Group Board

Agenda

Meeting in Public on Friday, 12 January 2024, 09:45 – 13:00

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

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	Report
	1.4	Action Log and Matters Arising	Chairman	Approve	Report
10:35	1.5	Group Chief Executive's Report	GCEO	Note	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	Verbal
	2.3	People Committees-in-Common Report	Committee Chair	Assure	Report
	2.4	Infrastructure Committees-in-Common Report	Committee Chair	Assure	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:15	3.1	Maternity Services Report	GDQSG	Review	Report
11:30	3.2	Healthcare Associated Infection Report	GDQSG	Review	Report
11:40	3.3	Finance Report – Month 8	GCFO	Review	Report
11:50	3.4	Integrated Quality and Performance Report	GDCEO	Review	Report
12:05	3.5	Emergency Preparedness, Resilience and Response Annual Submission	Managing Directors	Review	Report
12:15	3.6	Group Strategy Implementation Update	GDCEO	Review	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	4.1	New Risks and Issues Identified	Chairman	Note	Verbal
	4.2	Any Other Business	All	Note	Verbal
	4.3	Reflections on the Meeting	Chairman	Note	Verbal
12:40	-	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	Group Chairman	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
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^	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
Angela Paradise*^	Group Chief People Officer	GCPO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Tim Wright	Non-Executive Director - SGUH	TW
Phil Wilbraham*	Associate Non-Executive Director - ESTH	PW
In Attendance		
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Carolyn Cullen	Interim Corporate Governance Manager (minutes)	CC
Apologies		

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

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

Minutes of Group Board Meeting

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

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Andrew Asbury*^	Group Chief Infrastructure, Facilities & Environment Officer	GCIFEO
James Blythe*	Managing Director – ESTH	MD-ESTH
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^	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 – ESTH	DM
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director – SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Stephanie Sweeney	Group Director of Quality and 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 and Engagement Officer	GCCEO
Carolyn Cullen	Interim Corporate Governance Manager (Minutes)	CC
APOLOGIES		
Ann Beasley	Non-Executive Director - ESTH/SGUH	AB
Aruna Mehta	Non-Executive Director - ESTH	AM
Arlene Wellman	Group Chief Nursing Officer	GCNO
OBSERVERS		
Richard Mycroft	SGUH Governor – South West Lambeth	
Hilary Hartland	SGUH Governor - Merton	

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

Feedback from Board Visits

Board members provided feedback from visits undertaken across St George's Hospital. This included: McKissock Ward (neurosurgery), Brodie Ward (neurosurgery) Rose Centre (breast service), the Major Trauma Centre, the new MRI suite, Rodney Smith and Allingham Wards (acute medicine) and Freddie Hewitt and Nicholls Wards (paediatrics).

McKissock Ward (neurosurgery): Phil Wilbraham and the GCEO and MD-IC

Board members reported that the ward was well organised and the cleaning team was specifically praised by staff on the ward. Security issues could be challenging and this is an area of concern for staff. The ward had just received Platinum Ward Accreditation and staff were very proud of this. Board members noted the world class work in the field of neurosurgery that was being undertaken. The GCEO reported that patients did not have their name wrist bands due to a broken printer. The GCEO emphasised the importance of wrist bands and of having equipment that worked. Board members also noted the use of apprenticeships, which was something the Group wished to support in order to ensure a pipeline of trained staff.

Brodie Ward (neurosurgery): Yin Jones, Chris Elliott and the DGCEO

Board members commented positively on the outdoor area that patients could use, which had been developed following a donation. Board members noted that ward staff were very welcoming to patients. An issue raised by staff was repatriation of patients to other hospitals after initial recovery from surgery. This required escorts and transport and could be challenging to arrange and there were often delays with repatriation. Board members noted the opportunity to develop the balcony in this area and suggested asking the St George's Hospital Charity whether it would consider funding this.

Rose Centre (breast service): GCMO and GCPO

Board members commented that the Centre was inspiring and were particularly impressed by the 'one stop shop' approach to patient experience. 90% of patients were discharged on the day. On staffing, Board members noted the successful use of advanced nurse practitioners, which was augmenting the skills available. On estates, staff reported that a sewage leak which happened a year ago and was still an ongoing problem. The GCIFEO informed the Board that there was a capacity issue with the main sewer. To replace the sewer would take three months and services, including the Emergency Department, would need to be relocated to other parts of the estate to undertake the work which would prove extremely disruptive. While fixes and work-arounds were not ideal, this was a necessary trade-off given the disruption and costs associated with a more fundamental solution.

Major Trauma Centre: Jenny Higham and Derek Macallan

Board members were impressed with the bedside suction and oxygen facilities available. Minor repairs had been reported but to get items fixed took time. Staff reported frustration with the availability and booking of rehabilitation. Also, speedy discharge was limited by not being on the ICAP system and having to wait for prescriptions to be filled. Board members met the "Bionic Beauties" volunteers who had life changing injuries and came and supported patients currently receiving treatment. Board members wished to record their thanks to the "Bionic Beauties" for the work they do.

New MRI Suite: Andrew Murray and Martin Kirke and the MD-SGUH

Board members were extremely impressed by the new MRI suite and commented on the fantastic facilities. Morale in the department was good, with staff impressed by the training they had received on the new MRI. However, managing flow through the unit was difficult; outpatients were booked in but inpatients were a variable workload and often there were conflicts between the two different work streams. Staff also stated that they would also take on more research work if there was the capacity to do it. Board members noted that jobs in the MRI suite were physically demanding. The Suite was considering employing staff to assist with helping, and sometimes lifting, patients in and out of MRIs.

The unit had made good use of apprenticeships schemes which had led to apprentices becoming accredited and staying as full-time members of the unit.

Rodney Smith and Allingham Wards (acute medicine): Tim Wright and Peter Kane and the GCCAO and the DGCNO

Board members noted that Allingham Ward had a challenging case mix with patients who had alcohol abuse issues that had led to gastro or liver functioning difficulties, and staff often faced aggression from patients. These patients often spend weeks on the ward and patients commented on the friendliness of staff. Staff on Rodney Smith ward drew attention to their Workstations on Wheels (WoWs) which were excellent but large pieces of equipment, which could be difficult to store without impeding corridor space. Space for staff was a visible issue. Board members also discussed the boarding of patients from ED on the wards and the benefits and challenges associated with this.

Freddie Hewitt and Nicholls Wards (paediatrics): The Chairman and MD-ESTH and GCIFEO

Board members commented on the level of violence and aggression that was being experienced, particularly on the Freddie Hewitt Ward. The GCEO stated that management supported staff to "red card" family members who disrupt a ward, and explained that there needed to be an awareness campaign to let staff know what sanctions were available and how they would be supported. The Chairman added that she was impressed by the work of the play specialist who supports our paediatric patients.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted the apologies as set out above. The Chairman noted that the GCFO would join the meeting later in the morning as he was currently attending an external meeting of NHS finance directors.	
1.2	**Declarations of Interests**	
	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 notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley and Peter Kane as Non-Executive Directors; • Jacqueline Totterdell, Andrew Asbury, Paul Da Gama, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh and Arlene Wellman, as Executive Directors. There were no new declarations of interest.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 8 September 2023 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	

	The Group Board reviewed the Action Log and agreed to close the action relating to undertaking an effectiveness review of the new Infrastructure Committees-in-Common as this would be undertaken in line with the approach for all other Committees of the Boards.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO stated that she would take the report as read and briefly drew attention to the following issues: • **Operational pressures:** The GCEO drew attention to the increase in the numbers of mental health patients presenting in the Emergency Departments (ED) across the Group. This was a complex issue to manage and the Executive team was working with local mental health providers, community partners, the Integrated Care System (ICS), the Police, and local authorities to create more effective pathways for mental health patients. The GCEO acknowledged the pressures on staff in EDs as a result of both the numbers of patients with mental health needs attending and the wider challenges around the discharge of patients and patient flow through the hospital. • **Group Quality Update:** Sally Herne, an experienced NHS professional from NHS England (NHSE), had joined the organisation as Group Quality Governance Improvement Lead. She would be working on improving governance in maternity services and strengthening quality governance structures across the Group. The work would be in two phases, focusing first on maternity services specifically and subsequently looking more broadly at quality governance. • **Organisational culture & gesh100 event:** The GCEO stated that driving forward organisational culture was a key priority. On 14 November, the Group would hold its first leadership event with the "gesh 100". The purpose of this forum was to bring together leaders across the Group, develop a leadership community and discuss strategic priorities. • **Appointments, Awards and Events:** The GCEO expressed thanks to Betty Njuguna, previously Site Chief Nursing Officer for ESTH, who had left the Trust at the end of September 2023. Theresa Matthews, Deputy Chief Nurse, was acting into the role of Site Chief Nursing Officer (CNO) and the substantive role was out to advert**.** The Chairman invited comments and questions and the following points were raised and noted in discussion: • Martin Kirke welcomed the gesh 100, particularly having the senior leadership of the three sites meeting together in one forum. He suggested the forum was an excellent idea and expressed hope that this would help foster greater group-wide working. • Yin Jones asked about the timings of the gesh 100 meetings and asked how the corporate services restructuring would be addressed at the meeting.	

	• The GCEO added that the gesh 100 was a vehicle to bring senior managers together to exchange ideas and drive change. She welcomed the support of the Group Board for the initiative. **The Group Board noted the Group Chief Executive's Report.**	
2.0	**ITEMS FOR ASSURANCE**	
2.1	**Quality Committee-in-Common Report**	
	Andrew Murray, Joint Chair of the Quality Committees-in-Common, presented the key issues considered by the Quality Committees-in-Common at its meetings in September and October 2023 and drew particular attention to the following: • **Maternity Services:** 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 five of the ten Safety Actions were RAG-rated as 'green'. This represented a significant risk to the Trusts' 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 considered how the QIA process was working in practice, and sought assurance that the process is rigorous and configured in a way that would enable CIPs to be stopped, if there were deemed to be unacceptable safety and quality risks. The Committee received assurance that there was appropriate challenge, and a small number of CIPs had been stopped as a result of the QIA process. The Committee concluded that the process was working effectively overall. • **Quality and Safety Risks:** The Committee noted a concern raised by the Executive that the profile of quality and safety risks on the Trusts' Corporate Risk Registers did not fully reflect the current risk position. As a consequence, the risk profile was being reworked ahead of the January Committee meeting. **The Group Board noted the issues escalated by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in September and October 2023.**	
2.2	**Finance Committees-in-Common**	
	In the absence of the Committee Chair, Tim Wright, a member of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committee at its meetings in September and October 2023: • **Non-elective pathways:** both Trusts continued to be under pressure. Whilst the number of patients waiting in the EDs for more than 12 hours, following a decision to admit, was significantly above target, both Trusts achieved the 4-hour waiting standard of 76% (SGUH – 77.0%; ESTH 77.3%) in September. • **RTT trajectory:** both Trusts were above the RTT trajectory set to reduce the numbers of patients waiting for more than 52 weeks to commence treatment. ESTH was 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:** SGUH continued to remain strong; 98% of patients received their diagnostic test within six weeks of referral in September. The breach rate of 2% at SGUH was well within the national target of 5%. ESTH was reporting a breach rate of 5.4% in September, but this was the fifth consecutive month of improvement. • **Controls:** At the October Committee meeting, the GCFO outlined progress on controls, including the proposed implementation of the no PO (Purchase Order) no pay policy, which was approved by the Committee. • **Cash update:** The Committee had noted the approval from NHSE of the Q3 cash request from both Trusts. **The Group Board noted the issues escalated by the Finance Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in September and October 2023.**	
2.3	**People Committees-in-Common**	
	Yin Jones, Joint Chair of the People Committees-in-Common, set out the key issues considered by the Committees at its meetings in September and October 2023: • **Employee Relations (ER):** the Committee had received reports on ER performance at each Trust at its meeting in October 2023. The Committee noted that the ESTH ER function was more established, while SGUH ER function was more fragile and significant improvements were needed. A service improvement plan for SGUH had been put in place. 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. • **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) reports and action plans:** In October 2023, the Committees approved the WRES and WDES reports and action plans which were required to be published on the Trusts' respective websites by 31 October 2023. The Committee was disappointed by the decline in the performance of some of indicators despite the investment and effort that had been put into the culture programme. The Committee heard that the lack of progress in delivering agreed action plans was mainly due to resourcing. The Committee noted that the Group Board planned to take stock of the actions to deliver a step change in relation to 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. The Chairman invited comments and questions and the following issues were raised and noted in discussion: • Jenny Higham noted the decline in performance of some WRES and WDES indicators and suggested that, rather than focussing on all areas and indicators, targeted improvements might be a better use of limited resources. Yin Jones commented that the Committee had concluded that improving the quality of leadership would improve overall performance on a number of indicators.	

	• Martin Kirke stated that there needed to be greater focus on what worked elsewhere, and that action should be targeted on schemes that were known to have the greatest impact. • The GCPO explained that there had been investment in the development of staff networks. While the WRES figures were disappointing, the staff survey showed that BAME colleagues were not experiencing a less favourable work experience. • Chris Elliott commented on the low level of medical appraisals undertaken. Yin Jones replied that the Committee had considered that the small number of appraisers was a contributory factor. • Derek Macallan asked what controls were in place regarding the vacancy control panels to ensure that decisions on staffing did not affect quality. The DGCEO stated that there was clinical representation at each panel meeting where clinical and operational posts were considered. **The Group Board noted the issues escalated and the wider issues on which the Committees had received assurance in September and October 2022.**	
2.4	**Infrastructure Committees-in-Common**	
	In the absence of the Committee Chair, Phil Wilbraham, a member of the Infrastructure Committees-in-Common, presented the report on behalf of the Committee. The October 2023 meeting had been the inaugural meeting of the Committee and the following items were flagged to the Group Board: • **Estates Returns Information Collection (ERIC) and Premises Assurance Model (PAM):** Both Trusts had submitted their ERIC and PAM surveys over the summer, and the results were scheduled to be considered at the next meeting of the Committee. Early indications suggested continued progress for SGUH, but a potential rating decrease for ESTH. This was not necessarily a reflection of any drop in performance at ESTH but rather challenges at ESTH in providing evidenced documentation of compliance. To address this, a new reporting tool was being implemented to track PAM and ERIC metrics at ESTH. The reporting tool would provide the Committee with assurance regarding overall compliance and would highlight areas where evidence of compliance was absent. • **Electronic Patient Record (EPR) Implementation:** The Committee considered a progress report on the implementation of EPR at ESTH on a shared domain with St George's. With six months to 'go-live', which was planned for April 2024, the Committee was encouraged that the programme remained on track and that work had been undertaken to learn from other organisations that had undergone similar EPR rollouts. The Committee sought assurance regarding management of key risks to the delivery of the project, particularly clinical engagement, communications, and training. A key challenge was the need to balance safe levels of activity to ensure an effective 'go-live' and the need to avoid a reduction in elective activity. The MD-ESTH commented that it would be challenging to roll out EPR without reducing activity. The GCEO asked whether the Trust was intending to suspend reporting while the EPR implementation takes place. The GCFO replied that	

	NHSE have made clear that they are not expecting activity to drop during implementation. **The Group Board noted the issues escalated and the wider issues on which the Committee received assurance in October 2023.**	
2.5	**SGUH Audit Committee Report**	
	Peter Kane, Chair of the SGUH Audit Committee, set out the key issues discussed and agreed by the Committee at its meeting on 19 October 2023. The Committee had received its regular reports on counter fraud, cybersecurity and breaches and waivers. The Committee had also received an update on progress on the internal audit 2023/24 workplan. Audits of sickness absence, data quality, new starter onboarding, and rostering were all underway. Scopes had been issued for the remaining audits. The Committee had received two final internal audit reports, one IT systems not supported by central IT and one on cybersecurity, from the Trust's previous internal auditors, and both had been given limited assurance. The Committee was actively monitoring the management actions to the recommendations. Peter Kane stated that the Committee had considered the Group-wide tender for an external audit provider, which would be required for the audit of the accounts for 2024/25. **The Group Board noted the report of the Committee's meeting held on 19 October 2023 and the matters on which it had received assurance.**	
2.6	**ESTH Audit Committee Report**	
	Peter Kane, Chair of the ESTH Audit Committee, set out the key issues considered by the Committee at its meeting on 19 October 2023, where it had received its regular reports on counter fraud, cybersecurity and breaches and waivers. An update from the Group Chief Finance Officer had been received on the planned retrospective review of the 2022/23 audit of Trust accounts. The Committee was informed that an initial report on lessons learnt would be shared with the Committee Chair at the end of November and a full report would be considered at the next meeting in February 2024. The external auditors had shared a list of issues they encountered during last year's audit and these would help to inform an action plan aimed at mitigating difficulties for the 2023/24 audit. Work for the 2023/24 audit would commence in December 2023 and the audit plan would be shared with the Committee in February for discussion and comments. The internal auditors had given an update on progress of the internal audit workplan. Fieldwork for the sickness absence audit had now finished and a draft report was expected to be issued shortly. The audits for data quality, new starter onboarding, and rostering were in progress. Peter Kane informed the Board that the Committee had expressed concern at the number of outstanding open internal audit actions that were awaiting management responses. This issue had been escalated to the GCCAO who was working with the relevant management leads to ensure there was an improved position for the next meeting. The Committee had also considered and approved the SBS Recovery Policy for salary overpayments and had approved the updated Debt Management Policy. **The Group Board:** • **Noted the update from the Audit Committee meeting held on 19 October 2023**	

	• **Noted 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** • **Noted the approval of the adoption of the SBS recovery policy for salary overpayments** • **Noted the approval of the updated Debt Management Policy.**	
3.0	**ITEMS FOR REVIEW**	
3.1	**Maternity Services Report**	
	The GCMO stated that the purpose of the report is to inform the Board of progress against the local and national agreed safety measures for maternity and to bring to the Board's attention any emerging safety concerns. Progress against the 10 Safety Actions in the Maternity Incentive Scheme (MIS) was discussed, and had been referenced during the discussion on the report from the Quality Committees-in-Common. Compliance with the MIS for both Trusts was a material risk for 2023/24. Safe Staffing for August 2023 was 85% at St Helier, 84% at Epsom and 90% at 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 covering staffing shortfalls. Mandatory Training compliance continued to be a risk at both Trusts. The Chairman reminded the Board that a special Board development session would be arranged in the new year to hear feedback from the national Maternity Safety Support Programme which was working with SGUH to support improvements in the service following the findings of the inspection by the Care Quality Commission (CQC) earlier in the year. A report of the CQC inspection of maternity services at ESTH had not yet been received but would be shared with the Board on receipt. **The Group Board:** • **Noted the compliance status against the MIS** • **Noted the risks and mitigations brought to the attention of the Board** • **Noted from 1 October 2023 the Maternity and Newborn Safety Investigations are now hosted by the CQC.**	
3.2	**Equality, Diversity, and Inclusion Report**	
	The GCPO stated that the People Committee was previously provided with action plans for the WRES, WDES across the two Trusts. As individual Trusts, SGUH and ESTH were mandated to produce these action plans. The GCPO stated that there was a good level of progress in delivering the action plan, particularly reasonable adjustments, DAL helpline, RIS scheme. However, there were areas where progress needed to be improved. The progress was reflective of the two small Equality, Diversity and Inclusion teams and the impact this has on their ability to deliver ambitious action plans whilst also delivering other major pieces of work for example the Public Sector Equality Duty (PSED) and Equality Delivery System for the NHS (EDS2). Further analysis of the Ethnicity Pay Gap was had been requested by People Committee at its June meeting. This analysis concluded that for ESTH and SGUH male Black/Black British colleagues had a particular disparity in earnings in comparison to their white counterparts which	

	needed to be addressed. This would be done by focussing on aspects of the WRES action plans and working with leaders in Estates and Facilities at ESTH, and with HR Business Partners. Peter Kane observed that WDES focusses on physical disability more than mental health and asked whether our Trusts need to look more widely at mental health and stress. The Chairman explained that the Group Board was scheduled to hold a detailed discussion at its development session in December to consider how best to achieve a step change on EDI over the coming year. **The Board:** • **Noted the progress made with the WRES/WDES action plans** • **Noted the progress regarding the actions to be taken regarding the pay disparity for male Black/Black British colleagues.**	
3.3	**Integrated Quality and Performance Report**	
	The GDCEO introduced the report and highlighted the following: • Elective Care: Both Trusts were challenged in maintaining their total waiting list size, but there had been a stabilisation in the rate of increase at ESTH and only a marginal increase at SGUH over the past three months. Industrial action continued to affect efforts to reduce the waiting list. Both trusts were above the trajectory that they set themselves to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH was particularly challenged with 917 patients waiting for more than 52 weeks at the end of August 2023, this was largely attributable to challenges within Gynaecology and Community Paediatrics services. This had been escalated to the South West London (SWL) system. Unfortunately, the pressure in Community Paediatrics at ESTH was 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 remained under control. • Diagnostics: Performance at SGUH continued to remain strong with 98% of patients receiving their diagnostic test within six weeks of referral in September. The breach rate of 2% at SGUH was well within the national target of 5%. ESTH was reporting a breach rate of 5.4% in September, which was a reduction of over 30% and the fifth consecutive month of improvement. • Theatre Productivity: Both Trusts remained challenged to reach the trajectory for 85% capped utilisation of theatre time (active utilisation of theatres within the allotted time). However, both were seeing steady improvements following on the implementation of a range of interventions. An active theatre utilisation group was exploring opportunities to continue to improve productivity in theatres. Plans were being developed, with a particular focus on paediatric day cases. • Cancer: Performance was generally on track at ESTH with some challenges at SGUH. Performance against the 28-Day Faster Diagnosis Standard (FDS) fell below the 75% target due to capacity constraints in the skin service. The team was formulating a plan with support from RM Partners. Further work at ICS level was envisaged following the	

	classification of dermatology as a fragile service across the system. Although SGUH was not achieving the 62-day cancer standard (64.9%), it was 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 would be revised from December to reflect the new rationalised metrics that came into effect in October. • Urgent and 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 higher, both Trusts achieved the 4-hour waiting standard of 76% (SGH – 77.0%; ESTH 77.3%) in September. • Integrated Care: Out of hours urgent care response was above the national standard (70%) for both Sutton Health and Care and Surrey Downs Health and Care. Utilisation of the virtual wards in both systems had plateaued, and this would be a focus for reducing avoidable bed days in hospitals over the winter. The Chairman invited comments and questions and the following points were raised and noted in discussion: • Andrew Murray noted that Gynaecology 52-week waiters was lower at SGUH than ESTH and asked whether each unit could help each other out. The DGCEO stated that collaborative working was being explored. The MD-SGUH reflected on whether a shared waiting list should be developed. Initial work has been done on a shared paediatric PTL. The GCEO concurred, and stated that learning from paediatrics could be exported. • The DGCEO stated that moving patients requiring specialist services around SW London had gained momentum. Clinical workloads across specialities were being assessed to highlight best practice and to look at the possibility of patient waits being reduced. **The Group Board noted the report.**	
3.4	**Finance Report (Month 6 2023/24)**	
	The GCFO introduced the Month 6 2023/24 finance report. The GCFO stated that ESTH had a deficit of £26.7m at the end of September, which was £3.6m adverse to plan. This was principally due to the impact of industrial action. Cost Improvement Plans (CIP) had delivered £12.3m at ESTH to date, against a plan of £14.5m. ESTH had a cash balance of £7.1m against the plan of £20.8m at the end of September. A submission for Q3 cash support had been approved by the Trust Board on the 8 September 2023 and an MoU (Memorandum of Understanding) had now been signed. The Trust was reviewing payment runs and debt collection to ensure working capital is managed effectively. At the end of September, ESTH has spent £10.9m on capital schemes against a planned spend of £23.7m. In relation to SGUH, the GCFO stated that SGUH was reporting a deficit of £27.0m at the end of September, which was £12.2m adverse to plan. As with ESTH, the deficit was largely due the impact of industrial action. Expenditure was reported at £7.4m adverse to plan, mainly due to premium temporary medical staffing costs to cover industrial action and premium temporary nursing costs across wards. Cost Improvement Plans were £3.0m adverse to plan. Capital was £28.9m underspent. At the end of Month 6, the cash balance at SGUH was £15.3m and as a result a cash request for Quarter 3 had been submitted.	

	The Group Board noted the Month 6 financial position.	
4.0	**ITEMS FOR DECISION**	
4.1	**Group Board Assurance Framework 2023/24: Strategic Risks**	
	The GCCAO introduced the draft strategic risks for the new Group Board Assurance Framework (Group BAF) which brings together, in one place, all relevant information on risks to the delivery of the Group Board's strategic objectives. The new Group strategy had been approved by both Trust Boards in April and was published in May 2023, and the Group Board had held development sessions in April 2023 and October 2023 to develop the new strategic risks for the Group BAF, linked to the new strategy. The GCCAO explained that, at the development session in October 2023, the Group Board had discussed the framing of draft strategic risks, the number of strategic risks for inclusion on the Group BAF and given a high-level overview of risk appetite for each draft strategic risk. Based on these discussions, 14 strategic risks had been developed alongside a proposed risk appetite position for each strategic risk. Also included in the Group BAF was a qualitative risk appetite approach to help guide consideration of wider decision-making in relation to risk. The GCCAO informed the Board that, subject to the approval of the strategic risks by the Group Board, the intention was to populate the Group BAF and take the relevant sections through Committees in December and January, ahead of presenting the first full draft Group BAF to the Group Board in February 2024. The Chairman invited comments and questions, and reminded Board members of the importance of agreeing a new set of strategic risks and cautioned against detailed amendments to the wording of the risks at this stage. The following issues were raised and noted in discussion: • Andrew Murray asked whether Strategic Risk 1 (SR1) should reference patient flow given the important role of system partners in addressing the risk. The GCCAO explained that SR1 focused on working across the local system and, when the BAF was populated with controls and actions it was likely that issues around discharge and flow would be reflected in this. However, in terms of referencing flow in the headline risk statement flow was currently captured within the SR8, which related to reducing waiting times and the risks associated with not achieving improvements in patient flow. • Peter Kane commented that this was an excellent report and enquired about whether the risks captured the issue of delayed discharge. The GCCAO agreed that the phrase 'delayed discharge' was not explicitly referenced in the strategic risks, but that this would be captured by SR8 (reducing waiting times) along with patient flow. • Peter Kane also enquired whether the financial sustainability risk (SR4) should reference a risk relating to whether the Trusts had sufficient funding. The GCCAO explained that the current wording of the risk had sought to frame the risk around the 3 E's (economy, efficiency, effectiveness). It was possible to include a reference to the availability of funds, though this may be sensitive in the context of wider discussions nationally about efficiency. The Chairman suggested that the Board retain the wording as drafted but acknowledged the challenges raised by Peter Kane.	

	The Group Board reviewed and approved the draft strategic risks and noted that the full first draft of the new Group Board Assurance Framework would be presented to the Group Board in February following review by the relevant Committees in January 2024.	
5.0	**ITEMS FOR NOTING**	
5.1	**Group Learning from Deaths Report, Q1 2023/24**	
	The GCMO explained that Trusts were required to collect and publish specified information on deaths on a quarterly basis. At ESTH the total number of inpatient deaths in Quarter 1 2023/24 was 336; and Structured Judgement Reviews (SJRs) were completed for 137 (40.8%) of deaths. Five deaths had an overall poor score. One death had an extremely poor score. All five deaths were reported as clinical incidents for further investigation. An annual thematic review of SJRs, where moderate or major concerns were raised, was being undertaken by the mortality review team to identify themes for improvement in the quality of care. The results of the review would be reported to the Quality Committees-in-Common. The nationally published SHMI mortality indicator (Summary Hospital-level Mortality Indicator) covering discharges from April 2022 to March 2023, showed a "higher than expected" level of deaths at ESTH. However, observed deaths had reduced compared to expected deaths, and this ratio was the lowest since early 2021. At SGUH, the total number of deaths in Quarter 1 was 368 of which 33 (9.0%) had gone through the SJR process. The latest SHMI data showed mortality was as expected. **The Group Board noted the continued compliance with the Learning from Deaths framework and noted that reasonable assurance had been given to this system of internal control**	
5.2	**Healthcare Associated Infection Report**	
	The GDQSG outlined the key issues arising in Infection Prevention and Control (IPC) across the Group and also provided a high-level overview of the St George's Annual IPC Report for 2022/23. **The Group Board noted the report.**	
6.0	**CLOSING ITEMS**	
6.1	**Any new risks and issues identified**	
	The DGCEO stated that pressures on the Emergency Departments were an identified risk on the two Trusts' Corporate Risk Registers. However, the risk relating to mounting pressure on ED staff and their resilience was increasing. The GCEO stated that there was a risk around culture, and the new strategic risks on the BAF referenced this.	
6.2	**Any other business**	
	The Chairman reminded the Board that this was Chris Elliott's final Board meeting as his term of office as Associate Non-Executive Director at ESTH was scheduled to end on 31 December 2023. The Chairman expressed her thanks to Chris Elliott for his knowledge and expertise and stated that his clinical background as a General Practitioner had given particular insight to many Board discussions.	

6.3	**Reflections on meeting**
	The Chairman invited Chris Elliott to give his reflections on the Board meeting. Chris Elliott offered the following reflections: • Many of the issues wrestled with during the meeting were not within the Group's gift to resolve, and the discussions had rightly focussed on how the Group could influence issues across the system and the region. • At times, it appeared that the "centre" had unrealistic expectations of a trust's ability to deliver in the current circumstances. For instance, when the EPR (Electronic Patient Records) system was rolled out, there was a real prospect that this would impact on activity. • Discussions on flow emphasised the importance of integration and partnership working with community services. Chris Elliott thanked Thirza Sawtell for her work on integration. The Chairman invited reflections from other Board members: • The GCMO stated that he thought the feedback from Committees should be considered early in the agenda and that he considered the reports well written. • Jenny Higham concurred and added that having the feedback reports first gave the Board a different dynamic. • The GCEO stated she welcomed the feedback reports being considered early in the meeting but thought that today the discussion of performance was curtailed.
6.4	**Patient / Staff Story**
	The Group Board welcomed Veronica Rechere, Patient Partner, Carer and member of the Patient Experience Partnership Group (PPEG), to present the patient story. Veronica Rechere was supported by Wendy Doyle, Associate Director, Patient Experience Partnership. Veronica's father had been a patient at SGUH for approximately 9 weeks. He was a patient on two senior health wards, Heberden and Marnham. Veronica, in visiting and caring for her father during this period, got to know staff and other families across both wards. Veronica made several observations during this period, some general and some specific, these observations were about the environment, quality of care, the food, communication and discharge. The key points of Veronica's feedback were: the importance of recognising and involving carers in improving the health of patients; encouraging feedback from patients/families; working with carers for a safe and effective discharge; and signposting to carers services to support families. Wendy Doyle stated that staff found listening to Veronica's observations extremely useful in understanding the lived experience of patients and families. This was particularly timely as work was underway to ensure that trusts were meeting the requirement of the Health and Social Care Act in identifying, recording, supporting, and involving carers to improve quality of care and effective discharge. The Chairman invited comments and questions from Board members and the following points were raised and noted in discussion:

	• Andrew Murray observed that it was a powerful story and the trust needed to listen to the feedback from carers. • The GCMO observed that conversations regarding mental capacity were most important and needed to be sensitively handled. • Jenny Higham asked what happened to those patients who do not have carers and whether other advocates were assigned. Jenny Higham suggested that carers needed training and support. • Yin Jones noted that the patient partner concept was extensively used but could be more widely advertised. • Derek Macallan stated that the treatment goals needed to be understood by the carer. He added that discharge letters could be made more informative for carers. The Chairman thanked Veronica Rechere and Wendy Doyle for attending.	
CLOSE		
The meeting closed at 12:45 pm		
QUESTIONS FROM MEMBER OF THE PUBLIC AND GOVERNORS		
There were no questions from the public or from Governors		

Date of next meeting:

10 am on 12 January 2024 Whitehall Lecture Theatre, Education Block, St Helier Hospital

Group Board (Public) - 12 January 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
There are currently no open actions on the Group Board (Public) Action Log								

Group Board

Meeting in Public on Friday, 12 January 2024

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	12 January 2024
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;
- Group Strategy;
- 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 We continue to be concerned by the ongoing conflict in the Middle East, which affects so many of our staff both directly and indirectly. I would like to take this opportunity to reiterate our values of respect, diversity and inclusivity. We are an organisation that does not tolerate prejudice in any form, and I encourage anyone who is concerned, or struggling, to come forward for support, as needed.

3.2 Operationally, we continue to manage the ongoing impact of sustained industrial action. The strikes dominate our operational environment, which is also facing the expected challenges of winter - including higher numbers of attendances and higher acuity. On top of the pressures of higher winter flows, we have also faced unexpected higher number of infections such as Norovirus across the NHS, heightening the pressures on our wards.

3.3 Junior Doctors held a three-day strike immediately prior to Christmas, and the longest ever strike in NHS history immediately after Christmas, lasting six days. As ever, our teams have been working extraordinarily hard to ensure that patients remain safe during this disruption. Inevitably, this will have an impact on our productivity as activity is postponed, with a knock-on effect for future operations and increasing pressure on our sites, which are already strained. We will work tirelessly, as we have been doing, to keep patients safe, reschedule our activity, and reduce the impact on emergency care. Across the NHS, reports show that the measures we have taken to open up extra beds and expedite discharge in advance of the strikes has supported a strong performance, even in our most challenging time at peak winter. We have also conducted a multi-channel communications campaign to support the public in seeking care in the most appropriate setting, including through additional GP access, and care in the community, to ease pressure where possible on our Emergency Departments. These actions combined have delivered a better performance in terms of ambulance handovers and Emergency Department waiting times across the NHS than this time last year, as we continue to learn from previous industrial actions and rise to the challenges of heightened pressures.

3.4 In addition, as part of our efforts to protect public health over the winter period, our flu and covid vaccination campaigns continue across our Sites, working on vaccinating all staff, and frontline staff in particular, with approximately 45% of staff receiving their flu vaccine; and approximately 18% (St George's) and 26% (Epsom and St Helier) receiving their covid vaccine. We will continue to encourage our staff to protect themselves, and those around them, from these viruses this winter.

3.5 As we look ahead to 2024, finances remain challenging. As we did last time, we will have the opportunity in this Board meeting to discuss our Group Finances. The Chief Financial Officer Andrew Grimshaw will provide an update on the positions of both St George's, and Epsom and St Helier Trusts, and I look forward to discussing this further.

4.0 Group Updates

4.1 As you will know, the consultation for the Principal Treatment Centre for Paediatric Cancer for London has now closed. Our response to the consultation can be viewed in full on our website, and we are grateful for your support on this important matter. In terms of next steps, NHS England

will now review all responses to the proposals, including all feedback and additional evidence. The decision about the future location of the children's cancer centre will be taken in spring of this year. Whilst we eagerly await the final decision, in the meantime our expert teams of practitioners continue to deliver outstanding care for children with cancer – as we have done so now for decades and as I am so proud of.

4.2 I also wanted to update you that progress continues on our Building Your Future Hospitals programme. With the support of our New Hospitals Programme sponsor, we have applied to draw down the funding necessary to proceed with applications for enabling works, design a Hospital 2.0-compliant new build, refresh the business case and make a planning application. We will update the Board with detailed timings of the next phase of this work once these are agreed.

4.3 Additionally, we now have new community rehabilitation services, which will support better care in the community for our patients of Epsom and St Helier. This change follows public engagement and consultation. From now, home-based support services are expanding and moving away from using care home beds and the new expanded community rehabilitation service, provided by Central London Community Healthcare NHS Trust (CLCH) will provide services delivered by therapists and rehab workers with support from nursing staff. This will increase our capacity to deliver care in the most effective and efficient way possible and I am delighted with this development.

5.0 Strategy Outlook

5.1 I also wanted to update you on our work underway to implement our Group-wide Strategy. We launched our Group Strategy eight months ago. Since then, we have embarked on an ambitious programme to implement our five-year vision throughout all layers of our organisation. Our 'CARE' framework encapsulates our priorities and focus, and we are leveraging this framework to inform local improvement, our nine strategic initiatives, and corporate enabling strategies. Specifically, we have launched a range of work to embed this framework throughout, including monthly Group and Site meetings that are structured around these principles, as well as Site Leadership team meetings; an ongoing communication campaign; individual team objectives and our quality improvement programme. Looking ahead to the coming year, I look forward to seeing our strategy embedded at the individual, team and organisational level using a number of different frameworks and incentives – including ward accreditation models, and business planning prioritisation.

5.2 Earlier last month, we participated in the second NHS Genomics Healthcare Summit, where we discussed the progress made on the first NHS Genomics Strategy. Progress includes NHS England publishing new data on genomics testing – demonstrating the progress in providing significant new diagnoses to babies and children who end up with or are born with a suspected genetic condition. New methods of testing can screens for over 6,000 diseases in a short space of time, compared to prior waiting times of many weeks. This provides critical time-saving to care pathways, saves resources, and provides clarity for families and their loved ones. This is an incredible development, and we are very proud to be part of the NHS's genomics strategy and contribute our expertise to this important area.

6.0 Appointments, Awards and Events

6.1 Appointments:

- Theresa Matthews, former Deputy Chief Nurse at Epsom and St Helier, has now been formally appointed to the post of Site Chief Nursing Officer, effective immediately. We are delighted to welcome Theresa into this post, and I know you will join me in congratulating her on this promotion.

7.2 Awards:

We are very proud to update you that there have been several awards and accolades in the last two months across the Group.

- **Claire Campbell Achievement Award:** Lauren Press and St George's Hospital Auditory Implant Service have been announced as the winners of the first Claire Campbell Awards for Outstanding Achievement. The awards were launched in memory of Claire, mother of two deaf children and passionate advocate for deaf young people, who died in November 2022. St George's Hospital Auditory Implant Service has been instrumental in making a lasting and significant change to so many deaf children and young people. The award judges heard that the team are always smiling, supportive and dedicated in often difficult and uncertain circumstances. The nomination, which specifically highlighted the work of David Selvadurai, Dhaval Mehta and Tash Gerrow, was made by the family of a deaf teenager who has been supported by the team for more than a decade.

- **Heritage Fund Grant:** St George's Hospital Charity has been awarded a National Lottery Heritage Fund grant of £249,209 for an exciting new heritage project at St George's Hospital - 'Our Hospital: conserving, curating and responding to St George's Art and Heritage Collection'. The three-year project focuses on conserving, cataloguing, reinterpreting, and digitising St George's Hospital's unique Art and Heritage Collection so it can be enjoyed by many more people. 'Our Hospital' will use the collection to showcase the hospital's impressive heritage, the diverse communities it serves, and the unheard stories of staff who have worked here, particularly those from under-represented groups.

- **Gratitude Reports:** October and November also saw the latest two Gratitude Reports published by Epsom and St Helier. The monthly reports collate feedback from patients, friends and families, and combined, some 75 individual members of ESTH staff and 51 teams were thanked.

- **One NHS Finance Awards:** And finally ESTH Finance Manager Tahira Butt scooped one of the prestigious national 'One NHS' Finance Awards. Before an audience of more than 750 NHS staff, Tahira claimed the gong in the Equality, Diversity and Inclusion category recognising her crucial role in creating an inclusive and fair culture at ESTH, driving positive change and enhancing staff engagement.

7.3 Events:

- Representing the diverse backgrounds that make gesh such an inclusive hospital group, we celebrated a wide range of winter festivals, including Diwali, Christmas, and Hanukkah with the support of our spiritual care team and Staff Networks. A massive thank you to the St George's Charity who also provided support. Staff working over the festive period were given several free meals and extra parking was made available.

- Disability History Month took place across the end of November into December. A range of events were delivered by internal and external speakers to empower staff to support patients and co-workers with Disabilities, learning disabilities and neurodiversity requirements. Disability History

Month coincided with the release of a new statutory training 'Oliver McGowan Training on Learning Disability and Autism'.

- Healthcare Support Workers Day was celebrated across the group, Highlighting the essential roles that support workers play across all health and social care settings across our Trusts.

- In celebration of 75 years of NHS and King Charles's 75th Birthday, one of St George's excellent Internationally Educated Nurses (IEN) attended the celebratory birthday ceremony and personally wished the King a happy birthday.

- With sustainability and commitments to Net Zero in mind, ESTH held lunch and learn sessions to coincide with the United Nations climate change conference COP28 in early December, where staff could find out the latest on environmental commitments and how they can get involved.

- And finally, December also saw Dame Tanni Grey-Thompson team up with ESTH for the Workforce Disability Conference. The 16-time Olympic medallist and Crossbench Peer will brought her experience to our expert-led panel discussion on how we can meet the challenges of disability and long-term conditions in the workplace.

Group Board

Meeting in Public on Friday, 12 January 2024

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 meeting in November 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:

- Health Inequalities: The Committee was pleased to review proposals for developing the role of the St George's, Epsom and St Helier University Hospitals and Health Group in addressing health inequalities and improving population health, a key focus of the Group strategy and an important issue for the NHS nationally. Work had been undertaken to explore the issues and the Committee was keen to review plans to translate aspirations into reality. To this end, the Committee agreed to review actions at its February 2024 meeting.

- Maternity Services: The Committee's discussions at the November 2023 meeting focused specifically on the issue of perinatal mortality. The Committee discussed the most recent data, noted that the report of excess mortality at SGUH in 2020 would now be received in February 2024, and endorsed proposals to undertake an external review of perinatal mortality at both ESTH and SGUH for the period January to December 2021.

- Supporting patients with mental health concerns in the Trusts' Emergency Departments (EDs): Following its review in July 2023 of the significant increases in the numbers of patients with mental health concerns presenting at EDs across the Group, the Committee reviewed progress in mitigating risks and in implementing actions to improve the care of patients with mental health concerns and to work with system partners. This will remain a key area of focus for the Committee over the coming months.

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 November 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, 12 January 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees-in-Common at its meeting in November 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 meeting on 30 November 2023 the Committees considered the following items of business:

November 2023
• Quality Performance Report (M7)*
• Serious Incidents Report
• Maternity Services Report*
• Update on Patient Safety Incident Response Framework
• SGUH – Head and Neck Service Review*
• Emergency Departments and Caring for patients with Mental Health concerns
• Winter Plans
• SGUH – Child Death Review Report
• NICE Compliance Report
• Cancer Patient Survey Results
• CQC Statement of Purpose

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

2.2 The Committee was quorate for the November meeting. The Committee did not meet in December 2023.

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) Health Inequalities

A key area of focus of the November 2023 Committee meeting was considering how the St George's, Epsom and St Helier University Hospitals and Health Group could play an impactful role as part of the wider South West London system in addressing health inequalities and improving population health, which was both a commitment in the Group strategy and one of the key priorities of the NHS nationally. It was becoming increasingly

important, but also increasingly challenging, as national challenges (the cost-of-living crisis, social care funding and capacity, lengthening waiting lists and NHS financial pressures) continue. The NHS national guidance for Integrated Care Systems and NHS Trusts was evolving in the context of an increasing focus on financial recovery, maintenance of safe urgent and emergency care, and recovery in key priority areas of planned care. The briefing provided for the meeting recommended an approach over the next year focusing on the national priority areas of:

- Improving dataset quality
- addressing one or two key priority areas in planned care waiting lists,
- addressing unplanned and emergency care High Intensity Service Users

Other opportunities for embedding a Health Inequalities approach to existing activity were highlighted, and recommendations were made regarding future assurance reporting. An initial assessment of Health Inequalities in A&E use and outpatient use across the group, undertaken by the SWL Integrated Care Board Director of Health Improvement, was provided. It was agreed that a detailed plan for work in this area for the Group should be brought to the February 2024 meeting.

b) Maternity Services

There is a separate item on maternity services on the agenda for the Group Board meeting on 12 January 2024. However, the Committee would like to highlight its ongoing focus in seeking assurance regarding the safety, quality, culture and governance of maternity services across the Group.

A particular focus of the maternity discussions at the November Quality Committee meeting was perinatal mortality. The Committee had previously requested for more real time data to be shared as the information shared from MBRRACE (Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries) was only available up to 2021. It was confirmed that year-to-date information was shared in the Integrated Quality and Performance Report (IQPR) in terms of still birth and neonatal mortality, and the longitudinal analysis was that there was no suggestion that there were any significant change in the trends.

At ESTH, the five -year perinatal mortality trends showed relatively stable rates, except for 2018 when the rate was 5% higher than the MBRRACE group average. Excluding congenital anomalies, mortality rates for ESTH have remained within 5% of its group average in each of the five years reported. A breakdown of the mortality rate for ESTH for 2021 showed that stillbirths were within 5% of the group average, while neonatal deaths were between 5% and 15% lower than the group average.

At SGUH, five-year perinatal mortality trends showed relatively stable rates except 2020 when the rate was more than 5% higher than its MBRRACE group average. A similar pattern was observed when congenital anomalies were excluded; mortality rates remained within 5% of its MBRRACE group average in each of the five years reported, except 2020. A breakdown of the mortality rate for 2021 showed that stillbirths were more than 5% higher than the group average, while neonatal deaths were within 5% of the group average. With 4,666 births in 2021, SGUH had the lowest number of births out of the 26 Trusts in its MBRRACE group of level 3 NICU and neonatal surgery sites.

The Committee heard that a gap analysis would be undertaken with reference to the recommended activity of Neonatal Intensive Care Units as described in the BAPM (British

Association of Perinatal Medicine) Framework for Practice October 2019, and this is scheduled to be presented to the Committee for review at its January 2024 meeting.

Where mortality rates are within 5% or higher of the MBRRACE comparator group or higher, MBRRACE recommends detailed local reviews. ESTH and SGUH undertook the detailed local reviews for deaths between January and December 2021, and the findings were considered by Committee last September. As the Committee has previously referenced, an external review is currently underway of the extended perinatal deaths at SGUH between January and December 2020. The report of this external review is now expected in February 2024 and the Committee will consider its findings in detail. The Committee also endorsed proposals to undertake an external review of all perinatal deaths between January and December 2021 for both ESTH and SGUH.

c) Caring for patients with mental health concerns in the Groups Emergency Departments (EDs)

The Committee has previously reported to the Group Board on its focus on safety and quality in the Emergency Departments across the Group, and in particular on the impact of significant numbers of mental health patients attending EDs. At its meeting in July, the Committee reviewed a detailed analysis of the growth in the numbers of patients with mental health issues attending ED and reviewed key risks and actions. At its November 2023 meeting, the Committee reviewed an update on the work being undertaken to improve the provision of care for patients with mental health issues presenting at the Emergency Departments.

ESTH: ESTH was continuing to work with both the Surrey and Borders Partnership (SABP) / Surrey ICB and South West London St Georges / SW London ICB, systems to explore mitigations to the pressures being experienced by both EDs in relation to mental health. SABP, which supported services at Epsom Hospital had proposed a number of steps, including increased Epsom involvement in the 'Mind and Body' improvement programme at an operational level, and consideration of a potential joint Clinical Decision Unit for mid/East Surrey. Engagement with SABP and Surrey Heartlands ICB was noted to have been positive and a structured programme was in place with good ESTH operational, clinical and executive engagement. With SWL / SWLStG there were four areas of current focus: an 'options appraisal' where each acute site in SWL has been asked to provisionally identify its preferred option for an on site mental health presence; a focus on reducing mental health sector delayed transfers of care and excess length of stay to improve flow into MH beds; an ongoing assessment of the SWL crisis assessment service; and a number of 'marginal gains' that can be implemented in the ED setting.

SGUH: The Committee heard that actions feed into five broad groups: infrastructure; education and training; workforce; quality improvement; and system working. A large number of actions had been taken to date including, for example, undertaking environmental risk assessment audits in ED and ward areas and training in de-escalation and safe restraint. All incidents were examined through a regular emergency department psychiatric liaison oversight group to ensure learning could be identified and improvements implemented. However, the Committee was also briefed on key outstanding challenges. Staffing of a substantive mental health team in ED remained a challenge, despite recent recruitment. Work was yet to begin to complete the self-assessment tool for the CQC Assessment of Mental Health services in Acute Trusts. The management of violence and aggression against staff and the safety of patients taking leave from the ED was at risk due to the implementation on 1 November 2023 of the new strategy by the Metropolitan Police whereby police would reduce their involvement with people displaying signs of a mental health crisis unless there is a clear risk to safety.

4.0 Key Issues on which the Committees received assurance

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

d) 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 across the Group in September 2023. A total of four 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 details 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 1 November 2023, there were a total of 30 open SI investigations at ESTH, 2 subject to a clock stop as external investigations were ongoing and 9 investigations overdue.

At SGUH, as at 18 October 2023 there were a total of 18 open SI investigations, 2 of which were subject to a clock stop due to external investigations by the Healthcare Safety Investigation Branch (HSIB), and 4 were subject to agreed extensions. There were no overdue investigations.

In terms of follow-up, the Committee heard that at ESTH there were 21 open actions, 16 of which were overdue. The number overdue was an improvement on the previous and the Managing Director – ESTH confirmed that the Site Leadership Team would review all outstanding actions to expedite further closures.

At SGUH, there were 70 open actions, of which 68 were within the deadline and 2 were overdue.

It was noted that the new Patient Safety Investigation Framework (PSIRF) was being trialled at both trusts. New style reports from these investigations were expected to be shared with the Committee from January 2024 alongside SI reports from areas in which PSIRF was yet to go live. The Committee requested that in future reports data be captured on a heat map basis from SIs from the last 6-to-12 months setting out which departments they had come from. The Committee considered that this would help it understand at an early stage any issues in particular areas of each Trust.

The Committee agreed that they received reasonable assurance in respect of the investigations of SI's across the Group.

e) Never Events

Part of the discussions at the November meeting focused on the Never Events which had taken place over recent months. Whilst it was recognised that there had been a number of

these incidents reported across both trusts over the past two years there had not been a substantial increase.

There had been an increase in incidents reported of wrong site surgery and the second largest number of Never Events Reported across the Group related to retained foreign objects.

It was noted that earlier in the year there had been a small number of Wrong Site Nerve Blocks identified. These count as Wrong site Surgery. Substantial review and improvement work had taken place in the service where these had been recorded and since then there had been no further cases reported.

In more recent months there had been a couple of Never Events within Dermatology. These had been with very complex patients but work was being undertaken to try and mitigate risks.

The teams recognised that there was a need to bring to Quality Committee some clearer groupwide assurance that was based on audit relating to quality improvement work including actions taken as a result of Never Events. This should relate to everything undertaken in theatres including procedures and surgery to show what the trends are in terms of compliance with safeguards that are meant to prevent Never Events

f) SGUH – Head and Neck Service Review by the Royal College of Surgeons

The Committee reviewed the report of the Royal College of Surgeons (RCS) invited review of the Head and Neck service at SGUH. The RCS carried out the review in April 2023 and the full report has been circulated to the Board. Within the report from the RCS, concerns were raised relating to the service in a number of key areas. Immediately following the review, the panel made two urgent verbal recommendations to the Trust, both of which were immediately actioned. The final report made 11 urgent recommendations to address patient safety risks, 3 important recommendations for service improvement, and 2 additional recommendations. The Clinical Director for Surgery was leading on the implementation of the action plan arising from the report. The GCMO confirmed that a lot of improvement and safety improvement work in the service had been undertaken before the RCS report had been received and the Trust would be taking actions to address the remaining findings of the RCS report.

g) Winter Plans 2023/24 – Quality and Safety

In November, the Committee reviews the Winter Plans for SGUH, ESTH and the Integrated Care Services. As the Finance Committees-in-Common leads on operational performance issues, the Committee focused specifically on the robustness of the plans in ensuring the quality and safety of services during the winter period. Each 'Site team' outlined the additional measures and mitigations which they would have in place to ensure the quality and safety for patients over the winter months and the Committee reviewed the plans in detail. Rather than repeat those plans in this report, the Committee wishes to highlight a number of cross cutting themes:

- Balancing risk: There had been some planning provision made for additional resources in the second half of 2023/24 and this had now been fully committed across both Trusts. However, the extent to which services could 'scale up' through this support did not match the increase in acuity and the demand for admission that was currently being seen. Therefore, plans were focussed on providing the mechanisms and clinical and operational oversight so that pressure on the sites

could be accurately assessed and mitigated largely within existing resources. The aim of the plans was to ensure that decision-makers could work closely with all parts of the hospitals and services to redistribute risk, for example by requiring boarding of patients onto wards, facilitating earlier moves (both of which shift risk downstream onto the wards), requesting support from ambulance Trusts to 'cohort' patients awaiting handover, or requesting the redistribution of some ambulances to other providers for a short time while the ED was decompressed. It was noted that the headroom of all providers to mutually support each other has been markedly reduced over recent winter periods.

- Partnership working: This was critical to ensuring quality and safety during the winter period. The balance of risk around individual patients and system demand was not limited to the acute setting and community, social care, mental health, voluntary sector, care sector and ambulance partners had competing priorities. Patients presented with increasing acuity and care packages often needed to be put in place with system partners to enable successful discharge. The key to ensuring prompt discharge and effective flow was strong system partnership arrangements.

- Staffing: The Committee also noted the central importance of staffing to the safe and effective provision of care during the winter period. The Committee acknowledged the extraordinary pressures on staff, particularly staff in the Emergency Departments during winter in particular. Supporting staff health and wellbeing was critical to providing safe care to patients.

5.0 Other issues considered by the Committees

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

a) National Patient Survey: Cancer (Adults)

The Committee reviewed the findings of the latest survey of adults being cared for with a confirmed primary diagnosis of cancer, discharge from an NHS Trust after an inpatient episode or day case attendance for cancer related treatment between April and June 2022. The survey comprised 59 questions across 14 domains to capture patient feedback in a range of areas. The demographics collected as part of this survey were age, deprivation (location), ethnicity, tumour group and cancer type to provide data on the response rates of different population groups and to understand how well the response reflects the eligible population.

