Group Board

Agenda

Meeting in Public on Thursday, 07 November 2024, 10:00 – 12:30

Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:00	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	Chairman	Approve	Verbal
	1.4	Action Log and Matters Arising	Chairman	Review	Verbal
10:05	1.5	Group Chief Executive Officer's Report	GCEO	Review	Verbal

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

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11.05	3.1	Interstitial Lung Disease at ESTH	GCMO	Review	Report
11:15	3.2	Maternity Services Report	GCNO	Review	Report
11:35	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report
11:55	3.4	Finance Report (Month 6, 2024/25)	GCFO	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**

-	4.1	Group Learning from Deaths Report, Q4 2023/24 and Q1 2024/25	GCMO	Note	Report
	4.2	Healthcare Associated Infection Report	GCNO	Note	Report
	4.3	Equality, Diversity and Inclusion: • WRES Action Plan • WDES Action Plan	GCPO	Note	Report

Closing items

Time	Item	Title	Presenter	Purpose	Format
12:00	5.1	New Risks and Issues Identified	Chairman	Note	Verbal
	5.2	Any Other Business	All	Note	Verbal
	5.3	Reflections on the Meeting	Chairman	Note	Verbal
12:10	5.4	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
Claire Sunderland Hay	Non-Executive Director - SGUH	CSH
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	GDDCA
Kelly Brown	Senior Corporate Governance Manager (minutes)	KB
Apologies		
Observers		

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

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

Minutes of Group Board Meeting

Meeting in Public on Thursday, 05 September 2024, 9.45am–12.50pm

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Director of Infrastructure and Estates	GCDIE
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
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
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Victoria Smith*^	Chief People Officer	CPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Stephanie Sweeney	Group Director of Quality and Safety Governance *(deputising for the GCNO)*	GDQSG
Philippa Tostevin	Non Executive Director = SGUH	PT
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
IN ATTENDANCE		
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Claire Sunderland-Hay	Associate Non-Executive Director Designate	CSH
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy and Integration	GDSI
APOLOGIES		
Arlene Wellman	Group Chief Nursing Officer	GCNO

** 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 Epsom Hospital. These included: **Emergency Department: James Blythe, Ann Beasley, Derek Macallan, Claire Sunderland-Hay:**

The group fed back that they had met with the 'streamer' who decided where patients should be directed and this seemed to work well. They had asked about mental health patients attending the ED and been told that there were 5 patients in a dedicated space. In the main ED they had spoken with one of the consultants who had raised dignity and privacy as the key concerns. Staff had also raised infection control as a significant concern, an example of which was the trolley space in front of the desk which was an area of higher high infection risk.

The Department was clean and clear with fire exits marked but it had been noted that micropore tape was being used on the isolation room electronic door which was not suitable.

Lots of single points of failure had been noted such as EMED, the transport provider, not accepting patients after 5pm and nursing homes not admitting after 7pm.

Board members had spoken with the relative of a patient who had been in the Department overnight and had fed back that they were ok with the care provided but had commented that the food needed to improve.

Gloucester Ward: On visiting Gloucester Ward, boarding had been raised as staff felt that patients did not always meet the criteria for boarding but the Ward was still required to take them. Staff commented that they did not think that communication on boarding had been well done and there had been little notice.

Board members reflected that despite this, staff were pitching in and doing their best. Ann Beasley commented that the visits had made the pressures in the ED real, the stress was palpable, which you could not get simply from reading the Board and Committee papers.

Maternity: Vicky Smith, Tim Wright and Martin Kirke

Martin Kirke reported that the staffing levels were good with individuals stating that they did not feel the financial constraints were having a negative impact on care. One person had mentioned the number of referrals coming from St Helier without additional funding. The number of older patients who had a higher level of risk of complications were also not supported by additional funding. Tariffs had not changed for some time.

There had been very good security and monitoring, which had been increased due a vulnerable patient. Board members had met with the safeguarding lead who gave a very good presentation.

James Blythe added that safeguarding referrals had gone up to mirror the socio-cultural complexities. There were advance meetings with the Surrey team to avoid issues at birth.

The lack of a second obstetrics theatre was raised as an issue but it was noted that the plan was to provide this in Q4 of 2024/25.

Tim Wright noted the number of births with 1800 at Epsom, 2300 at St Helier and 4500 at SGUH each year. The environment in maternity had been pleasant with one birthing suite already refurbished with plans in place for a second. There were two bays in the triage facility and staff had raised whether these could be better utilised.

Casey Ward: Richard Jennings, Yin Jones and Andrew Murray

Yin Jones fed back that Casey was a nice ward – light and airy and with a playroom. They met with two members of staff, one who had worked at Epsom from 32 years and another for 21. They had also spoken with a consultant. During the summer months there were 12 beds and 3 nurses and in winter, 16 beds and 4 nurses with patients staying between 1 and 150 days. The increase in the number of patients with mental health issues was noted.

Andrew Murray added that the ward had capacity for 22 beds. He commented that it did not seem that there was a lot of joined up working across the Group. The rise in mental health issues was a concern, with agreement that this was not the best place for those patients as they needed specialist mental health support.

Richard Jennings said it was important that the Group Board looked at fire safety as part of these visits. The Grenfell Inquiry findings provided a good opportunity to review how this was done.

In response to the observations about Group-wide collaboration, the GDCEO commented that work on a Group-wide paediatrics strategy and collaboration was planned.

The MD-ESTH said that the open bed levels on the ward had been carefully calibrated to respond to the higher need in winter so these levels were intentional. He noted that as well as being able to open 22 beds at Epsom there were 24 paediatric beds at St Helier.

Ophthalmology: Jacqueline Totterdell and Phil Wilbraham

Phil Wilbraham said that they had warmly greeted and the staff member had welcomed the opportunity to meet the GCEO. The department was clean, tidy and well organised with lots of patients waiting. There was a mixture of outpatient referrals and walk in patients from across South West London with different patient pathways to choose.

They heard about the role of nurse specialists in carrying out eye injections with 13 appointments each in the morning and afternoon. These injections were previously done by consultants but there had not been any additional nursing support now that nurse specialists had taken this on. They had also talked about continuous improvement and it was useful to have the context. Issues with patient transport were a concern – one patient had arrived at 10am and had still not been collected by 5pm when the department closed with a staff member paying for a taxi for the patient.

There were no beds in ophthalmology so patients who came in by ambulance had to be treated on a stretcher. Patient transport crews would not wait so this was a stressor on the workforce.

Everyone they met said they enjoyed working in the department and there was good leadership and team spirit. Staff had fed back that they would like more room as planned additional space had been taken up by a lift. There were pinch points with flow given only two rooms were available.

Jacqueline Totterdell added that the department felt well led and had low turnover. Patient transport was clearly an issue and one that harmed patients. The Surrey Heartlands Integrated Care Board (ICB) was an important partner in helping to fix this.

The MD-ESTH said that ESTH used to run the transport directly but the ICB had recommended a new contract with EMED. There had been a number of challenges with this, mostly with patients returning home as EMED would only accept bookings up until 5pm although the service itself ran until 11pm. The ESTH crew had been brought back into for 2 months to help and he had met with the ICB to try and discuss the EMED issues. Performance in relation to Renal transport had begun to drop off recently.

Recording of problems was a concern as it was important that such incidents were recorded on Datix, but EMED had their own patient incidents system. South West London had also approached the ICB about the problems.

The Chairman noted that it was good for the Group Board to be sighted on these issues.

Urology Centre: Gillan Norton and Philippa Tostevin

Phillipa Tostevin fed back that it had been a positive visit. The receptionist had been welcoming and considering it had last been refurbished in 2016, everything looked clean and fresh. The amount of equipment, which increased the fire risk, was noted. Storage was an issue.

Day surgery was being carried out, developing new procedures and saving money.

Everyone the Board members had met had been positive, but staff had said they would like more time for training. With new procedures being introduced there was a need for consultants to be able to do training. Staff also reported that they would like more time to discuss cases. Transport had been raised – the department closed at 5.45pm but some patients were having to stay all day or overnight.

Appointments were booked by GPs but the system had changed and led to some confusion for patients, sometimes arriving at the wrong hospital. It was noted that the waiting room was cool but the office very warm.

The Chairman added that she had been struck by the increasingly complex procedures that were being carried out, with the radiographer explaining how kidney stones were treated. Nurses were increasingly being trained to take on more procedures, which they were positive about. Team work was a strength.

The GDCEO said that urology at gesh was forward thinking in the way clinical skills from ESTH could be used across the Group. There were a wide range of cases with an almost equal number of men and women being seen.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting. Professor Philippa Tostevin, Head of the Centre of Clinical Education, Institute of Medical and Biomedical Education, was introduced. Professor Tostevin had been appointed by City St George's as the interim replacement for Jenny Higham as the University-nominated Non-Executive Director on the Board of St George's University Hospitals NHS Foundation Trust until the new Executive Dean of the School of Health and Medical Sciences was in post in the new year. The Chairman explained that the significant majority of Professor Tostevin's Fit and Proper Persons checks has been completed; the only outstanding check was the media and social media check and this was expected to be received imminently. All other checks had been received and were clear. Given Professor Tostevin's role at the University and in the hospital , where these checks would have previously been carried out, it was felt that there was minimal risk, and given the importance of City St George's University being represented at this time following the recent university merger, the Chairman proposed that Professor Tostevin join the meeting as a full Non Executive Director (NED) ahead of the final confirmation of the FPP and that her interim term of office as NED be commenced. SGUH Board members approved this proposal. Claire Sunderland-Hay was welcomed to the meeting as observer. Claire would join the Group Board as an Associate NED at SGUH once all Fit and Proper Persons checks had been completed. Mark Bagnall, Group Chief Infrastructure, Facilities and Environment Officer, Victoria Smith, Group Chief People Officer and Liz Dawson, Group Deputy Director of Corporate Affairs, were also welcomed to their first meetings. It was noted that Stephanie Sweeney was representing Arlene Wellman. Apologies were noted from Arlene Wellman and Thirza Sawtell would be joining the meeting late.	
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, Mark Bagnall, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Victoria Smith as Executive Directors. Yin Jones declared that she had been appointed as a member of the General Pharmaceutical Council Fitness to Practice Board. There were no other declarations other than those previously reported.	
1.3	**Minutes of the Previous Meeting**	
	Subject to the addition of Yin Jones as an attendee of the visit to the Rose Centre, the Minutes the Group Board meeting on 4 July 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 with any outstanding actions not due until November.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO updated the Group Board on the following issues: • **August Riots**: The GCEO shared that herself, the Chairman and a number of Executive Directors had met with the staff Reach Network following the rioting that had taken place across England the previous month and had heard how vulnerable staff members felt, mainly in their communities, but on occasion in the workplace as well. The Network had heard from staff members who had received appalling racist abuse on the hospital site in the wake of the riots. Although the unrest had settled down it had given fresh impetus to continue the work on equality and inclusion. The Workforce Racial Equality Standard (WRES) report, which would come to a future meeting of the Group Board, demonstrated that progress was being made but there was a need to re-focus on driving forward the Group's work to address racism and to promote inclusion. • **gesh 25**: The first of a series of events to recognise staff who had worked for the NHS for 25 years or more had been held in August with more than 30 colleagues receiving certificates followed by an afternoon tea for them and their guests with the CGEO, Chairman and other senior staff. There would be other events in the future so that all colleagues who had reached this milestone could be celebrated. • **High Performing Teams:** The GCEO had joined Site teams in their weekly huddles which used visual management boards. These discussions based on data, had improved communication and created a clearer understanding of priorities. Data was now being collected from all parts of the organisation and analysed by the Executive team. This would help 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 was an ongoing piece of work and the Group Board would be updated on progress.	

	Industrial Action: In response to a question from Peter Kane regarding industrial action, the GCEO noted that the junior doctors were yet to accept the recent pay offer although it was hoped that they would. It was acknowledged that there had been some valuable learning during strikes on ways of working that could be used at all times. The MD-SUGH said that this had been particularly evident in the ED and was being looked at in more detail. The pressure on consultants during this time had been relentless and although there had been some tensions, everyone had stepped up. The MD-ESTH concurred that there had been some ways of working that could continue, most notably at the 'front door' of the hospital and how patients were admitted. There had been more consultant-to-consultant communication particularly for patients within ED which had been positive. Other clinical professionals, such as Physician's Assistants (PA) had been working at the very top of their licence – although there was still some contention around the PA role, these were an important part of the New Hospitals Programme. The MD-ESTH said that it was important for junior doctors to feel connected to the hospital and so he, or a representative, attended their induction so that they knew they were both seen and heard by senior staff. The GMCO said that although pay was an important issue, more needed to be done to ensure that junior doctors felt valued. Junior doctors had more constraints and rigidity in their training, for example with location and only one year spent in each place – this meant that engagement with the organisation needed to be more specific. He concluded by saying that despite the industrial action, junior doctors had never 'left the fold' and there had been talk about the future after strikes. It did, however, have to be recognised that patient safety had been negatively impacted by the industrial action, as while the Group had done everything it could to keep patients safe during these periods the scale of cancelled procedures and appointments meant that patients were waiting longer for the care they needed and there was potential harm in this. **Mental Health and ED:** Under paragraph 2.2 of the report, Martin Kirke raised the issue of the high numbers of patients with mental health issues attending ED when this was not the setting best suited to their needs. He asked about system level space plans. The GCEO responded that there had been discussion on whether dedicated mental health space could be co-located within ED but this was not feasible. She had therefore re-commenced discussions with South West London and St George's Mental Health NHS Trust on what resource would be of most benefit to patients. These discussions were at a very early stage and a further update would be made in due course. **Principal Treatment Centre for Children's Cancer (4.1):** Ann Beasley asked whether there was a timeline for a response on the location of the Children's Cancer Centre. The GCEO explained that this was still with the Secretary of State with no timeline provided. The Chairman noted that the most recent publicity had been focused on SGUH and the Royal Marsden, but the outcome of the Secretary of State's decision could only be conjecture at this stage. **The Group Board noted the Group Chief Executive's Report.**	
2.0	**ITEMS FOR ASSURANCE**	

2.1	Quality Committee-in-Common Report

Andrew Murray, Chair of the Quality Committees-in-Common, presented the key issues considered by the Committees since the last Group Board meeting in July:

- **Emergency Departments:** All three Emergency Departments across the Group were continuing to operate under huge pressure and it was agreed by the Committees to be the biggest known patient safety risk. Issues ranged from the number of patients, the environment within the departments, and, as had been discussed earlier in the meeting, the increase in patients with mental health concerns who needed specialist mental health care. There was also an inability to discharge patients due to delays in care packages and continuing financial pressures in social care.

  The Committees had received assurances around the actions that were being taking with it being noted that, particularly at SGUH, there was more to be done.

- **Interstitial Lung Disease (ESTH):** This item was being monitored at each meeting with a report coming to the Group Board meeting in private later.

- **Maternity Services:** The Committees had received assurances on the progress on the actions within the maternity service. Although the Committees could identify from the narrative that progress on the actions was being made, there was a lack of specificity in the report to evidence this. As a consequence, the Committees had retained the assurance level at 'limited'. Changes were to be made to the report to address the comments from Committees and support them in their assurance review.

- **Patient Safety Report:** The report had been received with the Committees focusing on evidence of learning from incidents. It was concluded that although there was a reasonable level of assurance across the group, the Committees would like to be able to see more evidence of embedding of learning in the future.

- **Robotic Surgery:** The Committees had received assurances around robotic surgery at SGUH following an incident at Kingston Hospital NHS Foundation Trust. The Committees had a reasonable level assurance and believed the service to be well governed.

During discussion the following points were raised:

- In response to a question from Phil Wilbraham, the GCEO said that a London-wide strategy for robotic surgery was being developed, which was likely to be completed in the next 6 to 12 months. This would set the framework for the adoption of robotic surgery more widely. She acknowledged, however, that new surgeons had an expectation that they would use robotic surgery and were being trained in this.

- The GCMO confirmed that some patients with interstitial lung disease (ILD) were being recalled to ensure they were on the right treatment. This would be completed by the end of the month.

- The GMCO noted that safety within the ED was a shared concern with overcrowding and corridor care the main issue issues. A number of senior clinicians at SGUH had raised their concerns externally with the Care Quality Commission, having informed senior leaders first. The GCMO

	wanted to publicly thank those clinicians for the ethical and professional way they had approached the issue. This was endorsed by the Board. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in August 2024.**	
2.2	**Finance Committees-in-Common Report**	
	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in July and August. Both Trusts remained on plan for the year but this had only been achieved by bringing forward non-recurrent benefits earlier than scheduled. More information would be provided in the private session, but the scale of the challenge and the risk to the delivery of the plan should not be underestimated. The cost improvement plans (CIPs) had made good progress in identifying savings but the Committees had noted that there needed to be a focus on delivering these plans as well identifying new areas that could be addressed now, rather than in the future. Making savings impacted on cash management but Ann Beasley assured the Group Board that there would always be sufficient money to pay staff but there needed to careful cash handling. The South West London (SWL) Medium Term Financial Model (MTFM) had provided a framework but the Group wanted to look further ahead than this at some of the underlying drivers of the SWL financial position. The Committees had also looked at the performance of ED as well as the target of not having any patients waiting longer than 65 weeks for Referral-to-Treatment Time (RTT). It was anticipated that this would be met in the majority of cases by the end of September. The Chairman invited comments and questions from the Group Board. On the 65 week wait target, the MD-SUGH said that for SUGH, they were working with partners to make progress on this. **The Board:** • **Noted the issues considered by the Finance Committees-in-Common at its meetings in July and August.**	
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 Committees in August 2024: • The implementation plan for the new Group People Strategy had been reviewed by the new GCPO, with thanks due to her for the speed at which this had been done. It had been noted that the earlier areas of implementation had not gone as well as hoped because it had been reactive rather than looking at the root problems and with a focus on actions rather than results. • The Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports had been reviewed, with the NHS well ahead with work on these areas with lots of data available. Sustained	

improvement would take years but the changes at ESTH in particular were commended.

- Employee Relations practice was being reviewed, targeting disciplinary and grievance, with a strategy focused on getting the basics right. There was more to be done but the Committees were encouraged that things were heading in the right direction.

The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion:

- Ann Beasley remarked that the financial aspect of sickness absence had been raised at the Finance Committees-in-Common and asked about the role of line managers in addressing sickness absence and whether the sickness absence policy supporting them had been considered by the Committees.
- Martin Kirke responded that the internal audit reporting on sickness absence and process and polices was of high quality. However, the return-to-work process led by managers was not shown in the audit process so it was not clear that this was being done. Managers often cited time pressures as a reason for these meetings not taking place. There was a CIP on sickness absence with some good work being done on patterns of short-term sickness. A change in culture should also be looked at as there might be a perception that sickness absence was not a problem, but it did drive costs.
- The GCPO said that since joining the Group there had been a lot of conversations about sickness absence – this was a multi-disciplinary challenge not just one for HR. Specific issues were being targeted and she would report back in due course.
- The GCEO assured the Group Board that sickness absence was talked about at Group Executive meetings. One issue was that some managers were not yet equipped to have difficult conversations and did not feel confident in striking the balance between being compassionate and following up on absence. Managers needed to be able to have these discussions without relying on support from HR. Sickness absence had a financial impact and caused additional stress for colleagues. The issue had got worse since Covid and although it was essential to be kind and respectful, people had to be held to account.
- The Chairman commented that the NHS was behind the curve compared to other sectors in ensuring that managers were equipped to deal with these matters without HR support.
- Martin Kirke noted that it had been raised that some managers had reported feeling concerned if approaching a BAME colleague over absence, and that they may be accused of discrimination. The HR team were looking at how this could be addressed.
- Martin Kirke acknowledged the work the new GCPO was doing and the rigour she had brought.

The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in August 2024.

2.4	**Infrastructure Committee**

Ann Beasley, Chair of the Infrastructure Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in May and July.

The Committee, which covered both IT and Estates was struggling to find a rhythm on what it needed to cover and how often it should meet but some good work had been done on assurance of in-flight topics such as the Electronic Patient Record project (EPR), the introduction of which had been delayed. The Committee were confident in the new plans and that the EPR would be delivered next year.

Less progress had been made on strategic topics such as digital, where there was more work to be done, but it was starting to take shape.

On Estates, the Committees' role in assurance around this area still needed to be worked through with a framework being developed. At the moment there was too much data and it was necessary to identify exactly what assurances were needed at Committee level and how this should be provided. The recent arrival of the GCIFEO would assist with this.

On Building Your Future Hospitals (BYFH), further work was needed to explore risks in any potential delays to the new hospital build and any impact on the retained estate, particularly given the condition of the estate at St Helier Hospital. A plan needed to be developed as some buildings would reach the end of their life in 2030.

The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion:

- Tim Wright acknowledged the huge challenge in Estates and IT where more was expected with less money. In any strategy, there needed to be a balance of proactive and reactive activity. As much as possible was being done on cyber security and the Group was aligned with NHS good practice.
- The GCMO raised the issue of fire safety and the lessons that could be learned from the Grenfell tragedy. His experience was that there were a lot of thoughtful and diligent people looking after fire safety and on the small number of occasions he had identified a potential issue the team had been very responsive which was reassuring. Senior leaders needed to be very alert to fire safety risks and suggested that a piece of work was needed on how the Group Board reviewed this area.
- Yin Jones asked whether gesh was working with partners in South West London on a green strategy or whether we were further forward. Ann Beasley responded that the Green Plan was gesh specific but collaboration with South West London would take place where it was helpful and did not cause delays.
- The MD-ESTH said that with the arrival of the new GCIFEO this was an opportunity to inform the issues around the retained estate at ESTH and how best use could be made of it. The 6 Facet Survey that was underway would provide information and assurance. Fire safety was highlighted both as part of business as usual controls with any legislative changes kept under review. The new Building Safety Act was adding both time and costs but would make the new build safer.

	• The Chairman noted that a lot of risk was being carried in relation to the new build and future capital investment was something that needed to be looked at. • The GCIFEO gave his initial impressions on joining the Group saying that there was lot be done. He believed that fire safety at SGUH was well managed but the fire safety team could be more challenging. Other areas were less well structured and work was needed to ensure everyone was operating at the right standard. The 6 Facet Survey was a valuable tool but should be combined with our own views – prioritisation would be needed based on risk. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in August 2024.**	
3.1	**Group Maternity Services Report**	
	The GCMidO thanked the Quality Committees-in-Common for their feedback on how the report was presented and she would be working with Andrew Murray, Committee Chair, and the GCNO to address this ahead of the next meeting. She highlighted the following: • Good progress was being made on the Safety Actions, with Action 3 challenging but not insurmountable. The transitional care action was a process issue as this needed better recording. • Safety Action 6 was also challenging but would be achieved. • Safety Action 8 was a risk as there was low compliance levels with medical staff particularly in new born life saving. The GCMO said that there had been an improvement in completion rates for mandatory training for medical staff but more needed to be done. • The 90% staffing level was yet to be achieved at SGUH, with it currently in the low 80% range. • It had been decided to pause the UNICEF Baby Friendly Hospital initiative. ESTH had already achieved 'gold' and SGUH at level 3, one below 'gold'. This was because of the capacity needed to do this work alongside the CQC actions. • The lack of a second theatre at ESTH was an ongoing risk. The mitigations were set out in the report. • At SGUH, staffing was the key risk, with challenges regarding sickness absence and onboarding. The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion: • Ann Beasley asked whether there were any consequences to pausing the UNICEF accreditation. The GCMidO explained that there was prestige in holding the award and ESTH was the only London trust to achieve it, but this should be balanced against the staff time involved in the administrative aspects. The award looked at awareness of breastfeeding and supporting women, but the audit workload was a distraction. • In response to a question from Phil Wilbraham, the GCMidO said that there were regular meetings with the CQC, who were content with progress on	

	the actions, but there had been no indication of when the follow up inspection might be. • Philippa Tostevin noted that City University, which was now part of City St George's had a midwifery BSc and queried whether joint working could address some of the staffing issues. The GCMidO responded that at present student midwives were not placed at SGUH by City but she would follow this suggestion up. **The Board reviewed and noted the report.**	
3.3	**Integrated Quality and Performance Report**	
	The GDCEO presented the highlights from the Integrated Quality and Performance Report (IQPR) which had been presented to the Quality Committees-in-Common the previous week. The GDCEO made the following observations: • There had been an in-depth review of Emergency Department metrics looking at performance, quality and safety and how there could be collaboration with out of hospital care. • Operational performance was the second review area which had been considered by the Finance Committees-in-Common with a focus on progress towards the 65-week waiting time target. At ESTH the risk of not achieving was in gynaecology and, at SGUH, in neurology. On cancer national standards, ESTH had delivered against all three targets in June, but the picture was mixed at SGUH with a recovery plan in place for Breast cancer. The Chairman invited comments and questions from Group Board members and the following issues were raised and noted: • The MD-SGUH stated that the 65 week wait from RTT would be largely met with approximately 20 neurology patients being outside this. Achieving the 52-week RTT target was now the focus. • On the 65-week wait, the MD-ESTH said that weekly monitoring was taking place but there was a small number of gynaecology patients would be outside of this target. • It was agreed that although in some cases the RTT target would not be met because patients had delayed their treatment, this should not be seen as patient 'choice' as they had already waited more than 52 weeks and may not wish to postpone other plans they had made. • The MD-ESTH said that it had been useful to the hear the visit feedback on boarding as the communication around this had clearly worked better for some wards than others. Greater clarity on why a patient met the requirements for boarding may be needed. The GCMO noted the comments from ward staff on boarding, which would be addressed, as the ED team reported that it had greatly improved patient flow. • The MD-IC highlighted the need to strengthen partnership working on out of hospital care. • It was noted that delays with discharge were a persistent problem and all opportunities for using the discharge lounges had to be used. **The Board reviewed and noted the report.**	

3.4	**Group Finance Report (Month 4 2024/25)**	
	The GCFO reported that both Trusts were on plan at month 4 with deficit positions. Cash remained tight and there would need to be a bid for additional funding in Q3 but the process for doing this had not yet been published. The workforce plan and CIP development at the levels established was a challenge due to baseline pressures and would be hard to achieve. This was a material risk to the delivery of the plans. The Chairman invited comments and questions from Group Board members and the following issues were raised and noted in discussion: • In response to a question from Andrew Murray, the GCFO said that a request for additional funding could lead to NHS England review if the Trusts were significantly adverse from their plans. **The Group Board noted the Month 4 2024/25 financial positions for SGUH and ESTH.**	
4.0	**ITEMS FOR DECISION**	
4.1	**Group Pharmacy Strategy**	
	The GDCEO reminded the Group Board that this was the first clinical service to have a Group-wide strategy. It had been co-developed and endorsed by both Trust Chief Pharmacists, with the Site Chief Medical Officer for Epsom and St Helier acting as the Senior Responsible Officer (SRO) for the pharmacy collaboration and integration. The strategy had been considered in detail at the recent Board Development Day where the opportunities for research, resilience and best practice had been discussed. Quality of care benefits, including reducing length of stay, and a positive impact on staff recruitment were also aims of the strategy. The Chairman recorded thanks to both Chief Pharmacists, noting that the strategy gave a real articulation of the work to be done. Comments and questions from Group Board members were invited and the following issues were raised and noted in discussion: • Andrew Murray believed it to be a good strategy but suggested but it could be explicit on how it would help address health inequalities and how it would support reducing delays in discharging patients with Take Out Medications (TTO). Both acute Site Managing Directors acknowledged the TTO issue but felt that this was more related to delays in writing prescriptions. The MD-SGUH said that at SGUH there was a very good pharmacy team with a large number of pharmacists who could both write and transcribe prescriptions. • The GCEO reported that 50% of prescriptions were uncollected so they were often not prepared until the patient arrived at the pharmacy. • Peter Kane commented that the timescales for the implementation of the strategy and an end date were unclear, with Derek Macallan adding that adoption of new technologies and use of digital did not come across strongly in the strategy.	

	• The GDCEO responded to the points raised, explaining that, following the adoption of the strategy, the implementation plan would be developed and shared first with the Executive Collaboration Group and then the Group Executive and Quality Committees-in-Common. He believed that the strategy would improve outcomes, lead to more resilient staffing, reduce the length of stay and support the aim of 'right first time'. The aim of having equity of outcomes was clear but it would be more of a challenge to be explicit about this strategy could help to address health inequalities but this was implicit in all gesh work. **The Group Board approved the Group Pharmacy Strategy.**	
5.0	**ITEMS FOR NOTING**	
5.1	**Fit and Proper Person Test Compliance Report, 2023/24**	
	The GCCAO explained that the report provided assurance to the Group Board that all Board Directors at both Trusts within the Group were 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 had successfully undergone all of the required checks under the Fit and Proper Persons Test Framework in 2023/24 and the required submissions had been made to NHS England. The required Board Member References had also been completed for departing Board members in line with the requirements of the Framework. The GCCAO assured the Board that FFPT checks had been completed for one new Non-Executive Director at ESTH and one interim Executive Director at both Trusts in 2023/24. Beyond the reporting year (2023/24), two further Board members (both Executive Directors with appointments at both ESTH and SGUH) had joined the Trusts, and the relevant FPPT checks had been satisfactorily completed. The GCCAO noted that the process of undertaking the checks had not been as smooth as he would have liked as the external background checking company used by South West London Recruitment had been changed, without notice, part-way through the checks which had necessitated re-checking with the new provider. In addition, some of the standard checks undertaken by the new provider went beyond the level of detail that was required for the FPPT and this had caused some delays. The GCCAO added that, for 2024/25, the intention was that annual FFPT compliance checks, including DBS checking, would be aligned with the annual appraisal process. The Chairman thanked the GCCAO for what was a huge piece of work, noting that there had been some historic challenges with FPPT testing at SGUH in 2016/17 and, in light of this, additional vigilance had been particularly necessary. **The Group Board noted the report.**	
5.2	**Quality and Safety Strategy**	
	Having been approved in private session in July due to purdah, the Quality and Safety Strategy was noted.	
5.3	**Group Green Strategy**	

	Having been approved in private session in July due to purdah, the Group Green Strategy was noted.	
6.0	**CLOSING ITEMS**	
6.1	**Any new risks and issues identified**	
	No new risks were identified, however the GCIFEO was asked to review the wording of the fire safety risk items on the risk register.	GCIFEO
6.2	**Any other business**	
	There were no other matters of business.	
6.3	**Reflections on meeting**	
	The Chairman asked Victoria Smith (GCPO) to give her reflections, given this was her first meeting. The following observations and reflections were offered: • The GCPO reflected that she had been struck by the exceptional degree of transparency and openness which aligned with the organisation's aim of working in an ethical way. She had found the visits that had taken place ahead of the meeting to be useful and important learning and the staff had also been open, friendly and welcoming. The challenge of making the system work end-to-end was clear but she felt the discussions during the meeting had a nice balance between the operational and strategic. The GCPO said that to have attendees, such as the Head of Midwifery, present and hear first-hand the challenges was valuable. • Tim Wright added that he felt the department visits at the start of the meeting and the patient story at the end worked well and kept the board grounded. There was a challenge in ensuring that in the limited time available at meetings there was proper assurance in public and that debate was not stifled but also recognising that matters had already been considered by the Committees-in-Common.	
6.4	**Patient Story**	
	Lauren and Tom Shine, with their baby daughter Leni, joined the meeting. Lauren explained that she and Tom had been expecting their third child in July 2022, when they learned that, at 26 weeks, baby Elle was diagnosed with mosaic trisomy 2, a rare chromosomal anomaly syndrome. They had been told that Elle's diagnosis was not compatible with life and as a result they had to take the difficult decision to terminate the pregnancy. Lauren and Tom had been impressed with the care they received and told their story to staff last year. The family felt the care was compassionate and beautiful and that Elle was treated with the utmost dignity, which was so important to the whole family including their children. They added: • Mosaic trisomy 2 is an extremely rare condition which meant that the only information that had been provided, or that they could find, was a single paragraph. This made it difficult for them and the person passing on the information.	

- They had not been clear that having made the difficult decision to terminate the pregnancy it would not happen immediately and they had to return the next day. However, they very much appreciated being able to go to St Helier for the procedure where their other children, and later Leni, had been born.

There had been some stand out points from their care including the decision about whether to see Elle following delivery and whether their children should see her. They had been very much encouraged to only take decisions when they needed to and staff gave them the respect, time and advice needed for them to make decisions when they felt ready. Both they and their older children felt very supported by staff.

When Lauren returned to St Helier in June 2024 to have Leni, it had been a positive experience of an elective C section. She felt that the continuity provided by the obstetric team and having the same midwife from 2022 had been very helpful. Lauren had had all her children at St Helier and could not praise the team enough.

Both Lauren and Tom shared that they felt there was little information provided for people in their specific position - knowingly terminating a pregnancy. They felt that there was lots of resource for people suffering a stillbirth or neonatal death, but not for someone undergoing an 'elective' termination in these circumstances.

Lauren had bought in some resources for the bereavement room that covered women losing babies under all circumstances. These had been added to over time by others.

Suzanne Powroznyk, Maternity Matron (Inpatient Services) explained the learning raised by the maternity team:

- The resources generously provided by Lauren and Tom had really helped staff guide women who were experiencing loss in all its forms and enabled open conversations surrounding how women feel when terminating pregnancies at a late stage.
- Caring for Lauren and Tom also provided staff with a unique learning experience as staff counselled them over whether their children should meet Elle after her birth. This was one of the first times that staff have had a family together post baby loss in such a way, creating memories together. This was an experience that was now discussed in teaching and in the induction of new staff.

On behalf of the Group Board, the Chairman thanked the Shines for sharing such a difficult and personal story.

The MD-SGUH asked the Shines if there was anything the SGUH team could learn. Lauren Shine said that this was not intended as a criticism but the room at SGUH in which they had been given the news was more of a large cupboard and perhaps consideration could be given to where this type of appointment was held.

The person who had handed them the sheet with the information was not aware of the situation which had made it a bit awkward for everyone.

Members of the Group Board reiterated their thanks to the Shines for talking so openly about their experience and for the learning this provided.

CLOSE
The meeting closed at 12.50 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) - 7 November 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
	2-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	7-Nov-24	GCPO	GCPO to provide verbal update at meeting.	DUE
	2-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.	7-Nov-24	GCCAO	The ED risks for SGUH was considered by the SGUH Patient Safety and Quality Group meeting in October 2024, and a proposal to create a new risk on the CRR for ED safety is to be considered by the SGUH Site team and then the Group Executive, and - subject to this - will go through the Quality Committees-in-Common in December 2024. The ESTH ED risk on the CRR is currently being reviewed by the ESTh Site team and any changes will be presented following Site review to the Executive and QUality Committees-in-Common in December 2024.	DUE
PUBLIC20240905.1	5-Sep-24	6.1	Any new risks and issues identified	The GCIFEO was asked to review the fire safety risks for both SGUH and ESTH.	9-Jan-25	GCFIEO	To be considered by the Infrastructure Committees-in-Common following Executive review.	NOT YET DUE
	4-Jul-24	4.1	Board Assurance Framework	Review the strategic risk score for SR2 prior to the next scheduled Board review of the BAF	9-Jan-25	GCCAO	To be considered as part of the next Board update on the Board Assurance Framework at the January Group Board meeting.	NOT YET DUE
	4-Jul-24	4.1	Board Assurance Framework	Consideration to be given to how partnership working comes through the Board in a more explicit way	5-Dec-24	MD-IC	To be considered as part of the December Board development session on community services.	NOT YET DUE

Group Board

Meeting in Public on Thursday, 07 November 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, 07 November 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 National and Regional Updates

2.1 2024 Autumn Budget

On 30 October, the Chancellor presented a one-year budget, referred to as Phase 1, which outlines the updated spending for 2024/25 as well as the planned funding for the following year. A longer-term Spending Review, known as Phase 2, is expected to follow in late spring.

As part of this two-phased Spending Review, the Chancellor announced a £22 billion increase in total revenue and capital funding for health and social care. NHS England's ring-fenced revenue budget will increase by 4.7 per cent this year to £181.4 billion, followed by another increase of 3.3 per cent next year to £192 billion. The overall health and care budget—which may be allocated additional funds for initiatives like reducing elective waiting lists—will see an increase of 3.8 per cent this year and 3 per cent next year.

Additionally, the health and social care capital budget will rise by 9.8 per cent this year and 12.1 per cent next year, amounting to an overall increase of £3.1 billion.

The Chancellor briefly mentioned the New Hospital Programme, stating that the Health Secretary will provide more details about his review in the coming weeks, with a publication expected in the new year.

2.2 Visit from the Chancellor and Health Secretary

On 28 October, Rachel Reeves, Chancellor of the Exchequer and Wes Streeting, Secretary State for Health visited St George's University Hospital to see our services and meet colleagues. I took them on a tour of the trauma ward and neuroradiology, where they had the opportunity to meet with nurses, doctors, and other staff members who spoke openly with both Wes and Rachel. This visit coincided with an announcement made the previous night regarding NHS funding. The plan aims to support the delivery of an additional 40,000 elective appointments per week, backed by £1.5 billion in new capital funding for surgical hubs and scanners, along with an extra £70 million for radiotherapy machines.

National broadcast media and health correspondents joined the visit, which has received significant coverage. Major outlets, including The Times, The Telegraph, and the BBC, reported on the event, highlighting concerns raised by staff about outdated medical equipment during the tour. The visit also served as a platform for discussions on addressing long-standing issues within the NHS, and further reactions and coverage are expected in the coming days.

I had a brief meeting with the Secretary of State for Health, during which I shared our concerns about the condition of our estate at St Helier Hospital. I emphasised that in the past year alone, we have cancelled 600 operations due to the ageing estate and there is a risk that parts of the St Helier Hospital estate become unfit for the clinical services they currently accommodate in the near future.

2.3 10-Year NHS Plan

The government plans to consult the public on its 10-Year NHS Plan, with the first face-to-face meeting for CEOs set for November 5, 2024. This follows the publication of the Darzi Review, which provided a preliminary assessment of the NHS since the current government assumed office.

Initial indications of plans underway are to transition from acute care settings towards more community-focused health and care services. There is also an anticipated emphasis on preventative measures, early interventions, and a significant shift towards digital technologies, moving away from traditional analogue methods to enhance service delivery and accessibility.

2.4 The NHS Sexual Safety Charter

In September 2023, NHS England launched its first Sexual Safety Charter, which aims to enhance staff safety and improve the workplace environment. This Charter includes ten principles that align with the upcoming amendments to the Worker Protection Act, set to take effect in late October 2024. Along with the Charter, the NHS introduced national guidance that includes a National Policy Framework and training materials to assist local employers in preventing workplace sexual harassment. This initiative is seen as the beginning of a crucial effort to eliminate inappropriate sexual behaviour within the NHS.

During our recent Executive Question Time, a monthly engagement event for all staff across our Group, we discussed our plans to address sexual harassment in the workplace. We will be organising training sessions and workshops to create a programme that aligns with the principles of the NHS Sexual Safety Charter.

2.5 System Changes

2.5.1. In September, Sarah Blow announced her decision to leave her position as Chief Executive of the SWL Integrated Care System at the end of March 2025. After more than 30 years with the NHS and eight years as Chief Executive of the SW London system, she is choosing to take early retirement.

2.5.2. Additionally, NHS England's Chair, Richard Meddings, has announced his intention to step down at the end of the financial year. During his remaining time, he plans to support the development of the 10-Year Health Plan and allow sufficient time for a successor to be appointed.

3.0 Our Group

3.1 Group-Wide Electronic Patient Record System

The new Group-wide Electronic Patient Record System (EPR), set to launch in May 2025, will represent the largest technological transformation in a generation. This significant step towards a more digital NHS includes the implementation of iClip PRO, which will upgrade our systems and connect our care across St George's, Epsom, and St Helier hospitals.

This upgrade will allow clinical teams to access the information they need with just a click. With the new system, redundancies will be minimised—patients will no longer have to repeatedly share their medical histories. We will maintain up-to-date patient records, enabling better coordination of care across various specialties. Moreover, with one secure system in place, we can share information across the Group safely. In the coming weeks, Subject Matter Experts from Epsom and St Helier Hospitals will conduct End User Testing at the Malvern Centre in Sutton. Staff will also be invited to participate in system testing and training opportunities.

3.2 Quality Governance Review

As you may know, in March 2023, the Care Quality Commission (CQC) conducted an unannounced inspection of maternity services at St George's University Hospitals NHS Foundation Trust, highlighting the need for significant improvements in areas like triage processes, environment, staffing, and governance. Consequently, the Trust received a Section 29A Warning Notice.

To address these concerns, we initiated a review of quality governance, focusing on enhancing ward-to-reporting processes and identifying weaknesses in governance structures. This review was divided into two phases: the first assessing maternity services at SGUH and ESTH, with initial findings and recommendations for a Group-wide Maternity Quality Governance Improvement Programme.

A second phase of work has been commissioned to assess the maturity of quality governance arrangements at the divisional level. For this pilot phase, three divisions—Integrated Care, SGUH Surgery, Cancer Neurosciences and Theatres, and ESTH Renal—were selected to test the approach. This review has concluded, and a final report with key recommendations will be presented to the Board.

3.4 Improving Our Finances

Improving our financial position remains a top priority. While our Group is largely on target year to date, we forecast significant challenges for the remainder of the year, as NHS England has made it clear that all Trusts must deliver on the initial financial plans set. To address this, we have opted to participate in the National Independent Investigation review process. We have engaged the consulting firm Deloitte to help us identify additional opportunities and areas of focus as we approach year-end.

On 29 October, the Deloitte team joined our Group Finance Recovery Board, which meets once a month, and we have established the scope of their work. Over the next four weeks, I have asked them to (i) Review our financial position at month six and identify the key drivers behind our year-to-date performance, (ii) Assess grip and control across both Trusts using the NHS England checklist as a guide, (iii) Identify weaknesses in our current financial plans, suggest corrective actions, and highlight opportunities; and, (iv) Conduct structured reviews to facilitate thorough analyses, including pay spend, CIP slippage and risk, and governance structures. I will provide an update on recommendations following this review.

4.0 Events, Visits, and Our Staff

4.1. Events

4.1.1. We have received over 500 nominations for our inaugural Gesh CARE Awards, including more than 60 nominations from patients and the public. These awards are a direct response to last year's NHS Staff Survey, which showed that our workforce wanted more recognition for staff achievements to value our colleagues throughout the Group. Nominations are open to all staff

and volunteers for 12 awards linked to our CARE strategy. I am pleased to announce that Myleene Klass, a television and radio presenter, musician, campaigner, and a celebrated star of 'Loose Women,' will be joining us to express our appreciation to the colleagues and teams who have made a significant impact. Myleene is a dedicated advocate for the NHS, inspired by her mother, Magdalena, who has served as a nurse for 40 years following her arrival in the UK from the Philippines in the 1970s. Invitations will be sent out in the next few days.

4.1.2. We are actively promoting this year's NHS Staff Survey to encourage all colleagues to share their opinions. Unfortunately, we have not yet met our response targets. Therefore, we continue to work with managers and staff to ensure that everyone understands the importance of their feedback. We have assured staff that every comment will remain completely anonymous, and we are committed to sharing how we will address key recommendations. Additionally, everyone who completes the survey will be entered into a weekly prize draw for one of ten £50 vouchers. We are also sharing information on our external channels to ensure that the communities of SWL have their say too.

4.1.3. This October, we also celebrated Black History Month by sharing blogs from staff on the theme of "Reclaiming the Narrative." Additionally, we held our first gesh-wide Workforce Race Equality Standard (WRES) Conference, featuring guest speaker Roger Kline. Kline co-wrote "Too Hot to Handle," a report investigating racism in the NHS. He, along with out our Group Chief Nurse Arlene Wellman and Managing Director-ESTH, led an interactive workshop with staff to discuss the root causes of racism, promote learning and understanding, and inspire actionable steps to address racism and foster equity and inclusivity at gesh.

4.2. Staff Recognition and Awards

Congratulations to two of our internationally educated nurses who have been named 'Rising Stars' in the Royal College of Nursing's 2024 awards in London. The Rising Star awards recognise nurses, midwives, nursing support workers, and nursing/midwifery students from the Black, Asian, and minoritised ethnic communities who have made outstanding contributions to health and care in London over the past year.

Mark Mencias, a Clinical Nurse Specialist, established a pioneering nurse-led neurogenetics clinic at St George's University Hospital for individuals living in South London, Surrey, and Sussex. This clinic provides access to genetic testing, allowing patients to discover more quickly whether their health issues stem from a rare neurogenetic condition.

Sumitha Janaky, a Practice Educator, has created a 24/7 support group for internationally educated nurses. This Group offers pastoral care and support for their wellbeing, including a dedicated WhatsApp group. The initiative has been praised for helping to retain staff after they arrive in the UK.

I look forward to seeing Mark and Sumitha continue to excel and inspire others within our Group as they develop their careers.

4.3. Visits

Local MP Bobby Dean (Carshalton and Wallington) visited St Helier, touring several areas including maternity, nuclear medicine, and the Same Day Emergency Care Unit. During his visit, he received an update on our plans for the new Specialist Emergency Care Hospital in Sutton as well as the upgrades to our current facilities.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 07 November 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 (QCIC) at their meeting
in October 2024 and the matters the Committees wish to bring to the attention of the Group Board. These include:

- **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. This had now been completed and a number of patients had now also been considered at MDT Meetings. An external review by an independent panel of assessors from the Royal College of Physicians had been commissioned. The GCMO would shortly be writing to the families of patients who had sadly died, and a support helpline had been set up.

- **Concerns regarding Safety in the Group's Emergency Departments:** There continue 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. Having considered intra-departmental challenges at the previous QCIC, the paper and discussion at the meeting focused on patient flow and what work was being undertaken to try and relieve these pressures. Support from system partners was a focus of discussion.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in October 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, 07 November 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 October 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 meeting on 31 October 2024 the Committees considered the following items of business:

October 24
• Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF) • Group Update on quality and safety within the Group's Emergency Departments – with a focus on Patient Flow • Group Maternity Services Report* • Interstitial Lung Disease (ESTH)* • Governance of Quality and Safety within Integrated Care (Community Services) • Group Update on Infection Prevention and Control • Group Integrated Quality and Performance Report* • Group Learning from Deaths Report* • Association of Perioperative Report – Theatre Safety – Update Report (SGUH) • Group Medicines Management Update • Group Annual Safeguarding Reports • Group, National Inpatient Safety Results – 2023

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

2.2 The meeting was quorate in October 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) – Patient Flow

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 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 October the Committees received an update from the operational teams on issues specifically relating to flow which were impacting on the care of patients coming to the Group's Emergency Departments. These included:

- Key data that illustrated the **patient flow through each of the Sites**, including numbers of admissions, discharges and current typical occupancy.
- The **system architecture that each Place / Site operates within**, including the Urgent & Emergency Care Boards led by Local Government leaders.
- The transformation plans, and corresponding governance, held at **Place / Site**, including details of the **Group-wide Strategic Initiative 'Collaborating with Local Partners**' to improve Length-of-Stay
- Key **risks and issues around improving flow for each Place / Site**, and mitigating actions.

Points noted during the discussions included:

- In September 2024, a meeting was held with the Care Quality Commission (CQC) following a letter from St George's ED consultants expressing concerns about the pressures facing the department. The meeting included representatives from the CQC, St George's ED, Trust leadership, and community partners, including the CEO of SWL St George's. During the meeting, a new full capacity protocol was discussed and agreed upon as a critical step to address overcrowding within the ED.
- Patient Flow and Delays - Delays in patient flow throughout patient care journeys have been identified as a major cause of prolonged ED wait times, overcrowding, and impediments to delivering timely and effective care. The factors affecting patient flow are complex and numerous, leading to widespread impacts across many departments. To address these challenges, the teams had prioritised actions within Site and Place-based transformation plans, focusing on improvements at both the Site and Community levels, and collaborating with local partners through our Strategic Initiative.
- The issues were usually having most impact with patients who had an active decision to admit – with them often having to have very long waits on a trolley prior to a bed being found for them.
- A request from the local Chief Operating Officers to the ICB had been made to open up local available capacity to care for patients that could be considered under a Discharge to Assess pathway. This would greatly help with patient flow and had been successfully used during the Covid-19 pandemic. The QCIC expressed strong support for this request.
- SGUH as a Tertiary and Major Trauma Centre, was often having to deal with delayed repatriations to local hospitals, due to their own flow concerns.
- There was a lack of clarity about oversight and which board committee the Programme Steering Group for Length of Stay and Acute Frailty reported into and this will be clarified.
- No target dates were shown for St George's transformation programme actions and this information will be provided in due course.

The Committees agreed that lots of work was taking place across the trusts to try and resolve the concerns within the EDs. Although there was an increasing amount of stakeholder and partnership work, the Group was often dependent on the support of other organisations in order to gain optimal flow within the trust's EDs. The meeting would continue to receive updates on the concerns and progress on work being undertaken to resolve them.

b) Interstitial Lung Disease (ESTH)

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.

A separate paper / agenda item on this is included within the papers for the Board meeting (item 3.1) Points noted at the QCIC meeting included:

- The task of identifying all the patients with ILD seen by this respiratory consultant since 2019 had been completed.
- 216 cases of ILD had been identified as having had care that in some way did not meet best practice guidance. Of these 216 patients, 91(42%) are now deceased and 125 (58%) are living. The average life expectancy with the illness was three to three and half years
- All the living patients who needed some change or correction to their ILD management (with the exception of 2 whom the trust had not been able to contact) have now been seen (face-to-face or virtually) and the necessary changes or corrections to their management have been initiated.
- The GCMO is now writing to all the patients with ILD to make sure they are all informed of the issue and the actions been taken. An advice line has been set up for them to contact if they have concerns.
- The GCMO was also writing to bereaved families of patients who have died with ILD since 2019. Work continues to obtain accurate next-of-kin details for all these deceased patients. Families with concerns would be encouraged to contact the advice line.
- As outlined in the previous updates, the Royal College of Physicians Invited Review has now been commissioned, Terms of Reference have been finalised and a Review Panel has been appointed by the RCP.
- The Committee discussed Whistleblowing and the need to ensure that there was adequate escalation when issues of concerns were raised. Additionally, there was a need to ensure appropriate support for staff who raise concerns. Further information will be provided to the Committees about lessons learnt from ILD where there were challenges in raising concerns, delays in responding to concerns and inadequate support for those raising concerns.

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

reasonable 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. The report covered data for July and August 2024. Points to particularly note included:

- **ESTH:** There had been an increase in stillbirth/neonatal death cases that meet the criteria for reporting to MBRRACE-UK. All cases were being investigated through the nationally mandated Perinatal Mortality Review Tool process, which includes review by a multi-disciplinary panel with external representation. Early immediate review had not identified any common factors or themes emerging from these cases which range from gestations of 22-41 weeks.
- **Clinical Negligence Scheme for Trusts (CNST) Submission for 2024 –** The period from which evidence for this submission could be collected was the end of November 2024. At the time of the meeting both trusts were at risk of not complying with the following safety actions:
    - **Safety Action 4 :** Can you demonstrate an effective system of clinical workforce planning to the required standard
    - **Safety Action 8 :** Can you evidence 90% attendance for the relevant staff groups at foetal monitoring , 1 day emergencies and neonatal life support training

The Non Executive Members of the Committee stressed the importance of complying with both safety actions; in terms of being able to demonstrate safe organisations and being able to secure the financial rebate from CNST. The Executives outlined the process that they would undertake to secure compliance including direct contact by the GCMO with clinicians that needed to complete training. The Committee confirmed that they supported the actions proposed in relation to training and roster management.

The Committees agreed that there remained limited assurance relating to Maternity Services across the Group. This related to the concerns of achieving compliance with all the safety actions for CNST. The Committee also agreed that the report that they had received had improved from previous versions, with a clear Executive Summary which highlighted the areas which were of concern.

It was noted that it was intended to receive a Deep Dive on Maternity Services at the focus session of the QCIC at the end of November 2024.

b) Group Patient Safety and Incident Report - update on Patient Safety Incident Review Framework (PSIRF) and Never Events.

The Patient Safety Incident Response report was received along with an update on Never Events. The report also gave details of legacy Serious Incidents and their action plans. Key points from the report included:

- There were a further three Never Events in this reporting period, one at ESTH and two at SGUH. They all fall within the two categories that have been a theme in Never Events in recent times – retained foreign bodies (including, a Never Event involving a small fragment of equipment that broke/disassembled), and failure to excise the intended skin lesion in a patient with complex skin lesions. As with previous Never Events in these categories, the patients did not suffer long term harm, but additional safety-netting steps have been identified.
- Key safety themes in this reporting period, which include incidents relating to vulnerability through mental health issues or impaired mental capacity, incidents involving the inadvertent loss of patients from urgent planned treatment pathways, or missed opportunities to act on reports that indicate that a patient should be put on such a pathway
- The ongoing response to concerns, and harm, in the SGUH vascular laboratory and (historically) the vascular screening service was described, and it was confirmed that an update will be provided in a future report.
- Multiple examples of the ways in which safety learning is now being disseminated.
- An individual case in which a Never Event (retained guidewire) was averted through previous Never Event learning was shared.
- PSIRF training now meets the target (>85%) for all staff (93% at ESTH, 92% at SGUH), but, while improving, does not yet meet the target for Medical and Dental staff (78% at ESTH and 79% at SGUH).

Concerns were raised by the Committees in relation to outstanding actions from Serious Incidents and Never Events. It was noted that it was hoped that all outstanding Serious Incident investigations and outstanding actions would be closed by the end of December 2024. The Group would then have fully transitioned to working with the PSIRF.

The Committees requested to see data in the next report to show the trend for PSIRF training for Medical and Dental staff in the next report to ensure that the percentage was significantly increasing.

The Committees felt there was reasonable assurance regarding PSIRF across the Group. This was due to the issues with compliance with training requirements from Medical and Dental Staff. It was anticipated that this rating would improve when the training compliance had increased with this staff group. In respect of Never Events the level of assurance remained limited.

c) gesh Learning from Deaths Quarterly Report: Q4 (January – March) 2023/24 and Q1 (April – May) 2024/25

Trusts are required to collect, scrutinise and publish specified information on deaths on a quarterly basis. The full paper outlining the findings from the two trusts review of Deaths for Q4 2023/24 and Q1 2024/25 is included with the papers for the Board meeting (item 4.1).

Some key points to note from the report were:

- Overall mortality at ESTH appears to be improving. However, both measures (Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)) remain "higher than expected".
- Overall mortality at SGUH remains "as expected" as measured by SHMI, and "lower than expected" as measured by HSMR.

At ESTH:

- A high percentage of deaths (about 35%) continue to be scrutinised through Structured Judgment Review (SJRs)
- SJRs have highlighted that sepsis care was improving but that further work is needed to implement a joint approach with SGUH. The appointment of a new Clinical Lead for Sepsis will support this, with a focus on identifying and treating sepsis at the Front Door.
- There is an indication from Q4 that a disproportionate number of cardiac arrests may be occurring in ED, and again a concern that ED overcrowding may be contributing to this. An update on this will be included in the next report (this is discussed in Section 3.1).

At SGUH

- Latest SHMI data shows Acute Myocardial Infarction (AMI) mortality has moved to be in line with expected. However, a deep dive by Dr Foster shows that mortality was higher than would be expect in cardiology related procedure groups. Accordingly, the Cardiology Care Group are focussing their investigation work on procedures related mortality. Alongside this, all deaths following cardiology procedures are subject to SJR to see if there is any further relevant learning.

- NHS Blood and Transplant (NHSBT) has informed the Renal Transplant Service that they will be carrying out an external visit due to an outcomes alert. As a preliminary step NHSBT has been sent internal reviews. An update would be provided in the next report.

  There was a substantial discussion of the ESTH mortality data and further assurance sort that this was continuing to be investigated and that appropriate action was being taken.

  Overall the Committees agreed that the report provided good evidence on gesh's approach to learning from deaths and that this information was driving direct safety improvements. At SGUH it was felt that there was a substantial level of assurance relating to Learning from Deaths. For ESTH they felt that there was a reasonable level of assurance and confirmed that a higher rating could not be given until there was greater assurance around the SHMI.

d) Group Infection Prevention and Control Update Report

The Committees received the Group Infection Prevention and Control (IPC) Update Report covering the period July to September 2024.

Points particularly noted included the following key issues :

- ***C.difficile Infections (CDI):*** There had been an increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low level fluctuations in CDI cases observed prior to the COVID-19 pandemic. This shift to an upward trend for CDI, which was initially observed during the pandemic, suggests a need for additional efforts in order to return to and maintain previously low

prevalence levels. This rise in CDIs was confirmed to be a national concern with similar reporting occurring in many areas across the country.

It was noted that there had been some cases where patients had died and it had been deemed that CDI contributed to death was mentioned on Part 1 of the death certificate. These cases had been reported to the CQC. All cases were in the process of being reviewed by a multidisciplinary team led by the IPC Doctor, with a view to identifying an improvement plan.

- **COVID-19:** Consistent with local reports, there has been a significant increase in COVID-19 positive admissions particularly on the SGUH site which has resulted in bay/ward closures impacting on bed capacity. The health group continues to follow national testing and management guidance for COIVD-19.

The Committees agreed that they were reasonably assured that the Group was working well in respect of doing all it could to try and prevent IPC issues. The report clearly demonstrated what actions were being taken.

5.0 Other issues considered by the Committees

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

a) Group Annual Safeguarding Report

At the meeting of the Committees held in October 2024 the Group Annual Safeguarding Reports covering both Adults and Children were received. This was the first time that the Committees had received a Group report and not separate ones from the individual trusts. This followed the integration of the Safeguarding Teams for the trusts being integrated into one under the direction of a Group Associate Director of Safeguarding.

The purpose of the report was to demonstrate compliance with Statutory Requirements by providing an overview of the work undertaken by the safeguarding teams at ESTH and SGUH in 2023/24.

The report included an outline for 2023/24 of,

- Service achievements
- Risks and challenges
- Priorities for 2024/25

Going forward it was agreed that the Quality Committees in Common should received more regular updates on Safeguarding.

It was noted that there was a lack of compliance with the requirement to complete Safeguarding Adults Level 3 training at both trusts. This had been due to a number of issues including the capacity to deliver training due to ongoing vacancies with the team. Work was underway to try and resolve these concerns.

Members of the Committee expressed surprise in the reduction in the number of referrals relating to children from the previous year. At ESTH this related to the overall number of referrals for children and at SGUH to the number of inpatient referrals. It was requested that

checks were made on the figures to confirm their accuracy and to understand the reason for this.

Following questions from the Committees the GCNO confirmed that she was confident that the safeguarding referrals from the Groups Emergency Departments were accurate as there were robust processes in place in these departments. She confirmed that she agreed that there was a need to provide greater assurance that the need for referrals were being picked up as appropriate in other services.

b) Group National Inpatient Survey Results;

The Committees received and noted the National Adult Inpatient Survey 2023 for each Trust. Key findings included:

- Overall patient experience for ESTH showed an improvement on the previous year.
- Overall patient experience for SGUH was the same as last year.
- ESTH was 'worse' than the average Trusts for 2 questions (prevented from sleeping at night by hospital lighting, and enough information given about the care and treatment to be received on a virtual ward).
- SGUH was 'somewhat better' than the average Trusts for 1 question (information provided on what the patient should do when leaving hospital) and 'somewhat worse' for 1 question (prevented from sleeping at night by hospital lighting).

Trust specific improvement plans had been developed had been developed and oversight and monitoring of these would be undertaken by the site Patient Safety and Quality Groups and the gesh Quality Group.

c) SGUH - Association for Perioperative Practice (AfPP) Review Findings and Action Plan – 6-month review

Further to the paper presented in April 2024, the Committees received an update on progress against the suggested actions from the Association for Perioperative Practice (AfPP) review undertaken at SGUH in October 2023. The AfPP carried out a peer-review of theatres at SGUH and covered the inpatient theatres and day-case unit at SGUH and the Surgical Treatment Centre at Queen Mary's Hospital (QMH). The AfPP was commissioned by the Surgery, Neurosciences, Cancer and Theatres (SNCT) Division to undertake a peer review of theatres, following a rise in Never Events in a surgical setting in 2023. The aim of the review was to audit practice in theatres against the AfPP standards for patient safety to help identify areas for improvement.

The April report raised concerns relating to aspects of perioperative practice at SGUH, including: adherence to, and audit of, the nationally recognised 5 Steps to Safer Surgery (NaTSIPPS1) which has subsequently been updated to the 8 Steps to Safer Surgery (NaTSIPPS2); the availability of up-to-date policies; the quality of the estate; the adherence to Infection Prevention & Control (IPC) rules; the safety governance of operating list changes; and the culture and behaviours of staff. Some areas of good practice were also noted, and the AfPP reviewers found the staff welcoming and engaged with the review.

The paper provided an update on progress against the agreed actions. The Committees raised concerns on the length of time which it was taking to implement some of the actions. This included the updating of policies and standard operating procedures. The work needed to

improve IT functionality within Theatres had been undertaken but it was noted that other areas of concern such as updating equipment storage would take longer to resolve.

It was agreed that a further update should be brought to the meeting in six 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 October 2024.

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	2.2	
Report Title	**Report from Finance Committee-in-Common**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance Committee at its meetings in September and October 2024 (1st November) 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, 07 November 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in September and October (1st November) 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 27th September and 1st November 2024, the Committee considered the following items of business:

27th September 2024	1st November 2024
PUBLIC MEETING • Update from Group Recovery Board • Finance Report (M5) • CIP Update (M5) • Cash update • NHSE Workforce Planning and Controls Assurance Review • Costing update • MTFM update • Business case update • SWL Pathology report • IQPR	**PUBLIC MEETING** • Update from Group Recovery Board • Finance Report (M6)* • CIP Update (M6) • Workforce Controls submission • Business Planning 25/26 • Business case update • Productivity update • IQPR • Strategic Initiative Update - Collaboration with Local Partners (Place) • SWL Procurement partnership report

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Recovery Board update

The GCFO noted the key topics covered in the Financial Recovery Board and encouraged discussion on how the Group should improve financial performance.

b) Finance Report M6

Both trusts are showing an underlying adverse to plan in plan at M6 (ESTH £1.4m and SGH £2.0m), showing baseline pressures and CIP shortfalls in addition to previous variances for industrial action and cyber attack support impact.

c) CIP update

CIP progress was being made but not at the required level to get to a fully developed programme by year end.

d) Cash update

The GCFO noted the confirmation of deficit funding from NHSE whilst a Q3 cash submission was being progressed in September. Committee members noted that this deficit support would likely mean neither organisation would need a drawdown for the rest of 2024/25.

e) Workforce Controls submission

Both organisations made a self assessment together with actions to support better workforce controls. Committee members welcomed this plan.

f) Costing update

The Committee noted the latest costing information from the Group.

g) MTFM update

The GCFO introduced the update on the MTFM that both organisations fed into from SWL.

h) Productivity update

The SGH DFS noted actions being worked through based on the latest productivity information.

i) IQPR

Against the **4-hour ED waiting time standard**, SGUH delivered 78.3% in September 2024 exceeding target and demonstrating continuous improvement alongside other urgent and emergency care metrics including length of stay and ambulance handover times. ESTH length of stay also continues to see improving trend with revised boarding process implemented on Monday 2nd September successfully incorporating additional areas to board.

The number of 65-week waiters on a **Referral to Treatment (RTT)** pathway at ESTH increased in August 2024 to 192 pathways, against a month-end target of 25 with the highest volumes in Gynaecology (128), Dermatology (12) and Respiratory (11). However, extensive work to recover the Gynaecology position continues and there has been significant improvements in September. At SGUH, 49 patients were waiting for more than 65 weeks with the largest proportion of waits within Neurosurgery. This reduced to 8 patients at the end of September 2024.

ESTH delivered against all three **national cancer standards** in August 2024: 28-day Faster Diagnosis (86.7%), 31-day first treatment (100%) and GP 62-day first treatment (85.6%). SGUH Cancer 62-day Performance continued to exceed target achieving 77.2% in August 2024 and meeting 31-day first treatment target (97.6%)

Integrated Care Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in September 2024. Sutton Health & Care achieved 88.8% and Surrey Downs Health & Care, 86.2%, 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 being maintained at

Sutton. The re-enablement Unit at Sutton continues to be fully utilised with 100% occupancy through September 2024 and work is in progress to decrease length of stay to five days to support discharge flow.

j) Strategic Initiative Update - Collaboration with Local Partners (Place)

The IC-MD noted good progress by the group with the partnership community services of Surrey Downs and Sutton Health and Care.

