Group Board

Agenda

Meeting in Public on Friday, 10 November 2023, 09:45 – 13:00

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

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:45	-	Feedback from visits to various parts of the site	Board members	-	Verbal

Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:30	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	Chairman	Approve	Verbal
	1.4	Action Log and Matters Arising	Chairman	Review	Verbal
10:35	1.5	Group Chief Executive Officer's Report	GCEO	Review	Verbal

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:45	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	Infrastructure Committees-in-Common Report	Committee Chair	Assure	Report
	2.5	SGUH Audit Committee Report	Committee Chair	Assure	Report
	2.6	ESTH Audit Committee Report	Committee Chair	Assure	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:25	3.1	Maternity Services Report	GCNO	Review	Report
11:40	3.2	Equality, Diversity and Inclusion Report: • WRES Action Plan • WDES Action Plan	GCPO	Review	Report
11:50	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report
12:10	3.4	Finance Report (Month 6, 2023/24)	GCFO	Review	Report

Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:20	4.1	Group Board Assurance Framework 2023/24: Strategic Risks	GCCAO	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	5.1	Group Learning from Deaths Report, Q1 2023/24	GCMO	Note	Report
	5.2	Healthcare Associated Infection Report	GCNO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	6.1	New Risks and Issues Identified	Chairman	Note	Verbal
	6.2	Any Other Business	All	Note	Verbal
	6.3	Reflections on the Meeting	Chairman	Note	Verbal
12:40	6.4	Patient / Staff Story	GCNO	Review	Verbal
13:00	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

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

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

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

Minutes of Group Board Meeting

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

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

PRESENT		
Gillian Norton	Chairman – ESTH and SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Lizzie Alabaster	Site Chief Finance Officer – ESTH (*Deputising for GCFO*)	SCFO-ESTH
Andrew Asbury*^	Group Chief Infrastructure, Facilities & Environment Officer	GCIFEO
Ann Beasley	Non-Executive Director – ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Stephen Collier	Non-Executive Director – SGUH	SC
Chris Elliott*	Associate Non-Executive Director – ESTH	CE
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones^	Associate Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Martin Kirke	Non-Executive Director – ESTH	MK
Derek Macallan	Non-Executive Director	DM
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Aruna Mehta	Non-Executive Director – ESTH	AM
Nicole Porter-Garthford	Deputy Chief People Officer (*Deputising for GCPO*)	DCPO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
IN ATTENDANCE		
Deirdre LaBassiere	Deputy Director – Corporate Governance	DD-CG
Anna Macarthur	Director of Communications and Engagement	DCE
APOLOGIES		
Paul da Gama*^	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Andrew Murray	Non-Executive Director - SGUH	AM
OBSERVERS		
Alfredo Benedicto	SGUH Appointed Governor, Merton Healthwatch	ABen
Sarah Forrester	SGUH Appointed Governor – Healthwatch Wandsworth	SF
Richard Mycroft	SGUH Governor – South West Lambeth	RM
Huon Snelgrove	SGUH Staff Governor – Non-Clinical	HS

** 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 on the visits undertaken across the site: South West London Elective Orthopaedic Centre (SWLEOC), Gloucester Ward, Intensive Care Unit (ITU) and Coronary Care Unit (CCU), Casey and Ebbisham Wards, Neonatal Unit, Labour Ward, Birth Centre, and Buckley and Swift Wards.

SWELOC: Ann Beaseley, Jenny Higham, Aruna Mehta and the GDCEO
Board members reported that they were impressed by the facility, particularly the positive environment for patients and staff. The sense of pride shared by very energised staff was evident. Board members discussed with staff two recent Serious Incidents (SIs). These had been fully investigated and learning had been identified and disseminated. While the SIs had taken place over a short period of time, Board members were told that this was coincidental and no link between the two had been identified. Quality control issues relating to packaging were raised by staff, and it was suggested this be followed up by the Estates and Facilities team. The importance of Board-to-ward visits was also discussed.

Gloucester Ward, ITU and CCU: Phil Wilbraham, Chris Elliott, Andrew Asbury, James Marsh
Staff had reported they were pleased that Board members were visiting and expressed appreciation that their efforts were being acknowledged. Board members commented on the environment in Gloucester Ward, noting its cleanliness but also its design contributed the ward feeling cluttered with equipment. Board members were impressed by the strong sense of team cohesion on Gloucester Ward and with the supportive environment for junior doctors. A newly-qualified doctor had commented on the great team spirit and added that she enjoyed working on the Ward. Staff also reported that the multi-disciplinary team on the Ward worked effectively, with input from all members of staff. Challenges around staffing were highlighted, particularly relating to nurses in CCU and therapists in Gloucester Ward. Staff raised the issue of bank pay, noting that some bank staff were not prepared to work bank shifts unless they were paid at their substantive banding. Issues around the physical environment were also raised. Temporary air conditioning would help address problems with heat but this would pose challenges in terms of infection prevention and place additional burdens on the power supply.

Casey and Ebbisham Wards: Martin Kirke, Stephen Collier, James Blythe
Board members commented that there were some recurrent themes across the visits, highlighting that issues around staffing and the physical environment had been raised on this visit. Ebbisham Ward was commended for handling complex patients well. The Ward was tidy and well-organised but Board members commented that it was extremely hot around, particularly the reception area and there were air conditioning units. On staffing, sickness absence and maternity leave was a challenge that affected smaller wards such as Ebbisham, which placed particular pressures on the team. On Casey Ward, an in-patient paediatric unit with a largely medical case load, Board members commented that the ward was clean and staff were enthusiastic, friendly, and well-organised. The ward looked and felt engaging for younger patients although the poor condition of the bathroom was highlighted. While staff were keen to highlight their ability to flex staffing to manage peaks in demand, they commented on a number of staffing issues, including that their healthcare assistant had been taken away to support other non-clinical work as well as a concern that staff bank rates had not been adjusted to reflect the substantive NHS pays awards and that this had presented some challenges with filling bank shifts.

Neonatal Unit, Labour Ward and Birth Centre: Derek Macallan and Arlene Wellman
Board members had been made to feel very welcome at the Neonatal Unit, Labour Ward and Birth Centre. All areas were well organised and tidy with a positive team atmosphere. Staff reflected on the inspection by the Care Quality Commission (CQC) the previous week. Board members heard that the maternity triage area was very small and was able to accommodate only two people at a time. Staff also commented on the location of the bereavement room and the location of the theatre area as estates issues that required consideration. Very positive feedback had been provided by a patient who commented on how well she had been supported by the team. Concerns were raised about IT systems,

particularly relating to the challenges senior clinicians had experienced in organising the payment system for the private rooms. Staff commented that this was an inefficient use of clinicians' time but also impacted on the Trust's income given the difficulties in ensuring payments were made. Staff had suggested that midwives take on scrub roles in theatre to be more flexible in the use of staffing and the Director of Midwifery was exploring this.

Community Ward, Langley Wing: Gillian Norton, Yin Jones and Lizzie Alabaster
The Community Ward was a mixed ward for acute end of life care and community for people who were typically able to go home within days. It was a new ward that had received significant financial investment and was recognised by Board members for its cleanliness and friendly staff. Estates issues highlighted included signage which was said to be disorientating, non-functional fire doors and computer placement. Staff had previously raised concerns regarding difficulties in securely locking the drugs cupboard but this had now been fixed. The staffing environment was very positive, and Board members heard from an international nurse about how well supported she had felt. The Chairman commented on the valuable contribution of the ward, which from a cost-benefit perspective could have wider lessons across the NHS. The MD-IC confirmed that she could share the analysis undertaken by Surrey Downs and Healthcare Partnership and bring this through the appropriate Committee.

Buckley and Swift Wards: Kate Slemeck, Tim Wright and Peter Kane
Board members provided an overview of Swift Ward, a fully-staffed surgical elective ward with 22 beds of six-bedded bays and four side wards, and reported that the ward was spacious and tidy. The ward primarily served day patients but also cared for patients who had undergone bowel operations and gynaecological procedures. Staff reported that they were proud of the friends and family test scores achieved, with a 99% positive score, but highlighted concerns regarding the availability and reliability of medical equipment. Buckley Ward was the largest ward at ESTH. Bed capacity was a particular challenge given the average stay for patients was one month but often extended well beyond this and the difficulties in discharging medically fit patients was particularly acute. The matron reported that there had been a reduction in the use of agency staff over the last twelve months but staff sickness remained a challenge. In terms of estates, lack of storage for equipment such as hoists and also for drugs was highlighted as a particular concern and Board members commented that the ward felt cluttered. The matron had commented on the work being undertaken to explore the possibility of splitting the ward into two 20-bedded wards, and suggested this would be welcome.

The Chairman thanked Board members for the feedback. She also commented that it would be useful for the Board to receive a note from the MD-ESTH about the potential split of Buckley Ward when the business case had been finalised.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies.	
1.2	**Declarations of Interest**	
	The standing interests in relation to the 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 declared and noted by the two Trust Boards: • Gillian Norton as Group Chairman; • Ann Beasley and Peter Kane as Non-Executive Directors;	

	• Jacqueline Totterdell, Andrew Asbury, Richard Jennings, Stephen Jones, James Marsh and Arlene Wellman, as Executive Directors. There were no additional declarations of interest.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 7 July 2023 were approved as a true and accurate record, subject to one minor correction relating to the section on Board visits. Instead of "Outpatients (Clinic 1 and Freddie Hewitt Ward)", the minute should read, "Freddie Hewitt Ward and Outpatients (Clinic 1)" and Derek Macallan's name should be added to the list those attending.	
1.4	**Action Log and Matters Arising**	
	The Board reviewed and noted the Action Log, received the following updates, and agreed to close those actions proposed for closure: • **PUBLIC230707.1 – Mental health patients presenting at Emergency Departments (ED):** The GCEO explained that she had spoken to system partners and to the Borough Commander regarding the challenge of patients with mental health concerns presenting in ED. This remained an area of significant concern across the Group and actions were being explored to deal with the safety challenges presented. The Board agreed to close the specific action and noted that the Quality Committees-in-Common were continuing to actively review the safety aspects of this issue and would escalate issues to the Group Board as appropriate. • **PUBLIC230707.3 – HR policies:** The GCPO advised that work was ongoing to review and bring up-to-date the HR policies across the two Trusts. The People Committees-in-Common were scheduled to discuss this matter later in September and would continue to monitor this. On this basis the Group Board agreed to close the action at Board level.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO presented the report and reflected on both the sustained operational pressures faced by staff across the Group and the implications of the verdict in the trial of Lucy Letby and the events at the Countess of Chester Hospital. Everyone had been shocked by the horrific criminal acts that had been perpetrated and it was important that organisations reflected on how they could be assured of the safety of their services. The GCEO reflected on the disappointing outcome of the CQC inspection of maternity services at SGUH and the steps that had been taken to address the areas of concern highlighted. The service continued to be safe and was a positive environment for women to give birth in, as had been recognised by the CQC national patient experience survey, but there were issues around staffing, triage, estates and governance that needed to be addressed and improved. The following points were raised and noted in discussion: • Phil Wilbraham enquired about preparations being made for the upcoming combined industrial action by junior doctors and consultants. The MD-SGUH commented that considerable planning was being undertaken. The combined action made planning more straightforward as the activities that could be undertaken were clear. However, the knock-on impact elective work would be	

	significant and would result in large numbers of cancelled and delayed appointments. This presented risks in terms of patient harm and in terms of the impact on the elective backlog, which would be seen through the Integrated Quality and Performance Report (IQPR). Staff well-being remained a concern, particularly as there were some signs of tension and frustration. The impact on administrative staff should not be underestimated, given the need to repeatedly cancel and rebook patients. The MD-ESTH added that planning at service and divisional level was essential to managing the challenges and the priority was to keep each ward and service safe. • Jenny Higham expressed concerns about the mounting pressures on senior managers in the current context. The GCEO acknowledged the pressures on senior managers were particularly acute and emphasised the importance of appropriate support. She explained that she regularly checked in with staff and managers to provide support, and added that support from the Board was also crucial. The Chairman commented that she recognised huge strain on staff at the present time and emphasised that the Board will continue to offer appropriate support and supportive challenge. • Yin Jones asked about support for staff who face cultural barriers to speaking up. The GCCAO highlighted the importance of addressing these barriers and referenced the work of the Freedom To Speak Up (FTSU) teams in working with staff networks and with groups of staff in which few or no concerns were raised to understand the barriers they faced in raising concerns. More broadly, the culture programme was critical in building psychological safety. The GCMO added that local departmental initiatives were important and highlighted how a recent meeting of the Justice, Equality, Diversity and Inclusion (JEDI) at St George's had provided an electronic means of providing feedback in an anonymised way. • Chris Elliott inquired about the implications of Patient Safety Incident Response Framework (PSIRF). The GCEO acknowledged the scale of the change brought about by the new framework, placing far greater emphasis on themes and lessons learnt. The GCNO emphasised PSIRF held out great promise but acknowledged that it was important for the Board to understand how it could receive effective assurance under the new framework. The Board noted the Group Chief Executive's report.	
2.0	**ITEMS FOR REVIEW**	
2.1	**Maternity Services Report**	
	The GCNO introduced the report, which provided an update on the actions taken to respond to the concerns raised by the CQC following its inspection of maternity services at SGUH in March 2023, the development of a wider maternity services action plan, and progress in relation to locally and nationally agreed safety measures for maternity, including the compliance status for both Trusts with the NHS Resolution Maternity Incentive Scheme (MIS). The GCNO briefed the Board on the following items: • Actions to address the issues set out in the CQC's Section 29A Warning Notice had been completed and responses given to the CQC, with the exception of the maternity establishment which was currently being worked	

through and would be completed in September. The Trust was addressing the 15 “Must Do” actions and wider improvement actions were being implemented.

- Staffing had been a major area of focus and significant work had been undertaken to improve fill rates. There was an emphasis on ensuring a supervisory midwife was in place for every shift who would oversee activity on the birth centre, delivery suite and triage.
- The external MBRRACE review of the maternal and neo-natal deaths, which had been commissioned by the Board earlier in the year, was scheduled to be completed by end of October 2023.
- To strengthen assurance reporting on maternity services, the structure and format of the maternity services report had been revised in order to provide a more focused and data-based approach.
- Both Trusts had declared non-compliance with the MIS for Year 4. Year 5 data collection was underway but across the 10 safety actions under the scheme, both Trusts were currently reporting non-compliance across a number of areas, including transitional care and midwifery workforce planning and there were risks to compliance across a number of other safety actions.
- A CQC inspection of ESTH maternity services had taken place at the end of August 2023. High level feedback had been received the previous day and the Trust awaited receipt of the draft inspection report.

The following issues were raised and noted in discussion:

- Ann Beasley asked about the assurance the Group Board could take regarding the safety of mothers and babies attending the maternity services across the Group in the context of the two Trusts’ non-compliant positions in relation to the MIS. The GCNO clarified that the services provided at both Trusts were safe, and that the safety data from the services confirmed this. The safety actions in the MIS were important improvement actions, but non-compliance – though clearly important – did not demonstrate the absence of safe care. Actions were being taken to address the non-compliant areas, particularly in relation to transitional care and workforce planning.
- In relation to the action plans, Peter Kane enquired about amber and green ratings and delivery timelines and about the wider mitigation of risk. The GCNO clarified that all actions had been progressed, with the establishment review as the only outstanding item. This would be presented to the Quality Committees-in-Common in November 2023 and the Board could take assurance through this.
- Chris Elliot asked about the collection of case notes to review still birth rates at SGUH. The GCNO explained that some notes were missing and a report acknowledging this would be produced.
- Jenny Higham expressed concern about the disconnect between the assurance the Board had previously taken about the position of the service following the Ockenden visit and the issues identified by the CQC. The GCNO noted that the quality governance review would assist in exploring this. The Trust had secured the support of the NHS England Maternity Safety Support Programme (MSSP) and this would assist the service and the Board to understand the steps needed to improve the service and the quality of information and assurance presented to the Executive and Board.

	• The Chairman highlighted the challenge of defining a safe service and added that it was important to recognise that there was no nationally agreed set of metrics by which to measure the performance of maternity services. This would be discussed at a special Board development session in October. • The GCEO acknowledged that the CQC report on the SGUH maternity service had been very disappointing and considerable work had been undertaken to examine the issues within the service. The GCEO herself had personally spent considerable time examining the issues that had led to the inspection findings. Stepping back, the experience demonstrated the importance of triangulating data and this was why she was committed to developing a heatmap of services which drew together key sources of hard and soft data that could support the Executive and Board in understanding the underlying position of services, particularly those facing challenges. • Aruna Mehta underlined the interconnectedness of the quality governance and the cultural reviews. The GCEO agreed and explained that these elements would be combined, and that she and the Chairman had been exploring how to take the quality governance review forward given the constraints of the triple lock on expenditure. It was hoped that an individual could be seconded to the Group to lead this work. The Group Board reviewed and noted the report, and agreed the Board could take limited assurance in relation to the SGUH maternity service in light of the CQC's findings, notwithstanding the improvement actions discussed, and that it could take reasonable assurance in respect of the ESTH service, pending the outcome of the CQC inspection. In addition, the Group Board: • Noted the current compliance status against the CNST year 5 MIS • Noted that the Quality Committee in Common and Board will receive regular updates regarding progress against the MIS • Noted the formal closure of the Section 29A Warning Notice Action Plan and the development of the new CQC maternity services action plan to address the 15 'Must Do' recommendations and 6 'Should Do' recommendations • Noted that a Board development session would be held the following month on maternity services with the input of the London Regional Midwife and the London Regional Obstetrician.	
2.2	**Group Integrated Quality and Performance Report (IQPR)**	
	The GDCEO introduced the report and acknowledged the continuing operational pressures. The elective waiting list remained a challenge, a consequence of the cancellations resulting from the industrial action. Diagnostic Performance remained strong at SGUH as was cancer performance at ESTH. Significant challenges remained in relation to non-elective care and the 76% Emergency Department (ED) waiting times standard for both Trusts had not been achieved for June, despite the fact that performance was generally among the strongest in London. The MD-SGUH added that, in terms of elective activity, RTT waiting lists had risen but not substantially. 52-week waits are on target in June. On diagnostics, SGUH had achieved 98.8% against the national standard of 95% in June. The Finance Committees-in-Common were scheduled to receive a deep dive on theatre productivity and the workstreams to address productivity challenges. On cancer, SGUH performance was relatively good but remained fragile. The backlog of	

patients waiting for more than 62 days for treatment, which had previously gone down to 90, had risen to 134. The Trust was running some successful 'perfect weeks' to refocus on a number of specific challenges and this initiative has received positive feedback. In relation to urgent and emergency care, the inability to achieve the 76% standard in June was attributable to higher activity, slower flow and longer length of stays. In relation to ambulance handovers, performance had been good overall if challenging. A 45-minute handover pilot was to be undertaken on behalf of South West London (SWL) Integrated Care Board (ICB) and the Trust was working with London Ambulance Service (LAS) and the ICB to set this up from 11 September. This had been trialled and was being used elsewhere.

The MD- ESTH explained that, in terms of electives, the overall waiting list had stabilised but some areas, such as dermatology and gynaecology faced specific pressures. Some changes to work undertaken by community paediatricians had been agreed and were expected to help and the gynaecology team were considering different ways to treat patients. In relation to diagnostics, ESTH faced challenges in high volume diagnostic areas such as endoscopy, ultrasound and echo-cardiography due to internal workforce issues. Cancer performance remained strong in the 62-day target for treatment. Industrial action and capacity issues within the consultant workforce had impacted the 14-day first appointment metric with ongoing challenges in gynaecology and dermatology. In relation to non-elective care, June had been a very challenging month. To mitigate some of the challenges, the Trust was reviewing internal pathways to improve flow. In relation to staffing, notwithstanding feedback from staff during the visits earlier in the day, the data showed continuous increase in bank fill.

The MD-IC provided an overview of performance across Surrey Downs and Sutton. There was a long wait for beds for Pathway 2, which related to people who needed to go to bedded care but not acute care. This was the result of a lack of rehabilitation capacity. Incremental improvements continued at Surrey Downs and initiatives have been arranged to support more robust improvements. Two virtual wards were currently in place for Sutton and Surrey Downs which were both well regarded and had received good feedback from clinicians, patients and carers.

The following points were raised and noted in discussion:

- On staffing, Martin Kirke commented that one of the benefits of the Group was the ability to make comparisons, and he enquired about the apparent increase in SGUH agency usage as compared with the falling usage at ESTH. The MD-SGUH acknowledged that ESTH was doing better in relation to agency usage and SGUH was seeking to learn from ESTH.
- Aruna Mehta enquired about venous thromboembolism (VTE), ward accreditation and mortality rates at ESTH. On VTE, the GCNO explained that work was ongoing to improve VTE rates and promote Group-wide sharing of learning. Ward accreditation was progressing well at ESTH. The new Group-wide heat maps would include data on ward accreditation and it was important all wards were included. Mortality rates at ESTH had been discussed at length at the Quality Committees-in-Common. The Hospital Standardised Mortality Ratio (HSMR) has declined and was now stable. The Summary Hospital-level Mortality Indicator (SHMI) appeared to have peaked and was starting to plateau. Actions were being taken to strengthen the critical care outreach team, and there remained a particular focus on mortality in ED.
- Ann Beasley commented that the framing of the covering report needed greater contextualisation, and suggested that the measures described as

	'successes' risked being misconstrued. The GDCEO agreed and stated that the appointment of a new Group Director of Performance would help to ensure more tailored summary reporting on performance. • Chris Elliot expressed concerns about patient-initiated follow-up (PIFU) pathways, noting differences between SGUH and ESTH. The GDCEO explained that SGUH was working to improve data capture for PIFU and to align this with ESTH. Some of the challenges at SGUH related to existing IT, coding and capture of data. The Group Board noted the report.	
2.3	**Finance Report (Month 4 2023/24)**	
	The SCFO-ESTH introduced the Month 4 2023/24 finance report, and commented that both Trusts remained on plan excluding the impact of industrial action. At SGUH, the Trust was reporting a deficit of £21.6m at the end of July, which was £7.1m adverse to plan with due to the impact of the industrial action and the Elective Recovery Fund (ERF) shortfall, which itself reflected the impact of industrial action. At ESTH, the Trust is reporting a deficit of £20.1m at the end of May, which was £2.2m adverse against plan, which was the result of the same factors. The Group Board noted the report and the month 4 financial position.	
3.0	**ITEMS FOR ASSURANCE**	
3.1	**Quality Committees-in-Common Report**	
	Aruna Mehta, Joint-Chair of the Quality Committees-in-Common, presented the report and provided an overview of the issues considered by the Committee at its meeting in July 2023. Maternity services had been a key focus, with the Committee seeking assurance in relation to the progress in implementing actions to address the areas of concern highlighted by the CQC at SGUH and in relation to the independent review of MBBRACE data at SGUH. The Committee had agreed it could take limited assurance in relation to the SGUH maternity service report given the CQC's findings and the need to implement fully the action plan to achieve the identified 'must' and 'should' do actions, as well as the need for the Committee to see the outputs of the MBBRACE review. In relation to ESTH maternity services, the Committee agreed it could take reasonable assurance. The Committee had held a detailed discussion regarding the challenges of mental health patients presenting at ED, and had reviewed data demonstrating the stark increases in the number of admissions. The Committee had agreed to revisit the issue and review action plans at a subsequent meeting, acknowledging that many of the solutions would require a system-wide response. The Committee had also reviewed the processes by which the Group was undertaking quality impact assessments (QIA) of the Cost Improvement Plans (CIPs), given the scale of the financial challenges facing the Group. The Committee received assurance that the QIA processes were robust and would ensure that safety was not compromised and that the quality impact of any CIP was understood. The Committee requested further details of the operation of the QIA process, including a summary of QIAs completed to date, and also requested quarterly updates on QIAs going forward. The Chairman commended the report for providing clear assurance to the Board. The report was accessible and of excellent quality and was a model for other Committees. The Board noted the update.	

3.2	**Finance Committees-in-Common Report**	
	Ann Beasley, Chair of the Committee, provided an update on the meetings held in July and August 2023. Both Trusts were on plan for CIPs in month 4, albeit with slightly more non-recurrent savings than originally planned. SGUH had £16.5m and ESTH £11.8m fully developed CIPs, against targets of £62.1m and £37.3m respectively. The level of challenge was reflected in the increased risk scores. The Committee had, as usual, reviewed operational performance, the key points of which had been discussed earlier in the meeting under the item on the IQPR. The Committee had also reviewed ICT and estates risks at its July meeting, though these would, in future, be covered by the new Infrastructure Committees-in-Common which was scheduled to meet for the first time in October 2023. The Board noted the update	
3.3	**People Committees-in-Common Report**	
	Stephen Collier, Joint Chair of the People Committees-in-Common, highlighted key issues considered by the Committee at its meeting in July. The Committee continued to monitor workforce metrics carefully, with a focus on sickness absence, vacancy and appraisal rates. These metrics had implications for both cost and service quality, affecting both corporate and frontline support functions. The Committee had received a detailed report on temporary staffing at SGUH between July 2022 and June 2023 and, overall, the Committee considered that it had received reasonable assurance on temporary staffing at SGUH and would continue to monitor use of bank and agency staff through the regular reporting on workforce key performance indictors and the workforce improvement plan. The Committee considered the net gain in the workforce establishment at both Trusts. This growth contradicted the CIP targets which aimed at reducing establishment. While recognising the tension between delivering cost improvement plans and the importance of reducing waiting lists, the Committee expressed concern about the misalignment between efficiency plans and the continued growth in establishment, particularly in the context of financial plans. Martin Kirke expressed concern about the impact of industrial action on working relationships. The MD-ESTH responded that the Trust was supporting staff who were experiencing pressure from staff other in relation to their choices to strike or not through three approaches: directly addressing the issue with specific staff; maintaining a positive relationship with the Local Negotiating Committee; and through clear messaging throughout the Trust about respect for people's choices which was continuously reinforced. In relation to the issue of staff retention, the GCEO observed that there was evidence across 25 hospitals where significant inroads had been made and it would be useful for the Group to understand what needed to be done and how improvements could be implemented. The Chairman invited the Executive to reflect how best to provide assurance to the Board, potentially through the development of a Retention Plan. The Board noted the update.	
3.4	**Audit Committee Report (SGUH)**	
	Peter Kane, Chair of the Audit Committee, introduced the report that set out the key issues discussed and agreed by the Committee at its meetings on 3 August 2023. A clean set of accounts had been submitted to the Committee earlier in the	

	year and these had subsequently been approved by the SGUH Board. The Committee had noted the progress of the internal audit plan and looked forward to receiving the first set of reviews from the new internal auditors later in the year. The Committee had reviewed a number of management reports including data security, cyber security, counter-fraud and conflicts of interest. All areas showed signs of progress building on the previous year's performance. Chris Elliot queried whether the Committee had reviewed the impact of the clinical audit programme at SGUH or ESTH. Peter Kane responded that the role of the Audit Committee was to ensure the overall clinical audit programme was in place and that there were systems and processes to ensure the effective sharing of information and learning internally and across the Group. The GCMO added that audits were designed to demonstrate change in practice and stated that tracking the key items in audits year-on-year would, over time, demonstrate the impact. The Group Board noted the update from the Committee.	
3.5	**Audit Committee Report (ESTH)**	
	Peter Kane, Chair of the Audit Committee, outlined the report which sets out the key issues discussed and agreed by the Committee at its meetings on 14 July and 3 August 2023. There had been a delay in the approval of the annual accounts and work by the external auditors was ongoing. It was anticipated that the accounts would be ready for approval by the ESTH Board later in September ahead of the Trust's Annual Public Meeting. The Chair of the Committee had been working closely with the GCFO, the Site CFO-ESTH and the external auditors to ensure the audit work was completed and a full set of audited accounts were ready as soon as possible. Once the accounts had been approved, a lessons learnt exercise would be undertaken to ensure the Trust was not in the same position the following year. The Group Board noted the update and the ongoing work to finalise the accounts.	
4.0	**ITEMS FOR DECISION**	
4.1	**SWL Acute Provider Collaborative Memorandum of Understanding**	
	The GCEO introduced the report and highlighted that the South West London Acute Provider Collaborative Memorandum of Understanding had been updated following legislative changes through the Health and Care Act 2022. The updates related to the governance arrangements and continued principles of collaboration. Yin Jones asked whether the MoU would be extended automatically on the fifth anniversary of the commencement date. The GCEO would to look into this. The Group Board approved the updated South West London Acute Provider Collaborative Memorandum of Understanding.	
4.2	**Outpatient Transformation Self-Certification: Delegation of Authority to Finance Committee-in-Common**	
	The GDCEO presented the report and highlighted that on 4 August 2023, NHS England had written to all NHS trusts about protecting and expanding elective capacity, and specifically about increasing the pace of outpatient transformation in order to release capacity for patients awaiting their first contact and diagnosis. All trusts were required to provide assurance against a set of activities to drive outpatient recovery and to ensure this work was discussed and challenged at Board, and to undertake a Board self-certification process by 30 September 2023.	

	Given the scale and complexity of the work involved, it was not possible to bring that Board self-certification to this meeting. As a result, the Board was asked to delegate authority for reviewing and approving the self-certification to the Finance Committees-in-Common, so that it could be submitted on schedule. The Group Board noted the paper and delegated authority to the Finance Committees-in-Common to review the actions and approve the self-certification as set out in the NHSE letter of 4 August 2023.	
5.0	**ITEMS FOR NOTING**	
5.1	**Healthcare Associated Infection Report**	
	The Chairman commented that the report was for noting and invited the GCNO to highlight any key elements for the attention of the Board. The GCNO explained that the paper provided a monthly update on infection prevention and control. In terms of issues to highlight, she commented that *C.difficile* at ESTH was below the national threshold while at SGUH it was above the threshold. Similarly, *E-coli* blood stream infection ESTH is below the national threshold while SGUH was above. In relation to Carbapenemase-producing Enterobacterales (CPE) ESTH was above the national threshold and SGUH below. The Group Board received and noted the report.	
5.2	**Fit and Proper Persons Test: National Changes to Requirements**	
	The GCCAO introduced the report, which provided an overview of the new NHS England Fit and Proper Person Test (FPPT) Framework for Board members. The Framework followed the Kark Review of 2019 and had been published just prior to the verdict in the Letby trial. Some areas of the new Framework would take effect at the end of September 2023, specifically the new mandatory references and the introduction of the Leadership Competency Framework for new NEDs and Executives. Full implementation of the framework would take place from 31 March 2024, and this included the inclusion of the new FPPT information on the Electronic Staff Record (ESR). An updated FPPT policy would be developed and would be brought to the Board for approval. The following issues were raised and noted in discussion: • Ann Beasley inquired about mandatory references for Board members and asked whether these references would need to be agreed by the departing Board member. The GCCAO explained that the Framework stated that information to be used in the reference should be shared, but did not state explicitly whether the reference would need to be agreed, though in practice it was expected that these would be shared. • The Chairman raised the question of whether the new national requirements should extend to individuals who attend Board meetings but are not Board members. The GCCAO explained that the Framework includes specific requirements for those who attend Board in a formal acting-up arrangement. Extending the arrangements to cover other senior staff beyond this would be a matter for local decision-making, and consideration was being given to the pros and cons of this. • Martin Kirke inquired whether the Framework differentiated between Executive and Non-Executive Directors given that NEDs are not employees. The GCCAO clarified that the Framework applied to all Board members, and did	

	not distinguish between Executives and Non-Executives in terms of the overall requirements necessary to fulfil the FPPT. The Group Board noted the report.	
6.0	**CLOSING ITEMS**	
6.1	**Any new risks and issues identified**	
	There were no other new risks or issues identified for escalation to the Corporate Risk Register. The Chairman noted that the risks related to the impact of industrial action needed to captured the impact of the action on relationships where some staff were not taking industrial action. The GCCAO commented that he would review the framing of the risks relating to raising concerns in the context of the events at the Countess of Chester Hospital.	
6.2	**Any other business**	
	There were no items of any other business.	
6.3	**Reflections on meeting**	
	The Chairman invited the MD-ESTH to provide reflections on the meeting. The MD-ESTH commented that the feedback from visits was more focused and clear, with Board members building on each other's remarks. Non-Executives had offered both support and challenge during the meeting. This set the tone for the meeting and contributed to the balanced discussions that had taken place. The maternity services discussion, in particular, had openly acknowledged the difficulty of gaining assurance in the context of a positive previous external review and the challenges of identifying the appropriate metrics for measuring the position of the service. The Board was reflective in its approach to seeking assurance. The discussion on the Integrated Quality and Performance Report (IQPR) had been lengthier than was perhaps helpful given previous scrutiny at Committees. The following observations were made: • The Chairman highlighted the report of the Quality Committees-in-Common as a model for other Committees to use in providing a summary assurance report to the Board. The report had captured the salient points discussed by the Committee and had conveyed in an accessible and clear way the areas where the Committee had and had not been assured. • The Chairman also reflected on whether the reports from the Committees might be taken in future earlier on the agenda, and commented that this may hep provide more focus for the later discussion of the IQPR. • The GDCEO commented that consideration would be given to how best to present the IQPR at Board given its extensive scrutiny at Committee, recognising the need to avoid repetition while ensure proper transparency and public accountability. • Derek Macallan acknowledged the importance of focusing on impact data in addition to performance data. The Chairman expressed her thanks and appreciation to Stephen Collier, who was attending his final Board meeting ahead of his term of office ending on 12 October	

	2023. She commended his exceptional dedication, commitment and invaluable contributions to the improvement journey at St George's and in the development of the Group. The Board formally extended its thanks to Stephen Collier and noted that his presence would be greatly missed.	
6.4	**Patient / Staff Story**	
	The Group Board welcomed Sian Owen, Highly Specialised Speech and Language Therapist and Team Leader and Beth Wilson, Head of Children's Services Deputy Director Sutton and Health Care, to present the patient story. Child A had been referred to speech and language therapy and had been assessed along the typical clinical pathways. Ongoing treatment had been provided through reviews held every 3-4 months, with targets set out in a written report which was sent to the child's home and school. The therapist had offered a referral to Community Paediatrics but the parent, at that point, was not ready for this to happen. Subsequently, the parent requested this but by that stage the child was too old to access the service and the parent expressed dissatisfaction about the support that had been offered. A second opinion had been requested, which had been provided by a more senior specialist. Following reassessment and listening to the concerns of the parents, an offer had been made for the child to remain with the specialist therapist and the parents were happy to take up this offer. The team had identified key points of learning which included: recognising the importance of ensuring that robust and supportive systems were in place to ensure staff practised within their capabilities and were empowered to seek input from more experienced clinicians; ensuring service flexibility to allow for transfer of children between clinicians; improving experiences for children and parents; and supporting staff development. Two main actions had been taken in response: a series of staff training sessions was being organised to support learning and encourage development; and staff had been offered opportunities to observe more experienced colleagues. The Chairman thanked the staff for presenting the story and invited comments from Board members. The following points were raised and noted in discussion: • Chris Elliott enquired whether a Community Paediatric referral would have benefitted the child at an earlier stage and asked about the 'cut off' point for referral to Community Paediatrics. Sian Owen commented that the delay had not had a material impact and that the child had received the support required but acknowledged that the cut off points could be somewhat arbitrary and were a point of tension between the health and education systems and it was a concern that something risked being dropped at these critical points of intersection between systems. The Chairman agreed and commented on the tensions that existed between the funding of health and education. • The MD-ESTH commented that, as Place lead for Sutton and as a parent of a child with a learning neuro-developmental diagnosis, his experience was local authority partners consistently stated that diagnosis should not be necessary as a gateway to the right educational support and queried whether some of the settings that were difficult to access were educational settings where the assessment of the child's functional and support needs should have driven whether the child should have been able to access that setting and not whether they had a diagnosis. Beth Wilson agreed and stated that the service was strengthening the universal offer and identifying issues earlier by getting	

school nurses to link with nurseries and pre-schools to identify emerging needs earlier in order that pathways were clearer.

- Jenny Higham enquired whether the child's condition had improved and the MD-ESTH asked whether a Children's and Adolescents Mental Health Service (CAMHS) referral had been made and whether educational support had been delayed due to lack of diagnosis. In response, Sian Owens explained that the child had eventually received a diagnosis of autism and pathological demand avoidance through CAHMS. These were neurodivergent conditions which would remain but the child was improving in her engagement with the world and was able to communicate what she wanted. The delay in referral to Community Paediatrics had not harmed the child but it had been unnecessarily stressful for the parents.

- The MD-SGUH asked how the experience of transitioning between services could be improved. Beth Wilson highlighted the work the service was undertaking to improve communication and transition preparation. She advised that the service had a model for preparing children for adulthood and transition from pre-school to school, and from primary to secondary education. The service ensured there were good communication pathways and that the lead made sure information was passed on to the right people at the right time.

- Yin Jones asked whether good reasons had been provided for the initial refusal to refer. In response, Beth Wilson explained that the rationale for this was being reviewed.

The Chairman thanked Sian Owen and Beth Wilson for sharing the patient story which had helped the Board understand the challenges faced by children and parents. She added that she hoped the family would take comfort that the Group Board had listened carefully to issues raised and to the actions taken in response.

CLOSE

The meeting closed at 13:28

QUESTIONS FROM MEMBER OF THE PUBLIC AND GOVERNORS

Questions from the public and governors.

Five questions had been received from Mr Chelliah Lohendran in advance of the meeting:

1. Has the new hospital design passed the planning stage?
2. When will the building works starts?
3. How many Virtual wards beds this trust has?
4. Has the Hospital Maintenance work survey findings done by the members of the public completed? If not what % has been completed?
5. What area of both hospital settings has RAAC? If found, what steps has the Board taken to eliminate risk to patients, public and staff?

In response to questions, 1, 2 and 4, the GCIFEO stated that the Group was currently working closely with the New Hospitals Programme to incorporate their 'Hospital 2.0' design guidelines. When this work was complete, the Group would submit a planning application and confirm its anticipated start on site. The Government's aim was for the whole programme of work (including work on the existing Epsom and St Helier sites) to be complete by 2030. The Board was looking to commence some enabling works shortly. A full condition survey to re-baseline the maintenance backlog was being undertaken.

Many millions of pounds had been invested over recent years to improve facilities at Epsom and St Helier and the Trust continued to invest to ensure the estate was safe.

In response to question 5 relating to Re-inforced Auto-Claved Concrete (RAAC), the GCIFEO stated that extensive surveys had been conducted and there was no evidence of RAAC at either ESTH or SGUH. Further surveys would be undertaken and assurance would be provided to the Board on this.

In response to question 4, the MD-IC confirmed that 250 virtual beds had been commissioned and covered Surrey Downs, Sutton, Merton and Wandsworth.

The following questions were asked by members of the St George's Council of Governors:

- Richard Mycroft, Public Governor – South West Lambeth, thanked the MD-IC for providing helpful information on virtual wards. He inquired about what was done with data captured during Board visits. The GCCAO explained that a record of points raised was maintained and issues identified were followed up. The process by which feedback to the Board on what had been done in response was being reviewed and was being taken forward as part of work to put in place a regular programme of Board visits.
- Huon Snelgrove, Staff Governor – Non-Clinical, asked about initiatives and training to help staff to speak up. He also inquired about the new Patient Safety Incident Response Framework (PSIRF). The GCNO explained that PSIRF training was being delivered to staff across the Group, and there was a particular emphasis on investigations, psychological safety, team dynamics, and improvement. In relation to supporting staff to speak up, the GCMO emphasised the importance of creating an environment where staff feel comfortable speaking up. With the SGUH maternity service, the key issue was not that staff did not know how to articulate concerns, but rather that actions were not taken to address and respond to the concerns that had been raised. The GCCAO concurred and added that the two FTSU teams held regular listening events and training across wards and departments. Raising concerns had been integrated into the SGUH Mandatory and Statutory Training (MAST) programme and around 5,000 staff had now completed this.

Date of next meeting:

10 am on 10 November 2023 Hyde Park Room, Lanesborough Wing, St. George's Hospital

Group Board (Public) - 10 November 2023

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC230707.2	7 Jul 2023	2.1	Establishment of Infrastructure Committee-in-Common	GCIFEO to commission a review of committee effectiveness after 12 months of the committee being operational to assess if the goals set out in the terms of reference are being achieved.	12 Sep 2024	GCIFEO	An effectiveness review of the new Infrastructure Committees-in-Common is scheduled at the end of the financial year, alongside the effectiveness reviews of all other Board Committees. This will consider how the Committee is operating and any steps necessary to improve the operation and / or effectiveness of the Committee.	PROPOSED FOR CLOSURE

Group Board

Meeting in Public on Friday, 10 November 2023

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

Executive Summary

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

- Recent operational challenges;
- Winter planning and vaccination campaign;
- Group Financial Update;
- NHSE and Police launch of "Right Care, Right Person";
- Group Quality Update;
- Organisational culture & gesh100 event; and
- Appointments, Awards and Events.

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

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

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

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

1.0 Purpose of paper

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

2.0 Background

2.1 Regular update to the Board.

3.0 Reflections on Recent Events & Operational Update

3.1 I want to open my report to the Board by noting the horrific conflict happening in the Middle East. Many of my staff have been in touch and I know how deeply upsetting this horror is to watch. I extend my heartfelt sympathies to anyone who has been affected by the events in Israel and Gaza, either directly or indirectly. As ever, I want to underline that gesh is a place where all faiths are safe and supported, and that help is available for all staff should they need it. I am sure you will join me in hoping that this terrible conflict will come to an end as soon as possible.

3.2 Closer to home, and as the winter draws in, we are already experiencing heightened operational pressures across the Group, signalling what will be a challenging few months ahead. Both Epsom and St Helier, and St George's, have experienced Business Continuity Incidents recently. Our system is under significant strain, with acute demands at our front door on a daily basis. As ever, our extremely hard-working teams in our Emergency Departments at Epsom, St Helier and St George's and throughout our organisation, are rising to the challenge of higher patient attendances and higher acuity. We also have dealt with sustained disruption from industrial action, with the prospect of further strikes to prepare for, as a new ballot has been issued by the British Medical Association. A crucial part of our response to heightened operational challenges is to work as a Group to seek solutions where possible, and to collaborate with our system partners to help deliver the best possible patient care in all circumstances.

3.3 Specifically, an increase in the numbers of mental health patients presenting to our Emergency Departments has become a larger trend since Covid, with a sustained 25% increase in demand for mental health services generally, and people presenting with increased acuity. This is a complex issue which involves multiple parties working across the system to find solutions to ensure that the mental health patients receive the right care in the right way. We are working with our community partners, Integrated Care System (ICS), the Police, and our local authorities to create more effective and innovative pathways for mental health patients to reach the care they need at all of our Sites. More on this important issue later.

3.4 Our winter planning work across gesh is critical to supporting additional capacity needs in the winter months. We are also working hard on our winter vaccinations campaign to mitigate the risk of increased illnesses from flu and covid and protect vulnerable patients. So far, we have completed 6049 flu and covid vaccines for SGUH staff, and 4892 at ESTH.

3.5 In this Board meeting, we will have the opportunity to discuss our Group Finances. Led by our Chief Financial Officer Andrew Grimshaw, we will hear an update on the positions of both St George's, and Epsom and St Helier Trusts. My Executive Team are I continue to prioritise our financial grip and control, our efficiency, and our productivity programmes, to ensure we are in the best possible position for our organisation. I look forward to discussing this further.

4.0 "Right Care, Right Person" Model: Supporting Mental Health Patient Pathways

4.1 As I mentioned above, as a system we need to tackle the rise in presentation of mental health patients in our Emergency Departments. The number of mental health patients attending our emergency departments across Epsom, St Helier and St George's has increased post-Covid, and

although these numbers have since stabilised, around half of patients presenting with mental health needs in our Emergency Departments have no physical health needs.

4.2 Together with our fellow organisations in the community, and in coordination with our ICS, we are taking concrete steps to design and implement new strategies to create a sustainable system for mental health patient care. Specifically, as one of the first steps in the overall strategy, NHS England and the Police have launched "Right Care, Right Person" – a new model to enable more patients who need urgent mental health help to receive it from a healthcare professional in the best possible setting.

4.3 This new system changes the way the emergency services respond to calls involving concerns about mental health. It includes a 24/7 advice line which will support police officers who are attending to a person who is in mental health crisis. Expert practitioners will help advise police on whether a person needs to be sectioned, to ensure that the right therapeutic support from the NHS can be accessed, whilst also ensuring public safety. This model has been tried and tested in Humberside over the last three years. It will be the first step in a broader programme of work to support mental health patients in our system, to increase our capacity, agility and expertise in dealing with patients who are experiencing a mental health crisis, and simultaneously alleviate pressure in the emergency department setting. I will continue to update you on the long-term programme of work underway on mental health patient pathways.

5.0 Quality Update: Quality Governance Review & Maternity Services

5.1 I also wanted to update you on our latest work underway on our Group Quality governance. As we have discussed previously as a Board, we have decided it is right to secure an independent resource to review our quality governance structures across gesh, following recent Care Quality Commission (CQC) reports. The Board has previously approved specific terms of reference for this work, and we have now welcomed Sally Herne, a highly experienced NHS professional, to join our organisation. We have agreed, with the National team, that Sally will join us on a secondment as Group Quality Governance Improvement Lead. Sally joined us in October, and is undertaking a review of our quality governance structures across the Group, including two key phases to examine 1) our Group maternity services quality governance and 2) consider the wider effectiveness of quality governance from individual service level to Divisional, Site, Executive and Board level across both SGUH and ESTH and across the Group as whole. The purpose of this will be to apply the learning from the experience of maternity services at SGUH to clinical services across the Group. We are delighted to have Sally on board, and I am sure you will join me in supporting her work to review quality governance at gesh.

5.2 Specifically on Maternity Services, I wanted to update you that we are currently in discussion with the CQC following their report on Epsom and St Helier Maternity Services, and I will keep you updated on the outcome in due course. At St George's, following the recent inspection from the CQC following which concerns were raised via a Section 29a warning notice, the Trust requested an external review of the service as part of NHSE's support programme. In collaboration with the Chief Midwifery Officer for England, the Regional Chief Midwife and Obstetrician, the Lead Obstetrician for the Maternity Safety Support Programme and a Maternity Improvement Advisor an independent external review of maternity services was undertaken at St Georges Hospital. The team was on site between Monday 6 November and Thursday 9 November 2023 and utilised the NHSI self-assessment tool as a framework for the review. We are looking forward to receiving their report to further inform the improvement agenda for maternity services, and to determine what external support we maintain from NHSE. I will keep you closely informed of this important activity.

6.0 Organisational Culture: Collaboration, Freedom to Speak Up, and Leadership

6.1 Driving forward our Group's organisational culture remains a key priority for me, and my team. On 14 November, we are hosting our first gesh100 leadership forum. The purpose of this forum is to bring leaders from across our Group together, so we can discuss what it means to be a Group, and exchange ideas on the implementation, of our strategic priorities. This will be the first time that such a large number of leaders from across the Group have convened to discuss our organisation, and our role in shaping it. I am very excited to lead this event – which will be the first of regular leadership gatherings throughout each year.

6.2 Through this forum we will aim to foster collaboration and growth across the Group by providing a space for leaders to connect and challenge each other. Our first theme is "Culture" – a topic I am passionate about. As leaders, we play a crucial role in setting the organisational culture that will help us achieve our goals. For me, this means creating a culture of safety and respect; continuous improvement; compassionate and inclusive behaviour; and collaboration. I look forward to reporting back to you on the day, including the output of the valuable time spent together, and how this will contribute to our success in coming together as a Group.

6.3 As part of our work to continuously foster a culture in which everyone feels safe to raise concerns, we hosted Freedom to Speak Up month last month. The Chairman and I spoke at events at both St George's, and Epsom and St Helier, to voice our support for creating a culture of safety and respect. We want to nurture an environment where everyone feels safe to raise concerns, and in the first instance you should ideally be able to do so via your line manager. However, we realise this is not always possible, so we also are committed to making a number of other routes available, including through our Freedom to Speak Up guardians. This year's FTSU month was all about 'Breaking down Barriers' in relation to speaking up and we held 9 events across the organisation – both public and private – to celebrate a culture that supports openness and learning, and to give individuals a chance to learn about the ways they can safely raise concerns.

6.4 Creating an open culture will help us continuously improve and learn, so we can deliver the best possible care to our patients. This month, we have launched our staff survey. The staff survey is a key way of gaining open and honest feedback from our staff and helping staff feel engaged. Through a strong internal media campaign, we are encouraging participation as much as possible, and I look forward to updating you on our results.

6.5 The NHS is committed to equality, diversity and inclusion (EDI). We know that more diverse organisations are more successful, and we are committed to supporting our EDI goals now more than ever as we come together as a Group. We have now launched our Group-wide EDI Boards in our organisation, to oversee a Group-wide approach to our programmes which will contribute to targeted training, fairer recruitment, better talent management, and an inclusive culture.

6.6 We've been working hard to make our Group a better and fairer place to work, but we know we have more to do. October was Black History Month, and we held several events as part of this, including a Workforce Race and Equality Standard (WRES) conference at Epsom and St Helier, and a 'Let's talk about legacy' meeting at St George's. I was so proud to mark our first ever Daphne Steele Day on 16 October – the birthday of the NHS' first Black matron who had links with St George's.

7.0 Appointments, Awards and Events

7.1 Appointments: Betty Njuguna, who was ESTH's site Chief Nursing Officer, left the Trust at the end of September 2023. Over her time at the Trust, Betty helped us implement the Patient Safety Incident Response Framework and update our approach to quality governance, as well as

supporting the senior nursing community through a period of change and challenge. We wish Betty the very best for the future.

7.2 Theresa Matthews, Deputy Chief Nurse, is now acting site CNO and the substantive role is out to advert.

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

7.4 **JAG accreditation:** The coveted JAG accreditation is awarded to the highest-quality gastrointestinal endoscopy services in the NHS, and I'm pleased to say that our excellent team at ESTH has once again met the grade. Following an assessment by the Royal College of Physicians in February and earlier this month, we have received formal accreditation.

In their feedback, inspectors acknowledged that we had acted upon recent findings to strengthen the out of hours transfer pathway between Epsom and St Helier to improve care for patients. They also found that improvements had been made to protect patient privacy and dignity. My thanks to all the teams involved.

7.5 RLDatix Awards: The Integrated Workforce and Rostering Team are the first in the country to extend and implement ESRGo to the medical workforce. This piece of work has saved hundreds of hours of manual work by automating employee changes, and leavers and starters between ESR and Healthroster. The team were recognised for this at the RLDatix industry awards in the Innovative Quality Improvement category. Well done to the team.

7.6 **Cardiovascular and Interventional Radiological Society of Europe (CIRSE) Awards:** The CIRSE awards one Gold Medal each year to someone who has made outstanding contributions to the practice and science of interventional radiology on an international scale. The award is the highest honour that an interventional radiologist can achieve in Europe. This year, Professor Morgan, who leads St George's interventional radiology team, was the recipient of this prestigious award. He has undoubtedly impacted the lives of countless patients and I am so proud to have him as a part of our team at St George's.

7.7 **Awards for the St George's Garden Team: Congratulations** to the St George's gardens team who were recognised with three awards by the London Gardens Society in October. These were for various garden areas, displays, window boxes, across the site. It's such a great achievement for the grounds team to receive recognition of all of their planning and hard work each year.

7.8 **Sustainable Hand Hub wins at the National Orthopaedics Alliance Orthopaedics Awards:** The Queen Mary's Hospital Hand Hub won the Working Towards Net Zero – Greener NHS award for its Sustainable Hand Hub initiative in October. The Working Towards Net Zero – Greener NHS award was presented to Sarah Abbott, Surgeon at St George's. The service's carbon footprint has been reduced by using virtual triage to reduce patient travel, and by introducing sustainable measure within theatre. A huge well done to Sarah.

7.9 **Annual Health Care Support Worker (HCSW) of the Year Awards:** These awards are to highlight the dedication and professionalism shown by healthcare support workers across London, as they play a pivotal role in the delivery of exceptional patient care.

7.10 **Epsom and St Helier received four nominations:** ESTH Education and Workforce Team, ESTH Outpatients Department healthcare support workers team (both in Team of the Year), Czarina Alcantara (Innovation in Recruitment) and Grazina Arbutaviciene (HCSW of the Year). Congratulations to these individuals and teams for being put forward for these awards.

7.11 **Allied Health Professionals Day:** On Friday 13 October, we held events at St George's and Epsom and St Helier to announce our Allied Health Professions Day Award winners, who were nominated by staff from across the Group. As the third largest clinical workforce in healthcare, AHPs provide a pivotal role in supporting the NHS. Awards ranged from Diversity Champion of the year, Support Worker of the year, Team of the year and AHP of the year.

Group Board

Meeting in Public on Friday, 10 November 2023

Agenda Item	2.1	
Report Title	**Quality Committees-in-Common Report to Group Board**	
Non-Executive Lead	Aruna Mehta, Quality Committee Chair, ESTH Andrew Murray, Quality Committee Chair, SGUH	
Report Author(s)	Aruna Mehta, Quality Committee Chair, ESTH Andrew Murray, Quality Committee Chair, SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees-in-Common at its meetings in September and October 2023 and the matters the Committee wish to bring to the attention of the Group Board. The key issues the Committee wished to highlight to the Board are:

- Maternity Services: The Committee continued to monitor the progress of the external clinical review of all still birth and neonatal deaths at SGUH in 2020 and the report was now expected in February 2024. In relation to the Trusts' compliance with Year 5 of Maternity Incentive Scheme (MIS), the Committee was concerned that, for both ESTH and SGUH, only 5 of the 10 Safety Actions were RAG-rated as 'green', which presented a very significant risk that neither Trust will achieve the necessary progress to achieve compliance with the MIS in 2023/24.

- Quality Impact Assessment (QIA) of the Cost Improvement Plans (CIPs): Having reviewed the QIA process at its July meeting, the Committee reviewed how the QIA process was working in practice, and sought assurance that the process was rigorous and was configured in a way that would enable CIPs to be reviewed and, if necessary stopped, if they presented unacceptable safety and quality risks. The Committee received assurance that there was appropriate challenge, with some CIPs being reviewed and a small number stopped as a result of the QIA process and that the process was, overall, working effectively.

- Quality and Safety Risks: The Committee received a report on the quality and safety risks on the two Trust's Corporate Risk Registers and noted the concern raised to it by the Executive that the profile of quality and safety risks did not fully reflect the underlying current risk position The risk profile was being reworked; an interim position would be reported in November and a reworked set of quality and safety risks will be presented to the Committee in January.

Action required by Group Board

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

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

Quality Committees-in-Common Report
Group Board, 10 November 2023

1.0 Purpose of paper

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

2.0 Items considered by the Committees

2.1 At its meetings on 27 September and 26 October 2023 the Committees considered the following items of business:

September 2023	October 2023
• Quality Performance Report (M5) • Serious Incidents Report • Maternity Services Report* • Quality Governance Review Update • Group Healthcare Associated Infection Report • South West London Pathology Quality Report • SGUH Complaints and PALS Annual Report • Quality Impact Assessment of the Cost Improvement Programme • Programme for the Annual Deep Dive Programme	• Quality Performance Report (M6)* • Serious Incidents Report • Maternity Services Report* • Group Healthcare Associated Infection Report* (inc. SGUH Infection Preve • Learning from Deaths Report – Quarter 1 2023/24* • SGUH – Cardiac Surgery Update Report • ESTH - Child Death Overview Panel Report • Quality Impact Assessment of the Cost Improvement Programme • National Neonatal Audit programme • National Patient Survey – Urgent and Emergency Care • Quality and Safety Risks

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

2.2 The Committee was quorate for both meetings.

3.0 Key issues for escalation to the Group Board

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

a) Maternity Services

There is a separate item on maternity services on the agenda for the Group Board meeting on 10 November 2023. However, the Committee would like to highlight a number of aspects of its ongoing focus in seeking assurance regarding the safety, quality, culture and governance of maternity services across the Group.

In its report to the Group board on 7 July 2023, the Committee highlighted that it had been pressing for a clear timeline for the commencement of the external clinical review of all still birth and neonatal deaths at SGUH in 2020 in response to SGUH MBBRACE data showing outlier status in still birth and neonatal mortality rates. In the three Committee meetings held since the Group Board meeting on 7 July, the Committee has been encouraged that the review is underway and is progressing, albeit not to the timeframes originally envisaged. The review is considering 74 cases at SGUH and case notes have been provided by the Trust. The Committee understands that the report will now be received in February 2024 following which it will be presented to the Committee for consideration. Although the delay to the original timeframe is disappointing, the Committee recognises the importance of the review being conducted rigorously and comprehensively so that the causes are understood and lessons can be learnt. Data from the most recent MBBRACE report, based on data from 2021, demonstrates that SGUH is no longer an outlier. MBBRACE data for the ESTH maternity service remains in line with comparable trusts.

The Committee has continued to review both Trusts' compliance with Year 5 of NHS Resolution's Maternity Incentive Scheme (MIS), and considered the latest RAG-rated status for each Trust against each of the 10 Safety Actions in the MIS. The Committee was concerned that, for both ESTH and SGUH, only 5 of the 10 Safety Actions were RAG-rated as 'green', meaning these Safety Actions were on track to be compliant. For ESTH, the Safety Actions relating to transitional care, clinical workforce planning, and the saving babies care bundle were RAG rated 'amber', indicating some risks to compliance, while midwifery workforce planning and multi-disciplinary training were RAG-rated as red, indicating significant risks to achieving compliance. For SGUH, the Safety Actions relating to the Maternity Services Data Set (MSDS) and multi-disciplinary training were amber rated, while transitional care, midwifery workforce planning, and the saving babies care bundle were rated red. The Committee considered the actions being taken to improve the compliance position and address outstanding issues. However, the Committee considers that there is clearly a very significant risk that neither Trust will achieve the necessary progress to achieve compliance with the MIS in 2023/24.

The Committee also received an update on the commissioning of an independent external review of quality governance across the Group, prompted by the CQC's findings relating to the SGUH maternity service. The Committee heard that the costs of commissioning review meant that this was unlikely to be approved through the financial "triple lock" process, whereby all expenditure above £25k needed to be approved by the South West London Integrated Care Board and by the NHS England London Region. As a result, the Group Chairman and Group Chief Executive had agreed to second an individual from NHS England to the Group for a period of 12-months to help review and strengthen quality governance in line with the terms of reference previously agreed by the Group Board. The Committee recognised that this was a pragmatic solution under the circumstances and that it would ensure prompt action to strengthen quality governance.

At the meeting in October 2023, the Committee was informed that ESTH had received details from the National Neonatal Programme Audit suggesting that the maternity service at St Helier was a negative outlier in respect of cord clamping. At the time of the audit the Trust metric was 33% of relevant births where there was delay in the clamping of the cord against a national average of 40%. The Committee heard that an action plan and further

education had been introduced and the metric for ESTH had since risen to 37%. The Committee will continue to monitor this.

The Committee agreed that it could take limited assurance in relation to the SGUH maternity services report, given the findings of the CQC and the need to conclude the wider action plan to address areas for improvement, as well as both the need to see the outcomes of the external review of the 2020 MBBRACE data and progress in the improvements to quality governance. In relation to ESTH, the Committee agreed it could take reasonable assurance based on the information received, notwithstanding the Committee's concerns regarding the Trust's compliance position in relation to the MIS.

b) Quality Impact Assessments of Cost Improvement Plans

In its last report to the Group Board in September 2023, the Committee highlighted its scrutiny of the process for undertaking Quality Impact Assessments (QIAs) of Cost Improvement Plans (CIPs). The Committee considered this important given the scale of the financial challenges facing the Group and the need to ensure that in identifying and delivering CIPs, appropriate consideration was being given to safety and quality, and that mechanisms were in place to review, and if necessary stop, CIPs where these presented unacceptable risks to safety and quality.

Having reviewed the overall Group-wide and Site-based QIA processes at its July meeting, the Committee had requested further information on the operation of these processes, including a summary of the QIAs undertaken in the year to date and the outcomes of these processes. The purpose of this was to provide the Committee with assurance that the QIA processes were operating appropriately as envisaged. At its meeting in October 2023, the Committee reviewed the QIAs undertaken to date. During the current financial year 2023/4, the ESTH Site team had completed QIAs on 59 CIP proposals. Of these, 55 proposals were approved including 12 where amendments were made as a result of the QIA and subsequently approved, and 4 CIP proposals were rejected on the basis of the QIA. At SGUH, QIAs had been completed on 117 CIP proposals. Of these, 113 CIP proposals had been approved including 16 which were amended as a result of the QIA and subsequently approved, and 4 CIP proposals were rejected on the basis of the QIA. A Group level QIA panel considered CIPs where there were Group-wide implications, where the potential quality impact was significant, and where the proposals carried reputational implications. This Group level QIA panel had reviewed QIAs on 14 CIP proposals in the year to date, of which 12 had been approved including one where further information had been sought and was subsequently approved, and 2 CIP proposals had been rejected.

The Committee was pleased to received this further information, which indicated that the QIA process was working well and had the ability to intervene to request changes or, ultimately, stop proposals that presented an unacceptable risk to safety and quality. The Committee heard that one area of the process which had been identified as needing to be further strengthened was record keeping, and actions were being taken to ensure that, at all levels, QIA meetings were contemporaneously and retrievably documented and that a brief rationale for key decisions (particularly amendment or rejection) was always clearly documented.

Despite this area for improvement, the Committee agreed it could take reasonable assurance related to the process of undertaking robust Quality Impact Assessment of Cost Improvement Plans across the Group.

c) Quality and Safety Risks

Section 6 of this report (below) sets out some specific updates in relation to the quality and safety risks on both Trusts' Corporate Risk Registers. In receiving its regular report on quality and safety risks, however, the Committee noted the concern raised to it by the Executive that the profile of quality and safety risks on the two Trusts' Corporate Risk Registers did not fully reflect the underlying risk position on quality and safety across the two organisations. It heard that the Group Executive had agreed that the risks needed reworking as a matter of priority. A risk workshop, convened by the Group Chief Corporate Affairs Officer had been held in September to review the risks and begin the process of reassessing them, and the newly established GESH Quality Group, a management forum reporting into the Group Executive, would review the position in November 2023. A fully updated set of quality and safety risks will be presented to the Committee at its meeting in January and with an interim update in November.

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) Serious Incidents (SIs)

The Committee continues to receive monthly reporting on Serious Incidents, with commentary about immediate actions taken or relevant information about planned investigations, and learning from completed SI investigations. While the details of individual SIs are of course concerning, the Committee is assured that the Group has in place robust processes for identifying, investigating and reporting on SIs.

The Committee reviewed the details of Serious Incidents which had been reported in July and August 2023 across the Group. A total of 13 SIs had been recorded during this period at ESTH (including one Never Event) and seven SIs had been recorded at SGUH (also including one Never Event). The Committee received summary reports on each of the SIs and a summary of the immediate safety actions that had been implemented for each incident. The Committee also reviewed the SIs submitted for review to the Integrated Care Board and the learning that had been identified in each case. In terms of compliance, as at 31 August 2023, there were a total of 30 open SI investigations at ESTH, 1 of which was subject to a clock stop as external investigations were ongoing and 1 further SI was subject to an agreed extension. A total of 18 investigations were overdue. At SGUH, as at 31 August 2023, there were a total of 19 open SI investigations, 4 of which were subject to a clock stop due to external investigations by the Healthcare Safety Investigation Branch (HSIB), and 6 were subject to agreed extensions. There were no overdue investigations. In terms of follow-up, the Committee heard that at ESTH there were 25 open actions, 23 of which were overdue. At SGUH, there were 59 open actions, of which 57 were within the deadline and 2 were overdue.

Alongside its regular reports on SIs, at its meeting in September 2023, the Committee also received two thematic reports relating to areas where SIs had been previously reported, one of which related to haemodialysis at ESTH and the other to wrong site surgery at both Trusts. In relation to haemodialysis, the Committee reviewed the actions taken in response to two SIs in the Renal Units at ESTH. The Committee recognised that dialysis was a potentially high risk procedure. The main risks related to lines being dislodged and the key mitigation was patient education around the necessity of keeping these visible. Meetings were taking place at the sites where incidents had occurred to ensure that the appropriate learning had been embedded. Further visits would take place to the trust's satellite units to

gain assurance. These incidents occurred in the context of ESTH successfully and safely carrying out dialysis for around 800 patients three times a week, and many thousands of sessions per year.

In relation to wrong site surgery, where Never Events had been recorded at both Trusts, the Committee reviewed the actions to ensure that learning had been identified and embedded to prevent further such incidents in future. The Committee heard that since 2016 there had been 17 Wrong Site Never Events across ESTH and SGUH combined, but that there had been a recent increase in frequency, with a third of these Never Events having taken place during the current calendar year. Actions were being taken to appropriate completion of World Health Organisation Checklists, and a focus on accurate completion of the five steps to safer surgery. Staff training was also being undertaken as was work to promote improvements in theatre safety culture.

b) Group learning from deaths report, Q1 2023/24

The Q1 2023/24 Learning from Deaths report is on the Group Board agenda on 10 November 2023. Trusts are required to analyse data on deaths and identify learning on a quarterly basis and report on this to the Board, and the Committee reviewed the data and learning for Q1 2023/24 at its meeting in October 2023. To avoid repetition with the Board's own consideration of the report, the Committee would simply highlight the following issues. For ESTH, national risk adjusted mortality statistics published in August 2023 showed that the trust's Summary Hospital-level Mortality Indictor (SHMI) covering discharges from April 2022 to March 2023 was 'higher than expected' at 1.205. The 12-month rolling Hospital Standardised Mortality Ratio (HSMR) showed a similar trend. However, observed deaths had reduced compared to expected deaths and the latest available monthly value for the month of May 2023 was 98.9, below 100 for the first time since early 2021. Areas of focus were on quality of coding, cardiac arrest cases, multi-disciplinary involvement in structured judgement reviewed and in mortality and morbidity meetings. For SGUH, the latest SHMI data, which covers the period April 2022 to March 2023, showed mortality was as expected at 0.95. The HSMR data for the same period was lower than expected at 90.0. Key areas of focus for further work at SGUH were acute myocardial infarction (MI), major trauma and fractured neck of femur (NOF). The latest data showed that SGUH was now at the national average for trauma mortality (previously bottom quartile), but SHMI signals remain for acute MI and fracture NOF. The Committee considered it was able to take reasonable assurance on learning from deaths at Q1 2023/24.

c) SGUH Cardiac Surgery Report

The Committee continues to receive quarterly reporting on quality, safety and outcomes in the SGUH cardiac surgery service, continuing the oversight provided by the Committee prior to the formation of the hospital group. The report considered by the Committee was a combined report covering Q1 and Q2 2023/24. The Committee was assured that the latest data from the National Institute for Cardiovascular Research (NICOR), published in August 2023, demonstrated that the SGUH cardiac surgery unit as a whole continued to demonstrate mortality as expected. The Committee heard that the Trust continued to maintain close scrutiny and oversight of outcomes, post-operative complications, and surgical site infections as well as mortality. The challenges facing the unit had evolved in recent years and the focus of attention had extended beyond the recommendations of the Independent Mortality Review. The challenges now involved more practical operational issues: access by the unit to intensive care and enhanced care beds; recruitment and retention of cardiac anaesthetists; improving scheduling and access to theatres; and tracking of harm due to delays and cancellations. Four workstreams had been developed

to address these challenges. The Committee was encouraged that there had been significant improvements in flow through CTITU since ring fencing of beds had started in April 2023, but remained concerned with the ongoing challenges in recruiting and retaining cardiac anaesthetists, which was seen as the biggest risk to the delivery of the service. Waiting lists for cardiac surgery at the Trust currently stood at 150, with the longest wait at 30 weeks, which reflected a London-wide cardiac surgery waiting list challenge. The Committee heard that discussions continued with other South London centres regarding the secondment of an experienced surgeon to lead the service. The Committee welcomed the update and considered that it could take reasonable assurance from the report.

d) Infection Prevention and Control (IPC)

This report is on the agenda for the Group Board meeting for November 2023. The Committee received a comprehensive monthly report on infection prevention and control at both its September and October meetings and the Committee considered that this provided good assurance to the Committee that the Trust's governance and oversight of IPC is effective.

At the October meeting, consultant microbiologists from both trusts attended the meeting to talk through the concerns relating to the increasing number of *C.difficile* infections. The Committee heard that in August and September 2023 there had been 8 *C.difficile* infections at SGUH, of which 6 were classified as Hospital-Onset Healthcare-Associated (HOHA), and 2 as Community-Onset Healthcare-Associated (COHA). The year-to-date figure was 26 against the nationally set Trust threshold of 42. At ESTH, over same period there had been 8 HOHA *C.difficile* cases and 3 COHA cases. The year-to-date figure was 27 against the nationally set Trust threshold of 38. It was acknowledged that there continued to be a concern, locally, across South West London and wider London relating to the incidence of *C.Difficile* and the Committee heard that the Chief Nurse at NHS England was coordinating work to try to identify the causes of this increase.

Locally, there was also concern relating to the number of *E.coli* cases. The IPC teams continued to investigate these and collect data by source. Analysis of the cases identified predominantly a urinary source. The issues of urinary catheter associated infection will be addressed as part of the "Getting Back to Basics Campaign". The Committee noted that the SWL ICB was leading a project on trying to reduce these infections. Work would be undertaken to try and triangulate this information with the incidence of E Coli within the community.

Despite these challenges, the Committee agreed that, on balance, there was reasonable assurance relating to infection prevention and control across the Group.

e) South West London Pathology Quality Report

Both SGUH and ESTH are partners with other South West London trusts in South West London Pathology (SWLP), a joint venture hosted by SGUH. While the Finance Committees-in-Common receives periodic reports on the overall performance of SWLP, the Quality Committees-in-Common maintain oversight of the quality of the service. SWLP performs over 27 million tests to five hospitals in South West London and over 250 GP surgeries, with additional services provided to a number of other hospitals in the area. The Committee heard that the quality status within SWLP was assessed using several metrics which cover the scope of its activities including: accreditation status; service improvements; quality assurance indicators; staffing metrics; and risks and issues. These are reviewed regularly at monthly contract review meetings with SWLP partners. SWLP;'s accreditation to ISO15189 provided assurance as to the overall quality of the service, with

each laboratory undergoing an annual assessment conducted by the UK Accreditation Service. During 2022/23, SWLP had implemented 19 major service improvements, including the implementation of a new Laboratory Information Management System (LIMS). The Committee heard that had been a marked increase in activity over the past year for SWLP, which faced some challenges with turnaround times for diagnostic services and with staff turnover. The Committee reviewed the concerns which had been raised in the IPC report relating to delays with virology testing and were informed that the issues had been addressed. One emerging risk was highlighted to the Committee which related to the risk of delays in implementing LIMS across all sites as a result of the impact of the rollout of the new ESTH Electronic Patient Record system, due to go live in April 2024. However, the Committee heard that appropriate mitigations had been put in place and there were no quality concerns to highlight. The Committee agreed it could take reasonable assurance from the report and would continue to receive biannual reports from SWLP going forward.

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5.0 Other issues considered by the Committees

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

a) National Patient Survey: Urgent and Emergency Care

The Committee reviewed the finding of the latest survey of adult patients who attended either the emergency department (ED) or the urgent treatment centre (UTC) during September 2022. The survey aimed to look at the experience of patients who attended the Emergency Department (Type 1) and those who attended an Urgent Treatment Centre (Type 3). St George's took part in the survey for both Type 1 and Type 3 services, Epsom and St Helier took part in Type 1 only. The scores of both SGUH and ESTH were considered alongside other local trusts to highlight comparative patient experience and benchmarking against other organisations. The Group's results were overall were around the middle of the table for all trusts. The Committee noted that the scores for ESTH and SGUH were very similar, excluding the hospital environment score where ESTH scored much higher. Both trusts scored well on respect and dignity with scores of 8.9 out of 10. While some scores were lower than the survey results from 2020, this deterioration was in line with the national findings from the CQC in terms of patients reporting an overall deterioration in patient experience in emergency care. The Committee noted that the survey demonstrated that more work was needed around ensuring support for patients with protected characteristics. At SGUH issues were identified with transport arrangements and securing medicines when they left the department.

Overall, and in the context of the wider national position, the Committee agreed it could take reasonable assurance from the outcomes of the survey.

b) Complaints and PALs Annual Report (SGUH)

The Committee received the Complaints and PALs Annual Report 2022/23 for SGUH, having received a similar report for ESTH at its July meeting. The Committee noted in particular that the report demonstrated that the vast majority of complainants were of white British ethnicity which raised a question of as to whether patients of other ethnicities felt less able to raise concerns. The Committee also noted that the priorities for 2023/24 included making progress on health inequalities, and collating wider information on patient demographics to understand the health needs of the local population. The Committee suggested that it would not be enough to just collate information but that proactive work should be undertaken directly with patients to better understand the reasons why certain patient groups did and did not feel empowered to raise concerns.

6.0 Review of risks

6.1 As noted above, the Committee reviewed the quality and safety risks on the two Trusts' Corporate Risk Registers. Beyond the core issue of whether the quality risks reflected the reality of the quality and safety risks facing the two organisations, the Committee noted the following specific updates:

a) Industrial Action: A new risk had been opened in June 2023 to capture the risks to quality and safety of care both during periods of industrial action and as a result of cancellations. The risk was principally focused on the risks to the safety and quality of care but also had financial impacts and people-related impacts, particularly in terms of staff wellbeing. The risk score was currently 16 (4c x 4l) on the basis that although no direct patient harm had been identified, the scale of cancellations as a result of the action meant that, as during the Covid-19 pandemic, it was likely there would be harm albeit that this was hard to quantify at the present time. The Committee noted the inclusion of this risk on the Corporate Risk Registers of both Trusts.

b) Decision-making within the Mental Capacity Act (MCA) legal framework: This risk captured the risks of non-compliance with the changes to the MCA framework (such as improving the quality and timeliness of information shared between organisations) due to measures not being implemented in a timely way, which could impact on patients who may unlawfully be deprived of their liberty. The Committee noted and agreed the proposal to de-escalate this risk in the context of the delay in the implementation of the new legal framework at a national level. While planning would continue locally, the risk of non-compliance had reduced as a consequence. The risk would be managed below the level of the Corporate Risk Register by the Corporate Nursing directorate.

7.0 Recommendations

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

Group Board

Meeting on Friday, 10 November 2023

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 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

Action required by Group Board

The Board is asked to:

a. Note the paper

Committee Assurance

Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices

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

Appendix 3	Add Appendix Name – delete line if not needed

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

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, 10 November 2023

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 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 29th September 2023 and 27th October 2023, the Committee considered the following items of business:

September 2023	October 2023
PUBLIC MEETING • Finance Report (M5) • Risks and Mitigations • Controls Update • Cash update • Industrial Action • ERF Update • Productivity Update • IQPR • Protecting and expanding EL capacity • SGH PP/OVS policy • SWL Pathology report	**PUBLIC MEETING** • Finance Report (M6)* • Finance risk deep dive • Risks and Mitigations* • Controls Update • Cash update • NHS Contract sign off • Costing update • Productivity Update • IQPR • SWL Procurement Partnership Update

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

2.2 The Committee was quorate for both meetings.

3.0 Sources of Assurance

3.1 a) Finance Report M6

The GCFO noted that SGH and ESTH are £12.2m and £3.6m adverse to plan at M6 respectively, which is wholly owing to the impact of industrial action. This includes both an expenditure impact and an impact from loss of Elective Recovery Fund income. The expenditure impact is at £5.0m for SGH and £1.8m for ESTH and the income (ERF) variance is at £7.2m for SGH and £1.8m for ESTH.

b) Risks and Mitigations

The GCFO highlighted some of the key risks at each Trust in delivering the year end plan, as well as mitigations. Committee members discussed the merit of using additional sessions to deliver activity when theatre utilisation at the Trusts was not at the 85% benchmark.

c) IQPR

Non-elective pathways continue to be under pressure at both trusts. Whilst the number of patients waiting in the Emergency Department (ED) for more than 12 hours following a decision to admit is significantly above our ambition, both trusts achieved the 4-hour operating standard of 76% (SGH – 77.0%; ESTH 77.3%) in September.

Both trusts are above the **RTT** trajectory that they set themselves to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH is particularly challenged with 917 patients waiting for more than 52 weeks at the end of August 2023, largely attributable to challenges within Gynaecology and Community Paediatrics services.

Diagnostic performance at SGH continues to remain strong with 98% of patients receiving their diagnostic test within six weeks of referral in September. The breach rate of 2% at SGH is well within the national target of 5%. ESTH is reporting a breach rate of 5.4% in September, which is a reduction of over 30% and the fifth consecutive month of improvement.

Cancer performance is generally on track at ESTH with some challenges at SGH. Performance against the 28-Day Faster Diagnosis Standard (FDS) fell below the 75% national ambition due to capacity constraints in the skin service. Although SGH are not achieving the 62-day cancer standard (64.9%), it is broadly on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment.

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

a) Controls update

At the September and October committees the GCFO outlined progress on controls, including the proposed implementation of the no PO no pay policy, which was **approved by the committee.**

b) Cash update

The committee noted the approval from NHSE of the Q3 request at both organisations, although not at the original level requested. The Site CFOs explained the reasons and impacts of these decisions, as well as appropriate mitigations.

c) Costing update

The Committee **delegated authority to submit the National Cost Collection** to the GCFO awaiting confirmation of the deadline date.

d) NHS Contracts sign off update

The Committee **delegated agreement to and signature of the contracts** to the GCFO.

e) Industrial Action

Committee members noted the detail of the impact of industrial action in August and September.

f) ERF update

The GCFO introduced the paper on ERF, where committee members discussed the baseline adjustment for SDEC, and how this impacted both organisations.

g) Productivity update

Productivity continues to progress following deep dives earlier in the year, with further improvements to be made. Committee members focussed attention on Non Elective metrics.

h) Protecting and Expanding Elective Capacity

The COOs introduced their self-assessments for submission in September. **Committee members approved these self-assessments of** each Trust's processes on electives.

i) SWL Pathology Report

Committee members noted the report.

j) SWL Procurement Partnership Report

Committee members noted the report.

5.0 Implications

5.1 The Committee considered the group finance strategic risks as a deep dive in October. Operational risk would be considered at the November meeting.

5.2 The Committee agreed no changes to risk scores in finance where financial sustainability and investment risks are at 25 for both organisations. No changes to operational risk scores or assurance ratings were appropriate at the Q3 2023/24 position.

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 2023.

Group Board

Meeting in Public on Friday, 10 November 2023

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 meetings in September and October 2023 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) reports and action plans: In October 2023, the Committees approved the WRES and WDES reports and action plans which are required to be published on the Trusts' respective websites by 31 October 2023. The Committees were disappointed by the lack of improvement and decline in some of the indicators despite the investment and effort that had been put into the culture programme. The Committees heard that the lack of progress in delivering the agreed action plans was mainly due to resourcing issues. The Committee noted that the Group Board planned to discuss and take stock of the culture programme and wider work to make progress on equality, diversity and inclusion at its development session in December 2023. In order to ensure ongoing focus on progress, the Committee agreed to review the WRES and WDES action plans on a quarterly basis from November 2023 onwards.

- Employee Relations (ER): The Committee received reports on ER performance at each Trust at its meeting in October 2023. The Committee heard that the two organisations are in different places, with the ESTH function more established and in a better overall position, while the SGUH was more fragile and needed significant improvement. A service improvement programme had been put in place at SGUH, building on the internal review of ER which had been undertaken the previous year. The Committee discussed the challenges facing the ER service at SGUH, and the challenges that remained at ESTH. As SGUH was in the early stages of implementing actions to strengthen the service, the Committee agreed that it could take only limited assurance in relation to ER performance at SGUH, whereas it could take reasonable assurance for ER performance at ESTH.

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 September and October 2023.

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committees-in-Common Report
Group Board, 10 November 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meetings in September and October 2023 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

1.2 The role of the Committee, as set out in its terms of reference, is to provide assurance on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care.

2.0 Items considered by the Committees

2.1 At its meetings on 22 September and 20 October 2023, the Committee considered the following items of business:

September 2023	October 2023
• Group Chief People Officer Update Report, including Industrial Action Update • Corporate Risk Register – People Risks • Programme Update: Report from the Group Culture, Equity and Inclusion Programme Board • Talent Management: Onboarding • Staff Health and Wellbeing • Education Update – SGUH Undergraduate Medical Education - Risk • Workforce Race Equality Standard and Workforce Disability Equality Standard: Progress Update • Ethnicity Pay Gap Actions • Medical Revalidation Responsible Officer Annual Report and Q1 Report • People Management Group Report	• Industrial Action Update • Group Workforce Key Performance Indicators Report with metrics • Deep Dive – Employee Relations • Workforce Improvement Plan • Staff Support Counselling & Mediation • Staff survey – Top 10 and Bottom 10 departments for engagement with survey • General Medical Council National Training Survey • Guardian of Safe Working Annual Report and Q1 Report • WRES/WDES Reports and Action Plans • People Management Group

** Items marked with an asterisk are on the Group Board agenda as standalone items in November 2023.*

2.2 The Committees meet on a monthly basis, and the focus of meetings alternates between workforce operations in one month and culture, diversity, inclusion and organisational development the next. The chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH. The ESTH Committee Chair chaired the meeting in September and the SGUH Committee Chair chaired the meeting in October 2023.

2.3 In October 2023, Yin Jones took up the role of the SGUH Committee Chair from Stephen Collier, as Stephen's term as non-executive director for SGUH came to an end in mid October 2023.

3.0 Key issues for escalation to the Group Board

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

a) Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES) reports and action plans: This item is on the Group Board agenda for 10 November 2023. In October 2023, under delegated authority from the Group Board, the Committees approved the WRES and WDES reports and action plans which are required to be published on the Trusts' respective websites by 31 October 2023. The Committees were disappointed by the lack of improvement and decline in some of the indicators despite the investment and effort that had been put into the culture programme. The Committees heard that the lack of progress in delivering the agreed action plans was mainly due to resourcing issues. The Committee noted that the Group Board planned to discuss and take stock of the culture programme and wider work to make progress on equality, diversity and inclusion at its development session in December 2023. In order to ensure ongoing focus on progress, the Committee agreed to review the WRES and WDES action plans on a quarterly basis from November 2023 onwards.

b) Employee Relations (ER): The Committee received reports on ER performance at each Trust at its meeting in October 2023. The Committee heard that the two organisations are in different places, with the ESTH function more established and in a better overall position, while the SGUH was more fragile and needed significant improvement. A new Head of ER at SGUH had been in post since August 2023 and a service improvement programme had been put in place, building on the internal review of ER which had been undertaken the previous year. The Committee discussed the challenges facing the ER service at SGUH, and the challenges that remained at ESTH. As SGUH was in the early stages of implementing actions to strengthen the service, the Committee agreed that it could take only limited assurance in relation to ER performance at SGUH, whereas it could take reasonable assurance for ER performance at ESTH.

4.0 Key Issues on which the Committees received assurance

4.1 The Committees wish to report to the Group Board the following matters on which they received assurance:

a) Group Culture, Equity and Inclusion (CEI) Programme Board Update
The Committee received an update on the CEI programme at its meeting in September 2023. It heard that progress had been made on the first workstream - civility and psychological safety. Three staff lunchtime sessions had been held and were well attended, with attendance at around 1000 people across the 3 sessions. A session on how to give feedback was scheduled. A lot of activity and promotion was underway and the intranet pages had been updated with new content. Focus had been on the civility and psychological safety workstream and a number of processes, functions and interventions were needed to create an infrastructure to continue to influence, support and develop a culture of civility and psychological safety. The Committee heard that a range of workforce information and performance metrics were being developed, the purpose of which would be to measure progress with developing culture.

The Committee agreed it could take reasonable assurance from the update on the culture programme.

b) Talent Management: Onboarding

Linked to the culture programme, onboarding was one key element of the Group talent management strategy. The loss of talent through turnover within the first 12-18 months of service was high. The approach to onboarding would be to introduce it at a number of levels across the group and through a range of actions and interventions. The goal was to create a new positive experience throughout the new joiner pathway at GESH. Areas of focus were:

- Developing a new onboarding hub on the intranet of both Trusts for new starters to help them access key information, contacts and support and to signpost training and development opportunities.
- Putting in place personalised emails from GCEO to each new starter and emails to check in at 1 month, 6 months and 18 month intervals.
- Developing tools and resources for managers to support the new starter experience, including local inductions and buddy system support.

