Group Board

Agenda

Meeting in Public on Friday, 08 March 2024, 09:45 – 13:15

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

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

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

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:45	2.1	Quality Committees-in-Common Report – To Follow	Committee Chair	Assure	Report
	2.2	Finance Committees-in-Common Report	Committee Chair	Assure	Report
	2.3	People Committees-in-Common Report – To Follow	Committee Chair	Assure	Report
	2.4	Infrastructure Committees-in-Common Report	Committee Chair	Assure	Report
	2.5	SGUH Audit Committee Report	Committee Chair	Assure	Report
	2.6	ESTH Audit Committee Report	Committee Chair	Assure	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:25	3.1	Integrated Quality and Performance Report	GDCEO	Review	Report
11:45	3.2	Finance Report (Month 10, 2023/24)	GCFO	Review	Report

Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:55	4.1	Group Board Assurance Framework 2023/24	GCCAO	Approve	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:05	5.1	New Risks and Issues Identified	Chairman	Note	Verbal
	5.2	Any Other Business	All	Note	Verbal
	5.3	Reflections on the Meeting	Chairman	Note	Verbal
12:15	5.4	Patient / Staff Story	GCNO	Review	Verbal
12:45	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
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
Ralph Michell	Group Director of Strategy	GDOS
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
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
In Attendance		
Patricia Morrissey	Interim Deputy Director Corporate Affairs	IDDCA
Anna Macarthur	Group Chief Communications & Engagement Officer	GCCEO
Apologies		
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Tim Wright	Non-Executive Director – SGUH	TW
Observers		
Alfredo Benedicto	Appointed Governor, Healthwatch Merton	AB
Fay Greenway	Consultant Neurosurgeon, SGUH	FG
John Hallmark	Public Governor, Wandsworth	JH
Julian Ma	Appointed Governor, St George's University of London	JM
Jackie Parker	Public Governor, Wandsworth	JP

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, 12 January 2024, 09:45 – 13:00

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

PRESENT		
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 and SGUH	AB
James Blythe	Managing Director – ESTH	MD-ESTH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Aruna Mehta	Non-Executive Director – ESTH	AMe
Angela Paradise	Interim 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 and SGUH	PK
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director – SGUH	AMu
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – St George's	MD-SGUH
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
IN ATTENDANCE		
Anna Macarthur	Director of Communications and Engagement	DCCEO
Carolyn Cullen	Interim Corporate Governance Manager (Minutes)	CC
APOLOGIES		
Derek Macallan	Non-Executive Director - ESTH	DM
Martin Kirke	Non-Executive Director - ESTH	MK

** 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 Helier Hospital. These included: the Diabetes Centre, Pathology, Audiology, Frank Daes and B1, A3 and B3 wards, General Outpatients and Renal.

Diabetes Centre, Ferguson House: Peter Kane, Yin Jones and James Marsh

Peter Kane stated that it was clear that a highly responsive service was offered. Staff interacted immediately when entering the Centre and the strength of the team was evident. Although it was clear that the Centre did not have enough space, signs and noticeboards were well displayed. The team commented that there was good communication with local GPs, but added that they would like to ensure that there was good translation services for languages spoken locally by patients and relatives. Yin Jones commented that she was impressed by the efficiency of the call centre, which received between 500 and 700 calls a day, and by the politeness and efficiency of staff. James Marsh stated that staff reported cases of verbal abuse, and emphasised the importance of ensuring that staff were well supported.

Pathology: Tim Wright, James Blythe and Andrew Grimshaw

Tim Wright commented that he was impressed with the layout of the Pathology Department which had been increased in size 12 months ago. The Pathology service was run by South West London pathology. The lab itself had the capacity to undertake 100,000 tests per annum but was not currently running at full capacity. Andrew Grimshaw stated that the Lab provided services to providers across South West London, including Croydon University Hospitals and Kingston Hospital, and there was an opportunity to increase utilisation of the facility.

Audiology: Andrew Murray, Andrew Ashbury and Thirza Sawtell

Andrew Murray stated that the Audiology service was impressive and the attitude of the team very positive. Staff pride in their service was evident. Children's audiology currently had a thirteen week wait but the wait in adult audiology was just three weeks. An issue of recruitment and retention was raised during the visit and this was attributed to a lack of clear career progression.

Frank Dees and B1 Wards: Jenny Higham, Aruna Mehta, Richard Jennings and Stephen Jones

In Frank Dees Ward staff reported that there had been a recent heating failure and commented that that there had been insufficient portable heaters to keep patients warm during this period. When boarding patients from the Emergency Department, the ward could become quite crowded. On B1 Ward, Richard Jennings observed that the ward was well run, but commented that signage could be improved. Jenny Higham commented on the visible pipes, and the general poor ambience. James Blythe told the Board that refurbishment and signage for these wards were in the agreed capital plan.

A3 Ward and B3 Ward: Ann Beasley, Jacqueline Totterdell and Angela Paradise

Angela Paradise reported that the age of patients on A3 Ward was between 80 and 100 years. The ward was following good practice of getting patients up after 36 hours following hip operations. Staff were looking forward to the implementation of new electronic patient record which would increase efficiency in the ward. Ann Beasley had asked about computers on wheels and staff confirmed that access to technology could be better. Although many of the patients had dementia, the ward was not dementia friendly and more could be done to improve the environment for these patients. On B3 Major trauma ward the atmosphere was calm and efficient. EPR implementation was also raised by these staff, who were very positive about the potential positive impact the introduction of EPR would bring.

General Outpatients and Renal: Gillian Norton, Arlene Wellman and Kate Slemeck

Kate Slemeck stated that the Outpatients department was uncluttered and well organised, but that the fracture clinic area was cramped and busy. Kate Slemeck had met one of the orthopaedic surgeons during the visit who had stated that there was a real opportunity to provide cross-Group services for

orthopaedic patients. In the Renal Unit, staff were polite and welcoming. The Chairman had spoken to staff who had welcomed opportunities for cross-site working.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies from Martin Kirke, Non-Executive Director – ESTH, and Derek Macallan, Non-Executive Director – ESTH.	
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, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Angela Paradise 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 10 November 2023 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	There were no items on the Action Log for this meeting and no matters arising.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO updated the Board on the following: • **Recent Operational Challenges:** The two Trusts continued to successfully manage the ongoing impact of sustained industrial action, including six days of junior doctor strike action. This had coincided with the ongoing winter pressures, and there had been high numbers of attendances at the Trusts' emergency departments with increased patient acuity. However, staff were coping well given the pressures they faced. Additionally, there had been a high number of infections such as Norovirus, which had heightened the pressures both operationally and on staff. Changes to ways of working, initiated during the industrial disputes had provided learning and work was ongoing to identify how this could be integrated into future working practices. • **Strategic developments:** The consultation on the location of the Principal Treatment Centre (PTC) for Paediatric Cancer had closed on 18 December 2023. NHS England would now review responses. The timing for NHS	

England reaching and announcing a decision about the future location of the PTC had not been confirmed but was expected in Spring 2024.

- **Building Your Future Hospitals Programme (BYFH):** The Trust had applied to draw down the necessary funding to proceed with enabling works including commissioning a design brief for a compliant hospital, refreshing the business case and make the planning application. The Board would be updated with detailed timings of the next phase of this work in the spring.
- **Appointments and Events:** Theresa Matthews, former Deputy Chief Nurse at Epsom and St Helier, had been formally appointed to the post of Site Chief Nursing Officer for ESTH.

The Chairman invited comments and questions and the following issues were raised and noted in discussion:

- AMe expressed her thanks to the staff who stepped up to cover during industrial disputes. The GCMO added that he wished to convey his thanks particularly to consultants and pharmacy colleagues for their work during industrial disputes. The GCMO added that many lessons were learnt from implementing new ways of working which would be embedded into future working practices.
- PK asked the GCEO about her hopes and priorities for 2024. The GCEO explained that the ending of the industrial disputes was one of her principal hopes. The dispute was difficult for all concerned, and ending the dispute would help to alleviate operational pressures, tackle waiting lists and improve staff wellbeing. She added, however, that 2024 was likely to be an even tougher year financially for the NHS and that this would pose challenges for the Group.

The 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 Committee at its meeting in November 2023 and drew particular attention to the following:

- **Health inequalities**: The Committee had reviewed proposals for developing the Group's role in relation to addressing health inequalities and improving population health, which were key elements of the Group strategy as well as 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 and it planned to review detailed plans on health inequalities at its March 2024 meeting.
- **Maternity Services**: The Committee's discussions had focused specifically on the issue of perinatal mortality. The Committee had considered the most recent data available and had noted that the long-awaited report on excess mortality at SGUH in 2020 was now expected to be available for consideration at the February 2024 Committee. The Committee also endorsed proposals to undertake an external review of perinatal mortality at both SGUH and ESTH 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 presenting with mental health needs and assessed how best to work with system partners. This will remain a key area of focus for the Committee over the coming months. The Chairman invited comments and questions from Board members and the following issues were raised and noted in discussion: • AB commented that Committee's focus on health inequalities was welcome, but asked that inequalities relating to mental health be considered equally with those relating to physical health. • GCMO explained that that the relationship with local mental health providers was good. In reviewing health inequalities, the importance of promoting healthy lifestyles to influence diet and reduce obesity, as well as smoking cessation, should be seen as a collaborative endeavour with other health bodies, local authorities, and the voluntary sector. • The MD-ESTH stated that although relationships at a senior level with the Metropolitan and Surrey Police were effective, there needed to be a closer interface with local police on managing patients with mental health concerns and on violent incidents. The MD-SGUH stated that St George's had developed good relationships and liaison with local police, but noted that personnel regularly changed. In response to a comment by the Chairman about having been contacted directly over a weekend about on-call arrangements, the MD-SGUH stated that contact details for on call and out of hours would be more visibly communicated on the website and contact points. The Chairman asked that contact arrangements, for both strategic and operational liaison, be clarified with the Police for all our hospitals. **The Group Board noted the issues escalated by the Quality Committees-in-Common and noted the wider issues on which the Committees received assurance in November 2023**	
2.2	**Finance Committees-in-Common**	
	Ann Beasley, Committee Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committee at its meetings on 1 and 21 December 2023, and highlighted the following: • At month 8, SGUH was £8.7m adverse to plan and ESTH was on plan. Both Trusts were in line with financial forecast agreed with NHSE in November 2023. • Non-elective pathways continued to be under pressure at both Trusts. Both Trusts were above their Referral-to-Treatment Time (RTT) trajectory to reduce the numbers of patients waiting for more than 52 weeks to commence treatment. Particular pressures were evident at ESTH within the Gynaecology Service and Community Paediatrics. • Diagnostic performance at SGUH remained strong with 99.3% of patients receiving their diagnostic test within six weeks of referral. • Performance against the 28-Day Faster Diagnosis Standard (FDS) at SGUH continued below the 75% national target due to capacity constraints in the	