SGUH had a 45% response rate (651 out of 1,492) for 2022 and ESTH had a response rate of 55% (180 out of 328). However, the Committee noted that participation in the survey was not representative of the communities served by the two Trusts. A total of 73% of SGUH respondents and 78% of ESTH respondents to the survey were white and this was disproportionate to the make-up of the patients treated. The responses to various patient surveys not being representative of the local population had been raised by the Committee as part of the earlier discussion on health inequalities. It was agreed that greater focus was needed to help increase participation in patient surveys from all ethnic groups.

The survey predominantly used expected range charts to show the lowest and highest score for each question nationally, allowing trusts to understand what they are doing well and where improvements may be required to improve patient experience. SGUH results showed 17 questions out of 59 with an above expected range score, and no scores below

the expected range. ESTH results showed 2 questions above the expected range with 4 questions below the expected range. The report received by the committee provided an overview of the key results, highlighting positive outcomes and actions arising where improvements could be made. The action plan set out the improvements required to positively impact on patient experience based on the findings from the survey results.

b) SGUH – Chid Death Review Panel

The Committee received the summary report from the SGUH Child Death Review Panel. This annual report provided the details of deaths of children between 1 April 2022 and 31 March 2023 who were resident in Wandsworth as reported to the SGUH Child Death Review Service under the Statutory Child Death Review process and the local Child Death Review Partnership arrangements. This annual report also provided an overview of the work undertaken by the SGUH Child Death Review Service.

A number of key points of learning for 2022-23 had been drawn out from the report and include items relating to: impact on siblings and families; improvement in communication with social care teams when families transfer across boroughs to make sure follow up is completed; ensuring support is offered to all family members when there were concerns about contextual safeguarding; and clinical learning.

The Committee confirmed that they felt that the SGUH Child Death Review Report for 2022/23 provided substantial assurance of the arrangements in place.

6.0 Recommendations

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

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	2.2	
Report Title	**Report from Finance Committees-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 ordinary and extra-ordinary meetings in December 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 note the report.

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

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

[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, 12 January 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its ordinary and extra-ordinary meetings in December 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 1 December 2023 and 21 December 2023 (Extra-ordinary), the Committee considered the following items of business:

1st December 2023	21st December 2023 (Extra – Ordinary)
• Finance Report (M7) • Financial Forecast 23/24 • Controls Update • Cash update • Planning 24/25 • Productivity Update • IQPR* • Operational Risk deep dive • SWL Pathology report	• Finance Report/Forecast (M8)* • Cash update • Planning 24/25*

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

2.2 The Committee was quorate for both meetings.

3.0 Analysis

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

a) Financial forecast 23/24- Committee members noted that additional funding has helped with delivering 23/24 but this is predicated on including more non-recurrent savings would have implications for next financial year.

b) Ambulance handover at 45 minutes- Committee members noted the patient safety risk from the cohort who after 45 minutes are no longer under the care of paramedic team but who are not yet under the care of the medical teams in the Emergency Department.

4.0 Sources of Assurance

4.1 a) Finance Report M8

The GCFO noted that SGH are £8.7m adverse to plan and ESTH are on plan to date at M8. In addition, both organisations are in line with the financial forecast agreed with NHSE in November.

b) Financial Forecast 23/24

The GCFO introduced the financial forecast paper as agreed at the Extra-ordinary Group Board on Tuesday 21st November.

c) Financial Planning 24/25

The GCFO introduced an update on financial planning for 24/25, noting the significant challenges of each trust's underlying deficit. Committee members discussed how this gap might be closed, and the balance between setting a stretching but realistic CIP target.

d) IQPR

Non-elective pathways continue to be under pressure at both trusts. SGH 4-hour performance in October declined compared to September, reporting 75.5%, which is slightly below the national target but favourable compared to peers. ESTH achieved 76.5%

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 943 patients waiting for more than 52 weeks at the end of September 2023, the increase is mainly driven by pressures within Gynaecology Service and Community Paediatrics as well as the impact of industrial actions.

Diagnostic performance at SGH remains strong and well within the national target of 5%, with 99.3% of patients receiving their diagnostic test within six weeks of referral in October. ESTH is reporting a breach rate of 4.47% in October, meeting the national target of 5%.

Cancer performance is generally on track at ESTH with some challenges at SGH. Performance against the 28-Day Faster Diagnosis Standard (FDS) at SGH continues 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 (62.9%), it is on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment meeting plan in September.
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.

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

a) Controls update

The GCFO outlined progress on controls, and potentially enhancing controls moving forward.

b) Productivity update

Committee members noted the report.

c) Operational risk deep dive

See section 5.

d) SWL Pathology Report

Committee members noted the report.

5.0	Implications
5.1	The Committee considered the group operational-related risks on the SGUH and ESTH Trust Corporate Risk Register as a deep dive in December.
5.2	The Committee agreed proposed changes apart from the proposal to downgrade the SGH risk 2393 – Regularising Flow.

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 December 2023.

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	2.3	
Report Title	**People Committees-in-Common Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committee Chair, SGUH Martin Kirke, People Committee Chair, ESTH	
Report Author(s)	Yin Jones, People Committee Chair, SGUH Martin Kirke, People Committee Chair, ESTH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees-in-Common at its meeting on 24th November 2023. No meeting was held in December. The key issue the Committees wish to highlight to the Board is:

- Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) quarterly data update: The Committees received the first quarterly data update on the indicators for WRES and WDES, following its previous request to review such information on a regular basis. The Committee was concerned to ensure that further progress in improving the Trusts' WRES and WDES positions. Subsequent to the discussion at the People Committee, the Group Board reviewed WRES and WDES action plans and the Group Board agreed that a prioritised work plan be developed.

- NHS England (NHSE) Equality, Diversity and Inclusion (EDI) Plan compliance: The Committee reviewed the actions taken by the Trusts' to respond to the six high impact actions identified in the NHSE EDI Plan which had been published in June 2023. A number of the measures were already integrated into the wider culture programme. The Committees felt that it would be helpful to have the timescales for the actions, tracked against the national deadlines for delivery, as this would provide further assurance.

The Committee noted that a Group Board discussion on key actions to achieve a more fundamental improvement in the position was planned for December 2023.

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 November 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, 12 January 2024

1.0 Purpose of paper

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

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

2.0 Items considered by the Committees

2.1 At its meeting on 24 November 2023, the Committees considered the following items of business:

November 2023
• Industrial action • Programme Update: Report from the Group Culture, Equity and Inclusion Programme Board • Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) quarterly data update • Plan on NHS England Equality, Diversity and Inclusion (EDI) submission compliance • FTSU Q1-Q2 2023/24 report • Abuse of Staff by patients and visitors • Autumn Vaccination Campaign • Update on Certificate of Sponsorship Inspection and Action Plan • People Management Group Reports

2.2 The Committees meet on a monthly basis, and the focus of meetings alternates between workforce operations in one month and culture, diversity, inclusion and organisational development the next. The chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH. The ESTH Committee Chair chaired the culture focused meeting in November. There was no meeting held in December 2023.

3.0 Key issues for escalation to the Group Board

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

a) Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) quarterly data update
The Committees received the first quarterly update on the indicators for the WRES and WDES, following its earlier request to review the data on a more regular basis. The main points highlighted were:

- Disciplinary cases in general had reduced, with a greater reduction for white staff, compared to Black, Asian and Minority Ethnic (BAME) staff.
- Access to non-mandatory training: little change at SGUH with BAME staff slightly more likely to access non mandatory training than white staff. BAME staff at ESTH were half as likely to access training than white staff. It was noted that collecting data for non-mandatory training at ESTH was difficult.
- Uptake of apprenticeships had improved at both Trusts. At ESTH, of the 54 apprenticeships, 21 were taken up by white candidates, 3 were undisclosed and 30 were BAME candidates. SGUH had increased the number of apprenticeships.

The Committees also noted that both the Boards were outliers in terms of an under-representation of BAME communities. It was important that the Boards were more diverse ethnically, particularly in the context of the diversity of staff across both Trusts.

Subsequent to the discussion at the People Committee, the Group Board reviewed WRES and WDES action plans and the Group Board agreed that a prioritised work plan be developed.

b) <u>NHS England (NHSE) Equality, Diversity and Inclusion (EDI) Plan compliance</u>

The Committees were provided with a progress update on the Group's response to the 6 high impact actions contained within the NHS EDI Improvement Plan published in June 2023:

1. CEO, Chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable.

2. Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.

3. Develop and implement an improvement plan to eliminate pay gaps.

4. Develop and implement an improvement plan to address health inequalities within the workforce.

5. Implement a comprehensive induction, onboarding and development programme for internationally-recruited staff.

6. Create an environment that eliminates the conditions in which bullying, discrimination, harassment, and physical violence at work occur.

The Committee heard that a lot of activity had been undertaken to progress the 6 high impact actions. Most of the work was being implemented through the culture programme which included bullying and harassment; talent management; apprenticeships and existing WRES and WDES plans. Specific projects had been implemented, such as the 'Disability Advice Line' (DAL) and 'Ask Aunty' which supports international staff. All Non-Executive Directors had in place EDI objectives, which had been set following their 2022/23 appraisals. There was a suggestion of establishing a 'shadow Board' to involve staff from diverse backgrounds. The Committees felt that it would be helpful to have the timescales for the actions, tracked against the national deadlines for delivery, as this would provide further assurance.

The Committees agreed that they received reasonable assurance on progress with the EDI actions.

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:

c) Programme Update: Report from the Group Culture, Equity and Inclusion (CEI) Programme Board

The Committees received an update on the CEI programme. The key highlights were that activity and engagement was ongoing and focus had been on:

- Civility and Psychological Safety (CAPS): Around 2,000 members of staff had participated in the 'lunch and learn' events and other activities. Feedback had been positive. Toolkits were being developed to enable teams to support themselves.
- GESH100 Senior Leadership Forum: This had involved around 100 leaders across the two Trusts, including clinical/operational and corporate colleagues. Attendance on the day and feedback were positive. The main theme was culture and there was a lot of engagement and enthusiasm during the sessions. The next event was scheduled for April 2024.
- Development of infrastructure on culture programme: The team were putting in place the infrastructure needed to support the culture programme. These included work on recruitment, induction, appraisal, reward and recognition. The leads for the workstreams were in place.
- As at 22 November 2023, the staff survey response rate was 34% at SGUH and 47% at ESTH.

The Committees were disappointed with response rates to the staff survey, particularly at SGUH, and agreed it was important to understand the reasons why staff had not engaged to the extent desired. More work was required around ensuring the activity and engagement work was reaching the harder to reach staff. Overall, the Committees received reasonable assurance on the CEI Programme Board.

d) Freedom to Speak Up (FTSU) Q1/Q2 2023/24 report

The FTSU Guardians attended the Committee to present their reports for the first 2 quarters of 2023/24 and highlighted the following points:

SGUH:

- Between 1 April 2023 and 30 September 2023, a total of 101 concerns were raised, an increase of 8.6% compared with the 93 concerns raised in the same period the previous year. Of the 101 concerns raised, over 90% were closed by the Guardian without an investigation. The staff groups that raised the highest number of concerns are administrative and clerical staff 37 (36.6%), and nursing and midwifery staff 31 (30.69%).
- The dominant types of concern raised were around Trust systems and processes with 30 (29.70%), followed by leadership 26 (25.74%), behavioural relationships 24 (23.76%), cultural 22 (21.78%), bullying and harassment 21 (20.79%), patient

safety 10 (9.90%), infrastructure & environment 1. Concerns often have multiple themes to them.

- A total of 90.3 % of workers have undertaken the mandatory Speak Up training to date, which represents a significant increase. Additional training sessions for managers were also provided.
- Timely resolution of concerns and effective communication with the Guardian remains an issue. The Guardian is meeting regularly with the senior site team to progress concerns.
- The newly formed Raising Concerns Oversight and Triangulation Group, as a sub-group of the Group Executive, had its first meeting which was well attended by key stakeholders.
- A new case management approach was being developed by the Guardian and Executive Lead which would be in place by January 2024 and would enable the Guardian to provide further high-level reporting and tracking of cases.
- Priorities going forward were to align policies and processes across the Group.

ESTH:

- Between 1 April 2023 and 30 September 2023, a total of 131 concerns were raised with the Trust's Guardians. In the same period the previous year, there were 189 concerns.
- The staff groups which had raised the highest number of concerns over both quarters are Admin and Clerical (19 and 18) and Registered Nurses and Midwives (13 and 25). More senior staff had started to raise concerns.
- The main types of concern raised during this period, which has been consistent with 2022/23, have been concerns with elements about management conduct, discrimination, perceptions of bullying and harassment and patient safety. Common themes with SGUH relate to concerns around Trust infrastructure and process, perception of prejudicial behaviours, and staff health and wellbeing.
- Concerns around patient safety and quality increased from 10 cases in Q1 to 17 in Q2. Concerns around bullying and harassment increased from 14 in Q1 to 21 in Q2.
- ESTH would also be implementing the new case management system, which was being rolled out on a Group-wide basis.

The Committees raised concern about the longstanding concerns, particularly in the Emergency Department and Maternity. These were being addressed. The new Overview and Triangulation Group would look to help unblock outstanding concerns and ensure future concerns are resolved in a timely manner. The delays had been caused by a lack of resource and capacity and were often complex cases. Line manager capability also needed to be improved. It was noted that the new case management software will assist with the triangulation work. The Committees were reassured to hear that over 90% of concerns were closed by the Guardian at SGUH, without investigation.

The Committees received reasonable assurance on the FTSU Q1/Q2 2023/24 reports.

e) Autumn Vaccination Campaign

The Committees received an update on the Group-wide autumn vaccination programme for staff. It was reported that:

- Covid and Flu vaccinations were being delivered at all sites.

- The Campaign was due to run until March 2024, in line with the national programme. The Group was working with the SWL team.
- Uptake was significantly lower than previous years and the CQUIN target for Flu of 75% was unlikely to be met. More focus was required on an out of hours service.
- The data provided was from 18 September 2023 to 6 November 2023. For Flu vaccinations, the uptake was 37% at SGUH and 36% at ESTH. For the Covid vaccination, the uptake was 12% at SGUH and 22% at ESTH.
- Communications team was working on promoting the vaccinations to increase uptake.

Some Committee members provided positive feedback as users of the service at both Trusts. The Committees received reasonable assurance on the Autumn Vaccination Campaign.

5.0 Other issues considered by the Committees

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

a) Industrial Action

The Committees noted the latest update on industrial action. There would be further balloting for industrial action by consultants and Specialty and Specialist (SAS) doctors. Junior doctors were having discussions on pay and had a strike mandate until February 2024.

b) Abuse of Staff by patients and visitors – SGUH

Safe place to work (violence and aggression) was the second workstream of the culture programme. The work on violence and aggression pre-dates the culture programme. The Committees noted the policies and actions to comply with the NHS Violence Prevention and Reduction Standard (VPRS) which included a revised Violence Prevention and Reduction policy; actions to be taken; the Trust response to violence and aggression incidents and zero tolerance approach. The work would proceed as part of the culture programme. In the 12 months period since the last briefing paper, SGUH's overall compliance against the VPRS was judged to have increased from 35% to 47%.

The Committees noted the compliance score of 47% and wanted to know how this compared with other Trusts. Although the culture programme is Group-wide, the Group Executive would need to consider how to align all aspects of work regarding Violence Prevention and Reduction.

6.0 Recommendations

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

Group Board

Meeting in Public on Friday, 12 January 2024

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

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meeting on 12 December 2023. The key issues the Committee wished to highlight to the Board are:

1. **South West London Picture Archiving Communication systems (PACS) & Radiology Information Systems (RIS) Implementation:** The Committee was updated on the work to address the associated challenges in implementing the new PACS and RIS systems across the four acute Trusts in SW London. Progress has been made and new Go Live date at Croydon University Hospital of 24 February has been identified, with Go Live scheduled to follow at Kingston, St George's and finally Epsom and St Helier.
2. **Estates Assurance:** The Committee received reasonable assurance for estates at St George's noting the work to respond to operational and maintenance issues and incidents. The Committee received limited assurance for estates at Epsom and St Helier, noting the number of Estates risks as well as the backlog in Authorised Engineer audits.
3. **Health & Safety:** The Committee noted the two serious health & safety incidents which had taken place at St George's. Members asked for further assurances that there was sufficient resource to ensure the contractor management audit was completed and that the Trust was meetings its responsibilities against the Heath and Safety Executive (HSE) CDM regulations.

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 December 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, 12 January 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meeting on 12 December 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 At its meeting on 12 December 2023, the Committee considered the following items of business:

December 2023
• Group Digital Strategy Development
• Electronic Patient Record (EPR) Implementation
• South West London PACS & RIS Implementation
• Key Digital Risks
• Estates Assurance Report
• Facilities Assurance Report
• Group Chief Infrastructure, Facilities and Environment Officer Divisional Update
• Premises Assurance Model Update
• Medical Physics Report
• Group Green Plan Update
• Estates and Facilities Risks

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:

3.2 **SWL Picture Archiving Communication systems (PACS) & Radiology Information Systems (RIS)**
The Committee received an update on the SWL Picture Archiving Communication systems (PACS) & Radiology Information Systems (RIS) implementation going through SWL governance under the SWL Acute Provider Collaborative.

Members had been informed of challenges following the failure of two rounds of user testing at Croydon University Hospital. ICT colleagues continue to work through the issues with the supplier and are now aiming to go live in Croydon at the end of February 2024.

Sequencing the go live at the four SWL Trusts has also proven challenging as it requires aligning with existing complex programmes and factoring pressures on resource. Croydon are due to go live first; followed by Kingston, SGUH and then ESTH.

SGUH will have to go live in September 2024 before its contract with its current supplier expires in October. Go live at ESTH needs to avoid a clash with the EPR implementation as it is too great a risk in terms of resource and network pressures. Additional complexity is added by the legacy PACS at ESTH causing operational challenges requiring fixes which has improved stability. However, there is risk of a more robust fix and hardware upgrade needed to ensure maintenance of operational services.

There is confidence the plan can be delivered, despite the concerns around operational impact and potential cost implications. The GCFO is working with CFO colleagues across the ICS on contingency in the event of an extended programme.

4.0 Key Issues on which the Committees received assurance

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

4.2 **Estates Assurance Report**

The GCIEFO reported the lack of investment at both sites will mean that there will be greater difficulty in addressing long standing maintenance issues. This is exacerbated by an aging estate with increased risk of incidents which in turn results in reactive calls drawing away resource from proactive work. To balance resources, incidents are prioritised according to risk assessment with life threatening or patient facing incidents always treated as a priority. Both sites are successful in clearing incidents, but the pace in responding non-urgent works is proving a challenge to manage. There is confidence the backlog is coming down at St George's, but at ESTH it varies from area to area.

Recruitment continues to be difficult, with reliance on interims and contractors which has cost implications. A joint recruitment drive at both sites will look to address the challenges.

Members noted the two significant accidents involving contractors at St George's. These have been reported up to the HSE. Estates have implemented an active programme of auditing contractors to ensure they are working safely onsite. Members questioned how these incidents are reported at Board and asked where the Trust can be assured it is meeting CDM requirements. The Committee asked for an updated report on the audit at the next meeting to receive assurance.

The Committee received reasonable assurance for St George's noting the programme of authorised engineer (AE) audits. The Committee received limited assurance for ESTH because of the backlog in AE audits.

4.3 **Facilities Assurance Report**

The GCIFEO raised the following matters:

Both Trusts are continuing to report good levels of compliance to the cleaning standards. There has been investment at ESTH in new automated cleaning machinery which has helped drive up standards and help achieve the 2021 National Cleaning Standards

Challenges for site security persist with a significant increase in incidents involving violence and aggression. The GCIFEO flagged the increase in mental health pressures in ED and the impact on Security teams. Members requested a deep dive at later meeting on the rise in incidents to fully understand the reasons underlying the incidents and whether additional support or training for staff is required.

Longstanding issues with recruitment were raised, alongside the reliance on interims and overtime. Members asked whether recruitment for Estates and Facilities can be made easier to fast track recruitment as one cause of the high levels of vacancies particularly at ESTH is the length of time it takes to recruit staff, with applicants often finding other work elsewhere in less time. The Committee noted new approaches are being considered to drive up recruitment.

Site teams at both Trusts are engaging with local police in addressing security matters in ED and the wider context ensuring staff are receiving the proper support, through the reducing violence and aggression workstream.

Winter pressures are also impacting significantly on cleaning and transport team meaning resource needs to be diverted from other teams.

Members noted the lack of opportunity for staff to undertake 'Working At Height' training and stated the importance of staff being able to access the appropriate health and safety training.

These reports collectively demonstrate the proactive steps taken management to address compliance and to provide assurance in critical areas to the Infrastructure Committees, along with identified areas of improvement and progress.

5.0 Other issues considered by the Committees

5.1 Group Digital Strategy Development

The GCFO reported on the development of the Group Digital Strategy. A timeline has been set out for its development with scoping work starting in January 2024, followed by prioritisation of the requirements in February. A draft Strategy will be presented at the March meeting and introduced for 2024/25 to align with annual planning processes.

The GCFO stressed challenges include addressing the imbalance between clinical and operational wants and requirements and the resources to deliver them. Managing Group-wide competing aspirations and demands and aligning the Strategy with broader Group goals. There are also longstanding questions on how to address capacity and funding. The work will also need to consider priorities at a system, region and national level.

Members offered comments and suggested key uses cases are made to identify priorities and that the Strategy should connect to the GESH Strategy and how technology can drive improvements in patient outcomes and productivity. The importance of common systems to support processes was stressed and the need to be clear about what needs to be retained, retired or replaced.

5.2 Key Digital Risks

The GCFO presented an initial high-level articulation of the key risks for GESH Group Digital Services. A more detailed risk schedule is going to be developed with a commitment to a more thorough presentation of the risks by the end of January 2024.

The strategic risks outlined were:

- Needs (to upgrade/refresh systems) and user expectations exceed resources (capital, revenue and people) available.
- Legacy networks and platforms may fail before replacements operational.
- Cyber-security incidents may cause access issues over an extended period.
- Data and insight requirements to meet external reporting needs and internal management reporting exceed capacity or tools to deliver.
- Group/cross-site integration occurring before Group-level digital solutions in place.

Members noted the risks around meeting national expectations both in resource and capacity. The challenge of connecting high level risks with the risks sitting at each Trust and ensuring they are aligned and properly managed and reducing risk of exposure whilst maintaining a level of proportionality was also noted.

Members asked for future iterations of the risks to be presented in a risk register format to understand the impacts of mitigations and where to focus interventions. Clearer articulation of the specific interventions which can help reduce risks was also requested.

5.3 **Group Chief Infrastructure, Facilities and Environment Officer Divisional Update**

The GCIFEO reported the Group Executive has approved the proposals for Group Integration of Estates and Facilities with the initial focus being on management structures. Members were made aware of two complex issues for on Pay Models:

- The London Living Wage uplift was announced in October 2023. However, the Trust will only be able to award the increase in November 2024 as in-year awards are not affordable.
- At ESTH, staff have not currently received the Covid non-consolidated payment. This is being reviewed, noting the higher levels of pay awards that our non-Agenda for Change (AfC) staff have received this year compared to AfC staff.

The GCIFEO reported both issues were a cause of consternation with staff and that there was a likelihood the Unions will ballot members on potential industrial action.

All previous agreements on pay have been implemented and there are no staff paid less than the London Living Wage and no staff on spot salaries. The London Living Wage had also been backdated to April 2022.

5.4 **Premises Assurance Model**

The Premises Assurance Model (PAM) is an annual mandatory self-assessment of the Trust's Estates and Facilities performance to provide a snapshot of national best practice and regulatory requirements. Members were informed ratings for 2022/23 had improved at SGUH with increased scoring for 'outstanding', 'good' and 'requires minimal improvement'. There was also a significant decrease for areas rated as 'inadequate'. However, ratings at ESTH are significantly worse when compared with the previous year. A subsequent review undertaken by the Assistant Director of Non-Clinical Risk and Assurance in response to the submission found there were no performance issues or areas of major concern but related to a

documentation issue and the lack of data required to evidence ratings. Actions have been introduced to rebuild the evidence base at ESTH.

The GCEIFO reported a cloud-based system for more efficient management of scoring and collation of the evidence base is being introduced and will also allow real-time reporting throughout the year and allow both Trusts to track progress. The system is already in place at SGUH and will be introduced at ESTH with system training planned for January 2024.

5.5 **Medical Physics Report**

The GCIFEO reported on compliance within Medical Physics at both Trusts, highlighting the following key points:

- **National Compliance Metrics:** Of the 23 safety metrics in Part 1 of national compliance, 3 were partially compliant and 20 fully compliant. Of the 25 safety metrics in Part II, 22 were compliant and 3 were partially compliant.
- **MRI Assurance:** The Trusts received a pass for quality assurance testing for the NHS Breast Screening Programme, reflecting successful compliance. No Medicines and Healthcase products Regulatory Agency incidents reported.
- **Ionising Radiation Device Compliance**: The percentage of ionising radiation devices checked for performance and safety against national standards: 95% were compliant, none found to be non-compliant.

5.6 **Group Green Plan Update**

The Committee received an update on the Group Green Plan. The GCEIFO reported:

- The end of February 2024 has been targeted to bring the Group Green Plan to the Committee.
- Recruitment is underway for the Group Sustainability Team.
- The decarbonisation plan for ESTH is underway. The costs will be fully understood on completion of the Green Plan. Members noted the decarbonisation plan costs for SGUH have been estimated at £70m.
- The SWL Integrated Care Board have approved the Smart Theatres business case for Smart Theatre technology. This is a significant piece of work which will drive down carbon usage and make theatres more efficient across the Group. The work has been recognised by NHS England and is considered a UK exemplar digital project.

The Committee welcomed the additional funding noting there was still significant work needed to meet the 80% target reduction in carbon emissions by 2028-32.

5.7 **Estates and Facilities Risks**

The Committee received the Estates and Facilities risks sitting on the SGUH and ESTH Corporate Risk Registers with three risks relating to premises at SGUH and eight at ESTH. The Assistant Director of Non-Clinical Risk and Assurance is currently working on a refresh of relevant risks. This includes a thorough review of the risks sitting on risk registers at both Trusts and the Estates and Facilities approach to risk management, ensuring that Health & Safety risks are more visible to the Group Board.

The Committee received the Health & Safety and Fire Report for SGUH and welcomed the comprehensive and substantial assurances received for sites at St George's and at Queen Mary's Hospital.

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 December 2023.

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	**3.1**	
Report Title	**Group Maternity Services Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	**Bene Agbagwara-Osuji, Director of Midwifery and Gynaecology Nursing, Epsom and St Helier University Hospitals NHS Trust (ESTH)** **Laura Rowe, Lead Midwife for Clinical Governance and Risk (ESTH)** **Jan Bradley, Director of Midwifery and Gynaecology Nursing, St George's University Hospitals NHS Trust (SGUH)**	
Previously considered by	Quality Committees-in-Common	30 November 2024
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	7	1	2
SGH	7	1	2

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

The final self-assessment of compliance will be undertaken and presented to Board on 26 January 2024 before submission to the ICB on 2 February 2024.

3.0 Safe Staffing

Midwifery Safe Staffing for November 2023 was 98% for St Helier,95% 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

There has been an amendment to CNST year 5 guidance where to demonstrate compliance, 80% training should be achieved for doctors at the end of December 2023. Trusts need to have a Board approved action plan to achieve the 90% compliance for doctors by March 2024.

Training Category	Site	Staff Group	Performance November 2023	RAG
Prompt	ESTH	Consultant Obstetricians	70%	
	ESTH	Trainee and Staff Grade Obstetricians	78%	
	ESTH	Anaesthetics	61%	
	SGUH	Consultant Obstetricians	75%	
	SGUH	Trainee and Staff Grade Obstetricians	72%	
	SGUH	Anaesthetics	75%	

5.0 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 key areas of risk and mitigations

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, 12 January 2024

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. The Midwifery workforce reports for each Trust are available in the Reading Room.

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		

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

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	MBBRACE-UK 2021 Report: previously received at committee and in the addendum at Appendix 1

<table>
<tr><td></td><td></td><td>review, care planning and review of women reporting reduced fetal movements
➢ ESTH 1 neonatal death case review identified no concerns with care or service delivery issues</td><td></td></tr>
<tr><td colspan="6">Midwifery workforce is reported and monitored Monthly with local twice daily SITREPS to the Site and Group Nursing teams. There is a focus on Midwifery staffing levels as part of ongoing work.</td></tr>
<tr><td rowspan="4">Midwifery Workforce Planning</td><td></td><td></td><td>Fill Rate (>94%)</td><td>Band 7 Supervisory midwife (100%)</td><td>Triage, 2.0 wte per shift (100%)</td><td rowspan="4">Maternity Services Monthly Report Appendix 1</td></tr>
<tr><td>Nov 23</td><td>ESTH STH</td><td>98%</td><td>100%</td><td>100%</td></tr>
<tr><td>Nov 23</td><td>ESTH EGH</td><td>95%</td><td>100%</td><td>100%</td></tr>
<tr><td>Nov 23</td><td>SGUH</td><td>90%</td><td>95.1%</td><td>100%</td></tr>
<tr><td colspan="6">Compliance with CNST year 5 Maternity Incentive Scheme</td></tr>
<tr><td rowspan="2">10 Safety Actions Maternity Incentive Scheme Year 5 (CNST)</td><td colspan="2">ESTH</td><td colspan="2">SGUH</td><td rowspan="2">Maternity Services Monthly Report Appendix 1</td></tr>
<tr><td colspan="2">Risk of non-compliance:
• Safety Action 3: Transitional Care
• Safety Action 5: Midwifery Workforce Planning
• Safety Action 6: SBLCB</td><td colspan="2">Risk of non-compliance:
• Safety Action 3: Transitional Care
• Safety Action 5: Midwifery Workforce Planning
• Safety Action 6: SBLCB</td></tr>
<tr><td colspan="6"></td></tr>
<tr><td>Culture review: Maternity Services</td><td colspan="4">Governance review commissioned and Phase 1 includes culture review of maternity services</td><td>Terms of Reference previously received at committee</td></tr>
</table>

4.0 Key risks

4.1 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 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 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 key areas of risk and the mitigations
c) Note that the final CNST self-assessment position will be reviewed by the Board on 26 January 2023, prior to submission on 2 February 2024.

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

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Appendix 1

Maternity Services Monthly Report
Group Board

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

12 January 2024

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

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Internal and External Assurance Processes For Both Trusts

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

Internal Governance and Monitoring

- Monthly Division Risk Report monitored by Women's Health DMT
- Quarterly Quality Report to 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 regular 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
- MNSI (formally HSIB)
- MBRRACE-UK (PMRT)
- CNST
- LMNS (Surrey Heartlands and SWL)
- Maternity and Neonatal Voices Partnership
- NHS Resolution (ENS scheme)

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

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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 November 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)

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

CNST Year 5: Status position 14 December 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
1. PMRT	Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?	Yes and on track There is one case flagging on the MBRRACE-UK report as not met but MBRRACE-UK have confirmed that as we needed to assign the case to another Trust this will be picked up in the validation process and won't count as being not met (in line with the Technical Guidance).	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 ESTH quarterly report is shared in this report (December 2023)
2. MSDS	Are you submitting data to the Maternity Services Data Set to the required standard?	Yes - achieved	Yes - achieved	ESTH and SGUH have evidenced full compliance through the National Maternity Dashboard.
3. Transitional Care	Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?	Transitional care is being delivered but current staffing does not meet the BAPM standards. Joint NNU and Maternity task and finish group working on clear Job Descriptions and clarification of leadership for this service. An updated Transitional Care Guideline is expected to be completed in December 2023.	There is a plan to improve the current transitional care provision supported by the £330K year 4 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 was shared in October 2023. Q2 audits are in progress.

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St George's, Epsom and St Helier
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CNST Year 5: Status position 14 December 2023

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Safety Action	Action Description	ESTH: Status and risks	SGUH: Status and risks	Key deliverables to date and timeline for completion
4. Clinical Workforce Planning	Can you demonstrate an effective system of medical workforce planning to the required standard?	Evidence has now been received and signed-off by the Group Chief Nurse.	On track	Compliance with RCOG, BAPM and ACSA standards for obstetric medical, anaesthetic, neonatal medical and neonatal nursing staff.
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 approved by the Board, alongside a 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. Not meeting 100% compliance with supernumerary status over the May to Dec 2023 timeframe.	Trusts need to either meet (or be working towards an agreed action plan to meet) the BR+ staffing recommendation. Trusts also need to show 100% sustained compliance with co-ordinator supernumerary status between 30 May 2023 and 7 December 2023. **EGH have audited supernumerary status and although not 100% the audit has demonstrated overall compliance (<1 incident per week)**
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 will need completion for all 6 elements with evidence uploaded to NHS Futures and submission verified by the LMNS oversight quarterly meeting. The tool will be used to assess whether the threshold for CNST compliance in Year 5 has been met. Initial LMNS review showed 30% compliance overall.	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. Initial LMNS review showed 31% compliance overall.	Trusts must meet 70% of the interventions in SBLCBv3 overall with at least 50% of interventions in each of the 6 elements. Compliance will be assessed by the SWL LMNS on 16 January 2024. Both Trusts are currently non-compliant but work is in progress.

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CNST Year 5: Status position 14 December 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	Minutes of MNVP meetings and work plan needs to be signed off by the LMNS. Evidence from the MNVP leads of full remuneration.
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.	We have achieved 90% for Midwives and MSWs and 80% for obstetric medical and NNU nursing staff. An action plan to achieve 90% by March 2024 has been submitted for those staff group who did not meet the 90% target.	We will have achieved 90% Mandatory training compliance or all by December deadline.	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. Some physical evidence is outstanding but verbal assurance has been given that we are compliant.	Yes and on track	The Patient Safety Incident Response Plan (PSIRP) is included in this report at slide 29 (also seen at QCiC in November 2023). The PSIRP will also be presented to the Trust Board in January 2024.
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: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

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Perinatal Mortality

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

		ESTH				SGUH			
		December 2022 – November 2023		November 2023		December 2022 – November 2023		November 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
		3734	17 (includes 1 set of twins)	315	1	4348	40	357	3
Type of Mortality	Antepartum Stillbirths		11		1		18		3
	Intrapartum Stillbirths		3				2		
	Stillbirth of unknown timing		1				2		
	Neonatal Deaths		2				18		2
Gestational Age	<24 weeks		2				9		2
	24-27 weeks		5				14		1
	28 - 31 weeks		1		1		6		
	32 - 36 weeks		3				5		
	37-41 weeks		6				6		
	≥ 42 weeks						0		

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Perinatal Mortality Reviews

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PMRT Panel	Cases reviewed Nov 2023	Emerging Themes November 2023	Open Actions from previous reviews, year to date	
ESTH: 1 panel meeting	2	No new clear emerging themes identified to date	INC-138602	1. Review to be undertaken by the obstetric team of the blood tests required following a stillbirth (To be completed by 31/12/2023). ***This action has been extended as regional review is recommended.*** 2. Audit of maternal observations to be completed by 31/01/2024.
			INC-141041	1. Review the guidance on following-up MSU samples (31/03/2024) 2. Article in the risk newsletter to highlight the need to label the placenta appropriately in a twin pregnancy (31/12/2023).
SGUH: 2 panel meetings	6	6 cases were reviewed during this period. No new clear emerging themes identified to date.	Case 87359	1. SI case DW18805 (To be completed by 19/02/2024)
			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 (historical case)	1. Review guidelines regarding management of preterm labour. (To be completed by 30/04/2024)
			Case 87496 (historical case)	1. Create a database with women caseloaded by FMU 2. Define criteria for FMU midwifery caseload 3. Escalate to community to refer women via email. Clear communication with outcomes from these referrals needs to be documented on iclip and emailed to community team.
			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.

Perinatal Mortality Reviews
ESTH quarterly report

Epsom and St Helier University Hospitals NHS Trust

CNST Safety Action 1: Are you using the National Perinatal Mortality Review Tool to review perinatal deaths to the required standard?

- All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days and the surveillance information must be completed within one month of the death: **Since the last report in September 2023 there have been 2 eligible cases and both have been reported to MBRRACE-UK in accordance with the MIS Year 5 requirements as detailed in the table below.**

Case ID	Date of Death/Stillbirth	Date Reported	Surveillance Completed
89837	11/10/2023	13/10/2023	Y
90188	03/11/2023	03/11/2023	Y

- A review of 95% of all deaths of eligible babies from 30 May 2023 will have been started (and families informed) within two months of each death and at least 60% will have been reviewed by a multidisciplinary team and a PMRT draft report has generated within four months of each death and the report published within six months of each death: There are currently 7 eligible cases in the current MIS Year (30 May 2023 – 7 December 2023) and the Trust is currently on track to achieve this standard.

Perinatal Mortality Reviews
ESTH

Epsom and St Helier University Hospitals NHS Trust

Case ID	Date of Death	Review Started	Review Completed	Parents Informed	Notes
85599	19/01/2023 (Stillbirth at 38+3/40)	Y	Y	Y	This was an HSIB case so is outside the scope of Safety Action 1
87066	19/04/2023 (Stillbirth at 22+4/40	Y	Y	Y	***Outside current MIS period.***
87098	20/04/2023 (Stillbirth at 39+3/40)	Y	Y	Y	This woman was booked with another Trust and the IUD was confirmed by the booking Trust. Transferred to ESTH for delivery for social reasons. ***Outside current MIS period.***
87235	28/04/2023 (Neonatal death at 37/40)	Y	N	Y	This review has been delayed as awaiting further input from the NNU. This case is subject to a Coroner's inquest. ***Standard for draft report not met but outside current CNST period.***
87280	28/04/2023 (Neonatal death at 36+6/40)	Y	N	Y	This review has been delayed as awaiting further input from the NNU. ***Standard for draft not met but outside current CNST period.***
87401	09/05/2023 (Stillbirth at 33/40)	Y	Y	Y	Currently at the report writing stage. ***Outside current MIS period.***
87992	16/06/2023 (Stillbirth of Twin II at 23+4/40)	Y	Y	Y	***Standard met.***
89175	25/08/2023 (Stillbirth of twins at 25+2/40)	Y	Y	Y	***Standard met.***
89220	03/09/2023 (Stillbirth at 38/40)	Y	N	Y	***Standard not met due to information outstanding from another Trust. MBRRACE-UK have confirmed that this will not count towards CNST compliance.***
89837	11/10/2023 (Stillbirth of Twin at 33+5/40)	Y	Y	Y	***Standard met.***
90188	03/11/2023 (Stillbirth at 31+4/40)	Y	N	Y	***Standard met (timeframe for completion outside the current MIS period).***

Perinatal Mortality Reviews
ESTH

Epsom and St Helier University Hospitals NHS Trust

Quarterly analysis; the key points of note are

- All standards due in the current MIS year have currently been met. Over the last year, 11 reviews have been completed and 2 are in progress (2 reviews relate to twins and 2 reviews relate to HSIB cases).
- There has been a sharp increase in 2023 cases from 2022 (11 cases in 2022 and 17 cases in 2023); in 2023 there were 3 cases where women had not booked with or received any care from the Trust and 3 cases related to twin pregnancies. A further GESH-wide reviewed of stillbirth in being undertaken in early 2024.
- In the 11 reviews completed, there were no issues identified that would have contributed to the outcome.
- There were no clear themes identified.
- Themes and completion of actions continue to be reported monthly (see slide 9).

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Perinatal Mortality Reviews SGUH

Quarterly analysis due in end-January 2024

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Maternity Services Data Set

(MSDS)

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

- Formal confirmation has been received that both SGUH and ESTH have passed the requisite data quality checks for MSDS and this evidence has been signed-off by the GESH Chief Nursing Officer and NED

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Transitional Care Services/ATAIN

CNST Safety Action 3: Can you demonstrate that you have transitional care services in place to minimise separation of mothers and their babies?

- The ATAIN (avoiding term admission to the neonatal unit) report was shared at QCiC on 29 June 2023 and Group Board on 7 July 2023 for Q4 2022/2023
- The Q1 ATAIN data was shared at QCiC in September 2023 for ESTH (Epsom) and SGUH
- The Q1 ATAIN data was shared at QCiC in October 2023 for ESTH (St Helier) together with the ATAIN Action Plan for Board agreement (also included in the following slides to confirm the current position)
- The Q2 audits are underway and findings will be presented when available

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ATAIN Action Plan
CNST Safety Action 3

Current ATAIN action plan for sign-off by the Trust Board. This was presented and signed-off at the Safety Champions quarterly meeting on 20 November 2023.

ESTH ATAIN Action Plan (Current position as at November 2023)

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	To update quarterly on the results of the audits and any improvement action taken. This is a continuing audit as there is no nationally agreed standard for detection so learning will be based on the review of individual cases.
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 as at November 2023)

St George's University Hospitals NHS Foundation Trust

Point	Recommendation	Action plan	Lead	Status
SGUH 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
SGUH 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
SGUH 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
SGUH 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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Clinical Workforce Planning

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

- **ESTH:** Confirmation has been received from the obstetric, neonatal and anaesthetic teams/Safety Champions that we are compliant with all the standards (BAPM, RCOG and ACSA) and the evidence has been signed-off by the GESH Chief Nursing Officer and NED. The Trust do not employ long term locums, therefore no further action is required to demonstrate compliance. Evidence has been shared with the LMNS for LMNS Board sign-off.

- **SGUH**: As described in the Maternity Staffing paper November 2023 SGUH are fully compliant with BAPM and ACSA standard for medical staff. The RCOG standards are not yet met but the service will build an action plan to work towards compliance

- To meet the requirements of CNST the compliance statement needs to be ***formally recorded in the Group Board Minutes.***

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Midwifery Workforce Planning

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

- The updated Workforce Papers for ESTH and SGUH have been included as separate papers in the READING ROOM.
- To declare compliance with this safety action there needs to be evidence either than the funded staffing establishment meets the recommendations of Birthrate+ or an action plan approved by the Board detailing timescales of when a full funded establishment will be agreed and in place.

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Safe staffing

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Staff group	Measure	September 2023			October 2023			November 2023		
		ESTH STH	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH	ESTH STH	ESTH EGH	SGUH
Midwifery	Fill Rate (target >94%)	85%	84%	90%	86%	88%	90%	98%	95%	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%	100%	100%	100%	94%	100%	100%	95.1%
Triage staff SGUH, 2.0 wte per shift ESTH, 1wte per shift	Shift allocation 100%			85.5%	100%	100%	100%	100%	100%	100%

Red Flag Category	ESTH St Helier	ESTH Epsom	SGUH
Coordinator not supervisory	3	0	3 occasions in month - 60 shifts
Delay in time critical activity	1	0	2
Delayed induction of labour	1	22	1
Delayed pain relief	0	0	0
Delayed or cancelled care	0	0	3
Number of clinical incidents related to red flags	0	0	0

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Actions to Support Safe Staffing

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ESTH

- The overall fill rate in November 2023 was 96.5% (97.6% at STH and 94.5% 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. Consultation paper outlining reconfiguration of midwifery teams submitted to staffside.
- 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 November 2023 for SGUH was over 90%
- Proactive closure of the birthing centre has continued in order to mobilise staff to the delivery suite. On average the birth centre was open 81% in November which is a decrease from 85% in October
- No training was cancelled or rescheduled to redeploy staff
- Specialist midwives can work on the delivery suite when required to maintain safe staffing levels – no unplanned additional support has been required
- All staffing templates have been reviewed and maternity establishment review paper being finalised.
- The maternity staffing paper underpinned by the establishment review recommendations will bring us to the BR ratio of 1:24.

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Saving Babies Lives Care Bundle version 3

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

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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 agreeing whether Trusts are compliant with Safety Action 6 following Trust self-assessment from review of the evidence; 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%.** Following the first quarterly assessment by the LMNS this was amended to **30%** compliance**.** A further LMNS compliance assessment will take place in January 2024. Work is in progress to implement the new process guidelines and undertake audits to provide evidence. ***We are fully on track to implement this by March 2024.***

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%.** Following the first assessment by the LMNS this was amended to **31%** compliance**.** A further LMNS compliance assessment will take place in January 2024. 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: Listen to women, parents and families using maternity and neonatal services and coproduce services with users

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:

PROJECT	ACTION	MVP LEAD	TRUST LEAD	PROGRESS
Outreach to diverse voices	MVP working alongside Diane Weir to engage women from the Global Majority focus groups in MVP projects	Sally Hodgson Helen Pierce	Diane Weir	ongoing
Co-produce website	Recreate website in line with Ockenden / CQC recommendation	Sally Hodgson Helen Pierce	Louise Emmett	ongoing
Improve service user experience	Walk the wards feedback alongside service user forums and survey	Sally Hodgson Helen Pierce	Matrons	ongoing
Review of bereavement care	Bereavement pathway included in MVP service user survey, to ensure voices of bereaved families are heard	Sally Hodgson Helen Pierce	Bereavement MW	ongoing
Ongoing attendance at Trust meetings and relationship building / maintainance with Trust staff	To attend all meetings in line with Ockenden recommendation	Sally Hodgson Helen Pierce	All	ongoing
MVP annual report and workplan	To be produced and signed off prior to CNST submission	Sally Hodgson Helen Pierce		To be ratified 08/11/23

SGUH Maternity Voices Partnership
CNST Safety Action 7- Activity

St George's University Hospitals NHS Foundation Trust

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: Can you evidence the following 3 elements of local training plans and 'in-house', one day multi professional training?

Please note that in the latest iteration of the technical guidance for CNST the training target has been reduced to 80% in recognition of the challenges trusts are facing in relation to the industrial action.

Please note that the current Core Competency Framework V2 (Training Plan) has been attached for Board sign-off.

Confirmation has been received from both the NNU staffing and medical teams that their NLS training compliance is >80% as at 1st December 2021.

Amendment to CNST year 5 guidance
80% compliance at the end of the previously specified 12-month MIS reporting period (December 2022 to December 2023) will be accepted, provided there is an action plan approved by Trust Boards to recover this position to 90% within a maximum 12-week period from the end of the MIS compliance period.

In addition, evidence from rotating obstetric trainees having completed their training in another maternity unit during the reporting period (i.e. within a 12 month period) will be accepted.

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Mandatory training compliance

(rounded to the nearest whole number)

Type of Training and % compliance	Staff Group	October 23		November 23		In month performance	
		ESTH	SGUH	ESTH	SGUH	ESTH	SGUH
PROMPT 80%	Midwifery Staff	91%	90%	95%	87%	+4%	-3%
	Maternity Support Workers	87%	90%	89%	85%	+2%	-5%
	Consultant Obstetricians	89%	70%	93%	75%	+4%	+5%
	Trainee and Staff Grade Obstetricians	82%	78%	82%	72%	=	-6%
	Anaesthetics	79%	61%	88%	75%	+9%	+14%
CTG Training 80%	Midwifery Staff	99%	86%	97%	89%	-2%	+3%
	Obstetricians	80% (85% Consultant and 75% middle grades)	84%	82% (82% Consultant and 81% middle grades)	90%	+2%	+6%
NLS (Newborn Life Support) 80%	Midwifery Staff	91%	95%	95%	93%	+4%	-2%

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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 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 • ***An action plan is required to achieve 90% doctors training by 01/02/2024.***	1 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 now onboard and two additional sessions planned to support attendance • CTG – Obs Consultant training - further attendance for trainees planned • NLS – two sessions per month until December 2023 to ensure compliance by year end • Any attendee not able to attend training must have approval by DDoM	31 December 2023

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Maternity and Neonatal Safety and Quality Issues

CNST Safety Action 9: Can you demonstrate that there are robust processes in place to provide assurance to the Board on maternity and neonatal safety and quality issues?

- The Patient Safety Incident Response Plan (PSIRP) was developed in June 2023 and includes the detail on the patient safety incident type and the required response for all Trust services split by national requirements and local area focus. This was approved by the Trust Board in June 2023.
- Safety Champion meetings have been held in July and November 2023 and staff engagement events have continued with a Dashboard of progress against issues raised shared with all staff. ***Evidence of quarterly Safety Champions/Quad meetings needs to be formally recorded in the Board minutes.***
- The claims report has previously been presented to this committee.
- The Perinatal Quality Surveillance measures are all included in this report.

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

ESTH	SGUH
The CQC inspected ESTH on 29 and 30 August 2023. The Trust received the draft inspection report on 23 October 2023 and submitted the factual accuracy response on 2 November 2023. The final report 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 on 17 August 2023 and the service was rated Inadequate for Safe and Well Led. 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. Colleagues from NHSE Maternity Services Support Programme (MSSP) have been onsite to undertake an upstream diagnostic evaluating required support and actions required. The report is awaited. **Digital Transformation** • The Digital transformation project is due to launch on 20 November 2023 • VIEWPOINT 6 FMU Obstetric Scanning Implementation: There is a delay in the launch due to a suboptimal scheduling system and delay in presenting an 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 is 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
Death		**INC-142169:** Intrauterine death diagnosed at 31+2/40 at a routine scan. This case will be subject to PMRT review.
Moderate		**INC-142489:** 3rd degree tear. This grading will be revised following review if it is found to have been likely unpreventable.
Moderate		**INC-142725:** Baby sent for cooling. This case has been reported to MNSI and will be reported as a Serious Incident.
Moderate		**INC-143538:** Unexpected admission to the NNU.
Moderate		**INC-143609:** PPH.
Death		**INC-143962:** Intrauterine death at 38+1/40. This case has been reported to MNSI and we are awaiting confirmation that they will be investigating.
Moderate		**INC-143965:** 3rd degree tear. This grading will be revised following review if it is found to have been likely unpreventable.

Investigations and case reviews are in progress for all incidents

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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 (21)		There were 21 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. Labour notes are being redesigned to aid completion of haemorrhage proforma. New MOH protocol ratified at MGM Business and the working party is progressing with PPH guidelines
Moderate		DW198887/DW199114. Failure to act on adverse symptoms. Patient with internal bleeding deteriorated on post-natal ward overnight but symptoms and results not acted upon. SI declared.
Moderate		DW199477. Failure to escalate. Complexity of FMU TTTS case not escalated appropriately prior to and during procedure. SI declared
Moderate		DW199953. PPH 5.5 litres following twin LSCS. To be discussed at MGM cases 18th December and escalated to SIDM if required.
Moderate		DW200119. Placenta accreta 7 litre PPH requiring return to theatre twice and ITU admission.
Moderate (6)		6 incidents of 3rd degree tears. These were all reviewed at an MDT teams meeting. Plan for pelvic health team to roll out teaching on use of warm compresses.
Moderate (2)		IUDs. Have been reviewed by Governance and no care issues identified. For PMRT review.

Investigations and case reviews are in progress for all incidents

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Open Internal Serious Incident Investigations

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	ESTH	SGUH
Serious Incident cases open and under review	**INC-132408 –** Neonatal death following elective caesarean section in April 2023. The obstetric report is finalised and approved by the Medical Director but the neonatal conclusion is outstanding. The Medical Director is following this up. **INC-136979 –** This related to a retained vaginal pack and mitigating actions associated with the initial review have already been actioned. The panel was cancelled by the Investigating Officer and has had to be rescheduled. **INC-138556 –** This related to a neonatal brain injury following delivery and this case is being investigated by MNSI (Maternity and Newborn Safety Investigations Special Health Authority, formerly HSIB) **INC- 138976 –** This related to an intrapartum stillbirth and is being investigated by MNSI. **INC-142725 -** This related to a neonatal brain injury following delivery and this case is being investigated by MNSI.	**DW190568** – Intrapartum stillbirth. MNSI (formerly HSIB) investigation and final draft to be discussed at MGM 18/12/2023 **DW192960** – Neonatal cooling. MNSI investigation, currently undergoing factual accuracy **DW107360** - Intrapartum stillbirth. MNSI investigation. **DW198211/198899** – Post Partum Haemorrhage and ITU admission. **DW198887** – Failure to act on adverse symptoms **DW191656** – Neonatal unit admission and cooling. Rejected by MNSI **DW199477** – Fetal Medicine Unit - cord occlusion, failure to escalate. **DW188805** – Intrauterine death
SI cases closed in month	0	1

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Overdue Serious Incident Action Plans
Progress update

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Trust	INC/ Datix number	Progress update and timeline for delivery
ESTH	INC-118946	1. 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, it was agreed the completed by 30 November 2023. This has been further delayed due to the unexpected long term absence of the Epsom Hospital Matron. ***This has been escalated to the HoM.*** 2. MAU SOP to have been developed by Consultant Obstetrician. This had been completed but is not yet uploaded to VICTOR. ***An update has been requested.***
	INC-130133	1. Report to be discussed by 30 September 2023 at the consultants (paediatric and obstetric) meeting in relation to communication issues. ***Overdue – rescheduled meeting date to be confirmed.*** 2. The Practice Development Team to include resuscitaire checking in mandatory training by 31st October 2023 – ***Overdue due to sickness within the team - rescheduled date to be confirmed.***
SGUH	N/A	There are no overdue actions.

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Contributory Factors and Root Cause for Completed Serious Incident Reports

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Trust	Number closed in month	Root cause and learning
ESTH	0	There were no serious incident reports completed in November 2023.
SGUH	1	The root cause of a term baby's neurovascular event was dehydration following 19% weight loss. **Learning:** • The importance of antenatal information regarding additional support with breastfeeding being communicated with team supporting mother after birth. • The importance of completing the breastfeeding assessment prior to discharge from postnatal ward, and consideration of risk factors. • Mothers on the postnatal ward should receive adequate support from maternity staff with breastfeeding. • Babies with >10% weight loss must be referred to Acute Paediatric. • Baby's weight should be checked as part of an assess especially when reviewed for feeding in the community, irrespective of age of baby.