The onboarding schedule for roll out in SGUH would be replicated in ESTH from September 2023. The Committee agreed it could take reasonable assurance in terms of onboarding.

c) GESH Staff Health and Wellbeing

In September 2023, the Committees received the Health and Wellbeing activity for Q1-Q2 2023. It was confirmed that the Health and Wellbeing teams would be brought together across the Group which would provide an opportunity to standardise the offer and provision across GESH. There would be some challenges, for example, each Trust had a different and separate intranet. The discussions centred around metrics and measuring progress. Data would be provided to divisions and directorates to allow them to understand where they were on progress, as well as data to the ground level. The data would be part of scorecards and dashboards. The Committees received reasonable assurance.

d) Ethnicity Pay Gap Actions

At its meeting in June 2023, the Committees had requested a further analysis on Ethnicity Pay Gap data be undertaken. The analyses for ESTH and SGUH focused on male Black/Black British colleagues and demonstrated that there is a disparity in earnings for colleagues from that background in comparison to their white counterparts. The Committee emphasised that this disparity needed to be addressed and discussed how this could be achieved by focussing on certain aspects of the WRES action plans and implementing them through working with leaders in the areas where this was a particular issue, for example ESTH Estates and Facilities, and HR Business Partners.

e) Medical Revalidation Responsible Officer Annual Report 2022/23 and Q1 Report

The Committees received the annual report 2022/23 and the Q1 report 2023/24 from the Responsible Officers (ROs) for medical revalidation at each Trust at its meeting in September 2023. The Committees noted that both annual reports had been to Group Board in July 2023 and the compliance statements had been signed off by the GCEO.

For the Q1 reports, the RO for SGUH reported that the number of doctors connected to SGUH continued to increase and was at 1100. The compliance rate for appraisals had declined in the last quarter. A deep dive was being carried out. There was a small number of doctors who were more than 6 months overdue for their appraisals. Some of the doctors were struggling with the appraisal and documents and others were impacted by the industrial action. There was a slight increase in the number of doctors who had their revalidations deferred, due to a lack of information and revalidation plans were put in place for them. Going forward, areas of focus were locally employed doctors (LEDs) and overseas doctors, as they were often new to the NHS or new to the Trust. There would also be support provided for neurodiverse doctors and data collected on doctors to better understand the issues and institutional barriers.

The ESTH RO reported that, for Q1 2023/24, of the 157 doctors due to hold an appraisal meeting 103 appraisal meetings had taken place and 54 had not had an appraisal meeting, though plans were in place to address this.

The Committees discussed widening the appraiser pool to include non-medical appraisers. SGUH had considered non-consultant appraisers and would also consider non-medical appraisers. It was noted that appraisers could also be shared across the group and increase the numbers of appraisers. The Committee also heard that the two ROs had started to co-ordinate more with each other to explore opportunities for collaboration and coordination across the Group.

The Committees also discussed the consistency of appraisers. An appraisal form was used to ensure the doctor met the requirements for good medical practice and personal and professional development. There was also a quality assurance tool, to ensure standards were met. An audit was being carried out.

The Committee agreed it could take reasonable assurance from the report.

f) Group Workforce Key Performance Indicators (KPI) report

The KPI metrics data for August 2023 was presented in October 2023.

The vacancy rate at ESTH had fallen for the fourth consecutive month (including September) and was currently at 12.57%. The target was 10%. Community services reported the highest divisional vacancy rate at 17% and Estates and Facilities was reporting a vacancy rate of just under 25%. At SGUH, the vacancy rate had increased slightly to 9.10% and remained below the 10% target. Medicine and Cardiovascular reported the highest divisional vacancy rate at 10.91%.

Both Trusts were on target for core skills compliance, although focus would be required on areas that were not performing well. Both Trusts reported a monthly sickness absence rate of 4.73% at ESTH and 4.37% at SGUH, above the respective KPI targets of 3.80% and 3.20%.

The appraisals compliance rate at ESTH had fallen for a sixth consecutive month (including September) to 60%. It was noted that the clinical area rates were between 60-70% and that it was the corporate areas and Estates and Facilities with the low appraisal rates. SGUH appraisal compliance increased by 2% to 72%. The target was 90% for both Trusts. The team at SGUH was developing a package called ‘Action Appraisal’, which identifies the training available and supports compliance.

Regarding turnover, both Trusts exceeded the respective 12 months Trust KPI targets of 12% (ESTH) and 13% (SGUH) with ESTH at 14.18% and SGUH at 14.64%.

The Committee agreed it could take reasonable assurance from the report.

g) Workforce Improvement Plan (WIP)

In October 2023, the Committees received an update on the WIPs for the Trusts. The Trusts had different approaches. The cost savings would be the responsibility of the divisions and focus would be on improving performance. ESTH had a focus on bank and agency spend. PA Consulting was working at a system level on bank and agency spend. The Trusts were involved with the SWL system work on 1) standardising internal bank processes; and 2) creation of a SWL secondary bank as an intermediary step between internal bank and agency.

ESTH reported:

- There were 4 fully developed plans on temporary staffing being delivered. The biggest saving was from transitioning agency work to bank, through improving rostering.
- Working on reducing off framework agency spend with regular finance meetings, booking ahead and reviewing booking behaviours and trends. Also, increasing agency framework rate to attract staff from off framework agencies.
- Roster reviews were ongoing.

SGUH reported:

- There were 6 workstreams. Since the last meeting, the programme had been reviewed to strengthen the plan and drive it forward. There was also learning from ESTH in working closely with finance.
- A monthly steering group was set up for workstream leads to report progress and any challenges. Although there were a lot of the actions that were amber, these were in progress and longer term actions.
- Alignment with the People Strategy.
- Rostering workstream would be reviewed and gain learning from ESTH.

The Committees received reasonable assurance.

h) General Medical Council (GMC) National Training Survey (NTS)

The GMC national training survey is the largest annual survey of doctors (trainees and trainers) across the UK, benchmarking the quality of training, supervision and the learning environment. It was the first time the annual GMC NTS report was presented with the GOSW reports and staff survey paper, in the same meeting. The triangulation between the papers was helpful and welcomed by the Committees. Both Trusts reported the outcomes of their surveys.

ESTH reported:

- The areas of excellence were Paediatrics and Child Health, Ophthalmology and Foundation Year 2 medicine. The FY2 in medicine had been flagged previously. There had been a lot of investment in increasing staffing; increasing training time; and employed clinical training fellows to support the medicine trainees. As a result, there had been an improvement in the trainee experience.

- Obstetrics and Gynaecology training was commended by NHSE for sustained improvement in GMC results over the last two years and the Trust has been invited to share good practice across England at a Conference.
- Focus on improving trainee experience was in Medicine and there were 2 actions open.
- Surgery was flagged for training and rota design. The team was working on this.
- Learning was gained from other teams' experience at an annual trainee/trainers conference at Epsom. It was noted that the trainer's report was also important.

SGUH reported:

- There had been significant improvement from 2022, particularly in Cardiac Surgery where 2 higher trainees were reinstated.
- There had also been a significant improvement in Obstetrics and Gynaecology, after a lot of work with the postgraduate medical education team and the OD team. The Obstetrics unit was one of the top in London for trainee experience.
- Three areas to receive Health Education England (HEE) visits will be Diabetes and Endocrinology; General Surgery and Haematology.
- The actions to be taken will have a broader focus, such as infrastructure and basic facilities; educational governance; and working with the Guardian of Safe Working (GOSW) and Junior Doctors Forum for oversight of issues.
- An NHS Leadership Fellow was funding for this year who was working with the Organisational Development (OD) team to review the culture work, particularly in General Surgery and Medicine.
- A Wellbeing Fellow had been appointed to work with the NHS Dignity Fellow, to look at how we understand trainee wellbeing, which was a 'hard to reach' group.

It was noted that the action plans from the GMC NTS and Guardian of Safe Working exception reports needed to be brought together and track improvement.

The Committees received reasonable assurance on the GMC NTS.

i) <u>Guardian of Safe Working (GOSW) Annual Report and Q1 Report</u>
The Committees received the GOSW annual reports for 2022-23 and the Q1 report for April-June 2023.

For the ESTH GOSW annual report, it was highlighted that a lot of the data was collected from HEE and accounted for just over half of the doctors at ESTH. This was raised at the Local Negotiating Committee (LNC) and requested more accurate information. The rota gaps were managed locally. The exception reports were usually regarding the short term rota gaps to cover sickness. The GOSW was working with service managers to provide a clear process to cover short-term sickness. ESTH Q1 report highlight that:

- 83 exception reports were received in Q1, compared to 271 reports in Q3 of 2021/22.
- General Medicine remained the highest area for exception reports.
- Monthly reports were shared with service managers, across the directorates.
- New safeguarding measures were put in place on E-roster.
- There were 2 immediate safety concerns raised which were escalated and resolved.

Regarding the SGUH GOSW annual report for 2022/23, it was highlighted that it had been a difficult year for junior doctors with a lot of pressure during the winter and strike action.

Support was provided for junior doctors. There were over 600 exception reports, mainly concentrated over winter and largely from Acute and General Medicine. Locally employed doctors (LEDs) started to report from Q3 for the first time and this was attributed to the new LED Lead and International Medical Graduates (IMGs) group. Consultants were supportive in Medicine and encouraged reporting. The hospital at night system had caused delays in staff leaving late. A locum escalation policy will help with short notice rota gaps. The Junior Doctors Forum had been more active with good engagement. The doctors' mess had been re-decorated. Review of Cardiothoracic had seen an improvement and expecting more trainees. There had been visits in Haematology and Respiratory. A Haematology review was also due. The SGUH GOSW Q1 report highlighted that:

- Q1 is usually a quieter time. A total of 80 exception reports were received, mainly in Medicine.
- There had been a surge in exception reports from Cardiology, mainly due to rota gaps. More support had been provided, so there should be less rota gaps.
- A Diabetes and Endocrinology HEE visit was pending. The SGUH GOSW had been in touch with the trainees.

The Committees received reasonable assurance.

5.0 Other issues considered by the Committees

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

a) Group Chief People Officer Update Report, including Industrial Action Updates

Breaking the Silence: Addressing Sexual Misconduct in Healthcare Sexual Harassment Report

The Committee discussed the recently published in-depth study undertaken by the Royal College of Surgeons (RCS) which revealed the extent of sexual misconduct by colleagues – including sexual harassment, sexual assault, and rape – within the UK surgical workforce in the last five years. The review had found that two thirds of women (63.3%) had been the target of sexual harassment from colleagues, along with almost a quarter of men (23.7%). The research found nearly a third of women (29.9%) had been sexually assaulted by a colleague, while the majority of participants (89.5% of women, 81% of men) say they had witnessed some form of sexual misconduct. Sexual coercion was common, with 10.9% of women having experienced forced physical contact linked to career opportunities.

The Trusts did not have the data or feedback to suggest the data was representative of the Trusts, but it was likely that similar issues would be present given the scale of the RCS's review and its findings. Work had commenced on this and an update report would come to the Committees in due course. NHS England had developed a Sexual Safety in Healthcare – Organisational Charter. A lot of the requirements in the Charter were already in place. An action plan would be developed and combined with the Big 5.

Staff side at SGUH

The staff side relationship at ESTH was working well. The staff side relationship at SGUH was more challenged. Staff Side colleagues had raised concerns about Employee Relations and pay processes. It had been agreed with Staff Side that an away day would be arranged to review how the relationship could be improved.

Industrial Action

The Committees continued to receive regular updates on industrial action. The Government was consulting on proposals to bring in national minimum service during industrial action. The consultation was due to close on 14 November 2023.

Insourcing of the Bank Service in ESTH

The temporary staffing "Bank" service was successfully transferred from Bank Partners to ESTH on 1 August 2023. As anticipated, all employed staff with Bank Partners TUPE'd over to ESTH and have been successfully enrolled onto ESTH's systems, including payroll.

b) Staff survey – Top 10 and Bottom 10 departments for engagement with survey

In October, the Committees received an overview of the analysis of the top 10 and bottom 10 areas for staff engagement with the staff survey 2022 across the two Trusts. Other key workforce metrics were also included. The data had been shared with and made available to divisions, directorates and care groups. The analysis had also been presented to the culture boards in both organisations.

The staff engagement was the focus of the analysis because it was a key metric for the individual questions in the survey, that provided an overall score on staff engagement. A focus on staff engagement was in line with the work on culture and the workstreams civility and psychological safety; and high performing teams.

The culture programme was a key driver for the staff survey results and CQC maternity issues to look at a range of metrics and data to identify areas that needed support. A dashboard scorecard was being developed as a reassurance mechanism. The metrics would also help with the development of the evaluation of the culture programme.

The Committee was pleased to receive the report, which it considered provided important insight into teams and services that were more challenged. The Committee also noted that this data would be incorporated into the development of the new Group-wide heatmap.

c) ESTH national award:

The ESTH Integrated Workforce and Rostering Team won the category award 'Innovative Quality Improvement' at last month's RLDatix (previously known as Allocate) People Summit. The team was recognised for the successful implementation of the ESRGo interface in February 2023, (which has saved hundreds of hours of manual work by automating employee changes, leavers and starters between ESR and Healthroster) the team worked hard with RLDatix to make ESTH the first NHS trust in the country to extend and implement ESRGo to the medical workforce.

d) Staff Support Counselling & Mediation

The GCPO provided an overview of the range of services. There was more resource at SGUH, than ESTH. It was highlighted that:

- There was an increase in demand for counselling – at SGUH the demand had doubled since 2019/20. It was a proactive service, with the counsellor walking around the wards and approaching staff.
- Work on suicide prevention – SGUH had a better process for identifying and looking at risk. ESTH had a lower number of staff.
- Mediation was involved in preventing ER cases and formal processes.

It was seen as a positive that more staff were accessing the services, given the stress and pressure the workforce was under. The service in SGUH was recognised as an excellent service with positive informal feedback from staff.

The Committees requested data to be included in the next report on the effectiveness of psychological interventions. The Committees received reasonable assurance.

e) Development of Group Corporate Services

The Committees continue to oversee the Group Corporate Services programme and receive updates in a confidential session for assurance.

6.0 Review of risks

6.1 The People Committees-in-Common reviewed the People related Corporate Risk Register in September.

a) Corporate Risk Registers – People Risks

The Committees received the CRRs in September 2023. There were 14 people risks on the SGUH CRR and 13 on the ESTH CRR. The Group Executive had reviewed the CRRs.

The update on the risks relevant to both Trusts:

- The risk relating to raising concerns in the context of the national and local focus on this had been reviewed and the proposal was no change to the risk scores at 16.
- The risk relating to industrial action, with a risk score of 16, would be overseen by the Quality Committee, due to the implications on patient safety in the short term and the long term. The risk also covered staff health and wellbeing and finance.
- A new risk for both Trusts relating to sexual safety at work was being developed and would be brought to the Committee.
- The capacity and capability of middle management risk was being developed.
- Further work was required to align the risks across the Group.

For the SGUH people-related risks, there were no proposed changes to the risk scores in September. In terms of alignment, the risk on EDI was framed differently at both Trusts with the ESTH risk covering EDI across all of the protected characteristics, whereas the SGUH risk was focused on the diversity of senior management. The EDI risk needed to be framed more generally and include ethnicity of doctors going through disciplinary processes; actions from the WRES/WDES and the NHS EDI action plan.

For the ESTH risks, there was a proposal to change the risk score of the capacity and capability of the people directorate from 20 to 16, based on the likelihood score and a number of controls put in place, i.e. the stabilisation in recruitment. There had also been improvements to capability; revisions to key policies and processes. The backlog in ER cases had started to reduce.

The Committees agreed that a programme of deep dives on an individual risk each month would be helpful, starting with the older and static risks. The aim would be to review whether the Trusts were doing all they could, confirm when the actions would be completed and review the risk appetite.

The ESTH Committee agreed the proposal to reduce the risk score from 20 to 16 for the ESTH Capacity and Capability risk, based on the likelihood score and the number of controls in place and ongoing improvements in capability.

6.2 Education Update – SGUH Undergraduate Medical Education – Risk

The Committees were informed in September that undergraduate MBBS Quality visit and subsequent report in March 2023 identified a lack of clarity in how the received Undergraduate Medical Education Tariff (UGMT) was utilised across different divisions, directorates, and departments within the Trust. It also identified how the Trust spends significantly less of its funding on 'top-slice arrangements' in comparison to other similar sized providers of undergraduate education. The HEE noted that the lack of transparency and low level of 'top slice' were contributing factors towards the gaps in the provision of education.
The Committees were made aware of:

- The risk of not being able to understand, with sufficient clarity, exactly how the UGMT funding was utilised within the Trust.
- The Education Team being unable to increase the top slice of the UGMT from 5% to 10-15%, to respond to the various quality assurance reports and actions, as well as to deliver the educational services as part of the NHSE & SGUL Tri-Partite agreement for undergraduate medical education. One of the actions was to introduce a Band 6 team leader role to coordinate education; communicate the offer and support the educators in delivering the education. The post had gone to the VCP. There was concern that if funding was not identified, this role could cause a cost pressure to the Trust.
- The risk of failing to demonstrate transparent and effective utilisation of tariff funding in the annual NHSE 'Self-Assessment Return' which could trigger an external financial review by NHSE resulting in the loss of a portion of the education tariff, thereby affecting the Trust's financial stability.
- The Trust could also be referred to the GMC for the standard of the education provided.

There had been early discussions with the GCMO on how to resolve the issue.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in September and October 2023.

Group Board

Meeting in Public on Friday, 10 November 2023

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

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees-in-Common at its inaugural meeting in October 2023 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committee wished to highlight to the Board are:

(a) Electronic Patient Record Implementation: The Committee considered a progress report on the implementation of the EPR at ESTH on a shared domain with St George's, which is a key corporate enabler to the Group's five-year strategy. With six months to 'go-live', planned for April 2024, the Committee was encouraged that the programme remained on track and that work had been undertaken to engage with and learn from other organisations that had undergone a similar EPR roll-outs. The Committee sought assurance regarding the delivery of planned activity through to launch and in relation to the management of key risks to the delivery of the project. Key areas of focus were clinical engagement, staff communications, and staff training. A key challenge was the need to balance the need to plan safe levels of activity to ensure an effective go-live and the need to avoid a reduction in elective activity.

(b) Estates Returns Information Collection (ERIC) and Premises Assurance Model (PAM): Both Trusts had submitted their ERIC and PAM surveys over the summer, and the reports will be presented to the next meeting of the Committee. Early indications suggest continued progress for St George's but a potential rating decrease for Epsom and St Helier. This was not necessarily a reflection of any drop in performance at ESTH, but rather the ability of the ESTH service to provide the evidenced documentation of compliance. To address this, a new reporting tool is being implemented to track PAM and ERIC metrics at ESTH and this is expected to provide the Committee with assurance regarding both overall compliance and any areas in which evidence of compliance is absent.

Action required by Group Board

The Group Board is asked to note the issues escalated to by the Infrastructure Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in October 2023.

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

Infrastructure Committees-in-Common
Group Board, 10 November 2023

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meeting on 25 October 2023 and includes matters the Committee specifically wishes to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 This was the inaugural meeting of the Infrastructure Committee. The Committee considered the following items of business:

October 2023
• Infrastructure Committees-in-Common Terms of Reference
• Group Chief Infrastructure, Facilities and Environment Officer Key Issues Report
• Estates Assurance Report
• Facilities Assurance Report
• Group Green Plan Update
• Assurance and Compliance: Medical Physics and Clinical Engineering
• Digital Planning and Priorities
• Electronic Patient Record (EPR) Implementation Update
• High Risk Programmes and Areas of Focus

2.2 The Committee was quorate for the meeting.

3.0 Key issues for escalation to the Group Board

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

(a) Electronic Patient Record (EPR) Implementation Update

The Committee considered a progress report on the implementation of the EPR at ESTH on a shared domain with St George's, which is a key corporate enabler to the Group's five-year strategy. With six months to 'go-live', planned for April 2024, the Committee was encouraged that the programme remained on track and that work had been undertaken to engage with and learn from other organisations that had undergone a similar EPR roll-outs.

The Committee sought assurance regarding the delivery of planned activity through to launch and in relation to the management of key risks to the delivery of the project. In terms of organisational readiness, the Committee heard that training for both clinical and non-clinical staff was recognised as a key priority and that was critical to successful implementation. The bulk of the training would be delivered between January and March 2024, with the key challenge being releasing and backfilling staff to undertake the training during the challenging period of winter pressures. The Committee heard that detailed planning was being undertaken alongside the block booking of backfill. The project team was focusing on testing data migration and developing the risk matrix which was a priority for Care Quality Commission (CQC).

The Group had received support from NHS Digital's Trust System Support model (TSSM), which had undertaken its most recent review in July 2023. TSSM's review of progress against the action plan had found that the project was on track but had also highlighted the importance of clinical engagement and staff communications as a key area for focus. A communications plan was being developed and dedicated communications resource had been identified.

One key area of learning from other hospitals had been reducing activity in the run-up to and during the roll-out of a new EPR. However, the Committee heard that this was not considered to be an option given both the local and national focus on reducing the backlog of patients on the waiting list and the clear steer received from NHS England (NHSE) that flow and performance must not be disrupted. The Executive recognised criticality of maintaining reporting, including on referral to treatment time, and of the need to sustain performance levels throughout the rollout and work was being undertaken to plan safe activity levels to ensure an effective go-live while not impacting on elective recovery. This was a key area of focus for the Executive in overseeing the delivery of the programme.

Another area of learning from other Trusts was that the initial go-live of a new EPR system had gone smoothly and that the issues typically emerged after around six weeks. As a result, there was a real focus on not just the period up to go-live, but also the weeks and months beyond this.

The Committee sought assurance regarding the internal governance of the EPR programme and heard that a EPR Steering Group had been established which reported into Site Leadership Teams and the Group Executive. The Group Executive had held a detailed review of EPR implementation earlier in the month and the level of Executive oversight of the programme would step up further over the coming weeks and months as the 'go live' date approached. The Infrastructure Committees-in-Common will receive regular updates on implementation at each meeting both before and after the 'go live' date.

(b) <u>Estates Returns Information Collection (ERIC) and Premises Assurance Model (PAM):</u>

Both Trusts submitted their ERIC and PAM surveys over the summer, and the reports will be presented to the next meeting of the Committee. These surveys assess compliance and service delivery in estates and facilities, and provide a comprehensive and evidenced way of demonstrating compliance with key standards. Early indications suggested continued progress for St George's but a potential rating decrease for Epsom and St Helier. This was not necessarily a reflection of any drop in performance at ESTH, but rather the ability of the ESTH service to provide the evidenced documentation of compliance. To address this, a new reporting tool is being implemented to track PAM and ERIC metrics at ESTH and this is expected to provide the Committee with assurance regarding both overall compliance and any

areas in which evidence of compliance is absent. The Committee looks forward to receiving the full ERIC and PAM reports for both Trusts at its next meeting. These will be critical in assisting the Committee to understand the overall estates compliance position across the Group.

4.0 Key Issues on which the Committees received assurance

4.1 The Committees wish to report to the Group Board the following matters on which they received assurance:

a) Digital Planning and Priorities

Beyond the EPR project, which was the principal focus for IT resources and capacity, the Committee also reviewed a report setting out digital planning and priorities across the Group. The Committee heard that integration of digital services across the Group was planned once the EPR was successfully rolled out and other major projects had been delivered. Historic deficit positions meant that both Trusts had a significant backlog in terms of activities required to address gaps in capability or ageing infrastructure that was not fully fit for purpose, or did not meet the growing expectations of digital services to be always available and accessible from anywhere in an increasingly hostile cybersecurity environment.

At ESTH, the priority was the EPR project, and it was acknowledged that this would put pressure on current digital resource. Demand for ICT projects at ESTH was not matched to available resource, particularly in areas such as support for home working, additional IT hardware, service desk response times, business information, shadow IT, outage response, information governance training catch-up, and improving cybersecurity maturity. After the immediate priority around EPR, IT support for Building Your Future Hospitals Programme was the most significant priority.

At SGUH, the EPR roll-out at ESTH was also critical given that this was on a shared domain with SGUH. Beyond this, the IT department were focused on delivering a number of critical projects including network upgrades, capacity management, security matrix, as well as specific projects in maternity and cardiology.

Meeting staff expectations for accessible digital services is challenging due to lack of capital investment and tension arises when prioritising new system development with business-as-usual improvements and enhancements. Consultation with directorates to agree priorities is ongoing, the backlog may increase as the EPR project progresses.

Additional demands to support Group integration including Group-wide Teams and email implementation and the integration of digital functions including cyber security and information governance have emerged. Integration offers the opportunity for applications rationalisation, improved population health information and the development of the patient portal.

The Committee also heard that there had been two significant cyber incidents at St George's, one regarding the network and the other a malware incident had been reported to NHS England (NHSE). NHSE had investigated and provided recommendations which

were being implemented. NHSE commended the handling of incidents, particularly the proactive response and the strong professional skills of our teams.

b) Estates Assurance Report

The Committee reviewed the estates activities and performance at St George's over the past six months, noting that similar detailed scrutiny of the Epsom and St Helier estates position had been explored earlier in the year through the time-limited Estates Assurance Committee. Future meetings would consider the estates position across the Group as a whole.

The Committee heard that the principal area of focus for the SGUH estates team had been on statutory and mandatory compliance. There had been a general improvement over the past 3-4 years, but there were two areas of current concern. Firstly, the second combined heat and power plant had been offline for several months due to tube failures in one of the boilers. Efforts were underway to compel the external contractor to complete the necessary works. Secondly, a specialist team had been assembled to reduce the backlog maintenance. At the beginning of the period, there were 2,992 outstanding maintenance jobs. After ten weeks, as of 5 September a substantial reduction to 1,587 had been achieved.

The Committee reviewed the current position relating to audits completed by the Authorised Engineer (AE). The audit on medical gases had received reasonable-to-good assurance, with decontamination, heating and ventilation, water systems, fire safety, electrical services (HV), lifts, pressure systems and asbestos all receiving reasonable assurance. On fire safety, a more recent AE audit had been undertaken and the Trust was awaiting the report and the audit of electrical services (LV) was being rescheduled.

c) Facilities Assurance Report

The Committee received a detailed report which provided an overview of the work and key achievements of the St George's facilities management team.

A new food and drink strategy was being developed and was led by a consultant dietician. The new catering strategy would be fully implemented by the end of October and would be handed over to a new head of catering. Staff feedback on catering had improved from 3.4 out of 5 in January 2023 to 4.2 out of five in July 2023. However, supply chain challenges had affected patient feeding services, leading to reduced deliveries and short notice substitutions. Facilities was actively collaborating with the contractor to resolve these issues.

In relation to violence and aggression, the security team had dealt with a total of 40 security incidents in the Emergency Department and 54 incidents on Fredderick Hewitt Children's Ward. There had also been a particular security challenge relating to one of the intensive care units. The Committee heard that there had been positive engagement of police in assisting with these security concerns. The Committee reviewed the nature of the incidents that had been recorded in September, and noted that verbal abuse and physical abuse, assault or violence characterised the majority of incidents. The Committee will review the position relating to the new violence and aggression prevention standards at a future meeting.

d) Medical Physics and Clinical Engineering

The Committee received a compliance report relating to the St George's Medical Physics and Clinical Engineering department. The Committee heard that the department was

responsible for managing around 28,000 medical devices. A risk-based approach for maintenance was adopted, with 8,000 devices on scheduled planned maintenance and 20,000 on reactive maintenance. In terms of compliance with national metrics, 44 of 50 safety metrics were fully compliant and 6 were partially compliant. In relation to MRI compliance, the Trust had received a pass for the NHS Breast Screening Programme, reflecting successful compliance.

The Committee discussed reportable incidents to the Care Quality Commission in relation to ionising radiation and asked for further details about how the incidents had been investigated and reported through the Trust's governance processes, noting that the specific incidents discussed had not been reported to the Quality Committees-in-Common. The Committee recognised that these may not have been at a threshold to be considered as Serious Incidents, but sought further assurance on the process around CQC reportable incidents in the service.

The Committee considered that the report demonstrated the proactive steps taken by management to achieve compliance and to provide assurance in critical areas to the Committee, along with identified areas of improvement and progress. However, the Committee noted that the report referred to the SGUH Medical Physics department only, and asked that a similar report for the ESTH service be brought to the Committee at a future meeting.

5.0 Other issues considered by the Committees

5.1 The Committees also received the following reports:

a) Group Green Plan Update

The Committee reviewed a progress update on implementing the Green Plan across the Group. National targets were in place for all trusts to achieve net zero carbon by 2040, with an 80% reduction by 2028-32, and to achieve net zero carbon footprint plus (which contained a wider set of requirements) by 2045, with an 80% reduction by 2036-39. At ESTH, a successful bid had been made for a Heat Decarbonisation Plan, a new lower carbon patient menu had been introduced, and a new staff travel plan had been developed based on a survey of staff. St George's had secured funding of £500k from the 2022/23 South Wets London Green Plan Fund, which had supported a reduction in anaesthetic gas use, centralised nitrous oxide destruction for maternity, electric vehicle charging, and SMART theatres technology. On the latter, the Trust was a recognised UK leader. Theatres typically consume up to six times the energy of average hospital spaces and contribute up to 70% of hospital waste. The initial phase of the project, serving as proof of concept, has been implemented in two theatres which are now fully functional. The projects advantages encompass reduced energy use, improved care, reduced down time and improved flow. There is potential for the project's expansion to all theatres, pending funding approval from the South West London Integrated Care Board. In terms of priorities for 2023/24, the Committee heard that the development of a single Group-wide Green Plan and the targeting of external capital funding for decarbonisation projects were the areas of focus. Work was underway to recruit a Green Plan team and a set of key performance indicators was being developed for each workstream.

b) ICT: High Risk Programmes and Areas of Focus

The Committee was also briefed on the implementation of the new Picture Archiving and Communications System (PACS), primarily for radiology. This system is being implemented across four acute Trusts in SW London as existing products are coming to

the end of their life. A major benefit of the new PACS will be to create a single platform for sharing information between organisations. Challenges have arisen with the supplier's capacity, including two unsuccessful installation attempts at Croydon University Hospitals. High-level intervention with the supplier's Chief Executive is ongoing to ensure increased support, with a further update to be provided at the next meeting.

b) Infrastructure Committees-in-Common Terms of Reference

The Committee discussed the terms of reference which had been approved by the Group Board on 7 July 2023. The terms of reference would undergo review at the end of the financial year as part the wider review of Committee effectiveness. The Committee held an initial discussion about items to be covered at future meetings, and will review its full draft forward plan at its next meeting.

The Committee discussed what information should be presented. It was agreed that dashboards for estates and facilities, particularly covering adherence to cleaning standards, estates help desk data, and backlog maintenance would be developed. These would also provide metrics by way of improvement or decline and offer context in terms of the trusts' performance against comparator organisations. Likewise, on ICT the Committee noted that a cybersecurity dashboard had been requested by the Audit Committee and the Committee agreed this should also be reviewed at a future meeting.

While the terms of reference had established bi-monthly meetings for the Committee, it was decided that the second meeting would take place towards the end of November 2023. In terms of forward planning, it was agreed that, wherever possible, the Infrastructure Committees-in-Common would be scheduled to align with meetings of the ESTH Building Your Future Hospital Programme Board and to run these meetings on the same day given the inter-relationship between the new hospital and issues relating to the maintenance of the existing ESTH estate.

6.0 Recommendations

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

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	2.5	
Report Title	**SGUH Audit Committee report of the meeting held on 19 October**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	SGUH Audit Committee	19 October 2023
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meeting on 19 October 2023. The Committee received its regular reports on Counter Fraud, Cybersecurity and Breaches and Waivers.

The Committee was also updated on progress on the Internal Audit 2023/24 workplan. Members were pleased to be informed that the audits for Sickness Absence, Data Quality, New Starter Onboarding, and Rostering are all underway. Scopes have been issued for the remaining audits and auditors are engaging with management on planning. The Committee also received two late assurance reports which had been give limited assurance opinions by the Trust's previous auditors. Members considered the management responses which outlined the actions by the Trust taken in response to the recommendations.

There was also an update on the Group-wide tender for an External Audit provider. The Group Chief Finance Officer will be meeting with the Committee Chair to consider a revised process and timetable before asking the Council of Governors to approve the tender process.

Action required by the Board

The Board is asked to:

- note the report of the Committee's meeting held on 19 October 2023
-

Committee Assurance	
Committee	SGUH Audit Committee
Level of Assurance	Not applicable

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

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
There are no specific risks relevant to this report, beyond those set out in the individual reports to the Board.				
CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
As set out in substantive reports presented to the Board.				
Legal and / or Regulatory implications				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

Report of the SGUH Audit Committee

Group Board, 10 November 2023

1.0 Purpose of paper

1.1 The Audit Committee met on 19 October 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 Internal Audit Progress Report and final Internal Audit Reports

The Committee was updated on the work to deliver the 2023/24 audit workplan. The audits for Sickness Absence, Data Quality, New Starter Onboarding, and Rostering are underway. Scopes have also been issued and planning meetings arranged for the remaining audits on the plan. The Committee noted there were outstanding management actions from previous audits and that these have recently been escalated to the Group Chief Corporate Affairs Officer who is following up with relevant management and executive leads.

Members were told that planning for next year's Internal Audit workplan would be commencing soon and that they will have the opportunity to comment on the draft plan at the next meeting in February.

The Committee considered two late internal audit reports:

- IT Systems not supported by Central IT - Limited Assurance
- Cybersecurity - Limited Assurance

In relation to the IT Systems not supported by Central IT assurance report, the auditors had provided a limited assurance opinion and had highlighted the absence of a policy for the operation and monitoring of unsupported IT systems across the Trust, and that it was not possible to accurately ascertain the number of IT Systems not supported by IT.

The Committee was told that management had not signed off the report at the time it was originally issued as it was acknowledged that management engagement with and responses to the audit had been inadequate. This had been partially due to the audit coinciding with a significant infrastructure incident which necessitated prioritisation of resource. The Committee considered the updated response prepared by management which sets out the actions to ensure there is the proper governance in place to ensure there is no repetition and to respond to the findings set out in the assurance report. These include:

- Reference to an approach to Shadow IT agreed by the Information and Governance Group in March 2021
- A clearly defined managed and phased approach for monitoring of Shadow IT
- Increased emphasis on improving management of risks and improved infrastructure resilience.
- The ongoing discovery work to establish and control Shadow IT systems.

Members noted the urgency of the work and welcomed the ambition to realise improvements by the end of the financial year. Members will be receiving an update on progress at the February meeting. Further, the Committee requested that consideration be given to holding a follow-up internal audit as part of the 2024/25 internal audit plan.

With regards to the Cybersecurity assurance report, the previous auditors had issued a report with one urgent and eight important recommendations. Management responded saying the findings were not accurate and that they did not agree with many of the report's conclusions. The Committee heard the auditors had removed the urgent recommendation on receipt of additional evidence. However, a second report was issued also giving limited assurance, which has not been accepted by the Trust.

The Committee was given assurances that programmes have been put in place relating to readiness and preparations to respond to incidents, raising staff awareness of cybersecurity with a number of actions closed and a timetable to complete the remaining work. In response to concerns from the Committee, it was agreed to consider bringing forward the scheduled audit for Cybersecurity so Members can be assured on existing controls.

2.2 External Audit Progress Update

The Committee received an update from the external auditors on the preparations for the 2023/24 audit of Trust accounts. The Committee welcomed the assurances that the auditors had not encountered any issues and that the Committee could expect to receive audit recommendations and conclusions which are cognizant of wider sector issues. The Committee will have the opportunity to review and comment on the draft audit plan at the February meeting.

2.4 Counter Fraud Quarterly Report

The Committee considered its regular report on progress with current and new counter fraud cases under investigation and noted the work by the counter fraud team to raise awareness of emerging risks through attendance at corporate inductions and the preparations for International Fraud Awareness Week in November. There have been four new referrals to the team since the August meeting, relating to false identities and false documents. The Committee welcomed the Single Tender Waiver benchmarking report noting the Trust's good position against its peers.

2.5 Breaches and Waivers Report

The Committee considered the regular breaches and waivers report for Q2 2023/24. The Committee was told there had been a decrease in the usage of waivers from 16 in Q1 to ten in Q2, along with a decrease in value to £339,727. The instances of breached decreased in Q2 to six down from 14. There was also a decrease in value to £302,785. The Committee were informed the ongoing work to reduce usage through adherence to robust processes, engaging with stakeholders, improved tracking and regularly reviewing contracts.

2.6 Losses & Compensation Payments

The Committee received the report of the losses and compensation payments made by the Trust in the period 1 April to 30 September 2023. The Committee was informed there were significant write offs of stock in Cardiology. The Finance team is working with the team to understand the reasons and the Committee will be updated in future reports.

2.7 Aged Debt Report

The Committee noted the Trust's current debt position and approved the recommendations to write off non-NHS debt of £5.783m and NHS debt of £3.868m.

2.8 Better Payment Practice Code Improvement Plan

The Committee was asked to approve the Better Payment Practice Code Recovery Plan which had been drafted in response to a note from NHS England requesting improvements in the Trust's performance. The Committee was told the move to SBS, and previous recovery actions had not had the expected impact. A new high-level action plan has been developed

looking to improve areas such as systems, training, operational procedures and governance. The enhanced processes are expected to deliver a 25% to 30% improvement in performance over the next three months.

2.9 Information Governance and Cyber Security Update

The Committee received the Q2 2023/24 update which included a report of the cybersecurity incident at the Trust on 21 September. The incident was picked up by NHS England which implemented actions and resource in response. The site team have been working on remediation actions and are also implementing previously planned actions ahead of schedule. The Committee will be updated at its February meeting on the lessons learned from the incident.

The Committee was also updated on the latest IG mandatory training compliance for the 2023/24 Data Security and Protection Toolkit. The Trust is reporting c. 90% and expects to meet the 95% standard for December. The Committee also noted the latest iteration of the Cybersecurity dashboard.

2.10 Tender for External Audit Provider

The Committee received an update from the GCFO on the Group tender for a common External Audit provider. The existing contracts for the external auditors at both St Georges and Epsom run through to the end of 2024/25. This will allow a larger window for the tender process and a revised timetable is being developed which will be shared with the Committee Chair for discussion on an approach to the tender. The Council of Governors are being notified of the amended timeframes and the GCFO will be seeking their approval on an agreed way forward.

3.0 Recommendation

3.1 The Board is asked to:

- note the report of the Committee's meeting held on 19 October 2023

Peter Kane
Audit Committee Chair, NED
November 2023

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	2.6	
Report Title	**ESTH Audit Committee report of the meeting held on 19 October 2023**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	ESTH Audit Committee	19 October 2023
Purpose	**For Assurance**	

Executive Summary

The Audit Committee met on 19 October 2023, where it received its regular reports on Counter Fraud, Cybersecurity and Breaches and Waivers.

The Committee received an update from the Group Chief Finance Officer on the planned retrospective review of the 2022/23 audit of Trust accounts. Members were informed an initial report will be shared with the Committee Chair in November followed by a full report on the lessons learned from the audit to Members at the next meeting in February 2024. The external auditors have already shared their list of the issues they encountered during the audit. These will inform an action plan which will be implemented to mitigate potential issues for the 2023/24 audit. Members were informed that work for the 2023/24 audit will commence in December and the audit plan will be shared with the Committee in February for discussion and comments.

Internal Audit gave their update on progress of the Internal Audit workplan. The Committee heard that the fieldwork for the Sickness Absence audit has now finished, and a draft report is expected to be issued shortly. The audits for Data Quality, New Starter Onboarding, and Rostering are in progress and the auditors are working with management on preparations for the remaining audits on the workplan. The Committee expressed their concern at the number of outstanding open audit actions carried over from the 2022/23 plan awaiting management responses. The Committee was informed the matter had very recently been escalated to the Group Chief Corporate Affairs Officer who was working with the relevant management leads to ensure there is an improved position for the next meeting.

Action required by the Group Board

The Group Board is asked to:

a) Note the update from the Audit Committee meeting held on 19 October 2023.

b) Note the concerns of the Audit Committee at the timeliness of management responses to outstanding internal audit actions which have now been escalated to the Group Chief Corporate Affair Officer.
c) Note the approval of the adoption of the SBS recovery policy for salary overpayments.
d) Note the approval of the updated Debt Management Policy

Committee Assurance	
Committee	ESTH Audit Committee
Level of Assurance	Not applicable

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Audit Committee Report of the meeting held on 19 October 2023

Matters for the Board's attention

1.0 Purpose of paper

1.1 The Audit Committee met on 19 October 2023 and agreed to bring the following matters to the attention of the Board.

2.0 Matters for the Board's attention

2.1 External Audit

The GCFO reported the Trust's External Auditors have submitted their initial list of issues encountered during the audit of the 2022/23 accounts. These are being reviewed by the Site Finance team ahead of their own retrospective review of the audit process. The Finance team will be developing a common list of issues and actions which will be planned into the 2023/24 audit. The GCFO will be sharing his report of the lessons learned with the Audit Committee Chair in mid-November before taking the report to the Committee for formal consideration in February 2024. The Audit Committee welcomed the work to ensure a more successful audit in 2023/24 noting that scoping work and engagement with the auditors will begin earlier in the process.

The Audit Committee were also informed the financial environment across the NHS will make the 2023/24 audit challenging and colleagues will need to work together to address issues.

The External Auditors reported the preparatory work for the 23/23 audit will commence in December with the risk assessment and developing the audit plan which members will have the opportunity to review and comment on at the February meeting.

2.2 Internal Audit Progress Update & Recommendations Tracker

The Audit Committee received the Internal Audit update and noted the work in progress to deliver the 2023/24 internal audit workplan. The fieldwork for the Productivity - Sickness Absence audit has concluded. The audits for Data Quality, New Starter Onboarding, and Rostering are underway. Scopes have also been issued and planning meetings arranged for the remaining audits on the plan.

The Committee highlighted their disappointment at the number of open audit actions handed over from the previous auditors, with 19 management actions still awaiting a management response. Members expressed their concern that actions were not completed in a timely manner particularly with 17 of the outstanding actions being medium level actions. Members were informed that, in line with agreed protocols, the internal auditors have now escalated the follow up on the actions to the Group Chief Corporate Affair Officer. It was also highlighted that two thirds of the open actions pertain to actions due for completion at over the past three months. The GCCAO assured the Committee the actions are being followed-up with the relevant management leads and were being escalated as necessary to the relevant Executives. He suggested that his clear expectation was that there would be a much improved position for the next meeting in February 2024. Ahead of this, an update on progress would be shared with the Committee Chair in early December.

The GCCAO reported that he was in discussion with the auditors on arrangements for the 2024/25 Internal Audit workplan and the Committee can expect to see a more usual and balanced loading programme of audits through the year and will receive internal audit reports earlier in Q1. The back-loading of the 2023/24 internal audit plan was a consequence of the point at which the tender had been undertaken and the aware of contracts made in early 2023.

2.3 Information Governance / Cybersecurity Update

The Committee received the update for Q2 2023/24 which included the latest iteration of the Cybersecurity dashboard. The Committee noted the work to date and were informed they can expect the next iteration to be an improvement particularly in respect to how key indicators are visualised and easy to understand for a wide audience. The Committee also noted the work to improve mandatory IG training compliance for the 2023/24 Data Security and Protection Toolkit. The Trust has now passed the 95% threshold required for standards met. The Committee discussed the SWL Cyber Security Assessment which had rated Service Provider Management as red and how the Trust needed to review its older contracts with providers to ensure all ensure that providers connecting to the Trust's network are trustworthy and their processes are secure. The Committee were assured that work is underway to identify actions and timelines and that an action will be brought to the next meeting.

2.4 Counter Fraud Update Quarterly Report

The Committee considered its regular report on progress with current and new counter fraud cases under investigation and noted the work by the counter fraud team to raise awareness of emerging risks through attendance at corporate inductions and working with the Trust's Communication team to publicise International Fraud Awareness Week in November. Since the previous meeting, there have been seven new referrals to the team, relating to working whilst sick, timesheet fraud, private work in NHS time and abuse of position. Seven cases have been closed since August with no evidence of fraud found. Local Counter Fraud Service are also working with Internal Audit on a joint review of recruitment and visas to ensure pre-employment checks are being undertaken in line with the current Home Office guidance and the internal processes are being followed in relation to obtaining references, correct qualifications, and DBS checks.

2.5 Breaches and Waivers Report

The Committee considered the regular breaches and waivers report for Q2 2023/24. The Committee was told there had been an increase in the usage of waivers in Q2 from two in Q1 to four with an overall value increase to £92,060. There was also an increase in the instances of breaches from two to five, with an accompanying increase in value to £148,236. The Committee was told the increases follow historical patterns and there are no concerns for management, who continue to adhere to robust processes, engaging with stakeholders, improved tracking and regularly reviewing contracts to ensure usage is minimised.

2.6 Salary Overpayments

The Committee received the salary overpayments report welcoming the trend in reducing salary overpayments since Q3 of 2022/23. The Committee noted that based on current 2023/24 overpayments the Trust has reported a c.£600k annual improvement in gross

overpayments. Based on a typical overpayment recovery rate of 75% this results in a c.£148k CIP in M6 2023/24 for the improvements.

The Committee noted the actions to improve performance including additional reporting, improved payroll management, increased financial controls and awareness of budget holders. To support further improvements, the Committee approved the adoption of the SBS recovery policy, noting that the main change was the alignment of the timeframes for recovery, allowing for recovering overpayments over the same period as which the overpayments occurred. The Committee welcomed the processes for engaging with individuals who need to make repayments and the flexibility for responding to genuine hardship cases.

2.7 Losses & Compensations Payments

The Audit Committee noted the Trust made losses and compensation payments totalling £17,849 in the eight month period from 1 January 2023 to 31 August 2023 inclusive.

2.8 Aged Debt

The Committee was asked to approve the Debt Management Policy which had been reviewed and updated in response to a recommendation from an Internal Audit review. The policy has been made consistent with the SBS Policy on debt management which the Trust has been working to for several years now. In accordance with the recommendation from Internal Audit, the policy will be reviewed annually.

2.9 Tender for External Audit Provider

The Committee received an update from the GCFO on the Group tender for a common External Audit provider. The existing contracts for the external auditors at both Epsom and St George's run through to the end of 2024/25. This will allow a larger window for the tender process to be developed and undertaken and a revised timetable is being developed which will be shared with the Committee Chair for discussion on an approach to the tender.

3.0 Recommendations

3.1 The Board is asked to:

a) Note the update from the Audit Committee meeting held on 19 October 2023.
b) Note the concerns of the Audit Committee at the timeliness of management responses to outstanding internal audit actions which have now been escalated to the Group Chief Corporate Affair Officer.
c) Note the approval of the adoption of the SBS recovery policy for salary overpayments.
d) Note the approval of the updated Debt Management Policy

Peter Kane
Audit Committee Chair, NED
November 2023

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	3.1	
Report Title	**Maternity Services Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	**Bene Agbagwara-Osuji, Director of Midwifery and Gynaecology Nursing, Epsom and St Helier University Hospitals NHS Trust (ESTH)** **Laura Rowe, Lead Midwife for Clinical Governance and Risk (ESTH)** **Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH)**	
Previously considered by	Quality Committee in Common	26 October 2023
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

The purpose of the report is to inform the Board of progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns and activity to ensure safety within maternity units across the Group.

This report provides an update on the measures to monitor maternity and neonatal safety, as outlined in the NHSEI document 'Implementing a revised perinatal quality surveillance model' (December 2020) and a status update against the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5.

2.0 CNST Safety Action Summary Position

The summary table below sets out the current position against the 10 CNST Safety Actions in order to strengthen Site and Group oversight of Maternity Services, with the aim of providing assurance to the QCIC and Group Board.

SITE	Ontrack	Currently non-compliant	Safety Action with associated RISK
ESTH	5	2	3
SGH	5	3	2

3.0 Safe Staffing

Midwifery Safe Staffing for August 2023 was 85% for St Helier, 84% for Epsom and 90% for St George's, against a set threshold of 94%. Staff were redeployed from Continuity of Carer teams and community and non-clinically facing teams to assist in the covering of the staffing shortfalls.

4.0 Mandatory Training

Mandatory training compliance continues to be a risk in ESTH and SGH, although improvement has been seen when compared with last month for CTG training for SGUH Obstetricians with a move from 35% to 83.5%. Below are the staff groups that focus continues to be given to assist in compliance

Training Category	Site	Staff Group	Performance September 2023	RAG
Prompt	SGUH	Anaesthetics	60.9%	
	ESTH	Anaesthetics	70%	
	SGUH	Consultant Obstetricians	70%	
CTG Training	SGUH	Obstetricians	83.5%	

5.0 The Maternity and Newborn Safety Investigations (MNSI) programme

From 1 October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme previously part of the Healthcare Safety Investigation Branch (HSIB) will be hosted by the Care Quality Commission (CQC). There will be no change to operations or workforce and there will be no interruption to ongoing investigations.

6.0 Key Risks

The following risks identified in this report are brought to the attention of the Board Risk mitigations and improvement actions are described in Appendix 1:

Trust	**Risk**	**Mitigation/ improvement actions**
SGUH	There is a risk to recruitment and retention as staff report difficulties in speaking up, feeling heard and difficulties with management relationships	Increased visibility of leaders, walk rounds, safety champion meetings, culture work
SGUH Monthly KPIs	Non-compliance with mandatory training	Training plan in place and monitored. Booking staff onto courses
	Non-compliance with 94% fill rate for maternity staffing	Staff redeployed from CoC, community and non-clinical roles. Twice daily monitoring of red flags and twice daily Sitreps – resolve issues as they arise 24/7
	Non-compliance with 100% Band 7 Supervisory midwife	
ESTH Monthly KPIs	Non-compliance with mandatory training	Training plan in place and monitored. Booking staff onto courses
	Non-compliance with 94% fill rate for maternity staffing	Staff redeployed from CoC, community and non-clinical roles. Twice daily monitoring of red flags and twice daily Sitreps – resolve issues as they arise 24/7
SGUH CNST	Risk of non-compliance with Safety Action 3: Transitional Care	A service improvement proposal is being developed. Part use non-recurrent funding received via year 4 CNST

	Risk of non-compliance with Safety Action 5: Midwifery Workforce Planning	Establishment reviews and rostering templates
	Risk of non-compliance with Safety Action 6: Saving Babies Lives Bundle	Implementation tool launched. 44% self-assessed compliance so far
ESTH CNST	Risk of non-compliance with CNST Safety Action 5: Midwifery Workforce Planning	Business case to increase establishment to include B5 RN to run elective theatre services. Staff moved from CoC to prioritise inpatient rotas.
	Risk of non-compliance with CNST Safety Action 8: MDT Training	Training plan in place. Booking staff onto courses

Action required by Group Board

The Board is asked to:

a) Note the compliance status against the CNST year 5 MIS
b) Note the risks and mitigations brought to the attention of the Board
c) Note from 1 October 2023 the Maternity and Newborn Safety Investigations are now hosted by the CQC
d) Make recommendations for any further action

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

Appendices

Appendix No.	Appendix Name
Appendix 1	**Maternity Services Monthly Report**

Implications

Group Strategic Objectives

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

Risks

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

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

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

Enforcement undertakings applicable to ESTH and SGH Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity and inclusion implications

- National research recognises that there are protected characteristics which are at a greater risk of maternal and neonatal complications. The report presents the ethnicity for mortality data
- Ensuring continuity of care for women from Black, Asian and minority ethnic communities and from the most deprived groups is important and will continue to be considered. This model of care requires appropriate staffing levels to be implemented safely

Environmental sustainability implications

No issues to consider

Group Maternity Services Report
Group Board, 10 November 2023

1.0 Purpose of paper

1.1 The purpose of the report is to inform the Board of progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns; and activity to ensure safety within maternity units across the Group.

2.0 Background

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

2.2 Much of the CNST technical guidance is time bound, the first deadline was July this year related to Safety Action 2, MSDS (Maternity Services Data Set) which has been submitted and Trusts must pass all 11 requirements. ESTH has indicated that full compliance will be achieved. However, SGUH has identified an issue with the EUROKING SYSTEM EPR platform: Multiple errors have been identified and escalated to the National teams from all sites who use it. This issue has been recognised by NHS Resolution. The data submission submitted in July 2023 was successful and appeared to be error free. The outcome of the submission for both Trusts is expected in October 2023.

2.3 The second time bound element is Safety Action 5, which requires that a midwifery workforce review is undertaken 6 monthly and reported to Board. Work to inform the midwifery workforce review paper is underway and is anticipated to be presented at the November 2023 meeting.

2.4 The current position for CNST compliance is set out below against the NHS Resolution (NHSR) Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS) Year 5, (see further detail in section 3 below and at Appendix 1).

Safety Action	ESTH	SGUH
1. PMRT		
2. MSDS		
3.Transitional Care		
4. Clinical Workforce Planning		
5. Midwifery Workforce Planning		
6. Saving Babies Lives Care Bundle		
7. MVP		
8. Multidisciplinary Training		
9. Safety Champion		
10. NHS resolution		

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

2.6 The learning from the recent CQC inspection of Maternity Services at St George's Hospital identified the need to strengthen the assurance provided to Quality Committee and the Board. The assurance as set out in section 3 below will strengthen Site and Group level reporting and oversight of Maternity Services for reporting and assurance at QCIC and Group Board.

3.0 Maternity Services: Progress actions against local and national requirements

Assurance	Report Published	Status	Evidence
Review of MBRRACE cases in 2022 report			
MBBRACE-UK Audit Report	2022	• SGUH was identified as an outlier: over 5% higher than the average for comparable Trusts in the 2020 audit report • ESTH was identified as within 5% of the average for comparable Trusts • A review of the 74 cases at SGUH has been commissioned and the review of the case notes supplied is in progress. The external report is due in February 2024	MBBRACE-UK 2020 Report: previously received at committee Terms of Reference: previously received at committee PMRT Quarterly Report to committee
MBBRACE- UK Audit Report	2023	• The findings of the 2023 report are that both ESTH and SGUH were within the category of the 5% average for comparable Trusts • Local review undertaken by maternity teams in collaboration with local LMNS ➢ SGUH 36 stillbirth case reviews identified care and service delivery issues which potentially contributed to the outcome in 8 cases. Actions progressed in relation to staffing, escalation, triage, risk assessment and fetal monitoring ➢ SGUH 22 neonatal death case reviews identified no concerns with care or service delivery issues ➢ ESTH 13 stillbirth case reviews identified care and service delivery issues which potentially contributed to the outcome in 4 cases. Actions completed in relation to escalation for review, care planning and review of women reporting reduced fetal movements	MBBRACE-UK 2021 Report: previously received at committee and in the addendum at Appendix 1

		➢ ESTH 1 neonatal death case review identified no concerns with care or service delivery issues				
Midwifery workforce is reported and monitored Monthly with local twice daily SITREPS to the Site and Group Nursing teams. There is a focus on Midwifery staffing levels as part of ongoing work.						
Midwifery Workforce Planning			Fill Rate (>94%)	Band 7 Supervisory midwife (100%)	Triage, 2.0 wte per shift (100%)	Maternity Services Monthly Report Appendix 1
	Sept 23	ESTH STH	85%	100%	100%	
	Sept 23	ESTH EGH	84%	100%	100%	
	Sept 23	SGUH	90%	94%	100%	
Compliance with CNST year 5 Maternity Incentive Scheme						
10 Safety Actions Maternity Incentive Scheme Year 5 (CNST)	ESTH		SGUH			Maternity Services Monthly Report Appendix 1
	Risk of non-compliance: • Safety Action 5: Midwifery Workforce Planning • Safety Action 8: MDT Training		**Risk of non-compliance:** • Safety Action 3: Transitional Care • Safety Action 5: Midwifery Workforce Planning • Safety Action 6: Saving Babies Lives Bundle			
Training compliance in midwifery units have been identified as an on-going risk						
Multidisciplinary Training		Risk of non-compliance Safety Action 8: Multidisciplinary Training • ESTH: Performance across all staff groups ranges from 70% to 90% in September 2023 • SGUH: Performance across all staff groups ranges from 60.9% to 94.5% in September 2023. • A training plan to recover training compliance continues to be worked through				Maternity Services Monthly Report Appendix 1
Pillar 5						
Culture review: Maternity Services		Governance review commissioned and Phase 1 includes culture review of maternity services				Terms of Reference previously reived at committee

4.0 The Maternity and Newborn Safety Investigations (MNSI) programme

4.1 From 1 October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme previously part of the Healthcare Safety Investigation Branch (HSIB) will be hosted by the Care Quality Commission (CQC). There will be no change to operations or workforce and there will be no interruption to ongoing investigations.

4.2 The MNSI Programme has informed the Trust that the new arrangement with the CQC will ensure the continuation of the maternity programme and maintain the independence of maternity investigations within the NHS. This new chapter presents the opportunity for further collaboration

within the health and social care sector. It will also allow MNSI to access more resources as part of a larger organisation, including improved analytics capacity and the opportunity to contribute best practice learning through national reporting.

5.0 Key risks

5.1 The following key risks identified in this report are brought to the attention of the Board:

Trust	Risk	Mitigation/ improvement actions
SGUH	There is a risk to recruitment and retention as staff report difficulties in speaking up, feeling heard and difficulties with management relationships	Increased visibility of leaders, walk rounds, safety champion meetings, culture work
SGUH Monthly KPIs	Non-compliance with mandatory training	Training plan in place and monitored. Booking staff onto courses
	Non-compliance with 94% fill rate for maternity staffing	Staff redeployed from CoC, community and non-clinical roles. Twice daily monitoring of red flags and twice daily Sitreps – resolve issues as they arise 24/7
	Non-compliance with 100% Band 7 Supervisory midwife	
ESTH Monthly KPIs	Non-compliance with mandatory training	Training plan in place and monitored. Booking staff onto courses
	Non-compliance with 94% fill rate for maternity staffing	Staff redeployed from CoC, community and non-clinical roles. Twice daily monitoring of red flags and twice daily Sitreps – resolve issues as they arise 24/7
SGUH CNST	Risk of non-compliance with Safety Action 3: Transitional Care	A service improvement proposal is being developed. Part use non-recurrent funding received via year 4 CNST
	Risk of non-compliance with Safety Action 5: Midwifery Workforce Planning	Establishment reviews and rostering templates
	Risk of non-compliance with Safety Action 6: Saving Babies Lives Bundle	Implementation tool launched. 44% self-assessed compliance so far
ESTH CNST	Risk of non-compliance with CNST Safety Action 5: Midwifery Workforce Planning	Business case to increase establishment to include B5 RN to

		run elective theatre services. Staff moved from CoC to prioritise inpatient rotas.
	Risk of non-compliance with CNST Safety Action 8: MDT Training	Training plan in place. Booking staff onto courses

6.0 Recommendations

6.1 The Board is asked to:

a) Note the compliance status against the CNST year 5 MIS
b) Note the risks and mitigations brought to the attention of the Board
c) Note from 1 October 2023 the Maternity and Newborn Safety Investigations are now hosted by the CQC
d) Make recommendations for any further action

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Appendix 1

Maternity Services Monthly Report

Board

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

10 November 2023

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Internal and External Assurance Processes For Both Trusts

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

Internal Governance and Monitoring

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

External Governance and Monitoring

- Integrated Care Board
- CQC (including the Maternity Survey). Last CQC inspection was in March 2023 for SGUH and August 2023 for ESTH
- HSIB
- MBRRACE-UK (PMRT)
- CNST
- LMNS (Surrey Heartlands and SWL)
- Maternity and Neonatal Voices Partnership
- NHS Resolution (ENS scheme)

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

Safety Action	ESTH	SGUH
1. PMRT		
2. MSDS		
3.Transitional Care		
4. Clinical Workforce Planning		
5. Midwifery Workforce Planning		
6. Saving Babies Lives Care Bundle		
7. MVP		
8. Multidisciplinary Training		
9. Safety Champion		
10. NHS resolution		

RAG: Green (on track to deliver), Amber (off track but expected to deliver), Red (not expected to deliver)

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CNST Year 5: Status position September 2023

Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
1. PMRT	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes and on track	Yes and on track	Monthly updates to QCiC and Group Board as part of Maternity Services Report Q1 PMRT report shared at QCiC on 29 June 2023 and Group Board on 7 July 2023; ESTH - Q2 PMRT report shared at QCiC in September 2023 – the next quarterly report is due to be shared in December 2023.
2. MSDS	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes	There are current delays associated with the Maternity system Digital Transformation work In conjunction to this risk with • EUROKING SYSTEM EPR platform: Multiple errors have been identified and escalated to the National teams from all sites who use it. Recognised by NHS Res. However the first submission review was successful.	July data is used to demonstrate compliance (published October 2023) and has been submitted. ESTH received verbal confirmation from the SWL LMNS of full compliance with the requirements of the submission.
3. Transitional Care	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Transitional care cannot be delivered from current establishment. A service improvement proposal is being developed. Joint NNU and Maternity task and finish group working on clear Job Descriptions and clarification of leadership for this service.	Transitional care cannot be delivered in totality from the current establishment. A service improvement proposal is being developed and there is potential to partially support the proposal with the non-recurrent funding received via year 4 CNST MIS in 2023/24.	The ATAIN (avoiding term admission to the neonatal unit) report was shared at QCiC on 29 June 2023 for Q4 2022/2023 and Group Board on 7 July 2023.The Q1 ATAIN data was shared in September 2023 for ESTH (Epsom) and SGUH. St Helier data has been shared in this report.

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CNST Year 5: Status position September 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
4. Clinical Workforce Planning	Can you demonstrate an effective system of medical workforce planning to the required standard?	Standard Operating Procedure (SOP) required regarding compensatory rest. Evidence of SOP needed to be in place by October 2023 in order to demonstrate compliance. Audits of Medical workforce required.	On track	ESTH – the SOP has now been drafted awaiting ratification.
5. Midwifery Workforce Planning	Can you demonstrate an effective system of midwifery workforce planning to the required standard?	Current establishment does not meet Birth-rate plus recommendations. Staffing paper to be submitted alongside business case to increase establishment to include B5 RN to run elective theatre services. Not meeting BR+ staffing recommendations also impacts on the ability to meet 100% supernumerary status of the Band 7 labour ward coordinator. Whilst business case moves through internal process staff have been moved from CoC to prioritise inpatient rotas.	Birth rate plus review planned for January 2024 and work ongoing internally on Establishment reviews and rostering templates within maternity services supported by GCNO office.	Need to show 100% sustained compliance with co-ordinator supernumerary status between 30 May 2023 and 7 December 2023 and we are currently unable to demonstrate this.
6. Saving Babies Care Bundle	Can you demonstrate that you are on track to compliance with all elements of the Saving Babies' Lives Care Bundle Version Three?	The implementation tool has now been launched and will need completion for all 6 elements with evidence uploaded to NHS Futures and submission verified by the LMNS oversight. The tool will be used to assess whether we have met the threshold for CNST compliance in Year 5.	The implementation tool has now been launched and need completion for all 6 elements with evidence uploaded to NHS Futures and submission verified by the LMNS oversight. The tool will be used to assess whether we have met the threshold for CNST compliance in Year 5.	Providers must demonstrate implementation of 70% of the interventions in SBLCBv3 overall with at least 50% implementation of interventions in each of the 6 elements and compliance will be assessed by the SWL LMNS on 1 February 2024. ESTH/SGH – following an initial evidence review both Trusts are currently non-compliant, but work is in progress to work towards full compliance by March 2024.

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CNST Year 5: Status position September 2023

Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
7. MVP	Listen to women, parents and families using maternity and neonatal services and coproduce services with users.	Yes and on track	Yes and on track	Monthly updates to QCiC and Group Board as part of Maternity Services Report.
8. Multidisciplinary Training	Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training? • Fetal surveillance training. • Maternity emergencies and multi professional training? • Neonatal basic life support.	Mandatory training improvement plan in place and monthly monitoring of performance against trajectory	Mandatory training improvement plan in place and monthly monitoring of performance against trajectory	Anaesthetic staff booked to attend training with trajectory to meet compliance by 7 December 2023 - not following trajectory. SGUH Consultant Fetal Monitoring training booked for 26 September 2023. Monthly updates to QCiC and Group Board as part of Maternity Services Report.
9. Safety Champion	Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?	Yes and on track	Yes and on track	The Maternity Services Claims Scorecard for 2022 was received at Board on 7 July 2023. ESTH and SGH – the 2023 scorecard analysis was included in the report presented in September 2023.
10. NHS Resolution	Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB/CQC/MNSI) and to NHS Resolution's Early Notification (EN) Scheme from 30 May 2023 to 7 December 2023?	Yes and on track	Yes and on track	All qualifying cases reported to date. Monthly updates to QCiC and Group Board as part of Maternity Services Report

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PMRT

(Perinatal Mortality Reporting Tool)
CNST Safety Action 1

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Perinatal Mortality

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

		ESTH				SGUH			
		October 2022 – September 2023		September 2023		October 2022 – September 2023		September 2023	
		Total number of Births	Total number of Deaths	Total number of Births	Total number of Deaths	Total number of Births	Total Number of Deaths	Total number of Births	Total number of Deaths
		3672	17 (includes 1 set of twins)	329	1	5085	56	345	3
Type of Mortality	Antepartum Stillbirths		11		1		23		1
	Intrapartum Stillbirths		3				4		
	Stillbirth of unknown timing		1				2		
	Neonatal Deaths		2				27		2
Gestational Age	<24 weeks		3				15		1
	24-27 weeks		5				17		
	28 - 31 weeks		0				9		1
	32 - 36 weeks		3				7		
	37-41 weeks		6		1		8		1
	≥ 42 weeks								

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Perinatal Mortality by maternal ethnic group

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Ethnic Groups		ESTH						SGUH					
		October 2022 – September 2023			September 2023			October 2022 – September 2023			September 2023		
		Total number of Births	% of total number of births	% of total number of deaths	Total number of Births	% of total number of births	% of total number of deaths	Total number of births	% of total number of births by ethnicity	% of total number of Deaths by ethnicity	Total number of Births	% of total number of births by ethnicity	% of total number of deaths
Asian or Asian British	Indian	3672	0.3 (1)	5.9	304			5085	3.7 (188)		345	2.9 (10)	0.3 (1)
	Pakistani		0.3 (1)	5.9					5.9 (298)			4.6 (16)	
	Bangladeshi		0.3 (1)			0.3 (1)	100%		1.0 (53)			0.9 (3)	
	Chinese		0.3 (1)	5.9					0.4 (19)			0.6 (2)	
	Any other Asian background		0.3 (1)	5.9					7.3 (369)	0.2 (10)		6.7 (23)	
Black, Black British, Caribbean or African	Caribbean		0.5 (2)	11.8					3.4 (174)			3.2 (11)	
	African								8.9 (453)			10.7 (37)	0.3 (1)
	Any other Black, Black British, or Caribbean background								1.7 (85)	0.2 (11)		1.4 (5)	
Mixed or multiple ethnic groups	White and Black Caribbean								2.5 (129)			4.6 (16)	
	White and Black African								1.3 (66)			1.2 (4)	
	White and Asian								2.9 (148)			3.2 (11)	
	Any other Mixed or multiple ethnic background		0.8 (3)	17.7					7.4 (378)	0.08 (4)		5.5 (19)	0.3 (1)
White	English, Welsh, Scottish, Northern Irish or British		1.6 (6)	35.3					28.9 (1468)	0.33 (17)		27.8 (96)	
	Irish								0.9 (44)			0.9 (3)	
	Gypsy or Irish Traveller												
	Roma												
	Any other white background								19 (966)			18.6 (64)	
Other ethnic group	Arab												
	Any other ethnic group		0.3 (1)	5.9					3.3 (167)	0.04 (2)		3.5 (12)	
Not known									1.6 (80)	0.24 (12)		3.8 (13)	

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Perinatal Mortality Reviews

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PMRT Panel	Cases reviewed September 2023	Emerging Themes September 2023	Open Actions from previous reviews, year to date	
ESTH: No panel meeting	2	No new clear emerging themes identified to date	INC-131062	1. Review to be undertaken by the obstetric team of the blood tests required following a stillbirth (To be completed by 31/10/2023). ***This action may need to be extended following as regional review is recommended.***
SGUH: 2 panel meetings	5	5 cases were reviewed during this period. Only one case was found to have care issues, the actions had been described in this slide, therefore no new themes identified.	Case 87039 (Historical case)	1. Review of the pathway for women with high blood pressure controlled with multiple medications to identify which women will benefit from being scanned before 28 weeks. (To be completed by 28/02/2024).
			Case 86809	1. Review guidelines regarding management of preterm labour. (To be completed by 30/04/2024)
			Case 87496 (Historical case)	1. Actions and timeline for delivery to be confirmed by the FMU Matron.
			Case 81702 (historical case)	1. Implementation of a unique system to share information within maternity services which will be completed in line with the IT Project plan date to be confirmed.
			Case 87496 (historical case)	1. Awaiting ratification of Safeguarding guidelines to be completed by 31/12/2023.

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Maternity Services Data Set

(MSDS)
CNST Safety Action 2

Verbal confirmation that both SGUH and ESTH have passed the requisite data quality checks for MSDS.

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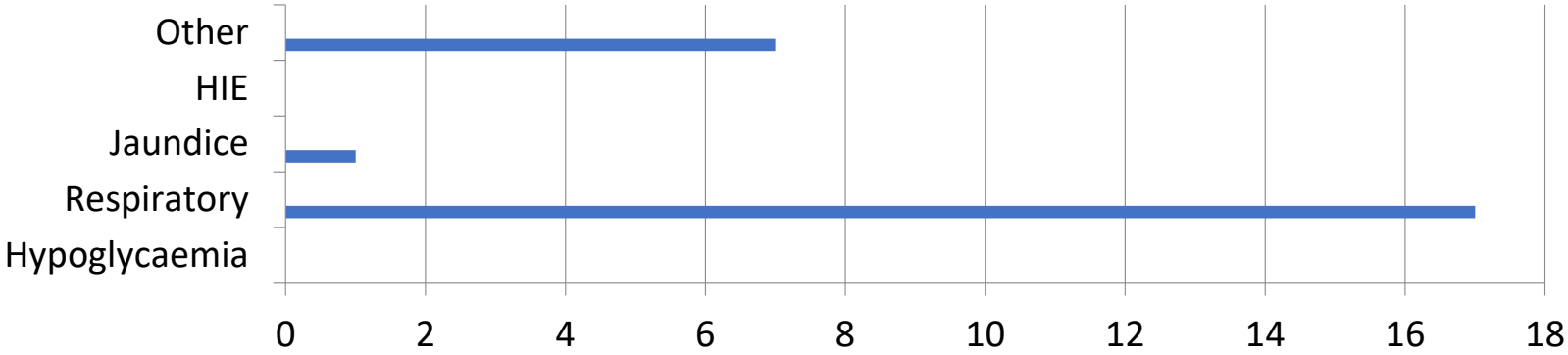
Transitional Care Services/ATAIN
CNST Safety Action 3

The ATAIN (avoiding term admission to the neonatal unit) report was shared at QCiC on 29 June 2023 for Q4 2022/2023 and Group Board on 7 July 2023.

The Q1 ATAIN data was shared at CQiC in September 2023 for ESTH (Epsom) and SGUH.

ESTH (St Helier) Q1 data is included below together with the ATAIN Action Plan.

ATAIN St Helier: April-June 2023
Cause of Admission



Other category (7) comprised:

1. Subgaleal Haemorrhage
2. Antenatal CLAP
3. Spontaneous Intestinal Perforation
4. Poor condition at birth (2)
5. Poor feeding
6. Social admission

Case Review Findings	
NNU admissions	25
Avoidable admissions	0
Serious Incident	0
Maternal Covid status during admission	Negative
Baby covid status during admission	Negative
Baby on NNU who could have been NGT fed on Transitional Care	0
NNU attenders for observation • Respiratory Distress (7) • Poor condition at birth and Cranial Ultrasound (1)	8

Learning/ Recommendations from ATAIN Review
1. To ensure all feeding assessments and support are continually provided and documented in Badgernet

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ATAIN Action Plan
CNST Safety Action 3

ESTH ATAIN Action Plan (open and closed in-month)

Epsom and St Helier University Hospitals NHS Trust

Point	Recommendation	Action plan	Lead	Status
EGH Some babies admitted to SCBU could potentially be admitted to Transitional Care with a different staffing model	To minimise avoidable admissions to SCBU	Task and finish group to review the TC model of care	Associate Director of Nursing	Task and finish group established with a view to meeting the BAPM staffing standard
EGH There were a number of small for gestational age babies (SGA) which were undetected antenatally	The rationale for transferring babies to SCBU for screen and treat should be documented	Continue quarterly on-going SGA audit to identify learning	Obstetric Consultant and Lead for SBLCB	On-going quarterly audits as part of SBLCBv3
STH Poor feeding was noted as a theme in some admissions	To ensure all feeding assessments are support are continually provided and documented in BadgerNet	Evidence this through an audit of feeding support and documentation with an associated action plan	Infant Feeding Lead Midwife	31/12/2023

SGUH ATAIN Action Plan – Current position

St George's University Hospitals NHS Foundation Trust

Point	Recommendation	Action plan	Lead	Status
SGH A number of term admissions could be avoided by having appropriately trained staff providing 24 hrs transitional care on postnatal ward.	To raise Transitional Care staffing at Trust level Implement targeted training plan	Transitional Care staffing on Trust risk register Enrol staff on appropriate training course to deliver targeted training	Neonatal Consultant	On-Going
SGH Minimise admissions to NNU as a result hypothermia and hypoglycaemia.	To minimise avoidable admissions to NNU	Handover topic for Delivery suite and post natal ward safety huddle	Delivery suite and postnatal ward matron	Completed
SGH Ensure patients with complex medical or obstetric requirements are receiving all necessary midwifery input.	To reduce the number of missed GTT referrals.	Remind obstetric staff about the importance of ensuring all checklists and antenatal tests are correctly completed	Clinical Director	Completed
SGH Simplify the process for completing GTT referrals at antenatal appointments.	To reduce the number of missed GTT referrals	Discussion with Digital midwife/Diabetes lead about completing changes necessary for online GTT referrals. Explore the possibility of automatic electronic referral triggers	Digital Midwife/Diabetes lead Midwife	On-Going

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Midwifery Workforce Planning
CNST Safety Action 5

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Safe staffing

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Staff group	Measure	July 2023			August 2023			September 2023		
		ESTH STH	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH
Midwifery	Fill Rate (target >94%)	91.6%	91%	95.6%	90%	88%	90%	85%	84%	90%
Obstetric	Expected vs fill	100%	100%	100%	100%	100%	100%	100%	100%	100 %
Band 7 supervisory midwife, 1.0 wte per shift	Shift allocation 100%	100%	100%	98.4%	100%	100%	98%	100%	100%	94%
Triage staff SGUH, 2.0 wte per shift ESTH, 1wte per shift	Shift allocation 100%			85.5%			93.3%	100%	100%	100%

Red Flag Category	ESTH St Helier	ESTH Epsom	SGUH
Coordinator not supervisory	7	16	4
Delay in time critical activity	1	0	2
Delayed induction of labour	5	0	2
Delayed pain relief	0	0	0
Delayed or cancelled care	1	0	0
Number of clinical incidents related to red flags	0	0	0

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Actions to Support Safe Staffing

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ESTH

- The overall fill rate in September 2023 was 84.5% (85% at STH and 84% at EGH due to sickness and maternity leave) against the target of 94%
- High cost agency was approved where staffing was at risk of being 30% lower than planned
- During the day shift, specialist midwives are utilised to support the clinical areas
- Continuity of Carer: Scoping has begun to reduce the number of continuity teams across both sites in order to meet staffing demands. One team on the Epsom site relocated to core inpatients from May 2023. This has mitigated immediate pressure until the project to review other teams is completed
- 3.6 wte midwives were redeployed from community services at St Helier to inpatient services, to protect the supernumerary status of the Band 7 midwife. Workload absorbed by community team leaders who previously had reduced clinical responsibility
- Current establishment does not meet Birth-Rate plus recommendations (11 Midwives short of the Birth-Rate plus recommendations). A staffing paper has been submitted to the Senior Leadership Team, alongside a business case, to increase establishment to include Band 5 registered nurses to support the running of elective theatre services. This will free up midwifery staff to support delivery of midwifery care

SGUH

- The overall fill rate in Sept 2023 for SGH was 90%
- Proactive closure of the birthing centre continues in order to mobilise staff to the delivery suite. On average the birth centre was open 80% in September
- Weekly review of actions to support safe staffing are undertaken as part of the on-going work to maintain safe staffing levels across the maternity services including provision of the home birth service where staff are reallocated to delivery suite if required. 8 women were booked in September; 5 successful Homebirths; 2 births in SGUH due to no cover; and 1 birth in SGUH due to clinical complication
- No training was cancelled or rescheduled to redeploy staff to the delivery suite although 2 midwives were reallocated to a later training date to maintain safety in their community teams
- Specialist midwives work on the delivery suite when required, to maintain safe staffing levels – no unplanned additional support was required
- All staffing templates are currently being reviewed and maternity establishment review paper being drafted

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Saving Babies Lives Care Bundle version 3
CNST Safety Action 6

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Safety Action 6 SBLCBv3

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SBLCBv3 was launched at the end of May 2023 and the implementation tool was launched in July 2023. There are 6 elements (**reducing smoking in pregnancy, fetal growth, raising awareness of reduced fetal movements, effective fetal monitoring, reducing pre-term birth and management of pre-existing diabetes).**

There are around 70 interventions across all elements. Trusts are required to use the SBLCBv3 implementation tool to upload evidence to NHS Futures. Evidence will be assessed by the LMNS and 2 engagement meetings need to be held to review the evidence to demonstrate compliance (1 each quarter).

The LMNS will be responsible for deciding whether Trusts are compliant with Safety Action 6; Trusts are required to have implemented 70% of the interventions with a minimum of 50% for each element, with 100% compliance by March 2024.

ESTH: upload of evidence to NHS Futures Platform has commenced with an overall self-assessed compliance rate **initially of 26%.** Meetings have been set up with the LMNS in October 2023 and November 2023 to assess evidence and work is in progress to implement the new process guidelines and undertake audits to provide evidence.

SGUH: are working with SWL to undertake quarterly reporting and hold appropriate stakeholder meetings. The upload of evidence to NHS Futures Platform has commenced with an overall self-assessed compliance **rate initially of 44%.** Meetings have been set up with the LMNS in October 2023 and November 2023 to assess evidence and work is in progress to implement the new process guidelines and undertake audits to provide evidence.

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Maternity Voices Partnership
CNST Safety Action 7

ESTH Maternity Voices Partnership
CNST Safety Action 7- Activity

Epsom and St Helier University Hospitals NHS Trust

The priorities for the Trust and the MVP are:

- Outreach/ diverse voices
- Co-produce website
- Improve service user experience
- Review of bereavement care
- Improved Social media presence as well as promotion of MVP through posters, postcards and banners
- Ongoing attendance at Trust meetings and relationship building/maintenance with the Trust staff

SGUH Maternity Voices Partnership
CNST Safety Action 7- Activity

Project	Project Area	Description	Initiated by	Co-production methods	MVP Lead	Trust Lead	Timeframe
1	Maternal Medicine	Work to support and develop ongoing Maternal Medicine hub across SWL	Ockenden	Appoint Maternal Medicine service user ambassador(s) to link with team	Not yet allocated	SWL Mat Med Lead Midwife	Underway - ongoing
2	Focus groups - Black and Asian Women	Provision of specific focus groups with Black and Asian women to ensure that their voices are heard and they have the opportunity to participate in other workstreams	Trust	Service user co-facilitator of sessions alongside staff Reach Out Event - Wandsworth	Core Connector	Maternity BAME Committee	Summer 2023
3	Parent Education Classes	Resumption of face-to-face Parent education classes and ongoing evaluation of these	Trust	Feedback from service users on survey monkey	Not yet allocated	Consultant Midwife	Completed Summer 2023
4	Walk and Talk or Stay and Play sessions for informal feedback / support	Visit existing venues (e.g. children's centres, playgroups) or create new events to bring service users together to share experiences and comment on other service developments	MVP	Attend local sessions to gather feedback	Not yet allocated	Consultant Midwife / Matron Community	Autumn 2023
5	Pain relief - Anaesthetics	Obtain feedback from women around postnatal pain relief	Trust	Feedback from service users on survey monkey	Not yet allocated	Awini Gunasekera, Lead Obstetric	Underway - ongoing
6	15 Steps	Carry out '15 steps' assessments in various areas, involving different groups of service users e.g. women with additional needs from Mulberry Teams	Trust	Recruit service users to participate in regular 15 steps programme in different areas of unit	Not yet allocated	Deputy Director of Midwifery	Q4 2023
7	IOL pathway experience	Input and support redesign of a home-from-home bay on Carmen for IOL women	Trust and MVP	Feedback from service users on survey monkey	Not yet allocated	Governance Midwife	Q3/4 2023

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Multidisciplinary Training
CNST Safety Action 8

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Mandatory training compliance

(rounded to the nearest whole number)

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Type of Training and % compliance	Staff Group	August 23		September 23		In month performance	
		ESTH	SGUH	ESTH	SGUH	ESTH	SGUH
PROMPT 90%	Midwifery Staff	89%	88.4%	90%	90%	+1%	+1.66%
	Maternity Support Workers	89%	90%	89%	90%	=	=%
	Consultant Obstetricians	89%	70%	89%	70.00%	=	=%
	Trainee and Staff Grade Obstetricians	84%	85.2%	86%	77.8%	+2%	-7.41%
	Anaesthetics	53%	76.5%	70%	60.9%	+17%	-15.57%
CTG Training 90%	Midwifery Staff	95%	91.88	97%	85.7%	+2%	-6.17%
	Obstetricians	89%	35%	85%	83.5%	-4%	+48.5%
NLS (Newborn Life Support) 90%	Midwifery Staff	89%	94.5%	90%	94.5%	+1%	-0.03%

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Mandatory training Improvement plan 2023-24

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Reason for negative performance against trajectory		Mandatory training improvement plan	By when
ESTH	There are multiple factors impacting on training performance including: • Sickness for midwifery staff • Rotation of junior doctors • Junior doctors strikes requiring staff to be pulled to work clinically • Previous poor anaesthetic attendance due to staffing issues • Depleted PDM team (due to new long term sickness)	• Database has been cross checked to ensure all staff are booked ahead of time • Monthly checks of staff off on long term sickness and maternity leave to ensure training is prioritised on their return • Robust DNA policy in place • Agreement with the HOM and DOM re. escalation plan for managers pulling staff from Mandatory training to cover clinical work • Involvement of MDT faculty to ensure all staff groups are engaged and booked to attend • Liaison with Anaesthetic and Obstetric roster co-ordinators • Request for further training hours submitted • All anaesthetists were booked to attend by the end of the year but are not meeting the current trajectory. • CTG training day now includes a competency assessment which will need to be completed on the day and should improve performance	December 2023
SGUH	• Two PROMPT sessions cancelled in March/April respectively in response to staffing challenges affecting attendance • Industrial Action impacting ability to plan • Consultant attendance restricted due to rosters • New MSW starters changing denominator • New anaesthetic trainees starting affecting denominator • New midwifery starters affecting the denominator	• PROMPT – new anaesthetic trainees scheduled this month and two additional sessions planned for October to support Obstetric attendance • CTG – Obs Consultant training 26.09.23 completed now reaching 90% compliance with further attendance for trainees planned • NLS – two sessions per month until December to ensure compliance by year end • Any attendee not able to attend training must have approval by DDoM	December 2023

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Maternity and Neonatal Safety and Quality Issues
CNST Safety Action 9

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

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ESTH	SGUH
The CQC inspected ESTH on 29 and 30 August 2023. Three urgent concerns were identified and rectified immediately in relation to out of date equipment on the NNU trolley, storage of Syntocinon and a typographical error on an emergency drug box. Other concerns were raised in relation to: • Triage (immediate action was taken to address telephone triage and increase staffing allocation and guidance updated) • Estates issues (various – immediate action was taken to close one bay on the ward and a risk assessment was completed by the IPC) • Consent and women's choice (limited information provided by the CQC. Consultant midwives are supporting women though the Birth Choices Clinic. The website is currently being updated in partnership with the MVP along with co-production of leaflets.) The concerns raised were responded to and additional evidence was submitted. The Trust was subsequently issued a section 29a Warning Notice on 18 September 2023 in regards to: • Triage • Estates issues • Consent • Medicines management • Dignity and respect • Records management • Oversight of services by leaders • Transitional care The Trust has made a significant number of representation against the warning notice and a response is awaited.	**Regulatory** Following the CQC inspection in March 2023 a warning notice was served under Section 29A of the Health and Social Care Act 2008 with reference to the following areas: • Staffing: levels of staff available to ensure mothers and babies were safe • Estates: the service does not have effective processes in place to maintain its environment and equipment to the required standards to keep women, pregnant people and babies safe • Governance: Leaders do not have effective or clear oversight and governance of maternity services • Triage: The service is not operating effective and timely triage processes to ensure the safety of women, pregnant people and babies Immediate actions were implemented and the Trust response was sent to the CQC on 28 June 2023. The full inspection report was published on17 August 2023 and the service was rated Inadequate. A CQC maternity services action plan has been developed to address the MUST and SHOULD Do's within the inspection report. **Staff Morale** The findings of the CQC inspection report have caused staff to feel deflated and to feel that their contributions to, for the greater part, good patient outcomes and experience were unrecognised. The Group, Site and Service Leadership have held multiple listening events and drop in feedback sessions with staff both at local service level and Trust wide to listen to staff and provide support. **Digital Transformation** • There are ongoing delays to the Digital transformation project • EUROKING SYSTEM EPR platform: Multiple errors have been identified and raised to National teams from all sites who use the system. **This could have significant impact on the Trust's ability to demonstrate compliance with CNST safety action 2** • VIEWPOINT 6 FMU Obstetric Scanning Implementation: Delay in launch due to suboptimal scheduling system and delay in presenting appropriate alternative to Clinical teams. The delay will cause minimal impact as the service will continue to utilise the old system with agreement from HMC to continue to offer support until issues are fully resolved. Planned go-live: March 2024

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ESTH Incidents graded at moderate harm and above

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

ESTH	Moderate / Severe Harm	Incident detail and immediate safety actions
Moderate		**INC-138934:** Maternity readmission with possible subdural haematoma (no patient safety incident occurred which contributed)
Death (Stillbirth)		**INC-138976:** Intrauterine death which occurred at 38/40. This will be reviewed via PMRT.
Moderate		**INC-139645:** Unexpected admission to the Neonatal Unit from the Birth Centre (no patient safety incident occurred which contributed)
Moderate		**INC-14006:** Woman had an emergency caesarean section; there had been a failure to perform a CTG when the woman attended triage the previous day
Moderate		**INC-140089:** PPH 1700mls following a forceps delivery
Moderate		**INC-140287:** PPH 2500mls following a forceps delivery

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SGUH Incidents graded at moderate harm and above

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

SGUH	Moderate / Severe Harm	Incident detail and immediate safety actions
Moderate (14)		There were 14 incidents relating to post-partum haemorrhages of 1.5 litres and above, or of lesser volumes where a transfusion was required. These cases have all been discussed in an MDT meeting and quarterly themes will be reported at MGM Business. Feedback has been given to medical and midwifery staff about the importance of completing clear postnatal plans and the PPH proforma. A project is underway to review the MOH guidelines and care management.
Moderate		**DW195117:** Maternity Unit on Divert (Red) during to midwifery staffing shortages. Senior management team worked with surge hub to divert services. Staffing supplemented with bank and agency booking. Senior management team onsite during day to assist with planning and organisation. 4 patients diverted to other Trusts for care. Ongoing action plan in place to mitigate staffing concerns.
Moderate (6)		6 incidents of 3rd degree tears. These will all be reviewed at an MDT teams meeting. In one case feedback was given to a clinician involved about angle of episiotomy.

