Group Board

Agenda

Meeting in Public on Thursday, 05 September 2024, 09.45 – 12:30

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

1.0 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	Report
	1.4	Action Log and Matters Arising	Chairman	Review	Report
10:35	1.5	Group Chief Executive Officer's Report	GCEO	Review	Report

2.0 Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10.45	2.1	Quality Committees-in-Common Report	Committee Chair	Assure	Report
10:55	2.2	Finance Committees-in-Common Report	Committee Chair	Assure	Report
11:05	2.3	People Committees-in-Common Report	Committee Chair	Assure	Report
11:15	2.4	Infrastructure Committees-in-Common Report	Committee Chair	Assure	Report

3.0 Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:25	3.1	Group Maternity Services Report	GCNO	Review	Report
11:35	3.2	Integrated Quality and Performance Report	GDCEO	Review	Report
11.45	3.3	Group Finance Report (Month 4 2024/25)	GCFO	Review	Report

4.0 Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:50	4.1	Group Pharmacy Strategy	SCMO-ESTH	Approve	Report

5.0 Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:05	5.1	Fit and Proper Persons Test Compliance Report, 2023/24	GCCAO	Note	Report
12.10	5.2	Quality and Safety Strategy	GDCEO	Note	Report
	5.3	Group Green Plan	GDCEO	Note	Report

6.0 Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12.15	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
12.20	6.4	Patient / Staff Story	GCNO	Review	Verbal
12:30	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones^	Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – SGUH & ESTH	PK
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Derek Macallan	Non-Executive Director - ESTH	DM
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Philippa Tostevin	Non-Executive Director - SGUH	PT
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
In Attendance		
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications & Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy	GDOS
Abisola Otepola-Littleford	Senior Business Manager for Group CEO	AOL
Becky Suckling	Site Chief Medical Officer – ESTH	SCMO-ESTH
Elizabeth Dawson	Group Deputy Director of Corporate Affairs (minutes)	GDDCA
Apologies		
Observers		
Kelly Brown	Senior Corporate Governance Manager	
Chelliah Lohendran	SGUH Governor	

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 of 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 Thursday, 04 July 2024, 10:00 – 13:10

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director – ESTH / SGUH, Vice Chair SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Derek Macallan	Non-Executive Director – ESTH	DM
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Yin Jones	Non-Executive Director – SGUH	YJ
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Angela Paradise*^	Group Chief People Officer	GCPO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – St George's	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		
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Benedicta Agbagwara-Osu	ESTH Director of Midwifery and Gynaecology Nursing *(Deputising for Group Chief Midwifery Officer)*	BAO
Edwin Addis	Corporate Governance Manager (Minutes)	CGM
APOLOGIES		

** 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

Board members provided feedback from visits undertaken across St George's Hospital. These included:

Rose Centre: Yin Jones, Phil Wilbraham and Jacqueline Totterdell

Phil Wilbraham reported that Rose Centre was a centre for breast screening. The Centre appeared to be run well and the team were happy. There was currently one vacancy. Staff were confident about filling the role and tend to get a lot of applicants. The team reported that they had some waiting times issues and that they worked every other Saturday to reduce the waiting list. In terms of estates, Board members concluded that the centre would benefit from some modernisation but recognised the financial constraints facing the Trust.

Delivery Suite: James Blythe, Victoria Smith and Andrew Murray

Andrew Murray noted that the Delivery Suite was clean, calm and well organised. It was not very busy at the time of the visit. The Matron was in control and explained that the triage process was working well and that a good mechanism had been put in place after a recent adverse event. They found that the Estates Team was responsive during the recent sewage leak. The Clinical Placement Facilitator (CPF) reported that student midwives at ESTH were getting lower levels of supervision than at SGUH and consideration was being given to how the existing CPF network between SGUH and ESTH could be improved.

Foetal Medicine Unit: Yin Jones, Stephen Jones and Tim Wright

Tim Wright reported that the Unit was busy and that Board members had received an informative overview of its work from one of the senior consultants. The Unit undertook scans at 12, 20 and 36 week stages of pregnancy. It also carried out groundbreaking surgical interventions on unborn babies with heart, circulatory and bladder problems. The team had a good relationship with suppliers and sometimes received new equipment to evaluate free of charge, which was beneficial to patients. Yin Jones added that the Unit was highly specialised and one of only three centres in the country that operated on unborn children. From an estates perspective, the team were to trying to explore whether an area currently used as administrative space could be used to increase the clinical space available for treatment.

Gordon Smith Ward: Arlene Wellman, Gillian Norton

Arlene Wellman stated that the staff on this haematology and oncology ward talked highly about the service, which looked after cancer and sickle cell patients. It was a clean and calm environment and Board members spoke with two clinical trial patients who praised the care they had received and were especially complimentary about the food. Board members also visited Trevor Howell Ward and spoke to staff and patients.

Heberden Ward (Senior Health): Peter Kane, Thirza Sawtell and Kate Slemeck

Peter Kane explained that Heberden Ward provided care for older people with dementia. The main challenge was long stays and delayed discharges due to delays with care packages. The ward was fully staffed, and it had a low turnover rate which was positive. The gold standard was achieved in the ward accreditation in February 2024. The team were proud of that achievement and were hoping to achieve the platinum standard in the near future. The team reported an issue with air conditioning that needed to be fixed.

Pre-Assessment (Willow Annex): Andrew Grimshaw, James Marsh and Derek Macallan

Derek Macallan reported that this team achieved two gold awards and was located in a prefabricated building used for surgical pre-assessments. There was a positive feel to the interactions between the team leader and team members and there were at least three freedom to speak up posters displayed. It felt like a safe place to work. Fire escapes were clearly signposted. In terms of estates issues, the staff area was too small for the 20-30 staff who worked there and it was a problem if more than 3 staff

members had a break at the same time. Derek Macallan concluded that it was a well-functioning unit and appeared to be well-led. James Marsh agreed and added that there was a real sense of team and pride in what they were delivering.

Thomas Young (Neurological rehab): Richard Jennings, Martin Kirke, Ann Beasley

Ann Beasley reported that the ward had Level 1 beds for patients with brain trauma, tumour and stroke. There was a lot of equipment but the ward was tidy with a nice layout. One of the issues highlighted was the length of stay which could be from 3 to 6 months, mainly because of delays caused by other parts of the system. Some patients with brain injuries could be verbally aggressive and staff did not always feel listened to when it came to dealing with this problem. Richard Jennings commented on the bed mix: 50% of beds were for patients who had acute stroke and started their journey on William Drummond ward before moving to Thomas Young Ward. The other half of beds was for Level 1 neuro rehab patients in general which included patients with brain injuries but also conditions such as Parkinson's and Multiple Sclerosis.

There was a discussion about whether the visits should continue to be unannounced and the GCNO agreed to discuss with colleagues and report back.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting. Victoria Smith, the incoming Group Chief People Officer (GCPO), was welcomed to her first Board meeting, on this occasion as an observer as she completed her induction and phased handover with Angela Paradise, Interim Group Chief People Officer. The Chairman noted that it was the last Group Board meeting for Jenny Higham, as well as for Angela Paradise, and the Group Board would have an opportunity to express its thanks to both at the end of the meeting.	
1.2	**Declarations of Interests**	
	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Angela Paradise and Arlene Wellman as Executive Directors. No new interests were declared.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the Group Board meeting on 2 May 2024 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	

	The Group Board reviewed and noted the Action Log and agreed to close action PUBLIC20240502.01 (Quality Committee annual report) which was proposed for closure. The Group Board received an update on the two open actions: • PUBLIC20240502.02 (Corporate Priorities): The GDCEO explained that the plan on a page for the 2024/25 priorities had been aligned with the CARE acrostic and with the financial plan. The Group Board agreed to close the action. • PUBLIC202401012.4 (Group Strategy implementation): The GDCEO explained that he would provide an update on this as part of the discussion on the Group Strategy in Part 2 of the meeting. On this basis, the Group Board agreed to close the action. The remaining three actions were not due yet.	
1.5	**Board membership: Implications of City St George's merger**	
	The GCCAO updated the Group Board on the implications of City St George's merger for the composition of the SGUH and ESTH Trust Boards. He explained that the SGUH Trust Board membership included a Non-Executive Director who was appointed by St George's University of London (SGUL), and that to date this had been the University Vice Chancellor, currently Jenny Higham. Likewise, the ESTH Trust Board made provision for a University-appointed Non-Executive Director, currently Derek Macallan. On 1 August 2024, SGUL was scheduled to merge with City University, and what was currently SGUL would form part of a new multi-site combined institution. With the merger, there would no longer be a separate SGUL Vice Chancellor. Instead, an Executive Dean would lead a new school of health and medical sciences. The proposal was that the new Executive Dean would, when appointed, take on the NED role on both the SGUH and ESTH Trust Boards. In the interim, it had been agreed that Professor Philippa Tostevin, Professor of Practice – Surgical Education and Head of the Centre for Clinical Education, would temporarily fill the NED role at SGUH until 31 December 2024, pending the arrival of the new Executive Dean. At ESTH, Derek Macallan would continue in his role until the same date. **The Group Board:** **a) Noted that Professor Tostevin would serve as NED on the Board of St George's University Hospitals NHS Foundation Trust until 31 December 2024, pending the arrival of a substantive Executive Dean of the University's school of health and medical sciences, and that Derek Macallan would continue at ESTH until the same date.** **b) Noted that the individual appointed by the new City St George's to serve on both the SGUH and ESTH Trust Boards would be the Executive Dean of the school of health and medical sciences for City St George's, once appointed.** **c) Noted that a minor update would be required to the SGUH Constitution to replace the reference to SGUL with City St George's.**	
1.6	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO updated the Group Board on the following issues: • **Staff news:** The GCEO welcomed the new Group Chief People Officer, Victoria Smith. Victoria would have overall responsibility for HR across the	

	Group, and one of her priorities will be to drive forward work on integrating and strengthening the HR function. • **Cyber-attack**: A recent cyber-attack had disrupted blood tests and transfusions at hospitals in South East London (King's College Hospital, Guy's and St Thomas' and some primary care services). St George's and Epsom and St Helier had not been directly affected by the cyber-attack but were active in supporting colleagues in South East London while they responded to the incident. • **St Georges Catering Services:** Catering services at St George's had been recognised as "exemplary" by NHS England (NHSE) and had been chosen to join the NHS Exemplar Trusts Programme for Catering. This was in recognition for innovation, high food standards, and consistent service in providing food for patients, staff and visitors. St George's was one of only 20 hospitals across the country to have been awarded this accreditation**.** • **ESTH Simulation and Human Factors team:** The Elena Power Centre for Simulation and Human Factors (EPC) at Epsom and St Helier had been named a Finalist for two HSJ Patient Safety Awards later this year. The awards were due to take place on 16 September 2024 and the EPC team was a finalist for both the Harnessing Human Factors Approach to Patient Safety and the Patient Safety Education and Training Award categories. In response to a question from Martin Kirke about whether the cyber-attack had caused any adverse impact on the Group's performance and finance, the GCEO said that the costs associated with supporting South East London in response to the cyber-attack were being tracked in order that the Group could demonstrate this to NHSE in the event that funding became available. **The Group Board noted the Group Chief Executive's Report.**	
2.0	**ITEMS FOR ASSURANCE**	
2.1	**Quality Committee-in-Common Report**	
	Derek Macallan, Non-Executive Director and chair of the June 2024 meeting of the Quality Committees-in-Common, presented the key issues considered by the Committees: • **Maternity Governance Management Response:** The Committees reviewed the management response to the independent review of maternity governance, which had been commissioned by the Group Board following the CQC inspection of maternity services at SGUH. The Committees were assured that an effective management action plan had been developed and that the Committees would closely oversee delivery of the actions. • **Patient Safety Incident Response Framework (PSIRF):** The Committees received an update on PSIRF implementation and heard that all services across the Group had now completed the transition from the Serious Incident (SI) Framework to PSIRF, which had been achieved within the established national timescales for transition. • **Group Quality and Safety Strategy**: The Committees reviewed the updated draft Quality and Safety Strategy and confirmed that they were content to support the presentation of the strategy to the Group Board for approval.	

	The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion: • The GCMO commented on the overcrowding in ED and explained that the Committee had considered the patient safety and quality implications of this, which was a key risk at both Trusts. He added that, taking into account that this was a national issue, there were still some things in the patient pathway such as discharge, that were within the Trusts' control and that standard operating procedures (SOPs) for triage and streaming in the departments needed to be fully understood by staff and consistently applied. • The GCEO agreed and noted that there was a big focus on maintaining safety in ED and on improving flow in both Trusts. She added that mental health and social care aspects were crucial for addressing the overcrowding. • The GCFO highlighted the quality and safety implications of the financial challenges across the Group. The cost pressures and quality and safety mitigations needed to be included in both the quality and finance reports. • The Chairman observed that the impact of the Cost Improvement Plans (CIPs) on staff morale needed to be recognised. Derek Macallan agreed and added that Quality Impact Assessments (QIA) were very important tools for assessing the impact of CIPs on patient safety and staff. • Ann Beasley stated that the planning assumptions could be contradictory. Hospitals need to deliver savings, but this was challenging and a whole system approach was needed, but the development of a long-term financial plan in South West London (SWL) was not moving forward fast enough. The Chairman summarised the discussion and stated that the Group needed to be explicit about the cost implications of CIPs on patient safety and to work closely with South West London and St George's Mental Health NHS Trust and with social care to reduce the length of stay. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in June 2024.**	
2.2	**Finance Committees-in-Common Report including updated Terms of Reference**	
	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committees at its meetings on 31 May and 28 June 2024: • **Financial pressures impacting on investment opportunity:** In considering the BAF risk, Committee members had noted the negative impact on staff morale of the financial pressures cross the Group, and the fact that proposals for investment to improve services could not always be supported. • **Ambulance Handover changes:** The Committee noted the risk of reducing the maximum handover time from 45 mins to 30 mins or 15 mins when corridor care was already being experienced at the Emergency Departments across the Group. • **Cyber-attacks:** The Committees discussed the impact of the recent cyber attacks on neighbouring Trusts and the work being undertaken at SGUH to support these hospitals. Committee members noted the financial impact	

	was being tracked. The Committees also acknowledged the risk of similar attacks in South West London. • **Virtual Ward:** The Committees considered the progress being made with partners across the health economy on Virtual Wards, with more progress expected in the coming months. • **Terms of Reference:** The terms of reference for the ESTH and SGUH Finance Committees had been reviewed and minor changes were proposed. The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion: • The MD-SGUH noted that, although overall ambulance handover performance at SGUH remained comparable to previous months, patients were waiting longer to be offloaded. • Tim Wright commented on the recent Synnovis cyber attack at neighbouring hospitals in the Capital and stated that it was important to continue to support these Trusts and procure resilient systems and mitigations. **The Board:** • **Noted the issues considered by the Finance Committees-in-Common at its meeting in May and June 2024.** • **Approved the updated Terms of Reference for both the SGUH and ESTH Finance Committees as reviewed and endorsed by the Finance Committees-in-Common.**	
2.3	**People Committees-in-Common Report**	
	Martin Kirke, Joint Chair of the People Committees-in-Common, set out the key issues discussed and considered by the Committee on 20 June 2024: • **NHS Staff Survey: Top 10 and lowest 10 performing departments:** The Committees had reviewed an analysis of the departments with the highest and lowest levels of engagement with the staff survey and the triangulation of engagement levels with a number of other key workforce indicators. The Committees welcomed the excellent format of the report and detailed analysis of the survey data presented in this form which provided helpful insight into those departments within each Trust that may be encountering challenges and may require support. • **Group Freedom to Speak Up Report 2023/24**: The Committees received a report from the newly appointed Group Freedom to Speak Up (FTSU) Guardian, which set out an analysis of the numbers of concerns raised by staff across the Group in 2023/24 and the trends and themes arising from those concerns. During discussion, the following points were raised and noted: • In response to a question about staff sickness levels, the GDCEO reported that actions were being taken to identify the services with a high number of people on sick leave and find solutions. • On FTSU, it was noted that the issues being raised by staff at each Trust were broadly similar, with concerns relating to Trust processes, particularly	

	recruitment and employee relations, management conduct, and bullying and harassment being the most prevalent. • The Group Board noted that Victoria Smith had started as the new substantive Group Chief People Officer on 1 July 2024, and that developing and strengthening the HR function across the Group would be a key priority. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in June 2024.**	
2.4	**Audit Committees-in-Common Report**	
	Peter Kane, Audit Committee Chair, set out the key issues discussed and agreed by the Audit Committees-in-Common at its inaugural meeting on 17 May 2024: • **Annual Report and Accounts 2023/24:** The Committee was assured by the progress on completing the annual report, annual accounts, and quality report ahead of the national deadline for submission on 28 June 2024. The Committees also received updates on the external audit work at both Trusts. The Audit Committees had met separately since the Committees-in-Common meeting on 17 May to recommend these to the Boards. The two Trust Boards had subsequently approved the annual reports and accounts for their respective Trusts. • **Internal Audit:** The Committee reviewed six internal audit final reports, four for SGUH and two for ESTH. The Committees discussed, in particular, those which had received 'partial' assurance conclusions. Good progress continued to be made in relation to following up on previous internal audit actions at both Trusts. The Committee reviewed the Head of Internal Audit Opinion reports for each Trust for 2023/24 and was assured by the 'reasonable assurance' ratings. Work was underway to ensure that the internal audit programme in 2024/25 was more evenly distributed through the year. • **Counter Fraud**: In terms of the Counter Fraud Annual Reports, both SGUH and ESTH returns proposed 'green' ratings for the two Trusts, with the Trusts assessed as fully compliant with the requirements, with supporting evidence of the counter fraud work undertaken. The Chairman commended the encouraging start for the Audit Committees meeting as Committees-in-Common and invited comments and questions from the Group Board. The following points were raised and noted in discussion: • Commenting on the internal audit on sickness absence, the GCEO noted that the sickness policy needed to be revisited and simplified for teams, especially teams with high sickness levels. The Interim GCPO confirmed that the policy was being reviewed. • In response to a question about ways to address sickness levels, the Interim GCPO noted that that line managers at all levels, supported by HR, needed to see the management of sickness as a key part of their roles. Staff Side needed to be involved too in reducing sickness levels. **The Board noted the report of the inaugural Audit Committees-in-Common meeting held on 17 May 2024 and the issues escalated to the Group Board.**	
2.4.1	**Audit Committee Annual Reports**	

	Peter Kane, Audit Committee Chair, explained that the report presented the annual report for 2023/24 of each Trust's separate Audit Committee and the outcomes of the Audit Committee effectiveness reviews for each Trust. Also included were some minor proposed changes to both the ESTH and SGUH Audit Committee Terms of Reference, which were intended to facilitate the Committees working as Committees-in-Common, and a forward plan of work for the Committee for 2024/25. The Chairman invited comments and questions from the Group Board. No issues were raised. **The Board:** • **Received and noted the annual reports from the SGUH and ESTH Audit Committees which set out how the Committees fulfilled their respective terms of reference in 2023/24.** • **Reviewed and endorsed the proposed minor changes to each Audit Committee's terms of reference.** • **Reviewed and endorsed the proposed forward workplan for the Committees for 2024/25.** • **Received and noted the outcomes of the 2023/24 Committee effectiveness review for each Trust's Audit Committee.**	
3.1	**Independent Review of Maternity Governance and Management Response**	
	The Chairman commented that the independent review of maternity governance had been commissioned following the CQC inspection of maternity services at SGUH in March 2023. The report had been discussed in significant depth at a Group Board development session in June 2024, at which Group Board members had the opportunity to discuss the findings and recommendations with the report author and to review the draft action plan. As a result, the item was on the Group Board agenda to ensure that the Group Board formally received the report and ensure appropriate transparency as to the findings and the Group's response. The GCNO provided a brief overview of the key findings of the report and the main elements of the action plan. She added that a second phase of the review would look more broadly at quality governance across the Group, with a particular focus on the robustness of quality governance at Divisional level. This phase two work would commence shortly. During discussion the following points were raised and noted: • The GCMO commented that the report provided a number of recommendations around culture and governance in maternity services which the Executive was committed to implementing. While the actions had defined completion dates, it was important for the Group Board to understand that it would take time for the actions to become fully embedded, particularly those relating to culture. The GCEO agreed and added that the Interim Director of Organisational Development and Culture within the HR Directorate would review the report and help support the cultural changes required. • The Chairman commented that the report had been very helpful in identifying the issues within the maternity service and the actions that were required. She observed that that the Group needed to ensure that issues	

	and concerns in quality and safety were monitored closely and escalated promptly, not only within maternity but across all departments. • On the report's recommendations on risk management, the GCCAO explained that a review of the risk management framework across the Group had commenced prior to the maternity review and that a revised framework would be finalised, with input from the relevant stakeholders, in the autumn. **The Group Board:** • **Noted the detailed observations of governance and culture.** • **Noted the risks identified for delivery of the improvements and mitigations required.** • **Considered the relevance of findings for the broader approach to quality governance.**	
3.2	**Group Maternity Services Report**	
	The Chairman welcomed Benedicta Agbagwara-Osu, Director of Midwifery and Gynaecology Nursing at ESTH, to the Group Board, who was deputising for the Group Chief Midwifery Officer. Dr Agbagwara-Osu provided an overview of the report and drew particular attention to the following: • In recognition of the compliance position of ESTH and SGUH with the ten Safety Actions in the Year 5 Maternity Incentive Scheme (MIS), NHS Resolution had issued a rebate equal to 10% of each Trust's contribution to the scheme, plus a share of the surplus funds in respect of trusts that did not achieve full compliance in all ten safety actions. For ESTH, the rebate was £1,062,661.25 and for SGUH the rebate was £833,789.07. • The MIS Year 6 Technical Guidance included the requirement for engagement events to be held with maternity and neonatal staff within each service every two months, an increase from the Year 5 guidance where the requirement had been quarterly. Both Trusts had met the requirement for this to be in place by 1 July 2024. A staff engagement event had taken place on 15 May 2024 and the dashboard of current on-going concerns was shared with staff. • Safety Action 1 in the MIS required Trusts to report all perinatal deaths to MBRRACE-UK (Mothers and Babies Reducing Risk through Audits and Confidential Enquiries) within seven working days. The SGUH maternity service undertook a monthly review of outcomes to ensure these were reflected accurately on the internal clinical dashboard and the South West London Local Maternity and Neonatal System (LMNS) collated dashboard. During this process, it was identified that two cases of neonatal deaths within the neonatal unit at SGUH in April 2024 had not been reported to MBRRACE-UK within the required timeframe. The service was taking a number of steps to prevent further such breaches. These actions included training on reporting requirements and undertaking twice weekly data runs from the neonatal system. • The Early Notification Scheme (ENS) arm of NHS Resolution had advised SGUH, via email on 17 June 2024, that it would be undertaking a thematic review of all cases the maternity service has referred to Maternity and Newborn Safety Investigations (MNSI) between 1 April 2017 – 31 May	

	2024. The review was primarily triggered by the CQC rating of "Inadequate" and the Trust's inclusion in the Maternity Safety Support Programme (MSSP). • Medical staff attendance at safeguarding training at ESTH was highlighted as a significant area of concern by the CQC following their inspection in August 2023. As of April 2024, training compliance for obstetric medical staff for safeguarding (adults and children) remained low at 39% (adults) and 79% (children). Work was ongoing to address this. • The NHS Staff Survey had highlighted staff burnout and a meeting with a culture coach had been organised to create an action plan, the details of which would be reported in next month's report. During discussion the following points were raised and noted: • In response to a question from Yin Jones about concerns around outcomes of some complex procedures in the Foetal Medicine Unit (FMU) at SGUH, Dr Agbagwara-Osu explained that the SGUH Site Chief Medical Officer had overseen a formal tightening of safety governance arrangements whereby complex procedures must now always involve two consultants. In addition, signatories to late termination forms must both be consultants. • The GCMO added that a peer review was also being commissioned in relation to FMU. He explained that there was no national benchmarking standard for quality and safety in foetal medicine, so peer review was a good solution. • The GCNO asked about an outstanding grievance and Dr Agbagwara-Osu explained that this related to an Agenda for Change query concerning payment for on-call work. The standing operating procedure needed to be updated but there would be cost implications should any substantive changes be made. The Chairman noted that Dr Agbagwara-Osu would be leaving ESTH shortly to take up a role at another Trust, and expressed the thanks of the Group Board for all of her work. **The Group Board:** • **Noted the key areas of success, risks, and mitigations.** • **Noted the MIS rebate awarded to both Trusts for meeting the defined Safety Actions in year 5 of the MIS.** • **Noted the newly published MIS year 6 guidance, the change to some safety actions, and the submission dates.** • **Noted that two neonatal cases at SGUH were not reported to MBRRACE-UK within the seven working day period and the actions the service have taken to address and mitigate occurrence of further incidents.**	
3.3	**Integrated Quality and Performance Report**	
	The GDCEO presented the highlights from the Integrated Quality and Performance Report (IQPR) as at May 2024: • Urgent and emergency care services at both Trusts continued to experience significant pressures. The 4-hour wait performance at SGUH in May 2024	

	was 76.8%, against a trajectory of 78.6%. ESTH had achieved 77.5% in relation to the 4-hour standard. • The key drivers for operational pressures at both Trusts were unplaced patients remaining in the Emergency Departments (ED). Attendance at ED by mental health patients was a particular pressure. The limited capacity within the EDs impacted on ambulance handover times. • SGUH had declared two Patient Safety Incidents (PSIIs) in May 2024. One of these incidents occurred in Obstetrics and the other in the Breast Clinic. The Trust had discharged its Duty of Candour and investigations were ongoing. At ESTH, seven Serious Incidents were reported, two of which were Never Events. These had been reported to the Quality Committee and the Group Board separately. The Chairman invited comments and questions from Group Board members and the following issues were raised and noted: • The MD-SGUH noted that the SGUH had performed well against the ERF (Elective Recovery Fund) targets and that theatre utilisation was moving in a positive direction. • The MD-IC commented that a new risk on long waits for therapy services (children wating for speech and language therapy) had been added to the site risk register. • The GDCEO added that mitigating actions were beginning to bear fruit and that waiting lists were being reduced. **The Board reviewed and noted the report.**	
3.4	**Group Finance Report (Month 2 2024/25)**	
	The GCFO reported that both Trusts were on plan at month 2, 2024/25, after bringing forward various non-recurrent benefits from later in the year. For both Trusts, delivery of the plan in full by year-end was a material risk. In relation to Cost Improvement Plans (CIP), ESTH delivery was £0.4m adverse year-to-date, with £2.2m of CIP remaining unidentified and £15m in opportunity on which firms plans needed to be developed. For SGUH, CIP delivery was on plan, with £24m in opportunity that needed to be translated into firm plans. The report outlined key actions that were being taken to help support delivery of the plan by year end and the Group Executive team were focused on delivering this. The Chairman invited comments and questions from Group Board members and the following issues were raised and noted in discussion: • In response to questions from Phil Wilbraham and Peter Kane about cost pressures, the GCFO explained that work on reducing temporary nursing spend continued. He observed that acuity and complexity was going up which affected financial pressures. The Chairman commented that it would be important to keep track of these issues and requirements that carried a financial cost so that the Trusts could highlight this when reporting to NHS England. • In response to a question on the impact of any deal by an incoming government to resolve the industrial action by junior doctors, the GCFO explained that the Group would find it challenging to absorb further costs in relation to any pay uplift unless this was funded centrally. If and when a pay	

	settlement was agreed, the Finance Committee would consider the financial implications to the Trusts. **The Group Board noted the Month 2 2024/25 financial positions for SGUH and ESTH.**	
4	**ITEMS FOR DECISION**	
4.1	**Group Board Assurance Framework**	
	The GCCAO introduced the report, noting that this was the first regular review of the new Group Board Assurance Framework (BAF) since it had been agreed by the Group Board in March 2024. For each strategic risk, the report set out the current strategic risk score and assurance rating, the target risk score, an explanations of the movements over the past three months, and the links from the BAF to the supporting risks on each Trust's Corporate Risk Registers. As the report was presented three months on from having agreed the starting position on the BAF, unsurprisingly there were no proposed changes to the headline risk scores or assurance ratings to any of the strategic risks at this stage. Detailed work had been undertaken with relevant leads to refine the actions to address gaps in control and assurance and present timelines for delivery of identified mitigating actions. There had also been some progress in completing these actions over the past three months but, as would be expected for the principal risks to the delivery of a five-year strategy, these were not sufficient, at this stage, to shift the headline risk scores. The Chairman invited comments and questions from Group Board members and the following issues were raised and noted in discussion: • Commenting on the high number of risks with 'limited assurance' ratings, Tim Wright observed that the driver appeared to be the wider financial challenges facing the Group and factors outside the Group's control. He suggested that the Group needed to focus on those areas that were within its power to change. The GCCAO agreed that a significant number of the risks had limited assurance ratings. This was to be expected at this stage of the BAF in that the risks had recently been defined against a new set of strategic objectives. As identified actions to address gaps in control were completed, it was expected that the assurance ratings would start to shift. However, the financial context undoubtedly imposed constraints on the delivery of the strategy which contributed to the position. Risks that were outside the control of the Group needed to be captured, as the BAF was a tool to help the Group Board understand the risks to the delivery of the strategy, but it was important to distinguish between actions that were within the power of the Group to deliver and those where actions by others, or actions to be taken in partnership with others, were required. • Ann Beasley enquired whether the risk score for strategic risk 2 (working with other hospitals through the acute provide collaborative) was set appropriately as a risk score of 12, given the challenges facing the APC. It was agreed that further consideration would be given to this, as well as how the Group Board could get a deeper understanding of collaborative and partnership working more generally. The GCCAO would work with the GCEO to consider the risk score for SR2, and the GCEO would give consideration to how best to bring partnership working issues through the Group Board. The Group Board agreed to keep the risk score for SR2 as a 12 but agreed this would be reviewed ahead of the next report on the BAF.	**GCCAO / GCEO**

	The Group Board: • **Reviewed the current risk scores and assurance ratings for each strategic risk on the Group BAF at the end of Q1 2024/25.** • **Noted the risks that had been reviewed by the relevant Committees.** • **For the risks reserved to the Group Board, reviewed and agreed the risk scores and assurance ratings at Q1 2024/25 and noted that the risk score for SR2 would be reviewed ahead of the next scheduled BAF review.**	
5.0	**CLOSING ITEMS**	
5.1	**Any new risks and issues identified**	
	No new risks were identified. The Group Board noted the previous discussion in relation to the calibration of the risk score on the BAF in relation to partnership working within the SWL APC.	
5.2	**Any other business**	
	The Chairman reminded the Group Board that it was Jenny Higham's final Board meeting before leaving her current role as Vice Chancellor of St George's University of London on 31 July 2024 to take up her new position as Vice Chancellor of the University of Suffolk. The Chairman thanked Jenny for her significant contribution to the Board since joining as a Non-Executive Director at the Trust in January 2016 and for her leadership of St George's University of London, with which the Trust shared a close working relationship. Jenny's contributions and insights both as a member of the St George's Trust Board and as a member of the Quality Committee had been greatly valued and she would be missed by all members of the Board. Members of the Group Board concurred and endorsed the Chairman's comments. The Chairman also thanked Angela Paradise, Interim Group Chief People Officer, for her hard work in leading the HR function across the Group over the previous six months, pending the arrival of Victoria Smith in the substantive role. Angela had led the HR function during an extremely challenging period and had successfully developed the new People Strategy for the Group. The Group Board extended its thanks and gratitude to Angela.	
5.3	**Reflections on meeting**	
	The Chairman asked Jenny Higham to give her reflections on the Group Board meeting, given this was her final meeting, and Jenny offered the following observations and reflections: • The meeting had been a good and productive one, with helpful contributions from Group Board members. • The discussions, particularly around the Committee reports, demonstrated how much assurance work was undertaken by the Committees on behalf of the two Trust Boards. • As had been mentioned in previous Group Board meetings, starting the day with visits across the site helped to ground the discussions in the care provided to patients and the work of the staff. However, the Group Board	

	needed to resolve the issue of whether pre-Board ward visits were announced or not. • Jenny reflected on her eight years as a member of the St George's Trust Board and commented that she had learnt a lot during her membership of the Board, had worked with a number of different leaders, and suggested that the Board could reflect positively on the progress achieved during this period, notwithstanding the significant challenges that remained. • Jenny had sought to advocate for education and research during her time as a Board member, and suggested that greater focus on these would be beneficial. • Jenny thanked the Chairman and her fellow Non-Executive Directors for their hard work and tenacity as well as resilience in sometimes difficult circumstances.	
5.4	**Patient Story**	
	The Chairman welcomed Mark Luboff to the meeting, along with Jennifer Randall, Head of Nursing for Acute Medicine. Mark had been a patient of St George's in August 2023 and shared his experiences of his care with the Group Board. Mark explained that he had multiple pulmonary embolisms in 2023 and suffered from Obstructive Sleep Apnoea and required the use of a CPAP (Continuous Positive Airway Pressure) machine. He also suffered from longstanding health anxiety. In late August 2023, Mark explained that he had experienced two weeks of very severe and debilitating chest cough and flu symptoms in August 2023 and had initially contacted NHS 111 for advice, which had booked him in for review at the SGUH Urgent Treatment Centre (UTC) the following morning. The UTC observed crackly lungs and sats of 85% and, as a result, Mark was sent through the Emergency Department (ED) and was subsequently admitted. Mark had been a patient in ED, the Acute Medical Unit (AMU), McEntee Ward and Caesar Hawkins Ward, and he reflected on both the positive and negative aspects of his care. He had not felt that his experiences warranted a complaint, but he had noted down his observations at the time and a friend had subsequently directed him to the patient experience team at the Trust. In terms of the positive aspects of his care, Mark commented on the excellent care he had received in ED from both medical and nursing staff at the point of triage and in relation to the explanation provided to him about the care he would need. His consultant was excellent and had gone to great lengths to reassure him, which had been very welcome given his health anxiety. He also found the medical care to have been very good as a whole. Alongside these positive experiences, however, Mark also observed some negative aspects and areas for learning which he shared with the Group Board. While the medical care as a whole had been very good, there had at times been a lack of patient centred care, particularly in the context of his health anxiety. He had not always received sufficient explanations of his transfers between departments. On McEntee Ward, he had needed to connect his CPAP machine to an oxygen supply but there was no available oxygen outlet for this, which meant that CPAP was not used at night, resulting in poor sleep. He reflected that nursing staff appeared to be under considerable pressure and were overstretched, and it appeared that some needed more training in using technology and providing help to patients who use a CPAP machine. He also said that there had been a mix-up over his medication. Mark added that the behaviour of some patients towards staff was outrageous, and he observed both physical and verbal abuse from patients towards staff which he regarded as unacceptable. He commented that it appeared that there was a lack of	

control exercised by anyone in authority over the behaviour of these patients or their family members in the wards. At the point of discharge in early September, it had taken six hours to receive one item of medication, which had delayed him leaving.

The Chairman thanked Mark for sharing his story. She thanked him for his positive comments on aspects of the care he had received and apologised for those aspects where the care was not at the standard the Board would have expected. The Chairman then asked Jennifer Randall for her reflections and the actions that had been taken in response to Mark's experiences. Jennifer commented that Mark's feedback had been with the relevant nursing leads. There was a need to improve working in partnership with patients and a wider recognition that patients with long term conditions often knew their condition the best. McEntee Ward was not the most appropriate ward for Mark to have been transferred to. Ideally, he would have gone straight to Caesar Hawkins Ward or stayed on AMU where his CPAP oxygen supply could have been better managed. AMU matrons were working with the coordinators to ensure effective triaging of patients to ensure patients were transferred to the most appropriate ward. It was recognised that wards could be noisy and that this could be challenging for patients who were trying to rest. At the time Mark had been a patient, there had been a 15% vacancy rate in AMU, and this would have had an impact on the workload of the nursing staff. The vacancy rate had since decreased to 4.7%.

The Chairman asked Board members for questions and comments and the following points were raised:

- The GCEO acknowledged there were issues with the timeliness of providing medication at the point of discharge. Pharmacy typically needed around an hour to dispense medicine, but there were sometimes delays in providing these to the wards.
- In relation to violence and aggression by patients towards staff, the GCEO explained that steps had been taken to address this and she was leading a programme of work to ensure staff were effectively supported in tackling violence and aggression towards them, which was unacceptable. A new policy on violence and aggression against staff was being developed as part of this programme of work, which would make it easier for staff to take action when faced with such abuse.
- The GCNO thanked Mark for his story and apologised on behalf on the nurses for the shortcomings in his care. She explained that caring for patients with health anxiety was something that nursing staff needed to be able to deal with.
- The GCMO also thanked Mark for his story for giving praise to staff where credit was due. He acknowledged that, for patients, being in hospital could be profoundly disempowering. There were clear lessons to be drawn from his story about how staff could listen better, improve care, and communicate better.

On behalf of the Group Board, the Chairman thanked Mark for sharing his story and for his continued support for the Trust.

CLOSE

The meeting closed at 13.10 pm

QUESTIONS FROM MEMBER OF THE PUBLIC AND SGUH GOVERNORS
There were no questions from members of the public and no SGUH Governors were in attendance at the meeting.

Group Board (Public) - 5 September 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20240308.1	08-Mar-24	2.3	People Committees in Common report	Publication timetable to be drawn up of statutory people-focused reports.		GCPO	Propose for closure and transfer to the People Committee who will consider a forward plan at its October meeting, including a list of the statutory reports.	PROPOSED FOR CLOSURE
	02-May-24	6.1	Any new risks and issues identified	The risk related to ED was flagged for recalibration, while this was not a new risk and was one of the central quality problems nationally, there had been a shift with much more corridor care taking place than had been the case previously. The Executive would revisit the calibration of the ED risk	07-Nov-24	GCCAO		NOT YET DUE
	02-May-24	6.3	Reflections on meeting	The Chairman asked that further consideration be given on how to better support the staff networks as these were not being fully utilised	07-Nov-24	GCPO		NOT YET DUE
	04-Jul-24	4.1	Board Assurance Framework	Review the strategic risk score for SR2 prior to the next scheduled Board review of the BAF, which would be in November	07-Nov-24	GCCAO		NOT YET DUE
	04-Jul-24	4.1	Board Assurance Framework	Consideration to be given to how partnership working comes through the Board in a more explicit way	07-Nov-24	Chairman/GCCAO		NOT YET DUE

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	1.5	
Report Title	**Group Chief Executive Officer's Report to Group Board**	
Non-Executive Lead	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

This report summarises key events over the past two months to update the Board on strategic and operational activity across the St George's, Epsom and St Helier University Hospitals and Health Group. Specifically, this includes updates on:

- The national context and impact at the trust level
- Our work to date
- Staff news and engagement
- Next steps

Action required by Group Board

The Group Board is asked to note the report.

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

Group Chief Executive Officer's Report

Group Board, 05 September 2024

1.0 Purpose of paper

1.1 This report provides the Group Board with an update from the Group Chief Executive Officer on strategic and operational activity across the St George's, Epsom and St Helier University Hospitals and Health Group.

2.0 Overview

2.1 Over the last few months, we have continued to work towards achieving our strategic ambitions of providing outstanding care across our hospital Group.

2.2 Staff across our Group continue to work hard to deliver high-quality care and timely treatment while achieving financial efficiency. The most critical operational pressures we face at both Trusts continue to be the high numbers of unplaced patients remaining in the EDs and the large number of patients with mental health needs presenting at our EDs, a setting which is often not best suited to their needs. Wider flow through our hospitals represents an ongoing challenge, and we are undertaking work to ease long lengths of stay, working closely with our partners across the wider system.

2.3 In mid-August, I joined the monthly meeting of the SGUH staff REACH Network, where I heard harrowing stories from staff about racist abuse directed at them, including at our hospital sites. I was shocked by the racist riots I saw on the news, across the country, and in our communities in south London over this past month. In my previous update, I wrote about the events we organised across our hospital group to celebrate our diverse teams.

Seeing this news reinforced my commitment to remind staff that people of all faiths and backgrounds are respected and valued members of our phenomenal team at gesh. I wrote to staff to remind all that discriminatory and racist behaviour will not be tolerated at gesh, and that we have incorporated the principles underlying diversity, equity, and inclusion into our CARE strategy and throughout our Group. However, this will not be enough, and we must continue to address any discriminatory conduct regardless of who it is against.

2.4 The remaining sections of this report will highlight the progress we have made within our Group and outline our upcoming plans for the next few months.

3.0 National Context and Updates

3.1 New Hospital Programme:

The New Hospital Programme was established in 2020 with the goal of building 40 new hospitals in England by 2030. The Programme also aims to revolutionise the development of NHS healthcare infrastructure, including the standardisation of hospital design.

Following an announcement from the Chancellor, the Department of Health and Social Care are reviewing the Programme with input from NHS England. We are awaiting further details of this review and any impact that this may have on ESTH's Building Your Future Hospitals scheme.

3.4 Clade 1 Mpox Virus

The World Health Organisation (WHO) has determined that the upsurge of mpox in the Democratic Republic of the Congo (DRC) and a growing number of countries in Africa constitutes a public health emergency of international concern. The emergence last year and rapid spread of a new virus strain in DRC, clade 1b, is one of the main reasons for the declaration. The WHO regional director for Europe has emphasised that Mpox is not the new COVID because authorities know how to control its spread.

We have produced Group-wide guidance on managing suspected cases and established clear pathways for both sites. To date, only one suspected case presented to Epsom Hospital ED on 19 August, which was managed as per our Group guidance. Precautions were taken, and the patient was discharged.

We are working to ensure that staff have access to the appropriate PPE as recommended by NHSE and have alternatives that can be used in the event of a suspected case.

4.0 Our Group

4.1 Principal Treatment Centre for Children's Cancer

Wandsworth Council is leading a campaign against the NHSE decision to move children's cancer services from St George's. In March, the decision was made to relocate children's cancer services for south London and the southeast to the Evelina London Children's Hospital in Lambeth from Autumn 2026. Currently, The Royal Marsden Hospital and St George's University Hospital collectively provide cancer care for approximately 1,400 children under the age of 15.

Council leaders from Sutton, Kingston, Richmond, Merton, Wandsworth, Surrey County, and Croydon have formally requested the Secretary of State for Health to review the decision to move specialist care services to the Evelina London Children's Hospital. They have provided evidence of significant costs associated with the relocation, the impact on health and health inequalities, treatment expertise and transportation, and the quality of patient and public engagement in the decision-making process. These findings were based on an independent review commissioned by the Mayor of London.

4.2 CQC Visit

On 6 and 8 March 2024, the CQC conducted focused, unannounced assessments of Urgent and Emergency Services at SGUH . The assessment was prompted by two separate incidents involving falls of patients in ED in which the patients subsequently died. The draft report was received on 19 August and is currently being checked for factual accuracy. Once the final report is received it will be shared.

4.3 Breast Cancer Services

Providing high-quality services is a top priority for us. We are currently focusing our efforts on resolving performance issues within our Breast Cancer Services at SGUH. The services have encountered significant operational challenges, and as a result, I have initiated a review of our processes and requested the development of a performance improvement plan to ensure that patients get the timely treatment they need. We are in close contact with RM Partners and the SWL ICB.

4.4. Surrey Downs Health and Care Partnership

The integrated Home First Service at Surrey Downs Health and Care Partnership provides health and social care support to people in their homes as an alternative to hospital admission or an extended acute stay. This work has been highlighted as national best practice by Amanda Pritchard, Chief Executive of NHSE. This recognition comes as updated operational guidance on virtual wards and single point of access hubs was published. Through this model of care, we are closing the gap between services and providing accessible, joined-up care.

5.0 Appointments, Events and Our Staff

5.1 Our Staff

Hyper Acute Stroke Unit
The Hyper Acute Stroke Unit (HASU) in William Drummond Ward at SGUH was awarded Gold Accreditation. This award is a testament to the staff's dedication and hard work and recognises the high standard of acute stroke care that the staff consistently deliver. HASU received eleven gold ratings (90+) out of the thirteen areas.

High Performing Teams
We are working to embed a management system that enables continuous improvement of access, quality, experience, and outcomes. Our aim is that by 2024, we will have successfully translated our gesh strategic objectives into priorities that are viable and understood at every level of the organisation; our performance data, systems, and behaviours are well aligned; and standardised improvement habits and tools are supported across gesh.

Currently, our site teams use a visual management board to support their weekly huddles. I have joined these discussions and have seen how it’s improved communication and created a clear understanding of priorities. We have started collecting data from all parts of the organisation and analysing it as an executive team. This will help us identify common themes and trends across different departments and bring attention to services that may require improvement, as well as areas where we can implement best practices. This work is ongoing, and we are excited to share more in the upcoming months.

5.2 Events

GESH Long Service Awards

At the beginning of this month, we hosted the inaugural "gesh 25" event to honour colleagues from across the Group who have dedicated over 25 years of service to the NHS. This marks a new approach by the Group to acknowledge and reward staff with 25 years or more of continuous NHS service. We organised an afternoon tea for 30 members of staff and inducted them into our digital Hall of Fame to document their accomplishments and service. This event is the first of six long service events across our sites over the coming months.

6.0 Recommendations

6.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	2.1	
Report Title	**Quality Committees-in-Common Report to Group Board**	
Non-Executive Lead	Andrew Murray, Quality Committees Chair, ESTH and SGUH	
Report Author(s)	Andrew Murray, Quality Committees Chair, ESTH and 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 their meeting in August 2024 and the matters the Committees wish to bring to the attention of the Group Board. These are:

- **Interstitial Lung Disease (ESTH):** The Committees reviewed an update report regarding the treatment of Interstitial Lung Disease (ILD) at ESTH and the actions being taken by the Trust to address quality and safety concerns in the treatment of ILD. An initial review of cases had been completed and had identified a number of patients who needed to be assessed within the Outpatient Clinics. A number of patients were now also being considered at MDT Meetings. An external review by an independent panel of assessors from the Royal College of Physicians had been commissioned. A separate review of culture and ways of working within the ESTH Respiratory Medicine Department, commissioned by the Trust had been undertaken and the outcomes had been shared with the team.

- **Concerns regarding Safety in the Group's Emergency Departments:** There continued to be concerns relating to safety within the Group's Emergency Departments. These were multifaceted and although much mitigation was in a place some challenges were difficult to resolve and required action outside of the department and with system partners. Issues such as not being able to admit patients in a timely manner were resulting in overcrowding and having to care for patients in unsuitable areas such as corridors.

Action required by Group Board

The Group Board is asked to note the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in August 2024.