	skin service. Further work at ICS level, following the classification of dermatology as a fragile service across the SW London system, should provide improvement. • For Integrated Care, the 2-hour urgent care response was being maintained above the national standard (70%) for both Sutton Health and Care and Surrey Downs Health and Care. However, utilisation of virtual wards had plateaued. AMu drew attention to the safety risks regarding the ambulance 45-minute handover target. The GCEO stated that this was an issue of concern to senior nurses as it was known that mortality rates of patients admitted via ED had risen. The MD-ESTH stated that there was a balance between the pressures of holding patients in EDs and placing patients on wards. The Chairman stated that she was concerned about the stress this target was putting on staff. The Chairman asked that the Quality Committees-in-Common review the impact of the 45-minute handover on the EDs across the Group, on wards as well as on staff and patients. **The Group Board noted the issues escalated by the Finance Committees-in-Common and noted the wider issues on which the Committees received assurance in December 2023**	**GCNO / GCMO**
2.3	**People Committees-in-Common**	
	Yin Jones, Joint Chair of the People Committees-in-Common, set out the key issues considered at its meeting on 24th November 2023: • **Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) quarterly data update**: The Committee had received the first quarterly data update on the indicators for WRES and WDES and was focussing on ensuring improvement to the Trusts' WRES and WDES positions. Subsequent to the discussion at the People Committee, the Group Board reviewed WRES and WDES action plans and 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 both Trusts to respond to the six high impact actions identified in the NHSE EDI Plan. The Committee noted that a number of measures are already integrated into the culture programme, but more work was needed. The Committee had asked that timescales for actions, tracked against national deadlines for delivery, be produced in order to provide further assurance. **The Group Board noted the issues escalated and the wider issues on which the People Committees received assurance in November 2023.**	
2.4	**Infrastructure Committees-in-Common**	
	Ann Beasley, Chair of the Infrastructure Committees-in-Common, set out the key issues considered by the Committee at its meeting on 12 December 2023: • **South West London Picture Archiving Communication systems (PACS) & Radiology Information Systems (RIS) Implementation**: The Committee received an update on implementation of the new PACS and RIS systems across the four acute Trusts in SW London. The new Go Live date at	

	Croydon University Hospital was 24 February 2024, with Go Live scheduled to follow at Kingston, St George's and finally Epsom and St Helier. • **Estates Assurance**: The Committee received reasonable assurance for estates at St George's noting that work was underway to respond to operational and maintenance issues. The Committee received limited assurance for estates at Epsom and St Helier, noting the number of Estates risks and the backlog in Authorised Engineer audits. • **Health and Safety**: The Committee noted two serious health & safety incidents had taken place at St George's. The Committee had asked for assurance that the contractor management audit was completed and for assurance that the Trust was meetings its responsibilities against the Health and Safety Executive (HSE) CDM regulations. The GCEO asked that arrangements for notification of serious health and safety incident to the GCEO and Board members be reviewed, and a protocol established. **The Group Board noted the issues escalated by the Infrastructure Committees-in-Common to the Group Board**	**GCIFEO**
3.0	**ITEMS FOR REVIEW**	
3.1	**Maternity Services Report**	
	The GCMO stated that the purpose of the report was to inform the Group Board about progress against the local and national agreed safety measures for maternity and neonates. Against the ten safety actions within the Maternity Incentive Scheme (MIS) within the Clinical Negligence Scheme for Trusts (CNST), ESTH had seven safety actions which were on track, one was currently non-compliant and two had safety actions with associated risks of delivery. At SGUH, seven safety actions were also on track, with one currently non-compliant and two with associated risks. The final compliance self-assessment would be considered by the Group Board in late January before submission to the Integrated Care Boards on 2 February 2024. At ESTH, the key risks on compliance with the MIS related to mandatory training, not meeting the fill rate for maternity staffing, non-compliance with midwifery workforce planning. At SGUH, the risks related to recruitment and retention of staff. Staff report difficulties in speaking up, feeling heard and difficulties with management relationships, non-compliance with mandatory training, non-compliance with the fill rate for maternity staffing, non-compliance with midwifery workforce planning, and a risk of non-compliance with Safety Action 6 were also identified. **The Group Board:** • **Noted the compliance status against the CNST year 5** • **Noted the key areas of risk and mitigations**	
3.2	**Healthcare Associated Infection Report**	
	The GCNO stated that all sites across the Group had seen an increase in respiratory infections, including COVID-19 and influenza, and this had resulted in significant impact on bed capacity. During the period 1 April to 30 November 2023, there have been a total of 524 COVID-19 infections, with 4 nosocomial deaths at ESTH and 22 nosocomial deaths at SGUH. All nosocomial deaths were subject to a review as per national guidance.	

	ESTH had breached the nationally-determined *C.difficile* threshold for the Trust for the first time in over four years. At SGUH, the Trust remained below the *C.difficile* nationally set objective. High levels of Legionella had been found in routine water sampling at various outlets at Epsom Hospital. An urgent meeting had been held with Estates leads and the Trust-appointed Authorising Engineers. As the areas with the highest counts were in non-clinical area it had been agreed that there would be no immediate need to install point of use filters. There has been one reported case of measles. The Trusts within the Group were alert to the measles outbreak affecting the London and Birmingham areas. **The Group Board received the Healthcare Associated Infection (Infection Control) Report for assurance.**	
3.3	**Group Financial Performance Month 8**	
	The GCFO informed the Board that additional national funding at Month 8 had improved the financial position of both Trusts. ESTH was now forecasting to be on plan by year end, and SGUH is forecasting a £15m adverse variance to plan at year end. This shortfall related to non-delivery of Cost Improvement Plans (CIPs) and baseline pressures. The cash position remained tight. ESTH had not made a cash request for Quarter 4 as a result of new national monies; SGUH had requested £19m of PDC (Public Dividend Capital) support for Q4. **The Group Board noted financial performance in Month 8.**	
3.4	**Integrated Quality and Performance Report**	
	The GDCEO introduced the report and highlighted the following: Urgent and Emergency Care pathways continue to be under pressure at both Trusts. The number of patients waiting in the Emergency Departments (EDs) for more than 12 hours is significantly higher than expected. Against the 4-hour wait standard of 76%. SGUH achieved a performance of 76.1%, and ESTH marginally missed the target with a performance of 75.5%. The key constraints remain bed capacity, acuity, and mental health presentations. Areas of challenge include: SGUH declared two Serious Incidents (SIs) and two Patient Safety Incident Investigations (PSIIs), including one Never Event in October 2023. The Never Event related to a wrong site skin surgery conducted in October 2023. Detailed investigation into high harm pressure ulcers continues with a Trust-wide action plan in place and a spotlight on pressure ulcers by designating November pressure ulcer month. **The Group Board noted the operational and quality information as at October 2023**	
3.5	**ESTH Emergency Preparedness, Resilience and Response Annual Submission**	
	The MD-ESTH stated that the Trust's emergency preparedness to meet the requirements of the Civil Contingencies Act (2004) and the NHS England Emergency Preparedness, Resilience and Response (EPRR) Framework (2022) was overall compliant. Action plans for areas rated as partially compliant were in	

	place as set out in the paper. The MD-ESTH stated that over the past year there had been improvements to the Trust's EPRR arrangements; including a full re-design of the EPRR training programme, which was now mandatory for all staff. The Trust had shown its resilience to respond to a variety of incidents in an efficient and effective way. **The Group Board:** • **Approved the Emergency Preparedness, Resilience and Response Annual Report** • **Approved the declaration of compliance against the core standards for EPRR**	
3.6	**SGUH Emergency Preparedness Resilience and Response – Assurance Outcome 2023**	
	The MD-SGUH asked the Group Board to note the substantial compliance rating for SGUH in the 2023 annual EPRR Assurance Process, with only one recommendation for improvement. This recommendation related to the compliance with information governance training. The Emergency Preparedness Team, which previously had vacancies, was now fully staffed**.** The Chairman welcomed the improvement to substantial compliance but noted the striking difference in format, content and length of reports for ESTH and SGUH and asked that, going forward, the two Trusts adopt a common reporting approach to the Group Board on this issue. **The Group Board noted the assurance outcome for the SGUH Emergency Preparedness Resilience and Response submission 2023.**	
3.7	**Group Strategy Implementation Update**	
	The GDCEO reminded the Group Board that the Group strategy had been launched eight months ago and the paper sought to provide an update on progress to date in implementing the strategy and the associated strategic initiatives, and proposed next steps for delivery. In April 2023, the Boards had agreed that corporate enabling strategies be developed for Digital, Estates, Sustainability, Quality and Safety, Research and Innovation, and People. Since approving the timelines, circumstances had changed which had impacted on the pace at which the enabling strategies could be developed. The GDCEO asked the Group Board to note the proposed revised timescales for developing these enabling strategies. To accelerate progress, he commented that it may be necessary to invest in additional resources in order to deliver this programme. The GDCEO explained that he planned to bring proposals for resourcing the delivery of the strategy to a future meeting, linked to forward planning for 2024/25. In relation to the risks to the delivery of the Group strategy, the GCCAO explained that the new Group Board Assurance Framework (BAF) has been structured around the four overarching CARE themes. The Group Board had signed off the strategic risks on 10 November 2023 and a full set of controls, mitigating actions and actions were currently being worked through. The BAF would be taken through relevant Committees in January 2024 and the full BAF would be presented to the Group Board for review in February 2024, and then to the Board meeting in public in March 2024. **The Group Board:** • **Noted progress in implementing the Group Strategy**	**GDCEO**

	• **Agreed the proposed revised timelines for approval of corporate enabling strategies** • **Noted 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 recommendations for Board consideration will be made in March 2024.**	
6.0	**CLOSING ITEMS**	
4.1	**Any new risks and issues identified**	
	There were no new risks identified.	
4.2	**Any other business**	
	The Chairman stated that there were two additional items of business: • This was Aruna Mehta's last Board meeting. The Chairman thanked Aruna for all her work and the support she had given to ESTH and the Group as a whole. The Chairman commented that Aruna would be much missed, a sentiment endorsed by the Group Board . • The Chairman also highlighted that it was the GCIFEO's last meeting in public as he would be leaving the Trust at the end of February 2024. The Chairman thanked GCIFEO for all his work.	
4.3	**Reflections on meeting**	
	The Chairman asked Aruna Mehta to give her reflections on the Group Board meeting. AM offered the following reflections: • AM stated that it had been a pleasure to visit the wards and meet staff. Ward visits contextualised the discussions and decisions at the Group Board meeting. • AM noted that discussion had been open, with fair challenge, showing the maturity of the Group Board. The GCEO agreed and stated that the Group Board was unified in its approach to difficult and challenging matters.	
4.4	**Patient / Staff Story**	
	The Group Board welcomed Mr Harwood, a member of a patient group at Queen Mary's Hospital that supported patients with prosthetic limbs. Mr Harwood had initially submitted a Board question; but the Board had asked Mr Harwood to present his story. Mr Harwood explained that he had been a patient at Queen Mary's Hospital since he was four years old, and he was now in his eighties. Mr Harwood had received his first prosthetic limbs when he was child and Queen Mary's had kept him mobile ever since. The question that Mr Harwood had submitted to the Board concerned how his patient group could be involved in inputting into decision-making on the award of contracts for prosthetic limb products as the group had valuable user experience. The Chairman agreed that patient experience should be a key component when considering products and contracts in areas such as prosthetics. The MD-SGUH also agreed that patient experience is a valuable input when letting contracts. She stated that she would check the timeline for contract award and would speak to Mr Harwood following the meeting to discuss how his patient group could be involved.	

