertaken in July 2023. A summary is written below, and a more detailed report is included in Appendix 4 in the Reading Room for ESTH C. *difficile* infection and E-coli – Root Cause Analysis.

The review showed that there were various risk factors that may have contributed to infection; with recent and or frequent hospitalisations being the most recurring theme for all cases.

The other themes/risk factors are:

- Multiple comorbidities
- Prolonged use antibiotics
- Prolonged use of PPI
- Long hospital stay
- Frequent hospital admissions
- Age (all patients were above 66)

As part of the review, poor documentation, delays in sampling and provision of a single/ side room were identified as non-causative factors which are not thought to have contributed to acquisition of *C. difficile* in these patients.

All cases were within Medicine division with only two cases on the same ward (Croft) in April and May but there was no pathway crossover.

Actions / Interventions: The Trust has achieved a significant reduction in healthcare associated *C. difficile* infections over several years. Cases between April to June were within the trajectory; however we must remain vigilant to reduce the risk of infection and also ensure that the significantly reduced national threshold is not breached for this financial year.

To help improve practice and compliance, in addition to training and sharing of lessons learned from the joint multi-disciplinary review of *C. difficile* infections, we will continue to build on what was achieved in previous years and ensure plans are in place to review and monitor the Trust's antimicrobial policy compliance, including robust prescribing practice, to reduce the risk of *C. difficile* infection and other multi resistant organisms.

5.1.2 For SGUH: There were 5 C.*difficile* infections during June 2023—five cases classified as Hospital-Onset Healthcare-Associated (HOHA). To date, the Trust has had 14 cases at the end of June (9 HOHA; 5 COHA). The *C. difficile* cases have occurred on 8 different wards across the Trust, all being sporadic by location. There were no outbreaks or Periods of Increased Incidence (PII) identified in June 2023.

A comprehensive paper summarizing the reviews of cases in the last year is included at Appendix 4. There are no new actions/recommendations.

5.2 *E.coli* Bloodstream Infections

5.2.1 For ESTH: There were 9 cases of E.coli bloodstream infections in June (4 COHA and 6 HOHA) and year to date is 18. Source of infection varies between each case and it is difficult to know the source of infection due to different factors such as inability to access community healthcare records. Some of the COHA cases, the patient had only been in our hospital for less than 8 hours but due the COHA definition, this counts towards Trust numbers. Following review, of the 18 cases, the source of infection in 7 cases remains unknown, 3 urinary tract infections, 1 skin/soft tissue, 1 hepatobiliary and the remainder were still under investigation at the time of writing the report.

The highest burden of *E coli* BSIs is deemed as community onset (62 cases to date). The recent review and previous ones indicated that it is very difficult to identify the source and to mitigate the risks associated with *E.coli* bloodstream infections, particularly if the source is hepatobiliary or unknown. Therefore the main focus to try and reduce the numbers is a focus on urinary catheter management and management of urinary tract infections.

Actions to reduce *E.coli* bloodstream infections:

- There was a proposal to have a joint improvement plan with a focus on urinary tract infections (UTI) and catheter management with the Integrated Care Board (led by the ICB Infection Control Nurse); however this has not been implemented yet. Working with the ICB would support management of the patient pathway and the interface between acute and community settings.
- Back to basics week with a focus on urinary catheter care and use of catheter passport. This is a joint project between IPC and the Continence lead nurse.
- Participate in the sector wide plan to reduce infections and use of urinary catheter passport in the community engaging other agencies including care/residential homes.

5.2.2 For SGUH: There were 10 cases of *E. coli* bacteraemia during June 2023, 5 (HOHA and 5 COHA). The Trusts' internal trajectory for quarter 1 is 22 and YTD cases are 35. As with C. difficile a comprehensive paper was submitted last month to QiCC and there are no new actions/recommendations. The key priorities are as follows:

- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch
- Continence service referral pathways and standards in development across Southwest London
- Corporate nursing and IPC team to establish task and finish group 'Getting back to Basics' - oversight steering group in process of being set up.
- Four work streams have been identified; this includes a 'Urinary Catheter Care' and the aim is to work with Urology CNS team to support education and awareness across Trust – initial meeting has taken place.
- *E. coli* focus week through senior nurses Back 2 the floor in with QI approach – to be planned

5.3. Carbapenemase-producing Enterobacterales (CPE)

5.3.1 For ESTH: A CPE outbreak was declared on Buckley ward following identification of a case as part of admission screening on a transfer from St. George's hospital in June. Four contacts were generated as part of contact tracing of which one was identified as being CPE positive. This second patient generated a further two contacts, both of which screened negative for CPE.

It is worth noting that this second patient that screened positive had been previously nursed in a single room for several weeks; however as per ward layout and standard staff allocation on the ward, the same group of staff looking after the index case were looking after the second case. An investigation has been undertaken and concluded that this may have resulted in cross transmission due to human and environmental factors. Both patients did not require escalation of treatment and have since been discharged.

Enhanced IPC measures were put into place and stood down when patients were discharged.

5.3.2 There were no CPE issues for SGUH this month.

5.4 Benchmarking with SW London Hospitals and London Integrated Care Systems

The healthcare associated infections reported for 1 April 2023 to 31 May 2023 in SW London are set out on slide 13 in Appendix 1 showing the performance of individual Trusts against the annual NHSE set thresholds.

Slide 14 in Appendix 1 shows how SWL ICS performed alongside other London ICS's and the NHSE set thresholds (including community apportioned cases).

6.0 Recommendations

6.1 The Board is asked to:

a. Receive for assurance the Healthcare Associated Infection (Infection Control) Report from a site and Group perspective and make any necessary recommendations
b. See Appendices 2 for additional information with reference to the management of C. difficile infection and E-coli

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Appendix 1

Infection Prevention and Control Report

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

September 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) across gesh with a particular focus on:

- Covid-19
- *Clostridioides difficile* (*C.difficile*)
- MRSA Bloodstream Infections
- Gram Negative Bloodstream Infections
- Surgical Site Infections (SSIs)
- IPC Related Incidents
- Hand Hygiene Compliance
- IPC Mandatory Training including Fit Testing

Trusts have a statutory requirement to report on these infections and issues in line with the Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections (updated 2023).

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 across Group

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 the aim of harmonising polices and practices.

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 June	30	21
Total deaths in month	21	6
Nosocomial infections	5	4
Nosocomial deaths	0	4
YTD positive cases	224	242
YTD nosocomial deaths	1	10
Outbreaks in month	0	0

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.

Both sites continue to undertake root cause analysis (RCAs) for nosocomial deaths that meet the new criteria.

In June, there were no cases that met the criteria for an RCA for both sites.

Covid-19 Update: Despite the publication of the new screening guidance, there continues to be high usage of PCR testing across both sites (and across the sector) despite implementation of the new policy and recommendations published in April 2023 for targeted screening and use of lateral flow tests for most cases.

Weekly data circulated via SW London Pathology Services is reviewed and shared with areas with high usage/noncompliance. Non-compliant areas are required to attend the group weekly IPC meeting to discuss reasons for the continued use of PCR tests/support them in making decisions to meet their patient needs. Divisional operational leads are responsible to ensure their Divisions are complaint with recommendations.

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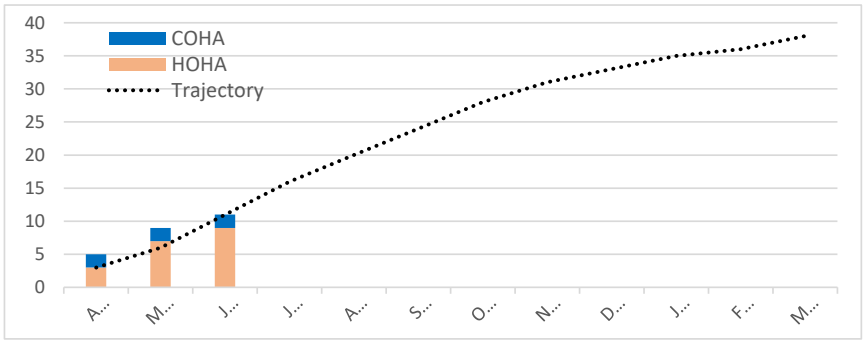
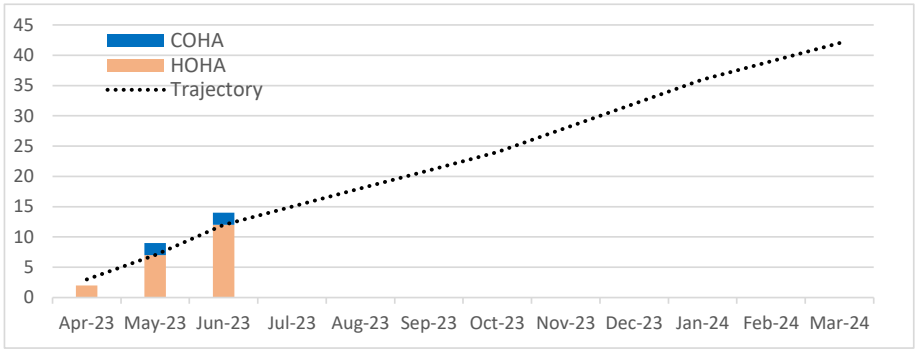
Clostridioides difficile (*C. difficile*)

ESTH



SGH



ESTH: In June there were 2 Trust attributed C. *difficile* cases, both Healthcare Onset Healthcare Associated, with one lapse in care identified as a result of a significant delay in administering C. *difficile* treatment. This was picked up at the weekly *C.difficile* ward round, treatment was commenced and the patient has since recovered and been discharged home.

SGUH: In June there were 5 C.*difficile* infections, all classified as Hospital-Onset Healthcare-Associated. The YTD 14 *C. diff* cases have primarily been in the MedCard division (10 cases) followed by Surgery (3 cases) and Children and Women's (1 case). The *C.difficile* cases have occurred in 8 different wards across the trust, all being sporadic by location.

Both sites: a focus on reducing C.*difficile* infections with the following key priorities:

- IPC team to establish task and finish group 'getting back to basics' week with refresher on diarrhoea management/prompt identification/isolation of suspected cases
- Antimicrobial stewardship and audits in conjunction with
- Timely review and completion of RCAs/share learning

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MRSA Bloodstream Infections

	ESTH	SGUH
Total cases in month	0	0
YTD cases	1	0
National objective	0	0

ESTH - There were no Trust attributed MRSA bloodstream infections in June. YTD: 1.

SGUH: There were no Trust attributed MRSA bloodstream infections. YTD= 0

National threshold for MRSA is zero avoidable cases.