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, 05 September 2024

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 August 2024 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 29 August 2024 the Committees considered the following items of business:

August 024
• Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF) • Update on quality and safety within the Group's Emergency Departments • Group Maternity Services Report* • Interstitial Lung Disease (ESTH)* • Head and Neck Service Update (SGUH) • Robotic Surgery (SGUH) • Group Integrated Quality and Performance Report* • Group Annual Complaints Report • Group Annual Infection Prevention and Control Annual Report • Research and Development Strategy

** Items marked with an asterisk are on the Group Board agenda as standalone items in September 2024.*

2.2 The meeting was quorate in August 2024.

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 at its meeting in public.

a) Quality and Safety within the Group's Emergency Departments (EDs)

The Committees had recognised for some time the considerable pressures that the Group's Emergency Departments were continuing to operate under. Issues ranged from the number and acuity of patients, the environment within the departments, an increase in patients with mental health concerns who needed specialist services, lack of ability to discharge patients due to delays in care packages and continuing financial pressures. It was now widely acknowledged that pressure and overcrowding within the Group's EDs presented the biggest known patient safety risk for the trusts.

At the meeting in August 2024 the Committees received detailed information relating to the different types of concerns and the actions being taken to try and address them.

Key points from the report included:

The Local Picture – Emergency Department Performance at SGUH and ESTH

- The GESH Emergency Departments are under similar strain to the rest of England and Wales. Whilst some metrics were improving, staff continue to say that the situation on the ground remains challenging due to multiple factors. ED consultants at SGUH recently wrote to the CQC to express concerns; and the CQC visited SGUH ED following three falls in ED, which sadly resulted in fatalities. The ED Consultants at ESTH wrote to the Managing Director with concerns about the pressures and safety risks.

Assurance on after action reviews and actions arising from recent SIs at SGUH

- In Q3/4 2023 there were two falls in SGUH ED that sadly resulted in death. In Q1 2024 there was a further fall in SGUH ED that sadly resulted in death. Action plans are in place, and implementation and monitoring was being done by the Falls Steering Group across all Sites.
- In June 2024, a baby was brought into the ED by ambulance and died unexpectedly. All appropriate external referrals have been made.
- Actions plans in response to the falls are underway, including the introduction of a Group-wide Falls Steering Group to provide oversight and governance to this area.
- The After Action Review following the third fall confirmed that all previous actions from the previous two fatal falls were completed, including placement of fall-risk patients in high visibility bays. The review highlighted several key learning points aimed at preventing future incidents and enhancing patient safety. Immediate actions in response to the death of the baby in ED have been completed including implementation of a new SOP for staff receiving LAS handover.

Long stay and complex patients in ED including safety of corridor care and falls prevention, mental health, safeguarding and repeat attenders.

- Increased corridor care due to overcrowding can lead to a compromise of privacy, dignity, nutrition, hydration and skin care.
- New Pathways: SGUH had embedded direct streaming to SDEC to reduce crowding and improve flow, expanding the service to include surgical SDEC.
- Focus on Ambulance Handovers**:** ESTH had improved ambulance handover times to reduce risk, resulting in increased corridor care usage but less time for ambulance handovers.
- ESTH: Intentional rounding is in place for all patients and in particular corridor care, and the team are addressing the privacy and dignity concerns. They are also monitoring the hours spent in the corridor and this supports getting patients into the right bed to reduce hours in the corridor.
- There continues to be an increase in the number of patients with Mental Health concerns being cared for in the Group's EDs. A key driver of risk is the length of stay for these patients, which is rising. This risk is particularly acute for patients assessed under the Mental Health Act who require specialist beds, and specialist care whilst they remain waiting in ED for transfer. ED is not a suitable environment for these patients,increasing the risk of deterioration for the patient and having a negative impact on the ED environment and staff.

Flow: 12-24 hours, action on DTAs and balancing risk across the Trusts

- Poor Patient Flow throughout the Hospitals remains a key driver of overcrowding in ED, as attendances and DTAs increase. There is a significant and impactful amount of work happening across the Group to tackle this. Further details would be shared at the next meeting.

The meeting raised concerns in respect of the staff within the departments who were continuing to have to work under difficult and pressurised circumstances. The suggestion was made that there needed to be explicit information on whether additional financial investment might make a difference to the issues within the EDs. The level of confidence in the various mitigations which had been put in place, and whether this would be sufficient to resolve the concerns was also queried.

Following questions from the meeting it was noted that, although the trusts were in a difficult financial position, this had not stopped investment in the departments. Financial investment remained focused on patient safety.

It was acknowledged by the Committees that the two trusts were working hard to ease the pressures within EDs and would continue to seek to identify further action. What was also required was a greater system wide response to resolve issues relating to difficulties with access to GPs, availability of community and social care and the need for better provision of services for patients with mental health concerns.

The Committees agreed that although lots of work was taking place across the trusts to try and resolve the concerns within the EDs there remained limited assurance. The meeting would continue to receive updates on the concerns and progress on work being undertaken to resolve them. This would include a focus on flow of patients through the trusts.

b) Interstitial Lung Disease (ESTH)

At their meeting in August 2024, the Committees reviewed an update relating to the treatment of Interstitial Lung Disease (ILD) at ESTH. Issues relating to the care of some patients with possible ILD had originally been highlighted to the Committees in March and June 2024. This had followed concerns raised through a number of avenues that indicated possible departures from recognised best practice in the treatment of ILD from one specific Consultant that may have led to harm as a result of patients not receiving disease modifying treatment in a timely way.

The Committees heard that the Trust was continuing to investigate the concerns and had taken action to identify and follow-up with those patients who may not have received timely care. Where there were concerns regarding care, patients were being contacted and were being invited to urgent Outpatient Appointments.

The Committees received confirmation that the Royal College of Physicians had been engaged to review a set number of case notes to make a judgement on the possible level of harm caused to patients.

A summary of the key workstreams relating to the treatment of patients with possible ILD was included within the update report for the Committees.

The Committees raised questions relating to ensuring Duty of Candour was being enacted. It was confirmed that although this was yet to be formally carried out in writing for patients, relatives and carers, staff had been guided to be open and transparent when seeing patients in person. Conversations should be recorded in patient notes. The Committees would receive assurance relating to Duty of Candour in due course.

The Committees agreed that the issues with how the Consultant had treated patients with possible ILD remained of significant concern but that they felt that had received assurance that appropriate action was being undertaken. The Committees would continue to receive updates to closely monitor progress.

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) Maternity Services Update

The Committees received the regular update report from the Group's maternity services. Points to particularly note included:

- **Risks at SGUH** - The existing staffing risk on the risk register, currently graded at 20, had been reassessed. Over time, the nature of the risk had evolved and no longer accurately reflected the current staffing challenges. To address this, the service had identified two specific risks that better capture the ongoing concerns:
  - **Recruitment Lag for Newly Qualified Midwives:** There was a significant time delay between the qualification of new midwives and their availability to start work, which is impacting staffing levels.
  - **High Levels of Short-Term Sickness**: Elevated rates of short-term sickness are affecting staff availability and, consequently, the fill rate.

- **Training –** there continued to be issues relating to compliance with training requirements, particularly relating to Anaesthetic and Obstetricians Consultants. This related to PROMPT Training, Neonatal Life Support and CTG training. Groups of staff had been directly booked onto training events to take place prior to the end of August 2024 to address this.

- **Safe Staffing** – It was noted that Safe Staffing levels continued to be different at the two trusts. This was in the process of being reviewed. Safe staffing levels at ESTH were within the compliance level but this had not been the case at SGUH in June 2024.
  - Short term sickness absences continue to be challenging on both sites. Work is being done to support managers to address sickness absence in accordance with Trust policy.

- Epsom had now appointed into their band 5 scrub/recovery nurse posts, with the staff members currently undergoing their induction to the department. St Helier will advertise for their additional 5.4 WTE band 5 nurses very shortly. A cross site band 7 theatre coordinator has also been successfully recruited.
- There has been a focus on ensuring that the flow of patients through the unit is improved, especially in reference to inductions of labour at the St Helier site. Although unavoidable delays still occasionally occur, patient flow and satisfaction appear to have improved.
- Both sites are awaiting newly qualified midwives to begin their orientation in late September 2024.
- The activity and acuity across the unit at SGUH had meant that the staffing deficits in May and June had been manageable without significant clinical impact.
- At SGUH, the unit was on boarding 5 WTE Band 6 Midwives from July onwards and interviewing for 6 WTE vacancies in August. The unit was on boarding 14 WTE Band 5 preceptorship midwives from September onward.

The Committees agreed that there was limited assurance relating to Maternity Services across the Group. More work was needed to ensure that the report to the Committees was as clear as possible and that there was evidence of changes being implemented.

b) <u>Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF)</u>

The Patient Safety Incident Response report had replaced the Serious Incident Report and aimed to provide the Committees with assurance that both trusts were meeting safety standards and learning from patient safety incidents. The report continued to include the legacy Serious Incidents whilst they are under investigation. Particular point of note in the report included:

- The Group had now transitioned to the Patient Safety Incident Response Framework (PSIRF) across all areas which replaced the previously used Serious Incident Framework.

- Details of the Patient safety incidents requiring further investigation for the most recent reporting period (May and June 2024) and compliance against current NHSE, ICB and internal reporting/investigating standards. Also included were immediate learning and actions identified as incidents occurred, as well as broader safety themes emerging from incident review and the actions being taken to address these. Details of themes were noted to be beginning to emerge from Patient safety incident investigations (PSIIs).

- Examples of learning responses including After Action Review and MDT learning reviews were included. The Committees were particularly pleased to see these examples as they demonstrated some of the new ways of working expected as part of the PSIRF.

- Progress with the Group PSIRF implementation plan was evidenced, including staff training and governance and division/care group progress. The Committees noted the

good progress in relation to training compliance - with 92% of staff at ESTH and 90.6% of staff at SGUH having completed Level 1 training (target 85%).

- The approach being taken to ensure there is wide dissemination of system learning, including exchange of learning between ESTH and SGUH, and triangulation with other sources of assurance that learning is leading to action and sustained improvements.

- Both sites continue significant work to embed a safety culture in the operating theatre setting following the increase, which QCiC had discussed previously, of Never Events involving wrong site surgery and retained foreign objects. In addition, emerging themes of Never Events outside of the theatre environment highlights the importance of the safety culture of LocSSIPs. Immediate actions as well as ongoing safety work was detailed and challenges were raised by the Committees about the importance of ensuring actions are effective and that compliance is audited.

Questions were raised by the Committees in relation to outstanding actions from Serious Incidents with assurance received that they continued to be worked through.

Overall the Committees felt that there was reasonable assurance relating to PSIRF across the Group, but that they would like to be able to see more evidence of embedding of learning into the future.

5.0 Other issues considered by the Committees s

5.1 The Committees wish to report to the Group Board the following matters on which they received reports or updates.

a) Research and Development Strategy

The meeting received an update on Research and Development work taking place across the two trusts.

It was noted that there had been continued good progress on the 2019 to 2024 SGUH research strategy, including additional core National Institute Health and Care Research (NIHR) funding of £441K for research infrastructure. The NIHR Clinical Research Facility had been fully established, and there had been an increase in early phase research along with the set-up of a Patient and Public Research Group. Overall, SGUH recruited patients to 269 clinical research studies in 2023/24 (almost the same as the previous year), however there was a fall in clinical trial patient recruitment by around 1,000 to 8,700.

ESTH had seen a significant increase in patients recruited to clinical research studies in 2023/24 of 20% to over 4,400, continuing a year-on-year increase. This places ESTH amongst the top performing NHS Trusts in South London, despite the constraints of having a “smaller” Trust managed budget within the Clinical Research Network. ESTH consistently outperformed the other smaller acute Trusts in South London in terms of research activity.

It was planned that a Group Research and Development Strategy would be developed which would be brought to the Quality Committees in Common when ready for approval.

b) Group Annual Complaints Report for 2023/24

The Committees received the Group Annual Complaints Report for 2023/24 noting that this was the first time that a GESH Group Complaints Report had been produced. The report outlined the 2024/2025 objectives relating to continuing to improve complaint handling.

The total number of GESH complaints received has increased from 1205 in 2022/2023 to 1323 in 2023/2024. This equated to a 9.8% increase.

Most GESH complaints in 2023/2024 related to clinical care treatments (45.5%) and communication (14.6%). In terms of divisional areas across both sites, the majority of complaints related to Medicine (ESTH) and Medicine and Cardiology (SGUH) divisions, a total of 252 (49.5%). It was recognised that these were the busiest Divisions within the Group.

The performance in responding to complaints had yet to be within guidelines, with only 58.2% completed within the allocated timescale, with particular issues noted at ESTH. The decrease in compliance was attributed to changes in the complaints process, staffing challenges and extension requirements for more complex complaints. The latter could be at the request of patients and/or staff. The two staff teams dealing with complaints had now been brought together as part of the Corporate Nursing Review and it was hoped that this would lead to an improvement with the compliance rates for responding to complaints. In February 2024, the Group Chief Nursing Officer initiated a comprehensive review of the complaints handling approach across the Sites, Divisions, and Services to develop a Group approach to handling complaints... It had been recognised that more must be done to monitor recommended actions identified from the investigation of a complaint and ensure the lessons are learnt across the Group.

The Committees discussed the fact that often patients / relatives / carers who were raising simple concerns, just wished to speak to somebody and an initial telephone call can quickly resolve issues satisfactorily. Whilst some areas were confident to use thus approach it was agreed that it should be promoted further and be built into the updated Group wide Complaints Policy which was currently being drawn up.

c) Group Annual Infection Prevention and Control Report

The Committees received the Group Annual Infection Prevention and Control Report for 2023/24. Points of note from the report included:

- **Gram Negative Bloodstream Infections (GNBSIs):** Across the group, there was a continued increase in incidences of HCAIs and in particular *C. difficile* and gram negative bloodstream infections (GNBSIs) such as *E.coli.* Despite interventions and efforts to reduce GNBSIs, both sites breached the national thresholds for *E.coli* for 2023/24.

  Both trusts had undertaken several reviews to identify themes or any learning to try and reduce the number of infections and in particular *E.coli* bloodstream infections. Some cases were attributed to catheter management. However it was confirmed to the Committees that it was often difficult to determine the source of these types of infection and that many people were now colonised with E.coli whilst usually showing no symptoms.

- **SGUH - MRSA bloodstream infections:** The Trust had zero MRSA bloodstream infections in 2023/24 against a nationally set MRSA objective of zero infections. This was the first time the Trust has had zero MRSA bloodstream infections since the introduction of mandatory surveillance in 2005.
- The total number of *C. difficile* cases for 2023/24 at SGUH was 41 against a national trajectory of 42. The Trust was 1 of 27 Acute Trusts out of 137 acute NHS Trusts that did not breach the set NHSE trajectory for 2023/24.

- **ESTH - MRSA bloodstream infections:** After three consecutive years of the Trust having had zero MRSA bloodstream infections since the national trajectory were introduced in 2006, in 2023/24, there were two MRSA bloodstream infections against a national set MRSA trajectory of zero infections. Post infection reviews were undertaken for both cases, one of which was an unavoidable case and the PIR concluded that this was an unavoidable case in a patient with multiple complex co-morbidities.
- **ESTH - *C. difficile:*** The Trust went over the NHS England national set trajectory for *C. difficile* infections. The total number of *C. difficile* cases for 2023/24 was 63 against a national trajectory of 38.

The Committees particularly noted the ongoing issues across all sites relating to aged estates, resulting in poor ventilation. These concerns increase the risks in respect of Infection Prevention and Control. Over 2024/25 one of the main priorities for the team would be to continue to work with trust Estates leads to ensure a robust system is in place to monitor risks associated with existing systems and ongoing building works compliance relating to ventilation.

d) SGUH Robotic Surgery

Following discussion at a Group Board meeting regarding a recent never event in a neighbouring South West London Trust, the Surgery, Theatres, Neurosciences and Cancer Division at SGUH was asked to provide assurance with regards to the governance process surrounding the robotic programme SGUH.

The robotic programme at SUGH was established more than a decade ago, initially in Urological surgery, and had since expanded into Thoracic Surgery, Lower GI Surgery, Head and Neck surgery and (imminently) gynaecological surgery. This expansion had been enabled by the recent permanent acquisition of a second robotic console that has now been used on the hospital site for over 12 months.

It was confirmed that the programme was overseen by a SGUH Robotic Steering Group, which meets monthly and is chaired by the Consultant Surgeon, who was instrumental in founding the robotic programme at SGUH. The management team from the robotic surgery manufacturer, Intuitive, are present at these meetings and they regularly share remotely collated data relating to the robotic surgical programme. Current data from Intuitive indicates that the service at SGUH is one of the highest performing robotic services nationally, with the utilisation of the trust robots being in the top percentile. There was currently no data to suggest any significant adverse outcomes robotic surgery at SGUH. However, a meeting was planned

for September 2024 to discuss the NHSE London Region's current review of the provision of robotic surgery. It would also give the opportunity to highlight areas of good practice, and to consider the future of the robotic service at SGUH as it becomes more mainstream within surgical practice.

The Group Chief Medical Officer reminded the meeting that the majority of newly qualified surgeons over the coming years would have expectations of being able to work with robots and other forms of technology when performing surgery. It was therefore important for the Group to be able to provide these opportunities in order to continue to attract new staff.

The Committees agreed that they had received reasonable assurance relating to governance of Robotic Surgery at SGUH and they welcomed the plan to receive a further update in a few months.

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 Committees received assurance in August 2024.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	Choose an item.	
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 August 2024 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: Note the paper

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Add Appendix Name – delete line if not needed
Appendix 2	Add Appendix Name – delete line if not needed

Appendix 3	Add Appendix Name – delete line if not needed

Implications

Group Strategic Objectives

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

Risks

[Summarise the key risks on the Corporate Risk Register and Board Assurance Framework to which this paper relates. Also set out any risks relevant to the content of the paper – set out further detail in the main body of the paper.]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

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, 05 September 2024

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 and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 26th July and 30th August 2024, the Committee considered the following items of business:

26th July 2024	30th August 2024
PUBLIC MEETING • Planning 24/25 • Finance Report (M3) • CIP Update (M3) • Cash update • Update from Group Recovery Board • Costing update • MTFM update • IQPR • Assurance Ratings for finance papers • Procurement committee approval process	**PUBLIC MEETING** • Finance Report (M4)* • CIP Update (M4) • Cash update • Update from Group Recovery Board • Productivity update • IQPR

**items marked with an asterisk are on the Group Board agenda as stand alone items in September 2024*

2.2 The Committee was quorate for both meetings.

3.0 Analysis

4.0 Sources of Assurance

4.1

a) Planning update

In July the GCFO noted the SWL plan close down letter received from NHSE. He noted that the letter clearly shows the importance of delivering the financial plan, as well as the required operational objectives.

b) Finance Report M4

The GCFO noted ESTH and SGH were on plan as at M4 24/25, although both organisations had pulled forward benefits from future months in order to deliver the plan.

c) CIP update

The GCFO noted the progress in turning schemes to 'Fully Developed' at the two trusts although too much CIP was sitting in 'Plans in Progress' or 'Opportunity'. Committee members noted the importance of delivering identified schemes as well as focussing on developing new ideas to save money.

d) Cash update

The GCFO introduced the cash update where a Q3 cash drawdown request would be worked up for approval by Chairs' action after the Group Board. Committee members discussed the various options while there was no further clarity on the deficit funding originally agreed by NHSE.

e) Recovery Board update

The GCFO informed the committee of the work being undertaken by the Recovery Board to improve the financial forecast for the group. Committee members welcomed a more radical approach to savings and a transparent approach with NHSE.

f) Costing update

The Committee noted the latest costing information from the Group.

g) MTFM update

The GCFO noted that with annual leave across August there has not been clear progress made on the SWL Medium Term Financial Model (MTFM) and this will need to be addressed in the coming weeks.

h) Productivity update

The SGH DFS noted challenges with data quality in information received from NHSE which makes drawing conclusions on published productivity data challenging. The organisations were picking this up directly with NHSE colleagues.

i) IQPR

Against the **4-hour ED** waiting time standard, SGUH delivered 81.6% in July 2024, exceeding trajectory and demonstrating continuous improvement alongside other urgent and emergency care metrics, including a significant reduction in LAS handover waiting times and length of stay. Whilst ESTH has seen a reduction in the super stranded patient cohort (LOS >21 days) and an uptick in SDEC activity, 4-hour performance in the ED remains challenged, with performance of 75.8% against 76.5% trajectory.

The number of **65-week waiters on a Referral to Treatment (RTT)** pathway at ESTH increased in June 2024 to 154 pathways, against a month-end target of 100. The Trust is still aiming to have zero 65 week waits by the end of September 2024, in line with the national target, other than patient choice delays. Gynaecology remains the most challenged specialty at ESTH with an increase in the inpatient/daycase waiting list due to a backlog clearance capacity gap. Insourcing arrangements are now in place in theatres as part of the gynae recovery plan to address this. At SGUH, the number of

RTT pathways exceeding 65 weeks has also increased with Neurosurgery being the most challenged specialty. There is a risk of approximately 20 patients being over 65 weeks by the end of September 2024, some due to patient choice.

ESTH delivered against all three **national cancer standards** in June 2024: 28-Day Faster Diagnosis (87.2%), 31-Day Decision to Treatment (100%), and 62-Day Referral to First Treatment (90.4%). SGUH performed better than trajectory for all three standards, 28-Day Faster Diagnosis (75%), 31-Day Decision to Treatment (96.2%) and 62 Day Referral to First Treatment (77.2%). At SGH Faster Diagnosis performance within Breast cancer has seen a decline in performance to a non-compliant position. A recovery action plan is in development with support from RMP. Lower Gi is most challenged with a performance of 53% with CTC access at QMH and endoscopy process delays being contributing factors, recovery actions are being developed.

Integrated Care Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in June 2024. Sutton Health & Care achieved 84.2% and Surrey Downs Health & Care, 90.4%, with a continued focus on encouraging more referrals. Virtual Ward occupancy target of 80% continues to be met at Surrey Downs and continued improvement seen at Sutton. The re-enablement Unit at Sutton was fully utilised with 100% occupancy through July 2024.

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

a) Assurance ratings for finance papers

The GCFO outlined the principles that would be used in deciding what assurance rating would be given in the cover sheet for finance papers moving forward.

b) Procurement committee approval process

The GCFO outlined an improved process for agreeing tender awards and preferred suppliers following the referencing issue outlined in the June Committee. **This was approved by committee members.**

5.0 Implications

5.1 The Committee considered the BAF operational-related risks at each committee and agreed with no change in the assessment at the current time.

5.2 The Committee considered the BAF finance risk at each committee and agreed with no change in the assessment - the highest score, ‘25’, for each organisation.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Board and the wider issues on which the Committee received assurance in July and August 2024.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	2.3	
Report Title	**People Committees-in-Common Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committee Chair, SGUH Martin Kirke, People Committee Chair, ESTH	
Report Author(s)	Yin Jones, 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 in August 2024 and the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- gesh People Strategy Implementation Plan: The Committees reviewed the implementation plan for the gesh People Strategy (2024-26). The implementation plan sets out the key pillars and underpinning activity that People/HR function will be responsible for delivering - working collaboratively with other teams across gesh. The Strategy will seek to support delivery of the gesh vision for 2028 – Outstanding Care, Together. The key milestones have been identified and progress will be monitored against these at regular intervals. The new GCPO noted that she had inherited the Strategy and suggested three minor amendments to better reflect our focus and activity. She explained that the programme plan would be finalised via Group Executive Meeting (GEM) and People Committees-in-Common (PCiC) with regular updates that will be brought to the Group Boad.

- High Impact Action Plan: Refreshed Focus for EDI: The Committee noted that there were several 'live' action plans relating to EDI across gesh. These plans were produced to deliver improvements which were informed by specific equality reports requirements e.g. WDES, WRES, Gender Pay Gap. The Committee welcomed the proposal outlined in this report to review all open actions and align activities with NHSE's High Impact Action Plan, which is a mandatory action plan designed to address the inequality and discrimination within the NHS.

- Employee Relations Annual Report: The Committees reviewed the reports for both ESTH and SGUH in detail and noted the progress being made by both trusts in improving Employee Relations services. Members welcomed the work that was being put into place to develop the services as Centres of Excellence for Employee Relations.

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 August 2024.

Committee Assurance	
Committee	People 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	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, 05 September 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meeting in August 2024 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 8 August 2024, the Committee considered the following items of business:

August 2024
• Group Chief People Officer Report • Medical Revalidation Responsible Officer Report: Annual 2023/24 and Q1 2024/25 for ESTH and SGUH. • Guardian of Safe Working Reports: Annual 2023/24 and Q1 2024/25 for ESTH and SGUH. • People Strategy Implementation Plan • Workforce Race Equality Standard (WRES) Report – combined report • Workforce Disability Equality Standard (WDES) Report – combined report • Equality Delivery System: Update on Domain 3 • High Impact Action Plan: Refreshed Focus on EDI • Workforce Performance Report • Area of focus: Employee Relations • Certificates of Sponsorship Update

2.2 The Committees are now meeting every two months as agreed by the Group Board, and the chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH. An informal meeting of the Chairs and GCPO takes place between Committee meetings.

3.0 Key issues for escalation to the Group Board

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

a) People Strategy Implementation Plan:

The Committees reviewed the paper and welcomed the new GCPO's plans to broaden accountability for improving organisational culture and the People function in general, as well

as re-establishing the EDI forum and reviewing OD (organisational development) interventions.

The People Strategy Implementation Plan set out actions that would be delivered from 2004 to 2006 against the following five key areas:

1) Get the basics right for our staff
2) Improve staff wellbeing
3) Inclusive culture driven by our values
4) Develop our workforce for the future, and
5) Embrace integrated ways of working.

The Committees welcomed the fact that the implementation plan had outlined the timeline as well as the metrics and KPIs for our core activities to ensure that impact and successes can be effectively measured. The GCPO explained that the implementation plan would be finalised via GEM and People Committees-in-Common with regular progress reports presented to the Group Board.

<u>High Impact Action Plan: Refreshed Focus for EDI:</u>

The Committees welcomed this action plan which aims to align current gesh EDI activities with NHSE's High Impact Action Plan (HIAP). HIAP is a mandatory improvement plan which sets out targeted actions to address inequality and discrimination within the NHS. Following the launch of the HIAP, an initial review of our internal action plans was carried out which identified that many of them aligned well with the HIAP.

The Committees noted that, at an organisational level, this approach would be grouped into our top 3 EDI priorities:

1. Improve representation, career development, and retention (NHS HIA2&3).
2. Improve health, wellbeing and experience of all staff (NHS HIA 3&4).
3. Improve allyship, behaviours and building workforce awareness and capability (NHS HIA 1&6)

The Committees noted that that gesh was in a much better place than one year ago and added that priority should be given to implementing good practice and developing a toolkit for line managers around succession planning and how talent is managed through good quality appraisals and talent pools.

b) <u>Employee Relations (ER) Annual Report:</u>

The Committees noted the volume of ER case work at both Trusts as well as the need for further work to strengthen the support provided to divisions to reduce and manage sickness absence. The number of live tribunal claims at ESTH was in line with other NHS Trusts and, whilst the number was higher at SGUH, it was not an outlier.

The Committees commented on the data presented in the report for disciplinary, grievance, employment tribunals and suspensions cases and requested narrative explanations and data analysis in future reports which would compare data from different quarters and identify trends.

The importance of having courageous conversations between line-managers and team members was highlighted as well as the need to support staff to discuss any issues much earlier and prevent formal grievances if possible.

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) Medical Revalidation Responsible Officer Report: Annual 2023/24 and Q1 2024/25 (April-June 2024)

The Committees received reports from the Responsible Officers (ROs) for medical revalidation at each Trust. At both trusts, the reasons for appraisal deferrals included maternity, sick and career leave as well as increased work pressures due to doctors' strike action. The largest number of postponements was for new starters to the Trust who were without a previous appraisal or those who were returning to practice after a break; these doctors require time to build evidence for a comprehensive appraisal.

As of 30th June 2024, there were 774 doctors connected to ESTH and 1213 doctors connected to SGUH. There had been a slight drop in the total number of doctors at ESTH and an increase at SGUH. The decrease at ESTH was the result of doctors who recently retired and a small cohort who had gone back into training, whereas the increase at SGUH was because some doctors had left the organisation but were yet to disconnect.

The Committees agreed to progress with signing the Statement of Compliance for 2023/24 for SGUH and ESTH.

b) Guardian of Safe Working (GOSW) Annual Report 2023-24 and Q1 2024/25 (April-June 2024)

The Committees received the GOSW reports for ESTH and SGUH which summarised the issues for junior doctors working in the two trusts over the year 2023-24. The year saw multiple episodes of strikes by junior doctors, and these were ongoing. This had impacted the wellbeing of junior doctors and had a significant impact on pay for those choosing to strike. Junior doctors were also impacted by consultant strikes. The Committees received reasonable assurance on the GOSW reports.

c) Workforce Race Equality Standard (WRES) Report – combined report

The Committees reviewed and noted the positive progress in a number of WRES indicators at both ESTH and SGUH. Despite the fact that the proportion of BAME staff had increased, both Trusts continue to grapple with disparities, particularly in senior leadership roles where BAME representation remains low. The reports will be finalised and presented to PCiC in September before coming to the Group Board for approval.

d) Workforce Disability Equality Standard (WDES) Report – combined report

The Committees reviewed and noted the findings for both ESTH and SGUH. The 2024 WDES reports for ESTH and SGUH provided a comprehensive overview of performance

across key metrics, including workforce representation, recruitment, formal capability processes, harassment and bullying, career progression opportunities, and board representation. Following approval from the PCiC, the Equality Diversity and Inclusion (EDI) leads will review the findings of this report against the current EDI action plan. This review will include an assessment of any gaps, identifying areas where further actions are required. The aim is to determine what additional measures the Trust can implement to improve the WDES findings and ensure a more inclusive and supportive work environment for all disabled staff.

e) Equality Delivery System: Update on Domain 3

The Committees reviewed and noted the information for Domain 3 of the Equality Delivery System (EDS). EDS was created to help NHS organisations improve their services and create work environments free of discrimination. There are three domains and the focus for this meeting was Domain 3: Inclusive Leadership.

- Domain 1: Commissioned or provided services - completed and reviewed by PCiC
- Domain 2: Workforce health and well-being - completed and reviewed by PCiC
- Domain 3: Inclusive leadership

An overview and outcomes for Domains 1 and 2 had previously been presented to the Executive via PCiC. Feedback from PCiC had been addressed and was being incorporated into the final report. As Domain 3 requires independent review, it will be shared with our selected reviewer for comment and suggested scoring. Once their scores are received, they will be incorporated into the final EDS report which will return to GEM and PCIC for approval to publish.

5.0 Other issues considered by the Committees

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

a) Workforce Performance Report

The Committees continued to receive regular updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance.

The Committees welcomed the fact that some updates were made to how this report is structured. Going forward, there will be more focus on the actions being taken to address the issues identified by the Workforce KPIs.

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 August 2024.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	2.4	
Report Title	**Infrastructure Committees-in-Common Report to Group Board**	
Non-Executive Lead	Ann Beasley, Chair of Infrastructure Committees-in-Common Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	
Report Author(s)	Ann Beasley, Chair of Infrastructure Committees-in-Common Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meetings on 24 May and 19 July 2024. The key issues the Committee wished to highlight to the Board are:

1. **South West London Electronic Patient Record (EPR) implementation:** The Go-live date in May 2025 had been brought forward by one week to 9th May 2025 to avoid potential capacity issues caused by the May half-term holidays and late May bank holiday. Due to delays with getting the new data migration partner, the team put mitigation in place to make sure that upload four took place from the 5 August 2024 as planned. No specific issues or concerns were flagged by EPR-SRO in relation to this. Additional work was commissioned to review the governance of the plan in conjunction with FD and to look at the finances as well. RSM, the internal auditors, started a review of the finances on 18 July 2024.

2. **Group Green Plan:** The gesh Group Green Plan Strategy was approved by the gesh Group Board in early July 2024 following consultation with site leadership teams and discussion at the Group Board development session. Work will now focus on the implementation, including producing baseline data and clarifying the governance and reporting surrounding the programme.

3. **Intensive Therapy Unit (ITU):** A minor delay in the timeline would push the completion of the ITU new build across the 2024/25-year end. The delay would be minor, but NHSE has rules which state that the Targeted Investment Funding (TIF) officially closes on 31 March 2025. The team were working through the issues and finding solutions, but the situation was complex because of the interrelationship with the PFI provider and Planning. The project started during Covid and has proved to be very challenging because of material inflationary pressures. Members welcomed the news that there is now good governance in place and that comprehensive reports are being produced.

Action required by Group Board
The Group Board is asked to note the issues escalated by the Infrastructure Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in May and July 2024.

Committee Assurance	
Committee	Infrastructure 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

Infrastructure Committees-in-Common
Group Board, 05 September 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meeting on 24 May 2029 and 19 July 2024 and includes matters the Committee specifically wishes to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 24 May 2024 and 19 July 2024, the Committee considered the following items of business:

May 2024	July 2024
• St George's Estates and Facilities Assurance updates (including estates update, facilities assurance report, medical physics report, health & safety and fire report and estates and facilities risk update). • Epsom and St Helier Estates and Facilities Assurance updates (including estates update, facilities update and medical physics report) • Group Green Plan Update • Digital Delivery & Work Plan • Digital Governance Development Update • Digital Risk Management Update • Electronic Patient Record (EPR) Programme update • SWL Picture Archive and Communication system (PACs) Update.	• St George's Estates and Facilities Assurance updates (including estates and facilities update, review of estates critical planned preventative maintenance, medical physics and clinical engineering report and strategy statement, health & safety and fire safety report). • Epsom and St Helier Estates and Facilities Assurance updates (including estates update, facilities update and medical physics update). • Group Green Plan Update • Digital Strategy Development • Digital Delivery Update • Digital Risk Management Update • EPR Programme update • PACs Update • ITU Update

2.2 The Committee was quorate for both meetings.

3.0 Key issues for escalation to the Group Board

The Committee wishes to highlight the following key matters for the attention of the Group Board:

3.1 SWL Electronic Patient Record (EPR) implementation progress

The Committee received an update on the shared Electronic Patient Record (EPR) programme to create a common EPR across gesh on a shared domain. The Go-live date in May 2025 was brought forward by one week to 9 May 2025 to avoid potential capacity issues

caused by the May half-term holidays and late May bank holiday. Due to delays with getting the new data migration partner, the team put mitigation in place to make sure that upload four took place from the 5 August 2024 as planned. No specific issues or concerns were flagged by EPR-SRO in relation to this. Additional work was commissioned to review the governance of the plan in conjunction with FD and to look at the finances as well. RSM, the internal auditors, started a review of the finances on 18 July 2024.

3.2 **gesh Group Green Plan and South West London Green Plan**

The Deputy Group Chief of Facilities, Infrastructure and Environment Officer reported the latest activity for the Group Green Plan:

- The gesh Group Green Plan Strategy was approved by the gesh Group Board in early July 2024 following consultation with site leadership teams and discussion at the Group Board development session. The Strategy will be formally launched in September 2024.
- The focus is now on the implementation of the Strategy and the governance and reporting surrounding the programme.
- Other works continue across gesh on projects delivering carbon reduction schemes at both ESTH and St George's.

Members welcomed the clarification of priorities for 2024/25 which include aligning the Green Plan with the corporate functions (Strategy, PMO, CI) and reporting on financial benefits and challenges of the Green Plan.

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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:

4.2 **Estates Assurance Report**

The Committee received assurance reports on both Trusts' estates performance and compliance. The National NHS Estates and Facilities Day was very well received on the 19 June 2024 and members of the Strategic Estates NHSE team visited Epsom and St. George's on the day with some very positive feedback.

Members welcomed the appointments of the new Assistant Director for Estates and Engineering at SGUH, Ashley Nayeck, who started with the Trust on the 8 July 2024 and the new Assistant Director for Facilities Dave Hubbert who started with the Trust on the 22 July 2024.

Recruitment continued to be a concern within the team, in particular in the field of nuclear medicine which is a highly specialised area with corresponding levels of competition for resources between Trusts.

The Committee discussed the infection control groups at the Community sites and requested an update at the next meeting on 13 September 2024.

4.3 **Facilities Assurance Reports**

The mobilisation of the new Security Contract at ESTH has now taken place successfully following a tendering exercise.

Violence and Aggression continued to feature heavily on all sites. The teams were being supported but this was having an impact on morale. Against last year, there had been an increase of 41% in the levels of reported incidents. This continued to be a real focus for the Site and Group teams. Both ESTH and SGUH need to complete self-assessments against the NHS Violence Prevention and Reduction (VPR) Standard and provide board assurance twice a year.

The GMB union advised its members from the non-emergency patient transport (NEPT) services to support a two-week work to rule action and carried out a successful ballot supporting two days of industrial action. This was managed well with all teams working together and with no impact to patients. This union action was over current levels of pay and terms and conditions. A separate grievance has also been received from the Unison union, in relation to the Cleaning, Catering and portering staff, again over pay, terms and conditions.

5.0 Other issues considered by the Committees

5.1 Medical Physics Report

The Committee received its regular report on ongoing mandatory and statutory compliance with medical physics and clinical engineering requirements. Compliance and activity levels within the team remained good for core activities around the maintenance of clinical equipment. There have also been improvements in the management and oversight of the Steris contract which covers decontamination – a further report will be presented at the September 2024 meeting.

5.2 Group Digital Strategy Development

The report outlined the following core priorities that will be achieved through a funded and resourced Digital Plan for 2 (+3) years:

- EPR: The ESTH EPR Programme is a significant development requiring support beyond 2024. The common domain will have a profound effect on how both trusts work beyond go-live.
- Core network and infrastructure (1 stability 2 Maintenance 3 Improvement): Platform to ensure smooth running of the hospital estate and clinical services, avoiding significant unplanned intervention and costs.
- gesh Integration: enablement of efficiencies and improved care through cross-site collaboration and service provision; focusing improvements on alignment of the functionality of underlying infrastructure.

5.3 Digital Delivery Update

The Committee received the report setting out areas of work (improvements/projects) being delivered across ESTH and SGUH:

- Demand for projects was putting pressure on delivery of BAU; maintenance, incident management; and optimisation were necessary for the proper daily function of the Trusts.
- A regular number of Digital incidents have occurred including Network outage/ Cyber Incident/ ePMA prescribing that impact on the smooth running of the hospital
- estate and clinical services. These required significant unplanned intervention and highlight requirement of proactive investment.

5.4 **Digital Risk Management Update**

A need was identified to reset the ESTH and SGUH approach to Risk Management, as the two IDT departments were not aligned to the new gesh Board Assurance Framework (BAF). A revised risk management process has been developed to:

- Review and reset current ESTH/SGUH Digital risks.
- Establish a Group-wide risk management review process aligned to planning and resource management.
- Align with reporting against BAF gaps in controls/management action.

5.6 SWL Picture Archiving Communication systems (PACS) update

The Committee received an update on the SWL Picture Archiving Communication systems (PACS). The overall project continued to face significant challenges. The Committee received an update on the rectification plan requested from the supplier and next steps and noted that it would receive updates on further developments at future meetings, and if necessary, the GCFO would engage with the Chair and NED if more urgent or frequent discussions were required.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Infrastructure Committees-in-Common to the Group Board and the wider issues on which the Committee received assurance in May and July 2024.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	3.1
Report Title	**Group Maternity Services Quality Report** **May and June 2024 data**
Executive Lead(s)	Professor Arlene Wellman MBE, Group Chief Nursing Officer and DIPC
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH Dr Benedicta Agbagwara-Osuji, Director of Midwifery and Gynaecology Nursing ESTH Janet Bradley, Director of Midwifery and Gynaecology Nursing SGUH
Previously considered by	Quality Committees in Common 29-08-2024 ESTH Senior Leadership Team 28-08-2024 SGUH Senior Leadership Team 27-08-2024 gesh Quality Group 08-08-2024 ESTH Perinatal Meeting 02-08-2024
Purpose	**For Assurance**

Executive Summary

1.0 Purpose

It is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (December 2020) that specified monthly indicators and other maternity metrics and information to monitor maternity and neonatal safety, is discussed by the Trust Board (or a designated sub-committee of the Trust Board) at every meeting.

The purpose of the report is to inform the Quality Committee in Common (designated sub-committee of the Trust Board) of 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.

The report data covers the position as of May and June 2024.

2.0 Significant changes since the last report

ESTH: There are no significant changes since the last report.

SGUH: The existing staffing risk on the risk register, currently graded at 20, has been reassessed. Over time, the nature of the risk has evolved and no longer accurately reflects the current staffing challenges. To address this, the service has identified two specific risks that better capture the ongoing concerns:

1. **Recruitment Lag for Newly Qualified Midwives:** There is a significant time delay between the qualification of new midwives and their availability to start work, which is impacting staffing levels.
2. **High Levels of Short-Term Sickness:** Elevated rates of short-term sickness are affecting staff availability and, consequently, the fill rate.

Given these developments, it is recommended that the original staffing risk be closed and replaced by these two newly identified risks. This has been taken through and supported by the directorate and divisional leadership as well as governance team.

In June, there was a tragic incident involving the deaths of a mother and her newborn at 23 weeks of pregnancy. MBRRACE has been notified, and the case has been referred to the Maternal and Neonatal Safety Improvement Programme (MNSI).

3.0 Successes

There are no significant changes since the last report.

4.0 Concerns and new risks

ESTH BFI Gold Accreditation

The Maternity Service has been notified by the UNICEF UK Baby Friendly Team that our Baby Friendly Initiative (BFI) Gold accreditation has been paused due to unmet standards in several key areas. The specific areas requiring attention are:

1. Core Standards Compliance: Evidence of compliance with core standards has fallen below the 80% threshold.
2. Reduction in Supplementation: Continued efforts are needed to minimise supplementation and consider strategies to reduce mixed feeding.
3. Staff Culture Survey: There has been insufficient improvement in two aspects of the staff culture survey, which requires further action.
4. Senior Staff Engagement: There is a need for increased engagement from senior staff in strategy meetings and training related to the initiative.
5. Infant Feeding Team Capacity: The infant feeding team needs to be restored to full capacity to meet BFI standards.

An action plan is currently being developed by the infant feeding team with input and oversight from the maternity senior leadership team, to address the issues raised.

During the Maternity and Neonatal Senior Leadership Team (SLT) meeting on 19th August 2024, chaired by the Group Chief Nursing Officer (GCNO), the ESTH maternity team discussed the ongoing challenges in maintaining our Baby Friendly Initiative (BFI) Gold accreditation. The team proposed a strategic pause in our efforts to maintain gold status, recommending that the focus of the infant feeding team be redirected towards providing more hands-on support in ward areas, rather than being primarily occupied with audits required for gold accreditation.
The GCNO has requested that the Group Chief Midwifery Officer (GCMidO) develop a detailed proposal outlining the rationale for this pause, which will be presented to the Group Executive team for consideration.

SGUH BFI Accreditation

SGUH currently holds a Baby Friendly Initiative (BFI) Stage 3 accreditation, which was initially attained in 2016 and successfully reaccredited in 2018. Stage 3 accreditation indicates that the hospital has effectively supported mothers and babies in their infant feeding choices while fostering close and loving relationships between parents and their babies. This accreditation aligns with the BFI's two-year reassessment cycle. The next level of accreditation is Gold, followed by the "Achieving Sustainability" stage.

However, further assessments were paused due to the COVID-19 pandemic and have remained on hold following the Care Quality Commission (CQC) assessment outcome of "Inadequate."

In January 2024, BFI issued a statement regarding services rated as “overall inadequate” by the CQC:

“Any accredited service rated ‘overall inadequate’ through a CQC (or equivalent) review will be contacted. It is considered inappropriate to maintain a Baby Friendly accreditation for as long as a CQC ‘overall inadequate’ rating is in place. In this circumstance, we would amend Baby Friendly status to ‘Ongoing monitoring’ until the CQC (or equivalent) repeats a visit and indicates an improved outcome.” ***(appendix 2, reading room)***

During this period of ongoing monitoring, BFI will maintain regular contact with the service and review audit outcomes and progress. The aim is to restore full accreditation as soon as the CQC rating improves, without the need for additional assessments.

ESTH and SGH CNST: Both sites have set up fortnightly CNST progress meetings to monitor on-going progress and compliance with the Maternity Incentive Scheme year 6. At ESTH, there has not been attendance by the MDT but rather midwifery staff only, which has been noted and communicated as a concern. Consequently, ESTH have encountered delays in receiving updates on several safety actions, including SA3, SA4, and SA8. There are similar concerns about MDT attendance at SGUH, however, the progress at SGUH has been steady, which is evidenced by improved positions across SA6 SBLCB.

5.0 ESTH Training compliance related to the Core Competency Framework (April - June 2024)

Type of Training and % compliance	Staff Group	ESTH April 24	ESTH May 24	ESTH June 24
PROMPT 90%	Midwifery Staff	98%	97%	96%
	Maternity Support Workers	90%	92%	95%
	Consultant Obstetricians	92%	93%	90%
	Trainee and Staff Grade Obstetricians	97%	94%	86%
	Anaesthetics	86%	90%	82%
CTG Training 90%	Midwifery Staff	92%	95%	95%
	Obstetricians	94%	94%	88%
NLS (Newborn Life Support) 90%	Midwifery Staff	98%	98%	96%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff (requested)	94%	96%	96%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff (requested)	No data	No data	No data

SGH Training compliance related to the Core Competency Framework (April - June 2024)

Type of Training and % compliance	Staff Group	SGH April 24	SGH May 24	SGH June 24
PROMPT 90%	Midwifery Staff	91%	93%	93%
	Maternity Support Workers	91%	88%	91%
	Consultant Obstetricians	90%	89%	89%

	Trainee and Staff Grade Obstetricians	97%	96%	100%
	Anaesthetics	100%	89% (Anaesthetic consultant)	100% (Anaesthetic consultant)
CTG Training 90%	Midwifery Staff	90%	87%	87%
	Obstetricians	93% (100% Consultant and 86% middle grades)	88% (95% Consultant and 80% middle grades)	88% (95% Consultant and 80% middle grades)
NLS (Newborn Life Support) 90%	Midwifery Staff	92%	97%	93%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	82%	81%	77%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	76.47% 76.92% - Consultant 76.0% - Specialty Reg	73.57% 76.92% - Consultant 70.37% – Specialty Reg	73.08% 80.77% - Consultant 65.38% -Specialty Reg

All obstetric trainees are booked into CTG training which will improve the compliance further.
All neonatal nursing staff due for NALS have been booked onto the next session at the end of August 2024.

Safe staffing - ESTH

Staff Group	**Measure**	**April 2024**		**May 2024**		**June 2024**	
Midwifery	Fill rate (target >90%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		94%	89%	91%	91%	95%	93%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

Short term sickness absences continue to be challenging on both sites, but sicknesses are managed effectively in accordance with Trust policy. There are several ongoing long-term sicknesses across the department, for a variety of reasons including muscular skeletal issues, which are being managed with occupational health input.

Epsom have now appointed into their band 5 scrub/recovery nurse posts, and the staff members are currently undergoing their induction to the department. St Helier will advertise for their 5.4WTE band 5 nurses very shortly. A cross site band 7 theatre coordinator has also been successfully recruited.

The reconfiguration of maternity staffing is near completion and the new rosters are expected to launch on 9th Sept 2024 across both sites. After the new teams are established, recruitment will continue to fill any remaining vacancies.