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

a) SWL Pathology report

The HOF SWLP noted latest highlights of the SWLP financial performance in 24/25.

b) SWL Procurement partnership report

Committee members welcomed the update on the Procurement partnership in SWL.

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 September and October (1st November) 2024.

Group Board

Meeting in Public on Thursday, 07 November 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 October 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:

- Group Chief People Officer Report: The Committees received a verbal update from the GCPO who outlined the new target operating model for the People function, including an update to our group employment contract, industrial relations issues and workforce planning.
- Workforce Race Equality Standard (WRES) Report – combined report: The report was presented to People Committees-in-Common on 24th October 2024 to approve on behalf of the Group Board because the deadline for publication was 31 October 2024.
- Workforce Disability Equality Standard (WDES) Report – combined report: As with WRES, the WDES report was presented to People Committees-in-Common on 24th October 2024 to approve on behalf of the Group Board because the deadline for publication was 31 October 2024.

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 October 2024.

Committee Assurance

Committee	People Committees-in-Common
Level of Assurance	Not Applicable

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

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

People Committees-in-Common Report
Group Board, 07 November 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 October 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 24 October 2024, the Committees considered the following items of business:

October 2024
• Group Chief People Officer Report • Medical Revalidation Responsible Officer Report for ESTH and SGUH. • Guardian of Safe Working Reports: Q2 2024/25 for ESTH and SGUH. • Covid and Flu Vaccination Programme Update (biannual) • General Medical Council National Training Survey (annual) • Nursing, Midwifery and AHP Professional Registration and Standards Report 2023/2024 • Workforce Race Equality Standard (WRES) Report – combined report for approval on behalf of the Board • Workforce Disability Equality Standard (WDES) Report – combined report for approval on behalf of the Board • NHS Staff Survey Roll Out Plans and Status • Education Update: Undergraduate Medical Education • Staff Health & Wellbeing Report • Staff Support Counselling & Mediation (biannual) • Workforce KPI Performance Report

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) Group Chief People Officer Update:

The Committees received the following verbal update from the Group Chief People Officer (GCPO) about the following areas:

1) A new target operating model for the People function would be created and the first priority was to form a new senior team. Three new direct reports to GCPO had been selected and would start as soon as their pre-employment checks and notice periods were completed
2) A new governance approach was being developed that would incorporate increased divisional and site level input as well as from the group executive. Two new groups would be established - a culture, equality and inclusion (CEI) forum that would have staff representatives from across the organisation and a people strategy delivery group that would be primarily for the people function but may well be expanded to include other stakeholders.
3) Integration work is progressing. An update to our employment contract was being implemented. The most significant change was that it would be a single gesh contract with a mobility clause in it. Proposals for integrated induction and mandatory and statutory training were also being developed. A single gesh wide suite of HR policies were also under development.
4) Culture and capability: all staff were being encouraged to complete the NHS staff survey and a new national sexual misconduct policy framework was being implemented with a new e-learning course and assurance framework.
5) Industrial relations issues: work was ongoing with staff-side representatives on dealing with 500 estates and facilities colleagues who were TUPE-d in 2021 on the London living wage contract rather than the AfC (agenda for change) contract. Secondly, a piece of work on location allowance in our integrated care setting was in progress and nearly reaching a conclusion. The outcome would be some clear principles about payment of different rates of High-Cost Area Supplement (HCAS) based on location and mobility requirements.
6) The AfC 5.5 % uplift would be implemented this month (October 2024) so colleagues would receive that uplift backdated to the 1st of April 2024. For very senior managers, a Remuneration Committee meeting would be held on the 7th of November 2024 to discuss the pay award. The Committees noted that the differences in the arrangements, which were outside the control of gesh, would need to be communicated effectively. Finally, the plan was to agree and implement the Bank rate uplifts before Christmas.
7) Workforce planning: our ambitious and challenging productivity cost saving target meant that it was very important to have the right controls in place (workforce costs being the largest proportion of our budget). The GCPO added that one of the new recruits had had a lot of success in this area in their current trust and the hope was that they would be able to do the same at gesh.

The Committees welcomed the news about the new governance approach for the People function and requested clarification on the mobility clause and whether an EIA (equality impact assessment) had been carried out. The GCPO explained that this would be included in the next update and clarified that the new mobility clause would apply to new hires only. There was also a discussion about harmonising the terms and conditions of employment and its implications in a unionised environment.

b) 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 continued to grapple with disparities, particularly in senior leadership roles where BAME representation remained low. As agreed, the report was presented to People Committees-in-Common on 24th October 2024 to approve on behalf of the Group Board because the deadline for publication was 31 October 2024. The ESTH WRES report was approved after the meeting by email because the ESTH People Committee was not quorate.

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

As with WRES, the Committees reviewed and noted the WDES findings for both trusts. 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. As agreed, the combined report was presented to People Committees-in-Common on 24th October 2024 to approve on behalf of the Group Board because the deadline for publication was 31 October 2024. The ESTH WDES report was approved after the meeting by email because the ESTH People Committee was not quorate.

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:

d) Medical Revalidation Responsible Officer Report: Q2 2024/25

The Committees received reports from the Responsible Officers (ROs) for medical revalidation at each Trust. As of 30th September 2024, there were 775 doctors connected to ESTH and 1177 doctors connected to SGUH.

At ESTH, the appraisal compliance rate was 94%, with 4 deferrals during the period and on-going effort to adopt the SARD version 7 which incorporated the GMP (good medical practice) 4.2 appraisal format. At SGUH, the compliance rate was 85% at the end of Q2, which was c. 6% less than at the end of Q1. Summer periods could be challenging with doctors starting and leaving the organisation, and the issues with coordination of diaries between appraisers and appraisees over the holiday period.

The Committees discussed methods for increasing the diversity of appraisers and concluded that the level of assurance was Reasonable to reflect the scope for improvement.

e) Guardian of Safe Working (GOSW) Q2 2024/25

The Committees received the GOSW reports for ESTH and SGUH which summarised the issues for junior doctors working in the two trusts at the end of Q2.

At ESTH, all doctors on the 2016 contract continued to be encouraged to submit Exception Reports via JDF (junior doctors' forum) and LFGs (local faculty groups). There was an increase in Exception reporting in FY2 Doctors at the St Helier site in General surgery which had been escalated to CT (Core Training) and DMD (Deanery Medical Director).

AT SGUH, a steep rise in number of exception reports was recorded, coinciding with new rotations in August and new FY doctors starting. A lower number of exception reports from locally employed doctors (LEDs) was received compared to the previous quarter. Applications for a new GOSW at SGUH were open and due to close in October 2024.

The Committees received reasonable assurance on the GOSW reports.

5.0 Other issues considered by the Committees

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

a) Covid and Flu Vaccination Autumn Campaign Update

In line with NHSE recommendations, a decision had been made to vaccinate staff and long stay inpatients. The month of September focussed on commencing delivery of the vaccine to all child age groups and pregnant women. Implementation for the Flu Campaign for staff commenced on the 3 October 2024. In alignment with updated guidance received by the Trusts on 18 August 2024 from NHSE, the COVID-19 vaccine would be offered free of charge to hospitals, allowing the Group to extend this offer to both staff and patients without additional costs. A short, targeted campaign was being held for staff between October and December 2024.

b) General Medical Council National Training Survey (NTS) 2024

The General Medical Council National Training Survey (GMC NTS) 2024 results provided the annual multi-dimensional feedback from the majority of doctors in postgraduate training and a proportion of consultant trainers.

SGUH received a good response in the GMC NTS 2024, with many departments and care groups in the top quartile. There had also been a reduction in open actions for improvement from greater than 55 to less than 5, and this improvement was testament to the strengthening of the educational governance processes across the Trust.

There was a positive performance in the GMC NTS 2024 for ESTH. There was sustained excellent performance within the paediatrics and emergency medicine departments, including paediatrics training at Epsom being showcased as a beacon of best practice nationally.

The Committees noted the findings of the survey at both trusts, the improvements made and the action plans for improvement in areas of concern.

c) Nursing, Midwifery and AHP Professional Registration and Standards Report 2023/2024

This report presented the procedures in place to monitor, review and provide assurance in relation to Nursing, Midwifery and AHP professional registration as well as a summary of current NMC and HCPC disciplinary cases.

The Committees:

- Noted the governance process for monitoring registrations and the management of registrants not re-registering.
- Noted the on-going work to sustain effective mechanisms to monitor and manage the registration and revalidation of all registrants.
- Supported the recommendations to form a gesh group Professional Standards meeting and to develop a gesh policy for Registration of Nursing, Nursing Associates and Midwifery Staff and Referral process.

d) NHS Staff Survey Roll Out Plans and Status

The NHS national staff survey was launched on 7th October 2024 and would run until end of November 2024. A comprehensive strategy was developed to significantly increase the staff survey response rate across both trusts. The strategy was built around five key strands: Communication, Line Manager Ownership, Leadership Endorsement, Divisional Engagement and Ownership, and HR and People Business Partner Support. These elements focused on enhancing visibility and support for the survey process, as well as addressing staff concerns around survey participation.

The Committees welcomed the ambitious internal participation target and praised numerous initiatives which created a sense of ambition and drive.

e) Education Update: Undergraduate Medical Education

The Committees noted and were assured by this report that provided an update on the developments and progress made following the MBBS Quality Assurance Visit conducted by St George's University of London on 1st March 2023. The next visit was scheduled for March 2027 (every 4 years). The MBBS Quality Standards for Clinical Placements, including student assistantships and student-selected components, were continuously monitored through the Quality Assurance Visit Self-Assessment Return (QAVSAR), the QA visit itself, and the accompanying summary reports.

f) Health and Wellbeing Report Q1&2 2024

The Committees noted the summary of Health and Wellbeing activity. The report provided information for both trusts, and specified where each activity has been delivered, its maturity and engagement numbers. The Health and Wellbeing interventions were planned and designed considering the latest evidence in the field, national guidance, organisational challenges and collaborative input from key teams (e.g. Organisational Development, Staff Support).

g) Staff Support Counselling & Mediation (biannual)

The Committees noted the update on the Staff Support Counselling Services and recognised their importance as a key investment in promoting the mental health of staff, reducing sickness periods, and promoting a psychologically resilient workforce.

h) 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. In the future, there will be more focus on the actions being taken to address the issues identified by the Workforce KPIs such as appraisal rates.

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 October 2024.

Group Board

Meeting in Public on Thursday, 07 November 2024

Agenda Item	2.4	
Report Title	**Audit Committees-in-Common report to the Group Board**	
Non-Executive Lead	Peter Kane, Audit Committee Chair	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the Audit Committees-in-Common at its inaugural meeting on 20 September 2024:

- Internal Audit: The Committee reviewed four internal audit final reports, two for SGUH and two for ESTH. The Committees discussed, in particular, those which had receive 'partial' assurance conclusions; Cyber Assessment Framework at ESTH and Pressure Ulcers at SGUH. The Committee agreed that all internal audits which received partial assurance must be brought back to the Committee within 6 months for a progress update.

- Information Governance: Both Trusts have successfully completed and published their 2023/24 Data Security Protection Toolkits (DSPT) as "standards met". For the 2024/25 DSPT A 'Baseline' Assessment of the 2024/25 DSPT is required to be submitted by 31st December 2024 and the final, full submission by end of June 2025.

Action required by the Board

The Board is asked to note the report of the Audit Committees-in-Common meeting held on 20 September 2024.

Committee Assurance	
Committee	Audit 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

There are no specific risks relevant to this report, beyond those set out in the individual reports to the Board.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Report of the Audit Committees-in-Common

Group Board, 07 November 2024

1.0 Purpose of paper

1.1 The Audit Committees-in-Common met on 20 September 2024. They noted that work on the external audit, internal audit and counter fraud plans was being progressed well. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 Audit Committee Report

2.1 External Audit 2024-25 Update

The Committees received assurance that work is underway to ensure the next external audit can be undertaken efficiently.

2.2 Internal Audit Progress Report

The Committees received a report, noting that the Emergency Planning, Resilience and Response audit at St George's and Epsom and St Helier has been removed from the plans. This was discussed and approved at the Executive Leadership Team meeting held on 3 September 2024. An audit of the EPR Project was added to the Epsom and St Helier Internal Audit Plan at the request of management. An audit of the PACs Project was also added to the Epsom and St Helier Internal Audit Plan at the request of management.

2.3 Final Internal Audit Reports

A large focus of the meeting was considering the final internal audit reports that had been issued since the previous Committee meetings in May:

- Security Data Protection Toolkit (moderate assurance) – ESTH and SGUH): This audit had been undertaken separately at both Trusts and the Committee considered these together so that appropriate Group-wide learning could be considered. The Committee noted that as a result of the audits, actions have been agreed between the auditors and management and welcomed the helpful recommendations to further strengthen controls.

- Cyber Assessment Framework (partial assurance - ESTH): This audit received partial assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. The Committee noted that as a result of the audit, nine actions were agreed; two of low-level priority, five of medium-level priority and two of high-level priority. The Committee received assurance from the management that the majority of these actions will be completed within six months time.

- Pressure Ulcers (partial assurance -SGUH): This audit received partial assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. The Committee noted that as a result of the audit, ten actions were agreed; two of low-level priority, five of medium-level priority and three of high-level priority. The Committee noted that work has now begun to address these gaps, and the audit has provided a very helpful baseline to focus minds when working towards improvement.

2.4 Internal Audit Thematic Analysis 2023/24 & Benchmarking

The Committee noted that from the combined sixteen reviews completed at St Georges, Epsom and St Helier University Hospitals the three most common themes from the management actions raised were Management or performance information (11 actions raised at SGUH and seven actions raised at ESTH),Policies, procedures and guidance (5 actions raised at SGUH and 10 actions raised at ESTH)and Poor record keeping (10 actions raised at SGUH and two actions raised at ESTH).

2.5 Information Governance and Cyber Security Update

The Committee noted that that both Trusts have successfully completed and published their 2023/24 Data Security Protection Toolkits (DSPT) as "standards met". For the 2024/25 DSPT a 'Baseline' Assessment of the 2024/25 DSPT is required to be submitted by 31st December 2024 and the final, full submission by end of June 2025. The Committee welcomed the report, requesting that the next report include trend data alongside the cyber security dashboard, to ensure the committee has comparative context as to what good practice looks like.

2.6 Group Information Governance and Compliance Annual Report

The Committee noted that the number of email threats detected has been increasing due to a large number of phishing attempts, however the source of these has been blocked. There is 1 outstanding Carecert relating to Cisco ASA Firewalls which will be resolved once the migration away is complete, this work is in progress.

2.7 Counter Fraud

The Committees received an update from the counter fraud specialists, who advised that they had received 31 new fraud referrals combined since the 1 April for ESTH and SGUH, indicating staff remain vigilant to fraud and bribery risks. During the reporting period, 23 referrals have been closed, with 18 remaining ongoing across both Trusts.

2.8 Group Breaches and Waivers Quarterly Report

The Committees received a report setting out the latest data on breaches and waivers.

For SGUH:

- Instances of waiver usage at SGUH in Q2 decreased to 1 (9 in Q1). The overall value has also decreased to £11,611 (£716,590 in Q1).
- Instances of breaches have decreased to 4 (16 in Q1). The overall value has also decreased to £552,852 (£1,259,838 in Q1).

For ESTH:

- Instances of waivers have increased to 5 (4 in Q1). The overall value has decreased to £353,870 (£555,765 in Q1).
- The instances of breaches have decreased to 5 (11 in Q1). The overall value of breaches also decreased to £495,996 (£814,562 in Q1).

The Committee noted that it would keep track of the roll out of the No PO/No PAY policy.

2.9 Group Aged Debt Report

The Committees approved the proposal by management to write off bad dept of a value of £6.3m for SGUH and £0.171m for ESTH.

3.0 Recommendation

3.1 The Board is asked to note the report of the Committee's meeting held on 20 September 2024

Peter Kane
Audit Committee Chair, NED

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	3.1	
Report Title	**Interstitial Lung Disease (ILD) at ESTH**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Richard Jennings, Group Chief Medical Officer	
Previously considered by	Quality Committee-in-Common	07 November 2024
Purpose	**For Assurance**	

Executive Summary

On 02 May 2024 the Group Board Meeting in Public discussed a report from Quality Committees-in-Common (QCiC) that described the actions being taken by the Trust to address quality and safety concerns in the treatment of Interstitial Lung Disease (ILD) at ESTH.

The report to the Group Board in May described the plans to commission an external review by an independent panel of assessors, and to complete a separate review of ways of working within the ESTH Respiratory Medicine Department.

Further reports on this issue were discussed at QCiC on 29 August 2024, as well as at Group Board in Private on 05 September 2024.

This current report to the Group Board Meeting in Public on 07 November 2024 provides an update on progress with these plans, and an overview of the current situation.

The Board agreed in September that this update and overview should be discussed at the November Board Meeting in public. This timing was chosen in order for there to be time to contact all the patients and families potentially affected before a public Board discussion, so that no patient or family would learn of this situation from the Board discussion without having been already offered information, and support.

Interstitial lung diseases are a broad spectrum of conditions. The majority of patients with Interstitial Lung Disease referred to in this paper are patients diagnosed with Idiopathic Pulmonary Fibrosis, for which the median survival after diagnosis (as given in the NHS England Service Specification for ILD) is 3-3.5 years. Idiopathic Pulmonary Fibrosis now accounts for more than 3000 deaths in England each year.

At various points in time, first from within the ESTH respiratory department in November 2019, just before the Covid pandemic, and later in 2023, from the same department and from different internal and external sources, there were reports of apparent departures from recognised best medical practice in the management of patients with Interstitial Lung Disease by a single respiratory consultant who was primarily based at St Helier Hospital until leaving the Trust in 2023.

The key concerns related to patients not being referred to a specialist ILD Multidisciplinary Team Meeting (MDT) for consideration of the best treatment options, and patients not being offered

potentially disease modifying treatments as these treatments evolved and became recognised in best practice guidelines.

All patients with ILD who were looked after by the respiratory consultant in the last five years have now had an initial internal review of their care.

All the patients with ILD who required any change or correction to their treatment have now been offered and have attended an appointment (either face-to-face or virtually) with a Consultant.

We can therefore be assured that (with the exception of the 2 patients we have not yet been able to contact) every current patient with ILD who needed a change to their ILD care (whether that change was a change in medication, an introduction of new treatment, or the arranging of further investigation) has now had that change initiated.

Steps have been taken to ensure that patients (or, where relevant, bereaved relatives) have been openly and transparently informed of any actual or potential shortcomings in care, and any Statutory Duty of Candour is being discharged as soon as is practicable when this is indicated.

The Trust has commissioned the Royal College of Physicians to undertake an Invited Review to assess whether the management of some patients has led to harm, and if so, to determine the degree of harm. The Review will also make recommendations to help the Trust and the Group to take any actions not already taken to optimise the safety of patient care. The agreed Terms of Reference (ToRs) of the RCP Review list these issues to be explored. The ToRs can be found in Appendix 2. The findings and recommendations of the RCP Review will be reported to the Board in due course.

In retrospect it is clear that concerns about the treatment of ILD were not sufficiently looked into at the time they were first raised in 2019, and although part of the reason for this is certainly the onset and extreme disruption of the covid 19 pandemic (which particularly impacted the respiratory team and coincided in time with the raising of these concerns), that there is important learning for this organisation about how serious concerns should be picked up and addressed and not be lost at times of great pressure. This paper describes some of the steps that have been taken, and continue to be taken, to learn from this and to make changes that make it easier for concern-raisers and whistleblowers to speak up, and for the organisation to respond promptly and effectively to those concerns.

Action required by Group Board
The Group Board is asked to note this update on the actions taken in relation to this issue.

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☒ Right care, right place, right time	
☐ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
As set out in report.				
CQC Theme				
☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☐ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
The Royal College of Physicians will charge a fee for the Invited Review.				
Legal and / or Regulatory implications				
As set out in this report.				
Equality, diversity and inclusion implications				
The RCP Invited review will consider all aspects of patient care and outcome and can highlight any concerns or recommendations in this area.				
Environmental sustainability implications				
N/A				

Interstitial Lung Disease (ILD) at ESTH

Group Board, 07 November 2024

1.0 Purpose of paper

1.1 On 02 May 2024 the Group Board Meeting in Public discussed a report from Quality Committees-in-Common that described the actions being taken by the Trust to address quality and safety concerns in the treatment of Interstitial Lung Disease (ILD) at ESTH. The report described the plans to commission an external review by an independent panel of assessors, and to complete a separate review of culture and ways of working within the ESTH Respiratory Medicine Department.

1.2 This paper provides further information about this issue and an update on the actions that are being taken.

2.0 Background – Interstitial Lung Disease, best practice management and arrangements at ESTH

2.1 Interstitial lung diseases are a broad spectrum of conditions which are characterised by inflammation or fibrosis of the alveolar wall leading to lowering oxygen levels. There are multiple different types of Interstitial Lung Disease; they are chronic, progressive conditions which can be difficult to diagnose and require collaborative expertise including a consultant respiratory physician, a chest radiologist and specialist nurses to reach a consensus for diagnosis and management. It is important to diagnose the type of Interstitial Lung Disease accurately to allow for specific treatment options to be considered in some cases where there is a potential for treatment, although not all types of ILD respond to disease modifying therapy. Prognosis is dependent on diagnostic types of Interstitial Lung Disease - some have a limited prognosis, with a median life expectancy of just three years following diagnosis, and others are more reversible with treatment. Whilst some treatment may be available locally, others require referral and assessment at a tertiary hospital.

2.2 The majority of patients with Interstitial Lung Disease referred to in this paper are patients diagnosed with Idiopathic Pulmonary Fibrosis, for which the median survival after diagnosis (as given in the NHS England Service Specification for ILD) is only 3-3.5 years. Idiopathic Pulmonary Fibrosis now accounts for more than 3000 deaths in England each year.

2.3 Best practice guidelines for the management of people with ILD were set out in national guidelines published by the British Thoracic Society in 2008, which recommended a multi professional approach, and NICE 2013 (*Idiopathic Pulmonary Fibrosis in Adults diagnosis and management* CG183 2013), which outlined the multidisciplinary team that should be involved in the diagnosis of ILD and the most appropriate medical management, including identifying therapies that were not indicated. This was supported by the Quality Standard for Idiopathic pulmonary fibrosis QS79 which specified that diagnosis should be made by a multidisciplinary team with the expertise in Interstitial Lung Disease. Subsequent technical updates outlined therapies and indications for use (*Nintedanib* NICE 2016 TA379; *Pirfenidone* NICE 2018 TA504) (references can be found in Appendix 1).

2.4 An Interstitial Lung Disease MDT commenced in 2018 at Epsom Hospital, and from 2019 this MDT was open to the discussion of all ESTH Trust patients, including those at St Helier Hospital, to support the clinical management of patients with ILD. This MDT included specialist input

from tertiary referral centre clinicians to support the use of newer antifibrotic agents. The management of patients through this MDT follows the best practice set out in the national guidance described above and works with a tertiary MDT run by Guy's & St Thomas' NHS Foundation Trust (GSTT).

3.0 Concerns raised about the management of patients with ILD at ESTH.

3.1 At various points in time, first from within the ESTH respiratory department in November 2019, just before the Covid pandemic, and later in 2023, from the same department and from different internal and external sources, there were reports of apparent departures from recognised best medical practice in the management of patients with Interstitial Lung Disease by a single respiratory consultant who was primarily based at St Helier Hospital until leaving the Trust in 2023.

3.2 The key concerns related to patients not being referred to a specialist ILD Multidisciplinary Team Meeting (MDT) for consideration of the best treatment options, and patients not being offered potentially disease modifying treatments as these treatments evolved and became recognised in best practice guidelines.

4.0 Actions taken so far to ensure patient safety

4.1 A Steering Group, chaired by the Group Chief Medical Officer, has been set up to direct and oversee the response to this issue. The Steering Group reports to the Group Executive Team (through the gesh Quality Group) and proves regular updates to the Quality Sub-Committee of the Board.

4.2 The most immediate priority has been to ensure that patients with ILD who were looked after by the respiratory consultant have had an initial internal review of their care, and that any necessary changes have been made to bring that care into line with current guidelines and best practice.

4.3 This has involved retrieving and reviewing the case notes of potentially affected patients looked after by the respiratory consultant since 2019, and up to when the respiratory consultant stopped working at the Trust. 2019 was chosen as the start of this time period because it was in 2019 that a specialist ILD multidisciplinary team meeting (MDT) first became available as a potential part of the care of patients at ESTH with ILD.

4.4 The work involved in doing this has been considerable, particularly as the main part of the patient records has been on paper rather than electronic. The notes of 1608 patients were identified as needing an internal clinical review, the purpose of which was to make sure that all patients with interstitial lung disease have been identified, and to make sure that if the reviewers had any concerns about the care given to these ILD patients, these concerns could be highlighted and action taken to bring the patients' management into line with recognised best practice. All of these records have now had this initial internal clinical review.

4.5 In total 231 cases were identified (out of the 1608 case notes referred to above) as having ILD, out of which 216 were identified as having had care that in some way did not meet best practice guidance. Of the 216 patients 91(42%) are now deceased and 125 (58%) are living. The clinical issues of concern were lack of investigation (20%); lack of referral to available ILD MDT (42%); no treatment (30%) and inappropriate treatment (9%). As previously reported, the

impression from this process is that some patients may have come to harm from departure from best practice through lack of access to potentially disease-modifying treatment.

4.6 A total of 34 patients identified via the case review process had been discharged from the Trust and required recall into the service. All but 2 of these patients have been contacted and recalled. The team have been unable to contact the 2 remaining patients with the available details and therefore contact is being attempted via the NHS central spine.

4.7 As of the 20 October 2024, all patients who required clinical review and were recalled to the service have been offered and have attended an appointment (either face-to-face or virtually) with a Consultant.

4.8 We can therefore be assured that (with the exception of the 2 patients we have not yet been able to contact) every living patient with ILD who needed a change to their ILD care (whether that change was a change in medication an introduction of new treatment or the arranging of further investigation) has now had that change initiated.

4.9 Because some of these changes/corrections take time, it will take us more time to be able to provide the assurance that every living patient with ILD is now established on the correct treatment pathway – some patients need some further investigations first, for instance - but we can be assured that in every case that change/correction has been initiated.

5.0 Assessment of any harm that may have happened due to departures from best practice

5.1 Because interstitial lung disease is a progressive disease that often shortens life despite best practice treatment, and because the majority of our ILD patients have been diagnosed with Idiopathic Pulmonary Fibrosis, which is a form of ILD for which the median survival after diagnosis is only 3-3.5 years, the assessment of whether, and to what degree, there may have been harm is not simple. Based on the assumption that harm is likely to have occurred in some cases, and that there may be important lessons to learn beyond those already identified, the Trust has commissioned the Royal College of Physicians to undertake an Invited Review to assess whether the management of some patients has led to harm, and if so, to determine the degree of harm. The Review will also make recommendations to help the Trust and the Group to take any actions not already taken to optimise the safety of patient care. The agreed Terms of Reference (ToRs) of the RCP Review list these issues to be explored. The ToRs can be found in Appendix 2.The findings and recommendations of the RCP Review will be reported to the Board in due course.

6.0 Approach to being open with patients and families, and discharging Statutory Duty of Candour

6.1 As and when patients were identified who needed a change or correction to their treatment, it was important that we were open and transparent with them in explaining that their previous management has not been in line with best practice. The GCMO and GCNO met with the clinical staff and have emphasised the importance of this, and guidance was been provided to staff to support them in being open with patients about this. These conversations were recorded contemporaneously in the patient notes, and the notes are being reviewed to ensure that this continues where necessary to be done clearly and unambiguously. As a further measure, the GCMO has written to all ILD patients explaining the issue, apologising, and inviting them to contact the advice line if they have concerns are questions that we have not yet addressed. The GCMO is also writing to those who were next-of-kin to patients who have died with ILD in 2019 to make sure that they are also informed of the concerns and the steps

being taken, and that they are invited to share any concerns they may have about the care their deceased relative received.

6.2 Statuary Duty of Candour is set out in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, Regulation 20. It requires that a Health Service body must act, as soon as reasonably practicable after becoming aware of a safety incident involving moderate or severe harm, to provide the patient or relevant person with an apology, an account of what happened, and information about what further enquiries are being carried out.

6.3 As described elsewhere in this paper, our understanding of any degree of harm to patients as a result of incorrect treatment is likely to evolve over time, as the external review by the RCP is carried out, and as any associated recommendations from the RCP regarding any further case reviews are enacted. As and when instances of moderate or severe harm are found, Statutory Duty of Candour will be enacted, and further assurance on this point will be provided to the Board in due course.

6.4 Given the progressive nature and often limited life expectancy associated with ILD, even when it is treated in line with current best practice, a proportion of patients who have received care for ILD since 2019 have already died. Case notes of patients who have died are included among those cases being reviewed by the RCP.

6.5 In order to support our ability to be open with any bereaved families in the future, and to discharge any future Statutory Duty of Candour, the GCMO has written to the local coroners (the Senior Coroner for London South, Croydon, and the Senior Coroner for Surrey, Woking) to make them aware of these concerns, so that this can be taken into account as the coroners see fit in any future coronial inquests or considerations.

7.0 History of the whistleblowing concerns and learning lessons from the Trust's response

7.1 Concerns were first raised about the treatment of patients with ILD through the Trust's internal DATIX reporting system in 2019. Concerns were raised again in 2023 from a number of sources, including DATIX incident reporting, complaints, Freedom to Speak Up reports and trainee doctor feedback to the Trust and to Health Education England. At this point, the respiratory consultant was stopped from undertaking any further clinical work at the Trust, and the measures described in this paper were initiated.

7.2 In retrospect it is clear that these concerns were not sufficiently looked into at the time they were first raised in 2019, and although part of the reason for this is certainly the onset and extreme disruption of the covid 19 pandemic (which particularly impacted the respiratory team and coincided in time with the raising of these concerns), that there is important learning for this organisation about how serious concerns should be picked up and addressed and not be lost at times of great pressure.

7.3 A number of important changes have already been made in response to this learning, in order to ensure that in future all concerns are fully picked up and examined, and that the approach to looking into all significant concerns is regularly overseen and tracked at executive level. The Freedom to Speak Up function has been strengthened in that there is now a regular executive-led group – the Concerns Triangulation and Oversight Group – chaired by the Group Chief Corporate Affairs Officer and attended by the GCMO and GCNO, in which all concerns that have been raised, through whatever source (e.g. Freedom to Speak Up, staff letters, DATIX reports, the CQC or other sources) are properly scrutinised and responded to. Other measures taken to improve the ability of whistleblowers and concern-raisers to speak

up, and to have confidence that their concerns will be responded to and that they will be protected, are described below.

8.0 Support for the department, and for any potential future whistleblowers

8.1 Recognising the importance of developing a culture in which all staff feel confident in raising concerns, and in which they can have confidence that those concerns will be heard and looked into, an Appreciative Inquiry was commissioned to examine ways of working in the ESTH Respiratory Department.

8.2 Many areas of positive practice were identified, but there are also areas in which teamworking can be strengthened and the relationship between the department and the senior leaders in the organisation can be more communicative and confident. The Site Leadership Team, with the GCMO and the GCNO, have held the two feedback meetings aimed at supporting the respiratory staff and providing them with confidence to work optimally as a team, and to work with senior leaders, in order to make sure that any concerns in the future are raised, looked into and dealt with in a timely and effective way.

8.3 The Group Chief Nursing Officer (GCNO) and the Group Chief Medical Officer (GCMO) have met a number of times with one of the main whistleblowers to better understand their experience of raising concerns.

8.4 The Group is creating an advisory forum for those who have raised concerns or been whistleblowers in the organisation, in order that their collective experiences can be heard by the Group Executive Team and their advice gained in order to make changes that give future potential whistleblowers and concern-raisers the confidence to speak up without fear of detrimental consequences.

8.5 The GCMO and GCNO and Group Chief Corporate Affairs Officer are working with the Group Chief Communications Officer to communicate regularly with all the staff with examples of positive change being made in response to the raising of concerns. Through this initiative, it is intended that a dialogue be maintained between the leaders of the organisation and the staff that enables a continuous improvement of processes and local practices and culture. The goal of this work, which will be reported on through to the Quality Committees-in-Common, is to promote openness, responsiveness and robust early protection for concern-raisers and whistleblowers.

9.0 Reporting so far to the Group Quality Committees-in-Common and to the Board

9.1 Reports on this issue, and updates on the actions being taken in response to this, have been discussed at the Group's Quality Committees-in-Common in March, June, August and October this year. This issue was also discussed at the Group Board meeting in private in May and July 2024 and in the Quality Committee's report to the Group Board meeting in public on 02 May 2024.

10.0 Key stakeholders & regulators

10.1 The Trust has provided updates on this issue to the following key regulators and stakeholders:

- The South West London Integrated Care Board
- NHSE London Region

- The Care Quality Commission
- The General Medical Council
- The local Primary Care leads
- The General Practitioners of individual patients
- The Senior Coroner for London South (Croydon) and the Senior Coroner for Surrey (Woking)
- The staff/whistleblowers who originally raised concerns.

11.0 Advice & support for patients and families

11.1 An advice telephone line has been set up for patients and families who may have concerns or questions. This advice line will be manned during normal working hours and is now active. The details of this advice line will be published on the gesh Group website.

12.0 Recommendations

12.1 The Board is asked to note this update on the actions taken in relation to this issue.

13.0 Appendix 1

13.1 The following list comprises of a number of references regarding interstitial lung disease.

- Interstitial-lung-disease-service-adult.pdf (england.nhs.uk)
- BTS Guideline for Interstitial Lung Disease (1).pdf (British Thoracic Society 2008)
- Overview | Nintedanib for treating idiopathic pulmonary fibrosis | Guidance | NICE
- Overview | Pirfenidone for treating idiopathic pulmonary fibrosis | Guidance | NICE

Royal College of Physicians | Invited Review
Terms of Reference

1. Objectives:

   - To undertake an invited review of the care of patients with a diagnosis of ILD at St George's, Epsom & St Helier University Hospitals and Health Group. The medical specialty is respiratory medicine.

2. Expertise required:

   - 1 x chair (medical director for invited reviews)
   - 3 x consultant respiratory physicians (2 general respiratory Consultant with expertise in ILD, and 1 tertiary centre ILD expert)
   - 1 x nurse specialist in ILD
   - 1 x lay reviewer

3. Methodology:

   - The findings of this review will be based on interviews with key individuals and a review of patient medical records to be conducted by appropriate specialists, using structured judgement review methodology. The review will take place both virtually using teleconference facilities (for the clinical record review) and in person (for the interviews). In undertaking the review, the review team will consider whether care is in line with national good practice and guidelines, and/or what would be considered by the view of a body of clinical professionals in a similar situation.

4. Issues to be explored:

   A) To conduct an independent clinical record review of the medical records of patients with a diagnosis of ILD since 2019 who received care from Dr X, to include:
      - 20 index patients identified by the internal review conducted by GESH
      - 10 randomly selected patients from the list of those included in the internal review:
        - Every 10th new patient diagnosed with ILD starting from 2019.
      - Consideration will be given to:
        - Assessment, investigations and initial treatment plans
        - Ongoing care and treatment
        - Communication with colleagues and MDT working
        - Interactions with patients and their family
        - Clinical record keeping

   B) To consider concerns about the clinical work of Dr X with specific reference to activity and outcomes, clinical decision making, implementation of treatment plans, MDT working and interactions with members of the wider medical and nursing team. This will include determining the professional relationship with colleagues at the Royal Brompton Hospital.

   C) To review the management of concerns about Dr X's practice by St. Helier University Hospitals NHS Trust and by GESH and give a view on whether opportunities to respond to them at an earlier stage were missed.

D) Highlight any new area of concern that arises during the invited review.

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	3.2
Report Title	**Group Maternity Services Quality Report** **July and August 2024 data**
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH Janet Bradley, Director of Midwifery and Gynaecology Outpatient Nursing SGH
Previously considered by	Quality Committees in Common 31 October 2024
Purpose	**For Assurance**

Executive Summary

1.0 Purpose: The purpose of this report is to inform the Group Board of significant changes, emerging safety concerns, new risks, and successes in maternity services across the Group. Documents which form part of the maternity services mandatory reporting requirements to the Board or it's designated committee are attached as appendices.

2.0 Significant changes since the last report

ESTH: There has been an increase in stillbirth/neonatal death cases (8 cases, 6 were below 28 weeks gestation and 2 above 30 weeks gestation) that meet the criteria for reporting to MBRRACE-UK. All cases are being investigated through the nationally mandated Perinatal Mortality Review Tool process, which includes review by a multi-disciplinary panel with external representation. Early immediate review has not identified any common factors or themes emerging from these cases which range from gestations of 22-41 weeks.

SGUH: There has been one episode of significant staffing challenge over the Bank Holiday weekend, 23-26 August. This resulted in delays in care, particularly for women requiring an induction of labour, as well as stress and distress to both patients and staff throughout the weekend. An MDT After Action Review (AAR) into the events took place on 25 September 2024. The root causes were a combination of high numbers of staff on annual leave (20.8% against the upper limit of 17%), unfilled shifts on the published rotas for all inpatient areas and the continuity of care team, short notice sickness absences, and staff cancelling their booked bank and agency shifts, which undid the mitigations that were put in place to safely manage the shifts.

3.0 New risks

ESTH:

- ESTH are using an old version of Excel which does not support the NHSE Dashboard toolkit which means that the ESTH Maternity Quality and Safety Dashboard Data cannot be

standardised alongside SGUH's. This has been escalated to the Divisional leadership team but has not yet been resolved.

SGUH:

- Midwifery staffing levels continue to be variable due to remaining gaps caused by the time lag between recruitment and then onboarding of newly qualified staff
- Instability of SGUH Midwifery Leadership team with the resignation of the DOM who has been promoted to a regional role and the secondment of the HOM to the fixed term interim role at ESTH. The Executive team are currently reviewing options to stabilise the maternity leadership across the Group.
- There was an unannounced Care Quality Inspection (CQC) inspection of the maternity service on 16 and 17 October 2024. The report is being awaited.

For both Trusts there is a requirement for an increased focus on Safety Action 8 for neonatal medical staff and anaesthetists and Safety Action 4 which relates to anaesthetic and neonatal workforce as part of the Maternity and Perinatal Incentive Scheme *(more detail can be found in the CNST update Appendix 2 in the Reading Room, slides 4, 7 and 9).*

Action required by Group Board

The Board is asked to:

a) Note the key areas of focus for CNST / MIS year 6 compliance (Safety Actions 4 and 8).
b) Note the CQC inspection of SGH maternity and potential for this to take place at ESTH.
c) Note the request to reframe the Midwifery staffing risk graded 16 at SGH and replace with two new staffing risks.
d) Provide feedback regarding levels of assurance with the new format of the report.

Appendices

Appendix No.	Maternity
Appendix 1	ESTH Perinatal Quality Surveillance Model
Appendix 2	**READING ROOM** ESTH CNST Compliance / Maternity and Neonatal Incentive Scheme Yr. 6 update
Appendix 3	ESTH PMRT Board Report
Appendix 4	**READING ROOM** - ESTH CQC Action Plan
Appendix 5	SGH Perinatal Quality Surveillance Model
Appendix 6	**READING ROOM** - SGH CNST Compliance/Maternity and Neonatal Incentive Scheme Yr. 6 update
Appendix 7	SGH PMRT Board Report
Appendix 8	**READING ROOM** - SGH CQC Action Plan
Appendix 9 & 10	SGH and ESTH Midwifery staffing 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.				
Equality, diversity and inclusion implications				
As set out in the paper.				
Environmental sustainability implications				
There are several environmental issues on the ESTH risk register, which have an impact on service and business continuity.				

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Group Maternity Services Quality Report

Group Board, 07 November 2024

1.0 Purpose of paper

1.1 The purpose of this report is to inform the Board of significant changes, ongoing and emerging safety concerns, new risks and successes in Maternity Service across the Group. The report also includes, as appendices, a Maternity and Perinatal Incentive Scheme update (incorporating any Board reporting requirements as set out in the NHS Resolution Technical Guidance and Audit Tool) and the mandated measures required as part of the NHSE Perinatal Quality Oversight Model (Perinatal Quality Surveillance Model data).

1.2 Detail the compliance with the Maternity and Perinatal Incentive Scheme (CNST) Year 6.

2.0 Background

2.1 The report data covers the position as of July and August 2024. The report covers:

- The maternity quality and safety dashboard
- The perinatal quality surveillance tool.
- Perinatal mortality by exception (full details available in the Perinatal Quality Surveillance Model (PQSM) report, appendices 1 and 5 ESTH and SGH respectively
- Risk register – by exception.
- External reporting and assurance e.g. CNST / MIS year 6 compliance
- Patient Experience
- Staff Experience
- National publication and reports related to maternity service.

In addition to the report, 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 at every meeting:

- Perinatal Quality Surveillance Model data has been included on a separate slide deck (see detail in READING ROOM Appendices 1 and 5, and pages 6 and 7 for high level summary).
- Clinical Negligence Scheme for Trusts (CNST) compliance (see detail in READING ROOM Appendices 2 and 6)
- Perinatal Mortality Review Tool (PMRT) (Appendices 3 and 7)
- Care Quality Commission (CQC) Action Plans (see detail in READING ROOM Appendices 4 and 8)
- Midwifery Staffing Reports (see detail in READING ROOM Appendices 4 and 8)

3.0 Maternity Quality and Safety Dashboard

3.1 Outcomes/Trends

The following tables shows the trends on key outcomes over the last 15 months for ESTH (April 2023 – August 2024 and January 2023 – August 2024 for SGH.

In August 2024 ESTH have four measures showing Special Cause Concerning Variation, which in the context of their charts equates to a single measure outside of the automatically generated control limits (i.e. not based on national benchmarking but on the standard deviation from our earlier averages).

NB. Currently the up-to-date Excel version required to accurately generate the SPC charts is not supported by ESTH and therefore y axis information is inaccurate in terms of numbers and in some cases date information is missing; this has been raised as a risk with the Board Level Safety Champion.

There has been an increase in moderate and above harm incidents, which correlates in part with the increase in stillbirth and neonatal deaths, although some incidents reported in August 2024 remain under review and may be downgraded. There has been an increase in postpartum haemorrhage rates and the Clinical Quality Lead is currently undertaking an audit to identify trends/learning.

It is important to note that in response to the CQC report and recommendations for SGUH, ESTH and SGUH have changed the way in which PPH and 3rd and 4th degree tears are graded. All PPH and 3rd and 4th degree tears are now graded as moderate harm, and the incidents are then revied before a final grading is made.

It should also be noted that the definition for supernumerary status of the band 7 co-ordinator changed in April 2024, with publication of the new Maternity Incentive Scheme year 6. This has resulted in better compliance for this standard for both Trusts, as seen on the dashboards.

The increase in post-partum haemorrhage seen on the SGUH dashboard, correlates to the service accepting more referrals in the placenta accreta service (PAS), to support Oxford and King's College Hospital maternity services.

The Committee is asked to note that the latest MBRRACE-UK Perinatal Mortality Report for 2022 birth has shown that both ESTH and SGUH 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.

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Maternity overview ESTH

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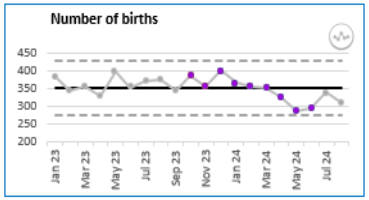
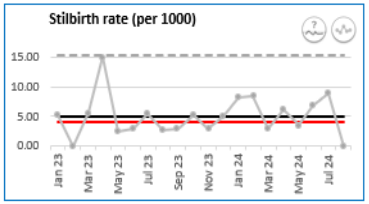
Maternity overview St Georges Maternity Unit

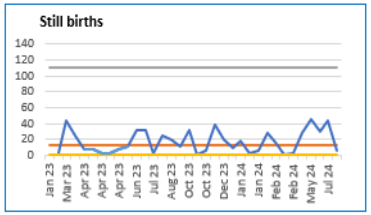
Latest month 01/08/24
Number of births 309
No significant change



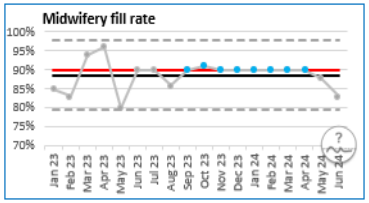
Latest month 01/08/24
Still birth rate/1000 0.0
No significant change



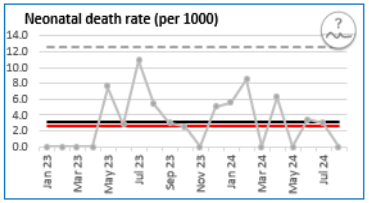
Date of last stillbirth 28/07/24
Average days between stillbirths 12.0
No significant change



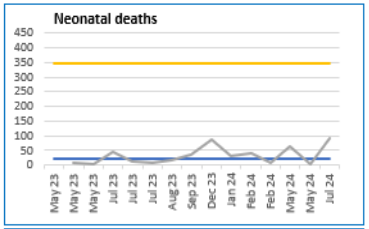
Latest month 01/06/24
Midwifery fill rate 90%
No significant change



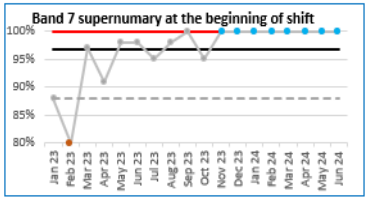
Latest month 01/08/24
Neonatal Death rate/1000 0.0
No significant change



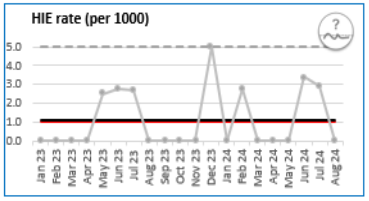
Date of last neonatal death 31/07/24
Average days between deaths 20.9
No significant change



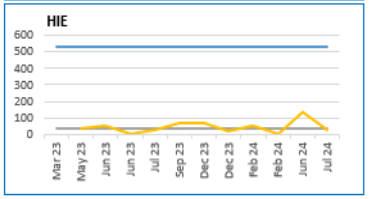
Latest month 01/06/24
Supernumary status 100%
Significant Improvement



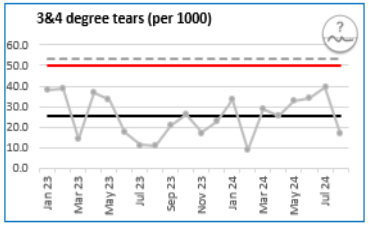
Latest month 01/08/24
HIE rate/1000 0.0
No significant change



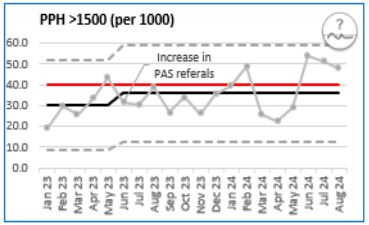
Date of last HIE 21/07/24
Average days between HIE 31.2
No significant change



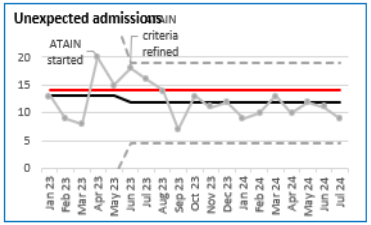
Latest month 01/08/24
3&4 degree tears (per 1000) 16.7
No significant change



Latest month 01/08/24
PPH >1500 (per 1000) 48.3
No significant change



Latest month 01/07/24
Unexpected admissions to NNU ATAIN 9.0
No significant change



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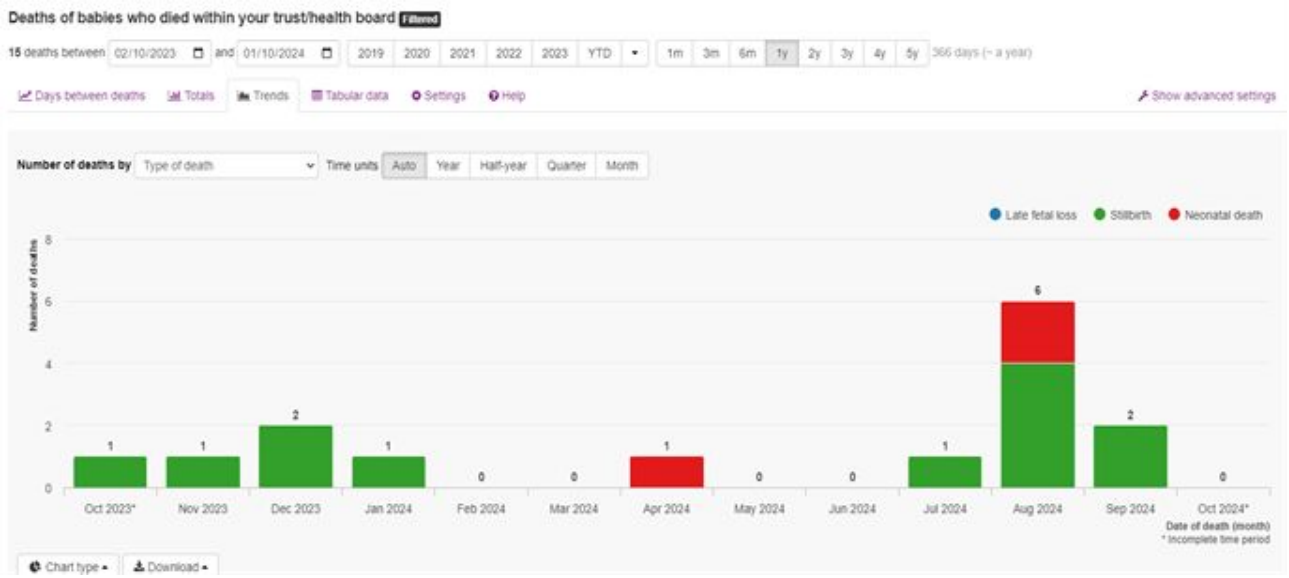
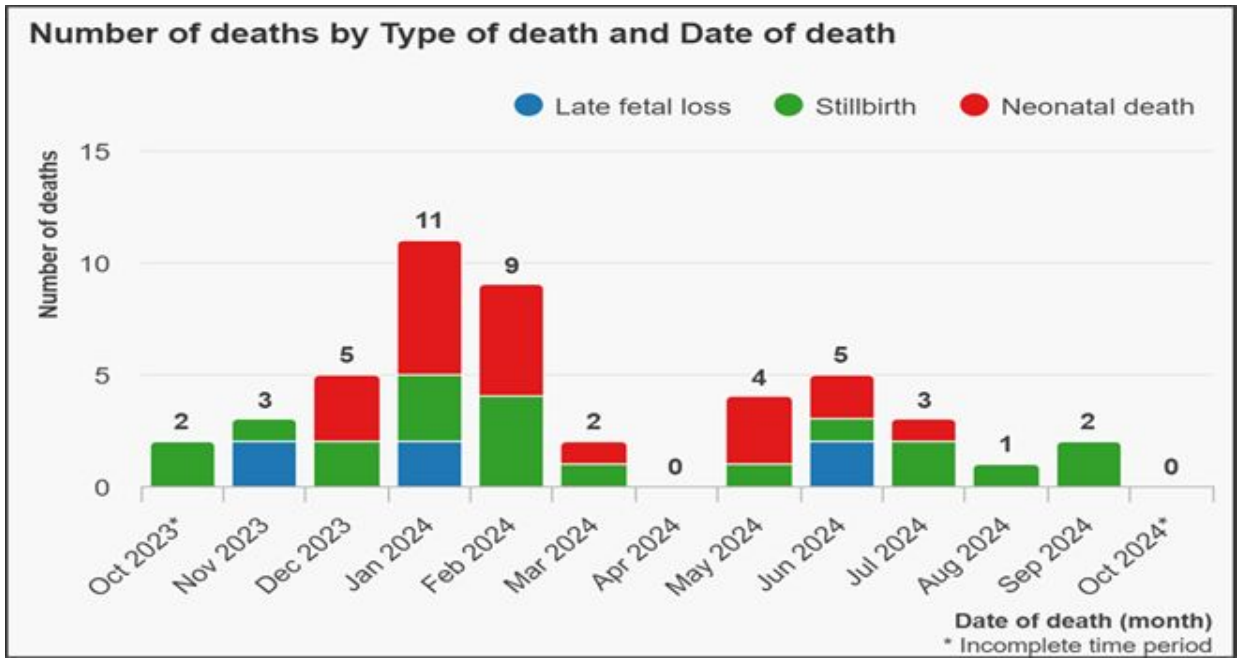
4.0 Perinatal morbidity and mortality

4.1 ESTH: from the MBRRACE-UK perinatal mortality review tool data



As demonstrated by the graph above there has been an increase in cases during July/August 2024. All cases are subject to a MDT review using the PMRT tool, but an early review has not identified any themes. The cases during July/August 2024 have been summarised below:

4.2 SGH: from the MBRRACE-UK perinatal mortality review tool data.



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5.0 Safe staffing

5.1 ESTH Safe Staffing

Staff Group	Measure	June 2024		July 2024		Aug 2024	
Midwifery	Fill rate (target >90%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		95%	93%	93%	91%	92%	90%
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%	

5.2 SGH Safe Staffing

Safer staffing July 2024

Ward name	Day						Night						Overall
	Registered Nurses/Midwives		Average fill rate-registered staff (%)	Care Staff		Average fill rate care staff (%)	Registered Nurses/Midwives		Average fill rate-registered staff (%)	Care Staff		Average fill rate care staff (%)	
	Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		
Carmen Suite	655	612	93%	394	362	92%	702	483	69%	368	357	97%	86%
Delivery Suite	5,418	3,955	73%	1,036	912	88%	5012	4004	80%	1,069	1,057	99%	79%
Gwillim Ward	2,263	1,822	81%	745	704	94%	1426	1407	99%	713	712	100%	90%

Safer staffing August 2024

Ward name	Day						Night						Overall
	Registered Nurses/Midwives		Average fill rate-registered staff (%)	Care Staff		Average fill rate care staff (%)	Registered Nurses/Midwives		Average fill rate-registered staff (%)	Care Staff		Average fill rate care staff (%)	
	Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		
Carmen Suite	688	632	92%	-	-	#DIV/0!	679	510	75%	0	0	#DIV/0!	84%
Delivery Suite	5,185	4,132	80%	972	919	95%	4695	3981	85%	1,035	1,035	100%	85%
Gwillim Ward	2,220	1,758	79%	708	706	100%	1357	1127	83%	690	690	100%	86%

Staff Group	Measure	July 2024	Aug 2024
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%	100%
Triage Staff 2+1 RM/MSW day 1+1 RM/MSW night	Shift allocation 100%	87.5%	77%

Triage staffing
2+1-day shift staffing numbers not met the 100% target. The new establishment for triage was uploaded to the roster on 20 May 2024. Ongoing recruitment underway to fill the new shift requirement.

5.3 SGH August bank holiday staffing incident

Over the course of the late bank holiday weekend in August, the clinical shifts were challenging due to deficits in staffing. This was the result of a combination of approved annual leave above the upper limit (20.8% against the upper limit of 17%), unfilled shifts on the published rotas for all inpatient areas and the continuity of care team, short notice sickness absences, and staff cancelling their booked bank and agency shifts.

The combination of these events undid the mitigations that were put in place to safely manage the shifts. The Site team were the point of escalation for the 24/08/2024 and 25/08/2024 as there was no Midwifery Manager on Call for these days, although the matron for Delivery Suite stepped in to support during the morning of 24/08/2024.

There were twenty-two datixs from this weekend: ten relating to delayed induction of labour, five relating to staffing, two shoulder dystocia's, one medication error and four incidents relating to clinical care of significance. The ten women who experienced delays to their induction of labour, went on to give birth across subsequent days, and did not experience any harm because of the delay, e.g. no IUD, stillbirth, neonatal death, or admission to NNU in this group.

In response to the incident immediate safety actions were agreed, e.g., matrons must attend the Trust bed meetings if the unit is OPEL 2 or above. In line with PSIRF, an AAR was undertaken with invitations to all staff working over the weekend and affected by the staff shortages. The AAR report will be taken through divisional governance and the Trust Clinical Incident Review Group (CIRG)

6.0 Training Compliance

6.1 ESTH

Type of Training and % compliance	Staff Group	ESTH July 24	ESTH Aug 24	ESTH Sept 24
PROMPT 90%	Midwifery Staff	95%	92%	94%
	Maternity Support Workers	88%	88%	94%
	Consultant Obstetricians	93%	93%	90%
	Trainee and Staff Grade Obstetricians	94%	92%	94%
	Anaesthetics	83%	78%	75%
CTG Training 90%	Midwifery Staff	95%	89%	90%
	Obstetricians	97%	95%	93% Cons/100% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	92%	94%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	86%	100%	
NLS (Newborn Life Support) 90%	Neonatal Medical Staff			7% Consultants 17% Middle grades

ESTH anaesthetist attendance at PROMPT training is currently non-compliant; all anaesthetists had booked to attend, but 3 did not attend as scheduled in September 2024. The neonatal medical staff attendance at NLS was provided for the first time in September 2024 and is currently non-compliant; this has been escalated to the Divisional Medical Director.

6.2 SGH

Type of Training and % compliance	Staff Group	SGH June 24	SGH July 24	SGH Aug 24
PROMPT 90%	Midwifery Staff	93%	92%	92%
	Maternity Support Workers	93%	91%	91%
	Consultant Obstetricians	89%	100%	100%
	Trainee and Staff Grade Obstetricians	100%	100%	100%
	Anaesthetics	100%	73%	73%
CTG Training 90%	Midwifery Staff	87%	86%	86%
	Obstetricians	95%	95%	95%
NLS (Newborn Life Support) 90%	Midwifery Staff	93%	95.39%	95.39%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	77%	92%	92%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	73.08% 80.77% - Consultant 65.38% -Specialty Reg	97% 100% - Consultant 94% - Specialty Reg	100%

There have been challenges with delayed uploading of neonatal training to the Trust portal, which impacted on the compliance rate seen in June. The service continues to work with the Aris team to ensure timely and accurate training data is available. Anaesthetist compliance for PROMPT fell in July and remained the same in August; all anaesthetists are booked to attend training and therefore SGH are on track to be compliant by the end of November 2024.

7.0 Risk register

7.1 ESTH

- Long term absence in the risk team has impacted investigation completion.

- Midwifery fill rates at EGH and STH have been below target in July and August 2024. This is being mitigated by reviewing staffing daily at the senior midwives huddle, and by using framework agency staff where necessary.

7.2 SGUH

SGUH has an "Extreme Risk" rated at 16 on the corporate risk register, titled "Shortage of Midwifery Staff." This risk was first logged on 12 October 2020. The midwifery shortage is linked to the ongoing national workforce shortage, as well as the recognition that the existing staffing establishment is insufficient to meet the complex needs of women presenting for maternity care. Over time, the nature of the original staffing risk has evolved and no longer accurately reflects the current challenges, particularly in light of the recent investment to increase midwifery staffing. In response, the service has identified two specific risks that better capture the ongoing concerns: **Recruitment Lag for Newly Qualified Midwives (graded 12):** There is a significant delay between the qualification of new midwives and their onboarding, which impacts staffing levels as they are not immediately available to start work. **High Levels of Short-Term Sickness (graded 12):** Elevated rates of short-term sickness, especially

in the delivery suite, are affecting staff availability, leading to a lower midwifery fill rate. This in turn impacts staff wellbeing and patient safety.

The proposal is that the original midwifery staffing risk be closed and replaced by these two newly identified risks and placed on the Divisional risk register. This proposal has been reviewed and supported by the directorate, divisional leadership, and the governance team. It has also been presented to the SGUH Patient Safety and Quality Group (PSQG), the Senior Leadership Team (SLT), gesh Quality Group and the Quality Committees in Common (QCiC) in August 2024. This proposal was also considered at the Group Executive meeting on 15 October 2024.

8.0 Clinical Negligence Scheme for Trusts (CNST) / Maternity Incentive Scheme (MIS) year 6

The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. There are 89 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.

The overview of compliance is presented for ESTH and SGH. Most requirements cannot be assessed as complete until after the end of the MIS period. For the purposes of this report 'red' indicates that we have not yet received any assurance or evidence of compliance, 'amber' indicates that work is in progress and on track, 'green' indicates that the action is complete, and evidence has been received.

8.1 ESTH – CNST compliance

	Safety Action Detail	RAG (Sept 2024)	Projected Submission RAG
1	*Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024?*	On Track (PMRT report included below)	
2.	*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*	Informal confirmation received from NHSE	
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?*	Transitional Care QI update included below	
4	*Can you demonstrate an effective system of clinical workforce planning to the required standard?*	Evidence outstanding (anaesthetic and neonatal workforce)	
5	*Can you demonstrate an effective system of midwifery workforce planning to the required standard*	Midwifery staffing report submitted	
6	*Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*	On track – update provided below	
7	*Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*	On track	
8	*Can you evidence of 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*	Currently non-compliant – update below	
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?*	On track – claims scorecard report included below	
10	*Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*	On track	

Safety Action 4, areas not met:
One case of consultant attendance at emergency situations was missed in July 2024, a plan to prevent re-occurrence (as per CNST requirement) has been requested from the consultant body.
Evidence of 24/7 obstetric anaesthetic cover and evidence that the neonatal medical and nursing workforce meet BAPM standards has been requested (not received yet), from the Neonatal Consultant Lead, and has been escalated to the Divisional Tri. This was also highlighted at October's SLT meeting.

Safety Action 8, areas not met:
Currently non-compliant with PROMPT for the anaesthetic group (75% in September against target of 90%), all anaesthetists were booked to attend training in September, but 3 did not attend as scheduled.

Also, non-compliant with NLS training for neonatal nursing and neonatal medical staff. Awaiting training data, this has been escalated to the Divisional Medical Director and Divisional Director of Operations.

Safety Action 4 is achievable, however there is a high risk of not meeting compliance for Safety Action 8 and this has been identified as an area of increased focus.

8.2 SGH – CNST compliance

	Safety Action Detail	RAG (Sept 2024)	Projected Submission RAG
1	*Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024?*	On Track (PMRT report included below)	
2.	*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*	Informal confirmation received from NHSE	
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?*	Transitional Care QI registered, and plans in place for development of TC team	
4	*Can you demonstrate an effective system of clinical workforce planning to the required standard?*	Evidence outstanding (obstetric and neonatal workforce)	
5	*Can you demonstrate an effective system of midwifery workforce planning to the required standard*	Midwifery staffing report submitted	
6	*Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*	On track – 86% at last review with SWL ICB (target 70%)	
7	*Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*	On track	
8	*Can you evidence of 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*	Currently non-compliant – PROMPT at 73% for anaesthetist	
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?*	On track	
10	*Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*	On track	

Safety action 4, areas not met:
Evidence for locums; certificate of eligibility to undertake short-term locums or ARCP or an action plan to address shortfall in compliance. Evidence of consultant attendance for clinical situations listed in the RCOG workforce document or an action plan to prevent further non-attendance. The women's health clinical director is liaising with the medical team to obtain this information.

Safety action 8, areas not met.
PROMPT training for anaesthetic group is at 73% against a target of 90%.

Both safety actions 4 and 8 are at medium risk of not achieving compliance at the end of the CNST reporting period (30 November 2024). However, all anaesthetists are booked to attend training and therefore SA8 is expected to be compliant by end of November 2024.

9.0 Claims

9.1 ESTH: one maternity inquest was held in August 2024; this related to a child death at 14 weeks of age (sudden infant death syndrome). There was no direct involvement of maternity services, but statements were provided around the sharing of safe sleeping information with families and carers.
There were no new or closed claims during July 2024; there was one new claim labelled as 'maternity' but this related to gynaecology (management of pregnancy of unknown origin).

9.2 SGH: in July and August 2024, SGH received two new CNST claim for obstetrics; a potential mother and baby claim regarding delayed diagnosis of neonatal hypoglycaemia and a claim alleging lack of follow up care. There were no claims closed in obstetrics in July and August 2024 and there are no upcoming trials or hearings for obstetrics in July or August 2024.

10.0 New events, reviews and reports

10.1 CQC review of maternity services.

Between 2022 – 2024, the CQC inspected 131 maternity services, and published their findings in a report in September 2024. They described finding examples of good care but were also *''worried that too many women and babies are not getting the care they ned or deserve".*

Of the 131 locations inspected, almost half were rated as requires improvement (36%) or inadequate (12%). Only 4% of services were rated as outstanding and 48% were rated as good. At 12 locations, ratings for being well-led dropped by 2 ratings levels and at 11 locations, ratings for being safe dropped by 2 levels.