	The GCEO stated that routinely obtaining feedback from patients and expert patient groups should be embedded into the Trusts' contracting procedures. The Chairman thanked Mr Harwood for all his work supporting and representing patients with prosthetics and also thanked him for attending the Group Board today.	
CLOSE		
The meeting closed at 12:45 pm		
QUESTIONS FROM MEMBER OF THE PUBLIC AND GOVERNORS		
There were no questions from the public or SGUH Governors		

Date of next meeting: 10 am on 9 March 2024

Group Board (Public) - 8 March 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC202401012.2	12-Jan-24	2.2	Finance Committees in Common report	The Chairman asked that the Quality Committees-in-Common review the impact of the 45-minute handover on the EDs across the Group, on wards as well as on staff and patients.		GCNO	The Quality Committees-in-Common are scheduled to consider this at their meeting in March 2024.	NOT YET DUE
PUBLIC202401012.3	12-Jan-24	2.4	Infrastructure Committees in Common	Health and Safety: GCEO asked that arrangements for notification of serious health and safety incident to the GCEO and Board members be reviewed, and a protocol established.		GCIFEO	The Group Executive has agreed that health and safety incidents should be included within the existing protocol for the escalation of issues to the Group Executive and Group Board. A wider review of arrangements for ensuring timely notification to the GCEO of serious health and safety incidents is being undertaken. Due date May 24.	NOT YET DUE
PUBLIC202401012.4	12-Jan-24	3.7	Group Strategy Implementation Update	The GDCEO plans to bring proposals for resourcing the delivery of the strategy to a future meeting, linked to forward planning for 2024/25.	08-Mar-24	GDCEO	The intention is for this to be discussed at the Group Board development session in March.	NOT YET DUE

Group Board

Meeting in Public on Friday, 08 March 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	08 March 2024
Purpose	**For Noting**	

Executive Summary

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

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

Action required by Group Board

The 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. Purpose of paper

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

2. Background

2.1. Regular update to the Board.

3. Introduction

3.1. February marks the two-year anniversary of St George's, Epsom and St Helier hospitals working together as a Group, and over this time, we see on a regular basis the benefits of working at scale. We closed phase one of our nursing consultation, formally integrating aspects of corporate nursing teams, and are progressing through other areas of corporate integration to support the Group's work.

Further integration efforts mean Corporate Affairs, Communications, People, Finance, Deputy CEO department, Corporate Medical teams, and parts of Estates & Facilities and IT departments, join together as Group teams over the next year. Though we will not achieve this within the timescales we hoped for, we are taking a flexible approach to ensure we get integration right and can support our staff through the transition.

We have made important observations during this process's early stages. First, many staff members feel strong loyalties to the institution's culture and have anxieties about the other. We have expressed a commitment to supporting a common culture that reflects our Group goals. Second, we are facing competing organisational pressures, and recognise that change management takes time. We are asking leaders to implement complex changes while simultaneously responding to major financial, operational, and quality challenges. To navigate through these challenges, we consider that it is crucial to continue to consult staff and staff representatives (including staff-side and line managers) to ensure they are involved in each step of the corporate integration roll out.

Despite changes and challenges, our teams have stayed dedicated to delivering outstanding care to our patients; the achievements mentioned in this report are proof of their commitment and talent.

4. National Context and Updates

4.1. Implementation of the first phase of Martha's Rule

Beginning in April, patients and their families in England will have the option to request a rapid second opinion if they are concerned about a condition worsening. This policy is referred to as "Martha's Rule".

Martha's Rule is based on Martha Mills' death after being admitted to King's College Hospital, London, due to injuring her pancreas while riding her bike. She later developed sepsis while in hospital. Her death was put down to failing to escalate her care or refer her to intensive care despite concerns raised by her family regarding her worsening condition. Martha's Rule aims to provide a swift escalation process for urgent review by a different critical care team in hospitals across the country and will be available 24 hours a day.

The first phase will see Martha's Rule rolled out to at least 100 acute or specialist provider sites in England in 2024/25, supported by funding of up to £10 million. NHSE will identify which acute provider sites will participate in this first phase and support the development of their local processes. Alongside this, drawing

from the local learning from new and existing schemes, NHSE will develop proposals for a national roll-out in the next spending review period.

We believe that as this policy expands in future years, these principles will greatly improve patient partnership and positively impact on patient outcomes and experiences.

4.2. Leadership Competency Framework for Board Members

The new NHSE leadership competency framework was recently published on 28 February and applies to all NHS, ICB, and NHSE board members.

The Framework sets out six domains that board members must assess themselves against as part of an annual fitness appraisal. Each domain reflects the NHS values and contains competencies that board members must demonstrate:

1. Driving high-quality and sustainable outcomes
2. Setting strategy and delivering long-term transformation
3. Promoting equality and inclusion, and reducing health and workforce inequalities
4. Providing robust governance and assurance
5. Delivering a compassionate, just and positive culture
6. Building a trust relationship with partners and communities

Each competency statement gives board members a multiple choice to assess themselves against, ranging from “almost always” to “no chance to demonstrate”. These competencies are aspirational, and there is recognition that not all can be achieved or demonstrated particularly for new members.

The framework was developed to support organisations recruit, appraise, and develop board members. It comes after NHSE announced an overhaul of the fit and proper person test last August, responding to a review of the regulations carried out nearly five years earlier by Tom Kark KC.

In terms of what this means for our Board:

- Board recruitment: The new LCF competency domains will be integrated into all Executive and Non-Executive role descriptions for all recruitment to Board roles across the Group from 1 April 2024. The LCF will be used to help evaluate applications and inform and candidate selection processes.

- Appraisal: The LCF will be incorporated into the annual appraisal process for all Board members across the Group and will be used in the collection of 360 feedback. As part of their appraisals, Board members will also be asked to undertake a self-assessment against the six competencies. This is starting with the Non-Executive Director appraisals for 2023/24 which have recently commenced, and which have been updated to incorporate the new approach to collecting 360 feedback. As annual appraisals for Executives have recently concluded, this will be rolled out for Executive Directors – including my own – in the next appraisal cycle.

- Development: Personal development plans will also need to take account of the LCF and training and development will focus around supporting directors to develop proficiency in all areas of the competency domains. NHS England also expect the LCF to be used to support the ongoing development of the Board as a whole.

An revised Appraisal Framework for NHS Chairs has also been published which includes all the competencies outlined in the new framework.

NHS England has stated that it will publish a Board Member Appraisal Framework by autumn 2024, which will include guidance on assessing the performance of directors against the six competency domains.

4.3. Principal Treatment Centre for Paediatric Cancer in South London

NHSE is planning the future location of the Principal Treatment Centre (PTC) for the catchment area of south London, Kent, Medway, most of Surrey, East Sussex, Brighton and Hove. Last year, SGUH and Evelina London Children's Hospital, (part of Guy's and St Thomas' NHS Foundation Trust) submitted bid proposals to become the new PTC, with both proposals scoring highly and taken forward for public consultation.

NHSE has advised that a decision will be made on Thursday, 14 March. NHSE London executives and the southeast executives will review the decision-making business case in a public, live-streamed meeting.

5. Our Group

5.1. South West London Acute Care Provider Collaborative

GESH work collaboratively with other acute Trusts in South West London (Croydon and Kingston) in the SWL Acute Provider Collaborative (SWL APC) to improve elective and diagnostic care as well as manage services such as pathology, recruitment, procurement and pharmacy.

We have agreed priorities in 2024/25 for our clinical networks. Networks are groups of secondary and primary care clinicians that have been leading and implementing best clinical practice across SWL since 2020. In 2024/25 we will focus our work on access, productivity, and reducing inequity in high volume specialities such as Audiology, Cardio-metabolic (Cardiology/Diabetes), Dermatology, ENT, Gastroenterology, Gynaecology, Neurology, Ophthalmology and Urology.

We have agreed to pilot a referral support service in ENT across SWL as a way of reducing inequity in waiting lists between SWL providers and supporting consistency of pathways. The pilot is expected to start in Q1 24/25 and will provide useful learning as to whether this would be appropriate for other specialities across providers.

5.2. CQC Maternity Report

The overall rating for maternity services at both hospitals has been lowered from 'Good' to 'Requires Improvement'. Inspectors have also rated the safety of maternity services at St Helier as 'Inadequate'. Reasons for the rating are related issues of safe staffing, triage and governance processes, and the hospital's ageing estate, which is no longer fit for purpose.

The Trust is actively working to address these issues and has taken immediate steps in response to the CQC's recommendations. This includes strengthening services by investing more than £2m over two years to increase staffing levels by 8% and taking remedial action regarding workplace and environmental hazards. Further, this month I began open sessions for all staff to discuss and feedback on the maternity inspection report with an aim to ensure a comprehensive response and show appreciation for the efforts we see from our staff.

5.3. CQC 2023 Maternity Experience Survey

Maternity teams across our Group have scored in the top two in London for care given to women and their babies. Teams at ESTH was ranked top in the capital, with services at SGUH named a close joint second for

their maternity care. The CQC's report showed improvements in a number of areas compared to previous years.

Key highlights from the report include:

- Women said they had been treated with kindness and compassion during pregnancy and birth, scoring St George's and Epsom 9.2/10 and St Helier 9.3/10.
- More women were treated with dignity and respect during antenatal care, up 6% at Epsom and St Helier and 2% at St George's Hospital to 9.6/10 at both trusts — in all cases above the national average.
- Women had high levels of trust and confidence in the staff caring for them, up from 8.3 to 9/10 (above national average) at Epsom and St Helier, whilst remaining high at 8.7/10 at St George's.
- Partners being able to stay and be involved in care was scored better than average, up from 9 to 9.3/10 at St George's and 9.6 to 9.9/10 at Epsom and St Helier.

Both SGUH and ESTH also performed better in a number of areas when compared to other trusts in the country – including treating people with dignity and respect during their antenatal appointments. These are fantastic results that we are proud of and demonstrate the ongoing success of our Group.

5.4. Visits

Maria Caulfield MP, Minister for Mental Health and Women's Health Strategy, chose to launch her new baby loss certificates from SGUH on 21 February. The announcement means women and birthing people who lose a baby before 24 weeks will have their loss formally recognised. This event was covered several media outlets.

6. Appointments, Events and Our Staff

6.1. Appointments

- My congratulations to Natilla Henry who has been appointed as our first ever Group Chief Midwifery Officer.
- Andrew Ashbury, our Group Chief Facilities, Infrastructure & Environmental Officer has now left the Trust. An interim appointment will be made with aims to permanently fill the role in April.
- Recruitment is underway to permanently fill the Chief People Officer role.

6.2. Events

6.2.1. GESH100 Leadership Forum

Our second GESH100 Leadership Forum is planned for 26 April with around 130 senior leaders coming together to exchange ideas and views. The first Forum focused on individual and collective leadership practice. This second event will examine what it takes to build, lead, and contribute to effective teams.

The Forum is a series of seminars that focus on exploring a wide range of topics relating to leadership practice through teamwork, organisational culture, and systems working. We committed to meeting three times per year with the third event scheduled for Friday 19 July 2024.