There has been a focus on ensuring that the flow of patients through the unit is improved, especially in reference to inductions of labour at the St Helier site. Although unavoidable delays still occasionally occur, patient flow and satisfaction appear to have improved.

Both sites are awaiting newly qualified midwives to begin their orientation in late September 2024.

Safe Staffing - SGH

Staff Group	Measure	SGUH April	SGUH May	SGUH June
Midwifery	Fill rate (target >90%)	90%	88%	83%
Obstetric	Expected vs fill	100%	100%	100%
Band 7 supernumerary midwife at beginning of shift CNST year 6	Shift allocation 100% at start	100%	100%	100%
Triage staff 2 wte per shift	Shift allocation	100%	100%	100%

Short term sickness absences continue to be challenging on the SGUH site (between 4.04 and 5.05% which is above Trust average of 3.2%). Sickness is managed in accordance with Trust policy with planned regular meetings with HR to support this process. There are several ongoing long-term sicknesses across the department, which are being managed with occupational health input.

The activity and acuity across the unit at SGUH has meant that the staffing deficits in May and June have been manageable without significant clinical impact.
The unit is onboarding 5WTE Band 6 Midwives from July onwards and interviewing for 6WTE vacancies in August. The unit is onboarding 14WTE Band 5 preceptorship midwives from September onward.

6.0 Current or upcoming plans/reviews/Quality Improvement

There is a requirement under CNST for the maternity and neonatal team to jointly register and undertake a QI project relating to transitional care and minimising the separation of mothers and babies. At ESTH, this is being led by the Associate Director of Nursing for Paediatric and Neonatal Services and remains outstanding currently.

SGUH neonatal team's QI project is supporting Perinatal optimisation, however, there is an outstanding action to register the project with the QI team.

ESTH and SGUH: There is an urgent need to review the current arrangements for midwifery manager on-call duties. This review is going through an options appraisal process in collaboration with key stakeholders, including ESTH, SGUH, HR and Finance. There is inconsistency in the availability payments received by staff across different groups and the payment has not been reviewed or uplifted in line with NHS Council recommendation since 2015. Furthermore, staff are entitled to compensation for work performed during the on-call period, regardless of whether this work is carried out from home or at the workplace. It is important to note that the Trust currently lacks a formal policy for on-call arrangements, resulting in an absence of clear guidance on statutory rights, such as compensatory rest.

Action required by Group Board

The Group Board is asked to:

a) Acknowledge the key areas of success, risks, and mitigations, and consider any potential areas for further improvement.

b) Note the actions being taken in response to midwifery on-call arrangements.

c) Note the compliance issues with newborn life support training for medical staff and the implications in not meeting CNST Safety Action 8 by 30th November 2024.

d) Note that UNICEF UK BFI has paused the gold accreditation status at ESTH due to some unmet standards and stage 3 accreditation is paused at SGH maternity due to the Inadequate rating from the Care Quality Commission.

Appendices	
Appendix No.	
Appendix 1	**READING ROOM** ESTH Perinatal Mortality Review/ Board report
Appendix 2	**READING ROOM** UNICEF Baby Friendly UK Statement, January 2024
Appendix 3	**READING ROOM** ESTH CQC action plan
Appendix 4	**READING ROOM** SGUH CQC action plan
Appendix 5	**READING ROOM** SGUH Whose Shoes Event 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				
N/A				
Legal and /or Regulatory implications				
There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations. Within the Maternity Service, on-call arrangements are contravening the Working Time Regulations 1998 in terms of compensatory rest and not in line with NHS Terms and Conditions of Service in several areas, such as, availability payment, compensatory rest and payment for work undertaken, among others.				
Equality, diversity and inclusion implications				
As set out in the paper.				
Environmental sustainability implications				
No issues to consider.				

Group Maternity Services Quality Report

Group Board 05 September 2024

1.0 Purpose of paper

1.1 It is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (December 2020) that specified monthly indicators, and other maternity metrics and information to monitor maternity and neonatal safety, is discussed by the Trust Board (or a designated sub-committee of the Trust Board) at every meeting.

The purpose of the report is therefore to inform the Trust Board of 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 the maternity units across the Group.

2.0 Background

2.1 The report data covers the position as of May and June 2024.

The report will continuously evolve in response to the requirements of the Maternity and Perinatal Incentive Scheme (CNST) and the assurance requirements as requested by the Trust Board and its sub-committee(s).

Currently the report includes:

- The reporting requirements as stipulated by the Maternity and Perinatal Incentive Scheme Technical Guidance (including the Perinatal Quality Surveillance Model data requirements)
- Trend data over 15 months in relation to outcomes for women and babies
- Findings of any external reviews, including MBRRACE-UK, CQC, Staff Survey, etc.
- MNSI reported cases since the last report
- Patient Safety Incident Investigations declared since the last report and progress against action plans
- Patient feedback from the MNVP, surveys, FFT and complaints since the last report
- Triangulated themes from incidents, claims, PMRT reviews, MNSI cases and complaints/patient feedback
- Compliance with the Core Competence Framework (mandatory training)
- Audit compliance and actions taken to address under-performance
- Staff feedback from engagement sessions
- Regulatory and legal issues: status of regulatory actions, Ockenden/MSSP recommendations or Coroner directions

3.0 Analysis

3.1 Maternity and Perinatal Incentive Scheme (CNST) – Year 6

The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. There are 86 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2024). The deadline

date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2025.

ESTH has convened a working party within the Women and Children's Health Division to monitor compliance with the requirements of the scheme, gather evidence, and complete the Excel audit and monitoring tool (new) which has been provided for Trusts to use for assurance purposes.

Work is on-going and there has been an increase in green actions (from 4 to 21) since the last report. The current position is:

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	2	0	2	0	4
4	17	3	0	0	20
5	0	3	3	0	6
6	4	2	0	0	6
7	4	1	2	0	7
8	4	14	0	0	18
9	0	3	6	0	9
10	0	8	0	0	8
Total	31	34	21	0	86

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

SGH has convened a working party to monitor compliance with the requirements of the scheme, gather evidence, and complete the Excel audit and monitoring tool which has been provided for Trusts to use for assurance purposes. SGH progress is below and shows an increase by 6 to 26 competed actions.

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	0	6	0	6
2	0	0	2	0	2
3	4	0	0	0	4
4	19	0	1	0	20
5	5	0	0	0	5
6	0	0	6	0	6
7	0	4	3	0	7
8	18	0	0	0	18
9	8	0	0	0	8
10	0	0	8	0	8
Total	54	4	26	0	84

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

gesh

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

3.1.1 Safety Action 1: *Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?*

We are required to submit a quarterly report to the Trust Board demonstrating compliance with the standards as stipulated in the CNST Year 6 Technical Guidance. Compliance will be reported bi-monthly at every QCiC meeting. Reports should be discussed with the Maternity Safety Champions.

- **All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days:**

Since the last report in June 2024 there have been no eligible cases for PMRT review at ESTH. The table shows reporting of eligible cases (termination of pregnancy and early IUD of a multiple) since 8th December 2023 which are not included within the standard.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review Y/N
90870	14/12/2023	14/12/2023	N (TOP)
91174	03/01/2024	04/01/2024	N (IUD of twin delivered at term)
91830	08/02/2024	09/02/2024	N (TOP)
92409	17/03/2024	18/03/2024	N (TOP)
92613	01/04/2024	02/04/2021	Y
94180	07/07/2024	08/07/2024	Y

- **For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.**
- **For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.**

Case ID	Date of Death	Review Started	Review Completed	Parents Informed	Notes
89220	03/09/2023 (Stillbirth at 38/40)	Y	N	Y	***MBRRACE-UK has confirmed that this will not count towards CNST compliance. This is a MNSI case and the report is still pending.***
90672	04/12/2023 (Stillbirth at 38+1/40)	Y	Y	Y	***Standard Met***
90702	05/12/2023 (Stillbirth at 36+1/40)	Y	N	Y	***Standard Met***
92613	02/04/2023 (Neonatal death at 34+4/40)	Y	N	Y	***Standard on track***
94180	07/07/2024 (Stillbirth at 36+4/40)	Y	N	Y	***Standard on track***

SGUH

All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days. In May and June 2024 St George's Hospital reported 8 eligible cases. The two cases in red were losses in the neonatal unit and it was noted that they had not been reported to MBRRACE within the seven working days. These were immediately uploaded to MBRRACE, and escalation made to the NHS Resolution Team describing this unusual error. In both cases the appropriate reviews of clinical care had begun. Mitigation has been sought from the NHS Resolution team and is pending.

ID	Date of death	Date reported	Supported by PMRT
94050	24/06/2024	28/06/2024	Yes
94020	23/06/2024	26/06/2024	Yes
93841	13/06/2024	17/06/2024	Yes
93789	10/06/2024	14/06/2024	Yes
93448	01/05/2024	23/05/2024	Yes
93447	02/05/2024	23/05/2024	Yes
93292	11/05/2024	13/05/2024	Yes

ESTH - Perinatal Mortality Reviews

The Perinatal Mortality cases reported and reviewed during the period 1st March 2023 to 30th April 2024 can be found in Appendix 1. In summary:

	May 2023 – April 2024	June 2023 – May 2024	July 2023 – June 2024
Antepartum stillbirths	**9**	**8**	**8**
Intrapartum stillbirths	**1**	**1**	**0**
Stillbirth (unknown timing	**0**	**0**	**0**
Early neonatal death	**1**	**1**	**1**
Late neonatal death	**0**	**0**	**0**
	(11)	**(10)**	**(9)**
<24 weeks	**1**	**1**	**0**
24 – 27 weeks	**2**	**2**	**2**
28 – 31 weeks	**1**	**1**	**1**
32 – 36 weeks	**4**	**3**	**3**
37 – 41 weeks	**3**	**3**	**3**
≥ 42 weeks	**0**	**0**	**0**

The table below shows a summary of cases discussed, themes and open actions in relation to Perinatal Mortality Reviews (PMRT) undertaken in May and June 2024 and should be read in conjunction with the summary Board report.

PMRT Panel	Cases reviewed May/June 2024	Emerging Themes	Open Actions from previous reviews, year to date	
ESTH: 1 panel meeting held (10/05/2024 with an external panel member)	INC-151063 (review still open awaiting PM results) ***Grading: A,A***	No new clear emerging themes identified to date that contributed to the deaths but the panel has noted that there is a trend of not completing partograms in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes). The case reviewed in May 2024 related to a pre-term neonatal death with known abnormalities diagnosed during the antenatal period; the panel concluded that there were no care or service delivery issues that would have contributed to the death.	INC-130317 and others INC-132938 INC-141041 INC-142169 and others	1. Review to be undertaken by the obstetric team, in conjunction with the regional team, of the blood tests required following a stillbirth. ***This action has been extended as regional review is recommended.*** 2. Diabetes guideline to include the management of women on Metformin post steroid administration (31/01/2024). 3. Process for following up results for women discharged before the results are available (31/03/2024). 4. To add issues around the completion of a partogram for IUD cases to mandatory BadgerNet update training (01/05/2024).

Report to be discussed with the maternity safety champions and evidence of this saved.

Completion of actions is monitored via a tracker and followed-up by the Risk Team. Non-completion of actions is escalated to the Head of Midwifery, the Director of Midwifery and/or the Divisional Medical Director.

There have been no clear themes emerging from the review of stillbirths and neonatal deaths that contributed to the outcome. The panel held in May 2024 included an external member.

The latest MBRRACE-UK Perinatal Mortality Report for 2022 birth has shown that ESTH are average when compared with similar Trusts for stillbirth (up to 5% higher or up to 5% lower) and lower than average for neonatal death (more than 5% and up to 15% lower). These are the same findings that were published in the 2021 report.

SGUH Perinatal Mortality Reviews

		SGUH			
		January 2023 – June 2024		May - June 2024	
		Total number of Births	Total Number of Deaths	Total number of Births	Total number of Deaths
		6382	73	681	8
Type of Mortality	Antepartum Stillbirths		30		2
	Intrapartum Stillbirths		3		1
	Stillbirth of unknown timing		5		1
	Neonatal Deaths		35		4
Gestational Age	<24 weeks		16		3
	24 - 27 weeks		25		1
	28 - 31 weeks		8		0
	32 - 36 weeks		11		0
	37 - 41 weeks		13		4
	≥ 42 weeks		0		0

The table below shows a summary of cases discussed, themes and open actions in relation to Perinatal Mortality Reviews (PMRT) undertaken in May and June 2024 and should be read in conjunction with the summary Board report.

PMRT Panel	9 Cases reviewed in May and June 2024	External panel member present Y/N	PMRT grading of cases (A-D)	Emerging Themes	Open Actions from previous reviews, year to date	
SGH: 3 panel meetings	ID 91193(NND-CUH-SGH)	Y	Antenatal and Intrapartum care: C Bereavement: A	There were 4 cases reviewed at the meetings in May and June 2024 where the panel considered there were care issues that ***would have made no difference*** to the outcome, including a missed opportunity to monitor fetal heart in DAU as per cardiologist plan. There was 4 cases reviewed in May and June 2024 where the panel considered there were care issues that ***may have made a difference*** to the outcome. An opportunity for early recognition of established labour was missed not allowing appropriate management. There was 0 cases reviewed in May and June 2024 where the panel identified care issues which they considered ***were likely to have made a difference*** to outcome, including the failure in the recognition of risks factors and appropriate management of the pregnancy during the antenatal period.	ID 90977	1. The development of the intubation check list that is now in use in the Neonatal Unit at SGH. 2. Currently the Neonatal team is developing a guideline for the use of the video laryngoscope.
	ID 91253(IUD-SGH)	Y	MNSI			
	ID 91350 (IUD-SGH)	Y	Antenatal care: A Bereavement: A			
	ID 91377(IUD- SGH)	Y	Antenatal care: B Bereavement: B			
	ID 91488(IUD-SGH)	Y	Antenatal care: B Bereavement care: A			
	ID 91519(NND-FPH-SGH)		Antenatal care: C Bereavement care: A			
	ID 91523(NND-Hillington/Kingston/SGH)		Antenatal care Hillington: C Intrapartum care: A Bereavement care: A			
	ID 91524 (NND-SGH)	Y	Antenatal care: B Intrapartum care: A Bereavement Care: C			
	ID 91907 (IUD-SGH)	Y	Antenatal care: B Bereavement care: A			

3.1.2 **Safety Action 2:** *Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*

Both ESTH and SGH are currently compliant, however, the final outcome will depend upon compliance for the July 2024 data, which will be published in October 2024.

3.1.3 **Safety Action 3:** *Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?*

ESTH: A pathway into TC is currently in place, but the configuration of the service is under review. There is a requirement to register a QI project in relation to TC by 01/10/2024 and to submit a report on progress to the Board by the end of the CNST period and the neonatal team are leading on this safety action; this has not yet been completed.

SGUH: TC is operational with recruitment underway to meet 24 hr neonatal workforce requirements. The QI project is supporting Perinatal optimisation and the specific workstream will be registered by 01/10/24 with reported progress to the Board.

3.1.4 **Safety Action 4:** *Can you demonstrate an effective system of clinical workforce planning to the required standard?*

There are several requirements around obstetric medical workforce, anaesthetic workforce, neonatal medical workforce and neonatal nursing workforce and a requirement to meet RCOG, ACSA and BAPM standards. Compliance needs to be formally noted in the Trust Board minutes; where the service are non-compliant and action plan needs to be agreed by the Board, LMNS and the ICB. The due date for these actions is 30/11/2024.

ESTH: For the last two CNST meetings at ESTH there has been no presentation from the areas responsible for Safety Action 4, therefore an update is outstanding.

SGUH: In SGUH, the clinical workforce safety action is on track to meet compliance.

Consultant attendance at emergencies

Trusts are required to monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. In May and June 2024 both ESTH and SGH were 100% compliant with consultant attendance.

3.1.5 **Safety Action 5:** *Can you demonstrate an effective system of midwifery workforce planning to the required standard?*

There is a requirement for a midwifery staff report to be presented to the Trust Board every 6 months and this is due in September 2024. There is a requirement to demonstrate that the staffing establishment meets the recommendation of the latest 3 yearly Birthrate+ report.

ESTH: The Trust Board agreed to staff ESTH service in line with recommendations in January 2024.

SGUH: is currently midway through a full Birthrate Plus review which is recommended to take place every three years (previously reported in 2021). The results of this are expected in September 2024.

All Maternity services are required to demonstrate that Labour Ward Co-ordinators have supernumerary status at the beginning of their shift and that there is an escalation process in place which describes action to be taken if the Labour Ward Co-ordinator loses their supernumerary status.

The current safe staffing report for ESTH is included below:

Staff Group	Measure	April 2024		May 2024		June 2024	
Midwifery	Fill rate (target >90%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		94%	89%	91%	91%	95%	93%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

Short term sickness absences continue to be challenging on both sites, but sicknesses are managed effectively in accordance with Trust policy. There are several ongoing long-term sicknesses across the department, for a variety of reasons including muscular skeletal issues, which are being managed with occupational health input.

Epsom have now appointed into their band 5 scrub/recovery nurse posts, and the staff members are currently undergoing their induction to the department. St Helier will advertise for their 5.4WTE band 5 nurses very shortly. A cross site band 7 theatre coordinator has also been successfully recruited.

The reconfiguration of maternity staffing in ESTH is now almost complete and is expected to launch on 9th Sept 2024 across both sites. After the new teams are established, recruitment will continue to fill any remaining vacancies.

There has been a focus on ensuring that the flow of patients through the unit at ESTH is improved, especially in reference to inductions of labour at the St Helier site. Although unavoidable delays still occasionally occur, patient flow and satisfaction appear to have improved.

All sites are awaiting newly qualified midwives to begin their orientation in late September 2024.

Red Flag Category - May 2024	ESTH St Helier	ESTH Epsom
Coordinator not supernumerary	3	0
Delay in critical activity	0	0
Delayed induction of labour	3	0
Delayed pain relief	0	0
Delayed or cancelled care	0	1
Number of clinical incidents related to red flags	2	0

Red Flag Category – June 2024	ESTH St Helier	ESTH Epsom
Coordinator not supernumerary	1	2
Delay in critical activity	2	0
Delayed induction of labour	0	0
Delayed pain relief	1	0
Delayed or cancelled care	1	0
Number of clinical incidents related to red flags	0	0

SGUH: The activity and acuity across the maternity unit at SGUH has meant that the staffing deficits in May and June were mitigated and have been manageable without significant operational or clinical impact.

Staff group	Measure	SGH April	SGH May	SGH June
Midwifery	Fill Rate (target >90%)	90%	88%	83%
Obstetric	Expected vs fill	100%	100%	100%
Band 7 supervisory midwife at beginning of shift CNST yr6	Shift allocation 100%	100%	100%	100%
Triage staff 2.0 wte per shift	Shift allocation 100%	100%	100%	100%

Red Flag Category	SGUH April (data on Datix)	SGUH May (data on Datix)	SGUH June (data on Datix)
Coordinator not supernumerary	0	0	0
Delay in time critical activity	0	1	0
Delayed induction of labour	0	0	1
Delayed pain relief	0	1	0

Delayed or cancelled care	3	0	2
Number of clinical incidents related to red flags	0	0	0

3.1.6 **Safety Action 6:** *Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*

The second quarterly review meeting by the LMNS/ICB took place in July 2024 and ESTH are currently assessed as 97% compliant, which is an improvement on the previous review where compliance was 93%.

SGUH was assessed as 84% compliant which is an increase from 79% during the previous review in April 24.

The next quarterly review meeting has been scheduled for October 2024. Plan for improvement to meet full compliance were discussed including.

- ESTH planned training for assessment for symphysis fundal height and strengthening our diabetes guidance to include hyperlinks to support organisations.
- SGH ongoing drive for electronic recording of CO monitoring at 36/40 and ratification of the Diabetes guidelines

ESTH: A review of incidents at ESTH over the last year was undertaken to identify any potential harms in relation to SBLCBv3 (01/07/2023 – 30/06/2024). Incident themes are reviewed monthly over a rolling 15-month period and the top categories over this period include:

- Readmission of babies
- Term babies admitted to the NNU
- PPH
- Maternal readmission
- 3rd/4th degree tear
- Antenatal delay in procedure
- Delay in postnatal care
- Manual removal of placenta

Looking further into incidents that resulted in moderate and above harm (01/07/2023 – 30/06/2024), there were 36 incidents in total and the following themes were identified:

- 3rd/4th degree tears (unrelated to SBLCBv3)
- Maternal complications following caesarean section (unrelated to SBLCBv3)
- Staff slips and trips (unrelated to SBLCBv3)
- Late maternal death from suicide (unrelated to SBLCBv3)
- Baby born in unexpectedly poor condition following a drug error. ***This related to Element 4 (fetal monitoring in labour) as MNSI concluded that there was a lack of recognition of deterioration in the CTG.***
- IUD of MCMA twin at 24+6/40 (no care concerns identified on PMRT)
- DVT/VTE (unrelated to SBLCBv3)
- Late miscarriage (this woman had a history of FGR but was managed appropriately in this pregnancy)
- Maternal readmission with clinical complications (unrelated to SBLCBv3)

- IUD at term (MNSI concluded that the AC was overestimated; however, this would not have altered the management which was in line with SBLCBv3)
- Term baby admitted to NNU (unrelated to SBLCBv3)
- Baby born with sub-optimal cord gases (unrelated to SBLCBv3)
- IUD at 31+4/40. ***The investigation highlighted issues in relation to Element 3 (raising awareness of reduced fetal movements), but concluded that this did not contribute to the outcome in this case.***
- Term baby born in poor condition requiring cooling (unrelated to SBLCBv3)
- Term baby born in poor condition (2 cases). ***The investigation highlighted issues in relation to Element 4 linked to equipment and escalation.***
- PPH (unrelated to SBLCBv3)
- IUD at 38+1/40 (unrelated to SBLCBv3)
- IUD at 36+1/40 (unrelated to SBLCBv3)
- Inverted uterus (unrelated to SBLCBv3)
- Fetal birth injury (unrelated to SBLCBv3)

The review has shown that there are no clear themes associated with potential harms relating to the elements of SBLCBv3. Element 4 (fetal monitoring in labour) was associated with 4 harm incidents over the year, but with the majority of women are undergoing fetal monitoring in labour (as opposed to those smoking, reporting reduced fetal movements, undergoing surveillance for pre-term birth or with existing diabetes).

All term admissions undergo an ATAIN review and there have been no significant concerns raised following these reviews in relation to avoidable admissions.

SGUH: A review of incidents at SGUH over the last year was undertaken to identify any potential harms in relation to SBLCBv3 (01/07/2023 – 30/06/2024). Incident themes are reviewed monthly over a rolling 15-month period and the top categories over this period include:

- Term babies admitted to the NNU
- PPH
- 3rd/4th degree tear
- Stillbirth
- Maternal admission to ITU
- Hysterectomy
- Neonatal Death

Looking further into incidents that resulted in moderate and above harm (01/07/2023 – 30/06/2024), there were 380 incidents in total and the following themes were identified:

- 3rd/4th degree tears (unrelated to SBLCBv3)
- Maternal admission to ITU (unrelated to SBLCBv3)
- Maternal death (unrelated to SBLCBv3)
- PPH (unrelated to SBLCBv3)
- Hysterectomy (Unrelated to SBLCBv3)
- Maternal postnatal readmission (unrelated to SBLCBv3)
- Fetal birth injury (unrelated to SBLCBv3)
- Unintended injury in the course of an operation (unrelated to SBLCBv3)
- Delay to act on adverse symptoms in infant (Unrelated to SVBLCBv3)
- IUD at 37+6 weeks MNSI investigation no safety actions (Unrelated to SVBLCBv3)

- IUD at 33+2 complex maternal medical history. PMRT grading B/A due to early discharge from DAU for IA at 29 weeks rather than 32 weeks. Did not contribute to outcome. (Unrelated to SVBLCBv3)
- IUD twin pregnancy Twin dies 12+3 and twin 2 24+4. PMRT grading B/A Did not contribute to outcome. (Unrelated to SVBLCBv3)
- IUD at 37+1 weeks MNSI investigation no safety actions. Management was in line with SVBLv3.
- IUD at 34 weeks PMRT grading A/A. Did not contribute to outcome (Unrelated to SVBLCBv3)
- IUD at 35+5 weeks PMRT grading B/B: issues with language which did not contribute to outcome. (Unrelated to SVBLCBv3)
- IUD at 40 weeks referred to MNSI awaiting report no immediate concerns identified. (Unrelated to SVBLCBv3)
- IUD 35 weeks PMRT grading B/B for parental concerns around communication. Did not contribute to outcome (Unrelated to SVBLCBv3)
- IUD at 27+5 weeks PMRT grading: A/A Did not contribute to outcome (Unrelated to SVBLCBv3)
- IUD at 40+1 referred to MNSI awaiting report no immediate concerns identified. (Unrelated to SVBLCBv3)
- IUD at 39+2 weeks referred to MNSI awaiting report no immediate concerns identified. Identified as growth below 10th centile antenatally offered induction of labour in 39th week as per local and national guidance. In line with SVBLv3 guidance.
- IUD at 37 weeks PMRT not yet completed. Abnormal brain ultrasound scan. (Unrelated to SVBLCBv3)
- IUD triplet one 26+5 PMRT grading B/A for antenatal referral not performed. Did not contribute to outcome (Unrelated to SVBLCBv3)
- NND with maternal death at 38 weeks referred to MNSI awaiting report. No concerns identified did not impact outcome (Unrelated to SVBLCBv3)
- NND Twins 32 weeks following maternal bilateral PE AI report no concerns identified that impacted on the outcome. (Unrelated to SVBLCBv3)
- NND 24 weeks PMRT grading A/A genetic anomaly. Did not contribute to outcome (Unrelated to SVBLCBv3)

The review has shown that there are no clear themes associated with potential harms relating to the elements of SBLCBv3.

All term admissions undergo an ATAIN review and there were no care issues identified in relation to SVBLv3. Themes identified were:

- Hypoglycaemia three cases
- Jaundice two cases
- Sepsis three cases
- Respiratory distress four cases.

Most of these babies could have been cared for in a transitional care setting. As per financial investment following the establishment review, neonatal staff are onboarding via the recruitment process to support 24 hour a day transitional care workforce on the postnatal ward.

3.1.7 **Safety Action 7:** *Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*

ESTH: has a well-established MNVP; however, this year there have been several additional requirements added to their role which are currently being discussed at a regional level, in recognition of the added workload with no increase in resource and time.

SGUH: undertook the MNVP Whose Shoes Event on 9th May. 'Whose Shoes?' is an engagement and coproduction tool, to facilitate hearing the voices of many stakeholders involved in maternity and neonatal services. With a board game, scenarios and poems prompt participants and allow safe and enriching conversation.

The event was well attended with a mixture of stakeholders. In total, there were 49 participants, from a variety of services and perspectives. Stakeholders included: service users, St George's Hospital midwifery staff, student midwives, medical students, Happy Baby Community doulas, Wandsworth Care Alliance, ICB staff and 3 senior management, NHS England Service User Voice Representative, Breath Works Researcher, and more.

Emerging Themes from the day included -

- Listening to patients & families
- Improving communication with patients
- Staff morale & wellbeing
- Technology-enabled care
- Improving patient education and knowledge-sharing
- Continuity of care and documentation
- Improving access to services & inclusion (e.g. feeding)
- Linguistic and Cultural Differences
- Supporting refugee women and birthing people
- Improved access to Advocacy & Emotional/Mental Health Support
- Patient's Right to Privacy and Confidentiality
- Improving multi-agency and cross-team conversation & collaboration
- Services Under Pressure

These themes and feedback gathered throughout the event will guide quality improvement for SGUH maternity and neonatal services.

3.1.8 **Safety Action 8:** *Can you evidence 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*

There is a requirement that 90% of paediatric/neonatal medical staff who attend neonatal resuscitations should have a valid Resuscitation Council NLS certification and in common with most providers in the region, this is likely to be challenging. This has been escalated through the regional teams and the requirement has been discussed at the CNST meeting to ensure the neonatal team are aware they need to report on their compliance with this.

ESTH current training statistics are as follows:

Type of Training and % compliance	Staff Group	ESTH April 24	ESTH May 24	ESTH June 24
PROMPT 90%	Midwifery Staff	98%	97%	96%
	Maternity Support Workers	90%	92%	95%
	Consultant Obstetricians	92%	93%	90%
	Trainee and Staff Grade Obstetricians	97%	94%	86%

	Anaesthetics	86%	90%	82%
CTG Training 90%	Midwifery Staff	92%	95%	95%
	Obstetricians	94%	94%	88%
NLS (Newborn Life Support) 90%	Midwifery Staff	98%	98%	96%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff (requested)	94%	96%	96%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff (requested)	No data	No data	No data

ESTH are awaiting confirmation from the neonatal specialty regarding compliance with doctor's training. Compliance for middle grade attendance at training has been impacted by the industrial action. Regarding the anaesthetists, the midwifery Practice Development Team are liaising with the simulation lead and roster co-ordinators with a view to the midwifery team taking over allocation of staff to training.

SGUH current training compliance is as below.

Type of Training and % compliance	Staff Group	SGH April 24	SGH May 24	SGH June 24
PROMPT 90%	Midwifery Staff	91%	93%	93%
	Maternity Support Workers	91%	88%	91%
	Consultant Obstetricians	90%	89%	89%
	Trainee and Staff Grade Obstetricians	97%	96%	100%
	Anaesthetics	100%	89% (anaesth consultant)	100%(anaesth consultant)
CTG Training 90%	Midwifery Staff	90%	87%	87%
	Obstetricians	93% (100% Consultant and 86% middle grades)	88% (95% Consultant and 80% middle grades)	88% (95% Consultant and 80% middle grades)
NLS (Newborn Life Support) 90%	Midwifery Staff	92%	97%	93%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	82%	81%	77%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	76.47% 76.92% - Consultant 76.0% - Specialty Reg	73.57% 76.92% - Consultant 70.37% – Specialty Reg	73.08% 80.77% -Consultant 65.38% -Specialty Reg

3.1.9 **Safety Action 9:** *Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*

Perinatal Quality Surveillance

This joint report includes all the elements required to be reported in accordance with the Perinatal Quality Surveillance data. The Executive and Non-Executive Board Safety Champions also hold

quarterly staff engagement meetings and monthly walkarounds of our maternity units and feedback via a report to the Quality Committee their observations, what staff is saying about working and providing care at gesh, how patients feel about their care and experience, and the action they [Board safety champions) are taking to support.

Information regarding the following has been included elsewhere in the report:

- CQC
- Perinatal Deaths (CNST Safety Action 1)
- Training Compliance (CNST Safety Action 8)
- Safe Staffing (CNST Safety Action 5)
- MNSI Cases (CNST Safety Action 10)

There have been no issues of Coroner Regulation 28 no other requests made directly with the Trust (e.g. CQC Section 29a, MNSI concerns etc.).

Moderate harm and above incidents

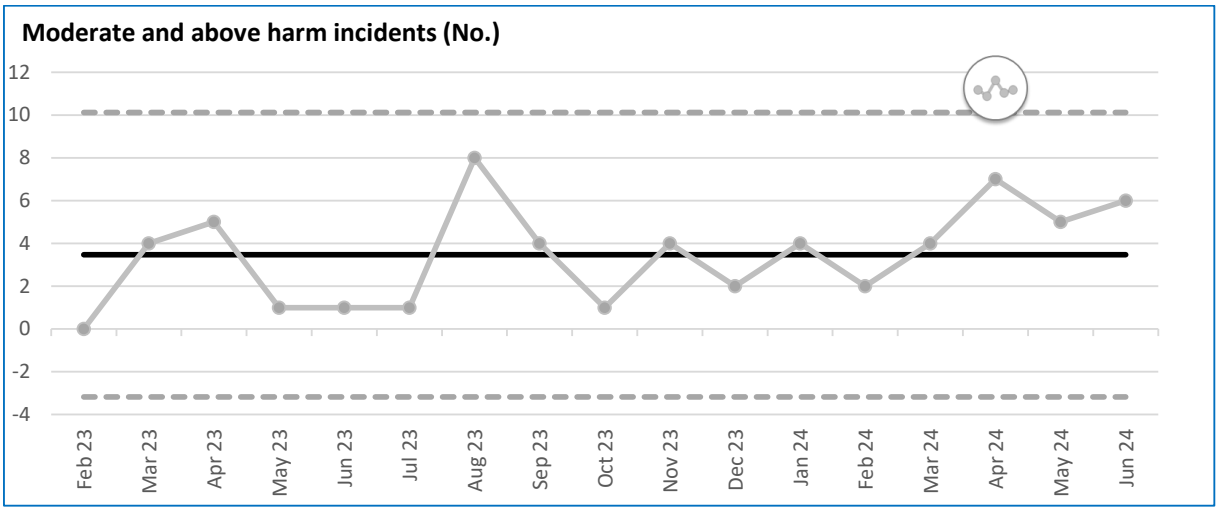
'Harm' relates to the degree of harm caused because of a patient safety incident and NHS England Guidance (maternity example) states that a harm grading should only be applied to maternity incidents if it is considered that a patient safety incident, such as an omission or error in care has led to, or contributed to the harm (NHS England, 2019). There is conflicting practice across both Surrey Heartlands and SWL LMNS regarding grading harm for outcomes where no patient safety incidents have occurred to contribute to the outcome, and this has been escalated through the region. MSSP confirmed that there is yet no updated NHSE guidance but acknowledged there is a need for this.

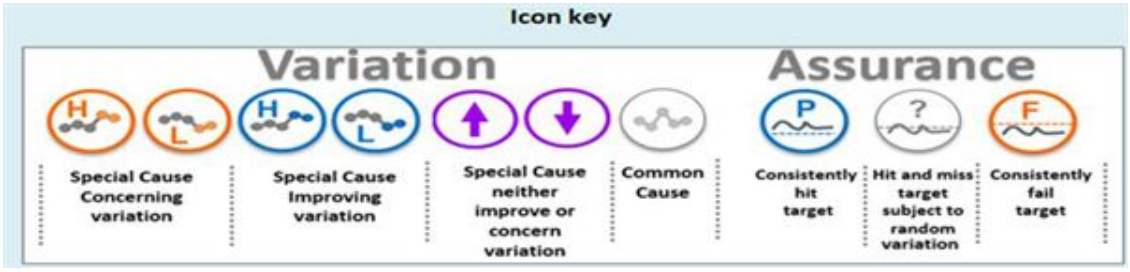
It is important to note that it is the current policy of the Trust to report harm based on the outcome, and therefore in most cases reported as moderate and above harm, this would have been unpreventable (such as postpartum haemorrhage and 3rd/4th degree tears) i.e., there were no patient safety incidents which contributed to the harm.

In ESTH in May 2024, there were 2 incidents which were reported as resulting in moderate harm and above; one related to a 3rd degree tears (with no contributory patient safety incident) and one related to an unexpected admission to the Neonatal Unit (with no contributory patient safety incident).

In ESTH in June 2024, there were 6 incidents which were reported as resulting in moderate harm and above; three related to 3rd degree tears (two are currently under review and one had no contributory PSII); two related to obstetric haemorrhage >1500mls and both of these are currently under review, and one related to a baby with a fractured humerus following delivery by caesarean section (the arm was hooked behind the head in utero).

The table below shows the trend of moderate harm grading over the last 15 months, with the caveat that the June 2024 incidents may be downgraded following review. This shows a stable position over time.





SGUH: In SGUH, there were 2 cases of severe harm relating to a maternal death and neonatal death. Both these cases have been discussed at DIRG (divisional incident review group) and CIRG (Clinical Incident Review Group) and referred to MNSI as per criteria but are awaiting consent from the family to release the patient's medical records to support external investigation.

In line with PSIRF an Incident Review Tool has been completed and two After Action Review (AAR) sessions held with staff relevant to aspects of the care pathway, to give greater context to the incident and provide clarity to the timeline.

In May and June there were 53 cases of moderate harm - 29 cases of post-partum haemorrhages (PPH) above 1.5l and 18 cases of perineal trauma in 3rd and 4th degree tears. There were five other cases of moderate harm which are as described below.

Investigations and case reviews are in progress for all incidents.

SGUH	Moderate / Severe Harm	Incident detail and immediate safety actions
Maternal Death		DW211153 Maternal collapse in theatre during emergency caesarean section, cardiac arrest, transfer to CICU and sadly passed away.
Neonatal death		DW211269 Baby delivered by EMCS after mum collapsed and full resuscitation required. Baby resuscitated and admitted to NICU. Baby sadly passed away

Moderate (29)	There were (29) incidents relating to post-partum haemorrhages of 1.5 litres and above. These cases have been discussed in an MDT meeting and quarterly themes will be reported at MGM Business. Feedback has been given to medical and midwifery staff about the importance of completing clear postnatal plans and the PPH proforma.
Moderate (6)	DW210672 IUD at 37 weeks PMRT case DW209625 Delays in receiving blood products during a MOH DW210224 10 cm sigmoid colon with serosal breach. Either side of sigmoid segment repaired, bladder adherent to anterior abdominal wall at EMCS, bladder checked no injury. DW210522 Right upper arm DVT at 16/40 DW208710 Patient aggressive to staff DW209033 Stillbirth at term. MNSI case
Moderate (18)	15 incidents of 3rd degree tears and 4th degree tears. These are reviewed at an MDT moderate cases meeting.

Patient Safety Incident Investigations (PSII)/Themes

ESTH: The maternity service transitioned to the PSIRF model on the 2 April 2024. In ESTH there are currently 8 reviews in progress, 2 of which will be progressed through the Perinatal Mortality Review Model and one of which has been declared as a PSII under PSIRF. There are no clear themes emerging however, this will continue to be reviewed in line with PSIRF standards.

There was one Serious Incident Report completed in May/June 2024 and this was presented to the Trust Incident Review Panel on 17th July 2024. The case was investigated by MNSI and there were no safety recommendations. Completion of actions from MNSI/PMRT/SI/PSII is monitored centrally via a tracker by the Maternity Risk Team. There are currently no overdue SI actions.

SGUH: At SGUH there was one serious incident report completed in June 2024, and this has been presented to the Trust SI panel and will be presented at the LMNS next quarterly meeting. There was learning identified and an associated action plan which has been reviewed and is being monitored by the Trust SI panel.

At SGUH there are no overdue actions for SI investigations.

ESTH Top 5 Incidents

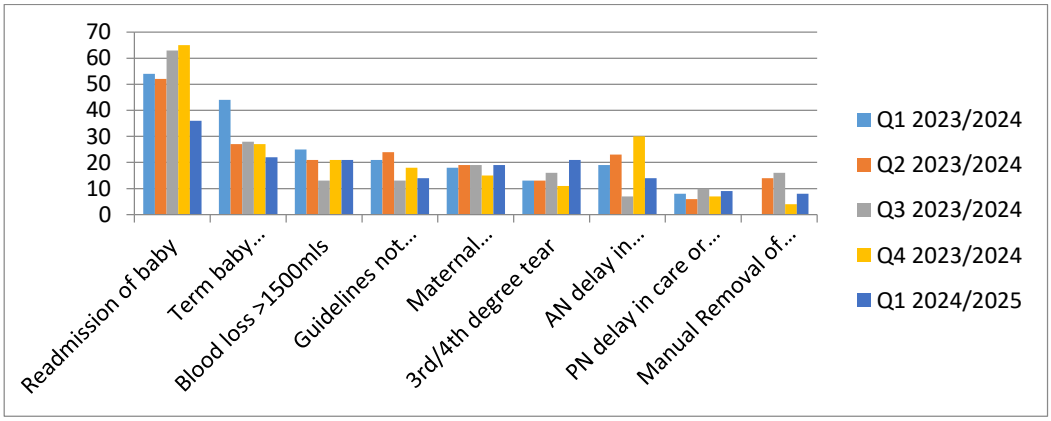
In May 2024, the top 5 reported incidents were:

- Readmission of baby
- Guidelines not followed (no themes)
- Blood loss >1500mls
- 3rd/4th degree tears
- Maternal readmission (=)
- Postnatal delay in care or procedure (=)
- Term baby admitted to the neonatal unit (=)

In June 2024, the top 5 reported incidents were:

- Term baby admitted to the neonatal unit
- Readmission of baby
- Maternal readmission (=)
- Antenatal delay in care or procedure (=)

- 3rd/4th degree tears
- Blood loss >1500mls



As readmission of babies has consistently been ESTH's most frequently reported incident and has a significant impact on both families and the service, a deep dive audit has commenced, and the findings and recommendations will be presented when the audit is completed.

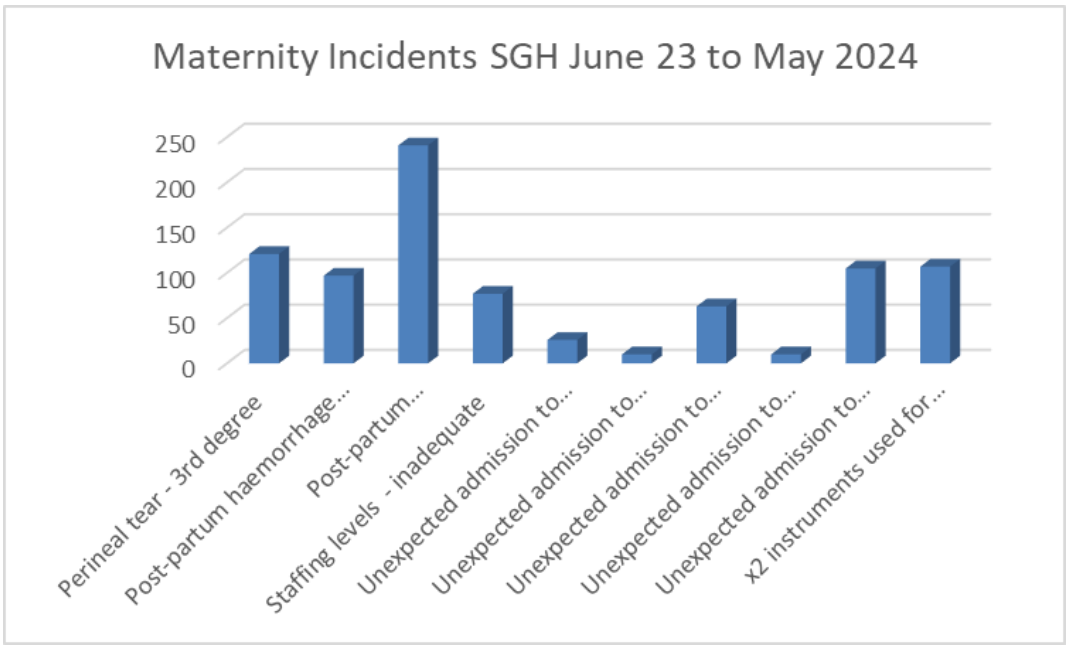
Current areas for local focus under PSIRP are around CTG monitoring, PPH and maternal HDU admission; however, 100% compliance with Element 4 (fetal monitoring in labour and PPH rates have been stable over time has been achieved. On-going thematic review of incidents has shown that readmission of both mothers and babies is an issue that now needs focus. We are currently in the process of developing a maternity specific PSIRP.

SGUH: At SGUH in May and June 2024 the top 5 incidents reported were as below.

- PPH >1500mls
- Unexpected admission to NNU
- 3rd Degree tears
- Length of wait for appointment for Home Blood Glucose Monitoring (HBGM)
- 2 instruments

The service continues its Qi workstream focusing on reducing and preventing postpartum haemorrhage where possible, whilst also addressing the proactive management of those haemorrhages that are anticipated and expected (in the case of complex pregnancies and adherent placentas). This continues to be an MDT Qi project with participation and leadership from obstetrics, anaesthetics, midwifery, and blood transfusion.

The maternity diabetic guideline is currently in consultation and soon to be ratified. The changes within will incorporate and reflect the requirements to align with SBLCB vs3. This includes changes to strengthen clinical pathways for both preexisting diabetics and those who are screened for and diagnosed with gestational diabetes. The challenge currently faced by the team regarding home blood glucose monitoring will be addressed by these changes.



Patient and staff experience and engagement

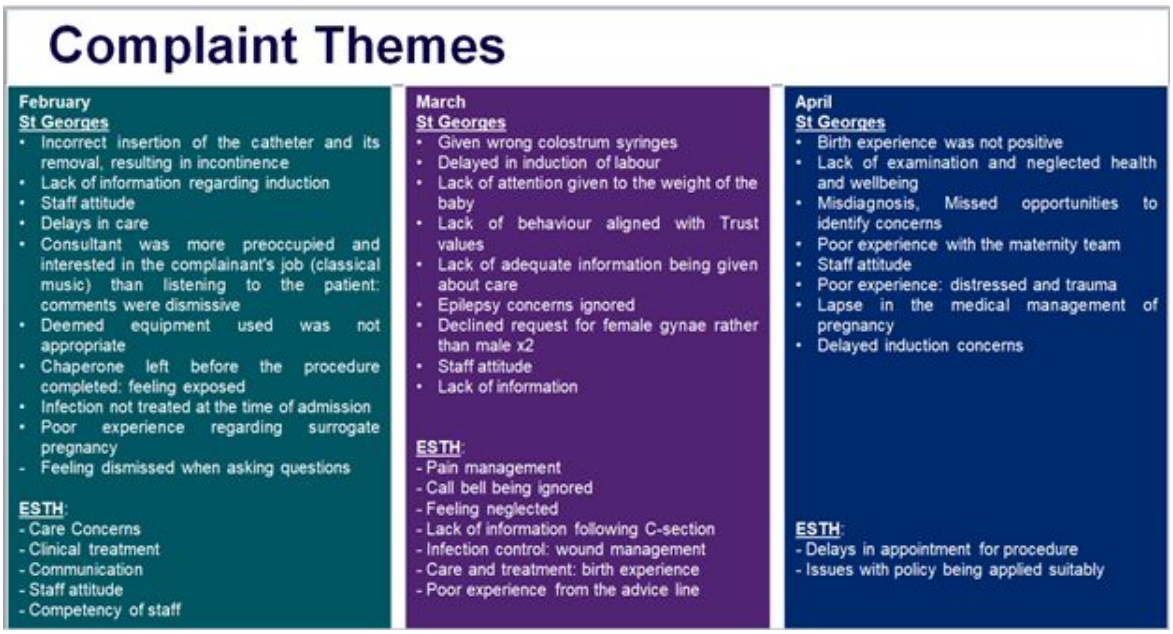
Friends and Family (FFT) feedback

ESTH: At the time of writing this report, the most recent available FFT feedback is from April and May 2024. There were 136 responses at ESTH in total of which 96% were positive, with compliments on the care provided by staff, the décor and the food. The negative comments were around the suspension of the homebirth service, the lack of unit tours for families, poor maintenance of the estate, joint appointments (e.g. infant feeding/blood glucose monitoring etc.), follow-up of blood tests, rude attitude of receptionists, postnatal ward staffing, lack of appointment times for home visits and delay in induction of labour due to workload.