The themes in the report include, responding and learning from incidents, risk assessment and triage, recruitment and retention of staff, estates and environment, inequalities and racism and communication with women and families. The full report can be found here: National review of maternity services in England 2022 to 2024 - Care Quality Commission

10.2 CQC inspection of SGH maternity October 2024

There was an unannounced CQC inspection of the SGH maternity service on 16 and 17 October 2024. The inspection team provided high level feedback at the end of day 2. They highlighted the improvements seen since the inspection in March 2023, e.g. good MDT working, high standard bereavement suite and documentation, matrons being visible, hands on and supportive, good HDU service, staff being open and honest and reported feeling supported. Further update will be provided to the Board, once the report is received for factual accuracy checking.

10.3 NHS Resolution Early Notification Scheme (ENS)

The Board is asked to note that the ENS arm of NHS Resolution notified SGUH via email on 17 June 2024, that they would be undertaking a thematic review of all cases the maternity service referred to MNSI between 1 April 2017 – 31 May 2024.

The review was primarily triggered by the CQC rating of "Inadequate" and SGUH's inclusion in the MSSP programme. Historically, the Trust had a low number of cases referred to MNSI, with performance in the Early Notification Scheme (ENS) initially rated green, and below the national average. After a period in amber (over the national average but less than twice the national average), the Trust returned to green. However, five cases reported in a short timeframe have pushed the Trust back into amber. The final status is pending as the national average for this period has not been calculated yet.

The report has not yet been received and the Board will receive an update at a future meeting.

10.4 ESTH appreciative Inquiry

An appreciative inquiry was undertaken in February/ March 2024 to better-understand the underlying reasons for delays in resolving apparently straightforward management and practice concerns across the midwifery service of Epsom and St Helier Hospitals. High level feedback was provided to the senior midwifery team during August 2024. Due to the sensitivity and possibility for individuals to be identified, the reviewer is in the process of preparing summary slides that can be shared with the wider team. Concurrently, the leadership triumvirate are considering actions and options to address the concerns raised.

11.0 Sources of assurance

11.1 ***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.

11.2 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.

12.0 Implications

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

- ESTH - there has been a significant increase in stillbirth and neonatal death in August 2024; there have been no themes identified from initial review. However the service is not an outlier.
- ESTH and SGH - There are areas of risk associated with compliance with Year 6 of the Maternity and Neonatal Incentive Scheme.
- SGH – the high-level feedback from the CQC inspection at St George's acknowledged that improvements have been made since the inspection in March 2024. However, there were some areas for improvement which included compliance which are addressed while the report is being awaited.

13.0 Recommendations

13.1 Group Board is asked to:

a) Note the key areas of focus for CNST / MIS year 6 compliance (Safety Actions 4 and 8).
b) Note the CQC inspection of SGH maternity services and potential for this to take place at ESTH.
c) Note the request to reframe the Midwifery staffing risk graded 16 at SGH and replace with two new staffing risks.
d) Provide feedback regarding levels of assurance with the new format of the report.

Appendix 3

PMRT - Perinatal Mortality Reviews Summary Report

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

Epsom and St Helier University Hospitals NHS Trust

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

1/5/2023 to 31/8/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *18*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
22	7	6	8	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
3	0	3	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

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

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Laura Rowe
Date report generated: 06/09/2024 10:20

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 8)

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

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

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Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 8)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	1	2	1	3	1	8
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	2	1	3	1	8
Hospital post-mortem declined	0	1	2	0	2	1	6
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	1	1	0	2
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	1	1	0	2
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	1	1	0	2
No	0	1	2	0	2	1	6

*Includes coronial/procurator fiscal post-mortems

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Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 8)

Role	Total Review sessions	Reviews with at least one
Chair	6	62% (5)
Vice Chair	5	50% (4)
Admin/Clerical	0	0%
Bereavement Team	10	100% (8)
Community Midwife	0	0%
External	7	75% (6)
Management Team	4	50% (4)
Midwife	59	100% (8)
Neonatal Nurse	0	0%
Neonatologist	6	62% (5)
Obstetrician	8	75% (6)
Other	1	12% (1)
Risk Manager or Governance Team	29	100% (8)
Safety Champion	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 8)

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

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 8)

Timing of death	Cause of death
Late fetal losses	**1 causes of death out of 1 reviews**
	Extreme prematurity maternal abruption chorioanmionitis
Stillbirths	**7 causes of death out of 7 reviews**
	The panel were confident, given the severity of the mother's symptoms of infection and the placental histology, that the cause of death was chorioamnionitis, which is an infection in the amniotic sac and placenta, secondary to E coli infection.
	Acute twin to twin transfusion syndrome.
	The cause of death was undetermined
	Intrauterine death of an appropriately grown and developed third trimester male fetus. Findings of hypoxia ischaemic injury on examination of the brain. Placental findings of maternal vascular malperfusion and a retroplacental haematoma.
	Acute twin to twin transfusion syndrome.
	Intra-uterine death of an appropriately grown and developed third trimester male fetus, the cause of which is attributed to the placental findings of a tight true umbilical cord knot with associated delayed villous maturation and high-grade chronic villitis with avascular villi.
	The cause of death was undetermined
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy which was not managed according to national or local guidelines	1	The PPROM guideline requires review in line with RCOG guidance and the Maternity Sepsis guideline. The report will be shared with the clinician who discharged the Mother and also at the cross site clinical risk meeting and the quality half day.

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

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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	6	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother presented with reduced fetal movements and there is no evidence that during her antenatal care she had been given written information about what to do if she experienced a change in fetal movements	3	No action entered
		No action entered
		To highlight to all staff at huddle and on mandatory training, the importance of discussing and documenting fetal movements at all antenatal appointments. In addition monthly push notifications will be set up on BadgerNet to encourage women to access the reduced movements leaflets.
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	2	In cases where a mother is progressing quickly in labour consideration should be given to assigning an additional midwife/maternity support worker to support the case midwife. They can then assist in completing documentation and observations. An audit programme is required that includes an audit on maternal observations. Currently the Trust are recruiting an Audit and Compliance Midwife.
		To add to mandatory risk training that when the labour assessment proforma on BadgerNet is completed, the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. This will also be fed back at the labour ward huddle and an item placed in the risk newsletter.
The baby had to be transferred elsewhere for the post-mortem	2	No action entered
		No action entered
The placental histology results differ from the antenatal ultrasound scan findings.	2	This discrepancy to be escalated to histology by the Divisional Medical Director.
		This discrepancy has been escalated to histology as this would have a bearing on the outcome.
This mother's progress in labour was not monitored on a partogram	2	No action entered

Report Generated by: Laura Rowe
Date report generated: 06/09/2024 10:20

		To add to mandatory risk training that when the labour assessment pro-forma on BadgerNet is completed the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. In addition this will be fed back at labour ward huddle and in the risk newsletter.
A completed bereavement checklist was not in the notes	1	No action entered
It was highlighted that there is no robust and prompt process in place for requesting notes from the Trust a woman was formerly booked at. This also raises issues of resource available to review notes if they are obtained.There are also issues with GDPR which need considering.	1	Review guideline with regard to requesting notes from previous Trusts, with due regard for GDPR. LR to take to LMNS to discuss possible centralised solutions.
Post delivery when Maddee contacted the Delivery Suite she was informed all the results of her tests were normal. The results of the blood were normal however the urine and swab results were not available. Subsequently the urine showed there was an infection that required antibiotics.	1	To add to mandatory risk training: -the 'microbiological tests and results' field in BadgerNet must be populated when a test has been undertaken. This will create an alert on Badgernet and highlight to staff there are outstanding results. -when a call is received on Delivery Suite from a woman, this conversation must be documented in the communication section of BadgerNet. This will also be discussed at labour ward huddle.
The baby was small for gestational age at birth, scans were indicated and performed but the baby was not identified as IUGR	1	No action entered

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

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Report Generated by: Laura Rowe
Date report generated: 06/09/2024 10:20

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

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother had preterm labour or had preterm prelabour rupture of membranes during her pregnancy which was not managed according to national or local guidelines

Report Generated by: Laura Rowe
Date report generated: 06/09/2024 10:20

Appendix 7

PMRT - Perinatal Mortality Reviews Summary Report

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

St George's Hospital, St George's University Hospitals NHS Foundation Trust

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

1/7/2024 to 30/9/2024

There are no published reviews for St George's Hospital, St George's University Hospitals NHS Foundation Trust in the period from 1/7/2024 to 30/9/2024

The board report for the period 01.07.24-30.09.24 is not complete as there are 6 cases in the period that have not yet been discussed at a PMRT meeting yet due to the following reasons:
• 2 cases are for Incident Review Tool and a date is in place to be discussed prior to PMRT
• 2 cases are planned for discussion on 23 October 2024
• 1 case is with MNSI
• 1 case is external to SGH and SGH are awaiting grading from the Trust that provided the patient's antenatal care

Report Generated by: Maria Gutierrez Vuong
Date report generated: 23/10/2024 09:22

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	3.3
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, 07 November 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 September 2024 including.

- Nil MRSA infections in-month and year-to-date at SGUH.
- No Category 4 Pressure ulcers were reported in September 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.
- ESTH performance against Friends and Family targets continue to be met and in Integrated Care linking with Accurx has resulted in an increase in FFT uptake.
- 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.

Key **challenged** areas are as follows.

- **Patient Safety Incidents Investigated (PSII)**: In September 2024, both ESTH and SGUH reported Patient Safety Incidents (PSIIs). SGUH recorded three PSIIs, including two Never Events: one involving wrong-site surgery and the other a retained object. ESTH reported two PSIIs, with one Never Event being a retained object. All incidents are currently under investigation to determine necessary learnings.

- **Falls**: At ESTH, two falls resulted in moderate harm on medical wards. One patient needed to return to surgery for wound dehiscence caused by the fall and has since been transferred to a local hospital. The other patient fell forward from the bed, sustaining a head injury (a nasal fracture with a nosebleed) that required plastic surgery to repair a forehead laceration. This patient has been moved for rehabilitation, and both incidents are currently under investigation.

  Similarly, at SGUH, there were two cases of moderate harm and one case of severe harm. Various response pathways, including the SWARM and After Action Review (AAR) approaches, have been implemented. Incident reviews highlighted concerns regarding inappropriate patient handling after falls, leading to a review of the Trust's available flat lifting equipment.

- **Pressure Ulcers:** In September 2024, there were 26 pressure ulcers related to medical devices, an increase from 18 reported in both July and August. Among these, four cases were categorized as stage 1, five as stage 2, ten as Deep Tissue Injuries (affecting vulnerable skin), and seven involved damage to the mucous membrane. A Trust-wide action plan has been established, with intensive care taking the lead on improvement initiatives.
- **Venous Thromboembolism (VTE) Risk Assessment rates:** The reporting of this quality indicator has recently been updated to comply with new national guidance, which requires that assessments be completed within 14 hours of admission, as recommended by NICE. Under this revised definition, SGUH reported 62.4%, while ESTH reached 80.1% against the national target of 95%. Efforts are underway to standardize reporting across GESH, and a group-wide task force is also reviewing the VTE risk assessment forms to enhance completion rates.
- **Complaints: –** At ESTH several actions are ongoing to aid recovery of response times, impacted by a lack of clear processes, alongside differing levels of ownership between the complaints and divisional teams.
- **Infection Control –** At ESTH, there has been an increase in C. difficile incidents in recent months. A plan is being implemented to review all cases in order to understand the causes and ensure the delivery of quality care.
- **Key challenges** In Integrated Care, challenges include pressure ulcer management, delayed escalation of patients within the Podiatry service for which a caseload and service review is underway, short-term absences among community nurses, and the need to embed new processes into the special school contract.

3.0 Operational Performance

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

Elective Care:

- ESTH have seen significant growth in PIFU activity increasing to 5% meeting target and is ahead of the ESTH March 2025 target of 3.5%. At SGUH, activity continues to increase with full rollout go-live on 23 September 2024 with all specialties having the functionality to place PIFU orders, which will considerably improve performance over the coming months.
- Advice & Guidance utilisation rates at both ESTH and SGUH continue to exceed the target of 16 requests per 100 outpatient appointments.
- At SGUH first and procedure outpatient (OP) attendances as a percentage of total OP appointments continues to exceed target achieving 51.6% - above the national ask of 49%.
- ESTH delivered against all three national cancer standards in August 2024: 28-day Faster Diagnosis (86.7%), 31-day first treatment (100%) and GP 62-day first treatment (85.6%). SGUH Cancer 62-day Performance continued to exceed target achieving 77.2% in August 2024 and meeting 31-day first treatment target (97.6%)
- At both Sutton and Surrey Downs, Adult Waiting list improvement has been maintained across all services with no 52+ week waiters.

Urgent & Emergency Care:

- Against the 4-hour ED waiting time standard, SGUH delivered 78.3% in September 2024 exceeding target and demonstrating continuous improvement alongside other urgent and emergency care metrics including length of stay and ambulance handover times. ESTH length of stay also continues to see improving trend with revised boarding process implemented on Monday 2nd September successfully incorporating additional areas to board.
- Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in September 2024. Sutton Health & Care achieved 88.8% and Surrey Downs Health & Care, 86.2%, 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 being maintained at Sutton. The re-enablement Unit at Sutton continues to be fully utilised with 100% occupancy through September 2024 and work is in progress to decrease length of stay to five days to support discharge flow.

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

Elective Care

- The number of 65-week waiters on a Referral to Treatment (RTT) pathway at ESTH increased in August 2024 to 192 pathways, against a month-end target of 25 with the highest volumes in Gynaecology (128), Dermatology (12) and Respiratory (11). However, extensive work to recover the Gynaecology position continues and there has been significant improvements in September. At SGUH, 49 patients were waiting for more than 65 weeks with the largest proportion of waits within Neurosurgery. This reduced to 8 patients at the end of September 2024.
- The number of 52 weeks waits at SGUH increased to 789 patients against a target of 496 seeing an increase within seeing an increase within Neurosurgery and Bariatric Surgery. Whilst ESTH 52-week position is still significant high at 884 patients there has been a reduction through August 2024. Gynaecology remains the most challenged specialty at ESTH with several actions being taken to mitigate and T&O (EOC) backlog continues to grow mainly due to referrals from partners outpacing their capacity.
- The waiting list size for children's services at Sutton Health & Care remains a challenge; this is a national issue recognised at SWL/Place with SWL ICB programme taking this forward with providers across SWL. At the end of September there were 27 patients within children's therapy waiting over 52 weeks a reduction compared to 42 in August 2024.
- Theatre capped utilisation rates at both sites remains below 85%. ESTH is impacted by on-the-day cancellations and estate issues through September 2024. However, performance remains above a peer average of 80.5%. At SGUH current performance is at 79%, the Day Surgery Unit and Queen Mary's Hospital (QMH) utilisation rates remain significantly below 85%, further work is being planned to understand the scope for improvement of average cases per session across different specialities, particularly at QMH.
- BADS metric on Model Hospital has changed, now measuring the total percentage of Outpatient Procedure and Day case Procedures as a proportion of all Procedures (Outpatient, Daycase and Inpatients). This is not comparable to previous data. Both ESTH and SGUH are performing in the lowest quartile reporting 78% and 80.9% retrospectively against a peer median of 85.2%. Data is being reviewed to understand and determine opportunities.

- At ESTH diagnostic performance further deteriorated in August 2024, mainly due to an increase in 6-week breaches within echo which has increased from 53 at the end of March 2024 to 467 at the end of August 2024. A recovery plan is in place and improvements expected from October 2024.

Urgent & Emergency Care

- Pressures in Urgent and Emergency Care (UEC) services remain at both Trusts with high proportions of beds continuing to be occupied by patients not meeting the criteria to reside, and adversely impacting flow. High numbers of unplaced patients including mental health patients remaining in EDs for prolonged periods remains a significant challenge. At ESTH, 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.
- At Sutton, within the HomeFirst Service there is a focus on improving referral to discharge time. The service is currently seeing an increase in Pathway 1 delays mainly attributable to discharge to domestic home with health care support. There is a Length of Stay reduction programme in progress with ESTH Sutton Healthcare and Surrey Downs.
- Virtual Ward occupancy at Sutton remains below target of 80% with rates at 62.4% through September. Engagement work with appropriate wards and with clinicians continues and teams are working to explore additional pathways into virtual ward in development.

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.

gesh

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

Group Integrated Quality & Performance Report

September 2024

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 25 October 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 to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
Deliver 78% 4-hr A&E Performance: SGUH – exceeded trajectory ESTH – below trajectory of 77%	**Deliver Financial Plan**: SGUH – Please refer to finance report ESTH – Please refer to finance report	**Improvement in fundamentals of care as per Quality Priorities** – **Falls** – progress under review **Pressure Ulcers** - improving **VTE Risk Assessments** – plans in place to standardise progress **Dementia Assessments** – under review	**Staff Turnover Rates*: Target 13%** SGUH – Achieving Target ESTH - Achieving 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) upcoming SDEC reporting to likely to adversely impact reported performance ESTH - 1.16 (above expected) (*partly/fully attributable to coding changes)*	**Staff Sickness Rates***: SGUH – Not achieving target of 3.2% ESTH - Not achieving target of 3.8%
Deliver 1.5 Days LOS Reduction with partners: SGUH – Behind Plan, improving trend ESTH - Behind Plan, improving trend	**Deliver 5.5% CIP** SGUH – Please refer to finance report ESTH - Please refer to finance report	**Eliminate RTT 65-week waits by September 2024:** SGUH – 8 patients (Sep 2024 update) ESTH - 117 patients (Sep 2024 update)	**Improvement in WRES and WDES Metrics**: TBC
Deliver 80% Virtual Ward Utilisation Rate: Sutton – Not achieving target Surrey Downs – Achieving target		**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- under review

* Proxy for Staff engagement whilst detailed metrics are developed

2

Executive Summary

Safe, High-Quality Care

St George's Hospital

Successes

Infection control: SGUH continues to report zero MRSA bacteraemia for the year.

Complaints: SGUH continues to meet the targets for the percentage of complaints responded to in 35 days and acknowledged within 3 working days.

Pressure Ulcers: No Category 4 pressure ulcers were reported August and September 2024. There were 5 Category 3 pressure ulcers in September, down from 10 in July and 8 in August 2024.

Mortality: SHMI performance remains classified as "As expected". It is important to note that the inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set at SGUH in the coming months is likely to adversely affect reported performance.

Challenges

Never Events: There were 2 Never Events reported in September 2024, one retained object and one wrong site surgery. Both are being investigated.

Patient Safety Incident Investigations (PSII) : 3 PSIIs were declared in September 2024 – all maternity related incidents. Two of the incidents are being investigated by Maternity and Newborn Safety Investigations.

Falls Prevention and Management: Two falls with moderate harm occurred in medical wards in September 2024. One patient had to return to theatre for wound dehiscence as a result of the fall and the other patient fell forward from sitting on the bed and suffered a head injury. Both cases are being investigated.

VTE: 62.4% of VTE risk assessments in September 2024 were within 14 hours of admission (as per NICE guidance). Work is underway to standardise reporting across gesh.

Pressure Ulcers: There were 26 medical device related pressure ulcers in September 2024. This is up from 18 in both July and August 2024. Four cases were category 1, 5 were category 2, 10 were Deep Tissue Injury's (vulnerable skin) and 7 damaged the mucous membrane. A Trust-wide action plan is in place with intensive care taking a lead on improvements.

Infection Control: There were 5 hospital acquired C. difficile infections and 8 cases of E. coli bacteraemia during September 2024. Of the 8 E. coli cases, 5 have been classified as Hospital-Onset Healthcare-Associated (HOHA) and 3 classified as Community-Onset Healthcare-Associated (COHA). An action plan is in place, with progress reported to the gesh Quality Group.

Epsom & St Helier

Successes

Falls Prevention and Management: During September we celebrated National Falls Awareness week; this was an opportunity to engage staff by way of fun quiz questions which allowed us to gauge staff knowledge on our Trust policies. This was a great success with over 250 staff getting involved.

Pressure Ulcers: The number of pressure ulcers remain low. There were 7 pressure ulcers in total in September, all category 2, this is the same as August but up from July 2024 (4).

Friends and Family Test: Performance against Friends and Family targets continue to be met.

Challenges

Never Events: There was 1 Never Event reported in September 2024 which was a retained object.

Falls Prevention and Management: A total of 83 falls were reported in the Acute Services in September 2024. This equates to 4.2 per 1,000 occupied bed day (OBDs), which is marginally higher than the previous month. Of these incidents, 61 occurred on adult inpatient wards (3.1 per 1,000 OBDs). Current data indicates 2 moderate harm and 1 severe harm (0.25 per 1,000 OBDs). Different response pathways have been taken, using both the SWARM and After-Action Review approach. Incident reviews have highlighted concerns regarding inappropriate patient handling post fall. This has prompted a review of the Trusts available flat lifting equipment.

VTE: Current VTE performance for September 2024 stands at 80.1%., this is down from 84% in August 2024. Wards with high patient turnover continue to face challenges, and timely completion of VTE risk assessments remains an issue. In response VTE Clinical Nurse Specialist ward visibility has been increased to monitor VTE prevention practice, advise, support and engage patients and staff directly.

Mortality: SHMI remains elevated, partly due to the inclusion of SDEC data in the Emergency Data Set, but is showing a decreasing trend. Actions to improve performance include deep dives and thematic analyses.

Complaints: Several actions are ongoing to aid recovery of response times, impacted by a lack of clear processes, alongside differing levels of ownership between the complaints and divisional teams.

Infection Control: C. difficile incidents have increased recently. A plan to review all cases is being implemented to understand the causes and ensure quality care, although no outbreaks have been reported.

Executive Summary
Operational Performance

St George's Hospital

Successes

- Elective Recovery Fund ahead of plan YTD for value weighted activity
- Elective activity in line with plan year to date. First and procedure outpatient (OP) attendances as a percentage of total OP appointments continues to exceed target achieving 51.6% - above the national ask of 49%. The number of first attendances continues to exceed plan.
- Patient Initiated Follow-up (PIFU) full specialty rollout went live on 23rd September 2024 , with all specialties having the functionality to place PIFU orders.
- Diagnostic waiting time performance continues to be within 5% of national recovery target, however challenges within Endoscopy and Gynae Ultrasound has seen the number of patients waiting over six weeks increase.
- Cancer 62-day Performance continued to exceed target achieving 77.2% in August 2024.
- Performance against the 4-hour operating standard exceeded target in September 2024, achieving 78.3%.
- Non-Elective Length of Stay is continuing to maintain the reductions averaging 6.1 days through September 2024, compared to 7 days LOS in April 2024.

Challenges

- The number of RTT pathways waiting for more than 65 weeks is behind plan with 49 patients. Neurosurgery is the most challenged specialty. Improvement through September expected with a September 65 week position of 8 against trajectory of potentially 20.
- DNA Rates continue to be above target with 10.2% of patients through September 2024 not attending their scheduled appointment, reviews of most challenged specialties under-way.
- Theatre Capped Utilisation rates remain below 85%. Continued emphasis on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. Deep dives into daycase rates underway through Recovery Meetings.
- Faster Diagnosis performance did not meet target in August 2024. Focused recovery plans across all specialties are in place
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside.

Epsom & St Helier

Successes

- PIFU rate achieved the national 5% target and is ahead of the ESTH March 2025 target of 3.5%.
- Theatre utilisation (capped) in September 2024 was 80.46%, consistently achieving 80% or over, since April 2024 and top quartile performance nationally.
- All cancer performance standards were achieved in August 2024: 28-day Faster Diagnosis (86.7%), 31-day first treatment (100%) and GP 62-day first treatment (85.6%).
- The EBUS pathology transfer of ESTH patients from STUG to ESTH successfully reduced the reporting time to 24 hours from previous time of 10 days. Working on a process map to implement pathology transfers from RMH (Oaks Centre).
- 52 week waits reduced from 921 in July 2024 to 884 in August 2024. The specialties with the highest 52-week cohorts were Gynaecology (321), Trauma & Orthopaedics (99) and Cardiology (72).
- Non elective length of stay continues to show a monthly reduction reporting 7.6 days in September 2024 compared to 7.9 days the previous month. We have seen a month-on-month reduction in length of stay from April onwards.
- 30-day readmission rates remain low at 4.4% in September 2024. This is well below the national average, and we are undertaking a comprehensive review to understand what is driving this.
- 12 hour waiting time in ED improved slightly compared to the previous month, although remains challenging due to onward flow from ED.

Challenges

- 65 week waits increased from 186 in July 2024 to 192 August 2024, with the highest volumes in Gynaecology (128), Dermatology (12) and Respiratory (11). However, extensive work to recover the Gynaecology position continues and there has been significant improvements in September.
- Diagnostic performance deteriorated again in August 2024, mainly due to an increase in 6-week breaches within ECHO which have increased from 53 at the end of March 2024 to 467 at the end of August 2024. A recovery plan is in place and improvements expected from October 2024.
- EUS capacity for diagnosing Upper GI cancers is limited as current waiting times are 3-4 weeks, although reduced from 5-6 weeks due to the RMH Oak Centre providing a weekly additional list.
- Diagnostic delays for Lung cancer patients noted as increasing number of patients are now referred to Navigational Bronchoscopy at the Royal Brompton.
- UEC pathway and flow remains a key challenge with a high proportion of patients requiring admission remaining in ED for a prolonged period of time. Continued high numbers of unplaced patients including mental health patients waiting for transfer to an inpatient mental health bed.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

2-hour Urgent Community Response (UCR) target continues to exceed target achieving 88.8% in September 2024.

Reablement unit occupancy rate 100%. Work in progress to decrease length of stay to five days to support discharge flow.

Childrens waiting list has decreased from 739 to 678 with a 40% reduction in children waiting over 52 weeks.

High levels of Mandatory and Statutory Training (MAST) maintained at 91.2%

Challenges

Waiting times for children's therapy over 52 weeks remain high, although have decreased from 42 to 27 with work in progress to continue to decrease wait list. Children's Occupational Therapy 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 86.2% in September 2024 while managing high levels of referral numbers.

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

Increase in occupancy rates to 87.8% in bedded care

High levels of Mandatory and Statutory Training (MAST) being maintained at 93.3%.

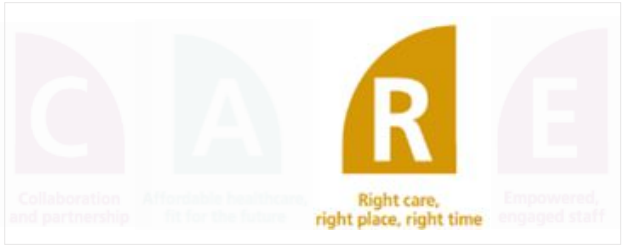
Non-Medical – appraisal rate is 95.2% showing further improvement.

Challenges

Vacancy rate is at 18.5%., improved from previous month. Focus on recruitment is to be continued .

Increase in sickness rate to above target to 4.6%

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	Sep 24	0	2	0				Sep 24	0	1	0			
Patient Safety Incidents Investigated	Sep 24	1	3	0				Sep 24	0	3	0			
Number of Falls With Harm (Moderate and Above)	Sep 24	1	2	1				Sep 24	3	3	1			
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Sep 24	0.04	0.09	0.12				Sep 24	0.10	0.15	0.03			
Pressure Ulcers - Acquired category 3	Sep 24	8	5	8				Sep 24	1	0	7			
Pressure Ulcers - Acquired category 4	Sep 24	0	0	0				Sep 24	0	0	0			
Infection Control - Number of MRSA	Sep 24	0	0	0				Sep 24	0	1	0			
Infection Control - Number of Cdiff - Hospital & Community	Sep 24	7	5	4				Sep 24	12	8	5			
Infection Control - Number of E-Coli	Sep 24	5	8	10				Sep 24	8	5	5			
VTE Risk Assessment	Sep 24	62.2%	63.5%	95.0%				Sep 24	81.0%	80.1%	95.0%			
Mortality - SHMI	May 24	0.92	0.91	1.00				May 24	1.15	1.16	1.00			
% Births with 3rd or 4th degree tear	Sep 24	1.6%	3.1%	-			3.1%	Sep 24	1.3%	3.1%	-			2.8%
% Births Post Partum Haemorrhage >1.5 L	Sep 24	4.5%	5.7%	-			2.9%	Sep 24	2.6%	2.4%	-			3.1%
Stillbirths per 1,000 births	Sep 24	0.0	5.7	-				Sep 24	12.7	6.8	-			
Neonatal deaths per 1,000 births	Sep 24	0.0	0.0	-				Sep 24	12.7	6.8	-			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Sep 24	0.0	2.9	-				Sep 24	0.0	0.0	-			

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

Mortality: SDEC reporting will be introduced over the next few months and likely to have an adverse impact on SHMI performance
*Never Events are a subset of PSIIs

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	Sep 24	52	76	-			
Complaints responded to in 35 days	Sep 24	92%	93%	85%			
Percentage of complaints acknowledged within three working days	Sep 24	100%	100%	100%			
Number of re-opened complaints in month	Sep 24	0	1	-			
Number of complaints not completed within 6 months from date of receipt	Sep 24	1	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Sep 24	0	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Sep 24	1	2	-			
Friends and Family Test - Inpatients Score	Sep 24	99%	98%	90%			
Friends and Family Test - Emergency Department Score	Sep 24	83%	80%	90%			
Friends and Family Test - Outpatients Score	Sep 24	95%	94%	90%			
Friends and Family Test - Maternity Score	Sep 24	100%	96%	90%			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 24	29	22	-			
Sep 24	44%	69%	85%			
Sep 24	100%	100%	-			
Sep 24	0	1	-			
Sep 24	16	7	-			
Sep 24	0	0	-			
Sep 24	1	0	-			
Sep 24	95%	95%	90%			
Sep 24	85%	82%	90%			
Sep 24	94%	94%	90%			
Sep 24	94%	80%	90%			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Sep 24	0	0	-		
Number of Falls	Sep 24	4	3	-		
Pressure Ulcers Category 3	Sep 24	4	2	0		
Pressure Ulcers Category 4	Sep 24	0	0	0		
Infection Control - Number of Cdiff	Sep 24	0	0	-		
Complaints	Sep 24	0	0	-		
Community FFT	Sep 24	96%	98%	90%		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sep 24	0	0	-		
Sep 24	15	18	-		
Sep 24	5	3	0		
Sep 24	0	0	0		
Sep 24	0	0	-		
Sep 24	1	0	-		
Sep 24	98%	98%	90%		

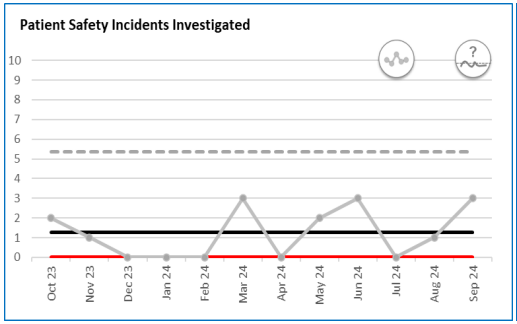
*Community FFT is a subset of Epsom and St Heliers FFT data.

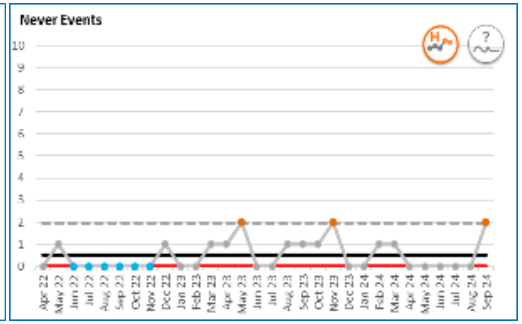
8

Safe, High-Quality Care

Incident Reporting

St George's





Cause of variance/non-compliance
3 PSII were declared in September 2024, 2 of which were Never Events

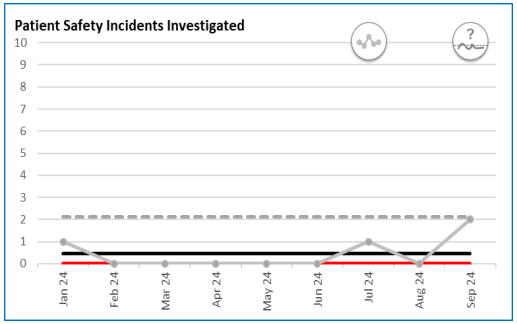
Summary / Actions
There were 3 Patient Safety Incident Investigations (PSIIs) declared in September 2024.
All of these were maternity related incidents, two of which are being investigated by MNSI (Maternity & Newborn Safety Investigations).

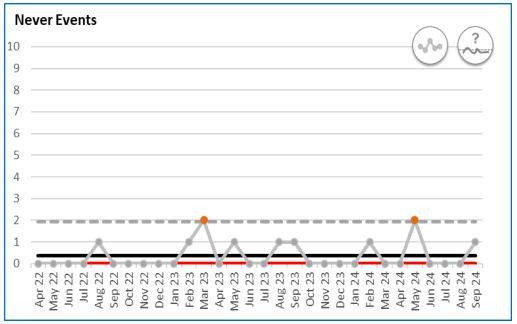
Cause of variance/non-compliance
2 Never Events were declared in September - a wrong site surgery and a retained object.

Summary / Actions
The retained foreign object Never event involved a titanium implant screw which was unintentionally retained following elective bimaxillary osteotomy in Maxillofacial. An MDT review is being undertaken to identify all the required learning and ensure that actions are put in place to prevent recurrence.

The wrong site surgery Never Event involved the wrong scar being excised during elective wide local excision (WLE) of malignant melanoma scar to the left back. An After Action Review (AAR) is taking place and the learning identified from this will be added to the cluster PSII that is investigating the previous Never Events on the skin cancer pathway.

Epsom & St Helier





Cause of variance/non-compliance
2 PSII were declared in September 2024 one of which was a Never Event (Retained Foreign object)

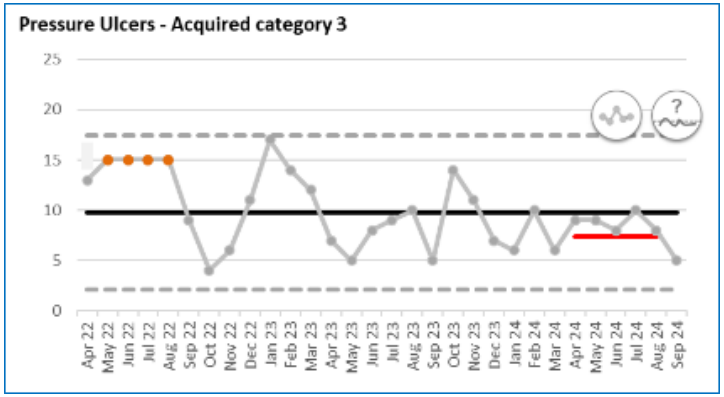
Summary / Actions
Both incidents are maternity related and will be externally investigated by Maternity and Newborn Safety Investigations (MNSI).

Cause of variance/non-compliance
1 Never Event was declared in September relating to a retained foreign object

Summary / Actions
Incident occurred in Gynaecology Theatres, relating to a retained foreign object post procedure (swab in a glove). The incident is being investigated as a PSII.

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers Category 3

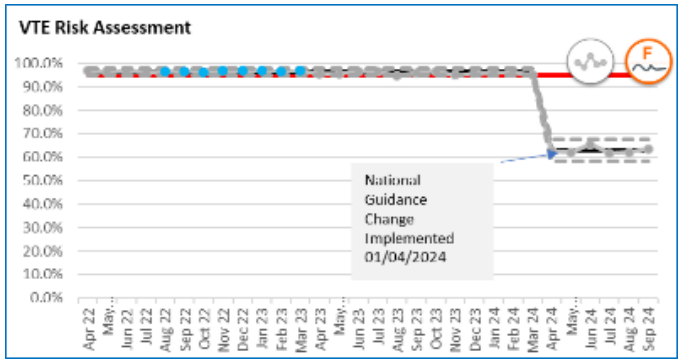


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Grade 3 Shows normal variation, however apart from this month, the monthly ambition to achieve 10% reduction has not been met.	• There were 5 Acquired Category 3 & 4 pressure ulcers in September 2024, this is down from 10 in July and 8 in August 2024. • Of the 5 acquired; 3 were acquired in Medicine/Cardiovascular, 1 acquired in Surgery, Neuro, Cancer and Theatres and 1 in Children's, Women's, Diagnostics and Therapies. • There were 26 medical device related pressure ulcers (MDRPUs), this is up from 18 in both July and August 2024. Zero MDRPUs were category 3, 4 and unstageable in August and September 2024. • Of the 26 MDRPUs in total; 4 were category 1, 5 were category 2, 10 were Deep Tissue Injury's (vulnerable skin) and 7 damaged the mucous membrane.	• Stop the pressure event in November 2024 to focus on medical devices; urinary catheters in particular • On-going mandatory and induction teaching sessions • Develop a poster for categories of pressure ulcers in dark skin tones – in progress • Teach pressure ulcer prevention to new nurses on induction - ongoing • Pressure Ulcer Prevention for adult nurses E-Learning available on EMAST • Pressure Ulcer Prevention:- E-learning for Paediatrics nurses available on EMAST • Pressure Ulcer Prevention:- E-learning for HCA's on EMAST • Ad-hoc Tissue Viability trolley teaching continuing with good feedback from teams. • Dynamic healthcare company representatives supporting with new mattress roll out program and education on mattress troubleshooting, priority wards completed, replacement plan continues • Trialling PUIRT (new governance process in line with PSIRF). Need to finalise and confirm process.	March 2025 achieve 10% reduction compared to 2023/24	Sufficient for assurance

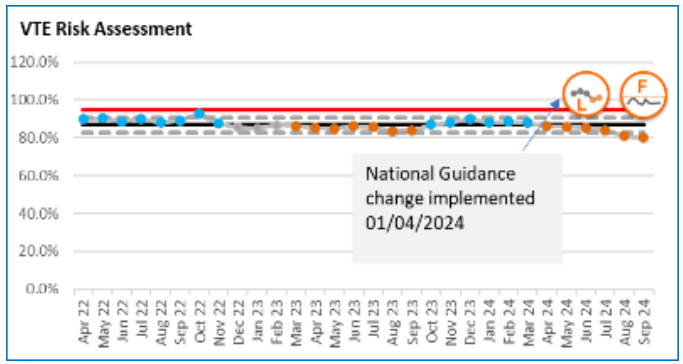
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



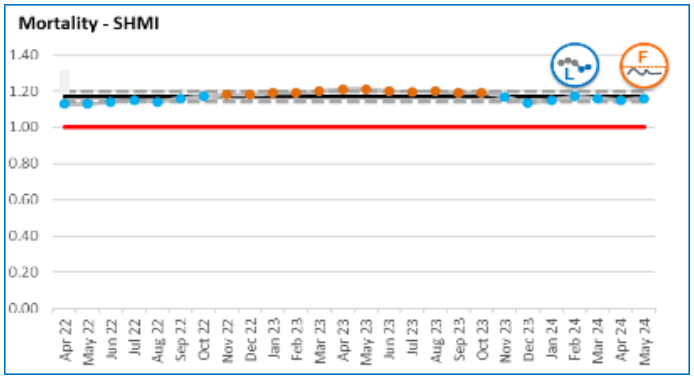
Epsom & St Helier

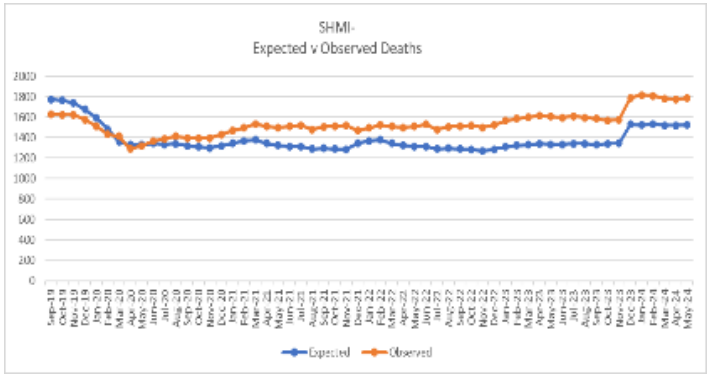


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE Performance – 63.5%. Not meeting target of 95%	National reporting of VTE risk assessments, which had been paused due to the pandemic, has now been reinstated. Previously, the guidance did not specify a time frame for completion. However, it now states that risk assessments should be completed within 14 hours, in line with NICE standards. As a result, reported performance has been affected.	• The Hospital Thrombosis Group and Clinical Informatics are working alongside ESTH to standardise reporting across gesh and have agreed on using DTA (decision to admit time) for patients admitted via ED. Further discussions are also planned to ensure various patient groups are cohorted in the same way for reporting. • A review is being carried out by gesh of the VTE risk assessment form and the rules applied to the alerts on iCLIP to encourage higher completion rates. • Targeted training and education will be provided to poorly performing areas as identified on Tableau.	Aim of incremental improvement: 10% by end of March 2025 and review progress.	Sufficient for assurance.
ESTH: VTE Performance – 80.1%. Not meeting target of 95%	VTE performance of 80.1% for September, down from 84% in August 2024. Considering the high turnover of patients in areas like Chuter Ede, AMU, Surgical Care Suite, Renal Day Case and M2, Gynae Day Unit, timely completion of VTE risk assessments remains an issue. **To note ESTH are using Ward Admission Time as the starting point for patients admitted via ED. Discussion ongoing to align across gesh.**	• Actions completed since last update: Updated VTE policy approved at Policy Review Group at the beginning of October 2024 and awaiting final SLT approval • Increased VTE Clinical Nurse Specialist ward visibility to monitor VTE prevention practice, advise, support and engage patients and staff directly with both risk assessment completion and prevention strategies	March 2025	Sufficient for assurance.

Safe, High-Quality Care

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



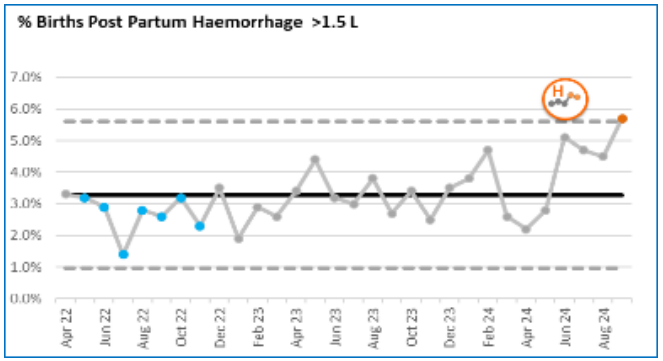


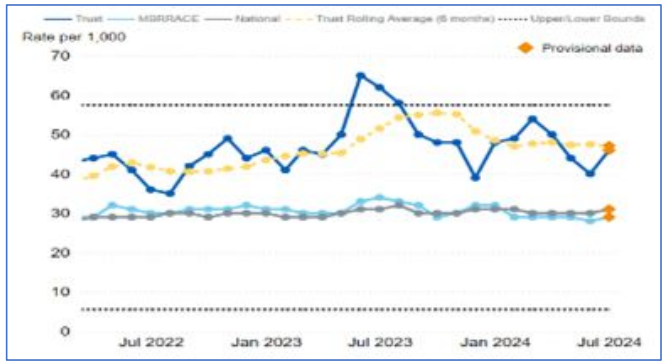
SHMI Source NHS Digital data based on rolling 12 months- June 2023 to May 2024 reported in October 2024

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 above 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. Other Trusts were due to report data in a similar fashion from July 2024. To date 4 Trusts in London have moved to this methodology but the majority continue to report SDEC data as inpatient data. •This has led to a fall in the expected number of deaths which is evident since this time point. ••SHMI remains elevated although the trend has been reducing, ESTH remains an outlier.	•Deep dives and thematic analyses of outlying areas have been completed which included electrolyte imbalances, UTI, COPD and pneumonia and did not show any quality concerns. •An in-depth review of themes from Structured Judgement Reviews (SJRs) has identified areas of improvement and cases where care concerns are identified are reported and investigated. •Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. •Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. •Clinician-Coder collaboration will be extremely beneficial to improve the recording. Coding has improved and is continuing to be reviewed but in areas such as UTI and Acute Bronchitis needs more improvement. •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 Maternity % Births Post Partum Haemorrhage >1.5 L



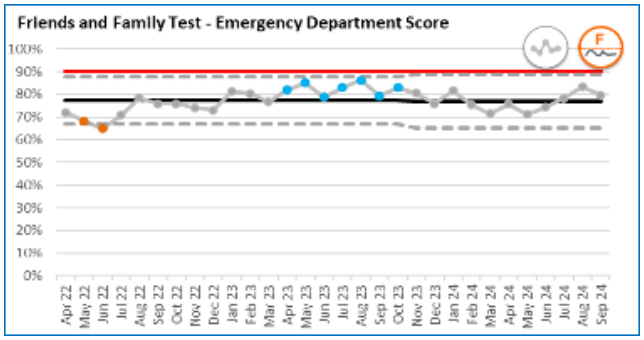


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Performance has just hit the upper process limit showing special cause variation of a concerning nature	*Peer Performance (MBRRACE Grouping) – 2.57% SGUH Performance – 5.7% The rate has increased above the upper control limit in September 2024 in our internal reporting tools. However against MBRRACE data although higher than peers we are not outliers as performance is within the upper and lower bounds. We have been taking an increased number of accreta referrals since June from Kings since the cyber attack and Oxford since their team changed which has resulted in a slight increase in the number of PPH's Accreta's (morbidly adherent placenta) are guaranteed to bleed and certainly influence the haemorrhage rate	This will be monitored, as we do not yet know if this will be sustained.	Under review	sufficient for assurance

*Benchmarking data from Maternity Services dashboard - NHS England Digital

Safe, High-Quality Care

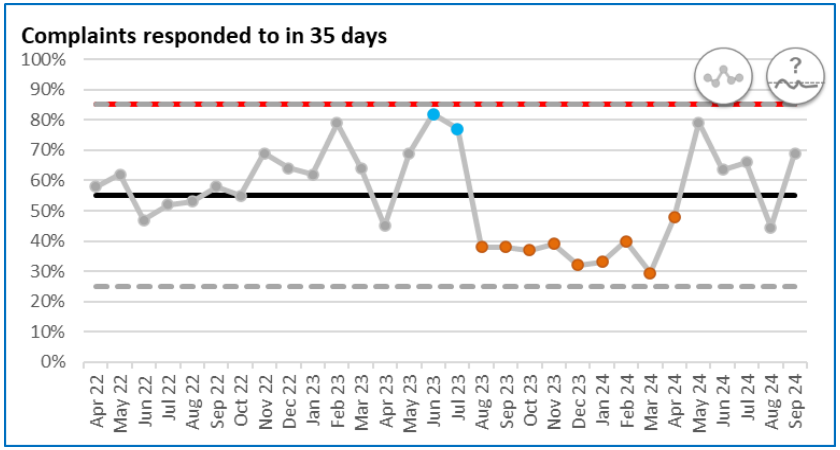
Exception Report | SGUH Patient Experience



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 well above the national average with 1,456 patients responding to the survey in September 2024. The number of patients that would recommend the department to friends and family was 80% for September 2024, slightly lower than August but an improvement on the previous months, and above the national average for EDs of 79%. During September 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. Since August, we can now see the FFT score and response rate by area, including Children & Young People Emergency Department, Urgent Treatment Centre and Enhanced Primary Care Hub. This will enable us to review the patient feedback from each area with the relevant leads, share with the teams and make it easier to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 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. We are also offering all patients a comfort pack, consisting of eye masks and ear plugs - ongoing 3. Nurse In Charge (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 ongoing 4. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles ongoing 5. 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 - ongoing 6. 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 - ongoing	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. Ongoing unplanned staff absence and reallocation of cases has supported some improvement to meet response timescales for the reporting period. As of 17 September 2024, there are a total of 104 open complaints for ESTH. 25 of which had been identified as needing investigation of 35 working days. Of these 25 complaints, 15 have breached the 35 working days response timescale: 4 of these are from August 2024.	Several actions as part of the complaint's improvement work stream are underway to support improving this metric and are ongoing and previously reported. A review and re-allocation of current cases has taken place within the complaints team to support completion of complaint responses and staffing support will be reviewed again at the end of December 2024.	December 2024	Not sufficient for assurance

Operational Performance

Operational Performance

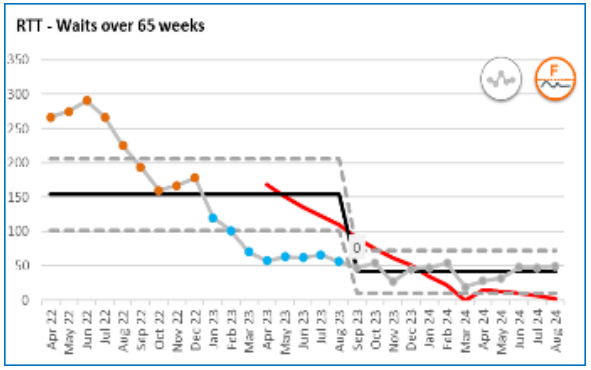
Overview Dashboard | Elective Care

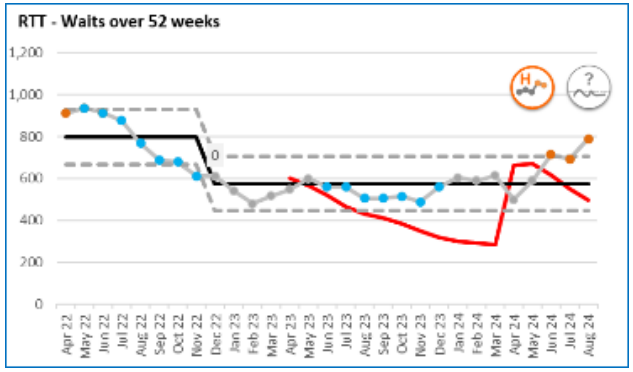
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Elective Ordinary Activity	Sep 24	1012	1055	1200				Sep 24	675	624	702			
Elective Daycase Activity	Sep 24	4426	4480	4546				Sep 24	3087	3153	3302			
Outpatient first attendances without a procedure - ERF scope	Sep 24	27443	28853	21595				Sep 24	11022	11563	11919			
Outpatient procedures - ERF scope	Sep 24	13498	11850	16153				Sep 24	11662	11023	11708			
Diagnostic Activity	Aug 24	19866	19245	21345				Aug 24	17801	17176	16691			
BADS All Daycase & Outpatient Procedures % of total procedures	Jun 24	80.4%	80.9%	83.6%			Lowest Quartile	Jun 24	77.7%	78.0%	83.6%			Lowest Quartile
Theatre Utilisation (Capped)	Sep 24	79.5%	79.1%	85.0%			Lowest Quartile	Sep 24	80.4%	80.5%	85.0%			2nd Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Aug 24	1.5%	1.0%	5.0%			Lowest Quartile	Aug 24	4.8%	5.0%	5.0%			Top Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Sep 24	53.2%	51.6%	49.0%				Sep 24	46.2%	46.0%	49.0%			
Outpatients Missed Appointments (DNA Rate)	Sep 24	10.9%	10.2%	8.0%			Lowest Quartile	Sep 24	6.5%	6.5%	6.0%			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Aug 24	17.9	16.9	16.0			2nd Quartile	Aug 24	52.4	53.3	16.0			Top Quartile
RTT - Waits over 65 weeks	Aug 24	47	49	2			Top Quartile	Aug 24	186	192	25			2nd Quartile
RTT - Waits over 52 weeks	Aug 24	693	789	496			3rd Quartile	Aug 24	921	884	775			2nd Quartile
RTT - Total Size Incomplete Waiting List	Aug 24	64793	66612	65457				Aug 24	50341	50566	46340			
RTT - Percentage within 18 weeks	Aug 24	65.6%	64.3%	92.0%			Top Quartile	Aug 24	65.5%	64.8%	92.0%			2nd Quartile
RTT - Median Waiting Time	Aug 24	12.0	12.6	-			Top Quartile	Aug 24	12.0	12.5	-			
Cancer - 28 Day Faster Diagnosis Standard	Aug 24	77.1%	70.4%	77.0%			2nd Quartile	Aug 24	87.4%	86.7%	77.0%			2nd Quartile
Cancer 31 Day Decision To Treat to Treatmnent Standard	Aug 24	97.1%	97.6%	96.0%			2nd Quartile	Aug 24	99.0%	100.0%	96.0%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Aug 24	80.9%	77.2%	70.0%			2nd Quartile	Aug 24	86.4%	85.6%	85.0%			Top Quartile
Diagnostics - 6 Week Waits	Aug 24	1.9%	3.5%	5.0%			Top Quartile	Aug 24	8.4%	8.5%	5.0%			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Sep 24	1	5	0			2nd Quartile	Sep 24	2	0	0			Top Quartile

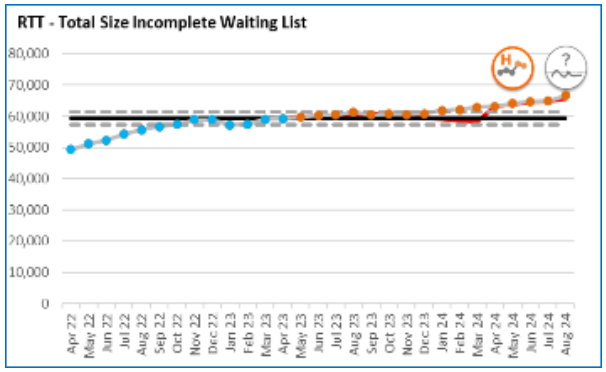
Targets based on internal plan for DC/EL activity and OP ERF Scope

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)



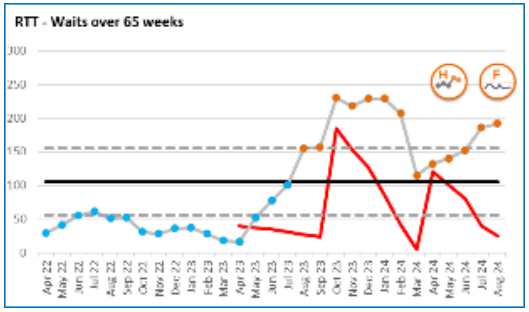


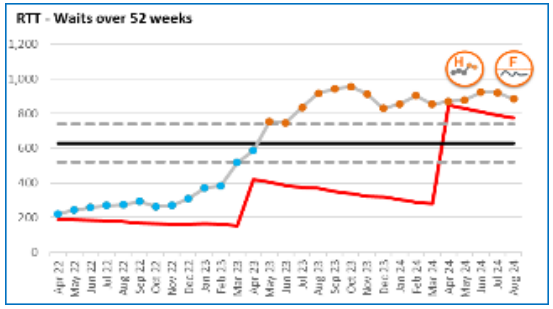


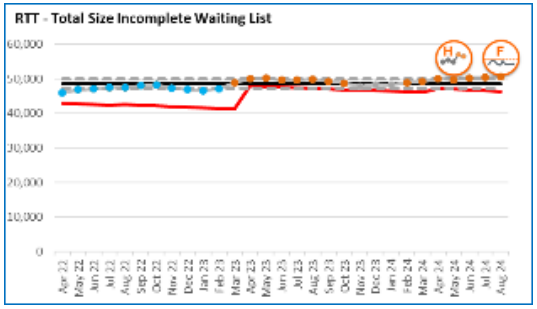
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 2 52 week waits behind plan of 496 Waiting list size behind plan increasing trend	• 65 week waits reporting 49 open pathways against plan of 2. Largest proportion of waits within Neurosurgery (15), Plastics (7), Gynae (7) • 2.8% Waiting list growth in the last month • Growth driven by non-admitted PTL • 789 patients >52 weeks. The biggest increase in Neurosurgery and Bariatric Surgery.	**Revised approach to managing long waits:** The elective access meeting has adopted some processes and principles around the management of long waits and this is now a priority agenda item on the weekly meeting. With specific actions monitored throughout. **Capacity Demand Modelling:** To fully understand our waiting list growth, we need to properly model what our core capacity is. Then we can focus on driving change and improvement on those areas with gaps **Back to Basics:** Review of PTL meetings to set clear agenda and actions. Holding people to account, learning from breach themes and managing processes **Booking Processes** We are reviewing how we book first outpatient appointments to improve the wait time for patients	**October 2024** **January 2025** **December 2024**	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



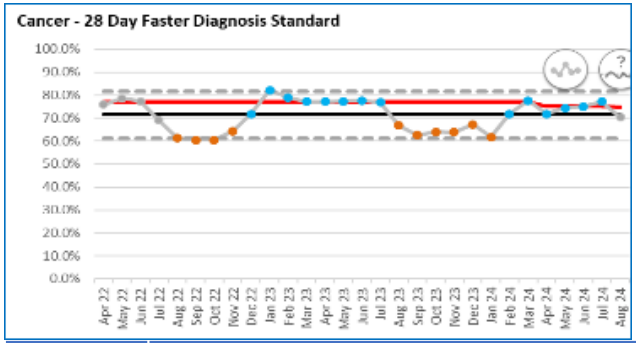




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan 52Wk & 65Wk waits not meeting plan special cause variation	• 52 week waits remained above the ambition of 775 in August 2024 with a total of **884** patients waiting more than 52 weeks. The specialties with the highest cohort were Gynaecology (321), Trauma & Orthopaedics (99) and Cardiology (72). • 65 week waits also remained above the ambition in August 2024 with a total of **192** patients waiting more than 65 weeks. The specialties with the highest cohort were Gynaecology (128), Dermatology (12) and Respiratory (11) • Gynaecology remains the most challenged specialty at ESTH with several actions being taken to mitigate. • T&O (EOC) backlog continues to grow mainly due to referrals from partners outpacing their capacity. • Challenges within several other specialties including Vascular, Paediatric Dentistry, Dermatology, Cardiology and Respiratory for a variety of reasons, as well as the recent loss of theatres for 10 weeks.	• 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 5672 at the end of August 2024. • To support the clearance of the 65 week gynaecology waiters and address the inpatient/daycase capacity gap in Gynaecology, insourcing commenced in August and continued throughout September. • T&O's main cause of increase in long waiters is lack of capacity (referrals from partners outpacing their capacity, with exception of a few consultants) and continuation of referrals being sent to SWLEOC at high RTT waits. EOC are working with Partners to raise issues regarding particular consultants capacity and reviewing options for internal pooling for patients who are happy to have surgery under a different consultant. Where internal pooling is not possible, if clinically appropriate patients are contacted by SWLEOC team and offered transfer of care to a consultant from a different Partner/SWLEOC. • 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. Challenges within several specialties for a variety of reasons as well as the recent loss of theatres for 10 weeks. ESTH are expected to have less than 120 65 week waits by the end of September 2024, and less than 75 by the end of October 2024.	Sufficient for assurance

Operational Performance

Exception Report| SGUH Cancer Faster Diagnosis Waiting Times

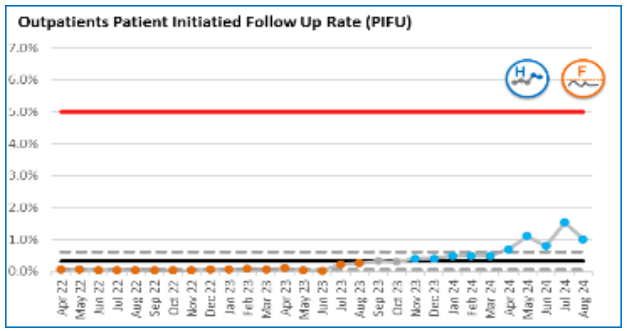


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS – Plan not met in Aug24	**Faster Diagnosis performance of 70.4%** • Gynaecology performance deteriorated and is currently (35.7%) due to timely triage and access to one stop clinics and scans. • Skin moved to a non compliant position (64.6%) due outpatient capacity management • Breast moved to a non-compliant position (75.7%) due to a sustained increased demand and a lack of capacity • Lower GI FDS improved • Radiology reporting turnaround times are impacting diagnostic waits. • Pathology workforce challenges are impacting all pathways with a deviation from agreed turnaround times. **62-day Performance continued to meet plan achieving 77.2%** • Compliance achieved by H&N, Skin and the consultant upgrade pathway. • Compliance achieved by H&N, Skin and Urology in the 62 day GP pathway. • Diagnostics and scanning delays impacting Gynaecology and GI services (50% and 33.3% respectively). • Theatre capacity constraints in Lung, Breast and Urology (Robotic access).	• **Gynaecology:** Increased focus on PTL management and one stop capacity coming online to reduce waits for first appointments. • **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's have been planned for September/ Octobers 24. • **Haem Oncology clinic** demand and capacity review is in progress. • **Breast** has a recovery plan in development with support from RMP. Cultural/ behaviours are being addresses along with operational issues. • **Service improvement** project manager joined in August 2024 and is supporting the cancer programme of work with a particular focus on skin. • Theatres (Robotic) have continued to hold Saturday sessions to provide capacity to match demand.	Recovery time scales are dependent on Resources.	sufficient for assurance

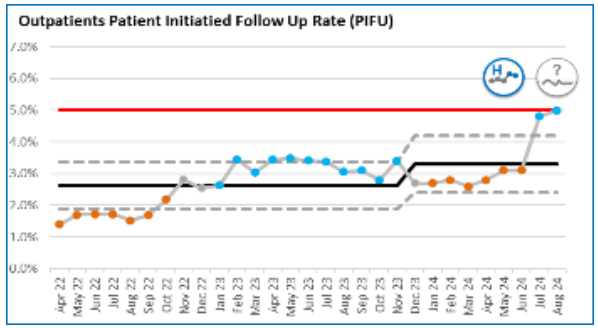
Operational Performance

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

St George's



Epsom & St Helier



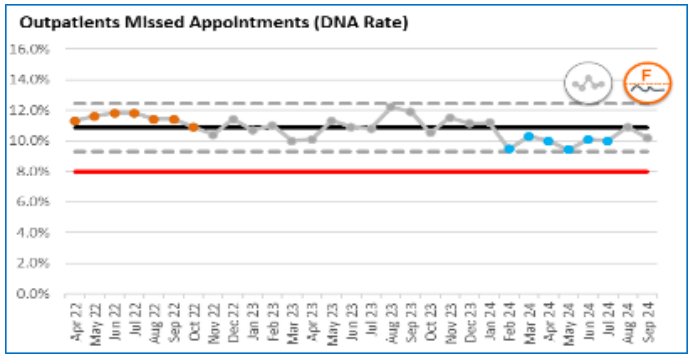
Rate reported one month in arrears in line with Model Hospital reporting

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 August was 1% - as per Model Hospital. Activity continues to increase with the technical solution to PIFU now designed and rolled out in 9 services	• From 23rd September (IT Transformation led project) all specialities will have the functionality to place PIFU orders, however we are phasing the approach to ensure correct governance of PIFU pathways • We currently have over 2400 patients on a PIFU pathway. Physiotherapy are our highest users achieving 6% position in September • October service to go live and Neurology, Neurosurgery and Audiology and November go live are Community Paediatrics	2% planned for October 2024 – post launch of PIFU order for all specialities	sufficient for assurance
ESTH PIFU Rate achieved in August 2024	Compliant in August 2024 as achieved the 5% target	• PIFU utilisation increased to achieve the 5% national target in August 2024. Multiple teams across the divisions have contributed to this growth which is very encouraging and a testament to clinical teams embracing new ways of working to the benefit of their patients and their service's capacity. • We continue to work with teams to share best practice and to use data to encourage clinician peer to peer discussions regarding which patients and conditions are suitable for either discharge or PIFU and which require a follow up. This work is supported by adapting the best practice template shared by Maidstone and Tunbridge Wells NHS Trust.	3.5% Trust target and 5% national target achieved in August 2024	sufficient for assurance