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Staff feedback to Maternity Safety Champions

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ESTH (session held 23 November 2023).			SGUH (Unit meeting held on 17 November 2023 – Health and Well being focus)		
Issue	**Action taken and by when**	**Progress update**	**Issue**	**Action taken and by when**	**Progress update**
1. Issues raised in relation to Research posts; there is external funding available but it is proving difficult to fund backfill. 2. NIPE – the on-going issues with NIPE have now been resolved as there is a NIPE midwife rostered to most shifts 3. There was a discussion about the future of transitional care.	1. The BLSC agreed to look into this issue. 2. Board Level Safety Champion to raise with Estates. 3. A working party has been established to review staffing and ensure increased neonatal nursing input.	1. Ongoing 2. Completed 3. Ongoing	1. MSSP high level feedback • What's Good • Immediate Concerns • Challenges • Next Steps Additional 1:1 meetings with staff and the MSSP team to facilitate all voices being heard.	1. Awaiting formal response to describe what support is recommended.	1. Sally Herne, Intensive Improvement Director Intensive Support for Challenged Systems is now onboard

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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 and NHSR (ENS)

CNST Safety Action 10: Have you reported 100% of qualifying cases to Healthcare Safety Investigation Branch (HSIB) (known as Maternity and Newborn Safety Investigations Special Health Authority (MNSI) from October 2023) and to NHS Resolution's Early Notification (EN) Scheme?

ESTH: Between 6 December 2022 and 7 December 2023 ESTH referred four cases to MNSI, two of which were also reported to the Early Notification Scheme (ENS), as they related to babies sent for therapeutic cooling. All four cases had letters informing families of the roles of MNSI and the ENS, therefore ESTH are fully compliant with this safety action.

SGUH: Between 6 December 2022 and 7 December 2023 SGUH referred four cases to MNSI, one of which has also reported to the Early Notification Scheme (ENS) as this related to a baby sent for therapeutic cooling. Three of these cases have had letters informing families of the roles of MNSI and the ENS. The fourth case is being triaged by MNSI pending acceptance or rejection and therefore SGUH are fully compliant with this safety action.

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Cases referred to MNSI
(Maternity and Newborn Safety Investigation Programme)

MNSI 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	3 cases: MI-032925, MI-032560 and MI-036504. Two of these cases relate to babies sent for therapeutic cooling and one case relates to an intrapartum stillbirth. In two cases there was some immediate learning; the drawing up and administration of Syntometrine, which was given in error instead of Pethidine and issues around fetal monitoring in labour.	3 cases: MI-030447 MI-028170 MI-035100
HSIB cases closed in month	0	0
HSIB open actions from previous cases	1	0
Actions based on recommendations and due date	There are 2 open actions relating to 6 recommendations for learning identified: • Include maternal observations documentation as a safety huddle message. • Review of the Routine Obstetric Ultrasound Guidance.	2 of the above cases are open and under review. One is awaiting approval of the final report and discussion regarding action plan at MGM

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Addendum for CNST compliance

- The Maternity Services Claims Scorecard for 2022 was received at Board on 7 July 2023
- The Maternity Services Claims Scorecard for 2023 was 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
- The PSIRPs for both Trusts were approved at Group Board in June 2023 and were included again in the November and December 2023 reports – see slides below
- Compliance statements for compliance with BAPM and ACSA standards for medical staff are included in the slides above

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Our Patient Safety Incident Response Plan (PSIRP)
National Requirements

National priority	Response
Incidents that meet the criteria set in the Never Events list 2018	Locally led Patient Safety Incident Investigation (PSII)
Deaths clinically assessed as more likely than not due to problems in care	Locally led
Maternity and neonatal incidents meeting the Healthcare Safety Investigation Branch (HSIB) criteria	Refer to HSIB for independent PSII
Child Deaths	Refer for Child Death Overview Panel review
Death of persons with learning disabilities	Refer for Learning Disability Mortality Review (LeDeR)
Safeguarding incidents in which: • Babies, children and young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/ violence. • Adults (over 18 years old) are in receipt of care and support needs by their Local Authority • The incident relates to FGM, Prevent (radicalisation to terrorism; modern slavery & human trafficking or domestic abuse/violence	Refer to local authority safeguarding lead.
Incidents in screening programmes	Refer to local Screening Quality Assurance Service for consideration or locally led learning response
Deaths in custody (e.g. police custody, in prison, etc) where heath provision is delivered by the NHS	Refer to the Prison and Probation Ombudsman (PPO) or the independent Office for Police Conduct (IOPC) to carry out the relevant investigations
Deaths of patients detained under the Mental Health Act (1983), or where the Mental Capacity Act (2005) applies, where there is reason to think that the death may be linked to problems in care (incidents meeting the Learning from Deaths criteria)	Locally led PSII by the provider in which the event occurred with STG/ESTH participation if required
Mental health related homicides	Referred to the NHS England and NHS Improvement Regional Independent Investigation team for consideration for an independent PSII Locally led PSII may be required with mental health provider as lead and STG / ESTH participation
Domestic Homicide	A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

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Our Patient Safety Incident Response Plan (PSIRP)
Local Focus

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Patient safety incident type or issue	Planned response
Medication Incident in relation to the monitoring of therapeutic medication levels (e.g. gentamicin, Vancomycin, anticoagulants)	Patient Safety Incident investigation (PSII)
Delayed management or treatment of a patient in the Emergency Department where there has been a delay in speciality referral.	PSII
Admission of a Mother to the Intensive Care Unit where there is a care concern	PSII
Post-Partum Haemorrhage over 1.5litre	MDT Review
Incident where there has been concerns over the interpretation of CTG recordings before or during labour	After Action Review
Hospital Acquired Venous Thromboembolism (VTE) – for any patient developing an VTE within 90 days of admission where chemical prophylaxis was indicated but not given	MDT Review
Acquired Pressure Ulcer for any complex patients who develop a pressure ulcer in the care of community services	MDT Review
Incident where the NEWS Escalation Criteria are not followed.	Swarm or after action review (depending on when the incident is identified, i.e. if identified at the time SWARM if identified after the event e.g. through mortality review process AAR)

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MBRRACE-UK January 2021 to December 2021

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

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

An external review of all SGUH stillbirths and neonatal deaths is underway for all cases in 2020. The report is due in February 2024.
The external review will be extended to look at all cases in 2021 at SGUH and ESTH.

Group Board

Meeting on Friday, 12 January 2024

Agenda Item	3.2	
Report Title	**Group Healthcare Associated Infection Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Group Clinical Director, Infection Prevention and Control**	
Previously considered by	Quality Committees-in-Common	30 November 2023
Purpose	**For Assurance**	

Executive Summary

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

Across both sites, we have seen an increase in and respiratory infections including COVID-19 and influenza resulting in significant impact on capacity due to bay/ward closures and it envisaged that this will continue throughout the winter months.

The table below shows a summary of HCAIs across the health group from the 1st of April to 30th of November 2023.

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 Oct: 4 HOHA, 3 COHA November: 8 HOHA, 0 COHA **YTD: 42** **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 Oct: 3 HOHA, 3 COHA Nov: 0 **YTD: 32** **2023/24 national threshold: 42**	
MRSA bloodstream infection	Apr: 0 May: 1 June: 0 July: 1 Aug: 0 Sept: 0 Oct: 0 Nov: 0 **YTD: 2** **2023/24 national threshold: 0**		Apr: 0 May: 0 June 0 July: 0 Aug: 0 Sept: 0 Oct: 0 Nov: 0 **YTD: 0** **2023/24 national threshold: 0**	
Pseudomonas aeruginosa	April: 0 May: 0 June: 0 July: 1 HOHA, 1 COHA Aug: 2 HOHA		Apr: 1 HOHA May: 4 HOHA, 3 COHA June: 1 HOHA July: 2 HOHA Aug: 3 HOHA	

	Sept: 1 HOHA Oct: 0 Nov: 0 HOHA, 2 COHA **YTD: 7** **2023/24 national threshold: 6**		Sept: 4 HOHA, 3 COHA Oct: 2 HOHA, 1 COHA Nov: 1 HOHA, 0 COHA **YTD: 25** **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 Sept:1 HOHA 3 COHA Oct: 2 HOHA Nov: 4 HOHA, 0COHA **YTD: 40** **2023/24 national threshold: 52**		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: 5 HOHA, 2 COHA Oct: 8 HOHA Nov: 8 HOHA, 2 COHA **YTD: 83** **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 Oct: 1 HOHA Nov: 1 HOHA, 4 COHA **YTD: 24** **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 Oct: 3 HOHA Nov: 4 HOHA, 2 COHA **YTD: 44** **2023/24 national threshold: 58**	
MSSA	April: 3 HOHA May: 1 HOHA June: 2 HOHA July: 2 HOHA Aug: 2 HOHA Sept: 4 HOHA Oct: 3 HOHA Nov: 3 HOHA **YTD: 20** **2023/24 national threshold: N/A**		April: 1 HOHA May: 2 HOHA June: 5 HOHA July: 6 HOHA Aug: 0 Sept: 5 HOHA Oct: 5 HOHA Nov: 4 HOHA **YTD: 28** **2023/24 national threshold: N/A**	
Covid-19 Update				
November	Covid-19 positive cases: 55 Covid-19 deaths: 5 Nosocomial infections: 23 Nosocomial deaths: 4 **YTD positive cases: 524** **YTD nosocomial deaths: 4**		Covid-19 cases: 50 Covid-19 deaths: 5 Nosocomial infections: 14 Nosocomial deaths: 0 **YTD positive cases: 643** **YTD nosocomial deaths: 22**	

Action required by Group Board

The Board is asked to receive the Healthcare Associated Infection (Infection Control) Report for assurance.

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

Appendices	
Appendix No.	**Appendix Name**

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, 12 January 2024

1.0 Purpose of paper

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

2.0 Summary of key performance measures

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

3.0 COVID-19 Update:

We have seen a slight increase in Covid-19 positive cases on admission and inpatients across the group which is consistent with local and national reports. In the period of 1 April to 30 November 2023, there have been a total of 524 new COVID-19 infections, 4 nosocomial deaths at ETSH and 643 cases and 22 nosocomial deaths at SGUH. All nosocomial deaths are subject to a review as per national guidance.

The health group continues to follow national guidance on the management of COVID-19 and the decision has been made to not re-introduce mandatory mask wearing for all staff. However, despite removing the mandatory need for our staff to wear masks, we have put measures into place to protect our most vulnerable patients i.e. patients who are unlikely to mount an effective vaccine response, such as haemato-oncology and solid organ or stem cell or bone marrow transplant patients.

In addition to the above, masks are mandatory in the following clinical areas/situations:

- Bays/rooms where there are confirmed Covid-19 positive patients.
- Wards/bays where there is a Covid outbreak.

As we approach winter which results in different types of respiratory infections and not just Covid-19, risk assessments are undertaken and staff wear masks as necessary. The option to wear a mask remains for staff and visitors who wish to continue to wear masks outside of the recommended areas above. Managing respiratory infections guidance remain under constant review, and updated as further information is published or in accordance with local community prevalence/review.

4.0 Key Issues

Epsom & St Helier Hospitals:

ESTH has breached *C.difficile*, *pseudomonas aeruginosa* and MRSA bloodstream infections national objectives. The trust has breached the national *C.difficile* objective for the first time in over 4 years.

To enable a greater understanding of the causes of individual cases and to determine whether there were any lapses in the quality of care provided in each case, a comprehensive review of all *C.difficile* cases was undertaken in November 2023. It is worth noting that the review did not reveal new themes from the last extensive review that was undertaken in early 2023.
The review showed that there were various risk factors that may have contributed to infection with recent and or frequent hospitalisations being the most recurring theme for all cases.

The most common themes/risk factors are:

- Multiple comorbidities

- Prolonged use antibiotics (mostly compliant with Trust antibiotic prescribing policy)
- Prolonged use of PPI (can increase risk of C difficile)
- Long hospital stay
- Frequent hospital admissions
- Age (all patients were above 65)

To help improve practice and compliance, in addition to training and sharing of lessons learned from the joint multi-disciplinary review of *C. difficile* infections, the Trust will continue to build on what was achieved in previous years and ensure plans are in place to review and monitor the Trust's antimicrobial policy compliance including robust prescribing practice to reduce the risk of *C. difficile* infection and other multi resistant organisms

Legionella, Epsom hospital: High levels of Legionella were found in routine water sampling in various outlets at Epsom hospital. An urgent meeting was held with the Estates leads and the Trust-appointed Authorising Engineers (W). Following review of the results, the sampling methodology used was questioned to be inaccurate as not consistent with the results which made it difficult to determine if contamination was localised or systemic or produce any conclusive action plan.

It should be noted that the areas with the highest counts were in non-clinical areas (plant rooms) therefore it was agreed that there would be no immediate need to install point of use filters. One of the main actions agreed was for the Water Safety Group (WSG) to review and agree on a standardised sampling process and for the Trust to use the sampling guide written by the Authorising Engineers.

In addition to the above, the following actions were agreed:

- Clean and chlorinate the softeners from the tank and all affected outlets
- Chlorinate both tanks, drain the water followed by resampling
- Collect pre and post flush samples on both calorifiers and from all affected outlets
- Continue with project to separate water tanks in Bradbury

St George's Hospital

HCAIs: The Trust remains below the *C. difficile* nationally set objective of 42 cases with a YTD of 32 cases at the end of November and no MRSA bloodstream infections.

Influenza: There was a significant increase in influenza cases with 26 cases detected in November reflecting a rise in community prevalence. There were two outbreaks in November 2023 on Marham and Allingham wards.

- **Marham Ward:** A total of 5 hospital acquired cases detected in three different bays. The ward was closed to admissions and transfers on 22 November 2023. A total of 7 HAIs were identified across all four bays by the end of the outbreak and the ward was reopened 28 November 2023.
- **Allingham Ward:** A total of 4 hospital associated cases were identified across different bays. The ward was closed on the 24th of November 2023 and the ward was reopened 30 November 2023.

Measles: A patient attended the Emergency Department on the 5th of November with a 5 day history of fever, and rash on body. The patient was moved from triage to majors and then to a 5 bedded bay before being isolated. The virology team the Health Protection team of the likely measles diagnosis on 06 November which was later confirmed on 11 November 2023.

As part of incident management, contact tracing was undertaken. A total of 10 patients were identified as contacts and were immune status assessed and Occupational Health followed up the staff contacts and none were found to be at risk and no further action was required.

One of the lessons learned from the incident is the need to raise awareness of the importance of prompt isolation for patients with an undiagnosed rash and in particular in the Emergency Department.

Integrated Care – Surrey Downs Health & Care

Mary Seacole Ward: Following the amalgamation of Alexandra and NEECH, there has been an increase in healthcare associated infections including *C. difficile* on the ward which has resulted in the bay/bays closures and a need for heightened IPC input and localised ongoing training with the staff.

Gram Negative Bloodstream Infections: The number of gram negative bloodstream infections such as *E.coli* has continued to rise across the health group. Both Trusts are likely to breach the national objectives for 2023/24. Several reviews have been undertaken to identify themes and any learning to try and reduce the number of infections and in particular *E.coli* bloodstream infections.

It should be noted that even though we may breach the national objective, our position is similar to that of other Trusts across SW London and the wider London region. NHS England are in the process of putting together a joint national network to address the common themes found across the region and any learning that can be adopted to reduce the number of infections.

As a health group we have opted to be part of the SW London ICS gram negative reduction group to learn and share any findings to reduce the risk of infections to our patients.

In addition to this and awaiting further national input, the following actions have been implemented across the group to help reduce *E.coli* bloodstream infections:

- Introduction of a urinary catheter passport to ensure standardised documentation process across SW London
- Continence service referral pathways and standards in development across SW London.
- Corporate nursing/heads of nursing/Continence Lead nurse and IPC team to establish task and finish group/oversight steering group for urinary catheter management
- Quarterly group wide urinary catheter audit to help improve practice and compliance and reduce catheter associated infections

5.0 Point Prevalence Survey on Healthcare Associated Infections, Antimicrobial Use and Antimicrobial Stewardship in England

Both sites participated in the UKHSA Point Prevalence Survey on Healthcare Associated Infections, Antimicrobial Use and Antimicrobial Stewardship in England. The purpose of the audit is to estimate the total burden (prevalence) of HCAIs and antimicrobial use in acute-care hospitals, community Trust sites and mental health sites.

Data analysis has been undertaken on both sites and uploaded onto the national database. Findings from the national survey will be shared once the results become available.

6.0 Recommendations

6.1 The Board is asked to:

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

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	3.3	
Report Title	**Group- Financial Performance M8**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO, Site CFO-SGUH, Site CFO-ESTH	
Previously considered by	Finance Committees-in-Common	21 December 2023
Purpose	**For Review**	

Executive Summary

Additional national funding recognised by both trusts at month 8 has improved the reported positions.

ESTH is now forecasting on plan with the previous months year to date adverse variance from the cost and lost income of Industrial Action being mitigated mitigated.

SGH is forecasting a £15m adverse variance for plan relating CIP and baseline pressures.

Action required by Group Board

The Board is asked to: Note the financial performance in M8

Committee Assurance	
Committee	Finance 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

[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

As set out in paper.

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

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

Group Board: 12 January 2024
23/24 M8 Financial Performance

Authors:

Andrew Grimshaw, Group Chief Finance Officer

George Harford, Site CFO-SGUH

Lizzie Alabaster, Site CFO-ESTH

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Key Actions

GESH

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	Issue	Action
Summary I&E	• Additional national funding recognised by both trusts at month 8 has improved the reported positions. • ESTH is now forecasting on plan with the previous months year to date adverse variance from the cost and lost income of Industrial Action being mitigated mitigated. • SGH is forecasting a £15m adverse variance for plan relating CIP and baseline pressures.	• 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,	• Continued focus on grip and control actions
CIP delivery	• ESTH delivery is in line with plan with a route to deliver the CIP target for 2324 • SGH £10.5m adverse to plan, with timing adjustment.	• Continued focus on the development and delivery of CIPs.
Capital	• In line with trend. The overall position is challenging at both trusts due to high levels of underspend. Actions in place at both trusts to mitigate including slipping schemes into 24/25.	• Careful monitoring and forecasting of capital will be required in both trusts across the year.
Cash	• Cash remains tight due to ongoing I&E pressures. • ESTH has not made a cash request for Q4 as a result of the new national monies noted above. • SGH have requested £19m of PDC support for Q4	• Continues close management of cash at both trusts. • Focus on debt recovery at SGH.

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Executive Summary

ESTH

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Area	Key Issues	Current Month (YTD)	Previous Month (YTD)	Risk FOT
Financial Position	The Trust is reporting a deficit of £28.3m at the end of November, which is on plan. The Trust has recevied new funding in month which has removed the previously reported deficit caused by Industrial action and enabled the Trust to meet its year to date plan.	On plan	£4.7m Adv to plan	Route to delivery of the financial plan identified. Some risk remains to delivery.
Income	Overall income is £8.0m favourable to plan. Patient Care income is £6.4m favourable which is due to Industrial Action income £3.9m; £1.0m for Epsom Capacity and £1.1m improvement in out of area risk. Other Operating Income improved is now £1.5m favourable YTD largely on staff recharges and R&D which are matched by expenditure.	£8.0m Fav to Plan	£0.9m Fav to Plan	Risk remains with ERF delivery and Surrey Heartlands growth
Expenditure	Expenditure is £8.5m adverse year to date, of this £2.3m is due to the net costs of the industrial action to the end of November. Additional expenditure above plan is offset by income with a route to deliver the financial plan.	£8.5m Adv to Plan	£5.9m Adv to Plan	Risk to holding run rate
Cost Improvement Plans	The CIP plan has delivered £22.2m to date against a plan of £22.1m. In month the Trust reported £4.7m of CIP against an in month plan of £3.8m. There is now a CIP plan and route to delivery in line with plan.	£0.1m Fav to plan	£0.7m Adv to plan	Route to delviery of CIP identfied
Capital	At the end of November, the Trust's has spent £15.8m against the internal plan of £34.6m. 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 will slip into future years. 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.	£18.8m Fav to plan	£14.3m Fav to plan	Forecast paper
Cash	The Trust has a cash balance of £27.2m at the end of November broadly in line the Q4 cashflow forecasts. The December revenue support of £11.3m was receipted on the 11th December.	In line with cash forecast	In line with cash forecast	

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University Hospitals and Health Group

M8 Performance

ESTH

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ESTH have agreed on a financial forecast equal to plan, of a deficit of £37.9m. At M8 ESTH is on track to deliver this forecast.

Performance Against Budget

Table 1 - Trust Total

		Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	582.1	49.3	56.1	6.8	387.2	393.6	6.4
	Other Op. Income	41.2	3.0	3.4	0.3	27.7	29.3	1.5
Income Total		**623.3**	**52.4**	**59.5**	**7.1**	**414.9**	**422.9**	**8.0**
Expenditure	Pay	(439.9)	(36.4)	(37.4)	(1.0)	(293.9)	(297.0)	(3.1)
	Non Pay	(193.6)	(16.3)	(17.9)	(1.6)	(130.9)	(136.3)	(5.4)
Expenditure Total		**(633.5)**	**(52.7)**	**(55.3)**	**(2.6)**	**(424.8)**	**(433.3)**	**(8.5)**
Post Ebitda		(27.6)	(2.3)	(2.1)	0.2	(18.4)	(17.8)	0.6
Grand Total		**(37.9)**	**(2.6)**	**2.0**	**4.7**	**(28.3)**	**(28.3)**	**(0.0)**

Year to date the Trust is on plan following the receipt of income to compensate for the cost of Industrial Action in the year to date.

Performance Against Forecast

Table 2 - Trust Total

		M8 Forecast £'m	M08 Actual £'m	M8 Variance (£m)
Income	Patient Care Income	53.8	56.1	2.3
	Other Op. Income	3.8	3.4	(0.4)
Income Total		**57.6**	**59.5**	**1.8**
Expenditure	Pay	(36.9)	(37.4)	(0.5)
	Non Pay	(18.0)	(17.9)	0.1
Expenditure Total		**(54.9)**	**(55.3)**	**(0.4)**
Post Ebitda		(0.7)	(2.1)	(1.4)
Grand Total		**2.0**	**2.0**	**(0.0)**

The Trust is on forecast overall at month 8, however income is £1.8m favourable as national guidance required all the industrial action income to be recorded in month. This was matched by less non recurrent benefit releases in month.

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

Executive Summary

SGH

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Area	Key Issues	Current Month (YTD)	Previous Month (YTD)	Risk FOT
Financial Position	The Trust is reporting a deficit of £23.8m at the end of November, which is £8.7m adverse to plan. The shortfall is due to CIP delivery shortfall and baseline pressures. The position reported is in line with forecast.	£8.7m Adv to Plan	£16.0m Adv to Plan	On track against revised forecast
Income	Excluding ERF, income is reported at £11.1m favourable to plan at Month 8. This is due to additional national income to cover industrial actions costs.	£11.1m Fav to plan	£3.6m Fav to plan	
Expenditure	Expenditure is reported at £19.8m adverse to plan at Month 8, 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.	£19.8m Adv to plan	£14.7m Adv to plan	
Cost Improvement Programme	CIPs are £10.5m adverse to plan. A bottom up review of CIP reporting in M9 will reduce this variance.	£10.5m Adv to plan	£6.7m Adv to plan	
Capital	YTD M08 Capital expenditure is £31.0m underspent. This is caused by an update to IFRS16 and is being reviewed sector wide. The sector wide review will likely to lead to a reduction in variance in M09 reporting. The Trust expects to be in line with plan at year end.	£31.0m underspent	£30.6m underspent	
Cash	At the end of Month 8, the Trust's cash balance was £5.1m. Cash request for Q4 submitted.	£5.1m which is £53.4m lower than Y/E	£9.3m which is £49.2m lower than Y/E	Cash position remains tight. Requires close management.

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

M8 Performance

SGH

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SGH have agreed on a financial forecast £15.1m adverse to plan, a deficit of £30.8m. At M8 SGH is on track to deliver this forecast.

Table 1 - Trust Total

			Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Excluding ERF	Income	SLA Income	918.1	76.8	85.4	8.6	615.0	625.8	10.8
		Other Income	152.2	14.5	13.4	(1.1)	101.6	101.9	0.3
	Income Total		1,070.3	91.3	98.8	7.5	716.7	727.7	11.1
	Expenditure	Pay	(684.8)	(56.6)	(61.4)	(4.9)	(460.0)	(483.0)	(23.0)
		Non Pay	(353.1)	(31.1)	(31.3)	(0.2)	(241.8)	(238.6)	3.2
	Expenditure Total		(1,037.9)	(87.7)	(92.7)	(5.1)	(701.9)	(721.6)	(19.8)
	Post Ebitda		(71.7)	(5.7)	(5.7)	0.0	(45.6)	(45.6)	0.0
	Grand Total		(39.3)	(2.1)	0.3	2.4	(30.8)	(39.5)	(8.7)
ERF	Income		23.6	2.0	6.8	4.9	15.7	15.7	0.0
	Reported Position		(15.7)	(0.2)	7.2	7.3	(15.1)	(23.8)	(8.7)

Year to date the Trust is adverse to plan owing to CIP and baseline pressures. Industrial action impact has been negated following receipt of compensating income.

Table 1 - Trust Total

		M8 Forecast (£m)	M8 Actual (£m)	M8 Variance (£m)
Income	SLA Income	91.9	92.2	0.3
	Other Income	13.2	13.4	0.2
Income Total		105.1	105.6	0.5
Expenditure	Pay	(60.4)	(61.4)	(1.0)
	Non Pay	(31.8)	(31.3)	0.5
Expenditure Total		(92.2)	(92.7)	(0.5)
Post Ebitda		(5.7)	(5.7)	0.0
Grand Total		7.2	7.2	(0.0)

The Trust is on forecast overall at month 8, with minor offsets in a few areas that will offset overall.

Group Board

Meeting on Friday, 12 January 2024

Agenda Item	3.4
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 provides an overview of the latest information on quality measures and operational performance including improvement actions across St George's Hospitals, Epsom and St Helier Hospitals, and Integrated Care for the month of October 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 October 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 (IQPR)

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

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

Equality, diversity, and inclusion implications

No EDI issues to consider.

Environmental sustainability implications

No environmental sustainability issues to consider.

Integrated Quality and Performance Report
Group Board, 12 January 2024

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 October 2023.

2.0 Quality & Safety

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

- Nil MRSA infections bringing year-to date cases to zero for SGH, and 2 for ESTH.
- No Never Events were reported at ESTH in October 23.
- VTE Risk Assessment remain above target for SGH.
- Observed mortality rates (Summary Hospital-level Mortality Indicator or SHMI) continuing to track below expected levels at SGH.
- Friends and Family Test Inpatients Response rates and Scores remain above target at both SGH and ESTH.
- No category 3 or above Pressure Ulcers at Surrey Downs Health & Care
- No open Serious Incidents at Sutton Health & Care

Key **challenged** areas are as follows.

- **Never Events & Serious Incidents**: SGH declared 2 Serious Incidents (SIs) and 2 Patient Safety Incident Investigations (PSIIs), including 1 Never Event in October 2023. The Never Event was related to a wrong site skin surgery conducted in October 2023. Immediate practical actions are underway in response to the Never Event, SIs and PSIIs. Investigations are being undertaken to identify relevant learning from the other incidents.

- **Grade 3 & 4 Pressure Ulcers:** SGH declared a total of 14 category 3, 4 and unstageable pressure ulcers in October 2023 [8 category 3, and 6 unstageable] of which 2 were 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. Trust marked Pressure Ulcer month in November 2023, focussing on prevention and maintenance of good practice.

- **Maternity:** The response to the CQC inspection at SGH continues with a focus on the MUST and SHOULD dos. Staff retention and recruitment activities continue with a pipeline of 4 WTE band 6 Midwives and 11 WTE preceptorship band 5 Midwives joining in the next few months. Work on standardised approaches across GESH on governance frameworks, including moving towards the Patient Safety Incident Response Framework

(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.

- **Venous Thromboembolism (VTE) Assessment rates** at ESTH remains low with Medicine, Renal and Planned Care divisions reporting screening rates below 90%. Teams are working towards Trust-wide action plan. Additionally, a Quality Improvement project is underway in Medicine to drive continuous improvement.

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

- An Increase seen in **diabetic patients requiring assisted management of insulin** at Sutton Health & Care

3.0 Operational Performance

ELECTIVE CARE

Outpatients & Waiting Lists

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), however, there has been stabilisation in the rate of growth at ESTH and SGH in recent months. Industrial action continues to impact the ambition to reduce the PTL (and is anticipated to influence the future state). Median waits are stable at approximately 11 weeks at both sites.

ESTH has an established Patient-Initiated Follow-Up (PIFU) 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 Long Waits

Both trusts are above their respective trajectories to reduce the numbers of patients waiting for more than 52 weeks to commence definitive routine treatment. ESTH is particularly challenged with 943 patients waiting for more than 52 weeks at the end of September 2023, largely attributable to challenges within Gynaecology and Community Paediatrics services. Plans are now in place to secure additional capacity to reduce the backlogs and eliminate 65-week waiters (157 as at the end of September 2023) in the next few months. The position on 78-week and 104-week waiters remains under control.

Diagnostics

Diagnostic performance at SGH remains strong, with 99% of patients waiting less than six weeks for their diagnostic tests as of the end of September 2023. ESTH recorded a fifth consecutive month of improvement in September 2023, achieving the national ambition of 95% with a performance rate of 95.5%.

Theatre Utilisation

Both trusts continue to make steady progress towards the national ambition of 85% capped utilisation of theatre time (active utilisation of theatres within the allotted time). When corrected for known data quality issues, ESTH and SGH have achieved above 80% in recent weeks and ranks in the second quartile nationally. Challenges at SGH remain in improving theatre utilisation in the surgical hub at Queen Mary's Hospital. An active theatre utilisation group is exploring opportunities to continue to improve productivity in theatres. Plans are also being developed to address the challenges in paediatric day case theatres.

Cancer Waiting Times

Cancer waiting times performance remains strong 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 at SGH in September 2023. 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 (62.9%), it is broadly on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment. The team is also developing a plan for the Breast service which remains fragile.

Cancer performance standards will be revised from December 2023 to reflect the new rationalised metrics that came into effect in October 2023. 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%).

URGENT & EMERGENCY CARE

Urgent and Emergency Care pathways continue to be under pressure at both trusts. While the number of patients waiting in the Emergency Department (ED) for more than 12 hours is significantly higher than expected, SGH achieved the 4-hour operating standard of 76.0% with a performance of 76.1%, and ESTH marginally missed with a performance of 75.5% in September 2023. The key constraints remain bed capacity, acuity, and mental health presentations. Both trusts continue to have a high focus on flow through the whole non-elective pathway including efforts to reduce ambulance handover delays.

INTEGRATED CARE

Urgent Community Response (UCR) consistently exceeds the national standard of 70% within 2 hours for both Sutton Health & Care (76%) and Surrey Downs Health & Care (82%), with a continued emphasis on encouraging more proactive referrals.

Teams are focusing on optimising and increasing utilisation of virtual ward bed capacity to ensure care is provided at the right settings and to ease the pressure on acute beds 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

October 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 a total of 105 falls in Oct23, this is similar to Sep23 (108). Falls/1000 bed days for October 2023 was 4.0, this down slightly from Sep23 (4.7) and in keeping with the previous 9 months were falls/1000 bed days has been consistently below the mean. The majority were no harm (89) and low harm (13) with no high or extreme harm falls.

Pressure Ulcers: Overall numbers of medical device-related pressure ulcers (MDRPUs) totalled 13 in Oct23 , this is similar to Sep23 (13) and Aug23 (14) and a decrease compared to 22 in Jul23. 2 of the 13 MDRPU's were category 3, 4 and unstageable pressure ulcer, this is similar to the previous 3 months (Sep- 1, Aug- 2, Jul- 3). The Trust reported 10 category 2 pressure ulcers in Oct23, this is down from 13 in Sep23.

Infection Control: The Trust has had no MRSA bloodstream infections in Oct23 and year to date. There were no confirmed outbreaks of Norovirus in Oct23.

MCA: Trust wide MCA Level 2 compliance and medical specific compliance continues to be the highest it has been for some time and is only 0.5% away from reaching CQC expected compliance.

Mental Health: Paediatric care group are trialling use of Mental Health Support Workers (MHSW) to support children and young people admitted in crisis with the hope of improving quality and safety. The ICB are supportive of a paediatric business case for enhanced mental health provision; an in-house mental health team. South-West London and St George's (SWLStG) Deputy Director of Nursing is working collaboratively with the Head of Nursing for Mental Health on projects of mutual benefit.

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

Maternity –October birth rate was 388 with high levels of obstetric complexity throughout with good clinical outcomes as reflected in the associated KPIs .

Challenges

Falls: The trust declared 3 moderate harm fall in Oct23, this is up from 1 in Sep. Detailed investigation continues with all moderate and above harm falls, lessons learnt will feed into the Trust wide action plan.

Pressure Ulcers: The Trust declared a total of 14 category 3, 4 and unstageable pressure ulcers in Oct23 [8 category 3 and 6 unstageable], of these, 2 were medical device related pressure ulcers (MDRPUs). This is an increase from 6 in Sep23 and 11 in Aug23, for Oct23 the number per 1000 bed days has moved above the mean and increased to 0.54, although remains below the upper process limit.

VTE: To improve clinical and nursing engagement in VTE risk assessment and treatments, Hospital Thrombosis Group (HTG) will be supported by Assistant Chief Nurse, and Deputy Chief Medical Officer (DCMO) to raise awareness in local services and trust wide to include teaching events, ie at junior doctors teaching forum, senior leaders sessions, and feature articles in patient safety bulletin.

Never Event/ Serious Incidents: The Trust declared 2 Serious Incident's (Sis) and 2 Patient Safety Incident Investigations (PSIIs), including 1 Never Event in Oct23. The Never Event was related to a wrong site skin surgery conducted in Oct23. Immediate practical actions are already underway in response to the Never Event and SI and PSII investigations are being undertaken to identify relevant learning from the other incidents.

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.. Retention and Recruitment ongoing with of vacancy of 4 WTE band 6 MW's and a pipeline of 11 WTE preceptorship band 5/6 Midwives (over establishment, as agreed by Senior Leadership Team) joining between now and Dec23 following NMC registration

Infection control: The overall numbers Covid-19 cases including nosocomial infections decreased again in Oct23 (93) compared to Sep23 (102) with 2 nosocomial cases with Covid-19 listed on Part 1A/B of their death certificate. Oct23 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. The pattern of C. difficile and E. Coli Bacteraemia cases is in line with the situation nationally and SGUH is not an outlier when comparing overall rates with other trusts. A Trust wide action plan is in place and 'Getting back to Basics' staff engagement events commenced in Oct23 and are on-going.

MCA: Compliance for Additional Clinical Services at 80% and Admin & Clerical at 67% has not shown any improvement since last month. Medical compliance has not changed this month, sitting at 75%. Training and staff engagement is on-going.

Mental Health: Right Care Right Person went live on 1st November 2023. The Trust reported 4 incidents where patients where not followed up by the police after walking out of hospital. These incidents have highlighted a need for training in RCRP risk assessment for staff and for policy updates so that the Trust can be clear in its response to patients walking out or going AWOL. St George's has the highest number of section 136 detentions across the 15-19 age group in South London patch, this is the drive behind the paediatric business case for enhanced mental health provision

Executive Summary
Safe, high-quality care (2)

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

Epsom & St Helier

Successes

Pressure Ulcers : The number of pressure ulcers remain consistent (the numbers have been low for the last 6 months).Staff from 2 wards have started undertaking dressings change for Negative Pressure Wound Therapy.

Falls Prevention and Management : Following the release of the National Patient Safety Alert (NSPA) : 'Medical beds, trolleys, bed rails, bed grab handles and lateral turning devices: risk of death from entrapment or falls' at the end of September, the Falls CNS and Director of Nursing for Fundamentals of Care met with the Quality & Patient Safety Manager in October to review the Trusts current compliance levels with the recommendations and complete an Action Plan for the monitoring and closure for this NSPA. It was identified that the recently updated 'Slips, Trips and Falls (Adult Patients) Policy; Including the safe use of Bedrails' covers the required the actions outlined in the alert. This includes staff training and the risk assessment process. The Contracts and Database Officer (EME Department) are supporting and providing evidence regarding maintenance of equipment. Aspects of the alert have also been raised for consideration by the Falls CNS to be included in the ongoing development of the bedrails Cerner documents.

Nutrition: A fully comprehensive training package in Enteral Nutrition has been designed for Community Nurses with roll out to commence in November for Surrey Downs and Sutton Health and Care. This includes a full competency assessment. E-MUST training is in place for Mary Seacole ward to support accurate MUST completion . Naso-Gastric Tube Training continues with update training still available alongside novice sessions.

VTE: Discussion with the Clinical Director of Medicine to address performance and closing outstanding incidents . Progress in discussions across the group for screening of patients. This will support screening for 16-17 year olds which isn't currently captured.

Infection Control: No MRSA blood stream infections reported in October (YTD: 2). A6 Renal ward entered a Period of Increased Incidence (PII) for C. diff. However, it was concluded that there was no cross transmission and the PII ended on 24/10/23. As of October 2023, 1271 staff have passed FFP3 Mask Fit testing, 406 on one type/model of FFP3 mask and 865 on two or more types. Monthly PPE compliance audits and Hand Hygiene Compliance audits are being undertaken in all clinical areas. A total of 61 inspections across 57 areas yielded a hand hygiene compliance score of 96%. A total of 39 inspections across 35 areas yielded a PPE compliance score of 91% for October.

Maternity: Out of the 10 elements ('Safety Actions') of CNST, 5 are on track. The second time bound CNST element is Safety Action 5, which requires that a midwifery workforce review is undertaken 6 monthly and reported to Board. The Midwifery workforce report is available in the Reading room at the November 2023 meeting.

Challenges

Pressure Ulcers: Uncertainty about the introduction of Cerner as there are not currently enough licences to support nursing staff uploading photos and making referrals. Shortage of Air pressure relieving mattress at both Epsom site and this was as a result of Mary Seacole (Community ward) requiring these devices leading to the shortage for patients in acute setting. 8 outstanding investigations from June 2023.

Falls: 3 falls with moderate harm this month.

Nutrition: 3 areas have not yet attended NGT Training which will be followed up. MUST assessments are still being completed on paper and outside of the required timeframes.

VTE: Clarity required for the investigation process which is in progress. Medicine , Renal and Planned Care are at below 90% screening figures which is impacting on compliance.

Mortality: Increasing ED mortality rate. ED audit plan in place to identify the specifics of the pathways mostly attributed to delays in waits in DTA patients.

Maternity: Out of the 10 elements ('Safety Actions') of CNST, 3 are associated with risk and 2 are non-compliant (Midwifery workforce planning and multidisciplinary training).

Infection Control: In October there were 7 Trust attributed C. difficile cases (4 HOHA, 3 COHA). There were 19 Covid-19 clusters which generated 56 contacts and 60 reported COVID-19 cases out of which 14 were nosocomial infections.

Mandatory infection control training compliance is overall 81% for clinical staff groups and 91% for non-clinical groups. IPC mandatory training and monitoring of compliance remains poor despite continued efforts by the IPC team to provide targeted/local training, especially for the clinical staff groups.

Following the microbiology laboratory move to St George's Hospital, there has been gaps in how our microbiology results/data is reported back to the ESTH BI team, challenging the accuracy of the data.

Executive Summary Elective Care

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

St George's Hospital

Successes

- RTT Incomplete waiting list size decreased by 864 patients through September. The number of 52 week waits stabilised with the number of patients waiting over 65 weeks continuing to meet plan however there is a risk within neurosciences (pain and neurosurgery in particular).
- Outpatient activity remains above plan
- Diagnostic performance continues to meet the recovery target of 95%, with 99.3% of patients waiting less than six weeks for a diagnostic test.

Challenges

- There are 528 patients with a projected wait of over 52 weeks for a first appointment on the waiting list. A recovery plan is in place and managed through Elective Access with a focus on three key areas to help improve elective productivity and performance:

  - Increase theatre activity to >80%
  - Reduce OP DNA rates to <10%
  - Increase accuracy on data capture for OP procedure coding

- Elective and Day Case activity across the Trust remains behind plan. Industrial Action has impacted delivery against plan. Continued focus on theatre scheduling, particularly 642 escalation processes to ensure fully booked theatre lists. Weekly deep dives into sessions capped utilisation below 65%.
- Issues related to patient flow impacting productivity in Neurosurgery due to the requirement for ITU post-op.
- Faster Diagnosis performance was non-complaint in September seeing a further deterioration reporting 62.5%. A deterioration of skin performance (21.5%), has impacted the overall recovery. 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. Turnaround times in Pathology also being addressed.
- 62 day performance remains challenged particularly within Breast with delays to one stop breast clinic and access to theatre.
- DNA rates remain high – aim to <10% - Currently adapting our text messaging reminder approach to improve communications to patients. Audit of all specialties and clinics with a high DNA rate.

Epsom & St Helier

Successes

- Diagnostics (DM01) continues to improve since the recovery plan was put in place in Jan23. Patients waiting more than 6 weeks in Oct23 reduced to 406 from 522 in Sep23. This is the first month that ESTH have been under the 5% diagnostic standard. The modalities with the highest volume of patients waiting over 6 weeks are Urodynamics (98) and ECHO (78).
- DNA rates in Oct23 remain below 5% for the fourth consecutive month.
- Capped theatre utilisation figures increased to 79% in Oct23 from 78% in Sep23. Uncapped theatre utilisation figures increased to 82% in Oct23 from 81% in Sep23.
- Performance achieved against the following key standards in Sep23: Faster Diagnosis (75%), 31 day first treatment (100%) and GP 62 day first treatment (87%).

Challenges

- ERF activity (outpatient & Inpatient/Day Case) is below plan in Oct23, mainly as a result of industrial action.
- 52 week waits has increased from 917 in Aug23 to 943 in Sep23. This increase is mainly driven by pressures in Gynaecology (311), Community Paediatrics (249) and Cardiology (89), as well as ongoing industrial action.
- Patients waiting over 65 weeks for treatment increased slightly from 155 in Aug23 to 157 in Sep23 (62 Community Paediatrics, 37 Gynaecology, 19 Cardiology, 13 Gastroenterology and 26 scattered across other specs).
- Referrals from GP to a consultant led service remain significantly above BAU levels within a number of key specialities. For example, Gynaecology referrals are 38% higher than business as usual year to date.
- The 14-day standard was not met in Sep23 with a performance of 65% against the 93% target. This was largely due to Dermatology service unable to meet the referral demand.
- 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 but this is being resolved by StG providing EBUS Service where the majority of the ESTH patients are now referred. However the turn around time is still longer than ideal as SWL Pathology processing of histopathology specimens is between 7 to 10 working days. Ideally, it should be 7 calendar days or less.

Executive Summary Non-Elective Care

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

St George's Hospital

Successes

- 4 hour operating standard although seeing a slight decline through Oct23 remains strong compared to peers with SGH placed 3rd in London and 13th nationally for all type performance.
- LAS performance for 60 minute delays improved significantly through the month, work is ongoing with LAS to improve offload times, and reporting in line with the departments LAS SOP and surge team.
- Hospital ambulance liaison officer (HALO) in place 4x per week, which is significantly improving LAS handovers, advising management where improvements could be made to facilitate more efficient handovers.
- Front of house clinician model which commenced 11 September continues to assist with streaming patients to appropriate alternative pathways, improving timely investigations and analgesia.
- The Trust has launched new IT Capacity Management software (CAPMAN) which has allowed time lags throughout a patient journey to be captured, which in turn will support improvements in ensuring a more timely pathway.
- SGH board members visited Mary Seacole ward in October, Amyand had their 10th year anniversary and Caesar Hawkins (Respiratory ward) received Silver IPC accreditation.

Challenges

- Through October the emergency department's ability to see patients in a timely way was extremely challenged, the majority of the month the department have had between 30 and 55 DTAs limiting capacity and on several days admissions were above plan across the board.
- High numbers of Mental Health patients in ED continues to be challenging.
- 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 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. Through October the Transfer of Care team also provided vital in-person support on the Wards to facilitate discharge.
- 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.

Epsom & St Helier

Successes

- Patients with a length of stay of > 21 days has slightly improved in October 2023 when compared to previous months and is now below the monthly ambition value.
- In October 2023 76.04% 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 from April 2023 to October 2023.
- Time to triage remains below the ambition of 15-minutes at 12-minutes in October 2023.

Challenges

- Mean daily double stranded (>14-day LOS) numbers remain above the locally agreed ambition for the sixth month in a row with no significant reduction
- Time to initial assessment for October 2023 was 108 minutes and remains above the ambition of 60 minutes.
- A high number of > 60-minute ambulance handovers in October 2023, reporting 107, however, an improvement when compared to September 2023 where we reported 120. Further improvements are expected from the work on the new W45 ambulance handover process which was implemented during October.

Executive Summary
Our People

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

St George's Hospital

Successes

Vacancy (Target 10%):
Vacancy rate continues to remain below the Trust target at 6.69%, which is a 1.14% improvement over the previous month. The vacancy rate has now been below the Trust target for well over a year.

Appraisal (Target 90%):
Non-Medical staff is sitting at 77.68%, this is a 1.44% increase over the previous month, with SWL Pathology being the best at 81.62% and the worst being Corporate at 54.12%.
Rates for Medical appraisal is currently at 80.63%, this is a 2.71% increase over the previous month, with SWL Pathology being the best at 92.86% and the worst being MedCard at 79.10%.

Challenges

Sickness (Target 3.2%)*:*
Trust is at 4.38%, this is a 0.19% increase over the previous month.
CWDT has the highest absence at 5.21%, whilst Corporate has the lowest with their absence being at 3.04%. Estates & Ancillary remain the highest Staffing Group at 8.04% with the lowest being Medical & Dental at 1.36%.

Vacancy (Target 10%):
Estates & Ancillary has the highest vacancy rate at 14.82%, with Medical & Dental appearing to be over established by 2.86%.

Turnover (Target 13%):
October's figure is 14.72%, which is a 0.10% decrease over the previous month, with Additional Clinical Services being the highest at 20.65% and Medical & Dental the lowest at 5.26%.

Epsom & St Helier

Successes

Turnover (Target 12%)
The rolling 12-month figure continues its 18-month drift downwards showing 13.5% as at the end of Oct23.

Medical Appraisal (Target 90%)
Medical Appraisal rates continue to show improvements with performance above target in Sept and Oct23.

MAST/ Core Skills(Target 85%)
Performance in October increased from 84.9% to 85.3% showing an improving position. Performance against the MAST indicator is regularly discussed and Managers able to track their trajectory and performance on ESR .

Challenges

Sickness (Target 3.8%)
The recent low was in April 23, but since then the trend is continuing upwards and hit 5.7% in Oct23.

Appraisal (Target 90%)
Non-medical appraisal rates are poor, however showed a slight improvement this month with performance increasing from 59.6% in Sep23 to 66% in Oct23. 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.

6

Executive Summary Integrated Care

Sutton Health & Care (SHC)

Successes

Virtual Ward: SWL have reviewed the occupancy thresholds for all SWL community providers, based on their demographic data. The new provisional baseline set for Sutton virtual ward has been agreed at 79 (not 130). This is consistent and will be approved/ signed off by the ICB in the coming months.

2-hour community response remains above the national trajectory set achieving 76.3% in month, with 82% year to date.

SHC remains within 3.7% agency cap in month 7 (2.4%)

High levels of MAST (90.15%)

Improvement in waiting lists across adult and children's services.

Challenges

Average waiting lists for SALT and OT Children's Therapy whilst improving remain high (routine).

Speech and Language (SALT) 23.31 (weeks); Occupational Therapy (OT) 17.71

Surrey Downs Health & Care(SDHC)

Successes

Consistently achieving the 2 hour UCR target with 82% in Oct23

Maintained the Improvement in waiting lists across all services.

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

Number of patients seen in VW increased to 242 with an occupancy rate of 79% percentage against the targeted 80% occupancy

High levels of MAST (93.4%) maintained.

Staff engagement and organisational development action plan in progress with a good response to the staff survey (above 60%).

Challenges

Discharge flow with a median of 3 days for referral to discharge (increase from 2days in Sep23) with improvement in pathway 3 maintained.

High vacancy rate (20%), Golden Hello scheme is in place and more recruitment events planned.
Drop in appraisal rate to 67.4% , related to many staff due for appraisals at the same time (start time with the organisation-TUPE transfer).

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

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

NHS
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	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
Never Events	0	1	1	1	0	6		0	1	1	0	0	3	
Serious Incidents	0	6	7	2	0	25		0	8	4	1	0	23	
Patient Safety Incidents Investigated	0			2	0	2		0				0	0	
Number of Falls With Harm (Moderate and Above)	0	2	1	4	0	19		0	1	3	4	0	15	
Pressure Ulcers - Acquired catergory 3&4	0	11	6	14	0	63		0	0	0	1	0	6	
Mental Capacity Act & Deprivation of Liberties - Level 1	90%	93%	93%	92%	90%	92%								
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	83.3%	84.7%	84.5%	85%	82%		85%	86.9%	87.0%	88.7%		87.5%	
Infection Control - Number of Cdiff - Hospital & Community	4	5	1	6	24	31		4	2	9	7	24	34	
Infection Control - Number of MRSA	0	0	0	0	0	0		0	0	0	0	0	2	
Infection Control - Number of E-Coli	7	8	7	8	42	49		5	5	4	2	30	36	
VTE Risk Assessment	95%	94.8%	95.7%	96.9%	95%	95.9%		95%	90.4%	90.9%		95%	85%	
Mortality - HSMR	<100	90.4	90.1	89.0	<100	89.9		<100	110.84	109.70	109.76	<100	111.06	
Mortality - SHMI	<1	0.95	0.94	0.95	<1	0.94		<1	1.21	1.21	1.20	<1	1.20	
Number of Complaints Received	NA	64	54	60	NA	435		NA	43	46	45	NA	286	
Complaints responded to in 25 days	85%	97%	100%	96%	85%	99%		85%	38%	38%	37%	85%	55%	
Percentage of complaints acknowledged within three days		78.1%	92.9%	96.7%		89.2%								
Friends and Family Test - Inpatients Respose Rate	20%	30%	32%	30%	20%	28%		20%	20%	21%	20%	20%	18.4%	
Friends and Family Test - Inpatients Score	90%	99%	99%	99%	90%	98%		90%	95%	95%	94%	90%	94.7%	
Friends and Family Test - Emergency Department Respose Rate	20%	11%	10%	10%	20%	11%		20%	6.0%	7.0%	7.0%	20%	6.7%	
Friends and Family Test - Emergency Department Score	90%	86%	79%	83%	90%	82%		90%	86.0%	83.0%	82.0%	90%	84.3%	
Friends and Family Test - Outpatients Respose Rate	20%	5.2%	5.5%	5.4%	20%	5%		20%	2.5%	3.1%	2.3%	20%	2.9%	
Friends and Family Test - Outpatients Score	90%	93%	94%	94%	90%	94%		90%	94.0%	94.0%	94.0%	90%	93.7%	

VTE data for ESTH only reported one month in retrospect

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

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

Maternity	St George's							Epsom and St. Helier						
	Monthly Target / Threashold	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
% Births with 3rd or 4th degree tear		1.1%	2.1%	2.6%		2.2%			1.0%	2.9%	1.4%	<3%	2.1%	
% Births Post Partum Haemorrhage >1.5 L	<4%	3.8%	2.7%	3.4%	<4%	3.4%		<4%	1.5%	2.7%	1.1%	<4%	2.3%	
Total Births	>433	364	337	384	5000	2505			329	302	352		2228	
Birth Rate - Vaginal	>60%	59.4%	55.5%	61.4%	>60%	58.4%			52.2%	47.7%	51.7%		49.7%	
Birth Rate - Instrumental	<14%	15.1%	13.9%	15.1%	<14%	14.0%			8.6%	10.3%	10.6%		10.9%	
Screening - booked before 9+6 weeks	>90%	55.9%	53.6%	55.2%	>90%	51.9%		>90%	84.8%	84.4%	84.7%	>90%	85.1%	
Screening - booked before 12+6 weeks	>90%	93.8%	92.0%	91.7%	>90%	91.4%		>90%	97.7%	98.5%	97.3%	>90%	98.2%	
1:1 support in labour	>80%	94.8%	98.0%	99.3%	>80%	97.1%		>95%	100.0%	100.0%	100.0%	>95%	99.5%	
Continuity of Care*		10.9%	8.1%	11.3%		10.1%			76.6%	79.3%	77.1%		78.7%	
Still births per 1000 births	<2.6	2.7	3.0	5.2	<2.6	5.7			0.00	3.30	5.68		2.2	
Neonatal deaths per 1000 births	<1.5	5.5	3.0	2.6	<1.5	3.5			0.00	3.30	2.84		1.8	
HIE (Hypoxic ischaemic encephalopathy rate	<2.2	0.0	0.0	0.0	<2.2	0.80			3.04	0.00	0.00		0.4	
Band 7 supernumerary status – rate	100%	98.0%	94.0%	100.0%	100%	96.4%			93.0%	89.0%	98.0%		89.7%	
MDT training compliance – rate	90%	88.4%	88.4%	75.8%	90%	82.8%			0.0%				79.6%	
Vacancy rate	<=10%	-6.7%	-2.2%	-2.2%	<=10%	-5.5%			4.2%	5.1%	4.5%		5.7%	
MDT handovers Rate	100%	100.0%	100.0%	100.0%	100%	93.3%		100%	100%	100%	100%		100.0%	
Friends and Family Test - Maternity Score	90%	85.7%	90.2%	94.2%	90%	89.9%		90%	97%	92%	95%		97%	
Friends and Family Test - Response Rate	20%	32.0%	27.6%	26.0%	20%	21.4%		20%	12%	8%	4%	20	7%	

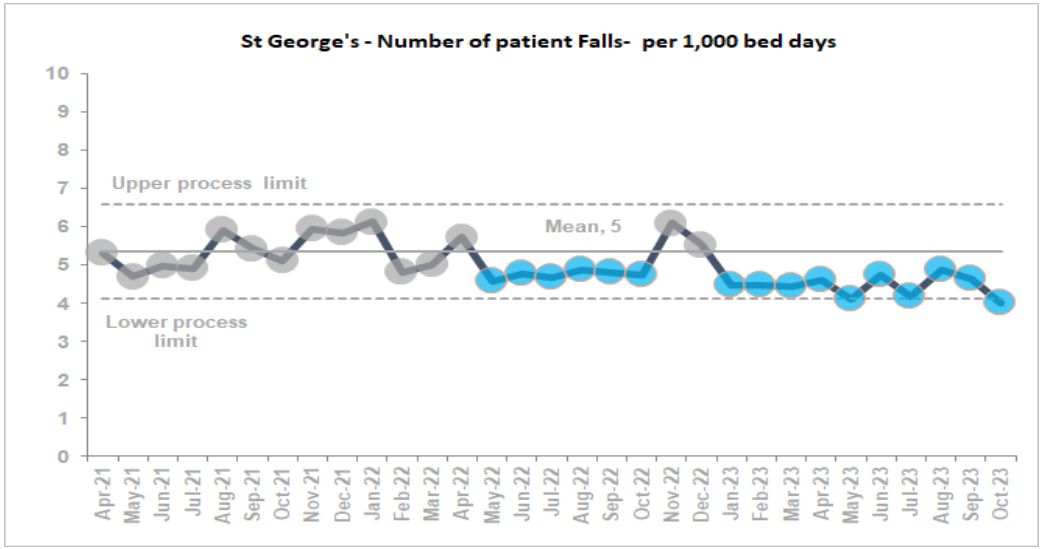
Blanks spaces indicate no data received

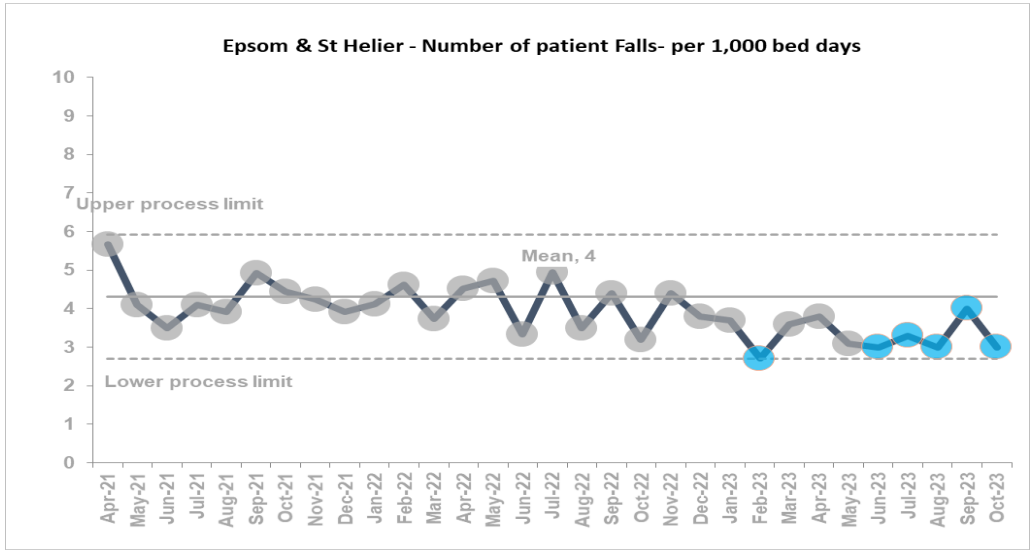
* Please note that CoC metrics have changed from May 2023 data to reflect NHS England requirements based on their definition. Data changes will be backdated to reflect NHS England reporting requirements as advised by NHS England.