SGUH: held their Whose Shoes event in May as described previously in the paper. The FFT submissions for May 2024 were 139 with 96% satisfaction rates and in June 2024 were 120 with 95% satisfaction rates. The positive feedback included compassionate and caring staff, birth options services and lifesaving interventions for a mother with multiple complexities and abnormally embedded placenta. The less positive feedback included administrative errors, lack of breastfeeding support and postnatal ward staffing ratios compared to antenatal pathways and delivery.

Complaints feedback

ESTH: The ESTH maternity service received two complaints in May 2024 and two complaints in June 2024. In May 2024, one complaint related to general concerns about her birth experience in 2022 and the other to general concerns about her episode of care between April and December 2023. In June 2024, one complaint related to the management of tongue tie and the other related to general concerns throughout labour and the postnatal period. On initial review, none of the complaints highlighted had serious care concerns.



SGUH: The maternity service at SGUH received three complaints in May and three in June. These complaints included waiting times, negative birth experience, communication, and clinical management. These are all being reviewed and responded to in line with the complaints process with feedback and learning shared across the teams.

Staff engagement

The Year 6 Technical Guidance for the Maternity and Perinatal Incentive Scheme includes the requirement for engagement events to be held with maternity and neonatal staff within each service every two months, which is an increase from the Year 5 guidance, which was quarterly. This should be in place by 1st July 2024. Issues raised and the progress made against them should be shared with all maternity and neonatal staff. A staff engagement event took place on 15th May 2024 and the dashboard of current on-going concerns was shared with staff beforehand. Issues currently on the Dashboard include:

- Maternity Manager on-call arrangements
- Issues with the BadgerNet app and appointments
- Parking
- Staffing issues
- Interpreting services
- Fetal Growth Surveillance
- Lack of de-brief appointments (demand outstripping capacity)
- Lack of office space for specialists
- Variation form and payroll concerns
- Lack of sonography staff
- Bank rates of pay
- Décor issues within STH
- Maternity website
- Lack of clinic venues in the community
- Transitional care staffing (now highlighted by the CQC)
- Complexity of the agency approval process

The next staff engagement event is scheduled for the 6 September 2024.

Claims scorecard review

The most recent claims scorecard was published in the summer of 2023; the analysis of this alongside incidents and complaints has been included in the table below.

The Trust had no claims in the yellow or green zones.
Red claims (High Value (over 1 million) and High Volume (3 or over)): There are 7 red claims with a value of £88,475,453, 5 which are on-going (not settled), one of which has been settled with periodical payments and one of which has been closed with no damages.

Blue claims (Low Value (<1 million) and High Volume (3 or over)): There were 58 blue claims with a value of £4,979,975

- 28 claims were settled with damages paid
- 18 claims were closed with nil damages paid
- 12 blue claims are currently open

There are no themes emerging from red claims which relate(d) to:

- Failure to diagnose Cornelia De Lange syndrome in the antenatal period (joint with SGUL)
- Inappropriate management of Syntocinon leading to HIE (settled out of court as causation denied)
- Abnormal CTG leading to HIE (this case has been closed with no damages as MRI confirmed that the insult occurred 2 week prior to birth (antenatal)
- Failure to monitor bilirubin levels leading to Bilirubin-induced neurological dysfunction (open)
- Traumatic delivery resulting in psychological injury for both parents (open)
- Failure to offer growth scan; this would have identified that the baby was in the breech position as an incidental finding (open claim for HIE II following a vaginal breech delivery)
- HIE III following maternal sepsis (open)

Blue claim themes:
There are no clear themes emerging from review of these claims, 3 of which related to gynaecological management in early pregnancy. Issues identified included:

- Failure of antenatal screening to detect abnormalities/maternal conditions
- Failure to respect women's choice/birth plans
- Retained products of conception
- CTG/monitoring in labour
- Failure to act appropriate on test results
- Diathermy injury
- Inadequate pain relief
- Feto-maternal haemorrhage

Blue claims continued……

- 3rd degree tear – woman claims that she should have been offered a caesarean section due to the estimated fetal weight
- Infection
- Shoulder dystocia – woman claims that she should have been offered a caesarean section due to the estimated fetal weight
- Management of placenta accreta
- Urinary incontinence following delivery
- Care in HDU
- PPH leading to HDU admission
- Trauma to the baby following forceps delivery
- Suturing leading to nerve damage
- Pressure damage
- Inappropriate discharge in early labour.

Correlation with complaints and incidents

Incidents
There are no clear themes emerging from the review of incidents that correlated with a trend in claims (there were no common themes identified in claims). CTG interpretation is a factor in a number of investigations and the fetal monitoring midwife continues to audit and make recommendations and cases where learning has been identified are used in mandatory training. There are regular informal CTG review sessions and a regular fetal surveillance newsletter is produced. CTG concerns have been identified as an area for local improvement on our PSIRF plan.

A theme had been identified previously by MNSI in relation to monitoring of fetal growth and training and audit has been strengthened in response to this. This has not emerged as a complaints theme over the last 5 quarters and best practice and performance is monitored via SBLCBv3 by both the Trust and the ICB.

Complaints
All complaints are triaged against the incident reporting system and are linked if there is an investigation on-going. Following receipt of the 2023 scorecard the themes from complaints were analysed over the last year but there was not clear correlation with claims due to no trend being evident. Emerging themes (3 or more mentions) for complaints included:

- Staff attitude (no correlation with claims)
- PPH cause and management (included as an area for local improvement on our PSIRF plan)
- Women feeling coerced into unwanted treatment following explanation of risks
- Management of gestation diabetes
- Lack of/delay in debrief appointments

May 2024 Claims report

In May 2024 the legal service received 3 new potential claims relating to maternity services for ESTH and 3 new claims for SGH maternity services. There were 3 claims closed at ESTH in May 2024 and 0 closed for SGH maternity services.

ESTH May 2024 New Claims

Ref	Claim Date	Incident Date	Claim Type	Synopsis
STH/2024/YKB/2054	28/05/2024	N/A	CNST	Disclosure request - The Claimant alleged that there has been a failure to undertake treatment to manage her labour/delivery to an appropriate standard.
STH/2024/KJ/2055	23/05/2024	21/10/2021	CNST	Disclosure request - Attempted elective c-section on 21/10/2021 Administration of the spinal anaesthetic led to the patient becoming asystole.
STH/2024/DM/2044	13/05/2024	28/11/2023	CNST	Disclosure request - Potential claim regarding the management of the patient following a C-section on 28.11.23 leading to an infection.

SGH May 2024 New Claims

24/015 T106554	15.5.24	14.7.2006	CNST	Patient was admitted at 41+5 weeks gestation There were indications of fetal distress and obstructed labour, and she underwent an emergency delivery on 14.7.06. At birth, the baby needed resuscitation and she suffered a fractured clavicle. She was transferred to NNU where she developed seizures in her first few days. An MRI confirmed a significant hypoxic-ischaemic brain injury. She has severe dystonic cerebral palsy with developmental delay. Allegations awaited.
24/021 3298765	31.5.24	1.12.23	CNST (ENS)	Patient had a difficult second stage labour and required forceps delivery. The baby was born in poor condition and needed resuscitation before transfer to NNU for therapeutic cooling.
24/022 X2326819	31.5.24	17.2.24	CNST (ENS)	Baby was born in a poor condition due to CTG becoming abnormal with late decelerations. Post birth, she was transferred to NNU for therapeutic cooling.

ESTH May 2024 - Closed Claims

Ref	Claim Date	Incident Date	Claim Type	Synopsis
TL/STH/2018/MA/902	15/08/2019	23/08/2016	CNST	Alleged negligence at St Helier Hospital on 23.8.16 for during a c-section resulting in injury to the urethra and failing to repair the injury during the operation resulting in nephrostomy and need for further procedures/surgery. No learning in this incident and no admissions required. This claim related to a recognised complication of surgery and no failings were identified by panel.
TL/STH/13/91	01/05/2018	24/10/2009	CNST	The Claimant's mother brought a claim concerning her child's delivery. Child has since been diagnosed with cerebral palsy. Placental abruption was not diagnosed at the time and there was an alleged delay in performing a c-section. This was settled with 50% discount for £3,520,000.
TL/STH/09/03	03/09/2012	01/11/2007	CNST	Claimant came to St Helier Hospital in Nov 2007 for the birth of her second child. The Claimant described reduced fetal movements and there was brown discharge, she was informed that the CTG was normal and discharged. She returned later that day again with reduced fetal

				movement; a CTG confirmed absent variability and decelerations and an emergency c section was performed. The baby suffered brain damage and had bilateral cerebral palsy. The child passed away in 2018. The main allegations relate to failing to consent sufficiently and discuss delivery options. This was settled for £200,000.

June 2024 Claims report

In June 2024 the legal service received one new potential claim relating to ESTH maternity services and five for SGH maternity Services. There was one claim closed in ESTH during June 2024 and none closed for SGH.

ESTH New Claims

Ref	Claim Date	Incident Date	Claim Type	Synopsis
EGH/2024/SW /2052	07/06/2024	24/10/2023	CNST	Claimant gave birth to her second child on 24/10/and opted for a managed 3rd stage of labour. The cord snapped during controlled cord traction and the woman needed to undergo a manual removal of placenta. The claim relates to an alleged mismanagement of the 3rd stage of labour.

SGUH June New Claims

Ref	Claim date	Incident date	Claim Type	Synopsis
24/023 3277814	03.06.2024	09.02.2024	CNST	ENS Term baby born in poor condition due to abnormal CTG and prolonged labour. Ventouse delivery and was born with poor tone and responsive issues. Baby was transferred to NICU for Cerebral Function Monitoring (CFM). Awaiting further information
24/024 3247200	03.06.2024	24.03.2024	CNST	ENS Term baby born via CS. Required resuscitation after birth and was admitted to NICU for intubation and ventilation. At 5 hours of life, baby suffered a seizure. Clinical suspicion of skull fracture was identified on examination.
24/025 3306184	04.06.2024	08.03.2023	CNST	Request for records relating to issues surrounding the mother's pregnancy in 2023. Further details to follow
24/029 H968187	06.06.2024	12.07.2023	CNST	It is alleged that there has been a failure to undertake appropriate treatment to manage the claimant's post birth infection. SI relates to a 'Jehovah's Witness blood refuser' who underwent a pre-term C-Sect with sizeable blood loss. She was treated with antibiotics and discharged. However, she was readmitted post birth, 7 days with necrotising chorioamnionitis. Claimant was returned to theatre for re-laparotomy and washout. She was then transferred to ITU for recovery and discharge
24/036 H960117	21.6.24	2.5.24	CNST	Potential claim but no information has been provided. More details to follow. Incident record shows that the claimant had a forceps delivery and suffered 1900ml blood loss on 2.5.24.

ESH Closed Claims

Ref	Claim Date	Incident Date	Claim Type	Synopsis
STH/24/GUR	07/11/2023	21/12/2019	CNST	The claim related to a baby born prematurely at 28/40 with lung disease who was transferred to a tertiary unit. The claimant alleged the severity of the condition was not recognised. The case was not admitted. The care was noted to be good and no learning was established.

ESTH SCORE survey

A SCORE survey was undertaken in December 2023; this survey measures the important dimensions of organisational culture, including safety culture, leadership, learning systems, staff resilience/levels of burnout and work-life balance, with the aim to make improvements. The full survey has been included in Appendix 3.

All except 2 domains (which remained about the same) showed deterioration since the last SCORE survey undertaken in 2019. Areas highlighted included:

- Midwives reported much high levels of workload strain compared with obstetric medical staff and other staff.
- Midwives reported high levels of burnout over all areas.
- There was a significant deterioration in the scores around safety climate.
- Midwives (including midwifery managers) reported poor levels of work-life balance when compared with obstetric medical and other groups of staff.
- Midwifery Managers were the most likely group of staff to leave the service.
- Community and Specialist midwives reported lower score than the other staff group.

Five facilitated sessions have been organised with each of the staff groups to get a better understanding of the issues. The finding of the staff survey and culture survey will be triangulated to form the basis of an improvement plan.

SGUH: The SGH SCORE survey feedback has been concluded and the following workstreams led by the matrons and clinical leads are now addressing areas the teams identified for development.

- Delivery of Excellent Clinical care
- High Levels of patient Satisfaction
- High Levels of Staff Satisfaction
- Excellent leadership
- Excellent facilities

The work at SGH is also being supported by the OD team in a broader capacity.

Primary drivers identified in CQC and other reviews	Proposed action to be prioritised and led by the OD team	Timeline
Senior leadership visibility	1. Review existing evidence for the need for more visibility of managers. 2. (If the detail for what needs would be met for greater visibility isn't understood) undertake 1 hour workshops with senior staff, junior Doctors, midwives and band 7s to understand staff needs and how senior staff can most add value being more present and visible. 3. Check in with key staff groups weekly on senior staff visibility and if it is achieving the needs identified in step 2 above.	1. August/Sept 2024 2. August/Sept 2024 3. Ongoing 4. August/Sept

	4. OD support to the proposed Team day planning to include reference to this and other aspects set out below	
Effective & engaged MDT team working	1. Review evidence for the strengths and areas for improvement in MDT team working. 2. MDT workshop to identify the priorities for improving culture for the MDT behaviours 3. Create a clear guide for what this looks like for each key priority for team working. A review of the priorities and how these have been delivered included in MDT meetings with actions owned by senior team members and reported back on to demonstrate progress and create pride in the effectiveness of MDT team work across the area.	1. August 2024 2. August 2024 3. Sept 2024
Staff experience a high level of psychological safety And Positive feedback from all staff groups including junior doctors	1. Review evidence and current systems for promoting staff to feel able to speak up 2. Put in place a campaign to reinforce the importance of this 3. Support managers to handle being challenged with guides and workshops 4. Enhance awareness of communication structures for speaking up and skills such as CUS, PACE and 5 step advocacy. Newsletters staff meetings and development sessions 5. Address concerns of fear of repercussions by taking action when staff report this. 6. Survey before and after using the culture of patient safety survey in the area.	1. Aug-Oct 2. Aug 2024 3. Sep and Oct 2024 4.& 5. Aug 2024 6. July-Aug & 6 months later

The service is also facilitating two away days for band 7 and band 8 colleagues (one in September and one in October 2024) to collectively contribute to shaping a positive culture across the service, celebrating midwifery as a profession, and regrouping as a leadership team. The OD and HRBP team are supporting the Directorate Tri to facilitate and lead this day.

3.1.10 **Safety Action 10:** *Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*

ESTH: There are currently no cases open with MNSI. There was one case closed during May 2024 and this was closed with no safety recommendations. There have been no cases that required reporting to MNSI/ENS so far during MIS Year 6.

There are currently no open actions for the Maternity Service in relation to completed MNSI reports.

SGUH: currently has eight cases with MNSI. MI- 037455, MI-036909, MI-036846, MI-037041, MI-037416, MI-037455, MI-037590 and MI-037591.

Three of these cases relate to babies who required therapeutic cooling, three cases were IUD. One neonatal death and one maternal death. There were 4 MNSI cases closed between May and June with no safety recommendations. There are no open actions for MNSI cases.

3.2 ESTH: Maternity Continuity of Carer (MCoC)

Maternity Workforce reconfiguration work is currently underway to reduce the current Maternity Continuity of Carer (MCoC) teams from 10 to 2 teams to ensure minimum safe staffing in each area. The two MCoC teams will focus on areas of social deprivation. There was a national requirement to reconfigure maternity services into teams providing continuity of care to women throughout the antenatal, intrapartum and postnatal periods; ESTH had reconfigured their services to meet this requirement, however, this initiative was suspended nationally, in view of the fact that maternity services in England were struggling to implement against a backdrop of national staffing challenges.

ESTH were criticised in the CQC report published in February 2024 for continuing with MCoC since safe staffing could not always be maintained in the in-patient area. At the time of the inspection, work was already underway to reduce the number of MCoC teams. The consultation with staff ended on the 15 April 2024 and managers are currently working on the allocation of staff to the appropriate area, based on their preferences where possible, and ensuring that we have the required numbers of staff in each area to maintain safety. This is expected to conclude in June 2024, with implementation in September 2024.

All staff have been reminded to complete their training needs analysis forms and those that feel they need clinical support have been advised to discuss the requirement with their line manager.

3.3 ESTH NHS Staff Survey 2023

In the latest staff survey, within the Division, 58% would recommend the organisation as a place to work and 65% would be happy for a friend/relative to be cared for by the organisation. This is a deterioration from the last staff survey, which showed 59.3% would recommend the division as a place to work and 67.2% would be happy for a friend or relative to receive treatment.

It is important to note that whilst some of the scores have improved, areas such as work-life balance, remain lower than the Trust average. This result was also reflected in the SCORE survey which was completed as part of the Trusts commitment to the Perinatal Cultural Leadership programme. Staff focus groups have commenced, facilitated by an external provider, who will be working with the leadership team in producing an improvement plan set to improve the culture within the department.

3.4 ESTH: CQC maternity patient survey published February 2024

The NHS Maternity Services 2023 Benchmark Report was published in early 2023. The survey, which is commissioned by the CQC, collects feedback on maternity care and the CQC use this data as part of their on-going monitoring or services.

The results were significantly improved since 2022; ESTH scored better than expected on 17 measures and did not receive any scores which were worse than expected. The headlines are:

- The Trust fell within the top five trusts in London in all measures (1st place).
- The Trust scored highest in London for care during pregnancy, labour and birth, care in the ward after birth and care at home after birth.
- Areas where we could improve includes care in the six weeks after birth (largely falling outside the ESTH service as women are discharged to the HV/GP usually at Day 10 postnatal), being

aware of user's medical history during antenatal appointments, personalised care and asking about mental health issues.

Action plans for areas of improvement are currently being co-produced with the MNVP. The ESTH MNVP had an away-day in March 2024, which included a workshop on areas of improvement noted in the CQC Maternity Survey.

3.5 Maternity Improvement Plan (including CQC action plan)

An interim maternity program manager is currently overseeing the coordination of actions outlined in the CQC action plan, working closely with colleagues to ensure prompt progress. Out of the 26 actions, 11 are on track, with evidence of advancement available. One action has been successfully completed, receiving executive approval. The remaining actions are in various stages of progress, with none having surpassed the agreed deadline at this time **(appendix 3, reading room).**

Theme	Progress Update	Further Actions
Estates Regulation 15 (1)(b)(c)(e)	• 15 steps peer review carried out in March 2024 supported by senior nursing team • March equipment spot check audit passed and remains green. Matrons will continue to carry out bi weekly spot checks.	On Track
Safe and Effective Care Regulation 12 (1)(2)(a)(b) Regulation 17 (1)(2)(c)	• A record keeping audit has been commenced with a compliance of 82% and 81% for May and June, to ensure records are accurate, complete and contemporaneous. Findings will be fed back to the risk team to be included in the regular risk report. • Triage and MAU guidelines have been updated in line with RCOG guidance. • An MAU SOP has been developed and audits are underway to review if the guideline and SOP are being followed, audits show 96% compliance for June. • A MEOWS audit template is now being utilised which shows 72% compliance intrapartum and 78% compliance in the postpartum stage, work is ongoing to ensure a SOP is developed in order for staff to have guidance to complete, and document modified early obstetric warning scores in order to identify and escalate women and birthing people at risk of deterioration. • June CTG audit compliance sat at 86% (STH) and 84% (EGH) and continues to be monitored in line with saving babies lives care bundle. • SBAR observational audits are now in place, 3 out of then observations partially used the SBAR format to handover and 7 fully used the tool.	On Track
Training Regulation 12 (1)(2)(c)	• PROMPT training for May and June were compliant in all staffing category's except the Anaesthetists which has been escalated. • Safeguarding training sits at 91% for midwives but only 43% for consultant obstetricians. Additional safeguarding study lessons have been scheduled for doctors to help with compliance.	On Track
Well Led Regulation 18 (1)(2)(a) Regulation 17 (1)(2)(a)(b)	• Phased recruitment for additional staffing in TC has been actioned. • Band 5 theatre scrub nurse job adverts went live end of April 2024. Once in post this will ensure the role of the recovery practitioner is carried out with the right level of qualification. • Bi weekly senior midwives meetings continue to ensure effective oversight of maternity services. • Staff annual appraisals are 91% compliance in June 2024.	On Track

SGUH: The SGH site continue to respond to the CQC inspection report with the first meeting of Evidence Assurance Panel planned for 31 July. Must Do actions 1 – staffing, Must do action 13 safeguarding, Must do action 14 IOL and Must Do action 15 Bereavement are due to be presented. Of the 15 Must Do actions issued to the service by the CQC, these have been RAG rated for completion status and 11 are green, 3 amber and 1 red **(appendix 4, reading room)**

3.6 Outcomes/Trends

The following tables shows the trends on key outcomes over the last 15 months; no significant trend is identified.

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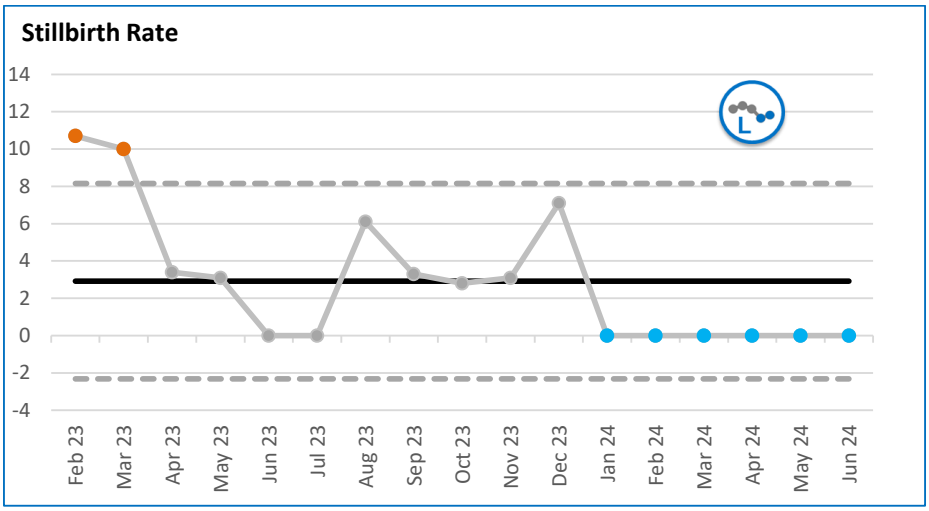
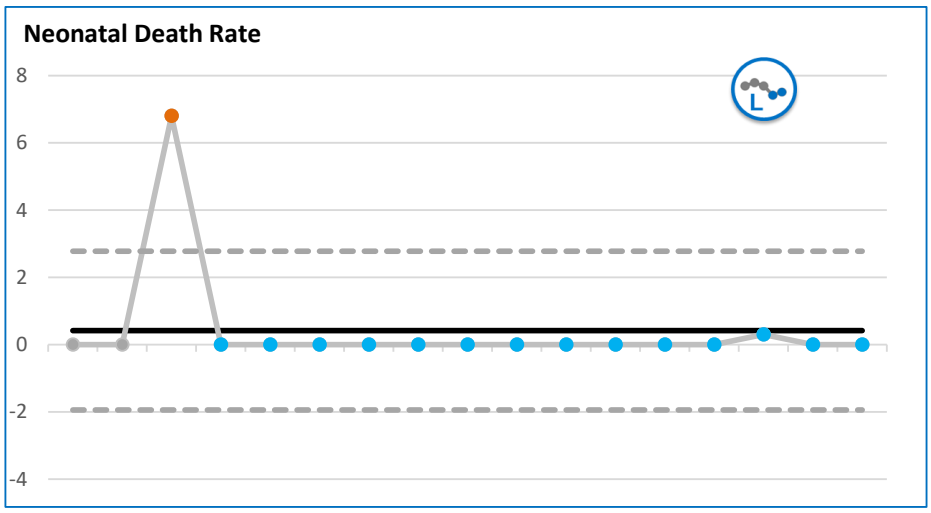
ESTH SPC Governance Dashboard

KPI	Latest month	Measure	Target	Variation
HIE cases (No.)	Jun 24	0	-	
Term admission to NNU (No.)	Jun 24	18	-	
Moderate and above harm incidents (No.)	Jun 24	6	-	
Stillbirth Rate	Jun 24	0.0	-	
Neonatal Death Rate	Jun 24	0.0	-	
3rd and 4th Degree Tear (No.)	Jun 24	7	-	
PPH >1500mls	Jun 24	6	-	

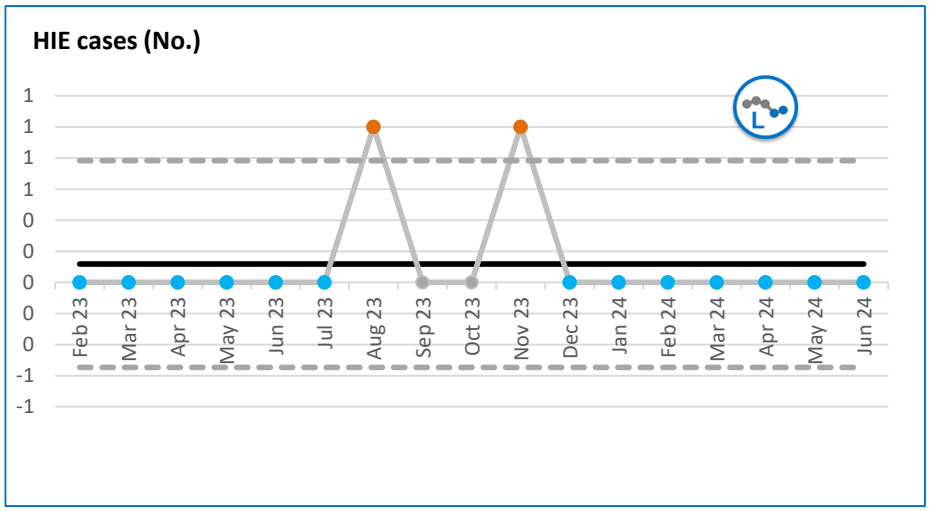
Stillbirth Rate: This system or process is of an **improving nature**.



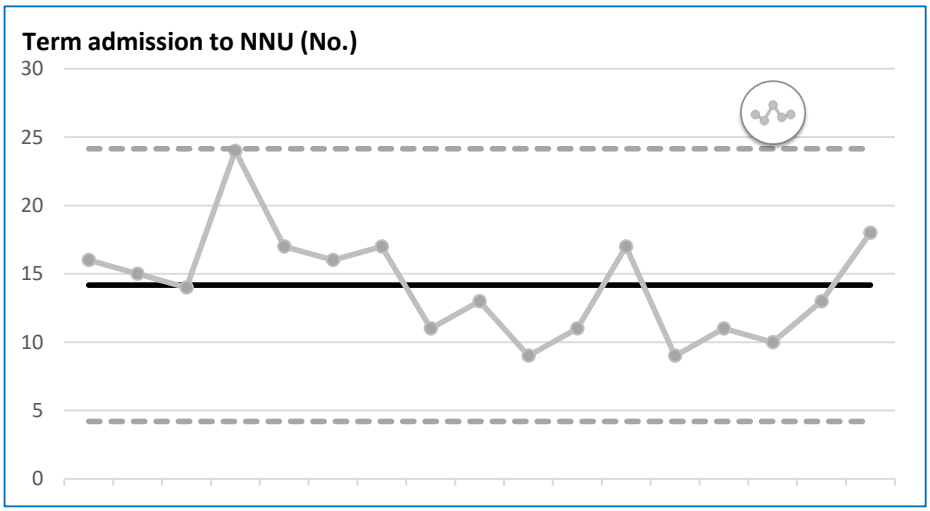
Neonatal Death Rate: This system or process is of an **improving nature**.



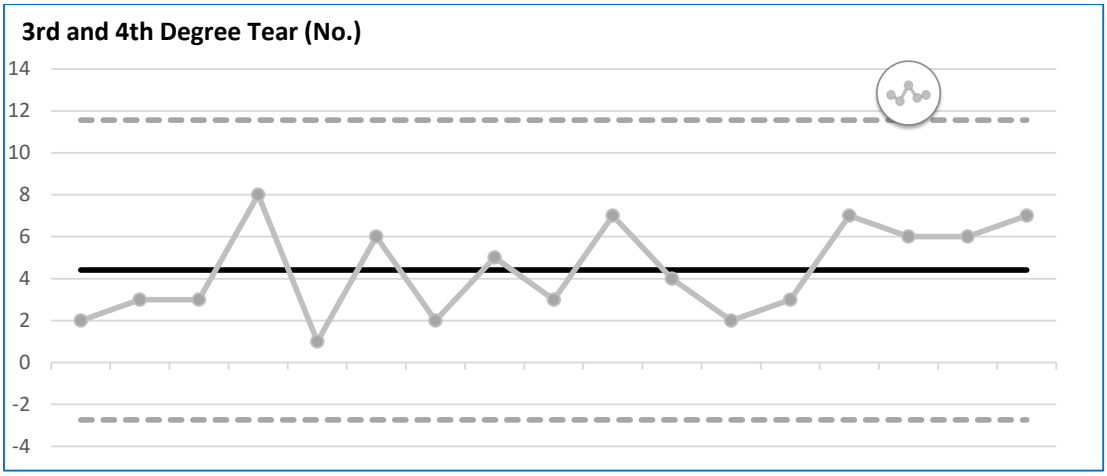
HIE Numbers: This system or process is of an **improving nature**.



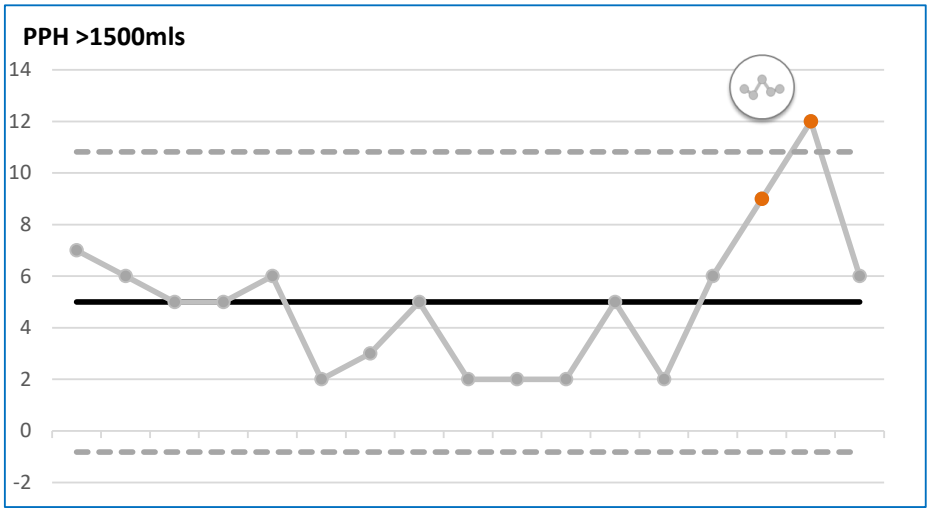
Number of term admissions to NNU: This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.



Third and fourth degree tears: This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



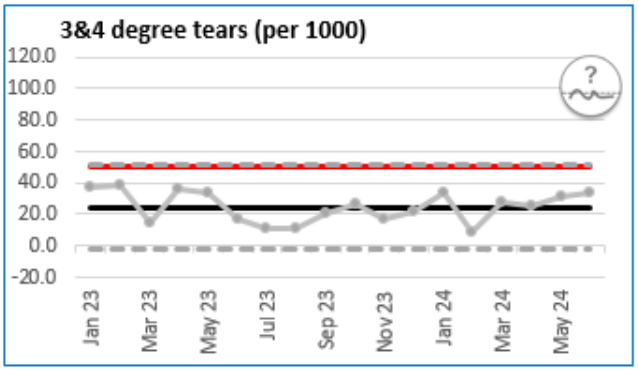
Post-Partum haemorrhage (PPH) ≥1500mls: This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



SGUH: clinical outcomes do not show any significant variation or concern.

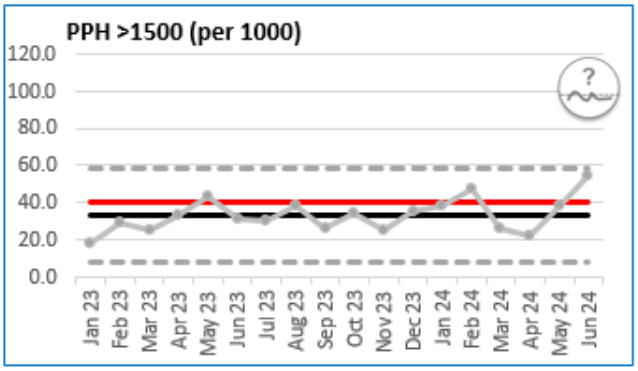
Latest month	01/06/24
3&4 degree tears (per 1000)	34.0

No significant change



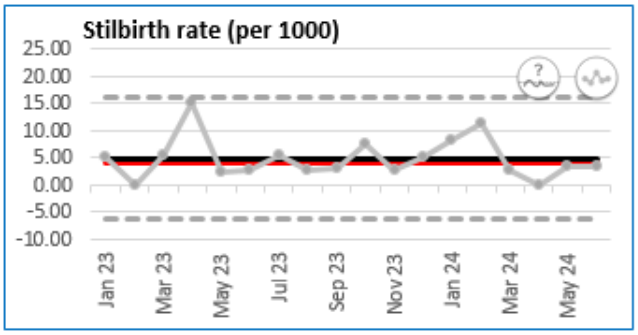
Latest month	01/06/24
PPH >1500 (per 1000)	54.0

No significant change



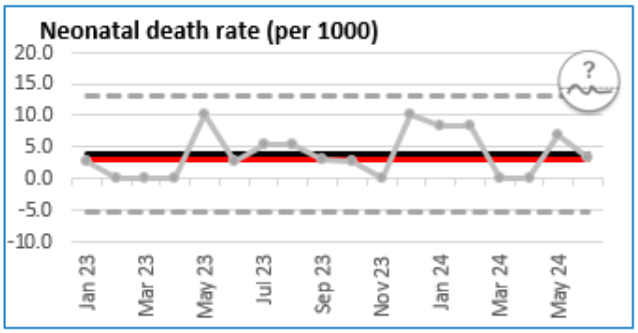
Latest month	01/06/24
Still birth rate/1000	**3.4**

No significant change



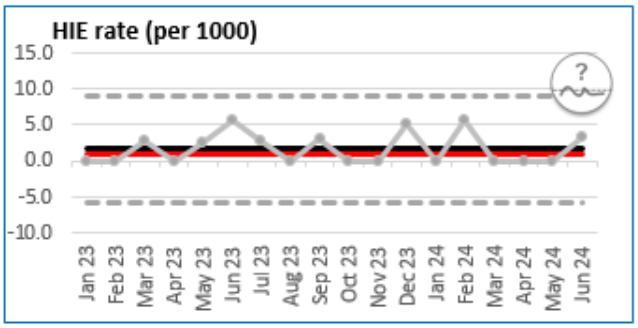
Latest month	01/06/24
Neonatal Death rate/1000	**3.4**

No significant change



Latest month	01/06/24
HIE rate/1000	**3.4**

No significant change



NB. the one case of HIE in June was also the baby who suffered a neonatal death.

3.7 Risk Register

ESTH: The ESTH risks are reviewed and presented at the maternity governance meetings and updated as required.

Risk Title	Date opened and initial risk rating	Current risk rating	Controls in place to manage the risk	Gaps in control	Update at the last review (summary)	Last reviewed	Next review date	Risk Owner
Lack of 2nd operating theatre	19/11/2007 (initial risk rating not recorded)	25	During OOH recourse to main theatre 5	During the daytime theatre 5 is in use for day cases	Business case to convert Rose (Labour Room) into a 2nd theatre has now been approved	17/05/2024 (last updated)	Risk Register reviewed at every monthly DMT meeting	Benedicta Agbagwara-Osuji
General environmental issues (issue identified by the CQC)	28/03/2024	15	Shower curtains in the STH Labour Room (in lieu of toilet doors) Estate regularly review the portal Contingence plan in place for lift breakdowns	Some issues identified by the CQC (such as sound-proofing in the bereavement rooms) require capital investment	Business case for sound-proofing submitted	07/05/2024	Risk Register reviewed at every monthly DMT meeting	Benedicta Agbagwara-Osuji
Maternity lifts breakdown	05/01/2012	12	At EGH the unit is accessed through SWLEOC. At EGH it is necessary to have an ambulance standing by outside the maternity unit.	The lift at STH is old and is constantly breaking down (following multiple repairs) with frequent entrapments. The new lift does not enable access to the underground tunnel/main theatres	A new external lift was installed in 2023 (but please see gaps in control)	08/11/2023	Risk Register reviewed at every monthly DMT meeting	Benedicta Agbagwara-Osuji
Staffing establishment and mandatory training	28/03/2023	12	We have removed content from our mandatory training programme and only include what is mandated by the Core Competency Training.	Our training uplift remains at 23 hours per midwife whilst in STG it is 34 hour per midwife for out content as needed to reduce.	A paper was submitted to the SLT (updated dated 08/11/2023)	08/11/2023	Risk Register reviewed at every monthly DMT meeting	Elizabeth Cullen
Transitional care	28/03/2024	12	Midwives and MSW are currently providing all neonatal care on TC and have been training to give antibiotics.	We are in breach of the BAPM/CNST standards as TC is currently not lead by the neonatal service (the TC Lead Neonatal Nurse was not replaced when she left).	An action plan is in place and being progress to ensure there is neonatal nursing staff presence/input on TC.	03/05/2024	Risk Register reviewed at every monthly DMT meeting	Kathryn Hughes

SGUH: The SGH risks are reviewed and presented at the maternity and divisional governance meetings and updated as required.

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Risk Title	Date opened and initial risk rating	Current Risk Level	Controls in place to manage risk	Gaps in control	Update at last review	Last reviewed	Next Review date	Risk Owner
Shortage of Midwifery Staffing	12/10/2020	Extreme Risk (16)	X2 Daily Sitrep Robust roster management Redeployment of staff in view of service needs Recruitment Additional escalation meeting during shift when acuity is high. Staff vacancies are sent to staff bank in a timely manner. Bleep holder to assist with clinical caseloads. Roster template to match current establishment	Loss of maternity bleep holder to clinical duties when staffing inadequate	Ongoing recruitment to cover 3.4WTE as agreed by Divisional Triumvirate-over the establishment now that the recruitment has been successful, to focus on maintaining the low vacancy rate and increase retention and staff well-being. Proposal for this risk to be closed and has approval for this at Directorate and Divisional level as it no longer reflects the concern. Two new risks pertaining to staffing to address the residual issues, short term sickness and onboarding issues have instead been proposed for opening. These have Divisional approval.	05/06/2024	Risk register reviewed monthly	Janet Bradley
Closure of Birth Centre	17/04/2023	High risk (12)	Women on birth centre transferred to delivery suite. X2 local daily escalation reviewing staff across the unit. Facilitating similar environment i.e. pool room on delivery suite	Staff shortage on some shifts due to short term sickness causing Birth centre midwives redeployment to delivery suite	4WTE Band 6 offered posts and 2 have start dates. 2 WTE onboarding. June 2024 birth centre open 64%.	05/06/2024	Risk register reviewed monthly	Janet Bradley
Euroking back copying and forward copying IT risk	01/08/2023	High risk (12)	Staff awareness through maternity Bulletins, emails. Alert message on Euroking for all staff to see when they log onto Euroking.	This is a national problem identified for all Trusts using Euroking and there has been a National Patient Safety alert.	Euroking replacement project (iCLIP) in progress.	06/02/2024	Risk register reviewed monthly	Janet Bradley
Infrastructure damage/sewerage flooding on the maternity unit	31/01/2013	High risk (12)	Business continuity updated. Monitoring of any reported adverse incidents relating to ceiling leakage Escalating all estate issues to Divisional and Directorate boards	Old infrastructure and lack of appropriate pipes map to facilitate infrastructure investigations	To continue reporting incidents to estates and escalate issues to division and directorate boards.	22/04/2024	Risk register reviewed monthly	Janet Bradley
Multiple Information Systems Migrating to a single digital platform. Project underway. To launch Feb 2025	13/10/2020	High risk (12)	Staff informed of the multiple systems at induction to the unit. Training provided for the electronic system iCLIP, E3, EPR. Historic patient records are now uploaded onto EDM. When referrals requiring one of the IT systems are made this is documented in the patient handheld notes.	Maternity systems are not fully integrated. One platform data system not yet in place	CERNER project in progress. This will be 1 digital place for all patient notes.	05/06/2024	Risk register reviewed monthly	Cheryl Stewart
Provision of Home Birth service	17/04/2023	High risk (12)	Call women who have been booked directly if service is suspended. X2 daily escalation meeting where staffing is reviewed redeployment of staff in view of service needs. Redeployment of inpatient midwives for current booked women for home birth service.	Staff shortage on some shifts due to short term sickness causing home birth midwives redeployment to delivery suite	No complaints received in 2024, service supports teams to provide additional cover where possible to avoid suspension	05/06/2024	Risk register reviewed monthly	Janet Bradley
Viewpoint 5 servers and application out-of-support IDT is working with Med Physics and clinical services to		High Risk (12)	Software overseen by Medical Physics Dept. Upgraded software has been funded. Upgrade project is in flight.	Delays in agreeing changes to workflows with clinical teams.	IDT is working with Med Physics and clinical services to transition to V6 Viewpoint and integrate this with iCLIP. Risk description updated to add	04/06/2024	Risk register reviewed monthly	Cheryl Stewart

transition to V6 Viewpoint and integrate this with iCLIP. Risk description updated to add risk and impact; controls added.					risk and impact; controls added.			
Diabetes team seeing 500+/year women with GDM in the same clinic for women with pre-existing diabetes.	10/04/2024	**High Risk (12)**	Provision of pregnancy care for women with pre-existing diabetes in an MDT clinic although this patient group forms a minority within the clinic which includes gestational diabetics and other endocrine patients. Weekly MDT meeting prior to clinic to support focused care	There are inadequate clinical rooms for required staff for the diabetic clinic. There is minimal headroom to cover for staff absence for most disciplines and no headroom for midwifery. Clinics currently take place on Mondays and therefore do not operate when there is a bank holiday. There is no safety nets in terms of MDT support for patients particularly those requiring weekly interventions.	To be reviewed in next risk register review	RISK opened June 2024	Risk register reviewed monthly	Yolande Van De L'Isle

3.8 Audit

The ESTH Maternity Service has a Compliance and Audit Midwife (fixed term) who will be in post until Autumn 2024. Much of her work has been taken up by the Saving Babies Lives Care Bundle v3, which has a requirement of around 60 audits in relation to:

- Smoking cessation
- Fetal Monitoring
- Fetal Growth restriction
- Reduced fetal movements
- Pre-term birth
- Management of pre-existing diabetes.

In April 2024, the ICB's quarterly assessment showed ESTH were 93% compliant with the 70 interventions, a 12% improvement since January 2024. The next assessments will be in August 2024. Quarterly assessments and re-audits will continue every six months until 100% compliance is achieved.

A formal audit program is being established, detailing named leads, frequency, and presentation, in response to the CQC inspection and associated information requests. Monthly compliance monitoring is in progress, with quarterly assurance reporting being implemented. Audit outcomes are generally positive, though a key compliance issue remains the low uptake of Adult Safeguarding training among Consultant Obstetricians, which has been escalated to the Board by the safeguarding lead.

3.8.1 **SGUH**: SBLCB In April 2024, the ICB's quarterly assessment showed SGH were 76% compliant with the 70 interventions, a 7% improvement since January 2024. The next assessments will be in August 2024. Quarterly assessments and re-audits will continue every six months until 100% compliance is achieved.

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3.9 MSSP ESTH visit.

The Maternity Service had a diagnostic review carried out by the Maternity Safety Support programme team between 7th – 10th May 2024. Following the CQC report of an inadequate rating for SGUH and the subsequent MSSP diagnostic review, a decision was made that it would be good practice to review the maternity services within the group.

The high-level findings were:

What's Good

- Welcoming engaged team - open and honest conversations
- Passionate and dedicated staff proud of services
- Matrons feel supported by leadership team
- Year 5 MIS compliant
- CQC national patient survey outcomes
- Low morbidity data
- BFI outcomes
- Low workforce turnover <3%
- Research team well resourced
- Pilot of translation system
- Pilot antenatal education
- Strong medical engagement
- Student experience mostly positive
- Choice of place of birth
- Well-developed preceptorship program with support
- Labour ward handover and ward round was well attended with MDT representation
- Safety champions were sighted on midwifery services and current issues
- QI processes
- Excellent obstetric staffing
- Cohesive team across the MDT
- Established maternal medicine links to network improvement
- Group FTSU process

Challenges

- MAU criteria
- BSOTS not implemented – competency of midwives for triage role
- Protected staffing Triage / supernumerary status of LW coordinator
- HDU trained staff
- Communication
- Home birth 2nd midwife provision
- Impact of CQC rating on staff and local women and families
- Confusion and anxiety about strategy and group model
- Ward to board reporting and flow of communication
- Bereavement services capacity and capability 7 day service/ facilities St Helier
- Gaps in anaesthetic consultant rota for daytime cover, should be 10 and only maximum of 6 Epsom site and 8 SH
- Complex layers of reporting / diluted the message
- Interim / seconded posts/ pay variation forms
- On call policy / process / escalation out of hours
- Uplift 20% BR+ recommended 22%

- Consistent poor compliance with uniform policy/IPC standards (hand hygiene)
- Huddle confidentiality – open environment, interruptions (patients and staff) (Epsom)
- Partial MDT huddle - inconsistent attendance of anaesthetic and theatre staff (Epsom)
- Fill rates and escalation; shift leader relies on SOS from colleagues to try to maintain safety
- Students at Epsom reported a poorer experience due to fill rate on clinical shifts, sometimes more students on shift than experienced mentors, or registered midwives (on occasions)
- Medical compliance with safeguarding training

4.0 Sources of assurance

4.1 ***MBRRACE-UK:*** The MBBRACE-UK Perinatal Mortality Report for 2022 has confirmed that neither ESTH nor SGUH are negative outliers for either stillbirth or neonatal death. Currently, GESH have commissioned an external review of stillbirth cases in 2020 and 2021; the 2020 review has been completed and has not raised any significant concerns. The report noted that a percentage of PMRT reviews did not have an external panel member. It should be noted that 2020 was during the height of the COVID-19 pandemic and the standards around PMRT (CNST) had been suspended.

The requirement of an external panel member is recommended, but in recognition of difficulty in sourcing an external panel member, this is not a mandatory requirement. The focus for CNST and recommended by NHS Resolution is on the completion of the PMRT reviews in a timely manner; it is important for the Trust to note that reviews should proceed in accordance with the timescales stipulated by CNST, and these should not be delayed where an external panel member cannot be sourced or doesn't attend. NHS Resolution recommends a selective approach to which cases would benefit most from the attendance of an external panel member.

4.2 The 2023 CQC Maternity Survey has provided positive and improved feedback from service users, with ESTH ranked as top in London and SGUH in second place.