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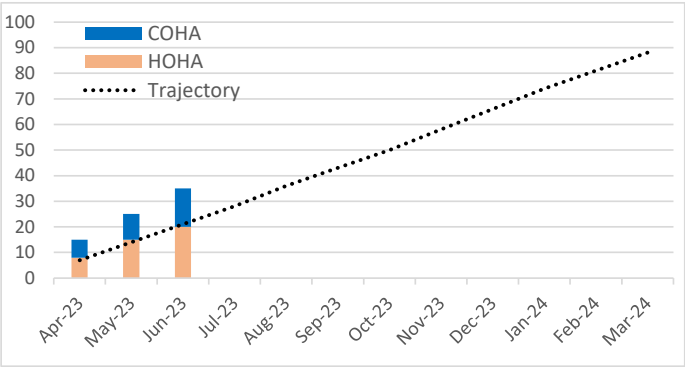
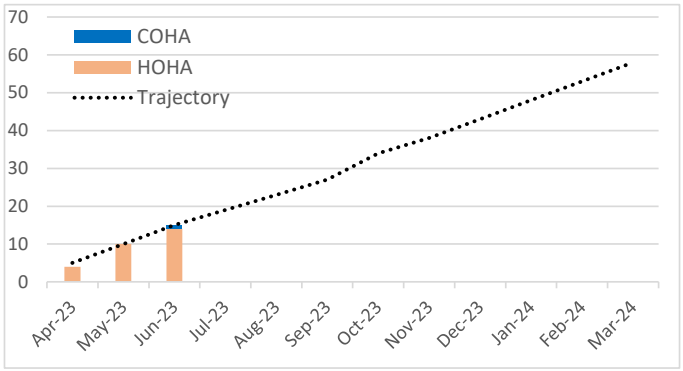
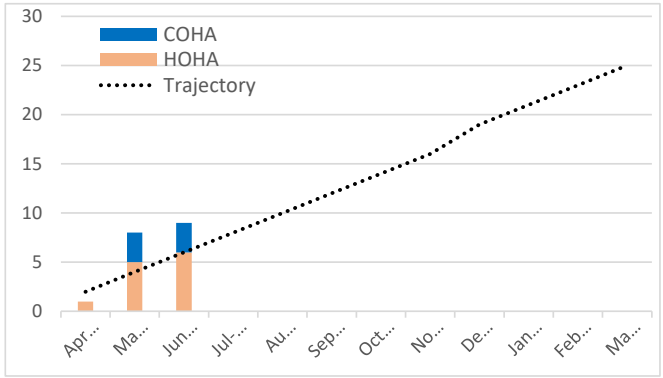
Gram Negative Bloodstream Infections - SGH



E.coli



Klebsiella spp.



Pseudomonas aeruginosa

SGUH: There were 10 cases of *E. coli* bacteremia in June 2023: 5 have been classified as Hospital Onset Healthcare Associated (HOHA); 5 have been classified as Community Onset Healthcare Associated (COHA). The Trusts' internal threshold for quarter 1 is 22 and YTD cases are 35. A comprehensive paper is included in the Reading Rooms

Key priorities to reduce *E.coli* bacteraemia for 2023/24 are:

- IPC team to work closely with the Urology CNS team to support education and awareness across Trust.
- *E. coli* focus week through "back to basics" week
- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch (ESTH digital passport already in use)
- Continence service referral pathways and standards in development across Southwest London

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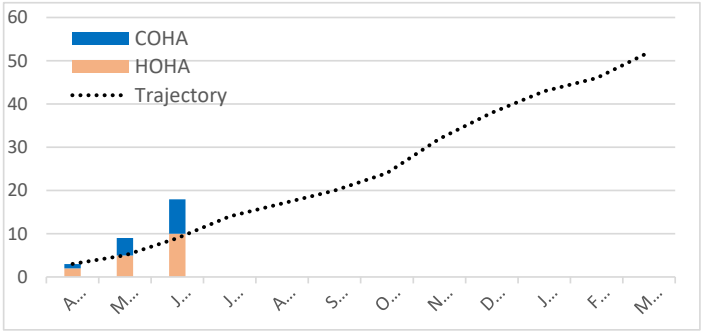
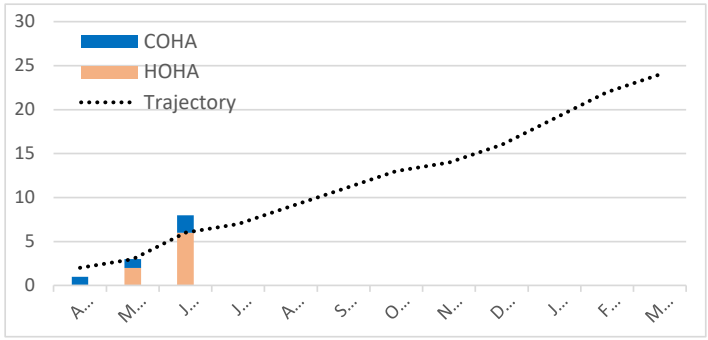
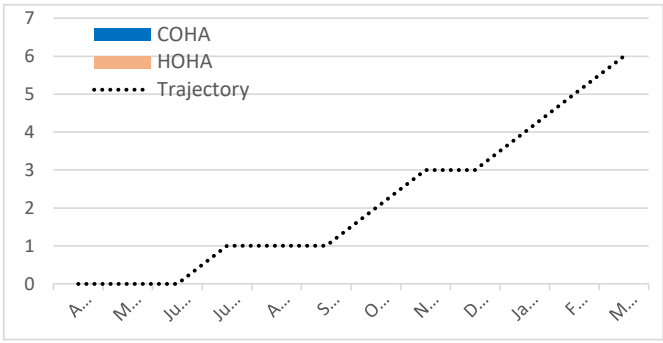
Gram negative Bloodstream Infections - ESTH



E.coli



Klebsiella spp.



Pseudomonas aeruginosa

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 of all 18 cases, the source of infection for the 9 cases in June are unknown (7), hepatobiliary (1) , Skin/soft tissue (1), urinary tract (3) and the 5 are still undergoing investigations.

Key priorities to reduce E.coli bacteraemia for 2023/24 are:

- IPC team to work closely with the Continence Lead nurse to support education and awareness around urinary catheter care/management.
- *E. coli* focus week through "back to basics" week and reintroduce digital urinary catheter care passport.
- Continence service referral pathways and standards in development across SW London
- Participate in the joint improvement plan with a focus on urinary tract infections (UTI) and catheter management with the Integrated Care Board.

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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.

ESTH: An orthopedic module for fractured neck of femur will be followed up between Oct-Dec 2023. There were no SSIs detected in the surveillance undertaken between January and March 2023 and one superficial SSI was detected between April to June 2023 and the patient required a wound washout in theatre. The SSI rate for the Trust has consistently been below the national threshold.

Due to concerns raised about post op wound infarctions in surgery, the IPC team will be undertaking an elective large bowel surgery will be undertaken in Quarter 3.

SWLEOC : undertakes continuous orthopaedic surveillance throughout the year. In 2022 there 4 hip SSI out of 1457 hip procedures, 3 SSIs out of 1563 knee procedures and 0 SSIs for both spinal and shoulder procedures.

For SGUH: As per UKHSA mandatory requirement, SGUH participates in two modules: Reduction of Long Bone Fracture and Coronary Artery Bypass Graft (CABG Data for the reduction of long bone fracture module has been submitted for Q4 (January-March 2023) at the end of June 2023.The IPC Team will begin surveillance for the new financial year at the beginning of Q2 for the months of July-September 2023.

SSI data for the coronary artery bypass graft is collected every quarter.

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IPC Related Incidents – June 2023

ESTH:

- **CPE:** A CPE outbreak was declared on Buckley ward following identification of a case as part of admission screening on a transfer from St. George's hospital in June. Four contacts were generated as part of contact tracing of which one was identified as being CPE positive. This second patient generated a further two contacts, both of which screened negative for CPE.
- It is worth noting that this second patient that screened positive had been previously nursed in a single room for several weeks; however as per ward layout and standard staff allocation on the ward, the same group of staff looking after the index case were looking after the second case. An investigation has been undertaken and concluded that this may have resulted in cross transmission due to human and environmental factors. Both patients did not require escalation of treatment and have since been discharged.

Integrated Care: There were no issues/concerns in integrated care.

SGUH:

- **CPE**: There was one CPE case found to be positive on admission screen at Epsom, after transfer from SGH in June (E.coli, NDM gene). This caused the closure of one bay on Florence Nightingale ward and generated 3 inpatient contacts. Contacts were screened and all patients were found to be negative showing that no transmission had occurred on the ward/bay.

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Hand Hygiene Compliance

ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH
97%	100%	100%	98%

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.

For both Trusts: Areas of low compliance are followed up by the site Chief Nursing Officers who are responsible for operational delivery of IPC. . Adhoc hand hygiene audits and spot checks are undertaken in the areas of low compliance by the IPC nurses.

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Fit Testing and IPC Mandatory Training Compliance

	ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH CWDT	SGUH MEDCARD	SGUH SNCT
Clinical Staff	89%	87%	90%	85%	85%	84%
Non-clinical staff	75%	86%	91%	91%	86%	89%
Fit Testing	**ESTH Total 2982**			**SGUH Total 3423**		

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, 2982 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. No new fit testers have been recruited and this has resulted in limited fit testing for the month of June 2023.
Total number of staff fit tested on the latest mask model: 3423 .

For both Trusts: IPC mandatory training and monitoring of compliance remains poor despite continued efforts by the IPC team to provide targeted/local training. At ESTH the current compliance per Division has been shared with the Site CNOs and CMOs to help with directorate/divisional accountability. Targeted face to face training has been offered to Divisions where staffing issues have been cited as a contribution to low compliance. Face to face training will continue to be offered as part of back to basics week

SW London Infection Prevention Control (IPC) April-May 2023

Table 1 sets out healthcare associated infections (HCAI) reported for 1st April 2023- 31st May2023 in SW London Trusts against the annual NHSE set thresholds.

St Georges NHS Trust is exceeding the thresholds for all gram negative bloodsteam infections (GNBSI's) and Clostridium difficile infections. Post infection reviews identify multifactorial factors including late presentation, sicker patients possibly due to pandemic. Modifiable practice AMR stewardship, review of catheter associated infections and other UTI's and hand hygiene. SGH have reported no MRSA infections for this period.