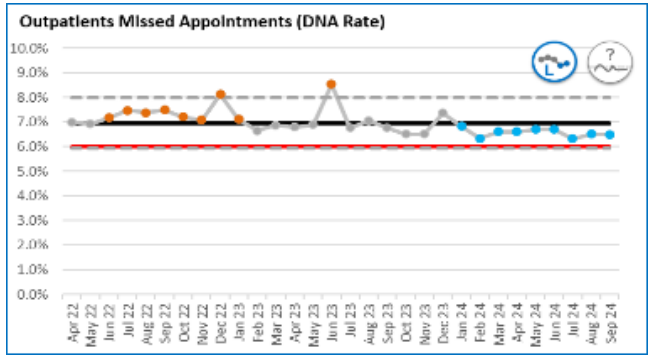
Operational Performance

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

St George's



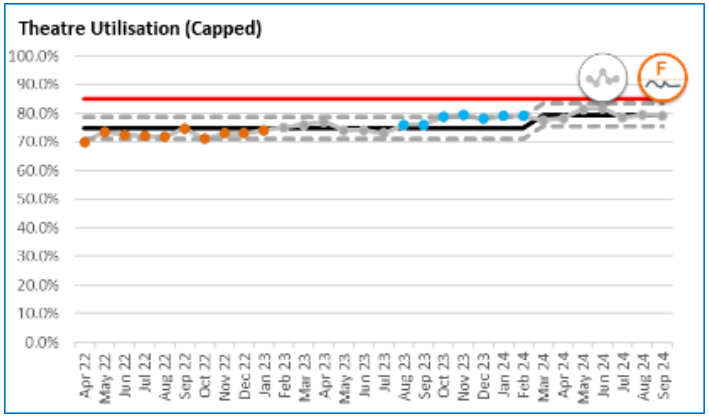
Epsom & St Helier



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	Current DNA rates of 10.2% are below the national mean however remains higher than 8% target. Highest levels of DNA rates remain in our new appointments	• Speciality line by line DNA weekly performance is presented to all operational leads in Elective Access Meeting. • There is a deep dive, with actions being undertaken in the areas with highest areas of DNA rates	TBC	sufficient for assurance
ESTH Normal variation, no significant change Failing target of 6%	DNA rates remained static, just 0.5% higher than our target of 6%. Reasons for non-compliance vary across the specialties, however there are common themes: Nurse clinics are not budgeted for on the text reminder service; Incorrect patient details are a factor for av.30% patients; A lack of an efficient 2-way text system for patients to contact us digitally.	• A bespoke Envoy text reminder pilot for specific Dermatology nurse clinics is running. • Discussions are starting regarding funding for expansion of the text reminder service to nurse clinics. • Reception teams continue to ask patients if their details have changed to help mitigate incorrect contact information. • The patient portal (scheduled for implementation after CERNER) will provide an efficient digital 2 way messaging process. Until then DrDoctor is being used for targeted clinics such as Paediatric Dermatology to reduce DNAs where the current text reminders are not proving effective enough.	TBC	sufficient for assurance

Operational Performance

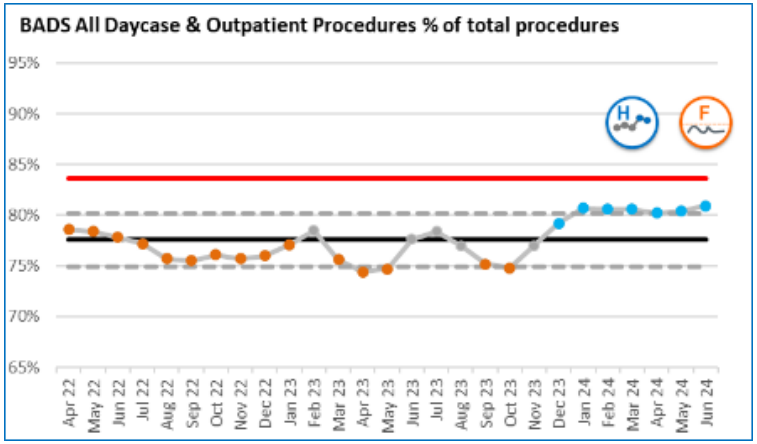
Exception Report| SGUH Theatre Utilisation (Capped)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Theatre Utilisation (capped): 79% 81%- IP 77%-DSU 67%- QMH	DSU and QMH utilisation significantly below target The surgical specialties with the lowest utilisation were Dentistry (74%), Gynae (74%) and Vascular (75%). In September, there were 39 OTDC reported.	• 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.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH Daycase & Outpatient BADS Procedure Rates

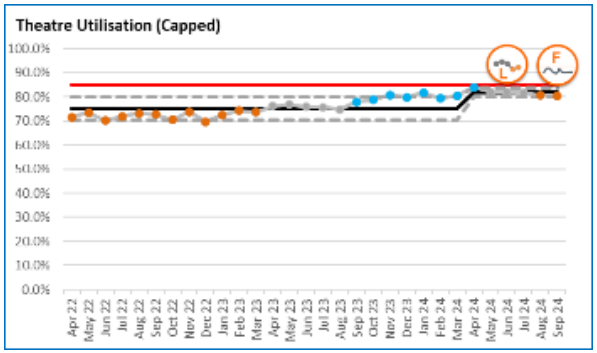


Please note Model Hospital have updated BADS methodology now including outpatient procedures. The calculation now measures the number of Outpatient Procedure and Day case Procedures as a proportion of all Procedures (Outpatient, Daycase and Inpatients). This is not comparable to previous data.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: Improving trend however performing below benchmark of 83.6%	Processing of patient length of stay remains an issue due to data process time lapse. Effects of data correction and improved recording continues to support 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 Model Hospital data suggests opportunity to covert to outpatient and daycase which is being reviewed.	• 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. • Deep dive into BADS metric to understand opportunity for improvement to be presented at Recovery Board October 2024.	TBC	Sufficient for assurance

Operational Performance

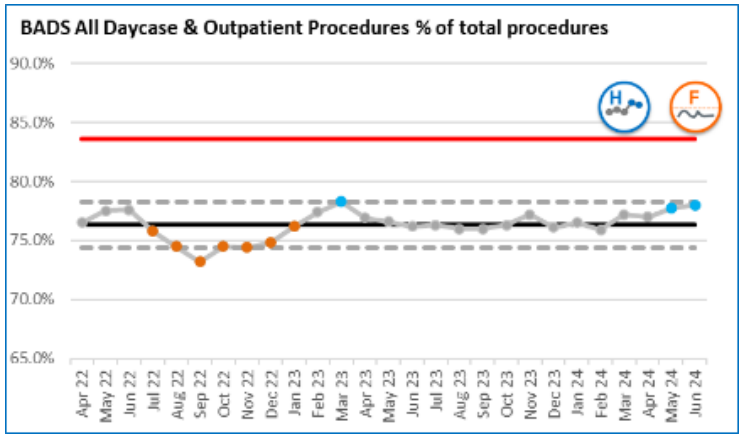
Exception Report | ESTH Theatre Utilisation (Capped)



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%)	B4 closed theatres now back up and running – as of 19th September. Late starts remained at an average of 18 mins which is well under target (30), early finishes were just under target (30) at 29 mins. OTDC fell from 9% in August, back down to our average of 8% in September. **Estate issues** was a top reason in Sept as Epsom was hit with ventilation issues which have now been resolved.	• **We remain in the top performing quartile nationally, as per Model Hospital.** Our value = 82% (09/09/2024). Our peer medium = 80.9% • For cancellations - **Clinical cancellations** continue to equate for over 40% of all cancellation reasons. **Patient Choice** is now our second biggest category. • Therefore, as part of the ESTH's **'On the day cancellation' (OTDC) Task & Finish Group**, the team has recommended that all patients booked at short notice (<72 hours) are asked if they are 'fit & well' at the point of booking. As we approach winter we expect to see a growing number of cancellations due to cough/cold. **DNA's** have also increased significantly from 6% to 14% in September, ESTH is therefore completing a deep dive to better understand how more can be avoided. • Work is underway to expand our **POA pilot** across ENT and T&O at Epsom - We have made an application for the GESH awards- wish us luck! • The ESTH **'Maternity T&F Group'** is due to meet again next month, the project is aimed at supporting Maternity to better utilise the elective lists they have at St Helier. A key objective is to provide the team with an electronic dashboard, training (which has now been provided) and time stamps (which have started being entered into iPM). • The ESTH **'Gynae Scheduling T&F Group'** started this week. This project is aimed at ensure effective planning/scheduling and management of Gynae operating sessions, and will include representation from Gynae & Theatre Service Managers, Transformation Lead, Theatre Nursing Leads, and PPCs.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH Daycase & Outpatient BADS Procedure Rates



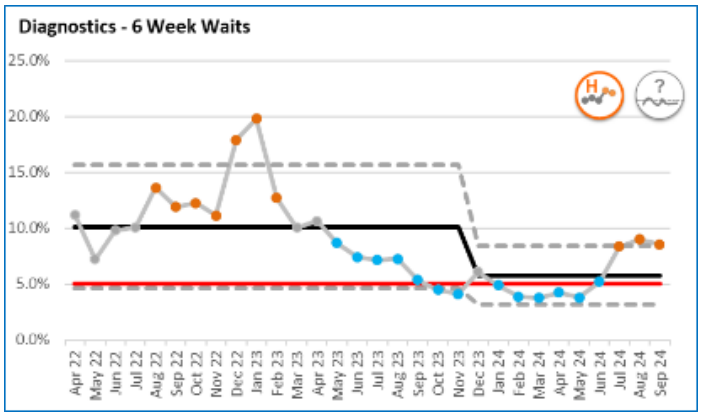
Please note Model Hospital have updated BADS methodology now including outpatient procedures.
The calculation now measures the number of Outpatient Procedure and Day case Procedures as a proportion of all Procedures (Outpatient, Daycase and Inpatients). This is not comparable to previous data.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Not meeting target, Improving trend	Model Hospital have recently informed us of a change/update to their BADS Performance metric. The new update to MHS will now include activity and targets for outpatient procedures. This is a significant shift from the previous MHS content which allowed monitoring of admitted patient care only (inpatient and daycase).	• Since the change, **performance has seen a decrease of on average -6%,** (84% down to 77%). • However, thanks to Nina Churchhill we now understand the **cause for the decline**. • SWLEOC has a lot of **activity that is recorded as inpatients but where the patient stays 0 days**. ESTH knows that EOC have done lots of great work on reducing so it is felt there is likely a process challenge. • **For example, for hip & knee replacement**s, the DC/OP rate is 0% on the Model Hospital. • If SWLEOC amend how they record activity this would improve the performance overall from approximately **78% to 82%.** Plus, it would give EOC the credit it deserves. • Transformation Leads have reached out to Operational Managers at EOC for a discussion.	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 8.5% not meeting target of 5%	At the end of August 2024 there are 873 patients waiting more than 6 weeks for their diagnostic (DM01), which is a slight decrease (4%) compared to July 2024. The PTL size has also seen a drop from the end of the previous month and as a result of both of these changes, our performance has remained fairly static at 91.5%. Largest proportion of 6 week breaches are within Echocardiology with 467 patients waiting >6weeks at the end of August 2024. Gynaecology Urodynamics also remains high with 126 patients waiting >6weeks at the end of August 2024.	• Echocardiography has seen a continual increase since April 2024, due to loss of external funding. From September we are expecting to see an initial increase in activity (through additional CDC/ERF funded capacity), moving the service back towards a more stable position, with further reduction in breaches from October onwards and additional locum support. In addition, ESTH has also agreed to recruit 2wte cardiology physiologists substantively, which we have a likely expected start (if recruitment is successful) from January 2025. We are also expecting a further small increase in capacity via Croydon mutual aid which is due to start in October 2024. • Gynaecology Urodynamics services continue to face high demand, and while we had planned to increase capacity by the end of September, this will be slightly delayed as one of our nurses needs to retake her exams. Once training is completed, we will introduce 16 additional appointment slots per month. We have also conducted Demand & Capacity (D&C) work to ensure we have sufficient resources in place to meet future demand. In addition, we are progressing with training Healthcare Assistants (HCAs) to support urodynamic procedures. These efforts will strengthen service delivery and improve patient care in the near future.	TBC	sufficient for assurance

Operational Performance

Overview Dashboard | Urgent and Emergency Care

St George's

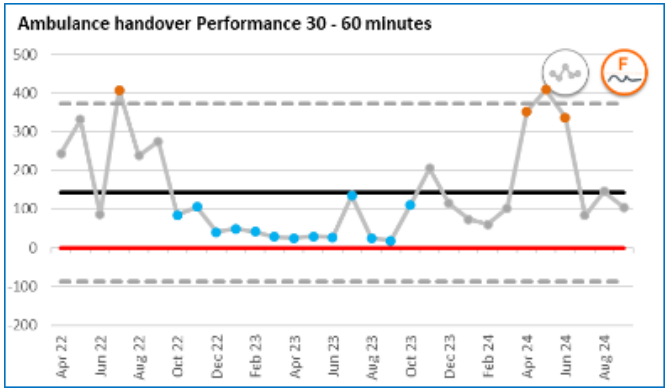
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
4 Hour Operating Standard	Sep 24	80.5%	78.3%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%)	Sep 24	8.0%	9.2%	8.8%			2nd Quartile
Ambulance handover Performance 30 - 60 minutes	Sep 24	146	105	0			
Ambulance handover Performance 60+ minutes	Sep 24	1	1	0			
Mental health delays 4 Hour Breaches	Sep 24	142	143	-			
30-Day Emergency Readmission Rate	Sep 24	11%	12%	-			
Non Elective Length of Stay	Sep 24	6.4	6.1	5.4			
Length of stay > 21 days (super stranded)	Sep 24	159	157	117			
Overnight G&A beds occupancy - Adults	Sep 24	95.3%	95.6%	90.8%			
Number of patients not meeting criteria to reside (Daily Avg)	Sep 24	138	136	86			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 24	77.6%	75.5%	78.0%			2nd Quartile
Sep 24	12.5%	12.4%	9.6%			3rd Quartile
Sep 24	233	377	0			
Sep 24	29	36	0			
			-			
Sep 24	6.1%	4.4%	-			
Sep 24	7.9	7.6	6.2			
Sep 24	159	165	123			
Sep 24	89.8%	89.1%	89.0%			
Sep 24	205	206	120			

Operational Performance

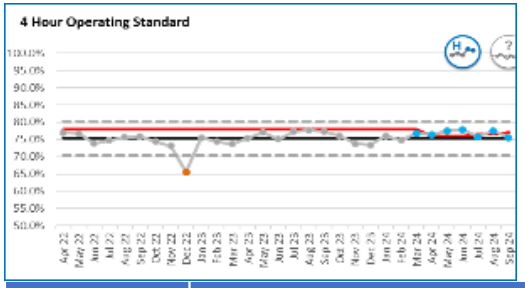
Exception Report| SGUH Ambulance Handovers

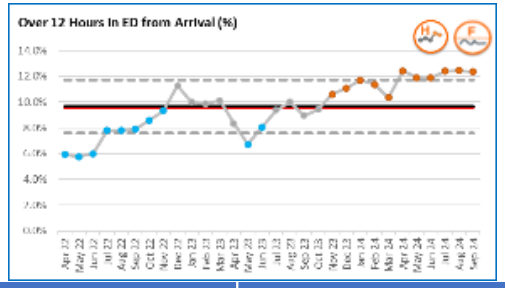


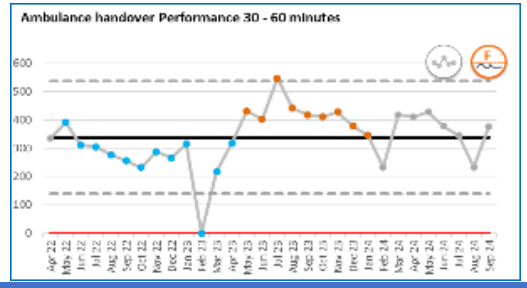
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH LAS Target consistently not met showing common cause variation.	Four Hour Performance in September 2024 fell to 78.3% compared to 80.53% in August. On average across the month, 88 ambulance conveyances arrived per day compared to 81 through August 2024. 81.2% of 2,639 LAS arrivals were off-loaded <15 minutes. Lower rates in the number of patients waiting for more than 30 minutes for ambulance handover are being maintained. The key drivers of operational pressures and delays are: • DTA's in department • high number of complex mental health patients spending >24hrs in department • Increased hours of corridor care	• Dedicated Treatment pod for faster delivery of IVs • Dedicated investigation cubicle to reduce time to finding equipment • Maintaining in-and-out spaces to aid flow • 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 • Further development of SDEC inclusion criteria • Direct access to Paediatric clinics for UTC plastic patients. • 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 • Increased discharge lounge capacity – starting September – allowing for increased criteria of patients that were previously rejected.	TBC	Internal validated figures reported

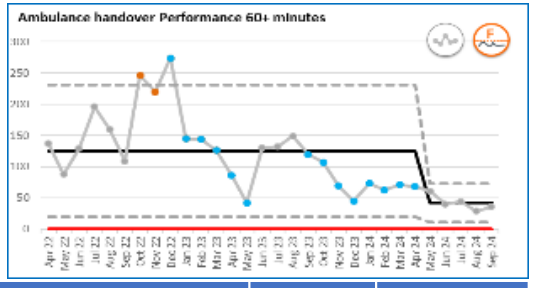
Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers





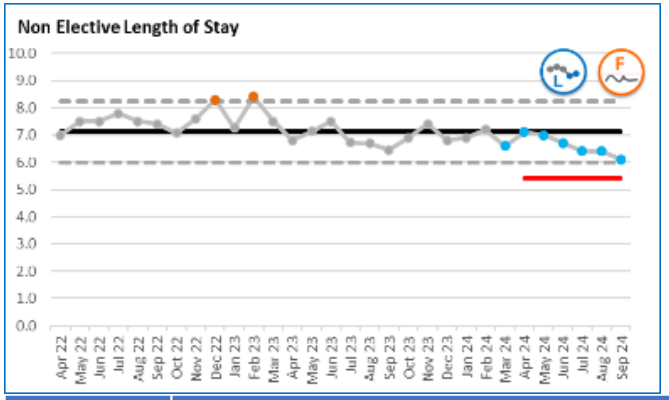


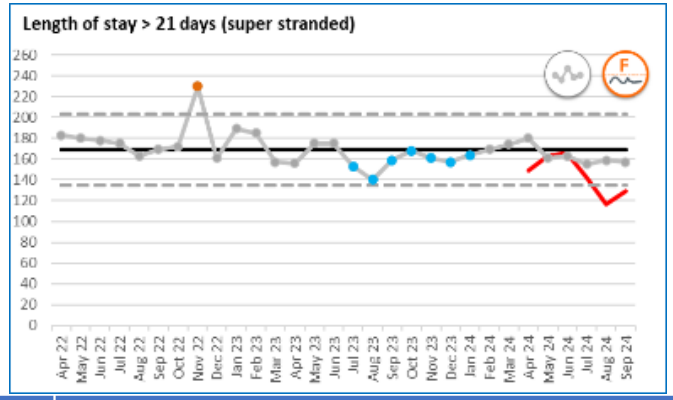


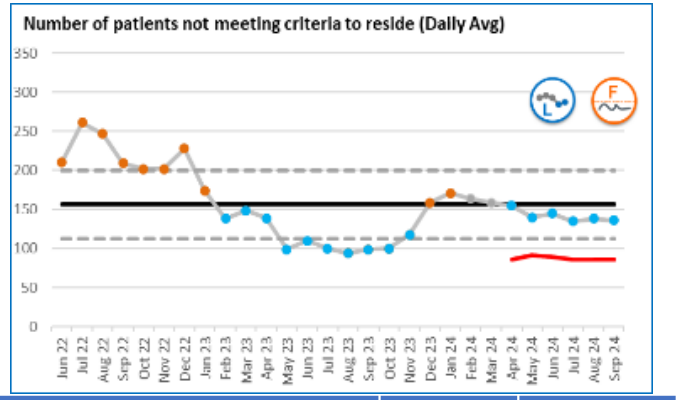
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 77% ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 30-60 Min Consistently not meeting target	We saw a deterioration in ED performance in September 2024, reporting 75.5% performance versus 77.6% in August 2024. Patients spending longer than 12-hours in ED remains challenging with 12.4% of patients spending longer than 12-hours in the department in September 2024. 30-day re-admission rates improved to 4.4% in September versus 6.1% in August 2024. A deterioration in 60-minute ambulance handover delays in September 2024 (36) compared to August 2024 (29). However, we continue to see a downward trajectory in 60-minute delays since November 2023 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 High numbers of MH 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 Urgent Care Transformation programme hosts an agreed set of priorities for 2024/25 which includes PLACE deliverables. This includes key outputs and supporting metrics, including but not limited to, the electronic streaming/redirection and direct booking of patients to UTC/SDEC/GP for patients who attend ED but do not require acute care to support alleviation of ED capacity and admission avoidance. • Work continues to support LAS direct conveyances to UTC, GP, SDEC, SACU, and timely internal surgical transfers from Epsom to St Helier. Activity within these areas continue to increase. • Through SWL winter money allocation we are working with Sutton PCN to support additional GP resource in ED over winter, due to commence late October/early November and will support the assessment and treatment of patients presenting to the department. • The launch of our Same Day Acute Frailty response service took place in April 2024. The provision is supported by a dedicated space and frailty MDT to ensure early and specialty assessment and treatment with clear exit pathways supporting direct/early flow from ED for appropriate patients supporting admission avoidance and reduced length of stay. Currently developing a proposal for enhanced clinical support to the frailty hub over the weekend which will include senior clinical in-reach/review to our frailty hub. • Focussed work with 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 rapid access clinics for appropriate patients presenting to ED.	TBC	sufficient for assurance

Operational Performance

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



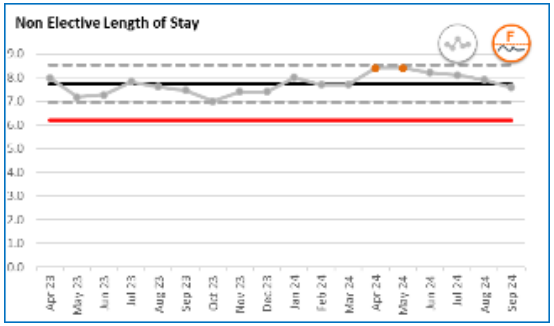


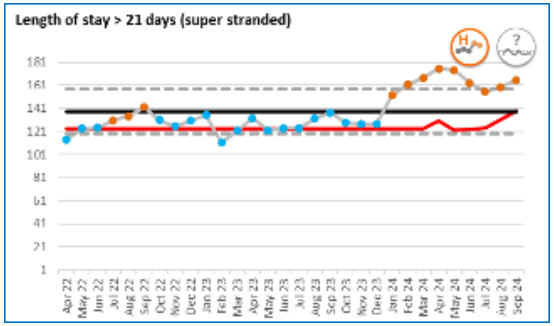


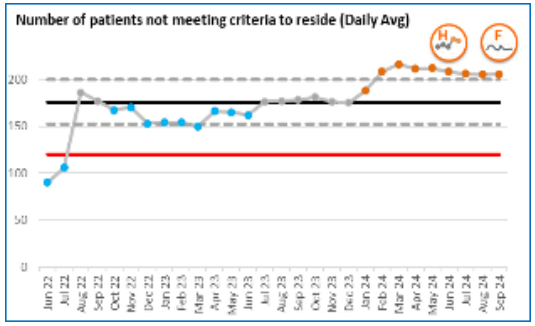
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR LOS Los>21days: Consistently not meeting target, all showing performance below mean	• Non-Elective Length of Stay showing a step change of improvement averaging 6.1 days through September 2024 • Largest cohort of patients with LOS>21 days Geriatric Medicine (avg. 31 beds per day) and Neurology (avg. 19 beds per day). • NCTR Delays – on average 136 beds per day across September. • Hospital and Social Care Interface process highlighted as highest reason for delay. In particular we see a significant number of patients awaiting Packages of Care, as well as beds in mental health institutions.	• The Emergency floor and the Integrated Care Transfer Hub continue to review if Social Workers & CLCH partners can attend on site. • There has been a notable increase in bedding in SDEC / AAA overnight which impacts ED exit flow the following day. Trust Assessor model is now BAU. • 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. • The division has agreed, with support from Senior Leadership Team to close one bay (6 beds) on MSW over the summer, planned for July – November inclusive. • Significant improvement in the number of NCTR forms completed prior to 9.30am daily, reflecting a more accurate number of patients NCTR. This is being reviewing in the daily 10.30am bed meetings.	TBC	sufficient for assurance

Operational Performance

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

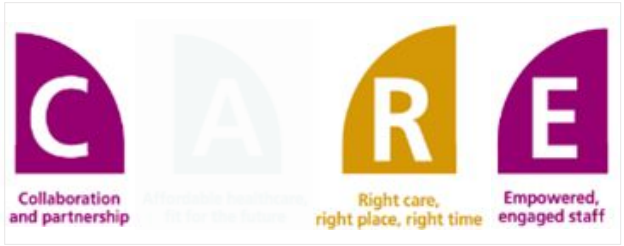






Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation not meeting plan Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Numbers of medically optimised patients on both hospital sites remain above the ambition with many patients requiring complex discharge planning to support discharge,. However, we continue to see a month-on-month improvement for non-elective LOS from a reported 8.4 days in May 2024, compared to 7.6 days in September 2024. An ongoing challenge relates to those patients on pathway 3 who require discharge to a nursing/residential home with a focussed piece of work undertaken to understand delays in deciding lead provider for discharge. This has been shared with ICB and LA colleagues and an agreement regarding timely and effective escalation 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. • The revised boarding process was implemented on Monday 2nd September successfully incorporating additional areas to board. • The complex paediatrics discharge panel meeting for complex patients who require additional support/escalation to progress discharge arrangements continues to operate. • The undertaking of weekly DMT led 14 day + LOS reviews continues. • 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 continued reduction in the number of patients with a >7-day, >14-day, >21-day, and >45-day LOS • Our Urgent Care KPI dashboard has been updated to reflect ED metrics including SDEC and UTC activity which shows increased redirection and utilisation in both areas month on month alleviating unnecessary activity in our ED department(s). LOS metrics at ward/ department level continue to receive ongoing scrutiny review enabling us to monitor areas reporting an increased LOS or patients holding no CTR allowing us to prioritise. • The review of individual patient flow/LOS work streams and attributed improvement trajectories continued to be monitored closely to ensure progression and impact on wider 1.5 days LOS reduction.	TBC	sufficient for assurance

Integrated Care



Integrated Care Performance

Overview Dashboard | Elective and Urgent & Emergency 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)	Sep 24	6	5	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	Sep 24	5	4	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Sep 24	0	3	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Sep 24	6	22	-			
Reablement Unit Bed Occupancy	Aug 24	100.0%	100.0%	100.0%			
Reablement Unit Length of Stay (Average)	Aug 24	10.0	10.0	5.0			
Two hour UCR performance	Sep 24	87.5%	88.8%	70.0%			
Two hour UCR referrals received	Sep 24	391	472	-			
Virtual ward - Admissions	Sep 24	231	274	-			
Virtual ward - Bed Occupancy	Sep 24	60.0%	62.4%	80.0%			
Virtual ward Length of Stay (Average)	Sep 24	7.6	5.4	-			
Total Waiting List Size Adult	Sep 24	1105	1025	-			
Total Waiting List Size Adult 18-52wks	Sep 24	1	2	-			
Total Waiting List Size Adult >52wks	Sep 24	0	1	-			
Total Waiting List Size Children	Sep 24	739	678	-			
Total Waiting List Size Children 18-52wks	Sep 24	315	290	-			
Total Waiting List Size Children >52wks	Sep 24	42	27	-			

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

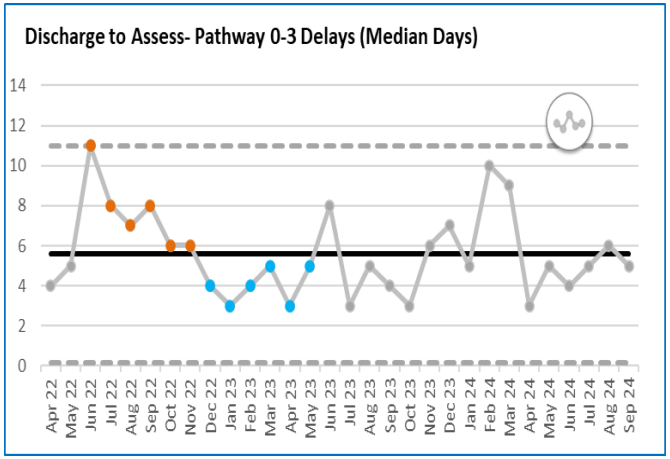
Surrey Downs

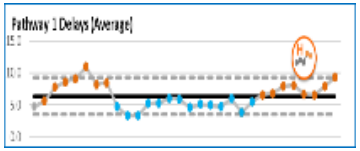
KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Sep 24	2	2	2			
Discharge to Assess- Pathway 1 Delays (Median Days)	Sep 24	1	2	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Sep 24	1	2	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Sep 24	17	19	-			
Community Hospitals Bed Occupancy	Sep 24	84.5%	87.8%	80.0%			
Community Hospitals Length of Stay (Average)	Sep 24	19	20	21			
Two hour UCR performance	Sep 24	89.5%	86.2%	70.0%			
Two hour UCR referrals received	Sep 24	522	530	-			
Virtual ward - Admissions	Sep 24	232	261	-			
Virtual ward - Bed Occupancy	Sep 24	84.0%	90.0%	80.0%			
Virtual ward Length of Stay (Average)	Sep 24	7.4	8.9	-			
Total Waiting List Size Adult	Sep 24	4882	5222	-			
Total Waiting List Size Adult 18-52wks	Sep 24	133	167	-			
Total Waiting List Size Adult >52wks	Sep 24	0	0	-			

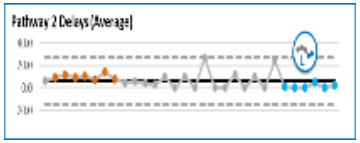
Integrated Care

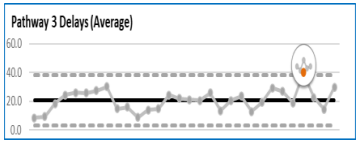
Exception Report| **Delayed Discharges (median days)**

Sutton Healthcare

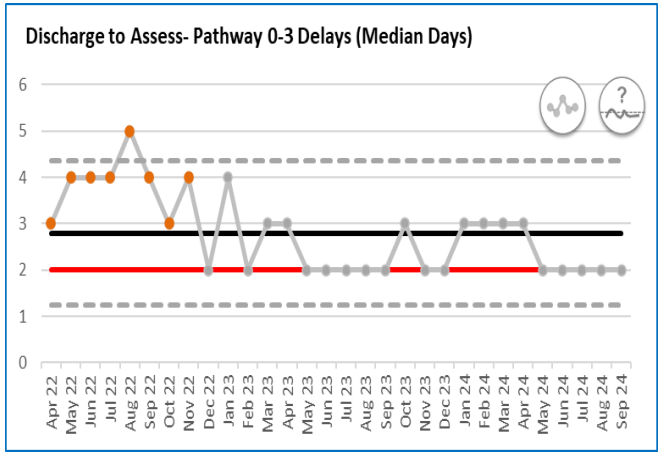


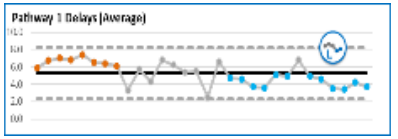


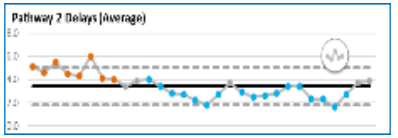


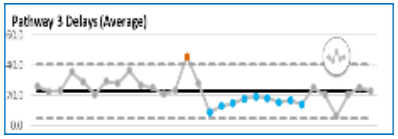


Surrey Downs





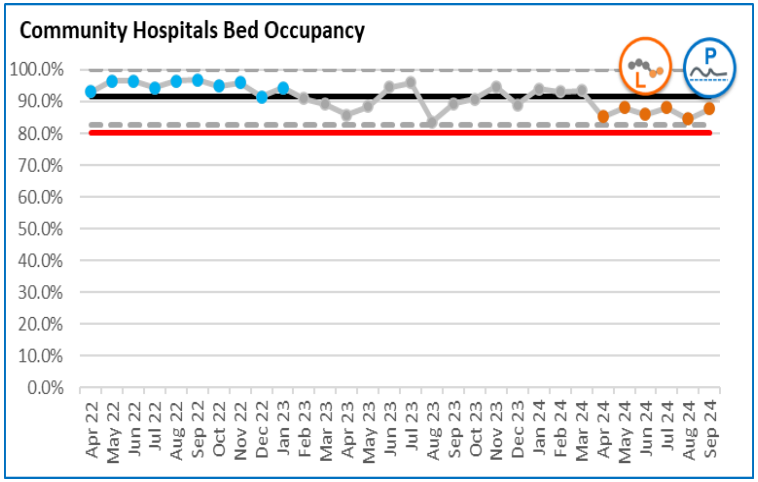


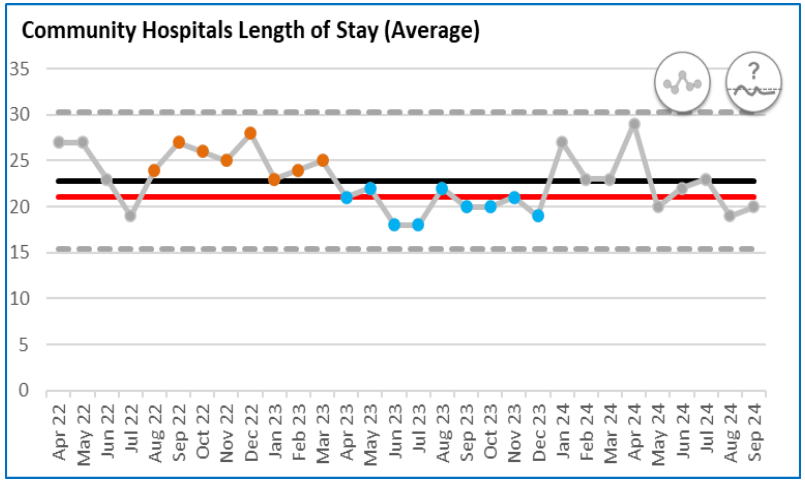


Site & Metric	Cause of variance/ non-compliance / challenges	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	• Normal variation for Pathways 0-3 combined, however Pathway 1 delays has seen a step change showing an increase in average days mainly attributable to discharge to domestic home with health care support. • On average 5 patients per day not meeting criteria to reside – primary delay reason – care transfer hub process – waiting for confirmation of immediate care needs. • Referrals to HomeFirst Service increased through September 2024.	• Focus on improving referral to discharge time. • Focus on TOCH process. • Length Of Stay reduction programme with ESTH and Sutton Alliance in progress.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Normal variation only with median days across September at 2 days in line with target with improvement being maintained. Pathway 2 delays has seen a slight increase over the past 2 months however showing normal variation.	• Length Of Stay reduction programme in development	N/A	Sufficient for assurance

Integrated Care

Exception Report| Surrey Downs Bed Occupancy & Length of Stay

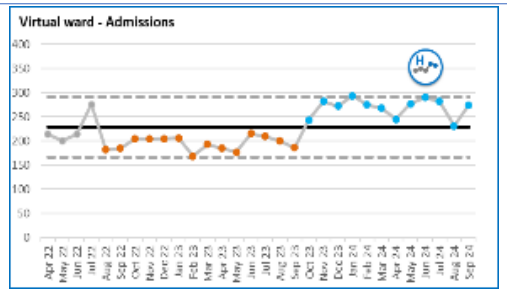
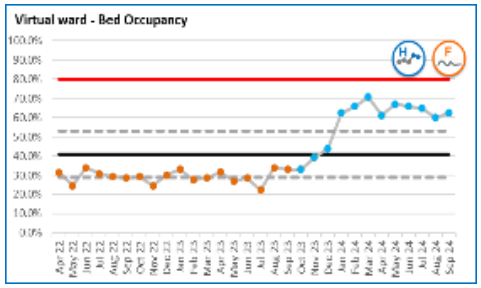
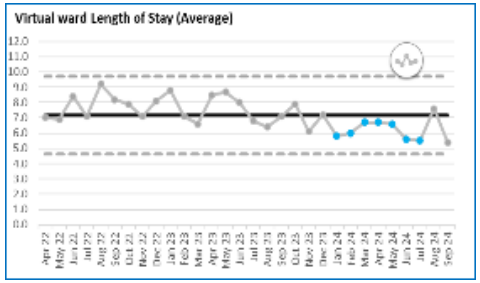
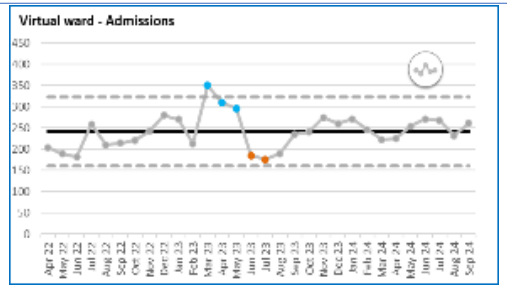
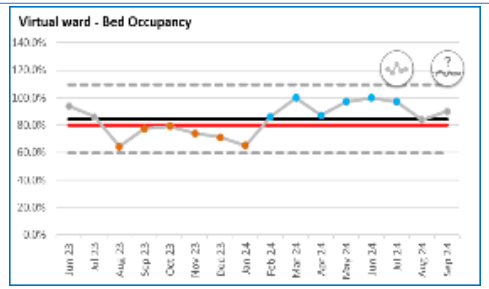
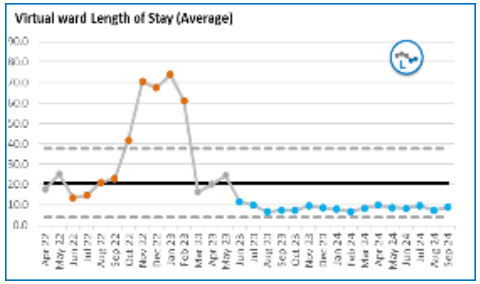




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs Health & Care	Bed occupancy continues to exceed target of 80% however levels have been below the mean for the past six months. Average length of stay showing normal variation and below target of 21 days through September.	• Process for escalations of delays is in place • Choice policy is implemented	TBC	Sufficient for assurance

Integrated Care

Exception Report | Virtual Wards

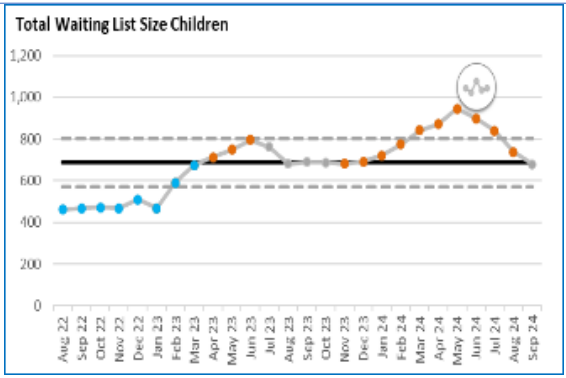
Sutton Healthcare			
Surrey Downs			

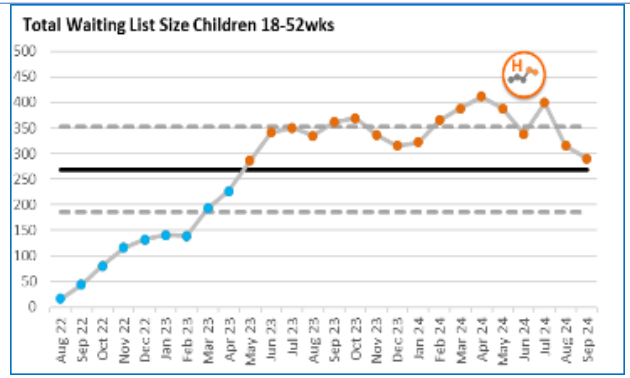
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Positive increase in admissions and bed occupancy in recent months, however occupancy rates are beneath target of 80%. Average length of stay showing normal variation and is below the mean through September 2024	• SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. • LoS reduction programme with ESTH and Sutton Alliance is in progress. • Engagement work with appropriate wards and with clinicians continues. • Work to explore additional pathways into virtual ward in development.	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

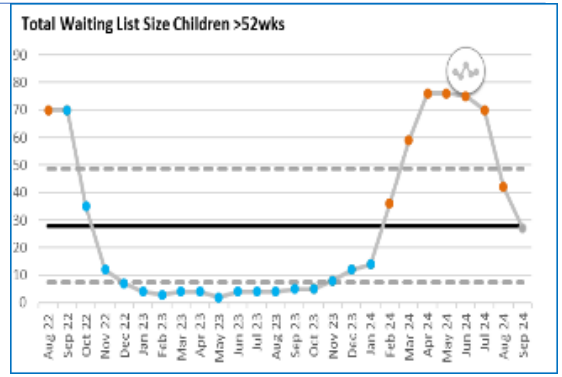
Integrated Care

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 27 children waiting for 52+ weeks, a decrease from 42 in the previous month.	• 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

39

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Sep 24	4.2%	4.6%	3.2%		F	
Agency rates	Sep 24	1.9%	1.5%	-	L		
MAST	Sep 24	90.9%	90.8%	85.0%	L	P	
Vacancy Rate	Sep 24	6.7%	7.7%	10.0%		P	
Appraisal Rate Medical	Sep 24	81.9%	80.4%	90.0%		F	
Appraisal Rate Non Medical	Sep 24	75.1%	73.8%	90.0%		F	
Turnover	Sep 24	12.7%	12.4%	13.0%	L	?	
Percentage BAME staff band 6 and above	Sep 24	45.6%	46.2%	-	H		

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 24	4.8%	4.9%	3.8%		F	
Sep 24	2.4%	2.3%	-	L		
Sep 24	87.3%	86.8%	85.0%	H	?	
Sep 24	12.0%	12.3%	10.0%		F	
Sep 24	96.4%	95.2%	90.0%		P	
Sep 24	78.8%	78.5%	90.0%		F	
Sep 24	11.5%	11.1%	12.0%	L	?	
Sep 24	39.2%	39.3%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Sep 24	5.6%	6.8%	3.8%		?	
Agency rates	Sep 24	3.5%	6.1%	-			
MAST	Sep 24	92.3%	91.2%	85.0%	H	P	
Vacancy Rate	Sep 24	18.1%	20.3%	10.0%	H	F	
Appraisal Rate Medical	Sep 24	100.0%	100.0%	90.0%	H	P	
Appraisal Rate Non Medical	Sep 24	77.1%	78.6%	90.0%	H	F	
Turnover	Sep 24	0.7%	1.4%	12.0%		P	
Percentage BAME staff band 6 and above	Sep 24	36.1%	35.8%	-	H		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sep 24	3.8%	4.5%	3.8%		?	
Sep 24	4.9%	5.4%	-	L		
Sep 24	94.8%	93.3%	85.0%	H	P	
Sep 24	21.1%	18.5%	10.0%	L	F	
Sep 24	100.0%	100.0%	90.0%	H	?	
Sep 24	95.2%	90.1%	90.0%	H	F	
Sep 24	1.8%	1.2%	12.0%		P	
Sep 24	19.8%	20.5%	-	H		

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

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	3.4	
Report Title	**Finance report Month 06 (September) PUBLIC**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	01 November 2024
Purpose	**For Noting**	

Executive Summary

Both ESTH and SGH are now off plan on an underlying basis by £1.4m and £2.0m respectively. This excludes the impact of industrial action and cyber attack support.

In addition there continue to be 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) 7th November 2024
24/25 M6 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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Group M6 position

GESH

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	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• Both ESTH and SGH are now off plan on an **underlying basis by £1.4m and £2.0m** respectively and this is after using a material number of non recurrent benefits above plan. • **Brought forward NR benefits** from later in the year (SGH £1.8m, ESTH £0.8m). • **Delivered mitigations** this is SGH £9.8m, ESTH £7.9m.	• Based on current performance the trust will not deliver the financial plan in full	• Continued focus on cost control and the development and delivery of CIPs through site management meetings. • Cost control review commissioned by SWL ICB.
Workforce costs and WTE plan	• Pay expenditure is overspent in both trusts. • WTEs for ESTH 143 WTE adverse to plan; 99 relating to adverse recurrent workforce CIP and the balance relating to baseline pressures, a driver of the adverse unmitigated forecast (ED, enhanced care, medical, Epsom bed capacity business case) • WTE at SGH is adverse to plan by 241 due to the 195 step up in CIP delivery planned for in M4 and Junior Doctor rotation of 38 WTE.	• M4 had a step change at both Trusts in the planned reduction in WTE as a result in step change in plan CIP. • Both Trusts have been unable to mitigate the adverse performance at M6.	• 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. • Cost control review commissioned by SWL ICB.
CIP delivery	• ESTH delivery £1.7m adverse to plan. Recurrent CIP £4.0m adverse. Slippage in WTE reduction recurrent planned CIP (WTE CIP 99 adverse) has been mitigated by non recurrent efficiency. • SGH £3.1m adverse to plan (although this includes b/f £0.8m benefit) with £3.7m less recurrent than plan.	• 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. • CIP review commissioned by SWL ICB.

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

Group M6 position

GESH

	Overview	What does this tell us?	What actions/mitigations are required?
Cash	• Both organisations are now in receipt of deficit funding which is deemed to have mitigated any cash risk. • As such neither organisation is expected to require cash drawdown in 2024/25.	• Following communication of the £120m system cash backing, both Trusts a cash request in Q3 is no longer required, or indeed Q4. • The Trusts allocation of the deficit funding is greater than the forecast cash requests. • Whilst the cash backing is for the planned deficit this does also mitigate the cash risk on the adverse forecast positions at both Trusts. Both Trusts held cash balances at the start of the year that are now available to mitigate pressures to the plan deficit. • Whilst the cash implication of the pressures is mitigated, the I&E pressure is still significant and unlikely to be supported. Additional cash just allows time for actions to deliver and mitigates risk if any actions are non cash backed.	• 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	• £1.1m adverse to plan	• Adverse position to plan driven by net costs and lost income associated with Industrial Action and financial baseline /CIP pressures. • These have been partially offset in the acute position by non recurrent items.	• Review and QIA of baseline pressures. • Review of CIP mitigations and stretch.
ESTH IC	• On plan YTD	• 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	• £1.4m adverse YTD	• Impact of Industrial action, Cyber, CIP and Ward pressures • These have been partially offset in the acute position by non recurrent items.	• 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)	• £3.5m adverse YTD	• inflationary pressures £1.0m • CIP non-delivery £2.5m	• Progress Corporate CIP development through BAU and Corp consolidation

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ESTH Trust Summary reported position

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		Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	649.4	73.5	73.5	(0.0)	323.8	326.7	2.9
	Other Op. Income	46.5	4.4	4.3	(0.2)	22.7	22.8	0.1
Income Total		**695.9**	**78.0**	**77.8**	**(0.2)**	**346.5**	**349.4**	**3.0**
Expenditure	Pay	(465.2)	(39.1)	(37.9)	1.2	(235.3)	(239.0)	(3.7)
	Non Pay	(205.2)	(16.8)	(18.7)	(1.9)	(103.0)	(105.3)	(2.3)
Expenditure Total		**(670.5)**	**(55.9)**	**(56.6)**	**(0.7)**	**(338.3)**	**(344.3)**	**(6.0)**
Post Ebitda		(31.5)	(2.7)	(2.5)	0.3	(15.3)	(14.5)	0.8
Grand Total		**(6.1)**	**19.4**	**18.7**	**(0.6)**	**(7.2)**	**(9.4)**	**(2.2)**

- The Trust is adverse to plan by £0.6m in month and £2.2m YTD. The adverse position YTD is due to income lost as a result of industrial action £0.8m and the remaining £1.4m is due to shortfall on efficiencies and baseline pressures. The gross adverse risk to plan in month was c. £3m. £1.6m pressures have been offset by bringing forward non recurrent action in the recovery plan.
- ICB income is above plan by £2.9m at the end of September. This is due to the release of income provisions offset by £0.8m loss of income in respect of industrial action and £0.5m adverse to ERF performance. **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 £0.2m adverse in month and is £0.1m favourable YTD.
- Pay is £1.2m favourable in month and £3.7m adverse YTD. The in month position includes the release of £1.4m annual leave accrual. YTD variance driven by £0.8m industrial action; £1.9m medical price baseline pressures; £0.8m escalation; £0.8m R&D offset by income and £0.9m A&E and SDEC pressures. Bank Nursing WTE and cost reduced in M06.
- Non pay is £1.9m adverse in month and £2.3m adverse YTD. Cardiology was £0.3m adverse in month but £1.3m adverse on pacemakers and Cath Lab consumables YTD, clinical supplies in EOC are £0.6m adverse YTD and Planned Care theatres are £0.4m adverse. The YTD position was mitigated by non-recurrent benefits intended for later in the year were released to cover overspends.
- Post EBITDA is £0.8m 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 M6 ESTH Scorecard

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ESHT Finance Scorecard

NHS South West London

Finance

	Category	YTD Plan	YTD Actual	YTD Variance	YTD RAG	% Variance	FY Plan	FOT	Variance	RAG	% FY Variance
OPEX	Substantive Pay	200.8	202.8	-1.9	G	-1.0%	400.6	403.2	-2.6	G	-0.7%
	Bank Pay	26.3	29.6	-3.3	R	-12.5%	48.9	53.6	-4.7	A	-9.6%
	Agency Pay	5.9	6.7	-0.7	R	-12.4%	11.3	11.9	-0.6	A	-5.3%
	Pay Costs	232.8	239.1	-6.3	A	-2.7%	460.3	468.8	-8.5	A	-1.8%
	NonPay Costs	115.4	117.5	-2.2	A	-1.9%	229.9	229.5	0.4	G	0.2%
	OPEX	349.9	356.6	-6.7	A	-1.9%	693.5	697.8	-4.3	A	-0.6%
Income	Operating income from patient ...	323.8	326.7	2.9	G	0.9%	649.4	651.4	2.0	G	0.3%
	Other operating income	22.7	22.8	0.1	G	0.3%	46.5	46.7	0.2	G	0.5%
	Total Operating Income	**346.5**	**349.4**	**3.0**	**G**	**0.9%**	**695.9**	**698.1**	**2.2**	**G**	**0.3%**
I&E	Reported I&E	-7.2	-9.4	-2.2	R	-31.3%	-5.1	-5.1	0.0	G	0.0%
	Recurrent I&E	-39.8	-40.6	-0.8	A	-2.0%	-73.9	-73.9	0.0	G	-0.0%
Cash	Cash & cash equivalents	8.5	8.5	0.0	G	0.0%	7.9	7.9	0.0	G	0.0%

ESTH has an in month adverse performance of £1.4m in addition to £0.8m adverse variance from income loss from IA. The adverse position is driven by c. £3m in month baseline pressures and adverse movement on CIP. This has been partially offset by bringing forward identified non recurrent mitigations from the recovery action plan. To mitigate in future months recovery actions resulting in a run rate improvement will be required.
Patient care income is above plan by £2.9m at the end of September. This is due to the release of income provisions offset by £0.8m loss of income in respect of industrial action and £0.5m adverse to ERF performance.
Pay is £3.7m adverse against its pay plan at the end of September, the in month position includes £1.4m release of annual leave accrual. At M6 the Trust is £0.8m above its agency plan; £2.8m above its bank plan and £0.4m above its plan for substantive staff due to adverse delivery of the WTE reduction plan and baseline pressures relating to ED, enhanced care, medical staffing.
Non pay is £2.2m adverse against its non-pay plan, with overspends on purchase of healthcare as a result of outsourcing ERF work offset by underspends on establishment costs.

Workforce

		Plan (in month)	Actual (in month)	Variance (in month)	RAG (in month)	% Variance (in month)
WTEs	Substantive WTE	6,502	6,511	-9	G	-0.1%
	Bank	791	918	-127	R	-16.0%
	Agency	152	161	-9	A	-5.6%
	Total WTEs	7,445	7,590	-144	A	-1.9%
Cost per WTE	Substantive	5.1	5.0	0.1	G	1.6%
	Bank	5.1	4.6	0.5	G	10.1%
	Agency	5.7	5.4	0.4	G	6.4%
	Total Cost per WTE	5.1	5.0	0.1	G	2.7%

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 7,645 is adverse to plan but still represents c. 250 WTE reduction from Q4 2324 averages.
The M6 144 adverse position is driven by 99 relating to adverse workforce CIP delivery and the balance relating the baseline pressures presented as a driver of the adverse unmitigated forecast.
The cost per WTE on bank is favourable in month due to a correction of an accrual error in M6.

Efficiency

	YTD Plan	YTD Actual	YTD Variance	RAG	% YTD Variance	FY Plan	FOT	Variance	RAG	% Variance
Recurrent Efficiency	11.5	7.4	-4.0	R	-35.3%	28.9	25.6	-3.3	R	-11.3%
NR Efficiency	3.8	6.2	2.4	G	61.6%	11.2	14.5	3.3	G	29.1%
Total Efficiency	15.3	13.6	-1.7	R	-11.0%	40.1	40.1	0.0	G	0.0%

The Trust is currently reporting a forecast delivery of £40.1m however the current risk to CIP delivery is estimated to be £10m. YTD, the trust is c£1.7m behind plan of c£15.3m. The YTD delivery is supported by inclusion of NR CIP not included in plan.
ERF CIP reported £0.5m adverse to plan at M6.

Performance

Metric	M03	M04	M05	YTD	Target	Variance
ERF	114%	111%	119%	114%	107%	7%
LoS*	11.7	11.4	10.6	11.4	10.4	-1.0
Outpatient attendances as a First or Procedure**	48%	47%	48%	47%	49%	-2%
A&E Target	78%	76%	78%	77%	78%	-1%

ERF performance YTD is 114%, 6% ahead of the YTD target. ESTH has a baseline that has activity baseline increase significantly in Q3 and Q4. ESTH activity and financial CIP from over performance was phased more equally over the year. Therefore, despite YTD 7% overperformance, the full year position is likely to be less favourable to plan. ERF CIP reported £0.5m adverse to plan at M6.
LoS action plan delivering but not having impact on LoS and Trust ability to deliver a financial CIP.

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SGH - Summary Reported Position

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		Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	1,032.1	105.0	106.4	1.3	523.9	527.7	3.8
	Other Operating Income	156.0	13.0	13.9	0.9	77.7	81.6	3.9
Income Total		**1,188.1**	**118.1**	**120.3**	**2.2**	**601.6**	**609.3**	**7.7**
Expenditure	Pay	(725.0)	(59.8)	(61.9)	(2.2)	(367.9)	(372.1)	(4.2)
	Non Pay	(442.4)	(36.7)	(37.5)	(0.8)	(229.0)	(236.3)	(7.3)
Expenditure Total		**(1,167.4)**	**(96.5)**	**(99.4)**	**(2.9)**	**(596.9)**	**(608.3)**	**(11.5)**
Post Ebitda		(25.1)	(1.8)	(1.8)	0.0	(13.4)	(13.4)	0.0
Grand Total		**(4.3)**	**19.8**	**19.1**	**(0.7)**	**(8.7)**	**(12.4)**	**(3.7)**

The Trust is reporting a £12.4m deficit YTD in M6, which is £3.7m adverse to plan. The YTD deficit position is driven by baseline pressures (£0.7m), CIP non-delivery (£1.3m), the impact of Industrial Action (£0.8m) and the impact of the Cyber Attack (£0.9m).

Income

- Income is £2.2m favourable to plan driven by £1.3m of IA funding recognised in month and £0.9m of Other Income offset by additional costs. The IA funding offsets costs recognised in previous months therefore the underlying position is £2.0m below plan. Of this £4.5m relates to additional income offset by additional costs, £2.5m to additional ICB income and £0.7m relates to ERF overperformance.

Pay

- Pay is £2.2m adverse to plan with 1.2m driven by a negative CIP target variance, £0.4m driven by medical pay (in particular an increase in substantive JDs), £0.4m driven by additional pay costs offset by Other Income and £0.2m driven by ward nursing. YTD IA and Cyber are driving a £1.5m adverse variance, resulting in an underlying YTD position that is £2.7m adverse. Ward Nursing is driving £1.9m of the YTD variance.

Non-Pay

- Non-Pay is £0.8m adverse to plan in month. This is driven by additional non pay costs offset by additional income, inflation and other non-pay pressures. YTD IA and Cyber are driving a £0.1m adverse variance and negative CIP target a £3.8m adverse variance resulting in an underlying YTD position that is £3.4m adverse. This adverse variance driven is by additional costs offset by additional income and corporate inflationary pressures.

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SWL Recovery Board SGH Scorecard

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SGH Finance Scorecard

NHS South West London

Finance

	Category	YTD Plan	YTD Actual	YTD Variance	YTD RAG	% Variance	FY Plan	FOT	Variance	RAG	% FY Variance
OPEX	Substantive Pay	327.8	335.3	-7.5	A	-2.3%	644.0	644.0	0.0	G	0.0%
	Bank Pay	31.2	30.0	1.2	G	3.9%	61.9	61.9	0.0	G	0.0%
	Agency Pay	8.9	6.8	2.1	G	24.0%	17.6	17.6	0.0	G	0.0%
	Pay Costs	367.9	372.1	-4.2	A	-1.1%	723.6	723.6	0.0	G	0.0%
	NonPay Costs	228.9	237.1	-8.2	A	-3.6%	443.5	442.7	0.8	G	0.2%
	OPEX	596.8	609.2	-12.4	A	-2.1%	1,167.1	1,166.3	0.8	G	0.1%
Income	Operating income from patient ...	523.6	527.7	4.1	G	0.8%	1,032.7	1,032.7	0.0	G	0.0%
	Other operating income	78.0	82.6	4.6	G	5.9%	154.3	155.3	1.0	G	0.6%
	Total Operating Income	**601.6**	**610.3**	**8.7**	**G**	**1.4%**	**1,187.0**	**1,188.0**	**1.0**	**G**	**0.1%**
I&E	Reported I&E	-8.7	-12.4	-3.7	R	-43.2%	-4.3	-4.3	0.0	G	0.0%
	Recurrent I&E	-46.6	-55.6	-9.0	R	-19.3%	-83.1	-87.6	-4.5	R	-5.4%
Cash	Cash & cash equivalents	17.1	17.1	0.0	G	0.0%	15.0	15.0	0.0	G	0.0%

Operational pressures have lead to an increase in ED cohorting and additional HCAs for boarding, also increases usage in UTC for GPs and additional cover for Consultants unable to work nights. Acute Medicine and Senior health ward nursing is also nursing increased due to Boarding nurse in Richmond, enhanced care. Jr Docs pressure include Less than full time trainees as well as significant gaps in rotas leads to high levels of bank and agency spend. Key areas are Neonatal, Plastics and T&O. Increased spend on clinical consumables, this is being reviewing versus improved additional ERF activity. Nonpay inflationary pressures above the 2% funded. Contracts that are causing inflationary pressure compared to planning assumptions. E.g. NHSBT (5-10%), Wandsworth Council rates (20%), Mitie contract (4.3%).
The income variance is broadly driven £1.2m related to Commercial pharmacy income with offsetting costs. £2.5m from SWL ICB in M5 to balance our position, is above planned levels of income. £1.3m IA income from NHSE offsetting IA costs.
Total pay costs at SGH are rated amber, with an overspend of 1.1% or £4.2m. IA/Cyber impacts account 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 £8.2m (3.6%) 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.

Workforce

		Plan (in month)	Actual (in month)	Variance (in month)	RAG (in month)	% Variance (in month)
WTEs	Substantive WTE	9,492	9,677	-185	A	-2.0%
	Bank	610	810	-200	R	-32.8%
	Agency	253	113	139	G	55.2%
	Total WTEs	10,355	10,600	-246	A	-2.4%
Cost per WTE	Substantive	5.6	5.8	-0.2	A	-3.9%
	Bank	8.4	5.8	2.6	G	30.8%
	Agency	5.8	7.6	-1.8	R	-30.8%
	Total Cost per WTE	5.8	5.8	-0.1	A	-1.2%

SGH are behind plan in M6 with increases in Junior Doctors 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.

Efficiency

	YTD Plan	YTD Actual	YTD Variance	RAG	% YTD Variance	FY Plan	FOT	Variance	RAG	% Variance
Recurrent Efficiency	18.4	14.7	-3.7	R	-20.1%	46.0	46.0	0.0	G	0.0%
NR Efficiency	9.3	9.9	0.6	G	6.2%	22.5	22.5	0.0	G	0.0%
Total Efficiency	27.8	24.6	-3.1	R	-11.2%	68.5	68.5	0.0	G	0.0%

SGH are £3.1m adverse to CIP targets, CIP risk as been identified as an FOT gap which mitigations are being worked though by the Exec. 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.

Performance

Metric	M03	M04	M05	YTD	Target	Variance
ERF	106%	108%	106%	110%	105%	5%
LoS*	8.1	7.7	8.0	8.8	9.4	0.5
Outpatient attendances as a First or Procedure**	49%	49%	49%	49%	49%	0%
A&E Target	82%	82%	81%	80%	78%	2%

Good progress on LOS although significant challenge expected to maintain and improve this position over the winter period.

*Based on 23/24 average of 11.30 days and ambition to reduce by 1.5 days
**Based on system target of 49%

Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	4.1	
Report Title	**gesh Learning from Deaths Quarterly Report: Q4 (January – March) 2023/24 and Q1 (April – May) 2024/25**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Martine Meyer AMD for Quality, ESTH Rumiko Yonezawa Associate Director for Business Intelligence, ESTH Jay Wijayarathne, Principal Clinical Analyst, ESTH Laura Rowe Lead Midwife for Clinical Governance and Risk ESTH Rebecca Suckling, Site CMO, ESTH Ashar Wadoodi, Learning from Deaths Lead, SGUH Kate Hutt, Group Head of Mortality & Effectiveness Amy Christensen, Group Senior Manager Learning from Mortality	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

Trusts are required to collect, scrutinise and publish specified information on deaths on a quarterly basis. This paper summarises the two sites' approaches to learning from deaths, and the key data and learning points.

This report has been considered by the Quality Committees-in-Common on 31st October 2024.

Some key points to note from this report are:

- Overall mortality at ESTH appears to be improving. However, both measures (SHMI and HSMR) remain "higher than expected".
- Overall mortality at SGUH remains "as expected" as measured by SHMI, and "lower than expected" as measured by HSMR (overall mortality is discussed in Section 2).

At ESTH:

- A high percentage of deaths (about 35%) continue to be scrutinised through Structured Judgment Reviews.

- Structured Judgment Reviews have highlighted that sepsis care is improving but that further work is needed to implement a joint approach with SGH. The appointment of a new Clinical Lead for Sepsis will support this, with a focus on identifying and treating sepsis at the Front Door (discussed in Section 3.1).

- There is an indication from Q4 that a disproportionate number of cardiac arrests may be occurring in ED, and again a concern that ED overcrowding may be contributing to this. An update on this will be included in the next report (this is discussed in Section 3.1).

At SGUH:

- Latest SHMI data shows Acute Myocardial Infarction (AMI) mortality has moved to be in line with expected (section 2.5). However, a deep dive by Dr Foster shows that mortality is higher than we would expect in cardiology related procedure groups. Accordingly, the Cardiology Care Group are focussing their investigation work on procedure related mortality. Alongside this, all deaths following cardiology procedures are subject to SJR to see if there is any further relevant learning. A final internal report is to be presented to the SGUH Mortality Monitoring Group (MMG) in January 2025 and will be included in the subsequent report (this is discussed in Section 3.2).

- NHS Blood and Transplant has informed the Renal Transplant Service that they will be carrying out an external visit due to an outcomes alert. As a preliminary step NHSBT has been sent internal reviews. An update will be provided in the next report (discussed in Section 3.2)

- Mortality & Morbidity (M&M) Meetings are well supported, and several improvements have been achieved since the last report, with better approval of minutes and implementation of action trackers. To build on this improvement the team will shortly publish revised M&M guidance clearly defining high quality meetings and promote increased focus on learning, in line with the Patient Safety Incident Response Framework (PSIRF) (Section 3.2). Further updates will be provided in future reports.

Group-wide and national issues:

- Significant progress has been achieved in relation to Phase 1 of the Medical Directorate Corporate Restructure, which has now been implemented. On 7th October mortality services including Learning from Deaths and Bereavement services began worlk as an integrated Group-wide team. The purpose of this is to spread best practice across the Group (e.g. SJRs at ESTH, support for M&Ms at SGUH) and to avoid duplication and unwarranted variation. Greater detail outlining initial objectives and progress to date will be provided in future Reports.

- Future iterations of this Learning from Deaths Report will provide further examples of this joint working across the group. For example, St George's expect to begin using the same mortality benchmarking platform as Epsom & St Helier, enabling clearer understanding and where useful, comparison.

- The Medical Examiner system was established on a statutory basis nationally on 9th September 2024. The ME services in our three acute hospitals managed the transition effectively and have maintained compliance with all national requirements. All in-patient

deaths and community deaths in their boroughs of responsibility have been scrutinised. Further detail is given in Section 5.

Action required by Group Board
That the Board note the continued work in accordance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these.

Committee Assurance	
Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

Appendices
Appendix 1: ESTH Mortality Overview
Appendix 2: To address QCiC Action Log 1.4 Oct 2023, Row 8 ESTH & SGH
Appendix 3: SGUH LFD NQB Dashboard

Implications

Group Strategic Objectives

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

Risks

Failure to achieve high standards in mortality governance presents a risk to the delivery of safe patient care.