6.2.2. Executive Question Time

Our Executive Question Time (EQT) is an opportunity to connect with all members of staff — from clinical to non-clinical roles — to hear from the GESH executive team, hear the latest news, and ask questions. Our most recent EQT which took place on 27 February focused on our reflections after two years of GESH, including progress and challenges.

Staff responded positively to EQT. Of 61 people surveyed, 85% reported that the session was helpful. Feedback on the sessions indicated that it provided useful updates on the Group and was an opportunity to get prompt answers to key questions.

6.3. Our Staff

6.3.1. Walkabouts

It's vital to 'get out of the boardroom' and understand what happens in every ward/department. I see walkarounds as a tool comparable to staff surveys or patient focus groups. It allows me to learn more about the pressures staff are facing, hear positive patient stories, and discuss with staff how we can continue to work together to provide the best care possible to the communities we serve.

6.3.2. GESH Staff Stories

We have recently launched GESH staff stories, where each employee can nominate members of their team to recognise exemplary working behaviour in line with our values. Our first inspiring story was released on 1 March, and highlights Joana Lopes Gomes who gives her perspective as an Adult Safeguarding Clinical Nurse Specialist at St Georges.

6.3.3. Violence and Aggression Task Force

No one should have to suffer being shouted at, physically abused, or subjected to discriminatory abuse while doing their job. Sadly, this is increasingly the case for many of my staff who are being abused and harmed by patients and visitors. They shouldn't have to tolerate it, and we are taking steps to address it. I have established a Violence and Aggression Taskforce to refresh our policies, with aims to make it more straightforward for staff members to report issues of violence and aggression. Our first meeting is scheduled for 12 April.

7. Closing

7.1. We have made progress over the last few months, but as always, there is still room for improvement. We recognise the financial gap and operational pressures in SWL next year will be challenging. This means we will need to make some radical decisions and change our ways of working. As such, our attention is now firmly on advancing the Group's strategies and improving finance and efficiency, quality and performance, and workforce at a local and system level.

Group Board

Meeting on Friday, 08 March 2024

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

Executive Summary

This report sets out the key issues considered by the Finance Committee at its meetings in January and February (actually 1st March) 2024 and sets out the matters the Committee wishes to bring to the attention of the Board.

Action required by Group Board

The Board is asked to: Note the paper.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/a
Appendix 2	N/a
Appendix 3	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, 08 March 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its its meetings in January and February (actually 1st March) and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 26th January and 1st March 2024, the Committee considered the following items of business:

26th January 2024	1st March 2024
PUBLIC MEETING • Finance Report/Forecast (M9) • Finance Risk deep dive • Controls Update • Cash update • Costing update • Planning 24/25 • IQPR • SWL Procurement Partnership update	**PUBLIC MEETING** • Finance Report/Forecast (M10)* • Cash update • Planning 24/25* • IQPR • SWL Pathology report

**items marked with an asterisk are on the Group Board agenda as stand alone items in March 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 Planning 24/25- Committee members noted that the balance of financial, operational and quality metrics was challenged as the Group planned for the coming 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 M10

The GCFO noted ESTH is £2.9m adverse to plan for the impact of December and January industrial action. SGH is £16.7m adverse owing to £6.3m industrial action and the remaining variance is owing to baseline pressure.

b) Cash update

The GCFO introduced the cash update which outlined both Trusts' cash position against the original Q4 forecast. Both Trusts are largely on plan to date as at mid-February.

c) Financial Planning 24/25

The GCFO introduced an update on financial planning for 24/25, noting the significant challenges of each trusts' 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. ESTH remain challenged across both sites with many unplaced patients remaining in the emergency department, increased ambulance delays and high numbers of mental health patients requiring admission. Despite that the 4-hour ED standard in January 2024 was delivered, reporting 76.1% performance. At SGH 4-hour performance declined to 69.1% reflective a challenging month with issues in managing the flow within the hospital, resulting in a high number of patients waiting for beds in both the emergency department and in inpatient areas.

Both trusts continue to exceed **RTT** trajectories to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH is particularly challenged with 830 patients waiting for more than 52 weeks at the end of December 2023, however this reduced by 9% compared to November 2023. The 65-week wait cohort at ESTH is seeing an increase due mainly to strike action and delays to insourcing plans for Gynaecology and Community Paediatrics. At SGH, the number of patients waiting over 65 weeks is exceeding plan and likely to remain challenged due to planned action. Neurosurgery is a specialty of concern although all potential 65-week breaches are being scrutinised weekly.

Diagnostic performance at SGH remains strong and within the national target of 5% (over 6 weeks), with 97.3% of patients receiving their diagnostic test within 6 weeks of referral in January 2024. Sleep studies and echo diagnostics have been particularly challenged. Echo continues to look for support from an insourcing company, however, to date they have been unable to supply staff to carry out stress echo tests which is the largest waiting cohort. ESTH is reporting a breach rate of 4.9% in January 2024 - an improvement on previous month and compliant with national ambition. The modalities with the highest volume of patients waiting over 6 weeks are Urodynamics, Endoscopy and Echo.

Cancer performance is on track at ESTH with some challenges at SGH. Performance against the 28-Day Faster Diagnosis Standard (FDS) at SGH continues to track below the 75% national ambition mainly due to capacity constraints in skin service and Histopathology delays. The improvement plan for histopathology turnaround times as well as the capacity and demand modelling for outpatients will support the overall improvement against this standard. Although SGH are not achieving the 62-day

national cancer standard (December 2023 at 80.1%) the monthly trajectory was met, and the service is on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment at the end of January 2024.

Integrated Care 2-hour Urgent Community Response (UCR) 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 will be a focus for reducing avoidable bed days in hospitals. Sutton has seen the median days referral to discharge increase over the past two months whilst also seeing an increase in virtual ward occupancy improving to 62.4%. This change is due to amended occupancy targets for Sutton as approved by the SWL Virtual Ward Board. Surrey Downs Health & Care observed a decline in time taken for discharges through the transfer of care hub from a median of 2 days in December 2023 to 3 days in January 2024 across all pathways combined. This is mainly due to winter pressures and an increase in number of referrals.

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) Costing update

The Committee approved the assurance statements and delegated authority to submit the final returns to the Group Chief Finance Officer.

c) SWL Procurement partnership update

Committee members noted the work undertaken on resourcing requirements.

d) SWL Pathology Report

Committee members noted the report.

5.0 Implications

5.1 The Committee considered the group finance-related risks for the new group Strategic Risk 4 on Financial Sustainability as a deep dive in January 2024.

5.2 The Committee agreed proposed risk scores (SGH=25; ESTH=20; and Group= 25), assurance ratings, target risks scores and controls proposed.

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 January and February 2024.

Group Board

Meeting in Public on Friday, 08 March 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 28 February 2024. The key issues the Committee wished to highlight to the Board are:

1. **South West London Electronic Patient Record (EPR) implementation:** The Committee received a progress update on implementing the shared EPR programme. The Committee discussed the phased approach to the programme and the internal and external challenge and assurance that will need to be satisfied ahead of receiving a revised implementation programme plan and timetable for go-live.

2. **Group Green Plan:** The Committee received an update on the Green Plan and welcomed the momentum in developing this and the engagement with wider plans across South West London. Members heard recruitment continues to the Green Plan team along with developing the governance, action plans and KPIs for workstreams and steering groups at both Trusts to manage workstreams. Members welcomed the imminent publication of the Epsom and St Helier decarbonisation plan which will inform decarbonisation priorities across the Group.

3. **Capital restraints and impact on Estates and ICT programmes:** The Committee noted the impact of the current financial environment and difficulties in securing the funding for key estates and ICT/Digital programmes. Members welcomed where additional investments had been made in CCTV and security in Emergency Departments at Epsom and at St Georges. The Committee discussed how reduced levels of capital funding available to address the backlog of legacy maintenance issues and historical underinvestment in ICT and Digital infrastructure are proving challenging as both Trusts undertake risk-based approaches and re-prioritisation of plans to ensure key programmes of work are delivered.

Action required by Group Board

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

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

Infrastructure Committees-in-Common Group Board, 08 March 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 28 February 2024 and includes matters the Committee specifically wishes to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meeting on 28 February 2024, the Committee considered the following items of business:

February 2024
• St George's Estates and Facilities Assurance updates (including: estates update, management of contractor safety audit, facilities assurance report, medical physics report, medical devices internal audit report)
• Epsom and St Helier Estates and Facilities Assurance updates (including: estates update, facilities assurance report, medical physics report)
• Group Green Plan and the South West London Green Plan updates
• Group Digital Strategy Development
• Digital Workplan
• Digital risk update
• Information Governance & Cyber Security update
• Digital Governance Development update
• Electronic Patient Record implementation update
• SWL Picture Archive and Communication system update

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 Electronic Patient Record (EPR) implementation progress

The Committee received an update on the shared Electronic Patient Record (EPR) programme to create a common EPR across GESH on a shared domain. Following the decision to pause implementation, the EPR programme team are undertaking a diagnostic

review to determine the factors leading to the need for an extension, which will inform a revised programme plan and timetable for implementation. The Committee noted that strengthened programme and digital leadership has been implemented and consideration had been given to how ICT and digital resources are deployed across the Group to support the work. Backfill arrangements are being reviewed to ensure resource and capacity for business-as-usual work. The diagnostic findings have supported the decision to pause implementation while solutions for the data warehouse and reporting workstreams go through external peer review and check and challenge sessions. An additional cycle of load testing is also taking place incorporating lessons learned from previous tests which will support the proposal for the revised go-live date. These sessions will look to provide assurances to the Executive before the plan is taken through the revised governance structures. The Infrastructure Committee will be asked to consider a recommendation by the Shared EPR Programme Board ahead of formal sign off of the plan and the new go-live date at the Group Board.

3.3 **GESH Group Green Plan and South West London Green Plan**

The Deputy Group Chief Facilities, Infrastructure and Environment Officer reported there has been a reset of the Green Plan influenced by the Group integration agenda to place the plan alongside the Group Estates Strategy and the South West London Green Plan. A redefined strategy including guiding principles, objectives, targets and KPIs for all workstreams is expected for May 2024. The work is being led by the Managing Directors at SGUH and ESTH, Steering groups for workstream leads have been set up at SGUH and will be replicated at ESTH. In addition, the Committee noted:

- Recruitment to the Green Team continues with expectation of being able to appoint to the Assistant Director role by close of March 2024.
- There are plans to introduce decarbonisation training for the Board at a future date.
- Consideration will be given to how to respond to capital investment challenges with external funding being targeted for decarbonisation programmes.
- Work with the SWL Integrated Care System on the SWL Green Plan. The Group will be taking a case study to the next SWL Integrated Care Board meeting.
- Interim arrangements are being explored to fill the Clinical Lead for Green Theatres role
- A detailed update paper on the successful Smart Theatres digital transformation programme will be presented at the next meeting.

Members welcomed the continued focus and momentum in developing a Group plan, noting the collaborative work across Group and the wider system. The challenge in realising the decarbonisation ambitions was highlighted in the context of capital funding challenges. The Committee will receive a detailed report on progress on decarbonisation work across the Group on completion of the Epsom and St Helier Heat Decarbonisation Plan.