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

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

Target: TBC	SGH: 4.0	ESTH: 3.0





SGH updates since last month

The Trust recorded a total of 105 falls in Oct23, this is similar to Sep23 (108). Falls/1000 bed days for Oct23 was 4.0, this down slightly from Sep23 (4.7) and in keeping with the previous 9 months were falls/1000 bed days has been consistently below the mean. The majority were no harm (89) and low harm (13).
There were no high or extreme harm falls in Oct23, this is the fifth consecutive month. There was however 3 moderate harm falls within inpatient areas, this is up from 1 in Sep23. Of these, 2 patients sustained subdural haematomas but fortunately no other neurological symptoms post fall. 1 has been discharged and 1 awaiting placement to a Nursing Home. The other patient sustained distal radius, ulna & 5th Metacarpal fractures and has now been discharged. All falls continue to be investigated and learning shared, a Trust level action plan is in place and monitored by the falls steering Group.

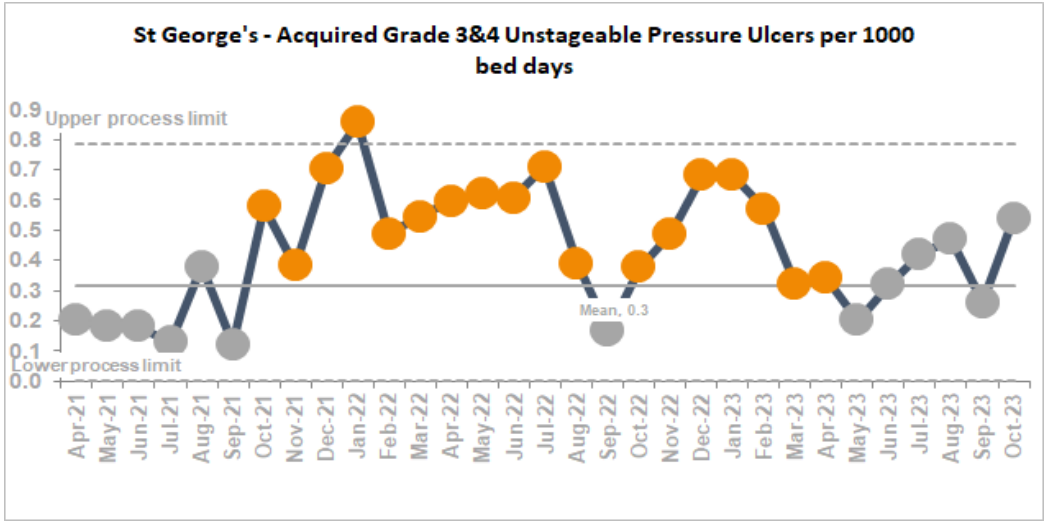
ESTH updates since last month

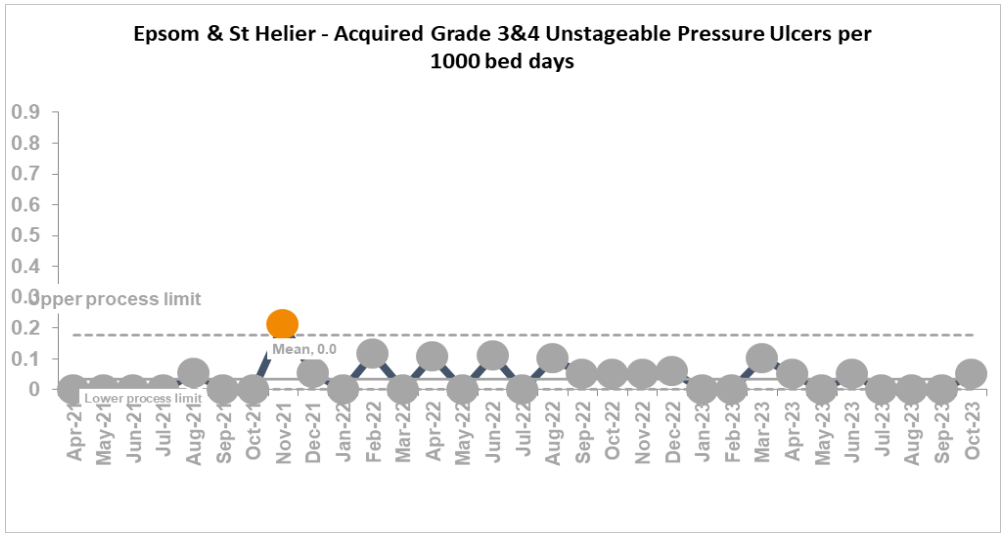
October saw a 14% reduction from the previous month in the total number of falls reported in the Acute Services, with 77 falls reported, equating to 3.88 falls per 1000 OBDs. The percentage of unwitnessed falls reduced by 6% compared to September data, with 67% of all falls in the Acute Services being unwitnessed. Incidences with harm remain higher than previous months, however they are all of moderate severity and a reduction in hip fractures has been observed over the past 3 months

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: 0.54	ESTH: 0.05





SGH updates since last month

There were a total of 14 category 3, 4 and unstageable pressure ulcers in Oct23 [8 category 3 and 6 unstageable], of these, 2 were medical device related pressure ulcers (MDRPUs). This is an increase from 6 in Sep23 and 11 in Aug23, for October the number per 1000 bed days has moved above the mean and increased to 0.54, although remains below the upper process limit. Overall numbers of medical device related pressure ulcers (MDRPUs) totalled 13 in Oct23, this is similar to Sep23 (13) and August 2023 (14) and a decrease compared to 22 in Jul23. 2 of the 13 MDRPU's were category 3, 4 and unstageable pressure ulcer, this is similar to the previous 3 months [Sep- 1, Aug- 2, July- 3].
The Trust reported 10 category 2 pressure ulcers in Oct23, this is down from 13 in Sep23 but remains higher than Aug23 (5). Detailed investigation into high harm pressure ulcers continues with a Trust wide action plan in place based on root cause themes and audit findings. Trust celebrated PU month in November focussing on Prevention and maintenance of good practice including ED.

ESTH updates since last month

8 Hospital acquired pressure ulcers : 3 category 2, 1 category 3 and 4 deep tissue injuries.

3 Deep Tissue Injuries are minor skin damage causing minimal harm to the patient with signs of improvement. However, Rapid Response Review (RRR) has been requested for the DTI acquired in Rapid Assessment Unit and Category 3 (Ward B5).

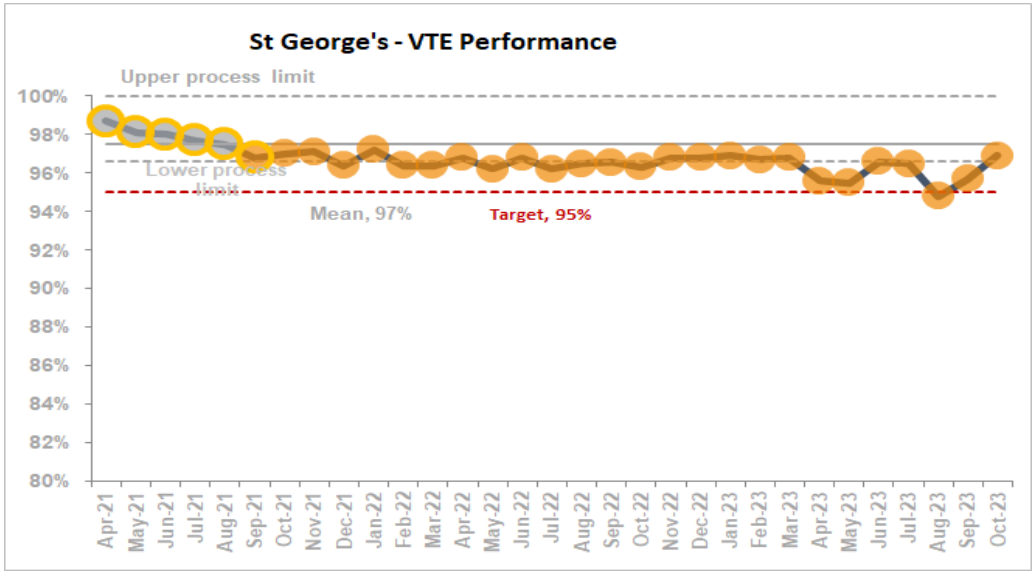
No severe harm.

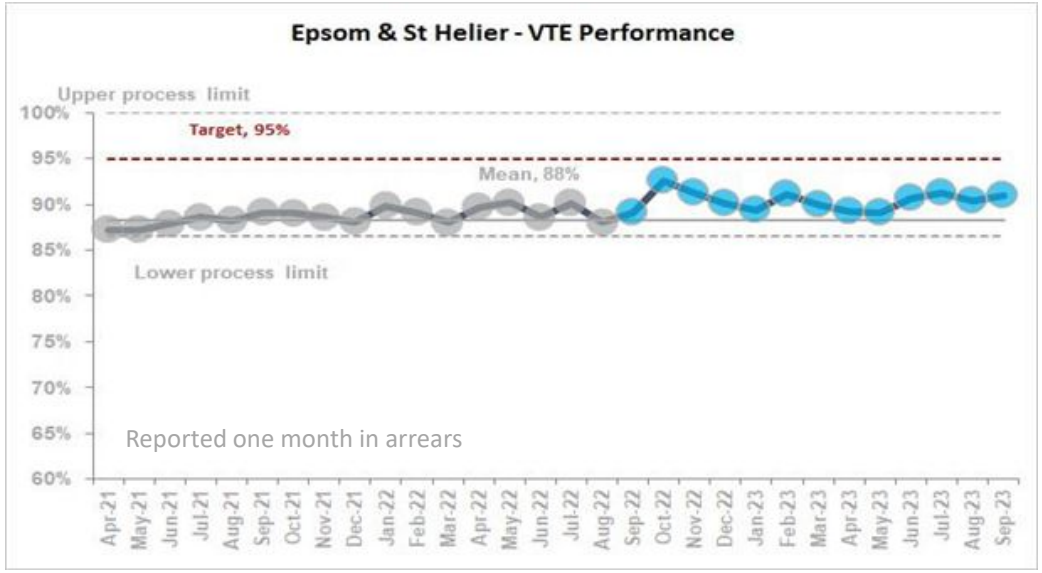
11

VTE Risk Assessment

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

Target: 95%	SGH: 96.9%	ESTH: 90.9%





SGH updates since last month

Performance against VTE Risk Assessment was slightly above target for Oct23 at 96.9%. To improve clinical and nursing engagement in VTE risk assessment and treatments, Hospital Thrombosis Group (HTG) will be supported by Assistant Chief Nurse, and Deputy Chief Medical Officer (DCMO) to raise awareness in local services and trust wide to include teaching events, ie at junior doctors teaching forum, senior leaders sessions, and feature articles in patient safety bulletin. The VTE prevention strategic working group will be reviewing medical and nursing tasks in the VTE risk assessment at the beginning of Dec23, and support ongoing action implementation including MAST compliance, Medical and Nursing engagements.

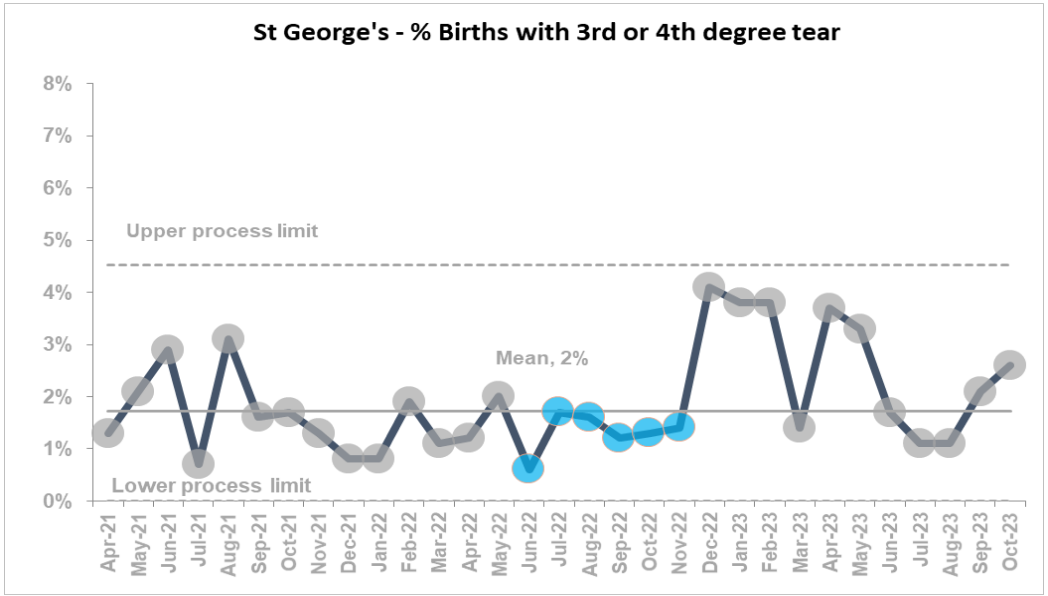
ESTH updates since last month

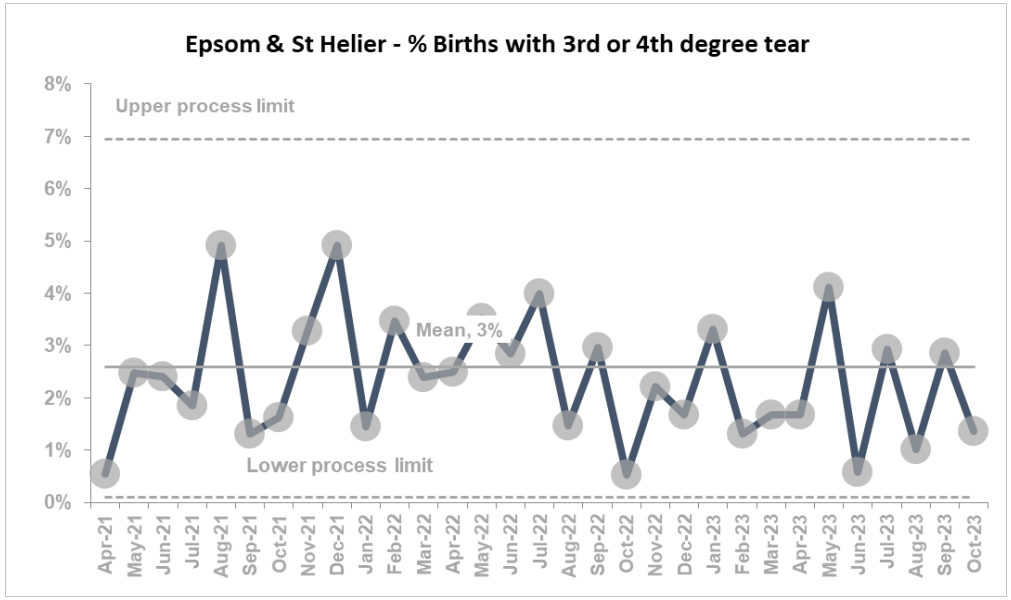
Improvement in the number of areas achieving 100%. Reduction in the number of Hospital Acquired Thrombosis maintained for the last 2 months. Initial meetings with Medicine Clinical Director to support improvement in screening and closure of outstanding incidents. A Quality Improvement Project is in progress.

% Births with 3rd or 4th degree tear

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

SGH Target:	SGH: 2.6%	ESTH Target:	ESTH: 1.4%





SGH updates since last month

The number of 3rd or 4th degree tears in Oct is 2.6% - this was ten 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. Each case will be individually reviewed to extrapolate learning where relevant

ESTH updates since last month

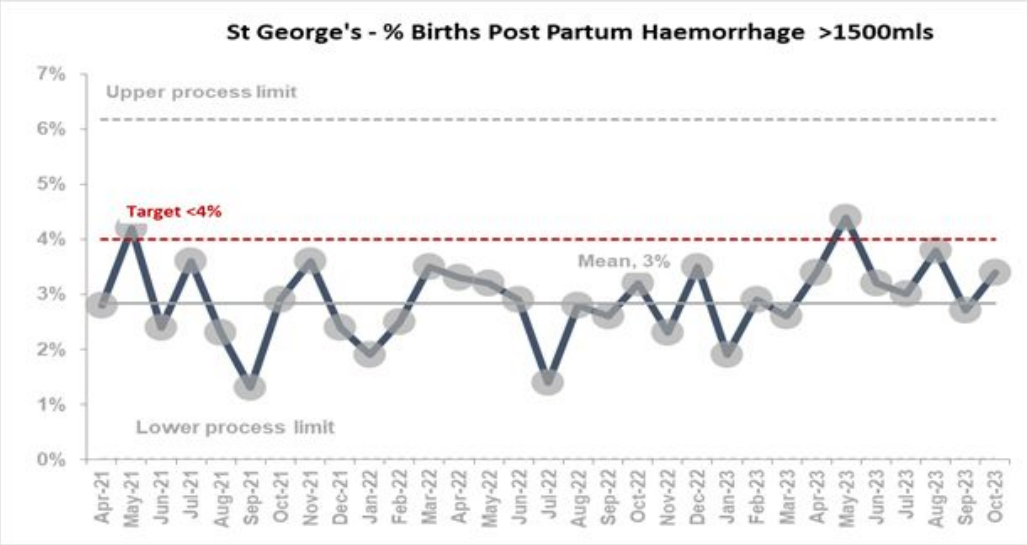
The number of cases remain below target and showing common cause variation.

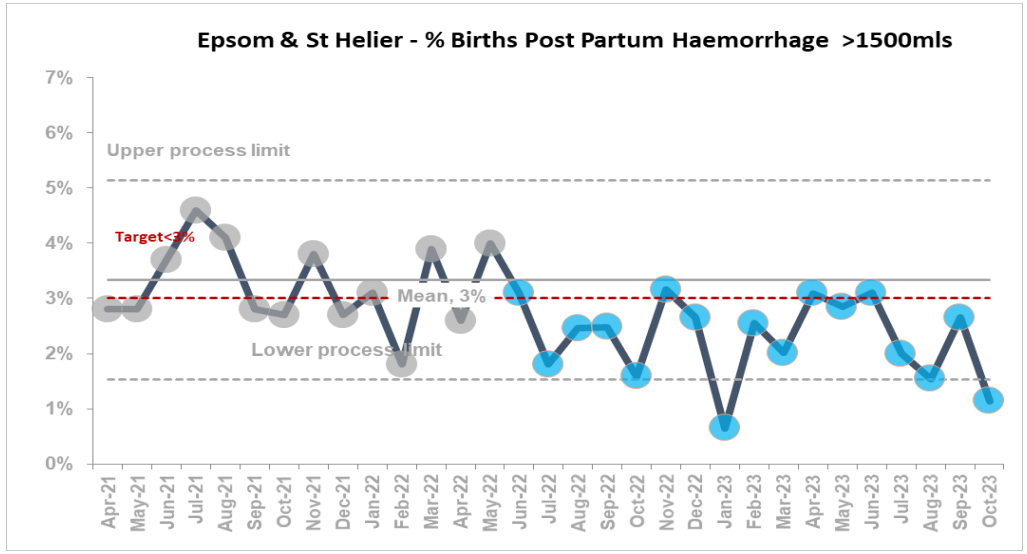
13

% Births Post-Partum Haemorrhage >1500mls

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

SGH Target: <4%	SGH: 3.4%	ESTH Target: <3%	ESTH: 1.1%





SGH updates since last month

There has been a rate for PPH >1500mls in October of 3.4% which equates to 13 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

The number of cases remain below target and mean.

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

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Quality - Analysis and Action

St George's, Epsom and St Helier

SGH current issues –

Infection Control: The overall numbers Covid-19 cases including nosocomial infections decreased again in Oct23 (93) compared to Sep23 (102). In total there were 10 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.
Oct23 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. The pattern of C. difficile and E. Coli Bacteraemia cases is in line with the situation nationally and SGUH is not an outlier when comparing overall rates with other trusts.
Never Event/ Serious Incidents: The Trust declared 2 SIs and 2 PSIIs (Patient Safety Incident Investigation), including 1 Never Event in October 2023. The Never Event was related to a wrong site skin surgery conducted in Oct23.
MCA: Overall trust MCA compliance is at 84.5% (Level 2) and 92.3% (Level 1). Level 2 MCA MAST is consistently positive at 92% for Allied Health Professional's and 93% for Nursing. Professional Scientific and Technical increased by 4% from 80% to 84%. Compliance for Additional Clinical Services at 80% and Admin & Clerical at 67% has not shown any improvement since last month. Medical compliance has not changed this month, sitting at 75%.
Mental Health: Right Care Right Person (RCRP) goes live from 1st November. The Trust reported 4 incidents where patients where not followed up by the police after walking out of hospital or going AWOL. These incidents have highlighted a need for training in RCRP risk assessment for staff and for policy updates so that the Trust can be clear in its response to patients walking out or going AWOL.
Maternity:-October birth rate was 388 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 Jan 2024. 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 Oct23 and on-going. 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 and SI and PSII investigations are being undertaken to identify relevant learning from the other incidents.
MCA: Achieve 85% or above trust wide compliance in line with CQC preparation. MCA team to evaluate audit findings for Oct23 which will be reported next month. This is following initiation of the teams new monthly auditing process which looks at 4 random case notes for all wards to establish a baseline and monitor improvements/identify areas requiring targeted support. Staff to continue the excellent work to achieve a high standard of care through improved compliance and most importantly, understanding of putting the MCA into regular practice.
Mental Health: Work continues on formalizing the mental health strategy and key performance indicators (KPIs) for St George's hospital, with launch planned for 2024/25. Right Care, Right Person policy and governance work commenced and ongoing.
Maternity: The response to the CQC inspection continues with high focus moving to MUST and SHOULD do's.
Retention and Recruitment ongoing with of vacancy of 4 WTE band 6 MW's and a pipeline of 11 WTE preceptorship band 5/6 Midwives (over establishment, as agreed by Senior Leadership Team) joining between now and Dec23 following NMC registration.

ESTH current issues –

Infection Control:

Infection Control: There was no Trust attributed MRSA bloodstream infection in October (YTD = 2). There were 7 Trust attributed C. difficile cases, (4 Healthcare Onset Healthcare Associated-HOHA and 3 Community Onset Healthcare Associated-COHA), 2 E-coli cases (2 HOHA), 1 Klebsiella cases (1 HOHA), and 3 MSSA cases (3 HOHA). No P. aeruginosa, CPE or Aspergillus infections were reported. A total of 60 Covid-19 infections were identified in October. There were 19 Covid-19 clusters in October and the IPC team continues to monitor and follow up contacts. Following the contact screening due to TB exposure on B6 Renal and ITU StH, the staff is now declared cleared, and the patient contacts are awaiting reports. Legionella Incident in C block, STH remains a safety concern and the lack of post-flush samples has created uncertainty regarding the effectiveness of the intervention. There was an MRSA transmission reported in NICU which was reported to the UKHSA, and the staff swabbing was done. Only 1 out of 7 swabs were positive and the staff awaiting re-swabbing results after treatment.

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. There are a number of outstanding investigations that require resolution by the divisions

Maternity: The MIS (currently year 5) supports the delivery of safer maternity care by incentivising an element of trust contributions to the Clinical Negligence Scheme for Trusts (CNST). Out of the 10 elements ('Safety Actions') of CNST, 5 are on track, 3 are associated with risk and 2 are non-compliant (Midwifery workforce planning and multidisciplinary training). Midwifery Safe Staffing for October 2023 was 85.5% for St Helier and 88% for Epsom against a set threshold of 94%. CQC visit was done on end of August and three urgent concerns were identified and rectified immediately. The concerns raised were responded to and additional evidence was submitted.

ESTH future action –

Infection Control: IPC team have arranged local bespoke training for different specialities with the aim of improving uptake. Assigned training requirements are being reviewed for some directorates with poor compliance. Fit Testing compliance was made mandatory, and the team continues to provide block bookings for areas as requested as well as a daily walk-in service on both sites 5 days per week. As per UKHSA mandatory requirement, an orthopaedic module (# neck of femur) will be chosen and followed up in Quarter 3 for the 2023/24 financial year. An optional large bowel surveillance will also be undertaken between Oct-Dec 2023.

VTE: Continue to work towards Trustwide action plan. Specific focus on areas not achieving the required target. Joint Quality Improvement project in Medicine to drive improvement. Meet with the Quality and Safety team to ensure parity in the investigation process

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.

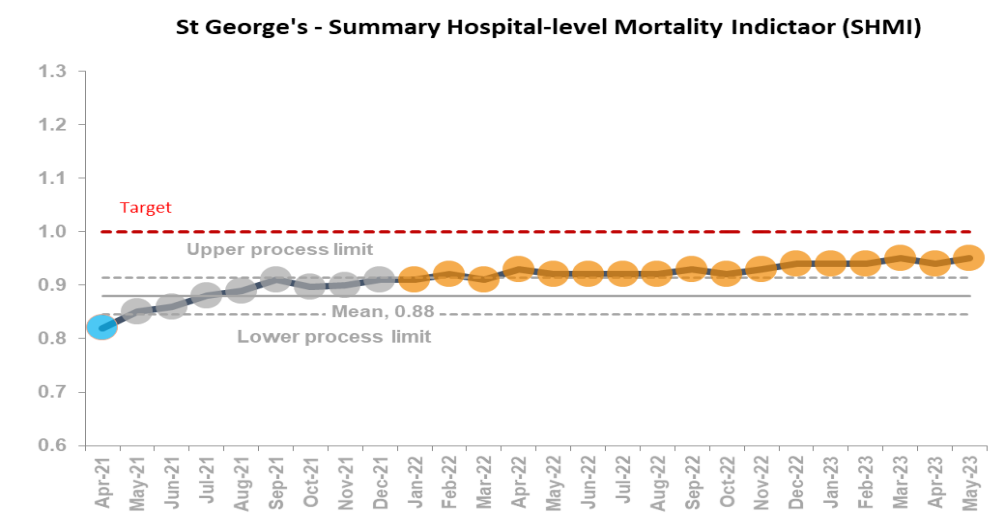
Maternity: Staff are redeployed from Continuity of Carer teams and community and non-clinically facing teams to assist in the covering of the staffing shortfalls. Mandatory training improvement plan is in place and monthly monitoring of performance against trajectory is carried out to improve multidisciplinary training. The Trust received the draft CQC inspection report on 23 October 2023 and submitted the factual accuracy response on 2 November 2023.

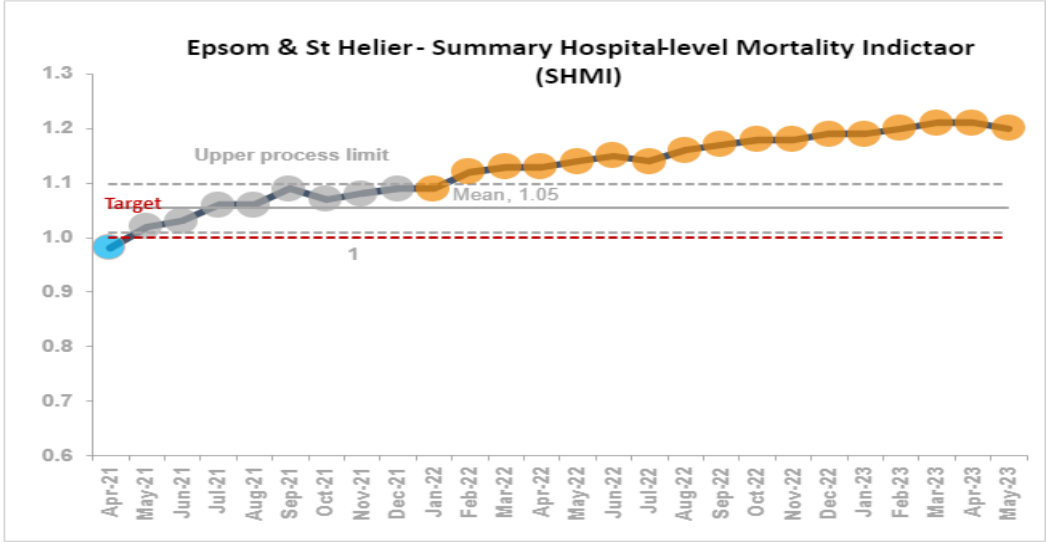
15

Mortality – SHMI

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

Target: <1	SGH: 0.95	ESTH: 1.20





SHMI data based on rolling 12 months- June 2022 to May 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 0.95.

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

Source NHS Digital

ESTH updates since last month

The SHMI encompasses patients admitted to hospitals in England who either passed away during their hospital stay or within 30 days after discharge, excluding deaths related to COVID-19 from the calculation.

The latest SHMI data for the rolling 12-month period from July 2022 to June 2023 was 'higher than expected' at a value of 1.1958. However, this is a further reduction from the previous value. The positive reduction which was reflected in the Crude Mortality Rate (CMR) and the HSMR (which are closely related in terms of the trend) is now visible in the SHMI as well. It should also be noted that the SHMI methodology does not incorporate any adjustments for patients documented as receiving palliative care.

Source NHS Digital

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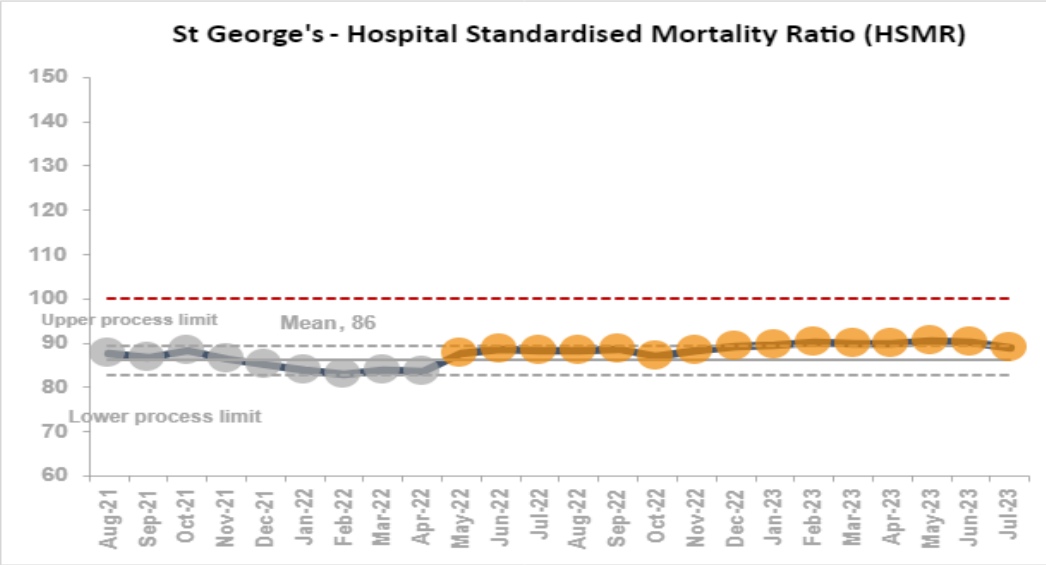
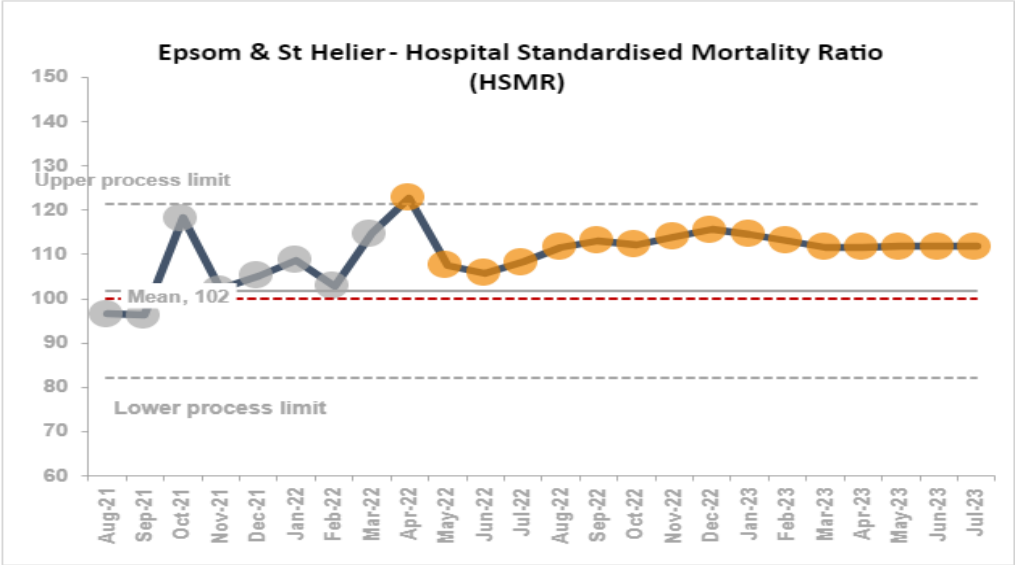
Mortality – HSMR

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

Target: <100	SGH: 89.0	ESTH: 109.8





SGH updates since last month

Latest HSMR, for the 12 months from August 2022 to July 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

HSMR is calculated by comparing the observed in-hospital deaths at the conclusion of a continuous inpatient spell (super-spell), to the expected number of in-hospital deaths across 56 specific Clinical Classification Software (CCS) diagnostic groups.
HSMR for the most recent 12-month rolling period spanning from September 2022 to August 2023 stood at 108.43. This is so far the least value since the last financial year. The monthly HSMR figures showed a positive trend with values going under 100 for several months (May 2023 at 99 and June 2023 at 98 and August at 97) despite the fact that there was a slight increase in July 2023 (103). Elective HSMR was 104 for the month of August attributable to the 3 elective deaths recorded in August. Also, 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

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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).
MMG agreed an action plan designed to improve understanding of outcomes within cardiology, where data indicate mortality that is higher than expected. Several pieces of analysis have been requested of Dr Foster, and we await their findings. The first coding validation meeting has been held and a programme of fortnightly review agreed.

In the latest SHMI data (June 2022 – May 2023) fractured neck of femur mortality is as expected and no mortality signal is observed in the National Hip Fracture Database (NHFD) data. However, the service has audited against the NHFD standards and found areas of poor compliance, suggesting that we could observe a mortality signal in the future. A Task & Finish group will work through the national standards, assessing performance and actions needed to improve.

Within major trauma mortality is no longer of concern, and attention has shifted to investigating other outcomes and length of stay. The national audit, TARN, has been discontinued, therefore we need to consider how we understand the quality of our trauma service, including mortality. This work will be addressed as part of the improvement work of a Task & Finish group, chaired by the Managing Director. The T&F group will flag any mortality concerns or action to MMG.

SGH future action -

The Mortality Review Team (MRT) has concluded the review of deaths occurring in ED during quarter 2. Twenty-six deaths were observed and reviewed through the SJR process. No poor or very poor care was identified, and no deaths were felt to be more than likely avoidable. As no significant concerns were identified MMG agreed there would be little value in extending the review period. In Q3 we will review a sample of deaths where patients have died after waiting more than 12 hours for admission. Teams from ED and Acute Medicine have contributed to the design of this work. Our methodology will be shared with ESTH to inform their work in this area.

Work is progressing to strengthen SJR processes. In addition to increasing the scope of reviews through a focussed investigation each quarter, validation work is also planned. The MRT will jointly consider cases where care has been rated poor or very poor and deaths with some level of avoidability. The aim of this work is to encourage consistency and reliability. It is also hoped that examples from ESTH can be examined to promote learning and sharing of best practice.

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 categorised as 'higher than expected' even though the 12-month rolling and monthly values follows a downward trend. The crude mortality rate is 1.5% for the month of October, but lower than the October 2022/23 (2.2%) and October 2021/22 (1.8%) values.

Out of the 129 SJRs completed for the Q2 2023/24, eight overall 'poor' ratings and one 'very poor' rating were recorded. The 'concerns in care' percentage (34.4%) 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.

Audits are being conducted on ED mortality, waiting times, and readmissions. Interim findings were presented during the RADAH committee meeting, and formal reports for necessary actions are anticipated in the coming months. The potential adoption of the REDS scoring system, with support from St. George's, is under consideration for implementation in the ED. Plans are in progress for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites before the Winter season. Discussions are ongoing to redesign sepsis care pathways with the aim of reducing sepsis-related mortalities through a targeted approach. The Patient Safety Incident Response Framework (PSIRF) is presently being implemented to establish and sustain effective systems and processes for responding to patient safety incidents, fostering a culture of learning and continuous improvement in patient safety.

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Monthly Overview – Elective Care (1)

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

	St George's							Epsom and St. Helier						
Responsive and Productive Services - Elective Care	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
Outpatient activity	65,498	67,502	67,907	68,882	437,590	475,030		56,335	51,526	51,492	53,571	357,604	359,775	
Patient Initiated follow ups (Number)		179	229			683			1,594	1,692			10,247	
Patient Initiated follow ups % of OP Activity	5%	0.3%	0.3%					5%	3.1%	3.2%				
Advice and Guidance Total Processed		1,654	1,119			8,976			1,712	1,292			9,668	
Advice and Guidance (Utilisation rate) per 100 First Outpatient Attendances	16	6.1	4.1					16	11.8	8.9				
Outpatient DNA rates	8%	12.2%	12.1%	10.4%	8%	11.1%			4.9%	4.8%	4.6%		5.0%	
New to follow up outpatient ratios		1.77	1.74	1.73		2.02			2.72	2.70	2.66		2.73	
Elective and day case activity	5,828	5,320	4,981	5,114	38,229	35,326		4,117	3,803	3,652	3,882	26,134	25,878	
Elective LOS		3.8	4.2	4.3		4.2			5.8	5.6	5.4		5.7	
Elective Day case rates	78%	78.0%	77.6%	81.0%	78%	79%		82%	82.8%	83.5%	84.0%	83%	83.1%	
Theatre Utilisation (Uncapped)	85%	80%	81%	83%	85.0%	82%		85%	75%	81%	80%	85%	77.5%	
Theatre Utilisation (Capped)	85%	76%	76%	79%	85.0%	75%		85%	72%	75%	76%	85%	74.0%	
Theatre Average Cases per Session		1.59	1.66	1.70		1.65			3.66	3.63	4.17		3.74	
On the day cancellations for Non Clinical Reasons		28	29	23		207			84	73	134		207	
On the day cancellations for Non Clinical Reasons & Re-booked within 28 Days	100%	96.4%	86.2%	82.6%	100%	86%								

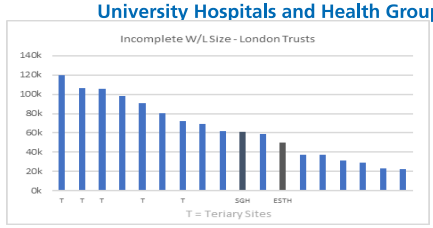
Monthly Overview – Elective Care (2)

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

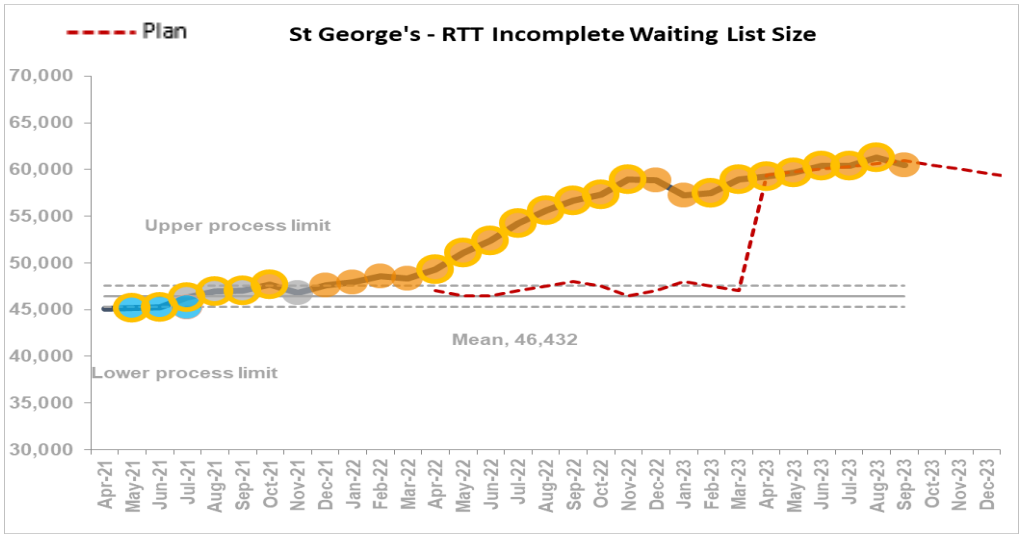
Responsive and Productive Services - Elective Care	St George's Monthly Target	St George's Jul-23	St George's Aug-23	St George's Sep-23	St George's YTD Target	St George's YTD Actual	St George's 13-Month Trend	Epsom and St. Helier Monthly Target	Epsom and St. Helier Jul-23	Epsom and St. Helier Aug-23	Epsom and St. Helier Sep-23	Epsom and St. Helier YTD Target	Epsom and St. Helier YTD Actual	Epsom and St. Helier 13-Month Trend
RTT – total size of waiting list*	60,946	60,411	61,295	60,431				47,086	49,667	49,845	49,272			
RTT -Incomplete Median Waiting Times		10.6	11.1	11.0					11.4	11.1	11.6			
RTT - Waits over 52 weeks*	412	559	506	506				351	835	917	943			
RTT - Waits over 65 weeks*	90	66	56	47				24	101	155	157			
RTT – Performance	92%	70.3%	70.2%	68.9%				92%	68.4%	67.6%	67.0%			
Cancer 14 Day Standard	93%	64.4%	51.2%	48.6%	93%			93%	74.4%	67.7%	65.0%	93%		
Cancer 14 Day Standard Breast Symptomatic	93%	78.6%	12.5%	26.5%	93%			NA	NA	NA	NA	NA	NA	
Cancer 31 Day Diagnosis to Treatment	96%	96.3%	93.2%	92.5%	96%			96%	100%	100%	100%	96%		
Cancer 31 Day Second or subsequent Treatment (Surgery)	94%	94.8%	96.8%	94.0%	94%			94%	100%	100%	NA	94%		
Cancer 31 Day Second or subsequent Treatment (Drug)	98%	100%	100%	100%	98%			98%	100%	NA	100%	98%		
Cancer 62 Day Referral to Treatment Screening	90%	51.9%	52.8%	53.0%	90%			90%	NA	NA	50%	90%		
Cancer 62 Day Referral to Treatment Standard	85%	55.4%	64.9%	62.9%	85%			85%	87.0%	87.0%	87.0%	85%		
No. of patients over 62 days	115	103	117	111	NA	NA		75	37	29	39	NA	NA	
Cancer – 28 day Faster Diagnosis Standard	75%	76.8%	66.8%	62.5%	75%	NA		75%	79.4%	76.2%	75.0%	75%	NA	
	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
Diagnostic activity		18,113	17,981	19,144		128,537			17,898	17,965	18,447		120,910	
Diagnostic performance	5%	1.2%	2.0%	0.7%				5%	7.3%	5.4%	4.5%			

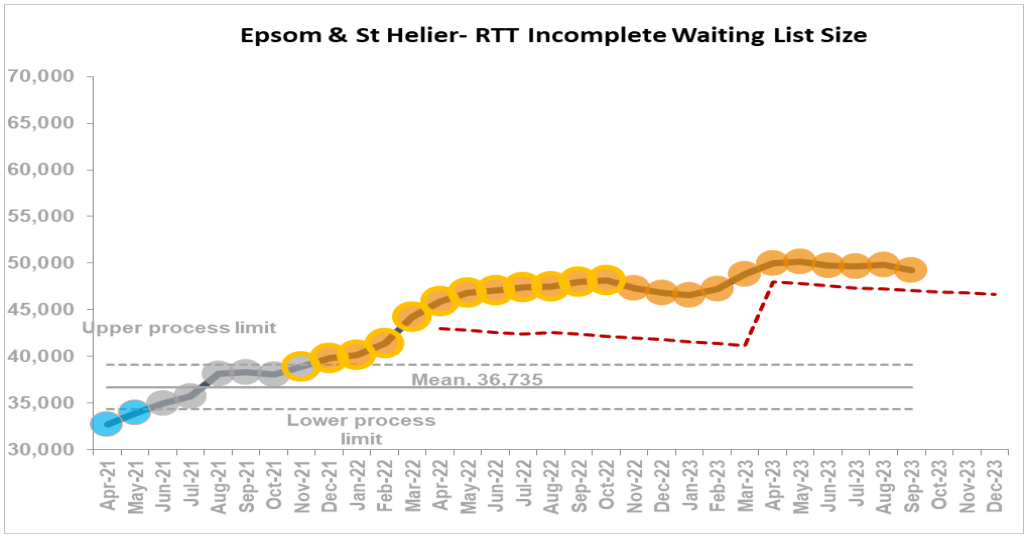
RTT – Total Waiting List Size

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



SGH Plan: 60,946	SGH: 60,431	ESTH Plan: 47,086	ESTH: 49,272





SGH updates since last month

PTL volume has decreased in September by 1.4% (864 pathways) currently meeting plan. Decrease is driven by the non-admitted PTL seeing a decrease of 961 pathways, many specialties have contributed to this position particularly Max Fax and ENT. The admitted PTL however has increased by 1.4% (97 pathways). The number of 18 week breaches has seen a further increase in September (+3% compared to August) main increase within T&O. Positively, the three highest volumed specialties, Cardiology, ENT and Neurosurgery have all seen decreases. 18w performance is down from last month (from 70.2% to 68.9%).

ESTH updates since last month

PTL volume has decreased slightly (by 1.1%), with (18w) breach numbers increasing very slightly (by 105 pathways, 0.7%). This has resulted in 18w performance going down slightly from last month (from 67.6% to 67.0%).

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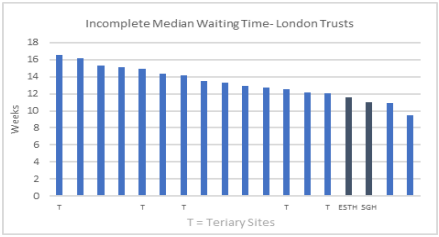
RTT – Median Waiting Times

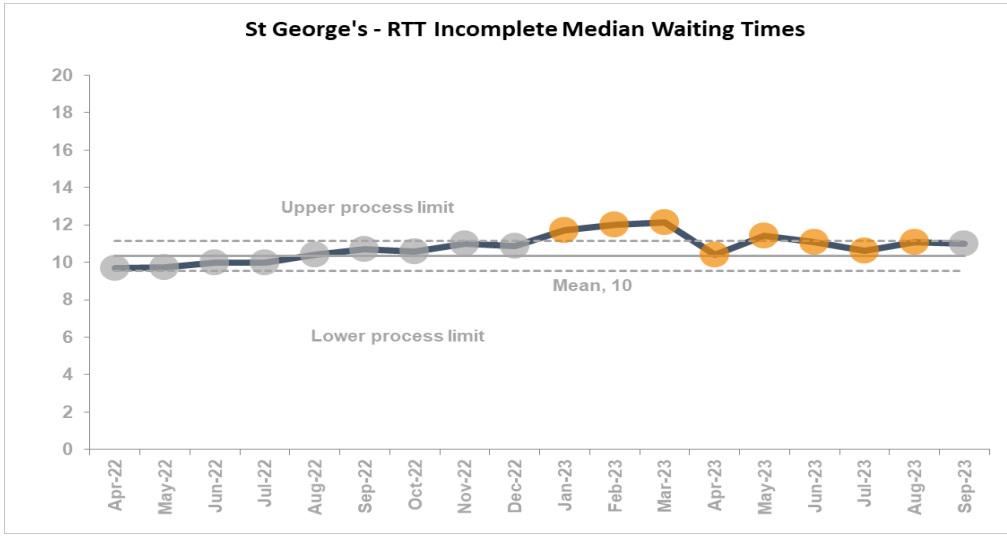
St George's, Epsom and St Helier University Hospitals and Health Group

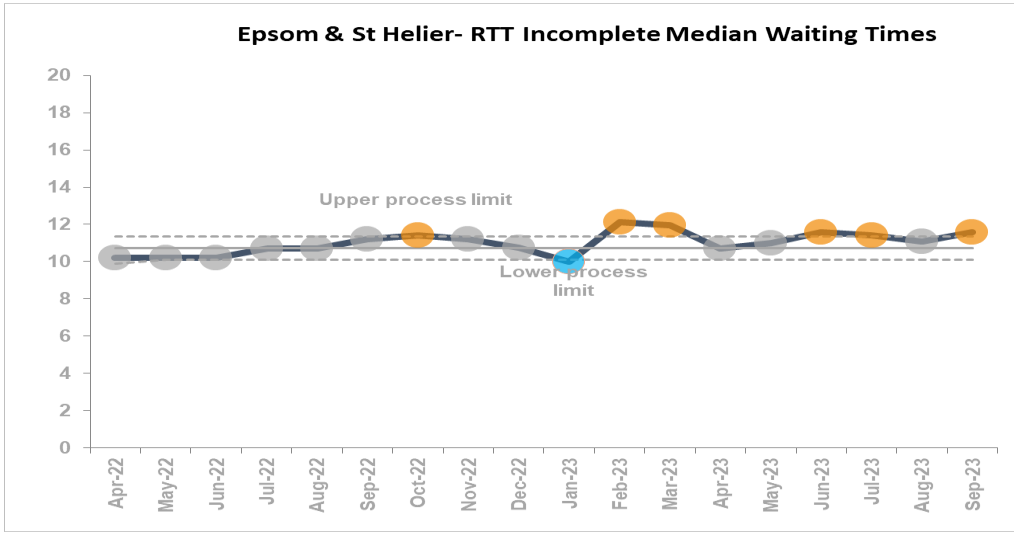
Average (median) waiting time (in weeks)
This is the mid-point of the RTT waiting times distribution. The median is the 50th percentile. It's the time that 50% of patients waited less than, e.g. the waiting time of the middle patient if you lined them up from shortest wait to longest wait.