- Gram negative bloodstream infections (GNBSI's) are increasing nationally rates particularly E-coli. There is a national and London review of GNBSI's . SW London are hosting a 2 year national hydration pilot with aim to reduce admissions with UTI's and Ecoli infections

Table 1 **Apr – May 23 against year thresholds**	**Croydon NHST**	**E&SH NHST**	**Kingston FT**	**SGH**	**RMH**
MRSA	0	1	0	0	0
MSSA	3	5	3	3	5
CDI	5/19 (26.3%)	9/38 (23.7%)	6/26 (23.07%)	9/42 (21.4%)	7/51 (13.7%)
E-coli	5/40 (12.5%)	9/52 (17.3%)	10/29 (34.5%)	25/88 (28.4%)	8/44 (18.2%)
Pseud A	4/9 (44.4%)	0/6	5/7 (71.4%)	7/25 (28.0%)	4/14 (28.6%)
Klebsiella	5/26 (19.2%)	3/24 (12.5%)	3/16 (18.7%)	10/58 (17.24%)	4/19 (21.0%)

SW London Infection Prevention Control (IPC) April-May 2023

Table 2 shows how SWL ICS performed alongside other London ICS's and the NHSE set thresholds. Unlike the Trusts, the ICS cases include all reported infections including community apportioned cases

All London ICS's apart from SWL are flagging red for CDI. Gram negative bloodstream infections .GNBSI are increasing nationally. Joint national work underway finding that increases in GNBSI's and CDI related to ITU activity, water related and PPE usage.. Thresholds are set by NHSE taking the lowest number of cases reported for the previous 2 years

- There appears to be a national seasonality to cases of GNBSI's with most cases reported between July and September.

Table 2	C-difficile	MRSA	MSSA	E-coli	Pseud A	Klebsiella sp.
SWL	39/246 (15.8%)	3	44	135/654 (20.6%)	25/104 (24.0%)	48/259 (18.5%)
SEL	56/275 (20.4%)	6	62	170/857 (19.8%)	25/149 (16.8%)	56/378 (14.8%)
NEL	58/246 (23.6%)	6	69	183/914 (20.0%)	33/148 (22.3%)	78/418 (18.7%)
NCL	50/297 (16.8%)	3	43	132/711 (18.6%)	31/131 (23.7%)	57/288 (19.8%)
NWL	65/343 (18.9%)	8	68	231/1,089 (21.2%)	22/169 (13.0%)	57/414 (13.8%)

Other IPC Issues/ Concerns for SW London

Water quality concerns identified at several healthcare premises. Legionella identified in high counts at the Nelson hospital and most recently St Johns Therapy centre. Both premises are owned by Fulcrum and are sublet by the head tenants CHP. Water Safety Group established and escalated to Health Protection team at South London UKHSA. Action plan has been developed and is under review. No related Legionella cases identified by UKHSA. Scarlett fever, iGAS and influenza now returned to normal seasonal levels. Covid Spring vaccination programme closes on 30 June.

APPENDIX 2

Clostridioides difficile and E-Coli

IPC Review

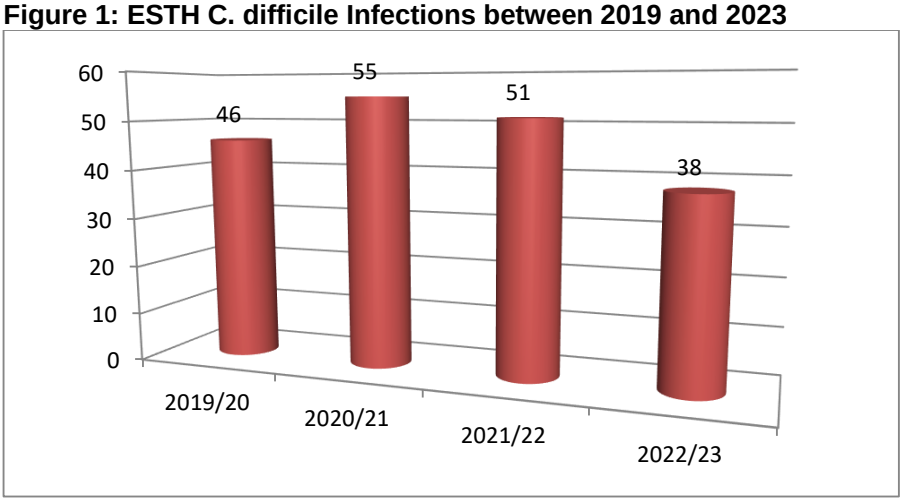
1.0 ESTH Clostridioides difficile Infections, April – June 2023

1.1 Background

Clostridioides difficile is a bacterium that may colonise healthy individual's gut, where it causes no symptoms (up to 3% of adults and 66% of babies). *C. difficile* causes disease when the normal gut flora is suppressed, usually by exposure to broad spectrum antibiotics.

Various interventions such as antimicrobial stewardship, improved diagnostics and infection prevention & control practices have helped achieve significant reductions in the incidence of *C. difficile* infection (CDI) in the last few years, see (Figure 1).

Figure 1: ESTH C. difficile Infections between 2019 and 2023



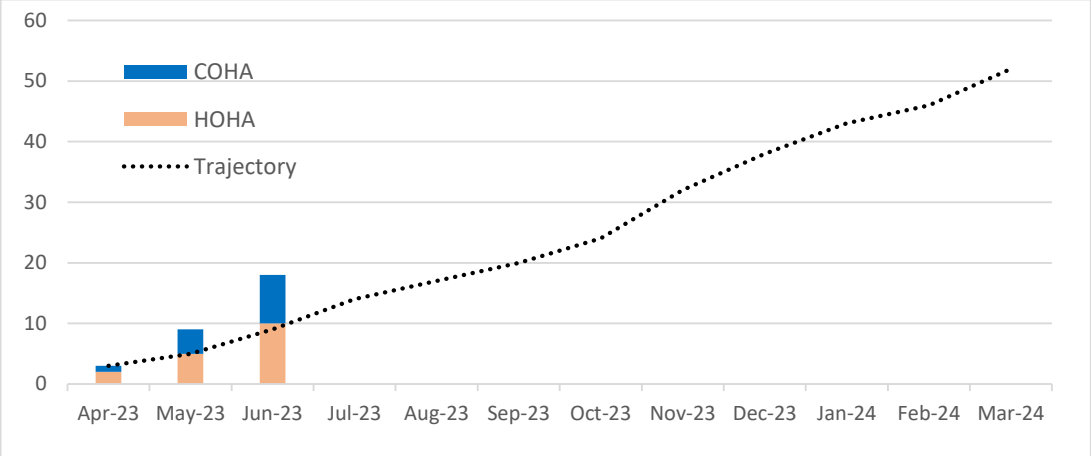
CDI cases are reported and apportioned to a Trust using the following criteria:

- Hospital onset healthcare associated (HOHA) - cases that are detected in the hospital two or more days after admission
- Community onset healthcare associated (COHA) - cases that occur in the community (or within two days of admission) when the patient has been an inpatient in the Trust reporting the case in the previous four weeks.

All cases in the above category count towards the overall Trust national objective. The national objective for the Trust for 2023/24 has been reduced from last year's objective of 51 to 38 cases.

In Quarter 1 (April-June) 2023, there were 11 cases apportioned to the Trust compared with the same period last year when there were 17 CDI cases.
Although we breached our local cumulative trajectory in April/May, by the end of June 2023 we had achieved the set local target of 11 cases. **Table 1** below shows a summary of cases to date.

Table 1: C difficile infections: April-June 2023



1.2 Case Reviews and Analysis

To enable a greater understanding of the causes of individual cases and to determine whether there were any lapses in the quality of care provided in each case, a comprehensive strategy is in place to review all cases across the Trust to reduce CDI transmission. All cases are reviewed by a multi-disciplinary team and the review enables the team to discuss the implementation of actions and necessary steps to address any problems identified the review is shared widely to avoid future recurrence. **Table 2** below shows a summary of the cases and risks/themes identified.

Table 2: RCA Analysis/Summary

Case	C diff Category	Division	Risk factors	Findings
1	COHA	N/A	• GP specimen. • Recent discharge from Royal Marsden prior to ESTH admission with sepsis. • Complex medical background • history of prolonged use of antibiotics	• N/A
2	COHA	N/A	• GP specimen • Frequent hospitalisations • Prolonged use of proton pump inhibitors (PPI) which can increase the risk of C diff	• N/A
3	HOHA	Medicine (C3)	• long-term use of PPIs • long term use of laxatives (known alcohol cirrhosis) • colorectal cancer	• Not isolated within 2 hours of onset of diarrhoea.

4	HOHA	Medicine (Buckley)	• recent cancer diagnosis and ongoing issues with constipation	• Delay in sending a sample, 4 days after onset of diarrhea. • Not isolated within 2 hours of onset of diarrhoea.
5	HOHA	Medicine (Gloucester)	• Prolonged use of antibiotics due to empyema and gastric cancer.	• Lack of isolation rooms • High level of acuity therefore patient was not isolated at the time stool sample was collected. • All IPC precautions were in place at the bedside include enhanced cleaning.
6	HOHA	Medicine (Croft)	• Care home patient with multiple comorbidities history of constipation • Prolonged laxative use.	• All IPC measures implemented in a timely manner.
7	HOHA	Medicine (STH – AMU)	• Prolonged hospital stay • Prolonged use of antibiotics	• Lack of documentation/IPC risk assessment not completed.
8	HOHA	Medicine (C1)	• Admitted with chest infection and a history of breast cancer.	• delay in starting C diff treatment delay in sampling (72 hours after onset of diarrhea) • No IPC precautions put into place • Delay in isolation **Lapse in care**
9	HOHA	Medicine (Buckley)	• Prolonged hospital admission • exposure to multiple antibiotics • Prolonged use of PPI	• All IPC measures implemented in a timely manner
10	HOHA	Medicine (C5)	• Admitted with diarrhoea. • Several hospital admissions • prolonged courses of antibiotics • Long term use of PPI	• Delay in sampling • Poor documentation
11	HOHA	Medicine (Croft)	• Transfer from SGH post craniotomy. Prolonged use of laxatives • Recent hospital admission.	• Poor documentation

The review shows that there were various risk factors that may have contributed to CDI with recent and or frequent hospitalisations being the most recurring theme for all cases.
Recent hospitalisation and exposure to antibiotics are two of the biggest risk factors for the development of CDI. Age (> 65 years) and gastric-acid suppression (use of PPIs) are also known to increase the risk of developing CDI.

The most common themes/risk factors are:

- Multiple comorbidities
- Prolonged use antibiotics
- Prolonged use of PPI
- Long hospital stay
- Frequent hospital admissions
- Age (all patients were above 66)

As part of the review, poor documentation, delays in sampling and in isolation were identified as non-causative factors which are not thought to have contributed to acquisition of CDI in these patients. All cases were within Medicine division and only two cases were on the same ward (Croft, April and May) but there was no pathway crossover.

In June there was one case associated with a lapse in care due to significant delay in commencing CDI treatment. Treatment was commenced on the third day after results being known. At the time of writing this paper, the patient had fully recovered and remained as inpatient to social issues.

1.3 Operational Issues
The operational pressures posed with managing and segregating Covid-19 patients has had an impact on how as an organisation we managed and prioritised the use of single rooms. Despite a move to the Covid-19 recovery programme and reduced community prevalence, to reduce the spread of Covid, where cohorting was not suitable, suspected/confirmed Covid-19 patients continue occupied the largest proportion of single rooms in the Trust.

Due to competing priorities for isolation rooms for the above and other multi resistant organisms, this resulted in delays in isolating patients who developed diarrhoea of unknown cause and implementation of IPC precautions in a timely manner, thus potentially increasing the risk of cross transmission to other patients.