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4.0 Key Issues on which the Committees received assurance

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

4.2 **Estates Assurance Report**

The Committee received assurance reports on both Trusts' estates performance and compliance. SGUH is meeting its performance targets but there are concerns over an increasing backlog with reduced levels of capital funding available to address legacy issues.

Maintenance teams continue to engage a risk-based approach with 100% of all safety-critical requests attended to and made safe. Members noted performance for critical planned preventative maintenance stands at 50% and the challenges in maintaining fire doors, ventilation, and electrical systems. The Committee will receive a detailed report at its next meeting which would include deep dives of the critical areas.

The Committee received the management contractor survey which had been implemented in response to incidents onsite at SGUH involving contractors. The audit had identified areas of improvement which have since been addressed. The Committee was assured the Health and Safety team are continuing to monitor progress and there had been no further incidents have been reported to date. The Committee suggested contractors could attend start-up meetings before onsite projects to ensure they were made familiar with those accountable for health and safety. Committee members asked whether an audit of contractors at ESTH was needed to ensure contractors working onsite hold the appropriate Construction Skills Certification Scheme qualifications.

The Committee noted significant challenges at ESTH which are exacerbated by an aging estate and management of the maintenance backlog. Improved compliance processes have been introduced, including a rebuild of its assets register on its computer aided facility management (CAFM) system to aid planned maintenance. The Trust is also awaiting the results of its 6-facet survey which will identify issues and priority areas.

The Committee welcomed the reasonable assurance for the programme of Authorised Engineer reports at SGUH. Members noted a more challenging position at ESTH should be addressed via a new lead Authorised Person allowing the appointment of authorised engineers to resolve delays in audits.

Staffing, sickness absence and recruitment continues to be challenging at both Trusts. While recruitment proves difficult, it is hoped that working as a group on recruitment drives will be more successful.

4.3 Facilities Assurance Reports

Both SGUH and ESTH continued to report high levels of compliance with cleaning standards. Committee members noted additional investment in new cleaning equipment would be needed at ESTH to ensure compliance with the national cleaning standards.

Both Trusts are implementing new car parking permit systems with pressures on resource reported at both sites. ESTH are introducing an app-based permit system which, if successful, could form a common parking permit platform and enable group wide permit parking.

The Committee was concerned to hear of increased incidents involving violence and aggression in the Emergency Departments across the Group. There has been a 309% increase in such incidents from 2022 to the year-end 2023. In response to a request made by Members at the December meeting, a deep dive of incidents involving violence and aggression was shared which highlights the risks faced by both patients and staff. The Committee welcomed the additional investment in improved and extended CCTV coverage and other safety and security infrastructure at ESTH. Members also welcomed the business cases for recruitment of additional security resource in ED at SGUH.

The Committee reiterated the importance of staff having an opportunity to undertake ‘Working at Height’ training and the necessity of staff being able to access the appropriate health and safety training.

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

5.0 Other issues considered by the Committees

5.1 Medical Physics Report

The Committee received its regular report on ongoing mandatory and statutory compliance with medical physics and clinical engineering requirements and welcomed the reasonable assurance provided by the internal audit review of medical devices. The Committee heard medical physics works closely with clinical governance colleagues on maintaining clinical assets using a risk-based approach to maintenance and replacement of devices, noting the ongoing challenges of capital funding for replacing devices beyond their life cycle. The Committee heard there are challenges in recruiting into nuclear medicines vacancies noting the potential impact on nuclear medicine contracts. The Committee noted this was a national issue.

5.2 Group Digital Strategy Development

The GCFO reported prioritisation of requirements is underway across the two Trusts in development of the Group Digital Strategy. The prioritisation work will attempt to reconcile areas of critical priority, competing aspirations and wider demands and seek to align the strategy with broader Group priorities and balance against finite resources. The strategy would highlight how the Group ensures its systems are both resilient and reliable, while resolving long term issues and planned critical programmes such as the upgrade of the SGUH network and ensure it is fit for purpose and acts as an enabler for future digital pieces across the Trust and Group. The Committee heard that the strategy would also consider the impact of larger projects like the SWL PACs and the EPR implementation on operational and clinical business as usual as well as wider digital ambitions.

5.3 Digital Workplan & Digital Leadership

The Committee received the report setting out the digital workstreams being delivered at SGUH and ESTH and noted:

- The digital response to the requirements of the Group Corporate Servies integration
- The significant challenges of resource and the requirement for capital funding as highlighted by the prioritisation work for the 2024/25 digital workplan.
- The expectation that current resource and capital restraints will see the workplan evolving as reprioritisation work reflects the constraints faced by the Trusts.
- The considerable impact of shared joint infrastructure projects like the joint EPR implementation work and its impact on resource and wider programmes of work.
- The pressures on maintaining business as usual systems at both Trusts along with ongoing maintenance, incident management and optimisation work.
- The complexity and the interdependencies of the different workstreams and the ongoing need for additional investment to maintain current high levels of demand and anticipated future demand.
- Digital ambitions need to be considered in the context of current restraints of capital and resource.

- The importance of ensuring shadow IT systems are well established and align with existing digital programmes and how digital support service driven shadow IT with controls and processes for managing risks in place.
- The SGUH network upgrade programme is considered a priority workstream which will drive other digital workstreams.
- The revised digital leadership and governance to enable greater oversight of the digital workstreams and support the Group collaborative agenda.
- The importance of digital leadership in meeting the current challenges and ensuring a more proactive and less reactive approach to delivering the digital agenda.

5.4 **Information Governance and Cyber Security**

The Committee noted the update on information governance and cybersecurity which had previously been received by the Audit Committee. The baseline assessment for the annual data security and protection toolkit would be submitted by both Trusts on 28 February with no major concerns reported at this stage. The final toolkit will be submitted by 30 June and will receive assurance from the internal auditors. Cybersecurity received a high level of focus as the risk of cyber threats continues to remain high. The Committee was informed cyber security across the Group is becoming more collaborative as the Trusts explore how they work more closely together.

5.5 **Key Digital Risks**

The GCFO reported there had been a reset of the ESTH and SGUH approach to digital risk management following the introduction of a Group Board Assurance Framework. A top-down high-level assessment of risks as identified by the Digital senior team alongside a bottom-up detailed review of risks and issues as seen by staff within the Digital teams will look to reconcile differences and align approaches. The Committee noted this approach will allow the Digital management team to pull together a comprehensive and integrated approach to risks establishing a clear thread from the strategy and Group objectives through the BAF and the Corporate Risk Registers to the digital workplan.

5.6 SWL Picture Archiving Communication systems (PACS) update

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. Representatives from the APC and the Trusts continue to work through the issues with the supplier to resolve challenges in implementing the shared system. ESTH was undertaking resilience testing of its existing PACs system to ensure there is contingency that would maintain continuity of supply in the event of an extended programme.

6.0 Recommendations

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

Group Board

Meeting on Friday, 08 March 2024

Agenda Item	2.5	
Report Title	**Audit Committee report of the meeting held on 1 February 2024**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	SGUH Audit Committee	1 February 2024
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the Committee at its meeting on 1 February 2024:

- Annual Report and Accounts 2023/24: The Committee was updated on the process for the preparation of the 2023/24 Annual Report and Accounts. The Group Communications Team will be leading the work on the Annual Report which aligns more closely this year with the Annual Report produced at Epsom and St Helier University Hospitals NHS Trust. The annual audit of the Trust accounts will commence in early February with no issues or concerns raised by the Trust's external auditors in their preliminary audit work.

- Internal Audit: The Committee welcomed the significant progress on following up on outstanding management actions from previous audits. The Committee also received a progress update on the 2023/24 internal audit workplan and noted that a number of audits had been delayed, creating a backlog of reviews to be considered at its next meeting. The Committee also reviewed and approved the 2024/25 internal audit workplan, which had greater alignment with the ESTH workplan.

- Audit Committee meetings in 2024/25: The Committee endorsed a proposal that it should operate as a Committee-in-Common with the ESTH Audit Committee from April 2024 and this has subsequently been agreed by the Group Board.

Action required by the Board

The Board is asked to note the report of the Committee's meeting held on 1 February 2024.

Committee Assurance

Committee	SGUH Audit Committee
Level of Assurance	Not applicable

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

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

Report of the SGUH Audit Committee

Group Board, 08 March 2024

1.0 Purpose of paper

1.1 The Audit Committee met on 1 February 2024 and agreed to bring the following matters to the attention of the Board.

2.0 Audit Committee Report

2.1 Annual Report, Accounts and Quality Accounts Plan and Timetable

The Committee was updated on the processes and timelines for the production of the 2023-24 Annual Report and Accounts. Submission to NHS England is expected by 30 June 2023. The Group Communications team will lead on the preparation of the Annual Report, including the commissioning of content and drafting. The Committee noted the importance of the report achieving the right tone in covering the Trust's successes and challenges over 2023-24. Key themes for the report are expected to include Group integration, strategy, finances, patient discharge and flow.

The Committee heard the annual Quality Account outlining the Group's Quality priorities, which would be incorporated into the Trust's final Annual Report, was being coordinated by Corporate Nursing and would be presented to the Quality Committee for review prior to review by the Audit Committee and Board. The Committee would review an early full working draft of the Annual Report at its meeting in May 2024.

The Committee also approved the accounting policies for the 2023-24 Annual Accounts.

2.2 External Audit 2023-24 Annual Plan and Fees

The Committee received the audit plan from the Trust's external auditors noting preliminary audit work started before the end of 2023 with good progress having been made in preparation for the annual audit of Trust accounts. The Trust is engaging with external auditors on the approach with no concerns or issues raised in advance of commencement in early February 2024. A Value for Money report would also be prepared alongside the final audit findings report which would consider any weaknesses and areas of risk in the Trust's financial arrangements as part of the overall risk assessment for 2023/24.

The Committee also noted an increase in external audit fees which reflects the current market position.

2.3 Internal Audit Progress Report

The Committee welcomed the improved position for the follow up of outstanding management actions with 18 actions confirmed as being implemented and five remaining actions currently in progress with revised implementation dates. This had moved on significantly since the last Committee meeting in October 2023.

The Committee was updated on delivery of the 2023/24 internal plan workplan noting that draft reports have been issued for the Medical Devices and Sickness Absence audits. The audit of

Data Quality was currently going through quality assurance prior to being issued. The internal auditors highlighted that there had been delays to some internal audits and acknowledged there would be an urgency to ensure the plan would be delivered by the end of March for the end of year head of internal audit opinion and annual governance statement. The Committee sought assurance that the plan could be delivered and the internal audit partner confirmed that this was the case but it required continuing engagement from nominated leads.

2.4 Draft Internal Audit Plan 2024/25

The Committee approved the draft internal audit workplan for 2024/25 which was developed in accordance with the five-year internal audit strategy with input from the Group Executive. The Committee was informed the workplan was designed to reflect the greater integration and alignment at Group level with the programme including audits which test Trust-specific controls; audits to be taken at both SGUH and ESTH as well as mandatory audits which would be undertaken at both Trusts. The Committee noted the 2024/25 audit plan was designed to maximise value for money across the Group as well as greater opportunities for learning from audits at both Trusts. The audit programme is scheduled to start Q1 2024/25 with pre-audit planning commencing over Q4 2023/24 to ensure a consistent release of final audit reviews over the next year.