Investigations and case reviews are in progress for all incidents

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Overdue Serious Incident Action Plans
Progress update

Trust	INC/ Datix number	Progress update and timeline for delivery
ESTH	INC-118946	There is 1 overdue action. The in-patient matrons to undertake a retrospective 3 month audit to evidence that any baby with suspected jaundice has a TCB taken prior to discharge. This action was due by 31 July 2023. Plans were then made for the audit to be completed by 30 September 2023. However, due to sickness and staffing challenges, the audit will be completed by November 2023
SGUH	N/A	There are no overdue actions.

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Contributory Factors and Root Cause for Completed Serious Incident Reports

Trust	Number of serious incidents closed in month	Root cause and learning
ESTH	1	There were no safety recommendations
SGUH	2	**Case 1:** The root cause was septicaemia caused by invasive group A streptococcus. **Learning:** • The importance of early obstetric input in cases involving pregnant or postnatal patients who present to the ED. • The importance of following sepsis pathway when patient develops high risk criteria. • LAS should inform the ED/maternity department when transferring postnatal patients who meet the red flag criteria on their admission pathway. • Information about recognising genital tract sepsis should be shared with the maternity staff at the other Trust. **Case 2:** The root cause of this neonatal death was severe fetal compromise in a pre-term baby. This was caused by rapidly evolving fetal anaemia secondary to a feto-maternal haemorrhage causing severe hypoxia in the baby prior to delivery. **Learning:** • To formalise the named consultant contact for complex FMU cases admitted to delivery suite. Although, there was good handover from the FMU consultant to the delivery suite in this case with a clear plan for her care, this plan should also include who can be contacted out of hours for advice. • The importance of following guidance on antenatal CTG interpretation. In this case the CTG deteriorated overnight with a reduction in the STV to levels which indicated severe hypoxia and should have prompted consideration for delivery sooner. • The need for education on fetal anaemia. There was a lack of appreciation by the delivery suite team overnight that the fetal anaemia may be evolving and therefore there may not be time to wait for the fetal transfusion. • The importance of all doctors' ward documentation to include CTG review and classification. This is a key point in time to ensure the CTG and all risk factors are considered to make an appropriate plan. • The importance of all patients with an abnormal CTG to have a face-to-face doctor's review and a management plan documented in the notes, which includes the patient's wishes. As part of any care plan for a patient, we should advise them on options and the pros and cons for these, whilst considering their preferences. • The need for escalation of a persistently abnormal CTG antenatally must be discussed with the on-call consultant. The on-call consultant should be a safety net with the expertise to consider all risk factors and potential management options for complex patients. When the case is unusual or of a more complex nature, they should be encouraged to seek a second opinion. • The need for second consultant ward or board round each 12-hour shift. This acts as a safety net for cases where the team on the floor have not recognised a deterioration in the clinical picture. • To use obstetric emergency call for any case which may need urgent transfer to theatre to ensure all team members aware.

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Service User feedback/ Patient Voice

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ESTH			SGUH		
Feedback	**Action**	**By when**	**Feedback**	**Action**	**By when**
1. Lack of referral for counselling.	1.1 Reminder to staff in the next risk newsletter of the referral process.	Completed	1. Prolonged waiting times in Antenatal Clinic due to staffing challenges and rescheduled appointments due to staffing sickness and absences	1.1 Apologies offered and matron supporting communication with women waiting. 1.2 Prospective planning for additional staff where existing gaps known 1.3 Area leads supported with improved escalation and effective planning	Completed
2. Correlation with scans and appointments which occur on the same day.	2.1 Women advised to contact the POD if appointments are inconvenient but currently no possible to ensure that these two separate consultation are concurrent.	Completed	2. Extreme cold in clinical, areas and rooms	2.1 Incidents of extreme cold logged and portable oil filled heaters mobilised where possible 2.2 Apologies offered and relocation offered where possible	Completed and ongoing
3. Lost property.	3.1 The leaflet ***"What to pack"*** to be updated 3.2 Reimburse the family via the losses form.	31/10/2023 Completed	3. Compliments regarding care from multiple families leaving Gwillim Ward directly to the DoM	3.1 Cascade and feedback to the clinical teams	Completed
4. Lack of infant feeding support.	4.1 Feedback of the issues to shared with Infant Feeding Lead for feed back into a response.	Completed	4. Community Midwife formally praised by family for going over and above with antenatal care which increased reassurance and a feeling of safety for the women.	4.1 Sent to the midwife involved and logged formally – actions shared to increase colleagues knowledge base	Completed
5. Delay in medication.	5.1 General reminder in the Autumn newsletter to manage expectations of drug rounds and offer explanations and apologies for any delays.	31/10/2023	5. Concerns from antenatal patient regarding the CQC report	5.1 Immediate contact by senior midwife (DDoM) and anxiety alleyed. 5.2 Face to face meeting arranged as follow up	Completed
6. Communication issues – medical staff.	6.1 Shared for wider learning	Completed			
7. Positive feedback in relation to infant feeding support, homebirth service, staff attitude and vaccination service.	7.1 Cascade and feedback to the clinical teams	Completed			

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Staff feedback to Maternity Safety Champions

ESTH (session held 4 August 2023). There was no meeting in September, the next meeting is scheduled for 06/11/23			SGUH (Unit meeting held on 11 September 2023 – H&W focus)		
Issue	**Action taken and by when**	**Progress update**	**Issue**	**Action taken and by when**	**Progress update**
1. Issues raised in relation to communication with staff relating to the workforce re-structure; reducing the MCoC to enable safe staffing.	1. Update to be provided to all staff by the Transformation Lead.	1. Completed	1. Increasing visibility of senior leaders across unit and Managers having a better understanding of the clinical environment	1. Senior leaders working bi-monthly clinical shifts to inform decision making about service and improve meaningful engagement	1. Diary review underway to lock in dates
2. Issue raised in relation to the poor state of décor on the Maternity Unit at the STH site.	2. Board Level Safety Champion to raise with Estates.	2. Completed and actions underway	2. Holding CTG meetings on DS rather than in Education room to support access for all	2. Fetal Monitoring team to facilitate where possible – space is a challenge	2. Sessions on Delivery Suite to be confirmed
3. There are delays in progressing the new website originating from the comms team.	3. Board Level Safety Champion agreed to progress.	3. Completed	3. Understanding the roles of the Operational teams (GM/SM/ASM)	3. Operational Lead to develop an information pack around roles of team	3. To be done as part of the improvement programme/workstream
4. The Community Matron raised the issue of the Malvern Centre; when the site is demolished we will need a new community venue.	4. Board Level Safety Champion to raise with Estates.	4. Completed. Requirement for new community venue included in works	4. Opportunities to meet as bands - different issues faced by each level.	4. Dates already set up for Band 5, Band 6, Band 7 and Band 8 – admin and MSW dates to be confirmed.	4. To be confirmed
5. NIPE issues (Newborn Infant Physical Examination)	5. All newly qualified midwives will now be NIPE trained. A NIPE MW to be allocated to STH on the rota (as for EGH).	5. Completed	5. Regular bidirectional communication	5. Dates confirmed for Exec meetings	5. Planned
6. Lack of office space at EGH.	6. Trust-wide issue. Board Level Safety Champion to view the space to inform next steps.	6. Completed and space issue discussed with teams	6. Regular meetings with matrons and their staff to discuss staffing and how their area is working so that changes can be implemented as a team.	6. Dates confirmed and additional routes to join shored up – teams links etc	6. Planned

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Feedback from ward and departmental visits and emerging themes

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ESTH	SGUH
The Group Chief Nurse and NED Safety Champion visited the department in the first week of September. They shared their gratitude with the team for the work that was put into the CQC visit. Feedback from staff was positive that they felt the visit had gone well and they were given the opportunity to speak if desired. Thanks was also passed onto the Senior Nurse team who had supported in the run up to the visit; maternity staff were grateful for the visibility and guidance.	The NED Safety Champion presented a report to the Group Board in October 2023 and highlighted the following issues: • Staffing • Bank rates • Staff speaking up and feeling heard • Management relationships • Triage • Serious incidents • MAST performance On 1 September 2023 the Group CEO, Group CNO, Group CMO and Director of Midwifery and Gynaecology Nursing held a drop in session for staff to discuss the learning from the recent CQC inspection. Members of the Group leadership team and Site leadership team visited the service on 5, 14 and 29 September 2023 and spoke to staff and women and birthing people. Staff provided positive feedback about working at SGUH, the preceptorship experience, onboarding from another acute provider as an experienced midwife, and patient satisfaction was high.

Placeholder for future reporting: Triangulation of themes from other sources e.g Freedom to Speak up, Complaints and PALs. Small group with core membership including the Board safety champions to review feedback from unit visits and triangulate with feedback from other sources e.g Complaints, FFT, FTSU, and PALs. First meeting 25 September 2023

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Referrals to HSIB
CNST Safety Action 10

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Cases referred to HSIB (Healthcare Safety Investigation Branch)

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

From 1 October 2023, the Maternity and Newborn Safety Investigations (MNSI) programme previously part of HSIB will be hosted by the CQC. There will be no change to operations or workforce and there will be no interruption to ongoing investigations.

	ESTH	**SGUH**
HSIB cases open and under review	2 cases: MI-032925 and MI-032560	2 cases: MI-030447 MI-028170
HSIB cases closed in month	0	0
HSIB open actions from previous cases	0	0
Actions based on recommendations and due date	There were no safety recommendations and actions are based on learning identified. There are 2 open actions relating to 6 recommendations for learning identified and none are overdue • include maternal observations documentation as a safety huddle message • review the Routine Obstetric Ultrasound Guidance	The above cases are open and under review and no reports completed yet.

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Addendum

The Maternity Services Claims Scorecard for 2022 was received at Board on 7 July 2023.

The Maternity Services Claims Scorecard for 2023 was included in the report presented in September 2023. It is included again as an addendum to this report to ensure it is received at Group Board on 10 November 2023.

The MBRRACE-UK 2021 published position was included in the report in August and September 2023 which shows that St George's is now within 5% of the average for comparable Trusts for perinatal deaths (stillbirths and neonatal deaths together). It is included again as an addendum to this report to ensure the Committee remains sighted on the external review that was commissioned of all stillbirths and neonatal deaths in 2020 when the Trust was an outlier with over 5% higher than the average for comparable Trusts for perinatal deaths. The external report is expected in February 2024.

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ESTH Maternity 2023 Claims Scorecard

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ESTH

The Trust had no claims in the yellow or green zones.

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

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

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

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

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

Blue claim themes:

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

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

Blue claims continued……

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

Correlation with complaints and incidents

Incidents

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

A theme had been identified previously by HSIB in relation to monitoring of fetal growth and training and audit has been strengthened in response to this.

Complaints

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

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

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SGUH Maternity 2023 Claims Scorecard

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SGUH

The Trust had no claims in the **Yellow** or **Green** zones.

Red zone claims (High Value (over 1 million) and High Volume (3 or over)):
There are **8** red claims with a value of £88,543,593, all of which are on-going (not settled).

Themes emerging from Red zone claims:
- Two of the eight claims concerned a failure to review CTG pathological reviews

The remaining claims did not have clear themes but related to:
- Failure to appropriately manage labour, resulting in hypoxia and needing long term care
- Failing to consent in order for the claimant to make an informed decision
- Delay in diagnosing Jaundice resulting in Kernicterus and brain damage
- Failure to monitor CL breastfeeding resulting in the development of hypoglycaemia and permanent brain damage
- Delay in providing oral antibiotics which would have prevented premature birth
- ENS 39+2 - induction of labour gestational diabetes. Emergency LSCS under general anaesthetic, uterine rapture confirmed at LSCS, The foetal heart was being intermittently monitored by CTG. An MRI performed showed appearances of hypoxic ischaemic injury associated with a profound, near total hypoxic ischaemic event at term

Blue zone claims (Low Value (<1 million) and High Volume (3 or over)):

There were **33** blue claims with a value of £4,500,322
- 13 claims were settled with damages paid
- 9 claims were closed with nil damages paid
- 11 blue claims are currently open

Blue claim themes:
The most common allegations relate to failing to assess the progress of labour and failing to seek timely reviews and in one case a baby was still-born as a result (open). Other issues identified included:

- Failure to under take c-section at earliest opportunity (open)
- Use of forceps against patients wishes, resulting in trauma to the baby (open)

Blue claims continued….
- Misdiagnosis of vaginal tear 3, resulting in surgery being carried out 12 months later (open)

- Improper administration of epidural leading to severe back pain (settled)
- Failure to interpret and report placenta praevia during ultra sound (open)
- Inappropriate discharge in early labour (settled)
- Failure to act upon a report of reduced movements and to commence CTG monitoring following the administration of pethidine, resulting in intrauterine asphyxia and psychiatric injury (open).

Correlation with complaints and incidents

Incidents
There were no clear themes emerging from the review of incidents that correlated with claims (there were no common themes identified in claims). Obstetric review and foetal monitoring were factors in a number of investigations. Where learning has been identified, review of guidelines have been carried out, breastfeeding pathways has been implemented and retraining has been recommended in some incidents which correlate with claims and complaints.

Complaints
All claims are linked to Complaints and Incidents as soon at they are notified to the Trust. It is noted that the issues identified in the Complaints review which correlated to claims included:

- Poor care received during labour
- Misdiagnosis of vaginal tear
- Failing to act upon a report of reduced movements and commence CTG

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

MBRRACE-UK January 2021 to December 2021

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

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MBRRACE-UK is a national audit programme (commissioned by all UK governments) to collect information about all late foetal losses, stillbirths, neonatal deaths and maternal deaths across the UK. **SGUH was an outlier in the 2020 audit due to the numbers of deaths being 5% higher than the average for comparable trusts.** All cases had been reviewed internally and reported through the Trusts internal governance processes and no issues identified. The Group Board commissioned an external review of all stillbirth and neonatal deaths in SGUH in 2020 to seek additional assurance and identification of any missed opportunities for learning. The review has commenced and the report is expected in October 2023.

Annual MBRRACE-UK figures for 2021 were published in May 2023.

ESTH: The data shows an improved position for Neonatal deaths at ESTH when compared with the average for comparable Trusts.
SGUH: The stabilised and adjusted rate for extended perinatal death (4.61) is the same as 2020 while the rate of stillbirths per 1000 live births is 4.21 which is worse than 2020. However there is an improved position overall for SGUH when compared with the average for comparable Trusts.

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

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

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	3.3	
Report Title	**Equality, Diversity and Inclusion Report: Workforce Racial Equality Standard and Workforce Disability Equality Standard Action Plans**	
Executive Lead(s)	Paul da Gama, Group Chief People Officer	
Report Author(s)	Sandra Ovid and Joseph Pavett-Downer	
Previously considered by	People Committee-in-Common	20 October 2023
Purpose	**For Approval / Decision**	

Executive Summary

This paper provides the Group Board with the reports on the Workforce Racial Equality Standard and Workforce Disability Equality Standard as provided by NHS England together with the accompanying action plans.

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 slides of the report and allow for comparison between the two Trusts. The WDES report compares data between Disabled and non-Disabled staff 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 Disabled members of staff.

In April 2015, NHS England introduced the WRES in response to consistent findings that BAME 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 BAME Board representation. 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 BAME 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.

All NHS providers are required to complete annual Workforce Disability Equality Standard (WDES) and Workforce Racial Equality Standard (WRES) reports. These reports are based on a snapshot of data from 31st March each year and aim to highlight progress against a number of key indicators of workforce equality.

In line with national requirements the WDES and WRES report and associated action plan should be reviewed internally and approved at Board before being published on the Trusts' websites. The deadline for publication is 31 October 2023. The key findings are outlined in the report with the full findings available as embedded PDFs within the appendices. The People Committee approved the

publication of the WRES and WDES reports and action plans ahead of the 31 October deadline under delegated authority rom the Group Board.

The overall picture in terms of the reports is a varied one with some indicators showing a degree of improvement but also a deterioration in others. Some indicators have also remained static.

There has been progress with the delivery of the action plan however parts of the plan remain undelivered. This is in part due to the actions being incorporated into Group-wide initiatives e.g. talent management but is also due to the small size of the ED&I teams. There has also been extensive work on PSED and EDS2 and on other related projects such as 'Ask Aunty' (support for overseas recruited staff) and the Disability Advice Line which is being delivered on behalf of the sector.

With this level of progress it is essential that we do not unnecessarily add to the action plan. The Committee has previously voiced its concerns over the tendency to add additional items to action plans despite the existing items having not been delivered. Consequently, the action plans have not been significantly changed as a result of this year's reports but additional related work is being taken forward through the Big 5 Culture Programme – anti-racism, tackling bullying and harassment, inclusive leadership. The programme is also establishing a 'golden thread' of ED&I and all 5 workstreams will need to be able to describe a positive contribution to ED&I.

Action required by Group Board

The Group Board is asked to:

a. Note the report
b. Note publication of the report and action plan on the Trusts' websites

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Group WRES Report and Action Plan FINAL
Appendix 2	Group WDES Report and Action Plan FINAL

Implications

Group Strategic Objectives

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

Risks

CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

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

Financial implications

There are no financial implications

Legal and / or Regulatory implications

The WRES and WDES reports and action plans need to be made available to the public via the Trusts' websites by 31st October, 2023.

Equality, diversity and inclusion implications

[Set out any equality, diversity and inclusion issues relevant to the issues described in this paper]

Environmental sustainability implications

[Set out any environmental sustainability issues relevant to the issues described in this paper]

Workforce Racial Equality Standard and Workforce Disability Equality Standard Reports and Actions

People Committees-in-Common, 20 October 2023

1.0	Purpose of paper

1.1 To inform the Group Board of the results of the WRES and WDES reports provided by NHS England; advise the Group Board on the progress made with delivering the action plans; and note the publication of the reports and action plans on the Trusts' websites.

2.0	Background

2.1 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 slides of the report and allow for comparison between the two Trusts.

The WDES report compares data between Disabled and non-Disabled staff 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 Disabled members of staff.

In April 2015, NHS England introduced the WRES in response to consistent findings that BAME 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 BAME Board representation.

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 BAME 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.

All NHS providers are required to complete annual Workforce Disability Equality Standard (WDES) and Workforce Racial Equality Standard (WRES) reports. These reports are based on a snapshot of data from 31st March each year and aim to highlight progress against a number of key indicators of workforce equality.

In line with national requirements the WDES and WRES report and associated action plan should be reviewed internally and approved at Board before being published on the Trusts' websites. The deadline for publication is 31st October 2023. The key findings are outlined in the report with the full findings available as embedded PDFs within the appendices.

3.0 Analysis

3.1 The analyses are contained within the slides below.

4.0 Sources of Assurance

4.1 The reports and progress made with delivery of action plans together with progress in relation to the indicators have been submitted to People Management Groups of both Trusts. The report was also provided to Group Executive colleagues on 17th October.

5.0 Implications

5.1 The results of the WRES and WDES analysis show that much work remains to be done to achieve the results the Trusts' wish to see. It is essential that we build on the successes that have been achieved but crucially we continue to deliver our action plans. Support for the Big 5 Culture Programme is essential if we are to see the required changes. This will assure the ED&I networks that the issues are being addressed and encourage them to continue their work and engage with the Trust in tackling the issues and help deliver the action plans and Culture Programme.

6.0 Recommendations

6.1 The Group Board is asked to:

a. Note the report;
b. Note the publication of the report and action plan on the Trusts' website.

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Workforce *Race* Equality Standard (WRES) 2022/2023

St. George's Hospitals NHS Foundation Trust

Workforce Race Equality Standard (WRES)

Purpose and Background

Purpose

- This paper provides an overview of the 2023 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 BAME 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 BAME 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 BAME 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 2023. All other indicators are from the 2022 staff survey.

Overview of Workforce Numbers – St George's

	2019	2020	2021	2022	2023
Total number of staff in organisation	8,884	8,873	9,154	9,608	9,915
% of BAME Staff	44.6%	46.1%	47.7%	50.1%	51.9%
% of staff who self-reported ethnicity	97.2%	96.7%	96.1%	97.0%	97.1

Overview of Workforce Numbers - ESTH

	2019	2020	2021	2022	2023
Total number of staff in organisation	5194	5854	6150	7092	7190
% of BAME Staff	36.7%	36.4%	38.1%	38.2%	42.0%
% of staff who self-reported ethnicity	94.6%	95.2%	95.6%	91.4%	92.4%

Outstanding care every time

Workforce Race Equality Standard (WRES)

Indicator Overview – St George's

Indicator		STG 2020	STG 2021	STG 2022	STG 2023	Performance vs. previous year	Exp. compared to White Staff	London Av. 2021	London Av. 2022
1	% of BAME staff in organisation	46.4%	47.7%	50.1%	**51.9%**	**Increased**		48.1%	49.9%
2	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	1.47	1.47	1.26	**1.5**	**Declined**		1.62	1.44
3	Relative likelihood of BAME staff entering the formal disciplinary process, compared to that of White staff	2.54	1.82	1.65	**1.67**	**Declined**		1.54	1.47
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	1.05	1.03	0.98	**0.95**	**Improved**		0.95	0.97
5	% of BAME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	27.4%	27.3%	23.3%	**27.0%**	**Declined**		31.1%	30.2%
6	% of BAME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	30.8%	30.1%	25.9%	**27.3%**	**Declined**		29.8%	28.1%
7	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	40.5%	41.1%	42.1%	**43.8%**	**Improved**		65.4%	43.6%
8	% of BAME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16.2%	18.0%	16.6%	**16.9%**	**Declined**		17.1%	16.7%
9	% difference between the organisations' board voting membership and its overall workforce	-28.2%	-33.1%	-31.4%	**-40.1%**	**Declined**		-26.2%	-26.1%

Outstanding care every time

Workforce Race Equality Standard (WRES)

Executive Summary – St George's

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 the report and associated action plan should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 31st October 2023.

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

Workforce Numbers

- Overall, the BME staff population at St George's continues to increase year on year (51.9%).
- 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

Non-Clinical Workforce

- For the second year BME representation at Band 6 is higher than the overall BME workforce at 54%. For the first time representation at band 7 is also higher than white representation and is in line with the Trust overall BME workforce at 52%.
- The number of white staff at VSM level has reduced from 21 to 11 staff members, the number of BME staff at VSM level has also reduced from 4 to 2 staff members.
- In % terms this means that 15% of VSMs are from a BME background, compared to 85% being white. This is the ratio of 5:1 white staff members to every 1 BME staff member appointed at VSM level. This has improved from a ratio of 8:1 last year.
- Of the 66 Band 8d and above posts only 18% are held by a BME member of staff, compared to 82% being held by a white member of staff (table H). There is no BME representation at Band 9, with all 15 posts held by a white members of staff (100%).

Clinical Workforce

- We have seen a positive increase in diversity within the medical group, with an increase of Black, Asian and Minority Ethnic Consultants (+140). Our 2022 ratio for medical staff was 55% white to 38% BME, this compares to 51% white to 43% BME in 2023. For consultants only, the ratio is 47% white to 48% BME.
- The lowest level of representation remains band 8a-c (29% BAME) and 8d-VSM. Of the 24 Band 8d and above posts only 21% are held by a BAME member of staff, compared to 79% being held by a white member of staff.
- We see similar low levels of representation at band 8d, of 15 posts only 3 (15%) are held by a BAME member of staff. This is a ratio of 5:1.

Recruitment

- White applicants at St George's are 1.5 times more likely to be appointed from shortlisting compared Black, Asian and Minority Ethnic (BME) applicants. This is an increase from 1.26 in 2022 and is the highest disparity since 2019.

Formal Disciplinary

- Black, Asian and Minority Ethnic staff are 1.67 times more likely (relative to white staff) to enter a formal disciplinary process. This compares to 1.65 2022.
- Whilst the relative likelihood has increased this is not due to an increase in the number of BAME staff entering the process – this has reduced year on year. However, the number of white staff has reduced at a higher rate therefore the likelihood of white staff (0.25%) entering the process is less than the of likelihood of BME staff (0.41%).

Outstanding care every time

Workforce Race Equality Standard (WRES)

Executive Summary cont. – St George's

Accessing non–mandatory training and CPD

- For the second year we see an increase in the number of BME staff accessing NMT and CPD.
- Conversely, we see a reduction in the number of White staff accessing non-mandatory training and continuing professional development. The likelihood of White staff accessing training and CPD has reduced by three percentage points (-3%) from 29% in 2022 to 27% in 2023.

Harassment, Bullying and Abuse

- The number of BME staff reporting they have experienced bullying, harassment or abuse (HBA) has increased across all 3 indicator groups (patients, colleagues and managers).
- Compared to 2021, HBA, towards BME staff, has increased from Patients/service (+4.7%), Other Staff (+1.4%), Managers (+0.3%).

<u>From patients, relatives or the public in the last 12 months</u>

- For white staff we see an increase from 30% to 31%. The gap between white and BME staff has reduced from 7% points in 2021 to 1% in 2022.
- Both white and BME women (32% and 30 respectively) report experiencing higher rates of HBA compared to male colleagues, with BME males reporting the lowest rates (21%).
- White Nurses and Midwives and Health Care Assistants (HCA) report the highest levels in this indicator at 46% and 45% respectively. For BME nurses and midwives this is 39% and for BME HCAs this is 31%.

<u>From Staff in the last 12 months</u>

- For BME staff, this has ncreased by 1.4 percentage points, from 25.9%.1% in 2021 to 27.3% in 2022. For white staff this has reduced increased by 3.6 percentage points.
- BME women report the highest rates in this indicator at 29%, with BME men reporting the lowest rates at 23%.
- BME nurses and midwives report the highest rates at 35%, with white general management and HCAs reporting the second highest at 31%

Believing that trust provides equal opportunities for career progression or promotion

- Continued upwards trend in the percentage of BME staff feeling the organisation provides equal opportunities for career progression or promotion. This has increased yearly since 2018 (+5.9 percentage points).
- Black staff reported than lowest satisfaction at 34% believing the trust provides equal opportunities.

Personally experienced discrimination at work from a manager, team leader or colleagues

- 16.9% of BME staff completing the staff survey indicated that they had experienced discrimination at work from a manager, team leader or colleague. This has increased slightly by 0.3 percentage points since last year.
- BME staff continue to report experiencing higher rates of discrimination – based on the responses they are twice as likely to experience discrimination compared to their white colleagues.
- Those that identified as Black and Mixed/Other indicated the highest levels of discrimination at 18% and 20% respectively. With White British staff reporting the lowest at 7%.
- Within professional groups BME staff in General Management reported the highest level of discrimination at 21% compared to just 5% for their white colleagues in General Management.
- BME Nurses and midwives reported the second highest levels at 20%, compared to 8% for their white colleagues.

Board Representation

- BME staff are significantly under-represented at Executive and Board level, in voting -42.8% and overall board representation is -40.1%).

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ESTH Workforce *Race* Equality Standard (WRES) 2022/2023

Epsom and St Helier Hospitals NHS Foundation Trust

Workforce Race Equality Standard (WRES) – Indicator Overview – ESTH

	Indicator	ESTH 2020	ESTH 2021	ESTH 2022	ESTH 2023	Performance vs. previous year	Exp. compared to White Staff	London Av. 2021	London Av. 2022
1	% of BAME staff in organisation			38.3%	41.0%	**Increase**		48.1%	49.9%
2	Relative likelihood of White applicants being appointed from shortlisting compared BAME applicants	2.52	1.79	1.04	1.30	**Declined**		1.62	1.44
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	**Declined**		1.54	1.47
4	Relative likelihood of White staff accessing non-mandatory training and CPD compared to BAME staff	0.54	1.29	1.07	1.35	**Declined**		0.95	0.97
5	% of BAME staff experiencing harassment, bullying or abuse *from patients, relatives or the public* in the last 12 months.	30%	29%	27.%	28.%	**Declined**		31.1%	30.2%
6	% of BAME staff experiencing harassment bullying or abuse *from staff* in the last 12 months	30%	30%	26.%	26%	**Static**		29.8%	28.1%
7	% of BAME staff believing that organisation provides equal opportunities for career progression or promotion	42%	48%	45%	46%	**Increase**		65.4%	43.6%
8	% of BAME staff personally experiencing discrimination at work from *manager/leader/ or other colleagues*.	16%	17%	16%	16%	**Static**		17.1%	16.7%
9	% difference between the organisations' board voting membership and its overall workforce	-16.3%	-15.8%	- 26.5%.	-29.9%	**Declined**		-26.2%	-26.1%

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Workforce Race Equality Standard (WRES) Executive Summary – ESTH

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 the report and associated action plan should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 31st October 2023. The key findings and metrics for this report submission are outlined below. Unless indicated, each point is compared to the previous reporting period:

Workforce Numbers

- Overall, the BME staff population at ESTH continues to increase year on year reflecting **41% an** increase of **2.7%** on the previous year.

- ESTH Black, Asian and Minority Ethnic workforce remains **8.9%** lower 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

Non-Clinical Workforce

- The disparity in the "Non Clinical workforce" seems to have slightly improved from 2022 to 2023, as the proportion of BME employees has increased.
- Representation at Bands 6-9 and above is lower than the overall BME workforce at **40%.**
- The number of employees not disclosing their ethnicity has also decreased, which could potentially indicate an improved comfort level or better data collection methods.
- However, the proportion of White employees in the workforce has remained nearly constant. These findings suggest there is still room for improvement in achieving a more balanced and diverse workforce.

- 10% of VSMs are from a BME background, compared to 85% being white. Of the Band 8d and above posts 54%% are held by BME members of staff.

Clinical Workforce

- It seems that the proportion of the BME workforce in the "Clinical workforce of which Non Medical - Headcount category has improved from 2022 to 2023. However, there is a small decrease in the number of people disclosing their ethnicity, as evidenced by the not disclosed category.
- The proportion of the White workforce has slightly decreased. These changes suggest some improvements in workforce diversity over the year.
- The lowest level of representation remains band 8b (**20.5%** BME) and 8d **(45.5%**) and –VSM (**100%).**

Recruitment

In both 2022 and 2023, this ratio is greater than 1 (**1.04** in 2022 and **1.30** in 2023), indicating that White staff were more likely to be appointed from shortlisting than BME staff in both years. In general, there has been a significant increase in the relative likelihood of appointment from shortlisting for all ethnic groups from 2022 to 2023. This suggests that the shortlisting process has become more effective in leading to appointments for all groups over the period.
However, it's also important to note that despite the improvements, there are still disparities. In 2023, White staff had a higher likelihood of being appointed from shortlisting compared to BME staff and those who did not disclose their ethnicity.

Formal Disciplinary

From these observations, it seems that the disparity in disciplinary actions between ethnic groups has not improved from 2022 to 2023. Relative likelihood was **1.22 to 1.45**

The likelihood of BME staff entering the disciplinary process compared to White staff has increased, even though the absolute likelihood for both groups has decreased.

The increase in the likelihood of staff with not disclosed ethnicity entering the disciplinary process could be due to various factors, such as changes in reporting or data collection methods, or actual changes in the disciplinary actions.

Outstanding care every time

Workforce Race Equality Standard (WRES) Executive Summary cont. – ESTH

Accessing non–mandatory training and CPD

- However, in 2023, the number of White staff accessing non-mandatory training and CPD significantly decreased. On the other hand, the number of BME staff accessing non-mandatory training and CPD decreased slightly, and only one 'Not disclosed' staff member accessed the training.

- The likelihood of staff accessing non-mandatory training and CPD decreased for all ethnic groups from 2022 to 2023. The largest decrease was observed in the White group, from approximately **2.6%** in 2022 to **0.7%** in 2023. The BME group also saw a decrease, but not as drastic, from approximately **2.43%** in 2022 to **1.36%** in 2023. Not disclosed decreased from **4.76%** to **0.18%**.

- In 2022, the relative likelihood of White staff accessing non-mandatory training and CPD compared to BME staff was approximately **1.07**, indicating that White staff were slightly more likely to access non-mandatory training and CPD than BME staff. However, in 2023, this relative likelihood decreased to **0.52**, suggesting that White staff were about half as likely as BME staff to access non-mandatory training and CPD. We will monitor this indicator to ensure parity amongst the groups

Harassment, Bullying and Abuse

- We see little disparity with experiences H&B between white and BME Staff for indicator(5&6) No significant deteriorations.

Believing that trust provides equal opportunities for career progression or promotion

- We see a -1.1% increase on the previous year this is not a significant increase in disparity between BME and White staff in regards to fairness in opportunity for career indicator 7.9%.

Personally experienced discrimination at work from a manager, team leader or colleagues

- BME staff continue to report experiencing higher rates of discrimination – based on the responses they are twice as likely to experience discrimination compared to their white colleagues. 15.8% of BME staff completing the staff survey indicated that they had experienced discrimination at work from a manager, team leader or colleague. This remained static since last year.
- We see disparity between BME and White staff in regards to discrimination of 6.1%

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 40%, a significant portion of the overall workforce, their representation on the board is considerably lower. Similarly, White employees are overrepresented on the board compared to their numbers in 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

Workforce in 2022: 2,713 (38.3% of the total workforce) Workforce in 2023: 2,949 (41.0% of the total workforce) Board Members in 2022: 2 (10% of the board) Board Members in 2023: 2 (11.1% of the board)

Analysis: The BME representation in the board is significantly lower than their representation in the overall workforce in both years. While BME representation in the workforce is around 38-41%, they only represent about 10-11% on the board.

White:

Workforce in 2022: 3,765 (53.1% of the total workforce) Workforce in 2023: 3,700 (51.5% of the total workforce) Board Members in 2022: 17 (85.0% of the board) Board Members in 2023: 16 (88.9% of the board)

Analysis: The White representation on the board is considerably higher than their representation in the overall workforce

Not disclosed:

Workforce in 2022: 609 (8.6% of the total workforce) Workforce in 2023: 541 (7.5% of the total workforce) Board Members in 2022: 1 (5% of the board) Board Members in 2023: 0 (0% of the board)

Analysis: Not disclosed representation on the board in 2022 is slightly lower than their workforce percentage, and in 2023, they have no representation on the board despite making up 7.52% of the workforce.

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Workforce Race Equality Standard (WRES)

WRES Indicators by Theme

Each of the 9 WRES indicators corresponds to one of these themes.

In the proposed action plans, projects and their actions are listed under each indicator within each thematic section.

Section 1: Improving Equal Representation in leadership

- **Indicator 1:** % BME staff in each of the AfC bands 1-9, medical & dental subgroups and VSM, including executive board members compared with the % of staff in the overall workforce
- **Indicator 9:** % difference between the organisation's board voting membership and its overall workforce

Section 2: Debiasing Recruitment

- **Indicator 2:** Relative likelihood of BAME staff being appointed from shortlisting across all posts

Section 3: Improving Career Development opportuties

- **Indicator 4:** Relative likelihood of staff accessing non-mandatory training and CPD
- **Indicator 7:** % staff believing that the Trust provides equal opportunities for career progression or promotion

Section 4: Building an Anti-Discrimination culture

- **Indicator 3:** Relative likelihood of staff entering the formal disciplinary process, as measured by entry into a formal disciplinary investigation
- **Indicator 5:** % staff experiencing harassment, bullying or abuse from patients, relatives or the public in last 12 months
- **Indicator 6:** % staff experiencing harassment, bullying or abuse from staff in last 12 months
- **Indicator 8:** In the last Percentage of staff who have personally experienced discrimination at work from manager/team leader or other colleagues in the last 12 months

Workforce Race Equality Standard (WRES)

Action Plan Key Projects

Key:

- Complete
- In progress
- Yet to be delivered
- Actions delivered – move to BAU

	Improving Equal **Representation** in Leadership	Debiasing **Recruitment**	Improving **Career Development** Opportunities	Building an **Anti-Discrimination** Culture
Epsom & St Helier	Executive and Director level EDI Objectives Trust-wide Model Employer Target Setting Succession Planning Executive Team People's Pledge Positive Action Initiative in Board Level Recruitment	De-biasing Recruitment Toolkit Recruitment Inclusion Specialist (RIS) Scheme Positive Action Initiatives	Personal Development Planning Equitable access to CPD Career Management Workshops	De-biasing Disciplinary Process Understanding staff and patient B&H concerns Transparent Reporting Routes EDI Training and Resources for Managers Allyship Development Programmes Inclusive Behaviours Comms Strategy Local Responses to Discrimination Hotspots
St George's	Inclusive Talent Management Approach Inclusive Succession Planning Executive Team Pledges Board Level Representation Reciprocal Mentoring	Training for Interviewees Debiasing Recruitment Process Recruitment Inclusion Specialist (RIS) Scheme	Active Career Conversations (ACC) for unsuccessful candidates Coaching & Mentoring Personal Development and Career Planning by Managers	Debiasing Disciplinary Process Reduce Reliance on Disciplinary Embedding our Values Based Behaviours Supporting Staff to Raise Concerns

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Workforce Disability Equality Standard (WDES)

2022/2023

Group Overview for People Committee in Common
October 2023

Workforce Disability Equality Standard (WDES) –
Purpose and Background

Purpose

- This paper provides an overview of the 2023 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 Disabled and non-Disabled staff 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 Disabled members of staff.
- 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 Disabled people. However, our ambition is to go far beyond what is mandated, and to become a truly great employer of Disabled people, 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 – St George's

	2021	2022	2023
Total number of staff in organisation	9,154	9,608	9,915
% of staff with a declared Disability on ESR	2.3%	2.9%	3.5%
% of staff which indicated a disability via Staff Survey	15.8%	15.7%	23.6%

Overview of Workforce Numbers – ESTH

	2021	2022	2023
Total number of staff in organisation	6154	7087	7092
% of staff with a declared Disability on ESR	3.5%	4.0	4.4%
% of staff which indicated a disability via Staff Survey	16.3%	17.4%	18.0%

Workforce Disability Equality Standard (WDES)

Indicator Overview – St George's

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	22 vs. 23
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%	4%	Increased	90%	89%	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	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	35.8%	34.8%	37.1%	Increased	28.4%	25.3%	27.5%	Increased
4b.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from managers	23.5%	21.1%	20.1%	Improved	13.1%	10.0%	11.7%	Increased
4c.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from other colleagues	34.4%	31.6%	32.1%	Increased	20.9%	17.8%	19.9%	Increased
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%	Reduced	47.7%	46.2%	45.7%	Reduced
5	Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion	42.7%	40.1%	44.1%	Improved	50.1%	48.4%	50.4%	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	35.1%	35.2%	32.0%	Reduced	25.8%	23.8%	22.4%	Reduced
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%	Reduced	49.1%	42.2%	40.5%	Reduced
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%	Reduced				
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	-2.0%	-3.0%	5.6%	Improved				

Workforce Disability Equality Standard (WDES)

Executive Summary – St George's

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 the WDES report and associated action plan should be reviewed internally and approved at Board before being published on the organisations website. The deadline for publication is 31st October 2023. The key findings are outlined below, the full findings are available in appendix B. Unless indicated, each point is compared to the previous reporting period:

Workforce Numbers and Declaration

- There is an 1% increase in the number of staff that have declared a disability. Overall, this group makes up 3.5% of the workforce – this is 4.4% for non-clinical staff groups and 3.5% for clinical staff groups.
- There is a higher number of staff with a disability in lower bands (non-clinical) however the headcount percentage remains consistent across all bands.
- There is a reduction in the number of staff with a disability status recorded as 'unknown', from 769 in 2021 to 754 in 2022 and 650 in 2023.
- Staff with a declared disability within the medical workforce remains very low, particularly the Consultant grade (1.63%).
- Whilst staff with a disability are under-represented at Executive and Board level within non-voting, they are positively represented in voting.

Recruitment

- Applicants without a disability are 1.15 times more likely to be appointed compared to applicants with a disability, this has reduced from 1.21 in 2022.

Capability

- Staff with a disability are 4.46 times more likely to enter the capability process compared to non-disabled staff. This high likelihood is due to the relatively low numbers of staff with a declared disability.
- As a percentage of each group 0.57% of the Disabled workforce have entered the process, compared to 0.13% of the workforce that do not have a declared disability.

Outstanding care every time

Workforce Disability Equality Standard (WDES)

Executive Summary cont. – St George's

Harassment, Bullying and Abuse

Both staff with a declared disability and those without a disability reported experiencing an increase in harassment, bullying and abuse compared to the previous year. Compared to 2021, HBA, towards staff with a disability, from:

- Patients/service users (4a) is up 2.3% and significantly higher (9.6%) than colleagues without a disability.
- Managers (4b) is up -1.1% and significantly higher (8.4%) than colleagues without a disability.
- Colleagues (4c) is up 0.5% and significantly higher (12.2%) than colleagues without a disability.
- The number of staff with a disability who felt able to report harassment, bullying or abuse has reduced by -3.6% compared to 2022. Both staff with a disability and those without reports similar rates (44.3% and 45.7% respectively).

Beliefs about equal opportunities, career progression and promotion

- Staff with a disability felt more confident about the Trust providing equal opportunities with regards to career progression and promotion – increasing from 40.1% in 2022 to 44.1% in 2023.
- Staff without a disability's confidence has also increased though at a lower rate which has therefore reduced the gap in perceptions between the groups – from 8% in 2022 to 6% in 2023.

Feeling pressure to go to work when unwell (presenteeism)

- Whilst a higher number of staff with a disability reported feeling pressure to come into work despite not feeling able to carry out their duties, this has reduced (-3.2%) 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 it's lowest (9.6%).
- Both staff with a disability and staff without a disability report feeling slightly *less pressured* compared to previous years.

Feeling that work is undervalued

- Whilst both groups report lower rates of feeling valued by the organisation, staff with a disability are still much less likely to feel that their work is valued.
- 30% of staff with a disability who responded to the Staff Survey said they felt the organisations valued their work - compared to 40% of staff without a disability. The gap between the two groups has reduced year on year and is at is lowest in 2022 (difference of 10.6%).

Adjustments in the workplace

- Only 61.7% of staff with a disability felt that reasonable adjustments had been made to enable them to carry out their work. This reduced by 1.3% points compared to last year.

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ESTH Workforce Disability Equality Standard (WDES) 2022/2023

Group Overview for People Committee in Common October 2023

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Workforce Disability Equality Standard (WDES) Indicator Overview - ESTH

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%	4.4%	Increased				
2	Relative likelihood of non-disabled staff compared to Disabled staff being appointed from shortlisting across all posts	1.07	2.32	1.2	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	12.33	4.95	7.99	Increased				
4a.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from patients/ service users	32.9%	32.0%	34.5%	Increased	28.2%	25.7%	27.0%	Increased
4b.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from managers	22.6%	20.9%	19.5%	Improved	14.0%	11.8%	11.9%	Increased
4c.	Staff Survey Q14: % of staff experiencing harassment, bullying or abuse from other colleagues	27.4%	25.7%	26.1%	Increased	20.2%	17.7%	18.2%	Increased
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	46.2%	49.3%	48.9%	Reduced	46.7%	50.8.%	49.4%	Reduced
5	Staff Survey Q15: % of staff believing that the Trust provides equal opportunities for career progression or promotion	51.4%	46.3%	46.0%	Reduced	53.4%	51.8.%	51.8%	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	33.1%	32.1%	33.5%	Increased	25.9%	26.2%	24.5%	Reduced
7	Staff Survey Q4: % of staff saying that they are satisfied with the extent to which their organisation values their work	35.1%	31.5%	32.7%	Increased	48.2%	41.9%	44.0%	increased
8	Staff Survey Q28b: % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work	69.2%	72.4%	66.2%	Reduced				
9	The staff engagement score for Disabled staff, compared to non-disabled staff	6.6	6.4	6.3	Reduced	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	-3.5%	-4.0%	-4.4%	Improved				

Workforce Disability Equality Standard (WDES) ESTH summary

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. The deadline for publication is 31st October 2023. The key findings are outlined below, the full findings are available in appendix B. Unless indicated, each point is compared to the previous reporting period:

Workforce Numbers and Declaration

There is an **0.4%** increase in the number of staff that have declared a disability. Overall, this group makes up **4.4%** of the workforce – this is **4.9%** for non-clinical staff groups and **4.6%** for clinical staff groups.

Disabled staff in non-clinical AfC roles

At Band 4 and under (e.g., administrative and technical support roles, estates officer):

- Disabled representation was 6.0%, overall
- Disabled staff were underrepresented at Band 4, 4.1%.

At Band 5 and over (graduate and management level roles):

- Disabled representation was 4.0%, overall.
- Disabled staff were proportionately represented by pay band.

Disabled staff in all clinical AfC roles

At Band 4 and under (e.g., clinical support workers and healthcare assistants):

- Disabled representation was 4.3%, overall.
- Disabled staff were proportionately represented by pay band.
- At Band 5 and over (e.g., clinical roles requiring professional registration including nurses):
- Disabled representation was 4.7%, overall.
- Disabled staff were proportionately represented by pay band.

There is a significant under representation of disabled individuals in the executive roles, as none of the executive board members are disabled. **While 20%** of the voting board members are disabled, the overall percentage increases to **12.5%** when considering the entire board.
The representation of disabled individuals is higher in non-executive roles **33.3%** compared to other categories. The vast majority of the board **87.5%** is non-disabled.

Outstanding care every time

Workforce Disability Equality Standard (WDES) ESTH summary

Executive Summary cont'd….

Recruitment

2023 data shows the 'relative likelihood of non-disabled staff appointed from shortlisting compared to disabled staff' is **1.20.** This is a significant decrease from the previous year of **2.35**

Higher Appointment Rates for Non-Disabled:

The data shows that non-disabled applicants have a higher likelihood of being appointed 11.39% compared to disabled applicants 9.47%. This is further supported by the relative likelihood metric stated above. The lowest rate is for 'not disclosed' applicants with an appointment rate at 7.97%.

Capability

There is a significant disparity between disabled and non-disabled staff in terms of entering the formal capability process, with disabled staff being almost **8 times** more likely to enter the formal capability process. **25%** of the disabled staff that entered the capability process did so due to ill-health, which was not the case for non-disabled staff.

Outstanding care every time

Workforce Disability Equality Standard (WDES) ESTH summary

Executive Summary continued.

Harassment, Bullying and Abuse 4a-d

The metric focuses on staff experiences related to harassment, bullying, or abuse based on their disability status (Disabled, Non-disabled, not stated). This includes experiences of abuse from different sources (patients/service users, managers, colleagues) and whether such incidents were reported. Also, please note the data for the 'not stated' cohort was not provided.

- Overall, disabled staff experience higher rates of harassment or abuse from every source compared to non-disabled staff. This is a trend and indicates non-disabled staff are less likely to experience bullying and harassment compared to disabled individuals.

- Patients/service users (4a) is up by **2.5%** and significantly higher **7.5%** than non-disabled staff.
- Managers (4b) shows difference in rates is particularly stark when it comes to harassment : **19.5%** for disabled staff compared to **11.9 %** for non-disabled staff.

- Colleagues (4c) is up by 0.4% and significantly higher **7.1%** than non-disabled staff.

- Reporting rates (4c) between disabled and non-disabled staff are roughly similar, hovering around **49%.** This indicates that the experience of harassment or bullying does not significantly affect the likelihood of reporting, regardless of disability status.

Beliefs about equal opportunities, career progression and promotion

- Disabled staff are slightly more optimistic about equal opportunities within the Trust compared to non-disabled staff. There's a **5.8%** difference in the belief between the two groups. This difference suggests that non-disabled staff might have faced or observed partialities practices related to career progression or promotion.

Feeling pressure to go to work when unwell (presenteeism)

- Disabled staff report a higher frequency of feeling pressured to attend work despite not feeling well enough, compared to their non-disabled counterparts which was lower. There's an **11%** difference between the two groups. This difference indicates that non-disabled staff have not experienced a more demanding or a less understanding work environment. This metric has remained static over the last three years.

Feeling that work is undervalued

- There's a noticeable gap of **11.3%** between disabled and non-disabled staff's perception of how much their work is valued by the Trust. Less than half of both categories believe the Trust values their work, but the sentiment is particularly lower among disabled staff.
- This difference suggests that disabled employees might face more challenges or feel less recognised compared to their non-disabled counterparts.

Adjustments in the workplace

A significant majority **(two-thirds)** of disabled staff believe that their employer has made the necessary adjustments to allow them to perform their jobs/duties effectively.
However, it's important to consider the remaining (**one-third)**. This segment feels that the adjustments made are not adequate, pointing towards potential areas for improvement

Outstanding care every time

Workforce Disability Equality Standard (WDES)

WDES Joint Action Plan - Metrics by Theme

For the 2022-23 WDES action plans, both ESTH and SGH will focus their plans around the following 3 key themes.

Each of the 10 WDES metrics corresponds to one of these themes.

In the proposed action plans, projects and their actions are listed under each indicator within each thematic section.

Section 1: Improving Equal **Representation** of People with a Disability

- **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 10:** % difference between the organisation's Board voting membership and its organisation's overall workforce

Section 2: Building an **Anti-Discrimination** Culture

- **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; and 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

Section 3: Improving **Managerial and Organisational Support** for Staff with a Disability

- **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; and b) Has your Trust taken action to facilitate the voices of Disabled staff in your organisation to be heard?

Workforce Disability Equality Standard (WDES)

Action Plan Key Projects 2022 - 2024

Key:
- Complete
- In progress
- Yet to be delivered
- Actions delivered – move to BAU

	Improving Equal **Representation** of People with a Disability	Building an **Anti-Discrimination** Culture	Improving **Managerial and Organisational Support** for Staff with a Disability
Epsom & St Helier	Increase Declaration Rates Develop an Inclusion Dashboard De-biasing Recruitment Toolkit Recruitment Inclusion Specialist Scheme Disability Advice Line (DAL) Disability Confident – Leaders Positive Action in Board Appointments Reciprocal Mentoring	Reduce Use of Capability Process for Disabled people Management Awareness Transparent Reporting Routes Listening to surface B&H concerns Positive Action Initiatives Personal Development Planning Equitable access to CPD Career Management Workshops	Listening to Disabled Staff Disability Passport Reasonable Adjustment Policy and Guidance Monitoring and Planning for Reasonable Adjustments Executive Team Pledges Presenteeism (new)
St George's	Increase Declaration Rates Recruitment Inclusion Specialist Scheme Develop an Inclusion Dashboard Disability Advice Line (DAL) Reciprocal Mentoring	Disability Awareness for all staff Individual Support Embedding our Values Based Behaviours Supporting Staff to Raise Concerns	Guidance and Processes Calibre Programme Manager Training Workplace Adjustments Executive Team Pledges Central Adjustments Fund

Note: Some projects i.e., increasing declaration rates or providing individual support do not have an end date and will be an ongoing focus that will move to BAU

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.

Outstanding care every time

Group Board

Meeting on Friday, 10 November 2023

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, ESTH & SGH Site COOs
Previously considered by	Quality Committees-in-Common Finance Committees-in-Common
Purpose	**For Assurance**

Executive Summary

This report consolidates the latest operational management and quality information and improvement actions across both St George's Hospital and Epsom and St Helier Hospitals for the month of September 2023.

Action required by Group Board

The Board is asked to review the report and note the operational and quality information and actions as of September 2023

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Integrated Quality and Performance Report

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

- Enforcement undertakings applicable to St George's and Epsom and St Helier Hospitals
- Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity, and inclusion implications

No EDI issues to consider.

Environmental sustainability implications

No environmental sustainability issues to consider.

Group Board, 10 November 2023

1.0 Purpose of paper

This report provides an overview of the key operational performance, quality and safety and outcomes information and improvement actions across St George's Hospitals (SGH), and Epsom and St Helier Hospitals (ESTH) and Integrated Care (IC) sites for the month of September 2023.

2.0 Quality &

2.1 ESTH, SGH and IC reported a number of quality-related **improvements** in September 2023 including.

- Nil MRSA infections bringing year-to date cases to zero for SGH, and 2 for ESTH.
- No Grade 3 or 4 hospital-acquire pressure ulcers were reported at ESTH and IC.
- Observed mortality rates (Summary Hospital-level Mortality Indicator or SHMI) continuing to track below expected levels at SGH.

2.2 Key **challenged** areas are as follows.

- **Never Events & Serious Incidents**: SGH declared 1 Never Event in September 2023, this related to a wrong site skin surgery conducted in February 2023. Immediate practical actions are already underway. Seven (7) Serious Incidents (including the 1 Never Event) were also in September 2023. ESTH declared 1 Never Event relating to retained guidewire in urethra following catheterisation, and 3 Serious Incidents. Actions have been commenced based on completed investigation findings.

- **Grade 3 & 4 Pressure Ulcers** There were 6 category 3 and 4 and unstageable pressure ulcers in September 2023 at SGH, a decrease on previous months and representing 0.26 cases per 1000 bed days. The Trust also reported 13 category 2 pressure ulcers and 14 medical device related pressure ulcers (MDRPUs). Detailed investigation into high harm pressure ulcers continues with a Trust-wide action plan in place based on root cause themes and audit findings.

- **Maternity:** The response to the CQC inspection at SGH continues with a focus on the MUST and SHOULD dos. Work on standardised approaches across GESH for governance frameworks, including moving towards PSIRF is ongoing. The leadership teams are engaging with local Health and Wellbeing teams and the NHSE Perinatal Culture and Leadership teams to support and develop a more positive culture across the workplace. Retention and recruitment activities are ongoing with a pipeline of 4 WTE band 6 Midwives and 11 WTE preceptorship band 5 Midwives joining in the next few months.

  The CQC inspected ESTH in August 2023 where 3 urgent concerns were identified and rectified immediately in relation to out-of-date equipment on the NNU trolley,

storage of Syntocinon, and a typographical error on an emergency drug box. Other concerns raised were responded to, and additional evidence was submitted. The Trust was subsequently issued a section 29a Warning Notice in relation to the issues noted on 18th September 2023. Five (5) out of 10 safety actions to achieve full compliance CNST Year 5 are off track, mainly due to staffing shortfall. Midwifery workforce planning status does not meet 'Birth-rate plus' recommendations. Midwifery Safe Staffing for August 2023 was 90% for St Helier and 88% for Epsom against a the threshold of 95%.

- **VTE Assessment rates** at ESTH remains low. The Thrombosis group and Planned Care division are exploring additional actions to deliver the improvements required.

- **Infection Prevention and Control –** C. difficile cases are exceeding stretched national targets for ESTH and SGH. Monthly cases are within the limits of common cause variation of statistical process controls.

- Increase in **diabetic patients requiring assisted management of insulin** at IC (Sutton Health & Care)

3.0 Operational Performance

3.1 ELECTIVE CARE

Outpatients

Maintaining waiting times for outpatients remains a priority across the Group with a focus on productivity, delivery of activity, as well as outpatient transformation. Both trusts remain challenged in maintaining their total waiting list size (PTL – Patient Tracking List), but there has been stabilisation in the rate of growth at ESTH and a marginal increase at SGH over the past three months. Industrial action continues to impact the ambition to reduce the PTL (and is anticipated to influence the future state).

ESTH has an established PIFU (patient-initiated follow-up) programme, which is delivering well across a range of specialties. The increase in PIFU rates at SGH reflects a retrospective submission of data, but a more sustainable step change is anticipated to be supported by the roll out across the 44 service groups of an improved IT solution for clinicians to capture outcomes from clinics (‘Orders to Schedule’) between October 2023 and March 2024, starting with the highest volume specialties.

RTT Waiting Times

Both trusts are above the trajectory that they set themselves to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH is particularly challenged with 917 patients waiting for more than 52 weeks at the end of August 2023, largely attributable to challenges within Gynaecology and Community Paediatrics services. Both specialties have been escalated as challenges to the south west London (SWL) system. In the short term, insourcing and ad hoc sessions are being explored, but it is likely that a broader system solution will be needed to achieve stabilisation. Unfortunately,

the pressure in Community Paediatrics at ESTH is translating into a significant rise in patients waiting more than 65 weeks for treatment (155 in August compared with 101 in July). The position on 78-week and 104-week waiters remains under control.

Diagnostics

Diagnostic performance at SGH continues to remain strong with 98% of patients receiving their diagnostic test within six weeks of referral in September. The breach rate of 2% at SGH is well within the national target of 5%. ESTH is reporting a breach rate of 5.4% in September, which is a reduction of over 30% and the fifth consecutive month of improvement.

Theatre Productivity

Both trusts remain challenged in reaching the trajectory for 85% capped utilisation of theatre time (active utilisation of theatres within the allotted time). However, both trusts are seeing steady improvements following in the implementation of a range of interventions. Challenges at SGH remain at improving theatre utilisation in the surgical hub at Queen Mary's Hospital, and for the most complex cases dependent on ITU onward care. An active theatre utilisation group is exploring opportunities to continue to improve productivity in theatres. Plans are being developed to address the challenges in paediatric day case theatres.

3.2 CANCER

Cancer performance is generally on track at ESTH with some challenges at SGH. Performance against the 28-Day Faster Diagnosis Standard (FDS) fell below the 75% national ambition due to capacity constraints in the skin service. The team is formulating a plan with support from RM Partners. Further work at ICS level is envisaged following the classification of dermatology as a fragile service across the system. Although SGH are not achieving the 62-day cancer standard (64.9%), it is broadly on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment.

Cancer performance standards will be revised from December to reflect the new rationalised metrics that came into effect in October. The three new standards are 28-Day Faster Diagnosis (75%), 62-Day Referral to Treatment for all referral routes (85%), and 31-Day from Decision to Treat to Treatment (96%).

3.3 URGENT & EMERGENCY CARE

Non-elective pathways continue to be under pressure at both trusts. Whilst the number of patients waiting in the Emergency Department (ED) for more than 12 hours following a decision to admit is significantly above our ambition, both trusts achieved the 4-hour operating standard of 76% (SGH – 77.0%; ESTH 77.3%) in September. Acuity and mental health presentations remain high and challenging, and downstream bed capacity is a key constraint. Both trusts continue to have a high focus on flow through the whole non-elective pathway. SGH has seen improvement in ambulance handover delays since peaks noted in October 2022, but ESTH continues to remain challenged.

INTEGRATED CARE

2-hour urgent care response is being maintained above the national standard (70%) for both Sutton Health and Care and Surrey Downs Health and Care, with a continued focus on encouraging more proactive referrals. Utilisation of the virtual wards in both systems has plateaued, and this will be a focus for reducing avoidable bed days in hospitals over the winter.

4.0 Sources of Assurance

4.1 Quality Committees-in-Common

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

4.2 Finance Committees-in-Common

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

6.0 Recommendations

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

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

Group Integrated Quality & Performance Report

September 2023

Presented by:
Dr. James Marsh, Group Deputy Chief Executive Officer

Executive Summary
Safe, high-quality care (1)

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

St George's Hospital

Successes

Falls: The Trust recorded 108 falls in September 2023 (4.7 falls/1000 bed days). This is down slightly from August 2023 (115) and in keeping with the previous 8 months were falls/1000 bed days has been consistently below the mean. There were no high or extreme harm falls in September 2023, this is the fourth consecutive month.

Pressure Ulcers: There were 6 category 3 and 4 and unstageable pressure ulcers in September 2023. This is a decrease in comparison to previous months. Medical device-associated pressure ulcers (MDAPUs) showed no change in September 2023, with a total of 14 cases, in comparison to the previous month, and a decrease from the 22 cases reported in July 2023. Only 1 of the 14 MDRPU's was a category 3, 4 and unstageable pressure ulcer, this is a decrease from 2 in August and 4 in July 2023.

VTE: The VTE Risk Assessment was achieved in September 2023

Infection Control: The Trust has had no MRSA bloodstream infections in September 2023 and year to date.

MCA: Mental Capacity Act level 2 compliance for nursing remains high at 93%. Medical compliance has significantly increased from 64% last month (pre junior doctors' rotation) to 72% in September 2023.

Mortality: Latest data on HSMR and SHMI show observed mortality rates remain below the expected rate.

Maternity –September birth rate was 337 with high levels of obstetric complexity throughout with good clinical outcomes. The service has launched a programme of promoting perineal pelvic health in collaboration with SWL LMNS.

Challenges

Falls: The trust declared 1 moderate harm from fall in September 2023. Comprehensive investigations are conducted for all falls resulting in moderate harm and higher. The lessons learnt will feed into the Trust wide action plan.

Pressure Ulcers: The Trust reported 13 category 2 pressure ulcers in September 2023, this is an increase from previous months [August – 5, July – 10, June – 7] and likely due to earlier identification. Detailed investigation into high harm pressure ulcers continues with a Trust wide action plan in place based on root cause themes and audit findings.

VTE: Although risk assessment completion performance was slightly above target for September 2023 this represents a decline in position in comparison to Q3&4 of 2022/23. An initial scoping meeting with key Hospital Thrombosis Group (HTG) members and Deputy Chief Medical Officer (DCMO) has taken place and actions have commenced including review of the VTE risk assessment.

Never Event/ Serious Incidents: The Trust declared 7 Serious Incidents in September 2023, including 1 Never Event, this related to a wrong site skin surgery conducted in February 2023. Immediate practical actions are already underway in response to the Never Event and actions have been commenced based on completed investigation findings for all other SIs.

Infection control: Covid-19 cases including nosocomial infections decreased in September 2023. Cases of C. difficile, E. coli bacteraemia, Klebsiella sp. Bacteraemia and Pseudomonas aeruginosa bacteraemia continue to trend above set NHSE trajectories for 2023/24. A Trust level 'Back to Basics' plan has commenced. A confirmed outbreak of Norovirus was reported on a medical ward in September 2023. Infection, prevention and control measures were followed to control and contain the outbreak which resulted in preventing the spread of Norovirus outside of one bay.

MCA: Compliance continues to require improvement from medical staff outside the junior doctor staff group.

Mental Health: In September 2023 there were 6 reported incidents of harm towards staff by patients presenting with poor mental health, this appears to have been precipitated by a continued lack of police presence and support for these patients in the community. paediatric staff are completing specialist violence and aggression management training with South -West London and St George's Trust in November 2023, the aim is to reduce episodes of restraint and violence and aggression towards staff

Mortality- Cardiology outcomes continue to flag in both Dr Foster data and SHMI. Higher than expected mortality is seen in coronary angioplasty and acute myocardial infarction

Maternity : The response to the CQC inspection continues with high focus moving to MUST and SHOULD do's. Focus on standardised approaches across GESH for governance frameworks, including moving towards PSIRF. The leadership teams are engaging with local Health and Wellbeing teams and the NHSE Perinatal Culture and Leadership teams to support and develop more positive culture across the workplace. This involves members across the MDT, banding and roles.

2

Executive Summary
Safe, high-quality care (2)

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

Epsom & St Helier

Successes

Nutrition: Overall MUST compliance has improved this month. Collaborative working with SGUH on the Cerner build and Nutrition care plans. 84 Nurses trained to insert NG tubes. Proposed District Nurse training in Gastrostomy and Jejunostomy management has been agreed.

VTE: Reduction in the number of Hospital acquired Thrombosis for the second month in a row

Pressure Ulcers: Reduction in hospital acquired pressure ulcers compared to the last 5 months. Effective use of CareFlow for referral with wound pictures to enable earlier intervention and advice from TVN and reduction. No severe harm reported this month. The annual foam mattress audit was completed with collaboration of the Fundamentals of Care (FoC) team and members from Drive Devilbiss (Mattress contractors). A total of 88 foam mattresses were condemned (68 at STH) and 20 at Epsom) and have been replaced with new ones. A new stock of more than 25 foam mattresses is now available on each site to meet the shortages reported in recent months.

Falls Prevention and Management: We celebrated Falls Awareness week; this coincided with the new Slips, Trips, Falls and Bedrails Policy going live across the Trust, key updates disseminated to staff via . a policy summary poster. Leaflets and business style pocket cards to provide information and guidance for staff on post fall management, methods of transfer, neurological observation frequency (NICE guidance) and Bedrail safety were shared. There was also a prompt response to the release of the MHRA National Patient Safety Alert for medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls. An action plan has been devised; the majority of actions have already been closed and signed off as complete.

Maternity: St Helier site had 37 deliveries in the Birth Centre, the most cases since June 2020.

Infection Control: No MRSA blood stream infections in September. FFP3 Mask Fit Testing compliance went live on ESR in mid-July, resulting in daily fitting requests, supported by block bookings and daily walk-in services. Monthly PPE compliance audits and Hand Hygiene Compliance audits are being undertaken in all clinical areas. The IPC team continues to collaborate with clinical staff to complete and review RCAs within 5 days of result with no lapses currently.

Challenges

Infection Control: In September there were 9 Trust attributed C. difficile cases. There were 18 Covid-19 clusters in September with 79 reported cases. A6 Renal ward entered a Period of Increased Incidence (PII) for C. diff. Legionella Incident in C block, STH remains a safety concern (counts exceeding 1,000 cfu) requiring further investigation. Clinical concerns about post-operative hip infections on ward A3 led to a review identifying two SIs potentially related to post-op wound management. Following the microbiology laboratory move to St George's Hospital, there has been gaps in how our microbiology results and data are reported back to the ESTH BI team, challenging the accuracy of the data.

VTE: Screening remains a challenge despite various initiatives

Mortality: Ratios remain higher than expected.

Never Event/Serious Incidents: The Trust declared 4 Serious Incidents in September 2023, including 1 Never Event relating to a retained foreign object.

Complaints: Response performance dropped in the last 2 months. Weekly complaints meetings held with the Group CNO to address issues and improve performance.

Falls: An increase in number of falls in the Acute Services, reporting 89 incidences, equating to 4.7 falls per 1000 OBDs compared to 3.6 the previous month. Three with harm.

Executive Summary Elective Care

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

St George's Hospital

Successes

- The number of patients waiting over 65 weeks continues to meet plan however there is a risk with 128 patients about to tip in which will jeopardise 0 patients waiting by March 2024.
- Reduction in the number of 52-week waiters seen in August although behind plan by 75 pathways.
- Currently 36% of the PTL has been validated to 12 weeks – NHSE ask to ensure that at least 90% of patients who have been waiting over 12 weeks are contacted by 31 October 2023.
- Cancer PTL week took place in September to support divisional teams understand the complexities of the PTL, and ensure validation and tracking is accurate.
- Diagnostic performance continues to meet the recovery target of 95%, with a performance of 98..02% of patients receiving a diagnostic test within 6 weeks of referral.
- Successful recruitment in cardiothoracic anaesthesia with three fixed term locum cardiothoracic anaesthetists starting between September-October. Planning is underway to increase the provision of cardiac surgery and cardiology in line with recent appointments.
- Work continues to improve Theatre utilisation, with the current focus being on the implementation of 642 escalation process to ensure theatre lists are fully booked

Challenges

- Elective and Day Case activity across the Trust remains behind plan, impacted by recent industrial action and will continue to be impacted in October.
- FDS Performance was non-complaint in August driven by a deterioration in Skin performance. Recovery is dependant on skin reducing 1st seen booking profile to below day 28. There are on going discussions with RMP to discuss and agree support for the service.
- 62 day performance remains challenged with delays identified in access to theatre, triaging delays, and access to Gynae scan.
- There are currently 597 patients on the RTT PTL with a projected wait of over 52 weeks for first appointment, Neurosurgery with the largest cohort. Risk within Neurosciences is a current risk to 65 week backlog. Focus on booking appointments for all patients in the 65-week cohort to ensure they are not waiting for an outpatient appointment after 31st October 2023.

Epsom & St Helier

Successes

- Diagnostics (DM01) remain pressured but in a stable position since the recovery plan was put in place in January. Patients waiting more than 6 weeks in September 2023 has reduced to 522 from 762 in August 2023. The modalities with the highest volume of patients waiting over 6 weeks are, NOUS (124), and Urodynamics (101 –mainly Gynae).
- In September 2023, outpatient activity is expected to be above plan once all appointments have been cashed up.
- DNA rates in September remained below 5% for the third consecutive month.
- Capped theatre utilisation figures increased to 75.3% in September.
- The following cancer waiting times targets were achieved in August 2023: Faster Diagnosis (76.2%), 31-day first treatment (100%) and GP 62-day first treatment (87%).
- Acquisition of an outpatient TPPB machine to reduce wait times for the frontend of the prostate pathway will support overall performance of cancer targets with a planned start date of November 2023.
- Lung CT guided biopsy waiting list has significantly reduced due to the radiology team working through a plan to increase IR capacity and the endoscopy unit has been supporting with providing recovery beds.
- SGH has provided weekly capacity, improving the turnaround times for EBUS.
- TAC wait times are meeting the 3-day target.

Challenges

- 52 week waits has increased from 835 in Jul23 to 917 in Aug23. This increase is mainly driven by pressures in Gynae (277), Community Paediatrics (260) and Cardiology (98), as well as ongoing industrial action. A further increase is expected in Sep23 once submitted.
- Referrals from GP to a consultant led service remain significantly above BAU levels within a number of key specialities.
- Patients waiting over 65 weeks for treatment increased from 101 in Jul23 to 155 in Aug23 (64 Community Paediatrics, 39 Gynae, 18 Cardiology, 14 Gastroenterology and 20 scattered across other specs)
- The 14-day standard was not met in August 2023 with a performance of 67.7% against the 93% target. This was largely due to Dermatology service unable to meet the GP TWR demand.
- Gynaecology has converted all of their routine capacity to TWW capacity. This has eliminated their ASI's, but had the predictable effect of extending the wait for a routine Gynaecology appointment.
- EUS capacity at RMH still has a wait time of 5-7 weeks, patient dependent, leading to a negative impact on cancer targets.
- EBUS capacity at UCLH remains a challenge with a wait of 2-3 weeks however mutual aid from SGH has provided weekly capacity and improved turnaround times.

4

Executive Summary Non-Elective Care

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

St George's Hospital

Successes

- The Trust continued to exceed the 4 hour operating standard at 77% in September. This places SGH 9th in London and 35th nationally.
- Non admitted pathway 4 hour performance was above 90% on 16 days of the month.
- LAS immediate handover pilot, commenced 11 September 2023. SOP has been enacted as agreed within the Trust in conjunction with LAS, this involves enhanced boarding and cohorting criteria
- Front of house clinician commenced11 September 2023, to allow a senior clinician streaming patients to appropriate alternative pathways, ensuring investigations happen early in journey and analgesia is given at early stage too (RATing).
- The Trust has launched new IT Capacity Management software - CAPMAN
- The Trust launched the Early Notification process for Social Workers to aid expedited discharge and to troubleshoot any key issues. In addition, the Trust has launched the updated D2A (Discharge to Assess) form in the Trust, with improvements made regarding Best Interest / Mental Capacity.
- Cavell Ward now closed leading to reduction to medical G&A beds, however we are continuing to work with local partners to reduce delays in onward care to mitigate this reduction.

Challenges

- The Emergency department's ability to see patients in a timely way was extremely challenged, where on several days ED had 7 consecutive hours of >30 attendances per hour, high acuity and quick succession of ambulance arrivals to the Trust. This lead to high number of DTAs with the position difficult to recover from.
- High number of mental health patients presenting in ED, often late in the evening.
- On the main hospital site, there remains a high number of patients not meeting the criteria to reside (NCTR), in addition to the high number of patients awaiting Pathway 2A (Merton and Wandsworth) and Pathway 3, over the last month
- The running of MADE "style" Events has resumed given increased operational pressure to due to the start of "Winter Pressures" and increased COVID19 on the ward. The ToC team also doing walkaround style events to facilitate discharge.

Epsom & St Helier

Successes

- Patients with a length of stay of > 14 days has improved in September 2023 when compared to previous months and is now below the monthly ambition value
- In September 2023 77.2%, of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival with the trust performing better than the operating plan of 76% despite an increase in operational pressures.
- Type 1 ED attendances have remained below the planning numbers for 6 months in a row

Challenges

- Mean daily Super Stranded numbers remain above the locally agreed ambition for the fifth month in a row with no significant reduction
- Time to initial assessment for September 2023 was 108 minutes and remains above the ambition of 60 minutes.
- A high number of > 60-minute ambulance handovers in September 2023, reporting 120, however, an improvement when compared to August 2023 where we reported 149.

Executive Summary
Our People

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

St George's Hospital

Successes

Sickness (Target 3.2%):
Rate has decreased from 4.37% to 4.19%, as of the end of September, with anxiety/stress/ depression and other psychiatric illnesses remaining the largest reason for absence.

Vacancy (Target 10%):
Vacancy rate still remains below the Trust target at 7.83%, which is an improvement over the previous month which was 9.10%. The vacancy rate has been below the Trust target for over a year now.

Challenges

Sickness (Target 3.2%):
Estates and Ancillary staff has the highest absence with group at 6.46%, with N&M at 4.95%.
Estates & Facilities Division staff sickness currently has the highest absence at 5.10% with Corporate the lowest at 2.33%.

Vacancy (Target 10%):
Admin & Clerical remain the highest vacancy rate at 15.19% with ACS at 10.25% and N&M at 9.93%.

Turnover (Target 13%):
September's figure is 14.82%, and in order, highest to lowest- Research & Development remains the highest at 37.27%, MedCard at 16.08%, Corporate at 15,68%, CWDT at 15.57%, SWL Pathology at 15.04%, SNTC at 11.88% and E&F at 11.09%.
Additional Clinical Services remains as the Staff Group which has the highest turnover at 20.19%, with N&M at 15.66%.

Appraisal (Target 90%):
Rates for Non-Medical staff is sitting at 76.24%, which is an increase over the previous month, with CWDT Division being the best at 80.08% and the worst being Corporate at 53.74%.
Rates for Medical appraisal is currently at 77.92%, which is a decrease over the previous month, with SNTC Division being the best at 80.39%% and the worst being CWDT at 76.25%.

Epsom & St Helier

Successes

Turnover (Target 12%)
The rolling 12-month figure continues its 18-month drift downwards showing 14% as at the end of Sept '23.

The B5 N&M turnover figures dipped slightly in September, as indeed did the vacancies for this group.

Challenges

Sickness (Target 3.8%)
The recent low was in April 23, but since then the trend is continuing upwards to hit 5.1%
N&M is steadily climbing to levels last seen in Jan 23

Appraisal (Target 90%)
Non-medical appraisal rates are poor and continue to decline month on month. The problem is particularly acute in Corporate areas which were 70% in September 22, but plumbing sub-33% levels in Sept 23.

Clinical areas better with 60%, but Integrated Care better still at 69%

This has been discussed at ESTH SLT and Divisions and Corporates alike asked to focus on improving this performance, but not at the expense of quality of appraisal.

Executive Summary Integrated Care

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

Sutton Health & Care (SHC)

Successes

2-hour Urgent Community Response remains above the national trajectory set at 70%. Month 6 – 73.1%.

Virtual Ward admissions remain high (admissions 186) with a stable mean LOS of 2 days.

SHC remains within 3.7% agency cap in the first five months of the year (2.9 %).

High levels of MAST (89.5%)

Improvement in waiting lists across adult services.

Challenges

Virtual Ward: SWL threshold cap set at 130 for SHC virtual ward occupancy. This is being discussed with SWL as the cap remains disproportionate to other boroughs and is impacting occupancy rate. SHC cap should be set at 80

Waiting lists for routine children's therapy services remain high - Speech and Language (SALT) 31.83 (weeks); Occupational Therapy (OT) 35.33

Surrey Downs Health & Care(SDHC)

Successes

Consistently achieving the 2-hour UCR target with 84.6% in September

Maintained the Improvement in waiting lists across all services.

Maintained good flow in pathway 2 with a 15 days LOS in community hospitals

Discharge flow with a median of 2 days for referral to discharge with improvement in pathway 3 maintained

Number of patients seen in VW increased with an occupancy rate of 77% percentage against the targeted 80% occupancy

High levels of MAST (92.7%) maintained.

Staff engagement and organisational development action plan in progress with a good initial response to the staff survey.

Challenges

High vacancy rate (18.9%), although an improvement from previous month is noted under target of 10%. Golden Hello scheme is in place and more recruitment events planned.

Drop in appraisal rate to 74.4% , related to many staff due for appraisals at the same time (start time with the organisation-TUPE transfer), also working on data quality issues.

High level in sickness rate –although improved from previous month still under target, ongoing work to support absence management.

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

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

Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target / Threshold	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Never Events	0	0	1	1	0	5		0	0	1	1	0	3	
Serious Incidents	0	1	6	7	0	23		0	2	8	4	0	22	
Number of Falls With Harm (Moderate and Above)	0	3	2	1	0	15		0	0	1	3	0	11	
Pressure Ulcers - Acquired catergory 3&4	0	10	11	6	0	49		0	0	0	0	0	4	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	93%	93%	93%	90%	92%		TBC						
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	80%	83%	85%	85%	81%		TBC						
Infection Control - Number of Cdiff - Hospital & Community	4	5	5	1	24	25		4	5	2	9	24	27	
Infection Control - Number of MRSA	0	0	0	0	0	0		0	1	0	0	0	2	
Infection Control - Number of E-Coli	7	7	8	7	42	41		5	7	5	4	30	34	
VTE Risk Assessment	95%	96.5%	94.8%	95.7%	95%	95.8%		95%	86.3%	85.8%	83.9%	95%	86%	
Mortality - HSMR	<100	90	90.4	90.1	<100	90.0		<100	111.80	110.84	109.70	<100	111.28	
Mortality - SHMI	<1	0.94	0.95	0.94	<1	0.94		<1	1.20	1.21	1.21	<1	1.20	
Number of Complaints Received	NA	62	64	54	NA	375		NA	37	43	46	NA	241	
Complaints responded to in 25 days	85%	100%	97%	100%	85%	99%		85%	77%	38%	33%	85%	57%	

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

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

Maternity	St George's							Epsom and St. Helier						
	Monthly Target / Threashold	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
% Births with 3rd or 4th degree tear	<5%	1.1%	1.1%	2.1%	<5%	2.2%		<3%	2.9%	1.0%	2.9%	<3%	2.2%	
% Births Post Partum Haemorrhage >1.5 L	<4%	3.0%	3.8%	2.7%	<4%	3.4%		<4%	2.0%	1.5%	2.7%	<4%	2.5%	
Total Births	>433	362	365	337	5000	2125			336	329	302		1876	
Birth Rate - Vaginal	>60%	59.5%	59.4%	54.5%	>60%	57.7%			49.0%	52.2%	47.7%		49.3%	
Birth Rate - Instrumental	<14%	12.2%	15.1%	13.9%	<14%	13.8%			12.0%	8.6%	10.3%		10.9%	
Screening - booked before 9+6 weeks	>90%	50.3%	55.9%	53.2%	>90%	51.3%		>90%	82.7%	84.8%	84.4%	>90%	85.1%	
Screening - booked before 12+6 weeks	>90%	89.1%	93.8%	92.0%	>90%	91.4%		>90%	98.6%	97.7%	98.5%	>90%	98.4%	
1:1 support in labour	>80%	95.1%	94.8%	98.0%	>80%	96.7%		>95%	100.0%	100.0%	100.0%	>95%	99.5%	
Continuity of Care*		8.1%	10.9%	8.1%		9.0%			78.8%	76.6%	79.3%		79.0%	
Still births per 1000 births	<2.6	8.3	2.7	3.0	<2.6	5.8			0.00	9.19	3.30		3.2	
Neonatal deaths per 1000 births	<1.5	11.1	5.5	3.0	<1.5	3.6			0.00	0.00	3.30		1.7	
HIE (Hypoxic Ischaemic encephalopathy rate	<2.2	2.7	0.0	0.0	<2.2	0.93			0.00	3.04	0.00		0.5	
Band 7 supernumerary status – rate	100%	93.5%	92.4%	100.0%	100%	95.8%			0.0%				86.7%	
MDT training compliance – rate	90%	88.4%	88.4%	81.0%	90%	82.7%			0.0%				79.6%	
Vacancy rate	<=10%	-6.7%	-6.7%	-2.2%	<=10%	-6.1%			0.0%				5.7%	
MDT handovers Rate	100%	100.0%	100.0%	100.0%	100%	92.2%			0%				100.0%	

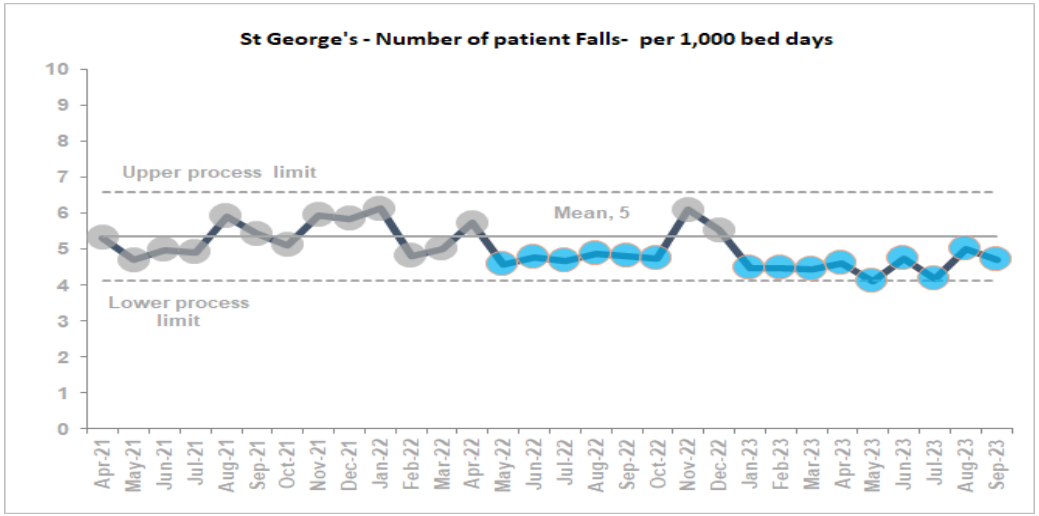
Blanks spaces indicate no data received

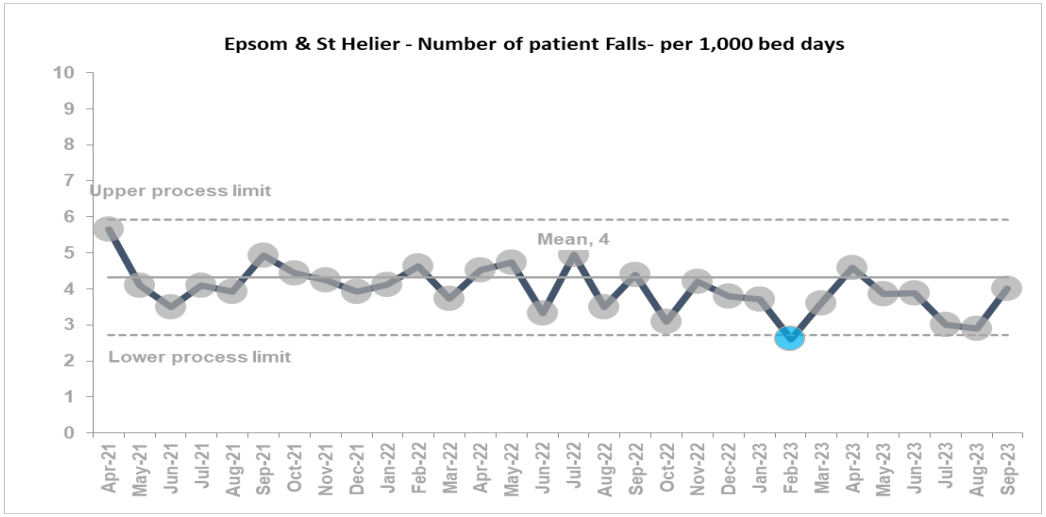
* Please note that CoC metrics have changed from May 2023 data to reflect NHS England requirements based on their definition. Data changes will be backdated to reflect NHS England reporting requirements as advised by NHS England.