SGH: 11 Wks

ESTH: 11.6 Wks





SGH updates since last month

The median waiting time for the RTT incomplete PTL remains consistent at 11 weeks.

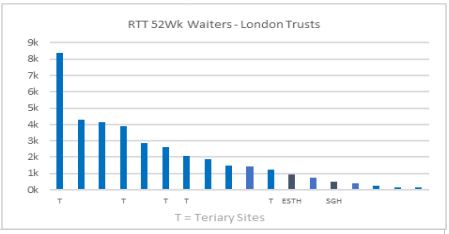
ESTH updates since last month

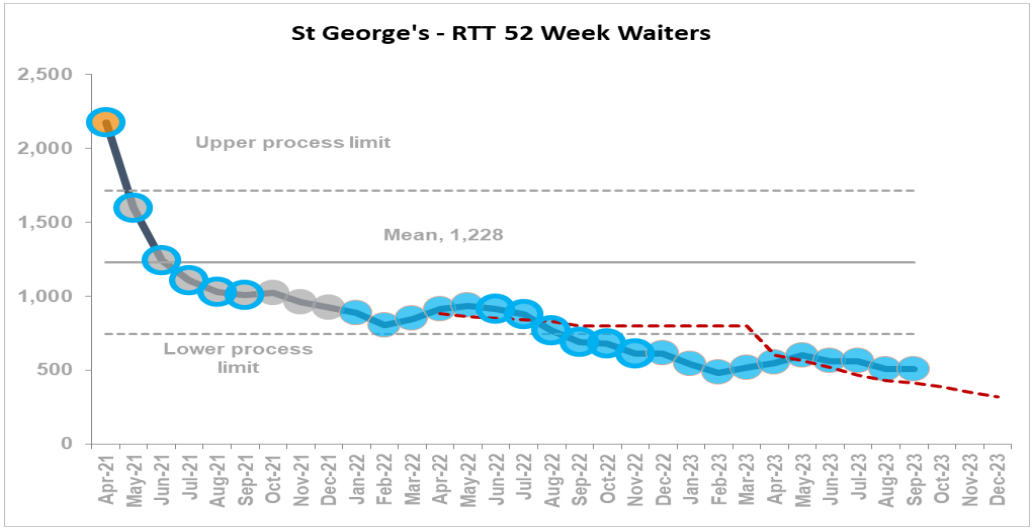
The median waiting times on the RTT incomplete PTL has been relatively consistent over the last 12 month period showing some periods of special cause variation, with an average waiting time of 11 weeks. The highest median waits are for Cardiology and Gynae (+15 weeks).

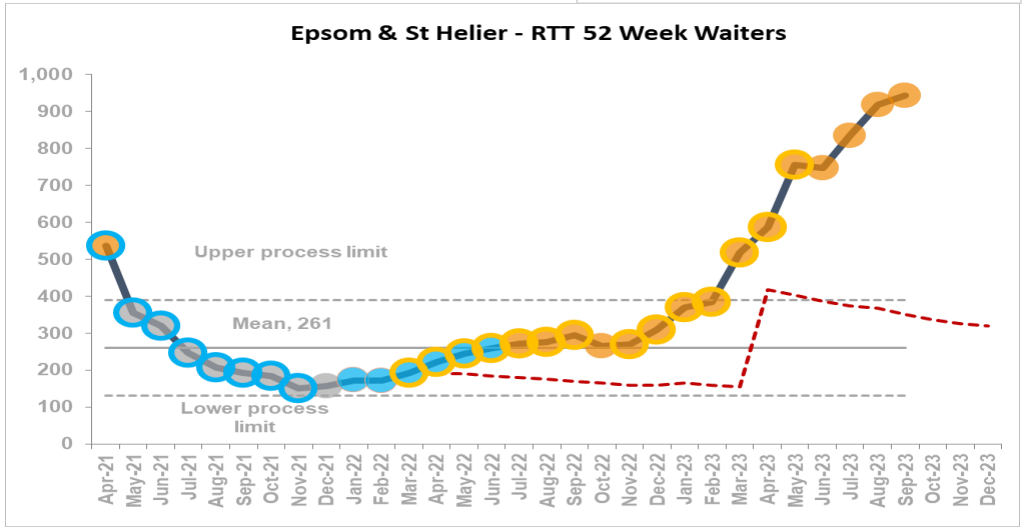
RTT – 52 Week Waiters

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

SGH Plan: 412	SGH: 506	ESTH Plan: 351	ESTH: 943







SGH updates since last month

At the end of September, 506 patients were waiting over 52-weeks on an incomplete pathway. Although this is above plan the Trust have seen some stabilisation seeing no increase compared to August. Cardiology and ENT, both holding the highest volume of breaches have seen positive reductions in the month however, this has been off set by increases within other specialties particularly Neurosurgery and Gastroenterology.

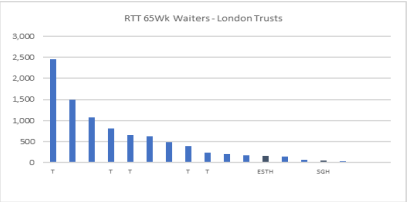
ESTH updates since last month

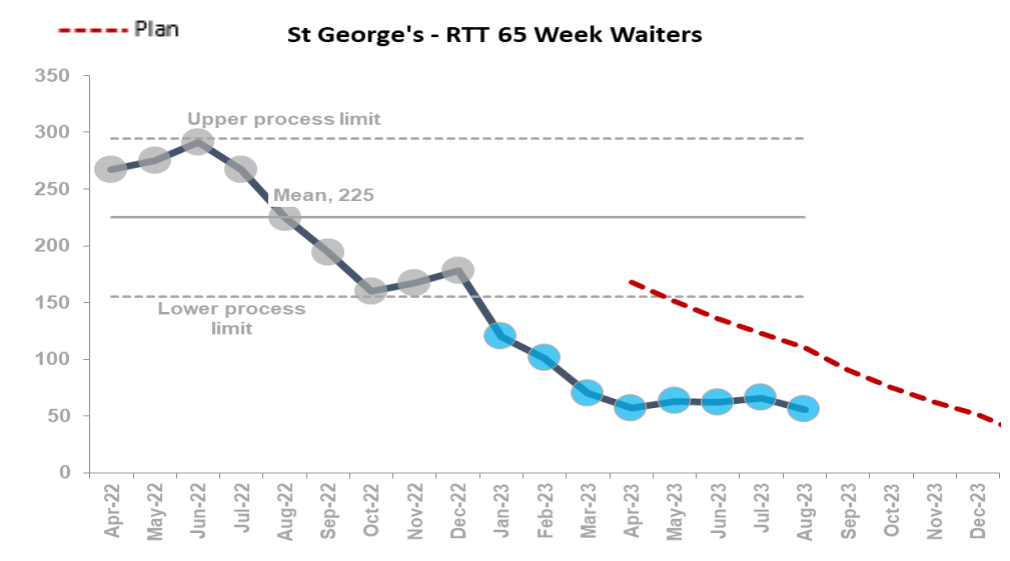
The month-end 52-week waits have increased (by 26 pathways, 2.8%). The largest volumes are within Gynaecology (311) and Paediatric Specialties (249).

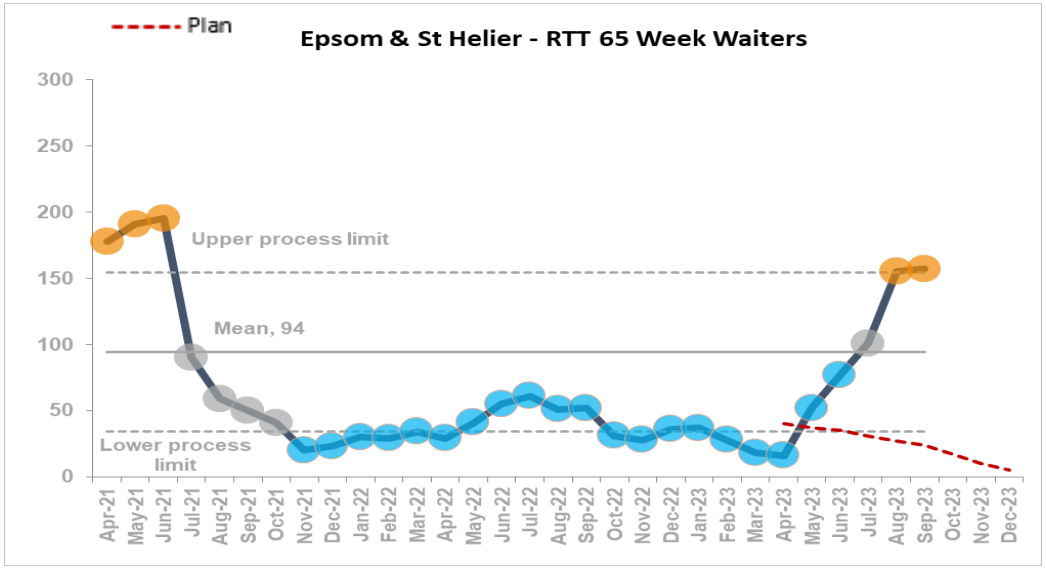
RTT – 65 Week Waiters

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

SGH Plan: 90	SGH: 47	ESTH Plan: 24	ESTH: 157







SGH updates since last month

At the end of September, the Trust reported 47 patients over 65 weeks, a reduction of 9 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 add challenge to delivering the plan of 0. We are looking at mitigations at this time.

ESTH updates since last month

At the end of September, 157 patients were waiting for more than 65 weeks for treatment (increase of 2 pathways) , against a plan of 24. The largest volumes are within Community Paediatrics (62) and Gynaecology (37).

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Elective / RTT Analysis and Action

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

SGH current issues –

There are 528 patients with a projected wait of over 52 weeks for a first appointment. The largest numbers are in Neurosurgery with 113 patients waiting and Cardiology with 94. 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 -

There are three key areas of focus for SGH to help improve elective productivity and performance
Increase theatre productivity to >80%
Reduce DNA rate to <10%
Increase accuracy in counting and coding of outpatient procedures

Increase theatre productivity to >80%
Through robust management of 642 meetings held regularly and scrutiny of data accuracy, we have begun to see an improvement in this metric. There will be a review of activity in all areas to ensure the right activity is taking place in the right setting. E.g. Minor OP procedures moved to procedure room
Reduce DNA rate to <10%
Adapt our text messaging reminder approach to improve communications to patients. Audit of all specialties and clinics with a high DNA rate
Increase accuracy in counting and coding of outpatient procedures
While the Trust awaits the build of Orders 2 Schedule to help improve data and procedure capture, there will be a temporary solution implemented in outpatients to improve productivity and accuracy of recording data and information

ESTH current issues –

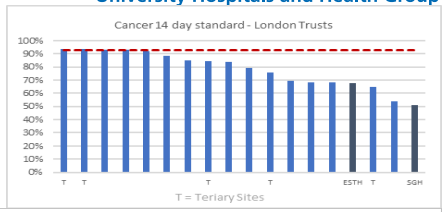
- 52 week waits has increased from 917 in Aug23 to 943 in Sep23. This increase is mainly driven by pressures in Gynaecology (311), Community Paediatrics (249) and Cardiology (89), as well as ongoing industrial action.
- Patients waiting over 65 weeks for treatment increased slightly from 155 in Aug23 to 157 in Sep23 (62 Community Paediatrics, 37 Gynaecology, 19 Cardiology, 13 Gastroenterology and 26 scattered across other specs).
- Referrals from GP to a consultant led service remain significantly above BAU levels within a number of key specialities. For example, Gynaecology referrals are 38% higher than BAU YTD.

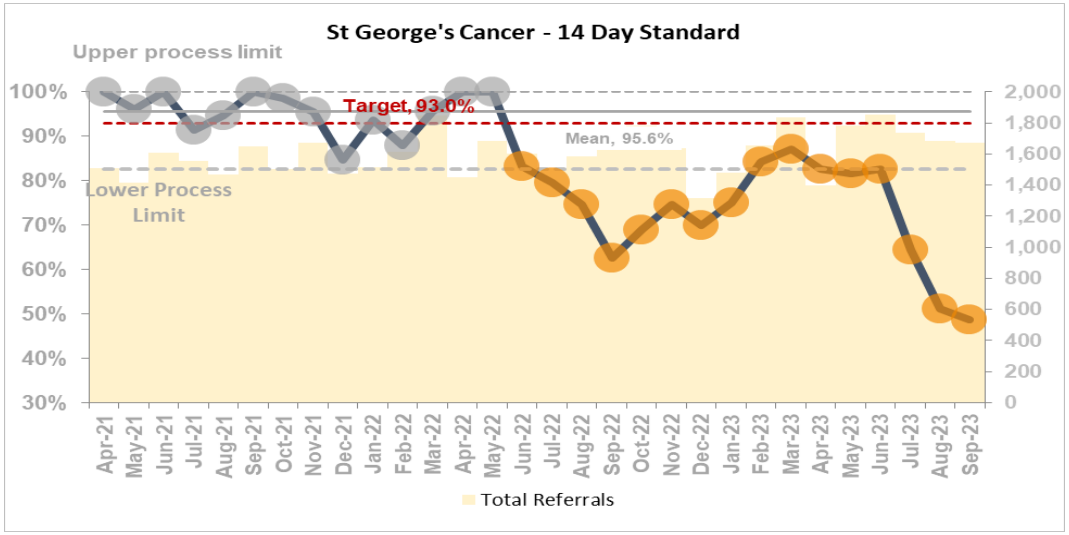
ESTH future action –

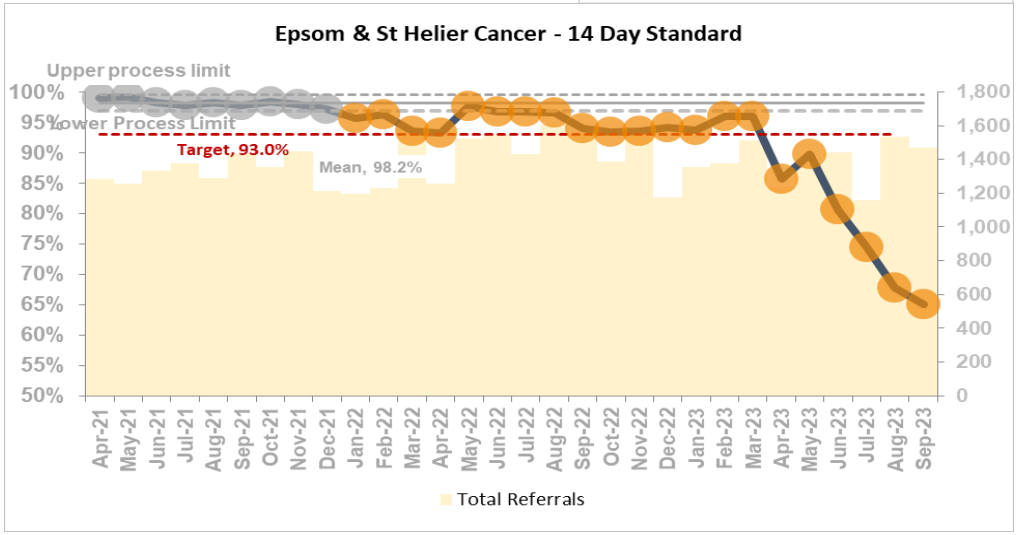
- All patients over 12 weeks who have not been seen or contacted in the past 12 weeks are being contacted using the DoctorDr platform to confirm if they still wish to be seen. 9543 patients contacted out of a total 12k. Of the 9543 patients contacted, 6100 responded (67% response rate).
- Local action/recovery plans in place for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology.
- Progressing with papers to use the independent sector for Community Paediatrics and Gynaecology.
- Exploring the option of increasing theatre capacity at QMH (Roehampton) theatres.
- 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

Target: 93%	SGH: 48.6%	ESTH: 65%







SGH updates since last month

Performance of this standard continued on a downward trend showing specialty cause variation with 48.6% of patients seen within two weeks of referral in September, referral numbers remain stable. All tumour groups with the exception of Upper GI are below 93%, significant challenge seen within Skin (7.6%), Breast (30.6%) and Gynaecology (66.9%). Skin holds the highest volume of referrals and increase in demand.

This target is being removed from the national cancer standards in Oct 2023, although we will continue to monitor it internally to support FDS delivery.

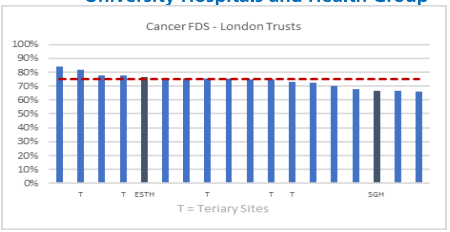
ESTH updates since last month

14 day standard in Sep23 is 65%, mainly due to Dermatology. An action plan is in place, converting routine slots to TWW and securing a locum to provide additional sessions. This is partly due to the delay of the start date of a Locum consultant. The team has pushed booking out to four weeks, however the actions undertaken has brought that back to within two weeks. From December onwards it is expected that Dermatology will meet the standard again.

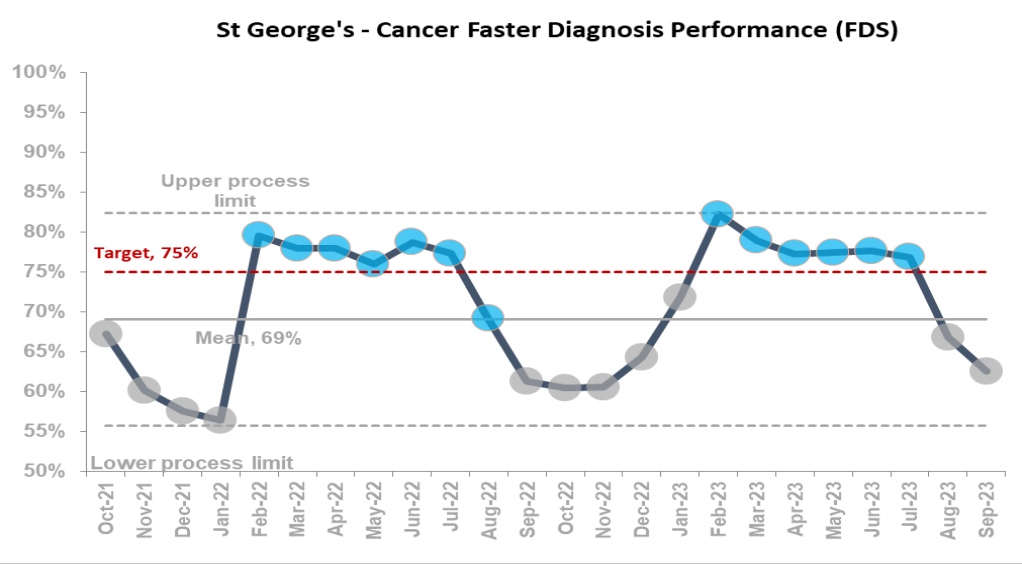
In Gynae, the TWW position is improving and a Locum Consultant starting imminently. The recently approved in-sourcing agreement will support the substantive team to continue to focus on meeting the TWW demand.

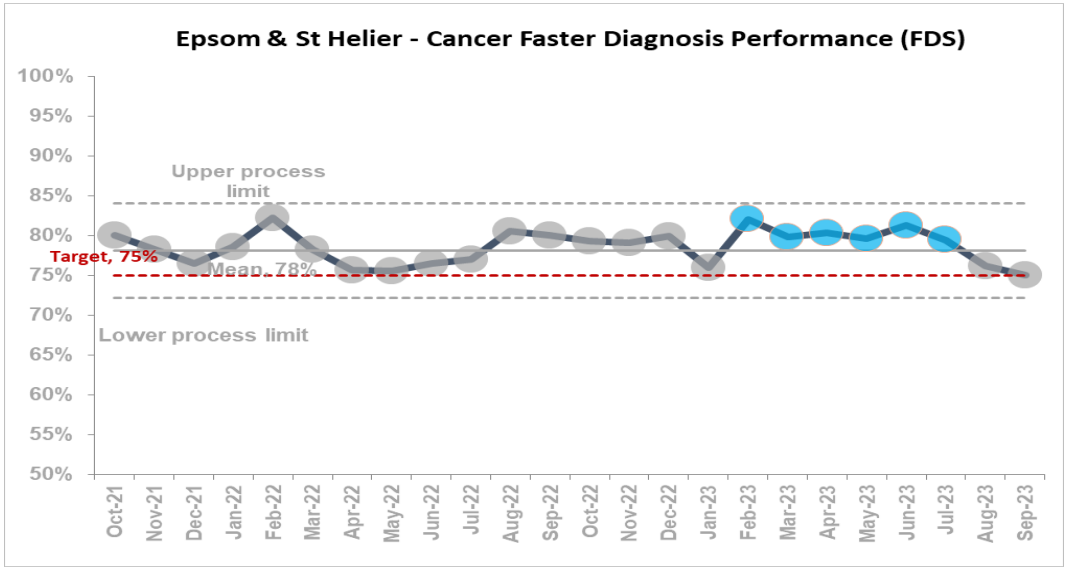
Cancer – Faster Diagnosis Standard

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



Target: 75%	SGH: 62.5%	ESTH: 75%





SGH updates since last month

Faster Diagnosis performance was non-complaint in September seeing a further deterioration reporting 62.5%. Challenges are driven by Skin who continue to have the largest proportion of patients waiting for more than 28 days seeing a downward trend in performance (29.9 % in September).

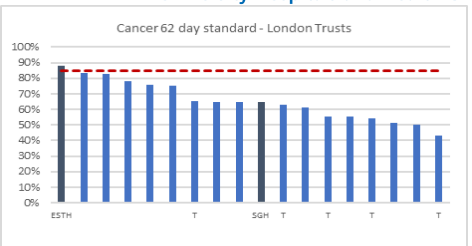
ESTH updates since last month

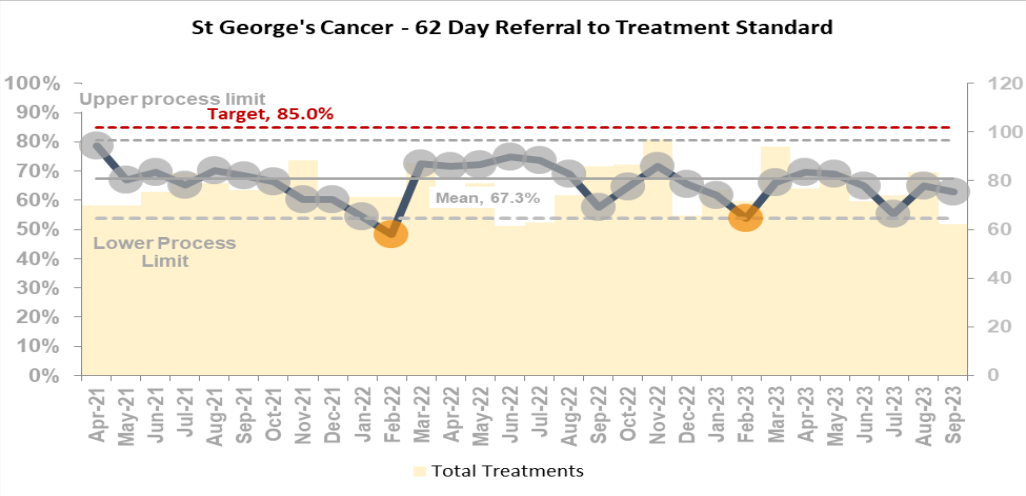
The Trust continues to meet the FDS standard of 75%, however, there has been a dip in performance from 76.2% in Aug23 to 75% in Sep23. The Trust expects to maintain overall performance whilst addressing FDS non-compliance drivers, particularly the challenges within Gynae, Lung and Skin.

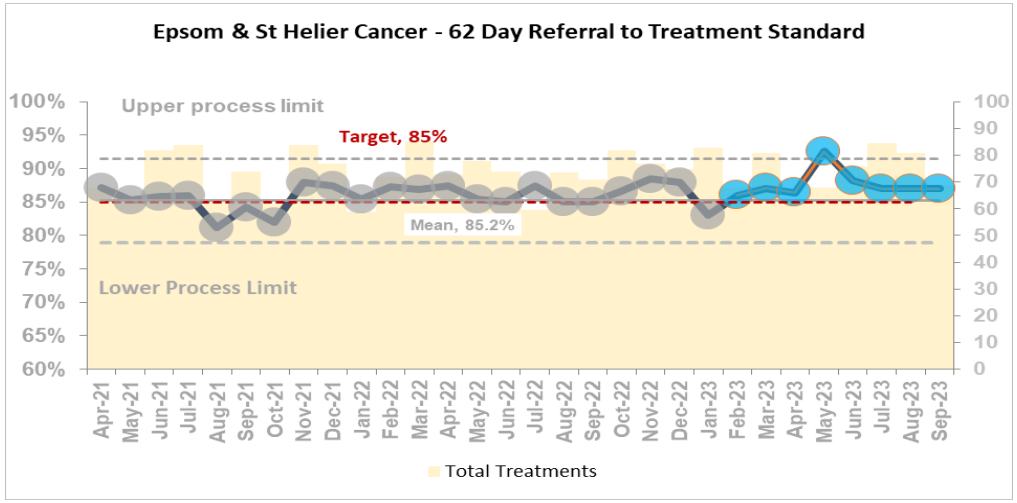
Cancer –62 Day Referral to Treatment Standard

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

Target: 85%	SGH: 62.9%	ESTH: 87%







SGH updates since last month

In September, the Trust reported a performance of 62.9% against the 62 day standard compared to 64.9% reported in August 23. Performance remains within the upper and lower control limits showing only common cause variation

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 – shadow reporting was shared for September with a performance of 67%.

ESTH updates since last month

Performance against 62 day standard continues to be achieved at 87% in September with 9 breaches.

The change in standards from October 2023 will mean that there will be one Headline 62-day referral to treatment standard (85%).

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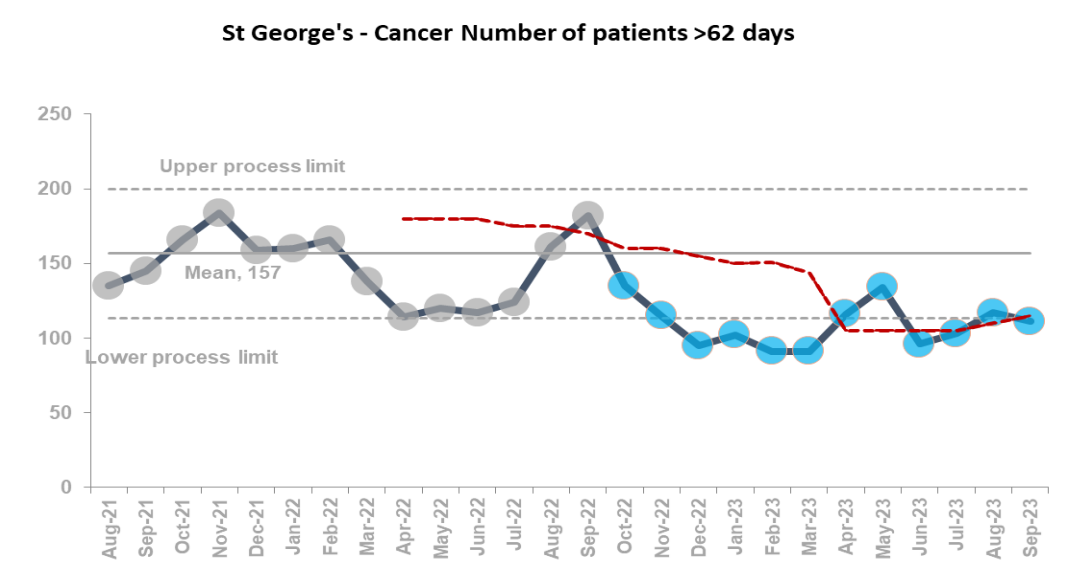
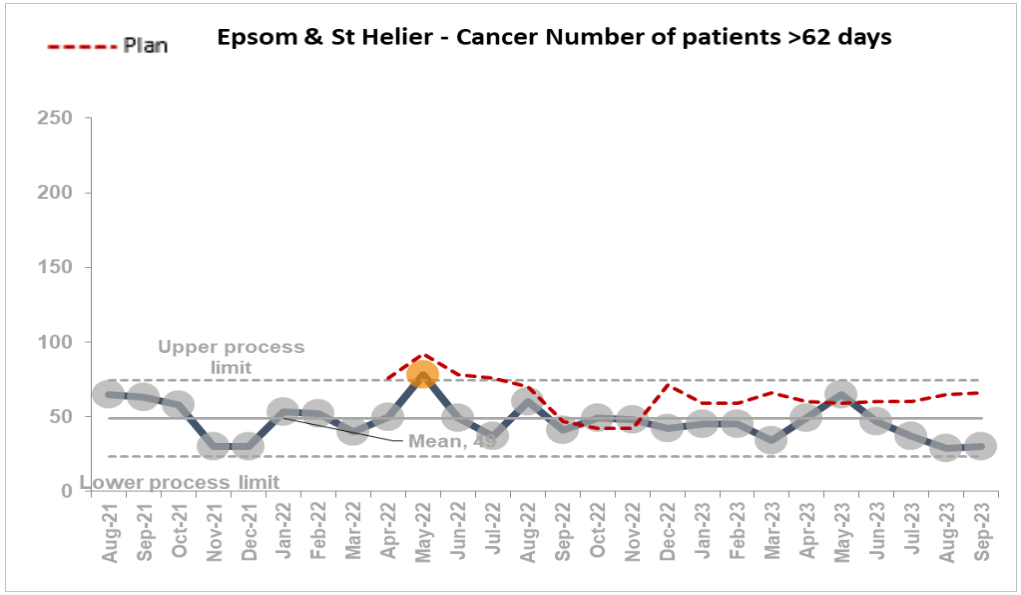
Cancer – Number of patients > 62 days

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

Plan: 115	SGH:111	Plan: 75	ESTH:39





SGH updates since last month

The back log was meeting trajectory in September 23. Lower GI hold the largest proportion of patients within the backlog. Patients are reviewed regularly at the weekly Cancer Access meeting expediting 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

NHS
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 227 appointment slot issues - current performance 8.3%
Gynaecology – current performance 31.2%
Breast - current performance 57.4%
FDS: A deterioration of skin performance (21.5%), has impacted the overall recovery. Recovery is dependant on skin reducing 1st seen booking profile to below day 28. Three tumour sites are currently compliant, Breast, Lung, UGI and Urology.
A number of Histopathology delays are seen with 35% of patients TAT >10 days, 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:
Breast (11 breaches) – delays to one stop breast clinic and access to theatre
H&N (2 breaches) – Multiple late inter-trust transfers.
Gynaecology (2breaches) – access to Gynae Scan and Hysteresocpy and triaging delays
LGI (2 breaches) – access to nurse led Telephone assessment clinic (TAC) – median wat is 19 days
Good news stories
- Urology is meeting FDS and 62 day GP referral to treatment standard

SGH future action –

- Faster Diagnosis to be compliant (75%) by March 2024. Trajectory not met in September 23 (some IA impact)
- 62 Day GP– Trajectory being reviewed to deliver 70% by March 2024 as per national ask - Trajectory not met in September 23
- 62-day backlog to achieve 105 patients by March 2024. Trajectory met in September 23

- Tumour specific actions:
- 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. Breast business case is on-going 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.
- H&N: RMP has funded 1:0 WTE nurse to support risk stratified triage, recruitment 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.

EBUS service provided by StG has improved procedure turnaround times, but more focus is necessary to address histological turnaround which is currently up to 10 working days.

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. Paediatric Skin capacity is also an issue that has been escalated to the service.

Upper GI Face to Face capacity has been challenged. The service are working to provide ad hoc capacity.

ESTH future action –

Dermatology - a locum consultant is commencing on the 13th November and the nurse Band 5 role is being extended to support dealing with the current demand. An overseas consultant has been successfully appointed undergoing recruitment checks.

Gynaecology - exploring different models of care for providing first encounter to Gynae TWW and CUPG patients. In-sourcing for gynae outpatient and colposcopy will support the substantive team focussing on the TWW demand.

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.

Outpatient Template biopsy (TPPB) work stream continues with a start date for outpatient TPPB machine planned for January 2024.

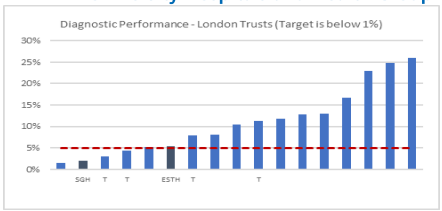
Delivery plans have been implemented by Cancer Services for the New National Cancer guidance (CWTv12) which has come into effect from 1st October 2023.
The Current 9 cancer standards have been reduced to 3 cancer standards by merging all 62 pathways together, all 31 day standards together and the 14 day and 28 day standards together.

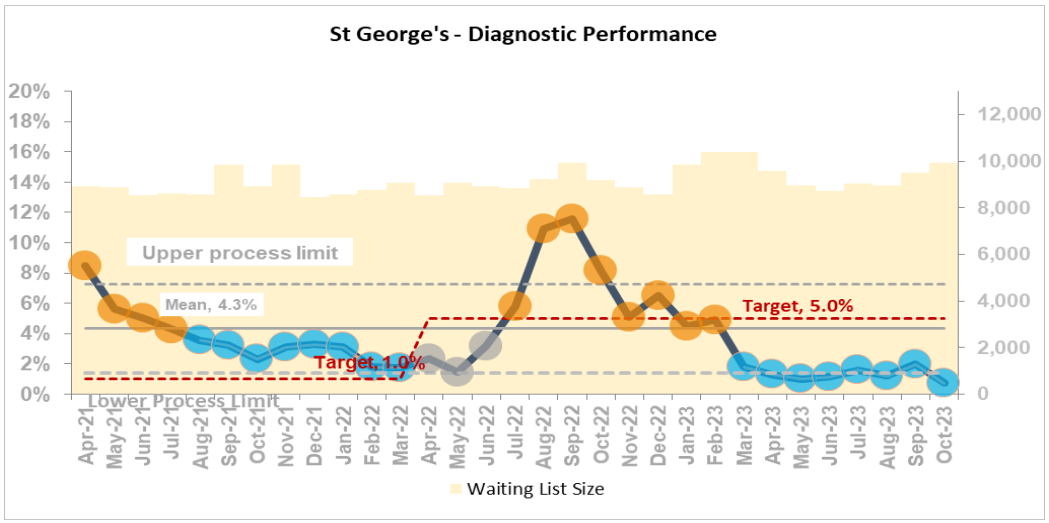
30

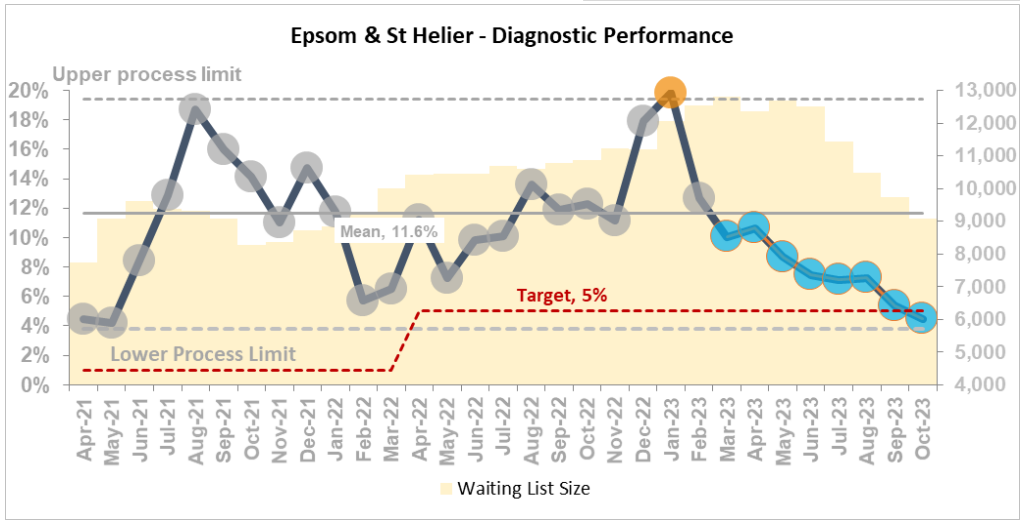
Diagnostic Performance

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

Target: 5%	SGH: 0.74%	ESTH: 4.47%







SGH updates since last month

At the end of October, the Trust reported that 99.3% of patients were waiting less than six weeks for their diagnostic test. In total 73 patients were waiting for more than six weeks a reduction of 61% compared to September, driven by a decrease in Gynae Ultrasound waits which increased due to reduced capacity in September.

ESTH updates since last month

At the end of October we are reporting four hundred and six breaches, which is a reduction of over 20% and the sixth consecutive month-end drop. The PTL size has also decreased since the end of the previous month, but at a slightly lesser rate, meaning that our performance has seen a further improvement (from 94.6% to 95.5%). This is the first month ESTH has met the national 5% standard.

Diagnostic Performance Analysis and Action

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

SGH current issues –

Sleep Studies - Performance in October – 12.3% of patients waiting more than six weeks – The service hold the largest proportion of breaches (59%) while SGH continue to see a high demand impacted by challenges across SWL and capacity is not meeting demand consistently. Demand volumes have been consistently higher than average for the past six month and are 43% higher compared to the same period last year. Demand has increased through direct GP referrals for diagnostic and via Consultant to Consultant referrals (respiratory) where demand to routine respiratory service has also increased.

ESTH current issues –

Imaging

Total diagnostics DM01 performance breaches for imaging in Oct23 are down to 73.

Oct23 had an imaging DMO1 performance of 99%.

Soliton upgrade affected access to reporting by Radiologists, delaying some reports for a week, but the radiologists have managed to clear the outstanding reports in a week.

CT bookings are fluctuating and having an impact on waiting list management due to issues with vetting. This is being looked at as part of job planning and radiologist rota management.

SGH future action –

Sleep Studies - There is additional capacity through CDC funding to create additional clinics to mitigate this as much as possible, in September the service provided four additional sessions and plan to do the same through October dependant on staff uptake of sessions . With demand still high this will continue to be difficult to manage long term and therefore looking at more sustainable capacity going forward.

Weekly performance meetings continue to be in place to monitor and escalate any performance / capacity issues.

ESTH future action –

Imaging

Interviews for chest consultant radiologist held in September were successful and candidate commences in Feb24.

Decreased scheduling staff using bank shifts whilst maintaining performance. Utilising weekend lists for all modalities and booking ahead for MRI. Working on booking for US and CT in advance.

Five Band 5 radiographers to commence in February working cross site.

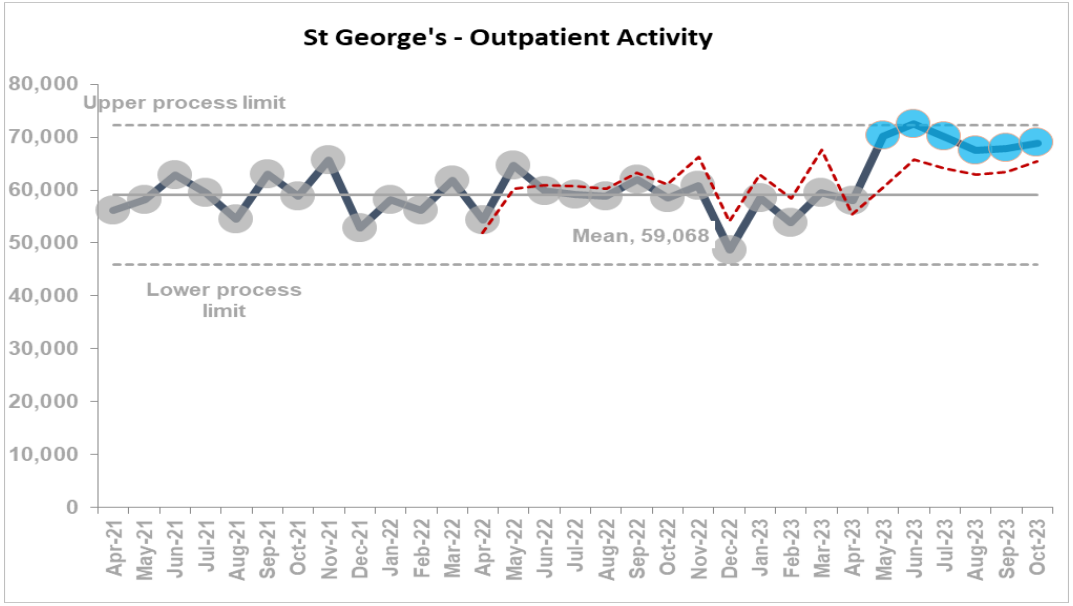
Weekly reviews of ultrasound, CT and MRI breaches, as well as a deep dive of planned appointments to avoid breaches, checking for DNA trends and bringing patients forward where possible.

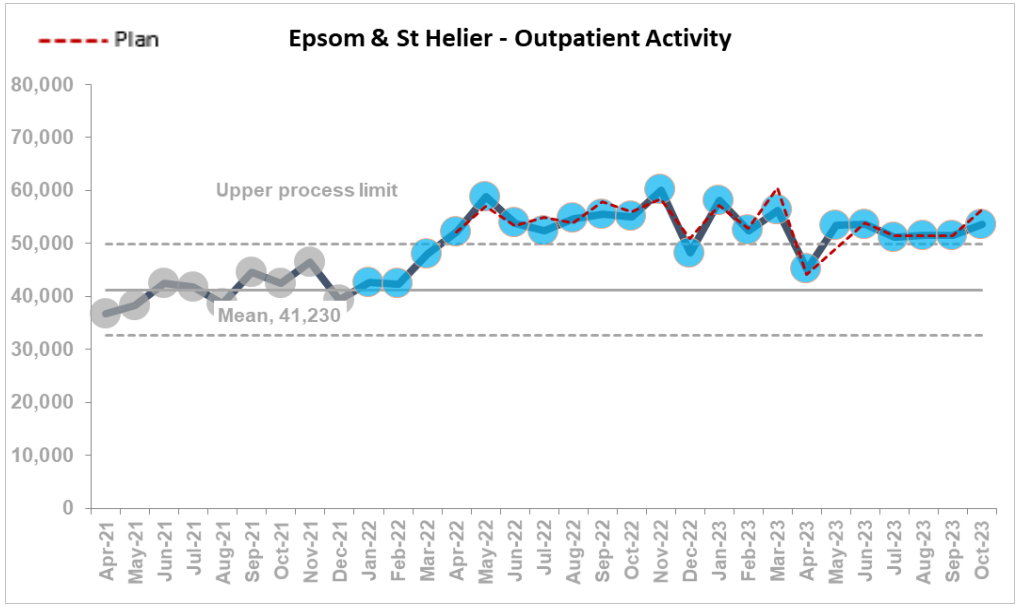
Daily operational huddles between clerical management and lead superintendents continuing as this is essential in maintaining the DMO1 performance.

Outpatient Activity

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

Plan: 65,498	SGH: 68,882	Plan: 56,335	ESTH: 53,571





SGH updates since last month

Outpatient performance continues above plan and above mean for the past six month period showing special cause improving variation. Activity levels will further increase for October once data catch up is complete.

ESTH updates since last month

October performance is currently below target however, this is expected to increase with data catch up / coding. YTD performance is ahead of plan.

Patient Initiated Follow-up (PIFU)

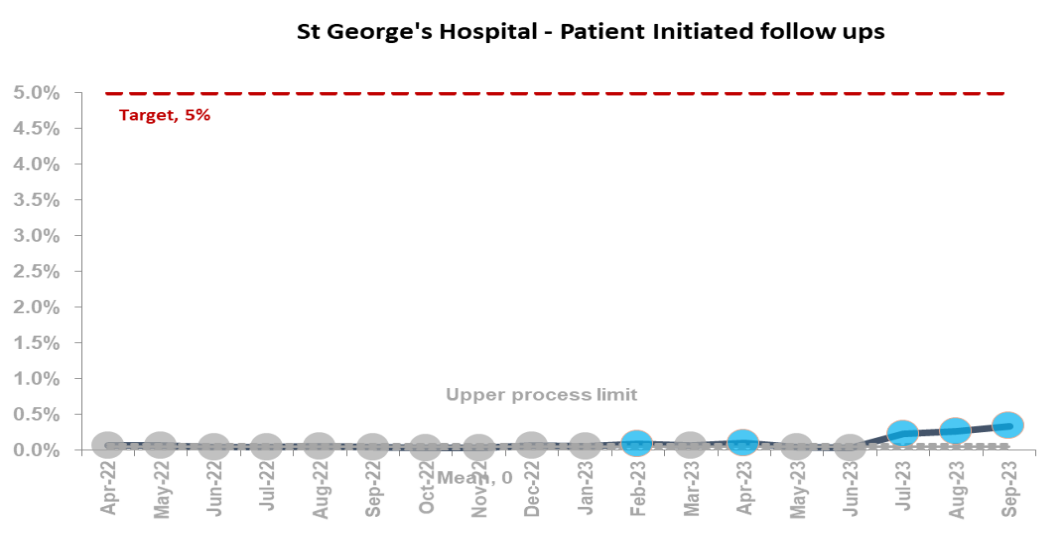
Percentage of episodes moved or discharged to a PIFU Pathway

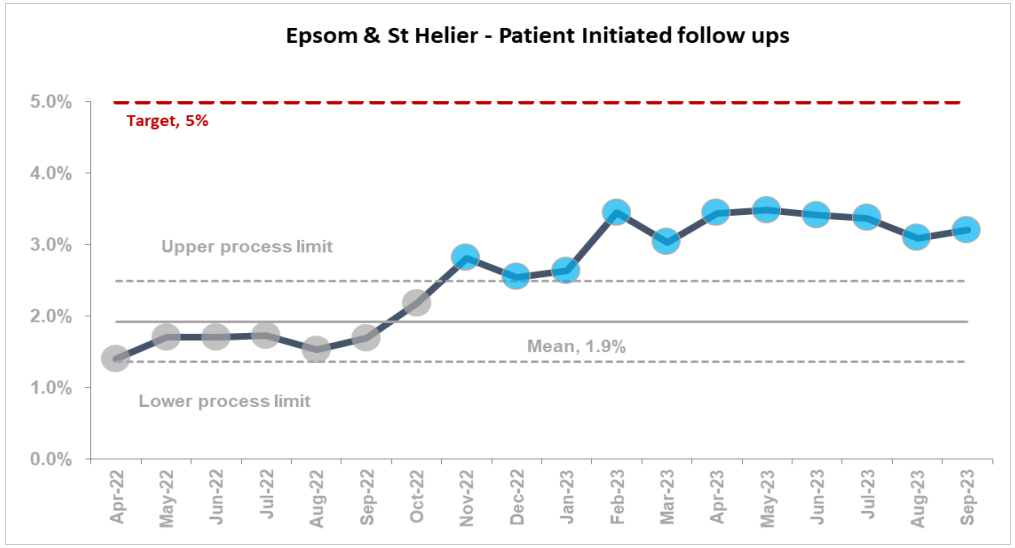
St George's, Epsom and St Helier University Hospitals and Health Group

Target: 5%	SGH: 0.3%

Target: 5%	ESTH: 3.2%

Reported one month in arrears in line with NHSE reporting





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.

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 remains above the upper control limit. PIFU continues to be encouraged in specialty business meetings and plans in place to increase further to meet the 5% target.

Advice & Guidance

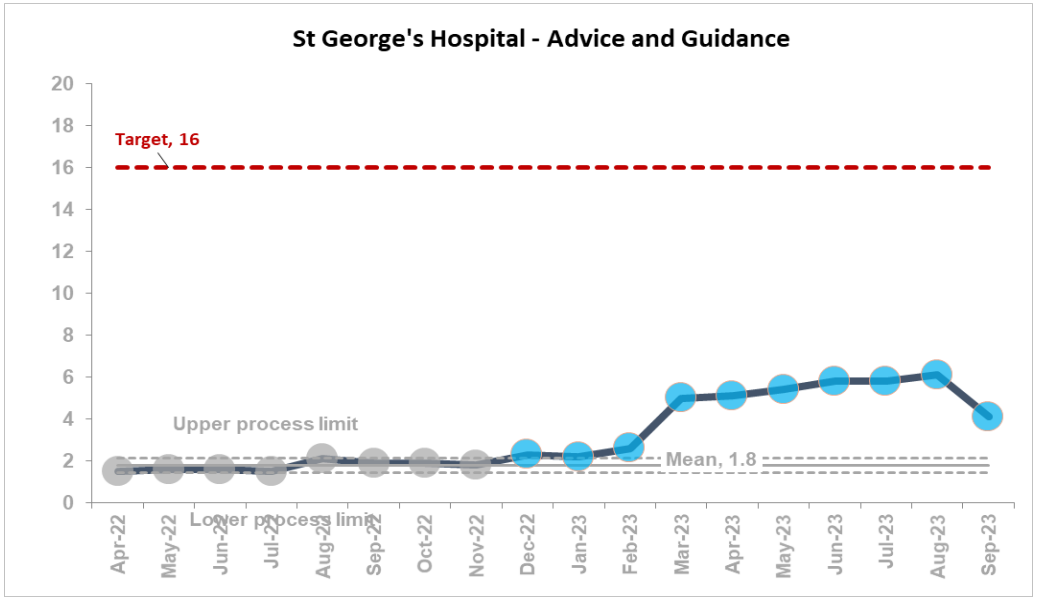
Utilisation of Specialist advice – Number of Processed Requests rate per 100 Outpatient First Attendances

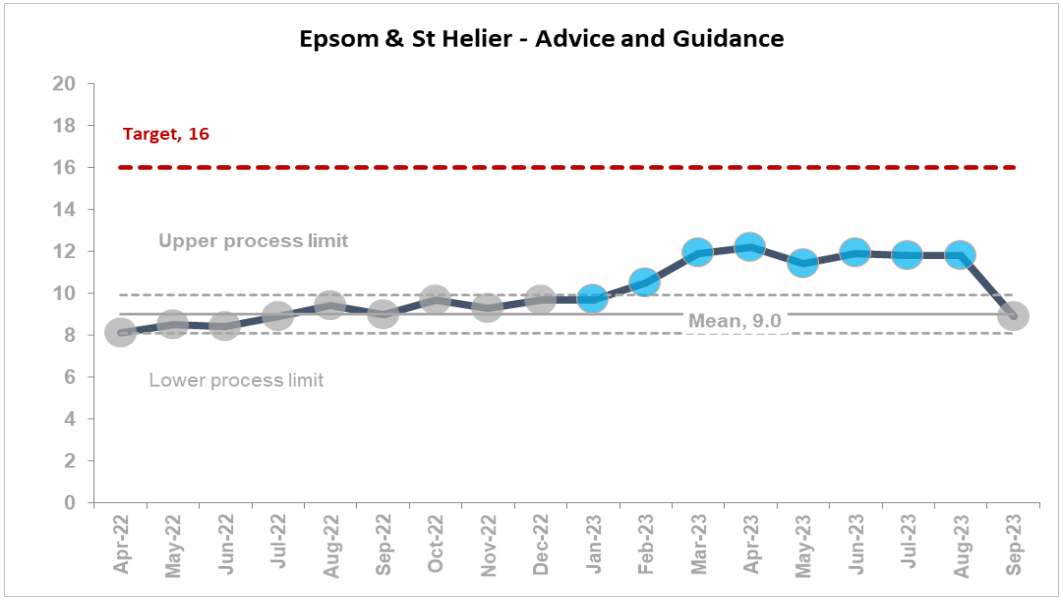
St George's, Epsom and St Helier University Hospitals and Health Group

Target: 16	SGH: 4.1

Target: 16	ESTH: 8.9

Reported one month in arrears in line with NHSE reporting based on FLEX data





SGH updates since last month

The above data only counts activity conducted through ERS A&G portal. Many St Georges services provide specialist clinical advice via requests submitted to ERS via the referral route, i.e. utilising the RAS and CAS queues. SWL have agreed in principle that this data should be included in the A&G activity reported. We have monthly meetings with primary care and our Deputy CMO has been discussing ongoing improvement actions with care groups.

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.

Outpatient Activity - Analysis and Action

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

SGH current issues –

PIFU – A process has now been embedded to capture PIFU data. IT support on the floor supporting the new process with services and SOP being finalised. Therapies are due to be our next service to launch this in

A&G – SGH still awaits sign off from the SWL sector to support submission of our RAS activity being recognised and reported. Some specialities are also struggling to identify dedicated resource within current job plans to A&G

DNA rates – Rates have improved slightly, reduced by 1.8% within two months. Services have been leading on DNA audits and findings show that after contacting approx. 9300 patients. With an average response rate of 31% - the most common themes were patients not having received a text or letter to tell them their appointment was happening (58%) and patient trying to contact the hospital to rearrange an appointment but being unsuccessful in getting through to a staff member (28%).

SGH future action –

Outpatient Transformation Board key workstreams for winter resilience planning:

Addressing protecting and expanding elective capacity self-certification – we have 12 step action plan and continue to deliver to this. 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

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 (100% completed – Passed!), ENT(90%) and Therapies (95%) –Gastro, Derm, Cardiology and Gynae in motion

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 has been delayed by a number of issues including resourcing, IT design timelines and RTT conditional logic within the system. Decision for new role out date to be discussed on 16th November, most likely January due to IT support across December and amount of change engagement required.