2.5 Counter Fraud Quarterly Report

The Committee considered its regular report on progress with current and new counter fraud cases under investigation and noted the work by the counter fraud team to raise awareness of emerging risks through attendance at corporate inductions and during International Fraud Awareness Week in November. There have been three new referrals to the team since the October meeting. The Committee heard that bespoke training sessions are proving successful in encouraging attendance helping raise attendance at fraud awareness, but additional work is required to encourage attendance, particularly for procurement, finance and ICT staff.

The Committee also approved the 2024-25 counter fraud workplan, noting requested revisions to the planned timings of some of the reviews.

2.6 Breaches and Waivers Report

The Committee considered the regular breaches and waivers report for Q3 2023/24. The Committee was told there had been a slight increase in the usage of waivers from ten in Q2 to 12, along with an increase in value to £422,791. Instances of breaches also increased in Q3 to ten from six in Q2. The value of breaches also increased to £1,908,929. The Committee was told that the implementation of the *No PO No Pay* policy had been suspended over the Christmas 2023 period as a precaution to ensure supply continuity. There will be a phased introduction of the policy supported by SBS and working with suppliers during transition.

2.7 Information Governance and Cyber Security Update

The Committee received the Q3 update which included the preparations for the annual Data Security and Protection Toolkit submission. An interim baseline assessment would be submitted by 29 February 2024. The Trust is working through the toolkit's requirements and penetration test scope is being developed for the final submission in June. The internal auditors will be providing assurance on both submissions. The Committee was told the Trust has been approved to receive remediation support from NHSE in the aftermath of the Trust's response to the cybersecurity incident last September to ensure the Trust continues to respond effectively to future threats. The Committee noted the progress on the cyber dashboard with the next iteration expected to include NHSE national benchmarking to allow comparison against peers.

2.8 Development of an Audit Committees-in-Common

The Committee considered a proposal for moving the Audit Committee to a meeting in-common with the Epsom and St Helier Audit Committee. The Committee agreed it was the appropriate time to move to an in-common approach with closer alignment between the agendas at SGUH and ESTH and an opportunity to support greater learning at each Trust. The Committee was assured there would be safeguards to maintain appropriate accountability of each Audit Committee of each Trust as separate statutory bodies. The Committee heard each Trust would continue to hold separate meetings to review the Annual Report and Accounts and receive external auditor reports, as well making the appropriate arrangements for ensuring Trust specific decisions are taken by the appointed Members of each committee. The Committee welcomed the proposed in-common approach with integrated agendas which would ensure meetings continue to use existing structure and facilitate more efficient meetings management as well enabling greater sharing of learning between the two committees. The Committee agreed to recommend the proposal to move to an in-common arrangement for the SGUH Audit Committee to the Group Board noting the safeguards to ensure the separation of statutory duties for each committee.

3.0 Recommendation

3.1 The Board is asked to note the report of the Committee's meeting held on 1 February 2024

Peter Kane
Audit Committee Chair, NED
March 2024

Group Board

Meeting on Friday, 08 March 2024

Agenda Item	2.6	
Report Title	**Audit Committee report of the meeting held on 1 February 2023**	
Non-Executive Lead	**Peter Kane, Audit Committee Chair**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Kevin Matthews, Senior Corporate Governance Manager	
Previously considered by	ESTH Audit Committee	01 February 2024
Purpose	**For Assurance**	

Executive Summary

The report sets out the key issues discussed and agreed by the ESTH Audit Committee at its meeting on 1 February 2024:

- Annual Report and Accounts: The Committee was updated on the process for the preparation of the 2023/24 Annual Report and Accounts. The Group Communications Team will be leading the work which aligns more closely this year with the Annual Report produced at St George's. The preliminary audit work for the annual audit of the Trust accounts will commence in early February.

- Internal Audit: The Committee welcomed progress in delivering the 2023/24 internal audit workplan and were pleased to note an improved position in following up on open management audit actions. The Committee also received four final internal audit reviews:
    - Surrey Downs and Sutton Health and Care Alliance **– Reasonable Assurance**
    - Cost Improvement Plans – **Reasonable Assurance**
    - Job Planning – **Reasonable Assurance**
    - Sickness Absence – **Partial Assurance**

  The Committee also approved the 2024/25 internal audit workplan.

- Audit Committee meetings in 2024/25: The Committee considered and endorsed a proposal for the Epsom and St Helier Audit Committee to work as a Committees-in-Common with the SGUH Audit Committee which had subsequently been approved by the Group Board.

Action required by the Group Board

The Group Board is asked to note the report of the Committee's meeting held on 1 February 2024.

Committee Assurance	
Committee	ESTH Audit Committee
Level of Assurance	Not applicable

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Audit Committee Report of the meeting held on 1 February 2024

Matters for the Board's attention

1.0 Purpose of paper

1.1 The Audit Committee met on 1 February 2024 and agreed to bring the following matters to the attention of the Board.

2.0 Matters for the Board's attention

2.1 Annual Report, Accounts and Quality Accounts Plan and Timetable

The Committee was updated on the processes and timelines for the production of the 2023-24 Annual Report and Accounts. Submission to NHS England is expected by 30 June 2024. The Group Communications team will lead on the preparation of the Annual Report, including the commissioning of content and drafting which will be more closely across both ESTH and SGUH acknowledging the greater integration of the two Trusts. The Committee noted there are different reporting requirements for each Trust which would be reflected in the final reports.

The Committee heard the annual Quality Account outlining the Group's Quality priorities, which would be incorporated into the Trust's final Annual Report, was being coordinated by Corporate Nursing and would be presented to the Quality Committee for review prior to review by the Audit Committee and Board.

A draft will be shared with the Committee in April 2024 and Members would have an opportunity to review an early full working draft of the Annual Report at its meeting in May 2024.

The Committee also approved the accounting policies for the 2023-24 Annual Accounts.

2.2 External Audit

The Committee was informed that the Trust's external auditors would be commencing their interim audit work in early February 2024. The Committee was pleased to hear there has been good engagement with the Trust and no issues or concerns have been flagged ahead of commencement. The Committee emphasised the importance of maintaining engagement and ensuring any issues are raised with the Committee as they arise.

2.3 Internal Audit Progress Update & Recommendations Tracker

The Audit Committee received an update on internal audit, noting there are six audits currently in progress and that the auditors are confident the plan will be delivered by the end of March. The Committee welcomed the much-improved position in following up on open audit actions. The auditors have followed up 26 outstanding actions since the October meeting with 15 actions confirmed as having been implemented and nine actions in progress along with a further two open actions.

2.4 Final Internal Audit Reports

The Committee received four final internal audit reports:

- Surrey Downs and Sutton Health and Care Alliance **– Reasonable Assurance**
- Cost Improvement Plans – **Reasonable Assurance**
- Job Planning – **Reasonable Assurance**

- Sickness Absence – **Partial Assurance**

The Committee was pleased to receive the reasonable assurance for the review of the Surrey Downs and Sutton Health and Care Alliance welcoming the assurance provided on areas of strong performance as well as identifying areas for improvement. There were three medium level management actions pertaining to roles and responsibilities; performance monitoring and collaboration agreements which had all been accepted by the Trust. Committee members welcomed the robust responses noting strengthened governance arrangements will be embedded for April 2024.

The Committee welcomed the reasonable assurance for Trust cost improvement plans and the accompanying audit recommendations to strengthen Trust controls and processes around project initiation documents, organisational structure, reporting and continuing the development and delivery of longer term recurrent or transformational cost improvement programme to improve the short and medium-term underlying financial position. The Committee noted all the recommendations have been accepted and are considered helpful in targeting areas for improvement.

The Committee also received the final audit review of job planning welcoming the reasonable assurance rating noting there were six medium level actions. The Trust accepted the recommendations which will support more effective processes going forward and are expected to be fully implemented during Q1 of 2024/25 Members were pleased to be told that the number of staff which have now completed their job planning exceeds the 85% target.

The Committee received the partial assurance for sickness absence noting concerns highlighted in the audit around compliance with Trust sickness absence policies and the lack of evidence that Trust processes for managing and monitoring of absence are being fully adhered to. The review raised three high-level recommendations for fitness for work statements, return to work interviews and long-term sickness absence. There were also a further three medium recommendations. The Committee expressed concerns that sickness absence levels are at 5.67% which is significantly higher than the threshold of 3.8%. The Committee raised additional concerns on the process for signing off on the management responses for the audit recommendations nothing this would be taken forward by the People Committee.

2.5 Draft Internal Audit Plan 2024/25

The Committee approved the draft internal audit workplan for 2024/25 which was developed in accordance with the five -year internal audit strategy with input from the Group Executive. The Committee was asked to note increased convergence of the plans across the Group including audits which test Trust-specific controls; audits to be taken at both ESTH and SGUH as well as mandatory audits which would be undertaken at both Trusts. Members noted the 2024/25 audit plan was designed to maximise value for money across the Group as well greater opportunities for learning from audits at both Trusts. The audit programme is scheduled to start Q1 2024/25 with pre-audit planning undertaken over Q4 2023/24 to ensure a consistent spread of final audit reviews throughout the year.

2.6 Information Governance / Cybersecurity Update

The Committee received its regular report which includes cyber threats faced and improvements undertaken at the Trust since the previous meeting. The Committee was pleased to hear new processes at the Trust meant work for the annual submission of the Data Security and Protection toolkit was ahead of schedule with almost 40% of the information required for the final submission and that the remaining information will be ready for uploading in June. The Trust is currently reporting 90% for staff cyber security training and expects to meet the 95% compliance threshold requirement during February.

The report also included the latest iteration of the cyber dashboard with Members noting the challenges in aligning the dashboard across the Group as each Trust uses different systems and platforms. Members requested the inclusion of trends information to allow comparison of Trust performance against national and system benchmarking.

2.7 Counter Fraud Update Quarterly Report

The Committee considered its regular report on progress with current and new counter fraud cases under investigation. Since the previous meeting, there have been three new referrals to the team relating to working whilst sick and failure to disclose. Ten cases have been closed with no evidence of fraud against the Trust having taken place. International Fraud Week took place in November and counter fraud held a number of fraud awareness activities as well as bespoke fraud and bribery sessions for staff in key risk areas such as finance, procurement and human resources.

The Committee also approved the 2024/25 counter fraud workplan, noting requested revisions to the planned timings of some of the reviews.

2.8 Breaches and Waivers Report

The Committee considered the regular breaches and waivers report for Q3 2023/24. The Committee was told the usage of both breaches and waivers in Q3 had remained static since Q2. There had been an overall increase in the value of both breaches and waivers since the previous quarter but these were relatively low for a Trust the size of ESTH. The Committee heard proactive work continues with reviews of contracts and engagement with stakeholders as the contracts management team works to mitigate any risks of increases in usage over the final quarter of the year.

2.9 IRFS 16 Leases

The Committee welcomed the progress in addressing concerns identified by external auditors in the robustness of the Trust's IFRS 16 Lease accounting, noting there has been a full review of properties and supporting documentation to ensure the correct accounting treatment can be applied to the right use assets in time for the 2023/24 accounts.