1.4 Actions / Interventions
The Trust has achieved a significant reduction in healthcare associated CDI cases over several years. CDI cases between April to June were within the trajectory; however we must remain vigilant to reduce the risk of infection and also achieve the significantly reduced national objective for this financial year.
To help improve practice and compliance, in addition to training and sharing of lessons learned from the joint multi-disciplinary review of CDI cases the focus will remain on the following key points:

- Continue to build on what was achieved in previous years and ensure plans are in place to review and monitor the Trust's antimicrobial policy compliance including robust prescribing practice to reduce the risk of CDI and other multi resistant organisms.
- Continue to build awareness and appropriate management of diarrhoea across the Trust.
- Ongoing plans to introduce AMS training to all clinicians, registered nurses and allied health professionals as part of mandatory training.
- Use of hydrogen peroxide vapour (HPV) to decontaminate the environment and patient equipment post CDI transfers/discharges.
- A weekly multi-disciplinary CDI ward round to review and ensure patients are on the appropriate treatment led by the Consultant Medical Microbiologist/Lead Infection Control Doctor, Consultant Gastroenterologist, Antimicrobial Pharmacist, Dietician and an Infection Control Nurse.
- Comprehensive reviews of all CDI cases to determine if any cases may be linked to a lapse in the quality of care provided and ensuring that agreed action plans or lessons learned are taken forward.

- A new short summary/feedback report with lessons learned has been created which is shared with clinical staff following a CDI.

The week beginning 24 July, the IPC team will be having a “back to basics” week with a particular focus on the current key issues/areas of concerns in IPC. In addition to other subject areas, the awareness/campaign will focus on staff training on the importance of early recognition of CDI, timely laboratory investigation for CDI, correct sampling and implementation of appropriate IPC precautions including timely isolation of patients with diarrhoea.

The Trust Antimicrobial Consultant Microbiologist has written a report detailing the antimicrobial stewardship which will be presented at the Infection Prevention & Control Committee and shared with other relevant committees including the group Quality in Common Committee (QiCC).

2.0 SGUH C. *difficile* infection – Root Cause Analysis

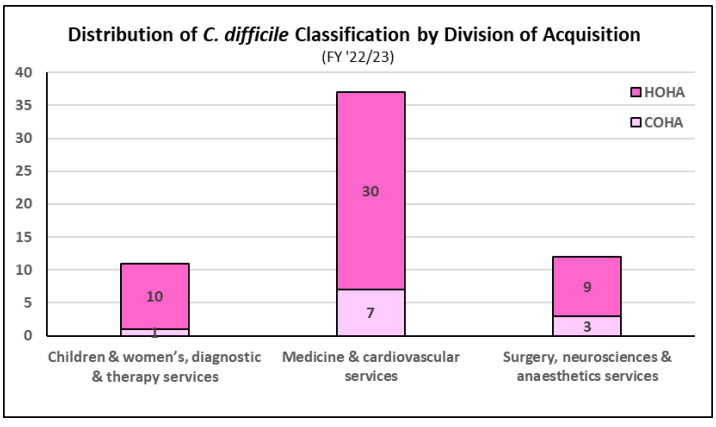
2.1 Analysis of Clostridioides difficile RCAs 2022/23:

The Trust has and continues to review all cases through Root Cause Analysis (RCA) to identify any potential lapses in care or any common themes that may have contributed to the C. diff infection. The Trust reports all cases of C. diff diagnosed in the hospital laboratory to NHS England using the following definitions:

- 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)—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)

By the end of the 2022-23 financial year, there were 60 cases apportioned to the Trust (49 HOHA; 11 COHA) which is above the set NHSE trajectory of 43 cases. These 60 cases were evenly distributed between Surgery and Children and Women’s division (12 and 11 cases respectively) with the majority of cases falling under the MedCard division (37 cases) (Figure 2).

Figure 2: C. diff Distribution by Division of Acquisition



A further breakdown of the 60 cases by ward of acquisition highlights six wards with an above average number of C. diff cases (average=2). Five of which are a part of the MedCard division and one a part of Children and Women's division (Figure 3).

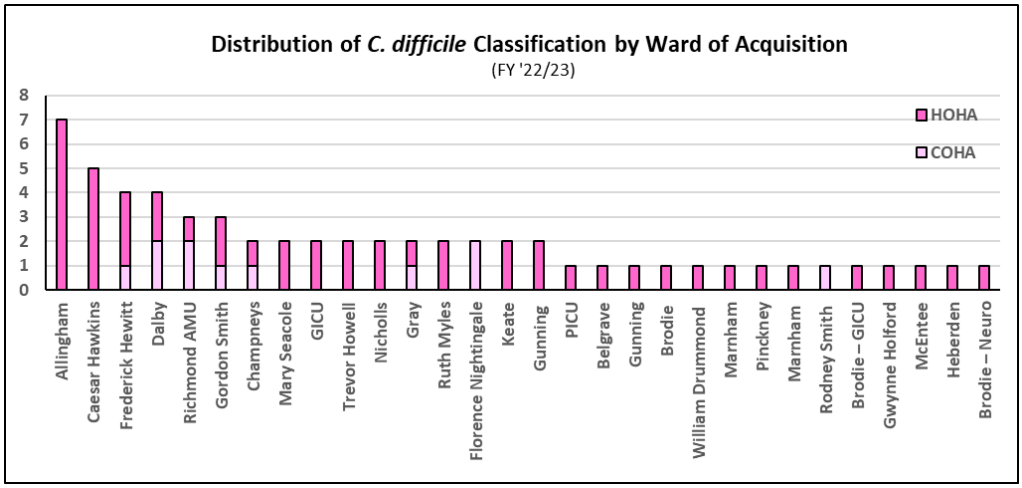
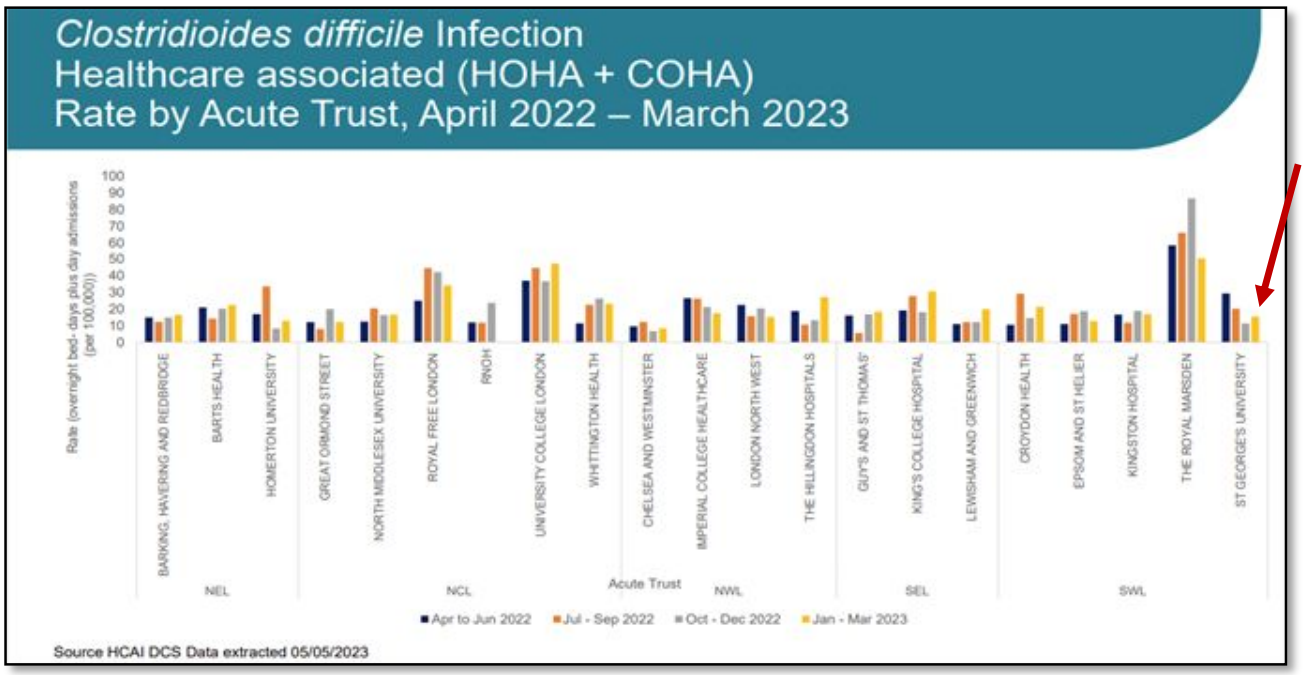


Figure 3: C. diff Distribution by Ward of Acquisition A comparative look at the rate of C. diff between St.

George's against other Acute Trusts, suggest that—although we have ended the financial year above NHSE trajectory—the Trust is not an outlier and falls within the median. In addition, around 14 other Acute Trusts have ended the financial year above trajectory, suggesting an overall rise in the overall incidence and prevalence of C. diff. (see figure 4).

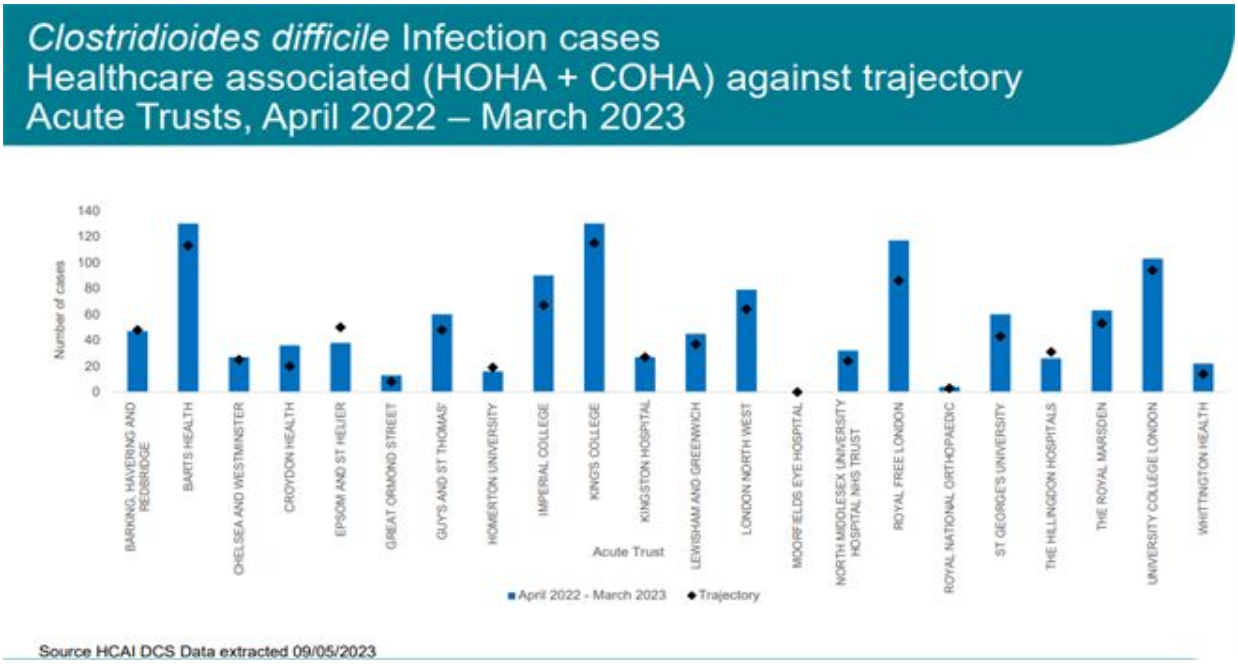
Figure 4: National C. diff Rates



It should be noted that thresholds were set based on historical figures for each healthcare organisation rather than the numbers of beds or complexity of the patients. It is possible that the Trust has a challenging CDI

trajectory because the Trust made strenuous efforts to control the infection in the years leading up to the trajectory being set, so the baseline was already low, (see figure 5).