CQC Theme

☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

Learning from Deaths' framework is regulated by CQC and NHS Improvement and demands trust actions including publication and discussion of data at Board level.

Equality, diversity and inclusion implications

Analysis of the HSMR by age, sex and ethnicity is possible at SGH using Dr Foster and ESTH using HED (Appendix 3). The new Medical Certificate of Cause of Death (MCCD) includes mandatory reporting on ethnicity which may support improved data collection.

Environmental sustainability implications
None Identified.

gesh Joint Learning from Deaths Quarterly Report
Q4 2023/24 (January – March 2024) and Q1 2024/25 (April – June 2024)

1.0 PURPOSE

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

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

2.0 NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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2.1 There have been 440 in-patient deaths in Q4 23/24 (January – March 2024) and 385 in Q1 24/25 (April – June 2024).

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS England]
The latest SHMI which covers discharges from June 2023 to May 2024 was '*higher than expected*' at a value of 1.17 in Q4 2023/24. This period covers 40,950 spells, with 1,785 deaths observed, against 1,525 expected.

SHMI data is also published by site and shows that mortality at St Helier has moved to within expected range (1.12). Mortality at Epsom remains higher than expected (1.25).

As described in previous reports, Epsom & St. Helier University Hospitals NHS Trust participated in a pilot with nine other trusts to shift Same Day Emergency Care (SDEC) data from the Admitted Patient Care (APC) dataset to the Emergency Care Data Set (ECDS). This change in data recording is known to affect SHMI. From July 2025, all NHS Trusts in England are expected to adopt this new data recording method.

In the latest data mortality was higher than expected in patients coded with a urinary tract infection and acute bronchitis. All other categories are 'as expected.'

Mortality analysis at diagnosis and procedure group level is considered at the Mortality Reviewer meeting which reports to the Reducing Avoidable Deaths and Harm Group (RADAH). A review will be conducted of certain cases coded under diagnostic groups with higher than expected mortality and findings presented to RADAH to identify any appropriate next steps.

SHMI for 10 diagnostic groups (June 2023 to May 2024)

Diagnosis group description	SHMI value	Banding
Septicaemia (except in labour), Shock	1.14	As expected
Cancer of bronchus; lung	1.44	As expected
Secondary malignancies	1.24	As expected
Fluid and electrolyte disorders	1.07	As expected
Acute myocardial infarction	0.69	As expected
Pneumonia (excluding TB/STD)	1.11	As expected
Acute bronchitis	1.79	Higher than expected
Gastrointestinal haemorrhage	0.99	As expected
Urinary tract infections	1.42	Higher than expected
Fracture of neck of femur (hip)	0.74	As expected

2.3 **Hospital Standardised Mortality Ratio (HSMR)** [source: Healthcare Evaluation Data (HED)]

The HSMR for the most recent 12-month rolling period, from June 2023 to May 2024, is 105.66, which is higher than expected. However, the monthly HSMR has been improving, though this may be due to common cause variation. The gap between expected and observed deaths has narrowed, reflecting the lower monthly values. It is important to note that the HSMR calculations include adjustments for patients documented as receiving palliative care.

The elevated national mortality rates form part of the mortality vigilance. Engagement with the Medical Examiner's office is vital to support the identification of quality concerns from Medical Examiners and families. While a high percentage of deaths at ESTH are reviewed using SJRs, the input from the Medical Examiner will continue to help us understand the quality of care, identify avoidable deaths and harm, and pinpoint areas requiring improvement.

HSMR for June 2023 – May 2024 data

	HSMR value	Banding
All admission methods	105.66	Higher than expected
Elective admissions	79.71	Lower than expected
Non elective admissions	106.15	Higher than expected

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2.4 There have been 348 in-patient deaths in Q4 23/24 (January – March 2024) and 333 Q1 24/25 (April – June 2024).

2.5 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
The latest SHMI data covers discharges from June 2023 to May 2024, and at 0.91 St George's mortality is as expected. This period covers 67,265 spells with 1,735 deaths observed, against 1,900 expected.

SHMI for 10 diagnostic groups (June 2023 to May 2024)

Diagnosis group	SHMI value	Banding
Septicaemia (except in labour), Shock	0.82	As expected
Cancer of bronchus; lung	0.79	As expected
Secondary malignancies	1.18	As expected
Fluid and electrolyte disorders	0.70	As expected
Acute myocardial infarction	1.05	As expected
Pneumonia (excluding TB/STD)	0.79	Lower than expected
Acute bronchitis	*	*
Gastrointestinal haemorrhage	0.70	As expected
Urinary tract infections	1.42	As expected
Fracture of neck of femur (hip)	0.88	As expected

* value not given due to small numbers

2.6 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
The most recent Dr Foster data covers discharges between July 2023 and June 2024. For this period mortality is lower than expected at 89.1

HSMR for June 2023 – May 2024 data

	Value	Banding
HSMR	89.1	Lower than expected
HSMR weekday emergency admission	82.5	Lower than expected
HSMR weekend emergency admission	88.5	As expected

3.0 LEARNING FROM DEATHS OBJECTIVES

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3.1 **Mortality Reviewers Group**
The Mortality Reviewer team has a focus on learning from deaths through structured judgement reviews as well as incident investigations as Investigating Officers. They provide a link between the Trust and the Medical Examiners (MEs), and the MEs work closely to review cases through SJRs. Areas of focus for quality improvement are agreed at the Reducing Avoidable Death and Harm (RADAH) meeting.

Review of SJRs with high/moderate concerns 2023/24:
A thematic review of 26 SJRs undertaken in 2023/24 with at least one high or moderate concern was carried out. There were fewer high/moderate concerns than in 2022-23 (26/636 this year, 38/497 last year).

The themes identified were poor recognition of clinical deterioration 7/26, lack of senior input on deteriorating patients or leadership of management plan (particularly on deterioration of patients) 6/26, late identification of COVID infection (especially

nosocomial) 3/26, and long stay in ED (up to 72 hours) 2/26. These themes differ from the 2022/23 review.

There has been considerable improvement in most of the areas identified in 2022-23: communication - not having a PTEP/ReSPECT document until cardiac arrest (7/38 cases last year, 1/26 this year). Not identifying sepsis or late initiation of antibiotics in sepsis (4/38 cases last year, 1/26 this year). Lack of senior input was higher than last year (3/38 last year, 6/26 this year). Inappropriate discharge prior to the patient's final admission was a theme identified last year (3/38). There is an ongoing audit relating to this (see Table 1 below).

Overall, there was an increase in single high/moderate concerns vs multiple concerns. These single areas had a large impact on care as over half 15/26 [58%] had a single category of concern compared to 13/38 [45%] in 2022-23. Only 3/26 patients with high/moderate concerns were rated as good or excellent compared to 17/38 the previous year. In both 2022-23 and 2023-24 reviews, if communication was identified as a high or moderate concern, all but one case had multiple areas of concern, as lack of communication had an impact on multiple areas of care.

All high/moderate concerns were followed through for further investigation through appropriate routes; Datix, consideration of incident response under PSIRF by Quality Manager, feedback for review at departmental M&M, nursing issues received nursing mortality SJR review. Themes were discussed at Mortality Reviewer meetings, departmental Quality meetings and at RADAH.

Priority Work Streams and Signals (ESTH)

Workstream	Priority area	Key updates
Mortality Data: Raised HSMR/SHMI	**Fluid and electrolyte disorders code (HSMR)**	Clinicians and MEs do not generally use this as a diagnosis, but it is used by Coders who code episodes of care in their totality and the primary diagnosis on the focus of care in that episode. There was an excess of deaths with this code noted in 2023/24. **Action:** A review of all 17 deaths with this code between April 2023-Jan 2024 was undertaken by the Lead Mortality Reviewer. In no case was electrolyte imbalance related to the cause of death or documented in the MCCD. In some cases, the electrolyte imbalance code was inaccurate and in other cases any electrolyte imbalance had been corrected prior to death. A number of the patients were also at the end of life where comfort would be deemed the priority for care. Clinician-coder meetings are to be started, to support optimal coding accuracy.

	Secondary Malignancies:	A sample of Secondary Malignancy deaths was subjected to a deep dive by the Lead Mortality Reviewer to review accuracy of diagnosis and coding and review care delivery. 17 cases were reviewed covering the period July 2023-June 2024. All had metastatic malignancy disease. 15/17 were reviewed on site by the Acute Oncology Service (AOS) within a mean time of 4 days; 2/17 had been reviewed by the Royal Marsden Hospital (RMH) before transfer. 14/17 were not for active oncology treatment (best supportive care). 17/17 were reviewed by the Palliative Care Team and all had a completed DNACPR. 9/17 had documented significant frailty. All patients had an independent scrutiny by a ME and only 3 were referred for an SJR, of which 2 received an 'adequate' rating and one a 'good' rating. 6/17 had a routine SJR undertaken, with 5 rated as 'good' overall care and 1 having an 'adequate' rating.
	Urinary Tract Infection (UTI)	There was an excess of deaths reported with this code. Previous analyses found that coding accuracy is sub-optimal, with approximately one third of patients having confirmed UTI, one third uncertain and one third not having confirmed evidence of UTI. A further analysis is being undertaken and will be reported in the subsequent report. The Clinician-Coder meetings have been asked to prioritise UTI diagnosis.
Learning from Structured Judgement Reviews	**1. Joint working with nursing increase opportunity for learning.**	**Infrastructure:** Two Mortality Review Team Nurse Advisors undertake reviews on nursing issues within an SJR when appropriate, supported by the lead mortality reviewer. The consultant mortality reviewers and MEs refer to nurses where they find cause for nursing concern. Nursing review recommendations are taken to senior nursing fora and to the Mortality Reviewer meetings. **Governance:** Supervision is provided from lead mortality reviewer and members of the mortality review group. **Development:** To continue to identify nursing and other health professions to increase the MDT approach to mortality review.

	2. Sepsis not identified or delayed provision of antibiotics	The Sepsis Audit in Q4 (23/24) and Q1 (24/25) showed an improvement in the number of patients being screened, assessed and escalated. There continues to be a delay in the administration of antibiotics. Although this remains the case, the delay from prescription to delivery has improved in both Q4 (23/24) and Q1 (24/25). Overcrowding in ED and the increase in volume of patients remaining in ED after the decision to admit are the main reasons for delay in the administration of antibiotics. Despite these pressures the majority of unwell patients were escalated appropriately. **Actions:** New Clinical Lead for Sepsis has been appointed in Q2 24/25 to support the strategy for Sepsis. She will enable further engagement with key partners throughout the hospital to understand the barriers and implement structures and process to improve identification and management of Sepsis, including further support to ED. Further support in ED has included additional IV trained nursing staff and increased pharmacy support.
	3. Inappropriate discharge prior to final admission	A review of all patients readmitted within 7 days of discharge between April-June 2023 who subsequently died highlighted that risk of death after readmission was higher if patients were discharged to their home or self-discharged against medical advice rather than patients discharged to care homes. **Actions:** Mortality reviewers will now consider both the previous admission as well as the current admission where possible to identify if there are areas for improvement in the discharge process. As part of the Clinical Audit Programme for 2024-25, readmissions will be audited in the Medicine division.
	4. Working with the Medical Examiner team to identify quality concerns	A Working Group is developing guidance for hypernatraemia. The MEs notify the working group lead of any identified cases of hypo/hypernatraemia to support the improvement programme.

<table>
<tr><td></td><td>5. Sharing Learning from SJRs</td><td>The Medical Examiner has presented to PSQG as a regular report to triangulate the themes identified by the Medical Examiner Team.
The Mortality Reviewers have presented an outline of the service and mortality review system at Quality Meetings to Critical Care, Anaesthesia, General Medicine and Urology.
From Q2 2024/25 there will be a regular quarterly ‘Learning from Deaths’ slot at each Divisional Quality meeting, presented by a Mortality Reviewer.</td></tr>
<tr><td>Resuscitation Team: Cardiac Arrest Outlier</td><td colspan="2">There has been a reduction in the total number of cardiac arrests (CA) from 128 in 2022-23 to 101 in 2023-24. Ward cardiac arrests have also reduced from 55 to 35 and survival to discharge has improved from 14.4% to 23.4%.

However, the number of patients > 75years, receiving CPR has increased again to 54.5% and is higher than similar hospitals (43.1%).

The number of cardiac arrests in ED continues to be significantly higher (50%) than similar hospitals (27.5%) and all hospitals (19.8%).

NCAA cumulative data for ESTH: Q4 2022/23 vs. Q4 2023/24
<table>
<tr><td></td><td>Q4 2022/23</td><td>Q4 2023/24</td></tr>
<tr><td>Total admissions</td><td>79,293</td><td>82,062</td></tr>
<tr><td>Total CA</td><td>128</td><td>101</td></tr>
<tr><td>CA/1,000 admissions</td><td>1.61</td><td>1.23</td></tr>
<tr><td>Ward CA</td><td>55</td><td>35</td></tr>
<tr><td>Ward CA/1,000 admissions</td><td>0.69</td><td>0.43</td></tr>
<tr><td>ROSC >20 minutes</td><td>43.8%</td><td>43.6%</td></tr>
<tr><td>Survival to discharge</td><td>14.4%</td><td>23.4%</td></tr>
</table>
Q1 analysis (includes data from 01/04/2024 to 30/06/2024)

Q1: Cardiac Arrests in Patients >75
<table>
<tr><td>ESTH</td><td>44.4%</td><td>(56.3% Q1 2023)</td></tr>
<tr><td>Similar hospitals</td><td>40.9%</td><td></td></tr>
<tr><td>All hospitals</td><td>41%</td><td></td></tr>
</table>
ESTH continues to resuscitate more people over 75 years than similar hospitals and nationally, but this figure is reduced from previous reports and comparable to similar Trusts.</td></tr>
</table>

	Q1 Cardiac Arrests within ED Footprint ESTH 44.4% (Q1 2023 similar) Similar hospitals 22.5% All hospitals 17.8% In Q1 nearly half of all Trust cardiac arrests occurred within the ED footprint (including SDEC areas). This is double the number in similar Trusts. This increase is being reviewed through case reviews and may be due to increased number of patients cared for in ED, longer length of stay in ED including after decision to admit and reduced monitoring of patients in ED due to department crowding. **Of note**: There were 27 adult cardiac arrests in Q1 2024/25 compared to 16 adult cardiac arrests in Q1 of 2023/24.
Surgical Pathway	Transfer of surgical patients from Epsom Hospital to St Helier Hospital for surgical review has in the past led to harm and treatment delay resulting in death, leading to important changes. **Governance:** The pathway for surgical referrals from the Royal Marsden Hospital has been improved to ensure that referrals are directed to the St Helier Surgical Department. **Action:** An updated SOP for surgical review and transfer of clinically deteriorating patients presenting to the Epsom ED has been approved by the site SLT and is now in place. A prospective audit of effectiveness is being undertaken by the Planned Care Division.
Respiratory Team: Management of Chest Drains	Management of chest drains is not consistent, and delays to chest drain insertion on wards and in ED have been noted. **Governance:** A new pleural flowchart is now in use after respiratory and EM input. The Trust also now has an established pleural procedures course.

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3.2 **Mortality Reviewers Group**

The Mortality Monitoring Group aims to create an environment where sharing learning becomes second nature. This is currently achieved through the learning from deaths model of SJR review and support of the M&M review team to improve meeting outputs and learning. Processes are monitored and ratified through MMG which is chaired by the Site Chief Medical Officer.

Table 2: Priority Work Streams and Signals (SGUH)

Workstream	Priority area	Key updates
Mortality investigations	**Cardiology diagnosis and procedure groups**	Following the Dr Foster deep dive into cardiology the Site CMO and Learning from Deaths Lead met with the Cardiology care group. The following actions have been agreed, primarily focused on procedure related mortality as this is where St George's appeared to be divergent from other Heart Attack Centres. • Audit of timeliness of cath lab access, looking at both high risk patients and non-STEMI. • Examination of accuracy of type II MI coding • A detailed review of procedure related mortality. This was agreed at MMG in September with a strict deadline of January 2025 for the final outcome report to be presented. The internal review will inform the need for, and if required the terms of reference of, external review. The latest SHMI data shows that AMI mortality is in line with expected (section 2.5).
	Emergency Department: Deaths following delayed admission from ED	In 2022 NHS England data showed that nationally 1.65 million people waited 12 hours or more in ED. Using the standardised mortality ratio (SMR) it was estimated that this resulted in over 23,000 excess deaths. As part of the learning from deaths enhanced scrutiny program it was decided that an adapted SJR process would be used to examine patient deaths following delayed admission from ED at St George's. MMG decided to focus the review on patients admitted under surgical specialties following a delay of over 8 hours who went on to die. This included general surgery, vascular surgery, and orthopaedics. In total 45 cases were examined As part of the enhanced scrutiny of these cases the SJR form was modified to include any significant changes in patient assessment i.e.

		NEWS scoring, or changes in medication from ED to ward. Although there were some significant findings from the project including delays to DVT prophylaxis no cases were found where the delays directly contributed to the cause of death. The conclusion from this work was that delays do adversely impact patient care, despite a direct correlation to mortality not being identified in our patient cohort. This work has been shared with the governance lead to inform ongoing quality and safety work.
Mortality and Morbidity (M&M) activity	The M&M team continue to monitor adherence to trust agreed standards for M&M meetings and a number of improvements have been achieved since the last report. The team are now supporting all but one specialty group. All speciality groups are producing minutes, with over 60% approved by the meeting chair or governance lead. The need to improve the monitoring of agreed actions has been identified in 13% of specialty groups. The M&M team, supported by the Learning from Deaths Lead, are continuing to provide support for care groups to improve their M&Ms to come into line with the trust guidance. We have visited several care groups including Trauma, Head and Neck, and ED. This will be an ongoing process, prioritising specialty groups that are most divergent from the trust approach. At present the focus is on care groups holding regular multi-disciplinary meetings in which minutes are shared routinely and actions are taken and monitored in order to promote learning. In support of this, the team has reviewed and defined more clearly what a high-quality M&M meeting looks like, considering both inputs and outputs. This work, based on the existing Terms of Reference, is to be discussed at the next MMG meeting. Triangulation of information to identify and promote learning is a key objective of the M&M team. Collaboration with the Patient Safety Team is ongoing and information is regularly shared to inform incident review and investigation.	
Special focus cases	As part of the ongoing focus on the cardiology signal within Dr Foster the mortality review team are currently reviewing death where patients have undergone a cardiology procedure. It is hoped that this enhanced oversight period will assist the work of the care group and provide a level of independent insight.	

External alert: Renal Transplant	Renal transplant outcomes have triggered an alert from NHS Blood and Transplant (NHSBT) because of 2 patient deaths and 2 kidney losses over a 12-month period. It is likely that the alert is a result of the deaths as kidney losses are within standard parameters. Deaths are fortunately rare in transplant and the expectation is <1 death every 2 years (Dr Foster). NHSBT have been sent internal reviews of the four cases. Both of the deaths were referred to the coroner and neither required an inquest. One of the deaths was in part related to health issues that the SI investigation at St George's (DW193312, STEIS 2023/20154) concluded should have resulted in the patient being suspended from the transplant list at his local centre. The other death was subject to a structured judgement review and patient safety incident review (DW175001) and it was agreed that it did not meet the criteria for a serious incident.

4.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

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4.1 Mortality Review Team

The Mortality Review team plays a key role in improving patient care by conducting Structured Judgement Reviews (SJRs) and incident investigations, closely collaborating with Medical Examiners. They identify and review cases that meet specific criteria. Insights from these reviews are discussed at the Reducing Avoidable Death and Harm (RADAH) meeting, where quality improvement areas are identified, helping to enhance patient safety and care outcomes across the Trust.

Reviews are performed on all cases in cases of:

- Deaths where the Medical Examiner has identified a potential concern.
- Deaths where bereaved families, or staff, have raised a significant concern.
- Deaths of inpatients with learning disabilities.
- Deaths of inpatients with severe mental illness.
- Deaths where the patient was not expected to die including all deaths following elective admission.
- Deaths of patients with COVID judged to be likely nosocomial.
- Deaths which are requested by the complaints team.
- Deaths where an inquest is being opened.
- Deaths where there is an unexpected cardiac arrest.

When the Mortality Review Team have capacity, they also undertake a number of routine SJRs, to benchmark general quality of care. Below is a summary of the overall assessment care ratings of the SJRs, conducted by the Mortality Review Team for Quarter 4 (2023/24) and Quarter 1 (2024/25).

Table: Overall Assessment of Care Ratings

Overall care judgement	Q4 23/24		Q4 24/25	
	Number	Percent	Number	Percent
Excellent care	3	1.6	5	4.2
Good care	100	53.2	54	45.4
Adequate care	75	39.9	56	47.1
Poor care	9	4.8	4	3.4
Very poor care	1	0.5	0	0
Total	**188**		**119**	

Any concerns identified through the SJR process are rated as minor, moderate, or high. High concerns are automatically reported through the clinical reporting system (DATIX) by the Mortality Reviewer, and where appropriate, a Rapid Review Report is recommended. Mortality Reviewers also liaise directly with the responsible consultant in cases where they recommend that learning for improvement be discussed at the relevant specialty-based mortality and morbidity meetings. In addition, they provide positive feedback to consultants when excellent care is observed. All SJRs assessed as overall ‘poor’, or ‘very poor’ care have a second SJR by another consultant Mortality Reviewer. The DATIX numbers for the 'poor' or 'very poor' ratings are 3299, 3350, 3397, 3398, 3345, 3553, 3542, 3505, 3566, 3525, 3935, 4017, 4058, and 4079.

During these quarters, independent reviews using the structured judgement review (SJR), have been completed for 188 deaths in Q4 (2023/24) and 119 in Q1 (2024/25), which represent 42.73% and 30.91% of all deaths respectively. The percentage of overall ‘poor/very poor’ assessments was 5.32% in Q4 (2023/24) and 3.36% in Q1 (2024/25). The percentage of overall ‘good/excellent’ assessments was 54.79% in Q4 (2023/24) and 49.58% in Q1 (2024/25) out of the rated SJRs.

The SJR methodology requires reviewers to identify concerns in care, their level and the type of concerns in care. In Q4 (2023/24), 84 care concerns were reported across 58 out of 188 rated SJRs, representing 30.9% of the total. In Q1 (2024/25), 52 care concerns were reported across 44 out of 119 rated SJRs, accounting for 37.0% of the total.

Below is a breakdown of the type of concern in care for the rated SJRs for Quarter 4 (2023/24) and Quarter 1 (2024/25).

Table: Type of concerns in care provided

Type of concern	Q4 (2023/24)		Q1 (2024/25)	
	Number	Percent	Number	Percent
Assessment/ Investigation/Diagnosis	14	16.7	10	19.2
Medication/IV fluids/electrolytes/Oxygen	9	10.7	04	7.7
Treatment and Management Plan	24	28.6	15	28.9
Infection management	4	4.8	02	3.9
Operation/invasive procedure	1	1.2	01	1.9

Clinical monitoring	5	6.0%	01	1.9
Resuscitation following a cardiac/respiratory arrest	3	3.6%	05	9.6
Communication	14	16.7	05	9.6
Other including organisational issues	10	11.9	09	17.3
Total	84		52	

4.2 **Learning from excellence**

In the reporting period the following areas were identified by the Mortality Review Team and fed back to individual teams and Divisions:

- The AHP and Stoma Nurse teams for excellent documentation and management plans.
- Early involvement by AOS (Acute Oncology Service) and Palliative Care in ED, with good early management plans.
- Respiratory team continue to provide good leadership.
- Stroke Team for Front Door assessments and teamwork.
- Surgical Team for their 'risk of death' assessments, well documented.
- Consistent improvement in DNACPR/PTEP completion.
- The Mortality Review Team Nurse Advisors are creating a new Template for nursing documentation which will be uploaded to CERNER. It includes a new category of Family, so that ward nursing staff can comment whether the patient/family have been kept updated.

4.3 **Learning from mortality in Mortality and Morbidity meetings.**

There is no dedicated M&M team at Epsom & St. Helier University Hospitals NHS Trust and there is not a minimum data set that is shared centrally. The M&M processes are held at divisional level.

The Learning from Deaths teams, along with bereavement services, are being brought together in Phase 1 of the Medical Directorate Corporate Restructure – the staff consultation The purpose of this is to spread best practice across the Group (e.g. SJRs at ESTH, support for M&Ms at SGUH) and to avoid duplication and unwarranted variation.

4.4 **Perinatal Mortality:**

The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the bi-monthly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the safety standard, each report also detailed potential areas for learning and improvement. Over the year there were no clear themes identified which contributed to the outcomes in these cases.

During Q4 2023/2024 there was one stillbirth reported; this case is not eligible for review as it related to the birth at term of a twin who had died in utero in early pregnancy. During Q1 2024/2025, there was one neonatal death reported; this related to a baby with known foetal abnormalities. Stillbirth and neonatal deaths are reviewed through MBRRACE-UK and reported separately to the Board. All child deaths are

reviewed locally by clinical teams and presented at the monthly paediatric Divisional Management Team meeting.

4.5 **Sharing learning from Mortality across the group**

There are regular meetings and good communication between St George's and Epsom & St Helier about patients who died either at Epsom & St Helier or St George's but have recently visited the other hospital within the group. Where there is concern regarding the death of a patient following transfer between both sites within 30 days, it has been agreed that the details will be shared and the case reviewed by the relevant mortality review team for potential learning.

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4.6 **Mortality Reviews Summary Data**

The need for SJRs was identified for 43 patients in Q4 23/24 and 51 patients during Q1 24/25 which equates to approximately 14% of inpatient deaths. The reasons for requesting a review are summarised below. In addition to patients that met that the national criteria for review a further 7 in Q4 and 15 in Q1 were carried out in areas of enhanced oversight. Areas of enhanced scrutiny form a significant part of mortality review at St George's, which also allows to independent insights for clinical teams about their good practices. Between January and May deaths following cardiac surgery were subject to increased oversight. From May to date patients that have died following a cardiology procedure are automatically selected for SJR.

All child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

Triggers for review	**Q4 23/24**	**Q1 24/25**
Confirmed learning disability +/- clinical diagnosis of autism	3	4
Significant mental health diagnosis	9	12
ME or clinical team detected possible learning or potential issue with care	6	8
Deaths following elective admission	8	8
Areas subject to enhanced oversight	7*	15*
Family raised significant concerns	0	3
Safeguarding queries	0	0
Focused review – long wait in ED deaths	10	0
Maternal Death	0	1
Total SJR during period	43	51

*Q4 23/24: cardiac surgery; Q1 24/25: cardiac surgery until mid-May, then cardiology procedures.

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 43 deaths reviewed in Q4 23/24 a problem that resulted in harm was identified in relation to 5 deaths (one person experienced 2 harms). In Q1 24/25 there was one death in which a problem in healthcare was judged to cause harm. These cases are included in section 4.6 Learning from Mortality.

Problems in healthcare identified.

Problem in healthcare	No harm		Possible harm		Harm		Total Q4 23/24	Total Q1 24/25
	Q4 23/24	Q1 24/25	Q4 23/24	Q1 23/24	Q4 23/24	Q1 24/25		
Assessment	2	1	0	2	1	0	3	3
Medication	0	1	2	0	0	0	2	1
Treatment	2	2	2	4	3	1	7	7
Infection control	0	1	1	2	0	0	1	3
Procedure	1	1	1	3	2	0	4	4
Monitoring	0	0	0	0	0	0	0	0
Resuscitation	0	0	1	0	0	0	1	0
Communication	1	0	3	1	0	0	4	1
Other	1	1	0	0	0	0	1	1
Total	7	7	10	12	6	1	**23**	**20**

Overall care rating

	Q4 23/24		Q1 23/24	
Overall care judgement	Number	Percent	Number	Percent
Excellent care	2	4.7	5	9.8
Good care	27	62.8	41	80.4
Adequate care	12	27.9	5	9.8
Poor care	2	4.7	0	0
Very poor care	0	0	0	0
Total	**43**		**51**	

Judgement on avoidability of death is made for all reviews

Avoidability of death judgement	Number Q4 23/24	Percentage Q4 23/24	Number Q1 24/25	Percentage Q1 24/25
Definitely not avoidable	32	74.4	39	76.5
Slight evidence of avoidability	7	16.3	9	17
Possibly avoidable but not very likely (less than 50:50)	1	2.3	2	3.8
Probably avoidable (more than 50:50)	0	0	0	0
Strong evidence of avoidability	3	7	0	0
Definitely avoidable	0	0	0	0
Unable to score as death not in Hospital	0	0	1	2
Total	**45**		**51**	

4.7 **Learning from mortality**

Any patients that are deemed by a single reviewer to have suffered poor care, or where there was strong evidence of avoidability, are discussed in a monthly mortality review meeting. The details of each case are presented for discussion and decision regarding the need for notification to the Patient Safety Team, if that has not already

been done, and/or referral to the clinical team to discuss in their M&M. This process helps to triangulate the M&M process, the SJR process and patient safety processes within the trust.

Structured judgement reviews are shared with clinical teams regardless of outcome so good practice can also be shared with the specialty group. This encourages transparency and positive associations with the M&M and learning from deaths teams.

4.8 **Cases from Quarter 4 23/24**

In Q4 there were five deaths where reviewers judged there to have been harm, or overall care to be poor, or strong evidence of avoidability. These are summarised below.

	Reasons for additional review	Learning
1	Poor care overall Strong evidence of avoidability Harm – treatment and assessment	There was judged to be strong evidence of avoidability by the SJR reviewer as both patients suffered unwitnessed catastrophic falls in ED. Both deaths were reported on Datix (DW204135, DW203982) and were investigated as a cluster SI (STEIS 2024/2052). The detailed investigation found the root cause to be no clear and applicable SOP or protocols with regard to enhanced care in the ED, resulting in a lack of enhanced care provision on the shifts in question. Flow and capacity were also factors. Learning was identified around the importance of ensuring timely completion of falls assessments in ascertaining the need for enhanced care provision. An action plan has been agreed with the aim of improving oversight of safety and risk at every shift and improving individual patient risk assessment and management of risk.
2	Poor care overall Strong evidence of avoidability Harm – treatment	
3	Strong evidence of avoidability Harm – procedure	SJR review raised questions regarding consent and aspects of the procedure. The clinical team responded in full to all questions confirming to the reviewer the appropriateness of consent and explaining clinical decision making during the procedure. The team committed to considering whether consent forms for cardiology procedures in the cath labs could be scanned to the electronic notes to improve accessibility. An incident was logged in relation (DW205166) and discussed at the CIRG on 22/07/2024. Following review of the rapid response report and documented discussion at the Cardiology M&M there does not appear to have

		been concerns with the procedure or further care provided which contributed to the outcome for this patient. It was agreed that this was a recognised complication of the procedure for which the patient was appropriately consented. The care provided was prompt, appropriate and thorough. It was confirmed that following review of the incident at DIRG that no further learning response is required and the incident should continue to be managed locally. The CIRG agreed with this decision.
4	Harm – treatment	Overall care in this case was judged to have been good and there was no evidence of avoidability. The harm identified was in relation to skin damage resulting from medical equipment. The reviewer did not feel this contributed to the outcome and noted the excellent support of the tissue viability team. Care of this patient was reviewed in response to an incident (DW203298) examined due to delayed surgery due to sickness absence. The SJR was considered as part of the review and no further action related to this harm was required.
5	Harm – procedure	Overall care in this case was judged to have been good and there was no evidence of avoidability. This was a very frail patient where harm was judged to have occurred as a result of an NG tube being misplaced. This was identified through checking of the placement and the patient was not fed through the tube. Following removal of the tube a clinical diagnosis of pneumothorax was made and a chest drain inserted. The reviewer found that this was appropriately reported (DW203836) and that the incident did not contribute. to the outcome.

4.9 **Cases from Quarter 1 24/25**

In this period there were two deaths where reviewers judged there to have been harm, or overall care to be poor, or strong evidence of avoidability. These are summarised below.

	Reasons for additional review	Learning
1	Poor care overall	This patient received elective surgical care at St George's under the gynaecology team and died not long after discharge in another hospital. Although we cannot comment on the cause of death, from the care that provided at St George's the SJR suggested that the patient was possibly not stable from a blood loss perspective at discharge. This incident was originally reviewed through the CWDT Divisional Incident Review Group (DIRG) in June 2024 (DW210179). Further information has been requested from the hospital where the patient died in order to assist

		with the review of this incident. There is currently no active PSII or PSIRF learning response and the incident remains under review in the CWDT division.
2	Harm – treatment	Overall care in this case was judged to have been good and there was no evidence of avoidability and elements of good practice were observed and highlighted. This patient was acutely unwell and was admitted following major trauma. Harm was identified as the patient developed a medical device related pressure ulcer (DW209117). A rapid response review as completed and actions identified in relation to skin inspection and nursing assessments and documentation. The reviewer did not feel that the harm contributed to the patient's outcome.

4.10 **Review processes and cross-site working**
St George's Learning from Deaths team continues to work with Epsom & St Helier in comparing and contrasting processes and are working to bring the learning from death reports more into line across both hospitals. This approach will be strengthened in the coming months as a result of integration of corporate medicine and development of a group approach.

5.0 MEDICAL EXAMINER SERVICE

Medical Examiner services in England are funded centrally by the NHS and are independent of host NHS trusts. All ME services report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each quarter all ME services are required to make a return directly to the office of the National ME.

EPSOM & ST HELIER

5.1 Sutton & Epsom (S&E) Medical Examiner (ME) service is hosted by Epsom & St Helier Hospitals (ESTH). The Sutton and Epsom Medical Examiner service has met all the key requirements reviewing 100% (440 Q4 23/24 & 385 Q124/25) of all Adult and Paediatric Deaths in the Trust. The ME service is not required to review cases where the death has been recorded as a Stillbirth. [See Table in section 5.5] **.

5.2 A key function of the ME service is to support the appropriate referral of deaths to the coroner. Data of referral and outcome is presented in the section 5.5. Through the proactive coordination by the Medical Examiner Service to ensure that Medical Certification of Cause of Death (MCCD) and death registration was achieved in a timely manner the impact of recent industrial action has been minimised.

5.3 The medical examiners service works closely with the mortality reviewers to identify individual cases where referral for mortality review is indicated. The number of deaths referred for an SJR by the ME service was 65 in Q4 23/24 and 76 in Q1 24/25. Of

these, 20 (10 Q4 23/24, 10 Q1 24/25) were for review of on-ward cardiac arrests and 10 (3 Q4 23/24, 7 Q1 24/25) were for COVID-related deaths. This number has steadily reduced following the significant reduction in COVID cases, the changes in working practices following action provided from previous SJR reviews plus the proportionate scrutiny undertaken by the MEs where the understanding and accuracy of review is now greater.

5.4 In addition to flagging areas where there are potential concerns, the ME service highlights cases where best practice was observed. Positive feedback is shared with the Patient Experience team, Ward teams and individuals on a regular basis. There were 295 pieces of positive feedback this quarter, many of which were highly complementary. This equates to 120/164 or 82% at EGH and 175/221 or 79% at STH where there were specific comments relating to the care provided or where the bereaved feedback is summarised by MEs as “no care concerns”. In summary, 319/385 or 82% of Trusts deaths resulted in positive feedback of some description.

Of note, wards caring for patients with respiratory issues and those treated in ED department have again been the recipients of positive feedback despite the pressures that both areas have experienced over the past weeks and months.

5.5 The Epsom & St Helier ME service supports and reviews deaths in the community setting covering the Primary Care Networks (PCNs) of Sutton (Cheam, Carshalton & Wallington) and Epsom. The service will become a statutory requirement from 9 September 2024 with all deaths requiring either Medical Examiner or Coroner signoff. The Community ME service is now fully established for both PCNs with all now referring deaths to the service for review. The Sutton and Epsom Medical Examiner service has since inception had Primary Care Doctors as medical examiners and this has supported the provision to the wider community. The number of Community deaths scrutinised was 205 in Q4 23/24 and 182 in Q1 24/25.

The service provided has been recognised as an exemplar at both regional and national level for collaborative and forward-thinking practice. Each quarter all ME offices are required to make a return directly to the office of the National ME, as summarised below.

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN REVIEWED BY THE ME Q4 (2023-24) & Q1 (2024/25)		
	Q4	**Q1**
Number of in-hospital deaths reviewed (in-patient **and** ED)	440	385
Adult deaths		
Cases not notified to the Coroner and MCCD issued directly	379	317
Cases notified to the Coroner and MCCD issued following agreement by Coroner	23	20
Cases referred to the Coroner and taken for investigation	47	46
Child deaths		
Cases not notified to the Coroner and MCCD issued directly	0	2
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0	0

Cases referred to the Coroner and taken for investigation (including ED)	0	0
Timeliness and rejections by registration service		
Number of MCCDs not completed within 3 calendar days (NB: no account is taken of B/H or weekend and requirement is 5 days)	102	80
Number of MCCDs rejected by registrar after ME scrutiny	0	0
Number of cases where urgent release of body is requested and achieved within requested time	22	13
Number of cases where urgent release of body is requested and NOT achieved within requested time	0	0
Achieving communication with the bereaved		
Number of deaths in which communication did not take place		
Reasons for no communication: Declined	1	0
No response	2	1
No NOK	2	1
Not documented	0	0
Detection of issues and actions		
ME referred for structured judgement review (including COVID related deaths and on-ward cardiac arrests)	65	76
ME referred to other clinical governance processes (including safeguarding, nursing issues)	0	0
ME referred to external organisation for review (including GP practices, LAS)	0	0
Families referred to PALS	10	1

Triggers for SJR by ME service

Triggers for review:	**Q4**	**Q1**
Confirmed learning disability +/- clinical diagnosis of autism	10	15
Bereaved raised concerns	7	6
ME or clinical team detected possible learning or potential issue with care	20	20
Unexpected death e.g. following elective admission	1	0
Maternal or neonatal death	0	0
Areas subject to enhanced oversight (learning will inform quality improvement work)	14	17
Provider learning/improvement where there is an unexpected cardiac arrest (OWCA)	10	10
Provider learning/improvement with COVID judged to be likely nosocomial (Covid Infections)	3	7
Death linked to a service specialty/specific diagnosis	0	1

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MERTON & WANDSWORTH MEDICAL EXAMINER SERVICE

5.6 Merton & Wandsworth (M&W) Medical Examiner (ME) service is hosted by St George's. In the last two quarters all the required KPIs and milestones were met. In

Q4 23/24 the ME service scrutinised all 348 deaths that occurred at St George's and 180 deaths that were referred by community providers. In Q1 24/25 activity was similar, with all 333 inpatient deaths and 183 deaths outside of hospital scrutinised.

5.7 The ME service became statutory on 9th September. A comprehensive implementation plan was formulated and progress monitored to ensure a seamless transition. Further feedback on this will be provided in subsequent reports.

5.8 Prior to commencement of the statutory system the service was in a strong position with 56 community providers in Merton & Wandsworth referring deaths for scrutiny. To further improve this position the service continues to promote community engagement and met with providers in this period. Non-engagement has been reported to the ICB.

5.10 Significant education and engagement with clinical teams within both St George's and Queen Mary's is underway and will continue to ensure all are familiar with the changes and are aware of amended processes.

5.11 A limited out of hours service, approved by the National ME, was introduced in Q4. The principal driver of this extended service is to support requests for rapid release of the deceased, usually to meet faith requirements. This pilot period has informed development of a robust process, supported by the Registration Service and the Clinical Site Team which has been launched from 9th September.

5.12 The Lead Medical Examiner is a regular faculty member for national Medical Examiner training and meetings with Coroner leads. He has attended a number of national events and shared learning with the wider team.

5.13 The ME service remains positively engaged with Trust Learning from Deaths processes and is currently the primary route through which deaths requiring structured judgement review are identified. In Q4 23/24 the ME service flagged 33 deaths for SJR, and 44 in Q1 24/25.

5.14 Feedback on the ME service is gathered as part of an end of life care and bereavement survey. In Q4 23/24 100% of the bereaved felt they were spoken to sensitively and given opportunity to ask questions and 84% reported that their experience of the service was excellent or very good. In Q1 24/25 these figures were 90% and 82% respectively.

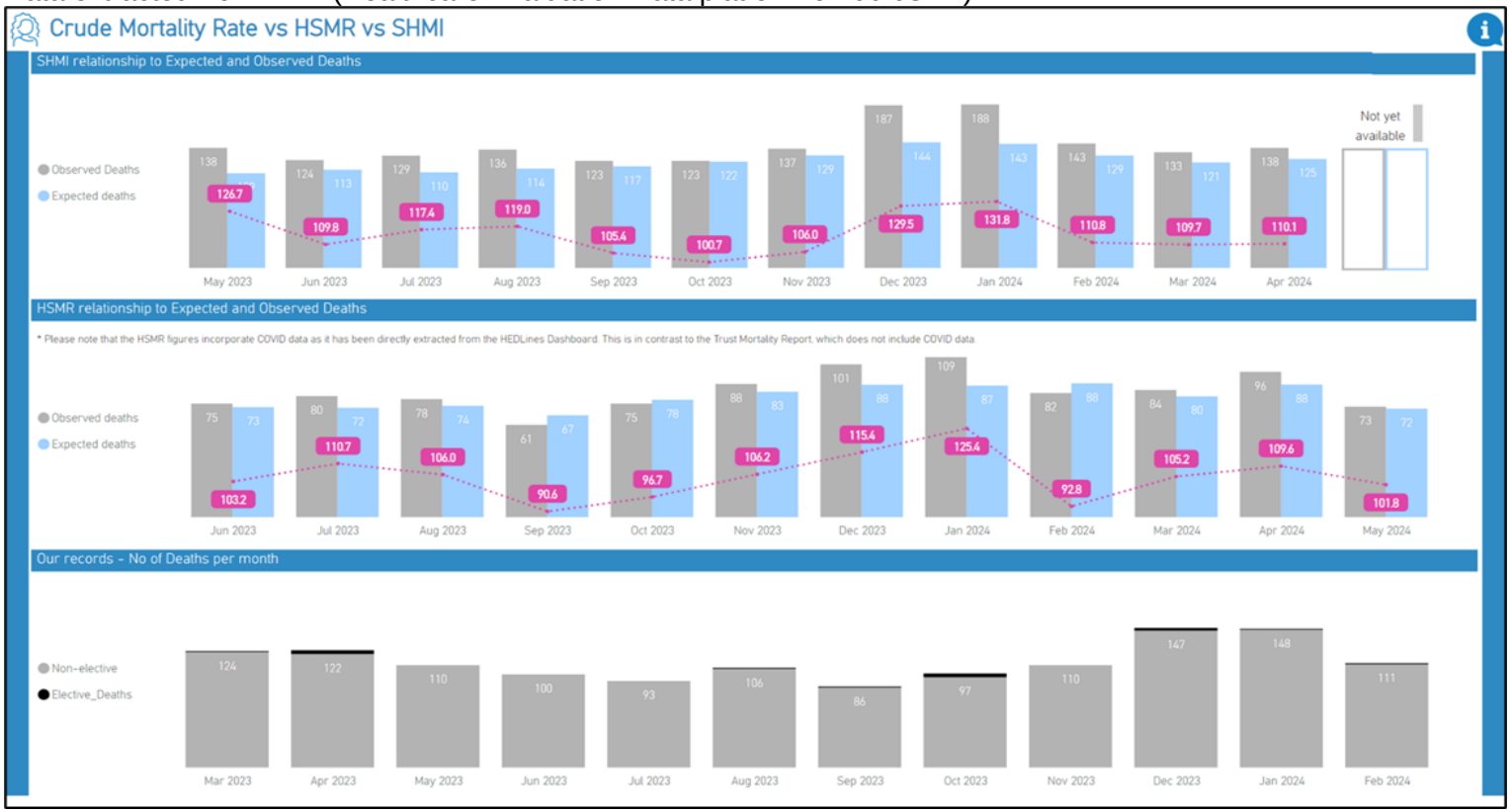
6.0 RECOMMENDATION

That the Board notes the continued work in accordance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these issues at both sites.

APPENDIX 1 (EPSOM & ST HELIER DATA)

ESTH Mortality Overview (Crude Mortality Rate vs. SHMI and HSMR[1])

Data extracted from HED (Healthcare Evaluation Data platform on 06.08.24)



[1]Please note that the data in Appendix A consists of monthly values for SHMI/HSMR, intending to illustrate trends, and differs from the 12-month rolling values mentioned in the report.

APPENDIX 2: To address QCiC Action Log 1.4 Oct 2023, Row 8

Analysis of protected characteristics
The Equality Act 2010 protects individuals from discrimination because of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

These are called protected characteristics.

In September 2022, the Quality Committee in Common requested that future Learning from Deaths reports should include analysis of themes by protected characteristics. In order to provide this analysis, it would be necessary to routinely and reliably collect this data for all patients. Currently, as part of routine data, NHS organisations collect data on age, sex, and race (if taken to be ethnicity). Data is not collected routinely and consistently across all patient populations for the other characteristics, and these are not compulsory fields in the patient management system.

EPSOM & ST HELIER DATA

The SHMI (Summary Hospital-level Mortality Indicator) can be analysed by age, sex, and deprivation quintile using the HED platform. Reviewing the most recent reporting period (April 2023 to March 2024) for these factors reveals that results are generally within expected levels, with some exceptions noted in specific categories. Metrics exceeding the 95% confidence interval are highlighted in blue on the graphs.

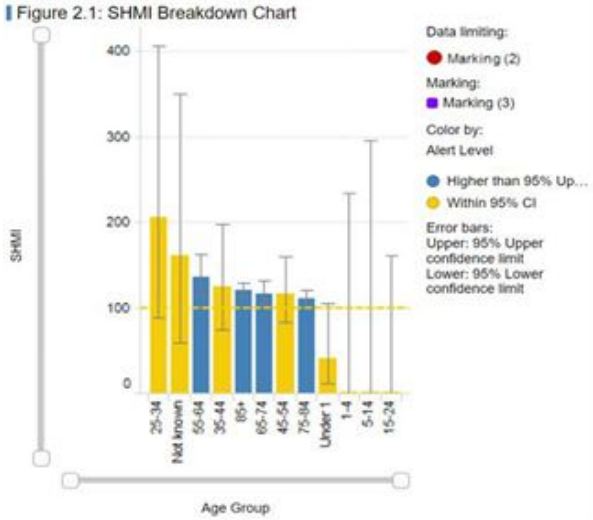
Both male and female categories are significant, as mortality surpasses the 95% upper confidence interval (CI). The age groups of 55-64, 65-74, 75-84, and 85+ stand out, showing mortality rates beyond the 95% upper CI. Deprivation Quintiles Q2 (less deprived), Q4 (less affluent), and Q5 (most affluent) demonstrate mortality rates exceeding the 95% upper CI.

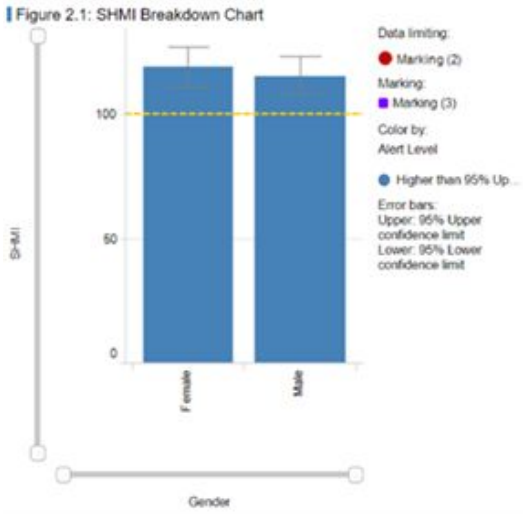
SHMI by Age groups

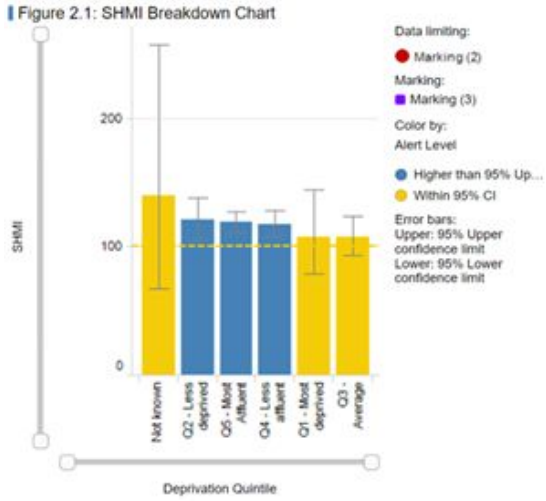
SHMI by Sex

SHMI by Deprivation Quintile

Data extracted from HED – Healthcare Evaluation Data platform on 22.08.2024



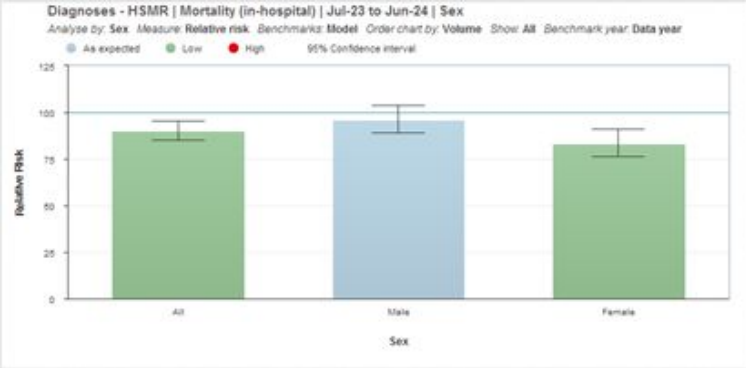


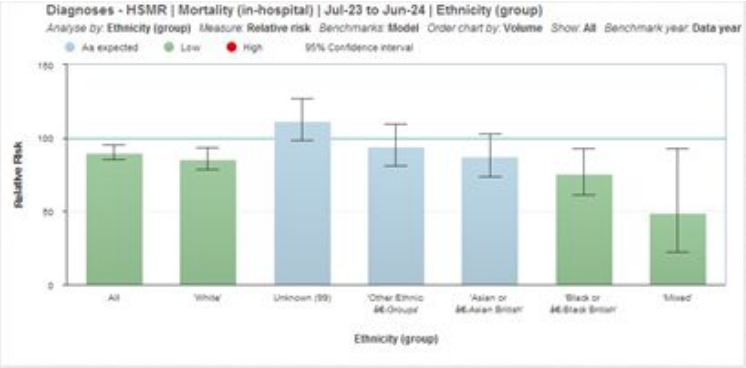


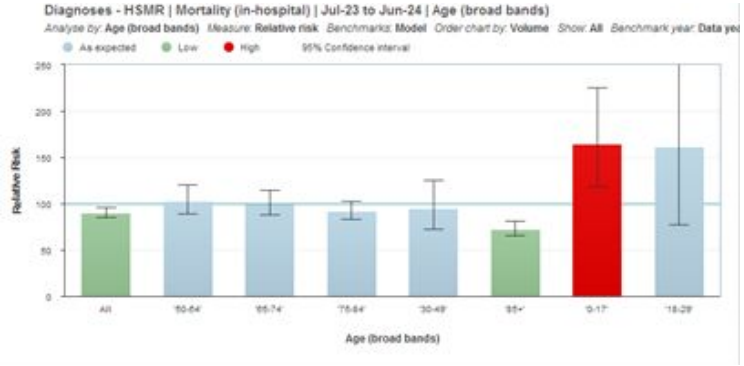
gesh

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

ST GEORGE'S DATA
Source: Dr Foster







Analysis by sex and ethnicity show that mortality is either as expected, or lower than expected. Analysis by age shows higher than expected mortality in the 0-17 age group.

Analysis by deprivation quintiles reveals no areas of higher than expected mortality.

APPENDIX 3: (ST GEORGE'S DATA)

Learning from Deaths Dashboard

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2024-25

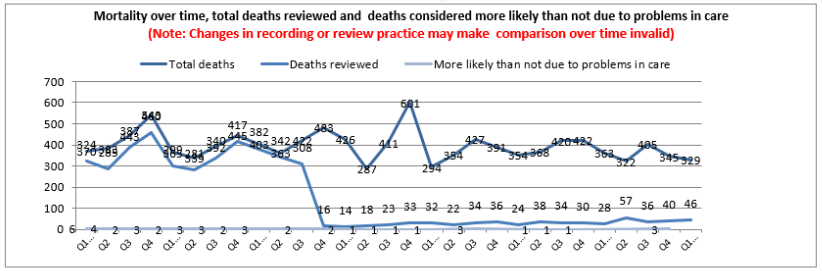
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
96	109	17	14	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
329	345	46	40	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
329	1435	46	161	0	3

Time Series: Start date 2017-18 Q1 — End date 2024-25 Q1



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	5	29.4%	This Month	12	70.6%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	4.3%	This Quarter (QTD)	9	19.6%	This Quarter (QTD	35	76.1%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	2	4.3%	This Year (YTD)	9	19.6%	This Year (YTD)	35	76.1%

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2024-25

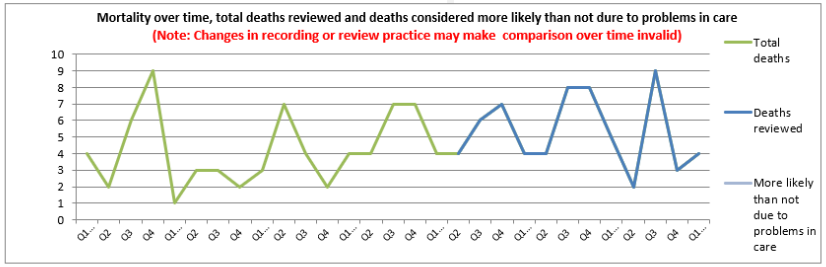
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	3			0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	19			0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	2	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	3	4	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	19	4	19	0	0

Time Series: Start date 2017-18 Q1 End date 2024-25 Q1



Group Board

Meeting on Thursday, 07 November 2024

Agenda Item	4.2	
Report Title	**Group Healthcare Associated Infection Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Group Clinical Director, Infection Prevention and Control**	
Previously considered by	Quality Committees-in-Common	31 October 2024
Purpose	**For Assurance**	

Executive Summary

This paper provides a quarterly update on Healthcare Associated Infections (HCAIs) and key issues/ concerns arising in Infection Prevention and Control (IPC) across the health group.

In Quarter 2, the key issues to highlight are summarised below.

C.difficile Infections (CDI): We have seen a substantial increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low level fluctuations in CDI cases observed prior to the COVID-19 pandemic. This shift to an upward trend for CDI, which was initially observed during the pandemic, suggests a need for additional efforts in order to return to and maintain previously low prevalence levels.

At ESTH by end of Quarter 2, there were 50 CDI cases and 7 patients died within 30 days of diagnosis with a case fatality rate of 14% against a national average of 18%. In 4 patients it was deemed that CDI contributed to death and CDI was mentioned on Part 1 of the death certificate for 2 patients. The reviews for the 4 cases are on-going (awaiting coroner's findings for 2 cases) by a multidisciplinary team led by the IPC Doctor, with a view to identifying an improvement plan.

SW London Pathology Services - ESTH: Ongoing issues with incorrect entry of sample collection dates with the SWL pathology, citing that dates on request forms are not legible or missing.
The ICD is working with pathology leads to find a solution to access request forms and ensure accurate data capture.

SGUH SCBU Gentamicin resistant *E. coli Incident*: Five cases (including a set of twins) of Gentamicin-Resistant *Escherichia coli* were identified between August and September in SCBU via routine weekly screening which is undertaken in NNU and SCBU. Two cases were initially identified in August and a further 3 cases in September, all colonisation and not invasive infections. All samples have been sent to the reference laboratory and still awaiting ribotyping results to determine if cross transmission occurred. An incident meeting has been held and the Unit is on enhanced IPC monitoring.

Currently, ribotyping is still pending for all five cases and SCBU is undergoing daily monitoring and frequent visits by the IPC Team who observe correct implementation of IPC precautions, the 5 moments of hand hygiene and the cleaning and decontamination of patient equipment. An incident meeting was held early October between the IPC and NNU Team where IPC issues were addressed.

Four out of the 5 babies have been discharged home and the remaining baby on the Unit is clinically well.

COVID-19: Consistent with local reports, there has been a significant increase in COVID-19 positive admissions particularly on the SGUH site which has resulted in bay/ward closures impacting on bed capacity. The health group continues to follow national testing and management guidance for COIVD-19.

Action required by Group Board

The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from Sites and Group for assurance
- Make any necessary recommendations

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Quarterly Group Infection Prevention and Control Report: July-September 2024
Appendix 2	READING ROOM: ESTH Quarter 2 IPC Report July – September 2024
Appendix 3	READING ROOM: SGUH Quarter 2 IPC Report July – September 2024
Appendix 4	READING ROOM: ESTH *C. difficile* Deaths Summary

Implications

Group Strategic Objectives

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

Risks

As set out in the paper

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

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

Financial implications

N/A

Legal and / or Regulatory implications

The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2023) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Health and Social Care Act (2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment

Equality, diversity and inclusion implications

No issues to consider

Environmental sustainability implications

No issues to consider

Group Healthcare Associated Infection Report
Group Board, 07 November 2024

1.0 Purpose of paper

This paper provides a quarterly update on HCAIs and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Group.

2.0 Summary of key performance measures

The paper supplements the IPC key performance measures and summary contained in the Integrated Performance Reports for both Trusts.

3.0 Key Issues:

3.1 C.difficile Infections (CDI): There has been a substantial increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low level fluctuations in CDI cases observed prior to the COVID-19 pandemic.

ESTH: During Q2 there were 32 Trust attributed CDI cases, (21 Healthcare Onset Healthcare Associated and 11 Community Onset Healthcare Associated). YTD is 50 with a trajectory of 63. The lead Infection Control Doctor is undertaking a prospective audit for all cases in 2024/25 and the findings will be shared accordingly.

All cases have been reviewed using the PSIRF model to assess if there were any lapses in care (3 lapse in care attributed to non-compliance with antibiotic use) and lessons to learn. Of the 50 cases, 7 patients died within 30 days of diagnosis of CDI with a case fatality rate of 14% (national average is 18%). In 3 of these 7 patients, the cause of death was not attributed to CDI. However, in 4 patients it was deemed that CDI contributed to death and it was mentioned on Part 1 of the death certificate for 2 patients, see Appendix 4 for a detailed summary. The reviews for the 4 cases are on-going (awaiting coroner's findings for 2 cases) with a multidisciplinary team led by the IPC Doctor and an improvement plan will be agreed.

It should be noted that all samples have been sent to the reference laboratory for ribotyping and none of the cases were similar suggesting there is no same strain that is circulating in our hospitals or evidence of cross infection.

SGUH: During Q2, there were 23 CDI cases (15 HOHA; 8 COHA), YTD 35 with a trajectory of 43. The 23 CDI cases during Q2 have primarily occurred in the Medicine & Cardiovascular Division. Ribotyping has been received for 17 cases, all different therefore ruling our possible cross transmission. Of the 28 cases reviewed to date, 5 cases have been identified as having a lapse in care, due to the inappropriate use of antibiotics.

The reviews have identified a recurring theme with cleaning and disinfection of patient equipment and commodes, more specifically the footrest, back and corners. This is fed back to wards in real time and advice given on appropriate decontamination of equipment. The IPC team also continues to emphasise the importance of cleaning and decontamination in all teaching/training sessions.

Despite SGUH breaching monthly CDI targets during Q2, a comparison between all NHS Trusts shows that SGUH was within the first quartile range with regard to CDI rates (per 100,000 bed days), meaning the Trust's performance is within the top 25% of the 135 Trusts who have submitted their figures during Q2 with a rate of 15.37 per 100,000 bed days.

In conclusion CDI numbers have been increasing and in particular at ESTH for the last few years and partly this reflects the changing CDI epidemiology at national level.

UK Health Security Agency (UKHSA, 2024) *Annual epidemiological commentary: Gram-negative, MRSA, MSSA bacteraemia and C. difficile infections, up to and including financial year 2023 to 2024* has stated that:

"Despite various hypotheses, the exact reasons for the unprecedented increase in hospital and community onset CDI cases remains unclear. It is unclear the extent to which the rise in CDI cases is influenced by increasing sampling rates. CDI seasonality has also shifted with rising infections cases between April to June and October to December".

The Table below shows similar challenges being faced across the South-West London sector.

Healthcare Associated Infections – SW London NHS Trusts: April-Sep 2024

Table 1	Croydon HS	E&SH	Kingston FT	SGH	RMH
MRSA	0	1	0	0	0
MSSA	8	15	7	18	2
CDI	16/23	50/63	19/29	35/43	31/40
E-coli	28/56	28/61	24/57	58/114	23/51
Pseud A	4/16	9/8	3/12	7/34	10/21
Klebsiella	13/28	19/25	13/17	38/62	18/2

3.2 SW London Pathology Services - ESTH: Ongoing issues with incorrect entry of sample collection dates with the SWL pathology, citing that dates on request forms are not legible or missing. Whilst both clinical staff and laboratory can work to improve the process, the issue is further compounded by the fact that IPC are unable to check request forms on the portal to clarify sample dates as this is not a feature offered by SWLP.

Incorrect entry of sample date can impact the attribution of cases particularly if the date used is when the sample was received in the laboratory. The ICD is working with pathology leads to find a solution to enable IPC to access to request forms.

3.3 COVID-19: Consistent with local reports, there has been a significant increase in COVID-19 positive admissions particularly on the SGUH site. The health group continues to follow national testing and management guidance for COVID-19.

ESTH: In Quarter 2 there were 228 COVID-19 cases across the Trust (22 cases from Surrey Downs & Sutton Health Care inpatient wards) compared to 257 in Quarter 1.

There were 38 COVID-19 deaths in Quarter 2 compared to 23 deaths in Quarter 1. One nosocomial deaths met the criteria for a review using the PSIRF model.

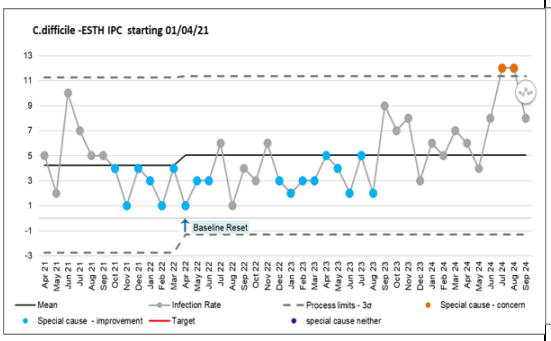
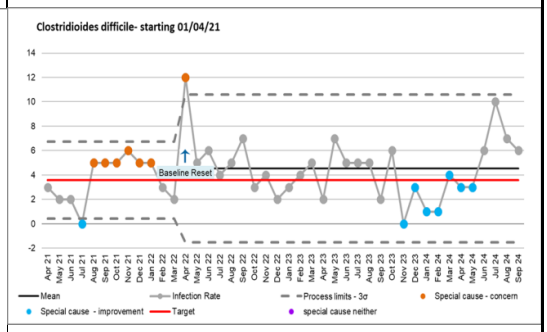
Outbreaks: There were 2 outbreaks reported in Quarter 2 on Frank Deas ward and Sutton Health and Care, Reablement Unit.