2.10 Development of an Audit Committees-in-Common

The Committee considered a proposal for moving the Audit Committee to a meeting in-common with the St George's Audit Committee. The Committee agreed it was the appropriate time to move to an in-common approach with closer alignment between the agendas at SGUH and ESTH and an opportunity to support greater learning at each Trust. The Committee was assured there would be safeguards to maintain appropriate accountability of each Audit Committee of each Trust as separate statutory bodies. The Committee heard each Trust would continue to hold separate meetings to review the Annual Report and Accounts and receive external auditor reports, as well making the appropriate arrangements for ensuring Trust specific decisions are taken by the appointed Members of each committee. The Committee welcomed the proposed in-common approach with integrated agendas which would facilitate more efficient meetings management as well as enabling greater sharing of learning between the two committees. The Committee agreed to recommend the proposal to move to an in-common arrangement for the ESTH Audit Committee to the Group Board noting the safeguards to ensure the separation of statutory duties for each committee.

2.11 Lessons Learned from the 2022/23 Audit of Accounts

The Committee considered the report of the lessons for the Trust from the audit of the 2022/23 accounts. The Committee was assured by the GFCO that actions and processes have been implemented to avoid repetition of the late submission of accounts. The 2023/24 audit would

be led by the Group Head of Financial Services who is already engaging with external auditors on the preliminary audit work as well as internal reviews of preparedness to ensure readiness and identify and source documentation for the audit. Regular touchpoint meeting have been scheduled with the Audit Committee Chair and auditors to enable more effective communication of key audit messages and report on progress of the audit. The Committee also welcomed the actions introduced by the auditors to improve their audit planning and quality assurance for the 2023/24 audit.

3.0 Recommendations

3.1 The Board is asked to note the report of the Committee's meeting held on 1 February 2024.

Peter Kane
Audit Committee Chair, NED
March 2024

Group Board

Meeting on Friday, 08 March 2024

Agenda Item	3.1
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 January 2024.

Action required by Group Board

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

Committee Assurance

Committee	Finance Committees-in-Common Please note that the Quality section of the IQPR has not been reviewed by a formal sub-committee of the Board in February 2024.
	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Appendices

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

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

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

Equality, diversity, and inclusion implications

No EDI issues to consider.

Environmental sustainability implications

No environmental sustainability issues to consider.

Group Board, 08 March 2024

1.0 Purpose of paper

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

2.0 Quality & Safety

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

- Nil MRSA infections in-month, bringing year-to-date cases to zero for SGH, and 2 for ESTH.
- No Never Events were reported in January 24.
- VTE Risk Assessment remain above target for SGH.
- Observed mortality rates (Summary Hospital-level Mortality Indicator or SHMI) continue to track below expected levels at SGH.
- Maternity teams across our Group have scored as the top two in London for care given to women and their babies in the 2023 Care Quality Commission's (CQC) patient survey published in February 2024. Teams at ESTH came top in the capital, with services at St George's named a close joint second for maternity care.
- Naso-Gastric Tube training is now available on both hospital sites at ESTH.
- 50% reduction in number of hospital-acquired venous thromboembolism (VTE) at ESTH.
- 100% of complaints received were responded to within 25 days at SGH.
- Significant improvement in community therapy waiting times at Surrey Downs Health & Care
- All Serious Incidents (SIs) for Integrated Care are either closed or on track with timelines.

Key **challenged** areas are as follows.

- **Serious Incidents**: SGH declared 3 Serious Incidents (SIs) in January 2024. Two in Obstetrics and one in Medicine (failure to monitor). The SI investigations are being undertaken to identify all the relevant learning and to determine from that learning what further risk mitigating actions. Seven SI's were reported at ESTH.
- **Friends and Family Test (Patient Experience) -** Response rates for Outpatients and Emergency Department continue to track below target of 20% at both SGH and ESTH. At SGH the department is working to improve the response rates with introducing an online option and QR code access in ED.
- **Venous Thromboembolism (VTE) Assessment rates** at ESTH remains low. The Site Senior Leadership Team is overseeing improvement work with support from colleagues from NHSE.

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

- **Mortality**: Summary Hospital-level Mortality Indicator (SHMI) shows a higher-than-expected level but declining mortality rates. Out of 167 Structured Judgement Reviews (SJR) conducted in Q3 2023/24, six received a 'poor' rating. However, there is a positive shift in the 'concerns in care' percentage, which is now at 31.9%.

- Key challenges in **Integrated Care** relate to**;** Falls (review to establish themes and additional mitigations), estates, staffing (sickness absences and recruitment), and delayed discharge.

3.0 Operational Performance

ELECTIVE CARE

1. Outpatients

Maintaining waiting times for outpatients remains a priority across the Group with a focus on productivity, delivery of activity, as well as outpatient transformation. Both trusts continue to face challenges in maintaining their total waiting list size (PTL – Patient Tracking List) and are not meeting the plan with increases seen across December 2024.

SGH continues to focus on increasing roll-out of Patient-Initiative Follow-Ups (PIFU) and reducing DNA rates closer to the national average with Outpatient Transformation Boards continuing to focus on key workstreams. The increase in PIFU rates at SGH reflects a retrospective submission of data, but a more sustainable step change is anticipated. A revamp of the PIFU process is currently in process in an effort to increase current performance from 0.4% towards the national target of 5%.

ESTH has an established PIFU (patient-initiated follow-up) programme, which continues to deliver well across a range of specialties with further opportunities being explored.

2. RTT Waiting Times

Both trusts continue to exceed trajectories to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH is particularly challenged with 830 patients waiting for more than 52 weeks at the end of December 2023, however this reduced by 9% compared to November 2023. The 65-week wait cohort at ESTH is seeing an increase due mainly to strike action and delays to insourcing plans for Gynaecology and Community Paediatrics. At SGH, the number of patients waiting over 65 weeks is exceeding plan and likely to remain challenged due to planned action. Neurosurgery is a specialty of concern although all potential 65-week breaches are being scrutinised weekly.

3. Diagnostics Waiting Times

Diagnostic performance at SGH remains strong and within the national target of 5% (over 6 weeks), with 97.3% of patients receiving their diagnostic test within 6 weeks of referral in January 2024. Sleep studies and echo diagnostics have been particularly challenged. Echo continues to look for support from an insourcing company, however, to date they have been unable to supply staff to carry out stress echo tests which is the largest waiting cohort. ESTH is reporting a breach rate of 4.9% in January 2024 - an improvement on previous month and compliant with national ambition. The

modalities with the highest volume of patients waiting over 6 weeks are Urodynamics, Endoscopy and Echo.

4. Theatre Productivity

Both trusts have made steady improvements and now reporting increased utilisation rates with ESTH achieving 81.7% in January 2024 in line with planned trajectory. There are however challenges in reaching the national ambition of 85% capped utilisation of theatre time (active utilisation of theatres within the allotted time). Key actions at SGH relate to improvements in scheduling, reporting, planning, and service developments with operational teams continuing to focus on early discharges and embedment of day of surgery admission pathways. Performance challenges at ESTH have been primarily driven by day case theatres, impacting Trust-wide performance, especially in Ophthalmology, Trauma & Orthopaedics (T&O), and Pain HVLC injection lists, as well as Urology biopsy services. Active theatre utilisation groups are exploring opportunities and have actions in place to continue to improve productivity in theatres.

CANCER WAITING TIMES

Cancer performance is on track at ESTH with some challenges at SGH. Performance against the 28-Day Faster Diagnosis Standard (FDS) at SGH continues to track below the 75% national ambition mainly due to capacity constraints in skin service and Histopathology delays. The improvement plan for histopathology turnaround times as well as the capacity and demand modelling for outpatients will support the overall improvement against this standard. Although SGH are not achieving the 62-day national cancer standard (December 2023 at 80.1%) the monthly trajectory was met, and the service is on track with the trajectory for maintaining the absolute number of patients waiting for more than 62 days for definitive treatment at the end of January 2024.

URGENT & EMERGENCY CARE

Non-elective pathways continue to be under pressure at both trusts. ESTH remain challenged across both sites with many unplaced patients remaining in the emergency department, increased ambulance delays and high numbers of mental health patients requiring admission. Despite that the 4-hour ED standard in January 2024 was delivered, reporting 76.1% performance. At SGH 4-hour performance declined to 69.1% reflective a challenging month with issues in managing the flow within the hospital, resulting in a high number of patients waiting for beds in both the emergency department and in inpatient areas. There are high numbers of medically fit patients occupying acute beds on both hospital sites, with many requiring complex discharge planning. Both trusts continue to have a high focus on flow through the whole non-elective pathway. There is ongoing work to address a data quality issue, which has been suppressing reported performance at SGH.

INTEGRATED CARE

2-hour Urgent Community Response (UCR) 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 will be a focus for reducing avoidable bed days in hospitals. Sutton has seen the median days referral to discharge increase over the past two months whilst also seeing an increase in virtual ward occupancy improving to 62.4%. This change is due to amended occupancy targets for Sutton as approved by the SWL Virtual Ward Board. Surrey Downs Health & Care observed a decline in time taken for discharges through the transfer of care hub from a median of 2 days in December 2023 to 3 days in January 2024 across all pathways combined. This is mainly due to winter pressures and an increase in number of referrals.

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

January 2024

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

Executive Summary
Safe, high-quality care

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

St George's Hospital

Successes

- **Pressure Ulcers**: Reduction in the numbers of category 2, 3, 4 and unstageable pressure ulcers
- **Infection control**: The Trust continues to report zero MRSA bacteraemia's for the year.
- **Complaints** responded to in 25 days – 100% compliance. Continue to work on sustaining the target of 85%.
- **SHMI** – Performance remains as expected at 0.94. The Mortality Monitoring Group (MMG) continues to monitor and considers mortality at diagnosis and procedure group level.
- **Maternity:-**Top second in London for CQC Maternity Patient Experience 2023. HIE rates showing sustained rate of variation of improvement.

Challenges

- **Falls:** Increase in number of moderate harm falls (5) and in total number of falls (135). Support from falls prevention nurse provided to areas with increases in falls rate, continuing with fall champion education meetings. Quality improvement project focused on continence care underway in Senior Health areas.
- **Infection Control:** Over the NHSE set trajectory for C. difficile and E. coli, Klebsiella and Pseudomonas bacteraemia despite on target for this month. All cases continue to be reviewed for learning and areas with confirmed C. difficile infection undergo increased surveillance from the IPC team. 'Gloves off Campaign' soft launch planned for February 2024.
- **Friends and Family** – Response rates for Outpatients and Emergency Department continue to be below national target of 20% and national performance averages at 12% for these areas. The response score of above 90% remains and departments working to improve the response rates with introducing an online option and QR code access in ED.
- **SHMI** – The indicator for Acute Myocardial Infarction shows that mortality for this diagnosis group is higher than expected at 1.35
- **Maternity – S**ervice continuing to explore ways to reduce preventable PPH incidents

Epsom & St Helier

Successes

Nutrition: Naso-Gastric Tube training is now available on both hospital sites. New Endoscopy Enteral Tube Insertion reports have gone 'live' to highlight additional information to assist the patients smooth discharge back to the community. eMUST Dashboard is now built and currently going through testing and will be available shortly.