Figure 5: CDI Acute Trusts April 2022 - March 2023 against trajectory.



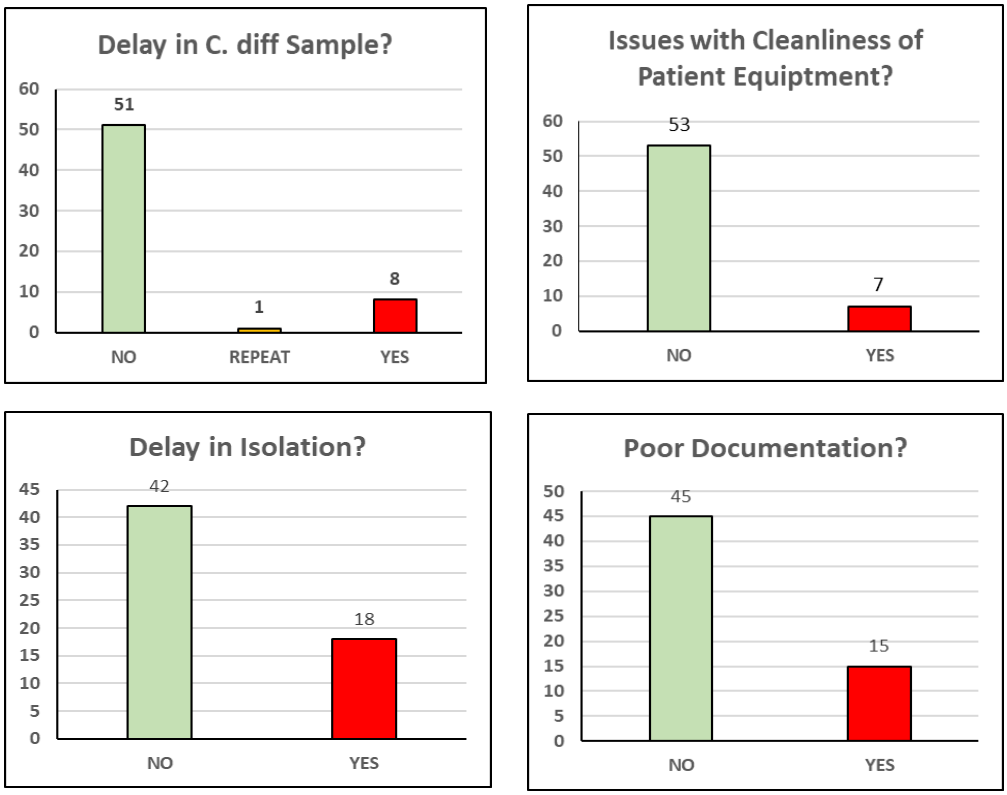
2.2 RCA Case Reviews

As per CDI standard operating procedure (SOP), cases of *Clostridioides difficile* meeting the criteria for external reporting are subject to a root cause analysis (RCA). All isolates of *C difficile* are also sent for ribotyping to look for any evidence of cross-infection and outbreaks. Following an initial review of the patient by micro and a ward round by IPC, the RCA is sent to the antimicrobial pharmacist for review. Once returned, feedback is given to the relevant nursing and medical teams with an opportunity to provide any additional comments on the RCA with regard to the case and findings. After the RCA is finally returned, it is then to be reviewed by IPC and the Infection Control Doctor (or available microbiologist). This has, at times, been difficult to achieve due to competing demands. Outcomes of RCA are noted at the Infection Prevention & Control Committee.

Most CDI cases have now been reviewed (58/60) to ascertain if there were any causative lapses in care e.g., inappropriate antimicrobial prescribing or serious lapses in environmental or medical devices cleaning which may have led to the acquisition of the case. However, most cases are likely to be attributable to the administration of appropriate antibiotics to patients with infections that were not preventable, and potentially life threatening if not treated with antibiotics.

An in-depth review of the key points and findings of the C. diff RCAs revealed key themes such as—10 of the 60 patients were admitted with diarrhoea, of which 4 were categorized as HOHA. Therefore, the importance a timely medical review of the patient and prompt sending of a stool sample before the 3-day mark can potentially reduce the number of cases apportioned to the Trust and therefore should be reiterated to staff members. In addition, four non-causative themes (sub-optimal practices that are unlikely to have led to acquisition of CDI) were identified and two were determined to be an area of concern: documentation issues and isolation of C. diff patients within 2 hours of suspected infectious diarrhoea (Figure 6).

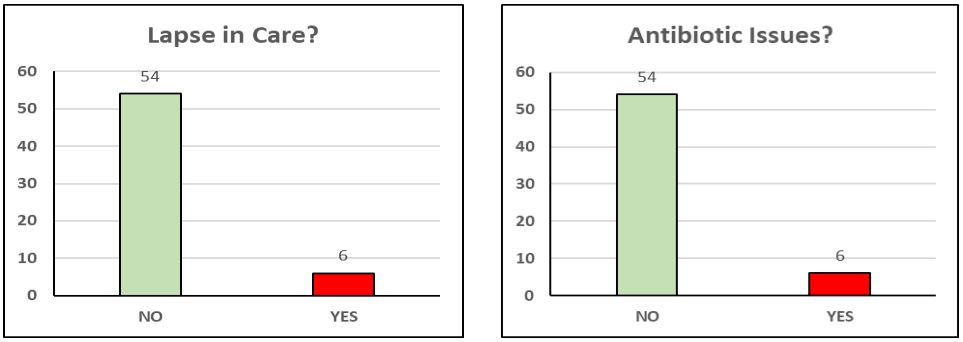
Figure 6: Non-causative Themes Identified



Of the 15 RCAs that highlight issues with documentation, the vast majority of them singled out an inconsistent stool chart. An inconsistent stool chart hinders the timely collection of appropriate stool samples from patients with signs and symptoms of C. diff, which is important to identify community-onset cases accurately. The second issue, delay in isolation, occurred in 18 of the 60 cases. The most common reason for the delay was a lack of side room availability.

2.3 Lapses in Care – Of the 58/60 cases reviewed so far, 6 were identified to be a lapse in care mostly in part due to the inappropriate use of antibiotics, which may have potentially been causative of the infection. One of the lapses in care was in relation to prescribing antimicrobial therapy to a microbiology result and not necessarily to the clinical picture of the patient. Each lapse is subject to a multidisciplinary meeting chaired by the Infection Control Doctor. The lapse may be challenged by the clinical team if it can be demonstrated the antimicrobial therapy was necessary. MDT meetings were held for two of these but unfortunately the relevant medical staff did not attend. Invites were sent for two other cases but no response received.

Figure 7: Lapses in Care



2.4 Period of increased surveillance and audit (PISA)

All wards where a CDI HOHA occurred and the patient has been thought to have acquired *Clostridium difficile*, undergo a period of increased surveillance and audit (PISA). This audit tool allows for observation of the management of patients with the infection and others with suspected infections including documentation of medical reviews, hand hygiene, Personal Protective Equipment (PPE), screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment (including commodes), management of clean linen and venous access devices (for MRSA) are also all audited during the PISA process. The ward must achieve 95% or above to pass PISA and if the first audit results in a pass, no further audits are required. If the first week is failed, then there must be 3 consecutive weeks of pass to be removed from the PISA process. This process allows for an ongoing focus on infection prevention & control issues where required and as an opportunity to escalate concerns where they are not resolved at local level.

2.5 Actions / Recommendations

Moving forward, the IPC Team will continue to work to reduce the cases of C difficile. This relies upon good antimicrobial stewardship (AMS), the earliest detection of possible C.difficile case and prompt isolation of patients with diarrhoea. All positive C. difficile stool samples will continued to be phoned out to the ward, and documented on iCLIP—by the IPC Team/Micro—as soon as they are available to suggest the proper infection control precautions and advice on the most appropriate antibiotic based on the clinical scenario. Improvement with regard to environmental cleaning, good hand hygiene technique and practice will help in reduce cases overall.

- Complete the review of all RCAs to identify any themes or lapses in care. Feedback via Divisions.

- Where 'Lapse in Care' has been identified, it is suggested these should be presented via the Care Group **Morbidity and Mortality** meetings and integrate into the clinical governance process.

- Review arrangements for the AMS committee especially around senior representation– Medical Director or AMD to provide senior leadership support and direction.
- 'Getting Back to Basics' Campaign: A meeting to discuss this workgroup and streams took place 7th June 2023. These workgroups will be overseen by a steering group.

  The following four streams have been identified:
  - Urinary Catheter care
  - *C. difficile* and AMS
  - Central and peripheral vascular access line care
  - Back to Basics – hand hygiene, Bare Below Elbows, Cleaning – environmental and equipment

3.0 Conclusion

Although the rate of improvement for CDI has slowed down over the years, it is worth noting that some infections are a consequence of factors outside the control of the Trust. UK Health Security Agency (UKHSA) has published reports showing great improvements in reducing CDI rates with some publications reporting that the "*NHS has reached an irreducible minimum level at which infections may occur regardless of the IPC practices in place*".

It may be challenging to continue to achieve further reductions as number of infections/ cases becomes smaller and smaller (with an objective of 38), especially as most of these infections occur in patients with multiple comorbidities who would have received clinically indicated antimicrobial therapy.