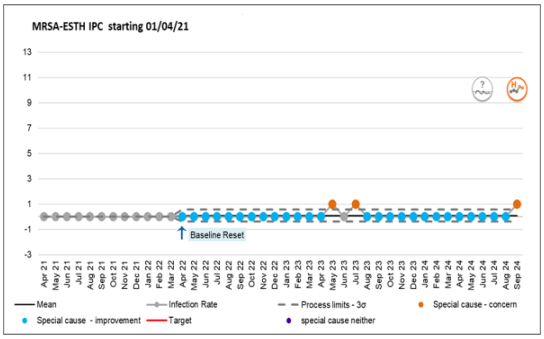
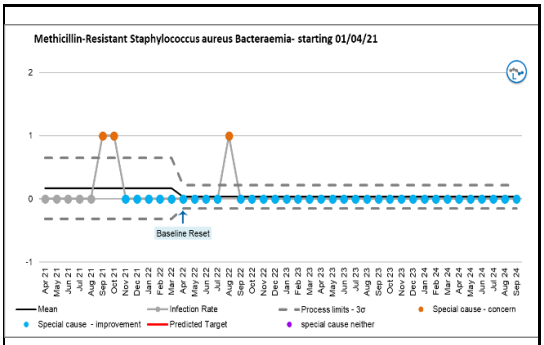
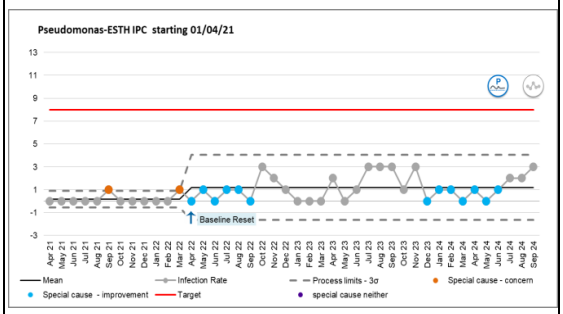
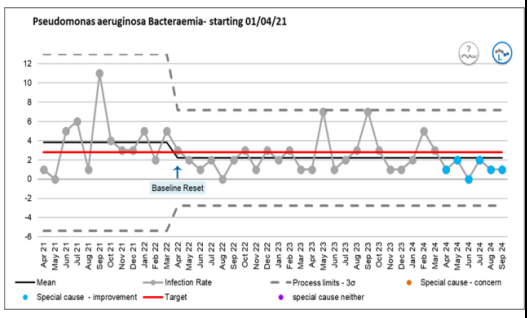
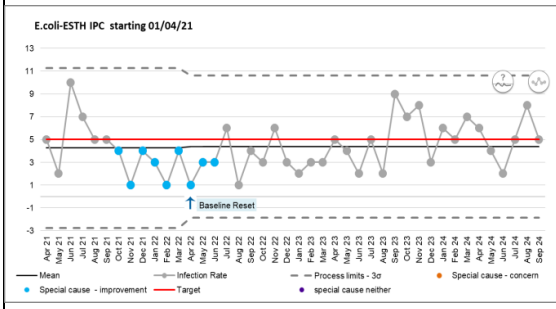
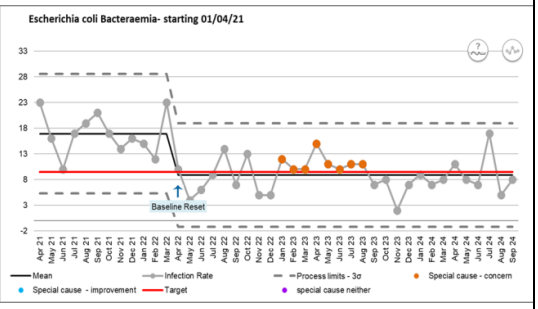
SGUH: There were 254 COVID-19 cases reported during Q2, of these 84 were nosocomial infections. During Q2, there were sixteen deaths where the patient tested positive for COVID-19 during their admission and one nosocomial COVID-19 had COVID-19 listed on Part 1A of their death certificate.

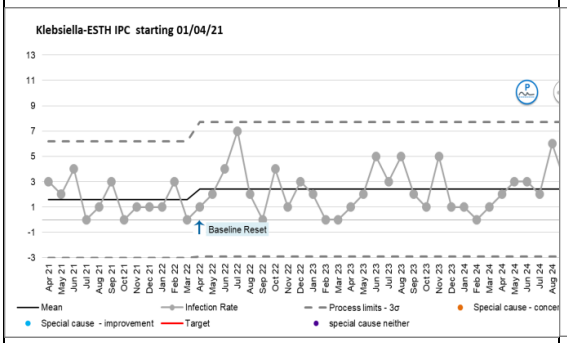
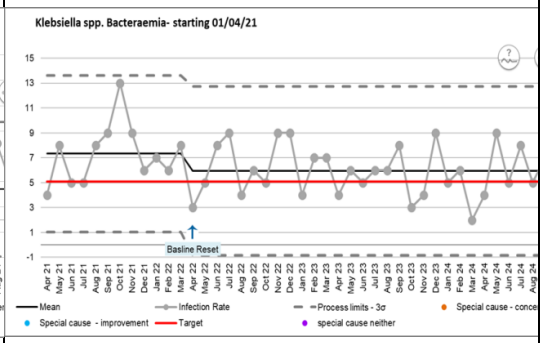
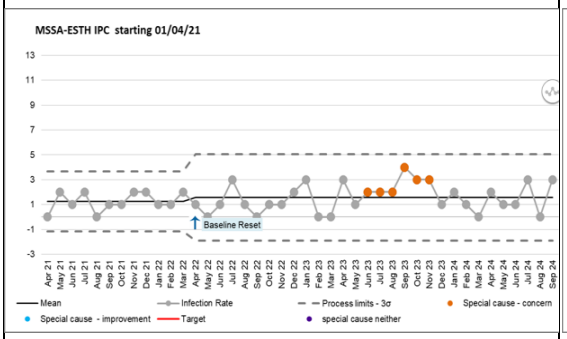
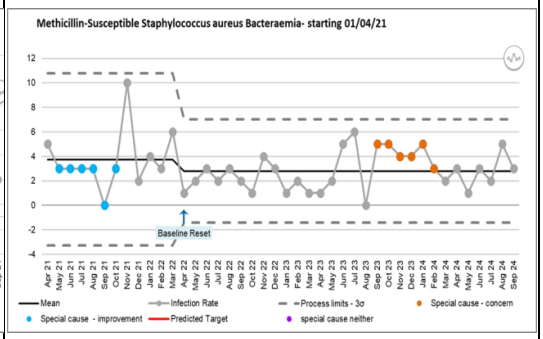
Outbreaks: During Q2, there were 12 COVID-19 outbreaks with a total of 59 nosocomial infections and an average bay closure of 9 days.

4.0 Healthcare Associated Infections

The table below summaries the quarterly HCAI position at site level. Efforts continue to achieve the aim of reducing the number of gram-negative infections. The IPC team continues to consistently monitor trends and new local/national initiatives to prevent and manage these infections.

HCAI	ESTH	SGUH
C. *difficile* infection	 There were 32 Trust attributed *C. difficile* cases, (21 Healthcare Onset Healthcare Associated and 11 Community Onset Healthcare Associated), YTD is 50	 There were 23 cases of nosocomial C.difficile infection in Q2 of 2024/25. This is a deterioration in performance when compared with twelve cases throughout Q2 of 2023/24

MRSA bloodstream infection	 There was one MRSA bloodstream infection reported in Q2. (YTD) is against a threshold of 0.	 2024/25 YTD: zero against a national threshold of zero, this is comparable in performance when compared to 2023/24.
Pseudomonas aeruginosa	 There were 7 Pseudomonas aeruginosa infections attributed to the Trust during this period (3 HOHA, 4 COHA) YTD is 9 which is over the set national threshold for 2024/25 which is 8 cases.	 There were 4 *Pseudomonas aeruginosa* bloodstream infections in Q2 of 2024/25. This is an improvement in performance when compared to twelve cases throughout Q2 of 2023/24
E-coli	 There were 18 cases of E.coli bloodstream infections during the period of July to September (5 HOHA and 13 COHA) and YTD is 28 against a national objective of 61 cases.	 There were 31 *Escherichia Coli* bloodstream infections in Q2 of 2024/25. This is a reduction in performance when compared to twenty-nine cases during Q2 of 2023/24.

Klebsiella spp.		
	There were 11 Klebsiella *sp*. infections reported during this period (4 HOHA, 7 COHA) YTD is 19 cases. The set national objective for 2024/25 is 25 cases.	There were 20 Klebsiella spp. bloodstream infections in Q2 of 2024/25. This is comparable in performance when compared with twenty cases throughout Q2 of 2023/24.
MSSA		
	There is no national trajectory for MSSA BSI. There were 6 MSSA infections reported during this period: 3 hospital-onset healthcare-associated (HOHA) infections each in July and September, bringing the year-to-date total to 6.	There were 10 MSSA bloodstream infections in Q2 2024/25. There is no national threshold. This is an improvement in performance when compared to eleven cases in Q2 of 2023/24.
Covid-19 Update December 2023	Covid-19 positive cases:186 Covid-19 deaths: 14 Nosocomial infections: 60 Nosocomial deaths: 2 **YTD positive cases: 710** **YTD nosocomial deaths: 6**	Covid-19 cases: 159 Covid-19 deaths: 12 Nosocomial infections: 54 Nosocomial deaths: 5 **YTD positive cases: 802** **YTD nosocomial deaths: 27**

5.0 Site Specific Updates

Epsom & St Helier Hospital

MRSA Bloodstream Infections: There was one Trust attributed MRSA bloodstream infection reported in Q2 on Alexandra Community Frailty Unit.

A 66 year old patient was admitted from a nursing home to EGH /ED via ambulance on the 21st of August. The patient is a bilateral leg amputee who is bedbound with multiple co-morbidities including a previous history of MRSA colonisation, multiple category 3 pressure ulcers and alcohol dependency. The patient was diagnosed with sepsis and admitted to Chuter Ede Ward. The patient

was noted to have sacral pressure ulcers and was reviewed by the Tissue Viability Nurse (TVN) and wound care plan established.

On admission, routine MRSA admission screen including the wounds were done and all came back as MRSA positive. MRSA skin suppression treatment was commenced and it was noted in the notes that the patient was non –compliant.

The patient's condition deteriorated on the 12th of September and blood cultures were taken from which MRSA was isolated and treatment was duly commenced. Repeat blood cultures were taken on the 14th of September and these were negative.

A multidisciplinary Post Infection Review (PIR) meeting was held and it was concluded that the MRSA positive result may possibly be a contaminant as MRSA was isolated in only one of the culture bottles. It was concluded that the result was possibly a contaminant and highly unlikely not a clinically significant infection and the patient recovered well within 48hrs with no additional complications. Contaminants can arise due to technique when collecting the sample especially in this case where the patient was heavily colonized. A training package for taking blood cultures is currently being reviewed.

St George's Hospital

5.1 SCBU: Gentamicin resistant *E. coli on* Incident: Rectal screening for MRSA and Gentamicin-Resistant organisms is undertaken on admission to Special Care Baby Unit (SCBU) and is continued weekly until discharge. At the end of August, the first case of a Gentamicin-Resistant *Escherichia coli* was identified followed by a second case the following week via routine screening. Both samples were sent for ribotyping and the ward was monitored for IPC compliance. A look back exercise regarding baby locations and incubator use was performed to identify further cases; none were identified at the time.

With the identification of a further three cases in mid to late September, a preliminary meeting was held between the IPC Team and NNU senior leaders to discuss potential transmission from baby to baby. Currently, ribotyping is still pending for all five cases and SCBU is undergoing daily monitoring and frequent visits by the IPC Team who observe correct implementation of IPC precautions, the 5 moments of hand hygiene and the cleaning and decontamination of patient equipment. An incident meeting was held early October between the IPC and NNU Team where IPC issues were addressed.

Four out of the 5 babies have discharged (one set of twins) and all babies were clinically well.

Integrated Care – Surrey Downs Health & Care

There were no major issues reported in Quarter 2 with the exception of the outbreak on the Sutton Health & Care Reablement Unit.

6.0 Groupwide Update

- The IPC leads across the group are in the process of updating policies and merging suitable ones to group policies.
- IPC and Estates teams are looking to put a joint business case to purchase Hydrogen Peroxide Vapour (HPV) decontamination machines across the group. HPV provides a higher level of decontamination in particular given the significant rise in CDI and multi resistant infections across our hospitals. To ensure standardisation in practice across the health group,

HPV decontamination will be introduced at SGUH as currently ESTH uses HPV decontamination for multi resistant organisms and CDI discharges and HPV is not used at SGUH.

7.0 Recommendations

6.1 The Committee is asked to:

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

Appendix – ESTH C. difficile Deaths Summary

Deaths involving Clostridioides difficile infection during 2024-25

Clostridioides difficile (C. difficile) is a bacterium that is found in people's intestines. It can be found in healthy people, where it causes no symptoms (up to 3% of adults and 66% of babies). However, it can cause disease when the normal bacteria in the gut are disadvantaged, usually by exposure to antibiotics.

The spectrum of the Clostridioides difficile infection (CDI) ranges from asymptomatic carriage and mild diarrhoea to fulminant disease with toxic megacolon. Although, there has been a significant reduction (72.6%) in the CDI burden in NHS hospitals across England, since the inception of mandatory CDI surveillance in FY 2007/08, there was 17.6% increase in the most recent data (Q1 2024/25). CDI continues to be an important healthcare associated infection in England, leading to significant morbidity and mortality. During 2023/24, 16,867 CDI cases were reported in England with 2,164 deaths within 30 days of a CDI resulting in a case fatality rate (CFR) of 12.9%. The CFR for healthcare associated CDI during 2023/24 was 18.6%.

At E&STH, a total of 50 cases of healthcare associated CDI (2024/25 trajectory is 63) have been diagnosed by the end of September 2024. Seven patients died within 30 days of diagnosis of CDI with a case fatality rate of 14%. In 3 of these 7 patients who died within 30 days of CDI, the cause of death was not attributed to CDI. However, in 4 patients it was deemed that CDI contributed to death and it was mentioned on the death certificate. Below are the findings of the RCA on these 4 patients.

	Patient 1	**Patient 2**	**Patient 3**	**Patient 4**
Age	86	64	78	84
Gender	Female	Female	Male	Male
COHA/HOHA	HOHA	HOHA	COHA	COHA
Previous CDI	Nil	Nil	Jan 2024	Nil
Date of admission	22/05/2024	07/06/2024	05/07/2024	12/07/2024
Date of sample	03/06/2024	22/06/2024	04/07/2024 (in ED)	11/07/2024 (in ED)
Date of Death	07/06/2024	23/06/2024	05/07/2024	13/07/2024
Admitted under	General Surgery	Trauma & Orthopaedics	Renal	General Medicine
Reason for admission	Abdominal pain & diarrhoea. CT: pelvic mass ?infection/ ?malignancy	Closed fracture left ankle following absence seizure at home.	Diarrhoea with decreased oral intake and increased lethargy	Fall at home Diarrhoea Scrotal abscess

Significant risk factors for CDI:	Lung CA PPI Antibiotics: Coamox & Cefurox	Antibiotics: Ceftriaxone & Coamox	Renal Tx 2008 Bowel CA 2023 Hemicolectomy 2023 CDI Jan 2024	Diverticular disease Recurrent UTIs requiring antibiotics
Findings of RCA	Delay in sample collection Delay in patient isolation Delay in treatment initiation No HPV/UV decontamination Antibiotics: yes, to treat pelvic mass/intra-abdominal sepsis.	Timely sample collection and patient isolation Antibiotics: Inadequate documentation of indication. Patient refusing iv antibiotics.	Sample collected appropriately CDI treatment has been considered on admission while waiting for results, in view of recent CDI and diarrhoea.	Timely sample collection and patient isolation Timely initiation of CDI treatment
Lapse of Care	Yes	MDT awaited	MDT awaited	No
Ribotype **Cluster/Outbreak**	017 No	002 No	078 No	005 No
Cause of Death	1a. Sepsis 1b. CDI 2. Lung Ca, Vascular dementia	No death certificate issued, as case referred to coroner (surgery in previous month)	No death certificate issued, as case referred to coroner (surgery in previous month, renal Tx in 2008)	1a. Urosepsis & CDI 2. Frailty of Old age, DM2 & AF
Actions	Reviewed by the Trust PSI review panel and recommended for discussion at MDT for further review to understand learning and actions. Investigation is on-going.	MDT review: on-going	MDT review: on-going	Nil

Summary & Conclusions:

The case fatality rate of healthcare associated CDI at ESTH (YTD, 2024/25) is 14% (cf. 18.6% CFR for HA CDI in England, 2023/24). All the four cases of healthcare associated CDI infections wherein CDI was deemed to have contributed to death are being investigated using PSIRF.

As shown in the table, lapse of care was identified in patient 1 through discussions at RCA, SI panel and MDT meetings, and a further MDT is due to happen later in October to finalise and agree on the improvement plan. No lapse of care was identified in case 4. However, a full analysis for case 2 and 3 is pending, while coroner's findings are awaited.

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

gesh

Workforce Race Equality Standard (WRES)
2023-2024 - ESTH

Workforce Race Equality Standard (WRES)

Executive Summary Key Points

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

In line with national requirements this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 31st October 2024.

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

Positive Developments

Improvement in 7 Out of 9 Indicators: Progress was observed in 7 of the 9 key indicators, with one indicator remaining consistent with last year's results.

Growth in BME Staff Population: The BME staff population at ESTH continues to grow year-on-year, now comprising **44.2%** of the workforce.

Reduction in Non-Clinical Workforce Disparity: The disparity within the Non-Clinical workforce has slightly improved, with slight increase in the proportion of BME employees from 2023 to 2024.

Significant Increase in Clinical Workforce Representation: BME staff representation within the Clinical Workforce has risen notably, from **47.5% to 50.9%.**

Improved Hiring Equity: The relative likelihood of White applicants being appointed over BME candidates has decreased from 1.30 in 2023 to 0.74 in 2024, reflecting progress towards equity in hiring practices. However, we need to achieve equity of '1' to ensure we are fully inclusive.

Reduction in Disciplinary Disparities: The likelihood of BME staff entering formal disciplinary processes decreased from 1.45 to 1.04, indicating a move closer to parity between different groups. However, we need to achieve equity of '1' to ensure we are fully inclusive.

Balanced Training Access: The relative likelihood of White staff accessing training compared to BME staff decreased from 0.52 in 2023, then increased to 1.01 in 2024, showing an initial improvement in balancing training access across groups and equity.

Areas for Improvement

- **Over-Representation in Lower Bands:** BME staff continue to be over-represented in pay bands, particularly in bands 2, 5, and Medical and Dental (MD), indicating a need for targeted career development and progression opportunities.
- **Underrepresentation on the Board/VSM:** There is a significant underrepresentation of BME staff in both voting and executive roles on the board, which does not reflect their overall workforce representation.
- **Underrepresentation in Higher Pay Bands:** BME staff are underrepresented in higher pay bands, specifically in bands 7 through to 9 and Very Senior Management (VSM), highlighting a significant gap in advancement to senior leadership positions this is an area for attention.

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Workforce Race Equality Standard (WRES)

Purpose and Background

Purpose

- This paper provides an overview of the 2023-24 Workforce Race Equality Standard (WRES) findings.
- The report will be published on the Trust website.
- The Board is asked to receive this report for information and approve for publication.

Background

- In April 2015, NHS England introduced the WRES in response to consistent findings that BME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.
- Since April 2015, the WRES has been included in the full length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2024. All other indicators are from the 2023 staff survey.

Overview of Workforce Numbers - ESTH						
	2019	2020	2021	2022	2023	2024
Total number of staff in organisation	5194	5854	6150	7092	7190	7410
% of BME Staff	36.7%	36.4%	38.1%	38.2%	42.0%	44.2%
% of staff who self-reported ethnicity	94.6%	95.2%	95.6%	91.4%	92.4%	93.9%

Workforce Race Equality Standard (WRES) – Indicator Overview

	Indicator	ESTH 2020	ESTH 2021	ESTH 2022	ESTH 2023	ESTH 2024	Performance vs. previous year	Exp. compared to White Staff	London Av. 2022	London Av. 2023
1	% of BAME staff in organisation	37%	38%	38%	41%	44.2%	**Improved**		49.9%	52.1%
2	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	2.52%	1.79%	1.04%	1.30%	0.74%	**Improved**		1.44%	1.47%
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	0.47	1.29	1.20	1.45	1.04	**Improved**		1.47%	1.41%
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.54%	1.29%	1.07%	0.52%	1.01%	**Declined**		0.97%	0.92%
5	% of BAME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	30%	29%	27%	28%	28%	**Static**		30.2%	32.1%
6	% of BAME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	30%	30%	26%	26%	25%	**Improved**		28.1%	28.3%
7	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	42%	48%	45%	46%	51%	**Improved**		43.6%	43.2%
8	% of BAME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16%	17%	16%	16%	15%	**Improved**		16.7%	16.1%
9	% difference between the organisations' board voting membership and its overall workforce	-23.1%	-27.3%	-10%	-16%	-26%	**Improved**		-26.1%	-27%
	% difference between the organisations' executive membership and its overall workforce	-25.1%	-14.3%	0	-10%	-33%	**Declined**		-33	-33

- **Relative Likelihood Close to 1**: Indicates equal likelihood of the outcome occurring in both White and BME (Black and Minority Ethnic) groups, suggesting parity between the groups
- **Relative Likelihood Greater than 1**: Indicates that the outcome is more likely to occur in the White ethnic group compared to the BME group
- **Relative Likelihood Less than 1:** Indicates that the outcome is less likely to occur in the BME group compared to the White group

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Workforce Race Equality Standard (WRES) Executive Summary – ESTH

Workforce Numbers

In 2024, we employ 7410 substantive employees, which is broken down as 3681 white (50%), 3277 BME (44.%) and 452 unknown (6%).

Our Black, Asian, and Minority Ethnic (BME) workforce has shown consistent annual growth since 2019-20. In the current reporting year, there was a significant 3.2% increase from the previous year, equating to an addition of 328 BME staff members.

Despite this positive trend, our BME workforce remains below the London average at **44%.** Specifically, our representation stands **7%** lower than the 2023 London average of **51.1%.**

Non-Clinical Workforce

In 2024, with a workforce of 1,996 employees (62% White, 26% BME, and 12% unknown ethnicity), BME representation among non-clinical staff rose by 1.9%, peaking at 37% in Band 8b, while the lowest BME representation is in Bands 8d+ (18%) and Bands 1-5 (22%).

Clinical Workforce

In 2024, the workforce 5,414 employees are 45% White, 51% BME, with a 3.5% increase in BME representation among clinical staff from the previous year, reaching 72% in Band 5 and 60% in medical staffing; the lowest BME representation is in Other - non AfC (17%) and senior Bands 8d+ (31%) and 8a-8c (33%.)

Recruitment

- The relative likelihood of White candidates being appointed from shortlisting compared to BME candidates has decreased from **1.30 in 2022-23 to 0.74 in 2023-24**, indicating a substantial improvement towards promoting equal opportunities and reducing biases in the recruitment process.

- While the improvement is notable, ensuring these positive changes are sustained through ongoing training and policy reviews is important to maintaining fairness and equity in the appointment process.

Formal Disciplinary

- A positive shift can be observed in reducing disciplinary disparities between White and BME staff from **2023 to 2024**. The decrease in the relative likelihood from **1.45 to 1.04** suggests that the gap in disciplinary actions between these groups is narrowing, moving closer to parity. This progress demonstrates the Trust's commitment to fostering equitable treatment across all ethnic groups.

- Despite improvements in equity for White and BME staff, those who didn't disclose their ethnicity continue to experience significantly higher rates of disciplinary actions, with a slight increase from **1.85% in 2023 to 1.99%** in **2024**. This consistent trend underscores the need to address the underlying causes contributing to this disparity, ensuring fair and unbiased disciplinary practices across all groups.

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Workforce Race Equality Standard (WRES) Executive Summary cont. – ESTH 7

Accessing non–mandatory training and CPD:

- All groups experienced significant fluctuations in training access rates from **2022 to 2024**, with a notable decrease in 2023 followed by an increase in 2024. This pattern suggests variable opportunities for professional development over the period.
- Both White and BME staff accessed training at higher rates than Non-disclosed staff in 2024, which may indicate specific challenges or barriers faced by staff who choose not to disclose their ethnicity.
- The relative likelihood of White staff accessing training compared to BME staff decreased from **1.07 in 2022 to 0.52 in 2023**, and then increased to **1.01** in 2024. This trend shows an initial improvement in balancing training access, followed by a return to near parity, indicating ongoing efforts to ensure equitable training opportunities among ethnic groups.

Harassment, Bullying and Abuse:

- BME staff reported a slight decrease in harassment from external sources (patients and relatives) over the years, stabilising at 28% in **2022-23 and 2023-24.** Meanwhile, harassment from fellow staff members showed a more significant decrease from **30% to 25%** during the same period. These trends suggest that while external harassment has plateaued, the emphasis on improving workplace culture and promoting 'freedom to speak up' initiatives during the Exec Question Time may be gradually enhancing the work environment and reducing staff-on-staff harassment.

Believing that trust provides equal opportunities for career progression or promotion:

- The notable rise from **46% to 51%** in BME staff's belief in equal career opportunities coincides with an increase in access to non-mandatory training, as discussed earlier under WRES Indicator 4. The overall uptake in training participation, likely driven by the Trust's dissemination of upskilling and training opportunities may be contributing to improved perceptions of fairness and accessibility in career advancement.

Personally experienced discrimination at work from a manager, team leader or colleagues:

- According to responses from the staff survey, BME staff report higher discrimination rates than White colleagues, though modest improvement is noted. Discrimination reports decreased from **16% to 15%** for BME staff and from **10% to 9%** for White staff. These changes suggest initiatives addressing discrimination are beginning to have a positive impact. Moving forward, we should focus heavily on practical steps and the evidence base behind them.

Board Representation:

- The board's ethnic representation, especially for BME employees, is not proportional to the overall workforce's ethnic composition. While BME employees make up **44.2%** of the overall workforce, their representation on the board is considerably lower at **11.1%.** Similarly, White employees are over-represented on the board at **88.9%** compared to their **50%,** share of the workforce. Efforts may need to be made to ensure that the board's ethnic composition is more representative of the workforce's diversity.

BME:

- BME staff are under-represented on the board, both in voting **(18%)** and executive **(13%)** roles, relative to their overall workforce representation. This indicates a significant gap in diversity at the board level, suggesting that BME staff are not proportionately represented in senior leadership positions, underscoring the need for targeted efforts to improve BME representation at the board level.

White:

- White staff are significantly overrepresented on the board across all categories (total, voting **(82%),** non-voting **(100%),** executive **(90%)** and non-executive **(88%),** This indicates an imbalance in board composition, suggesting that white board members hold a disproportionately large number of board positions, which highlights a need for efforts to create a more equitable and representative board.

Not disclosed:

With **100%** of board members disclosing their ethnicity, it suggests that staff may be increasingly comfortable doing the same. This transparency promotes an inclusive culture and helps ensure all groups are well-represented at the highest levels of the Trust.

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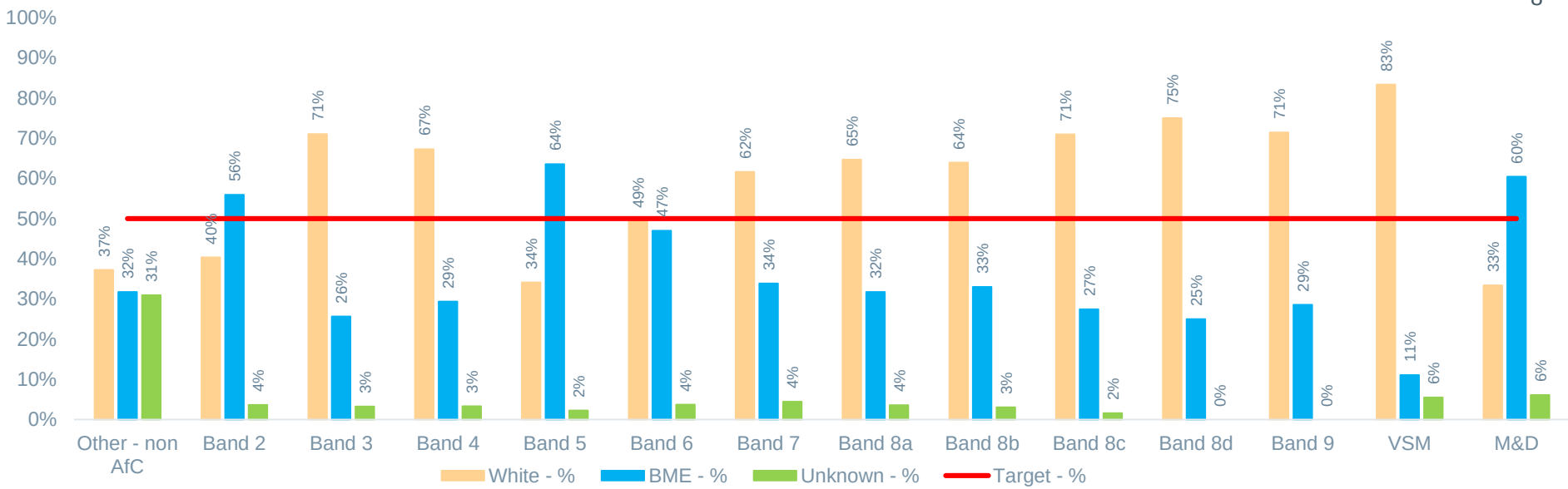
ESTH - Clinical & Non-Clinical WRES Workforce Representation



Observations

In 2024, we employ 7410 substantive employees, which is broken down as 3681 white (50%), 3277 BME (44%) and 452 unknown (6%).

Our Black, Asian, and Minority Ethnic (BME) workforce has demonstrated a steady increase year on year since 2019-20. For the current reporting year, we have observed a notable increase of 3.2% compared to the previous year, translating to 328 additional BME staff members.

Comparison to London Average

Despite this positive trend, our BME workforce remains below the London average at 44%. Specifically, our representation stands 7% lower than the 2023 London average of 51.1%.

Workforce Distribution

While we continue to see an annual rise in our BME workforce, our data indicates a disparity in career progression. BME staff are currently under-represented in higher pay bands, specifically in bands 7 through 9. 'Other – non AfC' relates to staff on local contracts in Estate and Facilities. Ethnicity recorded for 31% (or 193 staff) is unknown. An exercise with Estates and Facilities managers is in place to have missing information corrected.

Conclusion

We remain committed to addressing these disparities and fostering an inclusive environment that supports equitable career advancement for all staff members.

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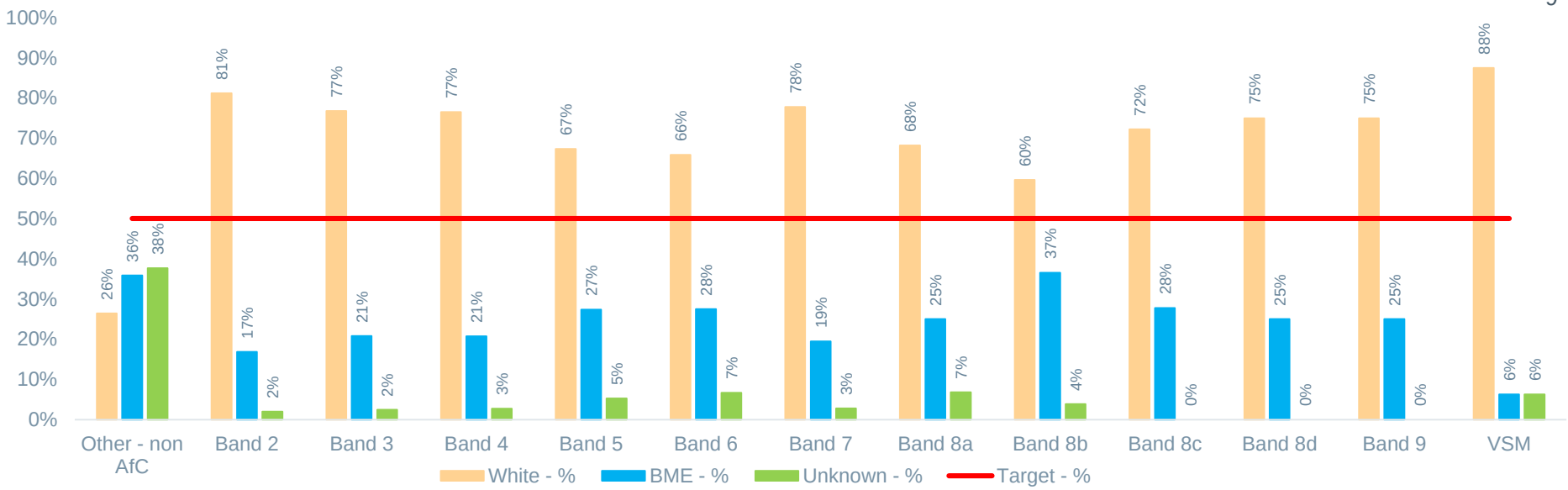
ESTH - WRES Workforce Representation – **Non-Clinical Staff Only**



Observations

In 2024, we employ 1996 substantive employees, which is broken down as 1243 white (62%), 517BME (26%) and 236 unknown (12%).

For non-Clinical staff, overall BME % has increased by 1.9% compared to the previous year. Band 8b saw the highest BME representation at 37%.

Compared to last year we have seen an increase of white Staff (+19), compared to an increase (+42) BME staff members.

The lowest level of representation is Bands 8d+ (18% BME / 6 staff) and Bands 1 to 5 (22% / 237 staff).

Grade Grouping	2021/22			2022/23			2023/24		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Other - non AfC	23%	19%	58%	25%	29%	47%	26%	36%	38%
Bands 1 to 5	77%	19%	4%	75%	21%	4%	75%	22%	3%
Bands 6 to 7	73%	22%	6%	70%	25%	5%	70%	24%	5%
Bands 8a to 8c	64%	29%	7%	66%	29%	5%	66%	29%	5%
Bands 8d+	84%	14%	2%	78%	20%	2%	80%	18%	3%
Medical	62%	20%	18%	62%	24%	14%	62%	26%	12%
Grand Total	**50%**	**45%**	**5%**	**48%**	**48%**	**5%**	**45%**	**51%**	**4%**

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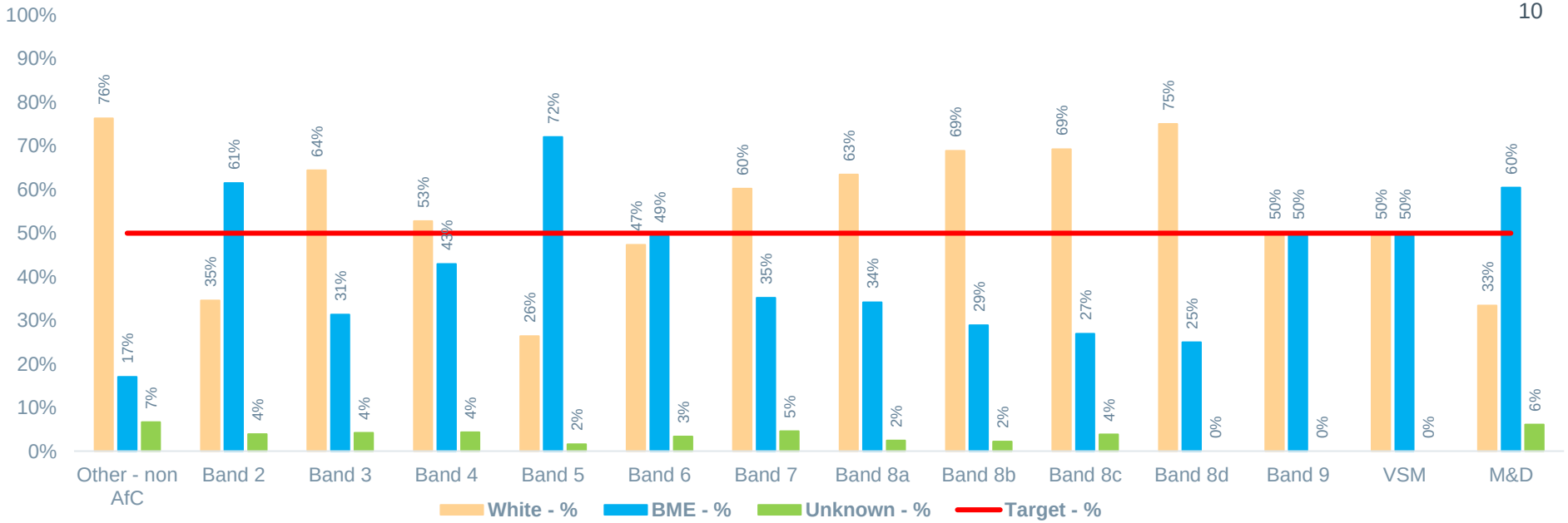
ESTH - WRES Workforce Representation – **Clinical Staff Only**



Observations

In 2024, we employ 5414 substantive employees, which is broken down as 2438 White (45%), 2760 BME (51%) and 216 unknown (4%).

For Clinical staff, overall BME % has increased by 3.5% compared to the previous year. Band 5 saw the highest BME representation at 72%. Compared to last year we have seen a reduction of white Staff (-38), compared to an increase (+286) BME staff members. This is largely due to an increase at Bands 2, 5, 6 and medical staffing.

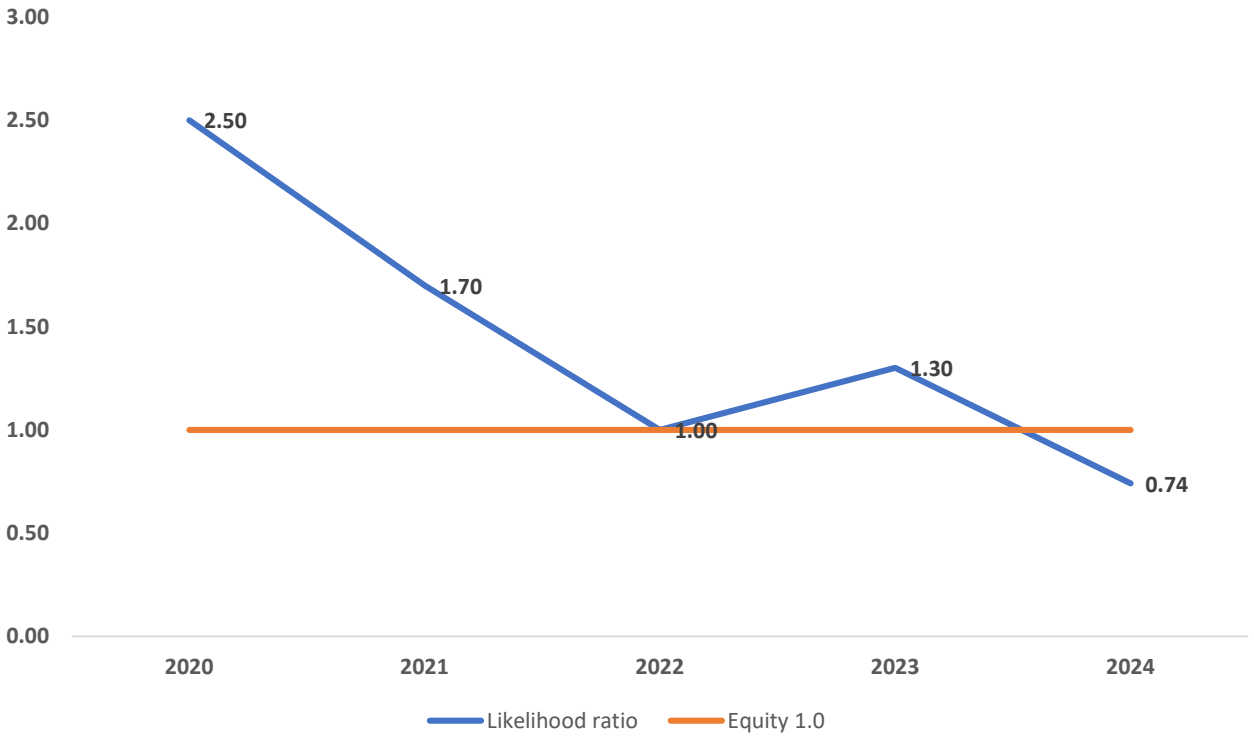
Medical staffing has seen a BME % increase from 56% in 2022 to 60% in 2024.

The lowest level of representation remains Other - non AfC (17% BME / 23 staff), Bands 8d+ (31% / 4 staff) and Bands 8a to 8c (33% / 104 staff).

Grade Grouping	2021/22			2022/23			2023/24		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Other - non AfC	73%	18%	9%	78%	16%	6%	76%	17%	7%
Bands 1 to 5	45%	50%	5%	42%	54%	4%	39%	58%	3%
Bands 6 to 7	56%	39%	5%	55%	40%	5%	53%	43%	4%
Bands 8a to 8c	66%	29%	5%	67%	29%	4%	65%	33%	3%
Bands 8d+	64%	36%	0%	47%	53%	0%	69%	31%	0%
Medical	39%	56%	6%	36%	56%	7%	33%	60%	6%
Grand Total	**50%**	**45%**	**5%**	**48%**	**48%**	**5%**	**45%**	**51%**	**4%**

Outstanding care every time

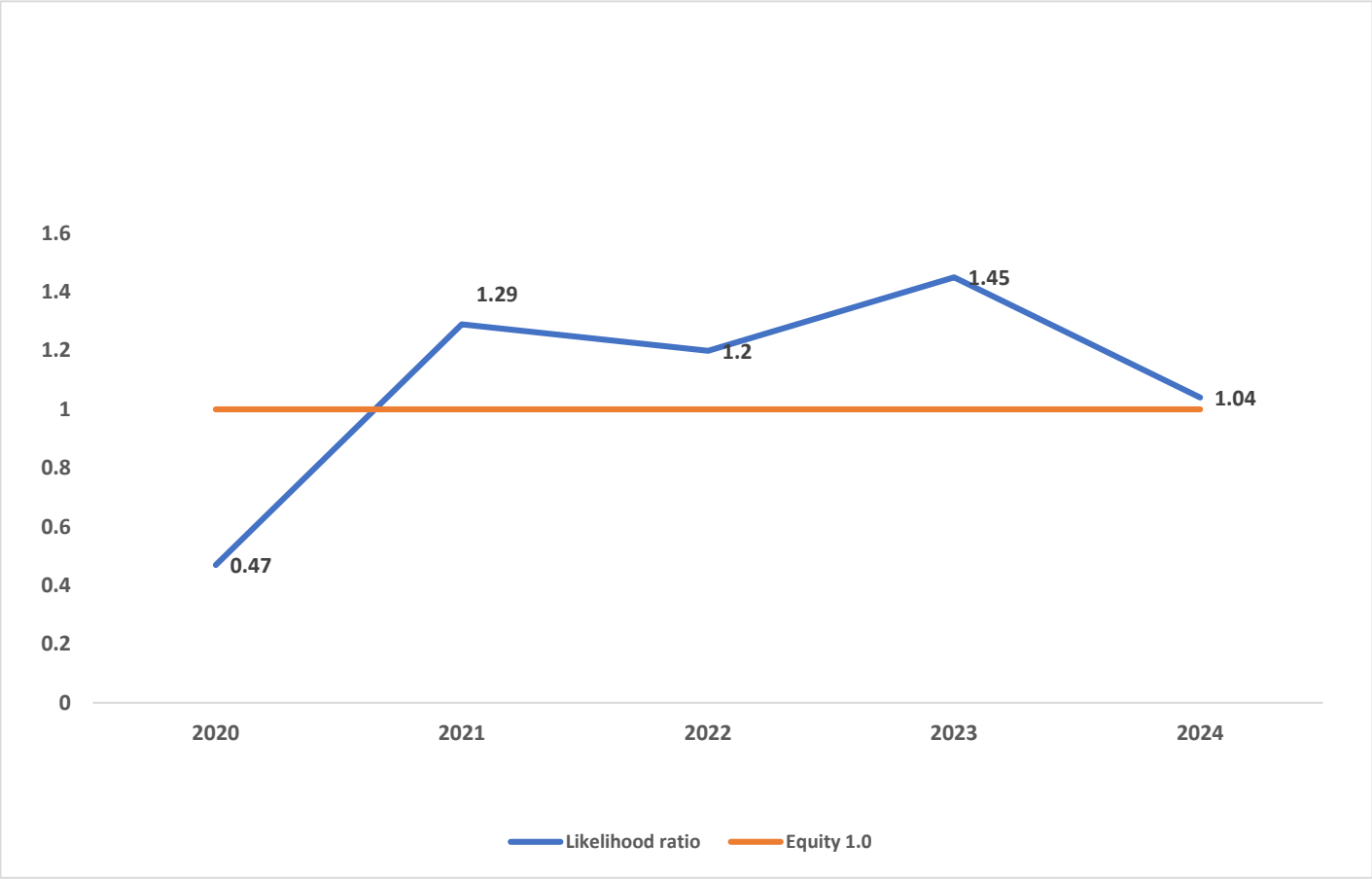
WRES Relative likelihood of appointment from shortlisting (White/BME 2020-2024



Observations
At March 2024 the likelihood ratio was **0.74 lower than "1.0"** or equity to a small degree. Specifically, 227 out of 1851 white candidates were appointed from shortlisting (12.2%) of white candidates) compared to 556 out of 3370 BME candidates (16.4%) of BME candidates).

Example: a value of "2.0" would indicate that White candidates were twice as likely as BME candidates to be appointed from shortlisting, whilst a value of "0.5" would indicate that White candidates were half as likely as BME candidates to be appointed from shortlisting.

Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff 2020-2024

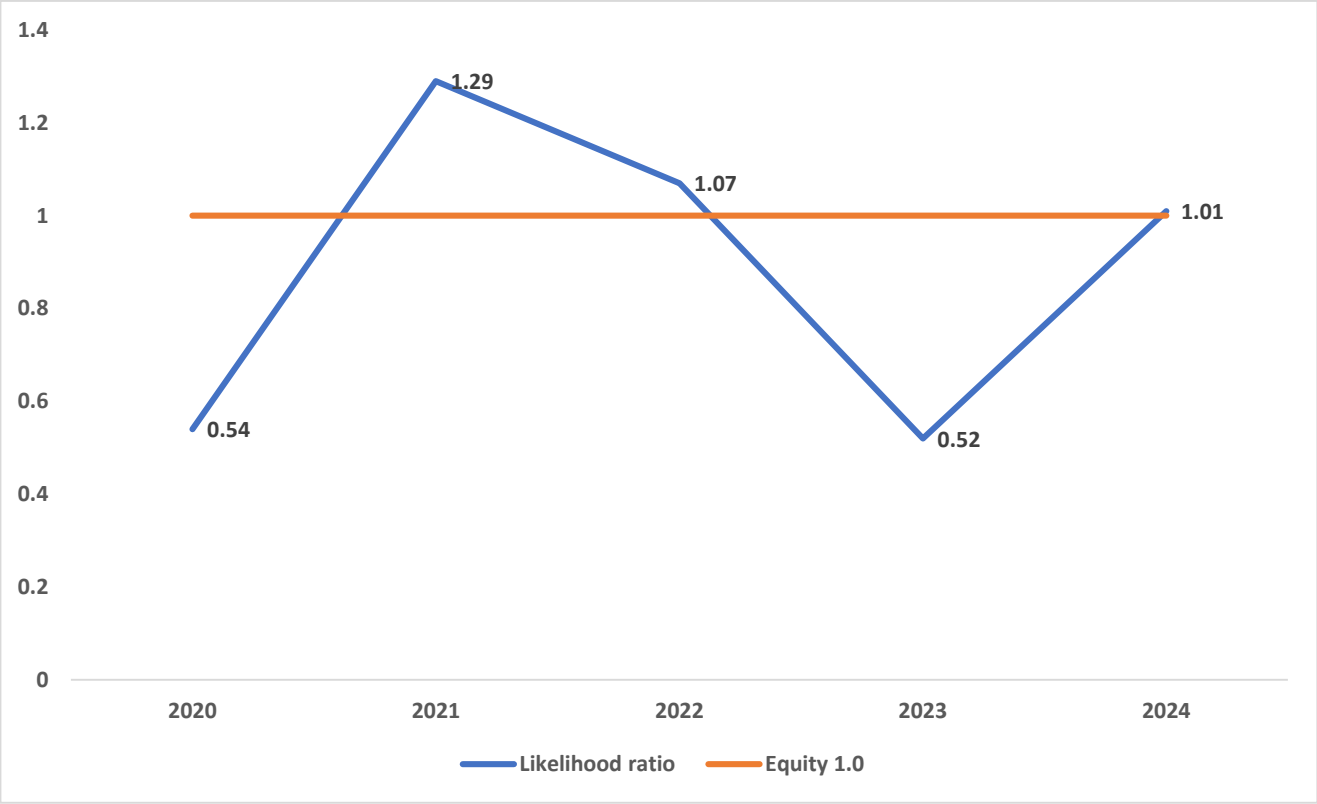


Observations

At March 2024 the likelihood ratio was **1.04; not significantly different from "1.0"** or equity. Specifically, 13 out of 3277 BME staff entered formal disciplinary proceedings (16.4% of the BME workforce) compared to 14 out of 3681 white staff (12.2% of the white workforce).

Example: a value of "2.0" would indicate that BME staff were twice as likely as White staff to enter a formal disciplinary process, whilst a value of "0.5" would indicate that BME staff were half as likely as White staff to enter a formal disciplinary process.

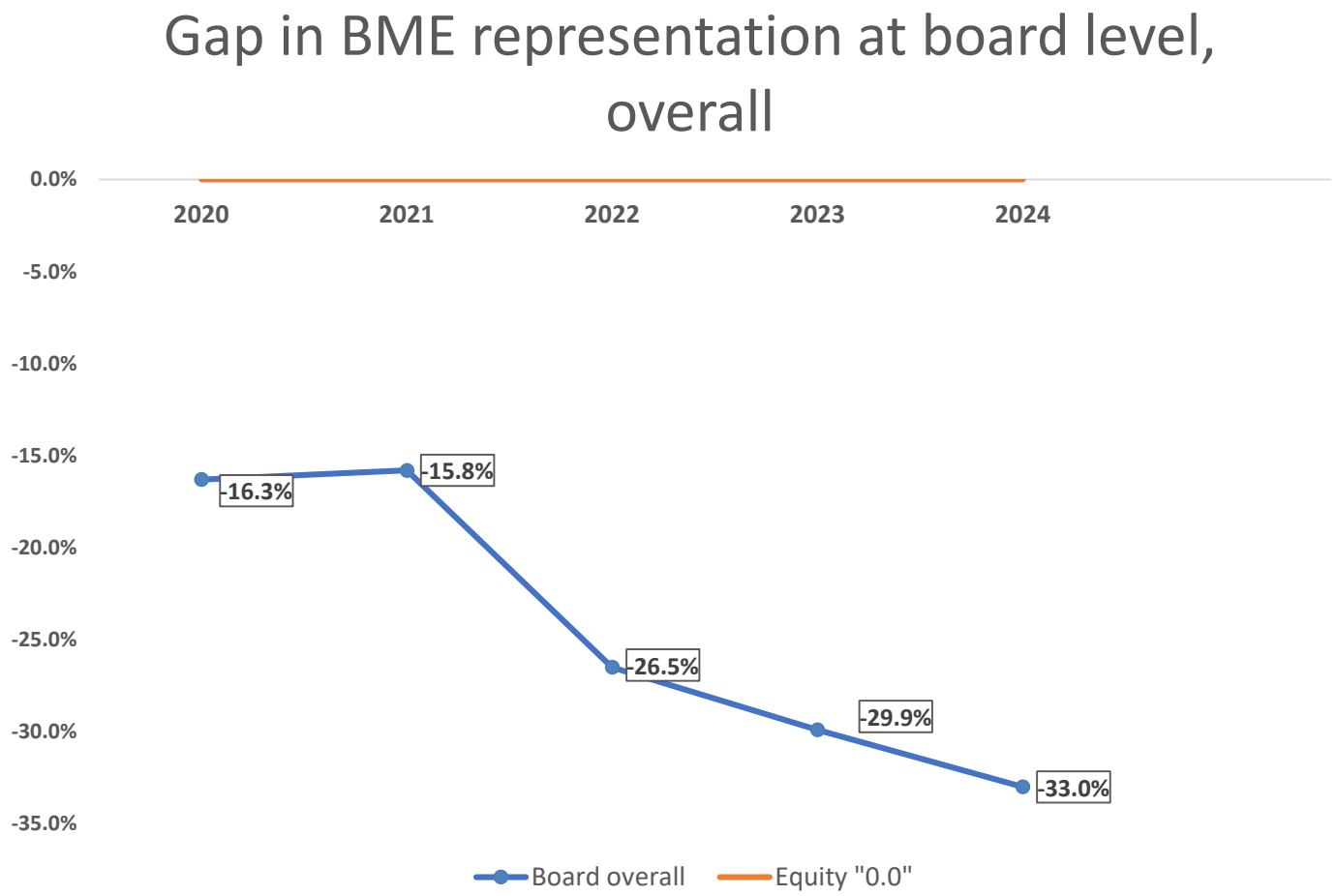
Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff 2020-2024



Observations

At March 2024 the likelihood ratio **was 1.01; not significantly different from "1.0**" or equity to a small degree. Specifically, 113 out of 3681 white staff undertook non-mandatory training (3% of the white workforce) compared to 100 out of 3277 BME staff (3% of the BME workforce).

Overall board membership

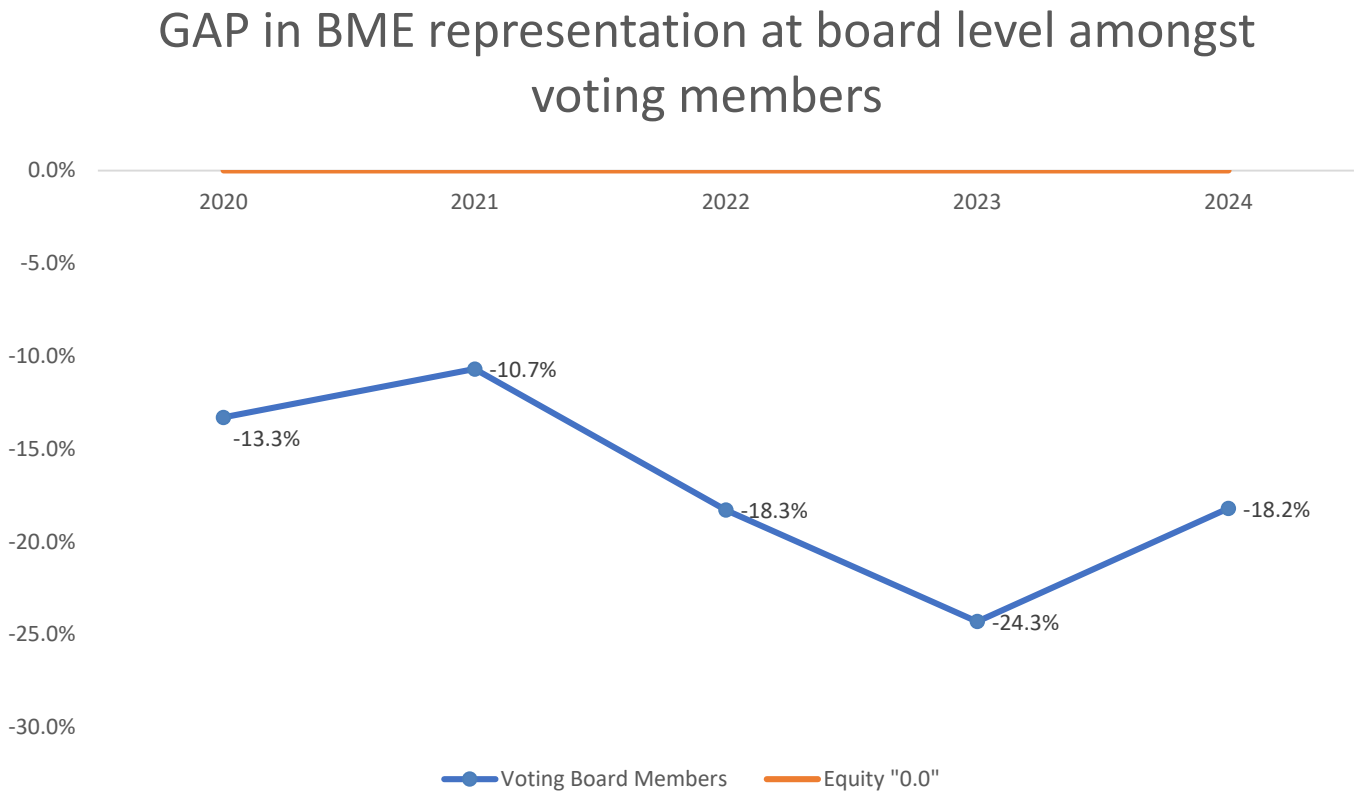


Observations

At March 2023, the difference between BME representation on the board and in the workforce was -33.0%. BME staff are significantly under-represented overall.

The board representation indicator is calculated by subtracting the percentage of BME staff in the workforce from the percentage of BME members on the board of directors.
A value of "0.0" indicates equal representation.
A positive value shows a higher percentage of BME members on the board than in the workforce, while a negative value shows a lower percentage. These calculations are done for all board members, as well as voting and executive members separately.

Voting board membership - 2020-2024

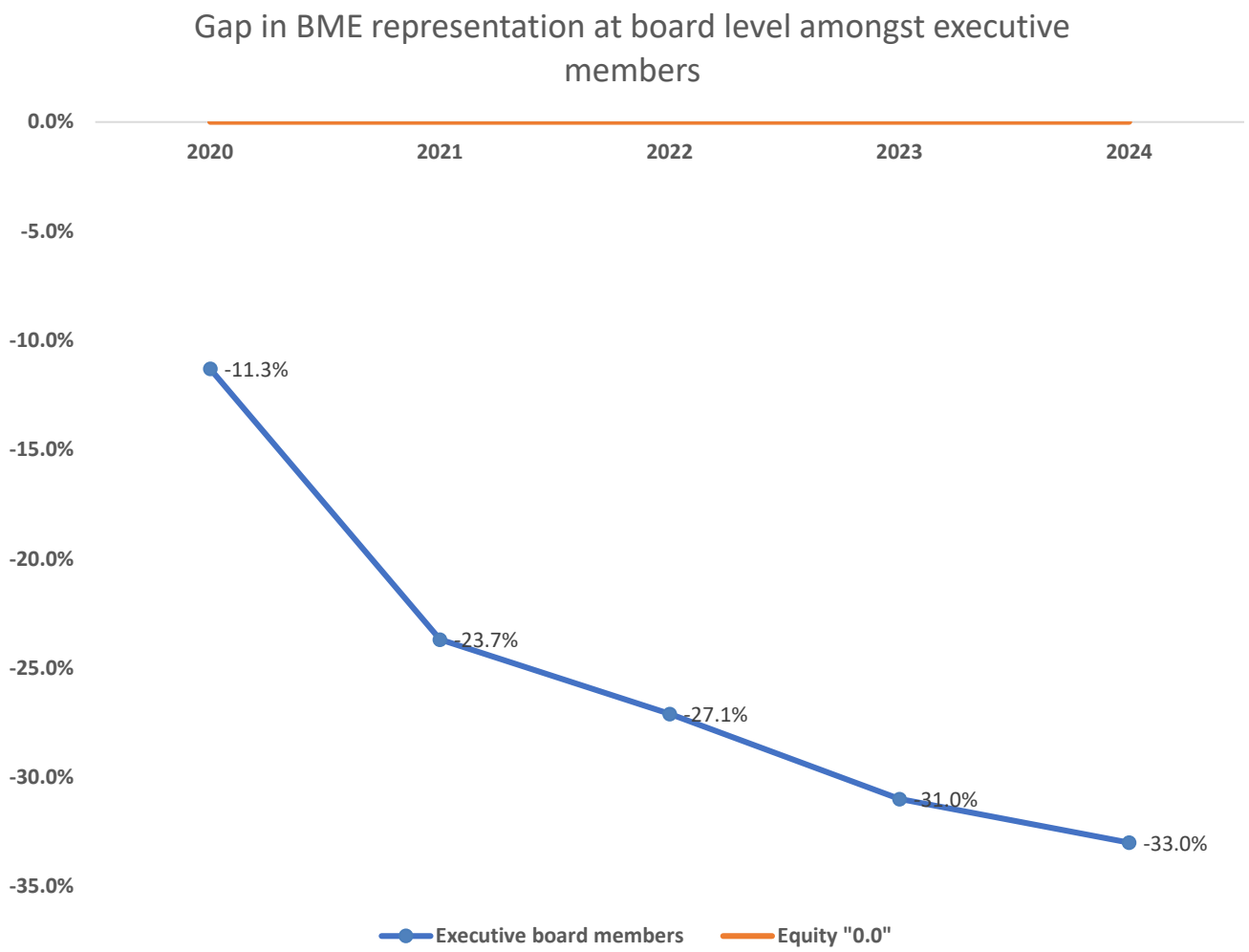


Observations

At March 2024, the difference between BME representation on the board and in the workforce was -18.2% amongst voting members.

BME members were underrepresented on the board.

Executive board membership -2020-2024



Observations

At March 2024, the difference between BME representation on the board and in the workforce was -33.0% amongst executive members. BME members were underrepresented on the board.

- **Workforce Race Equality Standard (WRES)**
- Connecting the dots with our People Strategy 2024-2026

Our vision is that by 2028 gesh will be among the top five acute trusts in London for staff engagement. We will achieve this through a focus on five key areas:

These key *'People'* areas have been reviewed, alongside NHS England's EDI Improvement Plan (also known as High Impact Action Plan), and used to help shape our EDI priority workstreams for 2024-2026:

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- **Workforce Race Equality Standard (WRES)**
- Next Steps

Our existing Culture and D&I Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2024-26**.

Following publication of our WRES and WDES Reports in late October 2024 we will commence a final review and Board approval of the specific actions which will enable us to deliver against our People Strategy and NHSE's EDI Improvement Plan.

An overview of these action plans will be published shortly.

Fig 1: Our 2024-2026 People Priority Domains

Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

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Workforce Race Equality Standard (WRES)

Appendix A: Definitions of ethnicity: people covered by the WRES

- **In line with Health Education England's WRES Guidance and national WRES reporting metrics, the term 'BME' and 'White' are used to describe the two groups of staff referred to in this report**.
- The definitions of "black and minority ethnic" and "white" used in Health Education England's (HEE) WRES guidance 2024 have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex B.
- "White" staff include white British, Irish, Eastern European and any other white i.e. categories 1–4 in the table in.
- The "black and minority ethnic" staff category includes all others except "unknown" and "not stated."
- To aggregate data for BME staff, organisations should include categories 5-18 from current values and exclude "not stated" and any "NULL" values.
- The treatment of staff from ethnic categories [2 – White Irish] or [3 – Gypsy or Irish Traveler] or [4 – Any other White background] i.e. Eastern European who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data and take appropriate action.
- Source: WRES Additional Information 2024 for NHS Trusts and Foundation Trusts (30/04/2024)

Ethnicity" refers to: ONS definitions found here: [Ethnic group, national identity and religion - Office for National Statistics (ons.gov.uk)]

Ethnic Categories 2021

WHITE
1 – White –British / Welsh / Scottish / Northern Irish / British
2 – White –Irish
3 - Gypsy or Irish Traveller
4 – Any other white background please describe

MIXED / MULTIPLE ETHNIC GROUPS

5 – White and Black Caribbean
6 – White and Black African
7 – White and Asian
8 – Any other mixed / multiple ethnic background please describe

ASIAN / ASIAN BRITISH
9– Asian or Asian British –Indian
10 – Asian or Asian British –Pakistani

11 – Asian or Asian British – Bangladeshi

12 - Asian or Asian British – Chinese

13 – Any other Asian background please describe

BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
14 – Black or black British – African

15 – Black or black British – Caribbean

16 – Any other black background please describe

ANY OTHER ETHNIC GROUP
17 – Arab
18 – Any other ethnic group please describe

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Workforce Race Equality Standard (WRES)

Appendix B: High Impact Action Plan Framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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

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Workforce Race Equality Standard (WRES) 2023/2024 Report

St George's University Hospitals NHS Foundation Trust

Published: 00/00/2024

Workforce Race Equality Standard (WRES)

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Workforce Race Equality Standard (WRES)

Executive summary

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

In line with national requirements, this report and any associated action plans should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2024.

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

Improved indicators

- We have seen an improvement in 8 out of the 10 indicators, the remaining 2 have remained static.
- Overall, the BME staff population at St George's continues to increase year on year (53.6%).
- Relative likelihood of BME staff entering the formal disciplinary processes has reduced.
- For the second year we see an increase in the number of BME staff accessing non-mandatory training and continuing professional development.
- Reported experiences of Harassment, Bullying and Abuse have reduced, from patient-staff and staff-staff.
- There is a reduction in reports experiences of discrimination from managers and colleagues – this is now lower than the London average.
- Continued upward trend in the percentage of BME staff feeling the organisation provides equal opportunities for career progression or promotion. This has increased yearly since 2018 (+6.1 percentage points).
- The % difference between the organisations' board voting membership and its overall workforce has improved from -43% to -35%.

Reduced / static indicators

- BME staff are over-represented in lower bands.
- The number of white staff at VSM level has reduced from 24 to 20, and BME staff from 3 to 2.
- BME staff make up just 8.7% of non-clinical VSM posts – compared to 87% white. This is the ratio of 10:1 white staff members to every 1 BME staff member appointed at VSM level (compared to 8:1 last year).
- Of the 87 non-clinical Band 8d and above posts only 15% are held by a BME member of staff, compared to 83% being held by a white member of staff.
- The relative likelihood of white applicants being appointed from shortlisting compared to BME applicants has remained static at 1.5.
- Of the Band 8d, only 3 of 18 clinical Band 8d post are held by a BME member of staff. This is a ratio of 5:1.
- BME staff are significantly under-represented at Executive which remains about 41% for the second year.