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

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

Target: TBC	SGH: 4.7	ESTH: 4.0





SGH updates since last month

The Trust recorded a total of 108 falls in September 2023, with falls/1000 bed days at 4.7, this down slightly from August 2023 (115) and in keeping with the previous 8 months were falls/1000 bed days has been consistently below the mean. The majority were no harm (94) and low harm (13).
There were no high or extreme harm falls in September 2023, this is the fourth consecutive month. There was however 1 moderate harm fall within a medical inpatient area in September 2023, this resulted in a bone fracture, zero resulted in fractured neck of femur. The fracture is being conservatively managed and the patient is awaiting repatriation to their local hospital. All falls continue to be investigated and learning shared, a Trust level action plan is in place and monitored by the falls steering Group

ESTH updates since last month

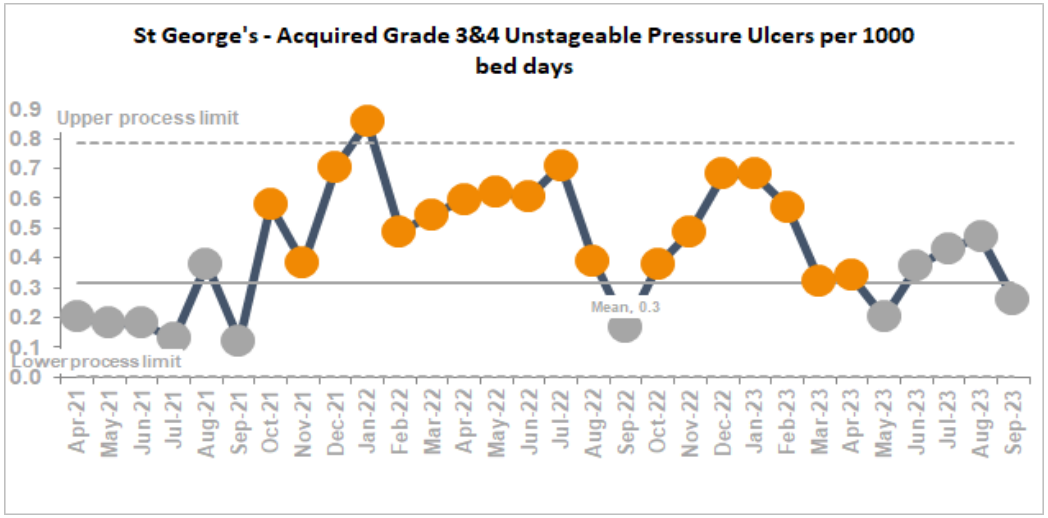
September has seen an increase in number of falls in the Acute Services, reporting 89 incidences, equating to 4.7 falls per 1000 OBDs compared to 3.6 the previous month.

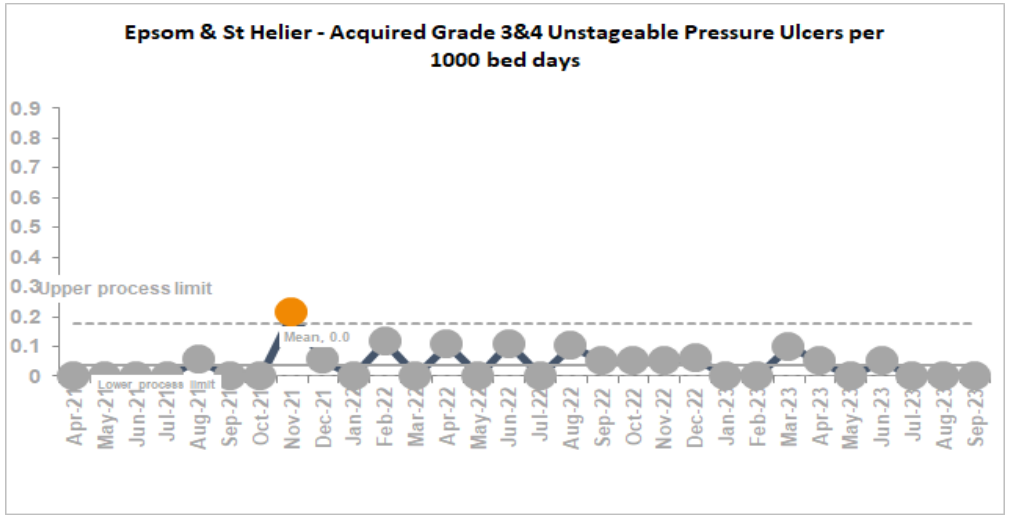
There was also an increase in incidents with harm; at present these have been categorised as moderate harm (wrist / finger / small thin acute subdural haematoma). After Action Reviews remain outstanding, however, the Falls CNS has initiated investigations and communications with staff involved and the relevant Divisions.

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

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

Target: TBC	SGH: 0.26	ESTH: 0.00





SGH updates since last month

There were a total of 6 category 3, 4 and unstageable pressure ulcers in September 2023 [4 category 3 and 2 unstageable], this is a decrease in comparison to previous months with 11 reported in August 2023 and 10 in July 2023, for September the number per 1000 bed days sits just below the mean (0.26). The Trust reported 13 category 2 pressure ulcers in September 2023, this is an increase from previous months [August – 5, July – 10, June – 7] and likely due to earlier identification. Overall numbers of medical device related pressure ulcers (MDRPUs) totalled 14 in September 2023, this is the same as August (14) and a decrease compared to 22 in July 2023. Only 1 of the 14 MDRPU's was a category 3, 4 and unstageable pressure ulcer, this is a decrease from 2 in August and 4 in July 2023. Detailed investigation into high harm pressure ulcers continues with a Trust wide action plan in place based on root cause themes and audit findings

ESTH updates since last month

7 Hospital acquired pressure ulcers (HAPU) (table 1) 3 category 2 and 4 deep tissue injuries.

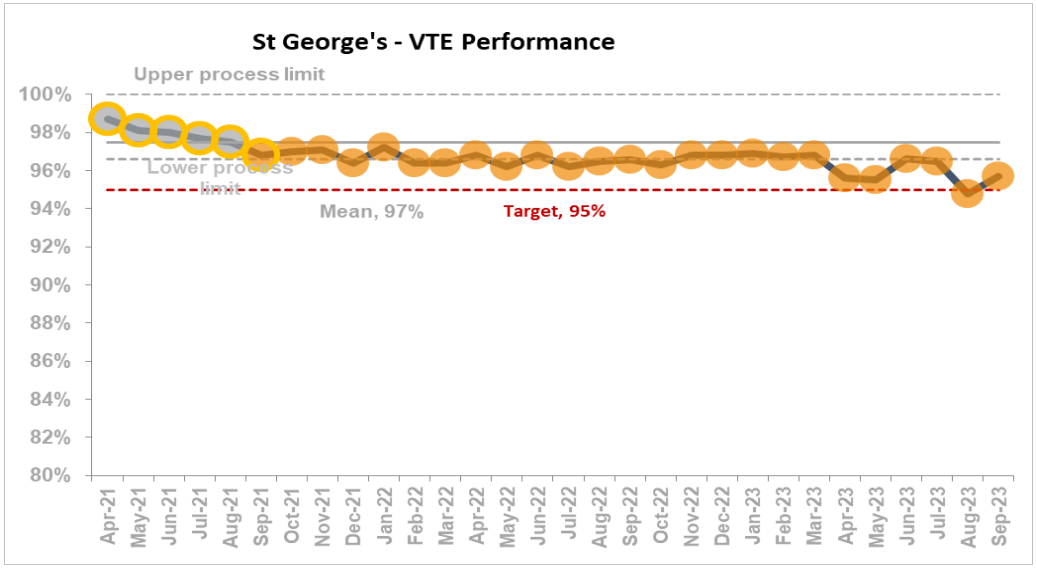
All the acquired pressure ulcers are with minor skin damage causing minimal harm to the patient.

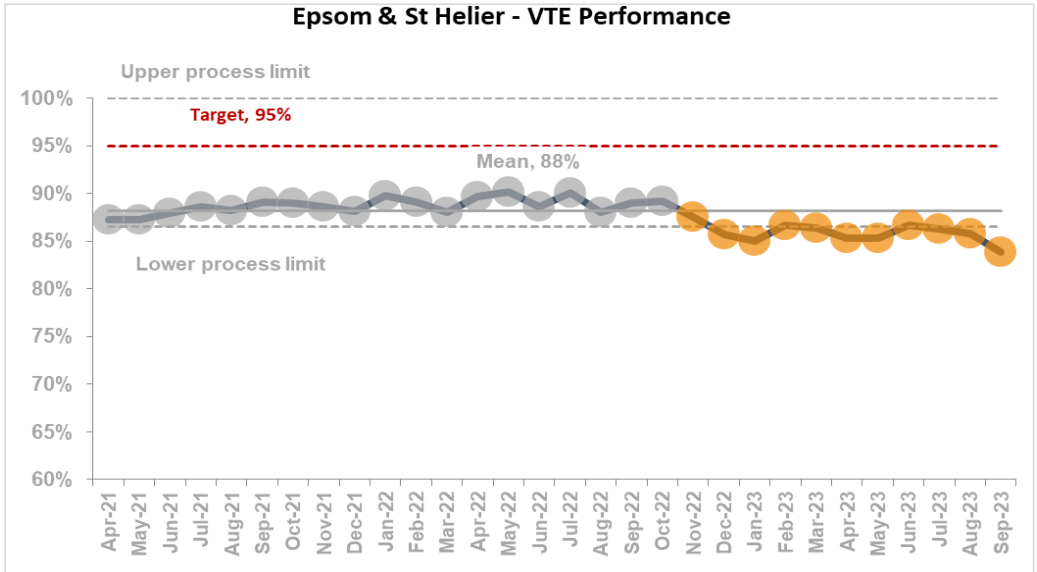
11

VTE Risk Assessment

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

Target: 95%	SGH: 95.7%	ESTH: 83.9%





SGH updates since last month

Performance against VTE Risk Assessment was slightly above target for September 2023 at 95.7%. Although risk assessment completion performance was slightly above target for September 2023 this represents a decline in position in comparison to Q3&4 of 2022/23. Initial scoping meeting with key Hospital Thrombosis Group (HTG) members and Deputy Chief Medical Officer (DCMO) has taken place to discuss ongoing effort to improve hospital acquired thrombosis, with better Multidisciplinary Team (MDT) engagement. VTE risk assessment undergoing review with view to streamline, it is hoped this will help to engage prompt timely assessment and treatment by clinical teams. Targeted group/specialty teaching to commence, specifically including junior doctors and new staff members. HTG to produce featured learning to be included in an upcoming Trust
Safety Bulletin.

ESTH updates since last month

Performance remains low despite initiatives by the divisions, in particular with Medicine. Improvements expected once EPR is in place.
Discussion planned with the Clinical Director for Medicine to improve screening figures. Thrombosis group is being revamped.
Planned Care division utilising QI project to improve the position.

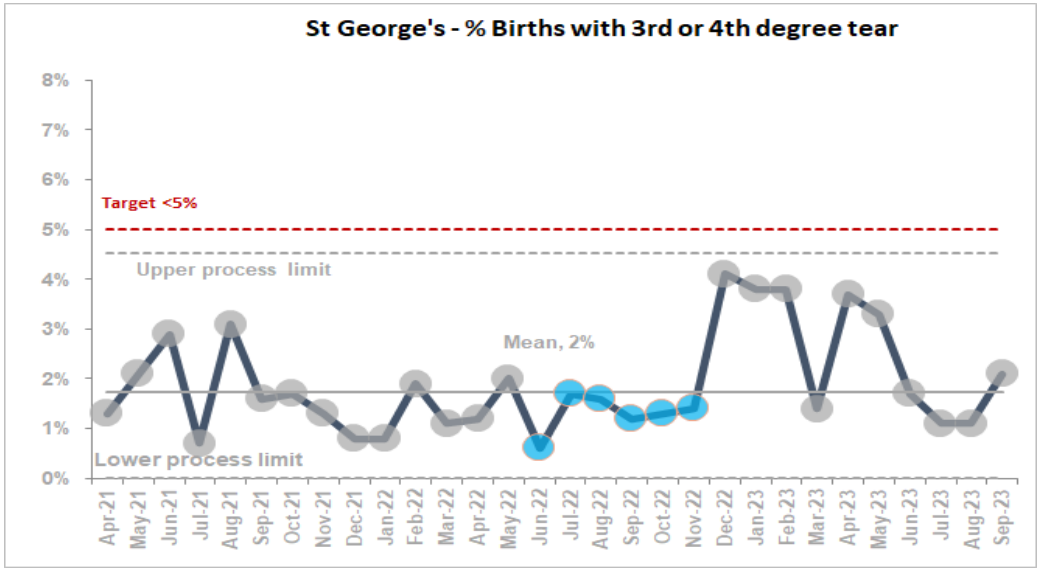
Note that the absence of EPR is contributing to the low performance and Cerner implementation is expected to help the improvement.

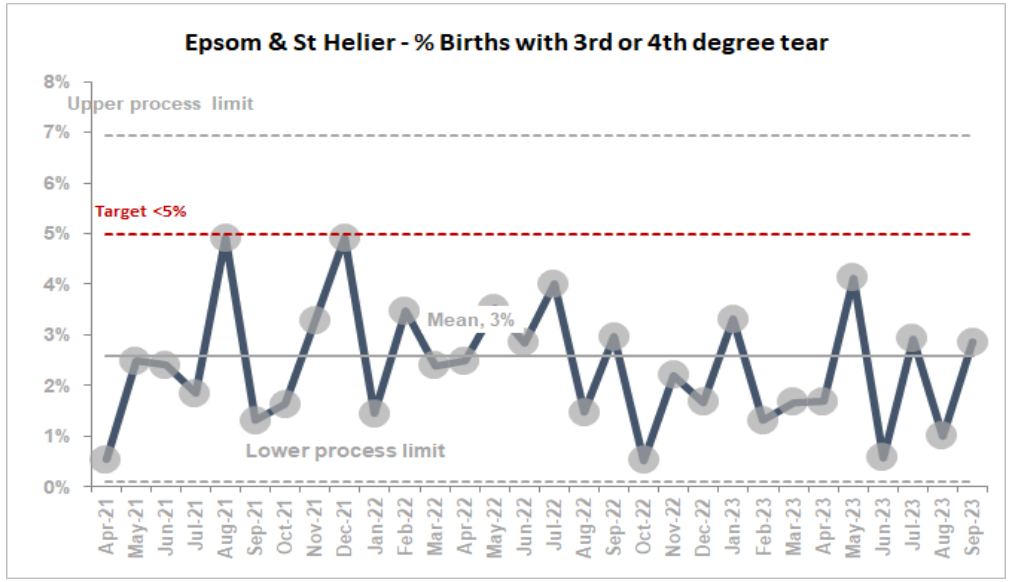
12

% Births with 3rd or 4th degree tear

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

SGH Target: <5%	SGH: 2.1%	ESTH Target: <5%	ESTH: 2.9%





SGH updates since last month

The number of 3rd or 4th degree tears in Sept is 2.1% - this was seven cases. Incidents of perineal trauma are not wholly preventable however we audit against recommended practice of 'hands on' and outcomes remain well below the national average. Perineal protection at delivery is an area of focus and point of discussion and education across the MDT groups. We have now launched our Perineal Pelvic Health Programme as part of a joint project across SWL and a national pilot.

ESTH updates since last month

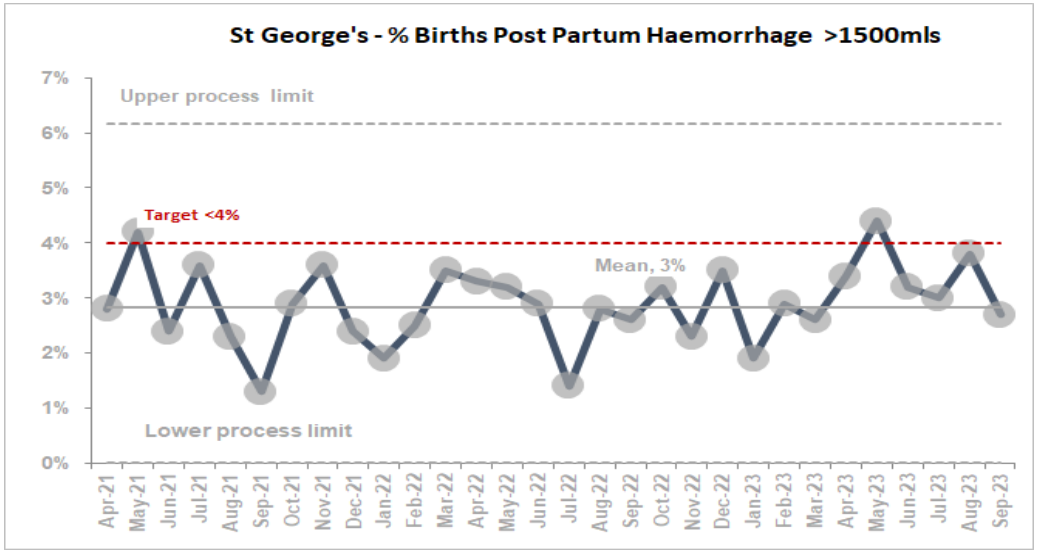
Five cases of 3rd degree tears recorded for September, all at St Helier site.
Epsom site had zero 3rd degree tears two month in a row.

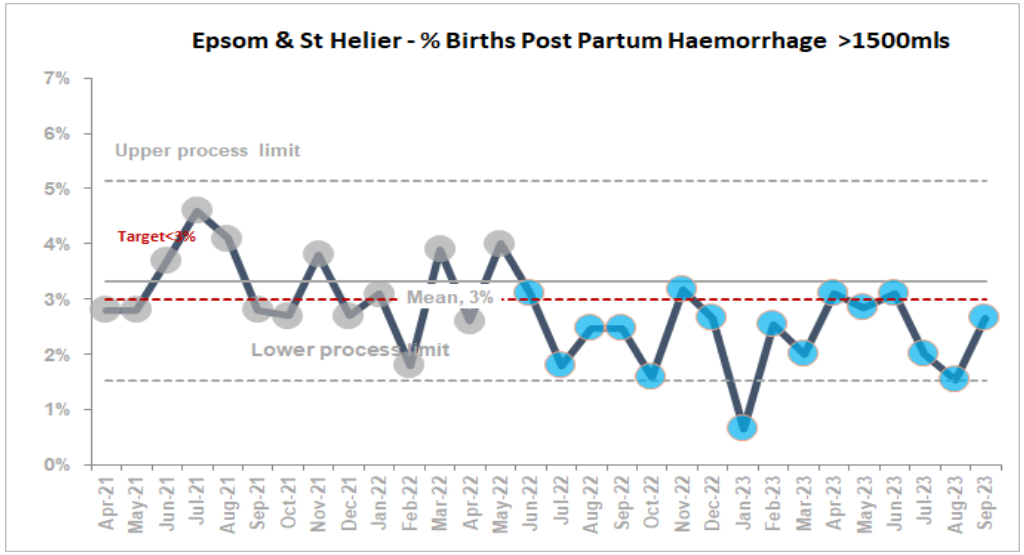
13

% Births Post-Partum Haemorrhage >1500mls

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

SGH Target: <4%	SGH: 2.7%	ESTH Target: <3%	ESTH: 2.7%





SGH updates since last month

There has been a rate for PPH >1500mls in September of 2.7% which equates to 9 cases.

Each case is reviewed on an individual basis and in line with Patient Safety Incident Response Framework principles. We review cases of PPH according to morbidity, mode of delivery and intrapartum pathway.

It is important to note that SGH is specially commissioned to provide an AIP service (abnormally invasive placenta) for women who are diagnosed in pregnancy. Women are referred from SWL and outer Surrey and Sussex border for this care – this is associated with an increased mortality rate specifically haemorrhage.

ESTH updates since last month

There were 8 cases of obstetric haemorrhage >1500mls, 3 at St Helier and 5 at Epsom.

All cases are reviewed by the Labour Ward Lead consultant who also audits this data periodically.

14

Quality - Analysis and Action

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

SGH current issues –

Infection Control: The overall numbers Covid-19 cases including nosocomial infections decreased in September 2023 (total-102) compared to August 2023 (total- 128). In total there were 8 patient deaths where patients tested positive for Covid-19, 2 of these were nosocomial cases that had Covid-19 listed on Part 1A/B of their death certificate.
September 2023 cases of C. difficile, E. coli bacteraemia, Klebsiella sp. bacteraemia and Pseudomonas aeruginosa bacteraemia continue to trend above set NHSE trajectories for the financial year 2023/24.
A confirmed outbreak of Norovirus was reported on 1 medical ward in September 2023. Infection, prevention and control measures were followed to control and contain the outbreak which resulted in preventing the spread of Norovirus outside of one bay.

Never Event/ Serious Incidents: : The Trust declared 1 Never Event in September 2023, this related to a wrong site skin surgery conducted in February 2023. In total the Trust declared 7 Serious Incidents in September 2023 (1 NE).

MCA: Mental Capacity Act level 2 compliance for nursing remains high at 93%. Level 2 MCA MAST for Additional Clinical services has improved now sitting at 83%, and Professional Scientific and Technical at 80% for August 2023. Although there is still work to do, medical compliance has significantly increased from 64% last month (pre junior doctors' rotation percentage to 72% in August 2023. Compliance continues to require improvement from medical staff outside the junior doctor staff group. .
Mental Health: 'We can talk' launch happened on 26th September 2023, lots of staff attended. Over 100 staff have registered for the training with a course completion rate of 24% which is an improvement from last month.

Maternity:-September birth rate was 337 with high levels of obstetric complexity throughout with good clinical outcomes as reflected in the associated KPI's however current establishment does not meet Birth-rate plus recommendations. Not meeting BR+ staffing recommendations also impacts on the ability to meet 100% supernumerary status of the Band 7 labour ward coordinator and wider staffing challenges. Commissioned full BR plus review for year end. Internal establishment review near completion lead by Group Chief Nursing Officer (GCNO)

SGH future action -

Infection Control: A Trust level C.difficile, E. coli bacteraemia, Klebsiella sp. Bacteraemia and Pseudomonas aeruginosa bacteraemia infection action plan is in place. Corporate nursing and IPC team have established a task and finish group, with a 'Getting back to Basics' staff engagement events commenced in October 2023. Completion and review of all C.difficile cases to identify learning and lapses in care. Feedback is provided via the Divisions and where a 'Lapse in Care' is identified, it is presented via the Care Group Morbidity and Mortality meetings and integrated into the clinical governance process.

Never Event/ Serious Incidents: Immediate practical actions are already underway in response to the Never Event, including placement of mirrors in Dermatology outpatient clinic rooms and a review the of the services photography procedures, learning has been shared across the organisation. Actions have been commenced based on completed investigation findings for all other SIs.

MCA: Auditing processes within the MCA team have been reviewed to ensure they provide useful insight into the use of the MCA within clinical areas. The team factor in the impact of new rotational visits to clinical areas into this audit and whether there have been any improvements in knowledge and literacy in documentation. Awaiting MAST team update of e-learning for Level 1 and 2. **Mental Health:** Work continues for to formalise annual mental health strategy and key performance indicators (KPIs) for St George's hospital, with launch planned for 2024/25. Vacant posts remain out to advert and paediatric staff are completing specialist violence and aggression management training with South West London and St George's Trust in November 2023, the aim is to reduce episodes of restraint and violence and aggression towards staff.
Maternity-Maternity-The response to the CQC inspection continues with high focus moving to MUST and SHOULD do's..
Retention and Recruitment ongoing with a pipeline of 4 WTE band 6 MW's and 11 WTE preceptorship band 5 Midwives (over establishment, as agreed by Senior Leadership Team) joining between now and Dec 2023 following NMC registration.

ESTH current issues –

Infection Control:

There was no Trust attributed MRSA bloodstream infection in September (YTD= 2). There were 9 Trust attributed C. difficile cases, (6 Healthcare Onset Healthcare Associated-HOHA and 3 Community Onset Healthcare Associated-COHA), 1 P. aeruginosa case, 4 E-coli cases (1 HOHA, 3-COHA), 2 Klebsiella cases (2 COHA) and 4 MSSA cases (4 HOHA). A total of 79 Covid-19 infections were identified in September. There were 18 Covid-19 clusters in September and the IPC team continues to monitor and follow up contacts. There were 4 new flu cases and no flu clusters in September.

Detailed report is presented at the Quality Committee.

Following the microbiology laboratory move to St George's Hospital (SWL Pathology Services), there has been gaps in how our microbiology results/data is reported back to the ESTH BI team affecting the accuracy of the reports.

Pressure Ulcers : The Annual foam mattress audit was completed with collaboration of the FoC team and members from Drive Devilbiss (Mattress contractors). A total of 88 foam mattresses were condemned (68 STH), (20 Epsom) and has been replaced with new one. A new stock of 25+ foam mattresses is now available on each site to meet the recent shortages reported over the last few months.

VTE: Risk Assessment Screening remains a challenge with little improvement.

Maternity: The CQC inspected ESTH on 29 and 30 August 2023. Three urgent concerns were identified and rectified immediately in relation to out of date equipment on the NNU trolley, storage of Syntocinon and a typographical error on an emergency drug box. Other concerns raised were responded to and additional evidence was submitted. The Trust subsequently issued a section 29a Warning Notice in relation to the issues noted on 18th September 2023.

5 out of 10 safety actions to achieve full compliance CNST Year 5 are off track, mainly due to staffing shortfall. Midwifery workforce planning status does not meet 'Birth-rate plus' recommendations. Midwifery Safe Staffing for August 2023 was 90% for St Helier and 88% for Epsom against a set threshold of 95%.

ESTH future action –

VTE: Meetings will be held with Medicine division to improve screening figures. Review with Quality team to ensure investigation is consistent across the group and aligned with the other Fundamental of Care Teams.

Pressure Ulcers : Implementation of Purpose -T as pressure ulcer risk assessment, to work on feedback format/ survey to improve Tissue Viability Service across both sites. To work on Implementation of compression therapy by upskilling staff to undertake silver standard (Double K-lite bandaging) for management of patients with venous leg ulcers.

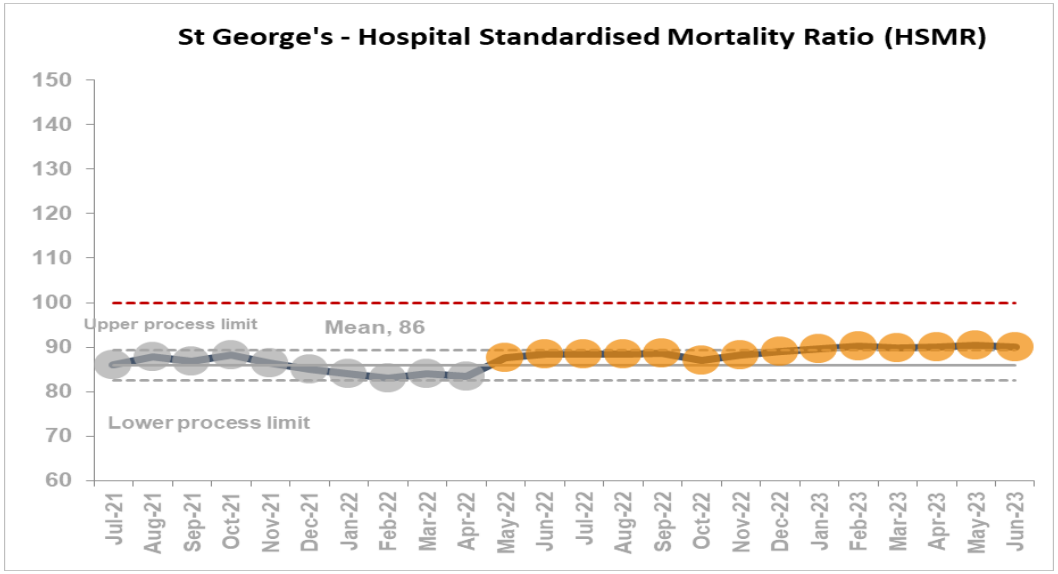
Maternity:

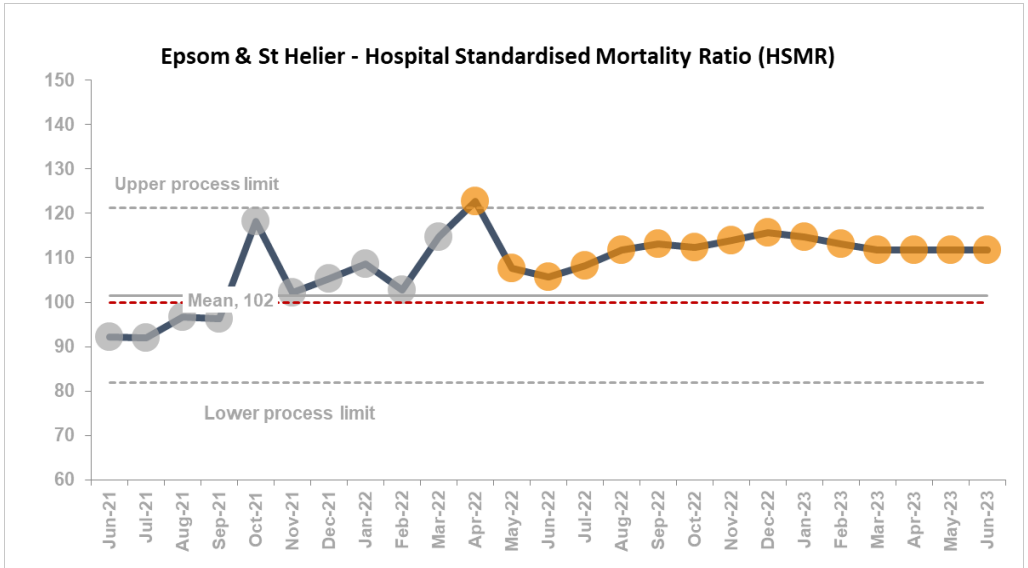
Staff redeployed from Continuity of Carer teams and community and non-clinically facing teams to assist in the covering of the staffing shortfall. Mandatory training improvement plan is in place and monthly monitoring of performance against trajectory is carried out to improve multidisciplinary training.

Mortality – HSMR

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

Target: <100	SGH: 90.1	ESTH: 109.7





SGH updates since last month

Latest HSMR, for the 12 months from July 2022 to June 2023 shows our mortality remains lower than expected. Looking specifically at emergency admissions, mortality remains lower than expected for those patients admitted during the week and as expected for those admitted at the weekend.

Data source: Dr Foster

ESTH updates since last month

12-month rolling HSMR has further reduced to 109.7 for the period from August 2022 to July 2023. Even though the HSMR remains over the expected level, the downward trend in HSMR is reassuring with the monthly figures for the months of May and June 2023. It has come down below 100 for two consecutive months, however, there's a rise above 100 in the ratio for the month of July 2023. The HSMR for the non-elective cases has also reduced near to 100 for the months of May and June. There's a rise in the ratio in July and this is reflected in the overall ratio. There are no elective deaths for June and July therefore the non-elective HSMR is 0.

There is no obvious difference in HSMR between patients admitted during the week and those admitted over the weekend, but both cohorts remain above the expected level.

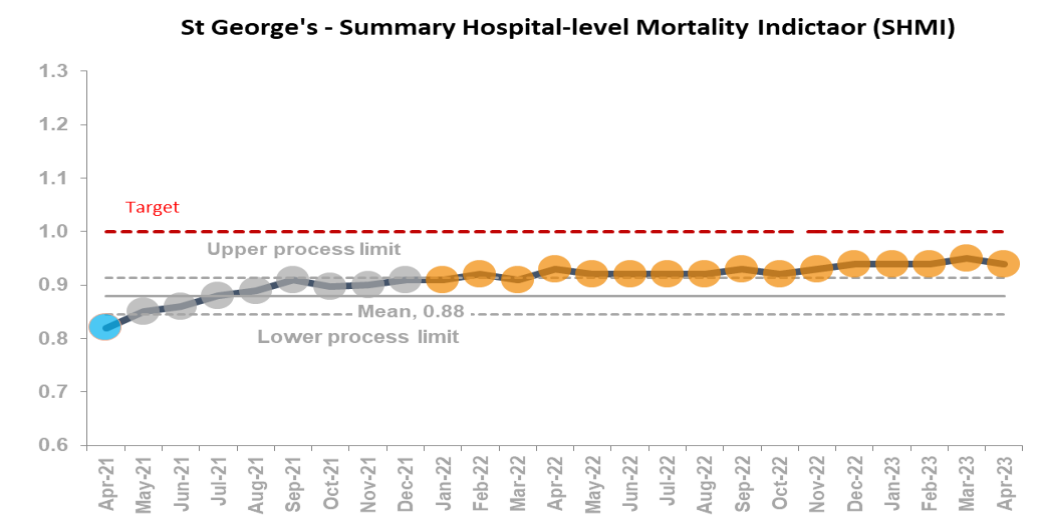
Data source: HED

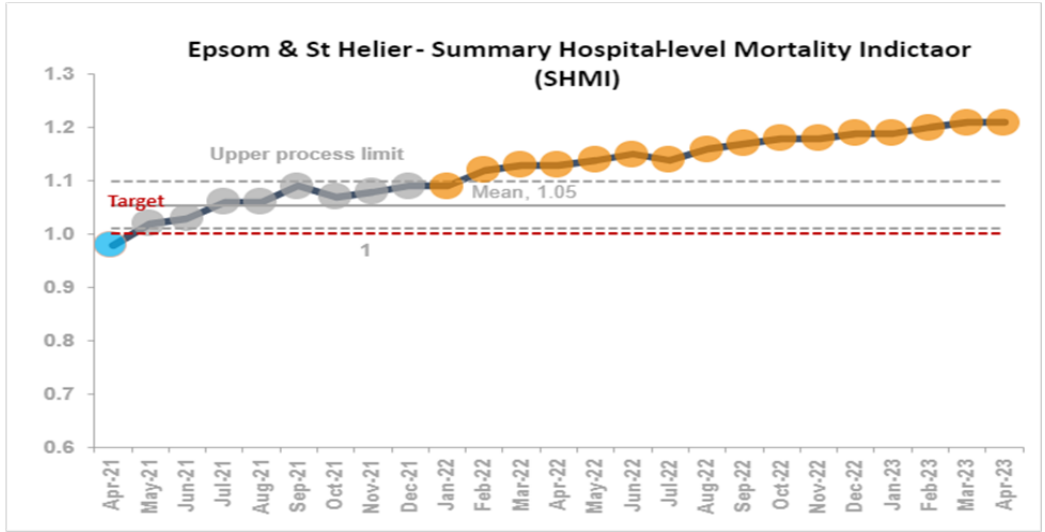
16

Mortality – SHMI

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

Target: <1	SGH: 0.94	ESTH: 1.21





SHMI data based on rolling 12 months- May 2022 to April 2023

SGH updates since last month

The SHMI is the ratio between the actual number of patients who die following hospitalisation at the trust and the number that would be expected to die on the basis of average England figures. For SGH performance remains as expected at 0.94.

SHMI data is based on a rolling 12 month period and reflective of the period May 2022 to April 2023 (published 14th September 23).

Source NHS Digital

ESTH updates since last month

The SHMI covers patients admitted to hospitals in England who died either while in hospital or within 30 days of being discharged (except the deaths that occurred due to COVID-19).

The latest data reviewed by the Trust Committee for the 12-month rolling SHMI is 1.21 for the month of April 2023. However, this might not be reflecting the reduction in the Crude Mortality Rate (CMR) and the HSMR (which are closely related in terms of the trend) since the latest data available is for April 2023. Also, this is a rolling 12-month value, which smooths out the changes, therefore not reflecting a drastic change immediately. The monthly value for SHMI is coming down and follows a similar trend as CMR and HSMR.

Source NHS Digital

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Mortality - Analysis and Action

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

SGH current issues –

The Mortality Monitoring Group (MMG) consider mortality at diagnosis and procedure group level, examining HSMR data (via Dr Foster) and SHMI data (NHS Digital).

In a small number of cardiology diagnosis groups Dr Foster data and SHMI continue to show outcomes that are not in line with what would be expected. The clinical team has previously looked in detail at the treatment of many of the patients within these groups. This has not revealed areas of immediate concern and therefore MMG has endorsed a renewed focus on establishing a clear understanding of the data in order to understand what these signals represent. The clinical coding team are supporting this and will be working alongside the clinical team to ensure that coding is appropriate and accurate, focussing in particular on comorbidities and non-ST elevation myocardial infarctions. A number of pieces of analysis will also be requested of Dr Foster, which should be provided by the end of October.

SGH future action -

The clinical coding team also propose to support ongoing coding review of fractured neck of femur patients. As part of the investigation of SHMI data for this diagnosis group a coding review has been completed and presented to MMG which showed good practice overall with opportunity for small improvements. The Learning from Deaths Lead is seeking input from the clinical lead for Orthopaedics to inform and support the work proposed by the Orthogeriatric team.

The Mortality Review Team has almost concluded the review of deaths occurring in ED during quarter 2. Interim analysis, shared with MMG, did not identify areas of clinical concern. Full analysis will be shared once all reviews have been completed. In quarter 3 we will be identifying patients that have waited over 12 hours in ED and then have died following admission. Lead clinicians from ED and Acute Medicine teams are working with the team to formulate questions for the review which will be used to enhance the SJR methodology.

ESTH current issues –

The RADAH (Reducing Avoidable Death and Harm) Committee reviews HSMR, SHMI, and diagnosis-level mortality statistics, as well as crude mortality rates, on a monthly basis.
12-month rolling value for HSMR has reduced than the previous month even though it remains above the optimal level. 12-month rolling SHMI value is also categorised as 'higher than expected' despite the fact that the monthly value follows a downward trend. The crude mortality rate is 1.4% for the month of September, but lower than the September 2022/23 (1.8%) and September 2021/22 (1.5%) values.

Out of the 120 SJRs completed for the Q2 2023/24, eight overall 'poor' ratings and one 'very poor' rating were recorded. The 'concerns in care' percentage (34.5% was lower than the Q1 2023/24 (38.3%).

ESTH future action –

The Trust continues to investigate all unexpected deaths using the mortality review and SJR procedures. With the assistance of the mortality review committee and medical examiner's office, deep dives into outliers are carried out and work continues to guarantee safe patient care. As a result, the trends now show an encouraging pattern.

ED mortality and waiting times and readmission audits are underway and interim results were discussed at the RADAH committee meeting with the hope of producing formal reports for action in the upcoming months. Recruitment of additional staff to provide Critical Care Outreach on both sites 24/7 is planned to be completed before Winer. Discussions are being held with a view to redesign sepsis care pathways to reduce sepsis mortalities as a targeted approach. Patient Safety Incident Response Framework (PSIRF) is being implemented currently to develop and maintain effective systems and processes for responding to patient safety incidents for the purpose of learning and improving patient safety.

Monthly Overview – Elective Care (1)

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

Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	63,376	69,829	67,051	65,250	372,092	402,235		51,436	51,113	51,388	49,473	301,269	304,047	
Patient Initiated follow ups		161	179	229		683			1,724	1,561	1,678		6,961	
Advice and Guidance		1,278	1,284	1,246		7,027			2,359	2,402	2,228		8,975	
Outpatient DNA rates	8%	10.7%	12.2%	12.0%	8%	11.1%			4.8%	4.9%	4.8%		5.1%	
New to follow up outpatient ratios		1.74	1.76	1.70		2.04			2.67	2.72	2.70		2.75	
Elective and day case activity	5,557	4,792	5,315	4,833	32,401	30,059		3,759	3,894	3,804	3,650	22,017	21,995	
Elective LOS		4.4	3.8	3.9		4.2			5.7	5.8	5.6		5.7	
Elective Day case rates	78%	79.0%	78.0%	77.6%	78%	78%		82%	83.5%	82.8%	83.5%	83%	83.0%	
Theatre Utilisation (Uncapped)	85%	82%	80%	81%	85.0%	82%		85%	77%	75%	79%	85%	76.5%	
Theatre Utilisation (Capped)	85%	73%	76%	76%	85.0%	75%		85%	73%	72%	75%	85%	73.3%	
Theatre Average Cases per Session		1.68	1.61	1.59		1.64			3.59	3.66	3.63		3.66	
On the day cancellations for Non Clinical Reasons		36	28	29		184			60	70	94		184	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	72.2%	96.4%	86.2%	100%	87%								

Monthly Overview – Elective Care (2)

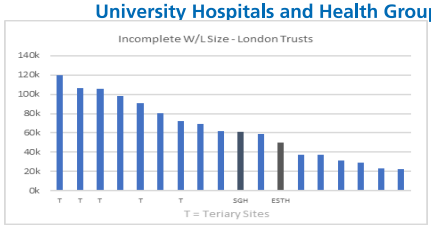
St George's, Epsom and St Helier University Hospitals and Health Group

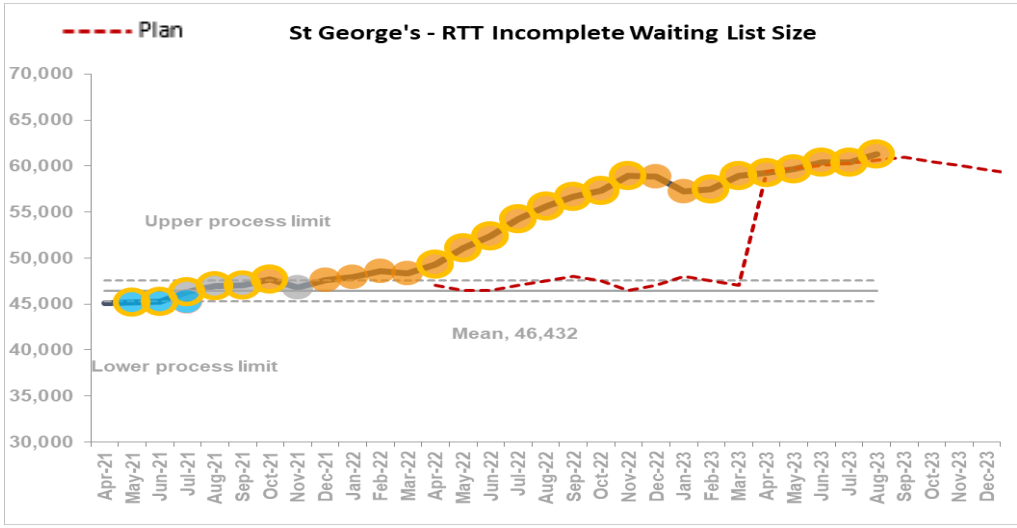
Responsive and Productive Services - Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Jun-23	Jul-23	Aug-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jun-23	Jul-23	Aug-23	YTD Target	YTD Actual	13-Month Trend
RTT – total size of waiting list*	60,642	60,364	60,411	61,295				47,268	49,717	49,667	49,845			
RTT -Incomplete Median Waiting Times		11.1	10.6	10.7					11.0	11.6	11.4			
RTT - Waits over 52 weeks*	431	560	559	506				368	747	835	917			
RTT - Waits over 65 weeks*	122	62	66	56				27	77	101	155			
RTT – Performance	92%	70.3%	70.3%	70.2%				92%	68.0%	68.4%	67.6%			
Cancer 14 Day Standard	93%	82.5%	64.4%	51.2%	93%			93%	80.7%	74.4%	67.7%	93%		
Cancer 14 Day Standard Breast Symptomatic	93%	86.1%	78.6%	12.5%	93%			NA	NA	NA	NA	NA	NA	
Cancer 31 Day Diagnosis to Treatment	96%	96.1%	96.3%	93.2%	96%			96%	100%	100%	100%	96%		
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.3%	94.8%	96.8%	94%			94%	100%	100%	100%	94%		
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	98%			98%	NA	100%	NA	98%		
Cancer 62 Day Referral to Treatment Screening	90%	58.0%	51.9%	52.8%	90%			90%	100%	NA	NA	90%		
Cancer 62 Day Referral to Treatment Standard	85%	65.0%	55.4%	64.9%	85%			85%	88.2%	87.0%	87.0%	85%		
No. of patients over 62 days	110	96	103	117	NA	NA		65	49	65	47	NA	NA	
Cancer – 28 day Faster Diagnosis Standard	75%	77.6%	76.8%	66.8%	75%	NA		75%	81.2%	79.4%	76.2%	75%	NA	
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Diagnostic activity		18,457	18,113	17,981		91,412			17,772	17,898	17,965		102,463	
Diagnostic performance	5%	1.6%	1.2%	2.0%				5%	7.1%	7.3%	5.4%			

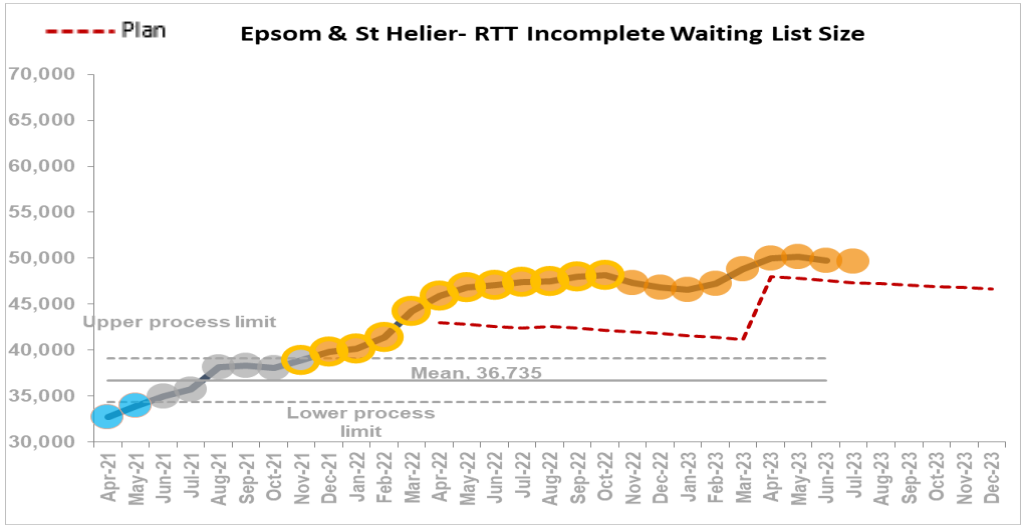
RTT – Total Waiting List Size

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

SGH Plan: 60,642	SGH: 61,295	ESTH Plan: 47,268	ESTH: 49,845







SGH updates since last month

PTL volume has increased in August by 1.5% (884 pathways) and not currently meeting plan. Increase continues to be seen within the non-admitted pathway with 1,040 more patients at the end of August compared to July. The admitted PTL saw a decrease of 2.2% (156 patients) driven by Gastroenterology.

Performance is stable at 70.2%. The number of 18 week breaches have increased by 1.9% (343 pathways), although we are continuing to look at validation of all pathways.

ESTH updates since last month

PTL volume has increased slightly (by 0.4%), with (18w) breach numbers also increasing, but at a much higher rate (by 479 pathways, 3.1%). This has resulted in 18w performance going down from last month (from 68.4% to 67.6%).

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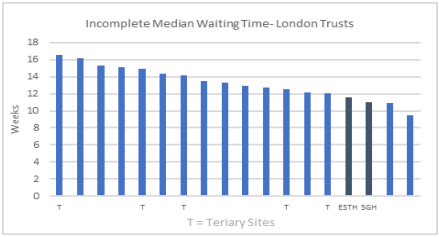
RTT – Median Waiting Times

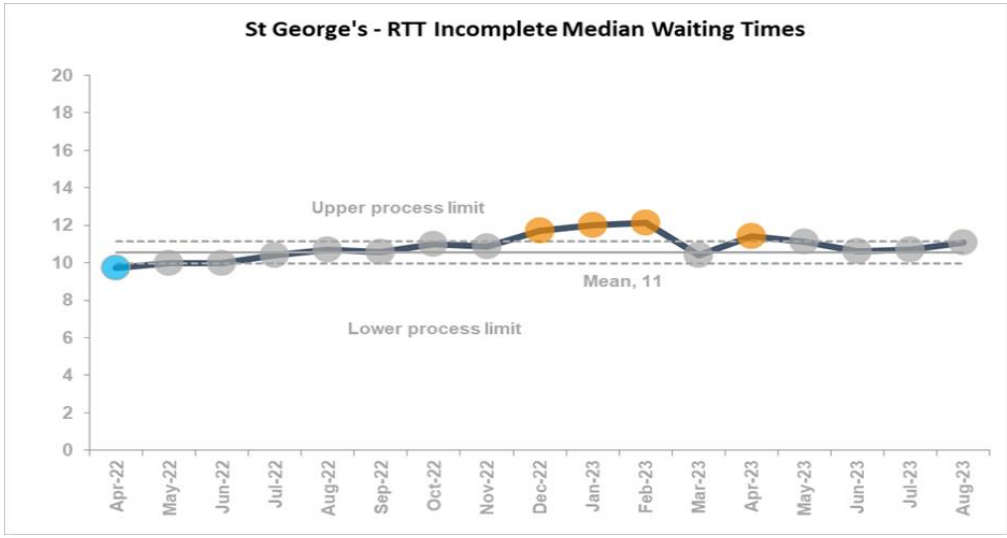
St George's, Epsom and St Helier University Hospitals and Health Group

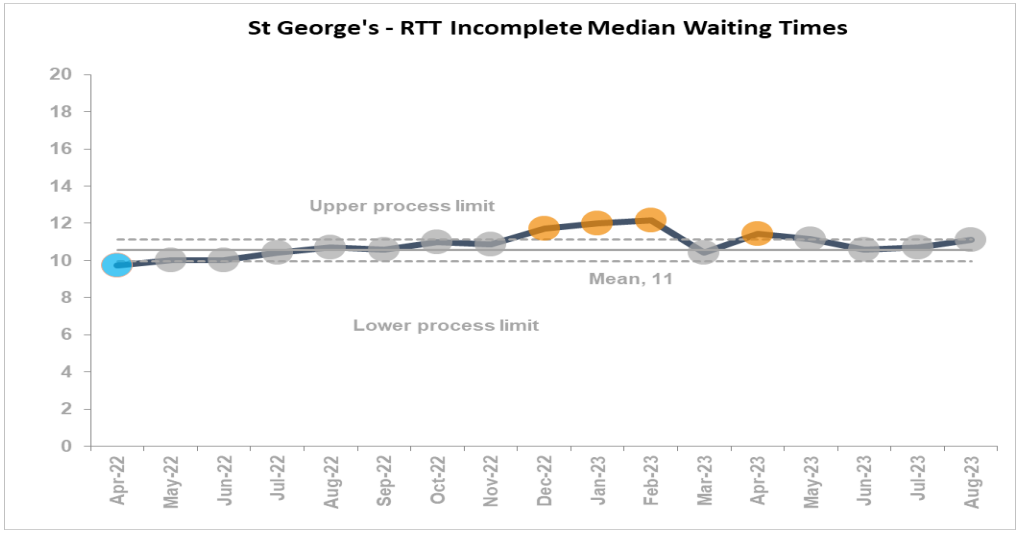
Average (median) waiting time (in weeks)
This is the mid-point of the RTT waiting times distribution. The median is the 50th percentile. It's the time that 50% of patients waited less than, e.g. the waiting time of the middle patient if you lined them up from shortest wait to longest wait.



SGH: 11.1 Wks

ESTH: 11.1 Wks





SGH updates since last month

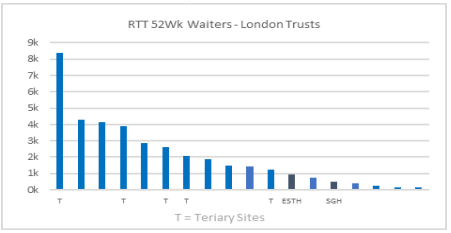
The median waiting time for the RTT incomplete PTL remains consistent at 11 weeks. General Surgery has the highest average wait of 18 weeks, however compared to the rest of London, performance is mid quartile.

ESTH updates since last month

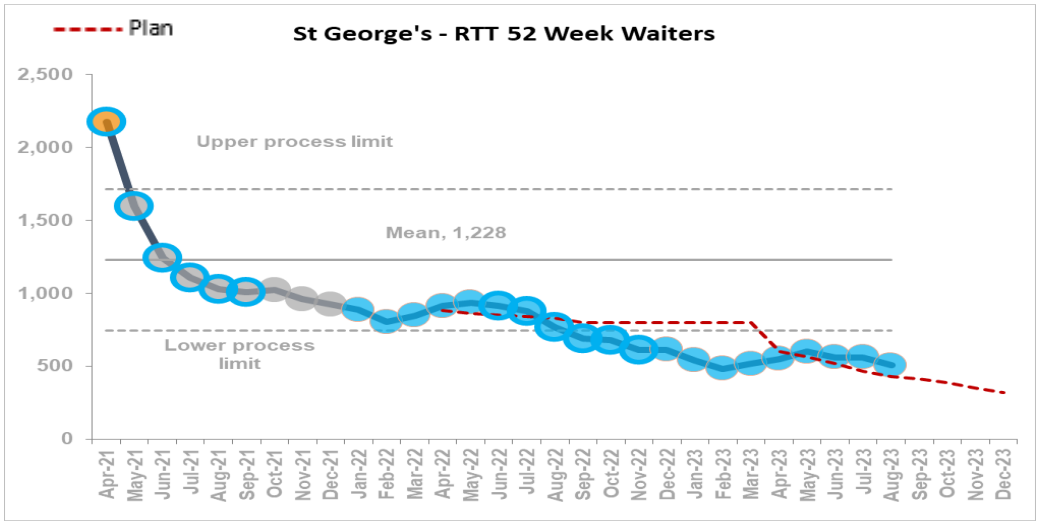
The median waiting times on the RTT incomplete PTL has been relatively consistent over the last 12 month period showing some periods of special cause variation, with an average waiting time of 11 weeks. The highest median waits are for Cardiology and Gynae (+15 weeks).

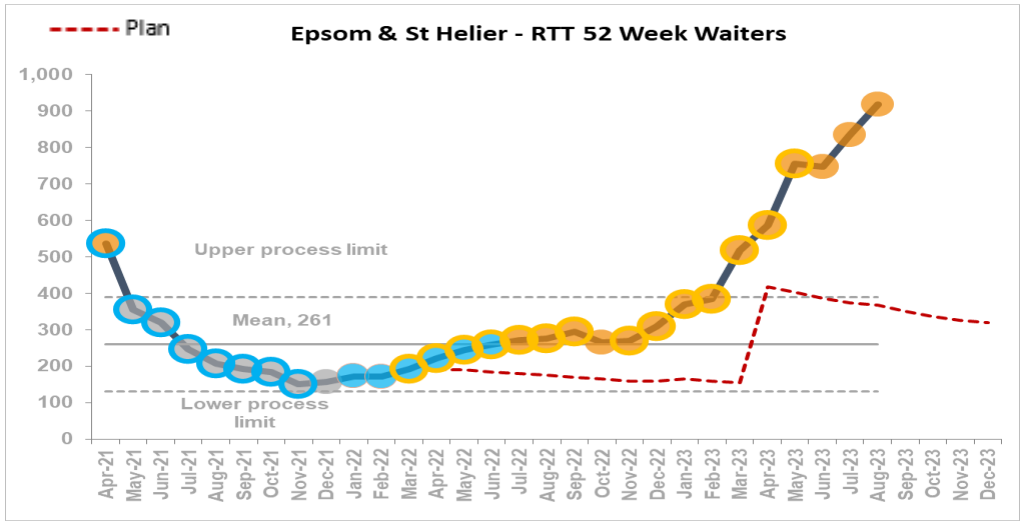
RTT – 52 Week Waiters

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



SGH Plan: 431	SGH: 506	ESTH Plan: 368	ESTH: 917





SGH updates since last month

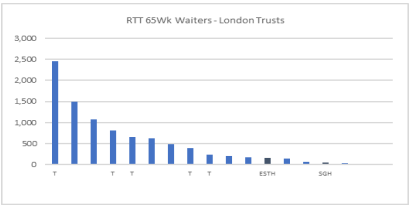
At the end of August, 506 patients were waiting over 52-weeks on an incomplete pathway. Although this is above plan the Trust have seen a positive reduction of 9.5% compared to July (53 pathways) driven by Cardiology and ENT on the admitted PTL and Gynaecology on the non-admitted pathway. At Trust level, Cardiology continue to hold the largest proportion of 52-week breaches.

ESTH updates since last month

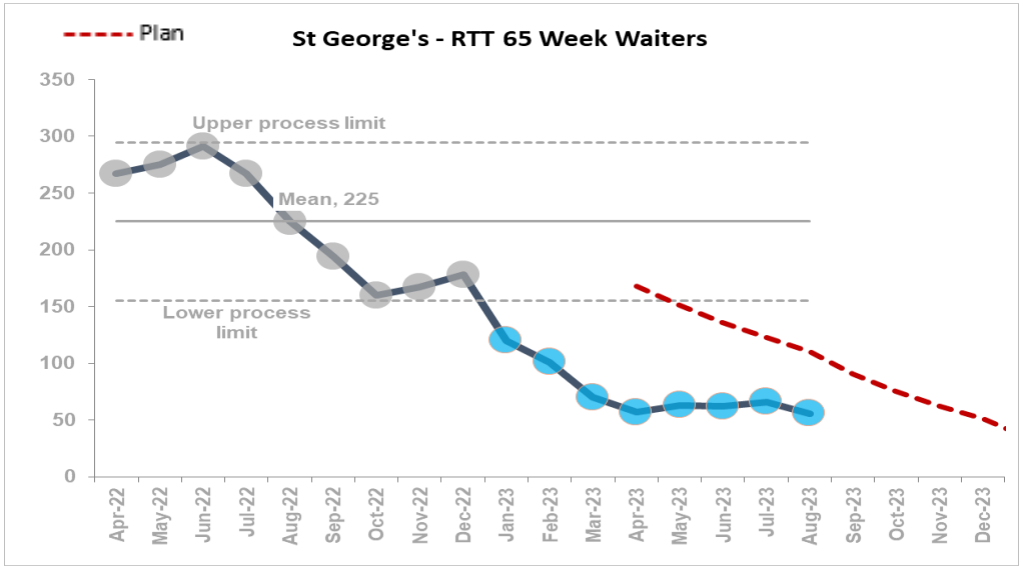
The month-end 52-week waits have increased fairly significantly (by 82 pathways, 9.8%) and notably above plan. There were no 104+ week waiters, and seven 78+ week waiters (the longest wait being 87 weeks). The largest proportion of waits remain within Gynae and Community Paediatrics.

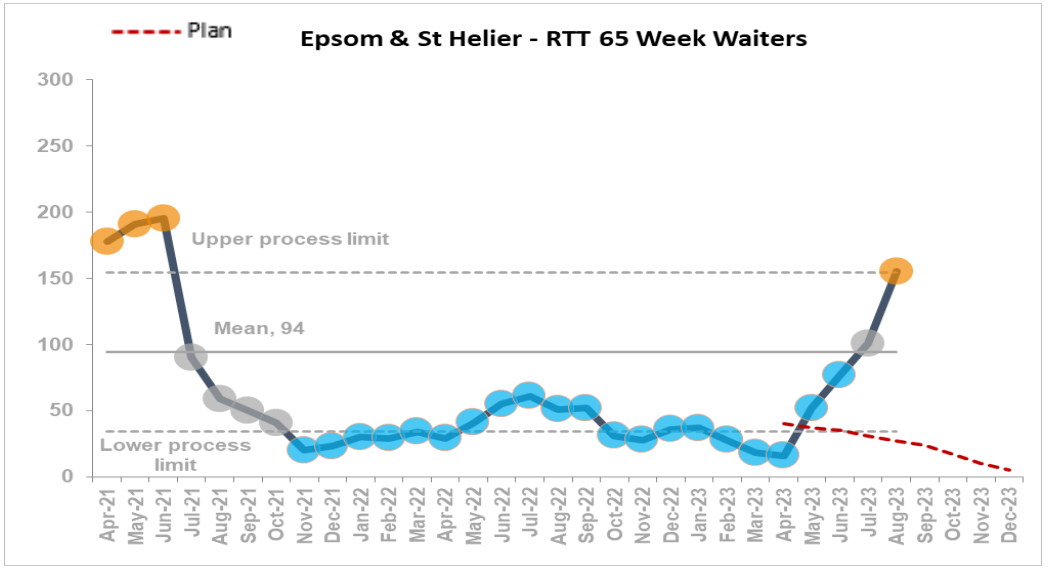
RTT – 65 Week Waiters

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



SGH Plan: 110	SGH: 56	ESTH Plan: 27	ESTH: 155





SGH updates since last month

At the end of August, the Trust reported 56 patients over 65 weeks, a reduction of 10 on the previous month. The number of patients waiting over 65 weeks continues to meet plan to deliver zero 65 week waits by March 2024, however there is risk in neurosurgery, where the 65-week cohort (those who will breach before 31 March 2024) has a large proportion of un-booked patients, which will mean we will not deliver plan of 0. We are looking at mitigations at this time.

ESTH updates since last month

At the end of August, 155 patients were waiting for more than 65 weeks for treatment (increase of 54 pathways) , against a plan of 27. Waits have significantly risen over the last four months and now performing above the upper control limit showing special case variation.

Elective / RTT Analysis and Action

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

SGH current issues –

There are 597 patients with a projected wait of over 52 weeks for a first appointment. The largest numbers are in Neurosurgery with 235 patients waiting. A recovery plan is in place and managed through Elective Access.

The number of patients waiting over 65 weeks is ahead of plan and on track to achieve year end targets. There is risk within neurosciences (pain and neurosurgery in particular)

The number of 52-week incomplete pathways is currently behind plan, partly due to the impact of industrial action.

SGH future action -

Focus on reducing the volume of outpatient data quality issues that may be artificially inflating the PTL size.

All patients waiting over 12 weeks are being contacted via text message as part of the self-assessment process for the outpatient elements of protecting and expanding elective capacity. Validation texts sent to 21,378 patients waiting over 12 weeks – 45% of these patients have responded. Currently 36% of the PTL (based on the criteria within the letter) has been validated to 12 weeks. A further 13,000 PTL validations (outside the scope of this exercise) have been completed as part of BAU. The PTL DQ is at 6.7% against a threshold of 10%

Focus on booking appointments for all patients in the 65-week cohort to ensure they are not waiting for an outpatient appointment after 31st October 2023.

Roll out of a temporary fix for 'Orders to Schedule' which will generate PIFU PTL and support OP FU reduction at the end of from October in T&O and urology. The roll out of |Orders to Schedule has been delayed again to 28th November 2023, any further slippage will push back to 2024.

ESTH current issues –

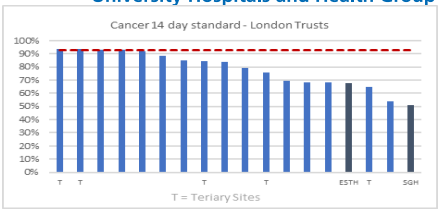
- 52 week waits has increased from 835 in Jul23 to 917 in Aug23. This increase is mainly driven by pressures in Gynae (277), Community Paediatrics (260) and Cardiology (98), as well as ongoing industrial action. A further increase is expected in Sep23 once submitted.
- Referrals from GP to a consultant led service remain significantly above BAU levels within a number of key specialities such as Gynaecology (+38%), Gastroenterology (+19%), Paediatric Specialities (+16%) and Respiratory (+15%).
- Patients waiting over 65 weeks for treatment increased from 101 in Jul23 to 155 in Aug23 (64 Community Paediatrics, 39 Gynae, 18 Cardiology, 14 Gastroenterology and 20 scattered across other specs)
- The Admitted PTL (excluding diagnostics) slightly increased from 7750 at the end of Aug23 to 7867 at the end of Sep23.

ESTH future action –

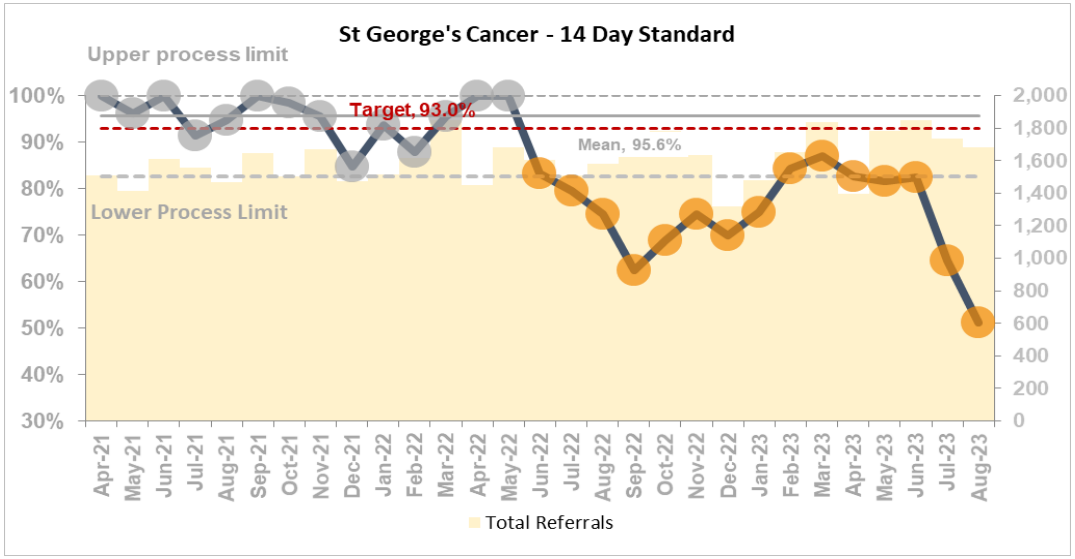
- All patients over 12 weeks who have not been seen or contacted in the past 12 weeks are being contacted using the DoctorDr platform to confirm if they still wish to be seen. Deadline of 31st October to contact over 90% within this cohort and will remain an ongoing exercise.
- Local action/recovery plans in place for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology.
- Progressing with papers to use the independent sector for Community Paediatrics and Gynaecology.
- Divisions and performance team continue to work in collaboration to micro-manage 52WWs on a daily basis and expedite next steps. Updates being provided to SWL on a weekly basis for patients 60weeks+

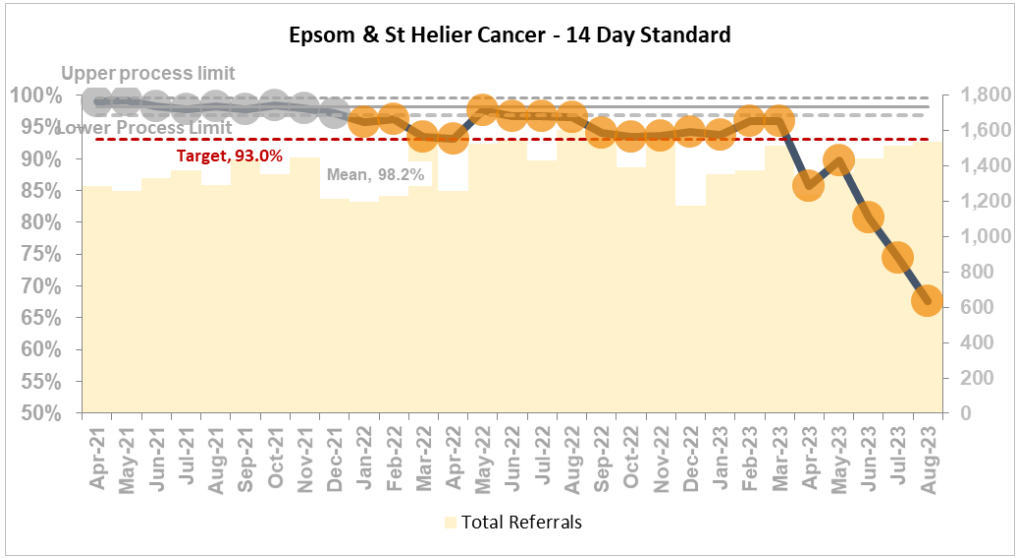
Cancer – 14 Day Referral to Seen Standard

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



Target: 93%	SGH: 51.2%	ESTH: 67.7%





SGH updates since last month

Performance of this standard has significantly dropped over the past two months with 51.2% of patients seen within 2 weeks of referral in August. Performance remains below the lower control limit showing specialty cause variation. Challenges within Breast and Skin have notably contributed to the overall Trust deterioration in performance.

This target is being removed from the national cancer standards in October 2023, although we will continue to monitor it internally to support FDS delivery.

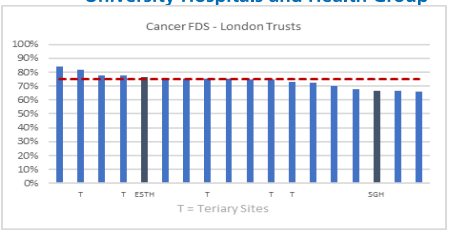
ESTH updates since last month

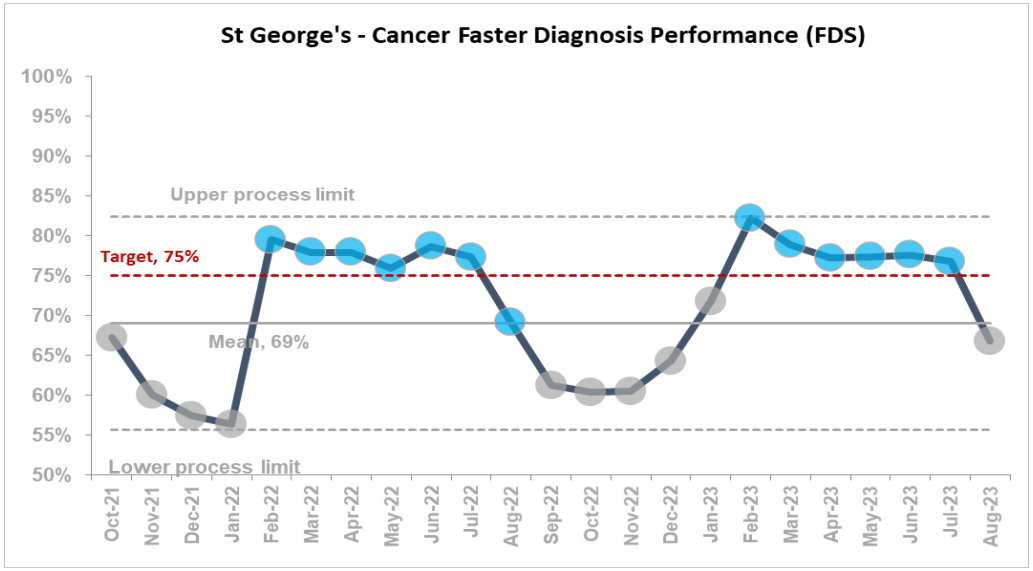
Performance against the 14 day standard continued to see a decrease in August with a Trust performance of 67.7%. This was significantly driven by Skin performance where in August, 10.5% of patients were seen within 14 days of their referral. Skin have been working through a recovery plan to increase TWW clinics, including use of an Agency Locum who will be funded through RMP funding. Both Skin and Gynae continue to build ad hoc clinics, and Gynae has pulled Registrar resource from other rotas to support.

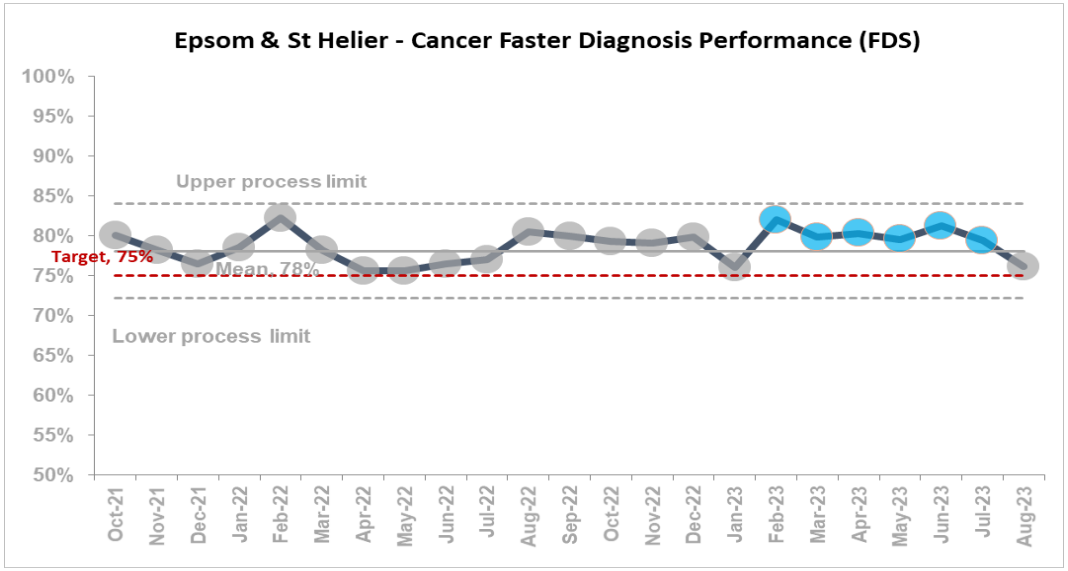
Cancer – Faster Diagnosis Standard

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

Target: 75%	SGH: 66.8%	ESTH: 76.2%







SGH updates since last month

Faster Diagnosis performance was non-complaint in August with 66.8% of patients receiving communication of diagnosis of cancer within 28 days of urgent referral compared to 76.8% in July. Performance has deteriorated below the mean for the first time in seven months. Delivery has been impacted due to capacity issues in the Skin pathway. This is not an easy fix although options are being sought for additional capacity.

ESTH updates since last month

The Trust continues to meet the FDS standard of 75%, however a dip in performance is seen reporting 76.2% compared to 79.4% in July. The Trust expects to maintain overall performance whilst addressing FDS non-compliance drivers, particularly the challenges within Gynae and Skin.

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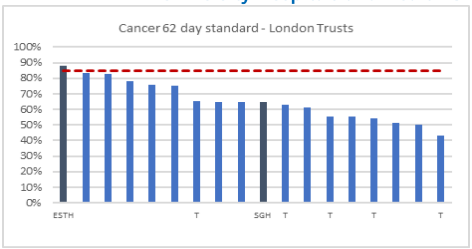
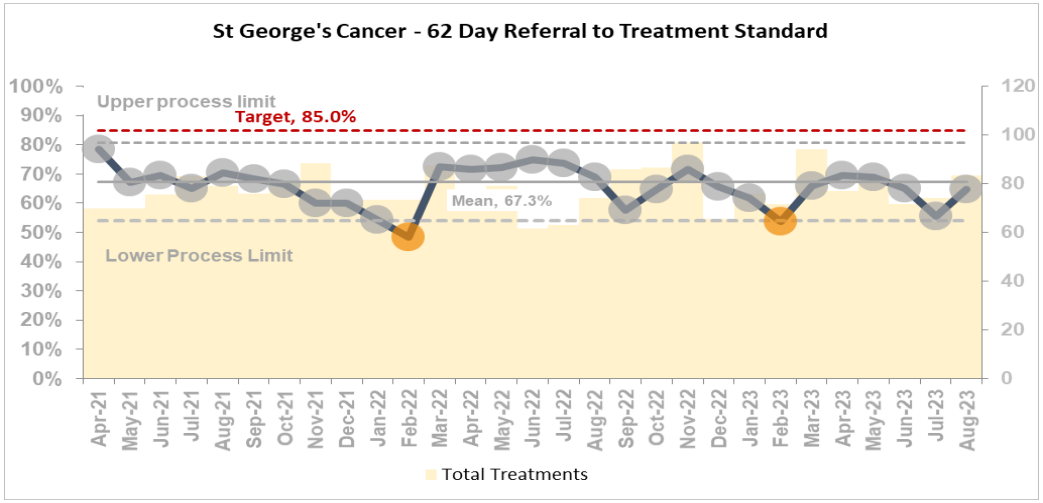
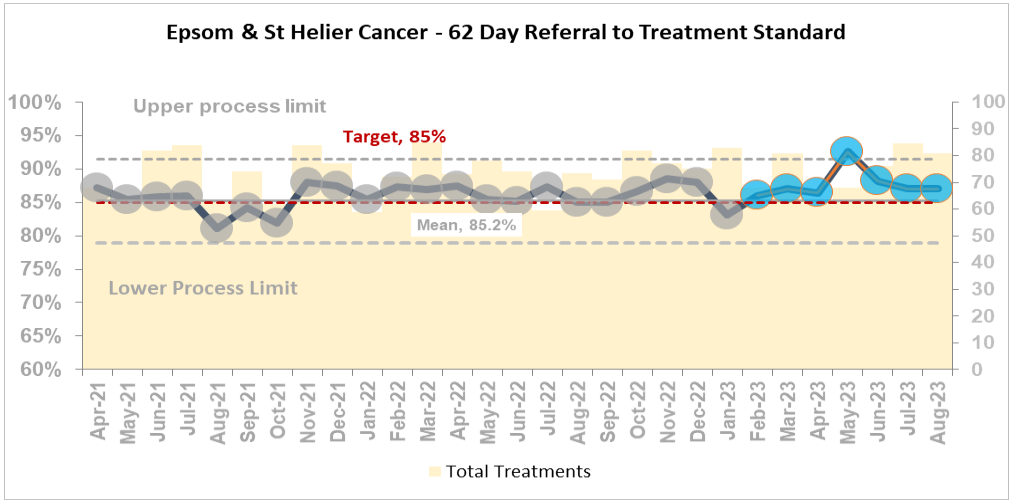
Cancer –62 Day Referral to Treatment Standard

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



Target: 85%	SGH: 64.9%	ESTH: 87%





SGH updates since last month

In August, the Trust reported a performance of 64.9% against the 62 day standard compared to 55.4% reported in July. In total there were 6.5 patients (0.5 being a shared breach) seen after 62 days. Although performance improved, all tumour groups are currently not meeting the 85% target.
The change in standards from October 2023 will mean that there will be one Headline 62-day referral to treatment standard (85%) merging the screening, consultant upgrade and 62 day GP referral to treatment pathway.

ESTH updates since last month

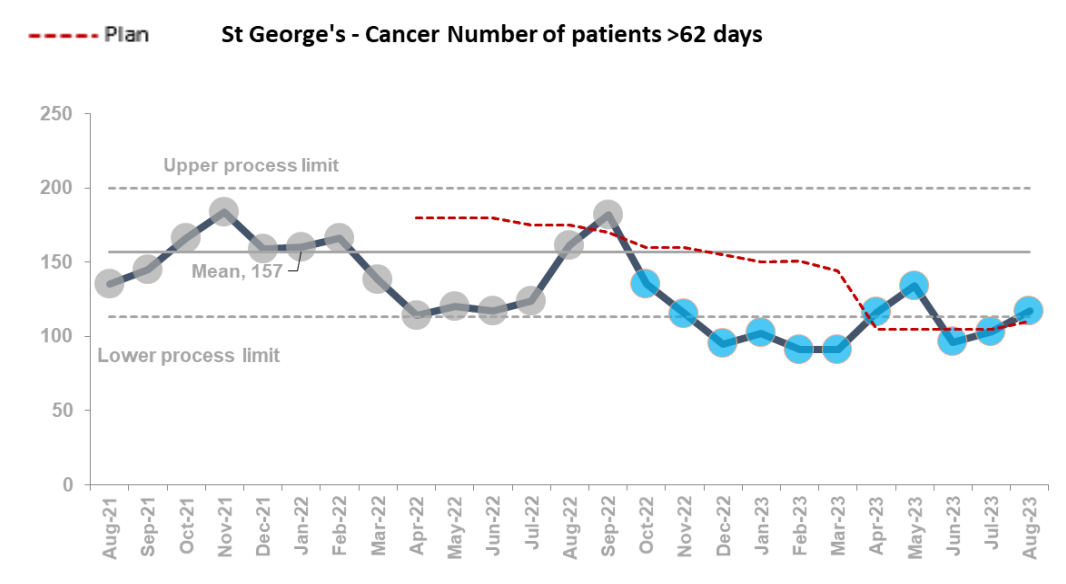
Performance against 62 day standard continues to be achieved at 87% in August with 10.5 breaches.

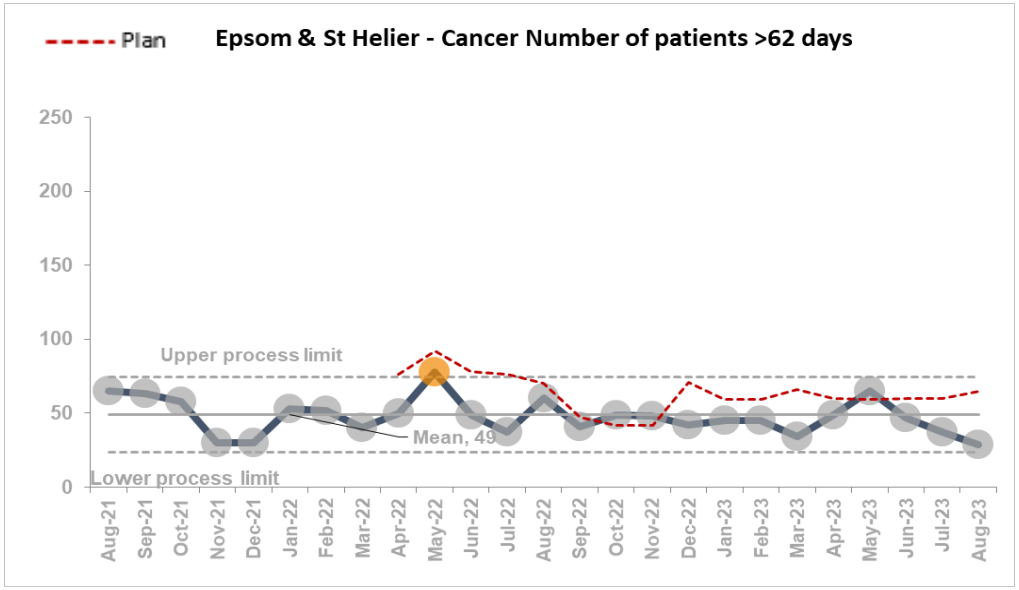
The change in standards from October 2023 will mean that there will be one Headline 62-day referral to treatment standard (85%).

Cancer – Number of patients > 62 days

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

Plan: 110	SGH:117	Plan: 65	ESTH:29





SGH updates since last month

The back log was slightly behind trajectory in August 23. Lower GI hold the largest proportion of patients within the backlog. Patients are reviewed regularly and a "Cancer Week" was held in September to review all patients and expedite actions where possible.

ESTH updates since last month

The 62 day backlog remains ahead of trajectory. The Trust ensures clinical impact review is frequently carried out on those patients by the clinical leads for cancer in the relevant tumour sites to ensure optimal patient healthcare.

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Cancer Performance Analysis and Action

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

SGH current issues

TWW: Significant challenges were seen in the areas below:

- Skin has a backlog of 289 appointment slot issues - **current performance 10.2%**
- Breast experienced reduced capacity in August, a locum gap and lack of Xyla clinics during august with an average wait of 19 days **– current performance 14.2%**

FDS: A deterioration of skin performance **(49.9%),** has impacted the overall recovery. Recovery is dependant on skin reducing 1st seen booking profile to below day 28. Three tumour sites were compliant, Breast, Gynaecology and Lung. A number of Histopathology delays are seen with 39% of patients TAT passed day 10, with the most impact in skin. Radiological delays impacting CTC due to patient choice on the locations of scans at STG v QMH.

62-day GP Performance:

- Urology (6 breaches) – delays to template biopsy in prostate and access to theatre (average wait 15 days from DTT).
- Breast (6 breaches) – delays to one stop breast clinic and access to theatre (average wait 20 days from DTT) and consultant availability
- H&N (4 breaches) – Multiple late inter-trust transfers.
- Gynaecology (3 breaches) – access to Gynae Scan and Hysto and triaging delays– median wait is 14 days
- LGI (3 breaches) – access to nurse led Telephone assessment clinic (TAC) – median wat is 17 days

All being managed by the divisional teams.

SGH future action –

- Faster Diagnosis to be compliant **(75%)** by March 2024. **Trajectory not met in August 23** (some IA impact)
- 62 Day GP– **Trajectory being reviewed to deliver 70% by March 2024 as per national ask**
- 62-day backlog to achieve 105 patients by March 2024. **Trajectory not met in August 23**

Tumour specific actions:

Cancer PTL week took place in September to support divisional teams understand the complexities of the PTL.

Skin: There are on going discussions with RMP to discuss and agree support for the skin service.

Lung – The targeted Lung health checks program scaled up from the 01 October 23. A business case has been formulated to be discussed and agreed.

Breast: An extension of Xyla clinic funding is place till the end of the year. A new locum started in October 23.

Haematology: Additional Lymphoma consultant support for 3 months is in place; Recruitment in progress.

Lower GI: RMP funding is in place for a B4 Navigator & B6 nursing post to develop the PSFU pathway. Recruitment is in progress and scoping for the IT build is underway.

Urology: There is a CNS and Bladder Navigator that is RMP funded to support the Haematuria pathway across the network. There is expansion of the nurse led prostate biopsy service with training in progress for additional nurses.

H&N: RMP has funded 1:0 WTE nurse to support risk stratified triage, recruitment/ VCP is in progress.