5.0 Implications

5.1 The following key messages have been identified in this report:

- The publication of new Technical Guidance for the Maternity and Perinatal Incentive Scheme Year 6.
- There are no clear themes emerging in respect of the ESTH and SGUH Maternity Service.
- ESTH - the impact of the aging estate on ability of the service to provide a modern Maternity Service in line with national guidance.
- ESTH and SGUH trends of outcomes have remained stable over the last 15 months.
- Consideration needs to be given to completion dates for actions, particularly around PMRT, to ensure that they are achievable.
- A programme of safety champions engagement sessions has been re-established.
- ESTH: Medical training data for newborn life support is unavailable and challenging to obtain.
- SGUH: newborn life support training for medical staff is well below the compliance threshold.

6.0 Recommendations

6.1 The Group Board is asked to.

a) Acknowledge the key areas of success, risks, and mitigations, and consider any potential areas for further improvement.

b) Note the actions being taken in response to midwifery on-call arrangements.

c) Note the compliance issues with newborn life support training for medical staff and the implications in not meeting CNST Safety Action 8 by 30th November 2024.

d) Note that UNICEF UK Baby Friendly Initiative team has paused the gold accreditation status at ESTH due to some unmet standards and stage 3 accreditation is paused at SGH maternity due to the Inadequate rating from the Care Quality Commission.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	3.2
Report Title	**Integrated Quality and Performance Report**
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer
Report Author(s)	Group Director of Performance & PMO
Previously considered by	Quality Committees-in-Common Finance Committees-in-Common
Purpose	**For Assurance**

Executive Summary

This report provides an overview of the key operational performance and quality measure information, and improvement actions across St George's Hospitals (SGH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

Action required by Group Board

The Board is asked to review the report and note the operational and quality information and actions as of July 2024.

Committee Assurance

Committee	Finance Committees-in-Common 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

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Integrated Quality and Performance Report (IQPR)

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, 05 September 2024

1.0 Purpose of paper

This report provides an overview of the key operational performance, quality, safety, and outcomes information, as well as improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

2.0 Quality & Safety

ESTH, SGH and IC reported a number of quality-related improvements and successes in July 2024 including.

- Nil MRSA infections in-month and year-to-date at SGUH, and ESTH.
- No Never Events were reported in July 2024 for SGUH and ESTH.
- Observed mortality rates as measured by the (Summary Hospital-level Mortality Indicator (SHMI) continue to track below expected levels at SGUH.
- SGUH continues to be on or above target for the percentage of complaints responded to in 35 days and acknowledged within three working days.
- At ESTH there has been a significant reduction in both the total number of falls reported and the percentage of unwitnessed falls in July 2024.
- At ESTH, there were no reported cases of category 3 or 4 pressure ulcers. The service is now closer to rolling out Purpose-T learning via online training
- Integrated Care now have Organisational Membership to The Queen's Nursing Institute providing access to learning, education, shared forums and coaching opportunities from dedicated Community Nursing focused organisation and peers.
- Integrated Care - Contract awarded for service provision to two specialist schools (Wandsworth & Merton).

Key **challenged** areas are as follows.

- **Patient Safety Incidents Reports**: ESTH declared one Patient Safety Incidents (PSIIs) in July 2024, actions will focus on learning from an accidental removal of a patient from the waiting list for gallbladder surgery.

- **Falls**: At ESTH, one incident involving moderate harm was reported in July 2024. This incident was investigated using a SWARM-style review, where staff immediately gather at the site/ward after an incident to quickly analyse what happened, how it occurred, and to decide on actions needed to mitigate risks on the ward. This was the first SWARM meeting conducted for a falls incident under the new Incident Response Pathway.

Similarly, SGUH reported one moderate fall in July 2024. The patient sustained fractures to the left inferior pubic ramus and left iliac bone. The fractures were conservatively managed, and the patient has since been discharged.

- **Pressure Ulcers:** In July 2024, there were 14 acquired Category 3, 4, and unstageable pressure ulcers at SGUH, including one Category 4 pressure ulcer. Four of these pressure ulcers were acquired on a single medical ward. The investigation revealed a combination of factors, including a high-acuity patient cohort and the use of temporary staff to cover sickness absences and maternity leave as common themes. A meeting has since taken place between the SGUH CNO and nursing leaders in that area, resulting in the development of a robust action plan. Within Integrated Care, the PSIRF has identified the need to focus on improvements.
- **Venous Thromboembolism (VTE) Risk Assessment rates:** Reporting of this quality indicator has recently changed to align with revised national guidance, which stipulates that assessments must be completed within 14 hours of admission, as recommended by NICE. Against this revised definition and the national target of 95% for assessments within 14 hours of admission, SGUH achieved 63% and ESTH 84%. Work is underway to standardise reporting across gesh and a group-wide task group is also reviewing the VTE risk assessment forms to improve completion rates.

- **Complaints –** At ESTH meeting the target of complaints responded to within 35 days, has been challenging as the current process is not robust and does not enable a consistent monitoring approach. Additionally, the configuration of the current tool (Datix) makes data capture difficult and other factors such as high sickness absence rates and operational pressures have further contributed to the issue. Several actions are in place to aid recovery including, weekly divisional complaints meeting, weekly case reviews, revision of investigation completion timescales, revision of Datix parameters, access to Datix for divisions, configuration of the monitoring tool and roll-out of weekly complaints reports.

- **Key challenges in Integrated Care** relate to Pressure Ulcer Management, Increase in falls with injury: Mary Seacole Unit, managing complexity of patient's health versus social impact.

3.0 Operational Performance

All three sites - ESTH, SGUH and IC – reported a number of operational performance improvements and successes in May 2024. The key highlights are as follows.

- Advice & Guidance utilisation rates at both ESTH and SGUH continue to exceed the target of 16 requests per 100 outpatient appointments.
- Patient Initiated Follow-up (PIFU) activity continues to increase at SGUH with full rollout scheduled for September 2024 which will considerably improve our performance.
- ESTH delivered against all three national cancer standards in June 2024: 28-Day Faster Diagnosis (87.2%), 31-Day Decision to Treatment (100%), and 62-Day Referral to First Treatment (90.4%). SGUH performed better than trajectory for all three standards, 28-Day Faster Diagnosis (75%), 31-Day Decision to Treatment (96.2%) and 62 Day Referral to First Treatment (77.2%).
- Improvements in waiting list management for adult services continues at Sutton and Surrey Downs Health and Care. Waiting list initiative with Musculoskeletal and Podiatry services held their first Community Assess and Support Day (CASD).

- Performance in capped theatre utilisation is being maintained at ESTH, achieving top quartile performance nationally against the national target of 85%. ESTH ranks first in South West London for the proportion of all admissions that were day cases (BADS Procedures) with a performance of 84%.
- Diagnostic waiting time performance at SGUH continues to be within 5% of national recovery target with 1.9% patients waiting for more than six weeks at the end of June 2024.
- Against the 4-hour ED waiting time standard, SGUH delivered 81.6% in July 2024 exceeding trajectory and demonstrating continuous improvement alongside other urgent and emergency care metrics including a significant reduction in LAS handover waiting times and length of stay.
- At ESTH, the number of patients with a LOS of >7-days, >14-days and >21-days has reduced in July 2024 when compared to June 2024.
- Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in June 2024. Sutton Health & Care achieved 84.2% and Surrey Downs Health & Care, 90.4%, with a continued focus on encouraging more referrals. Virtual Ward occupancy target of 80% continues to be met at Surrey Downs and continued step change of improvement seen at Sutton. The re-enablement Unit at Sutton was fully utilised with 100% occupancy through July 2024.

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

- The number of 65-week waiters on a Referral to Treatment (RTT) pathway at ESTH increased in June 2024 to 154 pathways, against a month-end target of 100. The Trust is still aiming to have zero 65 week waits by the end of September 2024, in line with the national target, other than patient choice delays. Gynaecology remains the most challenged specialty at ESTH with an increase in the inpatient/daycase waiting list due to a backlog clearance capacity gap. Insourcing arrangements are now in place in theatres as part of the gynae recovery plan to address this. At SGUH, the number of RTT pathways exceeding 65 weeks has also increased with Neurosurgery being the most challenged specialty. There is a risk of approximately 20 patients being over 65 weeks by the end of September 2024, some due to patient choice.
- The waiting list size for children's services at Sutton Health & Care remains a challenge; this is a national issue recognised at SWL/Place. The number of children waiting longer than 52 weeks for therapy remains high (70 patients).
- Theatre capped utilisation rates reduced to 77% at SGUH through July 2024 due to delays to the start of lists which led to over runs. The delays were caused by estates issues. There is continued emphasis on scheduling and the new 6-4-2 meeting structure rolled out in July 2024 and overseen by the site Chief Operating Officer.
- Diagnostic waits at ESTH have increased with 5.2% of patients waiting for more than 6 weeks at the end of June 2024. This is mainly due to an increase within Echocardiography. Funding has been secured to support additional capacity while a long-term plan is worked up.
- DNA rates at both ESTH and SGUH remain above target, with noticeable improvements in recent months. At ESTH, a pilot of DrDoctor to provide a 2-way text for Paediatric Dermatology was carried out which resulted in a 0% DNA rate. This will be replicated for September 2024, supported by the Elective Transformation team. SGUH are exploring a number of improvement

opportunities including data quality of inactive slots and services reviewing their appointments that have one-way reminder texts monthly for Day 7 and Day 2 before appointments.

- Pressures in Urgent and Emergency Care (UEC) services remain at both Trusts with high numbers of medically optimised patients occupying acute beds. High numbers of unplaced patients including mental health patients continue to stay in ED for prolonged periods. Actions to mitigate the pressures in ED are being considered at a local and SWL level.
- Whilst ESTH has seen a reduction in the super stranded patient cohort (LOS >21 days) and an uptick in SDEC activity, 4-hour performance in the ED remains challenged, with performance of 75.8% against 76.5% trajectory. The UEC pathway and patient flow continue to be key challenges, with a significant proportion of patients (12.3%) waiting more than 12 hours in EDs. The number of unplaced patients, including those with mental health conditions, who remain in the ED for prolonged periods also remains high.

4.0 Sources of Assurance

4.1 Quality Committees-in-Common

Reasonable Assurance. The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance.

4.2 Finance Committees-in-Common

Reasonable Assurance. The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance.

6.0 Recommendations

6.1 The Board is asked to note the report and make suggestions for any further action.

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

Group Integrated Quality & Performance Report

July 2024

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 23 August 2024

Board to Ward Improvement Priorities for 2024/25

Board Level Metrics Dashboard

C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Work with other teams and partners to improve patient flow through our services.	Live within our means: improve productivity & reduce costs.	Keep our patients safe – including those waiting for our care.	Get all our colleagues involved in improving our service.
Deliver 78% 4-hr A&E Performance: SGUH – On track ESTH – Trajectory not met	**Deliver Financial Plan**: SGUH – TBC ESTH – TBC	Improvement vs 23/24 on fundamentals of care - Falls, Pressure Ulcers, VTE Risk Assessments, Dementia Assessments - **TBC**	**Staff Turnover Rates*: Target 13%** SGUH – Below Target ESTH - Below Target
Maintain ED 12hr Waits at 23/24 Level or below: SGUH – On Track (normal variation) ESTH - Special cause concerning variation	**Deliver 5% Productivity (ERF)** SGUH – On Track ESTH – Behind Plan	**Achieve Mortality Ratios (SMHI) of 1 or less**: SGUH – 0.91 below expected ESTH - 1.17 above expected (*partly/fully attributable to coding changes)*	**Staff Sickness Rates***: SGUH – Above Target of 3.2% ESTH - Above Target of 3.8%
Delivery 1.5 Days LOS Reduction: SGUH – Behind Plan ESTH - Behind Plan	**Deliver 5.5% CIP** SGUH – TBC ESTH - TBC	**Eliminate RTT 65-week waits by September 2024**: SGUH – At risk ESTH - At risk	**Improvement in WRES and WDES Metrics**: TBC
Deliver 80% Virtual Ward Utilisation Rate: Sutton – Not Achieving Surrey Downs - Achieving		**Deliver 62- Day Cancer Waiting Times Operational Plan Targets**: SGUH – Exceeding Plan ESTH - Exceeding Plan	**Improvement in % of staff saying they would recommend the organisation as a place to work** - Improvement on previous year (results based on 2023/24 compared to 2022/23 SGUH – Improvement ESTH - Non-improvement

* Proxy for Staff engagement whilst detailed metrics are developed

2

Executive Summary

Safe, High-Quality Care

St George's Hospital

Successes

- **Never Events**: There were no Never Events or Patient Safety Incident Investigation (PSIIs) in July 2024.
- **Infection control**: SGUH continues to report zero MRSA bacteraemia for the year.
- **Complaints:** SGUH continues to be on or above target for the percentage of complaints responded to in 35 days and acknowledged within 3 working days.

Challenges

- **Falls Prevention and Management:** There was one moderate fall in July 2024 (zero major or extreme), this occurred on a medical ward, the patient sustained a left inferior pubic ramus and left iliac bone fracture. The fracture was conservatively managed, and the patient has since been discharged.
- **Pressure Ulcers:** There were 14 Acquired Category 3, 4 and unstageable pressure ulcers in July 2024, 1 was category 4. Four of the pressure ulcers were acquired on one medical ward, the investigation has shown a mixture of issues with a high acuity cohort and use of temporary staff to cover sickness and maternity leave the common theme. A meeting has taken place with the SGUH CNO and nursing leaders in that area with a robust action plan now developed.
- **Infection Control:** There were 10 hospital acquired C. difficile infections and 17 cases of E. coli bacteraemia during July 2024. Of the 17 E. coli cases, 13 have been classified as Hospital-Onset Healthcare-Associated (HOHA) and 4 classified as Community-Onset Healthcare-Associated (COHA). An action plan is in place with progress reported to the gesh Quality Group.
- **Patient Experience in ED** : The proportion of patients that would recommend the department to friends and family continues to track below the national target of 90%.
- **VTE:** SGUH reported a VTE risk assessment performance of 63% for Q1 of 2024/25, using the revised national guidance requiring reporting to be consistent with NICE recommendation of assessments within 14 hours of admission. Further work is underway to standardise reporting across gesh.

Epsom & St Helier

Successes

Falls Prevention and Management: There has been a significant reduction in both the total number of falls reported and the percentage of unwitnessed falls in July 2024. Acute Services reported 60 falls (2.9 falls per 1,000 OBDs), a reduction of 28% from the previous month (44 of these incidents were Inpatient falls). Unwitnessed falls reduced from 65% in June 2024 to 57% in July 2024. There was one incident with moderate harm reported in July 2024; this incident was investigated using a SWARM style review where, immediately after an incident, staff 'swarm' to the site / ward to quickly analyse what happened and how it happened and decide what needs to be done to reduce risk on the ward where the incident occurred. This is the first SWARM meeting held for a falls incident in line with the new Incident Response Pathway, allowing multiple Multi-Disciplinary Team (MDT members to attend and staff of all bandings being given the opportunity to speak openly and gain insight and learning.

Pressure Ulcers: The number of pressure ulcers remain low. Six hospital-acquired pressure ulcers; four category 2, and two deep tissue injuries. No category 3 or 4 pressure ulcers were reported. The service is a step closer to implementing Purpose-T learning via online training.

VTE Risk Assessments: Reporting has been aligned to revised national guidance requiring submissions to be consistent with the NICE recommendation of assessments within 14 hours of admission. Patient Safety Incident Response Framework (PSIRF) implementation process is being undertaken in investigations of VTE incidents to highlight processes under System Engineering Initiative for Patient Safety, with VTE Clinical Nurse Specialist participation in After Action Reviews.

Challenges

Falls Prevention and Management: Templates for inpatient falls have been developed to align with PSIRF. These were adapted from the Trust's generic templates and the Royal College of Physicians falls specific templates. The documents have been shared at the PSIRF Implementation meetings; however, they have not been progressed as yet.

Hospital Acquired Thrombosis (HAT): There are 18 Hospital Acquired Thrombosis-VTE reported in July 2024, compared to 14 in June 2024. Only 2 of the HATs in July have been reported to Datix by the responsible Divisions.

Executive Summary
Operational Performance

St George's Hospital

Successes
- Advice and Guidance utilisation rates at SGUH continue to improve and exceed target.
- Patient Initiated Follow-up (PIFU) activity continues to increase. Currently rolled out in six services (T&O, Urology, Plastics, Gynae, Dermatology and Therapies) with full rollout scheduled for September 2024. This will considerably improve our performance and improve our Outpatient value weighted activity as a result over the coming months.
- The first and procedure outpatient (OP) attendances as a percentage of total OP appointments continues to exceed target achieving 52% - above the national ask of 49%.
- Faster Diagnosis cancer performance in June 2024 was 75.1 % meeting plan of 75 %.
- 62-day Performance was at 77.2% against a plan of 75% for June 2024, but above the system target of 70%.
- Diagnostic performance waiting time performance continues to be within 5% of national recovery target with 1.9% patients waiting for more than six weeks at the end of June 2024.
- Performance against the 4-hour operating standard exceeded the plan in July 2024, achieving 81.6%. Ambulance handover times improved significantly, weekly meetings with LAS continuing.
- The number of super stranded in-patients (length of stay over 21 days) remained below plan. Non-elective length of stay has decreased for a 3rd consecutive month nearing 6 days.
- There has been significant improvement in the number of NCTR forms completed prior to 9.30am daily, which in turn is now reflecting a more accurate number of patients NCTR.

Challenges
- The number of RTT pathways waiting for more than 52 and 65 weeks has increased with Neurosurgery the most challenged specialty. We have a risk of approximately 20 patients being over 65 weeks by the end of September, some due to patient choice.
- Waiting list size continues to see increasing growth, 12-week validation of new patients has been absent while we migrated to a new IT platform. This has impacted the wait list.
- Faster Diagnosis performance within Breast has seen a decline in performance to a non-compliant position due to Breast moved to a non-compliant position. A recovery action plan is in development with support from RMP. Lower Gi most challenged with a performance of 53% with CTC access at QMH and endoscopy process delays being contributing factors, recovery actions being developed.
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside, and Pathway 2A (Merton + Wandsworth) and Pathway 3 awaiting discharge, impacting on flow.
- Over 72-hour mental health breaches in the ED continues to be an issue. This is being reviewed at an ICS level to see what can be done to mitigate the pressures in ED across SWL.

Epsom & St Helier

Successes
- ESTH ranks first in SWL for the proportion of all admissions that were day cases (BADS Procedures) with a performance of 84%.
- PIFU rate improvement was sustained.
- Theatre utilisation (capped) in July 2024 was 82%, consistently achieving over 80% since April 2024.
- All cancer performance standards were achieved in June 2024: 28-day Faster Diagnosis (87.2%), 31-day first treatment (100%) and GP 62-day first treatment (90.4%).
- Although Gynaecology long waits remain high, the total Gynaecology PTL has reduced from 6499 at the end of 2023 to 5625 at the end of June 2024.
- Community Paediatric long waits continue to improve month on month.
- There has been an increase in SDEC activity in July 2024 (620) when compared to June 2024 (420).
- The number of patients with a LOS of >7-days, >14-days and >21-days has reduced in July 2024 when compared to June 2024.
- Readmission rates have reduced from 5.9% in June 2024 to 5.6% in July 2024.
- UTC ED performance was 83.9% in July 2024.

Challenges
- 52 and 65 week waits increased again from May 2024 to June 2024, with the highest volumes of 65 week waits in Gynaecology (106), Dermatology (9) and Cardiology (8). Gynaecology also remains the biggest challenge for 52 week waits with 382 at the end of June 2024. There is now in-sourcing in place in theatres as part of the gynae recovery plan to address this.
- Diagnostic performance was below target in June 2024, mainly due to an increase within ECHO. Funding has been secured to support additional ECHO capacity while a long-term plan is worked up.
- EUS capacity for diagnosing Upper GI cancers is limited as current waiting times are 3-4 weeks, although a reduction from 5-6 weeks due to the opening of RMH Oak Centre and a weekly additional list.
- UEC pathway and flow remains a key challenge with a high proportion of patients waiting more than 12 hours in EDs (12.3%). Continued high numbers of unplaced patients including mental health patients remaining in ED for prolonged periods.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

2-hour Urgent Community Response (UCR) target continues to exceed target achieving 84.2% in May 2024.

Reablement unit occupancy 100% with decreased length of stay – 7 days. Work in progress to decrease length of stay to five days to support discharge flow.

Discharge to assess (pathway 3 delays) reduced to 18. Work in progress to decrease length of stay to support discharge flow.

High levels of MAST maintained at 91.2%

Challenges

Waiting times for children's therapy over 52 weeks remain high although have decreased from 70 with work in progress to decrease wait list. Children's OT services hold the highest proportion.

Surrey Downs Health & Care(SDHC)

Successes

Maintained 2 median days for discharge of patients through Transfer of Care hub

Consistently achieving the 2-hour UCR target with 90.4% in July 2024 while managing high levels of referral numbers.

Maintained the Improvement in waiting lists across all services with no 52+ week waiters

Maintaining occupancy rates of above 80% in community hospitals.

Increase in number of patients supported through VW to 268 with 90.4% occupancy rate.

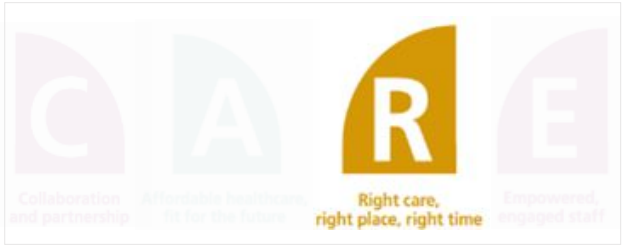
High levels of Mandatory and Statutory Training (MAST) being maintained at 94.9%.

Non-Medical – appraisal rate is 94.9% showing further improvement.

Challenges

Sickness rate remains above target, mainly due to long term sickness. Robust absence management process in place .

Quality & Safety



Safe, High-Quality Care

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Jul 24	0	0	0				Jul 24	0	0	0			
Patient Safety Incidents Investigated	Jul 24	3	0	0				Jul 24	0	1	0			
Number of Falls With Harm (Moderate and Above)	Jul 24	2	1	0				Jul 24	0	1	0			
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Jul 24	0.09	0.04	0.00				Jul 24	0.00	0.06	0.00			
Pressure Ulcers - Acquired category 3	Jul 24	8	10	8		F		Jul 24	0	0	0			
Pressure Ulcers - Acquired category 4	Jul 24	0	1	0				Jul 24	0	0	0			
Infection Control - Number of MRSA	Jul 24	0	0	0	L			Jul 24	0	0	0	L		
Infection Control - Number of Cdiff - Hospital & Community	Jul 24	6	10	4				Jul 24	8	11	4			
Infection Control - Number of E-Coli	Jul 24	8	17	7	H			Jul 24	1	5	7			
VTE Risk Assessment	Jul 24	65.3%	61.8%	95.0%		F		Jul 24	85.3%	84.3%	95.0%	L	F	
Mortality - SHMI	Mar 24	0.93	0.91	1.00	L	P		Mar 24	1.17	1.17	1.00		F	
% Births with 3rd or 4th degree tear	Jul 24	3.4%	3.8%	-				Jul 24	4.4%	1.1%	-			
% Births Post Partum Haemorrhage >1.5 L	Jul 24	5.1%	4.7%	4.0%				Jul 24	2.1%	4.3%	4.0%			
Stillbirths per 1,000 births	Jul 24	3.4	5.9	4.0				Jul 24	0.0	0.3	0.0			
Neonatal deaths per 1,000 births	Jul 24	3.4	2.5	2.6				Jul 24	0.0	0.0	0.0			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Jul 24	0.0	0.0	2.2	L			Jul 24	0.0	0.0	0.0	L		

New VTE guidance implemented from Q1 2024 to monitor VTE assessment completed within 14 hours.

- SGUH previously monitored against no time frame and are using Decision to Admit date / time as the clock start
- ESTH monitored against 24 hours and are using admission date / time as clock start

Safe, High-Quality Care

Overview Dashboard | Patient Experience & Integrated Care

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Number of Complaints Received	Jul 24	70	64	-			
Complaints responded to in 35 days	Jul 24	95%	89%	85%			
Percentage of complaints acknowledged within three working days	Jul 24	100%	100%	100%			
Number of re-opened complaints in month	Jul 24	4	3	-			
Number of complaints not completed within 6 months from date of receipt	Jul 24	1	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Jul 24	0	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Jul 24	1	2	-			
Friends and Family Test - Inpatients Score	Jul 24	97%	97%	90%			
Friends and Family Test - Emergency Department Score	Jul 24	74%	78%	90%			
Friends and Family Test - Outpatients Score	Jul 24	94%	94%	90%			
Friends and Family Test - Maternity Score	Jul 24	85%	79%	90%			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 24	26	32	-			
Jul 24	64%	66%	85%			
Jul 24	100%	100%	100%			
Jul 24	1	2	-			
Jul 24	28	10	-			
Jul 24	0	0	-			
Jul 24	0	0	-			
Jul 24	95%	96%	90%			
Jul 24	80%	82%	90%			
Jul 24	93%	94%	90%			
Jul 24	98%	99%	90%			

Sutton Healthcare

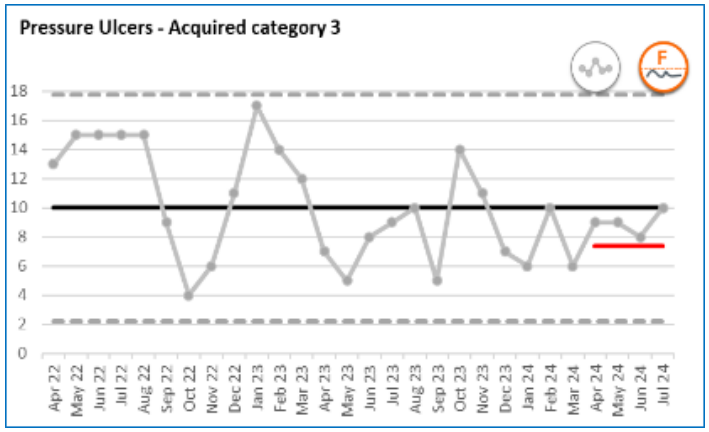
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Serious Incidents	Jul 24	1	0	-		
Pressure Ulcers Category 3	Jul 24	5	3	-		
Pressure Ulcers Category 4	Jul 24	0	0	0		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Jul 24	1	0	-		
Jul 24	6	5	-		
Jul 24	0	1	0		

Safe, High-Quality Care

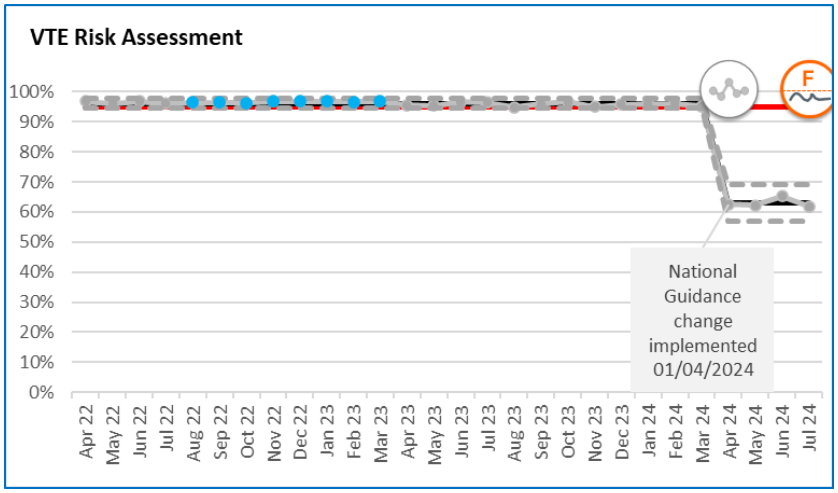
Exception Report | SGUH Pressure Ulcers Category 3



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Grade 3 Shows normal variation however not meeting monthly ambition to achieve 10% reduction	There were 14 Acquired Category 3 & 4 and unstageable pressure ulcers in July 2024, this is significantly higher than previous months although still within process limits. Of the 14: • 9 were acquired in Medicine/Cardiovascular, 3 acquired in SNCT and 2 acquired in CWDT • 3 were related to medical devices, none of these patients were cared for intensive care areas • 4 pressure ulcers were acquired on a single medical ward, these have been investigated as a cluster. This has shown a mixture of issues with an extremely high acuity cohort and use of temporary staff to cover substantive sickness and maternity leave the common theme.	• Services where harm has occurred continue to complete investigations and produce local action plans that are managed within the division • Healthcare Assistant targeted e-learning signed off and to be launched • Quality review meeting held between Site CNO, GESH ADON Quality and Accreditation, Matron and Ward Manager of service with cluster of pressure ulcers. Robust action plan in place, new Ward Manager in role since end of July 2024 • Pressure relieving mattress audit completed by medical physics after concerns raised about stock by Corporate Nursing, replacement programme agreed and monitored via pressure ulcer steering group • Trust wide pressure ulcer prevention action plan to be updated once RSM report published, draft received in August 2024	March 2025 achieve 10% reduction compared to 2023/24.	sufficient for assurance

Safe, High-Quality Care

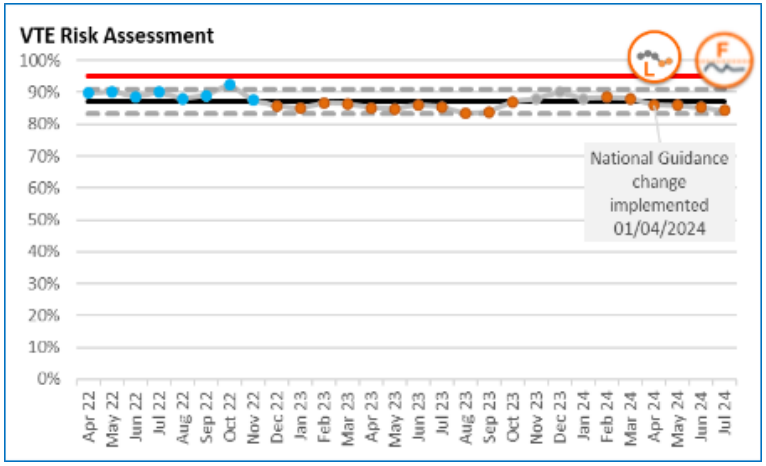
Exception Report | SGUH VTE Risk Assessment



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH VTE Performance A step change seen due to change in guidance. Not meeting target of 95%	VTE risk assessment data submission to NHS England Digital has been reinstated (paused since the Covid pandemic). Previously there was no time criteria within the guidance, but it now states that risk assessment should be completed within 14 hours (in line with NICE standards). Performance has consequently been affected and the overall Q1 figure submitted was 62.9% for St Georges. To note SGUH are using DTA (decision to admit time) as the starting point.	• The Hospital Thrombosis Group and Clinical Informatics are working alongside ESH to standardise reporting across the GESH Group. • Targeted training and education for poorly performing areas as identified on Tableau • On-going GESH task group to review the VTE risk assessment form to improve completion rates	Aim of incremental improvement: 10% by end of Quarter 3 and review.	Sufficient for assurance. DTA used as clock start this differs to ESTH which uses admission time. Discussion ongoing for this to be aligned.

Safe, High-Quality Care

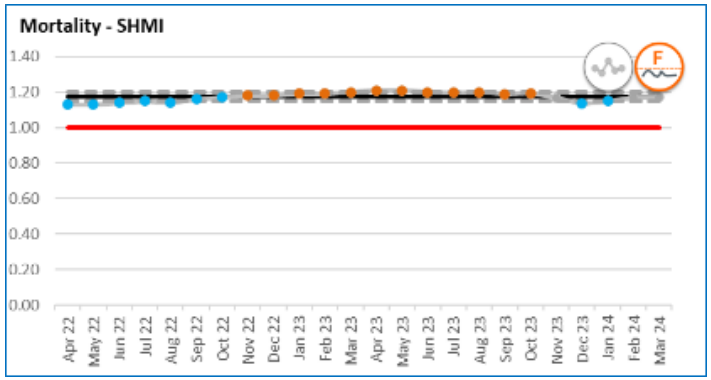
Exception Report | ESTH VTE Risk Assessment

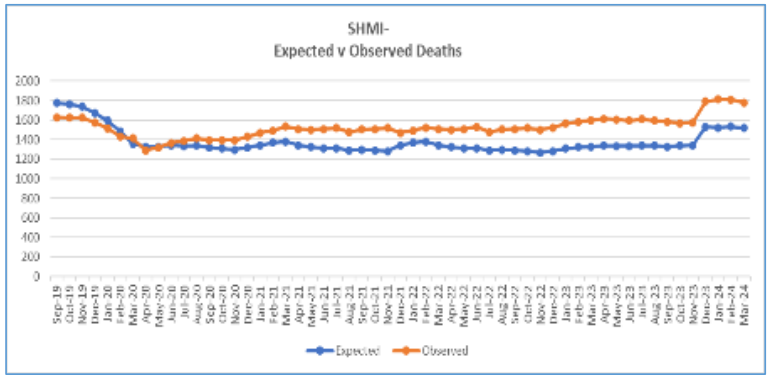


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH VTE Performance Shows a concerning variation with the target consistently not being met.	Risk Assessment Screening remains a challenge. Lack of ownership by the appropriate health professionals and divisions remains an issue despite SLT oversight Variation in data collection across both Trusts To note ESTH are using admission date / time as the starting point.	• VTE Nurses met St George's counterpart on 29th July 2024 • Pharmacy analyst informed about adding size of mechanical devices to existing tasks in ePMA – application of this is ongoing • VTE risk assessment forms amended on iCM (clinical management system) to include patients 16 years old and above • Group oversight of information and reporting started in August 2024 • National reporting indicate that ESTH isn't an outlier in not achieving the national target. • Adjustment to 14-hour reporting will impact on data by an average of a 2% reduction • Work in progress to remove areas that do not need to report to provide more data cleansing • Discussion with Director of Performance to ensure Integrated Care has sight of and can report on their data	March 2025	Sufficient for assurance. Admission date / time used as clock start this differs to SGUH which uses DTA. Discussion ongoing for this to be aligned.

Safe, High-Quality Care

Exception Report | ESTH Summary Hospital- Level Mortality Index (SHMI)



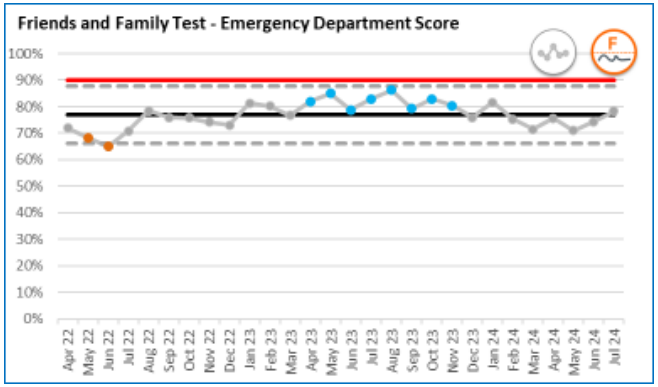


SHMI Source NHS Digital data based on rolling 12 months- April 2023 March 2024 reported in August 2024

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently exceeding expected rate	• Remains classified as 'higher than expected.' • During 2020, Epsom and St Helier University Hospitals NHS Trust (ESTH) stopped reporting Same Day Emergency Care (SDEC) as inpatient activity. This change has subsequently reduced the total spell count in the Summary Hospital-level Mortality Indicator (SHMI) model. • SHMI remains elevated although the trend has been reducing, ESTH remains an outlier. Whilst this is at least in part due to influence of the inclusion of SDEC data within the Emergency Data Set.	• Deep dives and thematic analyses are ongoing, with a focus on ensuring safe patient care. Analysis included electrolyte imbalances, ITI, COPD and pneumonia. The deep dives for all those areas have been completed and did not show any quality concerns • An in-depth review of themes from Structured Judgement Reviews (SJRs) has identified a list of actions being implemented • Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites • Coder-clinician collaboration to reinforce the message how Clinician-Coder collaboration will be extremely beneficial to improve the recording. Coding has improved and is continuing to be reviewed. • There are several enhanced monitoring workstreams including mortality reviewer and medical examiner scrutiny	Under review	sufficient for assurance

Safe, High-Quality Care

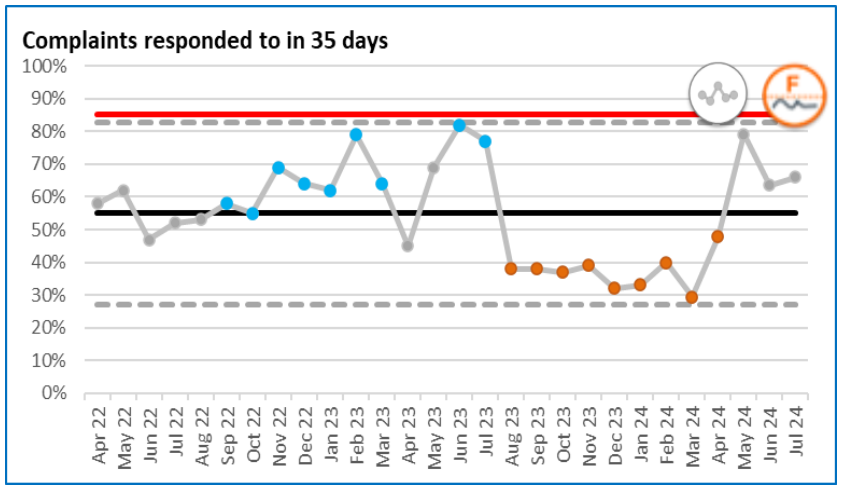
Exception Report | SGUH Patient Experience



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score Special case concerning variation Consistently failing target	The ED survey response rate continues to be good with 1,280 patients responding to the survey in July 2024. The number of patients that would recommend the department to friends and family was 78% for July 2024, an increase on the previous months, and just below the national average for EDs of 79%. During July 2024 the number of ED attendances and patients awaiting a bed in the department continued to be high with the most consistent theme for negative responses being waiting times.	Actions for improving patient experience whilst waiting in ED include: 1. Corridor care checklist and intentional rounding - standardised documentation template for use by RNs when looking after patients in the corridor – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments 2. Majors A/B documentation template – standardised documentation template for use by RNs when looking after patients in Majors A and B – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments 3. NIC checklist on RATE – quality checklist to be completed by NIC at the start of each shift to identify safety checks completed within the department 4. ED matron assurance checklist on RATE – completion for each area during MoD rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles 5. Enhanced care process – formalised process to identify those patients requiring enhanced care, how to request enhanced care shifts to ensure their needs are met whilst in the department 6. Consultant Referral and Triage (RAT) rota **ongoing** • Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary 7. Same Day Emergency Care (SDEC) **ongoing** • 10 new clinical pathways for medical SDEC launched 15th May to redirect patients to medical service if more appropriate • Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic	TBC	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH Complaints responded to in 35 days



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Complaints responded to in 35 Days Consistently not meeting target,	There have been varying ownership levels between the complaints and divisional teams, with most of the responsibility sitting with the complaints team. This is a result of the complaint process that had been in place. As of 21 August 2024, there are a total of 103 open complaints for ESTH. 30 of which had been identified as needing investigation of 35 working days. Of these 30 complaints, 18 have breached the 35 working days response timescale: 5 of these are from July 2024.	Several actions as part of the complaint's improvement workstream are underway to support improving this metric and are ongoing: •Datix has been revised to give the complaints and divisional team equal access to their relevant complaints. •The 25 working days response timescale was revised to 35 working days on 3 June 2024 as part of complaints improvement work. Therefore, all complaints received from June 2024 requiring 25 working days would now be allocated 35 working days. The response timeframes for other more complex complaints have also been revised across the group •Introduction of weekly divisional complaints team meetings between the division and the complaints team. This enables discussion of each complaint and greater ownership of complaint investigations and timeframes	October 2024	Not sufficient for assurance

Operational Performance

C A R E

Collaboration and partnership

Affordable healthcare, fit for the future

Right care, right place, right time

Empowered, engaged staff

Operational Performance

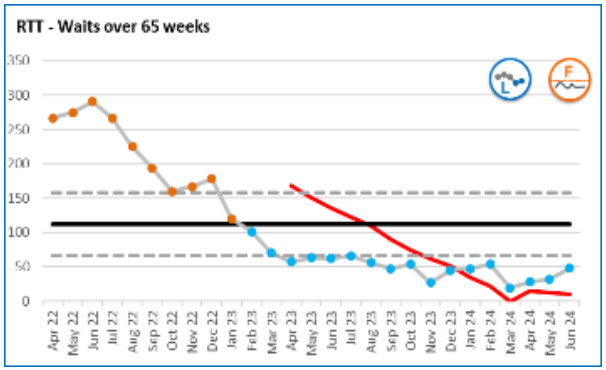
Overview Dashboard | Elective Care

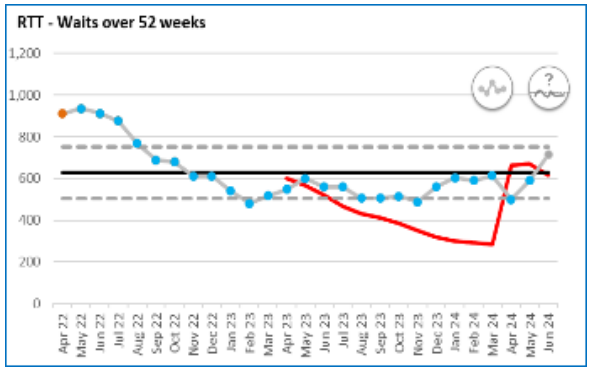
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Elective Ordinary Activity	Jul 24	1125	1108	1277				Jul 24	620	660	769			
Elective Daycase Activity	Jul 24	4653	4930	4928				Jul 24	2839	3287	3617			
Outpatient first attendances without a procedure - ERF scope	Jul 24	30738	31568	23295				Jul 24	11484	12237	13054			
Outpatient procedures - ERF scope	Jul 24	15291	13833	17595				Jul 24	11578	12421	12823			
Diagnostic Activity	Jun 24	19108	18352	19027				Jun 24	18066	17923	16691			
Day Case Rates (BADS Procedures)	Mar 24	70.2%	70.0%	85.0%			Lowest Quartile	Mar 24	84.0%	84.0%	85.0%			2nd Quartile
Theatre Utilisation (Capped)	Jul 24	81.7%	77.7%	85.0%			Top Quartile	Jul 24	82.0%	81.8%	85.0%			Top Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jun 24	1.1%	1.1%	5.0%			Lowest Quartile	Jun 24	3.1%	3.1%	5.0%			2nd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jul 24	53.6%	52.2%	49.0%				Jul 24	46.0%	46.6%	43.6%			
Outpatients Missed Appointments (DNA Rate)	Jul 24	10.1%	10.0%	8.0%			Lowest Quartile	Jul 24	6.7%	6.3%	6.0%			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Jun 24	22.7	18.5	16.0			3rd Quartile	Jun 24	57.3	53.0	16.0			2nd Quartile
RTT - Waits over 65 weeks	Jun 24	32	48	10			Top Quartile	Jun 24	140	152	100			2nd Quartile
RTT - Waits over 52 weeks	Jun 24	591	714	616			2nd Quartile	Jun 24	879	922	830			2nd Quartile
RTT - Total Size Incomplete Waiting List	Jun 24	64096	64657	64495				Jun 24	49728	50233	47048			
RTT - Percentage within 18 weeks	Jun 24	67.5%	66.2%	92.0%			2nd Quartile	Jun 24	67.6%	67.3%	92.0%			2nd Quartile
RTT - Median Waiting Time	Jun 24	11.9	12.1	-			Top Quartile	Jun 24	11.3	11.8	-			
Cancer - 28 Day Faster Diagnosis Standard	Jun 24	74.4%	75.0%	77.0%			3rd Quartile	Jun 24	86.4%	87.2%	77.0%			2nd Quartile
Cancer 31 Day Decision To Treat to Treatmnent Standard	Jun 24	96.1%	96.2%	96.0%			2nd Quartile	Jun 24	98.9%	100.0%	96.0%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Jun 24	80.0%	77.2%	70.0%			2nd Quartile	Jun 24	85.4%	90.4%	85.0%			Top Quartile
Diagnostics - 6 Week Waits	Jun 24	1.3%	1.9%	5.0%			Top Quartile	Jun 24	3.8%	5.2%	5.0%			Top Quartile
On the Day Cancellations not re-booked within 28 days	Jul 24	3	3	0				Jul 24	0	0	0			

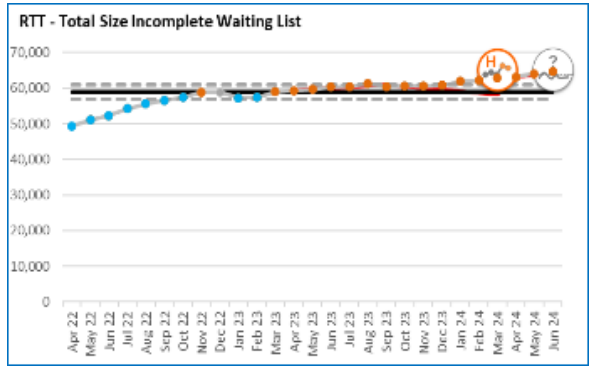
Targets based on internal plan for DC/EL activity and OP ERF Scope

Operational Performance

Exception Report| SGUH Referral to Treatment (RTT)



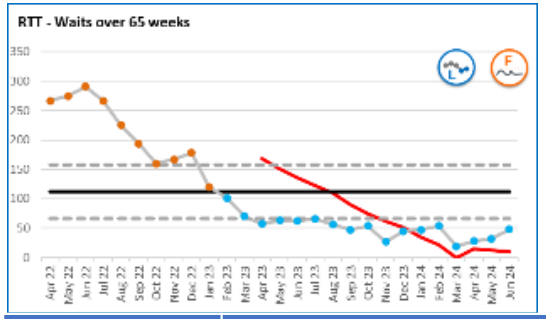


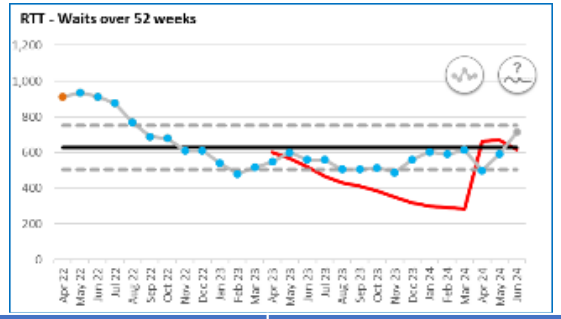


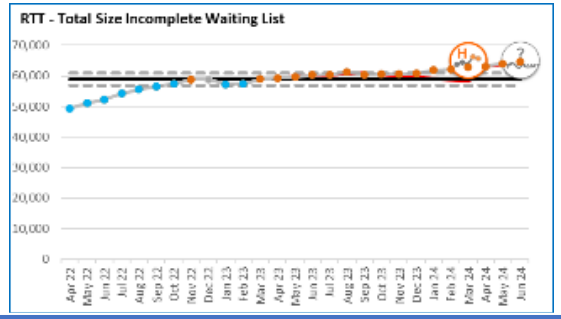
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 10 52 week waits behind plan of 616 Waiting List Size above plan of 63,605	• 65 week waits reporting 48 pathways against plan of 10. Largest proportion of waits within Neurosurgery (15), Plastics (8), Gynae (5) • 1.2% Waiting list growth in the last month within non-admitted pathways predominantly in Dermatology, Diabetes and Bariatric Surgery.	**Theatre Transformation Programme:** This is now set up to look at utilisation, late starts, early finishes, rising non pay costs, pre op assessment and general efficiencies to process **Revision of booking processes:** To reduce the unwanted variation to booking, the Trust is looking to standardise processes so that all administrative teams are following the same standard operating procedure. **Waiting List Validation:** We are moving our 'technical' wait list validation process over to the patient portal. This will allow us to run technical validations more frequently with less administrative burden. **Recovery plans:** Specialties not meeting ERF trajectory have been asked to finalise recovery plans to show actions and timelines to improve activity gaps	September 2024 (Risk with 20 patients)	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