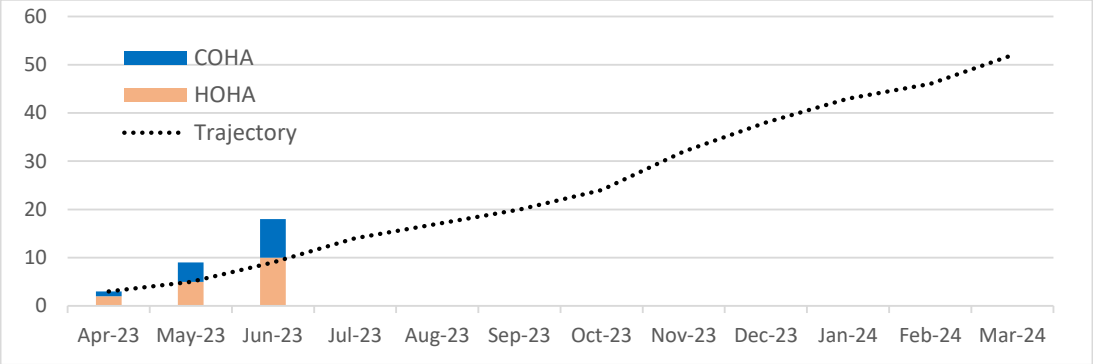
However continued and proactive efforts to prevent avoidable CDI are critical and the Trust must continue to ensure infections remain within reasonable limits.

4.0 ESTH E.coli Bloodstream Infections April to June 2023

There were 9 cases of E.coli bloodstream infections in June (4 COHA and 6 HOHA) and YTD is 18. Source of infection varies between each case and it is difficult to know the source of infection due to different factors such as inability to access community healthcare records. Some of the COHA cases, the patient had only been in our hospital for less than 8 hours but due the COHA definition, this counts towards our Trust cases. Following review, of the 18 cases, source of infection in 7 of the cases is unknown, 3 urinary tract infection, 1 skin/soft tissue, 1 hepatobiliary and the remainder were still under investigation at the time of writing the report

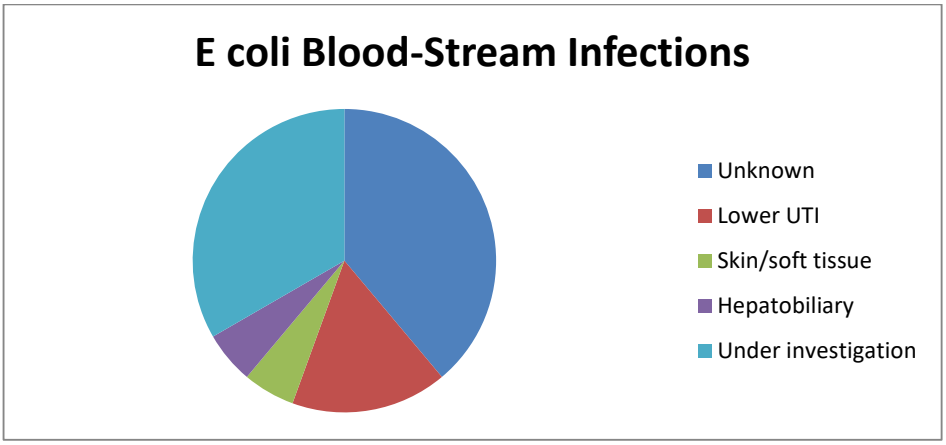
It should be noted that the highest burden of *E coli* BSIs is deemed as community onset and these are followed up by the ICB IPC team.

E.coli Cases: April – June 2023



The ICNs undertake review and identify risk factors for all Trust apportioned *E coli* bloodstream infections. There were 18 Trust apportioned *E coli* BSIs and 62 community onset *E coli* BSIs. **Figure 8** below shows the likely source of infection in the cases reviewed by the ICNs from April to June 2023.

Figure 8: Likely Source of E coli Blood-Stream Infections April-June 2023 (n=18).



Actions to reduce *E.coli* bloodstream infections at ESTH in 2023-24:

- There was a proposal to have a joint improvement plan with a focus on urinary tract infections (UTI) and catheter management with the Integrated Care Board (led by the ICB Infection Control Nurse); however this has not been implemented yet. Working with the ICB would help us manage the patient pathway and the interface between acute and community settings.
- Back to basics week with a focus on urinary catheter care and use of catheter passport. This is a joint project with the Continence lead nurse.
- Participate in the sector wide plan to reduce infections

5.0 SGUH Analysis of *E. coli* cases 2022/23:

The Trust has and continues to see an increase in *E. coli* bacteraemia cases. The IPC team continues to investigate and collect data by source. The Trust reports all cases of *E. coli* diagnosed in the hospital laboratory to NHS England using the following definitions:

- 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)—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)

By the end of the 2022-23 financial year, there were 105 cases apportioned to the Trust (74 HOHA; 31 COHA) which is above the set NHSE trajectory of 93 cases. The Trust was therefore over trajectory.

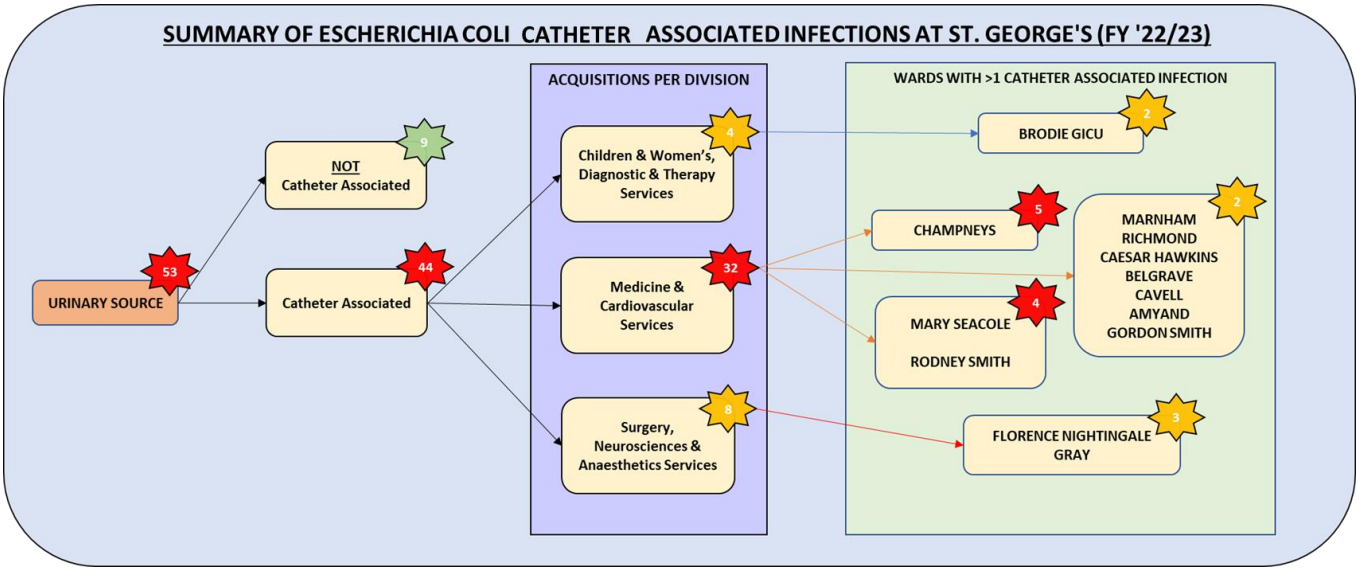
Analysis of these cases identified a majority with urine as the source (Table 3). Of the 53 cases where urine was identified as the source, 44 were further identified as catheter associated – the majority of these cases falling under the Med Card division (32 cases) with the following wards having the highest rates: Champneys, Mary Seacole, and Rodney Smith (Figure 9).

Table 3: *E. coli Source data for April 2022 – June 2023*

E. COLI			
2022-23			
Trajectory	93		**Percentages**
Total	105	Of 93	112.9%
Urine Source	53	Of 105	50.5%
Catheter Associated	44	Of 53	83.0%
2023-24			
Trajectory	88		**Percentages**
Total	28	Of 88	31.8%
Urine Source	10	Of 28	35.7%
Catheter Associated	8	Of 10	80.0%

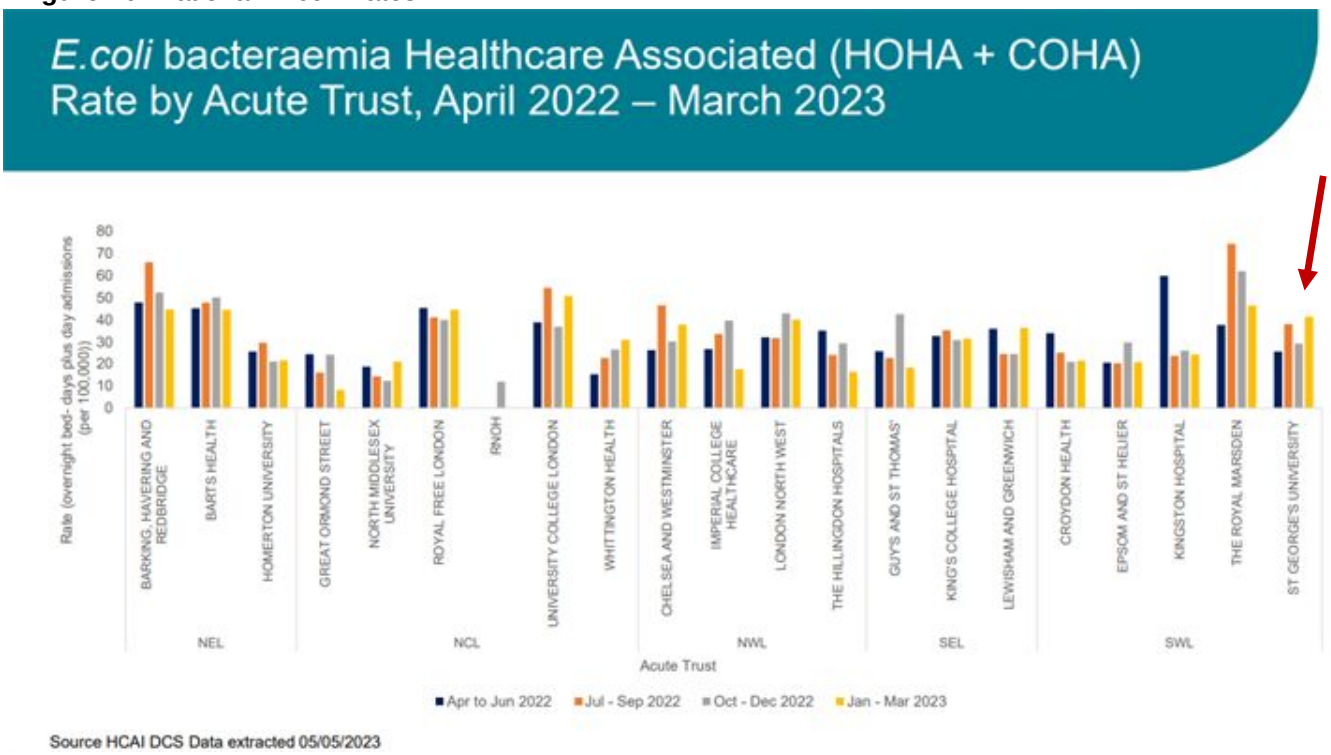
Brodie GICU/GICU—possible area of concern with a total of 5 catheter associated infections during 22/23

Figure 9: *Summary of E. coli Catheter Infection (2022-23)*



A comparative look at the rate of *E. coli* bacteraemia between St. George's against other Acute Trusts, suggest that—although we have ended the financial year above NHSE trajectory—the Trust is not an outlier and falls within the median (Figure 10).