Workforce Race Equality Standard (WRES)
Purpose, background and definitions

Purpose
- This paper provides an overview of the 2024 Workforce Race Equality Standard (WRES) findings.
- This report will be published on the Trust website.
- The Board is asked to receive this report and associated action plan for information and approve for publication.

Background
- In April 2015, NHS England introduced the WRES in response to consistent findings that BME applicants and staff consistently fared worse in employment outcomes and satisfaction surveys. The WRES was designed to enable NHS organisations to demonstrate progress against a number of key indicators of workforce equality, including a specific indicator to address the low levels of BME Board representation.
- Since April 2015, the WRES has been included in the full-length NHS Standard Contract and requires all providers of NHS services to address the issue of workforce race inequality by implementing and using the WRES.
- There are nine WRES indicators. Four of the indicators focus on workforce data, four are based on data from national NHS Staff Survey questions, and one indicator focuses upon BME board representation. The WRES highlights differences between the experience and treatment of White staff and BME staff in the NHS with a view to organisations closing those gaps through the development and implementation of action plans focused upon continuous improvement over time.
- The WRES is produced in line with Technical Guidance issued by NHS England.
- Indicators 1-3 and 9 are produced via the Electronic Staff Record (ESR) from a snapshot of data taken on 31st March 2024. All other indicators are from the 2023 staff survey.

Definitions of ethnicity: people covered by the WRES
- In line with Health Education England's WRES Guidance, the term 'BME' and 'white' are used to describe the two groups of staff referred to in this report.
- 'White' staff include white British, Irish, Eastern European and any other white. The 'Black and Minority Ethnic' staff category includes all others except 'unknown' and 'not stated.'
- Further information can be found in *appendix A: Definitions of ethnicity: people covered by the WRES.*

Overview of workforce numbers

	2019	2020	2021	2022	2023	**2024**
Total number of staff in organisation	8,884	8,873	9,154	9,608	9,915	**10,345**
% of BME Staff	44.6%	46.1%	47.7%	50.1%	51.9%	**53.6%**
% of staff who self-reported ethnicity	97.2%	96.7%	96.1%	97.0%	97.1	**97%**

Workforce Race Equality Standard

Indicator Overview

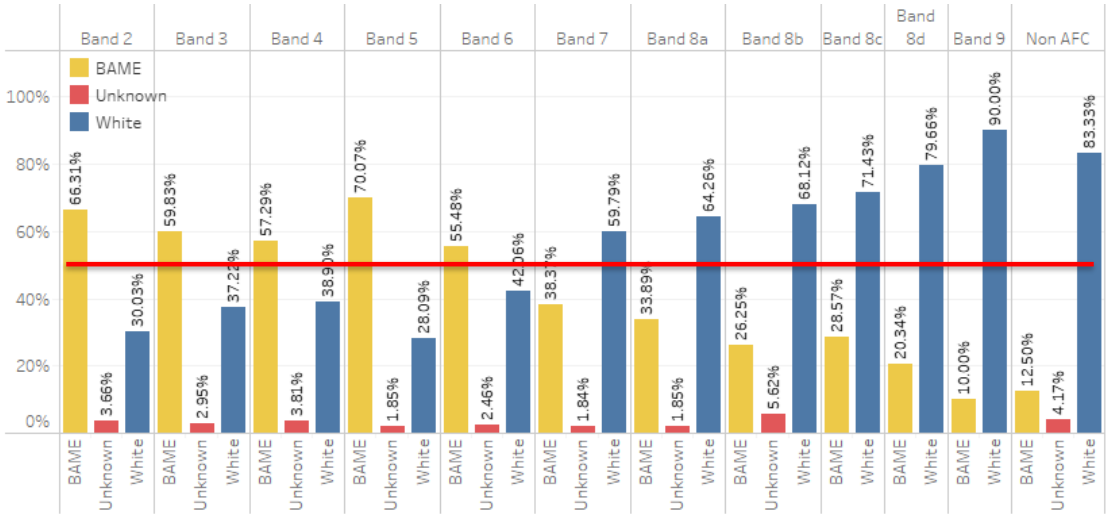
Indicator		STG 2021	STG 2022	STG 2023	STG 2024	Performance vs. previous year	Exp. compared to White Staff	London Av. 2022	London Av. 2023
1	% of BME staff in organisation	47.7%	50.1%	51.9%	**53.6%**	**Increased**		49.9%	52.1%
2	Relative likelihood of White applicants being appointed from shortlisting compared BME applicants	1.47	1.26	1.50	**1.52**	**Static***		1.44	1.47
3	Relative likelihood of BME staff entering the formal disciplinary process, compared to that of White staff	1.82	1.65	1.67	**1.48**	**Improved**		1.47	1.41
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff	1.03	0.98	0.95	**0.86**	**Improved**		0.97	0.92
5	% of BME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	27.3%	23.3%	27.0%	**25.7%**	**Improved**		30.2%	32.1%
6	% of BME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	30.1%	25.9%	27.3%	**26.9%**	**Improved**		28.1%	28.3%
7	% of BME staff believing that organisation provides equal opportunities for career progression or promotion	41.1%	42.1%	43.8%	**44.0%**	**Static***		43.6%	46.2%
8	% of BME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	18.0%	16.6%	16.9%	**15.9%**	**Improved**		16.7%	16.1%
9	% difference between the organisations' board voting membership and its overall workforce	-36%	-32%	-43%	**-35%**	**Improved**		-26%	-27%
	% difference between the organisations' board executive membership and its overall workforce'	-47%	-36%	-41%	**-41%**	**Static***		-33%	-33%

* Changes of +/- 0.5 or less are recorded as Static.

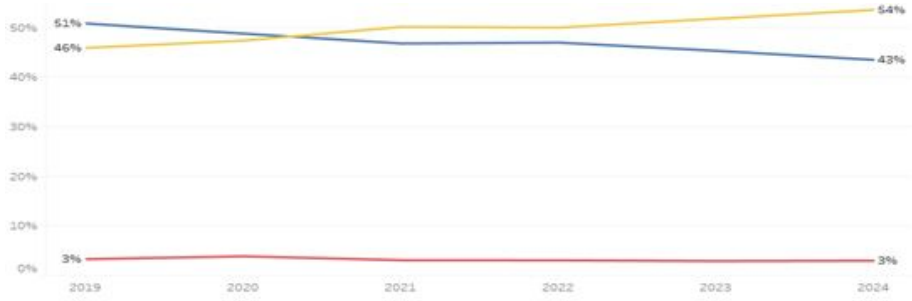
Workforce Race Equality Standard (WRES)

Indicator 1 *% of staff by AfC pay band and ethnicity*

Table A: % of Staff in each AFC Band by Ethnicity at St Georges

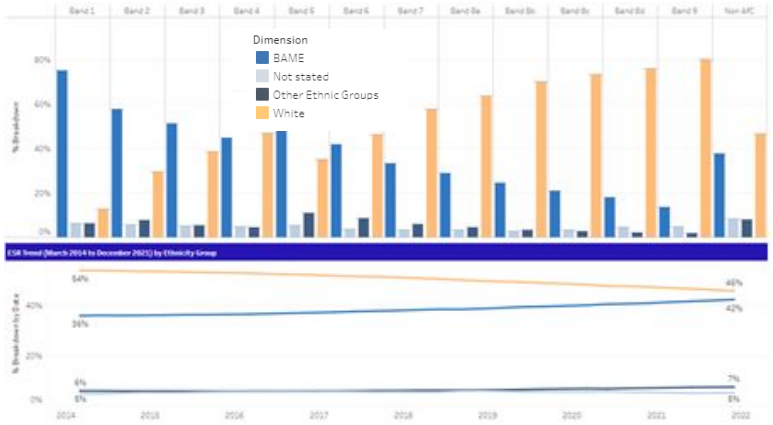


Note: The solid red line indicates the target for St George's to be representative across all AFC pay bands.



- Our Black, Asian and Minority Ethnic workforce has increased year on year since 2019 and continues to be representative of the local communities we serve.
- For the second consecutive reporting year, we see an increase of +1.8% in indicator 1. This is approximately an increase of 400 Black, Asian and Minority Ethnic members of staff.
- For the second consecutive year, our Black, Asian and Minority Ethnic workforce remains 2% higher than the London average. Whilst we see a continued annual increase across the workforce, our workforce data still highlights that Black, Asian and Minority Ethnic staff are over-represented in lower bands and under-represented in higher bands
- This is not unique to St George's and mirrors what we see across London NHS trusts (see table A and B).

Table B: % of Staff in each AFC Band by Ethnicity (London 2023)



Workforce Race Equality Standard (WRES)

Indicator 1

Clinical Staff - *% of staff by AfC pay band and ethnicity*

For Clinical staff (table C), we see an increase in the percentage of Black, Asian and Minority Ethnic staff across 7 of the 11 AFC bands. Compared to last year we have seen a reduction of white Staff (-51), compared to an increased (+248) BME staff members. This is largely due to an increase at Bands 2, 5 and 6.

We have seen a year-on-year increase in diversity with the consultant group, from 38% in 2022 to 47% in 2024. In terms of percentage our 2024 ratio for consultant staff was 49% white to 47% BME – this is the closest to representative we have seen within the consultant workforce (to the organisations overall).

The lowest level of representation remains band 8a-c (31% BME) and 8d+. Of the 25 Band 8d and above posts only 20% are held by a BME member of staff, compared to 80% being held by a white member of staff (table E). We see similar low levels of representation at band 8d, of 18 posts only 3 (17%) are held by a BME member of staff. This is a ratio of 5:1.

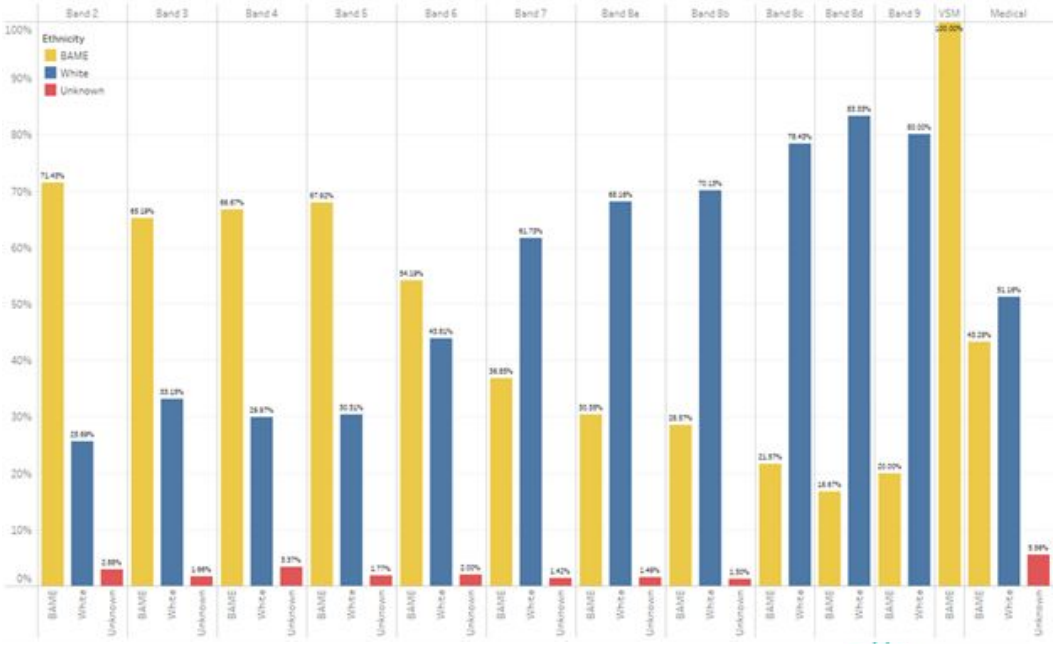
Table D: No. of Clinical Staff in each AFC Band:

Clinical	2024 Headcount			2022 vs. 2021			2023 vs. 2022			2024 vs. 2023		
	White	BME	Null	White	BME	Null	White	BME	Null	White	BME	Null
Band 2	181	616	25	0	1	0	-23	2	-7	-24	46	2
Band 3	135	241	6	1	1	0	-7	41	0	15	5	0
Band 4	93	191	9	0	0	0	-1	43	3	4	-7	-1
Band 5	369	1083	26	3	3	0	-48	79	-3	-58	126	1
Band 6	634	858	34	7	4	0	-24	59	-4	-24	44	4
Band 7	763	454	20	14	8	0	18	21	2	26	14	3
Band 8a	272	139	7	6	1	0	12	9	-2	-2	17	1
Band 8b	62	25	3	4	0	0	-4	4	0	8	3	2
Band 8c	43	11	0	2	0	0	2	-1	0	3	0	0
Band 8d	15	3	0	0	0	0	3	1	0	0	0	0
Band 9	5	1	0	0	0	0	0	0	0	1	0	0
VSM	0	1	0	0	0	0	-1	1	0	0	0	0
Consultants	421	277	45	3	0	0	23	13	0	19	17	0
Career Grade	15	29	4	-2	-7	0	6	18	3	-1	-2	-2
Trainee Grade	381	449	33	0	0	0	23	-1	2	0	62	-5

Table E: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Band 1 - 5	32.9%	64.4%	2.5%	29.3%	68.4%	2.2%	26.2%	71.6%	2.2%
Band 6 - 7	53.2%	44.8%	1.8%	51.7%	46.5%	1.7%	50.6%	47.5%	2.0%
Band 8a-8c	69.6%	28.5%	1.8%	69.4%	29.3%	1.3%	67.1%	31.1%	1.8%
Band 8D +	85.0%	15.0%	0.0%	79.2%	20.8%	0.0%	80.0%	20.0%	0.0%
Medical	55.1%	37.9%	6.8%	51.1%	43.3%	5.6%	49.4%	45.6%	5.0%

Table C: % of Clinical Staff in each AFC Band at St George's:



Workforce Race Equality Standard (WRES)

Indicator 1

Non-Clinical - *% of staff by AfC pay band and ethnicity*

For Non-Clinical staff we see an increase in the percentage of Black, Asian and Minority Ethnic staff across 8 of the 11 AFC bands. This compares to increase in the number of white staff in 7 of the 11 AFC bands.

For the second year BME representation at Band 6 and Band 7 is greater than White representation and close to the organisation overall of 54% – with 49% at Band 6 and 50% at Band 7.

The number of white staff at VSM level has reduced from 24 to 20, with the number of BME staff reducing from 3 to 2. This means that BME staff make up just 8.7% of non-clinical VSM posts – compared to 87% White. This is the ratio of 10:1 white staff members to every 1 BME staff member appointed at VSM level. This has increased from a ratio of 8:1 last year.

Of the 78 Band 8d and above posts only 15% are held by a BME member of staff, compared to 83% being held by a white member of staff (table H).

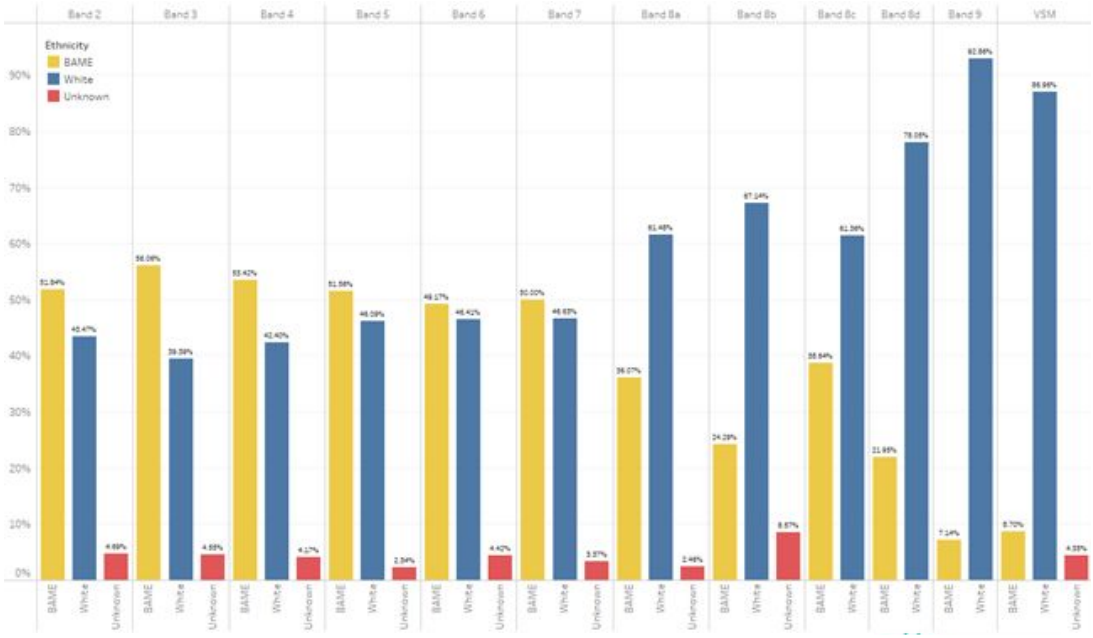
Table G: No. of BME Non-Clinical Staff in each AFC Band at St George's:

Non-Clinical	2024 Headcount			2022 vs. 2021			2023 vs. 2022			2024 vs. 2023		
	White	BME	Null	White	BME	Null	White	BME	Null	White	BME	Null
Band 2	213	254	23	2	0	1	-14	-18	0	-18	14	0
Band 3	130	185	15	1	0	0	-12	-18	0	1	14	1
Band 4	254	320	25	1	0	0	-5	31	-1	18	39	4
Band 5	118	132	6	2	1	0	3	9	3	-11	9	-2
Band 6	84	89	8	0	-1	0	0	14	0	17	-6	4
Band 7	83	89	6	0	0	0	0	7	0	4	1	4
Band 8a	75	44	3	1	0	0	-7	1	-1	9	4	-1
Band 8b	47	17	6	0	0	0	4	1	2	1	-6	1
Band 8c	27	17	0	0	0	0	3	-1	-1	0	3	0
Band 8d	32	9	0	0	0	0	0	1	-1	4	-1	0
Band 9	13	1	0	0	0	0	3	-1	0	-2	1	0
VSM	20	2	1	4	2	0	3	-1	1	-4	-1	0

Table H: % of staff by ethnic group (clustered):

Cluster	2022			2023			2024		
	White	BAME	Unknown	White	BAME	Unknown	White	BAME	Unknown
Band 1 - 5	46.0%	50.0%	3.8%	45.1%	50.7%	4.1%	42.7%	53.2%	4.1%
Band 6 - 7	46.3%	51.7%	1.9%	43.6%	54.6%	1.8%	46.5%	49.6%	3.9%
Band 8a-8c	61.8%	34.0%	4.0%	61.8%	34.2%	4.0%	63.1%	33.1%	3.8%
Band 8D +	81.4%	17.1%	1.4%	82.7%	16.0%	1.2%	83.3%	15.4%	1.3%

Table F: % of BME vs. White Non-Clinical Staff by Grade at St George's:

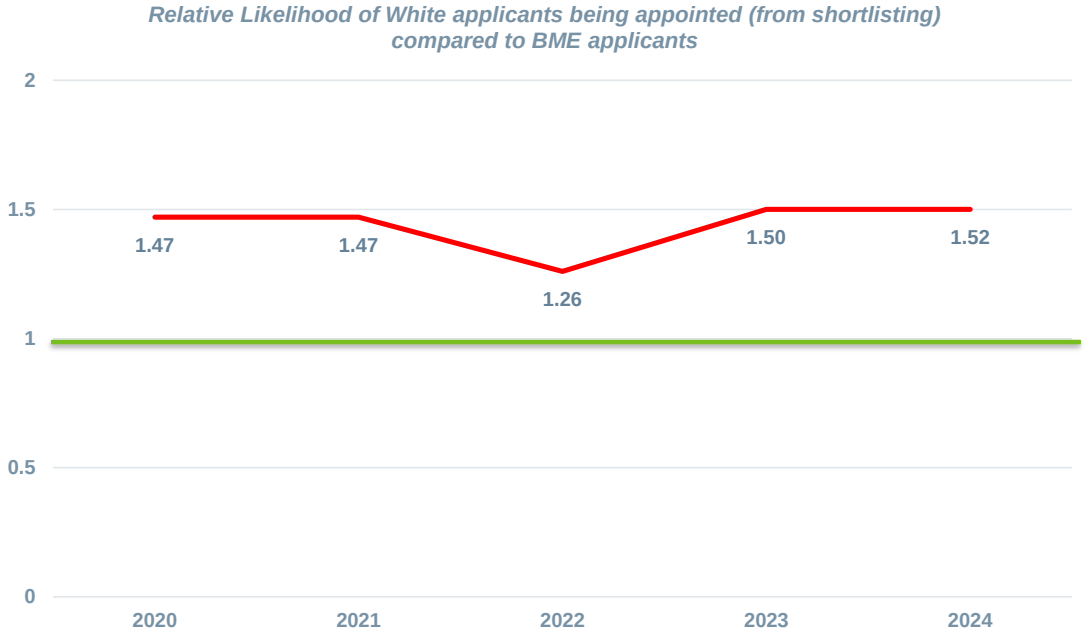


Workforce Race Equality Standard (WRES)

Indicator 2

Relative likelihood of white applicants being appointed from shortlisting compared to BME applicants

- Our 2024 figures show that white applicants at St George's are 1.52 times more likely to be appointed from shortlisting compared Black, Asian and Minority Ethnic (BME) applicants. This is a small increase of 0.02% from 1.50 in 2023.
- In 2024 the likelihood of Black, Asian and Minority Ethnic applicants being appointed from shortlisting reduced from 27% to 18% - this means that of the 9825 shortlisted BME applicants, 1783 were appointed. The number of shortlisted BME applicants increased from 7751 in 2023 to 9825 in 2024.
- For white applicants, the likelihood of appointment has decreased from 33.5% in 2023 to 27% in 2024.
- For those that did not record an ethnicity we have seen a significant increase in the likelihood of appointment from 43% in 2023 to 72% in 2024. This is due to a notable increase in the number of shortlisted applicants and the number of appointed applicants (with an ethnicity recorded as 'unknown').



Note: The solid green line indicates the target relative likelihood of 1.0

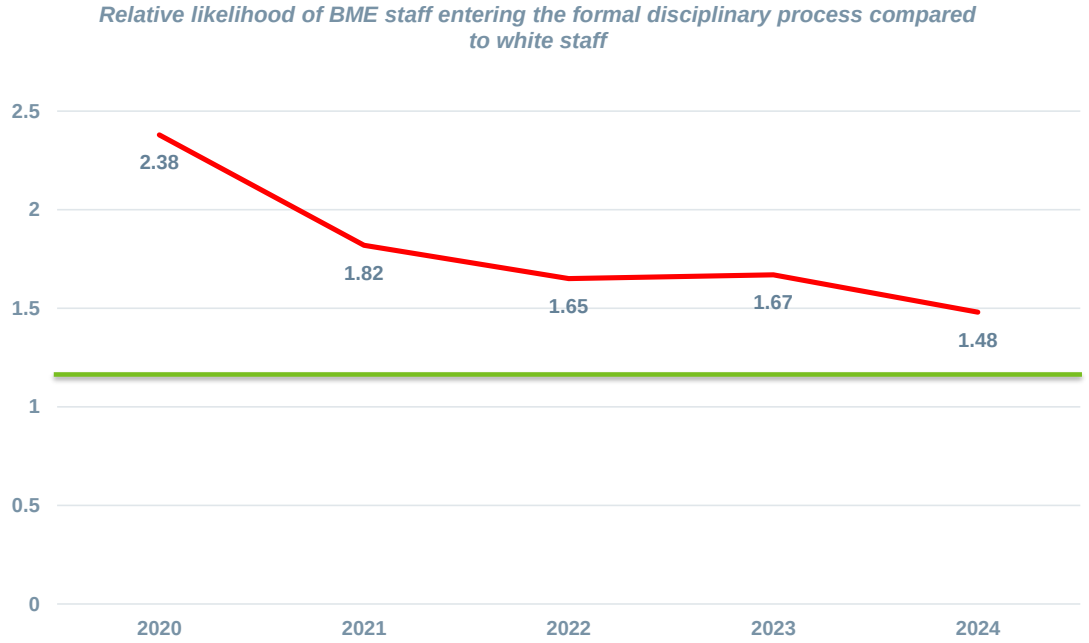
2020	2021	2022	2023	2024
1.47	1.47	1.26	1.50	**1.52**

Workforce Race Equality Standard (WRES)

Indicator 3

Relative likelihood of BME staff entering the formal disciplinary process compared to white staff

- Our 2024 figures show that BME staff at St George's are more likely to enter the disciplinary process compared to white staff.
- Over the last five years we have seen a significant reduction in the relative likelihood of BME entering the disciplinary process, from 2.38 times more likely in 2020, to 1.48 in 2024.
- The number of BME staff entering the disciplinary process has increase compared to last year - from 21 in 2023 to 33 BME staff members in 2024. This is an increase of 57% on the previous year.
- The number of white staff entering the disciplinary process has also increased, from 11 in 2023 to 18 in 2024. This is an increase of 64% on the previous year.



Note: The solid green line indicates the target relative likelihood of 1.0

2020	2021	2022	2023	2024
2.38	1.82	1.65	**1.67**	**1.48**

Workforce Race Equality Standard (WRES)

Indicator 4

Relative likelihood of white staff accessing non–mandatory training and CPD compared to BME staff

For the fourth year we see an increase in the number of Black, Asian and Minority Ethnic staff accessing non-mandatory training and continuing professional development (CPD). The likelihood of BME staff accessing non-mandatory training and CPD has increased to 34%, from 29% in 2023.

In 2023 we saw a 2-percentage point reduction in the number of white staff accessing non-mandatory training and continuing professional development, dropping to a likelihood of 27%. This has returned to a likelihood of 29% in 2024.

In 2024 we see the greatest disparity, in terms of likelihood of each ethnic group accessing training, with a 5 percentage point difference – in previous years this has been between 1-2 percentage points.

	2021			2022			2023			2024		
	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown	White	BME	Unknown
Number of staff in workforce	4464	4336	354	4495	4817	296	4486	5141	288	4495	5542	308
Number of staff accessing non-mandatory training and CPD	1142	1076	60	1324	1444	62	1222	1478	63	1300	1863	81
Likelihood of staff accessing non-mandatory training and CPD	26%	25%	17%	29%	30%	21%	27%	29%	22%	29%	34%	26%
Relative likelihood of white staff accessing compared to BME staff	**1.03**			**0.98**			**0.95**			**0.86**		

Workforce Race Equality Standard (WRES)

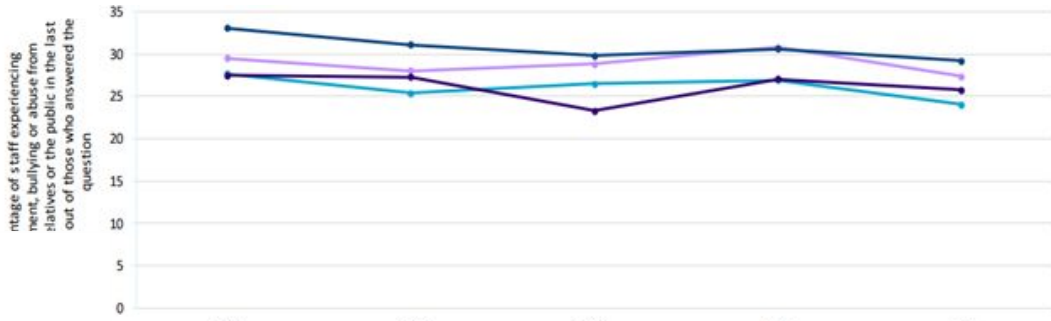
Indicator 5

% of staff experiencing harassment, bullying or abuse from patients, relatives or the public in the last 12 months

- For the second year, the percentage of staff who experienced harassment, bullying or abuse from **patients, relatives or the public** in the last 12 months was lower for BME staff (26%) than for white staff (29%).
- In terms of the percentage of BME staff who experienced harassment, bullying or abuse from patients, relatives or the public in the last 12 months, the Trust performed better than 65% of Trusts and worse than 35% of Trusts
- For white staff we see a decrease from 31% to 29%. The gap between white and BME staff has remained at around 3.5 percentage points for the second year.
- Both white and BME women (34% and 28% respectively) report experiencing higher rates of HBA compared to male colleagues, with white males reporting the lowest rates (21%). This has reduced for BME women and increased for white women
- White nurses and midwives and Health Care Assistants (HCA) report the highest levels in this indicator.

Ethnicity / Gender	Survey Year					
	2018	2019	2020	2021	2022	2023
Overall	**31.0%**	**31.0%**	**29.0%**	**27.0%**	**29.0%**	**28.0%**
White women	37.0%	35.0%	34.0%	32.0%	32.0%	34.0%
BME women	28.0%	30.0%	29.0%	25.0%	30.0%	28.0%
White men	27.0%	27.0%	23.0%	24.0%	25.0%	21.0%
BME men	23.0%	22.0%	20.0%	18.0%	21.0%	22.0%

% of staff experiencing harassment, bullying or abuse from patients/relatives or the public



	2019	2020	2021	2022	2023
White staff: Your org	33.04%	31.10%	29.79%	30.62%	29.22%
All other ethnic groups*: Your org	27.44%	27.26%	23.30%	27.01%	25.72%
White staff: Average	27.67%	25.36%	26.47%	26.91%	24.05%
All other ethnic groups*: Average	29.51%	28.01%	28.84%	30.82%	27.34%
White staff: Responses	2621	2524	2484	2296	1832
All other ethnic groups*: Responses	1902	1904	2034	2025	1552

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

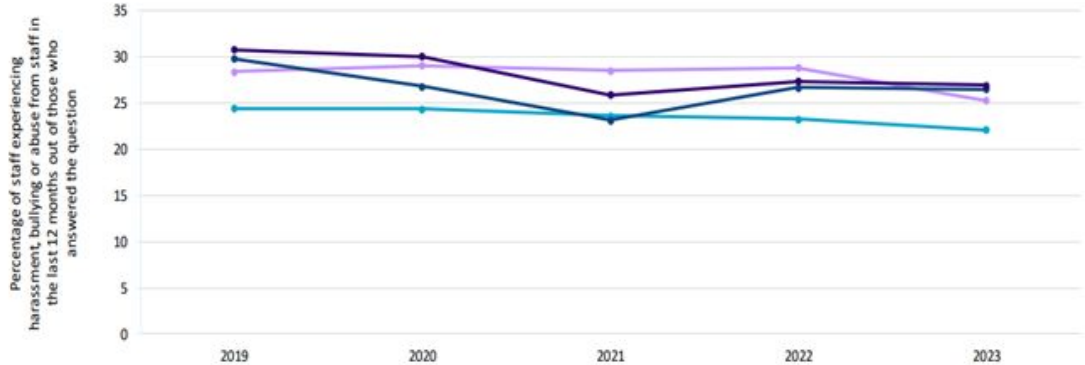
Indicator 6

% of staff experiencing harassment, bullying or abuse from staff in the last 12 months

- Reported rates of staff experiencing harassment, bullying or abuse from other staff remains fairly static since last year's staff survey. Whilst there is a slight reduction, moving in the right direction, it is very minor.
- For BME staff at St George's this has reduced by 0.4 percentage points, from 27.3% in 2022 to 26.9% in 2023.
- For white staff this has reduced by 0.2 percentage points.
- St George's performed better than 29% and worse than 71% of Trusts in this indicator.
- For the second year, BME women report the highest rates in this indicator at 30%, with BME men reporting the lowest rates at 22%.
- White estate and ancillary staff report the highest rates at 40%, with white nurse and midwifery staff reporting the second highest at 35%

Ethnicity / Gender	Survey Year					
	2018	2019	2020	2021	2022	2023
Overall	**30%**	**30%**	**28%**	**24%**	**27%**	**28%**
White women	30%	29%	26%	23%	26%	27%
BME women	31%	34%	31%	27%	29%	30%
White men	28%	30%	26%	22%	26%	27%
BME men	31%	24%	25%	21%	23%	22%

% of BME staff experiencing harassment, bullying or abuse from staff



	2019	2020	2021	2022	2023
White staff: Your org	29.83%	26.82%	23.14%	26.71%	26.49%
All other ethnic groups*: Your org	30.78%	30.06%	25.87%	27.34%	26.94%
White staff: Average	24.44%	24.37%	23.65%	23.25%	22.12%
All other ethnic groups*: Average	28.39%	29.07%	28.53%	28.81%	25.25%
White staff: Responses	2625	2524	2494	2295	1832
All other ethnic groups*: Responses	1894	1906	2041	2030	1546

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

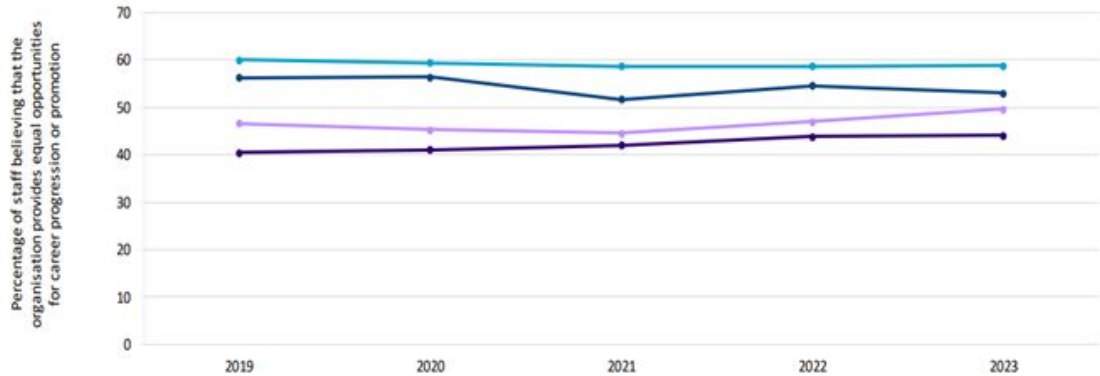
Indicator 7

% of staff believing that trust provides equal opportunities for career progression or promotion

- 44% of BME staff felt the organisation provides equal opportunities for career progression or promotion. This follows a continued upwards trend since 2018 (+6.1 percentage points).
- This compares to 53% of white staff, which has reduced by 1.53 percentage points compared to last year.
- The gap in perception between white and BME staff has reduced from 11 percentage points in 2022 to 9 percentage points in 2023.
- Both white and BME staff at St George's still feel less confident compared to staff nationally.
- St George's performed better than 26% of trusts and worse than 72% of trusts nationally.
- White British and Asian staff report the highest in this indicator, 56% and 50% respectively.
- Black staff reported than lowest satisfaction at 38%, this has improved compared to 34% last year and is the highest since reporting began in 2018.

	Ethnicity / Gender	Survey Year					
		2018	2019	2020	2021	2022	2023
Grouped	White	55%	56%	56%	52%	55%	53%
	BME	38%	40%	41%	42%	44%	44%
Detailed	White British	56%	57%	58%	54%	57%	56%
	White other	54%	53%	53%	45%	50%	44%
	Asian	44%	45%	48%	48%	50%	50%
	Black	28%	30%	29%	30%	34%	38%
	Mixed/other	39%	48%	44%	46%	40%	41%

% of staff believing that trust provides equal opportunities for career progression or promotion



	2019	2020	2021	2022	2023
White staff: Your org	56.28%	56.39%	51.67%	54.59%	53.06%
All other ethnic groups*: Your org	40.46%	41.12%	42.08%	43.82%	44.05%
White staff: Average	60.00%	59.39%	58.64%	58.65%	58.84%
All other ethnic groups*: Average	46.62%	45.24%	44.56%	47.00%	49.64%
White staff: Responses	2603	2566	2551	2277	1898
All other ethnic groups*: Responses	1886	1953	2096	2013	1664

*Staff from all other ethnic groups combined

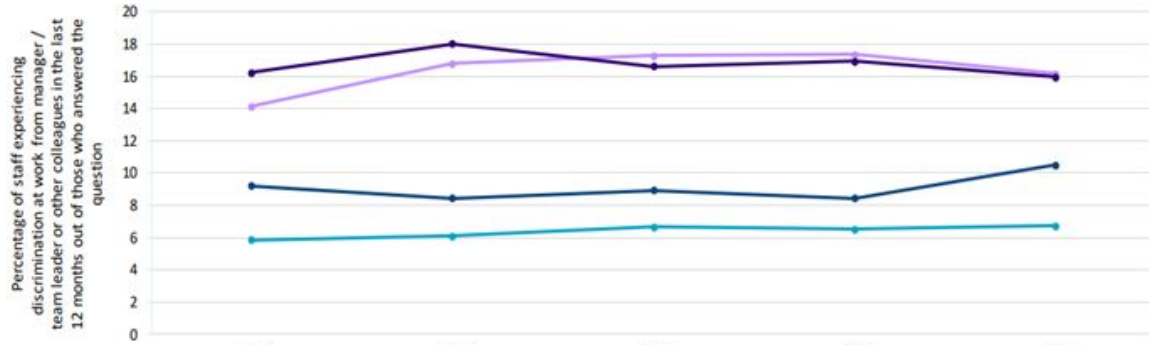
Workforce Race Equality Standard (WRES)

Indicator 8

% of staff that personally experienced discrimination at work from a manager or colleagues

- In 2023, 15.9% of BME staff completing the staff survey indicated that they had experienced discrimination at work from a manager or colleague. This has reduced slightly, by 0.97 percentage points, since last year.
- This is the lowest reported rate, for BME staff, since 2019.
- For white staff, this has increased compared to last year, from 8.45% in 2022 to 10.48% in 2023.
- Whilst BME staff continue to report experiencing higher rates of discrimination, compared to white colleagues, the gap in experience is at its lowest in five years. From a gap of 8.48 percentage points to 5.48 percentage points.
- St George's performed better than 40% of trusts and worse than 60% of trust nationally.

% of staff that personally experienced discrimination at work from a manager or colleagues



	2019	2020	2021	2022	2023
White staff: Your org	9.21%	8.42%	8.91%	8.45%	10.48%
All other ethnic groups*: Your org	16.22%	18.02%	16.60%	16.93%	15.96%
White staff: Average	5.85%	6.09%	6.67%	6.52%	6.73%
All other ethnic groups*: Average	14.14%	16.77%	17.28%	17.33%	16.17%
White staff: Responses	2606	2578	2560	2297	1898
All other ethnic groups*: Responses	1886	1964	2102	2020	1654

*Staff from all other ethnic groups combined

Workforce Race Equality Standard (WRES)

Indicator 9

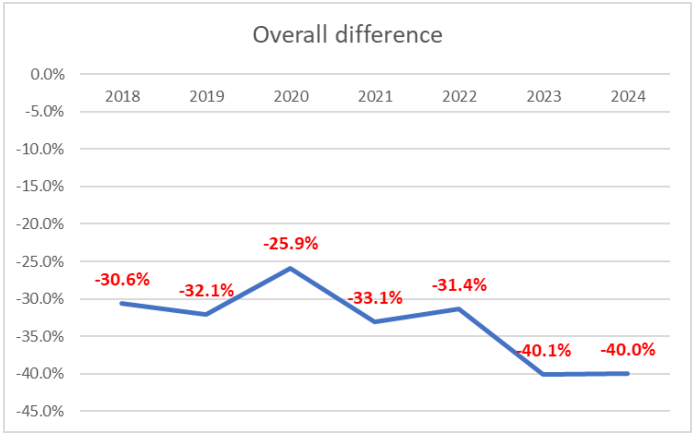
% of board members by ethnicity compared to BME workforce

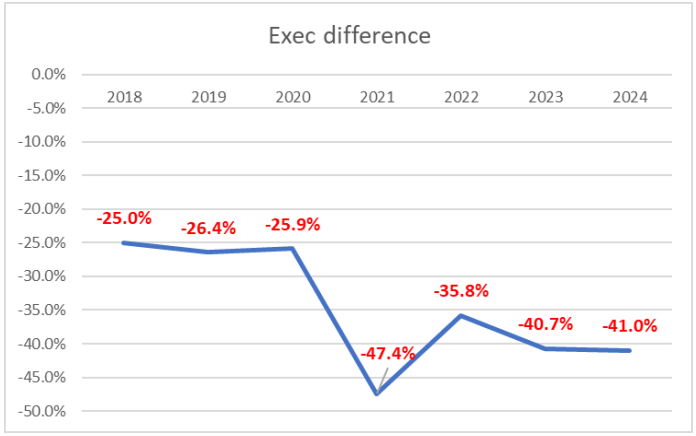
As of 31 March 2024, the Trust Board of Directors comprised 15 members, two of whom identify as Black, Asian and Minority Ethnic (one non-executive director, and one executive director). Of this, the Board comprised 11 voting members, seven of whom were non-executive directors and four were executive directors. Of these 11 voting members of the Board, two voting Board members identify as BME. This means BME staff are -35% under-represented at Board level.

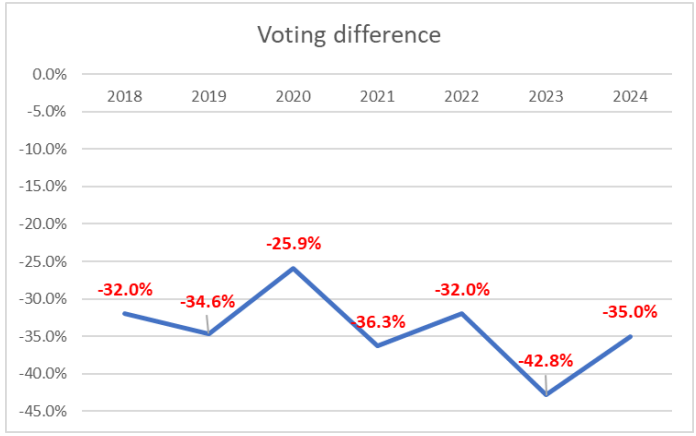
On 12 October 2023, a longstanding Non-Executive Director at the Trust came to the end of their term of office, after seven years as a Non-Executive Director at the Trust. In the summer of 2023, the Trust ran an appointments process to identify a successor. Unfortunately, the panel were unable to make an appointment. A non-voting Associate Non-Executive Director who identified as BME was appointed to cover the voting NED role on an acting-up basis. Following a competitive external appointments process in the spring and summer, this individual was appointed substantively to the voting NED in October 2024.

Two further Board appointments will be made to the Board by December 2024, the Trust Chair and a Non-Executive Director, both voting positions on the Board. In discussion with the Council of Governors, it has been agreed that identifying a strong and diverse field of candidates is a key priority in these upcoming appointments processes. The roles are being advertised to ensure a diverse field and the search firms supporting the appointments have been asked by the Trust to actively seek applications from across the protected characteristics.

The Trust is committed to appointing to ensuring future appointments to all Board level roles (executive and non-executive) are appropriately targeted to ensure a diverse range of candidates.







Workforce Race Equality Standard (WRES)

Next steps

Our existing Culture and Diversity and Inclusion Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2024-26**.

Following publication of our WRES and WDES Reports in late October 2024 we will commence a final review and Board approval of the specific actions which will enable us to deliver against our People Strategy and NHSE's EDI Improvement Plan.

An overview of these action plans will be published shortly.

Fig 1: Our 2024-2026 People Priority Domains

Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Workforce Race Equality Standard (WRES)

Appendix A: Definitions of ethnicity: people covered by the WRES

- **In line with Health Education England's WRES guidance and national WRES reporting metrics, the term 'BME' and 'white' are used to describe the two groups of staff referred to in this report**.
- The definitions of 'black and minority ethnic' and 'white' used in Health Education England's (HEE) WRES guidance 2024 have followed the national reporting requirements of ethnic category in the NHS data model and dictionary and are as used in NHS Digital data. At the time of publication these definitions were based upon the 2001 ONS Census categories for ethnicity. These are presented in Annex B.
- 'White' staff include white British, Irish, Eastern European and any other white i.e. categories 1–4 in the table in.
- The 'black and minority ethnic' staff category includes all others except 'unknown' and 'not stated.'
- To aggregate data for BME staff, organisations should include categories 5-18 from current values and exclude 'not stated' and any 'NULL' values.
- The treatment of staff from ethic categories [2 – white Irish] or [3 – Gypsy or Irish Traveler] or [4 – Any other white background] i.e. eastern European who may, in some organisations, be a significant minority group and experience considerable discrimination, is considered in the WRES FAQs document. Where this is the case, organisations should also explore such discrimination using workforce and staff survey data and take appropriate action.
- Source: WRES Additional Information 2024 for NHS Trusts and Foundation Trusts (30/04/2024)

Ethnicity refers to: ONS definitions found here: Ethnic group, national identity and religion - Office for National Statistics (ons.gov.uk)

Ethnic Categories 2021

WHITE
1 – White –British / Welsh / Scottish / Northern Irish / British
2 – White –Irish
3 - Gypsy or Irish Traveller
4 – Any other white background please describe

MIXED / MULTIPLE ETHNIC GROUPS
5 – White and Black Caribbean
6 – White and Black African
7 – White and Asian
8 – Any other mixed / multiple ethnic background please describe

ASIAN / ASIAN BRITISH
9– Asian or Asian British –Indian
10 – Asian or Asian British –Pakistani
11 – Asian or Asian British – Bangladeshi
12 - Asian or Asian British – Chinese
13 – Any other Asian background please describe

BLACK / AFRICAN / CARIBBEAN / BLACK BRITISH
14 – Black or black British – African
15 – Black or black British – Caribbean
16 – Any other black background please describe

ANY OTHER ETHNIC GROUP
17 – Arab
18 – Any other ethnic group please describe

Workforce Race Equality Standard (WRES)

Appendix B: High impact action plan framework

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

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

gesh

Epsom and St Helier University Hospitals NHS Trust

Workforce Disability Equality Standard (WDES) 2023/2024

People Committee in Common September - 2024

ESTH Workforce Disability Equality Standard (WRES) Content

Outstanding care every time

Workforce Disability Equality Standard (WDES)

Purpose and Background

Purpose

- This paper provides an overview of the 2024 Workforce Disability Equality Standard (WDES) findings.
- The report will be published on the Trusts' websites
- The Board is asked to receive this report for information and approve for publication.

Background

- The WDES was introduced in 2019 and is designed to improve the experiences of people with a disability working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.
- The WDES report compares data between staff with disabilities and without disabilities in order to identify disparities and barriers in the workplace. These findings inform the organisation's WDES Action Plan, which aims to directly address inequalities faced by members of staff with disabilities.
- We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of people with disabilities. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of people with disabilities, and an exemplar for other NHS Trusts.

What is 'Disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a person with a disability as:

"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a staff with a disability, it is almost always more important to understand and support the effects of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are without aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.

Overview of Workforce Numbers – ESTH

	2021	2022	2023	2024
Total number of staff in organisation	6150	7092	7190	**7410**
% of staff with a declared Disability on ESR	4.39%	4.50%	4.37%	**4.25%**
% of staff which indicated a disability via Staff Survey	8.4%	9.4%	8.5%	**8.7%**

every time

Workforce Disability Equality Standard (WDES)

Background

The WDES was introduced in 2019 and is designed to improve the experiences of people with a disability working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.

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We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of people with a disability. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of people with a disability, and an exemplar for other NHS Trusts.

Table A	Indicator Description
Metric 1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
Metric 4	Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Metric 5	Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 6	Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Metric 7	Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Metric 8	Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
Metric 10	% difference between the organisation's Board voting membership and its organisation's overall workforce

Outstanding care every time

Workforce Disability Equality Standard (WDES) Indicator Overview

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Metric	Description	Staff with a disability				Staff without a disability			
		2021	2022	2023	22 vs. 23	2021	2022	2023	
1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)	3.5%	4.0%	4.3%	Increased				
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.08	1.21	1.15	Improved				
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	0	4.78	4.26	Improved				
4a.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from patients/ service users	32.0%	34.5%	32.3%	Improved	25.7%	27.0%	26.7%	Improved
4b.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from managers	20.9%	19.5%	18.2%	Improved	11.8%	11.9%	11.8%	Improved
4c.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from other colleagues	25.7%	26.1%	26.4%	Declined	17.7%	18.2%	18.1%	Improved
4.d	Staff Survey Q14: % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	49.3%	48.9%	48.4%	Improved	50.8%	49.9%	44.7%	Declined
5	Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion	46.3%	46.0%	46.0%	Static	51.8%	51.8%	54.0%	Improved
6	Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	32.1%	33.5%	30.0%	Improved	26.2%	24.5%	24.0%	Improved
7	Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work	31.5%	32.7%	37.7%	Improved	41.9%	44.0%	46.1%	Improved
8	Staff Survey Q28b: % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	72.0%	66.2%	43.0%	Declined				
9	The staff engagement score for Disabled staff, compared to non-disabled staff	6.6	6.2	6.3	Improved	7.1	6.9	6.9	Static
10	% difference between the organisation's Board voting membership and its organisation's overall workforce with a declared disability	16.0%	12.3%	26.0%	Improved				

Workforce Disability Equality Standard (WDES) ESTH

Executive Summary

All NHS providers are required to complete an annual Workforce Disability Equality Standard (WDES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality. Data for WDES indicators 4 to 9a are drawn from questions in the most recent NHS staff survey. In line with national requirements this report and associated action plan should be reviewed internally and approved at Board before being published on the organisations website.

Workforce Numbers:

- The total number of staff in the Trust increased from 2023 to 7,410 in 2024, and also the percentage of staff with a disability slightly increased from 4.0% to 4.3%. This marginal increase in the proportion of staff with a disability, amidst a growing overall workforce, suggests that the rate of increase in staff with a disability hiring is not keeping pace. This trend highlights a potential area for enhanced focus on inclusivity and targeted recruitment efforts to better support and integrate disabled individuals within the workforce.

Non-Clinical Workforce:

- The percentage of Non-Clinical staff reporting disabilities slightly increased from 4.89% in 2022-23 to 5.1% in 2023-24. This minor increase suggests a stable or slightly improved environment in terms of disability inclusion within the Trust.
- There was a notable decrease in the percentage of Non-Clinical staff who did not disclose their disability status, dropping from 22.55% in 2022-23 to 20.50% in 2023-24. This decrease, coupled with the slight increase in staff reporting as disabled, indicates a trend towards greater transparency and openness in disclosing disability status, which may reflect positively on the Trust's efforts to foster an inclusive and supportive work environment.

Clinical Workforce:

- The percentage of clinical staff reporting as Disabled decreased from 4.17% in 2023 to 3.95% in 2024. This slight decrease might suggest changes in the composition of the workforce or fluctuations in recruitment and retention strategies that impact the proportion of staff self-identifying as disabled.
- The percentage of clinical staff who didn't disclose their disability status decreased from 11.08% in 2022-23 to 9.88% in 2023-24. This reduction suggests a significant improvement in transparency within the clinical workforce, with more staff choosing to declare their disability status.

Recruitment:

- The relative likelihood of non-disabled applicants being appointed from shortlisting increased from 1.21 in 2022-2023 to 1.15 in 2023-2024, indicating a growing advantage for candidates without disabilities in the hiring process.
- This widening gap in the likelihood of appointment highlights potential disparities in the recruitment process that may put applicants with a disability at a disadvantage, emphasising the need for enhancements to equitable hiring practices to ensure fairness across all applicant groups.

Formal Disciplinary:

- The relative likelihood of staff with disabilities entering the formal capability process compared to staff without disabilities dropped from 4.78 in 2023 to 4.26 in 2024, indicating a substantial improvement in equitable treatment.
- The zero relative likelihood in 2024 suggests that staff without disabilities were not subjected to formal capability procedures, reflecting positive changes in management practices and increased fairness in the process.

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Workforce Disability Equality Standard (WDES) ESTH summary

Executive Summary cont'd….

Harassment, Bullying and Abuse

- Staff with disabilities reported a slight decrease in harassment from public/patients/service users, dropping from 34.50% in 2022-23 to 32.30% in 2023-24. Harassment from managers also decreased from 19.50% to 18.20% during the same period. However, harassment from other colleagues remained relatively stable, with a slight increase from 26.10% to 26.40%. Reporting of the latest occurrence of harassment slightly decreased from 48.9% to 48.4%.
- For staff without disabilities, harassment levels remained stable, with a decrease in reporting from 49.9% to 44.7%. These trends suggest that while there is progress in reducing external and managerial harassment for staff with disabilities, there is a need to address harassment from colleagues and improve reporting mechanisms for all staff.

Believing that trust provides equal opportunities for career progression or promotion

- The percentage of staff with disabilities who believe in equal opportunities for career progression or promotion remains constant at 46%. In contrast, there is an increase in the percentage of staff without disabilities who believe in equal opportunities, rising from 52% in 2022-23 to 54% in 2023-24.
- This indicates a persistent perception gap between staff with disabilities and without disabilities regarding equal career opportunities, with non-disabled staff consistently having a more positive outlook on career progression prospects.
- The stability in the disabled staff's perception suggests that more efforts may be needed to address their concerns and improve their confidence in equal career opportunities.

Feeling pressured to work despite not feeling well enough to perform

- The data reveals a positive shift in reducing the pressure on staff to work while unwell, with improvements observed in both staff with disabilities and staff without disabilities. Reduced from 33.5% to 30%.
- Non-disabled staff: Reduced from 24.5% to 24%. Although the reduction is modest, it indicates progress in addressing health and well-being concerns.
- Staff with disabilities experienced a more significant reduction compared to non-disabled staff
- Continued monitoring and sustained efforts are recommended to

Satisfaction with the extent to which the organisation

- There is a positive trend in increasing satisfaction with how the organisation values staff work. Staff with disabilities increased from 32.7% to 37.7%. Non-disabled staff increased from 44% to 46.1%
- The increase in satisfaction is notably higher among staff without disabilities, suggesting that improvements in this area are more pronounced for them.
- Staff with disabilities, however, have shown an increase also in satisfaction
- The data reflects promising advancements in reducing the pressure on staff to work while unwell and increasing satisfaction with organisational valuation of work
- Further efforts should aim to sustain these positive trends and address any emerging concerns.

Percentage of staff receiving adequate adjustment(s)

A significant majority of staff with disabilities believe that the organisation has not made sufficient adjustments to enable them to perform their jobs effectively. There has been a notable decrease in this belief from 66.2% to 43% in 2024.

- The reduction in the percentage of staff with disabilities who feel inadequately supported may indicate recent improvements in workplace accommodations and adjustments. This could include better physical accessibility, enhanced assistive technologies, or more flexible work arrangements
- Enhanced communication about available adjustments and support resources such as the DAL may have increased awareness among staff with disabilities, leading to a more positive perception of the changes implemented
- The organisation introduced targeted initiatives, DAL service Disability related policies, and training programs aimed at addressing the specific needs of disabled employees.
- From January 2024 to date, 14.2% of the disabled workforce has requested reasonable adjustments support from the DAL service. In comparison, 315 staff with disabilities (4.25%) have disclosed their disability
- Assess and Identify Issues Perform thorough evaluations through the DAL service to pinpoint the specific areas where adjustments are still lacking for the 43% of staff with disabilities who feel inadequately supported. Understanding these shortcomings will help address their concerns effectively.
- Despite ongoing initiatives , the remaining 43% of disabled staff who still feel that adjustments are inadequate highlight areas for further improvement. This underscores the need for continued efforts to identify and address gaps in support.

Outstanding care every time

Workforce Disability Equality Standard (WDES) Executive Summary cont. – ESTH

Staff engagement score (0-10)

Staff with disabilities are less optimistic about engaging within the Trust compared to staff without disabilities, with a 0.5% difference between the two groups. This indicates that staff without disabilities are more likely to engage and voice their concerns

Board Representation

- While the Board has shown improvements in representation over the past few years, the workforce shows less than 5% declared disabilities across the reporting period (2019-2024). The Trust demonstrated a consistent improvement in aligning its Board executive membership with its workforce from 2019 to 2022, with a slight regression in 2023. However, 2024 saw an increase in representation, moving from underrepresentation (-4.4%) to overrepresentation (+7.0%). This signals a shift, potentially indicating the success of efforts to enhance disability inclusion at the executive level.

Disabled:

- Staff with disabilities have higher representation in voting and non-executive board roles compared to their overall workforce representation, indicating strong inclusion efforts in key decision-making roles. This reflects positively on the Trust's efforts to include staff with disabilities in leadership positions.

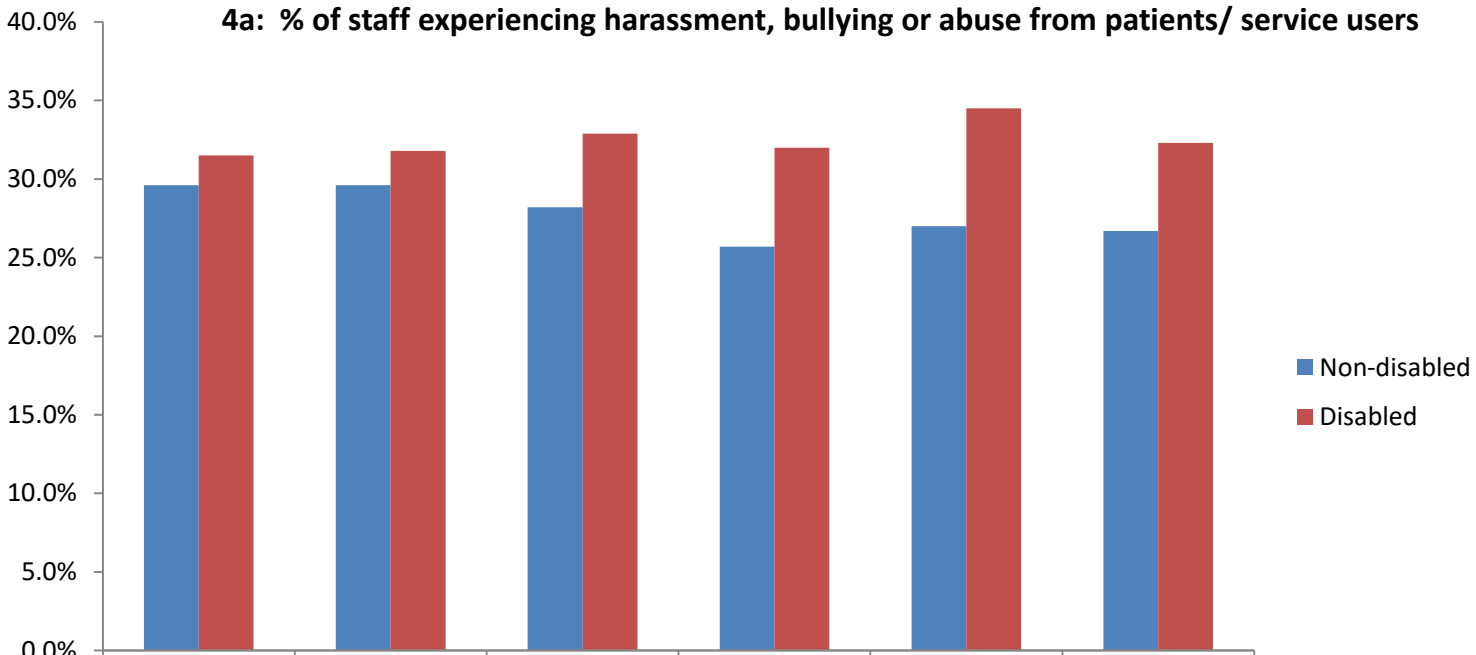
Non-disabled:

- Staff without disabilities representation on the board is proportional to their workforce representation, indicating a balanced approach in board composition.

Not disclosed:

- The absence of non-disclosed disability status among board members suggests that staff are willing to disclose their disability status, promoting transparency and ensuring that all groups are properly represented at the highest levels of the Trust.

Observations: Metric 4a

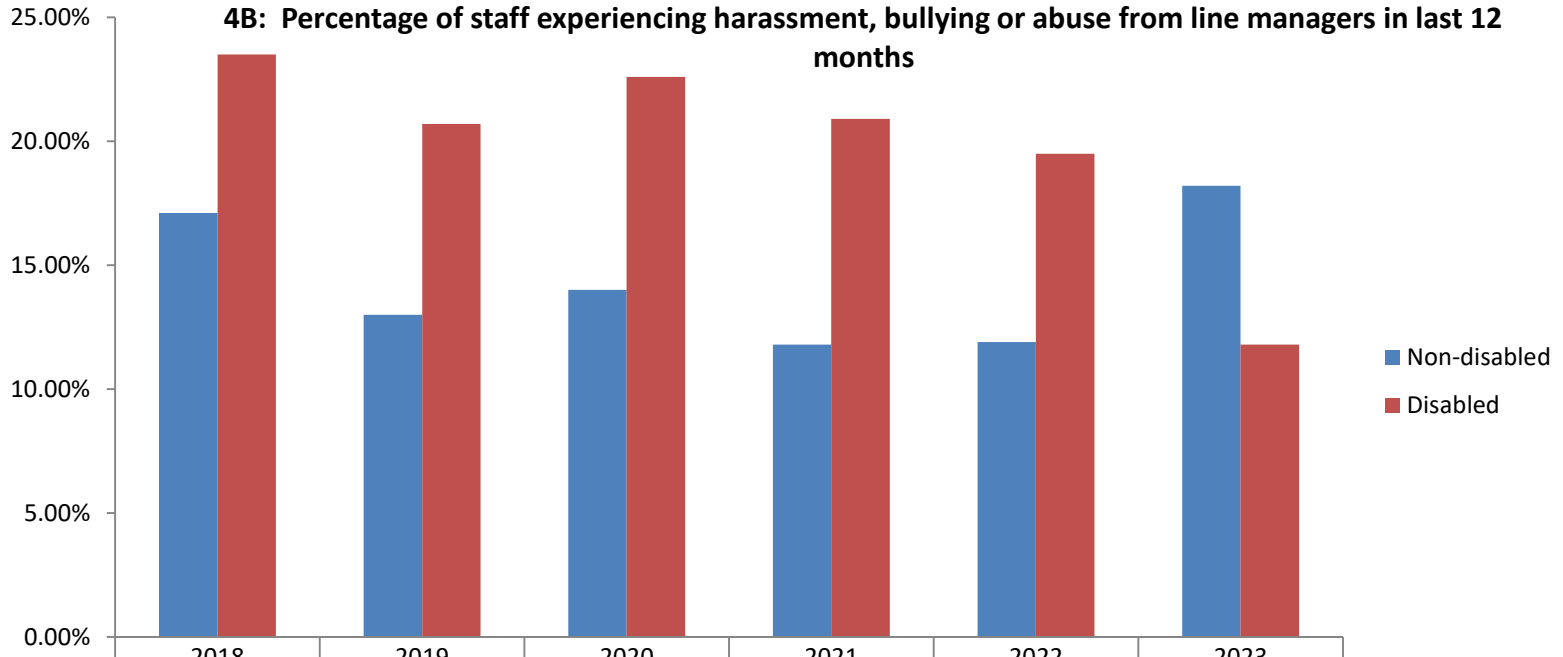


	2018	2019	2020	2021	2022	2023
Non-disabled	29.6%	29.6%	28.2%	25.7%	27.0%	26.7%
Disabled	31.5%	31.8%	32.9%	32.0%	34.5%	32.3%

The data reflects a disparity in the experiences of disabled and non-disabled staff with regard to harassment, bullying, or abuse from patients/service users. While non-disabled staff have seen improvements in recent years, disabled staff continue to face disproportionately higher levels of these negative experiences.

The widening gap, particularly in 2022, highlights the need for targeted interventions to address the specific challenges faced by disabled staff in ensuring a safer and more inclusive work environment. Improvements in 2023 for both groups are encouraging, but the persistent disparity requires on-going attention to reduce harassment for disabled staff to levels comparable to their non-disabled peers.