DNA audits – We had very positive feedback about the benefit of our MOTS following our audits. Services felt it allowed them to maximise text message reminder and carry out the letter mapping exercise. Number of call centre improvements to be made e.g. adding 'Did you know you can reschedule online?' message.

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.

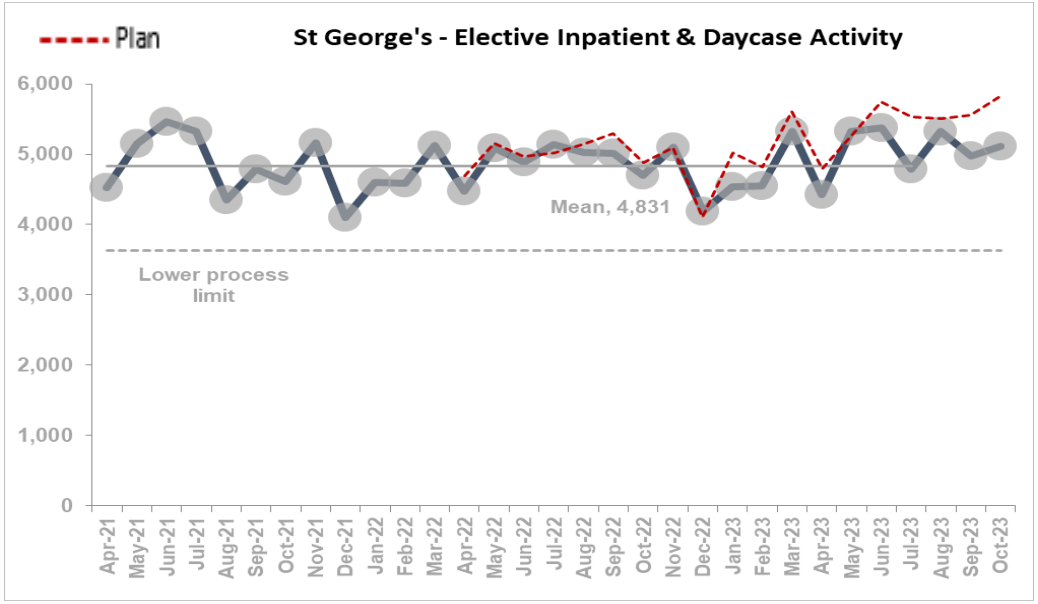
A&G / Pathway review / Referral Forms -The Quick View programme continues. Gastroenterology has been presented at the Gastroenterology SWL Clinical Network. The meeting for the initial Respiratory Quick View has now taken place. The initial draft is now being reviewed by the wider Respiratory clinician group at ESTH. Gynaecology and Endocrinology are the next set of Quick views scheduled for development Nov/ Dec.

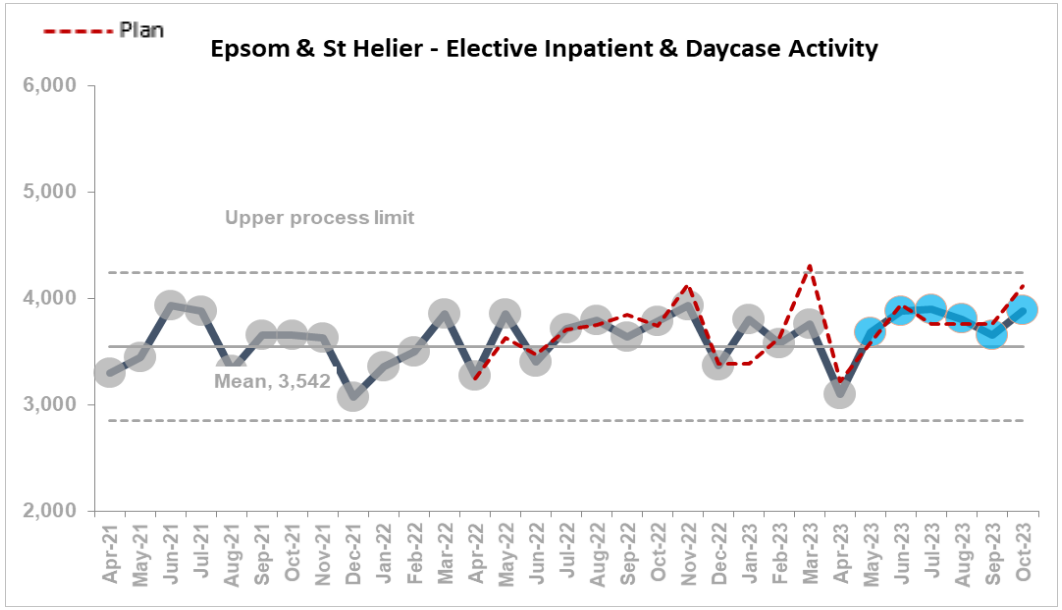
A Neurology triage support pack has been created to reduce the amount of clinician time required to respond to inappropriate referrals and to support equitability of advice provided to GPs.

Elective Inpatient & Daycase Activity

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

SGH Plan: 5,828	SGH: 5,114	ESTH Plan: 4,117	ESTH: 3,882





SGH updates since last month

Elective and Daycase performance is behind plan for October and YTD behind plan by 2,899 cases.

ESTH updates since last month

For the month of October elective activity is currently below plan. This is expected to further increase once data catch up / coding is completed. Activity levels across the last six month period have been above mean.

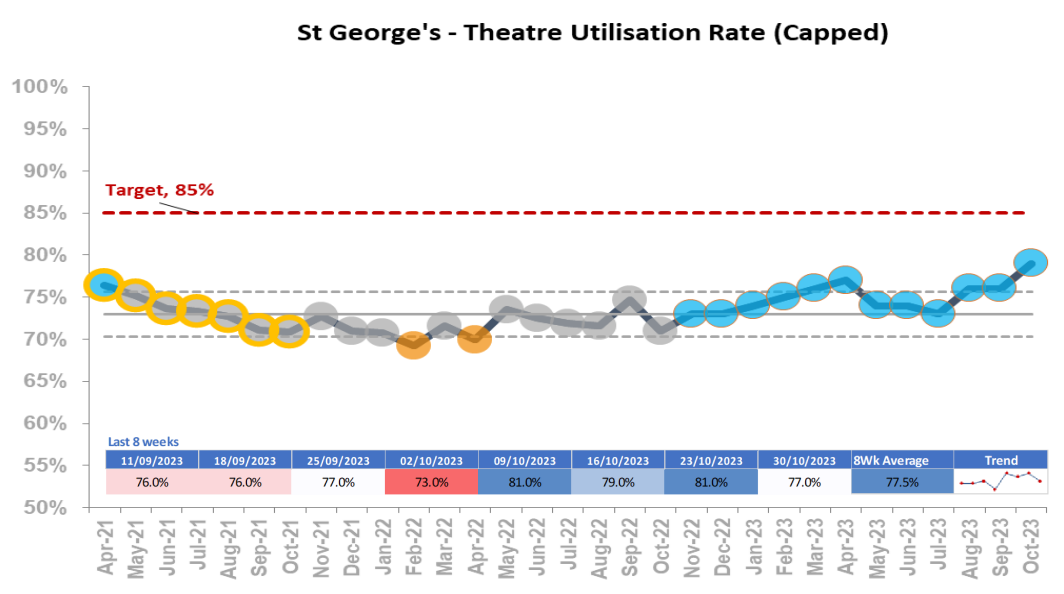
37

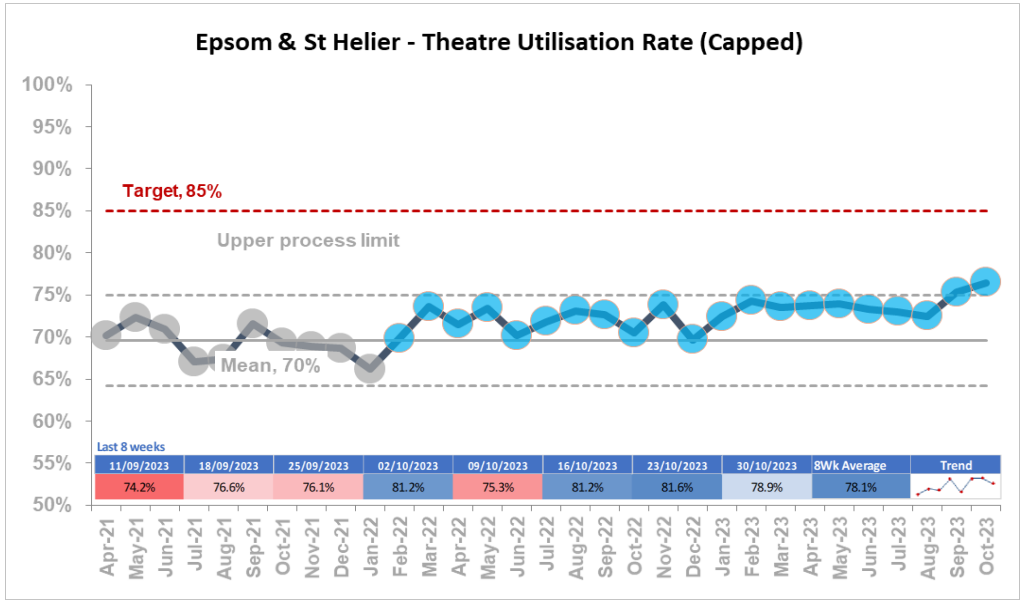
Theatre Productivity – Capped Utilisation

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: 79%	Target: 85%	ESTH: 76%





SGH updates since last month

Capped theatre utilisation rates increased above the mean in October, achieving 79% with plans to improve further across all theatre suites.

Uncapped utilisation rates are currently at 83%.

ESTH updates since last month

Capped utilisation figures increased to 78.7% in October, performance is above the upper control limit showing special cause variation of improvement.

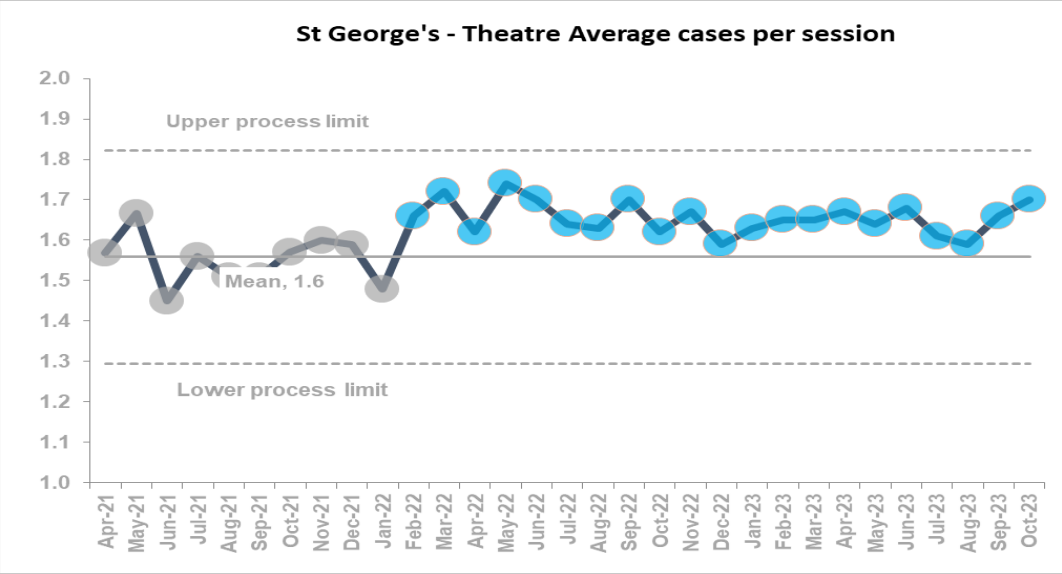
Uncapped utilisation rate in October increased to 82.4%

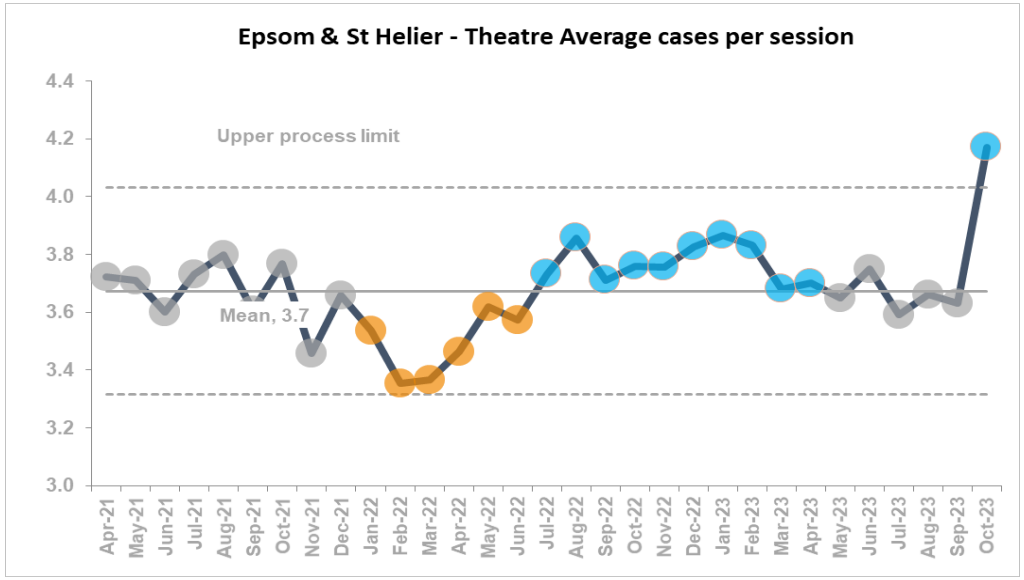
38

Theatre Productivity – Average Cases per Session

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

Target: TBC	SGH: 1.7	Target: TBC	ESTH: 4.17





SGH updates since last month

Theatre cases per session performance remains above the mean of the 2019/20 baseline, with on average through October 1.7 average cases per session, this reflects the complexity of our case mix compared to ESTH.

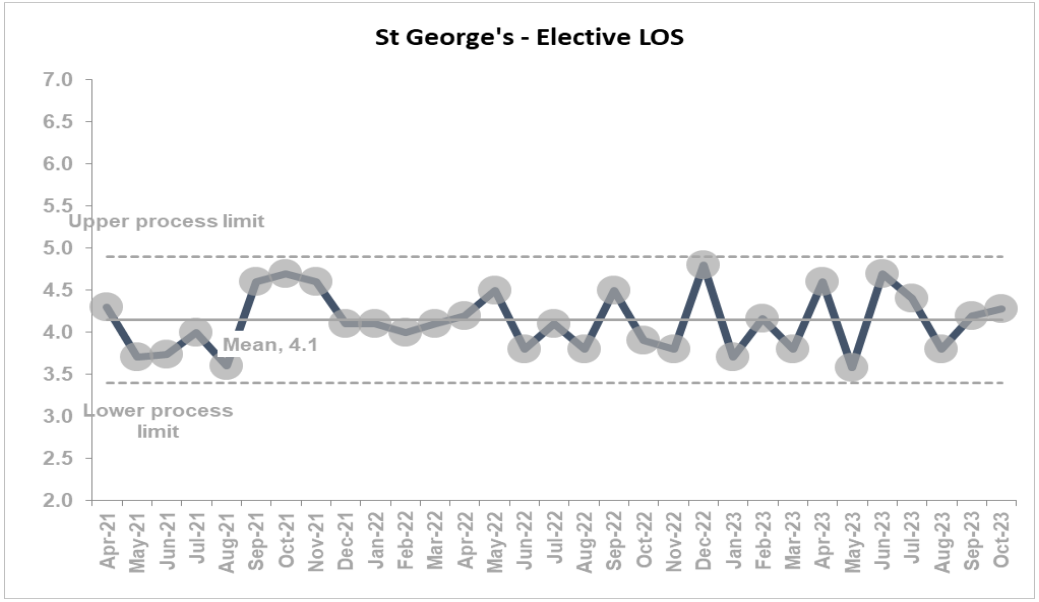
ESTH updates since last month

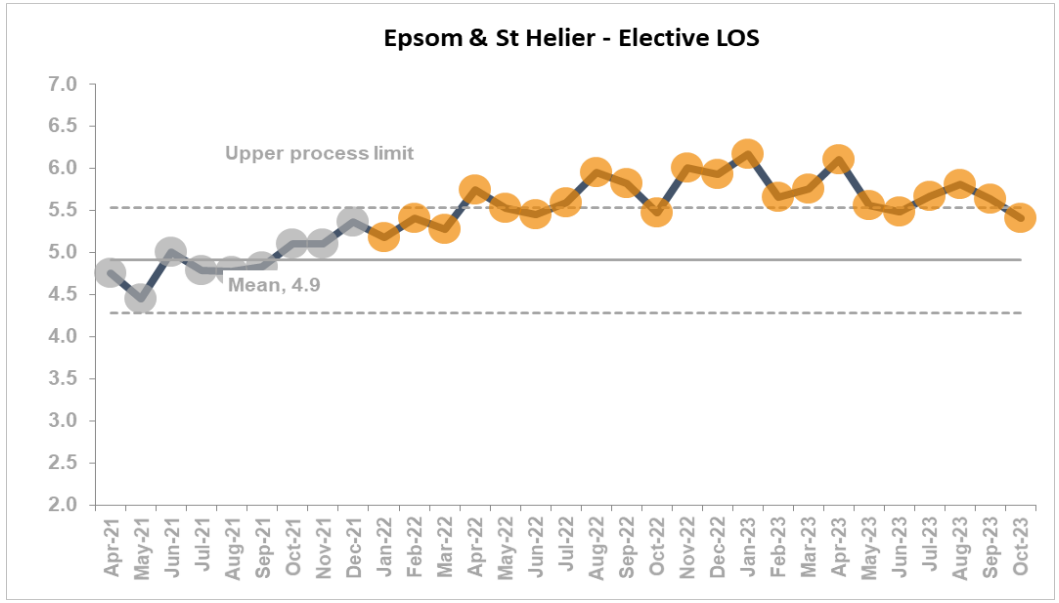
Average case per session in October positively increased to 4.17 cases per session performing above the upper control limit.

Elective Length of Stay

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

Target: N/A	SGH: 4.3	ESTH: 5.4





SGH updates since last month

Elective length of stay remains 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 October the average length of stay was 5.4 days.

40

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 in the first week of October, impacting available capacity, Theatre utilisation, number of 4 hour sessions delivered and cases completed.

Issues related to patient flow impacting productivity in Neurosurgery due to the requirement for ITU post-op.

Essential estates works required at QMH STC, with two downtime options being explored. Working to be carried out in early Summer 2024.

SGH future action -

In October, capped theatre utilisation was 79%, which was 3% above the previous month. Uncapped utilisation was 85%. The average case per session continues above the 2019/20 baseline at 1.7.

Scheduling: continued focus on scheduling, particularly 642 escalation processes to ensure fully booked theatre lists. Weekly deep dives into sessions capped utilisation below 65%.

Reporting: 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.

Planning: Implementation of new theatre timetable to improve access to robotic surgery and restore cardiac surgery operational footprint.

Service developments: Planning underway for the Theatre Transformation Programme, focusing on productivity, quality, patient safety and OD.

ESTH current issues –

- Performance challenges have been driven, in the main, by a difference in planned vs actual utilisation across the following specialities: Gynaecology, T&O, Dental, Ophthalmology, Pain and Urology.
- Detailed below are the key agreed mitigating actions by speciality.

ESTH future action –

Gynaecology: Issue: Demand for Egg Retrieval lists is unpredictable and can only be scheduled 48 hours in advance. In addition there are booking challenges with lists due to the + (plus) – (minus) procedures.

Identified cohort of approx. 90 patients to be contacted to come in at short notice to support any gaps in the egg lists, Commenced Monday 22 October.

Service commenced scheduling to revised procedure times – commenced Monday 22nd October.

Dental: Issue: Lists regularly impacted due to high number of short notice cancellations.

Commenced overbooking of lists to 6 cases to mitigate short notice cancellation impact with the aim to keep 5 cases on the date. Monitored at the daily Theatres huddle

T&O & Pain: Issue: HVLC injection lists impacted due to estates constraints, this results in the capping of lists and subsequent underutilisation. Pain list utilisation is also affected as a result of the required downtime between cases for clinical administration.

Completed initial review of theatre allocations on 25th October and agreed core principle to update theatre floorplan and reallocate specialties within the appropriate setting to ensure optimal utilisation.

Further bench marking to be undertaken and commenced exploring plans to relocate T&O and Pain injection lists into an outpatient setting in line with GIRFT.

Ophthalmology: Issue: Opportunity to increase the number of cataract cases per list in line with GIRFT recommendations.

Agreed to book 7 or 8 slots dependent on consultant. Whilst bilateral patients to be kept at 2 slots , the clinical lead has agreed that we do not need to allocate extra slot to a higher score patient which is expected to improve the overall utilisation of the list.

Urology: Issue: TB Biopsy lists capped at 6 cases which results in underutilised list between 70% - 75%.

Plans in progress to transfer Template biopsy list to an outpatient setting from Jan 24, in line with GIRFT recommendations. Booking rules revised to schedule to 5x biopsy + 1x flexi or 1x open case to support improve list utilisation.

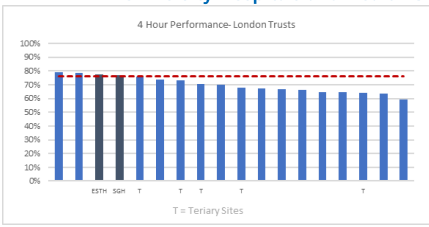
Monthly Overview – Non Elective Care

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

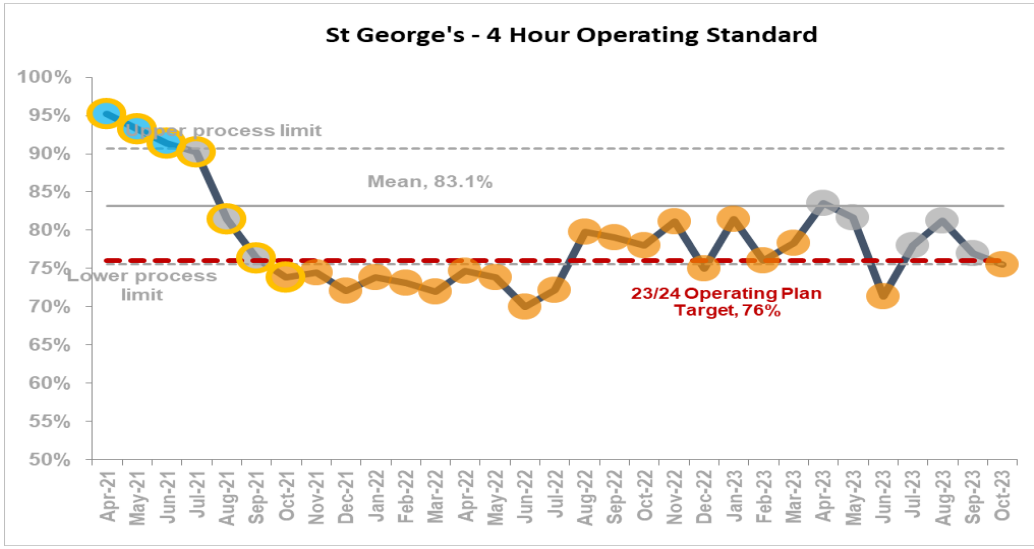
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	76%	81.3%	77.0%	75.5%	76%	78.7%		76%	77.7%	77.3%	76.1%	76%	76.5%	
Emergency Department LOS >12 Hours		833	1049	1145		6792			1762	1788	1837		11942	
12 Hour Trolley Waits	0	372	530	755	0	3544		0	538	462	551	0	2471	
Ambulance handover Performance 30 minutes	0	25	19	111	0	371		0	315	338	425	0	1663	
Ambulance handover Performance 60 minutes	0	46	158	35	0	441		0	149	120	107	0	646	
Non elective length of stay		6.7	6.4	6.8		6.87		TBC	7.6	7.5	7.0	TBC	7.55	
Mental health delays 4 Hour Breaches		130	131	101		831								
Redamission Rate - Non Elective		11.3%	9.5%	9.6%		10.7%		TBC	5.1%	5.7%	5.5%		5.4%	
Length of stay > 7 days (stranded)		330	344	392		369		TBC	319	312	310	TBC	302	
Length of stay > 21 days (super stranded)	172	140	159	168	172	161		123	132	137	128	114	128	
Overnight G&A beds occupancy - Adults	92.0%	95.7%	94.5%	97.0%	92.0%	95.6%		92.0%	89.9%	90.1%	93.0%	92.0%	90.6%	
Number of patients not meeting criteria to reside	83	94	99	100				104	177	178	181			

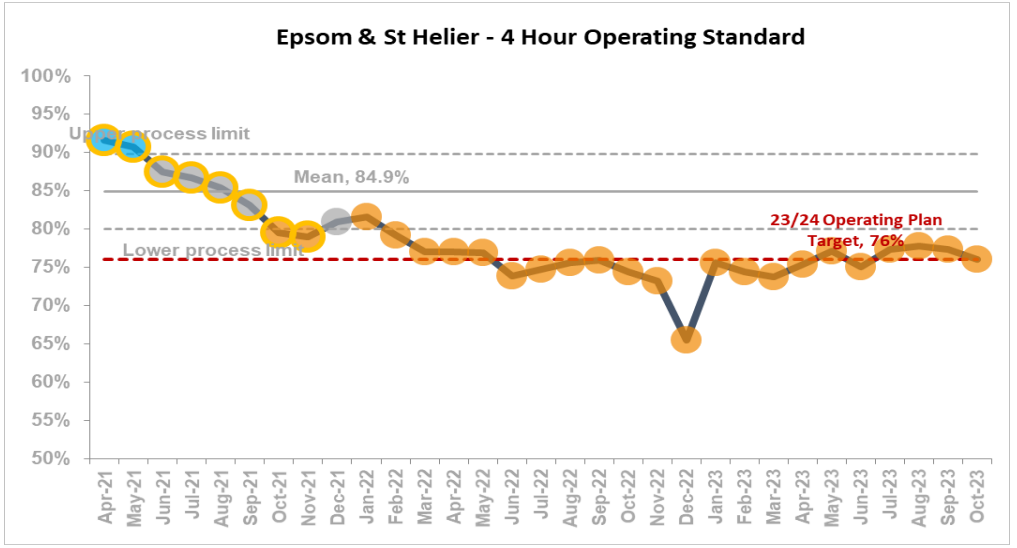
4 Hour Operating Standard

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



Target: 76%	SGH: 75.5%	ESTH: 76.5%





SGH updates since last month

4 hour performance dipped below the lower control limit with 75.5% of patients either admitted, discharged or transferred within 4 hours of their arrival. Monthly attendances are comparable to previous months however daily variation and days where attendances of more than 450 patients were seen along with high acuity (up to 60% of patients with a triage score of between 1-3).

ESTH updates since last month

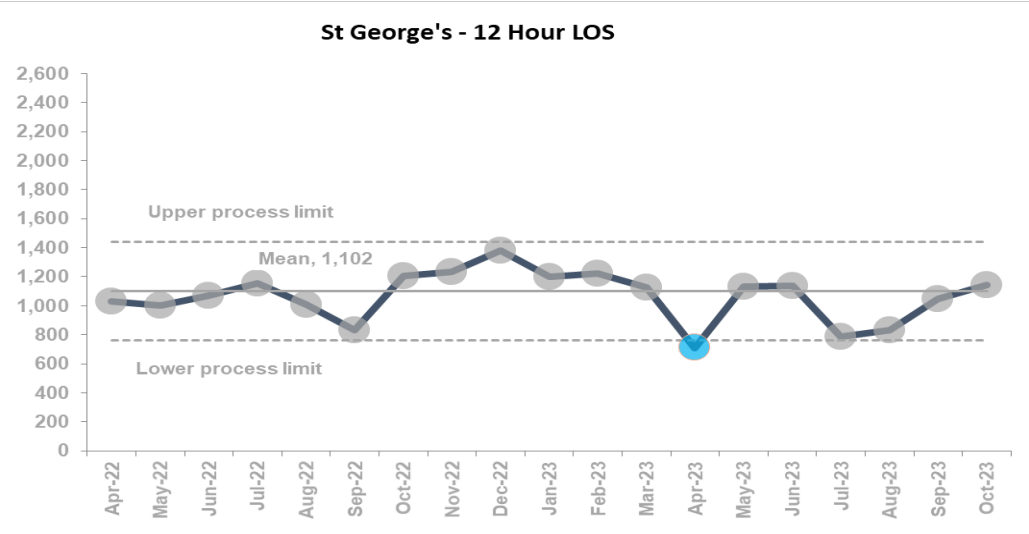
Across October 76.5%, of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival. Performance remains above the operating plan of 76%.

Emergency Department Length of Stay

Number of patients >12 hours from arrival to discharge

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

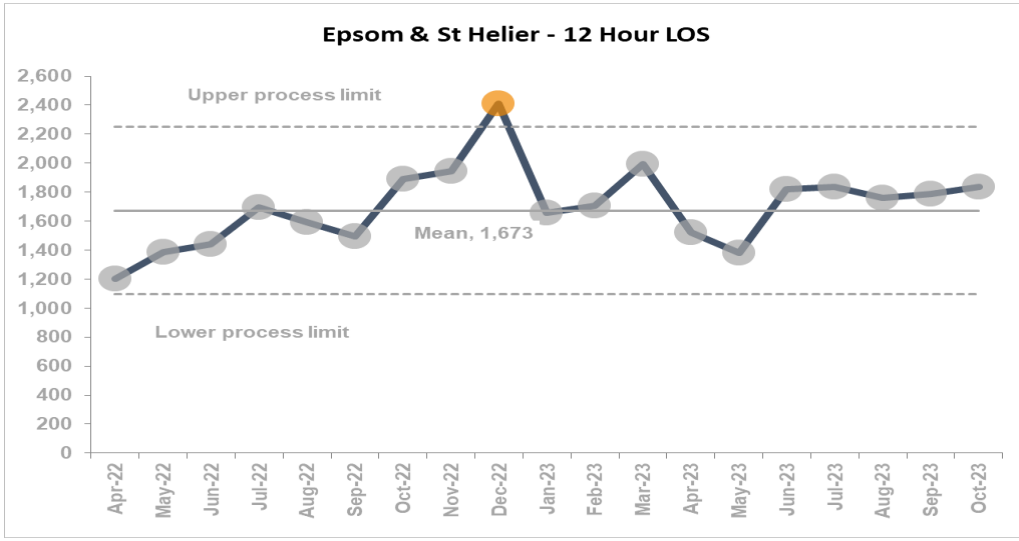
Target: TBC	SGH: 1,145



SGH updates since last month

Across the month 1,145 patents were reported to have spent more than 12 hours in the emergency department from their arrival. 12 hrs in ED is becoming a key metric for NHSE, Trusts and systems to track. Whilst numbers are significantly higher than we would like there are some data quality issues that are being addressed.

Target: TBC	ESTH: 1,837



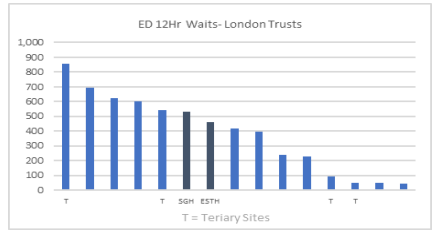
ESTH updates since last month

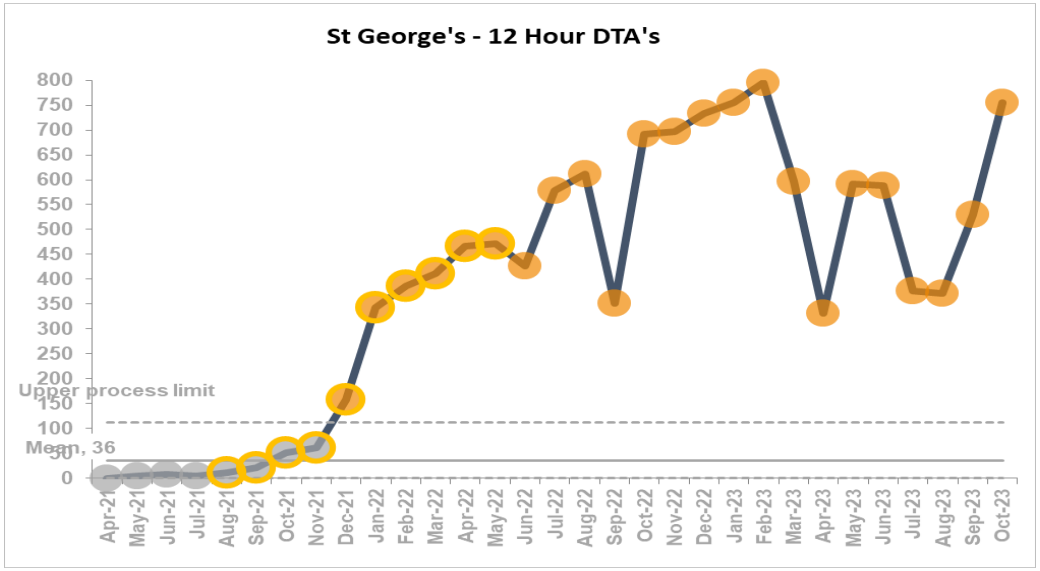
We continue to experience challenges in reducing length of stay in ED, with a significant number of patients waiting for an inpatient bed remaining in the emergency department. Length of stay in ED is also impacted by mental health patients waiting for transfer to a mental health inpatient bed.

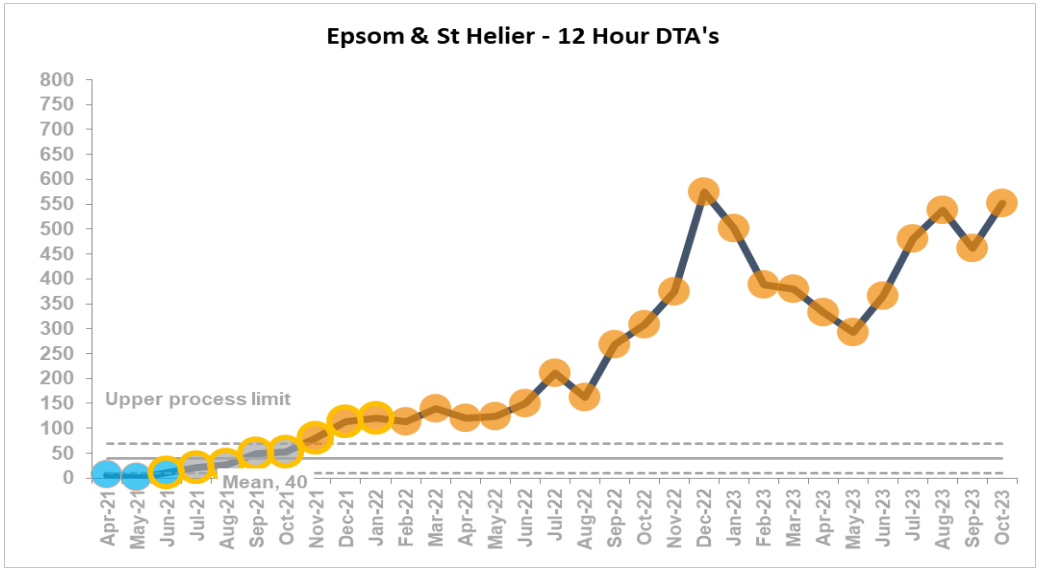
12 Hour DTA's

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

Target: 0	SGH: 755	ESTH: 551







SGH updates since last month

The number of 12 hour trolley wait breaches following decision to admit increased throughout October with on average 24 delays per day compared to 17 in September.

ESTH updates since last month

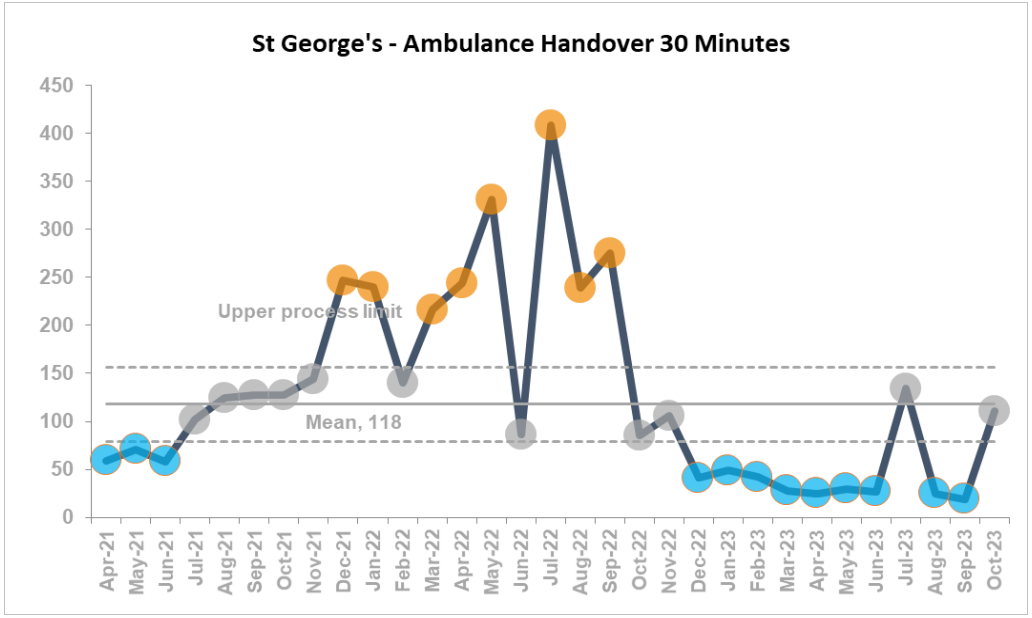
We are reporting 551 twelve hour breaches (up from 462 in September).

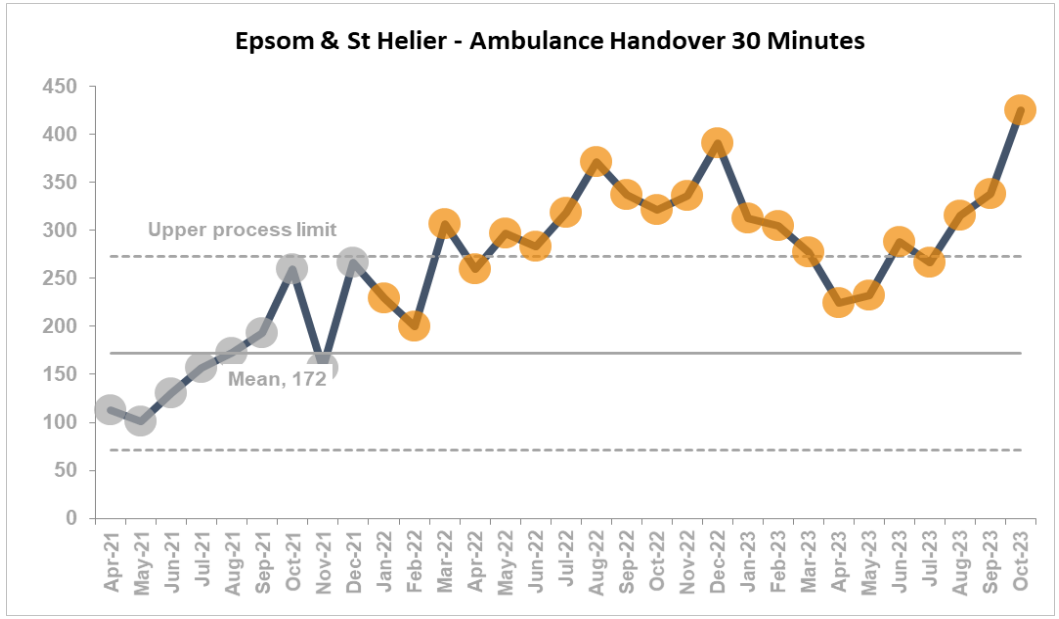
This metric will not be included in the report from next month as replaced by the total time in dept metric on previous slide, however, site teams will continue to monitor

Ambulance Handover Delays 30-60 minutes

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

Target: 0	SGH: 111	ESTH: 425





SGH updates since last month

Increase seen in the number of 30-60 minute delays through October (reduction seen in 60 minute) however performing within the upper and lower control limits showing common cause variation.

ESTH updates since last month

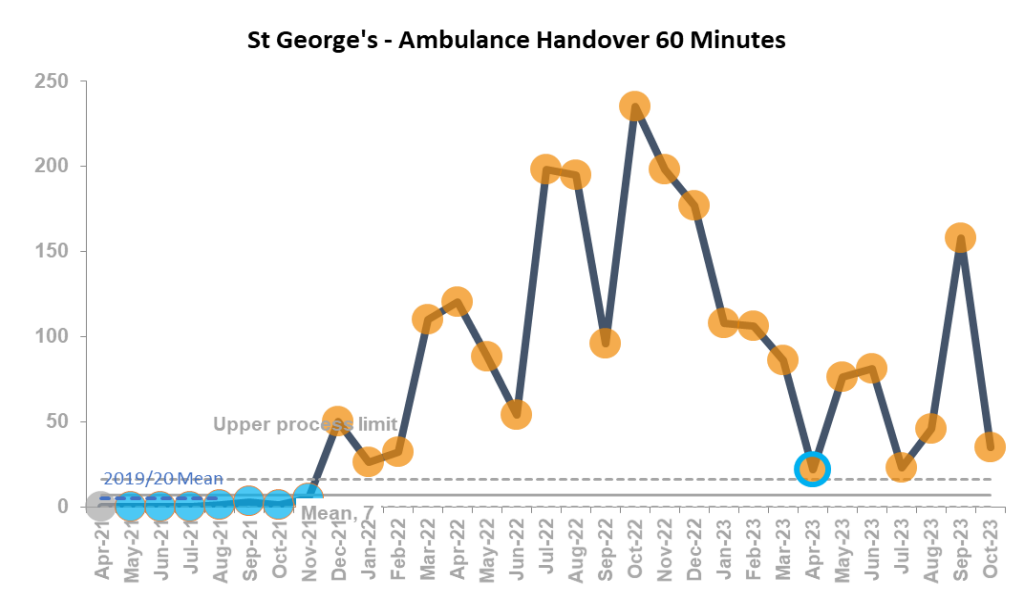
Performance against 30 minute handover delays remained above the upper control limit increasing through October, with on average 13 delays per day compared to 11 per day through September.

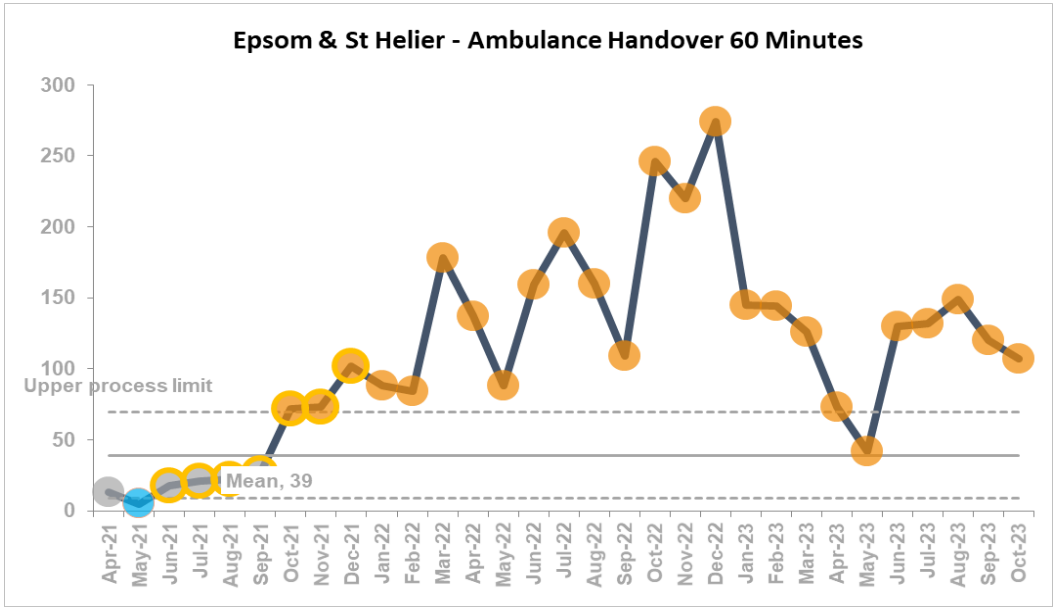
46

Ambulance Handover Delays 60 minutes

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

Target: 0	SGH: 35	ESTH: 107





SGH updates since last month

The number of patients delays for more than 60 minutes significantly decreased through October with 35 handover delays compared to 158 through September.

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ESTH updates since last month

60 minute handover delays remain high but decreased in the month of October, despite increases in over 30 minute delays.

Emergency Performance

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

SGH current issues –

Overall 4 hour performance (all Types) in October declined compared to September, closing the month at 75.5% which is slightly below the national target. This places SGH 3rd in London and 13th nationally for all type performance.

In October we achieved >90% non admitted performance for 8 days.

79% of LAS arrivals were offloaded <15 minutes during the month of October, which was a 10% decline in performance from previous month, this data is currently unvalidated and discussions have been had with ICB regarding the discrepancies in the current data. Work is ongoing with LAS to improve offload times, and reporting in line with the departments LAS SOP and surge team

Through October the department's ability to see patients in a timely way was extremely challenged, majority of the month the department have had between 30 and 55 DTAs limiting capacity, ED has received consecutive hours of >30 attendances per hour, Resus being over 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 –

Work ongoing with LAS to improve the timely PIN allocations ensuring factual breach and handover data for both LAS and the Trust.

ED are asking for support from the Trust to establish a cohorting nurse to support the cohort patients where LAS have declined cohorting.

HALO in place 4x per week, which is significantly improving LAS handovers, advising management where improvements could be made to facilitate more efficient handovers.

Enhanced boarding and cohorting continue to be business as usual across site. Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced.

Front of house clinician which commenced 11 September continues to assist with streaming patients to appropriate alternative pathways, improving timely investigations and analgesia.

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 > 76% against the ED 4-hour performance standard in Oct2023.

Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively, however, with a slight improvement in both metrics compared to the previous month. Time to triage continues to remain within the 15-minute standard at 12 minutes in Oct23, providing assurance that patients are seen soon after arrival in the department. The number of patients spending >12hrs in ED remains high, increasing to 9.3% in Oct23 compared to 8.6% in Sep23.

4-hour performance for admitted patients remains challenging, however, we are seeing earlier onward flow from ED through the proactive use of stretcher discharge lounge facilities and the implementation of boarding where appropriate.

Oct23 saw a high number of > 60-minute ambulance handover delays at 107, however, this is an improvement compared to Sep23 where we reported 120. On-going issues are reflective of challenging onward flow from the emergency department into downstream capacity with a requirement to implement 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 launched 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. We have seen a reduction in the number of > 1 hour ambulance delays since implementation, however, we are working with LAS to clarify the triggers for implementing LAS led cohorting. We will monitor progress over the next few weeks/months against a set of agreed KPIs

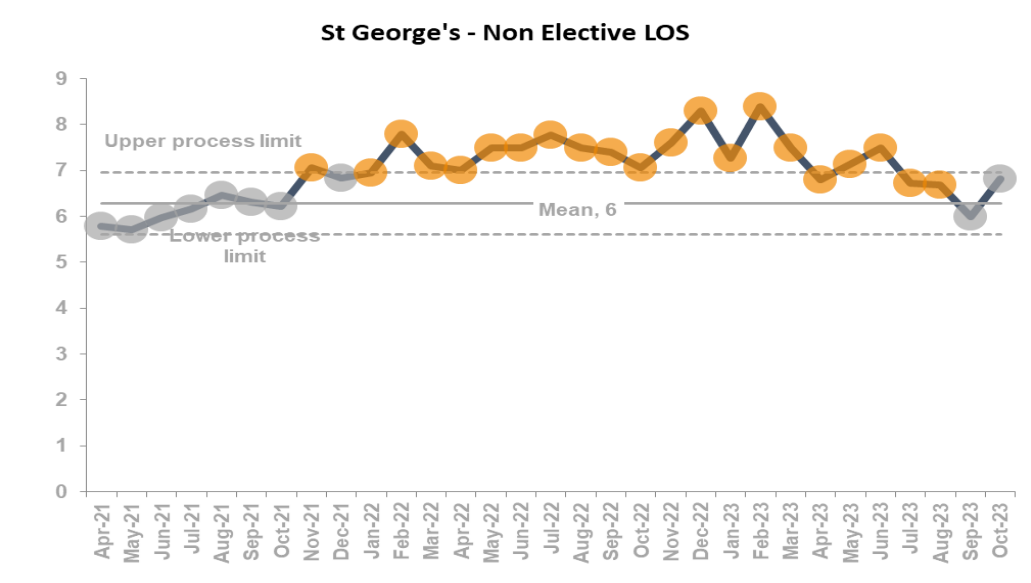
We are working with SWL and Surrey Heartlands who are leading programmes of work regarding the management of patients presenting in mental health crisis.

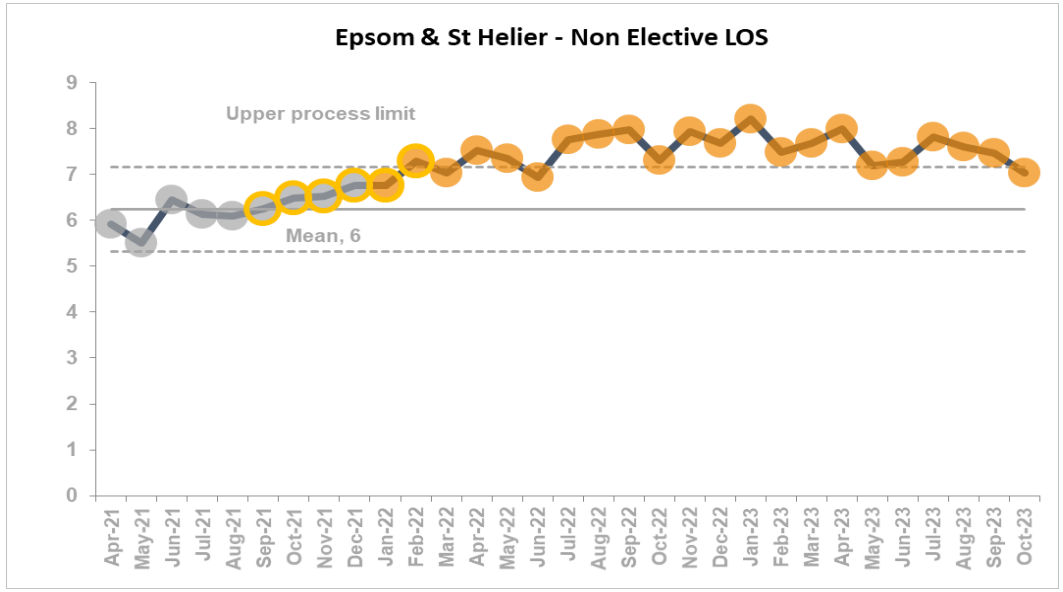
Alongside this we are reviewing our internal processes and resource to ensure that we are able to safely manage the increasing number of mental health patients presenting to both emergency departments. Following a new appointment to our urgent care transformation team we have met with internal stakeholders to agree additional areas of focus for inclusion in the work programme. Alongside the ambulance handover programme, we are also focusing on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC.

Non Elective Length of Stay

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

Target: TBC	SGH: 6.8	ESTH: 7





SGH updates since last month

Non-Elective length of stay although above the mean, remains below the upper control limit with on average patients staying in an hospital bed for 6.8 days. Both stranded LOS (>7 days) and super stranded LOS (> 21 days) increased across the month.