Figure 10: National *E. coli* Rates



5.1 Actions / Recommendations around E. coli - Key priorities for SGUH site for 2023-24

- IPC team to work closely with the Urology CNS team to support education and awareness across trust.
- E. coli/catheter care focus week through senior nurses Back 2 the Floor in June with QI approach
- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch.
- Continence service referral pathways and standards in development across Southwest London.
- Southwest London IPC sector to focus on gram negative bacteraemia with a group approach.
- NHS England 2-year hydration project focusing on community and elderly care. SW London awarded London's Aquarate - a bid to introduce a digital Hydrracup cup and mug across care homes and virtual wards in SW London.
- 'Getting Back to Basics' Campaign: A meeting to discuss this workgroup and streams took place 7th June 2023. These workgroups will be overseen by a steering group.
  The following four streams have been identified:
  - Urinary Catheter care
  - *C. difficile* and AMS
  - Central and peripheral vascular access line care
  - Back to Basics – hand hygiene, Bare Below Elbows, Cleaning – environmental and equipment

Group Board

Meeting in Public on Friday, 08 September 2023

Agenda Item	5.3	
Report Title	**The new Fit and Proper Persons Test Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer Paul da Gama, Group Chief People Officer	
Previously considered by	Group Executive	29 August 2023
Purpose	**For Review**	

Executive Summary

This paper provides the Group Board with an overview of the new *NHS England Fit and Proper Person Test Framework for board members*, which was published on 2 August 2023, and highlights the key changes introduced in the new framework. The new Fit and Proper Persons Test (FPPT) Framework builds on the existing system introduced in 2014 and incorporates recommendations from the Kark Review of the existing system, which was published in 2019. The key changes introduced by the new Framework are:

- New requirements on when a full FPPT assessment must be undertaken (which includes temporary appointments including acting-up arrangements of six weeks or more)
- New requirement to hold on each board member's Electronic Staff Record (ESR) information relating to the board member's employment, including upheld disciplinary, whistleblowing and employee behaviour
- New requirement for a mandatory reference for all board members (including for resignations and retirement)
- New requirements for joint appointments of board members to two or more NHS organisations

The new Framework is effective from 30 September 2023 and full implementation of the Framework is required by 31 March 2024. NHS England will require annual submissions of compliance from all NHS organisations via the relevant NHS regional director.

The FPPT policies and processes across the Group were last reviewed and updated in February 2023. Internal audits were conducted on both SGUH and ESTH systems, processes and controls and both Trusts received a 'substantial assurance' ratings in the reviews. This puts us in a good position for the introduction of the new Framework, but there will need to be adjustments of our systems, particularly to ESR, and the FPPT policy will need updating. A focused piece of work has commenced to ensure this is undertaken by the dates specified by NHS England. In the meantime, we will continue to undertake annual self-attestations of compliance for all Board members, along with the further annual check introduced over the past year. This will take place later this month (September 2023).

Action required by Group Board

The Board is asked to note the new Fit and Proper Persons Test Framework, the key changes introduced, and the high-level plans for implementation across the Group.

Committee Assurance	
Committee	Not Applicable
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

If we do not implement fully the new Fit and Proper Persons Test Framework and apply it consistently, there is a risk that directors could be appointed to the board who do not meet the required standards for appointment. This could potentially impact on patient safety and / or organisational performance and would likely trigger external regulatory intervention.

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 significant financial implications of the introduction of the new Framework. However, significant additional information is required to be held on each board member and managing this new process will require dedicated support within the Corporate Affairs directorate.

Legal and / or Regulatory implications

Full implementation of the new FPPT is mandatory and failure to do so could prompt regulatory intervention from the Care Quality Commission (CQC) or NHS England (NHSE).

Equality, diversity and inclusion implications

There are no specific equality, diversity, or inclusion implications associated with the introduction of the new FPPT Framework. However, the Framework is to be read in conjunction with the NHS People Plan, NHS Constitution, and the Nolan Principles. More broadly, it is important that we develop diverse Boards which reflect the populations we serve.

Environmental sustainability implications

There are no environmental or sustainability implications associated with the proposals in this paper.

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The new Fit and Proper Persons Test Framework

Group Board

Stephen Jones, Group Chief Corporate Affairs Officer
Paul da Gama, Group Chief People Officer

8 September 2023

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Executive Summary

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Issue

This paper provides the Group Board with an overview of the new *NHS England Fit and Proper Person Test Framework for board members*, which was published on 2 August 2023, and highlights the key changes introduced in the new framework.

Background and Context

The new Fit and Proper Persons Test (FPPT) Framework builds on the existing system introduced in 2014 and incorporates recommendations from the Kark Review of the existing system, which was published in 2019.

Key changes introduced by the new FPPT Framework

The key changes introduced by the new Framework are:

- New requirements on when a full FPPT assessment must be undertaken (which includes temporary appointments including acting-up arrangements of six weeks or more)
- New requirement to hold on each board member's Electronic Staff Record (ESR) information relating to the board member's employment, including upheld disciplinary, whistleblowing and employee behaviour
- New requirement for a mandatory reference for all board members (including for resignations and retirement)
- New requirements for joint appointments of board members to two or more NHS organisations

The new Framework is effective from 30 September 2023 and full implementation of the Framework is required by 31 March 2024. NHS England will require annual submissions of compliance from all NHS organisations via the relevant NHS regional director.

Group Readiness

The FPPT policies and processes across the Group were last reviewed and updated in February 2023. Internal audits were conducted on both SGUH and ESTH systems, processes and controls and both Trusts received a 'substantial assurance' ratings in the reviews. This puts us in a good position for the introduction of the new Framework, but there will need to be adjustments of our systems, particularly to ESR, and the FPPT policy will need updating. A focused piece of work has commenced to ensure this is undertaken by the dates specified by NHS England. In the meantime, we will continue to undertake annual self-attestations of compliance for all Board members, along with the further annual check introduced over the past year. This will take place later this month (September 2023).

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Background

Introduction of fit and proper person requirements and the Kark review

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The existing fit and proper persons framework

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In 2014, the Government introduced a 'fit and proper person' requirement which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the Care Quality Commission (CQC), which includes all provider licence holders and other NHS organisations to which licence conditions apply. These 'fit and proper person' requirement was introduced via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The Regulation 5 requirements are that:

a) The individual is of good character (whether the individual has been convicted of an offence; whether the individual has been erased, removed or struck off a register maintained by a regulator of health and social care professionals)

b) The individual has the qualifications, competence, skills and experiences that are necessary for the relevant office or position or the work for which they are employed

c) The individual is able by reason of their health of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed

d) The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity

e) None of the grounds of unfitness specified in the Regulation apply to the individual (undischarged bankrupt, subject of a bankruptcy restriction, insolvent, included in the children's or adults' barred lists for safeguarding, prohibited from holding relevant office)

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The Kark Review 2019

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In July 2018, Tom Kark KC was asked to lead The Kark Review (2019) was commissioned by the Government in July 2018 to review the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the current Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

The Review was tasked with determining whether the fit and proper person test was working in its existing form and how it might be adapted to ensure better leadership and management and prevent the employment of directors who are incompetent, misbehave or mismanage. It included looking at how effective the FPPT is "*in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors*". This followed concerns that the organisational failures at Mid Staffordshire NHS Foundation Trust and Winterbourne View Hospital was linked to the ability of poorly performing managers and directors to move between trusts.

The Review highlighted areas that it considered needed improvement to strengthen the existing regime, including seven recommendations to Government. The table opposite sets out the recommendations from the Kark review and the response from the Secretary of State for Health and Social Care.

	Recommendations	SofS response
1	All directors should meet specified standards of competence to sit on the board of any health-providing organisation. Where necessary, training should be available.	Accepted
2	That a central database of directors should be created to hold relevant information about qualifications and history.	Accepted
3	A mandatory reference requirement for each director should be introduced.	Accepted
4	The FPPT should be extended to all commissioners and other appropriate arm's length bodies.	Accepted
5	The power to disbar for serious misconduct.	Not accepted
6	Remove the words 'privy to' from regulation.	Accepted
7	Examine how FPPT works in social care.	Not accepted

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The new FPPT Framework

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The new FPPT Framework: Overview

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On 2 August 2023, NHS England published the new *Fit and Proper Persons Test Framework for board members*.

According to NHS England, the new Framework "supports the implementation of the recommendations from the Kark Review", "promotes the effectiveness of the underlying legal requirements", and "*introduce[s] a means of retaining information relating to testing the requirements of the FPPT for individual director, a set of standard competencies for all board directors, a new way of completing references with additional content whenever a director leaves an NHS board, and extension of the application to some other organisations, including NHS England and the CQC*".

The new Framework is effective from 30 September 2023 should be implemented by all boards going forward from that date. NHS organisations are not expected to collect historic information but are expected to use the Framework for all new board level appointments or promotions made and for annual assessments undertaken from the date the Framework is effective.

The Framework is to be read in conjunction with the NHS Constitution, the NHS People Plan, the People Promise, and the forthcoming NHS Leadership Competency Framework for leaders at board level. Board members are expected to demonstrate the core NHS values of: working together for patients; respect and dignity; commitment to quality of care; compassion; improving lives; everyone counts. They are also expected to abide by the 'Nolan principles', as defined by the Committee on Standards in Public life: selflessness; integrity; objectivity; accountability; openness; honesty; leadership.

The new Framework sets out:

- When the full FPPT assessment is needed
- Considerations around new appointments
- Additional considerations in relation to joint appointments
- The role of the Trust Chair in overseeing the FPPT
- The FPPT core elements to be considered in evaluating board members
- The circumstances in which there will be breaches to the core elements of the FPPT
- The requirements for a board member reference check
- The requirements for accurately maintaining FPPT information on each board member in the ESR record
- The record retention requirements
- Dispute resolution
- Quality assurance over the Framework

Ultimately accountability for adhering to the FPPT Framework resides with the Chair of the organisation. Chairs need to be able to demonstrate that appropriate systems and processes are in place to ensure that all new and existing board members are, and continue to be, fit and proper, and that no appointments breach any of he criteria of the Regulations.

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The new FPPT Framework: Key requirements

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Full FPPT assessments: Under the new Framework, a full FPPT assessment – a complete assessment by the employing organisation against the core elements (good character; possessing the qualifications, competence, skills required and experience; financial soundness – must be undertaken in the following circumstances:

1. New appointments in board member roles, whether permanent or temporary, where greater than six weeks. This includes: promotions within an NHS organisation; temporary appointments (including secondments) involving acting up into a board role on a non-permanent basis; existing board members at one NHS organisation who move to another NHS organisation in the role of a board member; individuals who join an NHS organisation in the role of a board member for the first time from an organisation outside the NHS.