RMP Digital funding of 120K has been agreed to support the delivery of Health Needs Assessment (eHNA) Cerner interface and the roll out of electronic ordering of cellular pathology (order comms).

ESTH current issues –

EUS capacity at RMH remains a challenge - current wait is 5-7 weeks.

Endobronchial capacity remains challenging throughout the network. RMP led project has increased capacity at St George's.

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

14 day first seen performance fell in the last four months due to capacity issues with Gynaecology and Dermatology.

The drop in 14 day performance is a risk to the Trust's 28 day FDS and 62 day standards.

ESTH future action –

Dermatology and Gynaecology recovery plans are in place to improve 2ww performance.

For Dermatology the key actions are increasing ad hoc clinics and using capacity for TWW clinics rather than RTT. The next stage is engaging a locum consultant who has already been identified and extending the nurse Band 5 role to support.

Gynaecology are using registrars pulled from other duties and exploring different models of care for providing first encounter to Gynae TWW and CUPG patients. There is also a Gynae in-sourcing plan which will support cancer and RTT.

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

STG has started providing EBUS capacity for ESTH patients and we are encouraging the respiratory team to increase their referrals to St Georges EBUS service.

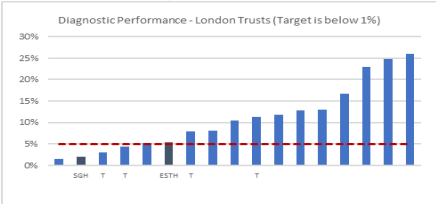
The outpatient Template biopsy (TPPB) work stream continues within Urology with governance oversight by the cancer management team. Acquisition of an outpatient TPPB machine is planned for November 2023.

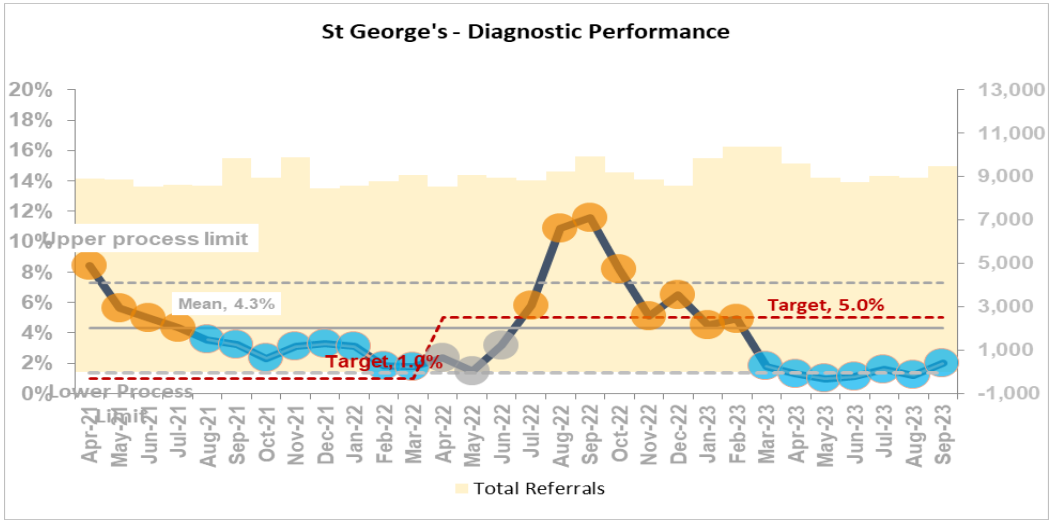
New National Cancer guidance (CWTv12) implemented nationally from 1st October treatments (November submission). Current 9 cancer standards reduced to 3 cancer standards by merging all 62 pathways together, all 31 day standards together and the 14 day and 28 day standards together. Cancer Services is currently delivering an implementation plan.

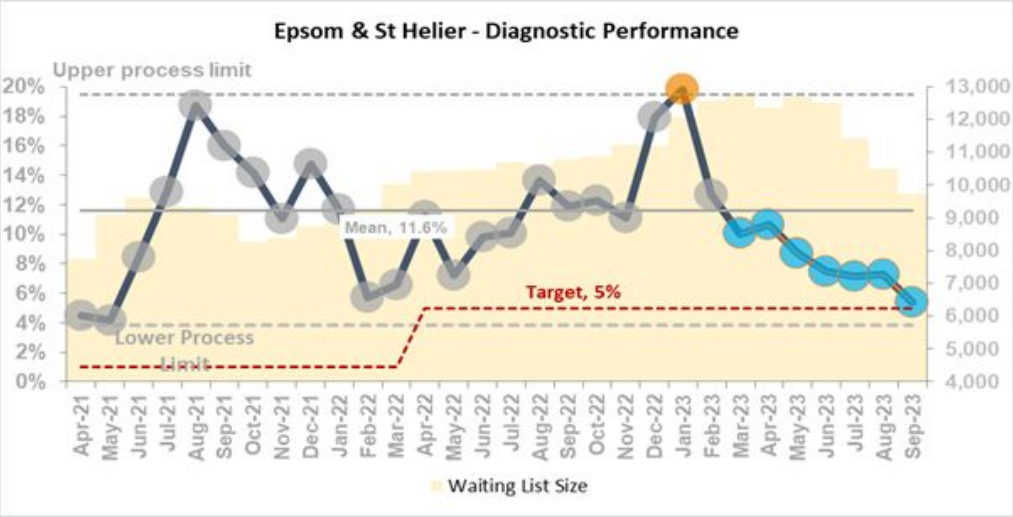
Diagnostic Performance

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

Target: 5%	SGH: 1.98%	ESTH: 5.37%







SGH updates since last month

At the end of September, the Trust reported 188 patients waiting for more than six weeks, this is an increase of 82 pathways. Performance is still strong compared to London peers and continue to meet the recovery target of 5%. The increase in breaches was heavily impacted by Ultrasound with unexpected staff leave within the department. All other areas including Endoscopy and Echo saw positive improvements reducing long waiting patients.

ESTH updates since last month

At the end of September the Trust are reporting 522 breaches, which is a reduction of over 30% and the fifth consecutive month-end drop. The PTL size has also decreased since the end of the previous month, but at a much lesser rate, meaning that our performance has seen a significant improvement (from 92.7% to 94.6%).

Diagnostic Performance Analysis and Action

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

SGH current issues –

Endoscopy - Endoscopy reported 33 patients waiting for more than six weeks a reduction of 42 long waiting patients compared to August. A proportion of patients require specialist lists including GA where industrial action has had an impact and varicocele which have been more challenging to accommodate.

Sleep Studies -SGH continue to see a high demand impacted by challenges across SWL and capacity is not meeting demand consistently. The Trust is performing well against London peers. The services continue to provide additional sessions where possible and in addition there has been extra capacity put on through CDC to mitigate this as much as possible.

Echo – Staffing challenges as well as industrial action have impacted capacity, however with additional sessions and staffing resource resumed to full capacity, recovery is expected in September.

Gynae Ultrasound – Unplanned leave in September reduced capacity significantly within the department and a high number of sessions were cancelled.

SGH future action –

Endoscopy - Additional Saturday lists continue running twice per month where there has been uptake from nursing and medical staff. These lists create capacity for the less complex cases. The service are continuing to use doctor doctor to validate and contact patients.

Sleep Studies - There is additional capacity through CDC funding to create additional clinics to mitigate this as much as possible. With demand still high this will continue to be difficult to manage long term and therefore looking at more sustainable capacity going forward.

Echocardiography (echos) - Additional sessions through October are in place to reduce the backlog. Advertising substantive recruitment of a fellow to support stress echo's and locum in place from September 2023.

Gynae Ultrasound – Additional capacity has been booked throughout October to reduce the backlog due to cancelled clinics through September. Performance expected to recover.

Weekly performance meetings continue to be in place to monitor and escalate any performance / capacity issues.

ESTH current issues –

Imaging: Total diagnostics DM01 performance breaches for imaging in September are still to be confirmed due to a technical issue with the reports and Soliton moving to the cloud. Data has been recovered and is in the process of being analyses however we predict that the September DMO1 Performance all modalities will be near to the 95% threshold.

There are some vacancies within the radiologist workforce which is impacting specialist lists such as biopsies and CT cardiac procedures with increased waiting times for these procedures however a specialist chest radiologist locum has assisted in reducing the specialist backlog.

Reporting is improving however continues to be challenging. Scans are being outsourced to help with the reporting backlog.

CT vetting numbers are fluctuating considerably and having an impact on waiting list management (Radiologist vacancies are contributing to vetting issues). We are seeing a slight improvement in September vetting.

ESTH future action –

Imaging

Radiologist locum and specialist grade radiologist both commencing on 5th October. Interviews for chest consultant radiologist held in September and successful candidate commences in February 2024.

Increase scheduling staff using bank staff and utilising weekend lists for all modalities and continued use of bank and agency staff to increase scanning capacity in order to maintain performance.

Five Band 5 radiographers have commenced in September working cross site.

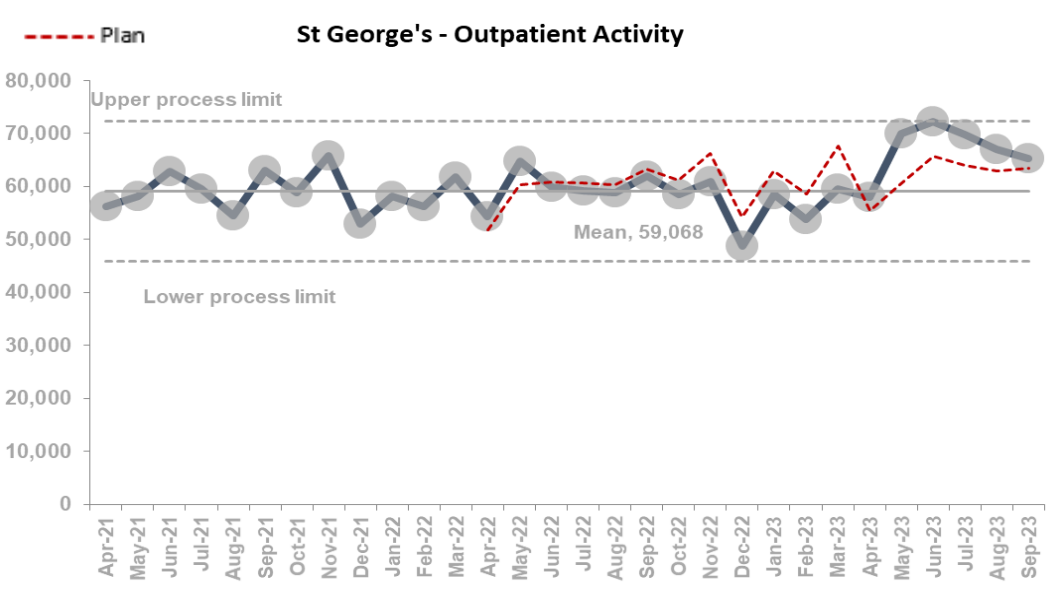
Deep dive of ultrasound breaches to try and get the monthly breaches down further. As well as deep dive of planned appointments to avoid breaches.

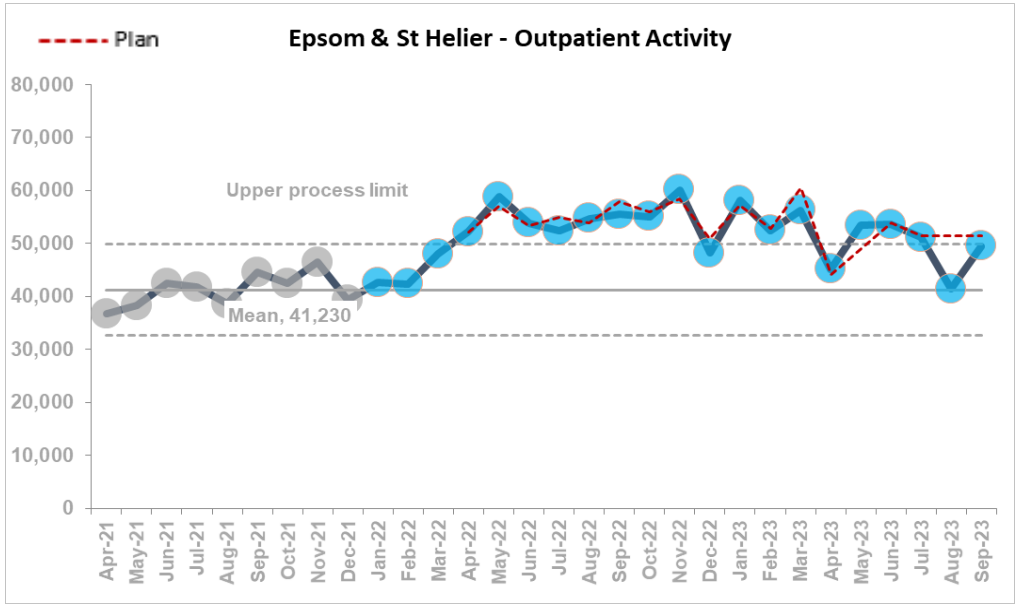
Daily operational huddles between clerical management and lead superintendents continuing as this is essential in maintaining the DMO1 performance.

Outpatient Activity

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

Plan: 63,376	SGH: 65,250	Plan: 51,436	ESTH: 49,473





SGH updates since last month

Outpatient performance continues above plan and will further increase for September once data catch up is complete.

ESTH updates since last month

September performance is currently below target however, this is expected to increase with data catch up / coding.

33

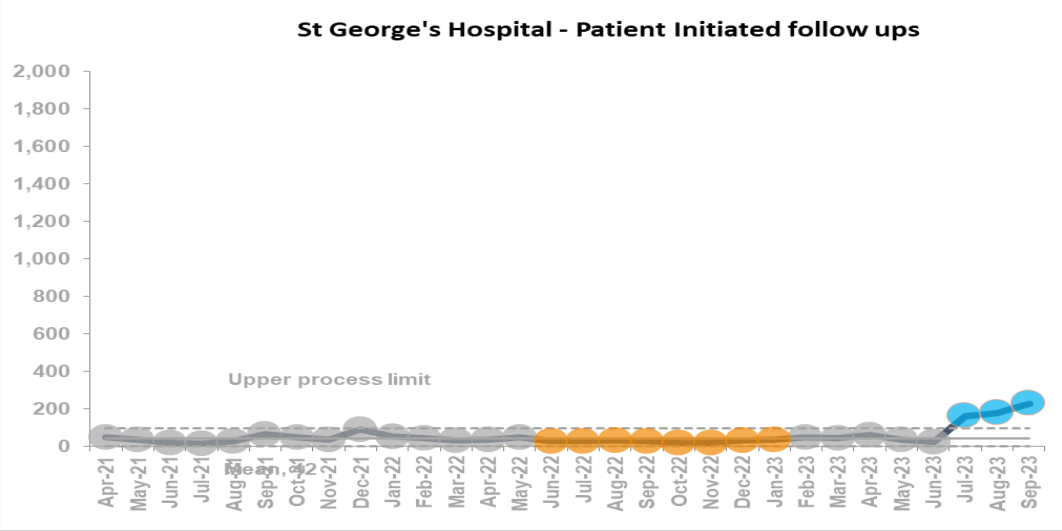
Patient Initiated Follow-up (PIFU)

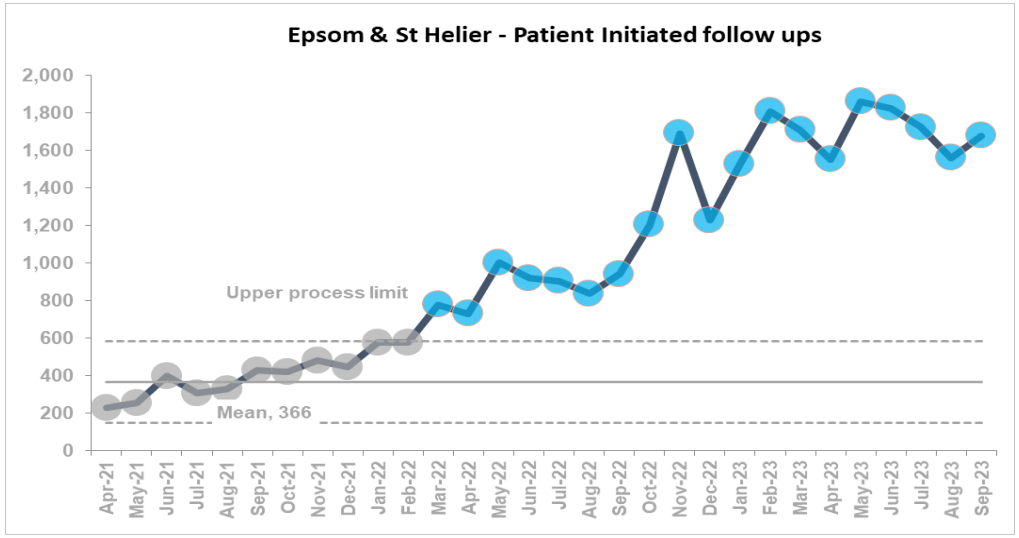
Number of episodes moved or discharged to a PIFU Pathway

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

Target: TBC	SGH: 229

Target: TBC	ESTH: 1,678





SGH updates since last month

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

ESTH team are involved in SGH PIFU design as it is a process they will inherit. Important to ensure this doesn't delay our stringent delivery plan due to resources of this.

The Trust has been supported in doing a retrospective submission of PIFU patients to NHSE. This data includes locally managed and confirmed PIFU pathways captured on the clinician's eCDOF form and therefore managed on a PIFU pathway and data has been reflected above.

ESTH updates since last month

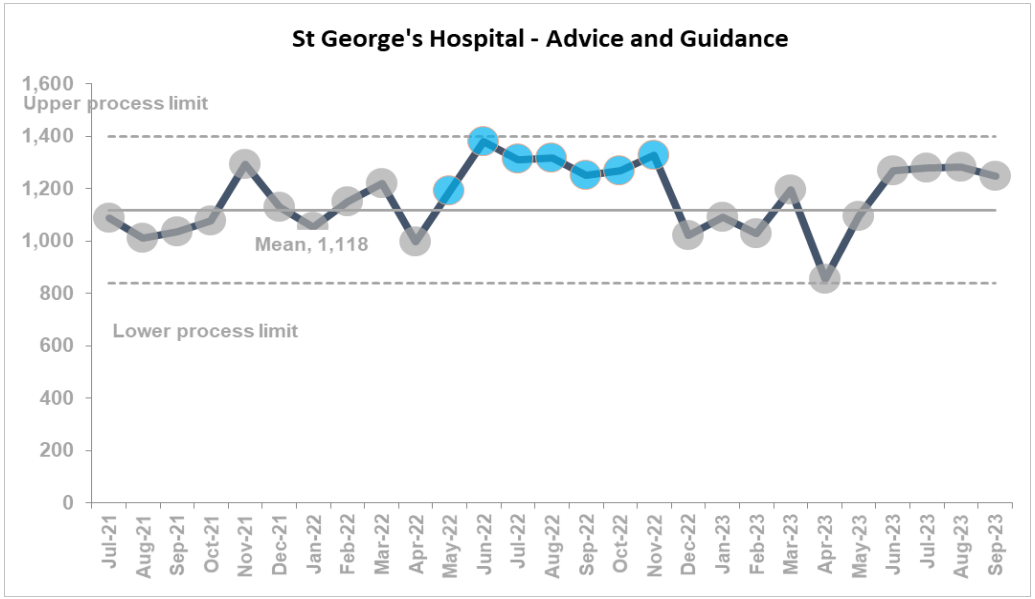
PIFU has increased slightly in September which is likely due to the return from annual leave over August. PIFU continues to be encouraged in specialty business meetings.

34

Advice & Guidance

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

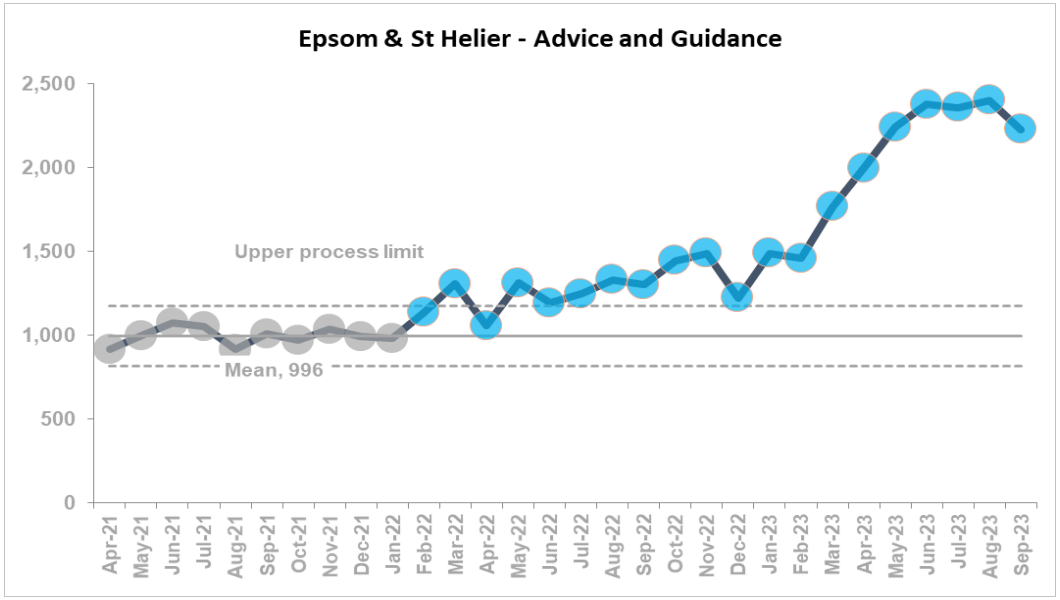
Target: TBC	SGH: 1,246



SGH updates since last month

Cerner are working on the solution to provide A&G type functionality. Latest estimate is availability to test Jan-24. This will enable SGH clinicians to perform A&G to referrals received on RAS queues (~5k month).

Target: TBC	ESTH: 2,228



ESTH updates since last month

A&G has plateaued in September and is likely linked to the introduction of targeted referral guidance at source, for example the quick view guides to support the implementation of SWL pathways.

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Outpatient Activity - Analysis and Action

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

SGH current issues –

Strikes action continued to impact our activity plans and administrative resource needed to work through cancellations and rescheduled appointments

We have prioritised the highest volume specialities to move onto PIFU from end of November once Orders to Schedule has launched, there is restricted IT resource dedicated to this project and this restricts earlier delivery date. First three specialities are Trauma and Orthopaedics, Urology and Therapies who'll deliver the highest yield of PIFU

A&G –Predicting increase in activity as data will be amended to include all RAS and CAS referrals as approved by NHSE – await formalised agreement from SWL

SGH future action –

Outpatient Transformation Board key workstreams for winter resilience planning:

1. **Addressing protecting and expanding elective capacity self-certification** – we have 12 step action plan, managed through Elective Access Committee to address the validation, first appointment and follow up asks. We will be updating frequently with progress reports against each action. We need to continue two essential part of the current transformation plan MOT and O2S to support delivery of the self-certification
2. **Outpatient 'MOT'** – Check information and configuration of all services is accurate, uses optimal resources and is peer group competitive in 1 year. T&O(100% completed – Passed!), Respiratory (100% completed - Passed!), Urology (95% completed) ENT(40%) and Gynae (40%) – next services will be Dermatology, Cardiology and Gastroenterology
3. **Orders to schedule** – (O2S IT project) Roll out new robust and efficient cashing up process and recording procedures in outpatients (QPOPE) – this project delivers our electronic solution to PIFU. Project team begun work – scene setting with senior's leaders meeting to be held on 19th July completed. Communication piece being worked up by the project team and first 'go live' is in November, with a temporary solution to go-live in October.

ESTH current issues –

PIFU – None.

A&G – ESTH continues to report nationally as per the national methodology and locally with the new methodology figures alongside. Awaiting update from region on the methodology that will be taken forward.

With the increase in the number of A&G requests, there has been an increased demand on clinician time to respond to the A&G. This is being partly mitigated with editable standard responses.

ESTH future action –

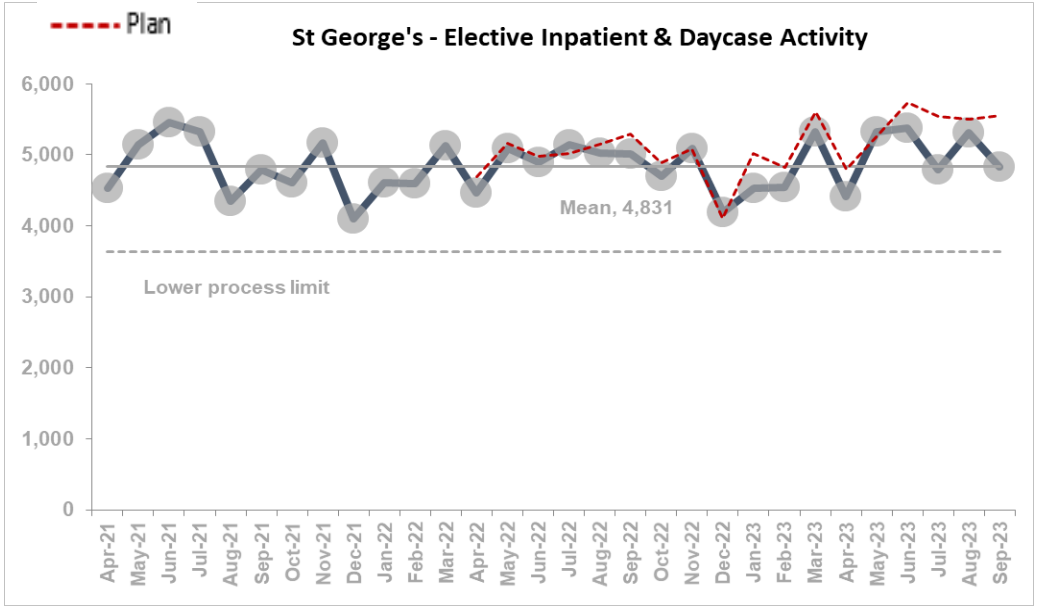
PIFU – The development of clinical protocols continues with a Cardiology PIFU arrhythmia (ILR devices) clinical protocol being drafted. The use of Zesty to provide patient questionnaires when patients activate a PIFU appointment to support further PIFU expansion being explored.

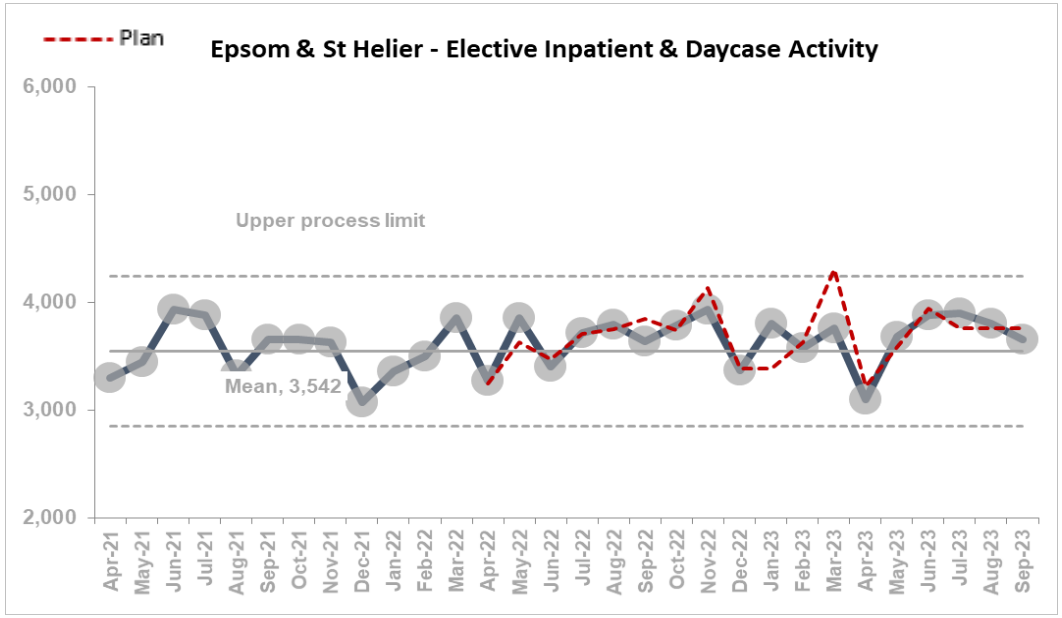
A&G / Pathway review / Referral Forms -The Quick View programme continues. Gastroenterology will be presented at the Gastroenterology SWL Clinical Network in October. The meeting for the initial Respiratory Quick View has now taken place. The initial draft is now being reviewed by the wider Respiratory clinician group at ESTH.

Elective Inpatient & Daycase Activity

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

SGH Plan: 5,557	SGH: 4,833	ESTH Plan: 3,759	ESTH: 3,650





SGH updates since last month

Elective and Daycase performance is behind plan for September, a significant driver of this is the impact of Industrial Actions.

ESTH updates since last month

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

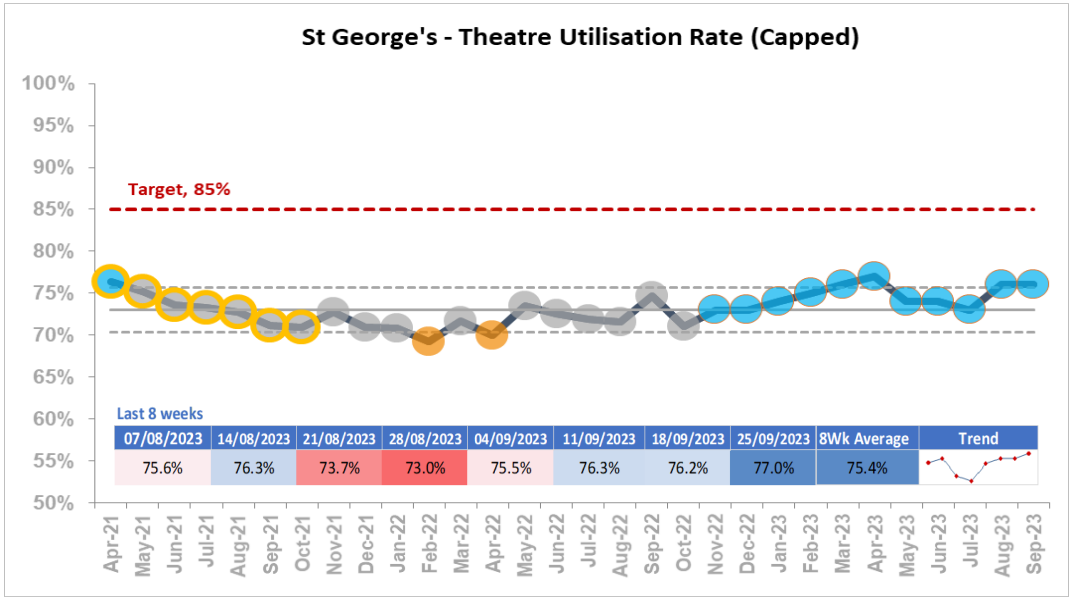
37

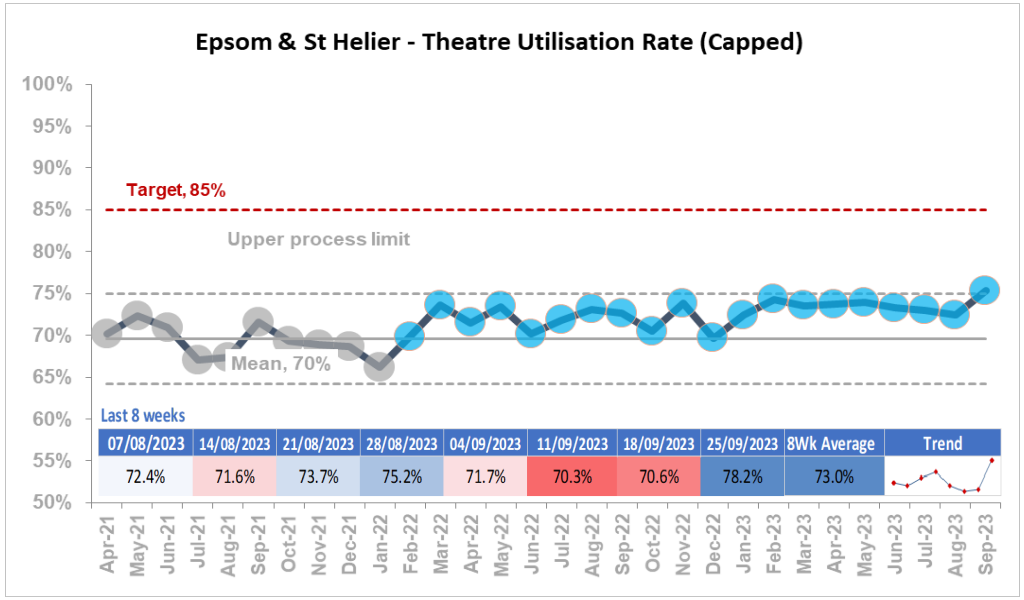
Theatre Productivity – Capped Utilisation

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

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

Target: 85%	SGH: 76%	Target: 85%	ESTH: 75.3%





SGH updates since last month

Capped theatre utilisation rates remain above the mean at 76% in September with plans to improve further across all theatre suites.

Uncapped utilisation rates are currently at 81%.

ESTH updates since last month

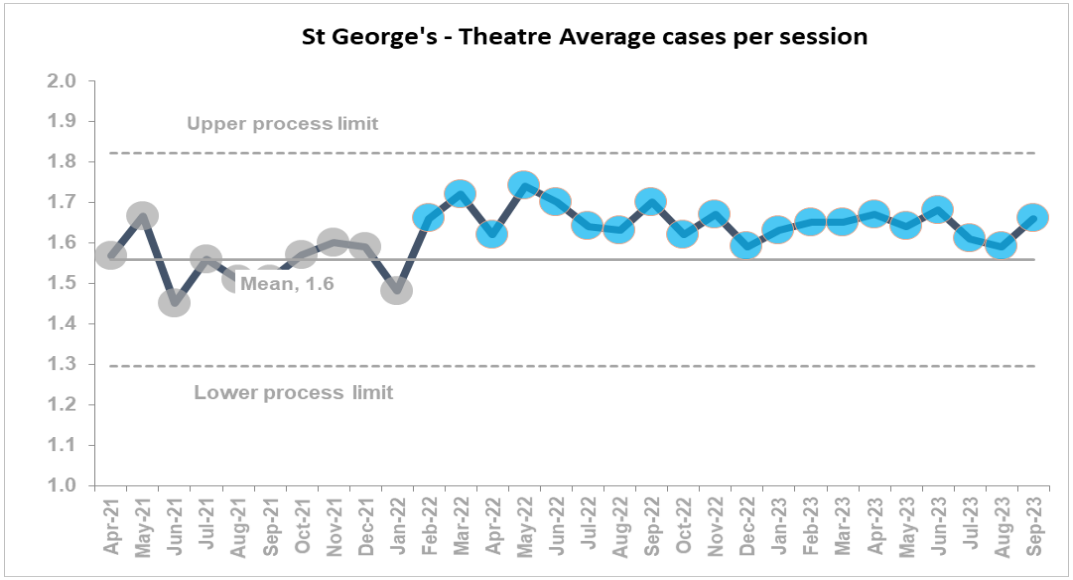
Capped utilisation figures increased to 75.3% in September, performance is above the upper control limit showing special cause variation of improvement.

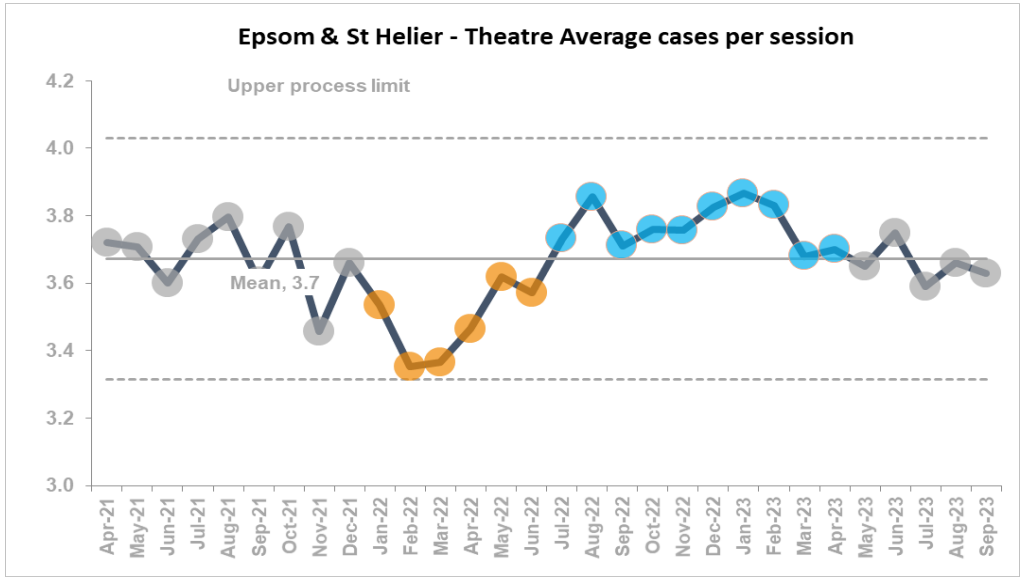
38

Theatre Productivity – Average Cases per Session

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

Target: TBC	SGH: 1.66	Target: TBC	ESTH: 3.63





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline, with on average through September 1.66 average cases per session, this reflects the complexity of our case mix compared to ESTH.

ESTH updates since last month

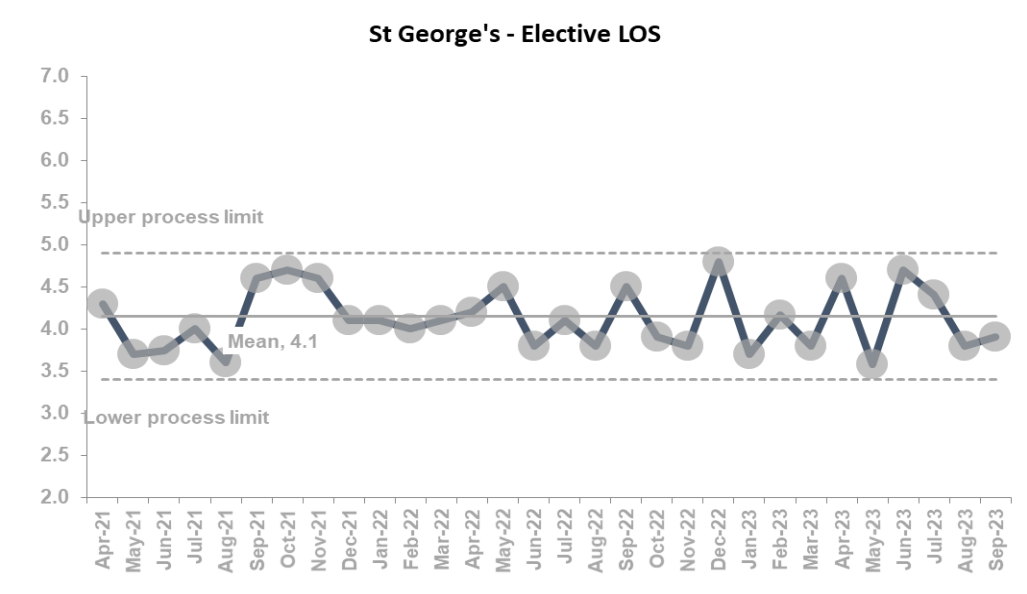
Average case per session shows common cause variation however continues below the mean in September with on average 3.63 cases per session.

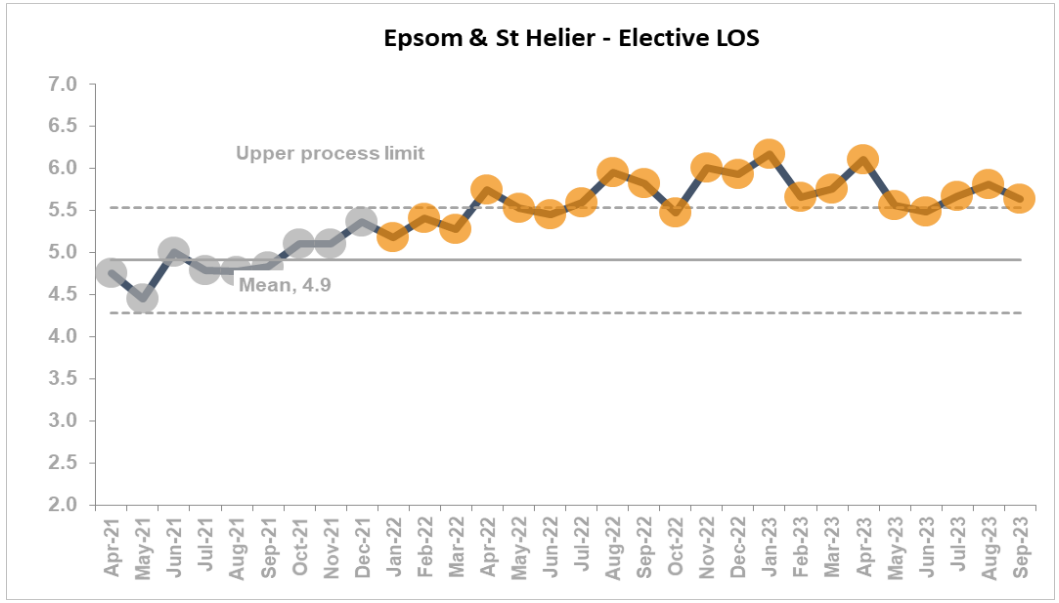
39

Elective Length of Stay

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

Target: N/A	SGH: 3.9	ESTH: 5.6





SGH updates since last month

Elective length of stay continues within the upper and lower control limits showing only common cause variation.

ESTH updates since last month

Average length of stay for patients admitted on an elective pathway continues above the upper control limit, across September the average length of stay was 5.6 days.

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Theatre Productivity - Analysis and Action

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

SGH current issues –

Challenges related to Industrial Actions continued through September, impacting available capacity, Theatre utilisation, number of 4 hour sessions delivered and cases completed

Successful recruitment in cardiothoracic anaesthesia with three fixed term locum cardiothoracic anaesthetists starting between September-October. Planning is underway to increase the provision of cardiac surgery and cardiology in line with recent appointments.

Essential estates works required at QMH STC, with two downtime options being explored, this will impact our performance as not included in our original production planning.

SGH future action -

In September, capped theatre utilisation was 76%, which was 1% above the previous month. Uncapped utilisation was 81%. The average case per session continues above the 2019/20 baseline at 1.69.
Work continues to improve Theatre utilisation, with the current focus being on the implementation of 642 escalation process to ensure theatre lists are fully booked. This new process comprises a weekly wrap-up email to DDOs and Deputy DDOs, highlighting underbooked lists. From November, elective lists for weeks 1 and 2 (exc. Cancer) with a booking profile of less than 70% will likely be stood down
In conjunction with Business Intelligence, there is an ongoing review of theatre performance data capturing and reporting assumptions. This will be part of the Theatre Transformation Programme, which will also focus on standardising Tableau reports and Surginet functionalities.
AfPP (Association for Perioperative Practice) audit is scheduled for October. This review will focus on Steps for Safer Surgery, Human Resources and Accountable items. The audit will also include a review of existing policies within theatres to ensure their alignment with best practice.

ESTH current issues –

- Trust-wide utilisation is currently impacted by St Helier and QMH paediatric theatres - a deep dive has taken place and site specific targeted action plans developed. St Helier site is mainly impacted by the Ophthalmology, Dental and fertility lists, QMH is impacted by bed stock and a nursing establishment shortfall.
- Fertility lists are challenged as a result of the subsequent unpredictability in being able to schedule to the lists in advance, work is underway to explore transferring the emergency fertility lists from Elective Theatres to an alternative appropriate setting. In the meantime the service are identifying an agreed cohort of standby urgent/ routine patients to support scheduling to the lists where there is shortfall in emergency patients.
- QMH - Lists at QMH are currently impacted by a Paediatric bed stock shortfall as a result of broken beds and a nursing establishment shortfall. The shortfall in bed stock has now been resolved and an agreed plan to increase Theatres nursing establishment is currently being worked through with the senior nursing leadership team.

ESTH future action –

- Clinical engagement to support a review into **planned vs actual utilisation**, to support the management of scheduling
- **Ophthalmology** Cataract lists have recently increased from 5 to 7 per list. Following the on going monitoring, it has been identified there is scope to further increase to 8 cataracts and discussion with the Operational and Clinical leads is in progress.
- **Dental** lists have recently increased from 4 to 5 cases per session, however, the list is routinely impacted by short notice/on the day cancellations. Discussion with the Clinical lead to request overbooking by one case to mitigate cancellations is in progress.
- **Pre TCI call** undertaken for GA patients and recruitment in progress to expand pre TCI call to St Helier patients and all LA patients.
- **Daily review of advanced booking** - SMs to commence attending list planning where routine lists are not scheduled to two weeks in advance.

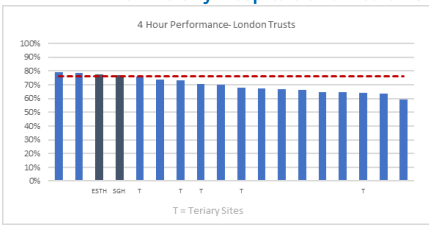
Monthly Overview – Non Elective Care

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

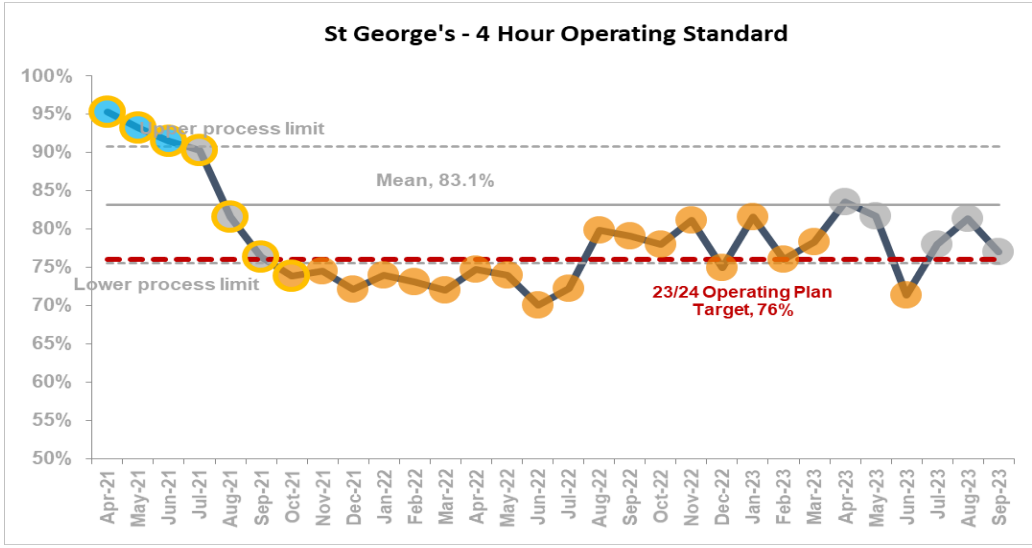
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	76%	78.0%	81.3%	77.0%	76%	0.0%		76%	77.3%	77.7%	77.3%	76%	76.6%	
12 Hour Trolley Waits	0	376	372	530	0	2789		0	480	538	462	0	2471	
Ambulance handover Performance 30 minutes	0	134	25	19	0	260		0	266	315	338	0	1663	
Ambulance handover Performance 60 minutes	0	23	46	158	0	406		0	132	149	120	0	646	
Non elective length of stay		6.5	6.7	6.5		6.85		TBC	7.8	7.6	7.5	TBC	7.55	
Mental health delays 4 Hour Breaches		102	130	131		730								
Redamission Rate - Non Elective		10.7%	11.3%	10.9%		11.1%		TBC	5.2%	5.1%	5.7%		5.4%	
Length of stay > 7 days (stranded)		335	330	344		366		TBC	301	319	312	TBC	302	
Length of stay > 21 days (super stranded)	172	153	140	159	172	160		123	123	132	137	114	128	
Overnight G&A beds occupancy - Adults	92.0%	93.6%	95.7%	94.5%	92.0%	95.3%		92.0%	92.3%	89.9%	90.1%	92.0%	90.6%	
Number of patients not meeting criteria to reside	83	110	100	94				104	162	176	177			

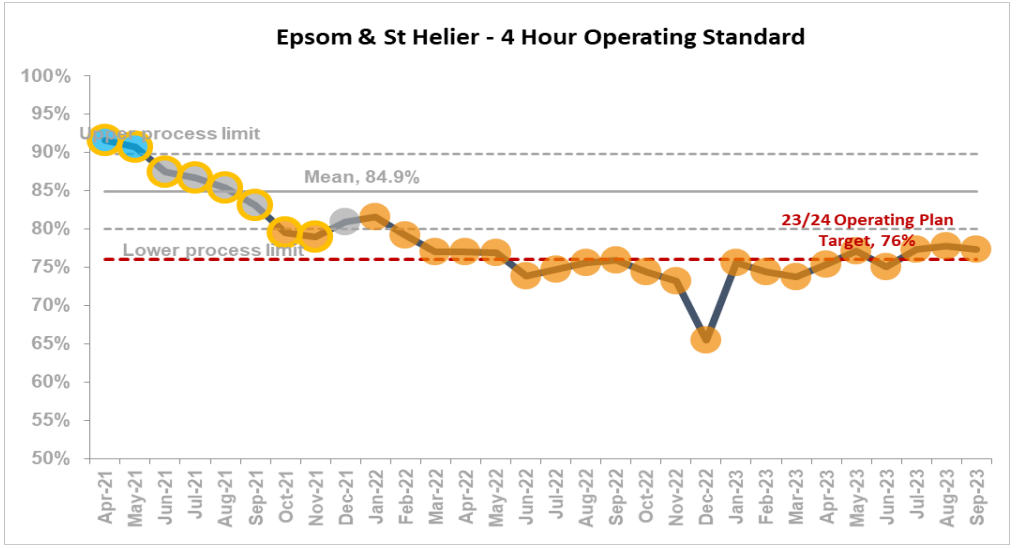
4 Hour Operating Standard

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



Target: 76%	SGH: 77%	ESTH: 77.3%





SGH updates since last month

4 hour performance dipped slightly in September with 77% of patients either admitted, discharged or transferred within 4 hours of their arrival, exceeding the operational target of 76%. The department was under pressure on a number of days where there were extremely high attendances (474 patients was the highest in the month) coupled with high ambulance conveyances.

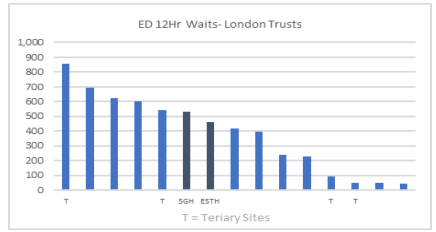
ESTH updates since last month

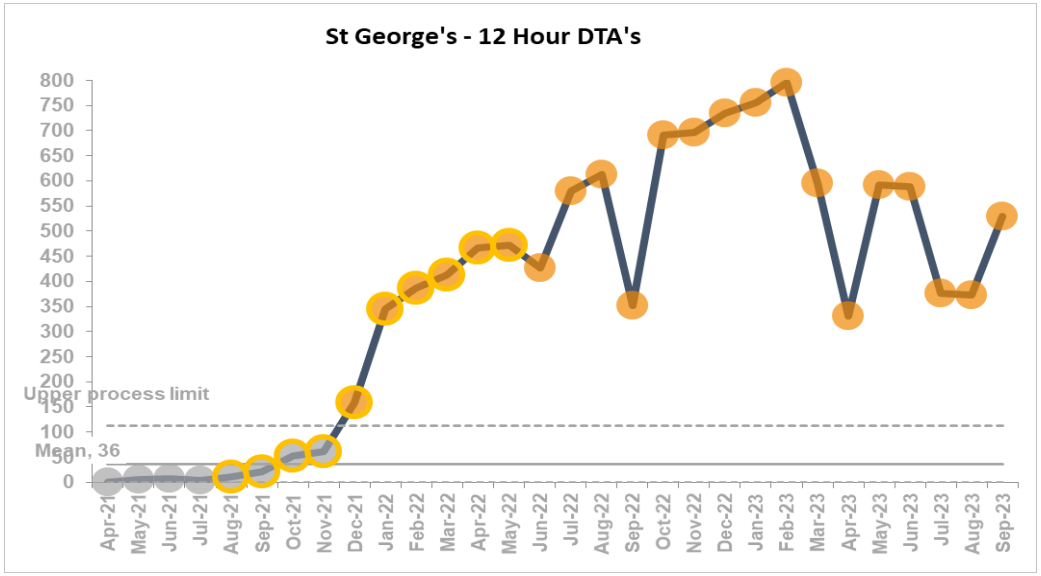
Across September 77.3%, of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival. Performance remains above the operating plan of 76%.

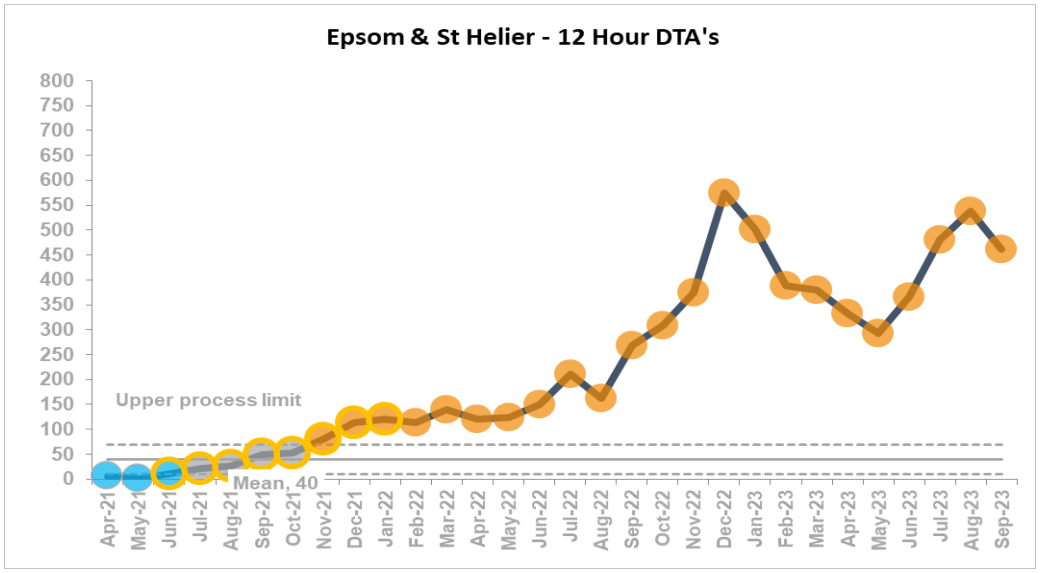
12 Hour DTA's

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

Target: 0	SGH: 530	ESTH: 462







SGH updates since last month

The number of 12 hour trolley wait breaches following decision to admit increased throughout September with on average 17 delays per day. This was impacted by a number of days where the admission take was significantly over predicted take. There are a number of actions being undertaken with system partners to improve the reduction in presentations/admission avoidance and increase in discharge numbers to improve flow.

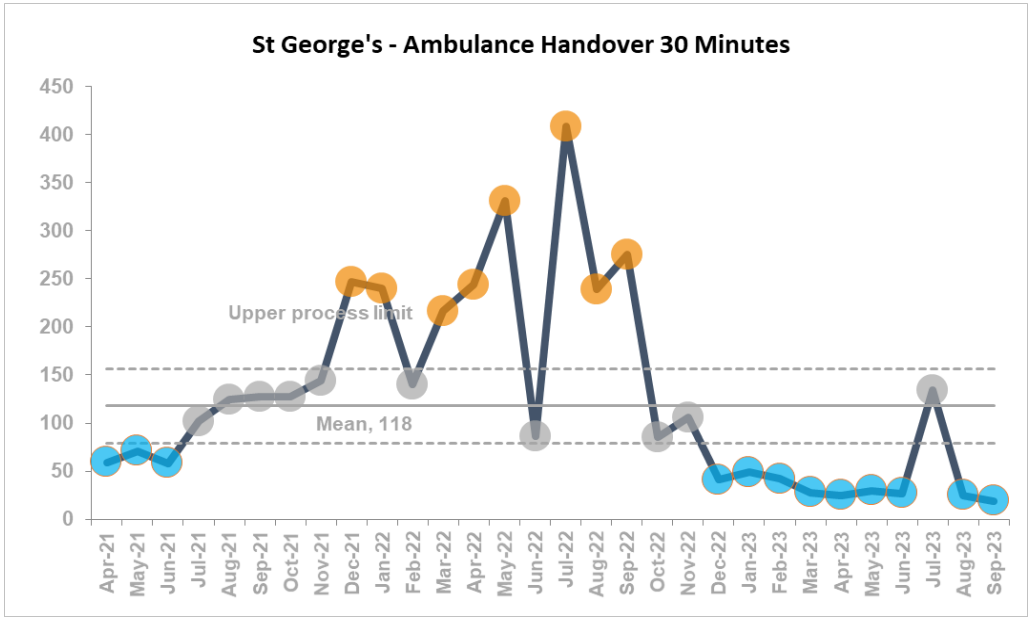
ESTH updates since last month

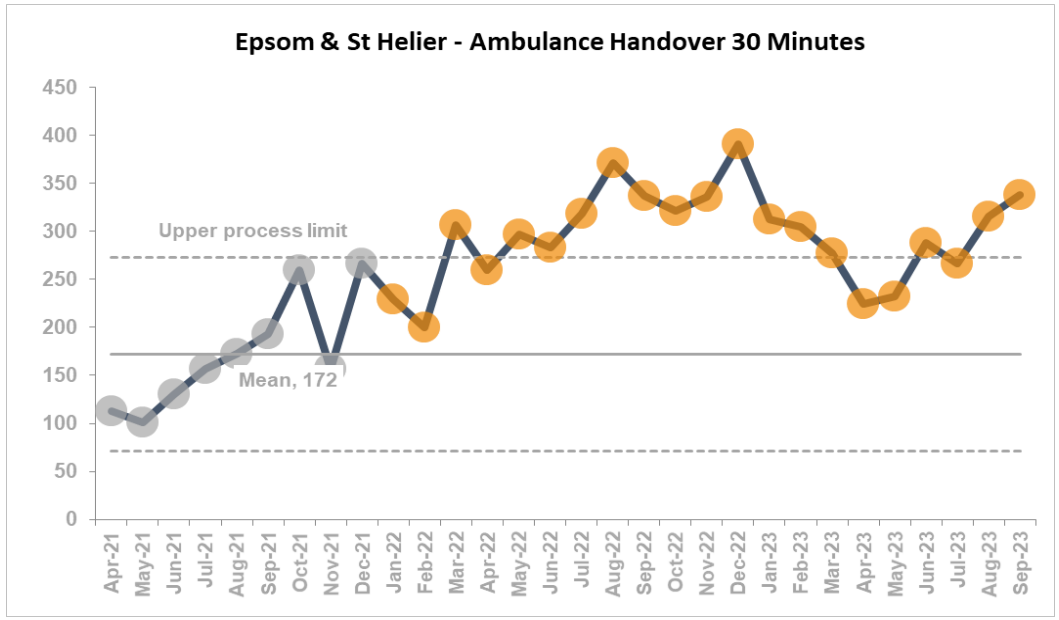
We are reporting 408 four hour trolley waits (an 8% increase from August) and 462 twelve hour breaches (a 14% decrease compared to August following three consecutive significant monthly increases).

Ambulance Handover Delays 30-60 minutes

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

Target: 0	SGH: 19	ESTH: 338





SGH updates since last month

Performance remains below the lower control limit with in total 19 30-60 minute delays in September.

ESTH updates since last month

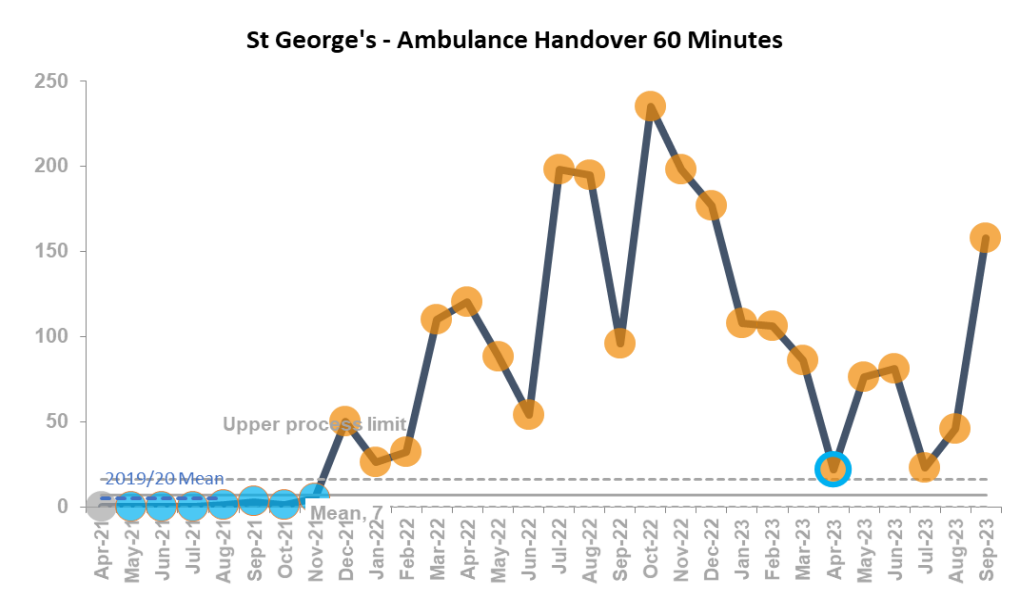
Performance against 30 minute handover delays remained above the upper control limit through September, with on average 11 delays per day.

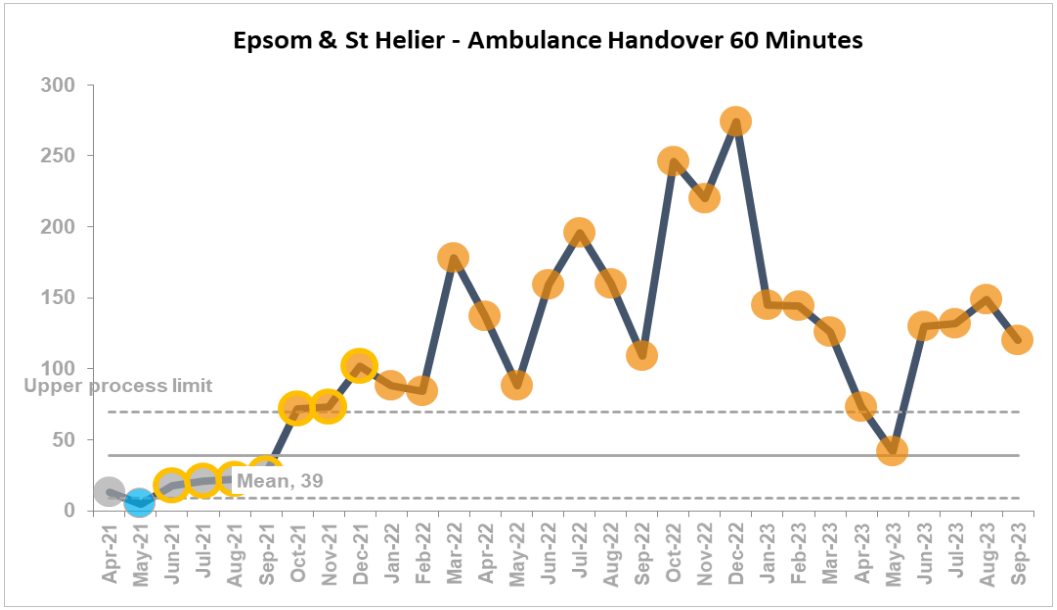
45

Ambulance Handover Delays 60 minutes

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

Target: 0	SGH: 158	ESTH: 120





SGH updates since last month

The number of patients delays for more than 60 minutes significantly increased through September with 158 patients delayed.

>45mins delays – 222 August
216 September
} From CAD the London Ambulance System (unvalidated)

We are working with the London Ambulance Trust to improve reporting as this is a known issue.

ESTH updates since last month

60 minute handover delays remain high and above the upper control limit.

46

Emergency Performance

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

SGH current issues –

Overall 4 hour performance (all Types) in September declined compared to August, closing the month at 77.02%. This places SGH 9th in London and 35th nationally for all type performance.

In September we achieved >90% non admitted performance for 16 days.

89% of LAS arrivals were offloaded <15 minutes during the month of September, which was a 4% decline in performance from previous month. Work is ongoing with LAS to improve offload times, and reporting in line with the departments LAS SOP and surge team

Through September the department's ability to see patients in a timely way was extremely challenged, where on several days ED had 7 consecutive hours of >30 attendances per hour, Resus being at capacity with high acuity and quick succession of ambulance arrivals to the Trust. On several days admissions were above plan across the board.

SGH future action –

LAS immediate handover pilot, commenced 11 September 2023. SOP has been enacted as agreed within the Trust in conjunction with LAS, this involves enhanced boarding and cohorting criteria. Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced.

Front of house clinician commenced11 September 2023, with senior clinician streaming patients to appropriate alternative pathways, ensuring investigations happen early in journey and analgesia is given at early stage too. Rota challenges sometimes prevent this from happening on a daily basis, so ED are reviewing the possibility of EP to support the speciality doctors in the Front of House rota.

High numbers of Mental Health patients in ED continues to be challenging.

ESTH current issues –

We remain challenged in maintaining non-elective flow across both hospital sites, however, continue to deliver an improving trajectory against the ED 4-hour performance standard at 77.2% in September 2023. Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively with a deterioration in both metrics compared to the previous month, however, time to triage continues to remain within the 15-minute standard at 12 minutes in September 2023, providing assurance that patients are seen soon after arrival in the department.

The number of patients spending > 12 hours in ED remains high, but has reduced to 8.6% in September 2023, compared to 10.6% the previous month.

4-hour performance for admitted patients remains challenging with onward flow from ED occurring during the late afternoon/evening period.

September 2023 saw a high number of > 60-minute ambulance handover delays at 120, however, this is an improvement compared to August 2023 where we reported 149. On-going issues are reflective of challenging onward flow from the emergency department into downstream capacity with a requirement to implement ambulance cohorting on a regular basis.

ESTH future action –

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

We are launching the 45-minute LAS ambulance handover process on Wednesday 11th October and have worked with key internal stakeholders and LAS to develop a standard operating procedure. This also includes a review of our Boarding/Plus 1 Policy and the development of key triggers to support timely decision making for boarding/plus 1. We will monitor progress over the next few weeks/months against a set of agreed KPIs.to ensure that there is a positive impact.

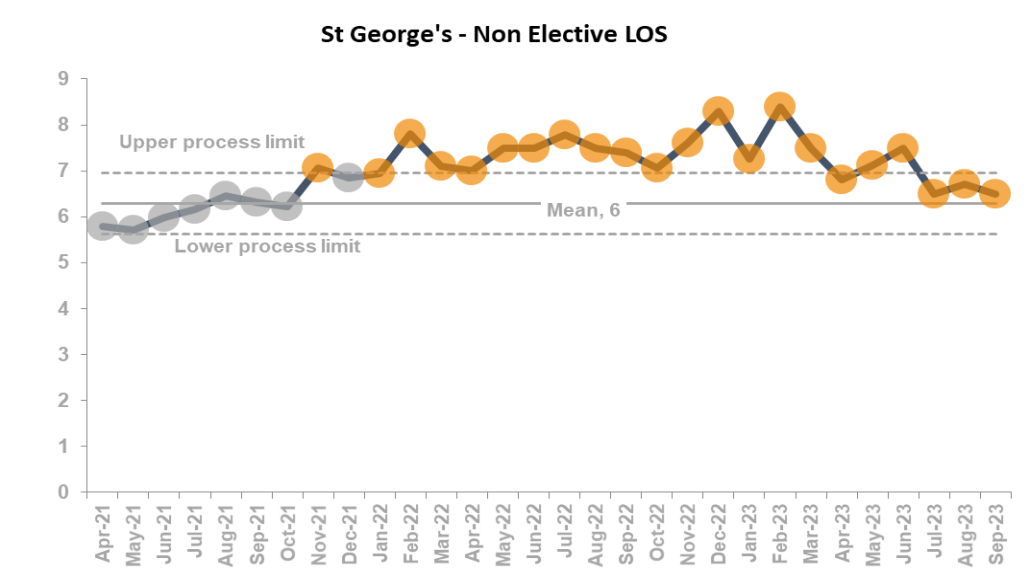
Following a new appointment to our urgent care transformation team we have met with internal stakeholders to agree additional areas of focus for inclusion in the work programme. Alongside the ambulance handover programme, we will also focus on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC.

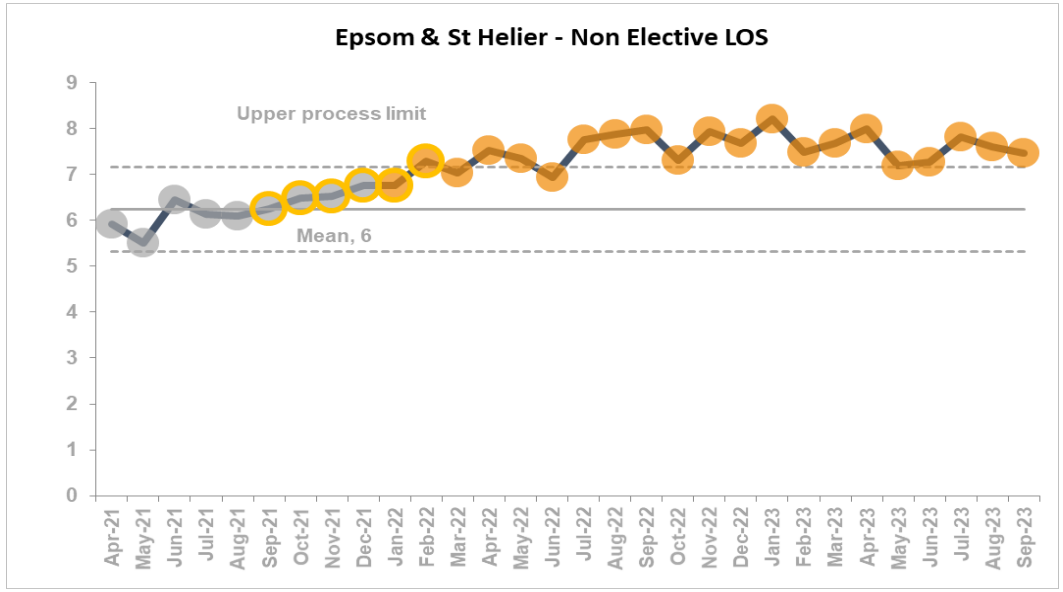
Our internal professional standards (IPS), including the development of IPS for our acute Gynae unit and SACU were formally launched on Monday 4th September, We have developed a set of KPIs to monitor adherence to these standards and these will be shared and discussed at our weekly hospital flow meeting.

Non Elective Length of Stay

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

Target: TBC	SGH: 6.5	ESTH: 7.6





SGH updates since last month

Non-Elective length of stay although above the mean, remains below the upper control limit for the third consecutive month with on average patients staying in an hospital bed for 6.5 days. Both stranded LOS (>7 days) and super stranded LOS (> 21 days) increased across the month.

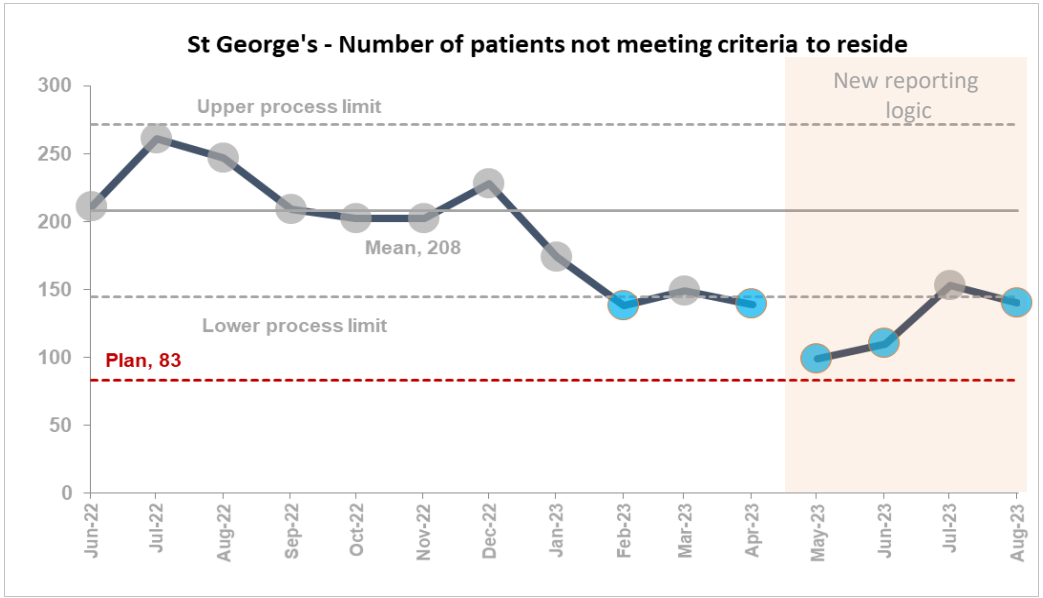
ESTH updates since last month

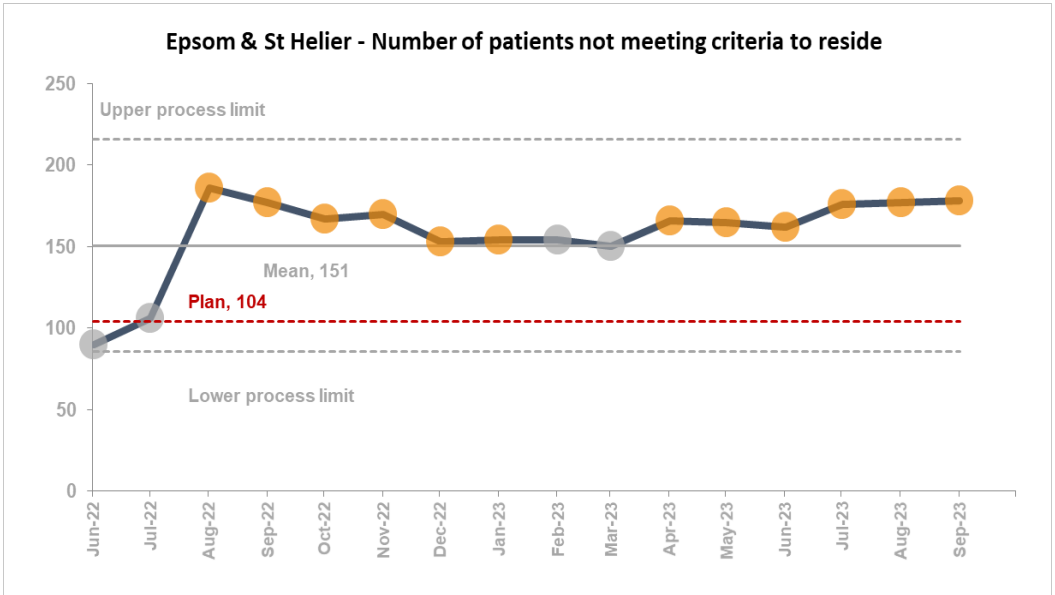
Non -elective length of stay remains above the upper control limit however a downward trend can be seen over the past 3 months. On average across September patients admitted on a non-elective pathways stayed for 7.6 days. The daily stranded (7 day LOS) reduced slightly however super stranded patients (21 day LOS) increased.

Patients not meeting criteria to reside

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

SGH Plan: 83	SGH: 99	ESTH Plan: 104	ESTH: 178





SGH updates since last month

September shows an increase in the number of patients not meeting the criteria to reside with on average 99 patients daily compared to 94 in August. The two areas with predominant delays are within Care Package (Social) - E1 and Residential home - Including interim (Social) - D1. This is still dependant on the delivery of the new NCTR form which is in the IT works pipeline.

ESTH updates since last month

The number of patients not meeting criteria to reside remains above the mean. On average there were 178 patients daily not meeting the criteria to reside in a hospital bed throughout September.

Length of Stay Performance - Analysis and Action

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

SGH current issues –

On the main hospital site, there remains a high number of patients not meeting the criteria to reside (NCTR), in addition to the high number of patients awaiting Pathway 2A (Merton + Wandsworth) and Pathway 3, over the last months. The Trust has launched new IT Capacity Management software.
Ongoing industrial action has impacted performance and we continue to plan/respond to each wave of industrial action. There are no future strike dates planned at time of writing for medical staff and radiographers, but future strikes are expected.
Cavell Ward now closed leading to reduction to medical G&A beds, however we are continuing to work with local partners to reduce delays in onward care to mitigate this reduction.

SGH future action –

The running of MADE "style" Events has resumed given increased operational pressure to due to the start of "Winter Pressures" and increased COVID19 on the ward. The ToC team also doing walkaround style events to facilitate discharge.
The Trust will continue engaging with Heathlands Community Rehab pilot.
The Trust launched the Early Notification process for Social Workers to aid expedited discharge and to troubleshoot any key issues when patient is admitted to hospital. Continues to be reviewed via Discharge Summit in October. In addition, the Trust has launched the updated D2A (Discharge to Assess) form in the Trust, with improvements made regarding Best Interest / Mental Capacity and will be reviewed again.
An updated Trust Regularising Flow SOP is in place with the implementation of boarding of inpatients as BAU irrespective of OPEL status or to only implement boarding when certain inpatient, operational triggers are met (OPEL status / Number of DTA's etc.) – staff and patient impact to be monitored. Impact on patient experience to be mitigated by launch of new information leaflet informing patient/family of impact before boarding.
The Trust's Transfer of Care has recently been moved to Corporate Division, and each staff member's role and responsibilities is being discussed with ICS oversight.

ESTH current issues –

Patients with a > 7day, > 14 day, and > 21-day length of stay have remained static over recent months; however, the Trust are now supporting twice weekly reviews of those patients holding a length of stay of 14+ days. Combined with an audit of pathway 2 and 3 patients on behalf of SWL in collaboration with STG to understand delays in pathways by provider over an 8 week duration commencing Monday 2nd October.

We are also focussing on improved flow across our sites and are undertaking a bed reconfiguration exercise on the Epsom Hospital site to ensure that we are making best use of the available bed base. This is alongside a review of our acute medicine model of care and bed management processes

Our on-going focus is ensuring the effectiveness of the discharge huddle on both hospital sites, improving earlier in the day discharge and weekend discharge.

ESTH future action –

We have made good progress regarding arrangements for the therapy led unit at St Helier and have now agreed the associated staffing model/governance. Recruitment is progressing to support the unit opening in December 2023. The Trust have drafted an exit strategy in the absence of recurrent funding for 2024/2025.

We are undertaking a focussed review of our discharge coordinator personnel, a shadowing exercise of resource to more fully understand individual roles and responsibilities and current structures. This intelligence in collaboration with wider staff engagement will inform a summary and recommendations for future ways of working.

We have also established a group to review our weekend discharge performance and processes. We have several key actions that we are progressing to improve identification and planning for patient discharges over the weekend period, this includes utilisation of our electronic system to ensure that all staff are working from one list, weekend MDT team reviews, amendments in site oversight and escalation with a SOP in final draft pending implementation.

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

Monthly Overview – Our People

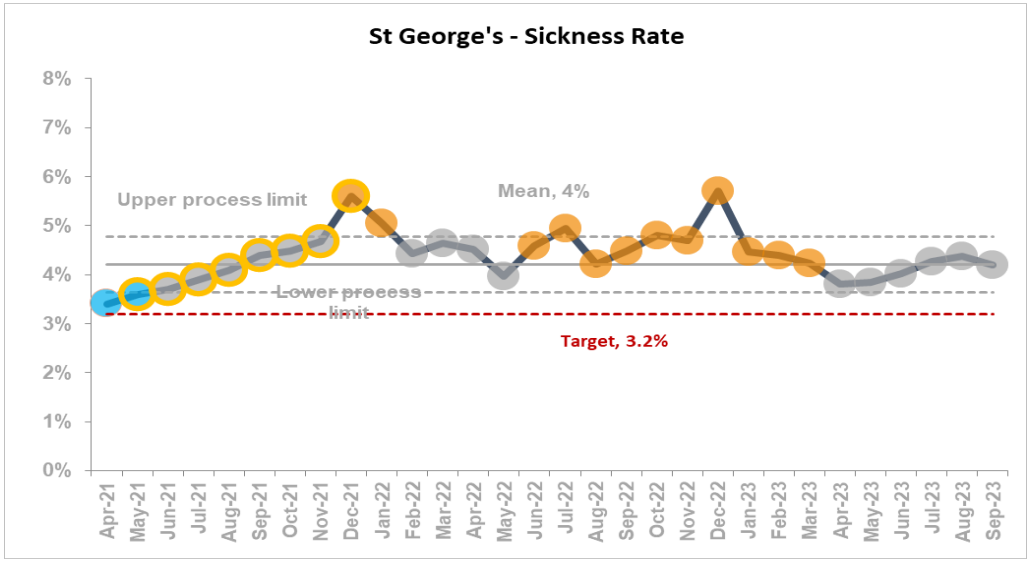
St George's, Epsom and St Helier University Hospitals and Health Group

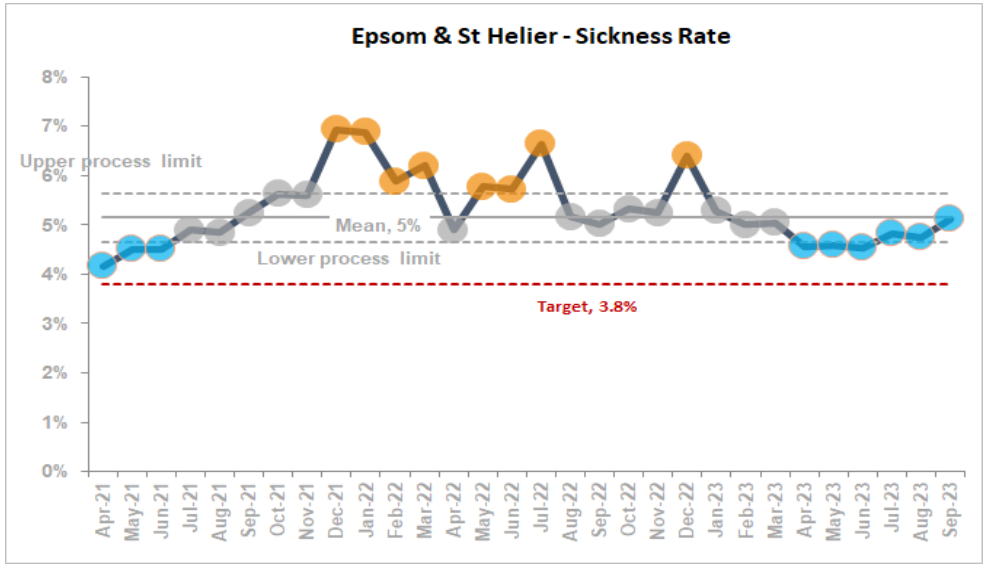
Our People	St George's							Epsom and St. Helier						
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	4.3%	4.4%	4.2%	3.2%	4.1%		3.8%	4.8%	4.7%	5.1%	3.8%	4.7%	
Agency rates	TBC	2.9%	2.9%	2.0%	TBC	2.9%		TBC	3.0%	0.9%	1.6%	TBC	2.6%	
MAST	85%	90.6%	90.4%	90.6%	85%	90.0%		85%	85.3%	84.9%	84.2%	85%	83.6%	
Vacancy	10%	9.1%	9.1%	7.8%	10%	8.7%		10%	13.0%	12.9%	12.6%	10%	13.0%	
Appraisal Rate Medical	90%	81.5%	81.0%	77.9%	90%	79.5%		90%	70.6%	57.6%	91.2%	90%	78.4%	
Appraisal Rate Non Medical	90%	70.3%	71.5%	76.2%	90%	71.2%		90%	63.1%	61.3%	59.4%	90%	64.0%	
Turnover	13%	14.9%	14.6%	14.8%	13%	14.9%		12%	14.6%	14.2%	14.0%	12%	14.7%	
Percentage BAME staff band 6 and above	TBC	44.7%	44.8%	45.1%	TBC	44.7%		TBC	38.2%	38.0%	38.1%	TBC	38.1%	

Staff Sickness Rate

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

SGH Target: 3.2%	4.2%	ESTH Target: 3.8%	5.1%





SGH updates since last month

The Trust's sickness rate is in line with performance achieved last month and showing a downward trend. The Sickness rate at 4.1% is above the target of 3.2%. and continues to show common cause variation.