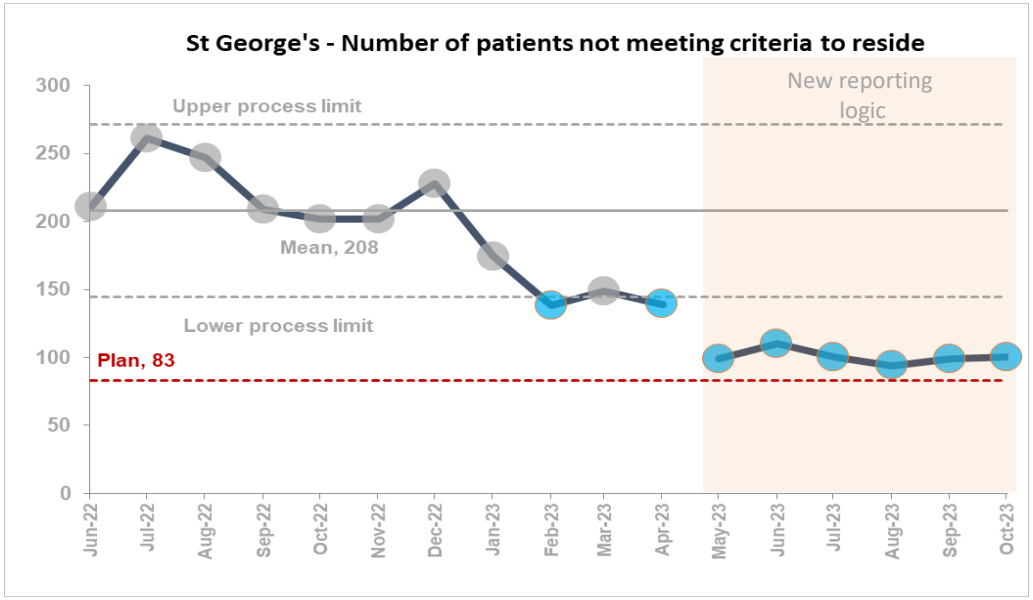
ESTH updates since last month

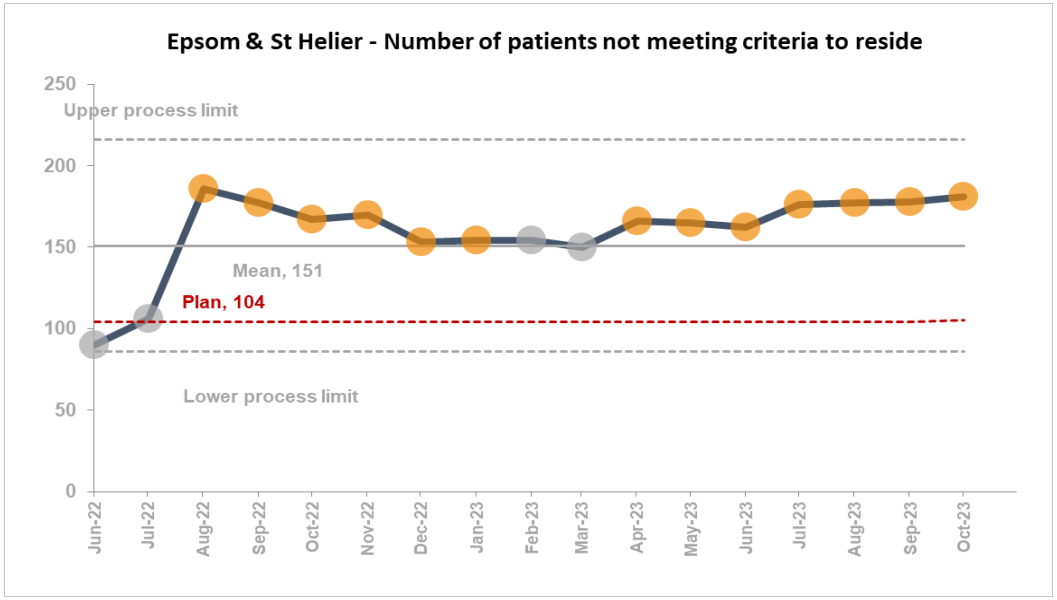
Non Elective length of stay has seen a downward trend in recent months moving below the upper control limit in October. On average across October patients admitted on non-elective pathways stayed for 7 days. The daily stranded (7 day LOS) super stranded patients (21 day LOS) decreased compared to September.

Patients not meeting criteria to reside

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

SGH Plan: 83	SGH: 100	ESTH Plan: 104	ESTH: 181





SGH updates since last month

October shows a slight increase in the number of patients not meeting the criteria to reside with on average 100 patients daily. The two areas with predominant delays are within Care Package (Social) - E1 and Residential home - Including interim (Social) - D1. The Trust is replacing Red2Green with the National Criteria to Reside tool for daily electronic tracking of all patients readiness for safe and timely discharge to improve patient flow and reduce length of stay. This will improve the recording and reporting of this metric.

ESTH updates since last month

The number of patients not meeting criteria to reside remains above the mean. On average there were 181 patients daily not meeting the criteria to reside in a hospital bed throughout October.

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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 which has allowed time lags throughout a patient journey to be captured, which in turn will support improvements in ensuring a more timely pathway. Ongoing industrial action has impacted performance, however there are no future strike dates planned at time of writing for medical staff and radiographers.

Cavell Ward partially reopened at the beginning of October and is now fully open and we are continuing to work with local partners to reduce delays in onward care to mitigate this reduction.
SGH board members visited Mary Seacole ward in October, Amyand had their 10th year anniversary and Caesar Hawkins (Respiratory ward) received Silver IPC accreditation.

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. Through October the ToC team also provided vital in-person support on the Wards 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 working with divisional teams to support 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 period commencing Monday 2nd October.

We are also focussing on those patients who are medically fit and are waiting for a ward-based action to progress discharge. Our therapy team undertake a daily review of these patients to ensure that associated actions are progressed as quickly as possible.

There is focus 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. We are working with Sutton Health and Care to support earlier opening of the unit with a plan to bring additional capacity on-line towards the end of November.

We have now completed a focussed review of our discharge coordinator personnel following 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.

gesh

Monthly Overview – Our People

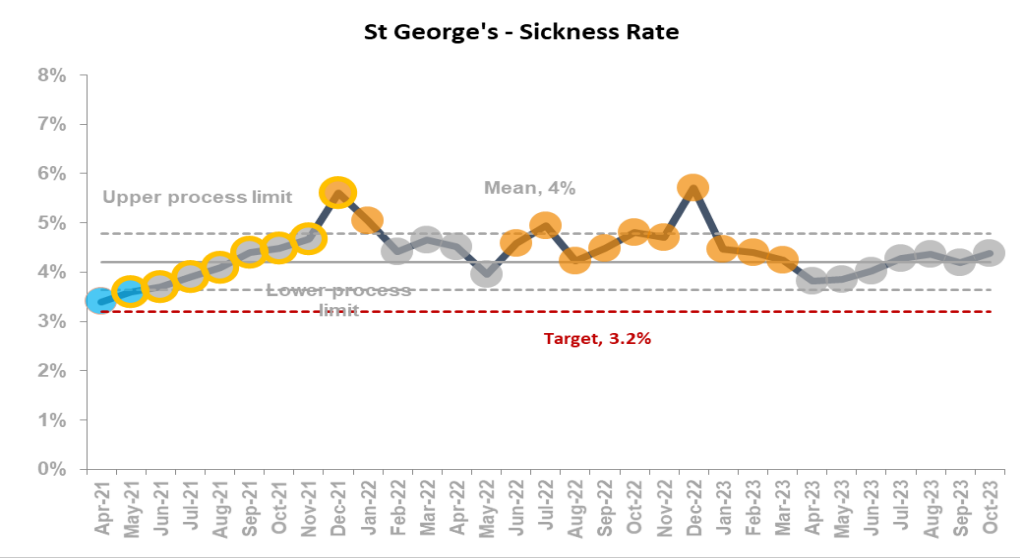
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

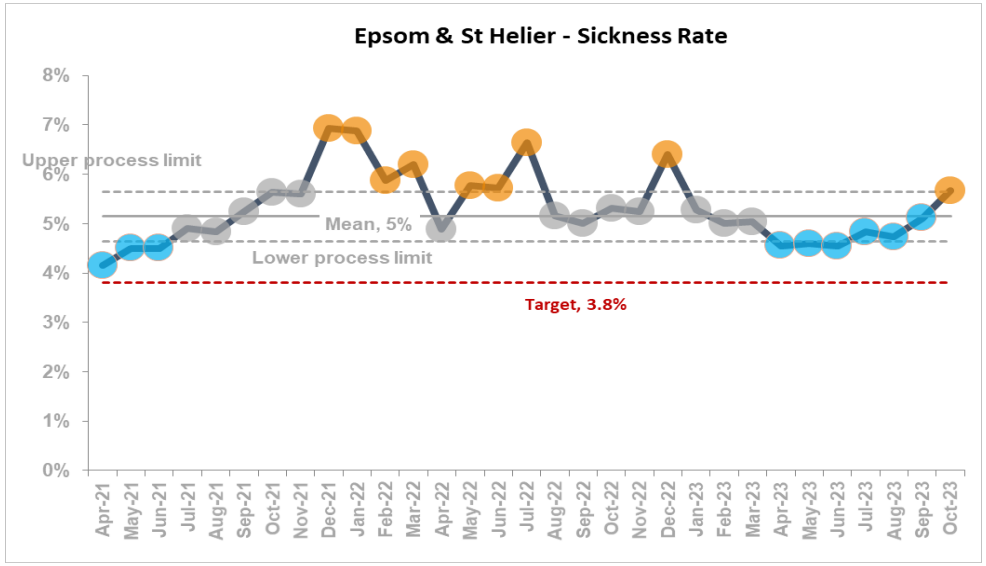
Our People	St George's							Epsom and St. Helier						
	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
Sickness Rate	3.2%	4.4%	4.2%	4.4%	3.2%	4.1%		3.8%	4.7%	5.1%	5.7%	3.8%	4.9%	
Agency rates	TBC	2.9%	2.0%	3.7%	TBC	3.0%		TBC	0.9%	1.6%	2.6%	TBC	2.6%	
MAST	85%	90.4%	90.6%	90.2%	85%	90.0%		85%	84.9%	84.2%	85.3%	85%	83.9%	
Vacancy	10%	9.1%	7.8%	6.7%	10%	8.4%		10%	12.9%	12.6%	12.1%	10%	12.8%	
Appraisal Rate Medical	90%	81.0%	77.9%	80.6%	90%	79.6%		90%	57.6%	91.2%	90.0%	90%	80.1%	
Appraisal Rate Non Medical	90%	71.5%	76.2%	77.7%	90%	72.2%		90%	61.3%	59.6%	66.0%	90%	64.3%	
Turnover	13%	14.6%	14.8%	14.7%	13%	14.9%		12%	14.2%	14.0%	13.5%	12%	14.6%	
Percentage BAME staff band 6 and above	TBC	44.8%	45.1%	44.7%	TBC	44.7%		TBC	38.0%	38.1%	38.1%	TBC	38.1%	

Staff Sickness Rate

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

SGH Target: 3.2%	4.0%	ESTH Target: 3.8%	5.7%





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 4.0% is above the target of 3.2%. and continues to show common cause variation.

ESTH updates since last month

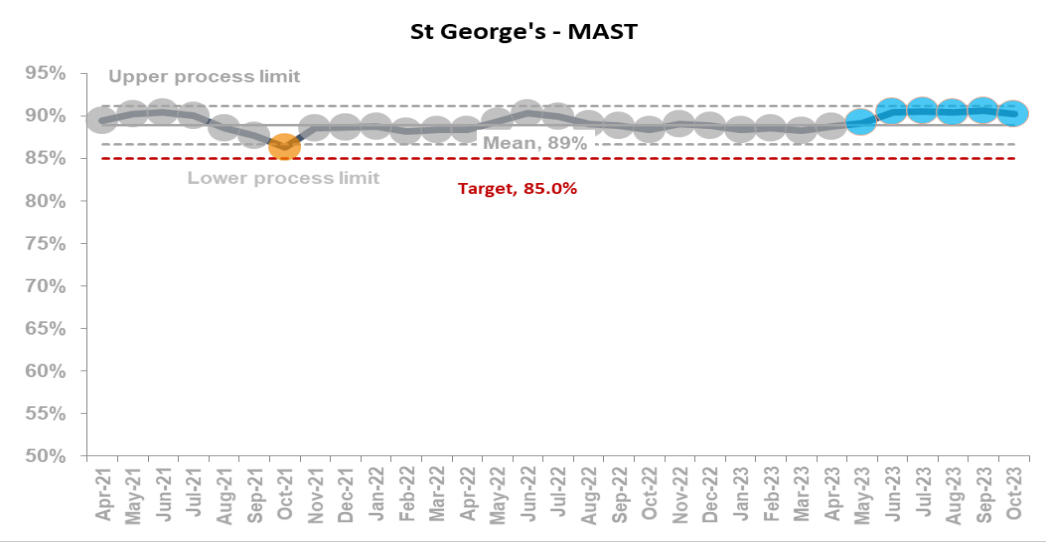
ESTH sickness absence increased by 0.6% to 5.7% against a KPI threshold target of 3.80%. and for the first time since April 23 is above the mean and shows special cause variation with a deteriorating position. 'Cold, Cough, Flu - Influenza' and 'Infectious diseases' were the top 3 reasons for sickness absence.

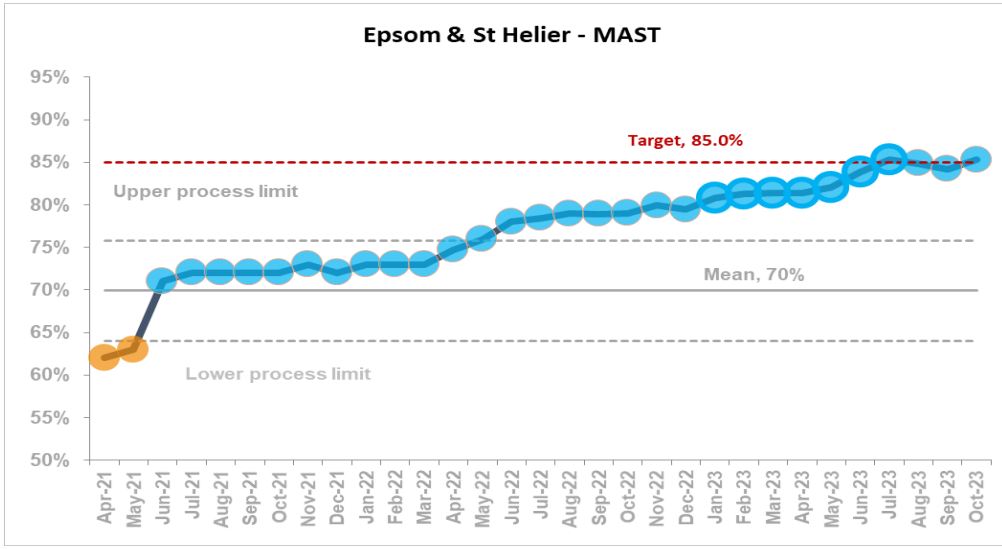
Long term sickness absence (episodes of sickness lasting 28 days or more) accounted for most of the sickness absence. 'Anxiety, Stress, depression - other psychiatric illnesses' was the most common reason for absence associated with long term sickness

Mandatory and Statutory Training (MAST)

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

SGH Target: 85%	90.2%	ESTH Target: 85%	85.3%





SGH updates since last month

Mandatory and Statutory Training (MAST) was 90.2% in October. The compliance rate continues to hold steady and has done so for the last year showing special cause variation with an improving position

ESTH updates since last month

Performance in October increased from 84.9% to 85.3% in October, showing special cause variation with an improving position. Performance against the MAST indicator is regularly discussed and 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.

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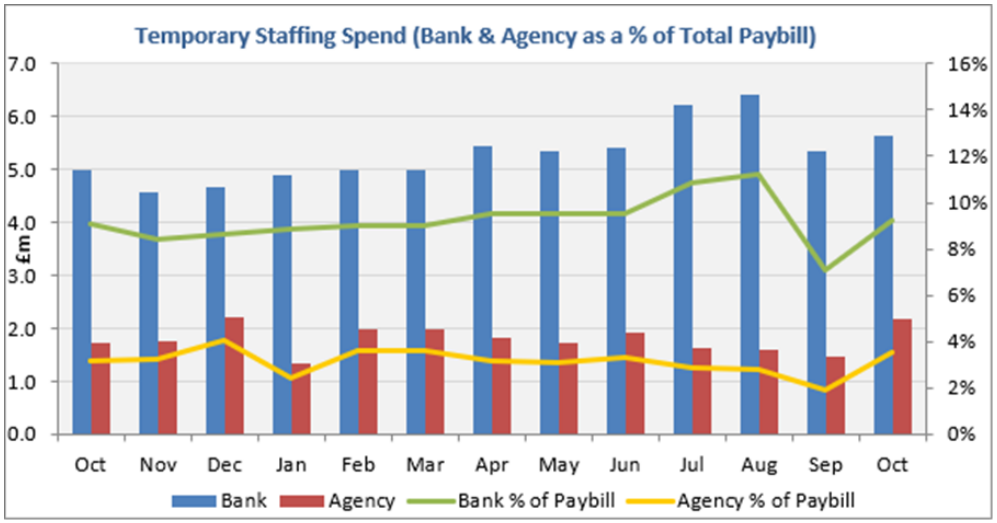
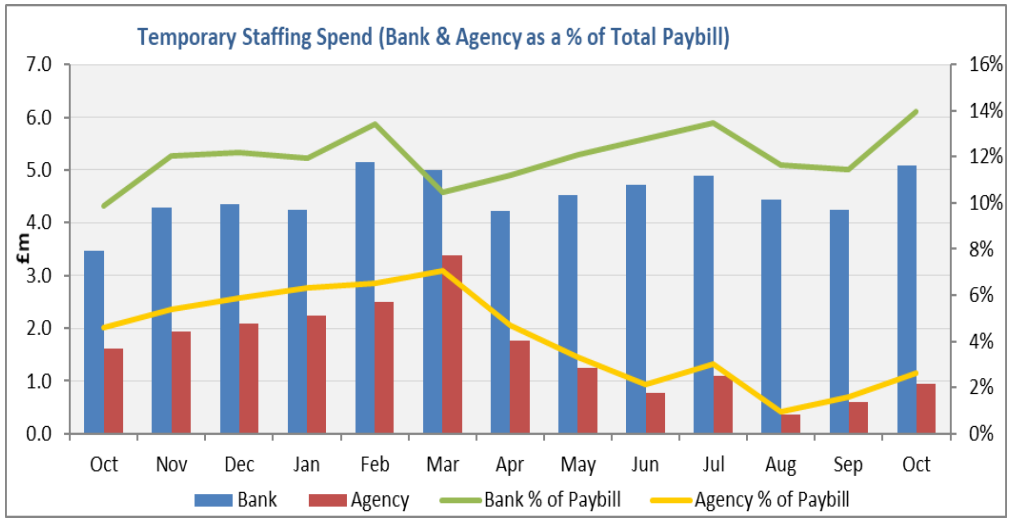
Agency and Bank Spend

St George's



Epsom & St Helier



Monthly Overview – Integrated Care

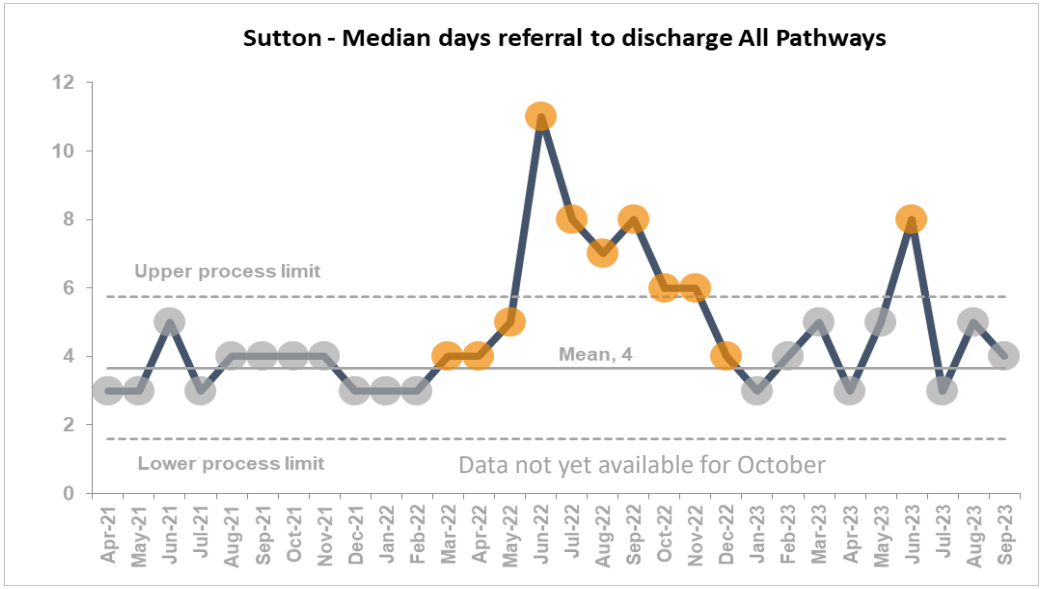
St George's, Epsom and St Helier University Hospitals and Health Group

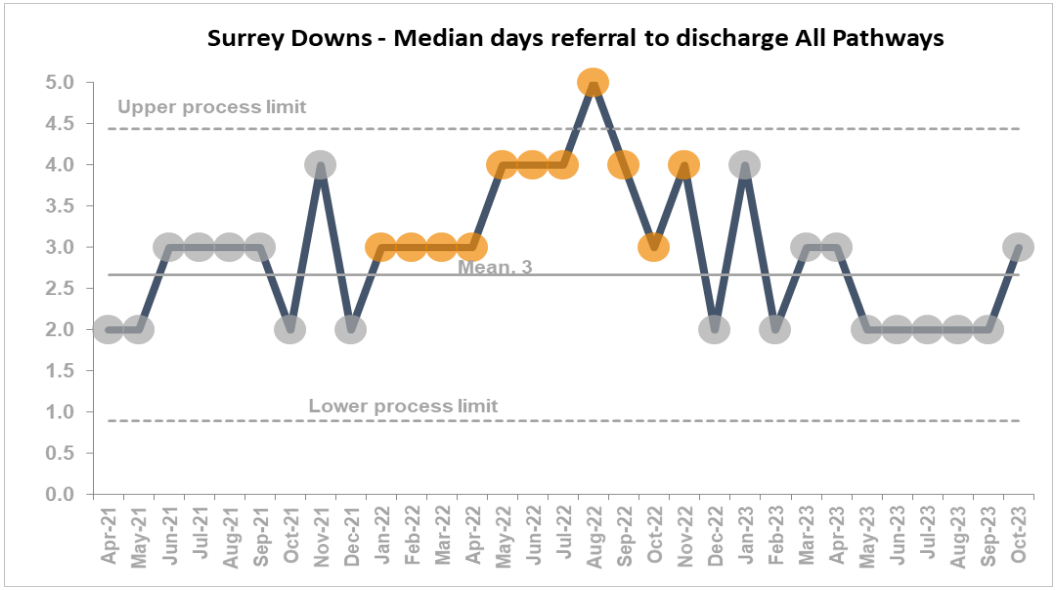
Responsive and Productive Services - Integrated Care	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Aug-23	Sep-23	Oct-23	YTD Target	YTD Actual	13-Month Trend
Median days referral to discharge All pathways		5	4	TBC		5			2	2	3		2	
Median days referral to discharge Pathway 1		4	3	TBC		4			2	2	3		2	
Median days referral to discharge Pathway 2		27	10	TBC		12			1	1	2		1	
Median days referral to discharge Pathway 3		18	12	TBC		13			12	15	13		17	
Two hour UCR performance	70%	87.7%	73.1%	76.3%	70%	82%		70%	84.8%	84.6%	81.7%	70%	82.8%	
Two hour UCR referrals received		187	219	249		1414			418	488	452		3079	
Community hospitals bed occupancy									84%	89%	91%		90%	
Community hospitals LoS									17	15	15		17	
Virtual ward - Admissions		200	186	244		1417			190	235	241		1632	
Virtual ward - Bed Occupancy	80%	33.8%	33.1%	33.0%				80%	64.4%	77.5%	79.0%			
Virtual ward LoS		2	2	2		2		14	4	3	4		8	
Total RTT Waiting List Size		1,326	1,207	1,182					626	599	607			
Total number of RTT patients waiting over 18 weeks		0	3	3					11	9	16			

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: 3 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.

Pathway 1 – Support to recover at Home; able to return home with support from Health and / or Social Care
Pathway 2 – Rehabilitation in a bedded setting
Pathway 3 - There has been a life changing event. Home is not an option at point of discharge from acute care.
EoL – End of Life

Surrey Downs Health & Care updates since last month

Median days from referral to discharge was 3 days in October , owing to winter pressures. Pathway 3 continues to have the highest referral to discharge time of 13 days through October. Pathway 2 median time is 2 days and pathway 1 three days

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

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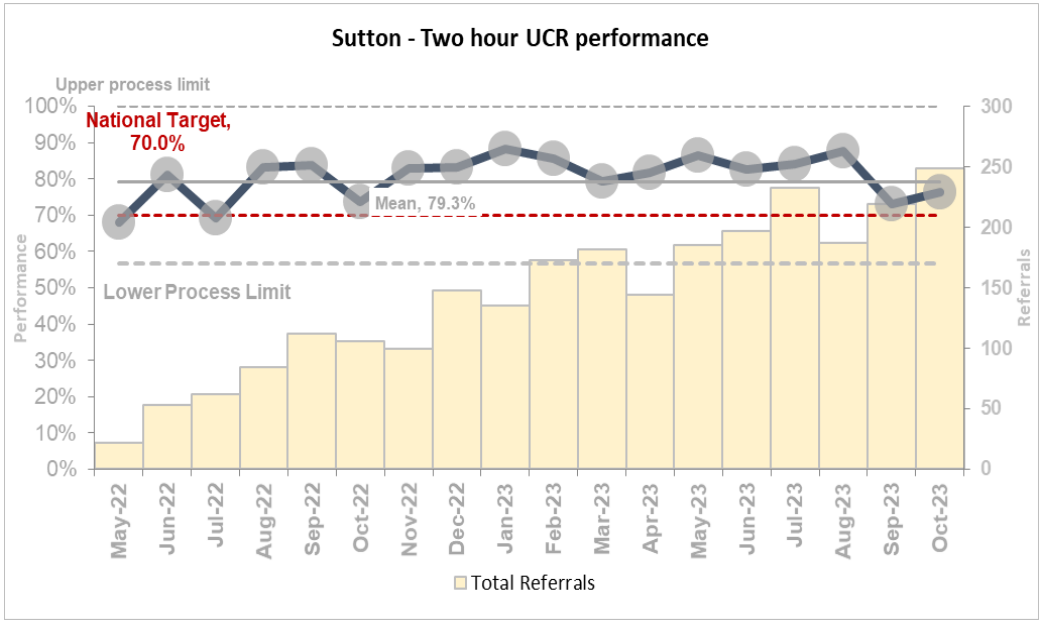
Ageing Well

2 hour urgent community response

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

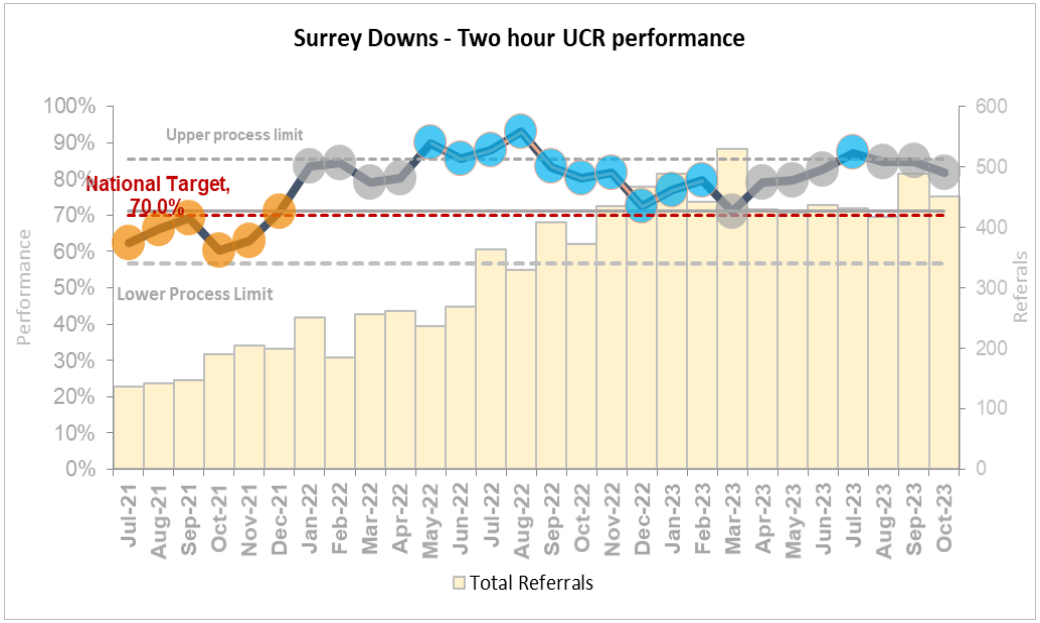
Sutton Target: 70%	Actual: 76.3%



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, remains below the mean for a consecutive month with a performance of 76.3%.

Surrey Downs Target: 70%	Actual: 81.68%



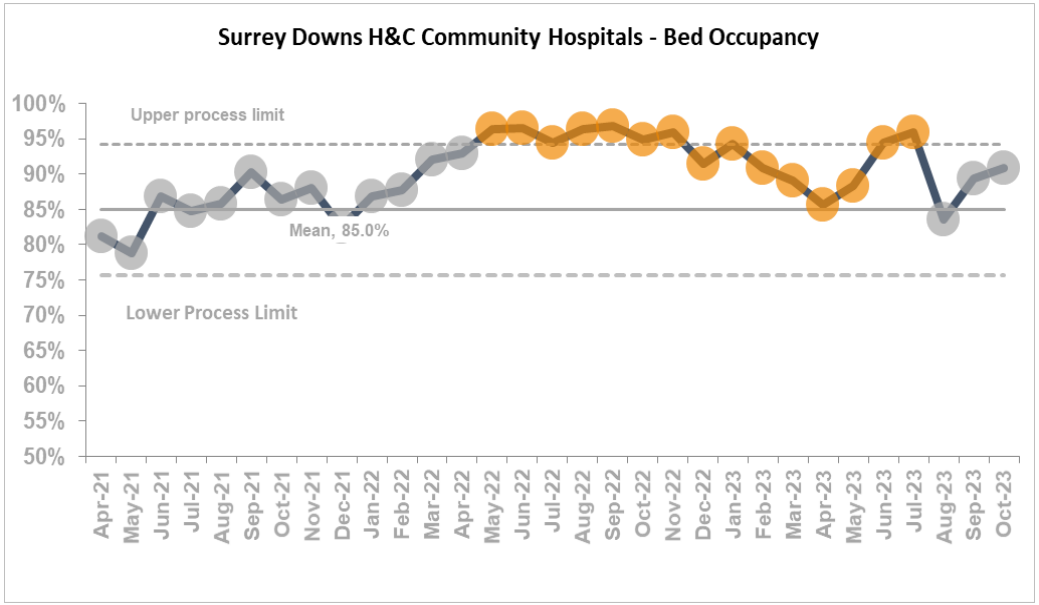
Surrey Downs Health & Care updates since last month

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, although seeing a decrease through October reporting 82%

Surrey Downs Health & Care
Bedded Care

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

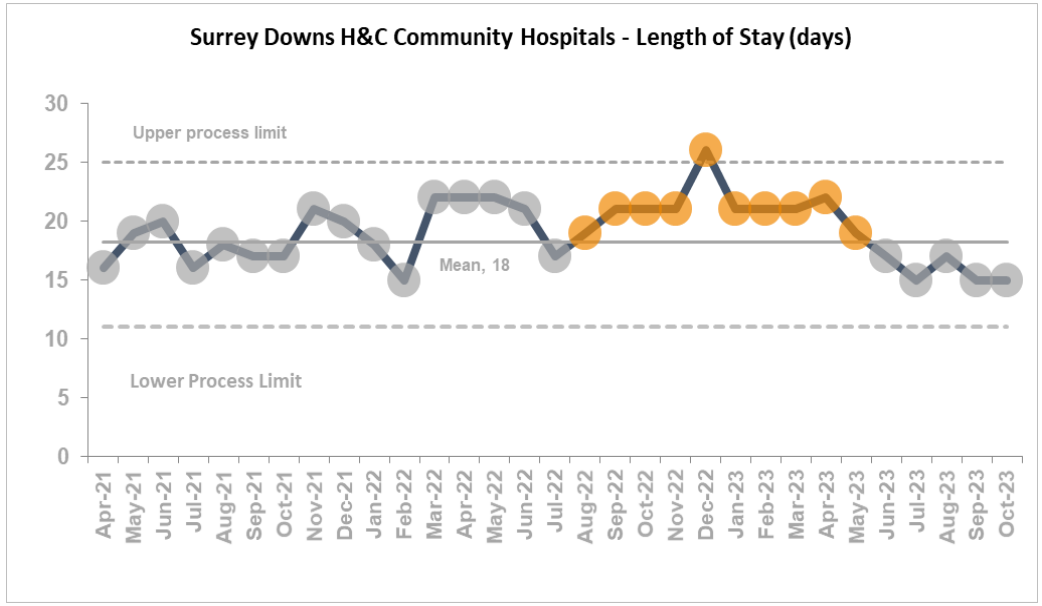
Bed Occupancy	Actual: 90.8%



Surrey Downs Health & Care updates since last month

SDHC runs 3 bedded units. Bed occupancy increased to 90.8% in October remaining within the upper and lower control limits however returning above the mean.

Length of Stay	Actual: 15 days



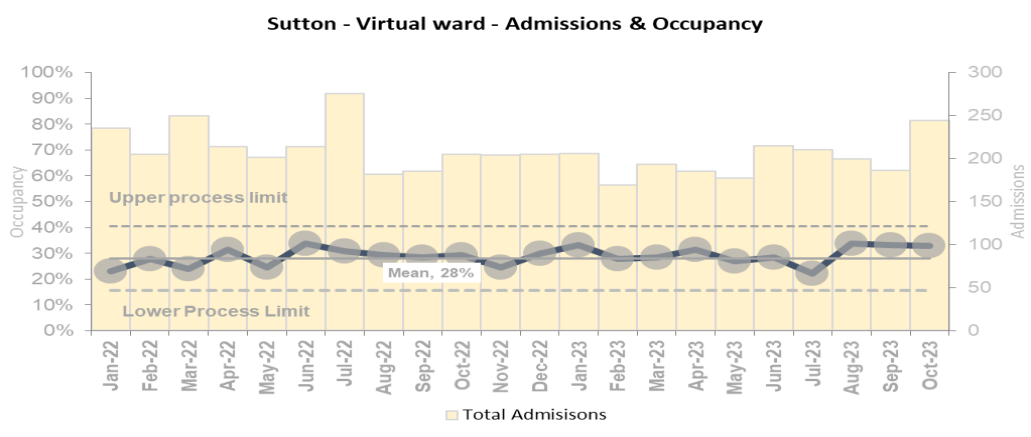
Surrey Downs Health & Care updates since last month

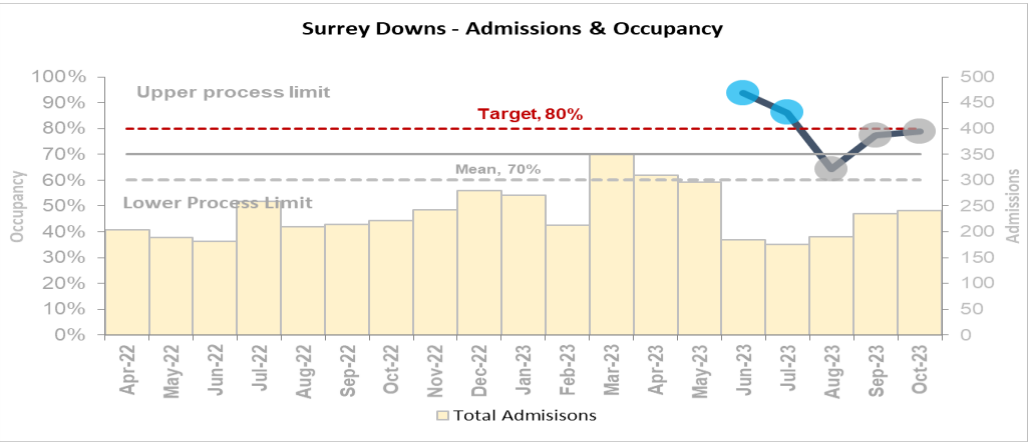
Length of stay in October was on average 15 days showing common cause variation and below the mean for the fifth consecutive month.

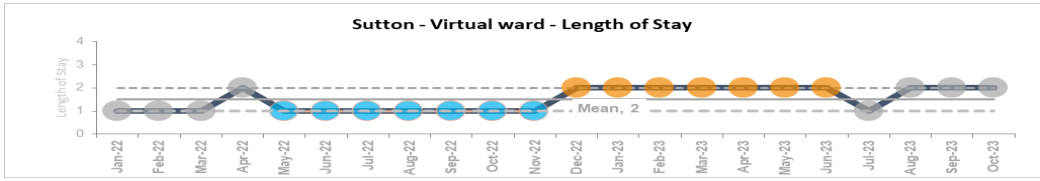
Virtual Ward
Admissions, Occupancy & Length of Stay

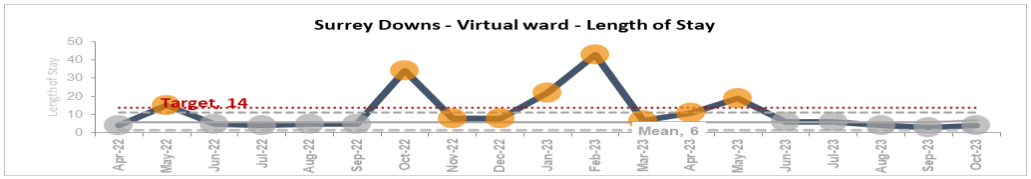
St George's, Epsom and St Helier University Hospitals and Health Group

Sutton Occupancy Target: >80%	Actual: 33%	Surrey Downs Occupancy Target: >80%	Actual: 79%









Sutton Health & Care updates since last month

Service stated on Dec 21. The number of admissions increased through October with the average length of stay remaining at 2 days.

Surrey Downs Health & Care updates since last month

Service started Sep 21. Average length of stay increased by one day through October, and starting to see a slight upward trend in admissions

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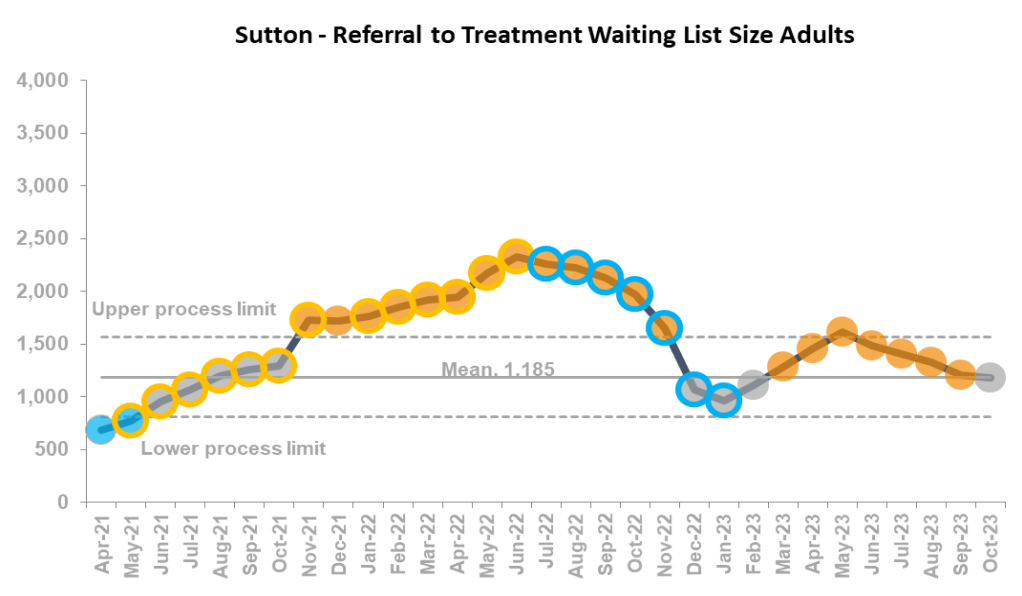
Referral to Treatment Waiting List Size

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

Sutton	Actual: 1,182

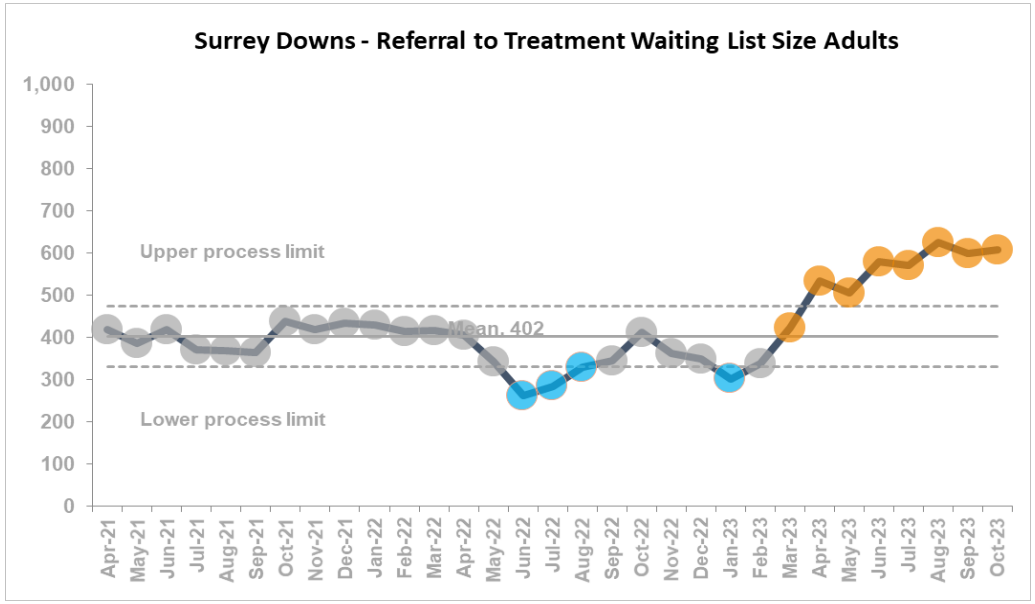


Sutton Health & Care updates since last month

RTT applies only to Diabetes and Musculoskeletal (MSK) pathways.

The number of patients on a RTT pathway continues on a downward trend reducing further in October with in total 1,182 pathways. There were three patients waiting for more than 18 weeks for treatment.

Surrey Downs	Actual: 607

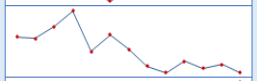
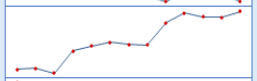
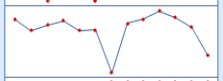
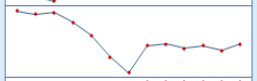
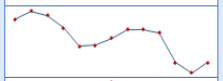
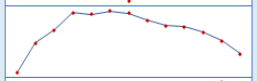


Surrey Downs Health & Care updates since last month

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 seeing a slight increase in October. There were 16 patients waiting for more than 18 weeks for treatment compared to 9 pathways in September.

Integrated Care – Our People

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

	Sutton Health & Care							Surrey Downs Health & Care						
Our People	**Monthly Target**	**Aug-23**	**Sep-23**	**Oct-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Aug-23**	**Sep-23**	**Oct-23**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Sickness Rate	3.2%	4.2%	5.7%	6.4%	3.2%	5.1%		3.8%	5.7%	5.4%	6.5%	3.8%	5.8%	
Agency rates		4.1%	2.9%	2.4%		3.2%			8.4%	9.3%	7.4%		9.2%	
MAST	85%	89.5%	89.5%	90.1%	85%	88.9%		85%	92.7%	92.7%	93.4%	85%	91.8%	
Vacancy	10%	16.0%	15.0%	12.1%	10%	14.4%		10%	19.7%	18.9%	20.0%	10%	19.0%	
Appraisal Rate Medical	90%	100.0%	100.0%	100.0%	90%	100.0%		90%	100.0%	100.0%	100.0%	90%	92.9%	
Appraisal Rate Non Medical	90%	63.2%	60.9%	63.3%	90%	66.7%		90%	79.6%	74.4%	67.3%	90%	80.5%	
Turnover	13%	0.3%	1.3%	1.5%	13%	1.3%		12%	1.5%	1.7%	0.0%	12%	1.2%	
Percentage BAME staff band 6 and above		35.8%	35.6%	36.0%		36.0%			18.8%	18.8%	18.6%		18.5%	

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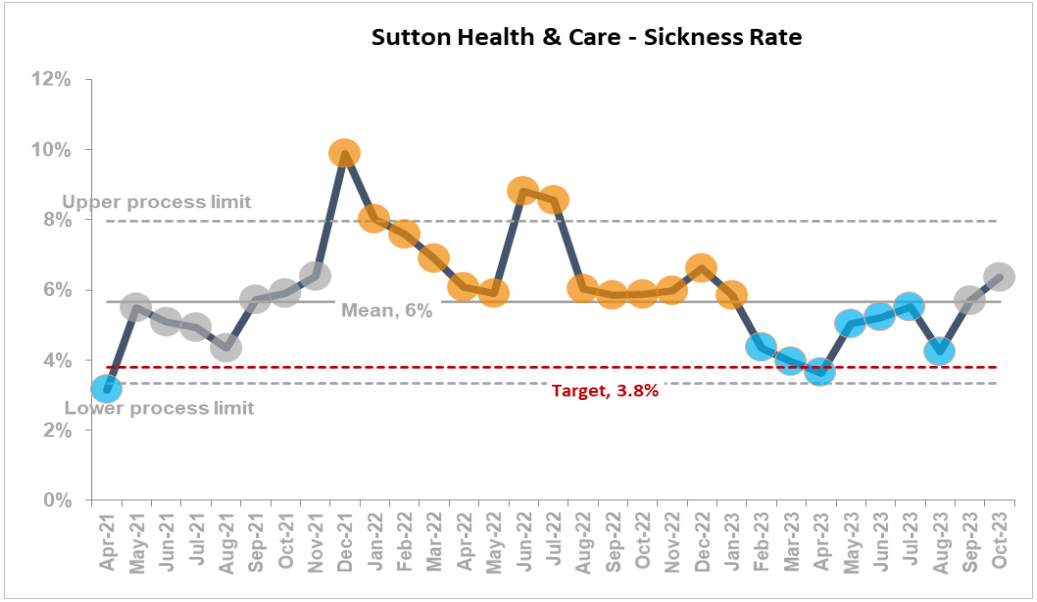
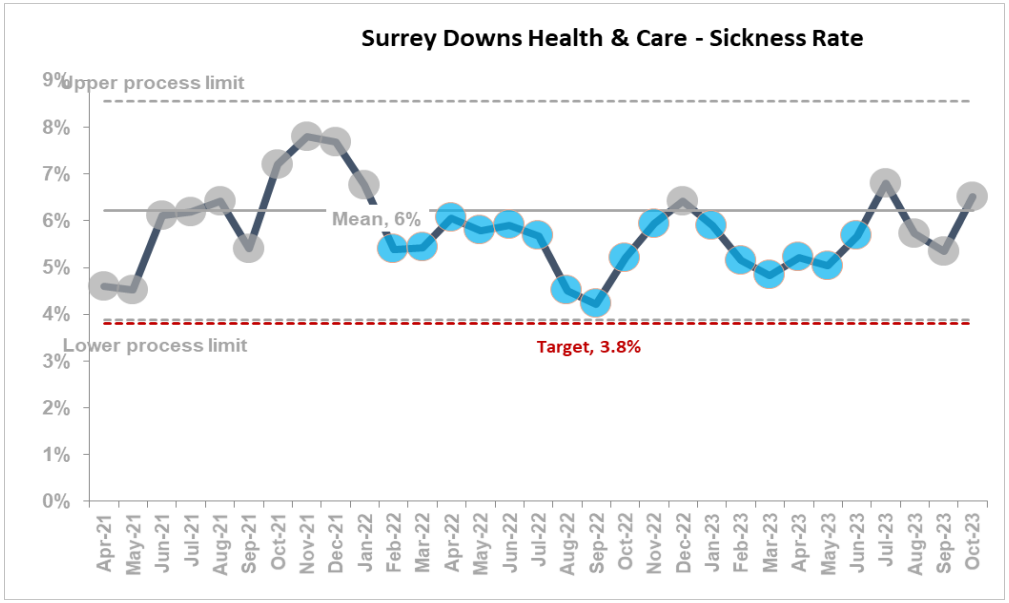
Staff Sickness Rates

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

Target: 3.8%	Sutton Health & Care: 6.4%	Surrey Downs Health & Care: 6.5%





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.

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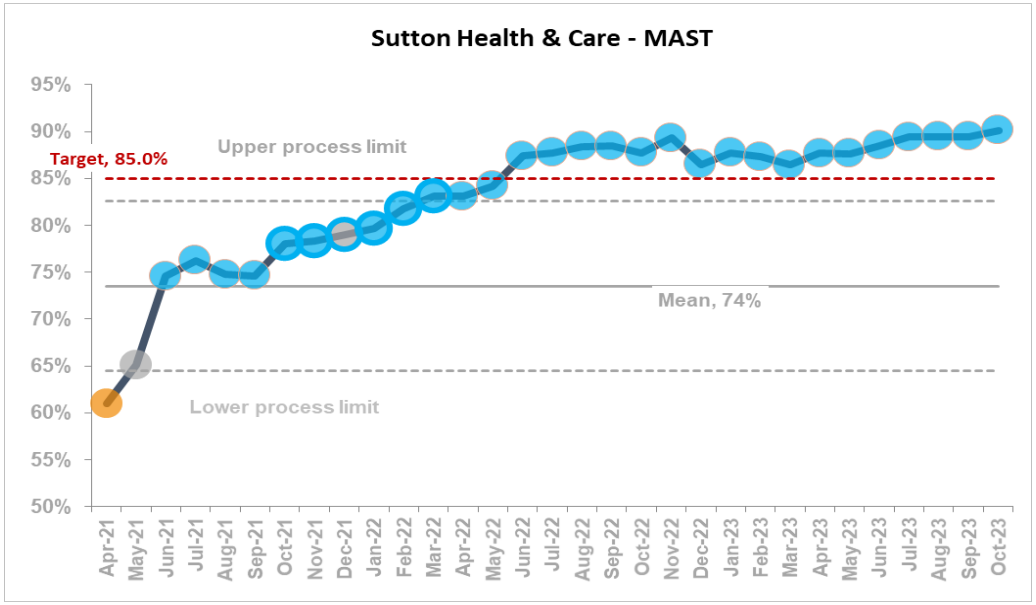
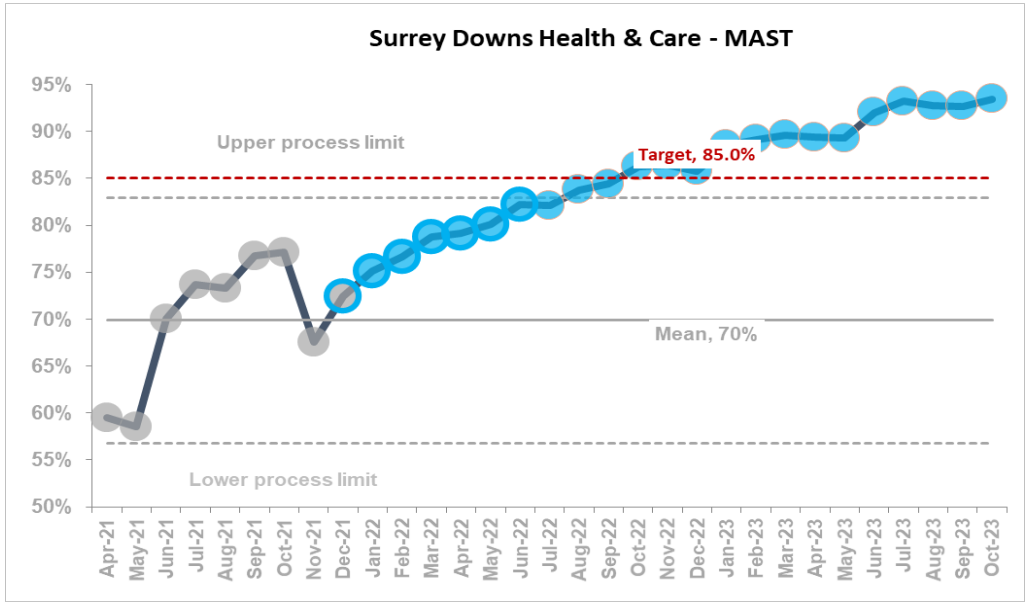
Mandatory and Statutory Training (MAST)

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

Target: 85%	Sutton Health & Care: 90.1%	Surrey Downs Health & Care: 93.4%





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 Oct22.

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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 remain high. Action plan in place with LBS (cognus) who provide therapy via education and social care.

Decrease in SHC appraisal rate.

Surrey Downs Health & Care current issues –

High level of vacancies, particularly in nursing.

Although improvement in agency usage rate still under the target

Drop in Appraisal rate

Increase in Absence rate

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.
3. Focus on appraisals.

Surrey Downs Health & Care future action –

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.

Continue to focus on Appraisals

Continue to work with managers on absence management

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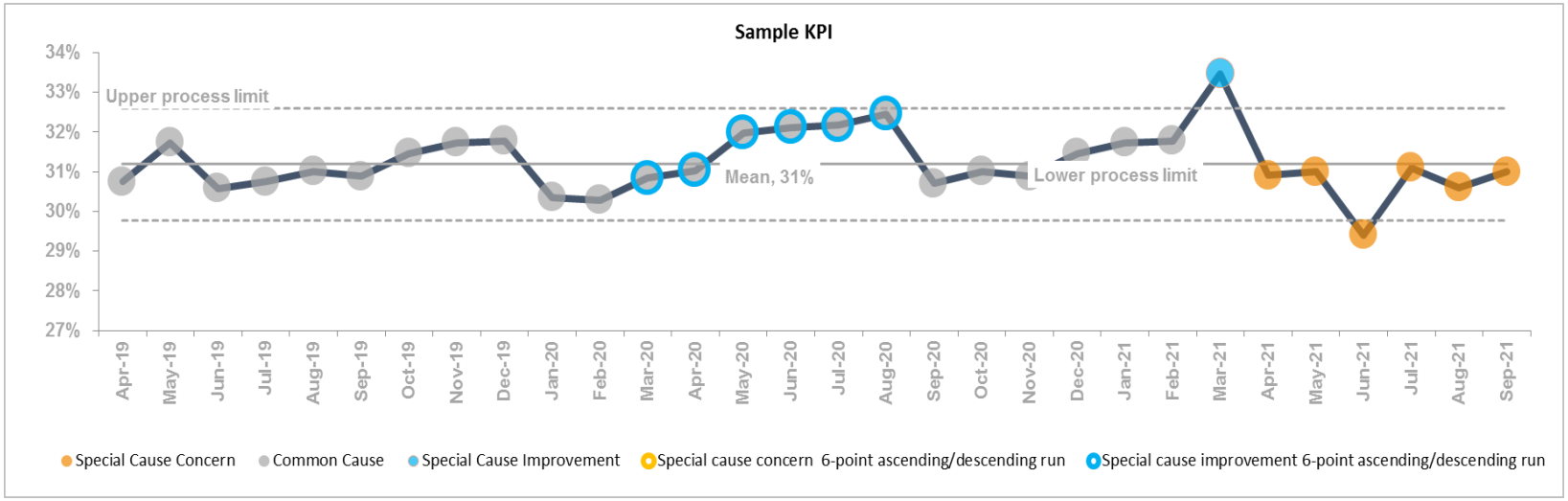
NHS
St George's, Epsom and St Helier
University Hospitals and Health Group

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
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CT	Computerised tomography
CUPG	Cancer of Unknown Primary Group
CWDT	Children's, Women's, Diagnostics & Therapies
CWT	Cancer Waiting Times
D2A	Discharge to Assess
DDO	Divisional Director of Operations
DM01	Diagnostic wating times
DNA	Did Not Attend
DTA	Decision to Admit
DTT	Decision to Treat

Terms	Description
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
KPI	Key Performance Indicator

Terms	Description
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
O2S	Orders to Schedule

Terms	Description
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
SGH	St Georges Hospital Trust

Terms	Description
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 in Public on Friday, 12 January 2024

Agenda Item	3.5	
Report Title	**EPRR Annual Compliance Statement**	
Executive Lead(s)	James Blythe, Managing Director - Epsom and St Helier	
Report Author(s)	Lee Tuvey, Head of EPRR	
Previously considered by	ESTH Site Leadership Team	-
Purpose	**For Approval / Decision**	

Executive Summary

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022).