2. When an individual board member changes role within their current NHS organisation (e.g. if an existing board member moves into a new board role that requires a different skillset).

3. Annually, that is, within a 12-month period of the date of the previous FPPT to review for any changes in the previous 12 months.

Self-attestations: Every board member is required to complete an annual self-attestation, to confirm that they are in adherence with the FPPT requirements.

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The new FPPT Framework: Key requirements

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Entry onto ESR: As part of the Framework, there will be an obligation to ensure we are formally capturing FPPT information – and wider information to support recruitment referencing and ongoing development of board members – and entering this onto board members' ESR records.

- Information held in ESR: The Framework sets out what must be collated on ESR, which will include information obtained both as part of the recruitment cycle, as well as through the yearly attestations/checks that all board members must provide. The information held on ERS includes:

Information held on ESR		
• Full name • Organisation (current employer) • Staff group • Job title (current job description) • Occupation code • Position title • Employment history (including details of all job titles, organisation departments, dates and role descriptions) • Training and development • References (from previous employers. And board member references including for resignations or early retirement)	• Last appraisal date • Disciplinary findings (any upheld finding under trust policies concerning behaviour, such as misconduct or mismanagement, inc. grievances upheld against board member, upheld whistleblowing claims against the board member or employee behaviour • Any ongoing on discontinued investigations relating to disciplinary / grievance / whistleblowing / employee behaviour should be recorded.	• Type of DBS disclosed • Date DBS received • Disqualified directors check • Date of medical clearance • Date of professional register check • Insolvency check • Self-attestation form signed • Social media check • Employment tribunal judgement check • Disqualification from being a charity trustee check • Board member reference • Sign-off by Chair / CEO

- Access to information held in ESR: The Framework sets out that information held on ESR regarding FPPT compliance for board members should be accessible to a limited number of people, defined by the Framework as typically including the Chair, Chief Executive, Senior Independent Director, Deputy Chair, Company Secretary, HR Director. Access will also be provided to relevant individuals within the CQC at a local level, where this information is necessary for their roles. There will be no access to board members FPPT information in one organisation by another organisation and there is no public register.

- Accountability for maintaining up-to-date information in ESR: The Chair will be accountable for ensuring information held in ESR under the Framework is up-to-date, and will be supported in this by the Company Secretary. NHS England Regional Directors will take on an oversight role to ensure individual NHS organisations are completing their FFPT, and this will involve NHS organisations making annual submissions to the NHS Regional Directors.

- Dispute resolution: Where a board member identified an issue with the data held on them relating to FPPT, they can request a review. Where this does not lead to a satisfactory resolution, there are further escalations internally and externally that can be made.

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The new FPPT Framework: Key requirements

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Established practices for joint appointments: As part of the Framework, there is now additional guidance provided for joint appointments, both for:

- Situations where two or more NHS organisations want to employ an individual to work across the different NHS organisations in the same role: the host/employing NHS organisation, when conducting their assessment will need input from the Chair of the other contracting NHS organisation. The host/employing NHS organisation will then provide a "letter of confirmation" to the other contracting NHS organisation to confirm the board member has met the requirements of the FPPT.
- When two or more organisations employ or appoint an individual for two or more separate roles at the same time: Each organisation has a responsibility to complete the FPPT.

Mandatory Board Member references: A board member reference is being introduced as part of the Framework and must be completed when a board member leaves the organisation (even if retiring) and saved to file in the event it is requested for a subsequent new board appointment at another organisation. The reference should reflect:

- The six competency domains in the Leadership Competency framework (which should be the basis of appraising board members);
- Appraisals from the last 3 years;
- Details of any serious complaints, disciplinaries, concerns over fitness and propriety.

The Framework also provides guidance on the references that we can expect to receive for any new appointments and a template is provided that will be reviewed. We will work with the SWL Recruitment hub on this.

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Governance and Assurance

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External assurance

- CQC: As part of Well-Led reviews, the CQC will consider the quality of processes and controls supporting FPPT, the quality of individual FPPT assessments, board member references, collation and quality of data within the database and local FPPT records. The CQC may intervene where there is evidence that proper processes have not been followed or are not in place for FPPT.

- NHS England: NHSE will have oversight through receipt and review of the annual FPPT submissions to NHSE Regional Directors.

- Internal Audit / External Review: Every three years, NHS organisations will be expected to have an internal audit to assess the processes, controls and compliance supporting the FPPT assessments. This will include sample testing of FPPT assessments and documentation.

Internal governance and assurance

- Organisations are expected to be clear about the reporting arrangements across the FPPT cycle. The Framework states that this is likely to include:

    - an update to a meeting of the board in public to confirm that the requirements for FPPT assessment have been satisfied at least annually;
    - consideration by the Audit Committee, e.g. where there is a related internal or external audit review included in the audit programme
    - providing relevant information to the Council of Governors for NHS Foundation Trusts

- For NHS Foundation Trusts, the Council of Governors continues to make Chair and NED appointments, and the initial FPPT assessment will now be included alongside existing recruitment checks. Information relating to performance appraisals of the Chair and NEDs will continue to be shared with the Council of Governors, and this will include the new competency framework which is being introduced in the coming months. The Council of Governors should also be advised of any outcome from a NED FPPT assessment as 'not fit and proper'. The Framework states that the Council should receive support from the Senior Independent Director or Company Secretary and use the governance arrangements already in place at their trusts, such as the Nomination and Remuneration Committee.

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New Fit and Proper Persons Test Process

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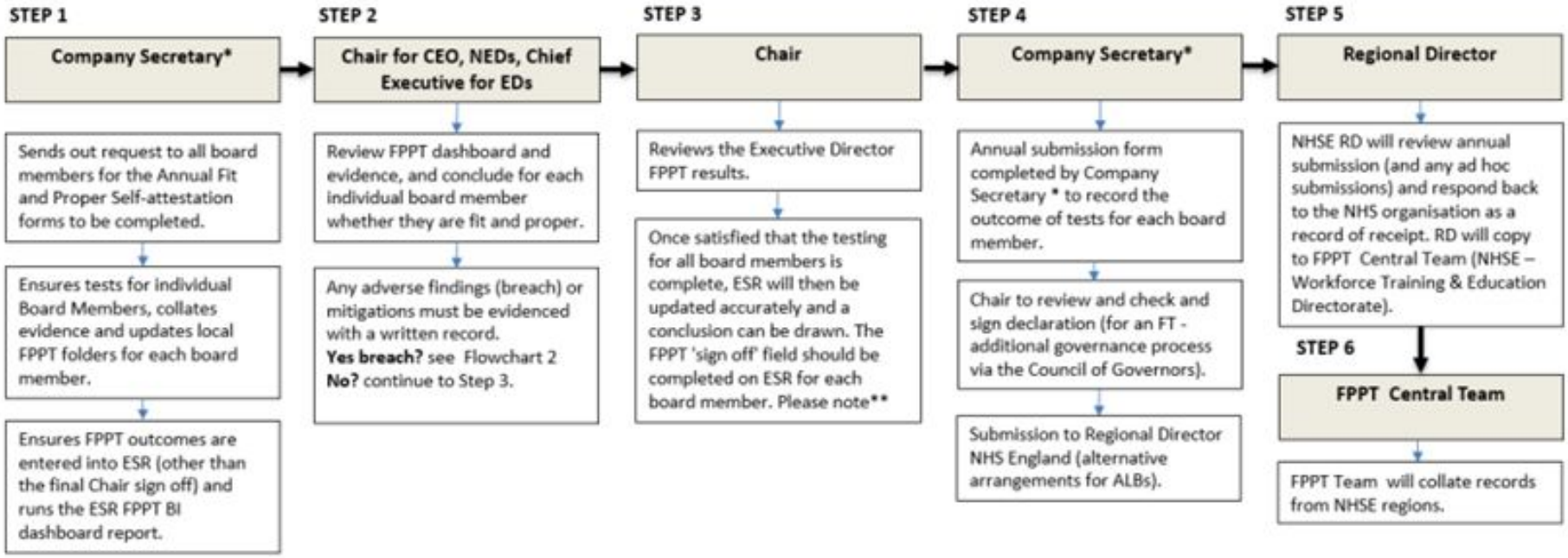
The Framework also sets out a step-by-step process for organisations to follow in undertaking FPPT assessments:



*Or senior member of staff nominated by and behalf of, the Chair, eg HRD
** SID/Deputy Chair to carry out FPPT on the Chair and 'sign off'
SID = Senior Independent Director
ESR= Electronic Staff Record

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Timescales for implementation

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NHS England has set the following timelines on the implementation of the new FPPT Framework:

As soon as possible	•Communicate with all Board members whose details will be included in ESR for the purpose of FPPT
From 30 September 2023	•Use the new Board member reference template for references of all new Board appointments •Complete and retain locally the new Board member reference for any Board member who leaves the Board •Use the Leadership Competency Framework as part of the assessment process when recruiting to all Board roles
By 31 March 2024	•Fully implement the FPPT Framework incorporating the LCF, including updating the ESR database
By end Q1 2024/25	•Incorporate the LCF into annual appraisals of all Board directors for 2023/24, using the Board appraisal framework

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Overview of readiness and next steps

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Overall, the Group is in a positive position for the implementation of the new FPPT Framework:

- In February 2023, the ESTH and SGUH Boards of Directors agreed an updated Group-wide Fit and Proper Persons Policy, which strengthened local FPPT processes at each Trust. In addition, we have strengthened our arrangements for undertaking annual checks of fit and proper person compliance, adding a set of detailed external checks to the existing annual self-attestations of compliance for each board member.
- In February 2023, both Trusts commissions their respective internal auditors at the time to undertake reviews of the governance, systems, processes and controls for maintaining fit and proper persons compliance, and our systems were assessed as providing substantial assurance.

Many of the requirements of the new Framework are already reflected in our current policy and processes. However, we are currently undertaking a detailed assessment of our policy and processes to ensure these reflect the requirements of the new Framework in full.

The principal changes we will need to reflect from the new Framework are:

- Update the FPPT policy, including incorporating details in the policy on the storage and treatment of information on ESR.
- Undertaking of full FPPT assessments where an existing board member takes on a different role on the board and where a new board member is appointed on a temporary basis of six weeks or more, including acting-up and interim arrangements;
- For any joint appointments, undertaking a full FPPT assessment and providing host organisation confirmation of compliance with FPPT checks;
- The requirements for a mandatory board member reference check;
- The requirements for accurately maintaining FPPT information on each board member in their ESR record;
- The record retention requirements and quality assurance over the Framework;
- The additional accountabilities of the Chair for the FPPT process and the role of the Senior Independent Director / Deputy Chair


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