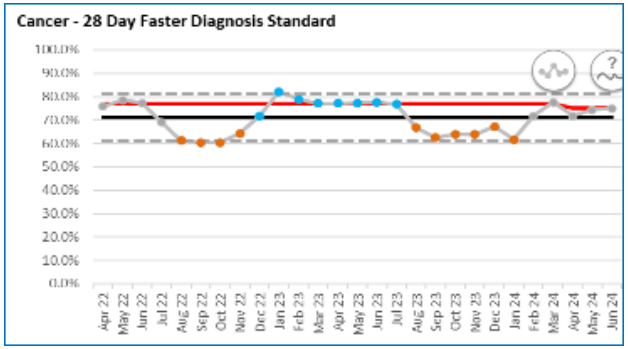




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan 52Wk & 65Wk waits not meeting plan special cause variation	• 52 week waits remained above the ambition of 810 in June 2024 with a total of **922** patients waiting more than 52 weeks. The specialties with the highest cohort were Gynaecology (382), Community Paediatrics (98) and Trauma & Orthopaedics (94). • 65 week waits also remained above the ambition of 80 in June 2024 with a total of **152** patients waiting more than 65 weeks. The specialties with the highest cohort were Gynaecology (106), Dermatology (9) and Cardiology (8). • Gynaecology remains the most challenged specialty at ESTH with an increase in the inpatient/daycase waiting list due to a backlog clearance capacity gap. • Dermatology waits are growing due to a SGH consultant gap in the ESTH Plastics service. • T&O (EOC) waits backlog due to a capacity gap with a Kingston surgeon.	• Recovery plans in place and ongoing for the most challenged specialties. • Gynaecology PTL and patients waiting for first appointment within this service has reduced significantly since insourcing began in January 2024. The total Gynaecology PTL has reduced from 6499 at the end of 2023 to 5625 at the end of June 2024. • To address the inpatient/daycase capacity gap in Gynaecology, and with the added pressure of two theatres being down at ESTH, mutual aid has been requested from SWL providers and insourcing has commenced to support the clearance of the 65 week gynaecology waiters, as well as ongoing monitoring of the plan being in place. • Dermatology to Plastics long waits being mitigated through a recent locum appointment, but SWL mutual aid has also been requested to mitigate further. • T&O's main driver of increased long waits is due to a lack of capacity for a Kingston surgeon (Al-Dadah) which has been escalated to Kingston to support with a resolution and there are also concerns with particular consultant capacity from other partners. This is being managed through the regular operational meetings and is being taken through the SWL COOs group. • Insourcing for Community Paediatrics continues, as well as the locum in post. This has supported the reduction in 65 week waits from 65 in January 2024 to 2 in June 2024. 52 week waits also reduced from 221 in January 2024 to 98 in June 2024. • Divisions and performance team continue to work in collaboration to manage 52 week waits daily and expedite next steps. Updates being provided to South West London on a weekly basis for patients 60weeks+. 65wk+ and 78+ clearance lists are also circulated to divisions to increase visibility and focus on long waiting pathways.	52 week recovery date to plan TBC. Challenged by Gynae, T&O (EOC) and recent loss of theatres. ESTH are still aiming to have zero 65 week waits by the end of September 2024, in line with the national target, other than patient choice delays.	Sufficient for assurance

Operational Performance

Exception Report| SGUH Cancer Faster Diagnosis Waiting Times

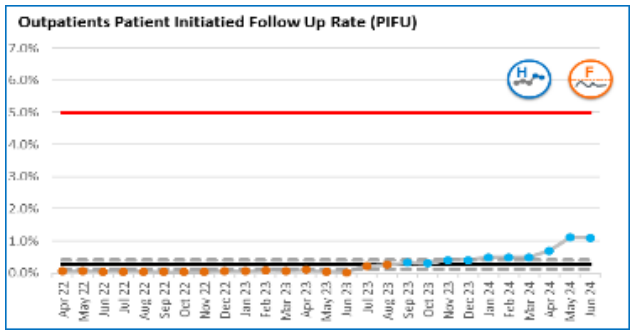


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS – Plan not consistently met however showing normal variation	**Faster Diagnosis performance of 75.1 % against plan of 75 % for June 2024.** • Improvement of 0.6% compared to May 2024. • Breast moved to a non-compliant position. • Lower GI most challenged with a performance of 53% with CTC access at QMH and endoscopy process delays are contributing factors. • Gynaecology (59.8%) continued to be behind target due to access to one stop clinics and scans. • Radiology diagnostic modalities are not consistently achieving the NHSE recommended turnaround time of 7 days for reporting of OP FDS diagnostics. • Pathology: Turn around time are being reviewed due to longer waits. **62-day Performance was at 77.2% against a plan of 75% for June 2024** • Front end delays due to Breast and Gynaecology • Theatre capacity constraints in Lung, H&N and Urology.	• **Summer Resilience funding (70K**) has been awarded for Q1 to support performance delivery. Tumour sites awarded include Haem, H&N, LGI, Derm, Breast and Urology. • **Gynaecology** plan to run an all-day one-stop clinic at QMH now expected to begin from September 2024. RMP funding has been agreed and will support this service to improve the position. Also changes to existing footprint on the SGH's site will increase hysteroscopy throughput. • **Pathology:** Dashboard under development to support real time tracking of pathology on winpath against patients in the cancer PTL with and FDS clock. • **Radiology:** Dashboard under development to support real time tracking of radiology scans and reports against national KPIs. • **Lung thoracic:** The delays are due to increased referrals relating to Targeted Lung Health Checks programme. Theatre WLI (10 have been planned for September 24. • **Haem Oncology clinic** demand and capacity review is under way. • **Breast** has a recovering plan in development with support from RMP. Cultural/ behaviours are being addresses along with operational issues.	Recovery time scales are dependent on resources	sufficient for assurance

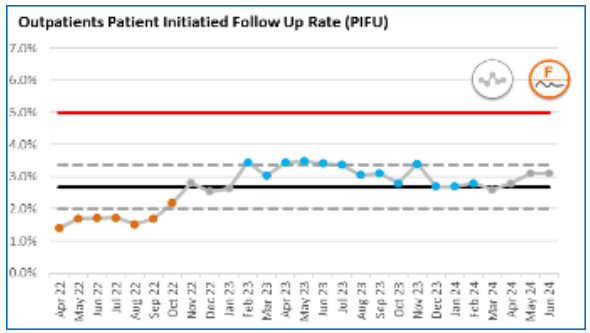
Operational Performance

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

St George's



Epsom & St Helier



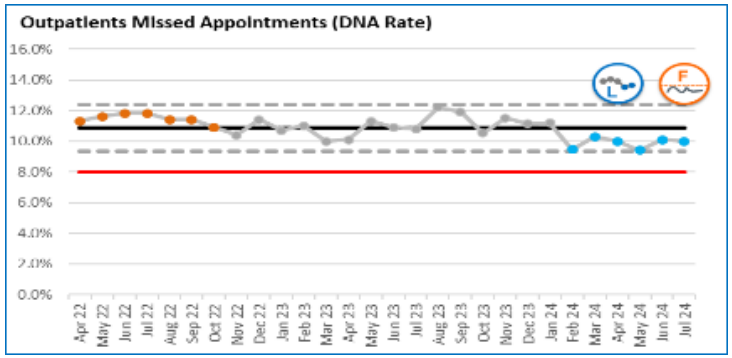
Rate reported one month in arrears in line with Model Hospital reporting

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend	In month performance for June was 1.1% - as per Model Hospital. Activity continues to increase with the technical solution to PIFU now designed and rolled out in 6 services (T&O, Urology, Plastics, Gynae, Dermatology and Therapies)	• 23rd September (IT Transformation led project) all specialist will be rolled out • This includes PIFU to Long Term Condition (LTC) and PIFU to discharge (6 options for timeframes signed off at working group) • Tableau report has now launched and shows PIFU Orders by Clinician, Speciality %, Patient Demographics and patient level details – we currently have 1551 patients on a PIFU pathway, 92% are PIFU to discharge and 8% are PIFU Long Term Conditions	2% planned for October 2024 – post launch of PIFU order for all specialities	sufficient for assurance
ESTH PIFU Rate: Consistently not meeting target	Engagement with PIFU amongst clinicians varies, but we continue to look for more opportunities for PIFU to Discharge and PIFU for Long Term Condition.	• PIFU growth was static in June 2024 which showed that recent growth in multiple specialties was sustained. • Work continues to explore further PIFU opportunities in Audiology (PIFU for Long Term Condition - LTC), Rheumatology (PIFU – LTC) and Urology (PIFU to Discharge).	3.5% planned for March 2025 (National Target 5%) 5% target not yet planned to achieve.	sufficient for assurance

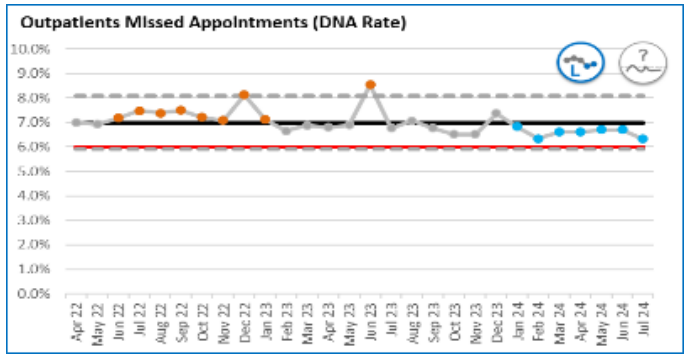
Operational Performance

Exception Report| ESTH & SGUH Missed Appointments (DNA Rate)

St George's



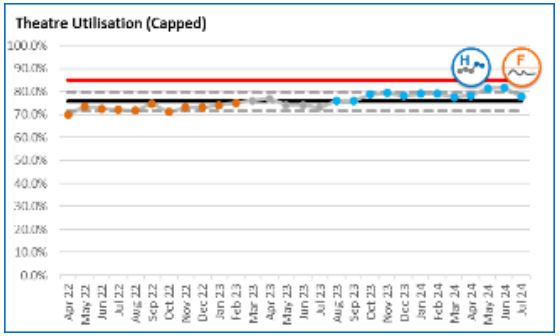
Epsom & St Helier

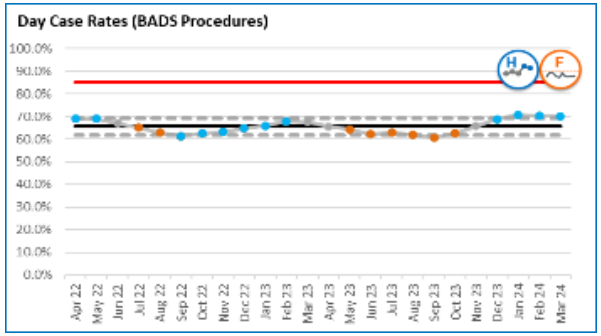


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Special cause variation of an improving nature however has consistently failed target	Continued improvement of position	• All services review their appointments that have one way reminder texts monthly for Day 7 and Day 2 before every appointment (one way message to patient but they cannot text back) – Gynae have done a focused approach to this and turned on over 20 + texts this month • BI and OP operational team supported review of reporting issues. Identified that SUS submission includes DNA % inclusive of both removed and active clinic slots – this is correctly included as advised by BI • OP team present clinics with high DNA every week at Elective Access prompting review and updates from specialities	TBC	sufficient for assurance
ESTH Normal variation, no significant change Failing target of 6%	DNA rates reduced slightly in July although they remain slightly above the target of 6%.	• DNA rates reduced slightly in July 2024. This is likely due to the continued use of the "DNA recipe" approach (add clinic to text reminder service; telephone patient audit where rates still high; targeted mitigations). • In July, a pilot of DrDoctor to provide a 2 way text for Paediatric Dermatology was carried out which resulted in a 0% DNA. This will be replicated for September, supported by the Elective Transformation team. • A key DNA theme has been identified from the multiple cross-trust DNA audits that have now been completed. On average 30% of patients that DNA have incorrect or missing contact information. How to mitigate this is now being explored with the support of the Outpatient Booking Centre.	TBC	sufficient for assurance

Operational Performance

Exception Report| SGUH Theatre Utilisation (Capped) & Daycase Rate

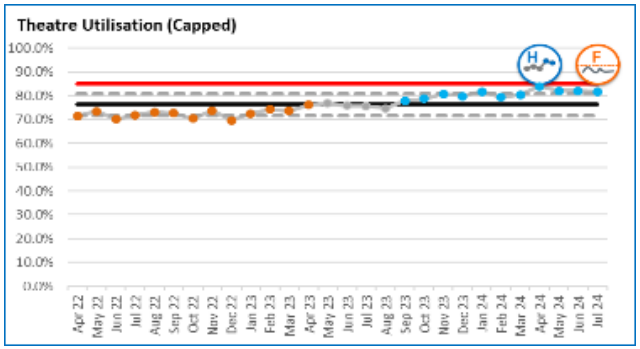




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Theatre Utilisation (capped): 78% 81%- IP 75%-DSU 62%- QMH Day Case Rates (BADS Procedures) not meeting 85% target with improving trend	• Estates issues in July 2024 caused some delays to the start of lists which led to over runs, negatively affecting capped theatre utilisation. • Furthermore, junior doctors IA impacted theatre productivity. Internal Tableau data suggests that Theatre utilisation has deteriorated by 4% from June to July, from 82% to 78%. However, Model Health data shows a capped theatre utilisation for July of 82.5 %. Ongoing work with BI to understand reasons for the discrepancy. • Data quality issues such as where patients on day case wards (particularly DSU wait) had LoS of 1 or more days. • Effects of data correction and improved recording continues to show an improving trend. • Procedures normally coded as daycase often booked as an elective overnight due to the complexity of patients referred to SGUH. Co-morbidities / pre-existing conditions are a factor in not being compliant with the BADS procedure national target	• Continued emphasis on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. New 6-4-2 meeting structure rolled out in July overseen by the Chief Operating Officer. • Lists not booked to more than 75% utilisation with 2 weeks' notice are being reviewed and stood down. Unless there is a clinical exception to this standard. • Further work is being planned to understand the scope for improvement of average cases per session across different specialities, particularly at QMH. • Theatre Transformation support started in May 2024, theatre user group meetings are now taking place regularly with each speciality to critically analyse theatre performance, in addition to demand and capacity. • BADS compliance is being discussed with all surgical specialities within theatre transformation deep dives to explore opportunity. • Further work is required to ensure cases are being coded appropriately from DTT. • Undertaking a significant piece of work on QMH which includes expanding the inclusion criteria at QMH which will increase throughput. • Recognition that SGUH often receives complex referrals due to tertiary status. Which means cases usually coded as a BADS procedure often have overnight stay etc, meaning they are counted as an elective ordinary	TBC	sufficient for assurance

Operational Performance

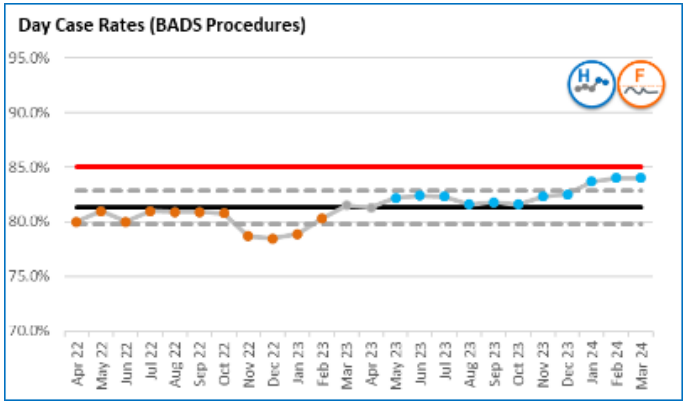
Exception Report | ESTH Theatre Utilisation (Capped)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%)	July's activity was reduced due to closures in STH B4 theatres (theatre b and theatre c) for maintenance. Utilisation remained over 80%, at 82%. Late starts remained at an average of 17 mins, as did early finishes (26 mins). ESTH's on the day cancellation rate was 8%, which is in line with our YTD average. The global Microsoft outage impacted Steris (decontamination) and this caused limitations with kit sterilisation. X5 patients were cancelled on the day as a result.	• **STH B4 Theatre closures** have impacted activity for Eyes, Gynaecology, Dental and Renal lists. The x2 theatres are planned to reopen on the 16th September. • A portion of eye activity has moved to Ashtead. Where possible, Gynaecology lists are being moved to A2 theatres, Epsom, and the teams are running weekend lists to mitigate the lost capacity. Where possible, dental lists are being displaced to Epsom. • Since June, x1 all day monthly **Paediatric Dentistry list** is being staffed at QMH on a Saturday to support brining down the waiting times. So far 24 additional patients have received treatment. • ESTH's ***'Get home SWIFTLY'*** T&F Group is starting to see promising signs of progress. Since the programme started, the Trust's average has increased from 61% to 63%. The team are looking at the staffing model on SWIFT, following a deep dive into elective inpatient bed usage. • As part of the ESTH's ***'On the day cancellation'*** (OTDC) Task & Finish Group, the Trust is deep diving into all of July's clinical cancellations (34) to see if there are common causes that can be avoidably addressed (e.g. UTIs/High blood pressure). • As a result of the ESTH ***'Perioperative Care pathway'*** pilot, x45 patients were triaged into a 'green pathway'. These low risk patients typically only require obs work, and patients are encouraged to do that immediately after their outpatient appointment with the Trust's 'Nurse of the Day' (similar to a one stop clinic). Largely, these patients will then not need a face-to-face or telephone appointment, which would have been the previous practice. As a result, capacity has been freed up for other patients to be cared for sooner. Conversations have started to roll out to more service users at Epsom, as currently the pilot only includes Urology & General Surgery.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH Daycase Rate (BADS Procedures)

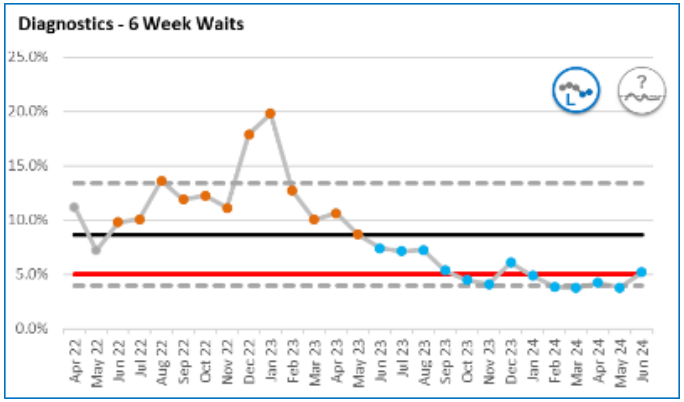


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Not meeting target of 85%. Improving trend	ESTH is close to the 85% target, but there is a definite opportunity for improvement. It is important to note that Endoscopy, ENT and Ophthalmology are all at 100% which will mask scores that are lower than peers in Urology, Gynaecology and General Surgery.	• ESTH **scores highest against SWL peers** for the proportion of all admissions that were day cases (BADS Directory of Procedures 6th Edition). ESTH day case rate is 84%, against a target of 85%. Peer median is 80.7 (Model Hospital). • ESTH's ***'Get home SWIFTLY'*** T&F Group is working hard to introduce a 'No one at Home policy' to reduce failed daycase procedures because of no escort. Plus, a robust post-operative retention standard operating procedure to reduce failed daycase procedures because a patient has been unable to pass urine. • ESTH have begun **sharing data on failed daycases** with services. This includes the numbers of patients that had an intended management as a daycase, but converted to an inpatient, and the reasons for the admission. The Trust is encouraging teams to review this, and think about what could be done differently. • Similarly, ESTH are also having conversations with specialties about cases that were **listed as an inpatient, but could have been daycase.**	TBC	sufficient for assurance

Data Source Model Hospital (3 months to month end)

Operational Performance

Exception Report| ESTH Diagnostic Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 5.2% not meeting target of 5%	At the end of June 2024 there are 594 patients waiting more than 6 weeks for their diagnostic (DM01), which is a significant increase (38%) compared to May 2024. The PTL size has seen a negligible increase from the end of the previous month as a result and performance has dropped from 96.2% to 94.8%. Largest proportion of 6 week breaches are within Echocardiology with 239 patients waiting >6weeks at the end of June 2024, compared to 139 patients at the end of May 2024. A further increase to ~450 in July 2024 is also expected.	• Echocardiography has increased month on month since April 2024 by a factor of c.100% each month, due to the loss of external funding, and a further increase from 239 in June 2024 to ~450 in July 2024 is expected. However, non-recurrent external funding has since been awarded and a stabilisation is expected in August 2024 with an improvement in September 2024. ESTH SLT has also agreed to recruit 2wte Physiologists to this team substantively to enable DM01 and IP Echo work to be put on a more stable and better value for money footing. • Gynaecology Urodynamics also remain high and additional training is being provided to upskill current nursing resource to undertake these procedures. Support from Planned Care (Urology CNS's) is also being explored.	TBC	sufficient for assurance

Operational Performance

Overview Dashboard | Urgent and Emergency Care

St George's

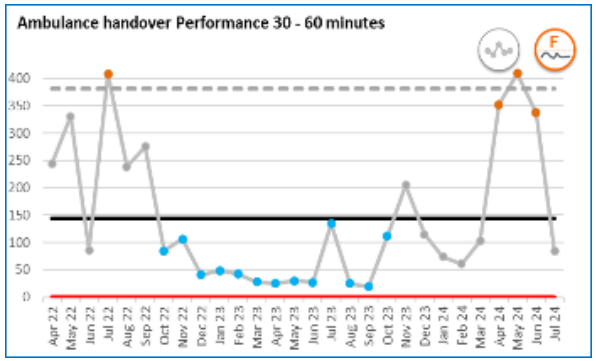
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
4 Hour Operating Standard	Jul 24	81.8%	81.6%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%)	Jul 24	5.5%	8.0%	-			
Ambulance handover Performance 30 - 60 minutes	Jul 24	337	84	0			
Ambulance handover Performance 60+ minutes	Jul 24	3	5	0			
Mental health delays 4 Hour Breaches	Jul 24	102	147	-			
30-Day Emergency Readmission Rate	Jul 24	11%	11%	-			
Non Elective Length of Stay	Jul 24	6.7	6.3	5.4			
Length of stay > 21 days (super stranded)	Jul 24	163	155	142			
Overnight G&A beds occupancy - Adults	Jul 24	95.0%	94.2%	91.5%			
Number of patients not meeting criteria to reside (Daily Avg)	Jul 24	145	135	86			

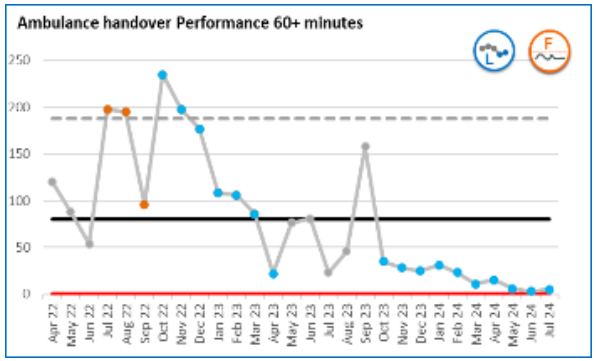
Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 24	77.9%	75.8%	78.0%			2nd Quartile
Jul 24	11.9%	12.3%	-			
Jul 24	418	389	0			
Jul 24	40	44	0			
			-			
Jul 24	5.9%	5.6%	-			
Jul 24	8.2	8.1	6.2			
Jul 24	163	155	123			
Jul 24	90.5%	87.7%	89.0%			
Jul 24	208	206	120			

Operational Performance

Exception Report | SGUH Ambulance Handovers

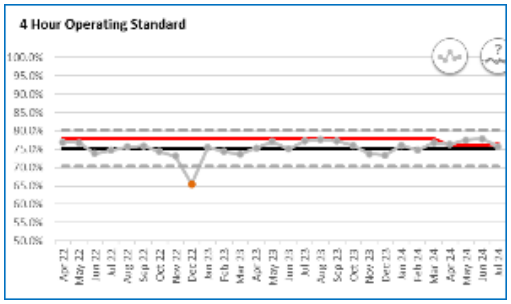


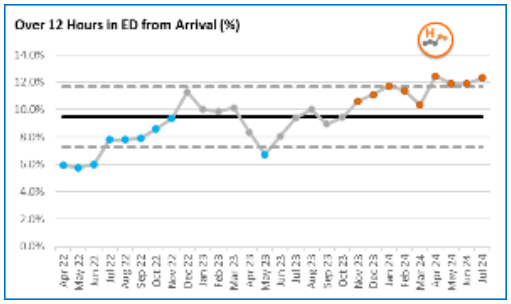


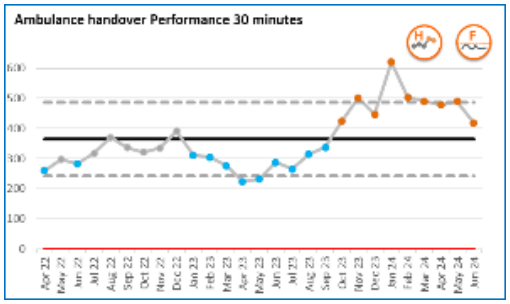
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH LAS Target consistently not met	Four Hour Performance in July 2024 was 81.% exceeding plan of 77.19%. On average across the month 90 ambulance conveyances arrived per day compared to 85 through June 2024. 81.5% of 2,784 LAS arrivals were off-loaded <15 minutes. Significant decrease in the number of patients waiting for more than 30 minutes for ambulance handover The key drivers of operational pressures and delays are: • DTA's in department high number of complex mental health patients spending 24hrs in department • Limited in-and-out spaces to see and treat patients	• Dedicated ECCU space (regardless of DTA status) opened 18th June • Increased number of in-and-out spaces • RAT rota fully established to redirect patients where appropriate • Continue to work with 111 to optimise UTC utilisation • Community in reach to aid admission avoidance to be pushed for • Development of SDEC Medical pathways live 15th May Surgical SDEC live in June Trusted assessor model (LAS straight to medical SDEC) launched June • Additional EP to front of house for UTC to improve wait times for investigations • Enhanced boarding and cohorting continue to be business as usual across site • Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced	August 2024	Internal validated figures reported

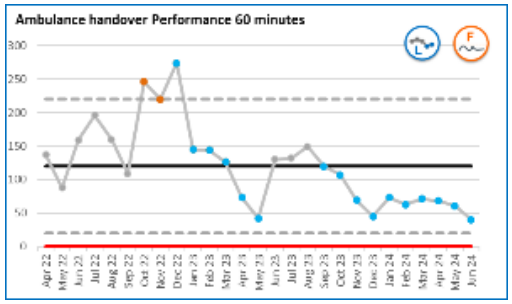
Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers





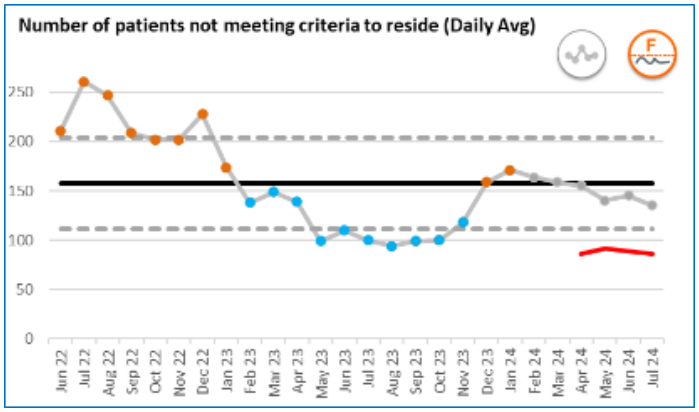


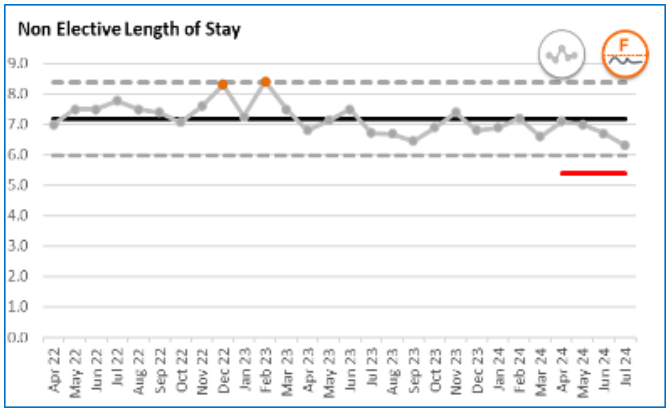


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance not meeting plan of 76.5% ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 30-60 Min Consistently not meeting target, Special cause variation of a CONCERNING nature.	We saw a slight deterioration in ED performance in July 2024, reporting 75.8% performance versus 77.9% in June 2024. Patients spending longer than 12-hours in ED remains challenging with 12.3% of patients spending longer than 12-hours in the department in July 2024. A marked improvement in 60-minute ambulance handover delays since November 2023, however, 44 delays reported in July 2024, a slight increase from 40 reported in June 2024 Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively, however time to triage performance remains within the 15-minute threshold We continue to see high numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• The Trust's 2024/25 Urgent Care Transformation programme hosts an agreed set of priorities for 2024/25 which now includes PLACE deliverables. This includes key outputs and supporting metrics, including but not limited to, the electronic streaming/redirection of patients to UTC/SDEC and community pathways for those patients who attend ED but do not require acute care to support alleviation of ED capacity and admission avoidance. • The launch of our Same Day Acute Frailty response service took place w/c 22nd April. The provision is supported by a dedicated space and frailty MDT to ensure early and specialty assessment, treatment with clear exit pathways supporting direct/early flow from ED for appropriate patients supporting admission avoidance and reduced length of stay. • We are focusing on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC. LAS direct to SDEC conveyances continue to be a priority with numbers of patients being conveyed directly to SDEC increasing month on month. • Focussed work with colleagues from Surrey and Borders Mental Health Trust continues to progress the development of a proposal/business case for a mental health CDU on the Epsom Hospital site. We are also working with SWL & St Georges Mental Health Trust to explore mental health rapid access clinics for appropriate patients presenting to ED.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH No Criteria to Reside (NCTR) and LOS

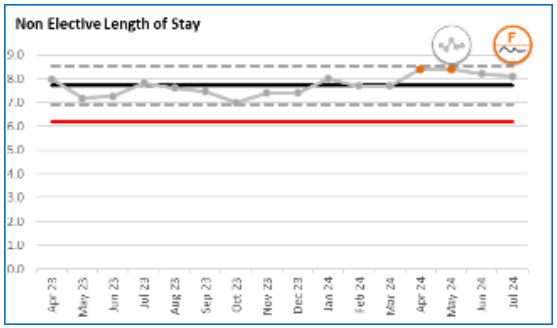


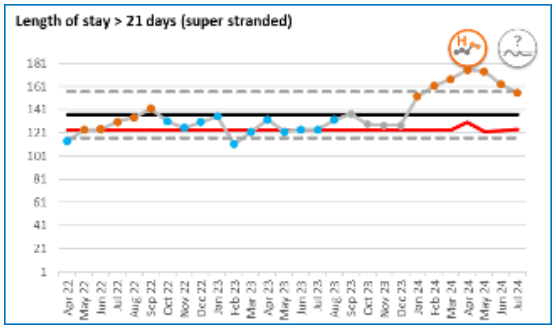


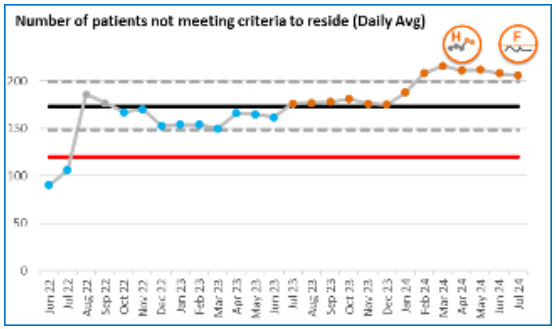
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR: Consistently not meeting target LOS - not meeting target of 5.4 days showing improving trend	• Non-Elective Length of Stay improved. • Largest cohort of patients awaiting; Speciality/ Medical/ Psychology Review or Plan, Care Package (Social) and Residential home - Including interim (Social) • There has been significant improvement in the number of NCTR forms completed prior to 9.30am daily, which in turn is now reflecting a more accurate number of patients NCTR. This is being reviewing in the daily 10.30am bed meetings. • Specialties with high volumes are Elderly Medicine Service and Trauma and Orthopaedics	• The Emergency floor and the Integrated Care Transfer Hub continue to review if Social Workers & CLCH partners can attend on site. • Good improvement in earlier discharges • MADE “style” Events has resumed given increased operational pressure • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • The Trust has replaced Red2Green with the National Criteria to Reside tool for daily electronic tracking patients' readiness for safe and timely discharge to improve patient flow and reduce length of stay. • Focussed sessions with ward teams to improve NCTR data capture and accuracy, supported by Transfer Of Care Team.	TBC	sufficient for assurance

Operational Performance

Exception Report| ESTH Length of Stay & No Criteria to Reside (NCTR)



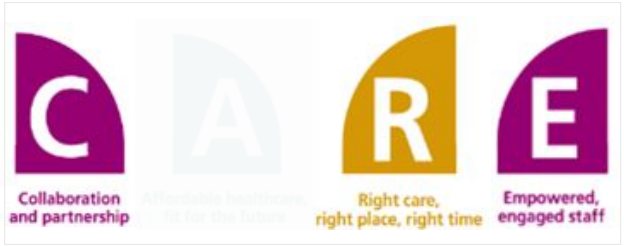




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS, Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Numbers of medically optimised patients on both hospital sites remain above the ambition with many patients requiring complex discharge planning to support discharge, however we have seen a month-on-month improvement for non-elective LOS at 8.1 days in July 2024, compared to 8.2 days in June 2024 and 8.4 days in May 2024. Patients holding a LOS of > 7 days, > 14 days, and > 21 days have reduced for the third month in a row with a further reduction in July 2024 compared to June 2024. An ongoing challenge relates to those patients on pathway 3 who require discharge to a nursing/residential home. A significant cohort of our medically fit patients are those requiring on-going acute therapy prior to discharge. This is also reflected in our non-CTR patient cohort, with a high number of patients waiting for a hospital-based action prior to discharge being progressed.	• Daily reports in place identifying those patients who are medically fit for discharge by specific discharge pathway, shared with internal and external stakeholders, including our therapy team to enable progression of key actions. • Trust-wide tabletop exercise took place on 7th August resulting in agreement regarding a revised boarding process incorporating additional areas for boarding to take place. Planned implementation date of Monday 2nd September. • Implementation of a complex discharge panel meeting for complex paediatric patients who require additional support/escalation to progress discharge arrangements • The undertaking of weekly DMT led 14 day + LOS reviews continues. • June saw the implementation of the Trust's complex discharge panel reviewing all patients with a LOS of > 45 days. The meeting includes key internal stakeholders, including CNO/deputy representation and relevant system partner(s) as appropriate. Data analysis demonstrates a weekly reduction in the number of patients with a >7-day, >14-day, >21-day, and >45-day LOS • Our LOS KPI dashboard has been reviewed and now includes LOS metrics at ward/ department level, enabling us to identify and focus on areas reporting an increased LOS. • We have undertaken a review of individual patient flow/LOS work streams and the identification of individual improvement trajectories and how these will contribute to a wider LOS reduction	TBC	sufficient for assurance

Length of stay activity for Epsom and St Helier includes activity for two community wards located in the acute hospital setting.

Integrated Care



Integrated Care Performance

Overview Dashboard | Integrated Care

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jul 24	4	5	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	Jul 24	3	4	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Jul 24	0	5	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Jul 24	32	18	-			
Reablement Unit Bed Occupancy	Jul 24	96.9%	100.0%	-			
Reablement Unit Length of Stay (Average)	Jul 24	11	7	-			
Two hour UCR performance	Jul 24	88.9%	84.2%	70.0%			
Two hour UCR referrals received	Jul 24	341	329	-			
Virtual ward - Admissions	Jul 24	290	282	-			
Virtual ward - Bed Occupancy	Jun 24	65.9%	65.9%	80.0%			
Virtual ward Length of Stay (Average)	Jul 24	5.6	5.5	-			
Total Waiting List Size Adult	Jul 24	1327	1046	-			
Total Waiting List Size Adult 18-52wks	Jul 24	2	9	-			
Total Waiting List Size Adult >52wks	Jul 24	0	0	-			
Total Waiting List Size Children	Jul 24	899	839	-			
Total Waiting List Size Children 18-52wks	Jul 24	338	399	-			
Total Waiting List Size Children >52wks	Jul 24	75	70	-			

Pathway 0 – Home with self-funded POC / Self funded placement / No support / family support / restart
Pathway 1 – Support to recover at home; able to return home with support
Pathway 2 – Rehabilitation or short term care in 24 hour bed based setting, community hospital
Pathway 3 Requires on-going 24-hour nursing care, often in bedded settings. Long term care likely to be required
EOL – Expected discharge and end of life in Community / Expected death on ward

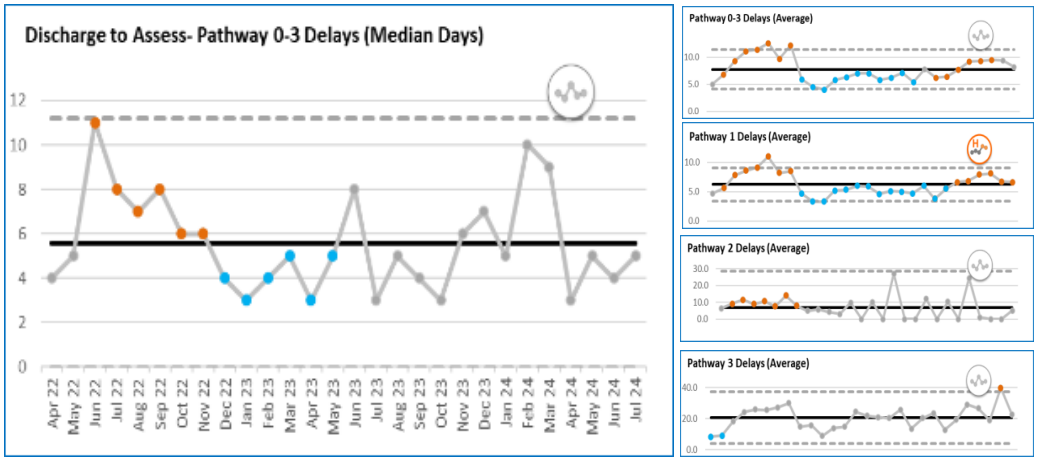
Surrey Downs

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jul 24	2	2	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	Jul 24	2	2	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Jul 24	1	2	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Jul 24	14	19	-			
Community Hospitals Bed Occupancy	Jul 24	88.0%	88.0%	80.0%			
Community Hospitals Length of Stay (Average)	Jul 24	20	23	-			
Two hour UCR performance	Jul 24	87.3%	90.4%	70.0%			
Two hour UCR referrals received	Jul 24	567	553	-			
Virtual ward - Admissions	Jul 24	254	271	-			
Virtual ward - Bed Occupancy	Jul 24	97.0%	97.0%	80.0%			
Virtual ward Length of Stay (Average)	Jul 24	8.8	9.6	-			
Total Waiting List Size Adult	Jul 24	4764	4738	-			
Total Waiting List Size Adult 18-52wks	Jul 24	107	98	-			
Total Waiting List Size Adult >52wks	Jul 24	0	0	-			

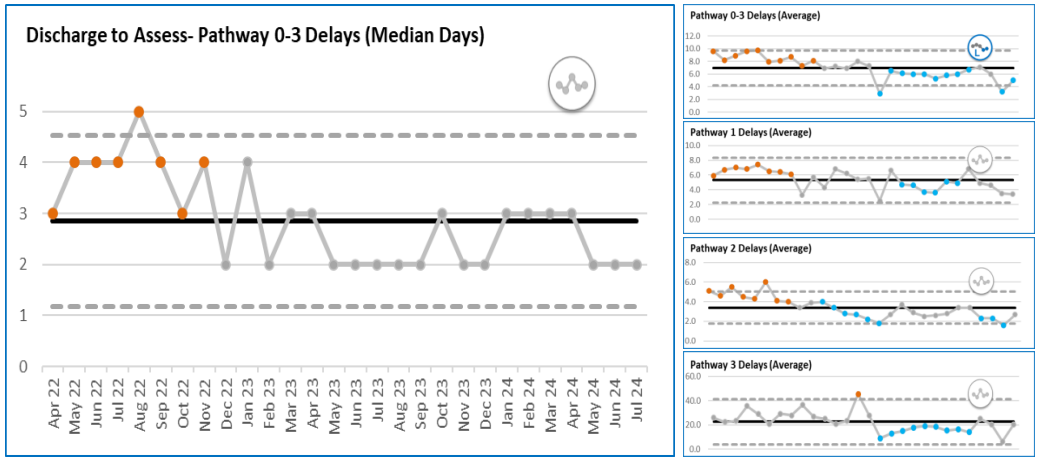
Integrated Care

Exception Report| **Median days Discharge to Assess**

Sutton Healthcare



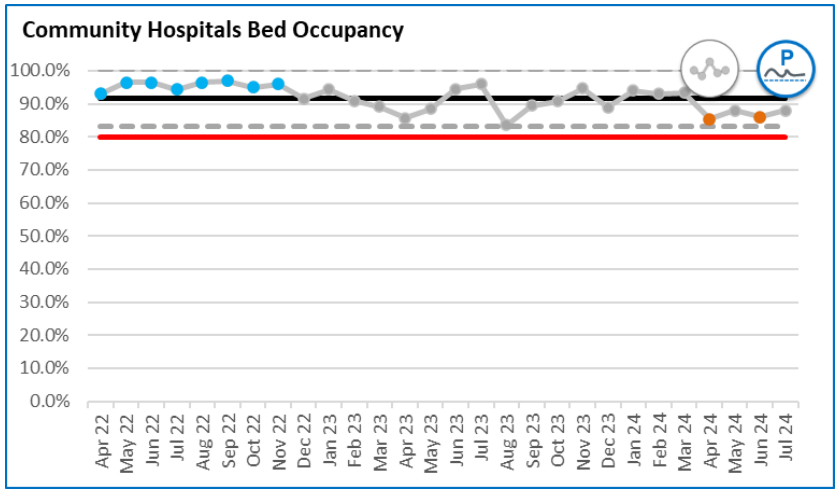
Surrey Downs

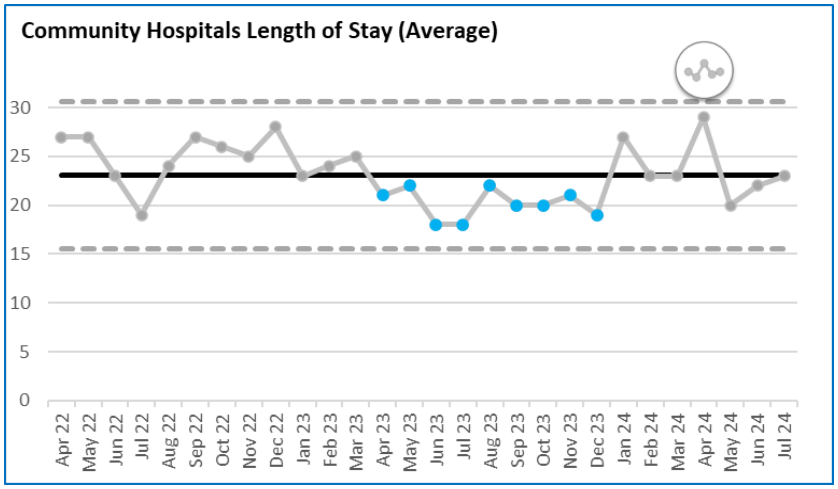


Site & Metric	Cause of variance/ non-compliance / challenges	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Normal variation for Pathways 0-3 combined. Pathway 1 delays (Support to recover at home; able to return home with support) has seen a special cause concerning trend.	• Focus on improving referral to discharge time. • LoS reduction programme with ESTH and Sutton Alliance in progress.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Normal variation only with median days at 2 across July.	• Improvement maintained in July • LOS reduction program in development	N/A	Sufficient for assurance

Integrated Care

Exception Report| Surrey Downs Bed Occupancy & Length of Stay



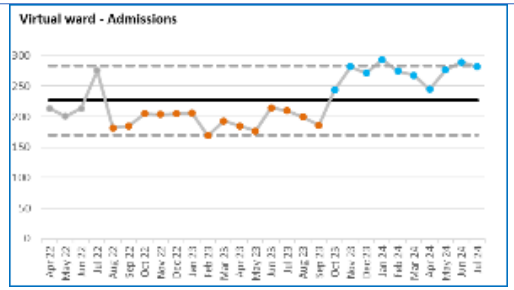


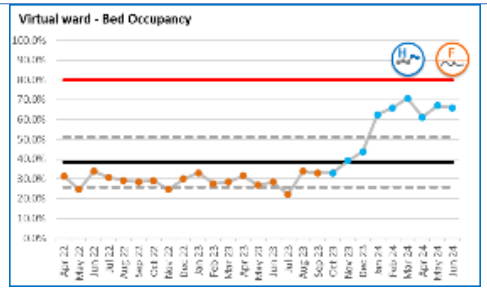
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs Health & Care	Bed occupancy continues to exceed target of 80% however levels have been below mean for the past four months. Average length of stay showing normal variation.	• Process for escalations of delays is in place • Choice policy is implemented	TBC	Sufficient for assurance