ESTH updates since last month

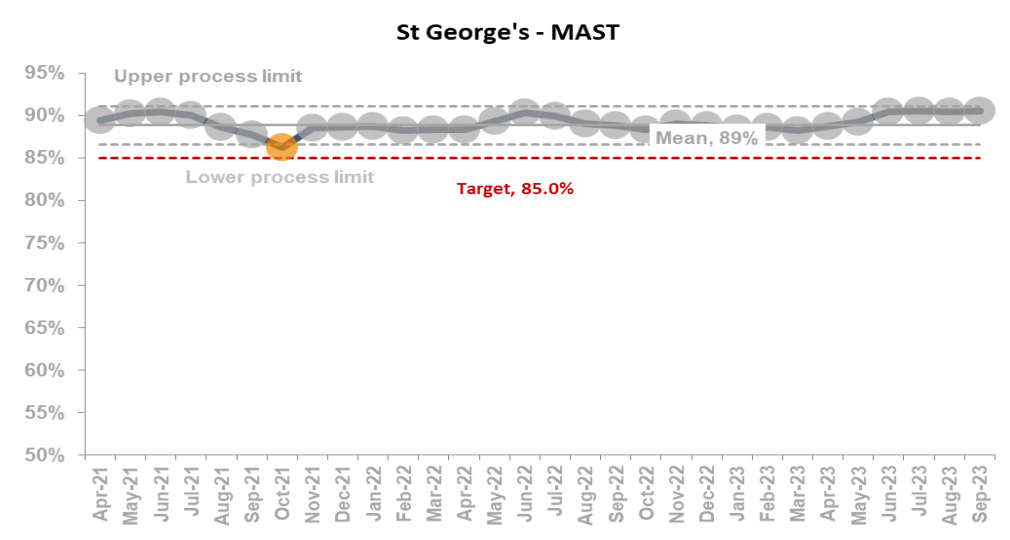
ESTH sickness absence increased by 0.38% to 5.11% and remains significantly above the KPI threshold target of 3.80%. 'Other known causes', 'Cold, Cough, Flu - Influenza' and 'Infectious diseases' were the top 3 reasons for sickness absence.

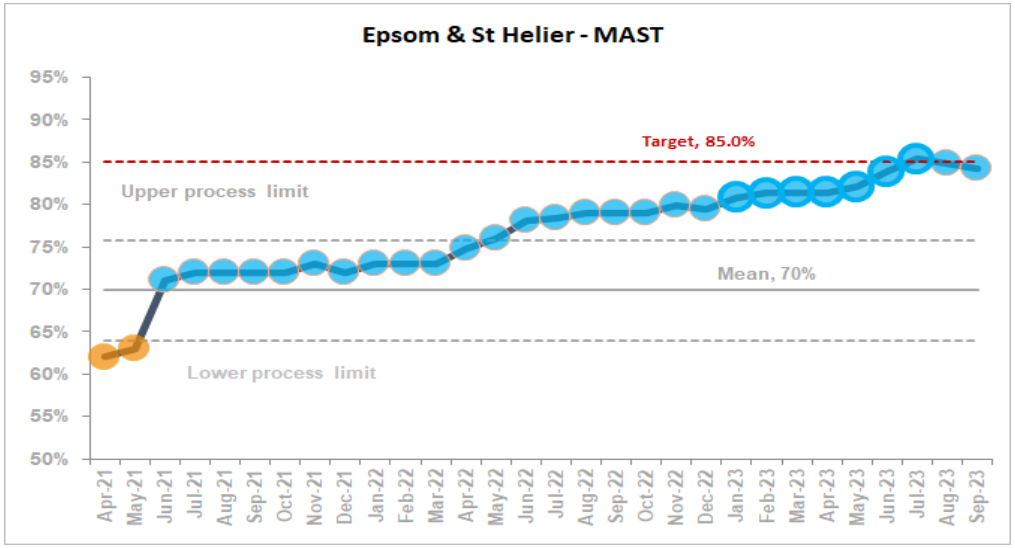
Long term sickness absence (episodes of sickness lasting 28 days or more) accounted for 15.6% of all sickness absence, a 2.2% decrease from the previous month. 'Anxiety, Stress, depression - other psychiatric illnesses' was the most common reason for absence associated with long term sickness (63 episodes, 27.7% of long-term sickness).

Mandatory and Statutory Training (MAST)

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

SGH Target: 85%	90.6%	ESTH Target: 85%	84.9%





SGH updates since last month

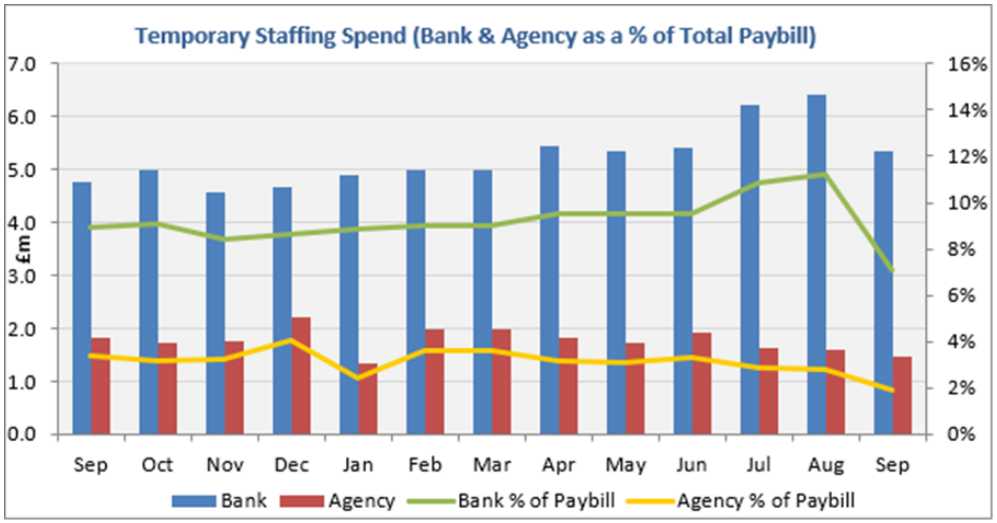
Mandatory and Statutory Training (MAST) was 90.6% in September. The compliance rate continues to hold steady and has done so for the last year showing common cause variation.

ESTH updates since last month

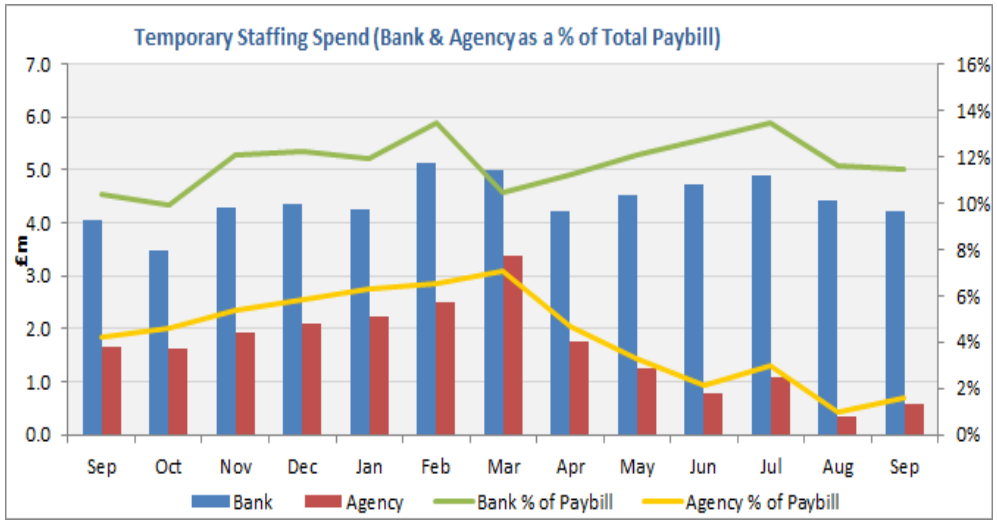
Performance in September was 84.9%, showing special cause variation with an improving position. As part of the Divisional HR meetings, performance against the MAST indicator is regularly discussed. Managers are able to track their trajectory and performance on ESR where they can compare their current and previous percentage to enable them to see clearly their rate of improvement or otherwise.

Agency and Bank Spend

St George's



Epsom & St Helier



Monthly Overview – Integrated Care

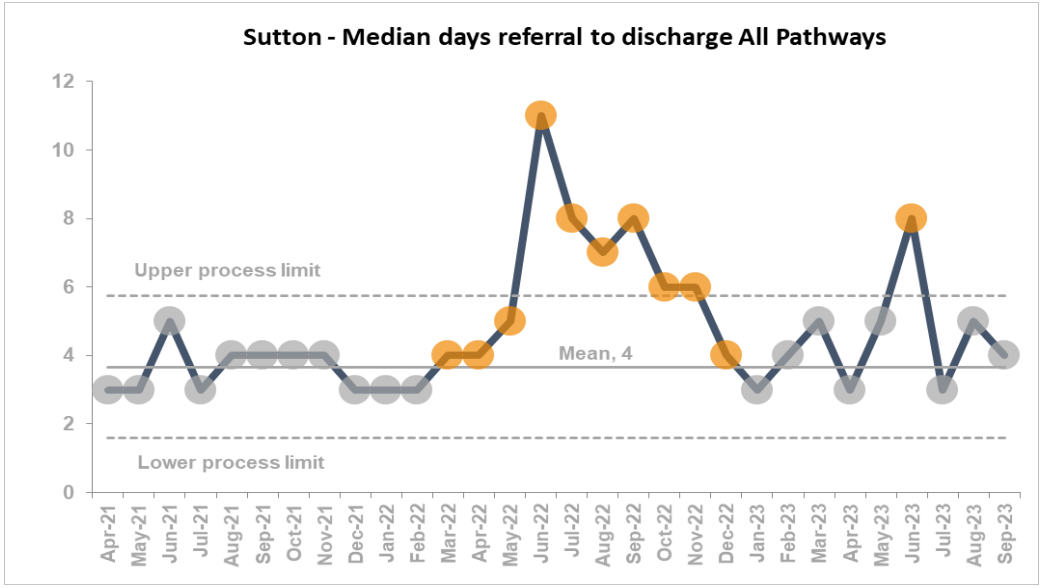
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

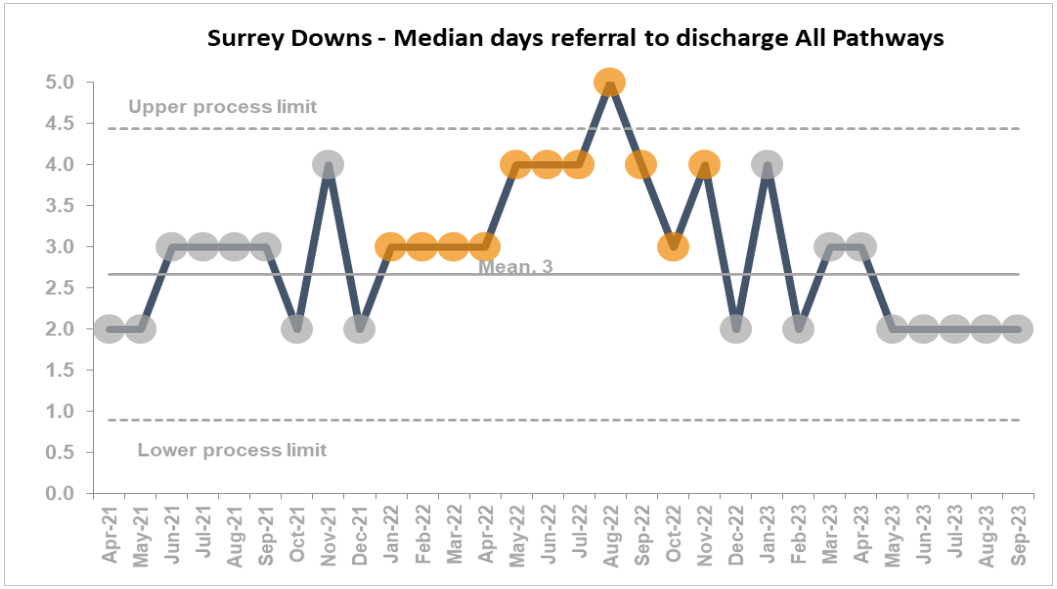
Responsive and Productive Services - Integrated Care	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Median days referral to discharge All pathways		3	5	4		5			2	2	2		2	
Median days referral to discharge Pathway 1		3	4	3		4			2	2	2		2	
Median days referral to discharge Pathway 2		0	27	10		12			1	1	1		1	
Median days referral to discharge Pathway 3		13	18	12		13			9	12	15		17	
Two hour UCR performance	70%	84.1%	87.7%	73.1%	70%	83%		70%	87.2%	84.8%	84.6%	70%	83.0%	
Two hour UCR referrals received		233	187	219		1165			431	418	488		2627	
Community hospitals bed occupancy									96%	84%	89%		90%	
Community hospitals LoS									15	17	15		18	
Virtual ward - Admissions		210	200	186		1173			176	190	235		1391	
Virtual ward - Bed Occupancy	80%	22.3%	33.8%	33.1%				80%	86.2%	64.4%	77.5%			
Virtual ward LoS		1	1	2		2		14	6	4	3		8	
Total RTT Waiting List Size		1,402	1,326	1,207					572	626	599			
Total number of RTT patients waiting over 18 weeks		0	0	3					9	11	9			

Median days referral to discharge All Pathways

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

Target: TBC	Sutton: 4 days	Surrey Downs: 2 days





Sutton Health & Care updates since last month

Length of stay reduced by one day in September continuing to show only common cause variation. Pathway 3 has the highest length of stay as expected with on average in-patients staying for 12 days.

Surrey Downs Health & Care updates since last month

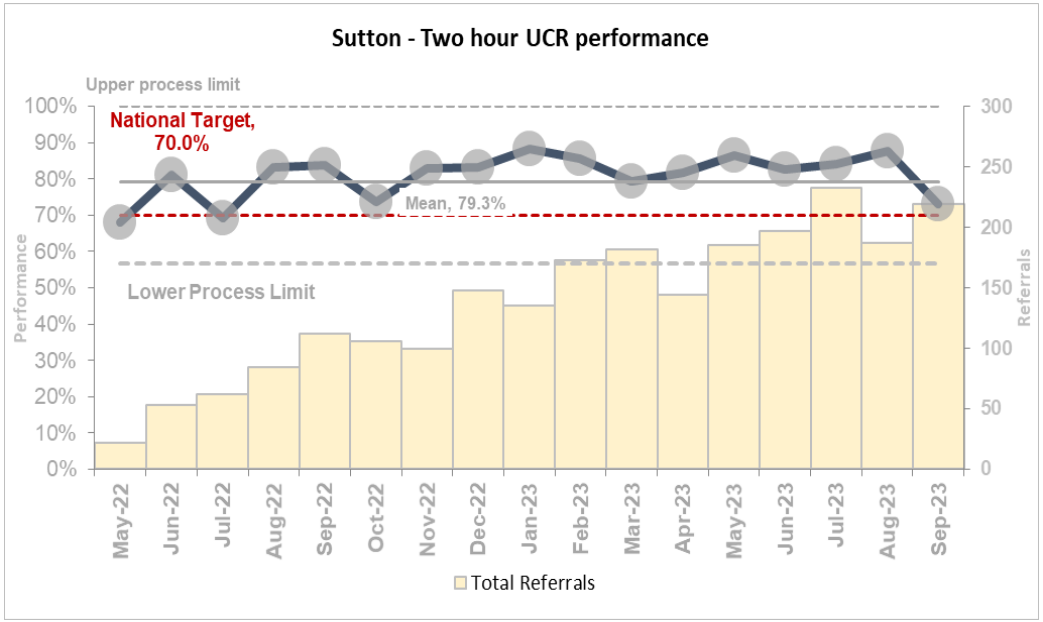
Median days from referral to discharge remains stable within the upper and lower control limit.. Pathway 3 continues to have the highest referral to discharge time of 15 days through September where patients require on-going 24-hour nursing care, often in bedded settings. Pathway 2 length of stay median time is one day and pathway 1 two days

Ageing Well

2 hour urgent community response

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

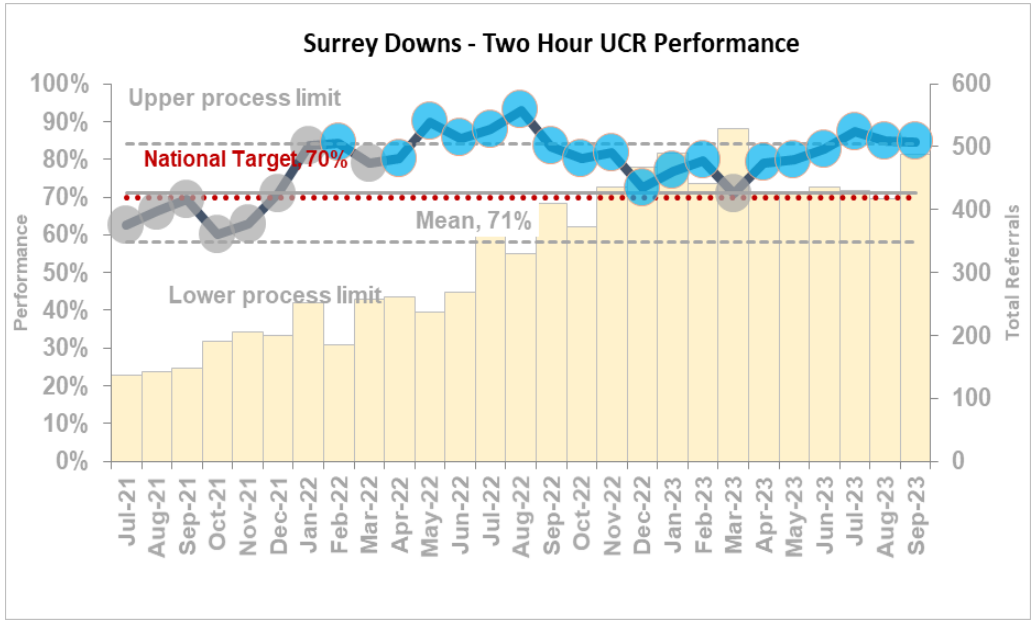
Sutton Target: 70%	Actual: 73.05%



Sutton Health & Care updates since last month

Providing urgent care within 2 hours of referral has a national target set by NHSE of 70%. Patients are often experiencing a medical crisis, the aim is to keep people independent preventing an avoidable hospital admission. The service started in May 22. Performance although remaining within the upper and lower control limit, decreased in September to 73%

Surrey Downs Target: 70%	Actual: 84.6%



Surrey Downs Health & Care updates since last month

Providing urgent care within 2 hours of referral has a national target set by NHSE of 70% designed to prevent hospital admission. The service started in Jul 21. Performance continues to exceed the target reporting 84.6% in September.

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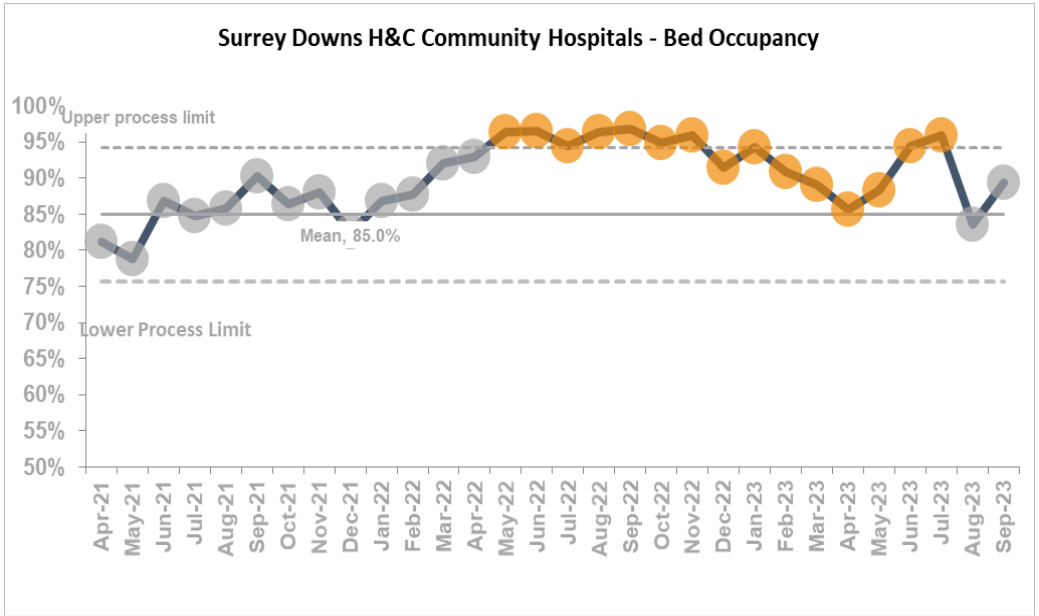
Surrey Downs Health & Care Community Hospitals

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

Bed Occupancy	Actual: 89.4%



Surrey Downs Health & Care updates since last month

SDHC runs 3 community hospitals and Alex Frailty on the Epsom site. Bed occupancy increased to 89.4% in September remaining within the upper and lower control limits showing common cause variation.
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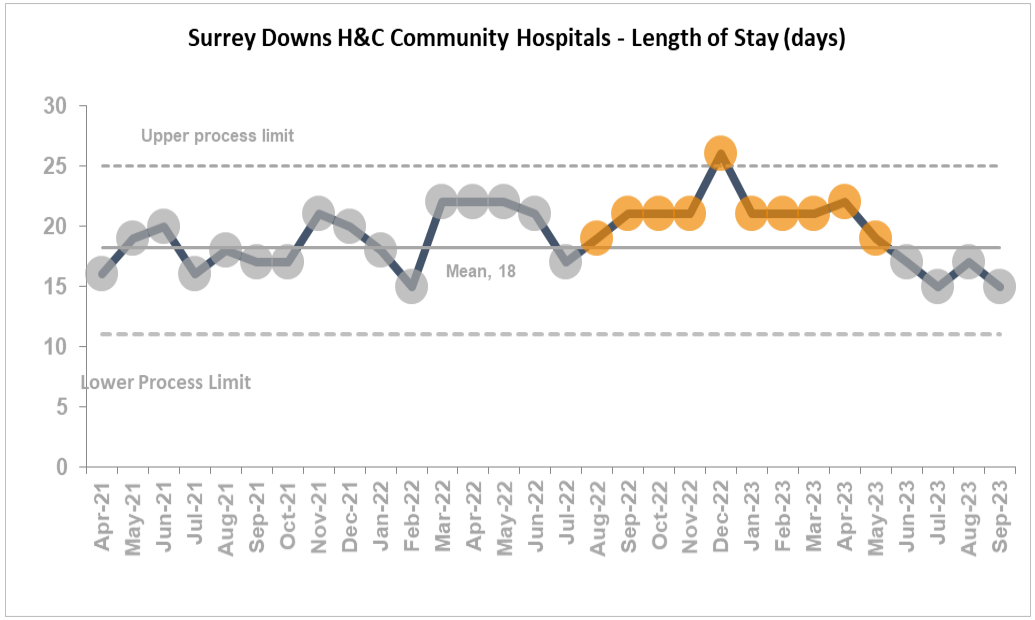
Length of Stay	Actual: 15 days



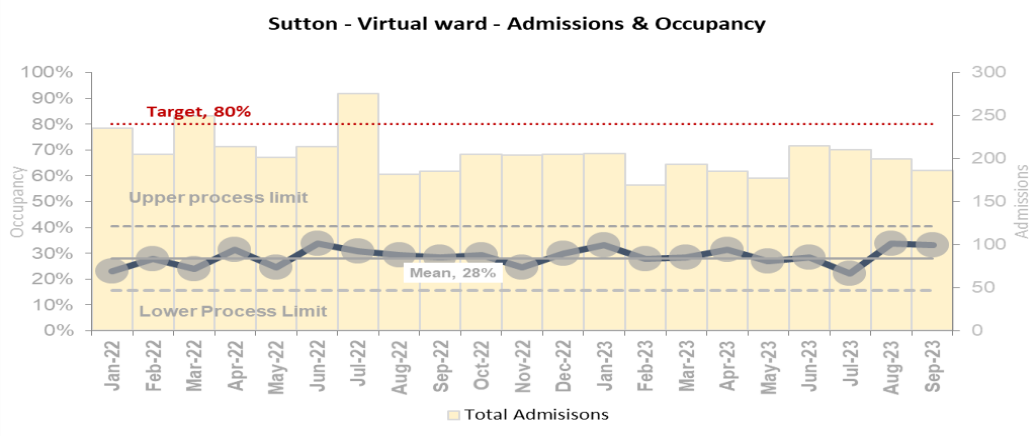
Surrey Downs Health & Care updates since last month

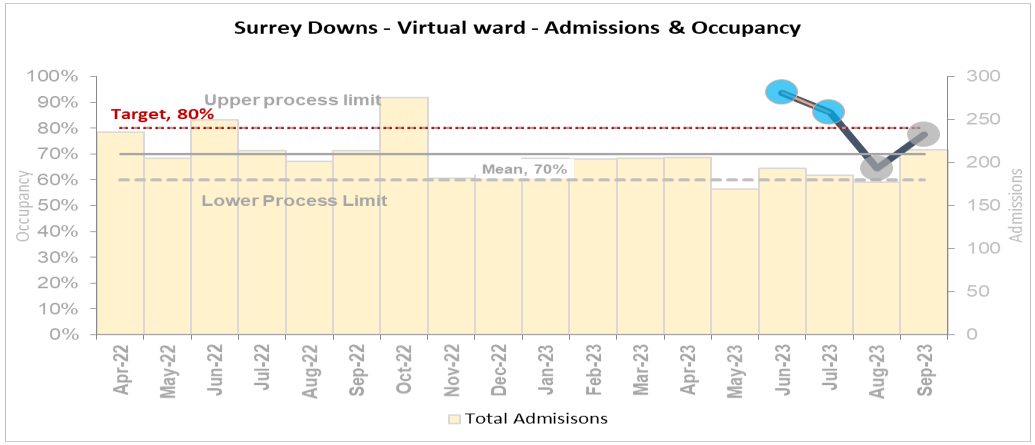
Length of stay in September was 15 days compared to 17 days through August, showing common cause variation and below the mean for the fourth consecutive month.

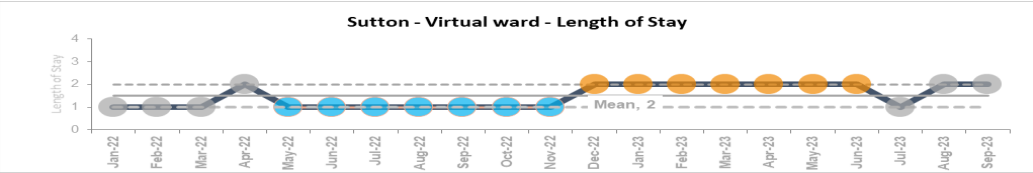
Virtual Ward
Admissions, Occupancy & Length of Stay

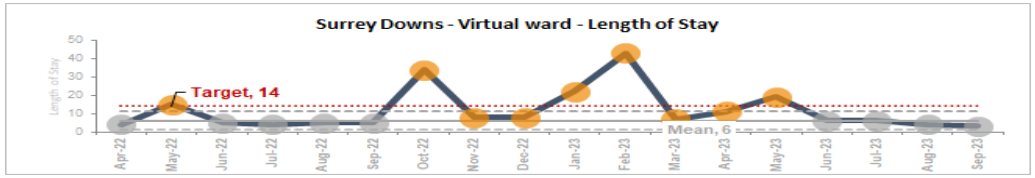
St George's, Epsom and St Helier
University Hospitals and Health Group

Sutton Occupancy Target: >80%	Actual: 33.1%	Surrey Downs Occupancy Target: >80%	Actual: 77%









Sutton Health & Care updates since last month

Service stated on Dec 21. Average LOS is currently at 2 days remaining within the upper and lower control limits.

Surrey Downs Health & Care updates since last month

Service started Sep 21. Average length of stay reduced in September performing below the mean for a consecutive month.

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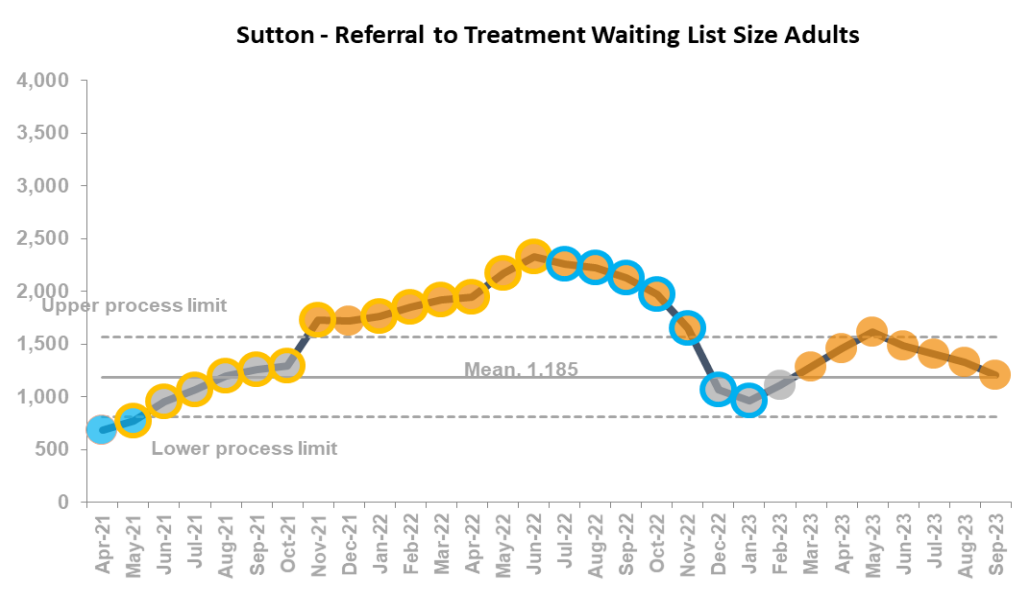
Referral to Treatment Waiting List Size

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

Sutton	Actual: 1,207

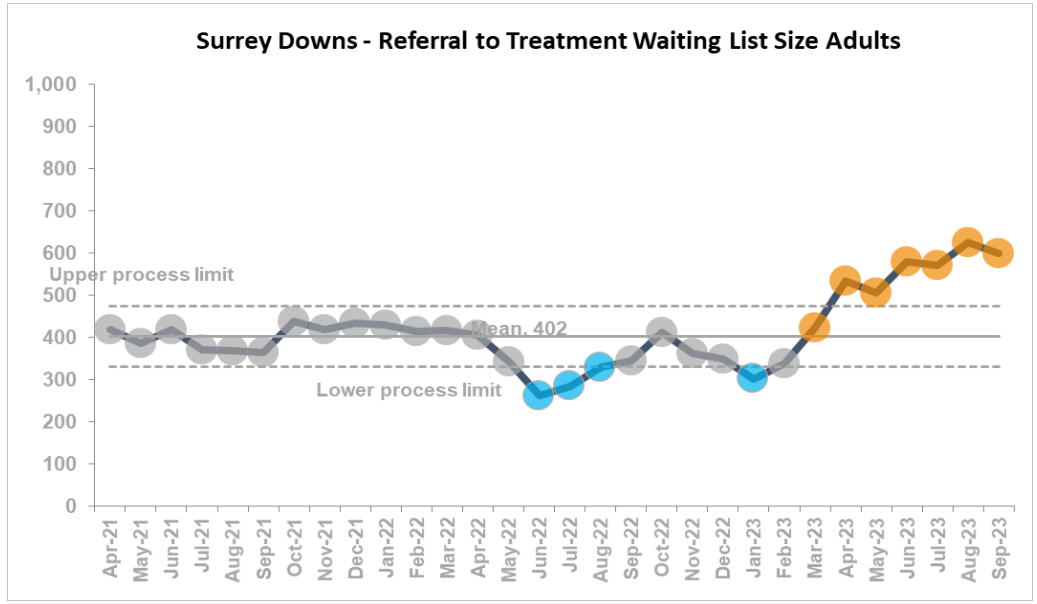


Sutton Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal (MSK) pathways.

At the end of September the number of patients on a RTT pathway reduced further by 119 pathways. There were three patients waiting for more than 18 weeks for treatment.

Surrey Downs	Actual: 599



Surrey Downs Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal Clinical Assessment and Triage Service (MSK CATS) pathways.

The number of patients on the RTT waiting list remains above the upper control limit, however seeing a decrease of 27 pathways in September. There were nine patients waiting for more than 18 weeks for treatment.

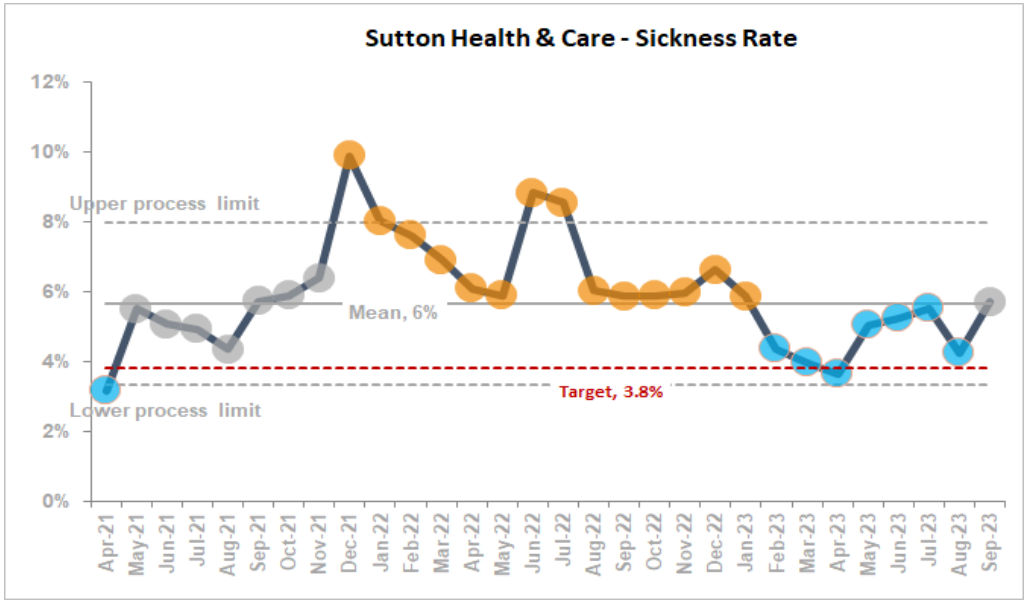
Integrated Care – Our People

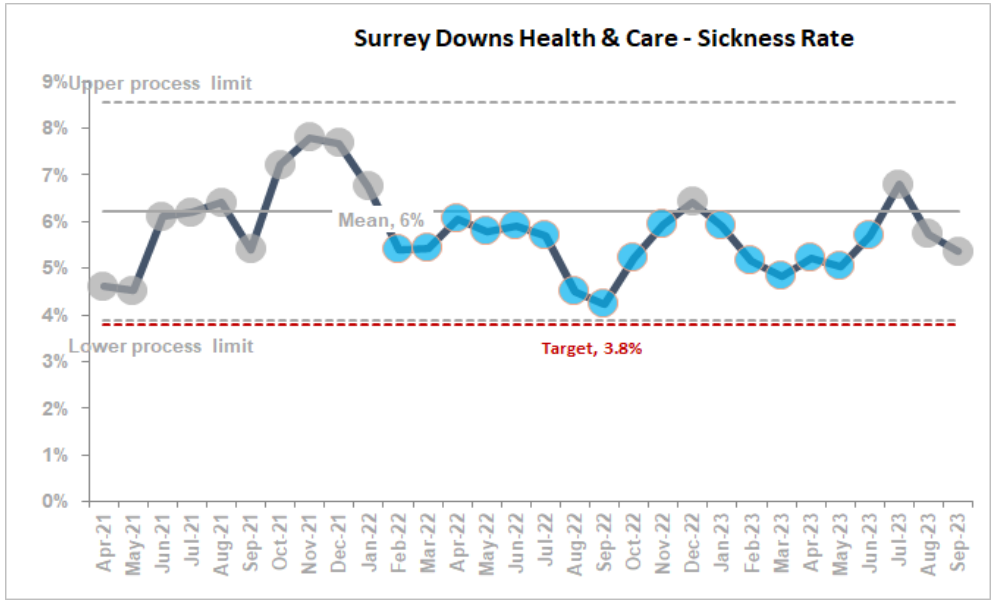
St George's, Epsom and St Helier University Hospitals and Health Group

Our People	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Jul-23	Aug-23	Sep-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	5.5%	4.2%	5.7%	3.2%	4.9%		3.8%	6.8%	5.7%	5.4%	3.8%	5.6%	
Agency rates		3.1%	4.1%	2.9%		3.3%			10.1%	8.4%	9.3%		9.5%	
MAST	85%	89.4%	89.5%	89.5%	85%	88.7%		85%	93.2%	92.7%	92.7%	85%	91.5%	
Vacancy	10%	16.7%	16.0%	15.0%	10%	14.8%		10%	19.2%	19.7%	18.9%	10%	18.8%	
Appraisal Rate Medical	90%	100.0%	100.0%	100.0%	90%	100.0%		90%	100.0%	100.0%	100.0%	90%	91.7%	
Appraisal Rate Non Medical	90%	69.9%	63.2%	60.9%	90%	67.3%		90%	82.5%	79.6%	74.4%	90%	82.7%	
Turnover	13%	1.2%	0.3%	1.3%	13%	1.3%		12%	1.7%	1.5%	1.7%	12%	1.2%	
Percentage BAME staff band 6 and above		36.9%	35.8%	35.6%		36.0%			17.9%	18.8%	18.8%		18.5%	

Staff Sickness Rates

Target: 3.8%	Sutton Health & Care: 5.7%	Surrey Downs Health & Care: 5.4%





Sutton Health & Care updates since last month

Sutton sickness rate further increased and above the ceiling target of 3.8%. Work continues with HR/OH to improve our short and long term sickness rates providing support to staff to enable them to return to work when able.

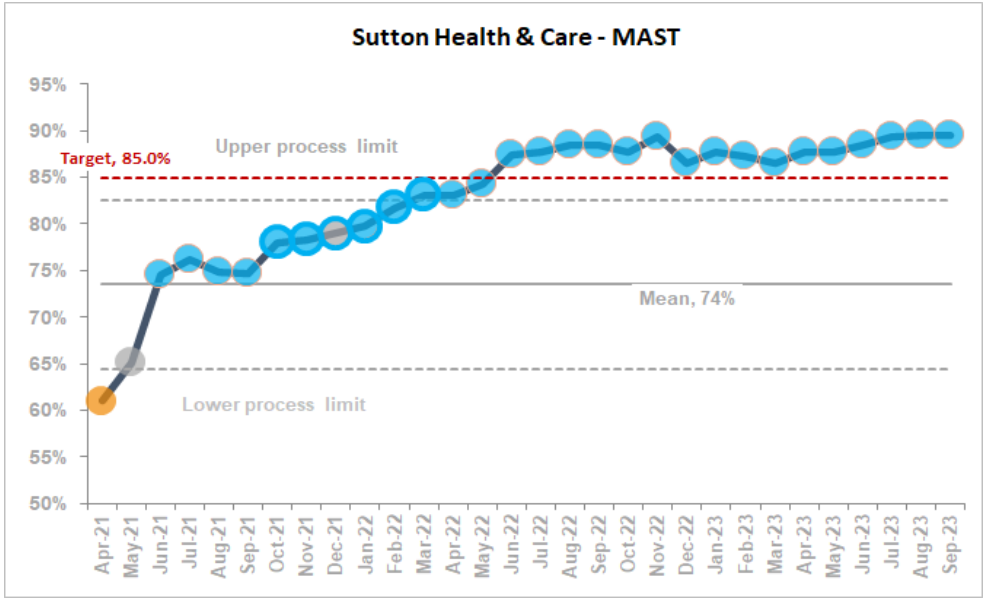
Surrey Downs Health & Care updates since last month

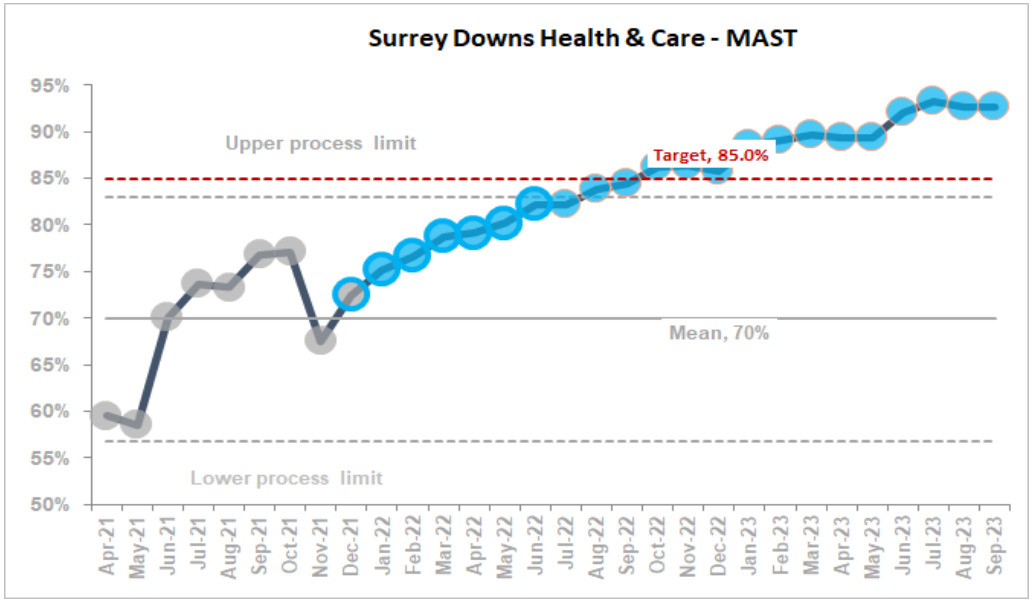
SDHC sickness absence rate has increased further and remains over the target of 3.8%. Training for managers on absence management and review of sickness is in place.

Mandatory and Statutory Training (MAST)

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

Target: 85%	Sutton Health & Care: 89.5%	Surrey Downs Health & Care: 92.7%





Sutton Health & Care updates since last month

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

Surrey Downs Health & Care updates since last month

MAST compliance continues to improve. This remains above KPI since October 2022.

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Integrated Care - Analysis and Action

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

Sutton Health & Care current issues –

Children's Therapy waiting lists (SALT and OT) for routine care. Action plan in place with LBS who provide therapy via education and social care.

Surrey Downs Health & Care current issues –

Staff survey results indicate lower percentage of people recommending the organisation than previous year

High level of vacancies, particularly in nursing.

Increase in agency usage due to opening additional beds to enable NEECH relocation

Sutton Health & Care future action –

1. Children's Therapy: collaboration with LBS to determine resolution of increased waiting lists across the borough.
2. Productivity / workforce: continued focus on safer staffing and reductions in agency and bank spend.

Surrey Downs Health & Care future action –

Continue to progress the action plan from Staff engagement and listening events

Welcome Payment for band 5 & 6 community nurses in place with further recruitment promotion planned

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

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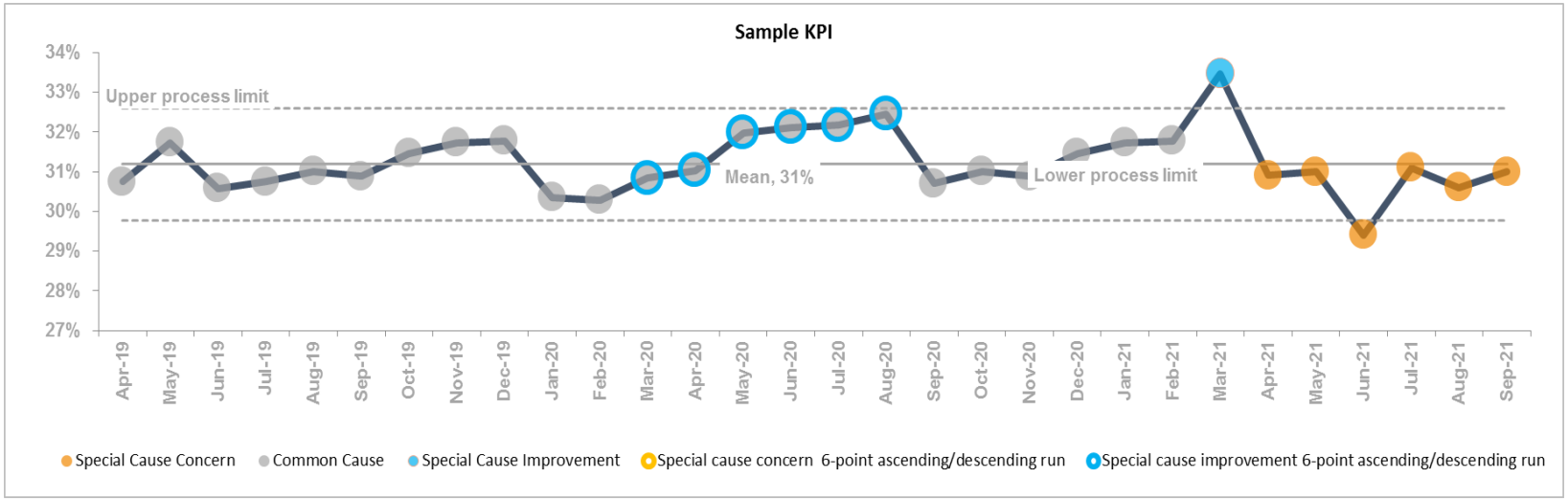
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

Appendices

Interpreting (Statistical Process Control) Charts

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

Guide on interpreting statistical process control charts



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

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

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

Glossary of Terms

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

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
CFU	Colony Forming Units
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CT	Computerised tomography
CUPG	Cancer of Unknown Primary Group
CWDT	Childrens, Womens, 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

Terms	Description
DTT	Decision to Treat
DQ	Data quality
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
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

Terms	Description
KPI	Key Performance Indicator
LA	Local anaesthetics
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

Terms	Description
O2S	Orders to Schedule
OBD	Occupied Bed Days
OPEL	Operational Pressures Escalation Levels
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

Terms	Description
SGH	St Georges Hospital Trust
SHC	Sutton Health and Care
SHMI	Summary Hospital-level Mortality Indicator
SJR	Structured Judgement Review
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 Friday, 10 November 2023

Agenda Item	3.4	
Report Title	**Group- Financial Performance M6**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO, SGH Site CFO, ESTH Site CFO	
Previously considered by	Finance Committees-in-Common	27 October 2023
Purpose	**For Review**	

Executive Summary
This paper sets out the financial performance YTD for each Trust. Both Trusts are on plan excluding the impact of Industrial Action on income and costs.

Action required by Finance Committees-in-Common	
The Committee is asked to: Note the financial performance in M6	
Committee Assurance	
Committee	Choose an item.
Level of Assurance	Choose an item.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Add Appendix Name – delete line if not needed
Appendix 2	Add Appendix Name – delete line if not needed
Appendix 3	Add Appendix Name – delete line if not needed

Implications	
Group Strategic Objectives	
☐ Collaboration & Partnerships	☐ Right care, right place, right time
☒ Affordable Services, fit for the future	☐ Empowered, engaged staff
Risks	
[Summarise the key risks on the Corporate Risk Register and Board Assurance Framework to which this paper relates. Also set out any risks relevant to the content of the paper – set out further detail in the main body of the paper.]	
CQC Theme	

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Epsom and St Helier University Hospitals NHS Trust

St George's University Hospitals NHS Foundation Trust

Trust Board (Public): 10th November 2023
23/24 M6 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

Year to Date Financial Information
Key actions

	Issue	Action
Summary I&E	Both Trusts are on plan excluding the impact of industrial action.	Continued focus on cost control and the development and delivery of CIPs through site management meetings.
Pay expenditure	Pay expenditure is **overspent against budget in both trusts**,	Increased focus on grip and control actions
CIP delivery	**ESTH £2.2m adverse, and SGH £3.0m adverse,** with timing adjustment at SGH.	Focus on the development and delivery of CIPs.
Capital	**In line with trend**. The overall position is challenging at both trusts.	Careful monitoring and forecasting of capital will be required in both trusts across the year.
Cash	**Cash update outlines ESTH and SGH current and expected drawdowns.**	See cash update

ESTH
Executive summary

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)	Risk FOT
Financial Position	The Trust is reporting a deficit of £26.7m at the end of September, which is £3.6m adverse against plan. The deficit is due to the impact of industrial action to date, £1.8m additional costs and £1.8m shortfall of ERF income net of the 2% agreed adjustment. Net of Industrial Action costs and loss of income the Trust is on plan but in M6 had to bring forward £0.8m of non recurrent benefits to support in month and has had to bring forward £2.1m additional non recurrent YTD.	£3.6m Adv to plan	£2.4m Adv to plan	
Income	Overall income is £0.7m adverse to plan. Patient Care income is £1.2m adverse of which £1.8m is the ERF shortfall. Other Operating Income is £0.5m favourable. Key risk is growth and MFF assumptions in the Surrey Heartlands Contract and ERF income.	£0.7m Adv to Plan	£0.2m Adv to Plan	See Productivity and Risks and Mitigations Papers
Expenditure	Expenditure is £4.5m adverse year to date, of this £1.8m is due to the net costs of the industrial action to the end of September. Baseline pressures of £4.9m are being held within the position are being reviewed for potential CIP. CIP delivery is £2.2m less than plan.	£4.5m Adv to Plan	£3.5m Adv to Plan	See Risks and mitigations paper
Cost Improvement Plans	The CIP plan has delivered £12.3m to date agaisnt a plan of £14.5m. In month the Trust reported £2.6m of CIP against an in month plan of £3.8m.	£2.2m Adv to plan	£1.0m Adv to plan	See Risks and mitigations paper
Capital	At the end of September, the Trust's has spent £10.9m against an external plan of £23.7m. This is largely driven by changes to the planned expenditure post submission once funding for Nationally Funded Schemes was confirmed and also slippage against delivery on some Nationally funded schemes - EPR and Epsom Car Park. EPR is phasing but the Epsom Car PArk requires a wider review. Internal BAU schemes are £2.0m behind plan. Phasing of internal schemes are profiled heavily in Q3 and Q4 as a result of the review of the capital plan in Q1 to manage within envelope delaying the start date of many schemes.	£12.8m Fav to plan	£9.3m Fav to plan	This paper
Cash	The Trust has a cash balance of £7.1m against the plan of £20.8m at the end of September. A submission for Q3 cash support was approved by the Trust Board on the 8th September and the MoU has now been signed. The Trust is investing significant time to reviewing payment runs and debt collection to ensure working capital is managed effectively and in line with payments from NHSE to support cash.	£13.7m Adv to plan	£0.2m Adv to plan	See Cash paper

Epsom and St Helier University Hospitals NHS Trust

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Income and expenditure

Table 1 - Trust Total

		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	581.0	48.5	47.6	(0.9)	289.1	287.8	(1.2)
	Other Op. Income	40.8	3.3	3.7	0.3	21.0	21.5	0.5
Income Total		**621.7**	**51.8**	**51.3**	**(0.5)**	**310.1**	**309.4**	**(0.7)**
Expenditure	Pay	(439.8)	(36.3)	(37.1)	(0.8)	(221.2)	(223.3)	(2.1)
	Non Pay	(192.1)	(15.8)	(16.0)	(0.1)	(98.2)	(100.6)	(2.4)
Expenditure Total		**(632.0)**	**(52.1)**	**(53.1)**	**(1.0)**	**(319.4)**	**(323.9)**	**(4.5)**
Post Ebitda		(27.6)	(2.3)	(2.0)	0.3	(13.8)	(12.1)	1.6
Grand Total		**(37.9)**	**(2.6)**	**(3.8)**	**(1.2)**	**(23.1)**	**(26.7)**	**(3.6)**

Table 2 - Acute Services

		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	516.5	43.0	42.1	(0.9)	256.8	255.5	(1.3)
	Other Op. Income	29.2	2.3	2.3	0.0	15.2	13.8	(1.4)
Income Total		**545.7**	**45.3**	**44.4**	**(0.9)**	**272.0**	**269.3**	**(2.7)**
Expenditure	Pay	(332.3)	(27.1)	(27.8)	(0.7)	(167.1)	(168.8)	(1.8)
	Non Pay	(123.5)	(10.0)	(9.9)	0.1	(63.2)	(63.0)	0.2
Expenditure Total		**(455.8)**	**(37.1)**	**(37.7)**	**(0.6)**	**(230.3)**	**(231.9)**	**(1.6)**
Post Ebitda		(27.6)	(2.3)	(2.0)	0.3	(13.8)	(11.9)	1.9
Grand Total		**62.3**	**5.9**	**4.7**	**(1.1)**	**28.0**	**25.6**	**(2.4)**

Table 3 - Integrated Care Services

		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	64.4	5.5	5.5	(0.0)	32.2	32.2	0.0
	Other Op. Income	2.5	0.2	0.3	0.0	1.3	1.5	0.2
Income Total		**67.0**	**5.8**	**5.8**	**0.0**	**33.5**	**33.7**	**0.2**
Expenditure	Pay	(53.2)	(4.6)	(4.4)	0.2	(26.7)	(26.2)	0.5
	Non Pay	(14.6)	(1.2)	(1.1)	0.1	(7.4)	(7.5)	(0.1)
Expenditure Total		**(67.8)**	**(5.8)**	**(5.5)**	**0.3**	**(34.1)**	**(33.7)**	**0.4**
Post Ebitda		0.0	0.0	(0.0)	(0.0)	0.0	(0.2)	(0.2)
Grand Total		**(0.9)**	**(0.0)**	**0.2**	**0.3**	**(0.6)**	**(0.2)**	**0.4**

Table 4 - Corporate Services

		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	0.1	0.0	0.0	0.0	0.0	0.1	0.1
	Other Op. Income	9.0	0.8	1.1	0.3	4.5	6.2	1.7
Income Total		**9.1**	**0.8**	**1.1**	**0.3**	**4.5**	**6.4**	**1.8**
Expenditure	Pay	(54.3)	(4.6)	(4.8)	(0.3)	(27.4)	(28.3)	(0.9)
	Non Pay	(54.1)	(4.6)	(5.0)	(0.4)	(27.7)	(30.1)	(2.4)
Expenditure Total		**(108.4)**	**(9.2)**	**(9.8)**	**(0.6)**	**(55.1)**	**(58.4)**	**(3.3)**
Post Ebitda		0.0	0.0	0.0	0.0	0.0	0.0	0.0
Grand Total		**(99.3)**	**(8.4)**	**(8.7)**	**(0.3)**	**(50.5)**	**(52.0)**	**(1.5)**

- Table 1 shows the overall Trust position while tables 2 and 3 report the acute and community positions respectively.
- These have been shown to reflect the statutory need to report the whole organisation but also the need to provide reports to the Board on the two segments within the Trust. ESTH corporate services have been included within the Trust total (table 1) and acute services (table 2) position.

Summary

- **YTD £3.6m adverse to plan due to industrial action costs and ERF (Elective Recovery Fund) income shortfall**

The Trust position (table 1)

- The Trust has a deficit of £26.7m which is £3.6m adverse to plan, the overspend is wholly related to costs incurred due to industrial action £1.8m and ERF income lost as a result of the industrial action £1.8m. Acute services are £2.4m adverse, Integrated Care is £0.4m favourable and Corporate Services are £1.5m adverse at the end of September.
- Income is £0.9m adverse in month of which £0.9m was due to the reappraisal of YTD industrial action losses. YTD ERF income is £1.8m adverse.
- Patient Care is £0.9m adverse in month and £1.2 m adverse YTD due to the £1.8m ERF income lost as a result of industrial action; High-cost drugs income is £0.2m favourable in month and £2.0m favourable YTD but this is offset by increased drugs expenditure.
- Other operating income is £0.3m favourable in month due to non-recurrent education income and is £0.5m favourable YTD as staff recharge income and car parking income are above plan.
- Pay expenditure is £0.8m adverse in month and £2.1m adverse YTD. The net costs of industrial action are £0.3m in month and £1.8m YTD.
- Other operating expenditure is £0.1m adverse in month and £2.4m adverse YTD. Drugs are £0.6m adverse in month and £3.1m adverse YTD this is offset by additional £2.0m patient care income. Cardiology is overspent by £0.2m in month and £1.2m YTD as activity and case-mix have changed since the expansion of the catheter lab.
- **Acute services (table 2).** Industrial action costs are the main issue to date.
- **Integrated care (table 3)**. £0.3m favourable in month due to the uplift for pay award funding in excess of cost. YTD £0.4m favourable.
- **Corporate Services (table 4)**. £0.3m adverse in month and £1.5m adverse YTD. Estates and Facilities are £1.5m adverse YTD with £0.2m on Energy; £0.4m on property maintenance;.£0.4m on cleaning and portering and £0.8m adverse on CIP.

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Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)	Risk FOT
Financial Position	The Trust is reporting a deficit of £27.0m at the end of September, which is £12.2m adverse to plan. The shortfall is due to ERF shortfall and impact of industrial action.	£12.2m Adv to Plan	£10.0m Adv to Plan	
Income	Excluding ERF, income is reported at £2.4m favourable to plan at Month 6. This is due to additional income to cover increased centralised costs.	£2.4m Fav to plan	£1.4m Fav to plan	See income risk slides
Expenditure	Expenditure is reported at £7.4m adverse to plan at Month 5, mainly due to premium temporary medical staffing costs to cover industrial action and premium temporary nursing costs across wards. Underlying non-pay is experiencing inflationary pressures currently mitigated in the position.	£7.4m Adv to plan	£5.4m Adv to plan	See expenditure risk slides
Cost Improvement Programme	CIPs are £3.0m adverse to plan.	£3.0m Adv to plan including timing adjustment	£1.5m Adv to plan including timing adjustment	See separate CIP paper
Capital	Capital is £28.9m underspent at M6, although in line with trend	£28.9m underspent	£2.2m underspent	See capital slides
Cash	At the end of Month 6, the Trust's cash balance was £15.3m. Cash request for Q3 submitted.	£15.3m which is £43.2m lower than Y/E	£10.2m which is £48.3m lower than Y/E	See separate cash paper

Month 6 Financial Performance

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Table 1 - Trust Total

			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	914.6	80.6	81.0	0.4	460.9	462.7	1.8
		Other Income	148.7	26.5	27.1	0.6	74.7	75.3	0.6
	Income Total		1,063.3	107.1	108.0	1.0	535.6	538.0	2.4
	Expenditure	Pay	(682.9)	(73.7)	(75.4)	(1.7)	(346.9)	(360.4)	(13.5)
		Non Pay	(348.1)	(28.3)	(28.6)	(0.3)	(181.5)	(175.4)	6.1
	Expenditure Total		(1,030.9)	(102.0)	(104.0)	(2.0)	(528.4)	(535.8)	(7.4)
	Post Ebitda		(71.7)	(7.2)	(7.2)	0.0	(33.8)	(33.8)	0.0
	Grand Total		(39.3)	(2.1)	(3.2)	(1.0)	(26.6)	(31.5)	(5.0)
ERF	Income		23.6	2.0	0.8	(1.1)	11.8	4.6	(7.2)
	Reported Position		(15.7)	(0.2)	(2.3)	(2.2)	(14.8)	(27.0)	(12.2)

Table 2- Acute Total

			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	913.5	80.5	80.7	0.2	460.3	461.4	1.2
		Other Income	125.1	24.5	25.1	0.6	62.9	63.3	0.4
	Income Total		1,038.6	105.0	105.8	0.8	523.2	524.7	1.5
	Expenditure	Pay	(602.3)	(66.7)	(69.0)	(2.3)	(306.3)	(320.2)	(13.9)
		Non Pay	(203.0)	(16.5)	(14.9)	1.7	(108.2)	(98.7)	9.6
	Expenditure Total		(805.3)	(83.2)	(83.9)	(0.6)	(414.5)	(418.9)	(4.4)
	Post Ebitda		(71.7)	(7.2)	(7.2)	0.0	(33.8)	(33.8)	0.0
	Grand Total		161.6	14.6	14.7	0.2	74.9	72.0	(2.8)
ERF	Income		23.6	2.0	0.8	(1.1)	11.8	4.6	(7.2)
	Reported Position		185.2	16.5	15.5	(1.0)	86.7	76.6	(10.1)

Table 3 - Corporate Total

			Full Year Budget (£m)	M6 Budget (£m)	M6 Actual (£m)	M6 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	1.1	0.1	0.3	0.2	0.7	1.3	0.6
		Other Income	23.6	2.0	2.0	(0.0)	11.8	12.0	0.2
	Income Total		24.7	2.1	2.2	0.2	12.5	13.3	0.9
	Expenditure	Pay	(80.6)	(7.0)	(6.4)	0.6	(40.7)	(40.2)	0.5
		Non Pay	(145.1)	(11.8)	(13.7)	(1.9)	(73.2)	(76.7)	(3.5)
	Expenditure Total		(225.6)	(18.8)	(20.1)	(1.4)	(113.9)	(116.9)	(3.0)
	Post Ebitda		(0.0)	0.0	0.0	0.0	0.0	0.0	0.0
	Grand Total		(200.9)	(16.7)	(17.9)	(1.2)	(101.4)	(103.6)	(2.1)
ERF	Income		0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Reported Position		(200.9)	(16.7)	(17.9)	(1.2)	(101.4)	(103.6)	(2.1)

Commentary

The Trust is reporting a £27.0m deficit in M6, which is £12.2m adverse to plan. The overall adverse variance to plan is due to ERF shortfall and the impact of industrial action.

The Trust has received £4.6m of ERF income, which is £7.2m under plan. This is due to the Trust not meeting its ERF target.

Excluding ERF income:

Income

- Income is £2.4m above plan, with additional income to cover increased centralised costs

Pay

- Pay is £13.5m overspent mainly due to premium temporary medical staffing costs to cover the industrial action and premium temporary nursing costs across wards

Non-Pay

- Non Pay is £6.1m underspent due to release of central provisions

Corporate Services

- Corporate Services are £2.1m overspent within Non-pay, partially driven by inflation

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	4.1	
Report Title	**Group Board Assurance Framework: Strategic Risks**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Group Executive Group Board	31 October 2023 06 October 2023
Purpose	**For Approval / Decision**	

Executive Summary

The Group Board brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives. It acts as the source of evidence the Board can rely on to be confident that risks to the delivery of the Board's strategic objectives are being managed and controlled effectively.

The new Group strategy, *Outstanding Care, Together 2023-28*, was approved by the Boards in April and published in May 2023. The Group Board has held development sessions in April 2023 and October 2023 to develop a new Group Board Assurance Framework, linked to the delivery of the new strategy.

For the development session in April 2023, the Boards discussed:

- the role and purpose of a Board Assurance Framework and good practice for BAFs
- how we could develop and use a new Group BAF
- Initial thinking around the principal risks to the delivery of the new Group Strategy

At the development session in October 2023, the Group Board discussed:

- The framing of draft strategic risks
- The number of strategic risks for inclusion on the Group BAF
- High level overview of risk appetite for each draft strategic risk

Based on the discussions and feedback at these Board development sessions, this paper sets out 14 proposed strategic risks on the new Group Board Assurance Framework, and the proposed risk appetite for each. Also included is a qualitative risk appetite approach to help guide consideration of the BAF and wider decision-making in relation to risk. Subject to the approval of the strategic risks by the Group Board, the intention is to populate the BAF and take the relevant sections through Committees ahead of presenting the full Group BAF to the Group Board in January 2024.

Action required by Group Board

The Group Board is asked to:

a) Review and approve the draft strategic risks
b) Note that the full Group Board Assurance Framework will be presented to the Board at its meeting in January 2024.

Committee Assurance	
Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Board Assurance Framework: Strategic Risks

Implications

Group Strategic Objectives

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

Risks

If we do not develop a Board Assurance Framework, then we will not have a formalised means of collating the key risks to the delivery of the Group Strategy or a framework for identifying the sources of assurance and actions to address identified gaps in assurance, resulting in our inability to provide assurance to the CQC on effective governance of risk.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no specific financial issues associated with this report. The key financial risks to the delivery of the strategy are set out in the document.

Legal and / or Regulatory implications

We are required to have a BAF that sets out the risks to the delivery of the strategy.

Equality, diversity and inclusion implications

There are no specific EDI issues associated with this report. The draft strategic risks include risks associated with EDI.

Environmental sustainability implications

There are no specific environmental sustainability implications of this report. The draft strategic risks include risks associated with environmental sustainability.

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Group Board Assurance Framework

Strategic Risks

Stephen Jones
Group Chief Corporate Affairs Officer

10 November 2023

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Introduction

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Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives. It acts as the source of evidence the Board can rely on to be confident that risks to the delivery of the Board's strategic objectives are being managed and controlled effectively.

The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed.

The BAF also provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of strategic risks.

Used effectively, the BAF provides a Board with real, evidence-based confidence that it is providing a thorough and effective oversight of risks to the organisation and its strategic objectives.

In a nutshell, the BAF is:

- A simple and comprehensive means of reporting to the Board that allows for effective prioritisation, focus and management of key strategic risks
- The main tool that the Board should use to discharge its overall responsibility for internal control and should inform the Annual Governance Statement
- A means of shaping and driving the Board agenda

Development of the new Group Board Assurance Framework

The new Group Strategy – *Outstanding Care, Together 2023-28* – was approved in April and published in May 2023.

The Group Board has held development sessions, principally in April 2023 and October 2023 to develop the new Group Board Assurance Framework.

For the development session in April 2023, the Boards discussed:

- the role and purpose of a Board Assurance Framework
- good practice for Board Assurance Frameworks
- how a BAF differs from a Corporate Risk Register
- how we could develop and use a new Group BAF
- Initial thinking around the principal risks to the delivery of the new Group Strategy

At the development session in October 2023, the Group Board discussed:

- The framing of draft strategic risks
- The number of strategic risks for inclusion on the Group BAF
- High level overview of risk appetite for each draft strategic risk

Based on the discussions and feedback at these Board development sessions, this paper sets out the proposed strategic risks on the new Group Board Assurance Framework, and the proposed risk appetite position for each, for review and approval by the Group Board. Also included is a qualitative risk appetite approach to help guide consideration of the BAF and wider decision-making in relation to risk.

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Group Board Assurance Framework: New strategic risks

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Risks to the delivery of the Group Strategy

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- The two Boards agreed the new Group Strategy in April 2023 and the strategy was published in May. The new Group BAF will be a single Group-wide document, reflecting the Group-wide strategy, and the risk template will identify controls, assurances gaps, actions and risks on the Corporate Risk Register that are Trust-specific.
- A good BAF starts with the strategy – it comprises strategic risks, which relate directly to achievement of the organisation's strategy and are identified 'top down' by the Board. The starting point for identifying the strategic risks should be the agreed strategic objectives.
- We have used our four overarching strategic themes to structure our Group BAF and define our strategic risks, and work out what will stop us from achieving those strategic objectives. Strategic risks on the BAF are, typically, risks that are relevant to the five-year life cycle of the strategy.
- The risks need to be comprehensive, covering all material risks to the delivery of the strategy – but they need to be manageable in number.
- The table that follows over the next two pages sets out 14 strategic risks proposed for inclusion on the new Group Board Assurance Framework. These are drafted on the basis of the feedback from discussions at the Board development session on 6 October.
- The wording of the risks is based on good practice in articulation of risk - "if…then…resulting in…" or Cause-Risk-Effect".

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Draft Strategic Risks

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Strategic Objective	Strategic Risk	Summary risk description	Full risk description
Collaboration and Partnership	SR1	**Working across our local systems**	*If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*
	SR2	**Working with other hospitals through our Acute Provider Collaborative**	*If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.*
	SR3	**Working together across our Group**	*If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.*
Affordable Services Fit for the Future	SR4	**Achieving financial sustainability**	*If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, then we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients.*
	SR5	**Modernising our estate**	*If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services*
	SR6	**Adopting digital technology**	*If we cannot build a robust digital infrastructure and adopt transformational digital solutions, then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement.*
	SR7	**Developing new treatments through innovation and research**	*If we do not create the right culture, infrastructure and partnerships, then we will not become a thriving centre for research and innovation and not attract sufficient research funding, resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff*

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Draft Strategic Risks

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Strategic Objective	Strategic Risk	Summary risk description	Full risk description
Right Care, Right Place, Right Time	SR8	**Reducing waiting times**	*If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, then we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*
	SR9	**Improving patient safety and reducing avoidable harm**	*If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable and harm and mortality and poorer clinical outcomes.*
	SR10	**Improving patient experience**	*If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, then we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services.*
	SR11	**Tackling health inequalities**	*If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, then we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.*
Empowered, Engaged Staff	SR12	**Putting staff experience and wellbeing at the heart of what we do**	*If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, then our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*
	SR13	**Fostering an inclusive culture that celebrates diversity**	*If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, then our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*
	SR14	**Developing tomorrow's workforce**	*If we do not retain, train and transform our workforce for the future, then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.*

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Group Board Assurance Framework: Risk appetite

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Risk appetite

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Background

The *Code of Governance for NHS Providers* states that "the Board is responsible for determining the nature and extent of the significant risks it is willing to take in achieving its strategic objectives". This means that at least once a year, the Group Board should consider the types of risk it may wish to exploit and / or can tolerate in the pursuit of its strategic objectives.

In broad terms, risk appetite may be defined as the amount of risk that the Group Board is willing to seek or accept in the pursuit of its long-term strategic objectives. It is key to achieving effective risk management and should be considered before risks are addressed.

The Group carries out analysis, makes judgements, takes decisions, and delivers care across our sites every day. We do not operate in a vacuum; equally risks are not static, nor are they mutually exclusive. We must therefore view risks holistically, assessing interdependencies across the system to provide a more rounded assessment of risk.

The Group recognises that it is not possible to eliminate all risks which are inherent in achieving our objectives and fulfilling our statutory duties and that we may need to consider and / or accept a certain degree of risk where it is in our and, ultimately, patients; best interests.

Risk appetite within the GESH Group therefore aims to prevent failure caused as a consequence of reckless risk-taking and ensure that management and the Group Board are taking the right risks for success (e.g. to deliver the safe and effective care, and to deliver value for money). It should facilitate a forward-looking view of risk and be adaptable to local circumstances to help drive management action and facilitate informed decisions, and is:

a) Set by the Group Board
b) Aligned with the Group Strategy, *Outstanding Care, Together 2023-28,* and corporate objectives and embedded into key business processes
c) Linked to the underlying risks we face and integrated with our control culture, balancing our propensity to take risk with the propensity to exercise control
d) Not a single, fixed concept. There will be a range of appetites for different risks and these appetites may vary over time; in particular the Group Board will have freedom to vary the amount of risk which it is prepared to take as circumstances changes, for example, during period of increased uncertainty or adverse changes in the operating environment
e) Reviewed once a year, or sooner if circumstances dictate.

The purpose of stating risk appetite within the Group is therefore to:

a) Provide awareness and an overall view of our risk profile, giving context to our risk position and exposure.
b) Help steer decision-making across the Group by providing a position against which potential decisions can be tested and challenged.
c) Provide guidance and an objective view on our ability to achieve longer term objectives that the Group is striving for – in particular through our Group Strategy.

Application

When risk appetite is defined rigidly it can impede innovation and make an organisation overly cautious. It can also fail to reflect the complexity and diversity of decision-making within an organisation, or group of organisations, such as the GESH Group, and across the wider health and social care system.

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Risk appetite

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Application (continued)

Due to the nature of our Group, and the statutory duties upon each of the two Trusts within it, the Group recognises that a one-dimensional (and heavily quantitative and directive) approach to risk appetite would not drive the right results. Therefore, in keeping with the culture of empowering and trusting our staff that we seek to promote, to drive consistency and enable staff to take well calculated risks and make accurate risk trade-off decisions to improve delivery when opportunities arise (and identify when a more cautious approach should be taken to mitigate a threat), it is proposed that the Group Board adopts a qualitative approach to risk appetite.

The aim is to make risk appetite considerations an intrinsic part of our risk management and business processes, not seen as something separate or extra, achieved as follows:

- Business processes: To ensure that the Group's day-to-day operations are well managed and that decisions are well controlled within local circumstances, we aim to ensure risk appetite considerations are an intrinsic part of how we do business; with the aim of improving organisational performance. Therefore, in some instances, for example from an operational perspective, risk appetite reflects the constraints that are already placed on staff in the organisation. For example, risk-reward trade-offs and / or appetite / tolerance limits are:

    i. Embedded within operating limits, delivery targets and KPIs, standing financial instructions, and / or delegation of authority arrangements.
    ii. An integral part of strategic and financial planning. For example, the annual budget process is linked to our business planning cycle which allows an overview of financial and other types of risk.
    i. Built into impact assessment processes and considered within programmes and projects (at the very outset of project conception, with the formal decision-making process and throughout deliver) actively guiding management to assess the level of risk beyond which programmes and projects would not be considered viable.

Risk processes:

a) A level-level qualitative risk appetite statement is proposed, structured around the Group's strategic aims.
b) As a guide for setting risk appetite or to find out if individual risks fall within an acceptable tolerance range, the risk appetite statement corresponds with risk heat map criterion.
c) Target level risk levels (i.e. the risk level that the affected risk owner, responsible governance forum believes is best for meeting the objectives / the level of risk we would like to deliver over time needed to achieve target level) are also assigned to each risk to ensure they are managed within set appetite.
d) The Group Executive will monitor strategic and corporate risks top down to ensure appetite is within tolerance range, that actions taken to reach target levels of risk are achievable and met, and /or that changes in one risk category do not unwittingly compound others. Strategic risks on the Group BAF will be overseen by Board Committees and the Group Board.
e) The approach to risk appetite also provides a way of steering risk appetite / tolerance discussions bottom up and should ensure consistency of approach for the Group as a whole, including day-to-day delivery of programmes and projects.

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What is our risk appetite?

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Risk appetite strategy

In order to help guide the establishment of risk appetite, and the trade-offs that are necessary when applying it, a risk appetite strategy has been developed to provide a high-level qualitative guide to inform the management of risk. This strategy is set out opposite.

Based on the discussions at the Board development session on 6 October 2023, we have also used the risk appetite framework used by the *Good Governance Institute* to help define our risk appetite for each of the 14 strategic risks on our new Group Board Assurance Framework:

	0 Avoid	1 Minimal	2 Cautious	3. Open	4. Seek	5. Mature
Description	Avoidance or risk and uncertainty is a key organisational objective	As Little as Reasonably Possible (ALARP). Preference for ultra-safe delivery options that have a low degree of inherent risk and only for limited reward potential	Preference for safe delivery options that have a low degree of inherent risk and may only have limited potential for reward	Willing to consider all potential delivery options and choose while also providing acceptable level of reward (and value for money)	Eager to be innovative and to choose options potentially offering higher business rewards (despite greater inherent risk)	Confident in setting high levels of risk appetite because controls, forward scanning and responsiveness systems are robust
Appetite	None	Low	Moderate	High	Significant	

Risk heat map

As a guide for setting risk appetite, and to determine if individual risks fall within an acceptable tolerance range, we have also used the following risk heat map criterion.

Likelihood	Consequence / Impact				
	1 – Very Low	2 – Low	3 – Moderate	4 – High	5 – Very High
5 – Very Likely	5	10	15	20	25
4 – Likely	4	8	12	16	20
3 – Possible	3	6	9	12	15
2 – Unlikely	2	4	6	8	10
1 – Rare	1	2	3	4	5

GESH Group Risk Appetite Strategy

The risk appetite of the St George's, Epsom and St Helier University Hospitals and Health Group is grounded in the NHS Constitution. The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

The GESH Group believes that no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients, taxpayers and our staff. Our approach to risk appetite inevitably involves risk trade-off conversations and a consideration of the counterfactual – giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, the GESH Group will tolerate some risks more than others. For example, the Group will seek to minimise avoidable risks to patient safety in the delivery of quality care and has a very low appetite for risks in this area. In the case of research and innovation, we are prepared to take managed "moderate to high risks" on the proviso the following has been undertaken:

- An assessment of what and where the current risks are
- That the potential future impact has been understood and agreed
- Rapid cycle monitoring is in place to enable swift corrective action should things go wrong
- Consideration of the position across the SWL and wider systems in which we operate
- Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e. whether it will lead to an increase or reduction in other categories of risk)
- Cost-benefit analysis and stated preference is undertaken
- Reliability and validity of data used to make the assessment has been considered
- Counterfactual risks have been considered to ensure management apply any learning before taking the risk
- We can demonstrate significant and measurable potential benefits)i.e. enhanced patient care, improved efficiency, and / or value-for-money delivery)

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What is our risk appetite?

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Strategic Objective	Strategic Risk	Summary risk description	Risk appetite
Collaboration and Partnership	SR1	Working across our local system	Cautious (Moderate)
	SR2	Working with other hospitals through our APC	Open (High)
	SR3	Working across the Group	Open (High)
Affordable Services Fit for the Future	SR4	Achieving financial sustainability	Cautious (Moderate)
	SR5	Modernising our estate	Open (High)
	SR6	Adopting digital technology	Open (High)
	SR7	Developing new treatments through research and innovation	Seek (Significant)
Right Care, Right Place, Right Time	SR8	Reducing waiting times	Cautious (Moderate)
	SR9	Improving safety and reducing avoidable harm	Minimal (Low)
	SR10	Improving patient experience	Open (High)
	SR11	Tackling health inequalities	Cautious (Moderate)
Empowered, Engaged Staff	SR12	Putting staff experience and wellbeing at the heart of what we do	Cautious (Moderate)
	SR13	Fostering and inclusive culture that celebrates diversity	Cautious (Moderate)
	SR14	Developing tomorrow's workforce	Open (High)

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Group Board Assurance Framework: Ownership & Oversight

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Ownership and management of strategic risks: Roles and responsibilities

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- It is important that there is clarity on roles and responsibilities in relation to the BAF, and that each tier of our corporate governance understands the role they play in relation it.

- **Ownership:** Ultimately, it is the Board which owns the BAF – the Board develops the Trust strategy, agrees the Strategic Risks to the delivery of the strategy, and is responsible for reviewing assurances and ensuring there is a robust process for managing the BAF and risk more generally. With our new Group Board arrangements, it would in practice be the Group Board committees-in-common which would review the BAF, with responsibility delegated from the Board. Board Committees play a role in supporting the Board to manage the BAF and test assurances in their respective areas, with the Audit Committee playing a key role in relation to the effectiveness of assurance systems and internal controls in the management of the BAF. The Executive's role is to manage the strategic risks on behalf of the Board, oversee actions to address gaps in controls and assurance, and propose changes and risk scores. The table on the next slide sets out respective responsibilities.

- **The BAF and the Corporate Risk Register:** We will highlight to the Board the "supporting risks" on the CRR that sit below each BAF risk as it is important that the BAF takes account of the CRR when taking assurance or defining strategic risk scores. But we will report on Strategic Risks in a way that sets out for each the controls, assurances, key indicators, and emerging risks so that the Board can understand the assurances that exist for each Strategic Risk.

- **Scoring the BAF:** The Board is ultimately responsible for scoring the Strategic Risks on the BAF, based on advice from the Executive and the assurances provided by the Board Committees. The Strategic Risks set out in this paper are deliberately not scored at this stage. Once the Strategic Risks are approved by the Group Board, the relevant Board Committees will be asked to review the controls, gaps in control, material actions to be taken to reduce the risk, and the assess the current risk score. This will be undertaken through the next round of Committee meetings, with the fully scored and worked-up Group BAF coming to the Group Board for review at the Q3 2023/24 position in January 2024.

- The pages that follow set out the role of each governance group in relation to the Group Board Assurance Framework, and the ownership at Executive level of each of the Strategic Risks.

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Ownership and management of strategic risks: Roles and responsibilities

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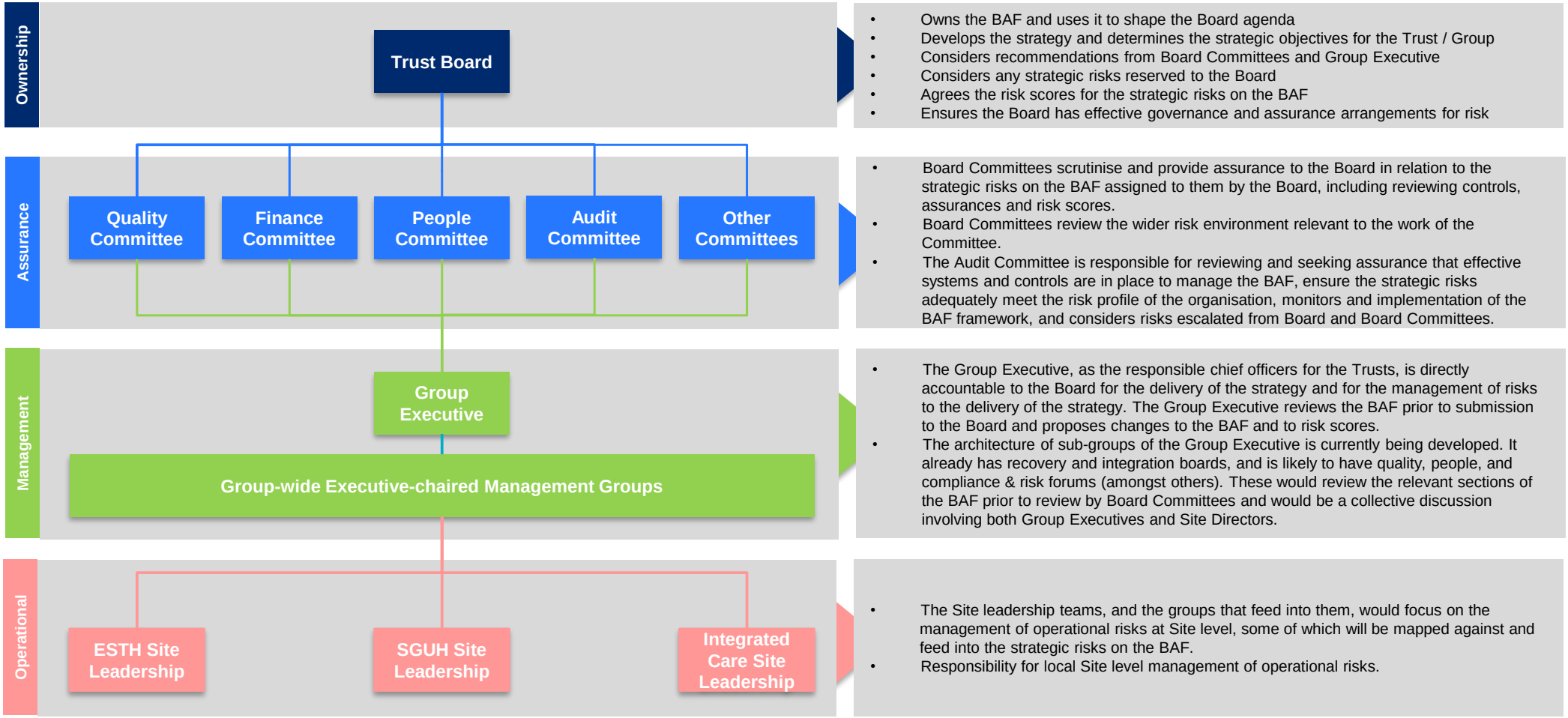

- Owns the BAF and uses it to shape the Board agenda
- Develops the strategy and determines the strategic objectives for the Trust / Group
- Considers recommendations from Board Committees and Group Executive
- Considers any strategic risks reserved to the Board
- Agrees the risk scores for the strategic risks on the BAF
- Ensures the Board has effective governance and assurance arrangements for risk

- Board Committees scrutinise and provide assurance to the Board in relation to the strategic risks on the BAF assigned to them by the Board, including reviewing controls, assurances and risk scores.
- Board Committees review the wider risk environment relevant to the work of the Committee.
- The Audit Committee is responsible for reviewing and seeking assurance that effective systems and controls are in place to manage the BAF, ensure the strategic risks adequately meet the risk profile of the organisation, monitors and implementation of the BAF framework, and considers risks escalated from Board and Board Committees.

- The Group Executive, as the responsible chief officers for the Trusts, is directly accountable to the Board for the delivery of the strategy and for the management of risks to the delivery of the strategy. The Group Executive reviews the BAF prior to submission to the Board and proposes changes to the BAF and to risk scores.
- The architecture of sub-groups of the Group Executive is currently being developed. It already has recovery and integration boards, and is likely to have quality, people, and compliance & risk forums (amongst others). These would review the relevant sections of the BAF prior to review by Board Committees and would be a collective discussion involving both Group Executives and Site Directors.

- The Site leadership teams, and the groups that feed into them, would focus on the management of operational risks at Site level, some of which will be mapped against and feed into the strategic risks on the BAF.
- Responsibility for local Site level management of operational risks.