The paper gives an overview of the incidents the Trust has responded to over the last 12 months, reports on the training and exercising programme along with the development of emergency response and resilience planning in the Trust.

The report also describes the annual EPRR assurance process that the Trust undertook this year, stating our compliance level against the core standards for EPRR, along with an action plan for any areas rated as partially compliant.

Action required by Group Board

The Group Board is asked to:

a) approve the Emergency Preparedness, Resilience and Response Annual Report.
b) To approve the declaration of compliance against the core standards for EPRR (appendix 1)

Board Assurance	
Board	Finance Committees-in-Common
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	

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

Legal and / or Regulatory implications

Equality, diversity and inclusion implications

Environmental sustainability implications

Emergency Preparedness, Resilience and Response (EPRR)

Annual Report 2023/24

1. Introduction

This paper provides a report on the Trust's emergency preparedness in order to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022).

The paper gives an overview of the incidents the Trust has responded to over the last 12 months, reports on the training and exercising programme along with the development of emergency response and resilience planning in the Trust.

The Trust has a suite of plans to deal with Major Incidents, Critical Incidents and Business Continuity issues. These plans conform to the Civil Contingencies Act (2004) and current NHS-wide guidance. All plans have been developed in consultation with internal and external stakeholders.

The report also describes the annual EPRR assurance process that the Trust undertook this year, stating our compliance level against the core standards for EPRR, along with an action plan for any areas rated as partially compliant.

2. Background

Emergency preparedness, resilience, and response (EPRR) is a core function of the NHS and is a statutory requirement of the Civil Continencies Act (2004). Responding to emergencies or disruptive events is also a key function of NHS providers as defined in the NHS Act (2006) and the Health and Social Care Act (2022), and a requirement detailed in the Care Quality Commission (CQC) 'Essential Standards of Quality and Safety' (2010) outcomes 4(1) and 6(b).

In December 2022, the UK Government published the UK Resilience Framework, which sets out an ambitious new vision and approach to strengthen the resilience of the UK up to the year 2030. The Civil Contingencies Act (2004) will continue to be the legislative basis for the framework, which is based on three core principles:

- Develop a shared understanding of the civil contingencies risks being faced;
- Prevention rather that cure, a greater emphasis of preparation and prevention; and,
- Resilience as a 'whole of society' endeavour, ensuring transparency and empowering everyone to contribute.

Under the Civil Contingencies Act (2004), and its associated guidance, the Trust has a duty, as a category one responder, to plan for and respond to a wide range of incidents that could affect health or patient care. These can range from extreme weather conditions; to an outbreak of an infectious disease, or a major transport incident to give just a few examples. The Trust is required to demonstrate it can respond to such incidents whilst providing critical services to the public.

As a category one responder, the Trust is subject to the following civil protection duties:

- Assess the risks of emergencies occurring and use this information to inform contingency planning.
- Put in place emergency plans.
- Put in place business continuity management arrangements.
- Ensure arrangements are in place to make information available to the public about civil protection matters, and maintain arrangements to warn, inform and advise the public in the event of an emergency.
- Share information with other local responders to enhance coordination.
- Cooperate with other local responders to enhance coordination and efficiency.

Nationally, there is a high level of focus on the risks and threats that organisations must be prepared for. It is therefore vital that there is a continued focus on the Trust's emergency preparedness and business continuity arrangements.

3. Governance

The overall responsibility for emergency preparedness, resilience and response for the Trust lies with the Group Chief Executive Officer. This duty is delegated to the Managing Director (Epsom and St Helier), who is supported by the Site Chief Operating Officer to discharge these duties and responsibilities. The Managing Director (Epsom and St Helier) is the nominated Accountable Emergency Officer (AEO) for the Trust.

The Emergency Preparedness, Resilience and Response (EPRR) Team leads of the operational delivery of the Trust's EPRR work programme. The EPRR Team is led by the Head of Clinical Site Management and EPRR (1 wte), supported by 1.76 wte EPRR Managers.

The Trust Resilience Committee meets quarterly, with its membership including senior members of staff from across the Trust, including all clinical divisions and support services. The core function of the committee is to coordinate the emergency preparedness function of the Trust, identifying priorities, and developing and implementing plans and procedures in accordance with the latest guidance to ensure that Trust can respond to, and recover from disruptive events / emergencies. The Committee also oversees the EPRR training and exercising programme.

A Business Continuity Sub-Group has been established, which reports to the Trust Resilience Committee, to further progress work within the Trust's business continuity management system. As part of the 2024 / 25 EPRR Work Programme, an Emergency Planning Sub-Group will also be established to further progress key priorities identified within the EPRR work programme.

The Trust Resilience Committee produces an annual report to the Board to provide assurance that the Trust is meeting its statutory and legal requirements.

4. Risk Assessment

The National Risk Register (NRR) was published in August 2023, which is an external version of the National Security Risk Assessment (NSRA), which details the governments assessment of the most serious risks facing the UK and is reviewed every 2 years.

Community Risk Registers (CRR's) are a collection of assessments of emergencies that may happen within a local area – these are reviewed regularly by Local Resilience Fora (LRF's) and Borough Resilience Fora (BRF's).

The Trust's emergency preparedness is informed by the NRR, along with the Surrey LRF Community Risk Register and both Sutton and Merton BRF's Community Risk Registers. EPRR risks are recorded on the Trust's Risk Management platform – DATIX.

5. Partnership Working

The Trust works in collaboration with a range of partner agencies, including NHS England (London), Surrey Heartlands Integrated Care Board (ICB), South West London Integrated Care Board (ICB), Local Authorities and other 'blue light' responders through formal standing meetings and ad hoc arrangements.

The Trust is represented at a number of resilience meetings including the following:

- Sutton Borough Resilience Forum
- Merton Borough Resilience Forum
- Surrey Local Health Resilience Partnership
- Surrey Local Resilience Forum
- Kent, Surrey, and Sussex CBRN Forum
- London Acute and Specialist Learning Set
- South West London ICS EPRR Group
- South West London and Surrey Trauma Emergency Planning Group
- Surrey Heartlands ICS EPRR Leads Group

6. EPRR Plans

The Trust has in place a suite of plans to enable a response to an incident:

Major Incident Response Plan

The Trust has a Major Incident Response Plan in place which details the actions the Trust would take in the event of a Major Incident (as defined by the EPRR Framework, 2022) was declared. The plan is supplemented with information and guidance on Mass Casualty incidents to ensure a scalable response to an incident. The Major Incident Plan is due for a full review in 2024, as part of the EPRR review cycle. The Trust Major Incident Response Plan was submitted as part of the NHS England EPRR assurance process and rated as compliant.

Trust Business Continuity (incorporating critical incident) Response Plan

The Trust has a well-rehearsed Trust Level Business Continuity Response Plan. It is recognised that further work is required on divisional and service level business continuity arrangements to further enhance the wider Trust plan – this work is included within the EPRR work programme for 2024. The Trust Major Incident Response Plan was submitted as part of the NHS England EPRR assurance process and rated as compliant.

Threat Specific Plans

The Trust also has a portfolio of threat specific plans – these are updated annually, or following an incident / exercise to capture learning:

- Chemical, Biological, Radiological and Nuclear (CBRN) and Hazardous Materials (HazMat) Response Plan
- Pandemic Response Plan
- Mass Countermeasures Response Plan
- Adverse Weather Response Plan
- Evacuations and Shelter Response Plan
- Operational Pressures Escalation Plan
- Lockdown Plan
- Fuel Disruption Response Plan

The Trust also ensures plans are in place for any significant events that may impact on Trust operations within the locality such as Epsom Derby.

Further work is required on the Trust's Lockdown arrangements to ensure a coordinated response across both acute and community settings – this is included within the work programme for 2024.

7. Live Events

The Trust has responded to the following incidents / events during 2023 / 24.

Date	Event
8th March 2023	Power Failure at Tadworth Children's Trust
21st March 2023	Business Continuity Incident – Capacity
2nd May 2023	Business Continuity Incident – Capacity
21st June 2023	Business Continuity Incident – Capacity
31st July 2023	Business Continuity Incident – Capacity
11th August 2023	Critical Incident – Evacuation of St Helier Emergency Department
23rd August 2023	Failure of Electronic Prescribing System
2nd October 2023	Business Continuity Incident – Sewage Leak – Epsom Emergency Department
9th October 2023	Power Failure at Tadworth Children's Trust
31st October 2023	Business Continuity Incident – Capacity (St Helier Site)

6th November 2023	Business Continuity Incident – Capacity (St Helier Site)
10th November 2023	Business Continuity Incident – Capacity (Epsom Site)
10th November 2023	Potential HazMat Incident – Epsom Emergency Department
29th November 2023	Business Continuity Incident – Capacity
12th December 2023	Business Continuity Incident – Capacity

Debriefs have been undertaken as part of the Trust EPRR Policy and Business Continuity Management Policy, with learning and lessons identified being used to improve the Trust's response arrangements.

In addition to the above, the Trust has had to plan for and respond to multiple periods of industrial action across the health sector during 2023:

Date	Industrial Action
11th January 2023	Ambulance Industrial Action – London Ambulance Service and South East Coast Ambulance Service
23rd January 2023	Ambulance Industrial Action – London Ambulance Service
6th February 2023	Ambulance Industrial Action – South East Coast Ambulance Service
10th February 2023	Ambulance Industrial Action – London Ambulance Service
20th February 2023	Ambulance Industrial Action – South East Coast Ambulance Service
6th March 2023	Ambulance Industrial Action – South East Coast Ambulance Service
13th – 16th March 2023	British Medical Association – Junior Doctor Industrial Action
11th – 15th April 2023	British Medical Association – Junior Doctor Industrial Action
14th – 17th June 2023	British Medical Association – Junior Doctor Industrial Action
13th – 18th June 2023	British Medical Association – Junior Doctor Industrial Action
20th – 21st July 2023	British Medical Association – Consultant Industrial Action
11th – 15th August 2023	British Medical Association – Junior Doctor Industrial Action
24th – 25th August 2023	British Medical Association – Consultant Industrial Action
19th – 20th September 2023	British Medical Association – Consultant Industrial Action
20th – 22nd September 2023	British Medical Association – Junior Doctor Industrial Action
2nd – 5th October 2023	British Medical Association – Combined Consultant and Junior Doctor Industrial Action
20th – 23rd December 2023	British Medical Association – Junior Doctor Industrial Action
3rd – 9th January 2024	British Medical Association – Junior Doctor Industrial Action

8. EPRR Training

Training is an essential part of the emergency preparedness and business continuity cycles. The EPRR undertake an annual training needs analysis (TNA) to inform training which should be included on the EPRR Training and Exercising Plan, along with the EPRR workplan.

In the period covered by this report, the following EPRR training has been delivered:

Training	No. of Staff Trained
EPRR Commander Training (Tactical)	30
EPRR Commander Training (Operational)	8

Principles of Health Command (delivered by NHSE)	10
Loggist Training	6*
CBRNe / HazMat Response	63
Junior Doctor Induction	25
ACT Training (delivered by Met Police)	8
Ad-Hoc Training Sessions	23

* due to be trained in January 2024

It should be noted that several training events have been cancelled / rescheduled due to industrial action or other responses to concurrent incidents. These events have either been rescheduled or additional sessions will be included in the 2024 training programme.

The EPRR Team have also worked with learning and development colleagues to ensure all staff have an awareness of EPRR within the Trust by featuring this in the Fire statutory and mandatory training. Other training opportunities have been explored and implemented including online CBRN / HAMZAT theory training for ED staff.

9. EPRR Exercising

The NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022) requires the Trust to regularly tests its emergency and resilience arrangements through a:

- Communications System Exercise – every 6 months
- Tabletop Exercise – every 12 months
- Live Play Exercise – every 3 years
- Command Post Exercise – every 3 years
- Incident Coordination Centre (ICC) Equipment Test – every 3 months

In the period covered by this report the following exercises have been delivered:

Date	Exercise Name	Exercise Type	Description
6th June 2023	Exercise Aether	Table-top	Trust wide tabletop exercise, aimed to test IT and service level business continuity arrangements to an IT and network outage.
13th November 2023	Exercise Hawkeye	Table-top	Trust wide tabletop exercise, aimed to test the Trusts arrangements to lockdown a site, or multiple sites in response to a threat.
13th December 2023	“The Floor” – ED Simulation	Table-top	ED focused simulation to test pressure surge arrangements within the ED footprint, major incident triage and major incident response.

The Trust exercised its communications systems during the response to the Critical Incident at St Helier whereby the Emergency Department was evacuation due to a possible gas leak.

A further communications system exercise is planned for quarter 4 of 2022/23. ICC equipment checks form part of the EPRR workplan and are undertaken at planned intervals.

The Trust delivered a live play exercise in 2022, whereby the evacuation of a community hospital was exercised with multi-agency partners. The Trust has also responded to multiple live incidents over the last 12 months – all of which have informed future planning arrangements. A live play exercise will therefore form part of the 2024/25 EPRR work plan.

10. Annual EPRR Assurance Outcome

The annual NHS England EPRR assurance process aims to seek assurance that NHS organisations in England are prepared to respond to emergencies and have arrangements in place to ensure resilience to allow continuation of safe patient care during disruptive events. Trusts are required to undertake a self-assessment of their compliance against the Core Standards for EPRR (2023) prior to a check and challenge meeting.

The NHS England Core Standards for EPRR (2023) set out the minimum requirements that NHS organisation and providers if NHS funded care must demonstrate. The Core Standards are split into 10 domains, covering a total of 62 standards:

1. Governance
2. Duty to assess risk
3. Duty to maintain plans
4. Command and Control
5. Training and Exercising
6. Response
7. Warning and Informing
8. Cooperation
9. Business Continuity
10. Chemical, Biological, Radiological and Nuclear (CBRN)

In addition to the above, every year a different ‘deep dive’ topic is chosen by NHS England (National Team), which provides an opportunity for a specific EPRR subject to be examined in further detail. This year’s chosen topic was EPRR Training, for which the Trust was assessed against a total of 10 standards.

In September 2023, the Trust submitted its self-assessment against the core standards for EPRR (2023). A check and challenge meeting was arranged for November 2023, led by NHS England (London Region) EPRR Team with representation from the Trust and South West London Integrated Care Board (ICB) colleagues. This meeting was also attended by the EPRR Team, Deputy Chief Operating Officer and Chief Operating Officer. During the meeting, core standards were discussed and compliance ratings were agreed.

A summary of the agreed compliance relating to the core standards can be found below:

Core Standard Domain	Total applicable standards	Fully Compliant	Partially Compliant	Non-compliant
Domain 1: Governance	6	6	0	0
Domain 2: Duty to assess risk	2	2	0	0
Domain 3: Duty to maintain plans	11	10	1	0
Domain 4: Command and Control	2	2	0	0
Domain 5: Training and Exercising	4	4	0	0
Domain 6: Response	7	7	0	0
Domain 7: Warning and Informing	4	4	0	0
Domain 8: Cooperation	4	4	0	0
Domain 9: Business Continuity	10	7	3	0
Domain 10: CBRN	12	12	0	0
Total	**62**	**58**	**4**	**0**
Deep Dive: EPRR Training	10	10	0	0
Overall Level of Compliance		**Substantially Compliant**		

An overall statement of compliance following the annual assurance process can be found in appendix 1.

The Trust recorded a total of 4 core standards which were assessed as partially complaint – these are detailed below, along with a high-level summary of the actions required to progress these:

Ref	Domain	Core Standard	Rating	Action Plan
17	Duty to maintain plans	Lockdown		Task and finish group established to work through arrangements across both acute and inpatient community settings. This includes a full re-write of the overarching lock down arrangements, along with the development of localised plans.
47	Business Continuity	Business Continuity Plans (BCP)		Action plan to be developed to work through gaps in planning. Overarching plans are in place but need to go to service level. Business Continuity Champions in place within both clinical and non-clinical divisions. To be monitored at Trust Resilience Committee via the Business Continuity Sub-Group.
49	Business Continuity	Data Protection and Security Toolkit		The DSPT is currently at “Approaching Standards” as 95% of staff were not recorded

				as completing their information governance training. Staff who have not completed their training have been contacted and an updated plan is due to go to NHS England in December 2023. It should be noted that this core standard is outside the remit of the EPRR Team.
51	Business Continuity	BC Audit		This action is linked to the Trust Business Continuity Management System (BCMS) and will be included as part of next year's cycle.

Full details of the Trust's agreed compliance against the core standards for EPRR (2023) can be found in appendix 2.

11. EPRR Work Programme 2024

The Trust remains committed to continually improving its emergency preparedness, resilience, and response arrangements. The EPRR Team have drafted the 2024 / 25 work programme, which includes the following priorities:

- Ensure all services have a current business impact assessment (BIA) and business continuity plan (BCP), which informs divisional business continuity arrangements.
- Continued engagement with CERNER team in relation to Electronic Patient Record (EPR) roll out.
- Undertake an audit of the Trust's business continuity management system as part of the business continuity cycle.
- Further develop lockdown arrangements for both acute and community sites, ensuring proportionate response plans are in place. This included a full review of the overarching Trust lockdown arrangements.
- Establishment of emergency planning sub-group to deliver key workstreams.
- Full roll out of EPRR Continual Professional Development Portfolios, mapped against National Occupational Standards (NOS) required to fulfil a specific role in incident response.
- All training to be in line with the NHS England Minimal Occupational Standards for EPRR, National Occupational Standards (NOS) and Skills for Justice requirements.

- Further explore training opportunities to capture as many staff as possible. This includes the use of online training packages, simulation, and live play elements.

12. Conclusion

In summary, it is clear that the past year has seen further developments within the Trust's emergency preparedness, resilience, and response arrangements. This includes a full re-design of the EPRR training programme, and EPRR awareness now included in mandatory training for all staff. The Trust has shown its resilience and ability to respond to a variety of incidents, where a vast amount of learning has been gained and has / will be incorporated into response arrangements. Over the next 12 months, the Trust will continue to develop its response capabilities, with a particular focus on business continuity arrangements at service level.

Appendix 1 – Statement of Compliance

2023 EPRR Assurance Process

Declaration of Level of Compliance

Epsom & St. Helier University Hospitals NHS Trust recently undertook the 2023 NHS England Emergency Preparedness, Resilience and Response (EPRR) Assurance Process which was led by NHS England (London Region). The Assurance process consisted of 62 core standards for EPRR which were assessed, and RAG rated.

Following the assurance review panel, the results of the Epsom & St. Helier University Hospitals NHS Trust assurance submission are as follows:

Green Ratings	58 core standards
Amber Ratings	4 core standards
Red Ratings	0 core standards

Epsom & St. Helier University Hospitals NHS Trust have been asked to provide the Trust Board with an overall level of compliance using the following criteria:

Compliance Levels	Criteria to achieve this level of compliance	
Fully Compliant	100% compliant	The organisation is 100% compliant will all the core standards they are expected to achieve. The organisation's Board has agreed with this position statement.
Substantially Compliant	89-99% compliant	The organisation is 89-99% compliant with all the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Partially Compliant	77-88% compliant	The organisation is 77-88% compliant with all the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months.
Non-Compliant	Less than 76% compliant	The organisation is less than 76% compliant with all the core standards they are expected to achieve. For each non-compliant core standard, the organisation's Board has agreed an action plan to meet compliance within the next 12 months. The action plan will be monitored via the relevant patch team to demonstrate progress towards compliance, reporting to the LHRP as required.

Using the results from the assurance review panel and the criteria above, it can be established that Epsom & St. Helier University Hospitals NHS Trust are **Substantially Compliant**.

Appendix 2 – Core Standard Compliance 2023

Ref	Domain	Standard Name	Standard Detail	RAG Rating
1	Governance	Senior Leadership	The organisation has appointed an Accountable Emergency Officer (AEO) responsible for Emergency Preparedness Resilience and Response (EPRR). This individual should be a board level director within their individual organisation, and have the appropriate authority, resources, and budget to direct the EPRR portfolio.	
2	Governance	EPRR Policy Statement	The organisation has an overarching EPRR policy or statement of intent. This should take into account the organisation's: • Business objectives and processes • Key suppliers and contractual arrangements • Risk assessment(s) • Functions and / or organisation, structural and staff changes.	
3	Governance	EPRR board reports	The Chief Executive Officer ensures that the Accountable Emergency Officer discharges their responsibilities to provide EPRR reports to the Board, no less than annually. The organisation publicly states its readiness and preparedness activities in annual reports within the organisation's own regulatory reporting requirements	
4	Governance	EPRR work programme	The organisation has an annual EPRR work programme, informed by: • current guidance and good practice • lessons identified from incidents and exercises • identified risks • outcomes of any assurance and audit processes The work programme should be regularly reported upon and shared with partners where appropriate.	
5	Governance	EPRR Resource	The Board / Governing Body is satisfied that the organisation has sufficient and appropriate resource to ensure it can fully discharge its EPRR duties.	
6	Governance	Continuous improvement	The organisation has clearly defined processes for capturing learning from incidents and exercises to inform the review and embed into EPRR arrangements.	
7	Duty to risk assess	Risk assessment	The organisation has a process in place to regularly assess the risks to the population it serves. This process should consider all relevant risk registers including community and national risk registers.	
8	Duty to risk assess	Risk Management	The organisation has a robust method of reporting, recording, monitoring, communicating, and escalating EPRR risks internally and externally	

9	Duty to maintain plans	Collaborative planning	Plans and arrangements have been developed in collaboration with relevant stakeholders' including emergency services and health partners to enhance joint working arrangements and to ensure the whole patient pathway is considered.	
10	Duty to maintain plans	Incident Response	In line with current guidance and legislation, the organisation has effective arrangements in place to define and respond to Critical and Major incidents as defined within the EPRR Framework.	
11	Duty to maintain plans	Adverse Weather	In line with current guidance and legislation, the organisation has effective arrangements in place for adverse weather events.	
12	Duty to maintain plans	Infectious disease	In line with current guidance and legislation, the organisation has arrangements in place to respond to an infectious disease outbreak within the organisation or the community it serves, covering a range of diseases including High Consequence Infectious Diseases.	
13	Duty to maintain plans	New and emerging pandemics	In line with current guidance and legislation and reflecting recent lessons identified, the organisation has arrangements in place to respond to a new and emerging pandemic	
14	Duty to maintain plans	Countermeasures	In line with current guidance and legislation, the organisation has arrangements in place. to support an incident requiring countermeasures or a mass countermeasure deployment	
15	Duty to maintain plans	Mass Casualty	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to incidents with mass casualties.	
16	Duty to maintain plans	Evacuation and shelter	In line with current guidance and legislation, the organisation has arrangements in place to evacuate and shelter patients, staff, and visitors.	
17	Duty to maintain plans	Lockdown	In line with current guidance, regulation and legislation, the organisation has arrangements in place to control access and egress for patients, staff, and visitors to and from the organisation's premises and key assets in an incident.	
18	Duty to maintain plans	Protected individuals	In line with current guidance and legislation, the organisation has arrangements in place to respond and manage 'protected individuals' including Very Important Persons (VIPs), high profile patients and visitors to the site.	
19	Duty to maintain plans	Excess fatalities	The organisation has contributed to, and understands, its role in the multiagency arrangements for excess deaths and mass fatalities, including mortuary arrangements. This includes arrangements for rising tide and sudden onset events.	
20	Command and control	On-call mechanism	The organisation has resilient and dedicated mechanisms and structures to enable 24/7 receipt and action of incident notifications, internal or external. This should provide the facility to respond to or escalate notifications to an executive level.	
21	Command and control	Trained on-call staff	Trained and up to date staff are available 24/7 to manage escalations, make decisions and identify key actions	
22	Training and exercising	EPRR Training	The organisation carries out training in line with a training needs analysis to ensure staff are current in their response role.	
23	Training and exercising	EPRR exercising and testing programme	In accordance with the minimum requirements, in line with current guidance, the organisation has an exercising and testing programme to safely* test incident response arrangements, (*no undue risk to exercise players or participants, or those patients in your care)	

24	Training and exercising	Responder training	The organisation has the ability to maintain training records and exercise attendance of all staff with key roles for response in accordance with the Minimum Occupational Standards. Individual responders and key decision makers should be supported to maintain a continuous personal development portfolio including involvement in exercising and incident response as well as any training undertaken to fulfil their role	
25	Training and exercising	Staff Awareness & Training	There are mechanisms in place to ensure staff are aware of their role in an incident and where to find plans relevant to their area of work or department.	
26	Response	Incident Co-ordination Centre (ICC)	The organisation has in place suitable and sufficient arrangements to effectively coordinate the response to an incident in line with national guidance. ICC arrangements need to be flexible and scalable to cope with a range of incidents and hours of operation required. An ICC must have dedicated business continuity arrangements in place and must be resilient to loss of utilities, including telecommunications, and to external hazards. ICC equipment should be tested in line with national guidance or after a major infrastructure change to ensure functionality and in a state of organisational readiness. Arrangements should be supported with access to documentation for its activation and operation.	
27	Response	Access to planning arrangements	Version controlled current response documents are available to relevant staff at all times. Staff should be aware of where they are stored and should be easily accessible.	
28	Response	Management of business continuity incidents	In line with current guidance and legislation, the organisation has effective arrangements in place to respond to a business continuity incident (as defined within the EPRR Framework).	
29	Response	Decision Logging	To ensure decisions are recorded during business continuity, critical and major incidents, the organisation must ensure: 1. Key response staff are aware of the need for creating their own personal records and decision logs to the required standards and storing them in accordance with the organisations' records management policy. 2. has 24-hour access to a trained Loggist(s) to ensure support to the decision maker	
30	Response	Situation Reports	The organisation has processes in place for receiving, completing, authorising, and submitting situation reports (SitReps) and briefings during the response to incidents including bespoke or incident dependent formats.	
31	Response	Access to 'Clinical Guidelines for Major Incidents and Mass Casualty events'	Key clinical staff (especially emergency department) have access to the 'Clinical Guidelines for Major Incidents and Mass Casualty events' handbook.	
32	Response	Access to 'CBRN incident: Clinical Management and health protection'	Clinical staff have access to the 'CBRN incident: Clinical Management and health protection' guidance. (Formerly published by PHE)	

33	Warning and informing	Warning and informing	The organisation aligns communications planning and activity with the organisation's EPRR planning and activity.	
34	Warning and informing	Incident Communication Plan	The organisation has a plan in place for communicating during an incident which can be enacted.	
35	Warning and informing	Communication with partners and stakeholders	The organisation has arrangements in place to communicate with patients, staff, partner organisations, stakeholders, and the public before, during and after a major incident, critical incident, or business continuity incident.	
36	Warning and informing	Media strategy	The organisation has arrangements in place to enable rapid and structured communication via the media and social media	
37	Cooperation	LHRP Engagement	The Accountable Emergency Officer, or a director level representative with delegated authority (to authorise plans and commit resources on behalf of their organisation) attends Local Health Resilience Partnership (LHRP) meetings.	
38	Cooperation	LRF / BRF Engagement	The organisation participates in, contributes to, or is adequately represented at Local Resilience Forum (LRF) or Borough Resilience Forum (BRF), demonstrating engagement and co-operation with partner responders.	
39	Cooperation	Mutual aid arrangements	The organisation has agreed mutual aid arrangements in place outlining the process for requesting, coordinating, and maintaining mutual aid resources. These arrangements may include staff, equipment, services, and supplies. In line with current NHS guidance, these arrangements may be formal and should include the process for requesting Military Aid to Civil Authorities (MACA) via NHS England.	
43	Cooperation	Information sharing	The organisation has an agreed protocol(s) for sharing appropriate information pertinent to the response with stakeholders and partners, during incidents.	
44	Business Continuity	BC policy statement	The organisation has in place a policy which includes a statement of intent to undertake business continuity. This includes the commitment to a Business Continuity Management System (BCMS) that aligns to the ISO standard 22301.	
45	Business Continuity	Business Continuity Management Systems (BCMS) scope and objectives	The organisation has established the scope and objectives of the BCMS in relation to the organisation, specifying the risk management process and how this will be documented. A definition of the scope of the programme ensures a clear understanding of which areas of the organisation are in and out of scope of the BC programme.	
46	Business Continuity	Business Impact Analysis/Assessment (BIA)	The organisation annually assesses and documents the impact of disruption to its services through Business Impact Analysis(es).	
47	Business Continuity	Business Continuity Plans (BCP)	The organisation has business continuity plans for the management of incidents. Detailing how it will respond, recover, and manage its services during disruptions to: • people • information and data • premises • suppliers and contractors	

			• IT and infrastructure	
48	Business Continuity	Testing and Exercising	The organisation has in place a procedure whereby testing and exercising of Business Continuity plans is undertaken on a yearly basis as a minimum, following organisational change or as a result of learning from other business continuity incidents.	
49	Business Continuity	Data Protection and Security Toolkit	Organisation's Information Technology department certify that they are compliant with the Data Protection and Security Toolkit on an annual basis.	
50	Business Continuity	BCMS monitoring and evaluation	The organisation's BCMS is monitored, measured, and evaluated against established Key Performance Indicators. Reports on these and the outcome of any exercises, and status of any corrective action are annually reported to the board.	
51	Business Continuity	BC audit	The organisation has a process for internal audit, and outcomes are included in the report to the board. The organisation has conducted audits at planned intervals to confirm they are conforming with its own business continuity programme.	
52	Business Continuity	BCMS continuous improvement process	There is a process in place to assess the effectiveness of the BCMS and take corrective action to ensure continual improvement to the BCMS.	
53	Business Continuity	Assurance of commissioned providers / suppliers BCPs	The organisation has in place a system to assess the business continuity plans of commissioned providers or suppliers; and are assured that these providers business continuity arrangements align and are interoperable with their own.	
55	Hazmat/CBRN	Governance	The organisation has identified responsible roles/people for the following elements of Hazmat/CBRN: - Accountability - via the AEO - Planning - Training - Equipment checks and maintenance Which should be clearly documented	
56	Hazmat/CBRN	Hazmat/CBRN risk assessments	Hazmat/CBRN risk assessments are in place which are appropriate to the organisation type	
57	Hazmat/CBRN	Specialist advice for Hazmat/CBRN exposure	Organisations have signposted key clinical staff on how to access appropriate and timely specialist advice for managing patients involved in Hazmat/CBRN incidents	
58	Hazmat/CBRN	Hazmat/CBRN planning arrangements	The organisation has up to date specific Hazmat/CBRN plans, and response arrangements aligned to the risk assessment, extending beyond IOR arrangements, and which are supported by a programme of regular training and exercising within the organisation and in conjunction with external stakeholders	

59	Hazmat/CBRN	Decontamination capability availability 24 /7	The organisation has adequate and appropriate wet decontamination capability that can be rapidly deployed to manage self-presenting patients, 24 hours a day, 7 days a week (for a minimum of four patients per hour) - this includes availability of staff to establish the decontamination facilities. There are sufficient trained staff on shift to allow for the continuation of decontamination until support and/or mutual aid can be provided - according to the organisation's risk assessment and plan(s) The organisations also have plans, training, and resources in place to enable the commencement of interim dry/wet, and improvised decontamination where necessary.	
60	Hazmat/CBRN	Equipment and supplies	The organisation holds appropriate equipment to ensure safe decontamination of patients and protection of staff. There is an accurate inventory of equipment required for decontaminating patients. Equipment is proportionate with the organisation's risk assessment of requirement - such as for the management of non-ambulant or collapsed patients. • Acute providers - see Equipment checklist: https://www.england.nhs.uk/wp-content/uploads/2018/07/eprr-decontamination-equipment-check-list.xlsx • Community, Mental Health, and Specialist service providers - see guidance 'Planning for the management of self-presenting patients in healthcare setting': https://webarchive.nationalarchives.gov.uk/20161104231146/https://www.england.nhs.uk/wp-content/uploads/2015/04/eprr-chemical-incidents.pdf	
61	Hazmat/CBRN	Equipment - Preventative Programme of Maintenance	There is a preventative programme of maintenance (PPM) in place, including routine checks for the maintenance, repair, calibration (where necessary) and replacement of out-of-date decontamination equipment to ensure that equipment is always available to respond to a Hazmat/CBRN incident. Equipment is maintained according to applicable industry standards and in line with manufacturer’s recommendations. The PPM should include where applicable: - PRPS Suits - Decontamination structures - Disrobe and rerobe structures - Water outlets - Shower tray pump - RAM GENE (radiation monitor) - calibration not required - Other decontamination equipment as identified by your local risk assessment e.g. IOR Rapid Response boxes There is a named individual (or role) responsible for completing these checks	
62	Hazmat/CBRN	Waste disposal arrangements	The organisation has clearly defined waste management processes within their Hazmat/CBRN plans	

63	Hazmat/CBRN	Hazmat/CBRN training resource	The organisation must have an adequate training resource to deliver Hazmat/CBRN training which is aligned to the organisational Hazmat/CBRN plan and associated risk assessments	
64	Hazmat/CBRN	Staff training - recognition and decontamination	The organisation undertakes training for all staff who are most likely to come into contact with potentially contaminated patients and patients requiring decontamination. Staff that may make contact with a potentially contaminated patients, whether in person or over the phone, are sufficiently trained in Initial Operational Response (IOR) principles and isolation when necessary. (This includes (but is not limited to) acute, community, mental health, and primary care settings such as minor injury units and urgent treatment centres) Staff undertaking patient decontamination are sufficiently trained to ensure a safe system of work can be implemented	
65	Hazmat/CBRN	PPE Access	Organisations must ensure that staff who come in to contact with patients requiring wet decontamination and patients with confirmed respiratory contamination have access to, and are trained to use, appropriate PPE. This includes maintaining the expected number of operational PRPS available for immediate deployment to safely undertake wet decontamination and/or access to FFP3 (or equivalent) 24/7	
66	Hazmat/CBRN	Exercising	Organisations must ensure that the exercising of Hazmat/CBRN plans and arrangements are incorporated in the organisations EPRR exercising and testing programme	

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	3.5	
Report Title	**SGUH Emergency Preparedness Resilience and Response – Assurance Outcome 2023**	
Executive Lead(s)	Kate Slemeck, Managing Director - St George's	
Report Author(s)	Tara Argent, Site Chief Operating Officer – SGUH Mike Laing, EPPR Manager	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

The Board is asked to note and acknowledge the delivery of a substantial compliance rating for StGUH in the 2023 annual EPRR Assurance Process, with only 1 recommendation for improvement. This relates to the compliance of information governance (IG) training, this is now monitored via the divisional Integrated quality performance reports IiQPR) monthly and then to the Site Trust Management Group meeting (TMG).

Action required by Group Board

The Board is asked to note the assurance outcome for the SGUH Emergency Preparedness Resilience and Response submission 2023.

Committee Assurance	
Committee	Finance 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 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				
As set out in report				
Equality, diversity and inclusion implications				
n/a				
Environmental sustainability implications				
n/a				

St George's EPPR Assurance Outcome 2023 findings and recommendations Group Board, 12 January 2024

EPRR Assurance process 2023-24

Annually, all NHS funded organisations are asked to provide an assurance return against the Emergency Preparedness, Resilience, and Response (EPRR) core standards. The London regional office then holds individual face to face review meetings with each organisation to discuss and agree a level of compliance. The Trusts overall level of compliance is based on the total percentage of amber and red ratings. The following RAG ratings were agreed at the review meeting.

The assurance process identified one area for improvement in the Trusts current arrangements and agreed that this year, the overall level of compliance against the **2023-24** core standards for EPRR is **Substantially Compliant**. This is an improvement of the **2022-23** outcome of **Partially Compliant**.

See ***(Figure 1.)*** EPRR assurance outcomes below.

To move the trust towards full compliance the Accountable Emergency Officer (AEO) has agreed that the monitoring of the Information Governance training compliance will be via the Trust Divisional IQPR meetings, this will be reported through to the Trust Emergency Preparedness Steering Group.

(Figure 1.) EPRR assurance outcomes

2023/24 EPRR assurance outcome		
Red ratings	**Amber ratings**	**Green ratings**
0	**1***	**67**
***Amber (01)-Core Standard 49: Data Protection Toolkit**		
2022/23 EPRR assurance outcome		
Red ratings	**Amber ratings**	**Green ratings**
0	**8**	**56**

Chemical Biological Radiological Nuclear and explosive (CBRNe) audit outcome.

The Trusts CBRNe arrangements were audited by London Ambulance Service (LAS) as part of the overall assurance process. Several areas of best practice were identified including the Trust CBRNe and aligned action cards.

Trust EPRR Resource (for noting)

The Emergency Preparedness Team is made up of the 1 x Emergency Preparedness Manager (Band 8b) and 1 x EPRR Officer (Band 7).

Group Board

Meeting in Public on Friday, 12 January 2024

Agenda Item	3.6	
Report Title	Group Strategy update	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Kath Brook, Strategy and Planning Manager Carl Phillips, Head of PMO	
Previously considered by	Group Executive	09 January 2024
Purpose	**For Review**	

Executive Summary

We are now eight months on from launching the Group Strategy.
Our strategy describes how we will achieve our vision through the delivery of:

1. **Local improvements**: against a framework of annual priorities aligned to our CARE objectives.
2. **Corporate enablers**: corporate departments, working with clinical teams developing and implementing enabling strategies.
3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work.

This report provides an update on progress to date and proposed next steps against the above delivery areas.

Action required by Group Board

The Board is asked to:

- Note progress in implementing the Group Strategy.
- Agree the proposed revised timelines for approval of corporate enabling strategies.
- Note that as part of business planning, the Group will need to review where it can afford to invest resource to accelerate progress (e.g. in relation to strategic initiatives), and that the Executive will bring recommendations for Board consideration in March 2024.

Committee Assurance	
Committee	NA
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy update

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

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Group Strategy update

Group Board

James Marsh
Group Deputy Chief Executive Officer

Report Authors:
Kath Brook, Strategy and Planning Manager
Carl Phillips, Head of PMO

12 January 2024

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Introduction

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3. Note that as part of business planning, the Group will need to review where it can afford to invest resource to accelerate progress (e.g. in relation to strategic initiatives), and that the Executive will bring recommendations for Board consideration in February/March.

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Approach to delivery

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Delivering our 5-year vision

Local improvement

A range of work is underway to embed the CARE framework across the organisations, and to support staff to pursue improvement against it (see slide 5)

Strategic initiatives

Each of our 9 strategic initiatives has an exec SRO, and work is underway to ensure there is a robust programme approach to delivery (see slides 6-12)

Corporate enablers

In April, the Board agreed that corporate enabling strategies should be developed for IT, estates, sustainability, research and innovation, quality and safety, and people. Work is underway to develop these strategies (see slide 13)

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Local improvement

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A range of work is underway to embed the CARE framework across the organisations, and to support staff to pursue improvement against it, for example:

- Monthly Group/Site Interface meetings are now structured around the new CARE framework, and site leadership teams use the framework to structure their discussions with divisions
- Ongoing communication campaign, with CARE branding being disseminated across our physical sites and virtually
- Individual teams have started articulating their priorities/purpose using the CARE framework, with the offer of facilitation available from corporate teams
- Quality Improvement programme (with cohorts being trained across both trusts) is explicitly aligned to delivering improvement against the CARE framework.

Although we have made progress with embedding the strategy since the initial launch, there is more we need to do and at pace, to maintain momentum and staff engagement.

Looking forward to 24/25, the Executive have agreed the below priority areas:

Area	Activities	Lead
Individual level	• Personal Development Policy at both Trust's revised to align with CARE objectives	HR department
Team level	• Ward Accreditation – amend current model to align with CARE objectives and rolled out across the Group	Corporate nursing
Organisation level	• As part of business planning, sites to set priorities for 24/25 aligned to CARE	Site leadership teams

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Strategic initiatives

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What We Have Done

- Aligned designated support to each initiative **(from Strategy, Continuous Improvement and Group PMO teams)**
- Worked with SROs and key stakeholders on identifying scope and breadth of each initiative
- Focused on moving the strategy (and 9 initiatives) from ideation and ambition into delivery phased programmes (with dedicated resource capacity)
- Set up centralised working areas for each initiative (to act as single version of truth), or linked to existing structures where programmes of work are already established and in flight
- Started to identify enabling projects and programmes sitting under initiatives that will drive outcomes and realise benefits (existing 'work in flight' plus work that needs accelerating)
- Explored and identified shared working opportunities (cross-sites; cross-functions) for economies in effort/scale
- Started the work of establishing metrics for success over an 18-month horizon
- Developing the delivery roadmap to achieve the strategic ambitions (across the 9 initiatives and supporting enablers)

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What We Promised You in July 2023

Item	Summary	Status
Initiative Spotlight' deeper dives – starting with EPR (then BYFH and Outpatients as existing programmes)	- Now business as usual into Group Executive Meeting (GEM) - Rotate focus around initiatives (fortnightly/monthly) and driven by key activity/milestones - In addition, monthly dashboard into GEM (across 9 summary view)	**Complete / BAU**
Over-arching Roadmap/plan (inc all initiatives) to track progress at high level – to develop	- The complexity and breadth of several initiatives, and identifying supporting projects/programmes supporting them, is taking longer than anticipated - Some initiatives are more formed than others (see following slides) - This is to be expected in terms of the ambition and scope of work we are undertaking (turning strategy/ambition into delivery) - Resource constraints in several areas due to emerging priorities and Consultation/Restructure have also impacted progress made to date	Ongoing
Scope; Key Benefits; Critical Path; Risks Assumptions Issues and Dependencies (RAID) log; Stakeholder Map; Governance Model – for each initiative	- As above - some initiatives are more formed than others - Resource constraints in several areas due to emerging priorities and Consultation/Restructure have also impacted progress made to date	Ongoing
More granular plans (per initiative) to track and manage key activity	- Maturity of plans at varied states across the more established programmes of work (EPR, BYFH, Outpatients) and some initiatives still taking shape from a delivery perspective – see following slides	Ongoing
Touchpoints and Governance for supporting work	- Supporting Governance agreed for all initiatives with regular focus across all (at GEM) - GEM also identify/target likely touchpoints and focus sessions required	**Complete / BAU**

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Progress to Date - Key Initiatives (Top 9)

Initiative / Programme	SRO / Exec Lead	Mature Plan	Status Overview (inc Key Achievements; Top 1-3 only)	Next Period Key Priorities (Top 1-3 only)
Building Your Future Hospitals	James Blythe	Developing	• Proposal for accelerated programme submitted to NHP on 1st Dec • G&T have developed initial design & massing options for SECH – all under discussion (with RMH & NHP) • This will determine the land requirement for the SECH and inform plan for site enablers • Organisational Readiness Diagnostic Assessment held with Q5 on 27th Nov 23. ESTH scored 2.8/5 with a target of 3 for this phase of the programme. Challenges identified around Digital Strategy, Benefits Management, Change Management, Operational Readiness and Attracting Philanthropy. Assessment is based on P3M3 maturity model • Recruitment planning underway to secure additional programme support	• Review feedback on proposal for accelerated programme and continue progressing plan for remobilisation • Review output of RMH & NHP discussions on SECH design options and plan next steps • G&T to develop detailed schedule (covering SECH redesign to accommodate H2.0, OBC refresh and preparation for planning application) • Draft plan to implement recommendations from Q5 as part of plans to remobilise programme
High Performing Teams & Leaders *(C|I)*	James Marsh	Developing	• Shared purpose & vision workstream – working with site COOs to develop site / divisional dashboards based around CARE objectives. • Team-based programme in development (due for launch early 2024) • Ongoing delivery of SGUH & ESTH QI programmes (inc coaching support for other improvement projects) • Developed core objectives & support measures to guide programme activity in next 6-12 months	• Detailed handover of programme to new SRO • Preparation for Board engagement workshop (Feb 2024) • Commence development of Quality Management System approach (in collaboration with site COOs) • Analyse results of Improvement Baseline responses from Exec team and outline implications / options for wider programme activities
Shared EPR	Andrew Grimshaw	Y	• Work continues on the implementation of the Shared EPR. • Active clinical engagement, training • Data quality checks underway to assess ability for accurate, safe and complete data migration to new EPR	• The Project Team will continue to work with the system provider, ICS, Regional and national colleagues to ensure a safe and complete transfer to the new system with an agreed Go-Live date.

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Progress to Date - Key Initiatives (Top 9)

Initiative / Programme	SRO / Exec Lead	Mature Plan	Status Overview (inc Key Achievements; Top 1-3 only)	Next Period Key Priorities (Top 1-3 only)
Transforming Outpatients	Richard Jennings	Site level plans but Group cut across less clear	• Independent programmes at site level established with dedicated teams • Group team identified 7 strategic workstreams which cut across all sites . The Group team will focus on improving: • Primary care interface (Advice & Guidance) with an aim to return 16 advice requests per 100 outpatient referrals. • Virtual and telephone appointments with an aim to expand the percentage of activity performed this way to 25% • Patient initiated follow with an aim to move 5% of patients to these pathways	• Establish governance and oversight framework for delivery of the strategic workstreams • Maintain progress across both sites as some staff move roles and ensure suitable and adequate replacements are in post • Continue roll out of PIFU order to GIRFT top 5 and other high-volume services (SGH) • Operational readiness for Cerner (ESTH)
SWL Collaboration	James Marsh	Y	• APC Programme in place to support clinical collaboration across SWL to support Outpatient Transformation, Elective Recovery and Patient Choice via Clinical Networks and APC Elective workstreams • Active Leadership roles / SRO to support existing partnership programmes across SWL (SWLEOC; SWL Procurement; SWL Pathology; SWL HR) • Developing ambition to scope new partnership programmes across SWL (eg support for fragile services, support services integration, further HR integration)	• Confirm Providers' commitment to breadth and scope of support for Clinical Networks to support prioritisation of workstreams for Clinical Networks across SWL and appropriate engagement of gesh clinicians to apply for clinical leadership roles. • Active gesh executive oversight during business planning to align partnership priorities and operational plans with gesh strategic aims • Oversight via executive integration group and group executive to support aligned gesh position on emerging collaboration programmes
Transforming Our Culture (Diversity & Inclusion)	Jacqueline Totterdell	Developing	• Culture the theme of first GESH 100 and use of audits (psychological safety and civility) • Latest lunchtime session PSIRF - 5 sessions currently delivered - 'Introducing Civility & Psychological safety ', 'The importance of Feedback 'and 'How to Give and Receive Feedback', Psych Safety and PSIRF, with over 1700 staff joining. Other sessions take total engaged c.2200 • Trainers (x3) in place for civility and better working relationships 1 day course –now available across GESH	• Handover to Safe Place of Work • Toolkits for teams to develop Civility and Psychological Safety • Use of psychological safety and civility audits in networks

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Progress to Date - Key Initiatives (Top 9)

Initiative / Programme	SRO / Exec Lead	Mature Plan	Status Overview (inc Key Achievements; Top 1-3 only)	Next Period Key Priorities (Top 1-3 only)
Collaboration with Local Partners (Surrey, Sutton, Merton & Wandsworth)	Thirza Sawtell	Developing	• Established programme of works, agreed with key leads (across Group) • Health inequalities (Phase 2) scoping work completed in November • Frailty plans in place for internal meeting at SGUH , ESTH tbc, in preparation for a wider collaborative frailty workshop with key stakeholders across place and neighbourhood to share good practice and future vision (planned for Q4)	• Health Inequalities (Phase 2) - report to be shared and next steps agreed following executive discussion session 1st December • Group frailty community to identify collaboration opportunities and scope wider external frailty workshop
Collaboration across GESH	James Marsh	Developing	• Corporate integration: consultation for 3 services complete (DCEO, comms, corp affairs), launch for nursing in new year, others in design phase • Work on renal FBC in progress • GESH Clinical Groups set up in paediatrics, clinical support services, surgery and medicine, overseeing pathfinder projects in pharmacy, urology, community paeds, paediatric gastro, cardiac/respiratory physiology.	• Explore ways to accelerate progress, during business planning period • Launch corporate nursing consultation, complete design phase for estates, finance, IT. • Progress work to close capital funding gap for Renal Development • Recruit project management capacity to support clinical integration projects
Strengthening our Specialist Services	Kate Slemeck	Developing	• Paediatric Cancer Primary Treatment Centre Public Consultation period ended with positive engagement from GESH staff, patients and public. Expected outcome announcement due Spring 2024. • Agreement from specialised services group to carry out work to improve oversight of our specialised services in terms of risk and opportunity. • Work on identifying major risks and growth opportunities in specialised services commenced	• Commence work on improving oversight or risk and opportunity of our specialised services starting with SNCT and Renal • Develop and present interim report on opportunities for growth, networking and consolidation. • Explore support for major trauma and neurosciences to formalise their key programmes of work

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What's Next? - Forward Plan

The Next Quarter's Focus:

- Drive delivery across initiatives ('Spotlight' sessions, Dashboard and 'OKRs - Metrics for Success' provide visibility and assurance to GEM/Board and opportunities for initiatives to escalate significant blockers)
- Continue identification of enabling projects and programmes sitting under initiatives that will drive outcomes and realise benefits (existing 'work in flight' plus work that needs accelerating)
- Continue identification of cross-dependencies (amongst initiatives)
- Continue to explore and develop shared working opportunities (cross-sites; cross-functions) for economies in effort/scale
- Establish regular Communications heartbeat (via intranet) across initiatives

For July's Group Board Update – Develop & Refine:

- Strategic and Delivery Roadmap – mapped with outcomes and targeted projects/programmes
- Key Metrics for Success (and status review)

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Corporate enablers

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In April 2023, the Board agreed that corporate enabling strategies should be developed for Digital, Estates, Sustainability, Quality and Safety, Research and Innovation, and People.

In July 2023, the Board agreed enabling strategy remits and timelines for development. Since approving the timelines, **circumstances have changed impacting the pace at which the enabling strategies can be developed.**

Proposed revised timescales for enabling strategy development:

Strategy	Original date for approval	Progress update	Proposal for revised timeline
Digital	March 24	Work ongoing to develop the strategy, with discussion at Infrastructure Committee in December 2023. External support being secured to develop vision for digitally-enabled SECH.	**Approval March 2024,** with board development session February 2024.
Research & Innovation	Spring 24	Board agreed to put development of strategy on hold until Group director of research recruited. This post is now expected to be recruited early Q1 24/25. Post will lead the research and innovation strategy development.	**Approval November 2024**, with board development session tbc.
People	January 24	Material for board development session prepared but postponed due to departure of Chief People Office (CPO). Interim CPO now expected to be in post January 2024.	**Two-year people plan, approved May 2024,** with board development session February 2024.
Quality & Safety	March 24	Board agreed in October 2023 that approval of the final strategy should be delayed, given competing pressures (corporate nursing and corporate medical services restructure, CQC) – but also encouraged the executive to find a way of articulating at an earlier point the priority activity that we already know we need to pursue.	Outline strategy approved March 2024 (setting out known priorities & questions for engagement), **final strategy approved July 2024.**
Estates	January 24	Work progressed, but development of a SWL Estates Strategy (with which the SGUH/ESTH estates teams are heavily involved) has impacted timelines. Proposal is that the Group should wait until the SWL estates strategy is approved (due March), and then publish an aligned GESH strategy.	**Approval May 2024**, with board development session in April 2024.
Green Plan	January 24	Work progressing and on course to be completed in February, ready for Board approval in March.	**Approval March 2024.**

Group Board is asked to support the proposed revised timeline

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Management of strategic risks

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The Group Board Assurance Framework (BAF) has been structured around our four overarching CARE strategic themes. The Board signed off the strategic risks in the revised format on 10 November 2023. The full set of controls, mitigating actions and risk reduction schedules are currently being worked through.

The BAF will be going through the Committees of the Board in January 2024 and the full BAF will be taken at the Board Development Seminar in February 2024, and then to the board in March 2024.

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Recommendations

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The Board is asked to:

1. Note progress in implementing the Group Strategy, through local improvement, delivery of strategic initiatives, and corporate enablers.
2. Agree the proposed revised timelines for approval of corporate enabling strategies.
3. Note that as part of business planning, the Group will need to review where it can afford to invest resource to accelerate progress (e.g. in relation to strategic initiatives), and that the Executive will bring recommendations for Board consideration in February/March 2024.