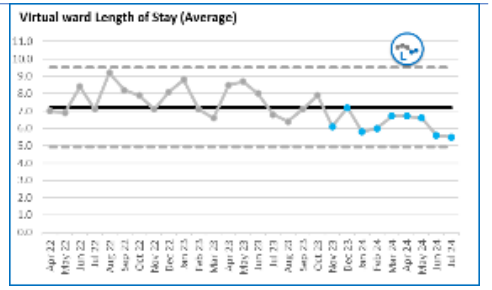
Integrated Care

Exception Report | **Virtual Wards**

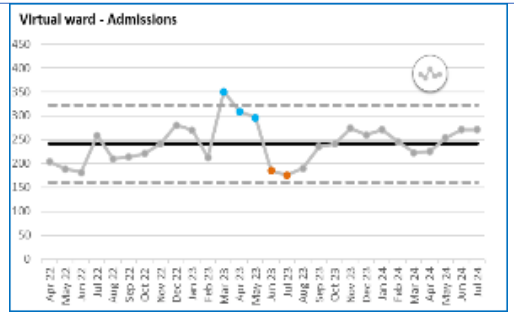
Sutton Healthcare

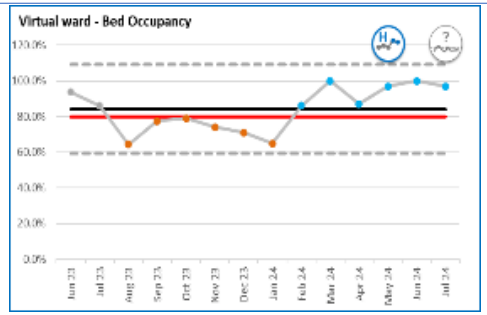


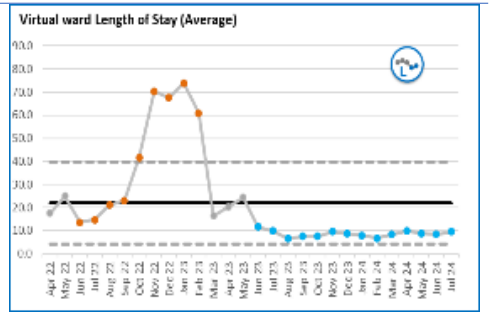




Surrey Downs





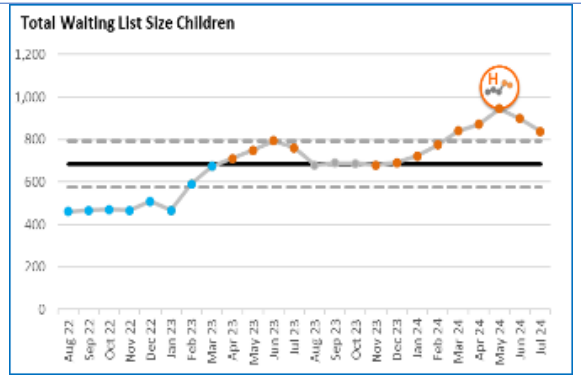


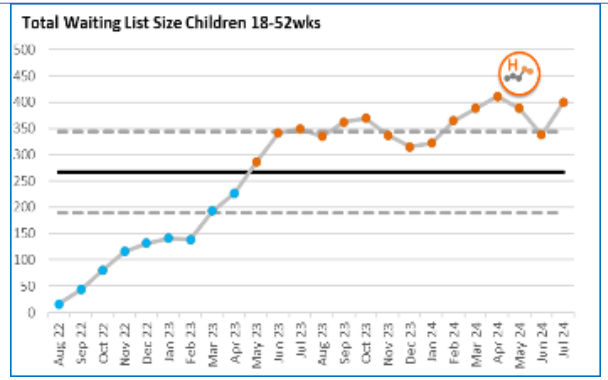
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Positive increase in admissions and bed occupancy in recent months. Average length of stay showing a positive and maintained reduction	• SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. • LoS reduction programme with ESTH and Sutton Alliance in progress • Engagement work with appropriate wards and with clinicians continues.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Performance as expected and showing normal variation. Bed occupancy continues to exceed target.	• On-going development of enhanced care in Virtual Wards.	N/A	Sufficient for assurance

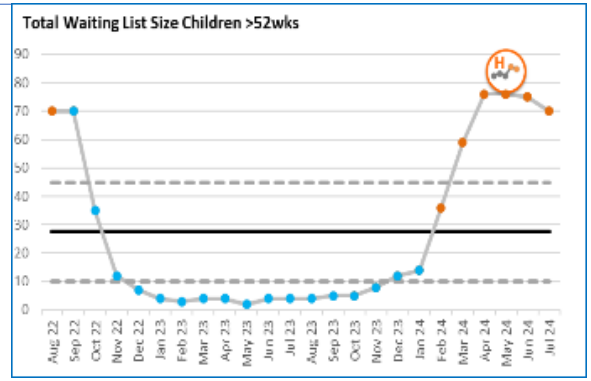
Integrated Care

Exception Report | Children's Waiting List Performance

Sutton Healthcare







Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	The growth in children requiring NHS therapy services is a national issue recognised at SWL/PLACE. SWL ICB programme taking this forward with providers across SWL. In Sutton there are 70 children waiting for 52+ weeks.	• PLACE/SWL Programme of work under way. • SHC Review of harms with Integrated Care CNO. • SHC additional triage/ support for parents • SHC additional clinic sessions run (note decrease in waiting lists) • Improvements also made in triage, priority clinics (productivity /efficiency). • EHCP targets remain on track.	TBC	Sufficient for assurance

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

Appendices

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Jul 24	4.2%	4.4%	3.2%			
Agency rates	Jul 24	2.2%	1.7%	-			
MAST	Jul 24	91.3%	91.3%	85.0%			
Vacancy Rate	Jul 24	7.7%	7.3%	10.0%			
Appraisal Rate Medical	Jul 24	83.9%	82.4%	90.0%			
Appraisal Rate Non Medical	Jul 24	76.6%	76.3%	90.0%			
Turnover	Jul 24	13.4%	13.0%	13.0%			
Percentage BAME staff band 6 and above	Jul 24	45.1%	44.5%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 24	5.0%	5.2%	3.8%			
Jul 24	2.9%	3.0%	-			
Jul 24	85.0%	86.5%	85.0%			
Jul 24	12.0%	12.0%	10.0%			
Jul 24	97.9%	100.0%	90.0%			
Jul 24	77.2%	78.7%	90.0%			
Jul 24	12.2%	11.8%	12.0%			
Jul 24	39.0%	39.0%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Jul 24	6.0%	6.1%	3.8%			
Agency rates	Jul 24	3.8%	5.5%	-			
MAST	Jul 24	90.6%	91.2%	85.0%			
Vacancy Rate	Jul 24	17.4%	17.5%	10.0%			
Appraisal Rate Medical	Jul 24	100.0%	100.0%	90.0%			
Appraisal Rate Non Medical	Jul 24	75.2%	78.7%	90.0%			
Turnover	Jul 24	1.6%	0.5%	12.0%			
Percentage BAME staff band 6 and above	Jul 24	36.9%	36.6%	-			

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jul 24	4.8%	4.5%	3.8%			
Jul 24	4.9%	4.5%	-			
Jul 24	93.2%	94.9%	85.0%			
Jul 24	19.3%	20.6%	10.0%			
Jul 24	100.0%	100.0%	90.0%			
Jul 24	89.5%	94.9%	90.0%			
Jul 24	1.4%	1.6%	12.0%			
Jul 24	20.1%	20.1%				

Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Appendix 2

Metric Technical Definitions and Data Sources

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

Glossary of Terms

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

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

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

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

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

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Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	3.3	
Report Title	**Finance report Month 04 (July) PUBLIC**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	30 August 2024
Purpose	**For Noting**	

Executive Summary

Both trusts are on plan at month 04. The plan position for both trusts at this point in the year is a deficit.

There are pressures in both plans that are being managed with non-recurrent resources and delivery of the plan by year end is at risk.

The paper outlines key actions being taken to help support delivery of the plan by year end. The Group Executive Team are focused on seeking to deliver this.

Action required by Group Board

The Board is asked to note this paper

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
	None

Implications

Group Strategic Objectives

☒ Collaboration & Partnerships

☒ Right care, right place, right time

☒ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks				
BAF SR4.				
CQC Theme				
☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes		☒ People		
☐ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☒ Finance and use of resources		☐ Local strategic priorities		
Financial implications				
IN support of delivering the Group financial plans.				
Legal and / or Regulatory implications				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

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Group Board (Public) 5th September 2024
24/25 M4 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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Group M4 position

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	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• Both organisations are on plan after bringing forward NR benefits from later in the year (SGH £1.8m, ESTH £0.8m). • SGH has also used additional NR benefits above plan of £0.8m in M4, as well as a YTD ERF delivery adjustment of £2.3m to support delivery of M4 CIP. • ESTH has also used additional NR benefits of £1.7m at M4 as well as £1.1m additional non recurrent balance sheet in CIP.	• Based on current performance the trusts will be challenged to deliver the financial plan in full.	• Continued focus on cost control and the development and delivery of CIPs through site management meetings.
Workforce costs and WTE plan	• Pay expenditure is overspent against budget in both trusts. • WTEs for ESTH 223 WTE adverse to plan as a result of phasing of c. 75 WTE baseline pressures (ED, enhanced care, medical, Epsom bed capacity business case) and 103 adverse WTE deliver of CIP at M4, • WTE at SGH is adverse to plan by 196 due to the 197 step up in CIP delivery planned for in M4.	• M4 had a step change at both Trusts in the planned reduction in WTE as a result in step change in plan CIP. • Both Trust have mitigated the adverse performance with on off items in M4 (SGH recurrent income one off and ESTH non recurrent one off). • As the M4 position has been mitigated by one off items, material risk that M5 CIP will not be achieved and risk this could impact bottom line reporting at M5.	• Both Trusts are reviewing mitigations for M5 CIP and WTE delivery, at a priority controls and actions to deliver against the workforce plan and following that potential non recurrent mitigations • Increased focus on control actions in key areas notably agency controls all staff groups, medical temporary staff costs, nursing rota management and continued challenge through vacancy control.
CIP delivery	• ESTH delivery is £0.2m favourable YTD. However, over delivery is on non recurrent items. Non recurrent CIP is £1.6m favourable to plan and mitigating a £1.4m adverse in non recurrent. • SGH on plan (although the latter includes b/f £0.8m benefit) with £15.2m in opportunity and £3.0m in unidentified.	• Underlying recurrent CIP performance at both Trusts not in line with plan driven by slippage on WTE reduction plan as per the workforce costs and CIP. • CIP delivery for the year has been risk assessed at 75% for ESTH and 73% for SGUH	• Continued focus on CIPs identification and delivery within the Trust. • Work actively with SWL groups to identify other opportunities and system wide actions, including estates, medical staffing and agency.

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Group M4 position

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	Overview	What does this tell us?	What actions/mitigations are required?
Capital	• ESTH M3 performance behind the PFR plan but in line with internal plan which built in slippage for delays in agreeing the SWL capital plan. • ESTH: Material risks remain on funding the EPR project, this is outside of the agreed capital plan. • SGH M3 YTD position is behind plan mainly due to SECH enabling unlikely to be drawn down in year and slippage in ITU • SGH: Minor delays in ITU could attract NHSE attention.	• ESTH: Based on the current position there is a CDEL and cash funding gap on EPR.	• Careful monitoring and forecasting of capital will be required in both trusts across the year. • Continued engagement with National and SWL ICB on funding mechanism for EPR. • Continue focus on key projects.
Cash	• NHSE have informed the system that the £120m system deficit cash backed support has been delayed from previously advised M3 payment. This is currently with treasury for approval and it is now unclear when this will be approved. • Material pressure on cash could be experienced at both trusts given potential risk against CIPs and other expenditure pressures.	• The cash monitoring regime Nationally is reviewing the current position and cash is potentially becoming more of an issue Nationally. • ESTH and SGH are now likely to require revenue deficit cash PDC support in year and there is a risk that the cash requirement does not triangulate to the deficit plan signed off (risk to CIP and baseline expenditure). • ESTH required support in M6 – SWL ICB mitigated the need for a cash support request with a £5.1m payment in advance agreement for M6.	• Cash update outlines ESTH and SGH current and expected drawdown position. • Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management.

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Site summary I&E

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	Head line I&E YTD	Key issues	Key actions
ESTH Acute	• £1.5m adverse to plan • £0.2m ahead of CIP plan	• Adverse position to plan driven by net costs and lost income associated with Industrial Action • Financial pressures driven by operational pressures on site resulting in beds open above plan, corridor care and enhanced care are being offset by bringing forward non recurrent items • The YTD favourable position on CIP is delivered by one off non recurrent mitigations. Underlying recurrent CIP is £1.6m adverse to plan YTD.	• Review and QIA of baseline pressures. • Review of CIP mitigations and stretch. • Review of further recovery actions
ESTH IC	• On plan in months and £0.2m adverse YTD • On plan for CIP	• Adverse position to plan driven by non-recurrent costs incurred in Q1 (particularly estate related in SHC). • Anticipated that position will come back into financial balance. • Pay costs and WTE reducing month on month across Integrated Care.	• Ongoing review of CIP plans in progress and actions to move to fully developed and delivery
SGH Acute	• £1.9m adverse	• Impact of Industrial action, Cyber, and Ward pressures	• Length of stay and flow action plan review and delivery • Weekly Thursday finance meetings in place to drive divisional delivery on baseline and CIP
Corporate (group)	• £1.1m adverse	• inflationary pressures £0.4m • CIP non-delivery £0.7m	• Progress Corporate CIP development through BAU and Corp consolidation

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ESTH Trust Summary reported position PFR

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		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	598.7	49.7	50.9	1.2	199.2	200.3	1.1
	Other Op. Income	45.0	3.8	3.7	(0.0)	14.2	14.8	0.6
Income Total		**643.7**	**53.5**	**54.7**	**1.2**	**213.3**	**215.1**	**1.8**
Expenditure	Pay	(460.9)	(38.2)	(40.1)	(1.8)	(156.6)	(160.9)	(4.3)
	Non Pay	(202.5)	(16.6)	(17.0)	(0.5)	(68.6)	(68.9)	(0.3)
Expenditure Total		**(663.4)**	**(54.8)**	**(57.1)**	**(2.3)**	**(225.2)**	**(229.8)**	**(4.6)**
Post Ebitda		(32.1)	(2.7)	(2.4)	0.3	(10.7)	(9.4)	1.3
Grand Total		**(51.7)**	**(4.0)**	**(4.8)**	**(0.8)**	**(22.5)**	**(24.1)**	**(1.5)**

The position above is as reported in the Trust's PFR, since it was submitted there have been a number for additional income streams around community services which have been built in to the Trust general ledger plan, these will be incorporated in the PFR next month. All the slides following this one are against the internal (general ledger) plan.

- The Trust is adverse to plan by £0.8m in month and £1.5m YTD. The adverse position wholly is due to industrial action costs (£0.7m) and income lost (£0.8m) as a result of the industrial action at the end of June and beginning of July.
- Patient Care Income is £1.1m favourable in month and on plan YTD. The position includes £2.8m of income accrual from last year which has been released to meet the plan excluding industrial action impacts. The position includes £0.8m loss from the industrial action YTD. There is no increase in ERF income in month as it fell by £0.2m in month but was offset by a matching coding gain from prior months. **It should be noted that the baseline trajectory for ERF income increases by £3m a quarter by Q4 so deliver the ERF CIP in future quarters the Trust needs to deliver a higher level of income before CIP can be booked. This is a key risk, despite the good Q1 reported position.**
- Other Operating Income is £0.1m adverse in month and is £0.6m favourable YTD. The in-month position includes £0.25m prior year Ariel income. YTD R&D is £0.5m favourable and Staff Recharge income is £0.3m favourable, these are both offset by matching costs.
- Pay is £1.8m adverse in month and £4.3m adverse YTD. In month adverse variance driven by £0.4m IA costs, £0.3m nursing expenditure relating to escalation capacity above plan offset by favourable A&C variances. YTD variance driven by £0.6m industrial action; £1.4m medical price baseline pressures, £0.4m R&D; £0.9m A&E and SDEC pressures.
- Non pay is £0.5m adverse in month and £0.3m adverse YTD. Cardiology was on plan in month but £0.8m adverse on pacemakers and Cath Lab consumables YTD. The YTD position is favourable as non-recurrent benefits intended for later in the year were released to cover overspends.
- Post EBITDA is £1.3m favourable due to interest received above plan. This is likely to reduce as the cash balance held reduces.

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SWL Recovery Board ESTH Scorecard

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Finance

ESHT		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance	FY Plan	FOT	Variance	RAG	% Variance
OPEX	Substantive	134.2	136.1	-1.9	A	-1.4%	401.2	401.2	0.0	G	0.0%
	Bank	18.2	19.9	-1.7	R	-9.4%	48.9	48.9	0.0	G	0.0%
	Agency	4.2	4.9	-0.7	R	-15.8%	11.3	11.3	0.0	G	0.0%
	Total Pay	**156.6**	**160.9**	**-4.3**	**A**	**-2.7%**	**460.9**	**460.9**	**0.0**	**G**	**0.0%**
	Non-pay	77.3	77.0	0.3	G	0.4%	228.7	229.2	-0.4	A	-0.2%
	Total OPEX	**233.9**	**237.8**	**-3.9**	**A**	**-1.7%**	**689.6**	**690.1**	**-0.4**	**A**	**-0.1%**
Income	Operating income patient care	199.2	200.3	1.1	G	0.6%	598.7	598.7	0.0	G	0.0%
	Other operating income	14.2	14.8	0.6	G	4.4%	45.0	45.0	0.0	G	0.0%
	Total Operating income	**213.3**	**215.1**	**1.8**	**G**	**0.8%**	**643.7**	**643.7**	**0.0**	**G**	**0.0%**
I&E	**Reported I&E**	**-22.5**	**-24.1**	**-1.5**	R	-6.8%	-51.7	-51.7	0.0	G	0.0%
	Recurrent I&E	**-28.3**	**-29.1**	**-0.8**	**A**	-2.8%	-73.9	-73.9	-0.0	G	0.0%
Cash	**Cash & cash equivalents**	**18.6**	**18.6**	**0.0**	G	0.0%	7.9	7.9	0.0	G	0.0%

Patient care income is 1.1m favourable as a result of: £1.3m additional integrated care non recurrent income offset by additional costs and £2.8m income accrual release from 2324. Underlying patient care income is adverse to plan based on ERF delivery.
Pay is £4.3m adverse YTD driven by £0.8m IA costs, £0.7m integrated costs with additional income, £1.3m nursing relating to bed capacity, enhanced care and ED corridor care offset, £1.4m medical. Annualised pay baseline pressures outside of IA are c. £7m The Trust and Group are undertaking a detailed review of pressures to QIA the impact of stopping.
Non pay is £0.3m favourable driven by non recurrent items to support the position offset by £0.7m integrated care unplanned costs with additional income. On an underlying basis non pay is adverse to plan and representing an annual £2m baseline pressure from inflation and usage.

Workforce

ESHT		Plan (in-month)	Actual (in-month)	Variance (in-month)	RAG	% Variance
WTEs	Substantive	6,496	6,514	-18	A	-0.3%
	Bank	789	967	-178	R	-22.5%
	Agency	152	180	-28	R	-18.5%
	Total WTEs	7,437	7,661	-224	A	-3.0%
Cost per WTE	Substantive	5.1	5.2	-0.0	A	-0.9%
	Bank	5.2	5.3	-0.2	A	-3.5%
	Agency	5.7	6.7	-1.0	R	-17.3%
	Total WTEs	5.1	5.2	-0.1	A	-1.7%

The ESTH WTE plan aligned to the financial plan – an adjustment was made to M12 WTE that assumed a reduction of 240 WTE from M1 to triangulate with the financial plan. This adjustment means that any WTE variance is fully triangulated to the financial plan. WTE at 7,661 is adverse to the plan but still represents c. 250 WTE reduction from Q4 2324 averages and is in line with WTE Q1 2324 even with levels of bed capacity funded investment.
The M4 224 adverse position is driven by 103 relating to adverse workforce CIP delivery following the stepchange in the CIP target at M4, 15 WTE adverse as a result delays of staff not transferring out of the trust and the balance relating the baseline pressures presented as a driver of the adverse unmitigated forecast position.

Efficiency

ESHT		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance	FY Plan	FOT	Variance	RAG	% Variance
Efficiency	Recurrent efficiency	5.8	4.2	-1.6	R	-27.5%	28.9	27.3	-1.6	R	-5.5%
	NR efficiency	2.2	4.0	1.8	G	83.4%	11.2	12.9	1.7	G	15.1%
	Total efficiency	**7.9**	**8.1**	**0.2**	G	2.7%	40.1	40.2	0.1	G	0.3%

YTD CIP £0.2m favourable to plan due to timing of CIP reporting. This will offset some of the forecast CIP gap at M5. £1.8m of non recurrent efficiencies were recognised in month to offset pay recurrent delivery. These included a £1.1m debt provision (not in plan so mitigating CIP plan schemes) and £0.5m of other non recurrent cash backed CIP.

Performance

Not updated by SWL at time of papers

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SGH - Summary Reported Position

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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	982.2	88.2	88.2	(0.0)	335.3	335.2	(0.0)
	Other Operating Income	154.4	13.1	14.3	1.2	51.4	54.2	2.7
Income Total		**1,136.6**	**101.3**	**102.5**	**1.2**	**386.7**	**389.4**	**2.7**
Expenditure	Pay	(721.7)	(61.9)	(60.6)	1.3	(247.5)	(248.5)	(1.0)
	Non Pay	(439.9)	(40.3)	(43.1)	(2.7)	(154.7)	(159.3)	(4.7)
Expenditure Total		**(1,161.6)**	**(102.3)**	**(103.6)**	**(1.4)**	**(402.2)**	**(407.9)**	**(5.7)**
Post Ebitda		(25.1)	(2.1)	(2.1)	0.0	(9.9)	(9.9)	0.0
Grand Total		**(50.1)**	**(3.1)**	**(3.2)**	**(0.1)**	**(25.4)**	**(28.4)**	**(3.0)**

The Trust is reporting a £28.4m deficit YTD in M4, which is £3.0m adverse to plan. The YTD deficit position is driven by the impact of Industrial Action (£2.1m) and Cyber Attack (£0.9m).

Income

- Income is £1.2m favourable in month with IA and Cyber driving a £0.1m adverse variance. The underlying in month position is £1.3m favourable driven by additional R&D, corporate and pharmacy income offset by additional costs. YTD IA and Cyber are driving a £1.4m adverse variance, resulting in an underlying YTD position that is £4.1m favourable. Of this £3.1m relating to additional income offset by additional costs and £0.9m relates to ERF overperformance.

Pay

- Pay is £1.3m favourable in month with IA and Cyber driving a £0.1m adverse variance. The underlying in month position is £1.4m favourable driven by a positive CIP target variance of £1.3m which is offset in non-pay. YTD IA and Cyber are driving a £1.5m adverse variance and CIP target a £1.4m positive variance resulting in an underlying YTD position that is £1.0m adverse, driven by ward nursing.

Non-Pay

- Non-Pay is £2.7m adverse in month. Of this £1.2m is driven by a negative CIP target variance which is offset in pay, while the remaining £1.5m in is driven by additional costs offset by additional income and corporate inflationary pressures. YTD IA and Cyber are driving a £0.1m adverse variance resulting in an underlying position that is £4.5m adverse. Of this £2.3m relates to a negative CIP target variance which is offset in pay and by ERF income The remaining £2.2m adverse variance driven by additional costs offset by additional income and corporate inflationary pressures.

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SWL Recovery Board SGH Scorecard

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Finance

SGH		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance	FY Plan	FOT	Variance	RAG	% Variance
OPEX	Substantive	216.3	222.9	-6.6	A	-3.0%	642.1	642.1	0.0	G	0.0%
	Bank	21.0	20.8	0.1	G	0.7%	61.9	61.9	0.0	G	0.0%
	Agency	6.0	4.8	1.1	G	18.8%	17.6	17.6	0.0	G	0.0%
	Total Pay	**247.5**	**248.5**	**-1.0**	**A**	**-0.4%**	**721.7**	**721.7**	**0.0**	**G**	**0.0%**
	Non-pay	155.0	159.9	-4.9	A	-3.2%	440.8	442.8	-2.0	A	-0.5%
	Total OPEX	**402.5**	**408.4**	**-5.9**	**A**	**-1.5%**	**1,162.5**	**1,164.5**	**-2.0**	**A**	**-0.2%**
Income	Operating income patient care	335.6	335.2	-0.4	A	-0.1%	983.8	983.8	0.0	G	0.0%
	Other operating income	51.1	55.1	4.1	G	7.9%	152.8	153.8	1.0	G	0.7%
	Total Operating income	**386.7**	**390.4**	**3.7**	**G**	**0.9%**	**1,136.6**	**1,137.6**	**1.0**	**G**	**0.1%**
I&E	**Reported I&E**	**-25.4**	**-28.4**	**-3.0**	**R**	-11.9%	-50.1	-50.1	-0.0	G	0.0%
	Recurrent I&E	**-31.6**	**-33.6**	**-2.0**	**R**	-6.4%	-70.8	-70.8	0.0	**G**	0.0%
Cash	**Cash & cash equivalents**	**31.6**	**47.7**	**16.1**	**G**	51.0%	15.0	15.0	0.0	**G**	0.0%

Total pay costs at SGH are rated amber, with an overspend of 0.4% or £1.0m. The Trust is £1.4m favourable on CIP target (offset in Non-Pay), with IA/Cyber impacts accounting for £1.5m adverse and challenges in ED and acute wards accounting for the majority of the balance. Non-pay has an adverse variance of £4.9m (3.2%) and this variance is partially driven by a mismatch in income and non pay which is in review. The remaining challenge is from CIP and inflationary pressure.

Efficiency

SGH		YTD Plan	YTD Actual	YTD Variance	RAG	% Variance	FY Plan	FOT	Variance	RAG	% Variance
Efficiency	Recurrent efficiency	9.2	9.3	0.1	G	1.1%	46.0	46.0	0.0	G	0.0%
	NR efficiency	4.9	4.8	-0.1	A	-2.1%	22.5	22.5	0.0	G	0.0%
	Total efficiency	**14.2**	**14.2**	**0.0**	**G**	0.0%	68.5	68.5	0.0	**G**	0.0%

SGH are now slightly ahead of plan on recurrent CIP, which is owing to a YTD performance adjustment related to ERF. The Trust will need to ensure that recurrent efficiency continues to be delivered in year so as not to increase the financial challenge in 2025/26. ERF also has challenges related to industrial action and cyber attack that will impact on delivery.

Workforce

SGH		Plan (in-month)	Actual (in-month)	Variance (in-month)	RAG	% Variance
WTEs	Substantive	9,492	9,574	-82	A	-0.9%
	Bank	610	838	-228	R	-37.4%
	Agency	253	143	110	G	43.5%
	Total WTEs	10,355	10,555	-201	A	-1.9%
Cost per WTE	Substantive	5.5	5.8	-0.2	A	-4.4%
	Bank	8.4	5.3	3.1	G	36.7%
	Agency	5.8	6.4	-0.6	R	-10.9%
	Total WTEs	5.7	5.7	-0.0	A	-0.7%

SGH are behind plan in M4 with increases in ward nursing and an additional CIP assumption of 223 WTE only partially delivered.
SGH have significantly lower agency WTEs than plan which is driving a favourable variance against total WTE plan. Agency costs per head, however, were higher than plan so the underspend in cost for agency is not of the same scale and the reduction in WTEs.

Group Board

Meeting on Thursday, 05 September 2024

Agenda Item	4.1	
Report Title	Group Pharmacy Strategy 2024-2028	
Executive Lead	James Marsh, Deputy Chief Executive Officer	
Report Author(s)	Jen Goddard, Strategy & Partnerships Manager	
Previously considered by	Group Executive Board	
Purpose	**For Approval / Decision**	

Executive Summary

The **Group Pharmacy Strategy** is the first of three intended group wide clinical strategies.

An initial vision for the Strategy was positively discussed at the Group Board Development session in June 2024 and the content has since been further developed collaboratively by the pharmacy senior leadership teams of both Trusts. A wide range of stakeholder engagement has taken place and feedback from staff, patients, Integrated Care System colleagues in Surrey and south west London, and key clinical and operational staff across the Group has informed the development of the strategy.

The Board is asked to approve the strategy.

Following approval of the strategy, the Group Executive will agree an implementation plan, which is intended to be finalised by the end of October 2024. This will include consideration of key implementation issues including:

- Outline phasing of key tasks/ milestones
- Roles and responsibilities for implementation
- Full business case for any additional resource required for delivery

Implementation will also be informed by the wider thinking on the future development of collaboration across the Group, which will be discussed in more detail at the October Board Development session.

Action required by Group Board

Group Board is asked to approve the proposed Group Pharmacy Strategy 2024-2028

Committee Assurance	
Committee	NA
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Pharmacy Strategy 2024-2028

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
As per report				
CQC Theme				
☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☐ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
There are some expected implementation costs to facilitate delivery of the strategy, but also significant anticipated financial benefits to be scoped in more detail. A business case covering these two aspects will be part of the implementation plan, which is intended to be finalised by the end of October 2024.				
Legal and / or Regulatory implications				
Not applicable.				
Equality, diversity and inclusion implications				
Equality, diversity and inclusion considerations included within the strategy.				
Environmental sustainability implications				
Sustainability considerations included within the strategy and also form part of the Group Green Plan.				

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Group Pharmacy Strategy 2024-2028

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Contents

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Executive summary

- The Group pharmacy strategy aims to collectively maximise the best of our pharmacy services across St George's, Epsom and St Helier University Hospitals and Health Group (gesh) to deliver **excellent and equitable outcomes for our patients**
- Senior pharmacy leadership teams across the two trusts have worked hard collectively to engage stakeholders and articulate:
    - A **vision** for how pharmacy services look in the future across the Group
    - **Key themes** that provide a framework for delivery building upon collaboration efforts to date
    - **Objectives** within these themes that will move us towards a more integrated pharmacy function whilst bearing in mind the careful consideration of legal parameters required of further integration
- The strategy framework will enable pharmacy to drive change across gesh at pace, enabling future scale across the wider south west London system where appropriate/ possible

Where are we now?

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Current pharmacy services

St George's (SGUH)

- St George's provides inpatient and outpatient pharmacy services across St George's and Queen Mary's Roehampton
- St George's has 266 pharmacy staff working across these sites, with 132 Pharmacists (50% of staff), 65 Pharmacy technicians (24%) and 69 Pharmacy support staff (26%), and an annual staff cost of £14.5m
- In June 2024 SGUH had a vacancy rate of 3.81% and turnover rate of 19.63% against Trust targets of 10% and 13% respectively
- The Trust has an £8.7m monthly medicines spend on medicines for all British National Formulary (BNF) Chapters

Epsom & St Helier (ESTH)

- Epsom & St Helier pharmacy has 138 staff working across both the Epsom and St Helier sites, with 57 Pharmacists (41% of staff), 41 Pharmacy technicians (30%) and 40 Pharmacy support staff (29%), and an annual staff cost of £7.2m, this workforce includes community services pharmacy staff working in Sutton Health and Care and Surrey Downs Health and Care
- ESTH is also planning for delivery of pharmacy services at the Specialist Emergency Care Hospital (SECH) from 2030
- In June 2024, the Trust had a vacancy rate of 17.3% and turnover rate of 24.06% against Trust targets of 10% and 12% respectively. These have improved significantly against historic highs of 27.8% (Feb 23) for vacancy rate and 42.45% (Nov 22) for turnover rate
- The Trust has a £3.4m monthly medicines spend on medicines for all British National Formulary (BNF) Chapters

Why do we need a Group pharmacy strategy?

Why do we need a Group pharmacy strategy?

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

National context

- Nationally there are significant changes planned for the pharmaceutical workforce, with reform of the education and training of pharmacists and pharmacy technicians, including preparing for every newly qualified pharmacist to be an independent prescriber on registration from September 2026
- These changes will also see the expansion of the clinical roles of pharmacy technicians and pharmacy practice changing to ensure their skills are integrated into multi-professional teamwork
- A focus on prevention continues nationally, including work on antimicrobial resistance, the governance of controlled drugs, and improved medicines use for children, people with mental health conditions and people with learning difficulties
- This is alongside other more operational changes for example, the plan to move high-volume, low risk aseptic medicines preparation into regional hubs to boost capacity and resilience - a "do once" approach
- All these changes look to drive better outcomes and value and reduce health inequalities resulting from the NHS's £17.2bn annual spend on medicine

Group context

- As well as responding to the national context, the development of the Group strategy builds on the closer operation of the two trusts in a Group model which provides a prime opportunity for clinical support services to collaborate more closely, adopting best practice and standardising care. It will also support delivery of Group priorities around improving flow and our financial position
- Our co-location with the newly merged City St George's University also provides significant opportunity to develop our research profile, with education and training programmes that attract our pharmacy workforce of the future

Why do we need a Group pharmacy strategy?

There are also key challenges and opportunities which form the basis of a case for change for pharmacy across the Group:

Recruitment and retention remain a challenge within pharmacy across the Group

- Both services recognise that the recruitment and retention of staff is a challenge particularly for certain roles e.g. pharmacy technicians, and turnover at both Trusts is higher than target. However, this is set in context against the national average for Pharmacy Depts being 18%, taking into consideration a large proportion of fixed term training placements that the departments host each year
- There have been historic vacancy rate challenges, particularly at ESTH, which have improved recently but are also set against the context of a national shortage of pharmacists and technicians

Finding capacity for digital advancement, research and innovation is also challenging

- Electronic Prescribing and Medicines Administration (ePMA) is under resourced at ESTH for day-to-day activities, before roll out of the new system is even considered. The impacts of ePMA downtime across the trusts also cause significant pressure on capacity
- Clinical trials are also under-resourced with the opportunity to do more in terms of research profile of the Group, which would in turn generate income and provide opportunities for staff and make roles more interesting

Variation exists across sites with respect to certain quality indicators

- There is variation across the sites in some quality key performance indicators reported to the Quality Committee in Common for e.g. ESTH have some actions to reduce the risk of discharge related medicines incidents for example, and both Trusts have identified actions around improving medicines reconciliation
- Feedback (for e.g. through Friends and Family test) outlines specific issues with outpatient pharmacy waits with significant numbers of patients reporting waiting longer for their prescriptions than they were initially informed at both organisations
- There is a clear driver therefore to learn collectively across the Group, identifying areas for quality improvement

Why do we need a Group pharmacy strategy cont…

Strong collaboration and leadership to date provide a platform to build on for the future

- Both services have good collaboration links across south west London, including through the Joint Formulary and with the Acute Provider Collaborative (APC). Collaboration across south west London supports adoption of best practice and aims to reduce variation across the system
- There is also a sector strategy to improve the provision of aseptically prepared medicines across South West London in development, and a review of radiopharmacy taking place with solutions being developed in collaboration with system partners which is critical particularly given the issues with radiopharmacy infrastructure at St George's
- There is also strong pharmacy leadership engagement with NHS South East Genomics Medicines Service Alliance
- Building the SECH also provides a clear opportunity to think towards the future in a collaborative manner

Pharmacy staff across the Group have already been working more closely together, and are keen to demonstrate the value of effective pharmacy provision

- Pharmacy teams across the two Trusts have recently been collaborating more closely on specific integration projects (e.g. shared band 7 recruitment, review of controlled drugs etc.) and are making good progress
- Our Group strategy outlines that Group collaboration for clinical services will be led and shaped by the services and staff in question via engagement, and significant engagement has been undertaken with key stakeholders in this strategy development
- The engagement has demonstrated that education, training and development, and robust career development pathways are clearly important to our pharmacy staff
- Both services also have strong diversity present throughout their service and want to continue to attract diverse applicants that reflect the communities they serve. Using the collective power of the Group model to ensure a range of opportunities in pharmacy is essential therefore to continue attracting pharmacy staff to our Group in the future

What do we want to achieve?

Group pharmacy vision

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

Our aim

Collectively maximising the best of our pharmacy services across gesh to deliver excellent and equitable outcomes for our patients

Vision for the future

A future pharmacy service that builds on the strengths of both trusts, so that patients experience the same high standards of care, and excellent outcomes no matter which hospital they attend in future or which catchment area they come from

Effective and sustainable use of our collective assets, driving maximum value at pace across the Group from the pharmacy infrastructure available to us, futureproofing for scale

Pharmacy staff moving to act as 'one workforce', with more joint roles, joint training, staff able to work across sites, and the development of new roles across the Group to attract staff to key roles

A well supported pharmacy workforce delivering safe and effective pharmaceutical care and working with other services to drive broader improvements in quality of care, using learning from other Group models

This Group pharmacy strategy outlines how we can seize the opportunities that Group working brings, to adopt best practice, deliver joint functions where appropriate, and improve pharmacy quality indicators and experience for our patients. Our pharmacy leadership teams have developed an ambitious strategy that articulates actionable areas for change but is also realistic and achievable, meeting national guidelines and respecting legal boundaries of our Group model.

Intended benefits of achieving our Group vision

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For patients:

- We will improve patient experience of pharmacy, particularly where there are known issues e.g. by reducing long outpatient pharmacy waits across the Group
- Our pharmacy service will be safer and offer a consistent high quality service, reducing the risk of medication related incidents/ errors
- Patients will have better outcomes through the use of precision and targeted medicines

For staff:

- Our pharmacy department will be a more attractive place to work, with clear and equitable opportunities for career development – supporting our current staff, attracting new staff and reducing vacancy rates
- Staff morale and resilience will be high as our pharmacy teams start to work closer together, benefiting from shared learning and knowledge, with aligned medicines policies/ guidelines providing consistency across the Group for other teams
- The Group will have a stronger pharmacy department workforce benefiting other clinical teams, with new roles e.g. independent prescribers playing a greater role in patient care – maximising the value and skills of pharmacists and the wider team

For the wider system and other key stakeholders:

- We will have a resilient pharmacy service across our Group – supporting prescribing to happen in the most appropriate setting and working closely with community and primary care clinicians
- Dedicated Group resource will enable a focus and specialisation on particular issues such as pursuing commercial opportunities and expanding pharmaceutical research activities
- Benefits of scale will be realised by working in collaboration with system partners when appropriate, and building on Group integration where possible for e.g. developing a Group wide Medicines information to be scale-able

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Pharmacy strategy on a page

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Our themes

- A valued and supported Group pharmacy workforce
- Innovative pharmacy provision financially fit for the future
- Integrated Group pharmacy functions and governance
- Strong Group foundations for future collaboration

Our aim

Collectively maximising the best of our pharmacy services across gesh to deliver excellent and equitable outcomes for our patients

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A well supported pharmacy workforce delivering safe and effective pharmaceutical care and working with other services to drive broader improvements in quality of care, using learning from other Group models

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University Hospitals and Health Group

Strategy themes

- A valued and supported Group pharmacy workforce
- Innovative pharmacy provision financially fit for the future
- Integrated Group pharmacy functions and governance
- Strong Group foundations for future collaboration

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A valued and supported Group pharmacy workforce

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

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
1	Implement one Group leadership structure for pharmacy	• One **centralised Group leadership structure** across the Group overseeing integrated Group pharmacy functions, and ensuring pharmacy delivery across all sites (including SECH in the future)	• This will provide consistency and support across the Group in professional leadership, and also oversight of integrated Group functions, whilst enabling site-level ownership of operational pharmacy delivery • Efficient/ lean Group management structures
2	Develop the Group education and training offer	• Embed an excellent **Group wide education and training programme** to ensure clear career development pathways in place for all staff roles including pharmacists, technicians, pharmacy assistants, administrators etc.	• Staff feel valued and supported, with clear and equitable opportunities to develop their career within the Group, encouraging staff retention • All staff across the Group benefit from a consistent education offer, with opportunities for placements/ learning in specialisms Group wide
3	Raise the profile of pharmacy across the Group	• Use the strategy as a driver to **showcase and communicate best pharmacy practice** across the Group, using a continuous improvement approach to transformation and change	• Implementing Group initiatives to recognise pharmacy staff and promote their good practice will demonstrate their value

A valued and supported Group pharmacy workforce

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
4	Shape the future of the pharmacy model and workforce across the Group	• Establish clear **mutual aid arrangements** across sites, including future consideration of SECH • Review all new vacant posts for their potential to be implemented as **new Group roles with shared recruitment processes** where appropriate • As the Group steps towards closer integration, work to **develop the most effective future Group pharmacy clinical model and workforce**, using Renal as a pathfinder and building succession planning into this work	• Builds resilience across the Group to respond to capacity issues within the workforce • Efficiency and reduced duplication by reviewing and recruiting to new roles once across the Group • Improved service resilience, and quality benefits by using learning from integrating Renal as a pilot to test the best way to drive future efficiency through integration
5	Embed promotion of equality, diversity and inclusion in the pharmacy workforce	• Across the Group ensure a **pharmacy workforce that is reflective of our local communities**, and celebrate this diversity • Ensure **equity of opportunity in recruitment and career** development and other processes	• Building a more diverse and inclusive pharmacy practice will better serve our population, and work to address any inequalities of representation, particularly at senior level within pharmacy teams

Innovative pharmacy provision financially fit for the future

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
6	Develop new models/ approaches for more effective pharmacy service delivery and improved patient experience and outcomes	• Embed the Interface Prescribing Policy with primary care to **ensure prescribing is happening in the right setting** • Collectively **review current outpatient dispensing delivered by the Group** to identify improvements to performance/ internal pathways • Work to **maximise the use of prescribing pharmacists in novel roles across the Group** e.g. in pharmacy led follow up clinics, and in MDT led discharge teams • Build on learning from community services about how to **link up pharmacy provision across the acute Trusts, community services and primary care** to deliver seamless transfer of care across the interfaces	• Working to implement a robust approach to integrated prescribing will ensure that only prescribing appropriate to an acute setting takes place in the Group, greatly benefitting flow • Review of outpatient dispensing will help to improve flow across the Group, reduce long outpatient waits and improve patient experience • Build on the work that is being done in some specialties to provide a greater role for pharmacist independent prescribers and to run clinics within a wider portfolio of services-reducing pressure on consultants and providing saving to the organisation as a whole • Smoothing pharmaceutical care across interfaces with primary and community care will also improve flow

Innovative pharmacy provision financially fit for the future

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

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
6	Develop new models/ approaches cont…	• Scope potential for **integration of certain specialist services** • Opportunity to **review and align Homecare provision** and do things once for e.g. reviewing service level agreements and supply chain arrangements collectively	• Specialist areas such as HIV, cancer etc. have the potential to be run as single services with shared ways of working jointly led by consultant pharmacists • Aligning Homecare will yield efficiencies for e.g. when changing suppliers through increased scale and working collectively
7	Develop an innovative and robust pharmacy model for SECH	• Work closely with the Building Your Future Hospitals Programme Team to **define requirements and plan for innovative pharmacy delivery at SECH** including required workforce transformation	• Safe provision at SECH that will facilitate effective flow, and people being treated in the right place at the right time through use of innovative roles e.g. advanced practitioners • Detailed planning will support clear pharmacy workforce transformation in advance of the new pharmacy operating model for the SECH • Robust liaison with healthcare planners will also ensure safe and futureproofed pharmacy facilities and infrastructure

Innovative pharmacy provision financially fit for the future

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
8	Integrate advancements in genomics and digital into Group pharmacy provision	• Support the development of **genomics informed medicines optimisation** and the building of genomics knowledge • Identify and **implement new digital solutions** as appropriate to advance health promotion, prevent disease, and optimise medication across the Group, specifically looking at robotics and automation opportunities	• Significant benefits to patient outcomes through the use of precision and targeted medicines including advanced therapeutic medicinal products • Digital advancements can support optimisation of pharmacy operations, improved efficiency, safer practice, and improved personalised care, potentially virtually which is also more environmentally sustainable

Integrated Group pharmacy functions and governance

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
9	Integrate specific pharmacy functions to operate as Group functions across all sites (including SECH in the future)	• **One Medicines Safety team** with a 'do it once' approach across the Group (aligning policies, approach to audits, responding to national alerts, considering strategic approach to new practices/technology) • **One Medicines Information service** providing an effective information model that could be scale-able in the future • **One Research and Development team** to grow research activity and clinical trials across the Group	• This will enable consistency across sites, and a less reactive, more proactive and efficient approach to medication safety • This enables timely access to expert pharmacy team members and quality information for Group wide teams related to medication queries, and support to patients to stop them returning to hospital unnecessarily. This service will also support the training of trainee pharmacists/ technicians • This enables a common approach for e.g. to MHRA requirements, ensuring access to clinical trials, and taking advantage of the wider Group population. Increasing research profile of the Group will generate income and provide opportunities for staff and make roles more interesting

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Integrated Group pharmacy functions and governance

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

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
9	Integrate specific pharmacy functions cont...	• **One Pharmacy Education & Training function** to consolidate and build upon work already taking place to provide a Group wide education and training offer • **One ePMA programme** jointly led across Group • **One integrated Group Renal pharmacy inpatient service** for the new renal build	• This will provide common frameworks for learning to ensure quality and consistency across Group pharmacy services • A shared ePMA programme provides resilience in capacity for implementation/ ongoing management of e-prescribing • Implementing one consultant pharmacist to lead the renal service jointly will support fluid movement of the staff across the Group and development of a strong system renal network
10	Develop Group pharmacy governance arrangements	• All policies being reviewed or developed for the future will be done once for the Group to move towards **Group pharmacy policies** • Delivery of **aligned governance, policies and audit of controlled drugs** • In future, **collective Group review of Patient Group Directions** (PGDs) and one PGD Advisory Group • An aspiration to **align clinical guidelines where possible**	• Aligning policies and integrating governance arrangements allows a broader "check and challenge" to ensure quality and safety of prescribing, tackling potential variation in quality across sites and increasing consistency. This also enables efficiency, doing work "once" across the Group • Movement towards aligned clinical guidelines will benefit other staff across the Group as they will be consistent across the Group which is useful particularly as other services look to collaborate/ integrate

Strong Group foundations for future collaboration

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

What do we want to achieve?

No.	Strategic objectives for 2024-2028	Detail	Benefits
11	Collaborate with system partners to futureproof for potential delivery at scale	• Align with and **support the London region and south west London system work on aseptics provision and strategy** • Input to and **support the Radiopharmacy review in south west London**, providing leadership as required • Collaborate with system stakeholders in the work to **review the Outpatient pharmacy delivery model collectively across the sector** • Work to **maximise income from collaboration with the Clinical Research Network (CRN) through commercial trials** across the Group • **Develop our other commercial activities** – including manufacturing and placement of pharmacists overseas	• This will give us clarity as a Group about what we want our relationship with wider system partners to look like • Where appropriate the Group will benefit from the financial and quality economies of scale by working at a system level in these areas rather than at Group level • Participating in a system wide review of the pharmacy outpatient model of delivery may enable more impactful change at scale • Increased income through Group collaboration and participation in commercial trials

How do we get there?

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Implementation approach

A regular pharmacy strategy delivery Group will oversee the resulting programme of integration work and will report into the Executive Collaboration Group, which feeds up to the Group Executive Meeting.

The implementation of the strategy will be overseen by a senior member of the Group's leadership acting as the Senior Responsible Officer.

The strategy's implementation will be evaluated every 6 months, with an implementation roadmap drawn up on approval of this strategy.