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Board, Committee & Executive oversight

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Strategic Objective	Strategic Risk	Summary risk description	Board level oversight	Executive review	Executive Lead
Collaboration and Partnership	SR1	Working across our local system	Group Board	Group Executive	Group Chief Executive Officer
	SR2	Working with other hospitals through our APC	Group Board	Group Executive	Group Chief Executive Officer
	SR3	Working across the Group	Group Board	Integration Oversight Group	Group Deputy Chief Executive Officer
Affordable Services Fit for the Future	SR4	Achieving financial sustainability	Finance Committee	GESH Recovery Group	Group Chief Finance Officer
	SR5	Modernising our estate	Infrastructure Committee	GESH Estates Group*	Group Chief Infrastructure, Facilities and Environment Officer
	SR6	Adopting digital technology	Infrastructure Committee	GESH Informatics Group*	Group Chief Finance Officer
	SR7	Developing new treatments through research and innovation	Quality Committee	GESH Quality Group	Group Chief Medical Officer
Right Care, Right Place, Right Time	SR8	Reducing waiting times	Finance Committee	GESH Quality Group	Site Managing Directors
	SR9	Improving safety and reducing avoidable harm	Quality Committee	GESH Quality Group	Group Chief Medical Officer & Group Chief Nursing Officer
	SR10	Improving patient experience	Quality Committee	GESH Quality Group	Group Chief Nursing Officer
	SR11	Tackling health inequalities	Quality Committee	GESH Quality Group	Group Chief Medical Officer
Empowered, Engaged Staff	SR12	Putting staff experience and wellbeing at the heart of what we do	People Committee	GESH People Group	Group Chief People Officer
	SR13	Fostering and inclusive culture that celebrates diversity	People Committee	GESH Culture, Equity and Inclusion Board	Group Chief Executive Officer
	SR14	Developing tomorrow's workforce	People Committee	GESH People Group	Group Chief People Officer

** Forum (or similar) to be established*

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Group Board

Meeting on Thursday, 11 November 2023

Agenda Item	5.1	
Report Title	**GESH Learning from Deaths Quarterly Report: Q1 2023/24**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Martine Meyer AMD for Quality, ESTH Rumiko Yonezawa Associate Director for Business Intelligence, ESTH Laura Rowe Lead Midwife for Clinical Governance and Risk ESTH Rebecca Suckling, Site CMO, ESTH Ashar Wadoodi, Learning from Deaths Lead, SGUH Kate Hutt, Head of Mortality Services, SGUH Rebecca Paulraj, Senior Business Manager, Medical Directorate, SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

Trusts are required to collect and publish specified information on deaths on a quarterly basis. This paper summarises the Trust's policy and approach to learning from deaths, and the key data and learning points.

ESTH - The total number of in-patient deaths in Q1 2023/24 was 336. Structured Judgement Reviews (SJR) were completed for 137 (40.77%) deaths. Five deaths had an overall poor score. One death had a very poor score. These were reported as clinical incidents via the clinical reporting system (DATIX) for further investigation. An annual thematic review of structure judgement reviews where there have been major and moderate concerns for 2022-23 is being undertaken by the mortality review team to identify themes for improvement in quality of care.

National published risk adjusted mortality statistics show that the latest overall mortality for SHMI covering discharges from April 2022 to March 2023, published in August 2023, was categorised as 'higher than expected' at 1.205. The 12-month rolling HSMR mortality ratio showed a similar trend to SHMI. However, observed deaths have reduced compared to expected deaths and the latest available monthly value for the month of May 2023 is 98.9, reaching under 100 for the first time since early 2021.

SGUH - The total number of deaths in Q1 2023/24 was 368 from which 33 (9.0%) patients underwent the SJR process. Owing to a slight drop in the number of cases reviewed we have included a temporary category for the next quarter which will include all deaths occurring in the emergency department.

The latest SHMI data which covers the period April 2022 to March 2023 shows mortality was as expected at 0.95. The HSMR data from Dr Foster covers the period from April 2022 to March 2023 and is lower than expected at 90.0.
The key areas of focus for further work are acute myocardial infarction (MI), major trauma and fractured neck of femur (NOF) and work is ongoing with care groups, supported by business intelligence, to understand the data and areas for focus and action within these groups. The latest TARN data shows that St George's is now at the national average for trauma mortality (previously bottom quartile), but SHMI signals remain for acute MI and fracture NOF.

Action required by Quality Committees-in-Common

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

Committee Assurance

Committee	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

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

[Set out briefly any financial implications relevant to the issues described in the paper]

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

[Set out any equality, diversity and inclusion issues relevant to the issues described in this paper]
Environmental sustainability implications
[Set out any environmental sustainability issues relevant to the issues described in this paper]

GESH Joint Learning From Deaths Quarterly Report

(Q1 2023/24 - April to June 2023)

1.0 PURPOSE

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

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

2.0 NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

ESTH

2.1 There have been 336 in-patient deaths in the period April – June 2023

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]

The SHMI is published by NHS Digital for a 12 month rolling period and 5 months in arrears. It takes into account all diagnostic groups, in hospital deaths and deaths occurring within 30 days of discharge. The SHMI data for the rolling years from April 2022 to March 2023 was higher than expected at 1.205.

The expected number of deaths for the calculation of SHMI is based on the historical data of our Trust and similar Trusts across England. Epsom & St. Helier University Hospitals NHS Trust was in a pilot of 10 trusts for removal of the Same Day Emergency Care (SDEC) data from the Admitted Patient Care dataset and moved to the Emergency Care Data Set. SHMI calculations utilise the Admitted Patient Care data set and removing the SDEC cohort is recognised to have some effect on reducing the number of number of expected deaths, so making the SHMI higher for that reason. All Trusts across England were due to remove the SDEC data from April 2023 but this has been delayed until April 2024.

It should be noted that COVID-19 activity has been excluded from the SHMI calculations. Since the SHMI statistical models are not designed to handle such pandemic activity, this exclusion avoids any errors that might occur.

An external review of Trust coding has indicated that clinicians are not consistently documenting patient co-morbidities from previous in-patient admissions, which affects SMHI/HSMR. This issue is resolved in Trusts which have EPR. There are also missed opportunities soon after admission for increasing the accuracy of diagnostic coding although the rate of symptom/sign coding is low which is encouraging.

NHS England provides SHMI values for ten diagnosis groups, as detailed below.

Published figures for April 2022 – March 2023*

Diagnosis group description	Spells	SHMI value	SHMI banding
Acute bronchitis	560	1.8748	Higher than expected
Urinary tract infections	865	1.4117	Higher than expected
Cancer of bronchus; lung	40	1.4897	As expected
Gastrointestinal hemorrhage	285	1.4066	As expected
Fluid and electrolyte disorders	265	1.4766	As expected
Pneumonia (excluding TB/STD)	1,380	1.2332	Higher than expected
Septicaemia (except in labour), Shock	280	1.1123	As expected
Secondary malignancies	105	1.2375	As expected
Acute myocardial infarction	240	0.6892	As expected
Fracture of neck of femur (hip)	420	0.6280	Lower than expected

*Data published in NHSE SHMI report. Accessible here.

https://app.powerbi.com/view?r=eyJrIjoiZTAzNGIwNGEtMDNmMS00ZjU1LWExMDYtNzk4Y2I3NTViYmI4IiwidCI6IjUwZjYwNzFmLWJiZmUtNDAxYS04ODAzLTY3Mzc0OGU2MjllMiIsImMiOjh9

Review of mortality analysis at diagnosis and procedure group level is considered by the Mortality Review Group which reports to the Reducing Avoidable Deaths and Harm Group.

2.3 **Hospital Standardised Mortality Ratio (HSMR)** [source HED]

The most recent 12 months of data reported by HED cover June 2022 to May 2023. The Hospital Standardised Mortality Ratio was showing a similar trend to SHMI, however the gap between observed deaths and expected deaths has reduced recently (*Pls see Appendix A for data*) . The 12-month rolling value for the latest 12 months is 110.8 and the monthly value for the month of May 2023 is 98.9, reaching under 100 for the first time since early 2021. Please note that the COVID-19 activity has also been excluded from the HSMR calculations.

Data for June 2022 – May 2023

	HSMR (basket of 56 diagnoses)	Banding
All admission methods	110.84	Higher than Expected
Elective admissions	104.86	Higher than Expected
Non elective admissions	110.92	Higher than Expected

SGUH

2.4 There have been 368 deaths in the period April 2023 to June 2023.

2.5 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
The latest SHMI data covers discharges from April 2022 to March 2023, and at 0.95 our mortality is as expected. This period covers 60, 435 spells, with 1,595 deaths observed against an expected 1,675.

Diagnosis group	SHMI value	Banding
Septicaemia (except in labour), Shock	0.93	As expected
Cancer of bronchus; lung	0.62	Lower than expected
Secondary malignancies	0.87	As expected
Fluid and electrolyte disorders	0.87	As expected
Acute myocardial infarction	1.38	Higher than expected
Pneumonia (excluding TB/STD)	0.93	As expected
Acute bronchitis	*	
Gastrointestinal haemorrhage	0.61	Lower than expected
Urinary tract infections	1.25	As expected
Fracture of neck of femur (hip)	1.77	Higher than expected

* value not given due to small numbers

2.6 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
The most recent Dr Foster data covers discharges between April 2022 and March 2023. For this period our mortality is lower than expected at 90.0.

	Value	Banding
HSMR	90.0	Lower than expected
HSMR weekday emergency admission	87.4	Lower than expected
HSMR weekend emergency admission	94.0	As expected

3.0 LEARNING FROM DEATHS OBJECTIVES

ESTH

3.1 Areas of Development

Mortality is reviewed in the Reducing Avoidable Death and Harm (RADAH) committee chaired by CMO. Areas of quality improvement are identified with actions monitored monthly.

Areas of focus are on quality of coding, cardiac arrest cases, multidisciplinary engagement in structured judgement reviews and mortality and mobidity meetings as quality improvement areas.

Table 1a. Priority Work Streams and Signals (ESTH)

Workstream	Priority area	Key updates
Mortality Data	**Raised SHMI**	**Acute Bronchitis Code** To investigate the raised SHMI in acute bronchitis a sample of cases were have been reviewed with the appropriate code - unspecified acute LRTI J22X. Of the cases 13/19 were likely cause of death, 4/19 possible cause of death. 2/19 unlikely cause of death. **Action:**Coding will work with Acute Medicine to resolve this issue. It will be monitored through RADAH **Urinary Tract Infection Code** A sample of UTI coded deaths were subjected to a deep dive in Q2 and Q3 2022 and it was found that only one third of the sample did the coding reflect an accurate diagnosis. A further UTI coding review in Q1 found that this had not changed. **Action**: Coding will work with Acute medicine to resolve this issue with regular clinician coding meetings.
Learning from Structured Judgement Reviews	**Joint working with nursing increase opportunity for learning.**	**Infrastructure;** There are now 2 nurses undertake SJR supported by lead mortality reviewer. The consultant mortality reviewers refer to nurses where they find cause for nursing concern. **Governance:** Supervision from lead mortality reviewer and members of the mortality review group. **Development;** Non funded for time so relying on availability of nursing team. Plan to evaluate impact and learning for this role.
Resuscitation Team	**Cardiac Arrest Outlier (outlier of cardiac arrests)**	SJRs have highlighted the need for appropriate, timely discussions around appropriate escalation of care. A ReSPECT Advanced Nurse Practitioner has been appointed to support ReSPECT discussion and documentation at Epsom hospital but is only funded until September 2023 St George's Hospital documentation will be used for recording decisions from April 2024 Daily huddle project is identifying patients without escalation plans and sick patients for early review. Outreach team (staffed by advanced care practitioners) on both sites has been funded and is being recruited to providing 24h outreach support.

		Monthly emergency call review by Divisions.
Learning from incidents and Structured Judgement reviews	**Surgical Pathway**	Incidents raised by mortality reviewers and themes from complaints have identified transfer of surgical patients from Epsom Hospital to St Helier Hospital for surgical review has sometimes led to harm. **Governance;** The standard operating procedure has been developed to improve the pathway of transfer and meetings with Royal Marsden Hospital to discuss referral pathways for patients. **Governance:** Bimonthly meetings with ED staff and General surgery to review surgical cases seen in ED and support pathway development. This has led to ability to request early appropriate imaging prior to transfer. **Infrastructure:** Need for increased number of surgical doctors at St Helier to improve time to review and decision making when surgical doctors in theatre
Learning from Structured Judgement Reviews		**Current elements under review** **Infrastructure** During Cath lab refurbishment, only three out of five labs were functional. Post COVID there has also been a flux in staffing. **Coding** Coding improvements are continuing and appear particularly important for patients outlying from cardiology.
Learning from Death	Mortality and morbidity meetings	Site CMOs are working together to review current practice at ESTH and compare with practice at St Georges to analyse the benefits of a centralised team supporting the Morbidity and Mortality programmes.

SGUH

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

Table 1b. Priority Work Streams and Signals (SGUH)

Workstream	Priority area	Key updates

Mortality investigations to be concluded	**Cardiology diagnosis and procedure groups, principally Acute myocardial infarction**	**Current elements under review** NICOR data suggests that door to balloon time (DTB) is not being met for a proportion of our STEMI patients. This appears to be more significant in patients who are being transferred into St George's and pathway review is underway. Ongoing analysis also suggests that the NSTEMI group have a higher than expected mortality. Benchmarking with other heart attack centres and work with Dr Foster to explore the data is in process as it remains unclear whether this is a true mortality increase. In the meantime, immediate actions have included review of the cardiogenic shock pathway to ensure shock is identified early and optimal care provided. **Infrastructure** Post COVID there has been a flux in staffing in cath labs but improvement work has optimised this. **Coding** Coding improvements are continuing and appear particularly important for patients outlying from cardiology.
	Major trauma (TARN)	**Infrastructure**: The major Trauma ward has been opened and six trauma fellows have now been appointed with good initial impact on flow. **Clinical:** The lead for neurosurgical trauma has had positive impact on the team and is working towards implementing the code black. **Governance:** The latest TARN data demonstrates that St Georges mortality is now at the national average having risen from the bottom quartile. See appendix 1.
	Fractured Neck of Femur	The SHMI signal in Hip Fractures is currently being evaluated by the orthogeriatrics team in tandem with the orthopaedic team. It is important to note that we are not signalling in Dr Foster and remain within control limits in the National Hip Fracture database. The team are in the process of auditing practice against national standards. **Anaesthetic Concerns:** > 80% of hip fractures should have a femoral nerve block. St George's currently falls below this. There is separately a piece of work ongoing in theatres to improve safety of nerve blocks following recent Never Events. **Surgical consideration:** > 80% of hip fractures should have surgery within 36hrs. At St Georges it is currently 65%. >90% should have a sliding hip screw (currently 50%).

		Ward problems: Patients should be managed on specialist wards to improve post operative care and mobilisation. **Orthogeriatrics:** 100% review in 72hrs (current 92%). This audit remains a work in progress and will be updated in the next report.
	Perinatal Mortality	MMG continues to receive quarterly reports from the Obstetric Governance Team summarising compliance with CNST safety action 1 concerned with the use of the Perinatal Mortality Review Tool methodology. The most recent report details reviews completed for deaths between July and September 2022. In the period 17 cases were reported to PMRT and 9 cases reviewed. Full compliance against the safety requirements was observed. In one case reviewed the panel identified care issues that may have made a difference to the outcome for the baby. Actions have been implemented to address the issues identified, including a review of CTG guidelines and discussion of learning at a consultant meeting. It should be noted that concerns about CTG monitoring have been raised through other means as well and the team are triangulating this to ensure appropriate action. An HSIB review was triggered in another case and the investigation identified issues which would have made a difference to the outcome. Actions centred on improved use of MEWS, assessment of risk factors, and escalation processes. Separately, the GCNO has commissioned a review of our MBRRACE data and the learning through our internal mortality monitoring group has been shared to inform this.
Mortality and Morbidity meetings development	Mortality template and TOR	We have recently successfully recruited to the M&M Team Leader role. This will be key to completing the planned audit of current practice and developing an action plan based on the findings.

4.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

ESTH

Mortality Review Team

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 137 deaths, which represent 40.77% of all deaths. Of the 137 of those in scope to have an SJR done, 134 were completed and 3 are awaiting review.

Reviews are performed on all cases where

- 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

An assessment of overall care is also provided for each death reviewed.

Although a relatively higher number of deaths received an SJR in Q1 than in previous quarters (101 in Q4, 119 in Q3; 142 Q2 of 2022/23). The percentage of overall 'poor/very poor' assessments was lower at 4.48% (7.14% Q4, 13.39% Q3; 6.38% Q2). The percentage of overall `good/excellent' assessments was higher at 67.17% (47.47% Q4, 50.89% Q3; 61.70% Q2 of 2022/23).

Overall care judgement	Number	Percentage
Excellent care	9	6.57%
Good care	81	59.12%
Adequate care	38	27.74%
Poor care	5	3.65%
Very poor care	1	0.73%
Awaiting rating	3	2.19%
Total	**137**	**100%**

Any concerns identified through the SJR process are assessed as minor, moderate or major. Major 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 for cases where they recommend learning for improvement to be discussed at the relevant specialty-based mortality and morbidity meetings. They provide positive feedback to consultants where there is excellent care. All SJRs

assessed as overall 'poor' or 'very poor' care have a second SJR by another consultant Mortality Reviewer (MR). There is good concordance between MRs.

The Mortality Reviewers contribute to the weekly SI/RRR panel and also have roles as Lead Investigators for SIs as part of their remit. Trust wide learning from Serious Incidents has been done through Topic of the Week, Quality Half-Days, Safety Flashes.

A review of SJRs major and moderate concerns across the whole of 2022-23 is being undertaken by the MR team to see whether there are any clear themes over time for learning tor improvement.

3.3 Learning from excellence

Examples of excellence identified by the Mortality Review Team have been fed back to individual teams and Divisions:

- The Stroke team at the Hyperactive Unit based at Epsom General Hospital was highlighted as providing very good management planning and documentation.
- Liaison Psychiatry provide good, clear and timely entries. They are often typed, which is helpful for clarity, and the establishment of CERNER next year at ESTH will obviate this additional process
- There is consistently good specialty Palliative Care Team input into end-of-life care with multi-professional involvement.
- Nursing Proformas on wards have improved daily documentation of essential aspects of care. Medical proformas for multi disciplinary ward rounds and weekend plans are also effective.
- There has been an improvement in quality of management of the deteriorating patient at the St Helier Hospital site during the day where the Critical Care Outreach Team are supporting the management of patient care.

3.4 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 and M processes are held at divisional level. The Site CMOs are working together to analyse the benefits of a central team to support the M&M process across the Group as part of the corporate integration programme.

3.4 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 quarterly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the safety standard, each report also detailed potential areas for learning and improvement. Over the year there were no clear themes identified.

Stillbirth and neonatal deaths are reviewed through MBRRACE-UK and reported separately to the Board. All child deaths are reviewed locally by clinical teams and presented at the monthly paediatric Divisional Management Team meeting.

3.5 **SJR Learning**

There is 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. A recent case reported from the mortality review team at St George's is being investigated as an SI. Going forward we will develop a policy to ensure that all cases where there has been a death of a patient who has crossed both sites within 30 days will be notified to the respective site for local learning.

SGUH

4.6 **Local Morbidity and Mortality Meetings**

The lead of the mortality team M Ijomoni has recently moved on to a patient safety role. We are extremely grateful for her efforts in putting together the current team who have now become an ingrained part of the M&M culture at St George's. The audit template for the M&M process is now near completion and we are hoping to have data available for the next report.

4.7 **Mortality Review Team**

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 33 deaths, which represent 9.0% of all deaths. 20 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office and 13 from other sources, which indicates an increased proportion of referrals from the wider Trust. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel. The reasons for requesting a review are summarised below.

The Mortality Review Team are committed to increasing the proportion and range of deaths reviewed. As the deaths that fall into the categories below, is consistently below 10 per cent it has been agreed by MMG that each quarter an area of focus will be identified, and those deaths will be selected for review. In Q2 the team will be reviewing all deaths that occur in the Emergency Department as we aim to understand the nationally reported increased risk of harm for patients with long waits in ED. At the time of reporting, we have achieved a review rate of over 15 percent for Q2.

Table 2 Triggers for SJR

Triggers for review	
Confirmed learning disability +/- clinical diagnosis of autism	5
Significant mental health diagnosis	6
ME or clinical team detected possible learning or potential issue with care	8
Deaths following elective admission	10
Areas subject to enhanced oversight	2
Family raised significant concerns	2

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 33 deaths reviewed this quarter problems were identified in relation to 10 deaths (30.3% of the patients reviewed). In total there were 16 problems, as 4 patients experienced more than 1 problem. Most of these problems did not lead to harm.

Table 3 Problems in healthcare identified

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	1	0	0	1
Medication	3	1	1	5
Treatment	1	0	0	1
Infection control	0	0	0	0
Procedure	0	1	1	2
Monitoring	1	1	0	2
Resuscitation	0	1	0	1
Communication	2	0	0	2
Other	1	0	1	2
Total	9	4	3	**16**

Table 4 Overall care rating

Overall care judgement	Number	Percentage
Excellent care	4	12.1%
Good care	18	54.5%
Adequate care	11	33.3%
Poor care	0	0
Very poor care	0	0
Total	**33**	

Table 5 Judgement on avoidability of death is made for all reviews

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	23	69.7%
Slight evidence of avoidability	4	12.1%
Possibly avoidable but not very likely (less than 50:50)	6	18.2%
Probably avoidable (more than 50:50)	0	0
Strong evidence of avoidability	0	0
Definitely avoidable	0	0
Total		

4.8 **Learning from mortality**

Overall care was adequate, good, or excellent. No care was deemed poor, and no cases were described as likely avoidable deaths.

Learning from mortality – SIDM reviews

In all the cases reviewed, none were deemed notifiable to the Patient Safety Team and, therefore, there are no SIDM links provided in this quarter. We have, however, provided reviews for cases which have been reported to the Patient Safety Team outside of the learning from deaths process.

4.9 **SJR Learning**

Having developed our relationship with St Helier's learning from deaths team we have reviewed a case at St George's which would not normally fall under our remit. This was a patient who

passed away at St Helier's but had undergone a lot of investigations at St George's, ultimately coming to a diagnosis of a terminal malignancy. The family of the deceased raised concerns at St Helier's about a delay to diagnosis which was largely related to the patient being on the wrong pathway. In a similar vein we have referred cases to out counterparts at St Helier's about patients who ultimately succumbed at St George's but were managed at St Helier's.

5.0 MEDICAL EXAMINER SERVICE

ESTH

5.1 100% of Adult and Paediatric Trust deaths (in-patients and 35 Emergency Department deaths) (369) [See Table in section 5.5]** were scrutinised by the Medical Examiner (ME) service in Q1. Of note, the ME quarterly reporting to the National ME office counts deaths where ME scrutiny has been completed in the current Quarter, even if the actual death was in the previous quarter. Coronial deaths reported to the coroner may also appear in the following quarter ME report, if at the time of submission the coroner outcome is unknown.

5.2 A key function of the ME service is to support the appropriate referral of deaths to the coroner. 55 (*59 in Q4)* adult deaths were referred. None of the 55 of the adult cases submitted were subject to further coronial investigation. Three child deaths were notified to the coroner with all forwarded for investigation or PM. Strike action has resulted in little or not impact on the service so far.

5.3 The number of deaths referred for an SJR by the ME service was 77. 8/77 were for review of on-ward cardiac arrests and 14/77 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 Medical Examiner (ME) service highlights cases where best practice was observed. Positive feedback is shared with the Patient Experience team.

5.5 The ESTH ME service is expanding scrutiny of deaths to the community setting, anticipating that this will become a statutory mandate at a national level. The Community ME service is now fully established for the Sutton PCN with all 23 practices and the assigned hospice reporting to the service. The service will now also support a further 11 Surrey GP practices; 6 are already on-board, with a further 1 planned to be on board in August and the final 4 in September (ie. By end Q2). Training continues to be provided on a one-to-one basis for those GPs who have requested additional support. 141 Community deaths were scrutinised in Q1 *(144 in Q4).*

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 SCRUTINISED BY THE ME Q1 (2023-24)	
Number of in-hospital deaths scrutinised (in-patient **and** ED)	**369****
Adult deaths	
Cases not notified to the Coroner and MCCD issued directly	311
Cases notified to the Coroner and MCCD issued following agreement by Coroner	21
Cases referred to the Coroner and taken for investigation	34
Child deaths	
Cases not notified to the Coroner and MCCD issued directly	0
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0
Cases referred to the Coroner and taken for investigation (including ED)	3
Timeliness and rejections by registration service	
Number of MCCDs not completed within 3 calendar days (NB: no account is taken of BH or weekend and requirement is 5 days)	87
Number of MCCDs rejected by registrar after ME scrutiny	0
Number of cases where urgent release of body is requested and achieved within requested time	5
Number of cases where urgent release of body is requested and NOT achieved within requested time	0
Achieving communication with the bereaved	
Number of deaths in which communication did not take place	3
Reasons for no communication: Declined	1
No response	0
No NOK	2
Not documented	0
Detection of issues and actions	
ME referred for structured judgement review (including COVID related deaths and on-ward cardiac arrests)	77
ME referred to other clinical governance processes (including safeguarding, nursing issues)	9
ME referred to external organisation for review (including GP practices, LAS)	1
Families referred to PALS	1

Triggers for SJR by ME service

Triggers for review:	
Confirmed learning disability +/- clinical diagnosis of autism	12
Bereaved raised concerns	2
ME or clinical team detected possible learning or potential issue with care	29
Unexpected death eg. following elective admission	2
Maternal or neonatal death	0
Areas subject to enhanced oversight (learning will inform quality improvement work)	31
Death linked to a service specialty/specific diagnosis	1

SGUH

MERTON & WANDSWORTH MEDICAL EXAMINER SERVICE

5.6 Merton & Wandsworth (M&W) Medical Examiner (ME) service is hosted by St George's. The service is funded centrally by the NHS and is independent of the Trust. All ME offices report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each quarter all ME offices are required to make a return directly to the office of the National ME. This quarter the M&W ME service met all the required KPIs and milestones, scrutinising each of the 368 deaths that occurred at St George's.

5.7 Despite the government's decision to delay the move to a statutory footing until April 2024, the ME service continues to work proactively with community providers to scrutinise non-coronial deaths which occur outside of the acute setting. This quarter has seen an increase in both the number of providers referring to the ME service and the number of deaths referred. 155 referrals were received from 36 providers.

5.8 The ME team is keen to continue the momentum of expansion and in the coming quarter will carry out a second targeted round of recruitment of community providers. Whilst it is recognised that some practices may not engage with the service prior to it being mandated the ME team are keen to on-board as many community partners as possible ahead of the April deadline.

5.9 In July the Lead ME welcomed a visit from the National Medical Director, Dr Alan Fletcher, and the Regional ME team. Dr Fletcher met senior leaders from the Trust, community stakeholders and the wider ME team. He congratulated the team on the successful implementation of the service locally and the progress achieved with community expansion. He also reflected on the positive feedback from clinical teams and families and was impressed by the support of the Trust in delivering the service.

5.10 The ME service remains positively engaged with Trust Learning from Deaths processes and is currently the primary route through with deaths requiring structured judgement review are identified. This quarter the ME service flagged 20 deaths for SJR.

5.11 Providing support and training to clinicians is considered by the Lead ME to be fundamental to the objectives of the ME service. In May the Lead ME and Head of Mortality Services provided an educational session to about 50 GP registrars as part of the St George's GP training programme.

5.12 Each quarter all ME offices are required to make a return directly to the office of the National ME, as summarised below

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Adult deaths	
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Child deaths	
Cases not notified to the Coroner and MCCD issued directly	0
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0
Cases referred to the Coroner and taken for investigation (including ED)	3
Timeliness and rejections by registration service	
Number of MCCDs not completed within 3 calendar days (NB: no account is taken of BH or weekend and requirement is 5 days)	87
Number of MCCDs rejected by registrar after ME scrutiny	0
Number of cases where urgent release of body is requested and achieved within requested time	5
Number of cases where urgent release of body is requested and NOT achieved within requested time	0
Achieving communication with the bereaved	
Number of deaths in which communication did not take place	3
Reasons for no communication: Declined	1
No response	0
No NOK	2
Not documented	0
Detection of issues and actions	
ME referred for structured judgement review (including COVID related deaths and on-ward cardiac arrests)	77
ME referred to other clinical governance processes (including safeguarding, nursing issues)	9
ME referred to external organisation for review (including GP practices, LAS)	1
Families referred to PALS	1

Triggers for SJR by ME service

Triggers for review:	
Confirmed learning disability +/- clinical diagnosis of autism	12
Bereaved raised concerns	2
ME or clinical team detected possible learning or potential issue with care	29
Unexpected death eg. following elective admission	2
Maternal or neonatal death	0
Areas subject to enhanced oversight (learning will inform quality improvement work)	31
Death linked to a service specialty/specific diagnosis	1

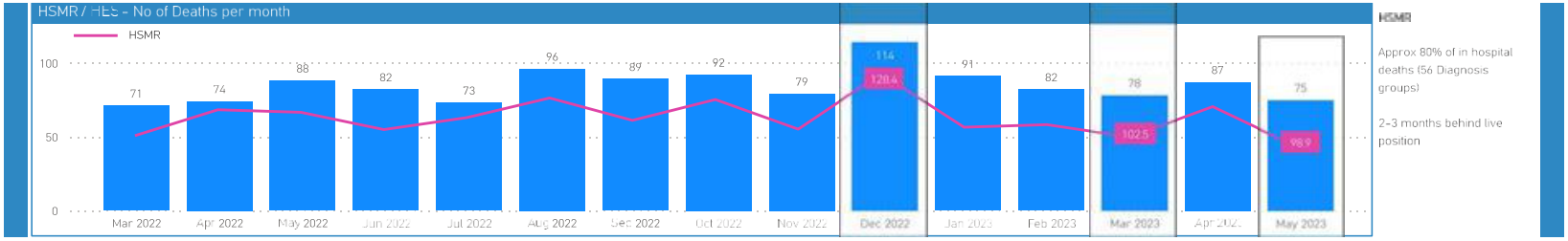
6.0 RECOMMENDATION

That the Committee note the continued compliance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these issues at both sites.

Tab 3.5 Group Learning from Deaths - Quarter 1 2023/24

APPENDIX A (ESTH DATA)

ESTH Mortality Overview (Crude Mortality Rate vs. HSMR)



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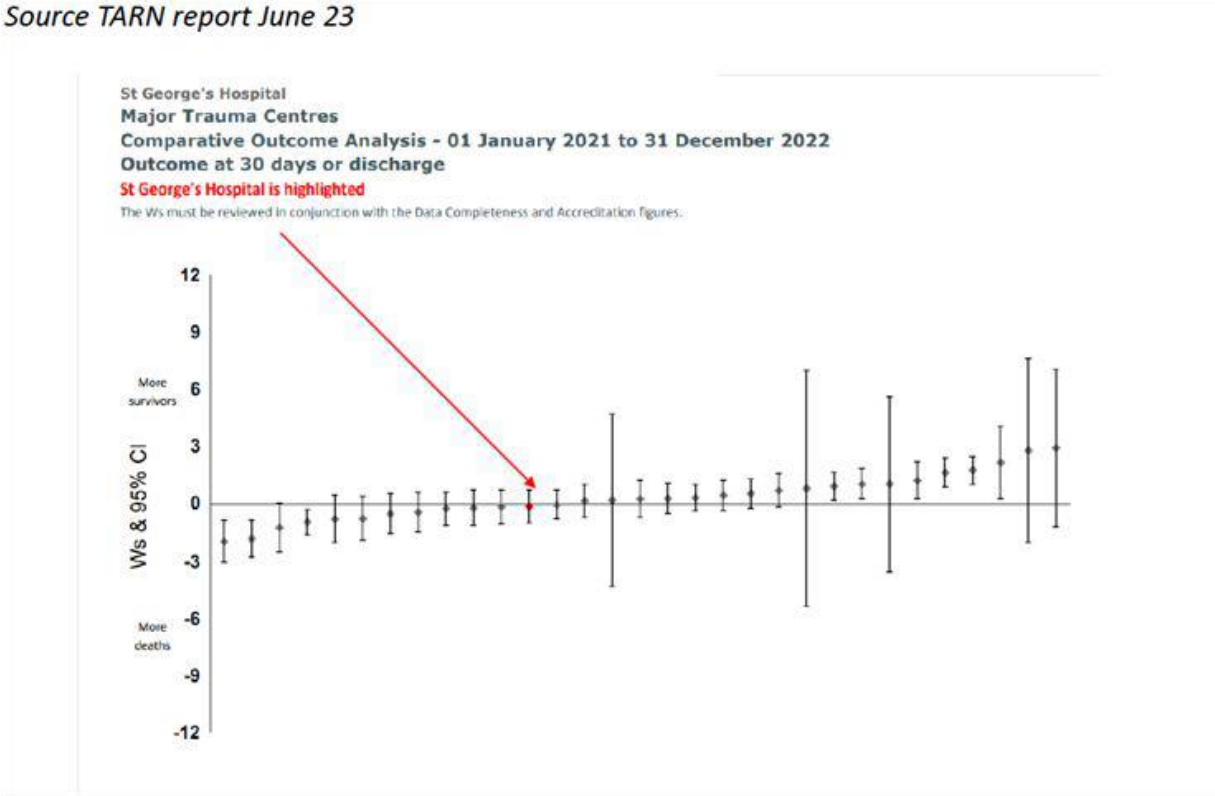
APPENDIX B (SGUH Data)

TARN comparative outcome analysis

Source TARN report June 23



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APPENDIX C (SGUH Data)

Learning from Deaths Dashboard

NHS

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2023-24

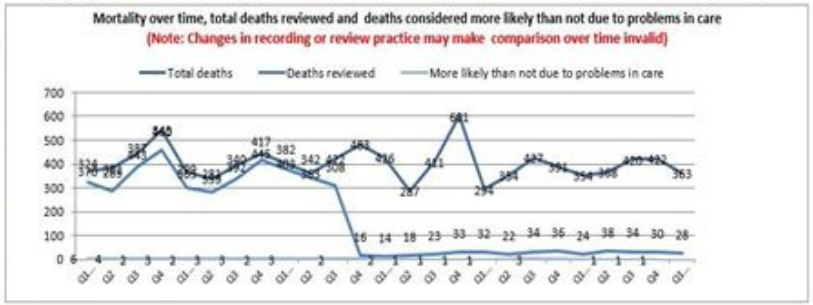
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

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
114	123	14	8	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
363	422	28	30	0	1
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
363	1564	28	126	0	3

Time Series: Start date 2017-18 Q1 End date 2023-24 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	3	21.4%	This Month	1	7.1%	This Month	10	71.4%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	6	21.4%	This Quarter (QTD)	3	10.7%	This Quarter (QTD	19	67.9%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	6	21.4%	This Year (YTD)	3	10.7%	This Year (YTD)	19	67.9%

Tab 3.5 Group Learning from Deaths - Quarter 1 2023/24

gesh

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

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - June 2023-24

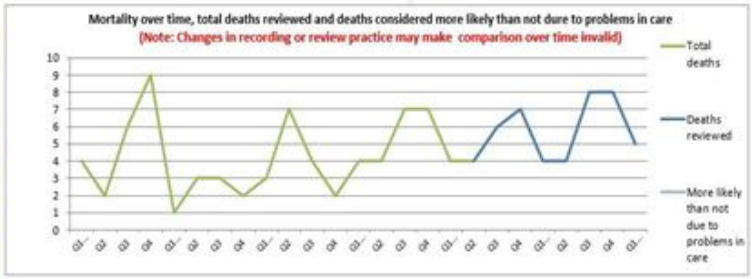
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping 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
3	2				
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	8				
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	24				

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
3	2	3	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	8	5	8	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
5	24	5	24	0	0

Time Series: Start date 2017-18 Q1 End date 2023-24 Q1



Agenda item 5.1

Tab 3.5 Group Learning from Deaths - Quarter 1 2023/24

Group Board

Meeting on Friday, 10 November 2023

Agenda Item	5.2	
Report Title	**Healthcare Associated Infection Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Director of Nursing/ Deputy Director of Infection Prevention and Control (ESTH)**	
Previously considered by	Quality Committees-in-Common	26 October 2023
Purpose	**For Assurance**	

Executive Summary

This paper provides a monthly update on Healthcare Associated Infections (HCAIs) and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Group (See Appendix 1).

The table below provides a high level summary of the monthly HCAI position at site level and the RAG rated position against the national thresholds for 2023/24.

Appendix 2 provides the SGUH Annual IPC Report for 2022-23.

HCAI	ESTH	RAG	SGUH	RAG
C. *difficile* infection	Apr: 3 HOHA, 2 COHA May: 4 HOHA, 0 COHA June: 2 HOHA, 0 COHA July: 5 HOHA, 0 COHA Aug: 2 HOHA Sept: 6 HOHA, 3 COHA **YTD: 27** **2023/24 national threshold: 38**		Apr: 2 HOHA May: 5 HOHA, 2 COHA June: 5 HOHA July: 5 HOHA Aug: 4 HOHA, 1 COHA Sept: 1 HOHA, 1 COHA **YTD: 26** **2023/24 national threshold: 42**	
MRSA bloodstream infection	Apr: 0 May: 1 June: 0 July: 1 Aug: 0 Sept:0 **YTD: 2** **2023/24 national threshold: 0**		Apr: 0 May: 0 June 0 July: 0 Aug: 0 Sept:0 **YTD: 0** **2023/24 national threshold: 0**	
Pseudomonas aeruginosa	April: 0 May: 0 June: 0 July: 1 HOHA, 1 COHA Aug: 2 HOHA Sept: 1 HOHA **YTD: 5** **2023/24 national threshold: 6**		Apr: 1 HOHA May: 4 HOHA, 3 COHA June: 1 HOHA July: 2 HOHA Aug: 3 HOHA Sept: 4 HOHA, 3 COHA **YTD: 21** **2023/24 national threshold: 25**	
E-coli	April: 2 HOHA, 1 COHA May: 3 HOHA, 3 COHA June: 5 HOHA, 4 COHA July: 4 HOHA, 3 COHA Aug: 2 HOHA, 3 COHA		April: 9 HOHA, 6 COHA amended Oct 23 May: 6 HOHA, 5 COHA amended Oct 23 June: 5 HOHA, 5 COHA July: 7 HOHA, 4 COHA Aug: 8 HOHA, 3 COHA	

		Sept:1 HOHA 3 COHA **YTD: 34** **2023/24 national threshold: 52**		Sept: 5 HOHA, 2 COHA **YTD: 65** **2023/24 national threshold: 88**	
	Klebsiella spp.	April: 0 HOHA, 1 COHA May: 2 HOHA, 0 COHA June: 4 HOHA, 1 COHA July: 2 HOHA, 1 COHA Aug: 2 HOHA, 3 COHA Sept: 2 COHA **YTD: 18** **2023/24 national threshold: 24**		April: 4 HOHA May: 6 HOHA June: 4 HOHA, 1 COHA July: 5 HOHA, 1 COHA Aug: 5 HOHA, 1 COHA amended Oct 23 Sept: 8 HOHA **YTD: 35** **2023/24 national threshold: 58**	
	MSSA	April: 3 HOHA May: 1 HOHA June: 2 HOHA July: 2 HOHA Aug: 2 HOHA Sept: 4 HOHA **YTD: 14** **2023/24 national threshold: N/A**		April: 1 HOHA May: 2 HOHA June: 5 HOHA July: 6 HOHA Aug: 0 Sept: 5 HOHA **YTD: 19** **2023/24 national threshold: N/A**	
	Covid-19 Update				
	September	Covid-19 cases: 79 Covid-19 deaths: 11 Nosocomial infections: 20 Nosocomial deaths: 0 **YTD positive cases: 409** **YTD nosocomial deaths: 1**		Covid-19 cases: 102 Covid-19 deaths: 8 Nosocomial infections: 37 Nosocomial deaths: 2 **YTD positive cases: 499** **YTD nosocomial deaths: 47**	

Action required by Quality Committees-in-Common

The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from the Sites and Group for assurance
- Receive the SGUH Annual IPC Report 2022-23
- Make any necessary recommendations for action

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Infection Prevention and Control Report – September 2023
Appendix 2	SGUH 2022/23 IPC Annual 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 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, 10 November 2023

1.0 Purpose of paper

This paper provides a monthly **update on HCAIs and key issues/ concerns arising in Infection Prevention and Control (IPC) across the Group** as summarised in Table 1 on the cover sheet and as detailed in Appendix 1.

This paper also provides a high level overview of the **St George's Annual IPC Report for 2022-23**, see Appendix 2.

2.0 Executive Summary: SGUH IPC Annual Report 2022-23

The St George's University Hospitals NHS Foundation Trust. IPC Annual Report 2022-23 provides Quality Committee in Common and the Board with information on Trust's performance. It provides assurance that suitable processes are being employed to prevent and control infections at SGUH.

During 2022-23 the Trust has moved back to business-as-usual stance with reference to COVID-19, removing previously established patient pathways and scaling back on testing.

In 2022-23 a total of 2,461 patients diagnosed with SARS-CoV-2 required a hospital admission, 2,251 were subsequently discharged (91.47%) and sadly there were 206 patients who died (8.37%). Of the 206 deaths, 45 deaths have COVID-19 listed on either Part 1A/B of their death certificate (1.83%).

A number of nosocomial Covid-19 outbreaks occurred often typified by asymptomatic illness, see section 13.8 of Appendix 2.

The Trust followed national IPC guidance published by the United Kingdom Health Security Agency (UKHSA) which formed the basis of all infection prevention strategies implemented during the year. These strategies were adopted across the St Georges', Epsom & St Helier University Hospitals Health Group.

The following should be noted:

- There was 1 case of Trust apportioned Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection); a reduction compared to 2 hospital acquired infections in 2021-22
- There were 25 Trust apportioned cases of Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2022-23; a reduction compared to 45 in 2021-22
- There were 60 cases of Trust apportioned *Clostridioides difficile* infection (CDI) against an NHS Improvement threshold of no more than 43 cases; an increase compared to 43 cases reported in 2021-22
- There were 105 cases of Trust apportioned *Escherichia coli* bacteraemia infection during 2022-23; an increase compared to 65 cases reported in 2021-22
- There were 76 cases of Trust apportioned *Klebsiella* bacteraemia infection during 2022-23; the same number of cases reported in 2021-22

- There were 23 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia infection during 2022-23; a reduction compared to 27 cases reported in 2021-22

The Trust experienced a spike in the numbers of influenza cases during the winter season 2022-2023 which is thought to be a consequence of COVID-19 no longer supressing the influenza virus. Due to this, a small number of wards were closed due to influenza outbreaks. Uptake of staff influenza vaccination, previously 72.3% during 2021-22, reduced to 49.4% for the 2022-23 financial year.

There was one Norovirus outbreak in January 2023 that affected 13 patients.

There were two outbreaks of CPE across two wards involving 5 patients in total.

3.0 Actions/ Recommendations to reduce *Clostridioides difficile* infection and *Escherichia coli* bacteraemia infection

3.1 Clostridioides difficile infection

The IPC Team will continue to work to reduce the number of CDI cases. This relies upon good antimicrobial stewardship (AMS), the earliest detection of possible CDI and prompt isolation of patients with diarrhoea due to a suspected infectious cause. Improvements in hand hygiene and environmental cleanliness will help to prevent C.diff transmission from patient to patient.

- The RCA process will be reviewed and brought into line with the new national Patient Safety Incident Review Process (PSIRF) to identify themes or lapses in care as part of a system-based approach. This is to be fed back via the Trust governance structures.
- Where a 'Lapse in Care' has been identified, the case will be discussed in the responsible care group's Morbidity and Mortality (M&M) meeting that form part of the Trusts clinical safety governance structures and process.
- Review arrangements for the AMS committee especially around senior representation– Medical Director or AMD to provide senior leadership support and direction.
- 'Getting Back to Basics' Campaign: A meeting to discuss this workgroup and streams took place 7 June 2023. These workgroups will be overseen by a steering group and the following four streams have been identified:

    1. Urinary Catheter care
    2. *C. difficile* and AMS
    3. Central and peripheral vascular access line care
    4. Back to Basics – hand hygiene, Bare Below Elbows, Cleaning – environmental and equipment

3.2 Escherichia coli bacteraemia infection

The Trust has continued to see an increase in *E. coli* bacteraemia cases; therefore, the IPC team investigate and collect data by source.

By the end of the 2022-23 financial year, there were 105 cases apportioned to the Trust (74 HOHA; 31 COHA) which is above the set NHSE trajectory of 93 cases. The Trust was therefore over trajectory.

Analysis of the 105 cases identified predominantly a urinary source. The issue of urinary catheter associated infection will be addressed as part of the "Getting Back to Basics Campaign" as referenced above.

4.0 Mandatory IPC training

The compliance rate for IPC *clinical* online MAST was 83% (n= 5321) and for *non-clinical* on-line MAST was 90% (n=2686) as of 20 June 2023 against the Trust target of 85%. This is sustained performance when compared to 2021-22 when compliance was 83% and 89% respectively.

In 2023-24 training performance will be again targeted at Medical and Dental non-clinical (50%) and Medical and Dental clinical (73%) staff groups who continue to be the least compliant groups.

5.0 Priorities for 2023-24

The following key areas will be prioritised by the IPC team at SGUH and across the Group in 2023-24:

- Improve IPC mandatory training compliance in Medical and Dental clinical and Medical and Dental non-clinical staff groups
- Work closely with the Urology CNS team to support urinary catheter education and awareness across trust
- E. coli/catheter care focus week through senior nurses Back to the Floor adopting a quality improvement approach
- Introduce health economy digital urinary catheter passport to ensure standardised documentation process across SW London
- Promote awareness of the continence service referral pathways and standards in development across SW London
- Work with the SW London IPC sector to focus on gram negative bacteraemia
- Promote awareness of NHS England 2-year hydration project focusing on community and elderly care
- Work on a collaborative ‘Getting Back to Basics’ Campaign:

6.0 Recommendations

6.1 The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from the Sites and Group for assurance
- Receive the SGUH Annual IPC Report 2022-23
- Make any necessary recommendations for action

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Infection Prevention and Control Report

Board

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

10 November 2023

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Introduction and Purpose of Report

This report provides a monthly update of key issues/ concerns arising in Infection Prevention and Control (IPC) across gesh with a particular focus on:

- COVID-19
- *Clostridioides difficile* (*C.difficile*)
- MRSA Bloodstream Infections
- Gram Negative Bloodstream Infections
- Surgical Site Infections (SSIs)
- IPC Related Incidents
- Hand Hygiene Compliance
- IPC Mandatory Training including Fit Testing

Trusts have a statutory requirement to report on these infections and issues in line with the Health and Social Care Act (2008): code of practice on the prevention and control of infections (updated 2023). A comparison of the incidence of these infections across SWL and across systems in London demonstrates the challenge in the prevention and management of these infections.

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

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Working together across Group

The site IPC teams meet weekly at the Group Infection Control meeting which is chaired by the Group Chief Nursing Officer and Director of Infection Prevention and Control. The meeting is attended by Site and Community Chief Nurses, Site Infection IPC Lead Nurses and Site Lead Infection Control Doctors (ICDs). Agreed Terms of Reference are in place.

This forum has the authority to make decisions on the application of national IPC guidance and to implement changes as appropriate across the Hospital Group or at Site level (ESTH and SGUH) in regard to the application of core IPC polices and standards as outlined in the Health and Social Care Act 2008. Members of the Group IPC forum have responsibility for delivery of any changes to IPC practice and to take the required actions through the normal operational management reporting lines at Site.

The Site IPC leads continue to work collaboratively across the Health Group with the aim of harmonising polices and practices.

The Site IPC Leads also continue to be proactive members of the monthly South West London IPC group where all Covid-related issues and other IPC issues are discussed to ensure consistency in guidelines and practice across SW London. The focus for the group is now shifting towards a reduction plan for gram negative blood stream infections.

Final decision making for all IPC related issues sits with the Group Chief Nursing Officer and Director of Infection Prevention and Control.

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COVID-19

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	ESTH (includes SDHC and SHC)	SGUH
Total cases in September	79	102
Total deaths in month	11	8
Nosocomial infections	20	37
Nosocomial deaths	0	2
YTD positive cases	409	499
YTD nosocomial deaths	1	47
Outbreaks/clusters in month	18 (18 clusters, no outbreaks)	5

The IPC team continues to lead and ensure robust IPC control measures are in place including prompt identification and segregation of suspected cases of COVID-19; in line with current national guidance.
There has been an increase in the number of new positive cases and nosocomial infections across both sites when compared to previous months. This is reflected in the community prevalence nationally.

Both sites continue to undertake root cause analysis (RCAs) for nosocomial deaths that meet the new criteria.
In September 2023, there were 2 cases that met the criteria for an RCA at SGUH and no cases at ESTH.

COVID-19 Update: Despite the publication of the new screening guidance, there continues to be high usage of PCR testing across both sites (and across the sector) despite implementation of the new policy and recommendations published in April 2023 for targeted screening and use of lateral flow tests for most cases.

Weekly data circulated via SW London Pathology Services is reviewed and shared with areas with high usage/noncompliance. In July, SGH Surgical clinical leads were invited to the weekly meeting where they discussed their rationale for wanting to continue screening elective surgical patients and maintaining a green pathway. The team attended the group meeting and reported that as of Monday 31 July 2023, the Division has stopped elective screening to comply with the national guidance. They raised their concern of potential risks and the group acknowledged that a potential risk remains for a small cohort of patients who are extremely vulnerable, therefore individual clinical assessments should be undertaken as per local/national policy and that the Board will be cited on this.

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MRSA Bloodstream Infections

	ESTH	SGUH
Total cases in September	0	0
YTD cases	2	0
National objective	0	0

ESTH: There were no Trust attributed MRSA bloodstream infections. YTD= 2

SGUH: There were no Trust attributed MRSA bloodstream infections. YTD= 0

National threshold for MRSA is zero avoidable cases.

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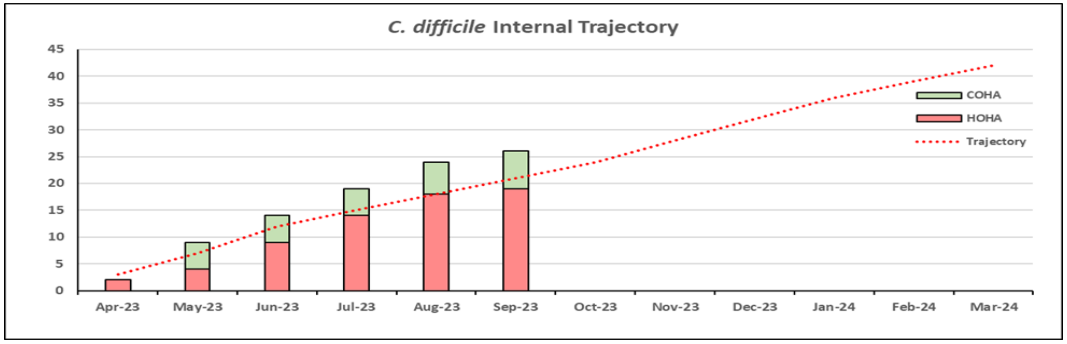
Clostridioides difficile (*C. difficile*) - SGUH



SGUH: In September there were 2 ***C.difficile*** infections, 1 classified as Hospital-Onset Healthcare-Associated and 1 classified as Community-Onset Healthcare-Associated (COHA). The Trust had 26 total cases at the end of September (19 HOHA; 7 COHA) and is therefore over the locally set trajectory which is 21 cases by end of September. The 26 *C. diffficille* cases have primarily been in the MedCard division (19 cases) followed by Surgery (6 cases) and Children and Women's (1 case) and have occurred in 16 different wards across the trust, sporadic by location. There were no CDI outbreaks, however, the one Period of Increased Incidence (PII) identified during August 2023 on Florence Nightingale Ward was not considered an outbreak due to the ribotyping being different—suggesting no evidence of cross-infection

Lapse in Care: Both *C. difficile* cases in September 2023 are awaiting a medical and nursing team review.
A C. difficile case which occurred in June was recently identified as a lapse in care. Which was attributed to antibiotic prescribing; the ward of acquisition was identified as Gray Ward and the case was presented to the Urology M&M (Morbidity and Mortality) meeting 28/09/2023.

Actions around C.difficile:
All wards where positive cases are identified undergo a period of increased surveillance and audit (PISA) until the area achieves the required standard for three consecutive weeks. Management of *C. diffficille* has also been identified as a priority for the IPC/Corporate 'Back to Basics' Programme.

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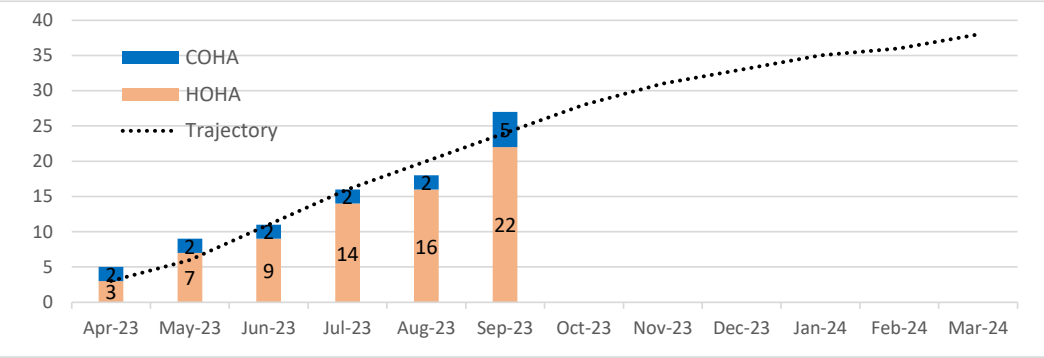
Clostridioides difficile (*C. difficile*) - ESTH



ESTH: In September there were 8 Trust attributed C. difficile cases, (6 HOHA and 3 COHA). YTD: 27 cases which is above the locally set trajectory for end of September (24).

Period of Increased Incidence (PII): UKHSA defines a Period of Increased Incidence (PII) as two toxin positive C. difficile cases being reported on the same ward within 28 days of each other.

A6 Renal ward entered into a PII on the 11th of August following identification of two positive cases within 28 days of each other. The first case was reported on the 14th of July (HOHA) and the second case on the 11th August.2 further cases were reported in September. A PII meeting was held and the ribotyping results came back different for all 4 cases, therefore cross transmission ruled out. Enhanced IPC measures to continue for 28 days from the day of last positive case.

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Gram Negative Bloodstream Infections including E. coli

In 2021, NHS England introduced national yearly thresholds for *E.coli*, *Klebsiella* and *Pseudomonas for* the first time in England, no threshold has been set for MSSA.

In addition to this, the categorisation of healthcare associated gram negative bloodstream infections (*Escherichia coli, Klebsiella spp.* and *Pseudomonas aeruginosa*) is now similar to that of *C.difficile* infections i.e. both HOHA and COHA cases counting towards the national threshold.

Key priorities to reduce *E.coli* bacteraemia across all sites for 2023/24 are:

- IPC team to work closely with the Urology CNS team to support education and awareness across Trust
- *E. coli* focus week through "back to basics" week
- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL patch (ESTH digital passport already in use)
- Continence service referral pathways and standards in development across Southwest London

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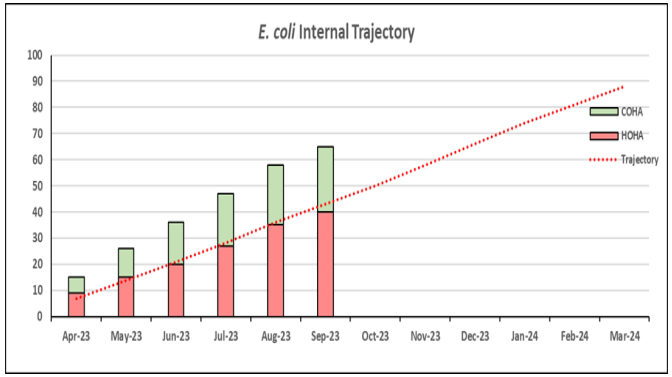
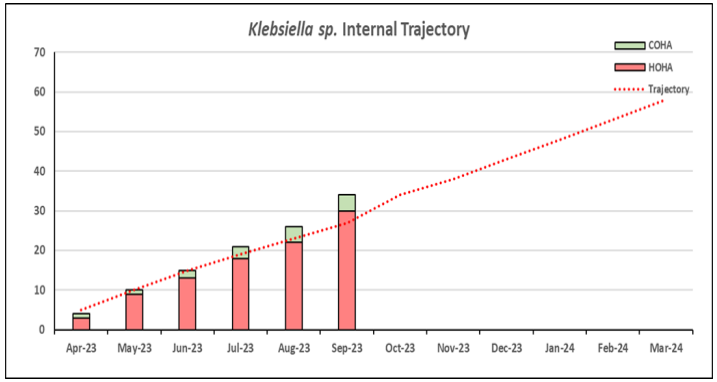
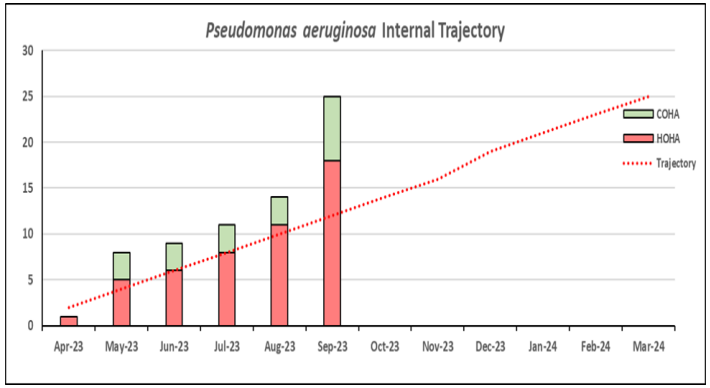
Gram Negative Bloodstream Infections - SGH



E.coli



Klebsiella spp.



Pseudomonas aeruginosa

There were 7 cases of ***E. coli*** **bacteremia** in September 2023: 5 have been classified as Hospital Onset Healthcare Associated (HOHA); 2 have been classified as Community Onset Healthcare Associated (COHA). The Trust had 65 cases at the end of September and is therefore *over* NHSE threshold. A comprehensive review has been undertaken and actions identified.

There have been 8 ***Klebsiella sp***. **bacteremia** cases in August — 8 HOHA and 0 COHA.

There has been 7 ***Pseudomonas aeruginosa*** **bacteremia** cases in August —4 HOHA and 3 COHA.

***Klebsiella spp*. and *Pseudomonas aeruginosa* bacteremia** are both over NHSE set trajectories for 2023-24. All cases continue to be reviewed on an ongoing basis.

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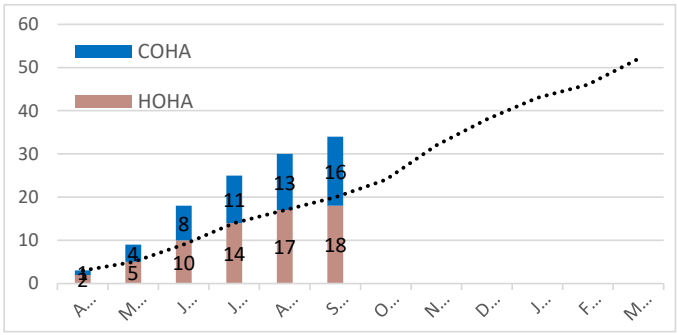
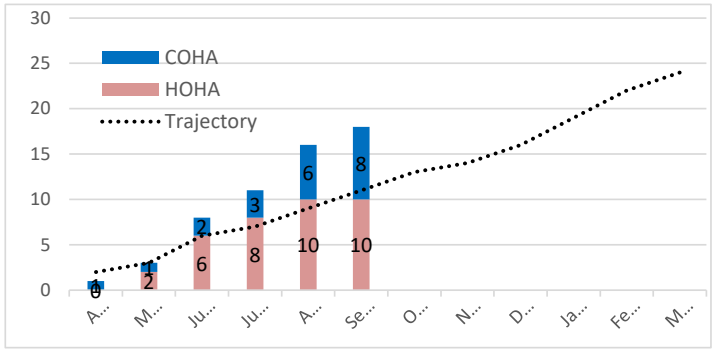
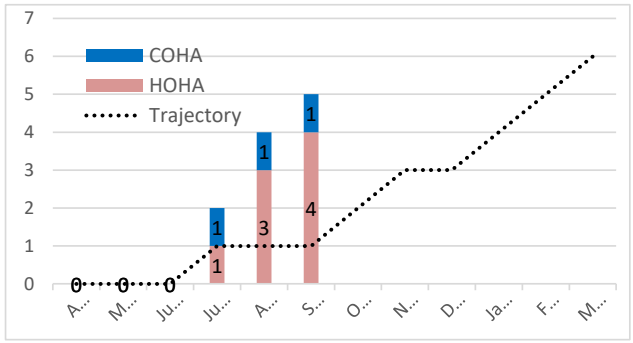
Gram negative Bloodstream Infections - ESTH



E.coli



Klebsiella spp.



Pseudomonas aeruginosa

There were 4 cases of **E.coli** bloodstream infections in September (1 HOHA, 3 COCHA) and YTD is 34. Source of infection varies between each case. Following review, of the 34 cases, source of infection in 11 of the cases is unknown, 5 urinary tract, 1 skin/soft tissue, 3 hepatobiliary, 1 gastrointestinal, 1 respiratory tract, and the remainder were still under investigation.

It should be noted that the highest burden of *E coli* BSIs is deemed as community onset and these are followed up by the ICB IPC team.

There were 2 ***Klebsiella sp.*** infections in September, 2 COHA, YTD 18 against the national threshold of 24 cases.

There was 1 ***Pseudomonas aeruginosa*** infections in September, YTD is 5 cases against a national threshold of 6 cases.

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Surgical Site Infections

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Context: NHS Trusts performing orthopaedic surgery are mandated by the Department of Health to carry out surgical site surveillance for a minimum of three consecutive months each financial year in hip replacement, knee replacement, repair of neck of femur, reduction of long bone fracture. The data is captured on the national UKHSA database. Other modules such as coronary artery bypass grafts, large bowel etc. are optional and can be undertaken to establish a local baseline.

SWLEOC : undertakes continuous orthopaedic surveillance throughout the year. Between January and March 2023, there were no identified SSIs for 320 hip procedures, 372 knee procedures 14 spinal procedures and 28 shoulder procedures. Surveillance is ongoing for the same modules for the period April-June 2023.

ESTH: An orthopedic module for fractured neck of femur and large bowel module will be followed up between Oct-Dec 2023. The orthopedic SSI rate for the Trust has consistently been below the national threshold.

SGUH: As per UKHSA mandatory requirement, SGUH participates in two modules: Reduction of Long Bone Fracture (RLBF) and Coronary Artery Bypass Graft (CABG).

The IPC Team is carrying out surveillance on RLBF for the months of July-September 2023; data collected during these months will be finalised and submitted by the end of December 2023.

Data for CABG surgery is collected quarterly by the Lead Cardiac Pre-Op Assessment CNS. Data collected for April-June 2023 was submitted at the end of September 2023. Of the 98 eligible patients, 3 patients were identified to have an infection (3.06%) which is higher than the national average of 2.6%.

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IPC Related Incidents – July 2023

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Integrated Care There were no issues/concerns

ESTH **MRSA:** There was one Trust attributed MRSA bloodstream infections in July. This patient was admitted onto the renal ward from St. Peter's hospital with a known MRSA bacteremia and despite triple therapy the bacteremia is ongoing. A set of repeat blood cultures was undertaken on the 20th of July and unfortunately MRSA was again isolated. According to UKHSA definition, repeat blood cultures taken after 14 days counts as a new infection therefore despite the patient being admitted with the bacteraemia, this case counts towards our Trust cases as well as for ASPH

CPE: In July, the IPC team investigated an unusual pattern of CPE positive patients in sputum cultures from 3 patients in ITU 3. The first case was identified in April, although not all were linked to time all patients were nursed in either bed 18 or 19 in ITU 3. UKHSA was asked to take samples from the sink and they confirmed low numbers of CPE on the strainer and biofilm beneath the strainer. It is difficult to establish the route of travel of CPE (patient to handwashing sink or vice versa) with the above information. We have reviewed the practice and use of handwashing sinks in the Unit have liaised with the Estates team to undertake high level disinfection of the drainage system and as a precautionary measure; plans are being looked at to ensure drain chlorination as part post discharge cleaning in areas where a patient with a known multi resistant organism is discharged from. All three patients were not clinically affected and have since been discharged.

Legionella: High levels of legionella counts were detected across several outlets in C block as part of routine testing for both pseudomonas and legionella. Following on from the initial findings and meetings with water subject matter experts from UKHSA and the Trust external Authorising Engineer, repeat tests were undertaken following the escalation of control measures under HTM04-01 including installation of Point of Use (POU) filters to outlets with high counts and daily high-velocity flushing

SGUH **Norovirus:** A confirmed outbreak of Norovirus was reported on Trevor Howell ward, commencing 22 September 2023. One bay was closed to admissions and transfers out between 21st to 29th September with a total of 4 patients confirmed positive and 11 staff affected with Norovirus symptoms. IPC measures were followed to control and contain the outbreak which resulted in preventing the spread of Norovirus outside of one bay.

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Hand Hygiene Compliance

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ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH
93%	100%	100%	98.8%

ESTH: Monthly hand hygiene compliance audits are being undertaken in all clinical areas. A total of 67 inspections across 62 areas yielded a hand hygiene compliance score of 97%. 31 areas have not had an inspection (67% completion compliance). Divisional directors of nursing are accountable to the site CNO for their compliance and action plans required as necessary.

SGUH: Monthly hand hygiene compliance audits are undertaken across clinical areas. This month 133 areas returned audits. These areas achieved an overall score of 98.8%. Hand hygiene audits are also carried out during Accreditation audits and any Period of Increased Surveillance (PISA) audits e.g. C. diff (HAI), Norovirus, Influenza, MRSA.

For both Trusts: Areas of low compliance are followed up by the site Chief Nursing Officers who are responsible for operational delivery of IPC. Adhoc hand hygiene audits and spot checks are undertaken in the areas of low compliance by the IPC nurses.

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Fit Testing

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ESTH Total 1357	**SGUH Total 3423**

All relevant staff are required to be fit tested on at least two tight-fitting Respiratory Protective Equipment (RPE) FFP3 Masks as per Health and Safety Executive (HSE) guidance.

ESTH: As of 30 September, 63% of staff have passed fit testing on two or more types/models of masks.

SGUH: The fit testing service at SGUH currently sits in the Health and Safety Directorate and in Corporate Nursing at ESTH. The work to integrate corporate services will consider where this service is managed in the Group. Currently no new fit testers have been recruited and this has resulted in limited fit testing at SGUH.

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IPC Mandatory Training Compliance

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	ESTH	Sutton Health & Care	Surrey Downs Health & Care	SGUH CWDT	SGUH MEDCA RD	SGUH SNCT
Clinical Staff	79%	88%	91%	80%	100%	81.4%
Non-clinical staff	91%	96%	97%	88.2%	93.3%	83.8%

ESTH: IPC mandatory training and monitoring of compliance remains poor despite continued efforts by the IPC team to provide targeted/local training. At ESTH the current compliance per Division has been shared with the Site CNOs and CMOs to help with directorate/divisional accountability. Targeted face to face training has been offered to Divisions where staffing issues have been cited as a contribution to low compliance. Face to face training will continue to be offered as part of back to basics week

SGUH: These figures reflect compliance with completion of MAST training, they are not reflective of actual scores on the IPC modules overall. Divisional representatives are required to report to the Infection Control Committee (ICC) on a regular basis and provide updates on their MAST compliance.

Appendix 2

Infection Prevention and Control

ANNUAL REPORT 2022-2023

St George's University Hospitals NHS
NHS Foundation Trust

Contents

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Executive Summary

The purpose of this report is to provide the Board with information on Trust's performance and provide assurance that suitable processes are being employed to prevent and control infections at St George's University Hospitals NHS Foundation Trust.

The Trust has slowly been moving back towards a business-as-usual stance regarding SARS-CoV-2, the virus that causes COVID-19, removing previous established patient pathways and scaling back on testing. During 2022-23 a total 2,461 patients diagnosed with SARS-CoV-2 required a hospital admission, 2,251 were subsequently discharged (91.47%) and sadly there were 206 patients who died (8.37%). Of the 206 deaths, 45 deaths have COVID-19 listed on either Part 1A/B of their death certificate (1.83%). This year the Trust saw a slight increase in discharged patients and a reduction in the *proportion* of COVID-19 deaths. A number of nosocomial outbreaks occurred at the Trust, though often typified by asymptomatic illness, see section 13.8 of this report.

The Trust followed national guidance published by the United Kingdom Health Security Agency (UKHSA) which formed the basis of all infection prevention strategies implemented during the year. These strategies were adopted across the St Georges', Epsom & St Helier University Hospitals Health Group.

During 2022-23 the Trust recorded one case of Trust apportioned Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia (blood stream infection). This compares to two hospital acquired infections during the previous year 2021-22.

There were 25 Trust apportioned cases of Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia during 2022-23 compared to 45 during 2021-22.

There were 60 cases of Trust apportioned *Clostridioides difficile* infection (CDI) against an NHS Improvement target of no more than 43 cases. This compares to 43 cases reported during 2021-22.

There were 105 cases of Trust apportioned *Escherichia coli* bacteraemia infection during 2022-23 compared to 65 cases reported during 2021-22.

There were 76 cases of Trust apportioned *Klebsiella* bacteraemia infection during 2022-23 compared to 48 cases reported during 2021-22.

There were 23 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia infection during 2022-23; a reduction compared to 27 cases reported during 2021-22.

The Trust experienced a spike in the numbers of influenza cases during the winter season 2022-2023 which is thought to be a consequence of COVID-19 no longer supressing the influenza virus. Due to this, a small number of wards were closed due to outbreaks. Uptake of staff influenza vaccination, previously 72.3% during 2021-22, was reduced to 49.4% for the 2022-23 financial year.

There was one Norovirus outbreak in January 2023 that affected 13 patients.

There were two outbreaks of CPE across two wards during the 2022-23 financial year involving 5 patients in total.

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1. Infection Control Team and Reporting Arrangements

Head of Infection Prevention & Control	1.0 wte
Infection Control Doctor/Consultant Microbiologist	5 PA's
Lead Nurse-Infection Prevention & Control	0.5 wte
Clinical Nurse Specialists- Infection Prevention & Control (Band 7)	3.0 wte
Infection Prevention & Control Nurse (Band 6)	3.0 wte
Infection Prevention & Control Nurse (Band 5)	1.0 wte
Infection Prevention & Control Support Worker	1.0 wte
Infection Prevention & Control Surveillance Scientist	1.5 wte
PA to infection Prevention & Control	1.0 wte

The **Trust Board** recognises and agrees their collective responsibility for minimising the risks of healthcare associated infection and agrees and supports how these risks are controlled. The responsibility for Infection Prevention and Control (IPC) lies with the Director of Infection Prevention & Control (DIPC). With the introduction of the St Georges', Epsom & St Helier University Hospitals Health (GESH) Group, this responsibility now sits with the Group Chief Nurse and DIPC. However, St George's retains a site Chief Nurse with delegated responsibility for Infection Prevention & Control, a Consultant Microbiologist as the Infection Control Doctor, and a Head of Infection Control.

The **Infection Control Doctor** is a Consultant Microbiologist and provides expert clinical microbiological and infection prevention advice and leadership, provides support for the wider Infection Prevention and Control Team (IPCT), and helps set the strategic direction.

The **Chief Nurse** provides leadership for the patient safety and quality agenda at the Trust of which IPC is a key element.

The **Head of Infection Control** is a senior nurse who provides leadership for the IPCT. The Head of Infection Control reports professionally to the Assistant Chief Nurse and works closely with the Infection Control Doctor and other Consultant Microbiologists to ensure the agreed IPC priorities are implemented and that an appropriate response is maintained to any infection prevention incident arising.

The **Infection Prevention & Control Committee (IPCC)** is the main forum for governance and monitoring of action around IPC practices at the Trust. The membership of the IPCC includes representation from all Trust Divisions, plus a representative from the UKHSA via the South London Health Protection Team. The IPCC is chaired by the St George's site Chief Nurse. A quarterly report from the IPCC is received at the Patient Safety & Quality Group and the Trust Quality Committee, which is a subcommittee of the Board, where the IPC annual report is also received.

The **Infection Prevention & Control Team (IPCT)** provides expert knowledge and day to day management of IPC related issues. The IPCT liaise regularly with clinicians and managers across the Trust. They are supported by IPC Link Practitioners based in clinical areas for whom study events are held. An IPC Healthcare Surveillance Scientist has been established at the Trust providing epidemiological skills to the IPCT. Members of the IPCT also attend and participate in (but are not limited to) the following groups / committees:

Infection Prevention & Control Committee	Antimicrobial Stewardship Group
Strategic Water Safety Group	Ventilation Safety Group
Operational Water Safety Group	Decontamination Group
Waste Project Group	Winter preparedness Groups

Occupational Health Groups	Building planning meetings
Matrons Environmental Action Team	Cleaning review meetings

2. Compliance with the Health and Social Care Act 2008

The Trust recognises that the effective prevention and control of healthcare associated infections (HCAI) is essential to ensure that patients using our services receive safe and effective care. Effective prevention and control must be an integral part of everyday practice and applied consistently by all trust staff to ensure the safety of our patients. In addition, good management and organisational processes are crucial to ensure high standards of infection prevention and control measures are maintained.

This report demonstrates how the Trust has systems in place to ensure compliance with each of the 10 criteria of the Health and Social Care Act 2008: Code of Practice for the NHS on the prevention and control of healthcare associated infections and related guidance. Evidence of compliance against each of the 10 criteria was reviewed periodically during the year and presented to the Infection Prevention & Control Committee. The Trust declared compliance with all ten criteria of the Hygiene Code (listed below in Table 1) during 2022-23.

Table 1: The Ten Criteria of the Health and Social Care Act 2008

Criterion	Detail	Date Reviewed
Criterion 1	Systems to manage and monitor the prevention & control of infection. These systems use risk assessments and consider the susceptibility of service users and any risks that their environment and other users may pose to them	19.04.2022
Criterion 2	Provide and maintain a clean and appropriate environment in managed premises that facilitates the prevention and control of infections	19.04.2022
Criterion 3	Ensure appropriate antimicrobial use to optimise patient outcomes and to reduce the risk of adverse events and antimicrobial resistance	19.04.2022
Criterion 4	Provide suitable accurate information on infections to service users, their visitors and any person concerned with providing further support or nursing / medical care in a timely fashion	21.06.2022
Criterion 5	Ensure prompt identification of people who have or are at risk of developing an infection so that they receive timely and appropriate treatment to reduce the risk of transmitting infection to other people	21.06.2022
Criterion 6	Systems to ensure that all care workers (including contractors and volunteers) are aware of and discharge their responsibilities in the process of preventing and controlling infection	17.08.2022
Criterion 7	Provide or secure adequate isolation facilities	17.08.2022
Criterion 8	Secure adequate access to laboratory support as appropriate	17.08.2022
Criterion 9	Have and adhere to policies, designed for the individual's care and provider organisations that will help to prevent and control infections	18.10.2022
Criterion 10	Providers have a system in place to manage the occupational health needs and obligations of staff in relation to infection	21.02.2023

A rolling programme of collation of evidence of compliance with the hygiene code will continue during 2022-23 as part of the calendar of business of the Infection Prevention & Control Committee.

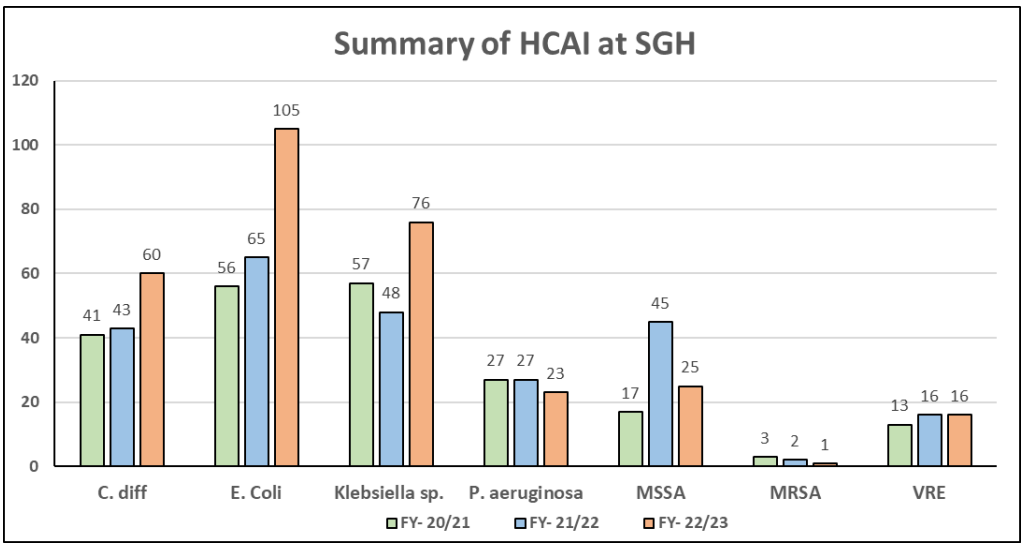
3. Summary of Infection Prevention and Control Performance

Trusts are required to participate in six mandatory reporting schemes:

1) Methicillin-resistant *Staphylococcus aureus* (MRSA) bacteraemia
2) Methicillin-sensitive *Staphylococcus aureus* (MSSA) bacteraemia
3) *Clostridioides difficile* infection
4) *Escherichia coli*, *Klebsiella* and *Pseudomonas aeruginosa* bacteraemia
5) Glycopeptide-resistant enterococcal bacteraemia (GRE)
6) Surgical Site Infection Surveillance

Figure 1 shows a summary of the Trust's infection prevention and control performance over the past three years with regards to 5 of the 6 mandatory reporting schemes.

Figure 1: Summary of Mandatory Reporting Figures



MRSA, MSSA, Gram-negative Bloodstream Infections (BSI) and laboratory detected *Clostridioides difficile* toxins are reported monthly via the UKHSA Healthcare Associated Infection (HCAI) Data Capture System.

4. MRSA Bacteraemia

MRSA bacteraemia are apportioned to the organisation based on the timing of the positive blood culture. The MRSA bacteraemia then undergoes a post infection review (PIR) process.

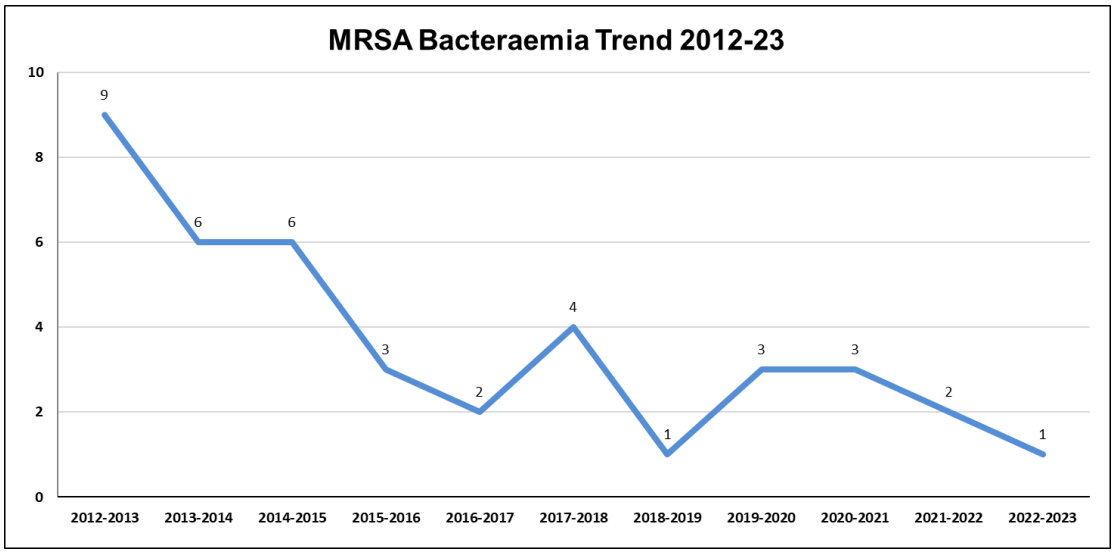
There has been one episode of a Trust apportioned MRSA bacteraemia during the 2022-23. Overall, cases of MRSA bacteraemia at the Trust have maintained a downward trajectory since 2012-13 (Figure 2).

Case 1: An MRSA bacteraemia was reported form a peripheral blood culture taken from a patient on CTICU on 19th August 2022. The patient, sadly, died. The cause of death was documented as MRSA on part 1b of the death certificate. The case was referred for Serious Incident (SI) review and discussed at the SIDM.

It was confirmed that the patient was colonised with MRSA (nose/groin) on admission to CTICU and managed appropriately; MRSA suppression therapy and IPC precautions were advised and administered. The patient had no previous admission to St George's Hospital and therefore likely that MRSA colonisation was acquired prior to admission to the trust, possibly community acquired or acquired at Kingston Hospital (previous admission).

The blood culture was taken 12 days post admission. The most likely portal of entry was felt to be the femoral line, not least as MRSA was detected from the femoral line tip. It cannot be ascertained for certain if failure to change the femoral line was causative, but it may have contributed to the bacteraemia occurring and this was acknowledged by the clinical team. The SIDM agreed that this incident did not meet the criteria of a SI.

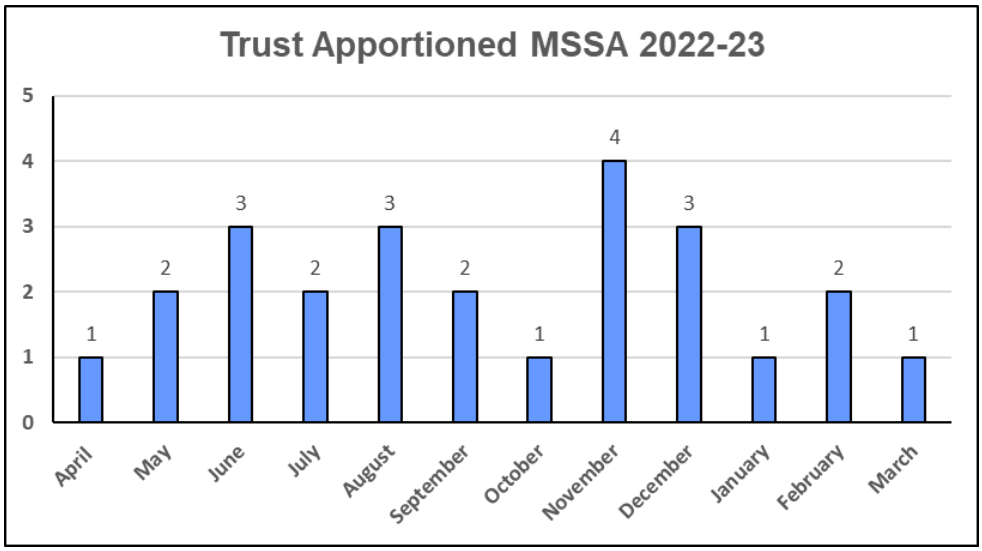
Figure 2: MRSA Bacteraemia Trend 2012-23



5. MSSA Bacteraemia

There were 25 cases of MSSA bacteraemia apportioned to the Trust during the 2022-23 financial year, where the blood culture was taken after the second day of admission (Figure 3). There are no national or local thresholds for MSSA bacteraemia in place at present. While not mandated, the Trust undertakes a Root Cause Analysis (RCA) on all Trust apportioned MSSA infections.

Figure 3: MSSA Trust Apportioned Bacteraemia 2022-23



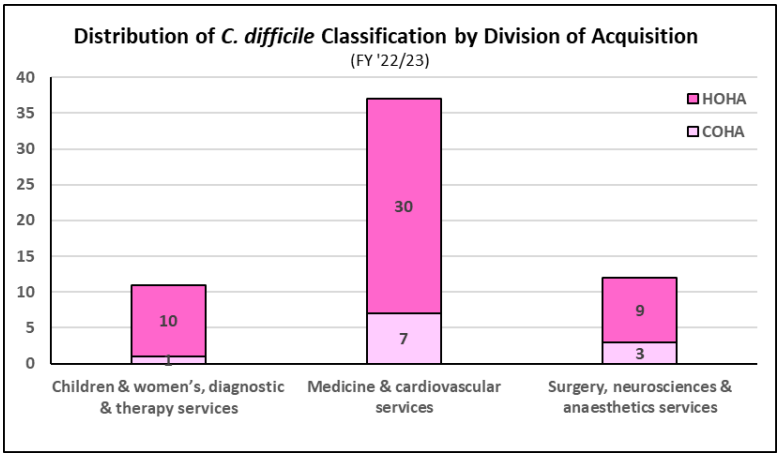
6. *Clostridioides difficile*

The Trust has and continues to review all hospital acquired cases of *Clostridioides difficile* infection through RCA to identify any potential lapses in care or any common themes that may have contributed to the infection. The Trust reports all cases of C. diff diagnosed in the hospital laboratory to NHS England using the following definitions:

- Hospital-onset healthcare-associated (HOHA)—Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- Community-onset healthcare-associated (COHA)—the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date).