Observations: Metric 4b

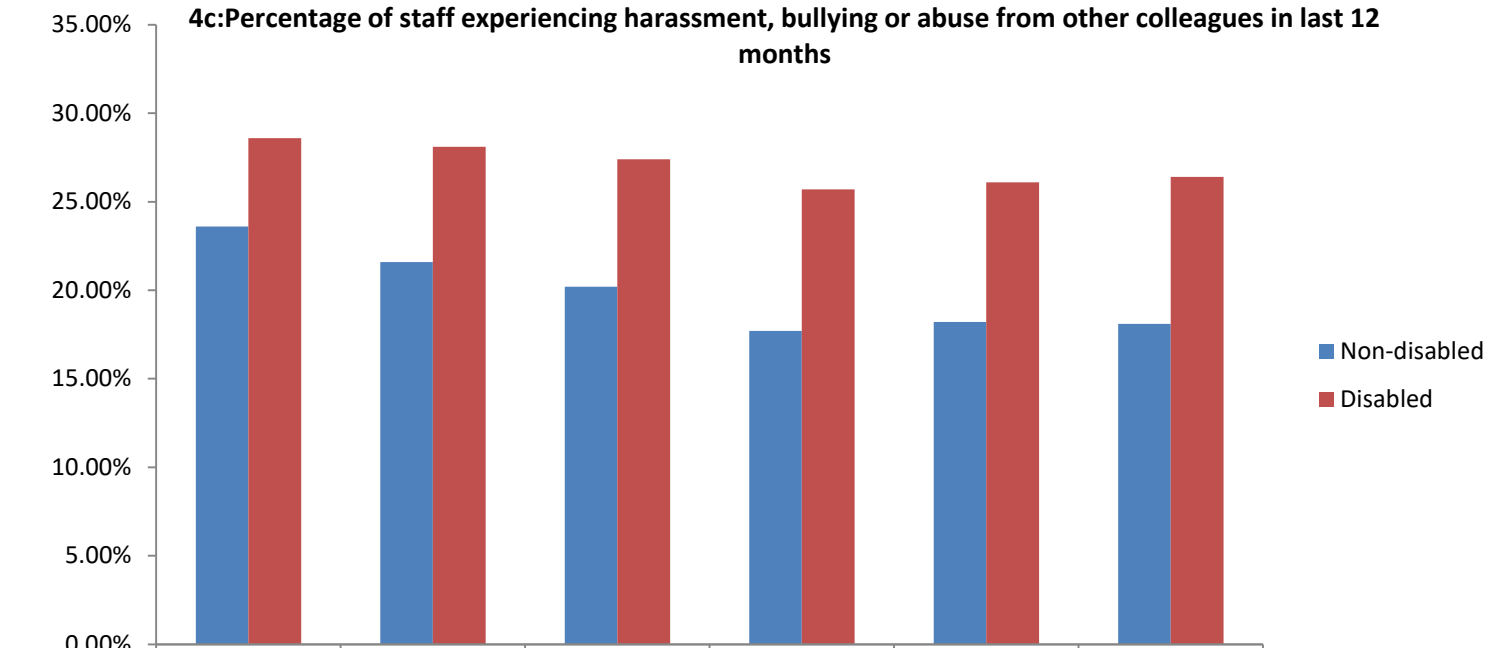


	2018	2019	2020	2021	2022	2023
Non-disabled	17.10%	13.00%	14.00%	11.80%	11.90%	18.20%
Disabled	23.50%	20.70%	22.60%	20.90%	19.50%	11.80%

The data highlights the experiences of disabled and non-disabled staff regarding harassment, bullying, and abuse from managers. From 2018 to 2022, disabled staff consistently reported higher rates of harassment. However, in 2023, there was a notable decline in their reported experiences, bringing them below those of non-disabled staff for the first time, where non-disabled staff experienced a significant increase in harassment.

The reasons behind these shifts in 2023 warrant further investigation. These changes underscore the necessity for on-going monitoring and targeted interventions to effectively address workplace harassment for all employees.

Observations: Metric 4c



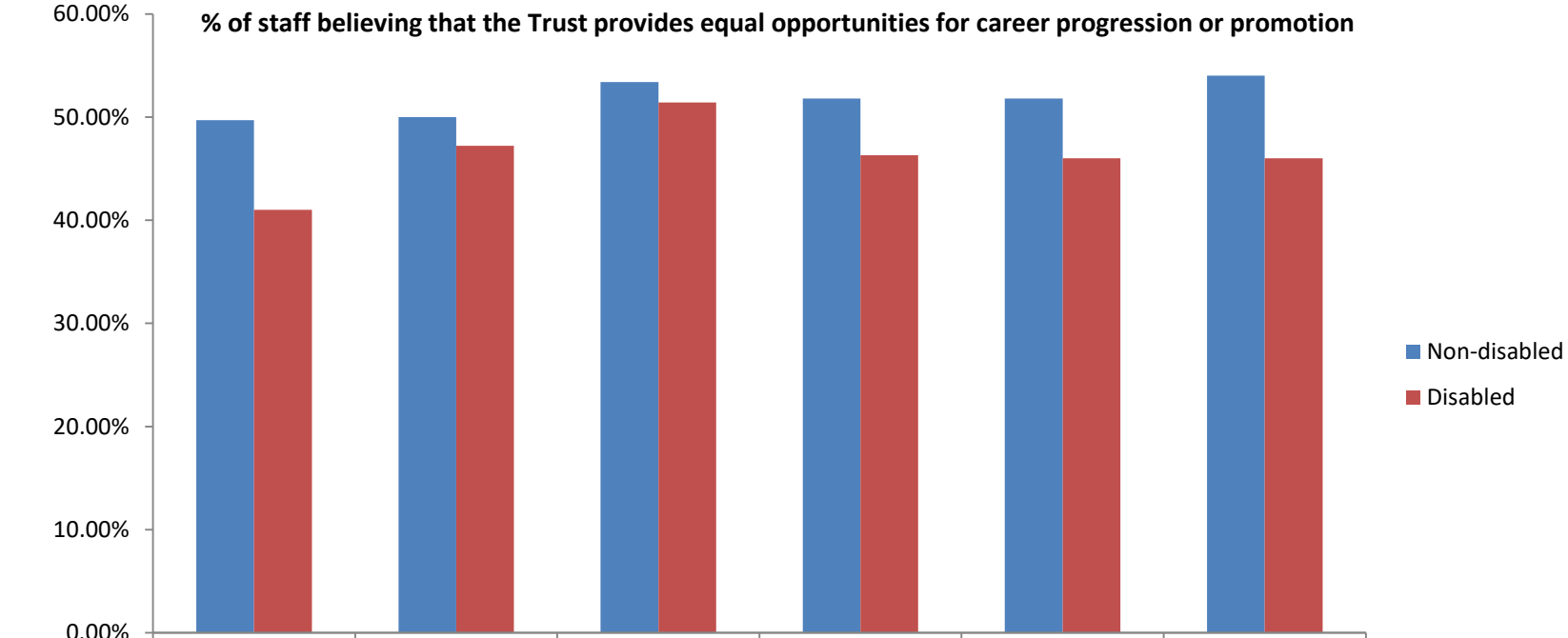
	2018	2019	2020	2021	2022	2023
Non-disabled	23.60%	21.60%	20.20%	17.70%	18.20%	18.10%
Disabled	28.60%	28.10%	27.40%	25.70%	26.10%	26.40%

The data above reveals a persistent and growing disparity between disabled and non-disabled staff in terms of harassment, bullying, or abuse from colleagues. While both groups experienced improvements from 2018 to 2021, the situation worsened slightly in 2022 and 2023, particularly for disabled staff.

Disabled employees have consistently faced higher levels of harassment, and the gap between the two groups has widened over time, indicating that disabled staff continue to face more significant challenges in their interactions with colleagues.

The overall trend suggests that while some progress has been made in reducing workplace harassment, disabled staff remain disproportionately affected, and this calls for focused interventions to foster a more inclusive and respectful working environment.

Observations: Metric 5

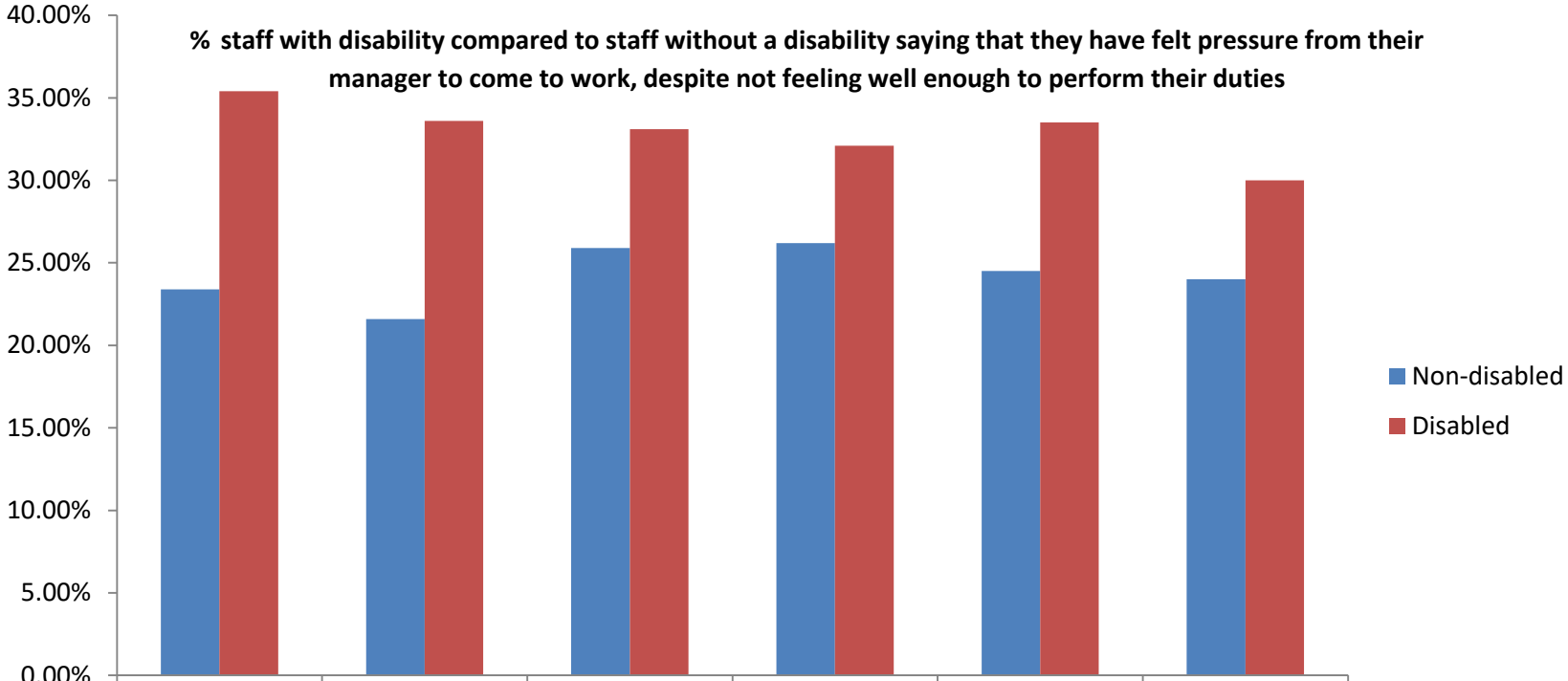


	2018	2019	2020	2021	2022	2023
Non-disabled	49.70%	50.00%	53.40%	51.80%	51.80%	54.00%
Disabled	41.00%	47.20%	51.40%	46.30%	46.00%	46.00%

The non-disabled staff's belief in equal opportunities shows a steady upward trend, while the belief among disabled staff fluctuated, peaking in 2020 but declining in the subsequent years.

There remains a notable gap between the perceptions of non-disabled and disabled staff regarding equal opportunities for career progression, highlighting an area for potential improvement in the Trust practices.

Observations: Metric 6

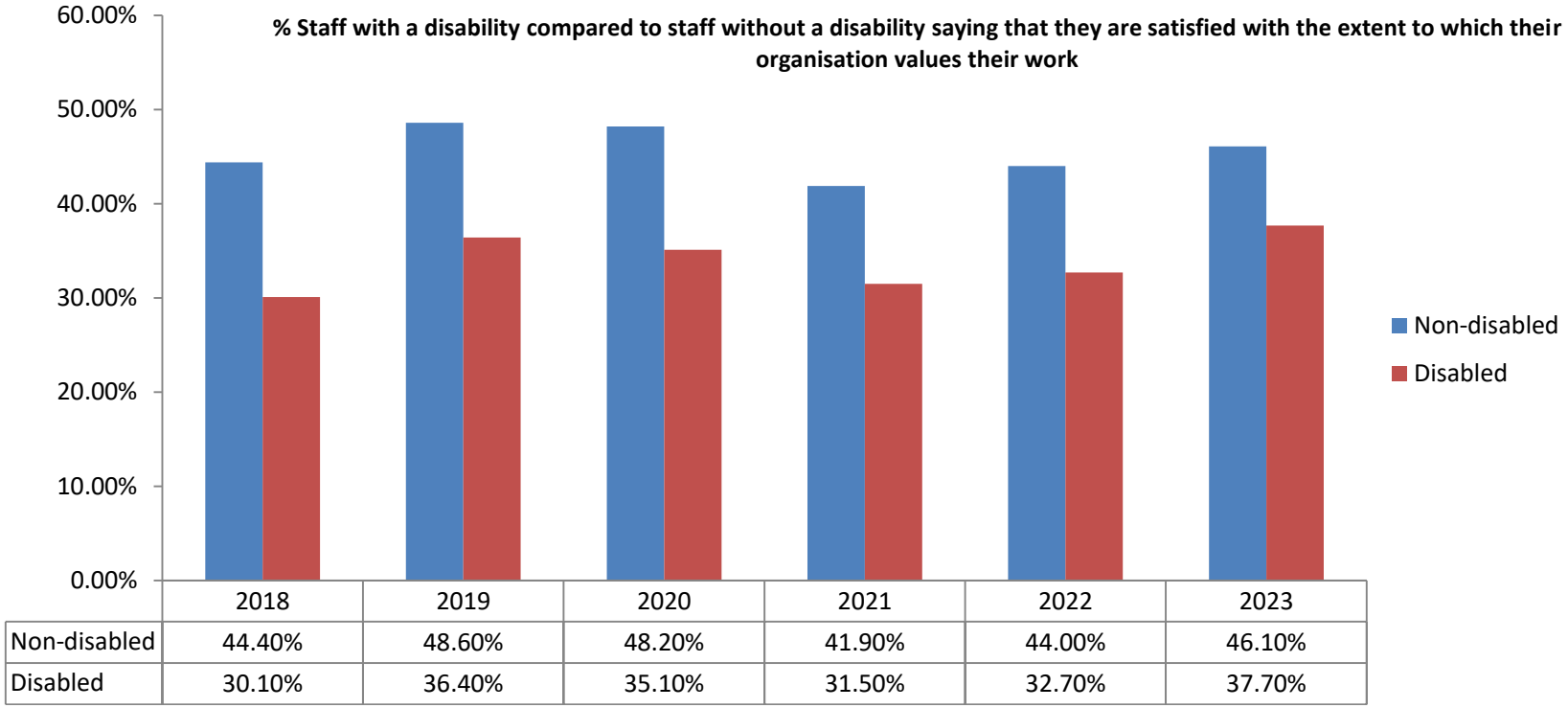


	2018	2019	2020	2021	2022	2023
Non-disabled	23.40%	21.60%	25.90%	26.20%	24.50%	24.00%
Disabled	35.40%	33.60%	33.10%	32.10%	33.50%	30.00%

Overall, while there has been a slight decrease in reported pressure from managers for staff to attend work despite illness for both groups, disabled staff consistently report feeling more pressured than their non-disabled counterparts.

Monitoring these trends are important for understanding workplace dynamics and the potential need for policy changes or support systems to better accommodate all employees, particularly those with disabilities.

Observations: Metric 7



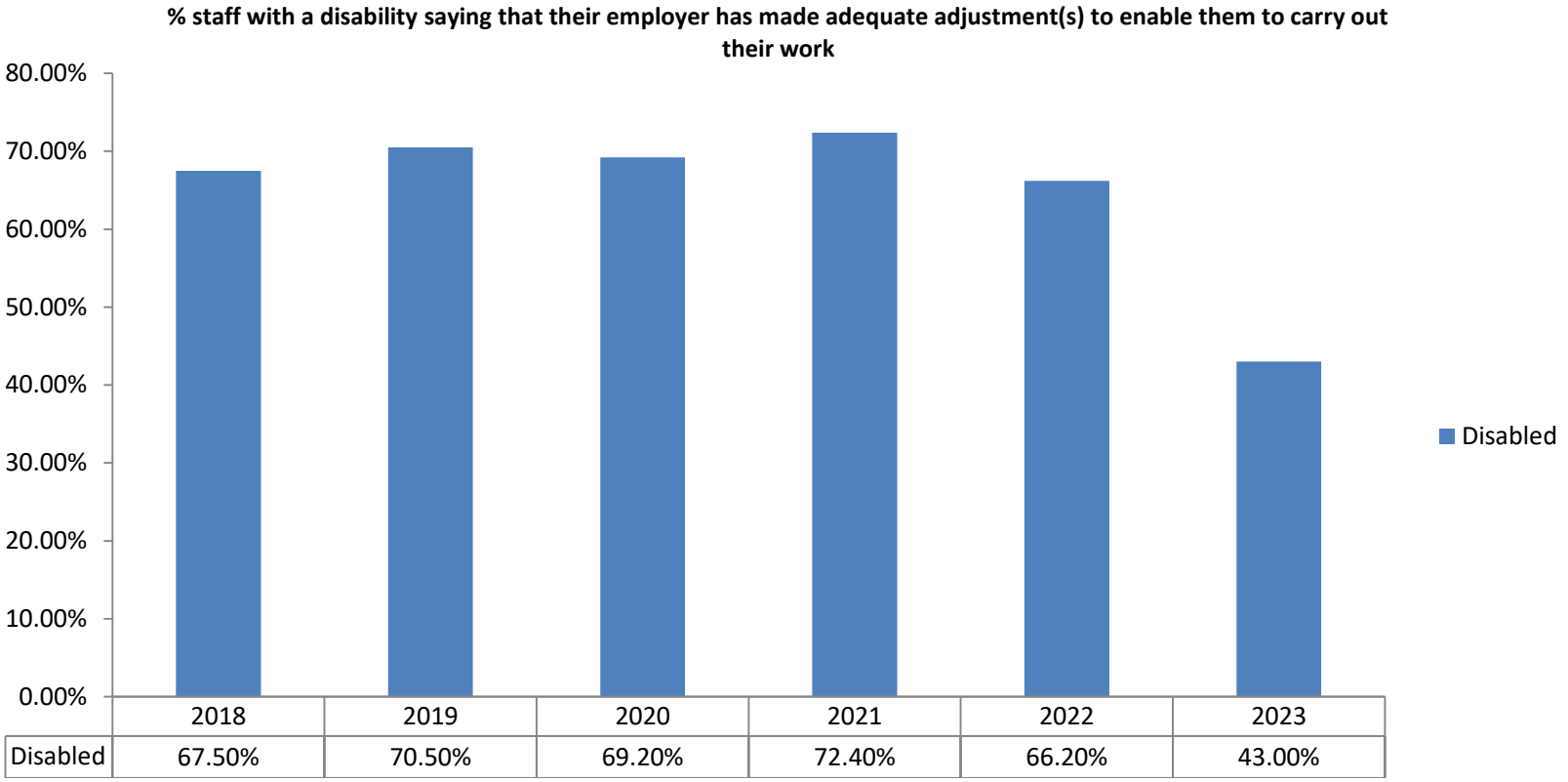
	2018	2019	2020	2021	2022	2023
Non-disabled	44.40%	48.60%	48.20%	41.90%	44.00%	46.10%
Disabled	30.10%	36.40%	35.10%	31.50%	32.70%	37.70%

There is a consistent gap between non-disabled and disabled staff regarding satisfaction with how their work is valued. For instance, in 2018, non-disabled staff reported 44.40% satisfaction, while disabled staff only reported 30.10%, a difference of 14.30%.

The gap has narrowed slightly in 2023, with the difference being 8.40 percentage points (46.10% for non-disabled and 37.70% for disabled).

While satisfaction levels for non-disabled staff remain higher than those for disabled staff, the overall trend shows an increase in satisfaction for disabled staff over the years. This improvement indicates positive changes at the Trust practices that may be enhancing the perceived value of employees' work, especially for those with disabilities. However, there is still a notable gap that the Trust should aim to address to ensure all employees feel valued in their work.

Observations: Metric 8

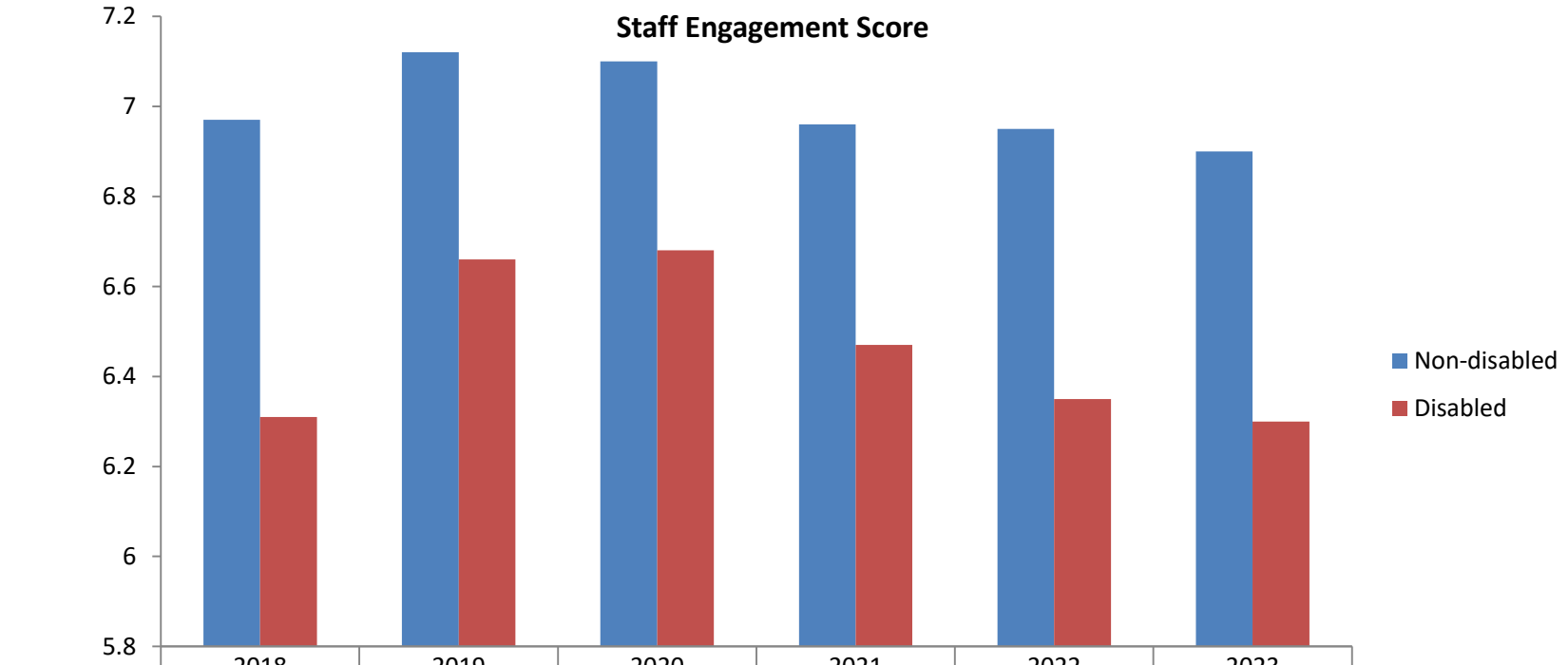


	2018	2019	2020	2021	2022	2023
Disabled	67.50%	70.50%	69.20%	72.40%	66.20%	43.00%

The data shows a concerning trend for disabled staff regarding reasonable adjustments made by their employers. After reaching a peak in 2021, satisfaction with reasonable adjustments has significantly declined, particularly by 2023. This suggests that the may need to review their policies and practices to ensure they adequately support their disabled employees and promote the DAL services.

Focus on continuous improvement and feedback from disabled employees is key to restoring trust and satisfaction with workplace accommodations, supported by initiatives like departmental adjustment champions under the DAL work plan.

Observations: Metric 9



	2018	2019	2020	2021	2022	2023
Non-disabled	6.97	7.12	7.1	6.96	6.95	6.9
Disabled	6.31	6.66	6.68	6.47	6.35	6.3

Overall, while the engagement scores for non-disabled staff remain higher and more stable over the years, the scores for disabled staff indicate a downward trend, particularly highlighted by the drop in 2023.

This consistent gap suggests that the Trust may need to focus on tailored engagement strategies to support disabled staff better and improve their overall workplace experience.

To improve engagement for disabled staff, the Trust should consider conducting further assessments to understand the unique challenges faced by this group and implement targeted initiatives to address their needs.

Outstanding care every time

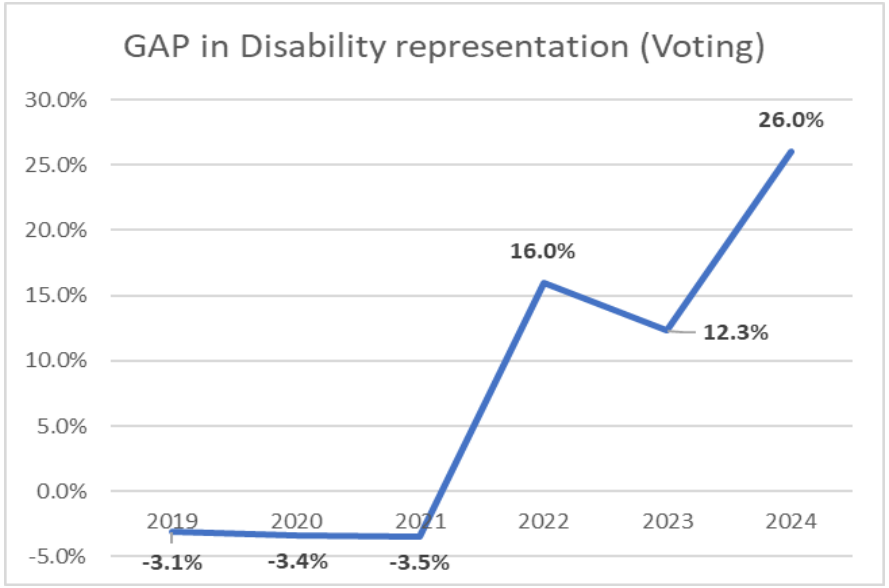
Observations: Metric 10

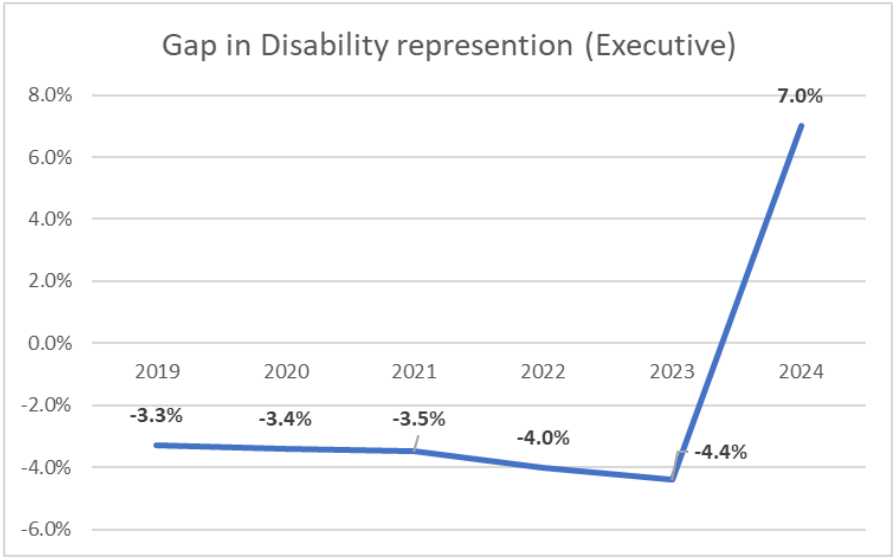
The data shows significant fluctuations in the percentage difference between the Trust's Board voting membership and the workforce with declared disabilities from 2019 to 2024.

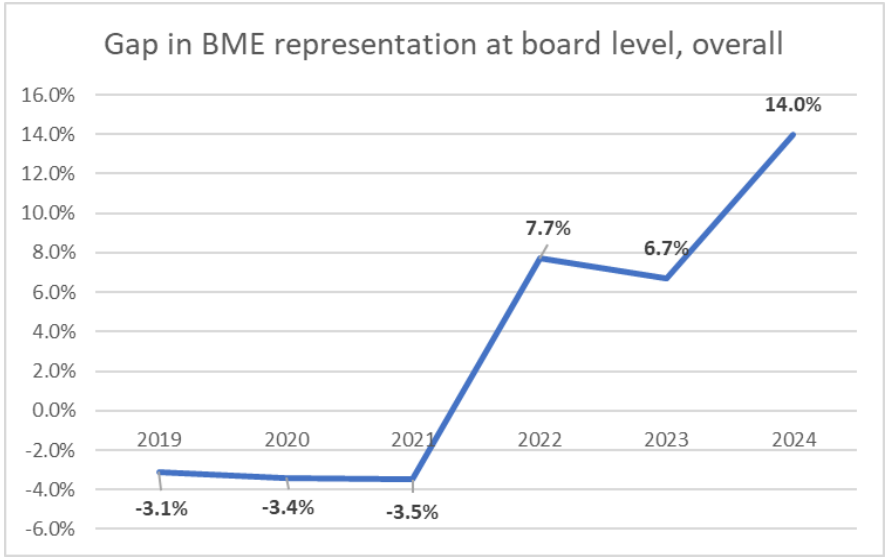
While the Board has shown improvements in representation over the past few years, the workforce shows less than 5% declared disabilities across the reporting period (2019-2024).

The Trust demonstrated a consistent improvement in aligning its Board executive membership with its workforce from 2019 to 2022, with a slight regression in 2023.

However, 2024 saw an increase in representation, moving from underrepresentation (-4.4%) to overrepresentation (+7.0%). This signals a shift, potentially indicating the success of efforts to enhance disability inclusion at the executive level.







Workforce Disability Equality Standard (WDES)

Next Steps

Our existing Culture and D&I Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2024-26**.

Following publication of our WRES and WDES Reports in late October 2024 we will commence a final review and Board approval of the specific actions which will enable us to deliver against our People Strategy and NHSE's EDI Improvement Plan.

An overview of these action plans will be published shortly.

Fig 1: Our 2024-2026 People Priority Domains

Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Outstanding care every time

Workforce Disability Equality Standard (WDES)

Appendix A: Legal Obligations of Employers and Workplace Adjustments (formerly Reasonable Adjustments)

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by people with a disability, it is permitted to treat applicants with a disability more favourably than their colleagues without a disability. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny people with a disability equality of outcome in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances.

The Equality Act 2010 also requires that reasonable adjustments (now 'workplace adjustments' are made to working conditions, policies and practices that put a staff member with a disability at a disadvantage. A workplace adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating an employee with a disability's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

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

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Workforce Disability Equality Standard (WDES)
2023/2024 Report

St George's University Hospitals NHS Foundation Trust

Published: 28/10/2024

Workforce Disability Equality Standard (WDES)

Contents

Workforce Disability Equality Standard (WDES)

Purpose and terminology

Purpose

- This paper provides an overview of the 2024 Workforce Disability Equality Standard (WDES) findings.
- This report will be published on the trust website.
- The Board is asked to receive this report for information and approve for publication.

Terminology

For the purposes of this report and in line with national WDES metrics, the term ‘disabled staff’ and ‘non-disabled staff’ are used to describe the two groups of staff referred to in this report. St George’s and its staff encourages the use of ‘staff with a disability’ and ‘staff without a disability’ respectively as preferred terminology to foster better inclusion, reduce disability associated stigma and recognise the disability is not one’s identity but rather something people live with.

Overview of workforce numbers

	2021	2022	2023	2024
Total number of staff in organisation	9,154	9,608	9,915	**10,345**
% of staff with a declared Disability on ESR	2.3%	2.9%	3.5%	**3.7%**
% of staff which indicated a disability via Staff Survey	6.5%	7.9%	6.9%	**6.0%**

Workforce Disability Equality Standard (WDES)

Background

The WDES was introduced in 2019 and is designed to improve the experiences of people with a disability working in or seeking employment within the NHS. This mandated collection of evidence-based metrics helps an organisation understand more about the experiences of its staff. The 10 metrics on which we report against each year are included in the table opposite.

The WDES report compares data between staff that have a *disability* and staff that do not have a disability in order to identify disparities and barriers in the workplace. These findings inform the organisation's D&I Action Plan, which aims to directly address inequalities faced by staff with protected characteristics.

We are pleased that the NHS, our parent organisation, is currently the only UK employer that mandates its member organisations to report annually on its representation and inclusion of staff with disabilities. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of people with disabilities, and an exemplar for other NHS trusts.

Table A	Indicator Description
Metric 1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)
Metric 2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts
Metric 3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure
Metric 4	Staff Survey Q13: % Disabled staff compared to non-disabled staff: a) experiencing harassment, bullying or abuse from different groups b) saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it
Metric 5	Staff Survey Q14: % Disabled staff compared to non-disabled staff believing that the Trust provides equal opportunities for career progression or promotion
Metric 6	Staff Survey Q11: % Disabled staff compared to non-disabled staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties
Metric 7	Staff Survey Q5: % Disabled staff compared to non-disabled staff saying that they are satisfied with the extent to which their organisation values their work
Metric 8	Staff Survey Q28b: % Disabled staff saying that their employer has made adequate adjustment(s) to enable them to carry out their work
Metric 9	a) The staff engagement score for Disabled staff, compared to non-disabled staff b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?
Metric 10	% difference between the organisation's Board voting membership and its organisation's overall workforce

Workforce Disability Equality Standard (WDES)

Our ambition

Serving a diverse population of 1.3 million and with over 10,000 employees, St George's is the largest healthcare provider in south west London. It is crucial that the diversity of our workforce reflects the diversity of the communities we serve, and we are proud that in 2024 the number of Electronic Staff Record (ESR) declarations for people with a disability has increased. We will continue to reinforce the importance of declaring one's disability on ESR to ensure adequate representation, resource allocation and support and importantly, reduce stigma by building inclusion.

St George's is committed to building a workforce in which each employee can enjoy a strong sense of belonging and where diversity, difference and uniqueness are truly valued. As well as being well-represented across all levels, we must ensure that people from marginalised groups, including people with a disability, are actively and always included, and that this inclusion is felt authentically at a personal level. Lip-service will not suffice.

Achieving strong diversity and inclusion of people with a disability at St George's will offer significant benefits for our organisation:

- Delivery of better patient care, because:
  - Staff who feel included, engaged, and supported have greater personal resources and resilience to offer thorough and compassionate care
  - Staff who are differently abled may offer enhanced empathy and support to patients due to their lived-experience of disability
  - Patients with disabilities may be more able to identify with and relate to our staff with a disability
- Stronger team performance by maximising our blend of skills, talents, knowledge, and professional experience
- Stronger individual performance by enabling staff with a disability to use their disability at work as advantage instead of a disadvantage
- Improved retention of our staff, especially our staff with a disability (including staff who may later become affected by a disability)
- A reduction in bullying, harassment, discrimination and other forms of exclusion by building greater understanding, appreciation and respect for people with disabilities
- Supporting our organisational journey towards adopting a more compassionate and inclusive culture.

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

Workforce Disability Equality Standard (WDES)

Executive summary

All NHS providers are required to complete an annual Workforce Disability Equality Standard (WDES) report. The report is based on a snapshot of data from 31st March each year and aims to highlight progress against a number of key indicators of workforce equality. Data for WDES indicators 4 to 9a are drawn from questions in the most recent NHS staff survey. In line with national requirements this report and associated action plan should be reviewed internally and approved at Board before being published on the organisation's website. The deadline for publication is 31st October 2024. The key findings are outlined below, the full findings are available in appendix B (awaiting document from NHSE). Unless indicated, each point is compared to the previous reporting period:

Workforce numbers and declaration

- At St George's 3.7% of the workforce have shared they have a disability on ESR, the Staff Survey indicates figure is closer to 6% of the workforce.
- Of the national working population, 10% have a disability, for Wandsworth, our local community, this is 11%.
- There is an 0.2 percentage point increase in the number of staff that have declared a disability. Overall, this group makes up 3.7% of the workforce – this is 4.8% for non-clinical staff groups and 3.7% for clinical staff groups.
- There is a higher number of staff with a disability in lower bands (non-clinical).
- There is a reduction in the number of staff with a disability status recorded as 'unknown', from 754 in 2022 to 650 in 2023 and 626 in 2024.
- Staff with a declared disability within the medical workforce remains very low, particularly the consultant grade (currently 0.94% reduced from 1.63% in 2023).
- Whilst staff with a disability are under-represented at Executive and Board level within non-voting, they are positively represented in voting and Non-Executive Director groups.

Recruitment

- Applicants without a disability are 1.26 times more likely to be appointed compared to applicants with a disability, this has increased from 1.15 in 2023.
- This is likelihood of appointment from shortlisting of 0.16 for those with a disability, compared to 0.21 for those that did not indicate they had a disability.

Workforce Disability Equality Standard (WDES)

Executive Summary cont.

Harassment, Bullying and Abuse

- There has been a reduction in the percentage of staff experiencing harassment, bullying and abuse from patients/service users and from colleagues but that trend does not follow for managers.
- 21.1% of staff with a disability reported HBA from managers. This is 5.8% above the national average(15.3%).

Beliefs about equal opportunities, career progression and promotion

- Fewer staff with a disability believe the trust provides equal opportunities with regards to career progression and promotion – with percentage reducing from 44.7% in 2023 to 41.5% in 2024.
- The gap in perceptions between the groups has widened – from 6% in 2023 to 8.5% in 2024.

Capability

- Staff with a disability are 4.08 times more likely to enter the capability process compared to staff that do not have a disability. This high likelihood is due to the relatively low numbers of staff with a declared disability.
- As a percentage of each group 0.26% of the workforce with a disability have entered the process, reducing from 0.57% last year, compared to 0.06% of the workforce that do not have a declared disability.

Feeling pressure to go to work when unwell (presenteeism)

- There has been a reduction in the number of staff with a disability who reported feeling pressure to come into work despite not feeling able to carry out their duties – from 32% in 2023 to 29% in 2024.
- Whilst this was also reported in previous years, this year the gap between staff with a disability and staff without a disability is at its lowest at 5.3% - a 4.3% drop from 2023 where it was 9.6%.
- Staff without a disability report feeling slightly *more pressured* compared to previous years.

Feeling that work is undervalued

- Whilst both groups report an improvement in rates of feeling valued by the organisation, staff with a disability are still much less likely to feel that their work is valued.
- 31.3% of staff with a disability who responded to the Staff Survey said they felt the organisations valued their work - compared to 43.6% of staff without a disability. The gap between the two groups has worsened in the past year – currently at 12.3% (increased from 10.6% in 2023).

Adjustments in the workplace

- Only 68.9% of staff with a disability felt that reasonable adjustments had been made to enable them to carry out their work. This improved by 7.2% points compared to last year.
- Last year, St George's was 10.7% behind the national average figure in this indicator. Progress in this area has reduced the gap to just 4.4% in the last 12 months.

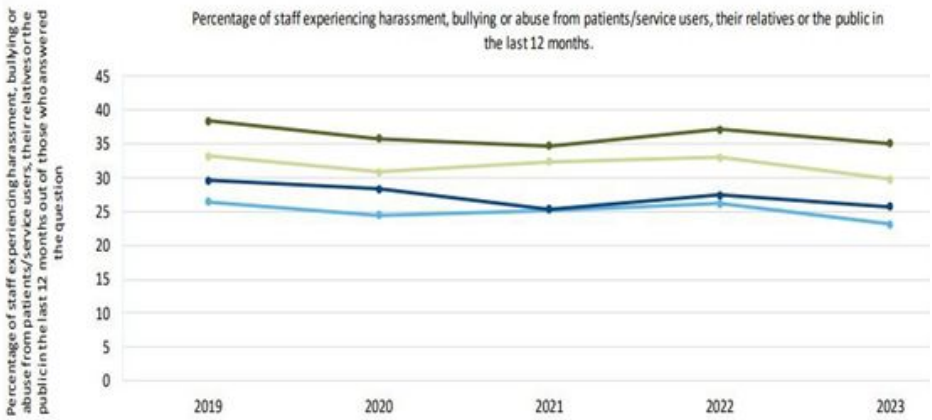
Workforce Disability Equality Standard (WDES)

Indicator overview – St George's

Metric	Description	Staff with a disability					Staff without a disability				
		2021	2022	2023	2024	23 vs. 24	2021	2022	2023	2024	23 vs. 24
1	% Disabled staff in AfC pay-bands (or medical and dental subgroups and VSMs) compared with the percentage of staff in the overall workforce (for both clinical and non-clinical groups)	2.3%	2.9%	3.5%	3.7%	Improved	90%	89%	90%	90%	N/A
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.08	1.21	1.15	1.26	Declined					
3	Relative likelihood of Disabled staff compared to non-disabled staff entering the formal capability process, as measured by entry into the formal capability procedure	0	4.78	4.26	4.08	Improved					
4a.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from patients/ service users	35.8%	34.8%	37.1%	35.1%	Improved	28.4%	25.3%	27.5%	25.8%	Improved
4b.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from managers	23.5%	21.1%	20.1%	21.1%	Declined	13.1%	10.0%	11.7%	12.6%	Declined
4c.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from other colleagues	34.4%	31.6%	32.1%	29.3%	Improved	20.9%	17.8%	19.9%	19.5%	Static
4.d	Staff Survey Q14: % of staff saying that the last time they experienced harassment, bullying or abuse at work, they or a colleague reported it	49.2%	47.9%	44.3%	50.7%	Improved	47.7%	46.2%	45.7%	51.1%	Improved
5	Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion	42.7%	40.1%	44.1%	41.5%	Declined	50.1%	48.4%	50.4%	50.0%	Static
6	Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties	35.1%	35.2%	32.0%	29.0%	Improved	25.8%	23.8%	22.4%	23.7%	Declined
7	Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work	34.9%	31.0%	29.9%	31.3%	Improved	49.1%	42.2%	40.5%	43.6%	Improved
8	Staff Survey Q28b: % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	71.5%	63.0%	61.7%	68.9%	Improved					
9	The staff engagement score for Disabled staff, compared to non-disabled staff	6.6	6.2	6.3	6.3	Static	7.1	6.9	6.9	6.9	Static
10	% difference between the organisation's Board voting membership and its organisation's overall workforce with a declared disability	-2.0%	-3.0%	5.6%	14.0%	Improved					

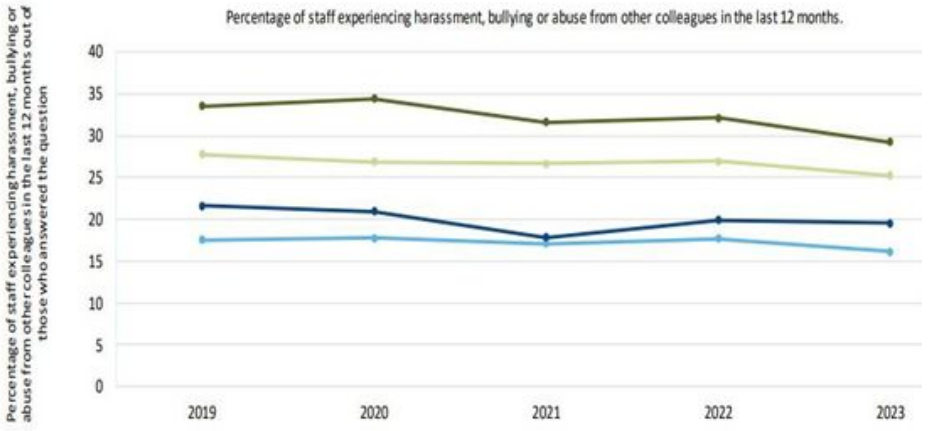
Workforce Disability Equality Standard (WDES)

Indicator 4a and 4b



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	38.40%	35.81%	34.76%	37.11%	35.06%
Staff without a LTC or illness: Your org	29.59%	28.38%	25.35%	27.47%	25.79%
Staff with a LTC or illness: Average	33.17%	30.86%	32.43%	32.98%	29.83%
Staff without a LTC or illness: Average	26.45%	24.53%	25.19%	26.16%	23.11%

- HBA from patients/service users (4a) is down 2.05 % points on the previous year and significantly higher than colleagues without a disability (+9.27%). Both reported rates at STG are higher than the national average.

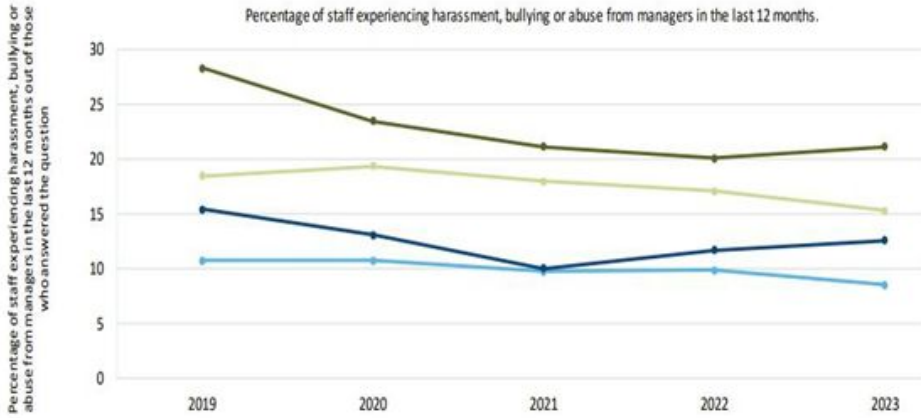


	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	33.52%	34.43%	31.58%	32.15%	29.26%
Staff without a LTC or illness: Your org	21.57%	20.92%	17.82%	19.86%	19.51%
Staff with a LTC or illness: Average	27.71%	26.89%	26.60%	26.93%	25.26%
Staff without a LTC or illness: Average	17.51%	17.79%	17.11%	17.67%	16.12%

- HBA from colleagues (4c) is down 2.8% points at 29.26% however this is still significantly higher than reported rates from staff without a disability (19.51%). Both reported rates at STG are higher than the national average.

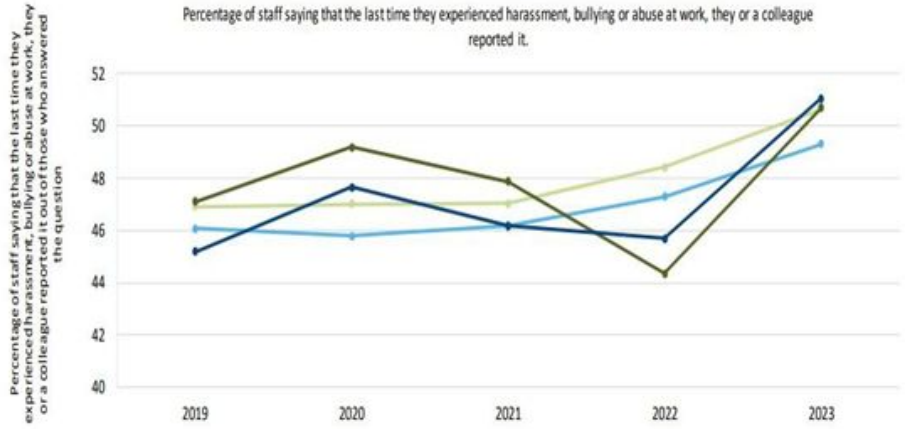
Workforce Disability Equality Standard (WDES)

Indicator 4c and 4d



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	28.30%	23.49%	21.16%	20.09%	21.12%
Staff without a LTC or illness: Your org	15.41%	13.11%	10.05%	11.68%	12.57%
Staff with a LTC or illness: Average	18.45%	19.35%	18.00%	17.09%	15.33%
Staff without a LTC or illness: Average	10.76%	10.78%	9.77%	9.88%	8.56%

- HBA from managers (4b) is up 1.3% points, and remains significantly higher than colleagues without a disability. Both reported rates at STG are higher than the national average.



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	47.10%	49.18%	47.88%	44.34%	50.68%
Staff without a LTC or illness: Your org	45.19%	47.66%	46.17%	45.69%	51.06%
Staff with a LTC or illness: Average	46.92%	47.01%	47.03%	48.43%	50.64%
Staff without a LTC or illness: Average	46.07%	45.80%	46.20%	47.30%	49.31%

- Reporting HBA has increased by 6.4% points compared to 2023. Both staff with a disability and those without reports similar rates (50.7% and 51.1% respectively).

Workforce Disability Equality Standard (WDES)

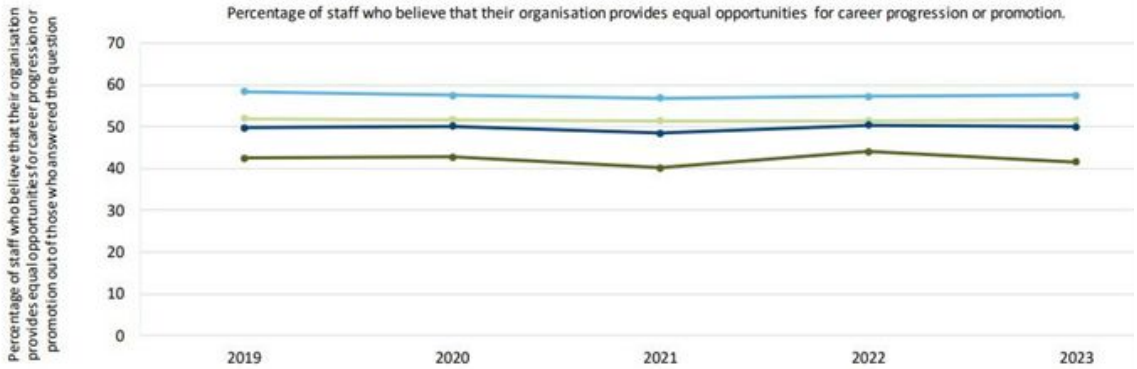
Indicator 5

Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion

Beliefs about equal opportunities, career progression and promotion

- Fewer staff with a disability believe the trust provides equal opportunities with regards to career progression and promotion – with percentage reducing from 44.7% in 2023 to 41.5% in 2024.
- The gap in perceptions between the groups has widened – from 6% in 2023 to 8.5% in 2024.

Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	42.42%	42.71%	40.11%	44.08%	41.51%
Staff without a LTC or illness: Your org	49.75%	50.06%	48.42%	50.36%	50.02%
Staff with a LTC or illness: Average	51.93%	51.61%	51.41%	51.39%	51.54%
Staff without a LTC or illness: Average	58.39%	57.45%	56.84%	57.25%	57.52%

Workforce Disability Equality Standard (WDES)

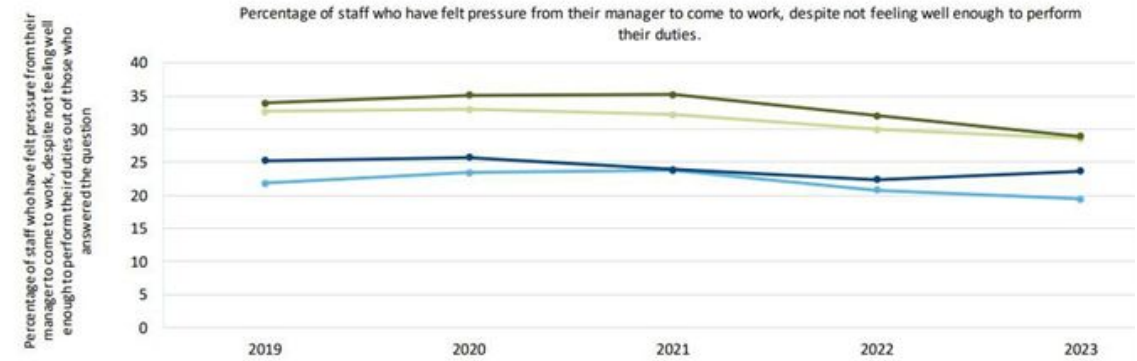
Indicator 6

Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

Feeling pressure to go to work when unwell (presenteeism)

- There has been a reduction in the number of staff with a disability who reported feeling pressure to come into work despite not feeling able to carry out their duties -3% compared to last year.
- Whilst this was also reported in previous years, this year the gap between staff with a disability and staff without a disability is at its lowest at 5.3% - a 4.3% drop from 2023 where it was 9.6%.
- Staff without a disability report feeling slightly *more pressured* compared to previous years

Staff Survey Q11: % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	33.97%	35.14%	35.22%	32.04%	28.95%
Staff without a LTC or illness: Your org	25.28%	25.80%	23.91%	22.40%	23.66%
Staff with a LTC or illness: Average	32.66%	33.00%	32.18%	29.97%	28.55%
Staff without a LTC or illness: Average	21.84%	23.44%	23.74%	20.80%	19.46%

Workforce Disability Equality Standard (WDES)

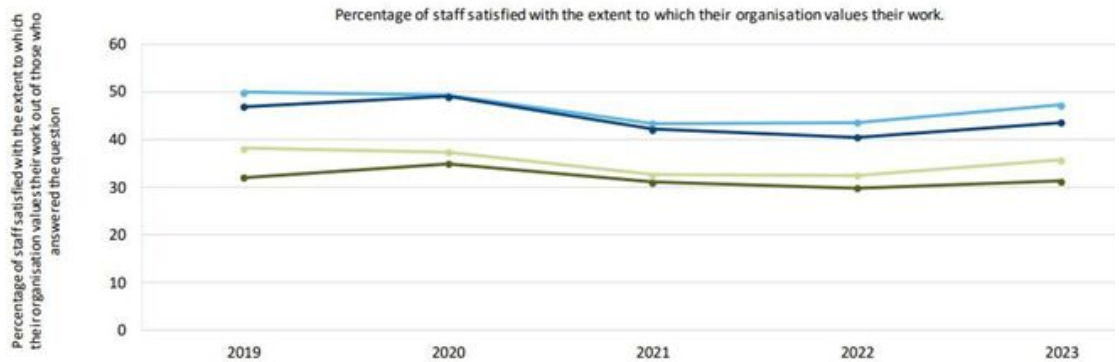
Indicator 7

Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work

Feeling that work is undervalued

- Whilst both groups report an improvement in rates of feeling valued by the organisation, staff with a disability are still much less likely to feel that their work is valued.
- 31.3% of staff with a disability who responded to the Staff Survey said they felt the organisations valued their work - compared to 43.6% of staff without a disability. The gap between the two groups has worsened in the past year – currently at 12.3% (increased from 10.6% in 2023).

Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work



	2019	2020	2021	2022	2023
Staff with a LTC or illness: Your org	32.02%	34.89%	30.99%	29.85%	31.27%
Staff without a LTC or illness: Your org	46.92%	49.05%	42.14%	40.45%	43.57%
Staff with a LTC or illness: Average	38.11%	37.36%	32.62%	32.46%	35.66%
Staff without a LTC or illness: Average	49.92%	49.27%	43.30%	43.56%	47.19%

Workforce Disability Equality Standard (WDES)

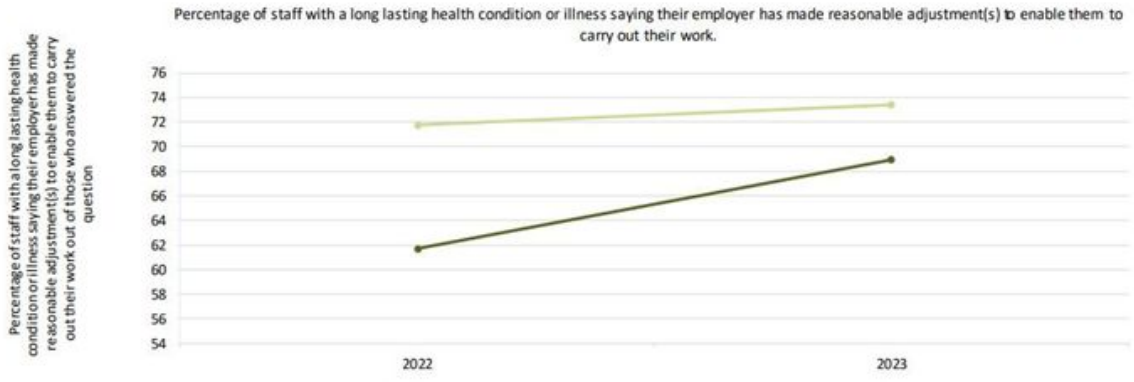
Indicator 8

Staff Survey Q28b: % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work

Adjustments in the workplace

- Only 68.9% of staff with a disability felt that reasonable adjustments had been made to enable them to carry out their work. This improved by 7.2 percentage points compared to last year.
- This is lower than the national average of 73%.
- Last year, St George's was 10.7% behind the national average figure in this indicator. Progress in this area has reduced the gap to just 4.4% in the last 12 months.

Staff Survey Q28b: % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work



	2022	2023
Staff with a LTC or illness: Your org	61.69%	68.89%
Staff with a LTC or illness: Average	71.76%	73.38%

Workforce Disability Equality Standard (WDES)

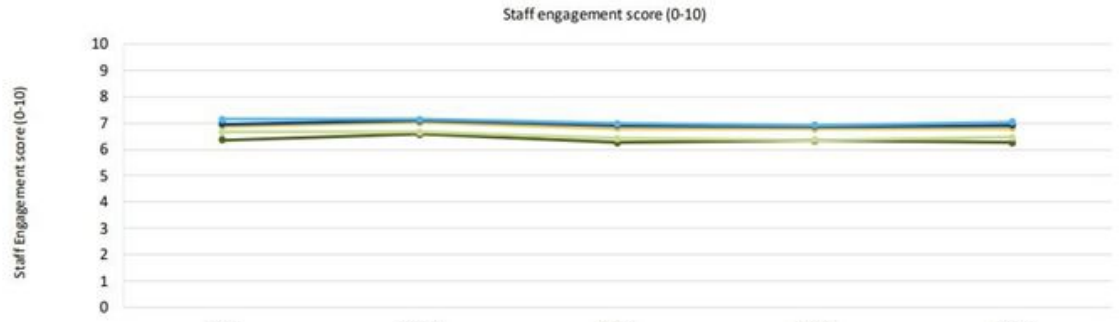
Indicator 9

Staff Survey: The staff engagement score for Disabled staff, compared to non-disabled staff

Engagement

- The overall indicator trend for engagement is stable. The overall is 6.80, compared to 6.26 for those with a disability and 6.92 for those without a disability.
- The national average is slightly higher for those with a disability at 6.46, compared to 6.26 at St George's.
- The staff engagement score is made up of three broad measures, outlined in more detail below:
  - ✓ motivation (related to individual job)
  - ✓ involvement (at ward and wider level)
  - ✓ advocacy (willingness to recommend the organisation as a place to work and to be treated).

Staff Survey: The staff engagement score for Disabled staff, compared to non-disabled staff



	2019	2020	2021	2022	2023
Organisation average	6.87	7.01	6.80	6.78	6.80
Staff with a LTC or illness: Your org	6.35	6.58	6.25	6.33	6.26
Staff without a LTC or illness: Your org	6.95	7.09	6.91	6.87	6.92
Staff with a LTC or illness: Average	6.65	6.65	6.42	6.35	6.46
Staff without a LTC or illness: Average	7.13	7.14	6.97	6.92	7.04

Workforce Disability Equality Standard (WDES)

Indicator 10

% difference between the organisation's Board voting membership and its organisation's overall workforce

As of 31 March 2024, the Trust Board of Directors comprised 15 members, two of whom have declared a Disability (one executive director and one non-executive director).

Of this, the Board comprised 11 voting members, seven of whom were non-executive directors and 4 were executive directors. Of these 11 voting members of the Board, two voting Board members have a declared disability. This means staff with are positively represented at all level, including Board overall (+13.33%) and Board voting (+18.8%).

Two further Board appointments will be made to the Board by December 2024, the Trust Chair and a Non-Executive Director, both voting positions on the Board. In discussion with the Council of Governors, it has been agreed that identifying a strong and diverse field of candidates is a key priority in these upcoming appointments processes. The roles are being advertised to ensure a diverse field and the search firms supporting the appointments have been asked by the Trust to actively seek applications from across the protected characteristics.

The trust is committed to appointing to ensuring future appointments to all Board level roles (executive and non-executive) are appropriately targeted to ensure a diverse range of candidates.

Metric	Indicator		Measure	# Disabled	% Disabled	# Non-disabled	% Non-disabled	# Unknown/Null	% Unknown/Null	Total
10	Percentage difference between the organisation's Board voting membership and its organisation's overall workforce, disaggregated: • By Voting membership of the Board • By Executive membership of the Board This is a snapshot as of at 31st March 2024.	Total Board members	Headcount	2	13.33%	12	80.00%	1	6.67%	15
		of which: Voting Board members	Headcount	2	18.18%	8	72.73%	1	9.09%	11
		: Non Voting Board members	Auto-Calculated	0	0.00%	4	100.00%	0	0.00%	4
		of which: Exec Board members	Headcount	1	12.50%	7	87.50%	0	0.00%	8
		: Non Executive Board members	Auto-Calculated	1	14.29%	5	71.43%	1	14.29%	7
		Difference (Total Board - Overall workforce)	Auto-Calculated		10%		-10%		1%	
		Difference (Voting membership - Overall Workforce)	Auto-Calculated		14%		-18%		3%	
		Difference (Executive membership - Overall Workforce)	Auto-Calculated		9%		-3%		-6%	

Workforce Disability Equality Standard (WDES)

Next Steps

Our existing Culture and D&I Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix b) and aligned to our People Strategy. **This has identified six gesh EDI workstreams for 2024-26**.

Following publication of our WRES and WDES Reports in late October 2024 we will commence a final review and Board approval of the specific actions which will enable us to deliver against our People Strategy and NHSE's EDI Improvement Plan.

An overview of these action plans will be published shortly.

Fig 1: Our 2024-2026 People Priority Domains

Leadership Commitment

- High Impact Action 1: Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Inclusive Recruitment and Talent Managment

- High Impact Action 2: Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity

Eliminating pay gaps

- High Impact Action 3: Develop and implement an improvement plan to eliminate pay gaps

Improving Health and Wellbeing

- High Impact Action 4: Develop and implement an improvement plan to address health inequalities within the workforce

Supporting Internationally Recruited Staff

- High Impact Action 5: Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff

Safeguarding our Workforce

- High Impact Action 6: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and physical violence at work occur

Workforce Disability Equality Standard (WDES)

Appendix A: Legal Obligations and Disability

Legal Obligations of Employers and Workplace Adjustments (formerly Reasonable Adjustments)

Protection against disability-based discrimination is enshrined in the Equality Act 2010. Due to the additional barriers faced by people with a disability, it is permitted to treat applicants with a disability more favourably than their colleagues without a disability. Understanding this, and the reasons for it, is crucial to removing the barriers that continue to deny people with a disability equality of outcome in work and more broadly.

The Equality Act 2010 protects employees, and covers areas including recruitment, assessment and selection, terms of employment, promotion and training opportunities, dismissal or redundancy, and discipline and grievances. The Equality Act 2010 also requires that reasonable adjustments (now 'workplace adjustments' are made to working conditions, policies and practices that put a staff member with a disability at a disadvantage. A workplace adjustment could include any of the following:

- making adjustments to premises or acquiring/modifying equipment
- providing a reader or interpreter, or employing a support worker
- reallocating an employee with a disability's duties to another person
- providing supervision, training, mentoring or other support
- transferring a person to fill an existing suitable vacancy without competitive interview
- altering working hours or the place of work
- allowing someone to be absent during working hours for rehabilitation, assessment or treatment
- modifying procedures for testing or assessment

Useful checklists and further detail on the legal obligations can be found in the Guidance relating to disability for the NHS document, published by NHS Employers. This guidance document also sets out examples of good practice (when not legally obligated), particularly around the supporting carers and disability related absence from work.

What is 'disability'?

Defining 'disability' is not always straightforward. The Equality Act 2010 defines a person with a disability as:

"someone who has a mental or physical impairment that has a substantial and long-term adverse effect on the person's ability to carry out normal day-to-day activities."

Some of the terms in this definition are open to interpretation, and further guidance is found in Appendix C. However, instead of trying to judge whether a person falls within the statutory definition of disability, we should focus on meeting the needs of the worker (or job applicant). In supporting a staff with a disability, it is almost always more important to understand and support the effects of a disability rather than the cause.

It is important to note that the definition of disability regards the person as they are without aids, support or medication (the exception being visual impairment where it can be addressed by use of wearing prescription spectacles). This is particularly relevant for those with mental health conditions who are able to control their condition with medication, and also for those with conditions such as epilepsy and diabetes that are otherwise controlled by medication.

Additional information on the definition of disability is attached in Appendix C, taken directly from guidance produced and published by NHS Employers. This guidance was published in 2014. We will continue to closely monitor best practice and guidance and communicates updates as necessary.