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	5.1	
Report Title	**Fit and Proper Persons Test Annual Compliance Report 2023/24**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	-	-
Purpose	**For Assurance**	

Executive Summary

This paper provides assurance to the Group Board that all Board Directors at both Trusts within the Group remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework for England published in August 2023.

All Directors on the Boards of both ESTH and SGUH have successfully undergone all of the required checks under the Fit and Proper Persons Test Framework in 2023/24 and the two Trusts have made the required submissions to NHS England.

One Non-Executive Director at SGUH, two Non-Executive Directors at ESTH, and two Executive Directors with appointments at both Trusts have left the organisations in 2023/24. The required Board Member References have been completed for these departing Board members in line with the requirements of the Framework.

One new Non-Executive Director joined ESTH and one Board member joined as an interim Executive Director at both Trusts in 2023/24. The relevant FPPT checks were completed for both.

Beyond the reporting year (2023/24), two further Board members (both Executive Directors with appointments at both ESTH and SGUH) have joined the Trusts, and the relevant FPPT checks have been satisfactorily completed.

Action required by Group Board

The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2023/24 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	FPPT Checks Annual Compliance 2023/24

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 FPPT Framework and apply it consistently, there is a risk that directors could be appointed to the boards 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. The increased requirements of the new Framework are being managed within the Corporate Affairs team.

Legal and / or Regulatory implications

Full implementation of the Fit and Proper Persons Test is a requirement under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the 2023 Fit and Proper Persons Test Framework for board members.

Equality, diversity and inclusion implications

There are no specific EDI implications associated with the fulfilment of the FPPT requirements.

Environmental sustainability implications

There are no specific environmental or sustainability implications associated with the FPPT requirements.

Fit and Proper Persons Test Annual Compliance Report 2023/24
Group Board, 05 September 2024

1.0 Purpose of paper

1.1 The purpose of this paper is to provide assurance to the Group Board that all Board Directors at both Trusts within the Group remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework for England published in August 2023.

2.0 Background

2.1 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' requirements were 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, or prohibited from holding relevant office).

2.2 In 2018, Tom Kark KC was asked by the Government to lead a review of the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the 2014 Regulations. The Kark 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 was "*in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors*". Published in 2019, the Review highlighted areas it considered needing improvement to strengthen the existing regime, including seven recommendations to Government. These included proposing that: all directors meet specific standards of competence to sit on the board of any health-providing

organisation; a central database of directors be established to hold relevant information about qualifications and history; a mandatory reference be required for each director; the test be applied to commissioners and arms length bodies.

2.3 In August 2023, NHS England published a new *Fit and Proper Persons Test Framework for board members* in response to the Kark Review, and grounded in the requirements of the 2014 Regulations. In publishing the new Framework, NHS England explained that it would "*support the implementation of the recommendations of the Kark Review*", "*promote the effectiveness of the underlying legal requirements*", and "*introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set a standard competences for all board directors, a new way of completing references with additional content whenever a director leave an NHS board, and extension of the application to some other organisations, including NHS England and the CQC*". The new Framework became effective on 30 September 2023, with certain provisions (such as the introduction of mandatory new Board member references and using a new Leadership Competency Framework in all new board member recruitment) being introduced immediately and other elements (such as requirements around the storing of information on the Electronic Staff Record) being introduced in a phased way ahead of full implementation of the Framework by 31 March 2024.

2.4 Under the new Framework, full Fit and Proper Person Test assessments must be undertaken:

- For all new appointments to board member roles, whether permanent or temporary, where greater than six weeks (including promotions, temporary appointments and secondments, acting-up arrangements.
- Where an individual board member changes role within their current organisation (e.g. if an existing board member moves into a new board role that requires a different skill set).
- Annually, for all existing board members, that is, within a 12-month period of the date of the previous FPPT assessment to review any changes over the previous 12 months.

2.5 As part of the Framework, there is a requirement for NHS organisations to formally capture FPPT information, and wider information to support recruitment referencing and ongoing development of board members, and entering this onto board members' ESR record.

2.6 For departing board members, the employing organisation is now required to complete a Board Member Reference in all circumstances, including retirement, which is retained in that individual's FPPT files in the event that it is requested for new board appointments at another NHS organisation.

2.7 In terms of assurance and oversight, the Framework sets out that:

- 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, and the retention of relevant data.
- NHS England has oversight through receipt of an annual FPPT submission by NHS organisations.
- Every three years, NHS organisations are expected to undertake an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.
- Annually, an update should be taken to a meeting in of the Board in public to confirm that the requirements for the FPPT have been satisfied.

3.0 Fit and Proper Persons Test: Summary of Checks Undertaken

3.1 The following checks are undertaken as part of the FPPT assessment for all Board members of Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH):

FPPT Checks for new starters	Annual FPPT Checks
Identity Check inc. Right to Work in the UK	FPPT Self Declaration
Disclosure and Barring Service Check	Check of Professional Registration (if applicable)
Check of educational qualifications	Check of Insolvency Register
References covering the past 6 years	Check of Disqualified Directors Register
Check of Professional Registration (if applicable)	Check of Charity Commission Register for Removed Trustees
Check of Insolvency Register	Check of Employment Tribunals Register
Check of Disqualified Directors Register	Media Check
Check of Charity Commission Register for Removed Trustees	Social Media Check
Check of Employment Tribunals Register	
Media Check	
Social Media Check	
FPPT Self Declaration	
Occupational Health Check	

3.2 Board Member References are also completed for all board members who have left the boards during 2023/24.

4.0 Fit and Proper Persons Test: Outcome and Compliance 2023/24

4.1 Under the supervision of the Group Chairman, who is accountable for FPPT under the Framework, all existing Board members of both ESTH and SGUH have undergone the annual FPPT assessment as outlined above for 2023/24:

- All Board members completed Annual FPPT Self Assessment Forms. These forms have been reviewed and are all satisfactory.
- The further annual check set out above were undertaken by an independent background checks company contracted by South West London Recruitment Hub. These have been completed for all Board members and no issues have been identified that affect the fit and proper status of any member of either Trust Board.

4.2 Appendix 1 sets out the completion of the tests for members of the ESTH and SGUH Boards in 2023/24.

4.3 Following the completion of the FPPT checks, both ESTH and SGUH have made annual compliance submissions to NHS England in line with the requirements of the Framework.

Departing Board members, 2023/24

4.4 During 2023/24, the following Board members have left the Boards of ESTH and SGUH:

Board member	Role	Trust	Date left	Board Member Reference Completed
Stephen Collier	Non-Executive Director	SGUH	12 October 2023	Y
Chris Elliott	Associate Non-Executive Director	ESTH	31 December 2023	Y
Aruna Mehta	Non-Executive Director	ESTH	31 January 2024	Y
Paul da Gama	Group Chief People Officer	SGUH and ESTH	31 December 2023	Y
Andrew Asbury	Group Chief Infrastructure, Facilities & Environment Officer	SGUH and ESTH	3 March 2024	Y

4.5 Under the new FPPT Framework, the employing NHS organisation is required to complete a Board Member Reference for any departing Board member using the prescribed reference template. Board Member References are completed by the Chairman for all Non-Executive Directors departing the organisation, and by the Chief Executive for all Executive Directors. Board Member References have been completed for all departing Board members of both ESTH and SGUH in 2023/24.

New Board members, 2023/24

4.6 During 2023/24, the following Board members joined the Boards of ESTH and SGUH:

Board member	Role	Trust	Date joined	FPPT completed
Andrew Murray	Non-Executive Director	ESTH*	1 February 2024	Y
Angela Paradise	Interim Group Chief People Officer	ESTH and SGUH	3 January 2024 (left 26 July 2024)	Y

** Andrew Murray holds a pre-existing appointment as a Non-Executive Director at SGUH*

4.6 In addition, from 13 October 2023 Yin Jones was appointed by the SGUH Council of Governors from her substantive role as Associate NED at SGUH to fill a substantive NED vacancy following the departure of Stephen Collier, SGUH Non-Executive Director. Relevant FPPT checks have been completed. A Board Member Reference is not required for changes in role.

New Board appointments in current year (2024/25)

4.3 Although beyond the scope of the reporting year (2023/24), the following two Board members have joined the Boards of ESTH and SGUH and have successfully completed all of the necessary checks to meet the FPPT requirements:

Board member	Role	Trust	Date joined	FPPT completed
Victoria Smith	Group Chief People Officer	ESTH and SGUH	1 July 2024	Y
Mark Bagnall	Group Chief Infrastructure, Facilities and Environment Officer	ESTH and SGUH	27 August 2024	Y
Yin Jones	Non-Executive Director	SGUH	2 September 2024*	Y

** Appointed to a substantive Non-Executive position having previously held the role on an interim basis from substantive role as an Associate NED since 13 October 2023*

4.4 Two further individuals who are in the process of being appointed to the Board of SGUH are currently undergoing FPPT assessments (Professor Philippa Tostevin, Non-Executive Director; and Claire Sunderland Hay, Associate Non-Executive Director) and will commence their terms of office upon completion of the checks.

Conclusion

4.5 All Directors on the Boards of both Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Trust satisfy the requirements of the Fit and Proper Persons Test required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and meet the requirements of NHS England's Fit and Proper Persons Test Framework for board members 2023.

5.0 Recommendations

5.1 The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2023/24 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

St George's University Hospitals NHS Foundation Trust - Fit and Proper Persons Test Annnual Compliance 2023/24

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Norton	Gillian	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Beasley	Ann	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Collier	Stephen	Non Executive Director (departed 12 October 2023)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Higham	Jenny	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Chiew Yin	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Wright	Timothy	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Asbury	Andrew	Group Chief Infrastructure, Facilities and Environment Officer (departed 3 March 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Da Gama	Paul	Group Chief People Officer (departed 31 December 2023)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Grimshaw	Andrew	Group Chief Finance Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Paradise	Angela	Interim Group Chief People Officer (departed 26 July 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Slemeck	Catriona	Managing Director - St George's	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Wellman	Arlene	Group Chief Nursing Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

Epsom and St Helier University Hospitals NHS Trust - Fit and Proper Persons Test Annnual Compliance 2023/24

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements Found	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Norton	Gillian	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Beasley	Ann	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Elliott	Chris	Associate Non-Executive Director (departed 31 December 2023)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Kane	Peter	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kirke	Martin	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Macallan	Derek	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Mehta	Aruna	Non Executive Director (departed 31 January 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Wilbraham	Phil	Associate Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Asbury	Andrew	Group Chief Infrastructure, Facilities and Environment Officer (departed 3 March 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Blythe	James	Managing Director - Epsom & St Helier	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Da Gama	Paul	Group Chief People Officer (departed 31 December 2023)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Grimshaw	Andrew	Group Chief Finance Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Paradise	Angela	Interim Group Chief People Officer (departed 26 July 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Sawtell	Thirza	Managing Director - Integrated Care	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Wellman	Arlene	Group Chief Nursing Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

Group Board

Meeting in Public on Thursday, 05 September 2024

Agenda Item	5.2	
Report Title	Group Quality and Safety Strategy 2024-2028	
Executive Lead	Dr Richard Jennings, Group Chief Medical Officer Arlene Wellman MBE, Group Chief Nursing Officer	
Report Author(s)	Zahra Abbas, Group Strategy and Planning Manager	
Previously considered by	Group Board in Private Quality Committee-in-Common Group Executive Group Board Development Session	4 July 2024 27 June 2024 25 June 2024 6 June 2024
Purpose	**For Noting**	

Executive Summary

The Group has developed a Quality and Safety Strategy. This is a key enabler in delivering our vision for 2028 – Outstanding Care, Together. The strategy sets out the key quality and safety priorities and the action we need to take over the next four years.

The strategy sets out our strategic objectives for 2024-2028 against these three areas:

1. **Strong Governance:** We will strengthen governance & oversight of quality and safety
2. **Better Flow / Shorter Waits:** We will improve flow through our services, so that patients get the right care, in the right place, more quickly.
3. **A Learning Organisation:** We will embed a culture of psychological safety, continuous improvement, learning from mistakes, and learning from others.

Against these three areas, a set of five priorities have been defined with corresponding actions. The objectives and actions have been aligned to our in-year quality priorities 2024/25. The strategy has been informed by ongoing work on the other enabling strategies and the health inequalities update to June QCiC. At the June 2023 Board Development session, the Board reviewed the emerging strategy, providing feedback, especially around ensuring we are including what is within our gift to address around patient flow, which has now been addressed. The Board meeting (in private) on 4th July 2024, which was during purdah, approved the strategy.

The strategy is now being placed in the public domain via the Group Board and is for noting.

Action required by Group Board

The Board is asked to note the Group Quality and Safety Strategy 2024-2028.

Committee Assurance	
Committee	Quality Committee-in-Common
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Quality & Safety Strategy 2024-28

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

Group Quality & Safety Strategy 2024-28

Arlene Wellman, CNO

Richard Jennings, CMO

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Our quality & safety strategy on a page

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

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

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

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

Group Quality & Safety Strategy.

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STRONG GOVERNANCE

We will strengthen governance & oversight of quality and safety

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

BETTER FLOW / SHORTER WAITS

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

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

A LEARNING ORGANISATION

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

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

Enablers

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

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Where are we now?

- We are operating in a **significantly challenging environment** with severe constraints around **finances** at both Group and ICS level.
- Furthermore, with people across the NHS waiting longer **in A&E and on waiting lists**, our emergency care pathways are experiencing **poor flow.**
- This has significant **consequences for quality and safety** including patient experience and outcomes.
- Given increased demand, and **significant resource constraints**, both financial and human, we must **prioritise the actions** we take over the next four years to ensure we meet our strategic objectives.
- **Industrial action and post COVID backlogs** continue to pose major challenges in managing long waiting lists and addressing health inequalities, alongside the increasing demands for services.
- We are facing ongoing challenges with **supply, recruitment and retention** and a workforce, which has experienced ongoing extreme pressures, resulting in morale issues and greater need to focus on staff wellbeing.

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Our Vision

This strategy sets out our strategic objectives for 2024-2028 against these three areas:

STRONG GOVERNANCE

We will strengthen governance & oversight of quality and safety

BETTER FLOW / SHORTER WAITS

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

A LEARNING ORGANISATION

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

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Strategic objectives and actions

STRONG GOVERNANCE
We will strengthen governance & oversight, to provide safe, effective & patient-centered care

#	Strategic Objectives for 2024-2028	Actions 2024 - 2028	In year quality priorities 2024/25
1	Reform our Group quality governance approach and embed this throughout the Group to ensure collective understanding of quality & safety.	• Define and embed a new Quality Management System across the Group, setting out our approach to quality improvement, quality control, quality planning and quality assurance using a continuous improvement approach • Building on the governance review of the Group maternity service we will now extend this approach to other clinical areas • Integrate corporate quality and safety functions within Nursing and Medicine to deliver a Group-wide approach	• Strengthen the governance and quality of our maternity services • We will strengthen our governance processes to ensure effective ward/service to Board reporting
2	Enhance patient safety by systematically learning from incidents through implementation of the Patient Safety Incident Reporting Framework and Learn from Patient Safety Events (LFPSE) service.	• Achieve required levels of mandatory patient safety training • Improve patient safety related learning across the Group (including the introduction of further learning events) • Improve involvement and experience of patients, families and staff in responding to patient safety incidents • Use the patient safety incident response framework to ensure a more co-ordinated and data-driven approach to patient safety incident response	• In line with the national patient safety strategy, we will implement the new patient safety incident response framework

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Strategic objectives and actions

BETTER FLOW / SHORTER WAITS

We will improve flow through our services, offering right care right place right time, to improve patient outcomes/experience

#	Strategic Objectives for 2024-2028	Actions 2024-2028	In year quality priorities 2024/25
3	Improve waiting list management for planned care, and improve patient flow in hospitals, so that all patients get timely, safe care in the appropriate environment and timely discharge. Mental health patients in Emergency Departments will be a focus, as will be improving the integrated care service for frail elderly patients at St George's. This will involve collaboration with system partners.	• Work with our mental health Trust to improve care for patients with mental illness, including in our ED and on paediatric wards • Work with partners in our local places to improve care for our frail elderly population – reducing attendances, reducing length of stay and speeding up discharge • Manage patients on waiting lists better, focusing on reducing the impact of health inequalities and deterioration through use of new tools and technologies, including emerging AI tools. • Improve our inpatient flow and ED overcrowding through better use of data around discharges and reducing variation	• We will deliver our flow programme

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Strategic objectives and actions

A LEARNING ORGANISATION

We will embed a culture of psychological safety, continuous improvement, learning from mistakes to improve patient outcomes/experience

#	Strategic Objectives for 2024-2028	Actions 2024-2028	In year quality priorities 2024/25
4	Develop an outstanding patient safety culture in which all our staff feel psychologically safe to speak up and confident the organisation will act in response.	• Through a multidisciplinary Raising Concerns Group, led by the CCAO and supported by the CNO/CMO, make it easier for staff to raise concerns on patient safety, improve how staff are supported through the process of raising concerns, and ensure staff see the positive impact from doing so	• We will integrate our Quality Improvement resources across the Group to maximise service improvement activity and actively encourage psychological safety in all improvement activity
5	Embed a new Group-wide approach to clinical effectiveness, incorporating better use of data and intelligence, and greater use of peer learning/review across our services.	• Develop a new Group-wide approach to clinical effectiveness and audit, led by a single Group-wide team • Strengthen use of data by our services, supporting them to learn from best practice across the Group • Determine minimum standards for addressing variation in how data is used by services and explore options for implementation.	• We will get the basics right every time and consistently complete risk assessments in line with expected standards of performance

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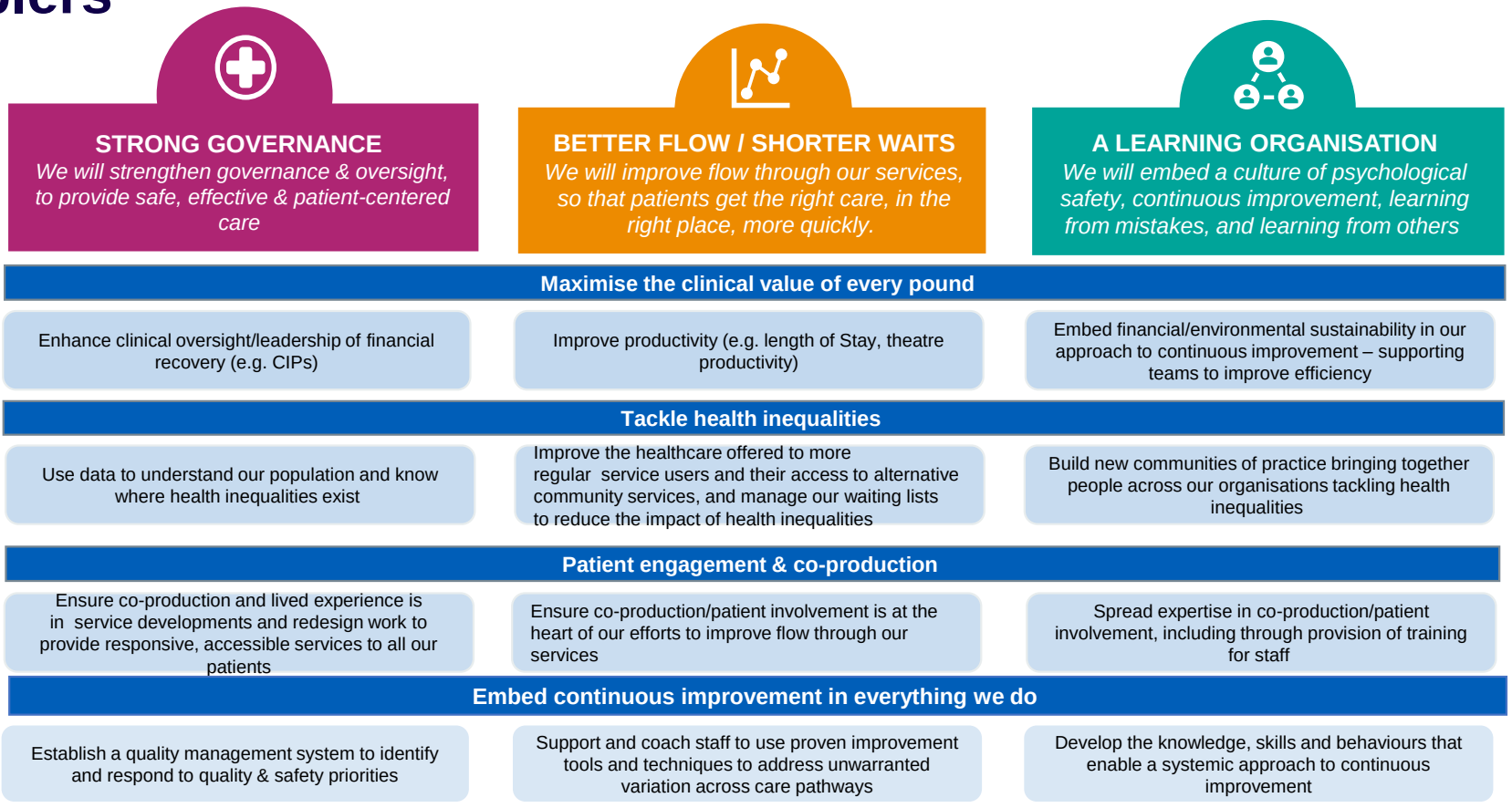
Enablers



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How do we get there?

Implementation

- We will develop a roadmap of the high-level milestones for achieving the strategy phased over the four years of delivery
- Implementation will then be delivered through annual action plans with agreed owners and timelines
- We will make sure our quality priorities are affordable and our strategic objectives can be delivered within existing resource.

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How do we get there?

Governance

- The implementation of the Strategy will be over seen by the Group Chief Medical Officer and Group Chief Nursing Officer as the Senior Responsible Officers.
- The programme will report into the gesh Quality group. That group should be accountable to the Group Executive and then on to Quality Committee.
- The Strategy's implementation will be evaluated every 6 months.

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	5.3	
Report Title	**Group Green Plan 2024-2028**	
Executive Lead	Jenni Doman, Deputy Group Officer, Facilities, Infrastructure and Environment	
Report Author(s)	Sam Hall – Group Green Plan Assistant Director Emma Norris – Group Head of Green Plan Jen Goddard – Strategy and Partnerships Manager	
Previously considered by	Group Board Group Executive Group Board Development Session	5 July 2024 25 June 2024 6 June 2024
Purpose	**For Approval / Decision**	

Executive Summary

The **Group Green Plan** is a key enabler to deliver our vision that by 2028 we will achieve outstanding care, together by integrating sustainability into everything we do.

A draft Group Green Plan was positively discussed at the Group Board Development session in June 2024 and the following amendments have been made based upon that discussion:

- Under the objective about supporting our clinical/ operational teams to consider sustainability in their delivery of care, it has been added that this may also include getting our clinicians out into the community to deliver appointments closer to home, reducing unnecessary patient transport and cost, and improving experience
- A section about taking a partnership approach to sustainability has been added into the enablers section, and references working closely with partners such as the University and Integrated Care Board
- The workforce enabler now notes that we will support staff to be empowered and enabled to take personal responsibility for sustainability
- The financial sustainability section at the start now details an indicative outline of the financial benefits of delivering the Green Plan is in development
- Finally, a glossary of terms has been added at the end of the Green Plan

The final Group Green Plan 2024-2028, approved by the Group Board in Private (due to purdah) on 4th July 2024, is attached in appendix 1 for noting.

Action required by Group Board

The Group Board is asked to note the final Group Green Plan 2024-2028.

Committee Assurance	
Committee	Infrastructure Committees-in-Common
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Green Plan 2024-2028

Implications

Group Strategic Objectives

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

Risks

As per report

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As per report

Legal and / or Regulatory implications

As per report

Equality, diversity and inclusion implications

As per report

Environmental sustainability implications

As per report

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Group Green Plan 2024-2028

Enabling delivery of our CARE strategy

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Executive Summary

As a Group we are committed to driving sustainable development to deliver our five-year strategy, and our vision for 2028 of outstanding care, together.

Our Group's strategic Green Plan acts to:

- Publicly set out our sustainability ambitions for our estates & facilities, travel & transport, clinical provision, and supply chain & procurement
- Define the strategic objectives for these key areas that will help us meet our legislative requirements and ambitions, including Net Zero Carbon
- Set out governance arrangements for how we will monitor and assure delivery of this Green Plan
- Demonstrate how we will evaluate our impact and continually improve our performance

Fundamentally our Green Plan is based upon becoming an environmentally sustainable organisation which follows four key principles:

- Eliminating waste and pollution
- Implementing the principles of a circular economy
- Regenerating nature and operating within ecosystem boundaries
- Developing the environmental management systems to support this

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Where are we now?

National

In June 2019 the UK government adopted the legally binding target of achieving Net Zero Carbon by 2050. Enacted through the Climate Change Act of 2008, this enables the UK to achieve its nationally determined contributions and help the international community to achieve the Paris Agreement 2015 target of limiting global warming to 2°C by the year 2100, with an aspiration of 1.5°C.

The NHS

The Vision: ***To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.***

In October 2020, the NHS became the world's first health service to commit to reaching Net Zero Carbon recognising that climate change has direct consequences for patients, the public, and the NHS as a whole. In July 2022, the NHS embedded the net zero requirement into legislation, through the Health and Care Act 2022. This places a duty on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards statutory emissions and environmental targets.

The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets:

- for emissions controlled directly - net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032
- for emissions that can be influenced - net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039

It also covers measures to adapt to any current or predicted impacts of climate change identified within the 2008 Climate Change Act. Trusts and integrated care boards (ICBs) will meet this new duty through the delivery of their localised Green Plans, and every Trust and ICB in the country is also required to have a board-level lead. To support these aims, statutory guidance including the Delivering a Net Zero National Health Service report and the Net Zero Supplier Roadmap, have been developed.

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Where are we now?

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Work to improve sustainability is already underway through the St George's Green Plan agreed by Board in July 2021, and the Epsom & St Helier Green Plan agreed at Board in June 2023. The Group strategy 2023-2028 outlines a Group wide gesh Green Plan as one of six corporate enabling strategies, and therefore this gesh Green Plan strategic document builds on progress to date as a key corporate enabler for delivery of our vision for 2028 – Outstanding Care, Together.

Some excellent progress to date on sustainability matters has also already been made at both St George's and Epsom & St Helier, including:

St George's (SGUH)

- An Estates Decarbonisation Strategy document has been produced, giving a pathway to Net Zero
- We have developed the UK's first SMART theatres, reducing energy use and improving patient flow and outcomes
- We have ended the use of highly polluting anaesthetic gases, moved to low carbon methods of administering anaesthetics, decommissioned our Nitrous Oxide manifold and installed Nitrous Oxide cracking technology
- A programme of work has been implemented encouraging active travel e.g. Cycle to work events held, Dr Bike (free bike repair workshops for staff), Cycle to Work Scheme, and offering only ULEZ compliant and electric lease cars

Epsom & St Helier (ESTH)

- A Heat Decarbonisation Plan document has been produced by an external contractor through the Low Carbon Skills Fund, giving a pathway to Net Zero for energy.
- A programme of work implemented encouraging active travel e.g. Staff travel survey, Travel Plan, Cycle to work events held, Dr Bike (free bike repair workshops for staff), Cycle to Work Scheme, and offering only ULEZ compliant & EV lease cars
- Low carbon patient menus have been implemented
- Tree planting scheme in place
- Grant received for walking aid return scheme

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Financial sustainability

Financial sustainability

Delivery of this green plan will also support financial sustainability longer term for gesh by:

- Reducing costs due to improved efficiency with a lower carbon footprint and lower energy demand. For example, moving from combined heat and power systems to air source heat pumps will reduce organisational running costs long term
- Future proofing the Trust against energy price shocks and by minimising the risk of emergency expenditure from climate issues
- Increasing self-sufficiency and reducing the risk associated with supply chain partners
- Delivering benefits of the circular economy by reusing equipment and supplies rather than buying new
- Improving the performance of clinical service delivery through efficiency savings, better use of staff time, and through reduced use of materials, transportation, and energy
- Acting as an anchor organisation communicating the co-benefits of environmental sustainability (e.g. active travel) thus improving health of patients and reducing the strain on services

To ensure delivery of commitments and funding to support this Green Plan we will investigate and explore external funding opportunities, alternative finance options, and innovative mechanisms designed to keep costs of change low. An indicative outline of the financial benefits of delivering this Green Plan is in development.

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Key challenges

Finance

In a financially challenging environment, internal and external funding needs to be accessed for longer term sustainability initiatives e.g. electric vehicle pool cars and charging points, and for developing and delivering investment grade proposals for estates heat decarbonisation

Capacity and capability

Building capacity and capability around "green" issues. Understanding needs to be developed across gesh that achieving sustainability is a requirement for the whole organisation not just estates and facilities

Accountability

Given that sustainability has many factors, setting up robust Group oversight whilst also having site-based action plans, and real ownership of actions within all sustainability workstreams is a challenge

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Opportunities

Scale and spread

The benefits of Group level collaboration provide a real opportunity to scale and spread what is working well at each site and also to share sustainability resources e.g. training, education and awareness raising materials

Building a reputation for sustainability

Delivering the gesh Green Plan will improve the reputation and standing of the organisation as a centre of sustainability excellence

Improved outcomes and efficiency

Using a continuous improvement approach to deliver the Group Green Plan will lead to efficiency savings, better clinical services and improved outcomes for patients

What do we want to achieve?

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

Estates and Facilities
- We will be well on the way to reducing our direct emissions of carbon by 80% to hit the 2032 target
- For indirect emissions, we will have made significant progress towards reaching the 80% reduction target (by 2036 to 2039)
- We will produce minimal waste and be meeting national waste targets
- Our current and new infrastructure will be sustainable, and resilient to the impacts of a changing climate
- Patients, staff and the public will benefit from flourishing grounds and outdoor spaces

Travel and Transport
- We will transition to an electric fleet, generating minimal harmful air pollution
- We will promote virtual care where possible
- We will promote zero emission travel for staff, patients and the public

Clinical provision
- Outstanding care will be provided across the Group in a financially and environmentally sustainable manner
- We will have minimised the environmental impact of the medicines and care we provide

Supply chain
- We will reuse and repair everything that can be reused and repaired
- Our hospital supplies will be sourced from environmentally friendly suppliers who can demonstrate a commitment to achieving Net Zero Carbon
- We will be applying the principles of a circular economy in all our procurement decisions i.e. avoiding single use equipment and buying reusable goods

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

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

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Principles

We will be guided by towards our vision for environmental sustainability by the following principles:

- The ecological principle – we rely on ecosystems as the basis of life and wealth, ecosystems are our life support systems
- The prevention of pollution principle – we have a responsibility to prevent pollution of and damage to our ecosystems
- The polluter pays principle – if we cause the pollution we should be responsible for the costs of cleaning it up
- The hierarchy approach – we will seek to prioritise prevention, then reduction, reuse and recycling of: waste, materials, energy and water
- The principles of a circular economy – ensuring we avoid extraction of raw materials and maximise reuse and recycling of materials
- Supporting regenerative processes over extractive processes – seeking to support ecological regeneration
- The principle of nonmaleficence – the obligation of a physician not to harm the patient, as the ancient Greek physician Hippocrates said "to do good or to do no harm" and in this case we recognise that damaging the environment damages the health of our patients

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Domains

- Estates and Facilities
- Travel and Transport
- Clinical provision
- Supply chain and procurement

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Estates and Facilities

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Where are we now?

This domain covers all functions which are responsibilities of Estates and Facilities including: waste, energy, capital projects, biodiversity, adaptation for climate change, and food & nutrition. The Green Plan Team is embedded in Estates & Facilities with the Deputy Group Officer for Facilities, Infrastructure and Environment leading on the Green Plan. Estates & Facilities is therefore at the heart of Group action on sustainability and is the division with the largest input into Green Plan Progress so far:

- St George's have developed the SMART Theatres project saving £750k and 1,346 tonnes of CO_2 every year
- We are replacing the fleet cars with Electric Vehicles (EVs) at St George's
- Both St George's and Epsom & St Helier have diverted all of their waste from landfill
- Our capital projects, Intensive care and Renal are targeting Building Research Establishment Environmental Assessment Method (BREEAM) ratings of "Very Good" and "Outstanding" respectively
- Our estates strategy is being informed by the Green Plan and Decarbonisation Strategies for St George's and Epsom & St Helier
- We have an abundant and varied set of gardens that provide a healing resource for staff, visitors and patients across gesh
- We have low carbon patient and canteen menus in place, digital ordering for the patient menu, and have moved to reusable cutlery and crockery and waste food recycling in the canteens across gesh

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Estates and Facilities

What do we want to achieve?

Energy - we will be delivering key elements of our roadmap to 80% carbon reduction by 2028-32 and net zero carbon by 2040 and have moved a significant portion of the estate from gas to electric heating. Significant upgrades will have been made to more efficient fabric, and low energy lighting, and smart metering. We will have minimised our air pollution through energy efficiency work.

Capital projects - our new buildings and refurbishments (Intensive care, Renal, SECH) will all meet the NHS Net Zero Building Standard (NZBS) and target the BREEAM ratings of "Outstanding" and "Very Good", demonstrating sustainable construction and minimising embodied carbon, as well as reducing their operational energy demand.

How will we get there?

To do this we will **deliver our Estates Decarbonisation Strategies for each site.** This will include:

- moving from gas to all electric heating and cooling, and improving the efficiency of our building fabric and lighting
- Applying for funding for further decarbonisation support to replace equipment coming to the end of its life through upcoming phases of the Public Sector Decarbonisation Scheme (PSDS) and Low Carbon Skills Fund (LCSF)
- Developing the on-site renewables capacity and battery storage

We will **achieve key standards in the delivery of all new capital projects (e.g. BREAAM and NZBS).** We will:

- Ensure ongoing delivery in line with the requirements of the Net Zero Building Standard
- Integrate the requirements of BREEAM/ NZBS into business as usual and achieve them where appropriate

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Estates and Facilities

What do we want to achieve?

Waste - our waste volumes going to incineration will be low, and we will have improved segregation and recycling rates. In particular we will be achieving the targets for reducing the carbon footprint of our waste to Net Zero and implementing the requirements of the Clinical Waste Strategy 60/20/20

Adaptation - our approach to adapting to climate change will be well defined, with clear protocols and risk assessments across the Group to respond to heat waves, cold weather, floods and other aspects of climate change.

Landscape and biodiversity - we will be recognised as a leader in this area, with a robust biodiversity management plan in place across all current and future group sites. We will work in partnership with our patients, staff and communities to enhance our biodiversity and connection to it.

How will we get there?

To do this we will **deliver national Clinical Waste targets**, and develop a detailed plan for delivering the required Clinical Waste Targets, and ensure that the waste targets are embedded in relevant contracts

We will **develop and implement group wide protocols/ plans for responding to climate emergencies,** assessing the vulnerability of the existing group estate against a list of key climate scenarios. We will develop group wide climate risk assessment templates, and group protocols/ action plans for responding to climate emergencies which will also include consideration of longer-term potential issues e.g. flooding and overheating

We will develop and **implement a group Biodiversity Management Plan.** This will include a review of open spaces across all current and future sites to prioritise the maintenance and development of landscape and biodiversity. We will identify opportunities to engage with staff, public and local communities to support ongoing promotion and development of biodiversity and wellbeing

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Estates and Facilities

What do we want to achieve?

Food and nutrition - our delivery of food and nutrition across gesh will ensure minimal food waste, organic certification of products, delivery of low carbon menus, local sourcing and reduced food miles, and enhanced nutritional content.

How will we get there?

We will **integrate sustainability into the delivery of food and nutrition** by mapping current food provision across sites and identifying opportunities for improvement. We will also develop improved purchasing and provision of 'sustainable' food e.g. organic certification, low carbon, locally sourced minimal waste

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Travel and Transport

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Where are we now?

This domain covers electrification of the group fleet and transport, and encouraging active travel (cycling, walking etc.). Good progress has been made to date with the following success:

- We have ensured all Trust Vehicles (owned and leased) are ULEZ compliant across gesh
- Also across gesh only Low Emissions Vehicles (LEV) and Zero Emissions Vehicles (ZEV) vehicles available to staff through Trust lease scheme
- An inter-site shuttle bus is available to staff and public at ESTH, and ESTH has a travel plan currently awaiting approval
- A digital parking system was introduced in April 2024 at ESTH saving the equivalent of 350 trees per year compared with the scratch card system
- Cycle to work schemes are in place for staff with active cycling groups at both Trusts and the Cycle2Work scheme is available for staff across the group (includes electric bikes)
- DASH cycle hire scheme is also available for staff at St George's
- "Dr Bike" free bike repair is available across both Trusts and keen to roll out further at ESTH

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Travel and Transport

What do we want to achieve?

Transport
The Group will be well along its roadmap of transition to an electric fleet with pooled community cars and couriers, shuttle buses, and an electric Patient Transport fleet generating minimal harmful air pollution

Travel
Our staff across the Group will be able to work flexibly as appropriate and supported to choose sustainable methods of transport for their commute, with high levels of staff using active travel

How will we get there?

We will **progress the transition to low carbon transport by implementing an electric fleet.** This will entail:

- A review of loading capacity across the Group
- A review of connection to the grid, and infrastructure/ investment required for charge points
- New vehicles leases for pooled/ community/ courier vehicles
- The Patient Transport Service vehicle provider to offer a proposal for ambulance charging infrastructure and transition to an all-electric fleet

A key focus will be to **promote active travel for staff, patients and the public:**

- We will prioritise promoting the health and cost benefits to staff of active travel as well as the reduction in air pollution
- A travel survey will be carried out annually and actions determined from staff feedback
- Criteria for staff parking across the Group will be reviewed and aligned
- An investment programme to be determined for staff cycling facilities
- A programme of awareness raising will be developed for staff to include information on public transport/ active travel and air quality awareness
- We will continue to work to develop air quality monitoring information by implementing an air quality node

Clinical provision

Where are we now?

Clinical provision is key to achieving sustainability, and this area covers optimising prescribing, substituting high carbon products for low-carbon alternatives, and making improvements in service delivery and waste processes. Additionally, development of more sustainable clinical models of care will also help to prevent unnecessary journeys through improved preventative medicine and enhanced digital care. So far, the following progress has been made

- We have decommissioned use of desflurane across gesh, moved to TIVA pumps and oral anaesthetics, significantly reducing the clinical carbon footprint
- St George's are planning to close nitrous manifolds in September 2024, and ESTH are planning to review nitrous oxide manifold closure in 2024/25
- Clinicians have been involved in the SMART theatres project and in implementing the Intercollegiate Green Theatre Checklist

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Clinical provision

What do we want to achieve?

Sustainable models of care - we will deliver the best quality of care while being mindful of its social, environmental and financial impact and we will take a whole systems approach to the way it is delivered. Our approach will embed consideration of sustainability into any existing or new clinical model/ service change.

Medicines - our clinical colleagues will be supported to optimise prescribing for example, by reducing the use of inhalers, nitrous oxide, and anaesthetic gases. We will have low levels of drug waste and will have minimised our emissions from medicines.

How will we get there?

We will **support our clinical and operational teams to consider sustainability in their delivery of care** by:

- Developing green toolkits and educational materials for clinical teams, to help them learn from early sustainability champion successes, and give them the tools to assess their own service provision. This will also include how to encourage discussions with patients about active travel, exercise etc.
- Ensuring sustainability is embedded as a requirement for consideration in any future service change
- Supporting programmes of work to avoid clinically unnecessary interventions
- Minimising environmental impact of delivery e.g. outpatient follow up activity to be delivered digitally and only by patient initiation, or seeking if possible to deliver patient care in community-based settings closer to people's homes
- Developing a programme of communication/ engagement to promote sustainability in service provision with clinical and operational colleagues, and other key stakeholders

We will **implement plans to optimise sustainability in pharmacy.** This will include:

- Manifold closures to reduce wastage (leaks)
- Introduction of N_2O cracking for patient-controlled delivery
- Promotion of Sevoflurane (least global warming potential)
- Investment in TIVA
- Increase of dry powder inhaler prescriptions
- Developing a programme of awareness raising for staff e.g. "don't open it unless you need it"

Supply chain and procurement

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Where are we now?

The NHS Carbon Footprint Plus considers an expanded scope of emissions that Trusts does not control directly but can influence (these are known as Scope 3 emissions). This includes consideration of all the products procured from our suppliers, where we can use our Group purchasing power to influence change. To date progress includes:

- Sustainability and social value added to all tender key performance indicators (KPIs)
- Carbon reduction plans required for all tenders from April 2024
- A sustainable procurement working group running across the Group

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Supply chain and procurement

What do we want to achieve?

Supply chain and procurement - we will be an ethical and sustainable procurer of goods and services, with clear requirements for all our suppliers to outline their own sustainability plans and pathway to net zero. We will implement the principles of a circular economy prioritising products that can be reused and recycled. Greatly reducing single use plastics, substituting high carbon products with low-carbon alternatives and procuring products from sustainable sources.

How will we get there?

We **will build sustainability requirements into procurement processes and contracts** and:

- Review procurement spend to identify high carbon products and contracts and develop a plan to tackle these as a priority
- Ensure social value/ sustainability has 10% weighting for all tender contract scoring
- Make sure KPIs for sustainability are built into all contracts
- The procurement team will engage with all suppliers on net zero requirements

We will **review all goods purchased against key sustainability criteria**

- This will ensure as a group we:
    - Remove any unnecessary single use plastics from supply chain by 2025
    - Ensure plastic packaging purchase contains at least 30% recycled plastic
    - Only purchase recycled paper
    - Only purchase reusable equipment and textiles
- Develop and promote a programme to ensure all products procured are reusable, recyclable and from sustainable sources.

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In summary there are 12 strategic objectives in the Green Plan, mapped below to where there are national requirements/ targets for delivery:

Domain	Ambitions from our vision	Strategic objectives 2024-2028	National targets/ requirements
Estates and Facilities	• We will be well on the way to reducing our direct emissions of carbon by 80% to hit the 2032 target • For indirect emissions, we will have made significant progress towards reaching the 80% reduction target (by 2036 to 2039) • We will produce minimal waste and be meeting national waste targets • Our current and new infrastructure will be sustainable, and resilient to the impacts of a changing climate • Patients, staff and the public will benefit from flourishing grounds and outdoor spaces	1: Deliver our Estates Decarbonisation Strategies for each site 2: Achieve key standards in the delivery of all new capital projects (e.g. BREAAM and NZBS) 3: Deliver national Clinical Waste targets 4: Develop and implement group wide protocols/plans for responding to climate emergencies 5: Implement a group biodiversity management plan 6: Integrate sustainability into the delivery of food and nutrition	1. Net zero carbon emissions targets 2. Net zero building standards 3. Clinical waste segregation targets
Travel and transport	• We will transition to an electric fleet, generating minimal harmful air pollution • We will promote virtual care where possible • We will promote zero emission travel for staff, patients and the public	7: Progress the transition to low carbon transport by implementing an electric fleet 8: Promote active travel for staff, patients and the public	7. From 2028 all new vehicles owned/ leased by the NHS will be zero emission vehicles
Clinical provision	• Outstanding care will be provided across the Group in a financially and environmentally sustainable manner • We will have minimised the environmental impact of the medicines and care we provide	9: Support our clinical and operational teams to consider sustainability in their delivery of care 10: Implement plans to optimise sustainability in pharmacy	10. NHS contract includes specific requirements to reduce piped nitrous oxide waste, and also for providers to reduce the proportion of desflurane to all volatile gases used in surgery to 2% or less by volume
Supply chain and procurement	• We will reuse and repair everything that can be reused and repaired • Our hospital supplies will be sourced from environmentally friendly suppliers who can demonstrate a commitment to achieving Net Zero Carbon • We will be applying the principles of a circular economy in all our procurement decisions i.e. avoiding single use equipment and buying reusable goods	11: Build sustainability requirements into procurement processes and contracts 12: Review all goods purchased against key sustainability criteria	11/12. From April 2028 all NHS suppliers will be required to publicly report targets, emissions and publish a Carbon Reduction Plan for global emissions aligned to the NHS net zero target

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Enablers

Quality and Digital Strategies

- This Green Plan will support delivery of the Quality Strategy, specifically the priority domain of "sustainably resourced". We will implement the principles of ISO14001 to ensure the consistency and rigour in developing appropriate management systems
- The Digital Strategy will align with the Green Plan in terms of leveraging the benefits of digital innovation e.g. use of patient apps to encourage patient access and communications

Workforce

- We will ensure all staff have the opportunity to access a Group programme of sustainability training and education from Board level down, this will be role specific and key to increase education and raise awareness in clinical and corporate teams
- We want staff to be enabled and empowered to take personal responsibility for ensuring sustainability in everything they do
- Workforce enablers will involve ensuring the sustainability team is fully recruited to enable ongoing Green Plan delivery
- Working in an integrated way with the Group Communications team will be vital to share sustainability messaging also
- There is also a key link into wellbeing and Health and Safety teams to align sustainability messages and promote the importance for workforce wellbeing

Partnership approach

- We will work closely with other stakeholders who utilise our estate or where we lease estate, particularly with St George's University of London as they merge with City, to ensure we are delivering against our sustainability vision in a collaborative manner
- We will also work closely with colleagues at SWL ICB, the London Sustainability team and national Greener NHS team to deliver our plan

How do we get there?

Group Green Plan

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

Implementation approach

Implement-ation

- We will develop a road map of the high-level milestones for achieving the strategy phased over the four years of delivery
- Implementation will then be delivered through annual action plans for each year of the strategy which will contain the detailed actions required to step gesh towards delivering key strategic objectives in each of the four domains
- Work to define the financial cost/ benefit analysis of actions will be a key part of implementation planning to ensure financial benefits are derived through implementation

Evaluating impact

- A scorecard/ dashboard will be developed with key metrics to track progress and impact such as:
  - Air quality improvements
  - Carbon Emissions
  - Efficiency savings
  - Sustainable procurement

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

Implementation approach

Governance

- There will be a gesh Green Plan Steering Group providing oversight for delivery of the gesh Green Plan
- Progress in each of the four domains will feed into this Steering Group
- The gesh Steering Group will report into the Group Executive meeting and then up to the Infrastructure Committee-in-Common
- Each site will progress delivery of local actions through existing governance meetings
- Progress against key elements of delivery may also be fed into external governance structures for e.g. South West London Procurement Partnership

Glossary of terms

Group Green Plan

Glossary

BREEAM	Building Research Establishment Environmental Assessment Method
EV	Electric Vehicle
ICB	Integrated Care Board
LCSF	Low Carbon Skills Fund
LEV	Low Emissions Vehicle
NOx	Nitrous Oxide
NZBS	Net Zero Building Standards
NZC	Net Zero Carbon
PSDS	Public Sector Decarbonisation Scheme
SECH	Specialist Emergency Care Hospital
TIVA	Total intravenous anaesthesia
ULEZ	Ultra Low Emission Zone
ZEV	Zero Emissions Vehicle