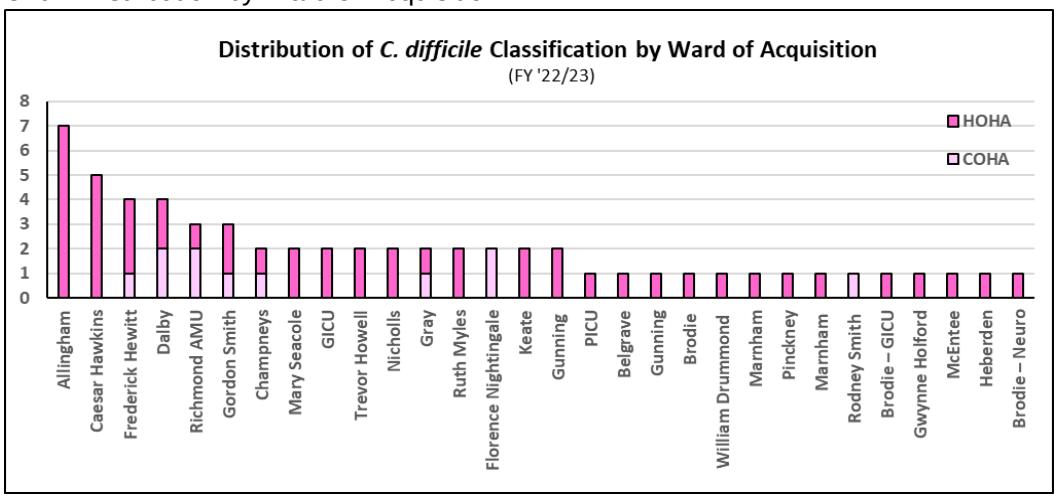
By the end of the 2022-23, there were 60 cases apportioned to the Trust (49 HOHA; 11 COHA) which is above the set NHSE trajectory of 43 cases. The 60 cases were evenly distributed between Surgery and Children and Women's division (12 and 11 cases respectively) with most cases falling under the MedCard division (37 cases) (Figure 4).

Figure 4: C. diff Distribution by Division of Acquisition



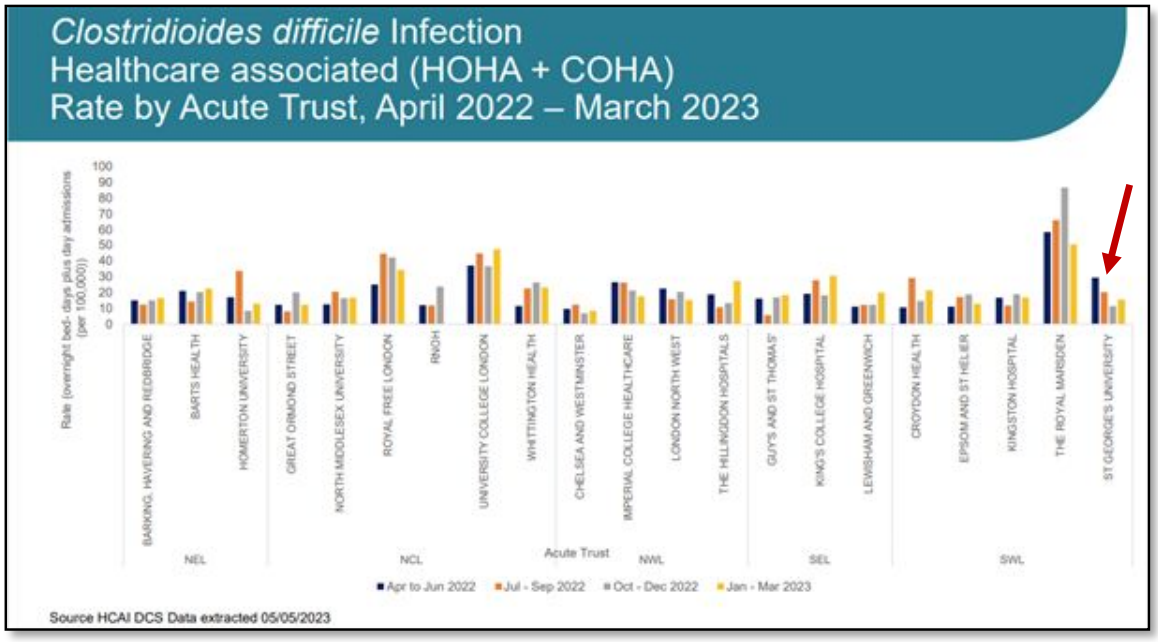
A further breakdown of the 60 cases by ward of acquisition highlights six wards with an above average number of C. diff cases (average=2); five from the MedCard division and one from Children and Women's division (Figure 5).

Figure 5: C. diff Distribution by Ward of Acquisition



A comparative look at the rate of C. diff between St. George's against other Acute Trusts suggest that although we have ended the financial year above NHSE trajectory, the Trust is not a national outlier and falls within the median. In addition, around 14 other Acute Trusts have ended the financial year above trajectory, suggesting an overall rise in the incidence and prevalence of C. diff. (see figure 6).

Figure 6: National C. diff Rates



It should be noted C. diff thresholds are based on historical figures for each healthcare organisation rather than the numbers of beds or patient complexity. It is possible that the Trust has a challenging C. diff trajectory because the Trust made strenuous efforts to control the infection in the years leading up to the trajectory being set, so the baseline was already low, (see figure 7).

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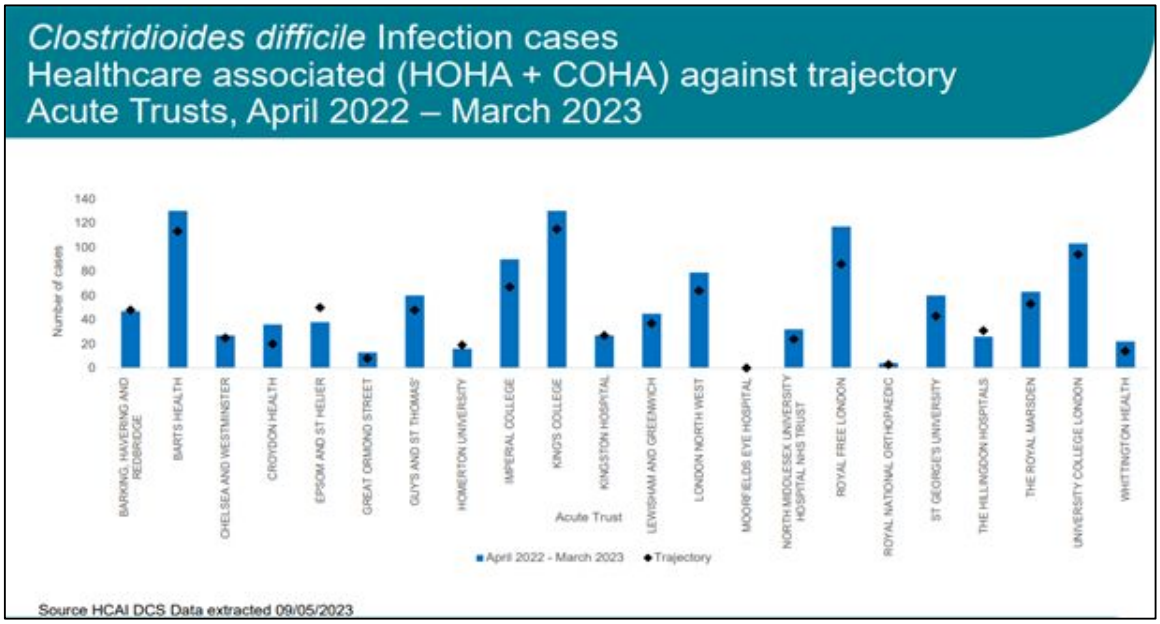
Figure 7: CDI Acute Trusts April 2022 - March 2023 Against Trajectory



6.1. RCA Case Reviews

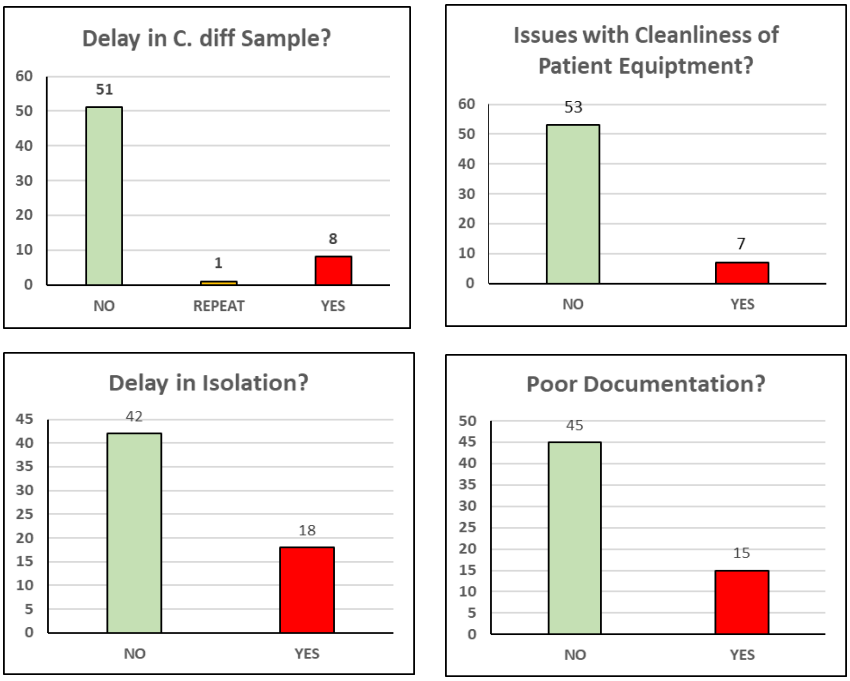
As per CDI standard operating procedure (SOP), cases of *Clostridioides difficile* meeting the criteria for external reporting are subject to a RCA. All isolates of *C difficile* are also sent for ribotyping to look for any evidence of cross-infection and outbreaks. Following an initial review of the patient by a microbiologist and a ward round by IPC, the RCA is sent to the antimicrobial pharmacist for review. Once returned, feedback is given to the relevant nursing and medical teams with an opportunity to provide any additional comments on the RCA regarding the case and findings. After the RCA is finally returned, it is then to be reviewed by IPC and the Infection Control Doctor (or available microbiologist). This has, at times, been difficult to achieve due to competing demands. Outcomes of RCA are noted at the Infection Prevention & Control Committee.

During 2022-23, all CDI cases were reviewed (60/60) to ascertain causative lapses in care e.g., inappropriate antimicrobial prescribing or serious lapses in environmental or equipment cleaning which may have led to the acquisition of the case. However, most CDI cases were attributable to the administration of 'appropriate' antibiotic therapy.

An in-depth review of the key points and findings of the C. diff RCAs revealed key themes such as

- 10 of the 60 patients were admitted with diarrhoea, of which 4 were categorized as HOHA. Therefore, the importance a timely medical review of the patient and prompt sending of a stool sample before the 3-day mark can potentially reduce the number of cases apportioned to the Trust.
- In addition, four non-causative themes (sub-optimal practices that are unlikely to have led to acquisition of CDI) were identified and two were determined to be an area of concern: documentation issues and prompt isolation of C. diff patients within 2 hours of suspected infectious diarrhoea (Figure 8).

Figure 8: Non-causative Themes Identified

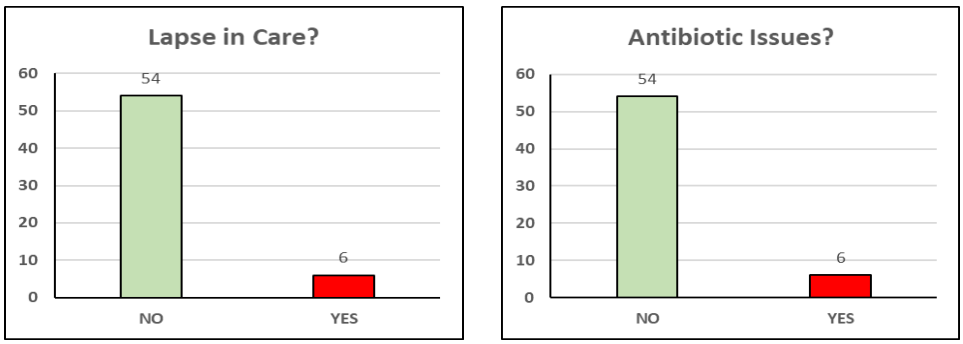


Of the 15 RCAs that highlight issues with documentation, most of them singled out an inconsistent stool chart. An inconsistent stool chart hinders the timely collection of appropriate stool samples from patients with signs and symptoms of C. diff, which is important to identify community-onset cases accurately. The second issue, delay in isolation, occurred in 18 of the 60 cases. The most common reason for the delay was a lack of side room availability.

6.2. Lapse in Care

Of the 60 cases reviewed, 6 were identified to be a lapse in care mostly in part due to the inappropriate use of antibiotics, which may have potentially been causative of the infection (Figure 9). One lapse in care was in relation to prescribing antimicrobial therapy to a microbiology result and not necessarily to the clinical picture of the patient. Each lapse is subject to a multidisciplinary meeting chaired by the Infection Control Doctor. Lapses in care may be challenged by the clinical team if it can be demonstrated that antimicrobial therapy was necessary. Engagement by clinical teams was suboptimal.

Figure 9: Lapses in Care



6.3. Period of increased surveillance and audit (PISA)

All wards where a CDI HOHA occurred undergo a period of increased surveillance and audit (PISA). PISA allows for a prolonged review of patients with CDI and others with suspected infections which includes

documentation of medical reviews, hand hygiene, Personal Protective Equipment (PPE), patient screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment (including commodes), management of clean linen and venous access devices (for MRSA) are also all audited during the PISA process. The ward must achieve 95% or above to pass PISA and if the first audit results in a pass, no further audits are required. If the first week is failed, the clinical area will continue with PISA until a pass is achieved over 3 consecutive weeks. This process allows for an ongoing focus on infection prevention & control issues where required and is an opportunity to escalate concerns where they are not resolved at local level.

6.4. Actions/Recommendations

Moving forward, the IPC Team will continue to work to reduce the number of CDI cases. This relies upon good antimicrobial stewardship (AMS), the earliest detection of possible CDI and prompt isolation of patients with diarrhoea due to a suspected infectious cause. All positive C. difficile stool samples will continue to be promptly relayed to the wards and documented on iCLIP by the IPC Team/Microbiologists, infection control precautions and antibiotic therapy will be discussed. Improvements in hand hygiene and environmental cleanliness will help to prevent C.diff transmission from patient to patient.

- The RCA process will be reviewed and brought into line with the new national **Patient Safety Incident Review Process (PSIRF)** to identify themes or lapses in care as part of a system-based approach. This is to be fed back via the Trust governance structures.

- Where a 'Lapse in Care' has been identified, the case will be discussed in the responsible care group's **Morbidity and Mortality (M&M)** meeting that form part of the Trusts clinical safety governance structures and process.

- Review arrangements for the AMS committee especially around senior representation– Medical Director or AMD to provide senior leadership support and direction.

- 'Getting Back to Basics' Campaign: A meeting to discuss this workgroup and streams took place 7th June 2023. These workgroups will be overseen by a steering group.

  The following four streams have been identified:

  - Urinary Catheter care
  - *C. difficile* and AMS
  - Central and peripheral vascular access line care
  - Back to Basics – hand hygiene, Bare Below Elbows, Cleaning – environmental and equipment

Figure 10: *Clostridioides difficile* Trend Against NHSE Target From 2012-23

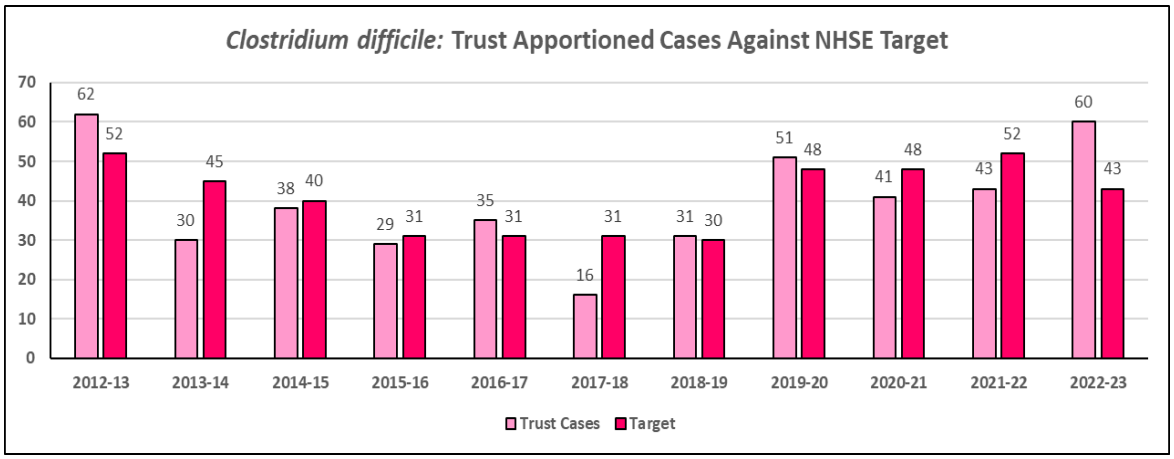
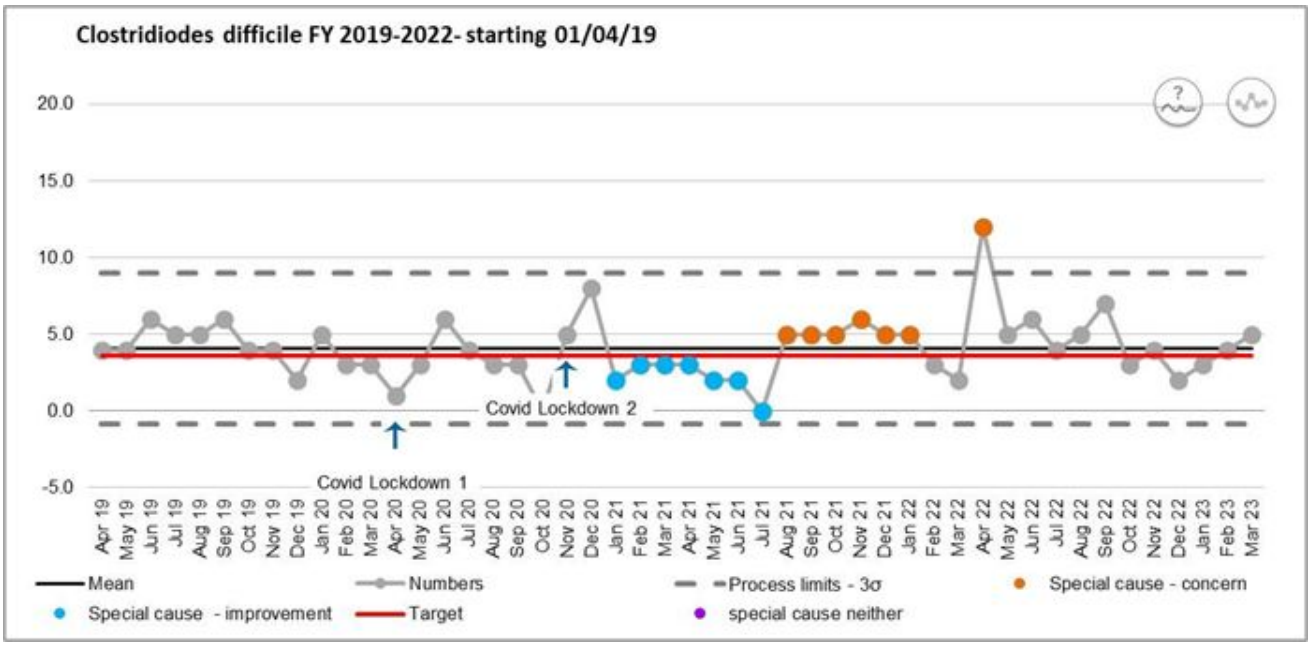


Figure 11: SPC Chart of C. difficile 2017-2019



In Figure 11, it is shown that there was only 1 month in 2022-2023 that C. difficile was significantly outside the process limits and there is only common cause variation i.e., not significantly better or worse than the previous years. Target values are not consistently achieved. Target shown is FY 22-23.

7. Gram-negative bacteraemia

All Trusts are required to report cases of gram-negative bacteraemia using similar mechanisms as for MRSA and MSSA bacteraemia using the following definitions:

- Hospital-onset healthcare-associated (HOHA)—Specimen date is ≥3 days after the current admission date (where day of admission is day 1)
- Community-onset healthcare-associated (COHA)—the patient was most recently discharged from the same reporting trust in the 28 days prior to the specimen date (where day 1 is the specimen date)

7.1. *Escherichia coli* bacteraemia

E. coli bacteria are frequently found in the intestines of humans and animals and can survive in the environment. There are many different types of *E. coli* causing a range of infections including urinary tract infection, cystitis and intestinal infection. When primary *E. coli* infection spreads to the blood it is known as *E. coli* blood stream infection (BSI) or bacteraemia.

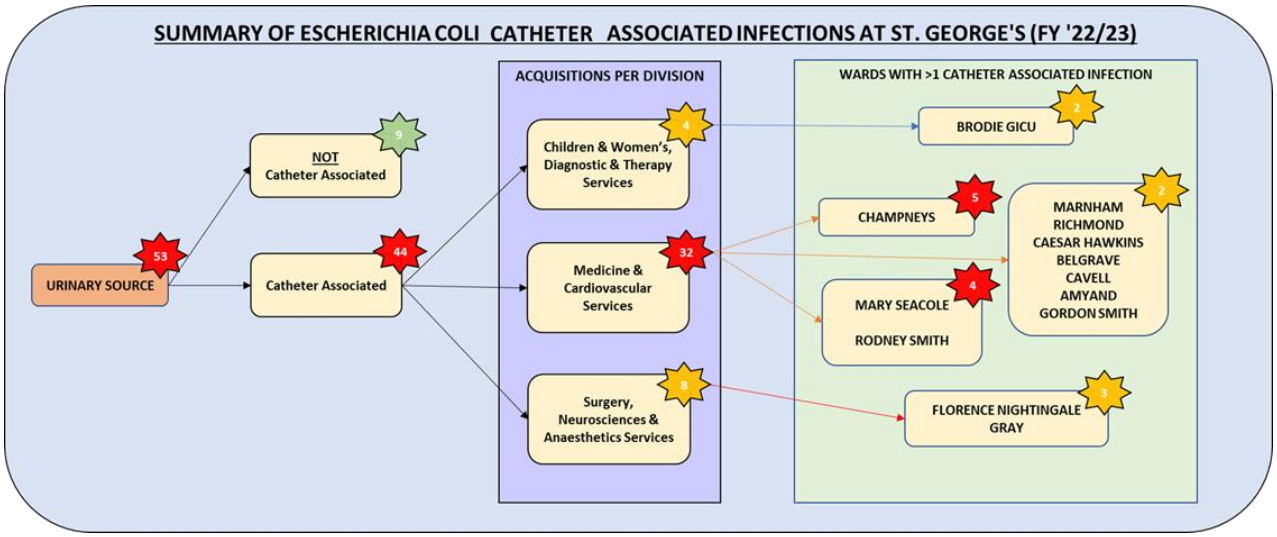
Typically, community acquired *E. coli* bacteraemia results from abdominal, biliary, or urinary tract sepsis. Hospital acquired cases of *E. coli* bacteraemia can also be associated with urinary catheter infections.

The Trust continues to see an increase in *E. coli* bacteraemia cases; therefore, the IPC team investigate and collect data by source.

By the end of the 2022-23 financial year, there were 105 cases apportioned to the Trust (74 HOHA; 31 COHA) which is above the set NHSE trajectory of 93 cases. The Trust was therefore over trajectory.

Analysis of each case identified predominantly a urinary source (53 cases) with a urinary catheter in situ (44 cases). Most of these cases occurred on Med Card wards division (32 cases) with the following wards having the highest rates: Champneys, Mary Seacole, and Rodney Smith (Figure 12). The issue of urinary catheter associated BSI will be addressed as part of the "Getting Back to Basics Campaign" – see C. difficile section.

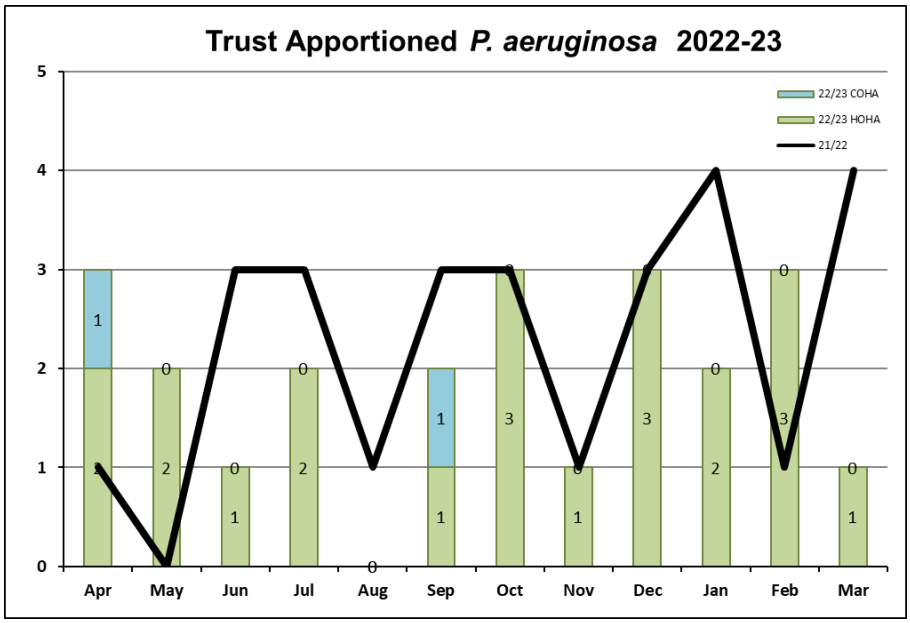
Figure 12: Summary of E. coli Catheter Associated Infections (2022-23)



7.2. Pseudomonas aeruginosa bacteraemia

There were 23 cases of Trust apportioned *Pseudomonas aeruginosa* bacteraemia during the 2022-23 financial year (Figure 13) against a NHSI/E trajectory of no more than 29 cases; therefore, the Trust remains below trajectory.

Figure 13: Trust Apportioned *Pseudomonas aeruginosa* 2022-23



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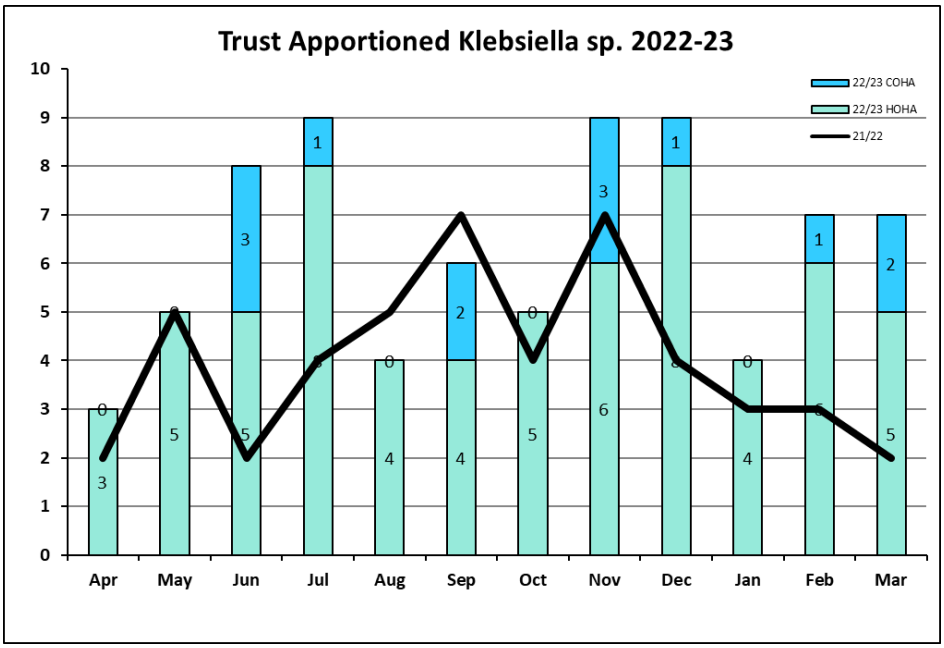
7.3. *Klebsiella* bacteraemia

There were 76 cases of *Klebsiella* bacteraemia reported during the 2022-23 financial year (Figure 14). The total of 76 cases is set against a trajectory of no more than 76 cases. The Trust therefore completed the year within this trajectory.

Figure 14: Trust Apportioned *Klebsiella sp*. 2022-23



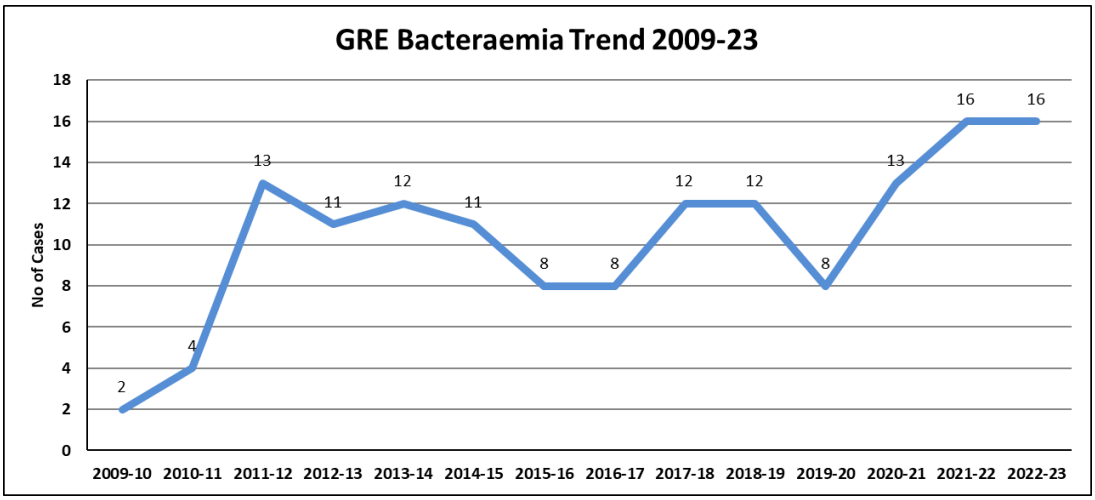
8. Glycopeptide Resistant Enterococcal Bacteraemia (GRE)

Enterococci bacteria are frequently found in the bowel of normal healthy individuals. They can cause a range of illnesses including urinary tract infections, bacteraemia (blood stream infections) and wound infections. Glycopeptide-resistant Enterococci (GRE) are enterococci that are resistant to glycopeptide antibiotics (vancomycin and teicoplanin). GRE are sometimes also referred to as VRE (Vancomycin-Resistant Enterococci).

GRE do not usually cause serious infections unless the individual is immunocompromised. GRE bacteraemia's are more commonly associated with renal and haematology units where there are immunocompromised patients and glycopeptide antibiotics are used frequently.

St George's figures are illustrated below (Figure 15). There are currently no national thresholds, however, St George's has maintained low levels of GRE with 16 cases reported during the 2022-23 financial year.

Figure 15: GRE Bacteraemia Trend 2009-23



9. Carbapenem Resistant Enterobacteriaceae (CRE)

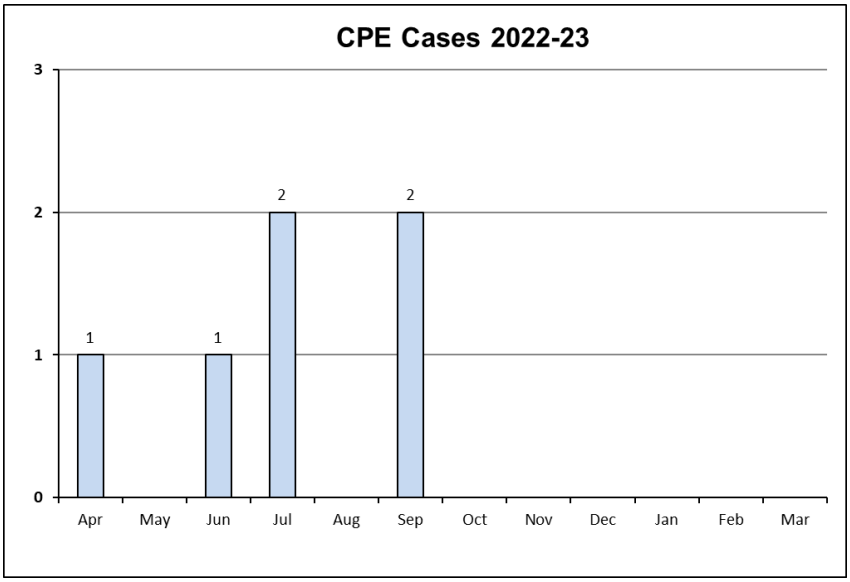
Carbapenems are a powerful group of broad-spectrum beta-lactam (penicillin-related) antibiotics. In many cases, these are our last effective defence against infections caused by multi-resistant bacteria. Enterobacteriaceae refer to a group of bacteria such as *E coli* and *Klebsiell*a, which are generally found in the intestine and can cause a range of infections such as urine tract infections, abdominal infections and bacteraemia.

Resistance to carbapenems has emerged and has spread across the world. Resistance to carbapenems is often combined with resistance to many other antibiotics, making infections caused by these organisms almost impossible to treat. The NHS has produced guidance on how to detect carbapenem resistant Enterobacteriaceae (CRE) and limit their spread.

The Trust has a policy, in line with national guidance, on the screening for these organisms. In addition, the Trust reports episodes to the voluntary UKHSA operated CPE database as well as submitting antibiotic resistance data to the PHE.

The Trust continues with low numbers of newly identified patients with CPE with a total of 6 cases during the 2022-23 financial year (Figure 16).

Figure 16: Distribution of CPE Cases 2022-23



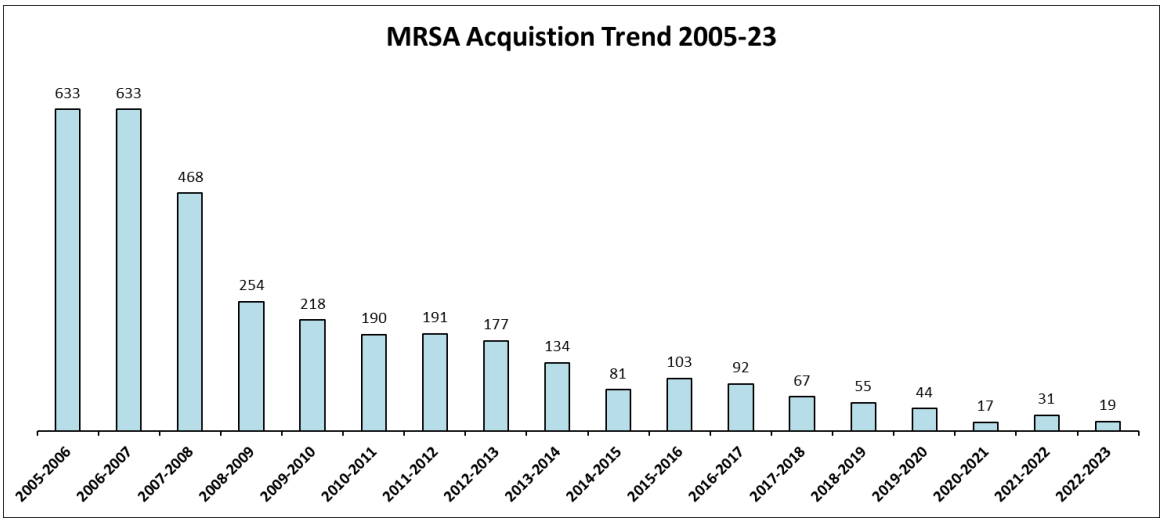
10. MRSA Acquisitions

Most strains of *Staphylococcus aureus* are sensitive to the more commonly used antibiotics, and infections can be effectively treated. Some *Staphylococcus aureus* bacteria are more resistant. Those resistant to 'penicillin-type' antibiotics are termed meticillin-resistant *Staphylococcus aureus* (MRSA).

The Infection Prevention and Control (IPC) team record all new MRSA acquisitions in the Trust as part of alert organism surveillance i.e., MRSA grown from clinical samples other than blood cultures, including screening swabs.

During the 2022-23 financial year, there were 19 cases where a patient became colonised with MRSA where there was no previous history, and it is likely to have been acquired in the hospital. The MRSA acquisitions trend from 2005-22 can be seen in Figure 17.

Figure 17: MRSA Acquisition Trend 2005-2023



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Not all admissions are screened for MRSA, following national guidance published in 2014, indicating that MRSA screening could be reduced to "high-risk" patients only. The Trust however screens the following patients:

- All emergency and elective admissions to high-risk areas.
- Patients on ICUs (screened on admission and weekly).
- All emergency and elective transfers from other hospitals or Care Homes on arrival or within 24 hours.
- All emergency and elective admissions/transfers who have been in hospital in the last 12 months (as in patient or day case).
- All emergency and elective admissions regardless of ward or speciality who have a previous history of MRSA.

11. Surgical Site Infection (SSI) Surveillance

The aim of the national surveillance programme for surgical site infection is to enhance the quality of patient care by encouraging hospitals to use data obtained from surveillance of SSI to review and guide clinical practice.

Data collected generates two rates of SSI: The cumulative incidence of SSI and all hospitals SSI rate. Both results will be presented in this report

The **Cumulative Incidence of SSI** is calculated from SSI detected during the inpatient stay and readmission with SSI. This rate is used for comparison against the national benchmark. Only SSIs identified by active surveillance in hospital are included in the main outcome measure for national surveillance because SSIs reported by patients cannot be verified. Table 2 shows cumulative incidence for Reduction of Long Bone and cumulative incidence for Coronary Artery Bypass Graft (CABG) SSI at the Trust during the 2022-23 financial year.

The **All-hospitals SSI** rate includes all SSIs detected during inpatient stay and readmission with SSI in addition to those infections detected in post-discharge surveillance and reported by patients up to 30 day's post-operation. Table 3 shows 'All hospitals' comparison for Reduction in Long Bone and 'All hospitals' comparison for CABG SSI at the Trust during the 2022-23 financial year.

Table 2: Cumulative Incidence of SSI

	Reduction of Long Bone		Coronary Artert Bypass Grafts	
SSI Period 2022-23	**St. George's**	**All Hospitals**	**St. George's**	**All Hospitals**
April- June 2022	2.7%	0.7%	3.2%	2.6%
July- September 2022	3.3%	0.7%	2.9%	2.5%
October- December 2022	No Participation		0.0%	2.6%
January- March 2023	2.4%	TBD	1.4%	TBD

The cumulative incidence of SSI (Table 2 above) are benchmark figures for the cumulative percentages for patient and readmission figures for 2022-23. The Trust was identified as a *high* outlier (lying within the top 10% of the distribution) for *both* modules during the April-June 2022 period and as a *high* outlier during the July-September 2022 period for the reduction of long bone fracture module.

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Table 3: 'All Hospitals' SSI

	Reduction of Long Bone		Coronary Artert Bypass Grafts	
SSI Period 2022-23	**St. George's**	**All Hospitals**	**St. George's**	**All Hospitals**
April- June 2022	2.7%	1.4%	4.3%	5.4%
July- September 2022	3.3%	1.3%	3.9%	5.2%
October- December 2022	No Participation		0.0%	5.2%
January- March 2023	TBD	TBD	TBD	TBD

All hospital comparison is an average of hospitals over the previous 5 years. UKHSA publishes SSI data by calendar year and not financial year.

The SSI surveillance programme (SSIS) provides an infrastructure for hospitals to collect data on up to 17 surgical categories. Infections that are reported using the SSIS data base should be investigated by the relevant multi-disciplinary team (MDT), surveillance nurses, ward manager and IPCT to identify issues / practices for improvement.

Results are then submitted to UK Health Security Agency (UKHSA) so that comparison between hospitals can be made.

During 2022-23 the Trust participated in the reduction of long bone fracture and coronary artery bypass graft (CABG) surgery modules.

11.1. Reduction of Long Bone Fracture

During the period of April-June 2022, there were three SSIs reported; all were detected upon readmission and classified as organ space. This resulted in the trust being a high outlier, 2.7% against a national benchmark of 0.7%.

During the period of July- September 2022, there were three SSIs reported; one was detected upon readmission and classified as organ space; the second during admission and classified as deep incisional; and the last was detected upon readmission to another hospital. This resulted in the trust being a high outlier, 3.3% against a national benchmark of 0.7%.

During the period of October-December 2022, the Trust did not participate in surveillance due to COVID pressure.

During the period of January- March 2023, there were two SSIs reported; both were detected upon readmission and classified as organ space. This resulted in the trust being a high outlier, 2.4% against a national benchmark of 0.7%.

Surveillance is undertaken for up to one year after an implant is placed. Patients may still present with SSI for up to one-year post-op and this is also reported to UKHSA as part of the surveillance.

11.2. Coronary Artery Bypass Grafts (CABG)

The cardio-thoracic Specialist Nurse in conjunction with Infection Prevention and Control Team undertook SSI surveillance of all CABG surgery. All wound infections are assessed by the cardiac surgery CNS team and/ or surgical consultant/ registrar, with follow-up as an outpatient. Root Cause analysis carried out by CNS and surgeon for all deep wounds.

During the period of April-June 2022, there were four SSIs reported; the first was detected post-discharge follow-up and classified as superficial; the remaining three were detected upon readmission and classified as superficial.

During the period of July-September 2022, there were four SSIs reported; two being detected upon readmission and both classified as superficial; the third detected during admission and classified as deep incisional; and the last was detected via other post discharge follow-up and was classified as superficial.

During the period of October-December 2022, there were no SSIs reported.

During the period of January-March 2023, there was one SSI reported which was detected upon readmission and classified as superficial.

11.2.1. Learning from SSI Reviews

A meeting was held to review the Trust's outlier position for CABG April-June 2022, the following actions were agreed:

- To liaise with cardiac surgeons regarding infections and review cases.
- To add wound closure to the RCA document.
- Determine if trends in Consultant Cardiac Surgeons and Registrars linked to cases in 2020 and 2021.
- Identify theatres in which surgery took place, any anomalies, changes in practice etc.
- Undertake sternal and leg wound care audits to ensure standards are optimal.
- Dressings – a current problem with supply of honeycomb dressings, one alternative is not transparent. Procurement not always able to supply requested dressings.
- Review monthly hand hygiene and decontamination of equipment audit scores.
- Discuss ICU issues with ICU clinical director including noncompliance with bare below elbows.
- Review SSI saving lives audit scores (pre; peri and post-op). Revise saving lives audit tool and undertake a minimum of ten wound care audits on Ben Weir ward.
- Undertake programme of ward nurse teaching on wound care management and SSI teaching.
- Teaching for theatre nurses for sternal and leg wound bundle in progress – to include ward staff and pre-assessment team.
- Review staff compliance with ANTT competencies on B. Weir and CTICU.
- Review any accreditation or walkabout findings that were undertaken October to December 2021 in Ben Weir, CTICU or Cardiac Theatres.
- Review cleanliness of equipment.
- Review patient education and teaching pre-and post-op on B. Weir to ensure the information is of a high standard and that education and teaching is routinely given to patients.

11.2.2. Additional Actions for the Trust

- Continue to monitor compliance with standard NICE guidance regarding theatre procedures including suturing. Theatres have changed suturing practices moving from staples to sutures in orthopaedic and cardiac surgery. Triclosan (antimicrobial) coated antimicrobial sutures are currently in use.
- Continue with feedback to surgical teams and other relevant stakeholders regarding infections, rates of SSIs and PHE reports.
- IPC walkabouts in theatres continue and feedback provided to theatre staff.
- Strengthen links with the T&O clinic to alert IPC when patients return with SSI or suspected SSI.
- Review the method of finding post discharge and patient reported SSIs.

12. Water Safety

The monitoring and preventative measures for control of Legionella and Pseudomonas in taps, showers and other water outlets continues in accordance with the Trust Water Safety Policy and Water Safety Plan. A system of filtering outlets remains in Lanesborough wing and water outlet testing remains in place. Detections of Legionella and Pseudomonas in the water of St James reduced significantly this year and as of December 2022 was no longer considered "systemically contaminated," resulting in the removal of Point of Use (POU) filters. Testing continues to take place and remedial works are carried out where positive detections are found. POU filters are put in place as required.

The strategy implemented in St James is being implemented into Lanesborough with future projects planned to improve overall safety in the water services. The Water Safety Team have implemented a continuous improvement strategy to manage the existing estate, and water sampling during the year shows low levels of contamination across all areas, including both main Trust buildings housing most wards.

Raised levels of Legionella were detected in the cold and hot water supply of the Nelson Centre since February 2023. The Nelson Centre is a PFI building owned by Fulcrum, managed by a facilities management company Kudos (owned by Fulcrum) with Community Health Partners (CHP) as primary tenant. CHP then sublets to a variety of tenants including SGH, Central London Community Health (CLCH) and The Nelson Medical Practice. St Georges has a variety of services onsite including outpatient clinics and endoscopy.

St George's were informed of the Legionella issue in March 2023 and point of use (POU) filters were immediately installed on all taps by St Georges estates to ensure patient and staff safety. The Trust has worked with all the stakeholders including, CHP, Fulcrum, Kudos, other tenants, the SWL ICB and the UKHSA to address the underlying issues. The complexity of the PFI structures has made this challenging, but progress has been made.

The Operational Water Management Group (OWSG) has led on management water safety and includes support from IPCT. The OWSG has met on a fortnightly basis and is led by the Head of Estates with representatives from Microbiology, Infection Control and contractor services in attendance.

13. Outbreak and Incidents

13.1. Carbapenemase Producing *Enterobacterales* (CPE)

Two outbreaks of CPE occurred during the 2022-23 financial year involving 5 patients in total.

The **first outbreak** of Carbapenemase Producing *Enterobacterales* was detected on the Neuro Intensive Care Unit (NICU) in March 2022, 2 cases were involved. Both isolates were sent to UKSHA reference laboratory at Colindale and were reported to be identical suggesting patient to patient transmission of the organism.

Outbreak review meetings were held with the support of South London Health Protection Team. Outbreak actions were put into place including enhanced environmental cleaning and the area entered a period of increased surveillance and audit (PISA). A total of 42 contacts were identified, 18 had been discharged and 24 remained as inpatients. For the remaining inpatient contacts, twice weekly screening was undertaken for 2 weeks then once weekly for a further 2 weeks. No further cases were detected.

The **second CPE outbreak** was detected in September 2022 on Brodie ward involving 3 patients, typing by the reference laboratory has shown that all three isolates match and have been given a designation of SGEO07EB-10.

Outbreak meetings were held with the support of South London Health Protection Team and the ward was put on a period of increased surveillance and audit, patient contact screening was also carried out, including CSUs in addition to rectal swabs. Environmental screening of the ward's dirty utility, affected bays and side rooms, plug holes and other facilities that were used by the affected patients was also undertaken.

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13.2. Monkeypox

A monkeypox exposure incident occurred in July 2022 which involved a patient presenting to the Emergency Department and transferring to two further wards- Nye Bevan Unit and Kent ward.

Monkeypox was not suspected initially as there was an alternative diagnosis of cellulitis and a wound swab yielded Streptococcus A, which supported this diagnosis. However, the patient later developed further lesions and Monkeypox was diagnosed. The patient was transferred to a single patient room on McEntee ward and was discharged home on 26/07/22.

Nine patient contacts were identified of which none have been reported to date as showing any symptoms.

13.3. Candida auris

Candida auris is a yeast that can cause outbreaks of infection and has a propensity for transmission between hospital patients. Of significance is that it is commonly resistant to first line anti-fungal drugs. Infection prevention and control measures are paramount to manage any colonisation or infection with *Candida auris* to prevent nosocomial spread.

A line related *Candida auris* candidemia was identified in a patient on McEntee ward from a blood culture taken on 13/07/22. The candidemia was thought to be line related. Subsequent screening also identified rectal and skin carriage, including axilla and groin.

The patient was card for in a single room resulting in reduced contact with other patients however, a one-off screen was undertaken for all other patients on the ward. A total of 17 patients, other than the index case were screened and no further positives identified. In line with other investigations of previous cases of *Candida auris*, some environmental sampling was undertaken of 20 screens in the environment, including a selection of medical devices and other touchpoints. The environmental screening yielded no positives.

The patient went to theatre for surgery on 22/07/22 and the case was done last on the list. The table and vicinity were wiped down using antimicrobial wipes as part of a standard clean, but an additional deep clean was not undertaken. However, the level of physical cleaning was judged to be acceptable, and so the risk to subsequent patients who had surgery the following morning was agreed to be extremely low. However, it was agreed that one of the patients who had open orthopaedic surgery should be told of this low-risk exposure and invited to come for screening for *Candida auris* as an extra precaution.

13.4. Clostridioides difficile

When more than one case occurs in a ward area an investigation occurs, including a PII or outbreak meeting, to determine if there has been nosocomial transmission in accordance with the following definitions.

- **A period of increased incidence (PII)** of CDI: two or more new cases (occurring >48 hours post admission, not relapses) in a 28-day period on a ward.

- **An outbreak** of *C. difficile* infection: two or more cases caused by the same strain (ribotype) related in time and place over a defined period that is based on the date of onset of the first case.

Table 4 shows a summary of all potential/confirmed period of increased incidences and outbreaks during the 2022-23 financial year.

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Table 4: Summary of PII and Outbreaks 2022-23

Ward	Number of Cases	Details
Allingham	3	All different ribotypes, so remains a period of increased incidence (not an outbreak). Other cases occurred as singular cases in different locations.
GICU	3	Two of which were the same ribotype, so therefore also technically an outbreak
Trevor Howell	2	Outbreak due same ribotype
Marnham	2	Two patients were CDI positive 17/09/2022 and 14/10/2022 just within a 28-day period. Ribotyping was not available on one specimen so it was not possible to determine if an outbreak had taken place. The patients overlapped in time but were not in the same bay. The ward underwent a full PISA.
Gordon Smith	2	Two patients were CDI positive 19 and 20 September 2022 respectively. They overlapped in the same bay for 10 days from 10-19 September 2022. Ribotyping was inconclusive due to no growth on one sample, so it was not possible to determine if there had been an outbreak.
Caesar Hawkins	3	HOHA cases each more than 28 days apart (23/04/202; 25/08/2022; 14/11/2022) so they do not constitute an outbreak.
Fredwrick Hewitt	2	Two patients were CDI positive 23/11/22 and 16/12/22 just within a 28-day period (23 days). They only overlapped on the ward for one day and both were in cubicles. Ribotyping results are now back and they different, indicating this has not been an outbreak on the ward.
Allingham	2	Patients were CDI positive 04/01/2023 and 12/01/2023. The patients overlapped in time but were not in the same bay. The ward underwent a full PISA. Unfortunately, ribotyping is not available on both specimens so it is not possible to determine if an outbreak has taken place

13.5. Pseudomonas aeruginosa

In December 2022, *Pseudomonas aeruginosa* was detected in a blood culture collected from a baby on the NNU. An incident meeting was held on 9 December 2022.

A review of the unit identified 8 further babies with positive microbiology results for *Pseudomonas aeruginosa* since April 2022. Environmental screening of filters and basins resulted in one positive swab from a filter in HDU 2. All taps on NNU had POU filters had applied, and the affected hand wash basin was taken out of use. Hand hygiene audits and environmental cleaning on the unit were of a good standard.

Comparing *Pseudomonas aeruginosa* rates to previous years established that the total number of babies identified in 2022 was not higher than had been seen in recent years, but the bloodstream infection was a serious finding.

In March 2022 there had been a discussion about the water usage on the unit when there were two babies identified with *Pseudomonas aeruginosa* colonisation/infection. In March 2022 some environmental screening for *Pseudomonas aeruginosa* was performed and was negative.

Babies are washed with tap water (nappy changes). There was discussion around the use of sterile water instead. The wording in guidance around this is somewhat ambiguous but sterile water is used at many other hospital units.

Actions taken:

- Isolates sent for typing if available.
- Water testing results obtained from Water Safety Team (WST); positive samples managed in accordance with water safety policy.
- Continued monitoring hand hygiene and cleaning on the unit.
- Records of cot spaces and incubators reviewed by IPC and nursing staff for any overlap.
- Maintain the switch to sterile water for nappy changes.

- Continue to monitor for any new cases and send for typing.

Typing results:

3 clinical specimens (from the 9 babies investigated in 2022) were available for typing, and VNTR analysis showed isolates were unique – meaning there was no link. The environmental sample from the filter was also sent for typing and was different from the clinical typing results.

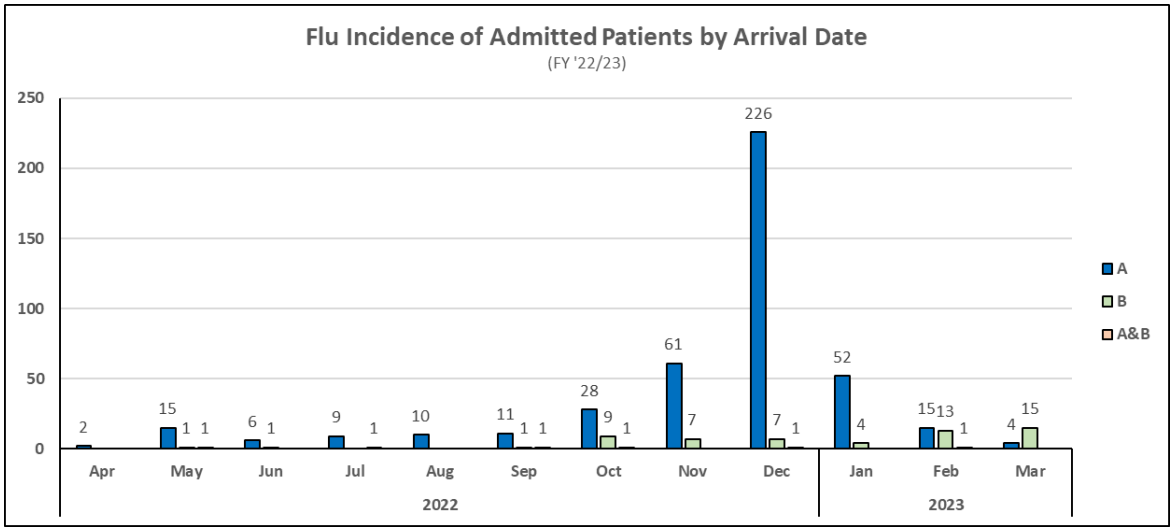
A subsequent sputum specimen was obtained in December from a baby (where the sample had previously not been available) was sent for typing (4th clinical specimen). It resulted similar to the baby with the positive blood culture, but they differ by one locus in the STS typing. Both these babies were in ICU 3 between the 19 November and 5 December 2022. The timing of the isolates (one month apart) makes it difficult to establish the index case. Also, the antibiograms were possibly different - the isolate that was typed was not actually tested. Micro consultant has asked the Reference lab for more work to be done on the specimen, which may provide a more definitive link. There has been no further feedback on this.

There have been 2 more cases of Pseudomonas isolated on the unit in February 2023. Both specimens have been sent for typing and one result is back. Again, it is unique from other reported isolates on the unit. The other isolate result is still pending. The NNU main unit continues to use sterile water for nappy changes, however, for bathing babies they are still using tap water.

13.6. Influenza Infections and Outbreaks

There were high numbers of influenza cases reported during the winter season of the 2022-23 (Figure 18). Consequently, there were four outbreaks during December 2022 and one in January 2023.

Figure 18: Influenza Incidence during the 2022



13.6.1 Staff Influenza Vaccination

The Trust's staff influenza vaccination campaign for 2022-23 led to an uptake of 67% among staff. See Table 5 for a breakdown by staff group.

Table 5: Uptake of Influenza Vaccination by Staff Group

Staff Group	Number of staff involved in direct patient care	No of HCWs vaccinated in this campaign	Vaccine uptake (%)

Doctors	1638	1096	67%
Nurses, Midwives & students	3769	2664	68%
Support to clinical staff & Admin	2814	1829	64%
Clinical – Allied Health Professionals	2347	1439	61%
Totals	10568	7028	67%
Total percentage patient facing			67%

13.7. Norovirus

One Norovirus outbreak occurred in January 2023 on a Senior Health ward. The ward closed between 5 to 26 January 2023 with 13 patients were affected. No further outbreaks were reported.

13.8. SARS-CoV-2 (COVID-19)

SARS-CoV-2, commonly referred to as COVID-19, continued to overshadow the work of the IPC Team and the wider hospital during the months of June, July, October, and December 2022—where an increase of community and nosocomial cases spiked (see Figure 19 and 20). The Trust uses the following definitions when classifying COVID-19 cases:

- Hospital-onset healthcare-associated (HOHA): positive >14 days after their hospital admission, where admission is day 1.
- Hospital-onset probable-association (HOPA): positive 8-14 days after their hospital admission, where admission is day 1.
- Hospital-onset indeterminate-association (HOIA): Positive 3-7 days after their hospital admission, where admission is day 1.
- Community-onset community-associated (COCA): Positive <3 days after their hospital admission, where admission is day 1.

COVID-19 during 2022-23 was less severe when compared to 2020/ 2021, reflecting a population with growing immunity to the virus because of a national vaccination programme.

Figure 19: Percent Change of SARS-CoV-2 Acquisitions 2022-23

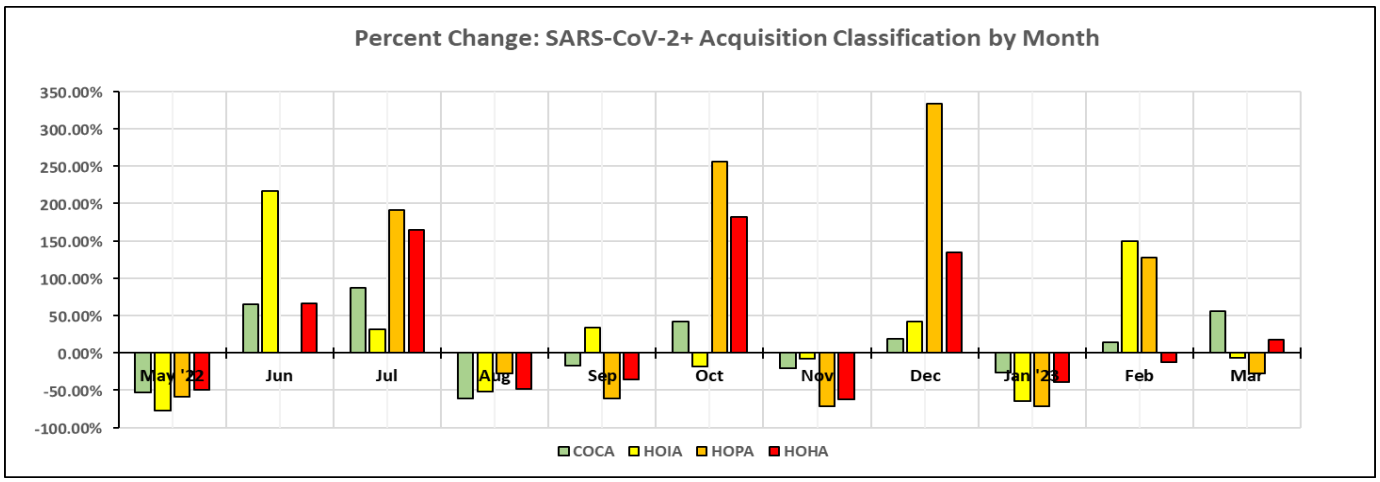
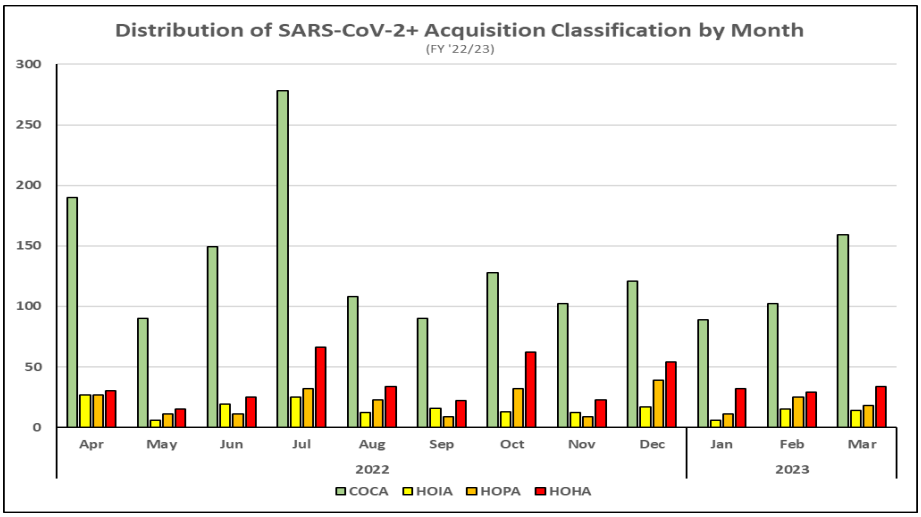


Figure 20: Distribution of SARS-CoV-2 Acquisition 2022-23



Nonetheless, the Trust experienced 69 COVID-19 outbreaks during the 2022-23 financial year (Table 6). Many COVID-19 outbreaks occurred in the Medicine & Cardiovascular Division (n=49) followed by the Surgery, Neurosciences & Anaesthetics Division (n=20). The Children & Women's, Diagnostic & Therapy Division experienced no COVID-19 outbreaks.

Table 6: COVID-19 Outbreaks in Chronological Order

Ward	Outbreak Declared	Division
Gunning	08/04/2022	Surgery, Neurosciences & Anaesthetics Services
Dalby	13/04/2022	Medicine & Cardiovascular Services
Gray	15/04/2022	Surgery, Neurosciences & Anaesthetics Services
Rodney Smith	25/04/2022	Medicine & Cardiovascular Services
Gunning	13/05/2022	Surgery, Neurosciences & Anaesthetics Services
Allingham	30/05/2022	Medicine & Cardiovascular Services
Amyand	17/06/2022	Medicine & Cardiovascular Services

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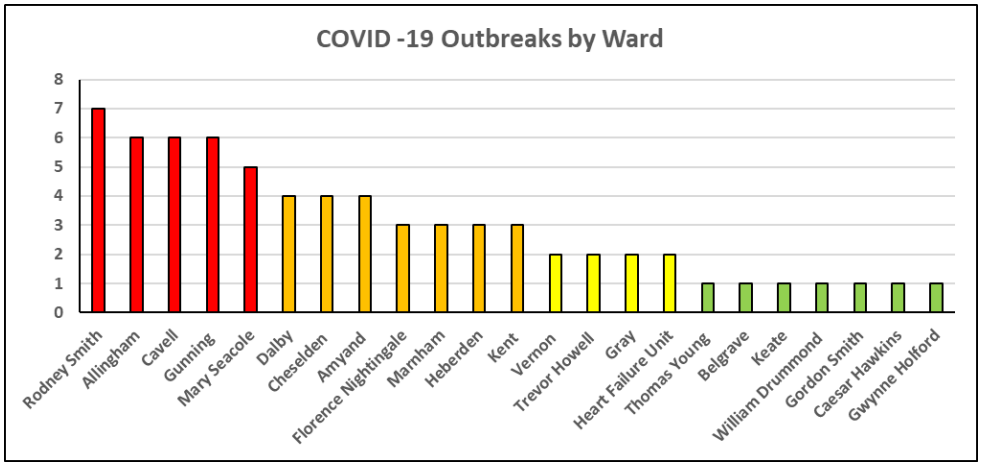
Mary Seacole	21/06/2022	Medicine & Cardiovascular Services
Cavell	25/06/2022	Medicine & Cardiovascular Services
William Drummond	27/06/2022	Surgery, Neurosciences & Anaesthetics Services
Heberden	04/07/2022	Medicine & Cardiovascular Services
Kent	04/07/2022	Surgery, Neurosciences & Anaesthetics Services
Vernon	04/07/2022	Surgery, Neurosciences & Anaesthetics Services
Cheselden	06/07/2022	Medicine & Cardiovascular Services
Allingham	12/07/2022	Medicine & Cardiovascular Services
Gray	12/07/2022	Surgery, Neurosciences & Anaesthetics Services
Mary Seacole	13/07/2022	Medicine & Cardiovascular Services
Rodney Smith	17/07/2022	Medicine & Cardiovascular Services
Amyand	17/07/2022	Medicine & Cardiovascular Services
Cavell	23/07/2022	Medicine & Cardiovascular Services
Trevor Howell	24/07/2022	Medicine & Cardiovascular Services
Florence Nightingale	25/07/2022	Surgery, Neurosciences & Anaesthetics Services
Allingham	13/08/2022	Medicine & Cardiovascular Services
Cavell	28/08/2022	Medicine & Cardiovascular Services
Cavell	26/09/2022	Medicine & Cardiovascular Services
Rodney Smith	29/09/2022	Medicine & Cardiovascular Services
Heberden	05/10/2022	Medicine & Cardiovascular Services
Thomas Young	07/10/2022	Surgery, Neurosciences & Anaesthetics Services
Kent	14/10/2022	Surgery, Neurosciences & Anaesthetics Services
Marnham	24/10/2022	Medicine & Cardiovascular Services
Gunning	24/10/2022	Surgery, Neurosciences & Anaesthetics Services
Mary Seacole	25/10/2022	Medicine & Cardiovascular Services
Cheselden	28/10/2022	Medicine & Cardiovascular Services
Cavell	17/11/2022	Medicine & Cardiovascular Services
Gwynne Holford	21/11/2022	Surgery, Neurosciences & Anaesthetics Services
Gunning	08/12/2022	Surgery, Neurosciences & Anaesthetics Services
Marnham	09/12/2022	Medicine & Cardiovascular Services
Rodney Smith	10/12/2022	Medicine & Cardiovascular Services
Cheselden	13/12/2022	Medicine & Cardiovascular Services
Trevor Howell	13/12/2022	Medicine & Cardiovascular Services
Keate	13/12/2022	Surgery, Neurosciences & Anaesthetics Services
Mary Seacole	14/12/2022	Medicine & Cardiovascular Services
Amyand	15/12/2022	Medicine & Cardiovascular Services
Heart Failure Unit	21/12/2022	Medicine & Cardiovascular Services
Florence Nightingale	21/12/2022	Surgery, Neurosciences & Anaesthetics Services
Dalby	23/12/2022	Medicine & Cardiovascular Services
Gordon Smith	25/12/2022	Medicine & Cardiovascular Services
Rodney Smith	30/12/2022	Medicine & Cardiovascular Services
Dalby	31/12/2022	Medicine & Cardiovascular Services
Allingham	02/01/2023	Medicine & Cardiovascular Services
Kent	02/01/2023	Surgery, Neurosciences & Anaesthetics Services
Gunning	07/01/2023	Surgery, Neurosciences & Anaesthetics Services
Vernon	13/01/2023	Surgery, Neurosciences & Anaesthetics Services

Caesar Hawkins	26/01/2023	Medicine & Cardiovascular Services
Rodney Smith	31/01/2023	Medicine & Cardiovascular Services
Amyand	10/02/2023	Medicine & Cardiovascular Services
Allingham	11/02/2023	Medicine & Cardiovascular Services
Cavell	14/02/2023	Medicine & Cardiovascular Services
Florence Nightingale	15/02/2023	Surgery, Neurosciences & Anaesthetics Services
Heberden	20/02/2023	Medicine & Cardiovascular Services
Gunning	22/02/2023	Surgery, Neurosciences & Anaesthetics Services
Cheselden	28/02/2023	Medicine & Cardiovascular Services
Rodney Smith	03/03/2023	Medicine & Cardiovascular Services
Dalby	06/03/2023	Medicine & Cardiovascular Services
Heart Failure Unit	08/03/2023	Medicine & Cardiovascular Services
Belgrave	15/03/2023	Medicine & Cardiovascular Services
Mary Seacole	18/03/2023	Medicine & Cardiovascular Services
Marnham	24/03/2023	Medicine & Cardiovascular Services
Allingham	25/03/2023	Medicine & Cardiovascular Services

A further breakdown of COVID-19 outbreaks during the 2022-23 shows that Rodney Smith, Allingham, Cavell, Gunning, and Mary Seacole had the greatest number of outbreaks (Figure 21).

Figure 21: Total Number of COVID-10 Outbreaks per Ward

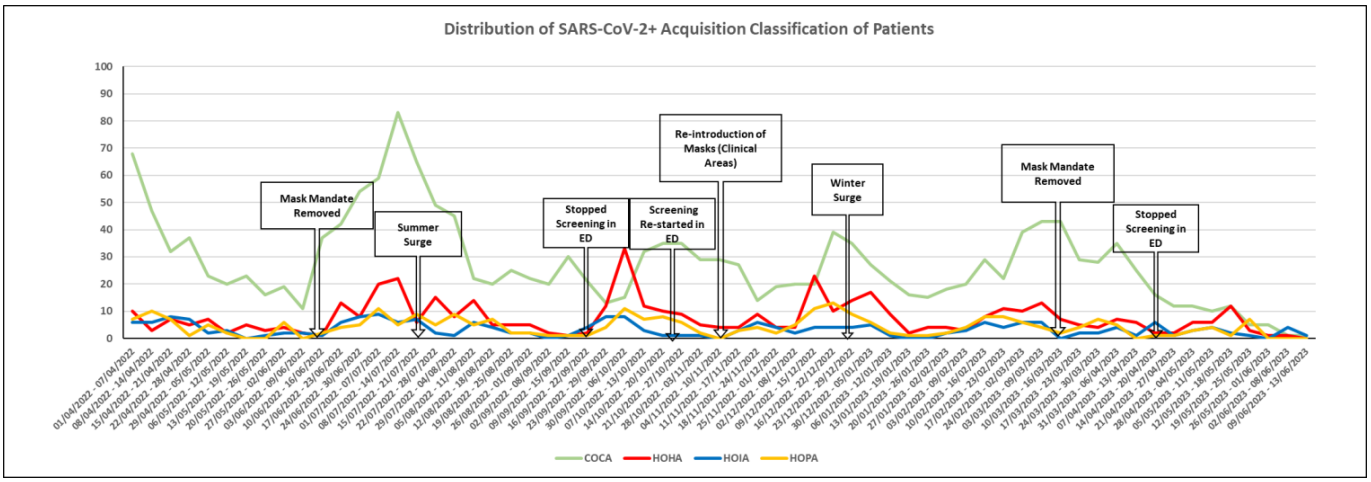


In terms of nosocomial infections, the IPC Team and the Trust have attempted to control and contain the infection, with a range of measures as set out in national guidance including:

- screening of patients on admission and at intervals thereafter (frequency determined by local risk profile)
- prompt isolation of COVID-19 cases in dedicated COVID wards
- isolation and screening of patient contacts
- staff screening (increased during outbreaks)
- mandatory mask-wearing by all staff (mandate later removed)
- molecular typing of isolates.

A timeline of key events related to COVID-19 during 2022-23 is shown in Figure 22.

Figure 22: Key COVID-19 Related Events 2022-23



The Emergency Department at St Georges continues to be all single cubicles, which has aided the prevention of cross transmission. The waiting area also continues to be fitted with substantial Perspex screens between waiting chairs in a further effort to create a physical barrier between patients. However, despite these best efforts, we still found that hospital spread of COVID-19 occurred in proportion to community rates.

Therefore, during the 2022-23 financial year 17.31% of cases were detected more than 14 days post admission to hospital (HOHA) (Table 7). The control measures were often disruptive to patients and the Trust was compelled to balance the risk of COVID-19 control measures against other risks such as delayed admission, overcrowding in ED, delayed or cancelled surgery, patients on dedicated COVID wards not receiving timely specialist care for their needs etc. The reasons for this inability to prevent all nosocomial COVID include the respiratory nature of spread, frequent asymptomatic infection in patients, visitors and staff, long incubation, and many wards with beds close together, in bays with no doors and no or minimal mechanical ventilation.

Table 7: Breakdown of COVID-19 Cases by Month

	April '22	May	June	July	August	September	October	November	December	January '23	February	March	Total	Percent
COCA	190	90	149	278	108	90	128	102	121	89	102	159	1606	**65.26%**
HOIA	27	6	19	25	12	16	13	12	17	6	15	14	182	**7.40%**
HOPA	27	11	11	32	23	9	32	9	39	11	25	18	247	**10.04%**
HOHA	30	15	25	66	34	22	62	23	54	32	29	34	426	**17.31%**
Total	274	122	204	401	177	137	235	146	231	138	171	225	2461	100.00%

14. Infection Control Compliance and Audit

Effective hand hygiene remains the single most important action staff can take to prevent the spread of infection. St George's has placed hand hygiene and monitoring of compliance with hand hygiene technique as a key ongoing priority for the IPCT and for infection prevention across the Trust. To ascertain compliance, each clinical area undertakes a monthly audit via the 'Saving Lives' programme. The audit includes a check on hand hygiene compliance for a range of members of the multi-disciplinary team including Nurses, Doctors,

Physiotherapists and Occupational Therapists. The audit scores reflect the units' compliance and allow them to address any areas of identified noncompliance or concern.

Non-compliance with infection control precautions are managed by the wards and Divisions however, for continued non-compliance a clear escalation process is in place in the trust.

In 2022-2023 a total of 47,357 hand hygiene observations were performed which was less than the year before (52,789 observations) Table 8 shows the number of hand hygiene audits performed and the number of issues identified.

Table 8: Hand Hygiene Audit Monthly Breakdown 2022-23

Month	Individual Audits	No Issues	Issues	Rate
April '22	4065	4009	56	98.6%
May	4113	4048	65	98.4%
June	4215	4146	69	98.4%
July	3735	3691	44	98.8%
August	3864	3815	49	98.7%
September	3780	3742	38	99.0%
October	3950	3897	53	98.7%
November	3805	3765	40	98.9%
December	3919	3868	51	98.7%
January '23	3931	3878	53	98.7%
February	3871	3821	50	98.7%
March	4109	4057	52	98.7%
TOTAL	**47357**	**46737**	**620**	**98.7%**

Hand hygiene audit results are displayed within Saving Lives scorecard and discussed at Care Group and Divisional meetings and in Divisional reports to the IPCC.

15. Bare Below the Elbow (BBE)

The Trust continues to monitor compliance with the Department of Health (DH) initiative 'Bare below the elbow' with all staff working in clinical areas. Compliance is monitored during hand hygiene audits, with results discussed at the IPCC. Staff are advised to locally resolve any non-compliance with colleagues and additional escalation to the DIPC, Clinical Director and/ or the Chief Medical Officer is available where BBE continues to be a challenge.

16. Period of Increased Surveillance and Audit (PISA)

The IPC team undertake a process of focussed surveillance and audit for wards with episodes of healthcare-associated infections (HCAI). All wards where patients acquire *Clostridioides difficile*, MRSA blood stream infection (BSI) or have a suspected/ confirmed MRSA outbreak, undergo a period of increased surveillance and audit (PISA). These tools allow observation of the management of patients including documentation of medical reviews, hand hygiene, Personal Protective Equipment (PPE), screening and isolation. General ward cleaning, hand hygiene, decontamination of patient equipment, management of clean linen and venous access devices (for MRSA) are also all audited during the PISA process.

The ward must achieve 95% or above to pass and must pass 3 consecutive weeks to be successful and to come off PISA. For *C. difficile* cases the Antimicrobial Stewardship (AMS) team review antimicrobial prescriptions for all patients on the ward. The ward must achieve 95% on one occasion to come off the AMS component of the PISA. On occasion, e.g., relapse of *C. difficile*, it may be decided that a PISA is not

indicated and only an RCA will be required for the episode. At times, a PISA may be carried out for more than one patient on the same ward i.e., where a period of increased incidence has been established or there is a subsequent case identified after the start of the initial PISA. In these instances, the PISA will continue until the criteria outlined above has been met.

There was one MRSA blood stream infection allocated to the Trust for the 2022-23 financial year and the PISA process was carried out on the ward.

48 wards were put on PISA out of 60 cases of Healthcare-Associated cases of *Clostridioides difficile*, this includes those with increased incidents and outbreaks. No PISAs were carried out on cases that were community-onset.

In addition, PISAs continue to be initiated on wards where an outbreak of COVID-19 was identified to ensure that basic IPC precautions and practices were in place during the first two quarters of the financial year. However, this process ended as the Trust transitioned to a business-as-usual approach as COVID-19 cases reduced in number and severity.

Feedback from PISAs are given to the ward team at the time of the visit and is followed up in writing.

During 2022-23 financial year, the average number of weeks that wards were on PISA continues to be approximately 7 weeks.

17. Saving Lives Audits

The Saving Lives Programme is a set of 'Care Bundles' or High Impact Interventions (HII) that are an evidence-based approach relating to key clinical procedures or care processes. They include:

- the insertion and care of venous access devices and urinary catheters
- prevention of surgical site infection
- ventilator associated pneumonia
- the spread of *Clostridioides difficile*
- isolation practices
- PPE usage.

These tools were updated in 2017 and are routinely audited 6-monthly (where applicable) by Infection Control Link Practitioners. Hand hygiene and Cleaning and Decontamination of Patient Equipment audits are carried out monthly.

Saving Lives audits are completed on the Trust's quality management reporting system (RaTE) and is broken down by Division and ward/department level to enable monitoring of compliance. It is accessible to all staff via the Trust intranet.

Performance is reported to the IPCC and clinical areas that perform poorly are required to produce an action plan to address any failings within an agreed timeframe.

18. Estates and Facilities

The Estates and Facilities (E&F) team in conjunction with the nursing and Infection Prevention & Control Team (IPCT) conducted audits to assure the Trust of its obligation to provide a safe care environment. The Trust average score for cleanliness:

- SGH - 97.47%. For very high-risk areas including critical care the score was 98.32%.
- QMH - 97.68%
- Essentia (Stormont, Tooting, Eileen Lecky Clinics) - 96.16%
- CHP premises (Nelson, StJTC, Surbiton) - 95.16%

In 2022-23 the E&F team also continued to be part of the audit teams for the ward accreditation programme. These included audits across the community sites, and Queen Mary's Hospital and actions were then taken to rectify any concerns when noted.

19. Cleanliness in Hospitals

Cleaning in hospitals has been governed by the National Specifications for Cleanliness in Hospitals in 2021. Each site has a target score which considers different risk categorisation and cleaning frequencies.

Throughout the 2022-23 financial year, additional enhanced cleaning was in place in many areas of the Trust to meet the challenge of COVID-19, Norovirus, CPE, and *C. difficile*. This included additional cleaning hours in dedicated cohort wards, and in high-risk areas such as the Emergency Department and in elderly care and surgical wards. Additional cleaning was also in place in high-risk areas such as oncology and haematology to help reduce the risk of infection in vulnerable patients.

20. Ward and Department Accreditation Audits

The ward accreditation programme is designed to engage staff and empower leaders to improve and maintain standards and quality of patient care and staff experience. The accreditation framework is based around 13 standards that were developed in line with the CQC key lines of enquiry. The wards progress through four levels (Requires improvement, Bronze, Silver and Gold) following formal accreditation visits based on standards of performance against agreed metrics.

The IPC nurses continue to participate in the ward accreditation audits, led by Corporate Nursing, and review the infection control practices and adherence to policy.

21. Infection Control Team Walkabouts

In addition to formal audits the Infection Prevention & Control Team also undertake regular scheduled visits to clinical areas to observe cleanliness of medical devices and the environment and IPC practice. Feedback is given to the nurse in charge following the visit and is followed up by communication to the Ward Manager, Matron and Head of Nursing.

22. Venous Access Service

The Venous Access Service is the primary service for insertion of all types of lines in the Trust and is committee to high standards of IPC in relation to the insertion and on-going care and management of vascular devices.

The team undertake weekly surveillance on the management of long-term vascular access devices and monitors any variation in weekly dressing compliance. If there is evidence of non-compliance, then this is addressed at the time with the bedside nurse and the nurse in charge. In addition, this measurement of compliance has now been added to the question set for the Trust's Ward Accreditation programme, along with observation of any peripheral cannulas.

The Venous Access Team continues to work alongside the IPCT and the iCLIP (patient management system) Team to further adapt the recording of venous access devices to ensure that it is as intuitive and user friendly as possible to record observations of venous access care.

23. IPC Mandatory and Statutory Training (MAST), Training and Education

23.1. IPC MAST Compliance

All wards and departments were encouraged to ensure that their compliance with MAST on-line training was greater than 85%. As at 20/06/2023, the compliance rate for IPC *clinical* online MAST was 83% (n= 5321)

and for *non-clinical* on-line MAST was 90% (n=2686) compared to 2021-22 when compliance was 83% and 89% respectively.

Medical and Dental non-clinical (50%) and Medical and Dental clinical (73%) staff group continue to be the least compliant groups.

23.2. Education and Training

The IPC nurses continue to deliver a range of training across the organisation throughout the year. As COVID-19 restrictions and social distancing have ended, the Trust has resumed induction sessions for the majority of the 2022-23 financial year.

Training was delivered to the following groups, primarily nurses. This included staff from the following locations and groups:

- Acute Medicine (including ED)
- Senior Health
- Renal
- Haematology/Oncology
- Surgery, Trauma and Orthopaedics
- Adult ICUs (GICU, CTICU, NICU)
- PICU
- NNU
- Paediatrics
- Nurse Induction/Overseas Nurses
- Nurse Preceptorship Programme
- HCA Induction
- Physician Associates
- Junior Doctors
- Medical Students
- Student Nurses
- Wheelchair Services
- Project Search Training

Hand hygiene training has resumed during the 2022-23 financial year. It has now been possible to take the Surewash machines to as many wards or departments as usual. In total, 230 staff members were able to practice their hand hygiene technique using one of the two machines.

23.3. Personal Protective Equipment (PPE) – Donning and Doffing Training

the IPC Team continues to support PPE donning and doffing training across the organisation to key staff groups and individuals, using a train-the-trainer model, to ensure safe practices. This continues throughout the year, as necessary and when requested, including additional training when outbreaks of Covid-19 were reported.

24. Support From UK Health Security Agency (South London Health Protection Team)

The IPC team continues to work closely with and are indebted to the consultants and scientists based at the South London Health Protection Team, part of the United Kingdom Health Security Agency (UKHSA) for the continuing support received. A member of that team will usually be part of any outbreak/incident investigation team and the help and advice received at those times is invaluable.

25. Priorities for 2023-24

Several actions will be prioritised by the IPCT during the 2023-24 financial year. Much of the priorities centre around HCAI infections at St. George's:

- IPC team to work closely with the Urology CNS team to support urinary catheter education and awareness across trust.
- E. coli/catheter care focus week through senior nurses Back to the Floor in June with QI approach
- Introduction of health economy digital urinary catheter passport into SGH to ensure standardised documentation process across SWL.
- Promote awareness of the continence service referral pathways and standards in development across Southwest London.
- Work with the Southwest London IPC sector to focus on gram negative bacteraemia with a group approach.

- Promote awareness of NHS England 2-year hydration project focusing on community and elderly care. SW London awarded London's Aquarate - a bid to introduce a digital Hydrracup cup and mug across care homes and virtual wards in SW London.
- Work on a collaborative 'Getting Back to Basics' Campaign: A meeting to discuss this workgroup and streams took place 7th June 2023. These workgroups will be overseen by a steering group.

  The following four streams identified are:

  - Urinary Catheter care
  - *C. difficile* and AMS
  - Central and peripheral vascular access line care
  - Back to Basics – hand hygiene, Bare Below Elbows, Cleaning – environmental and equipment

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26. Glossary of Terms

Term	Definition
Bacteraemia / BSI	The presence of bacteria in the blood / blood stream infection
C *difficile*	A bacterium that is one of the most common causes of infection of the colon. It can sometimes produce a toxin leading to colitis
Colonisation	Germs in or on the body but which not make the person unwell
CPE	Carbapenemase producing Enterobacteriaceae are Gram-negative bacteria that are resistant to the carbapenem class of antibiotics, considered the drugs of last resort for such infections
E. coli	*Escherichia coli* form part of the normal intestinal microflora in humans with some strains having the ability to cause disease. These can include food poisoning e.g., E. coli 0157 or infections of the urinary tract and bacteraemia
GRE	Glycopeptide resistant enterococci are bacteria resistant to the Glycopeptide antibiotics (vancomycin and teicoplanin) and are sometimes known as Vancomycin Resistant Enterococci (VRE)
Gram staining	A common technique used to differentiate two large groups of bacteria based on their different cell wall constituents. The Gram stain procedure distinguishes between Gram positive and Gram-negative groups by colouring these cells differently, thus affecting treatment options
HCAI	Healthcare Associated Infection: Any infection that develops as a result of receiving healthcare treatment
Influenza	A respiratory illness associated with infection with the influenza virus. Symptoms frequently include headache, fever, cough, sore throat, aching muscles and joints
MDT	Multi-disciplinary Team: A meeting of a range of specialists who are experts in different areas with different professional backgrounds, united as a team for the purpose of planning and implementing treatment programs for complex medical conditions
MSSA	Meticillin sensitive *Staphylococcus aureus*: a bacterium that commonly lives on the skin or inside the nose without causing problems, but which can cause infections e.g., in a wound or blood stream
MRSA	Meticillin resistant *Staphylococcus aureus*: strains of *Staphylococcus aureus* which is resistant to a number of antibiotics
RCA	Root cause analysis: A process for identifying “root causes” of problems or events leading to an approach for responding to them
SGH	St George’s Hospital (St George’s University Hospitals NHS Foundation Trust)
NHSI	NHS Improvement – an NHS body that oversees Trust driving quality improvement

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