- **Falls Prevention and Management:** Training continues to be delivered on a monthly basis with 35 Registered Nurses and 22 Health Care Support Workers attending during the month of January. In addition, this bespoke training was delivered at the Frailty Wards study days. To comply with the Bedrails National Safety Patient Alert, an audit has now been developed and will go live on Tendable this month. The Falls Champion programme is due to commence in February, with 12 inpatient areas having nominated staff to participate. The Falls Consultant Nurse Specialist has developed a programme which will cover aspects of Patient Safety Incident Response Framework and encourage staff to understand and be involved with Hot Debriefs/SWARM post fall.
- **Pressure Ulcers:** The number of pressure ulcers remain consistently low. There were 8 incidents An overall increase in referrals.
- **VTE:** Reduction in number of Hospital Acquired Cases (50%). Really good work by AMU St Helier . Reported to Quality in Common

Challenges

- **Pressure Ulcers:** One unstageable case requiring Rapid review. Increase in referrals (420 this month) is challenging as limited service until new Tissue Viability Nurse starts.
- **Falls:** 3 incidents with moderate levels of harm occurred in the Acute Services Inpatient wards, all on the same escalation ward
- **VTE:** Slow progress In changes to the policy and new ways of working
- **Infection Control**: A total of 186 Covid-19 infections were identified in December resulting in 47 different clusters with bay/ward closures. Of these, 60 cases were detected 15 or more days post admission.
- **Mortality**: SHMI decreased from previous figures but remains classified as 'higher than expected.' The crude mortality rate for January is documented at 2.2% and is close to the same month last year. The pattern reflects the challenges imposed by winter pressures. Out of 167 Structured Judgement Reviews (SJR) conducted in Q3 2023/24, six received a 'poor' rating. However, there is a positive shift in the 'concerns in care' percentage, which is now at 31.9%.

2

Executive Summary Elective Care

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

St George's Hospital

Successes

- The number of patients waiting 65 weeks or longer on a RTT pathway remains ahead of plan, however this is at risk due to ongoing industrial action (IA).
- A review of the Patient Initiated Follow Up process (PIFU) is currently being progressed. In an effort to increase current performance from 0.4% towards the national target of 5%
- 31-day cancer standard continued to be met whilst also seeing an improved performance against the 62 day standard exceeding trajectory of 70% (achieving 80.1%), in January 2024.
- Theatre capped utilisation improved by 1% from previous month from 78% in December to 79% in January. This improvement trend continues into February

Challenges

- Industrial action is impacting capacity to continue to reduce long waits on the RTT PTL. Neurosurgery is a specialty of concern although all potential 65 week breaches are being scrutinised weekly at Elective Access meetings, a separate long waits meeting which is a subgroup of Elective Access has been commissioned.
- The focus areas for SGUH to improve elective productivity and performance continue to be:
  Increase theatre productivity to >80% (now looking at number of cases per list)
  Reduce DNA rate closer to the national average
  Increase accuracy in the counting and coding of outpatient procedures
- A new theatre performance meeting is being established to ensure lists are fully optimised and booking rules adhered to, including reviewing human factors, start times, number of cases per list etc.
- Faster diagnosis delivery continues to be an issue, a business case in progress to improve the skin service capacity which has the biggest impact on delivery. We are working closely with SWLP to improve data flows to support turn around times. Implementation from quarter one of a gynae one-stop clinic will also improve performance.

Epsom & St Helier

Successes

- Patients waiting over 52 weeks for treatment reduced from 913 in November 2023 to 830 in December 2023. The specialties with the highest cohort are Gynaecology (283), Community Paediatrics (201) and Cardiology (87).
- DNA rates were 4.8% in January 2024.
- ERF activity (outpatient & inpatient/daycase) was above plan in January 2024.
- Theatre utilisation increased in January 2024 with capped at 81.7% and uncapped at 85%.
- Diagnostics (DM01) waiting more than 6 weeks in January 2024 reduced to 397 from 437 in December 2023 with performance improving to 95.07% in January 2024. The modalities with the highest volume of patients waiting over 6 weeks are Urodynamics (94), Endoscopy (91), ECHO (69) and Cystoscopy (63).
- Performance achieved against the following key standards in December 2023: Faster Diagnosis (79.3%), 31 day first treatment (99%) and GP 62 day first treatment (86.7%).

Challenges

- Patients waiting over 65 weeks for treatment increased from 218 in November 2023 to 229 in December 2023. The specialties with the highest cohort are Gynaecology (95), Community Paediatrics (55) and Cardiology (28).
- Referrals from GP to a consultant led service remain significantly above BAU (19/20) levels within a number of key specialities such as Gynaecology (+35%) and Paediatrics (+18%) year to date (Apr23-Jan24).
- The 14-day KPI was not met once again in December 2023 but performance improved to 90.4% against the 93% target. This is largely due to Gynaecology capacity issue. Performance should improve with the start of a new consultant and the Clinical Lead providing two additional TWR clinics from April 2024.
- EUS capacity at RMH still has a wait time of 4-5 weeks, patient dependent, leading to a negative impact on cancer targets. RMH Oak Centre has provided one list in January and the second will be provided at the end of February 2024 which will further improve the EUS return around times.
- EBUS capacity has been 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 and this has been raised as a concern with the RMP project manager.

3

Executive Summary Non-Elective Care

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

St George's Hospital

Successes

- There is a new task and finish group chaired by the site Managing Director to drive improvement in the urgent care setting working to the five areas as set out by NHSE:
  - Streaming and redirection and initial assessment
  - Senior decision maker and RAT
  - Maximise the use of UTC's4Improving ambulance handovers and direct access
  - Reducing time in department – 12 hours and IPS and escalation
- The >30min handover delays have reduced in January despite the pressure on the department.
- The running of Multi Agency Discharge "style"(MADE) Events have resumed given the increased operational pressure with a high bed occupancy rate and lack of patient flow.
- Focussed >21-day LoS reviews continue with system partner input, we are also working closely with CLCH to see how we can find alternative discharge pathways for patients to create flow.
- Through January the Transfer of Care team provided vital in-person support on the wards to facilitate discharge, our integrated transfer of care hub is now operational to support flow.

Challenges

- Overall 4 hour performance (all Types) in January 2024 reflected a challenging month with a 5% decrease compared to December 2023, closing the month at 69%. This placed SGH 15th in London and 94th nationally for all type performance, however we have seen a significant increase in attendances which correlates to dips in performance.
- 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.
- There has been significant flow constraints due to infectious outbreaks, for example Flu, Covid and Norovirus. This at times has lead to the need to open up additional escalation areas such as Brodie to support decompressing the Emergency Department.
- Mental Health patients in ED often have long waits, which does impact on the ability, we continue to work as part of the SWL programme for mental health improvement.
- We are putting a focus on our validation of front door "4-hour" data and the processes/system interface's as we have undertaken an audit and realise that we are not reflecting an accurate performance position.

Epsom & St Helier

Successes

- Despite an extremely challenging month, the trust delivered the 4-hour ED performance standard in January 2024, reporting 76.1% performance.
- Time to triage remains below the ambition of 15-minutes, reporting 12 minutes in January 2024.
- Type 1 attendances are below the planning numbers for January 2024, with 12680 attendances.

Challenges

- > 60-minute ambulance handover delays have improved over the last few months, however, remain high at 73 in January 2024.
- Time to initial assessment in January 2024 was 102 minutes and remains above the ambition of 60 minutes. This is an improvement compared to December 2023 (114 minutes).
- 11.7% of patients attending ED spent longer than 12-hours in the department in January 2024, largely due to challenged onward flow from ED to inpatient wards.

Executive Summary Integrated Care

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

Sutton Health & Care (SHC)

Successes

Virtual Ward: occupancy rates have improved to 62.4%. This change is due to amended occupancy targets for Sutton as approved by the SWL Virtual Ward Board in December 2023.

2-hour Urgent Community Response (UCR) target was met at 76%.

High levels of Mandatory and Statutory Training (MAST) is being maintained (87.4%).

Appraisal rate has increased to 70.2%.

Use of agency remains low- 3.4%, with YTD 3.5%.

Challenges

Average waiting lists for SALT and OT Children's Therapy whilst improving remains high (routine). Mitigations are in place.

Vacancy rates 19% (this increase has been due to the new service provision- SHC reablement unit from December 2023). Recruitment mitigations are in place.

Surrey Downs Health & Care(SDHC)

Successes

Consistently achieving the 2-hour UCR target with 82.1% in January 2024. A record number of 630 patients were seen under the UCR service

Maintained the Improvement in waiting lists across all services.

Bedded care maintained a good LOS with an average 17 days

High levels of MAST (91.8)% maintained.

Improvement in sickness rate to 4.3% from 6.3% in December

Improvement in agency usage rate

Challenges

Decline in time taken for discharges through the transfer of care hub from a median of 2 days in December to 3 days in January across all pathways combined. This is mainly due to winter pressures and an increase in number of referrals especially pathway 1. Pathways 2 and 3 maintained the median days same as last month .

Number of patients admitted to VW were increased in VW were 271 but the occupancy rate is reduced to 65% percentage against the targeted 80% occupancy.

High vacancy rate (19.6%), Golden Hello scheme is in place and more recruitment events planned. Although the appraisal rate is improved still below the target at 73.6%, related to many staff due for appraisals at the same time (start time with the organisation-TUPE transfer).

Quality & Safety

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

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

Safe, High Quality Care	St George's							Epsom and St. Helier						
	Monthly Target / Threshold	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend
SAFE														
Never Events	0	2	0	0	0	8		0	0	0	0	0	3	
Serious Incidents	0	8	5	3	0	41		0	9	3	7	0	42	
Patient Safety Incident Investigations	0	1	0	0	0	3		0				0	0	
Number of Falls With Harm (Moderate and Above)	0	1	4	5	0	28		0	3	1	2	0	20	
Pressure Ulcers - Acquired catergory 3&4	0	13	8	7	0	91		0	0	0	0	0	6	
Mental Capacity Act & Deprivation of Liberties - Level 2	85%	84.6%	85.1%	85.8%	85%	83%		85%	88.3%	88.8%	88.4%		88.0%	
Infection Control - Number of Cdiff - Hospital & Community	3	0	3	1	36	36		4	8	3	6	35	51	
Infection Control - Number of MRSA	0	0	0	0	0	0		0	0	0	0	0	2	
Infection Control - Number of E-Coli	8	10	7	9	74	99		5	4	4	4	47	48	
VTE Risk Assessment	95%	95.1%	95.8%	96.1%	95%	95.9%		95%	87.1%	88.1%		95%		
Mortality - SHMI (12 month rolling)	<1	0.95	0.95	0.94	<1	0.94		<1	1.20	1.20	1.19	<1	1.20	
% Births with 3rd or 4th degree tear		1.7%	2.2%	3.3%		2.3%			3.7%	2.5%	1.2%		2%	
% Births Post Partum Haemorrhage >1.5 L		2.5%	3.5%	3.8%		3.4%			1.3%	1.4%	2.9%	<4%	2.2%	
Stillbirths per 1000 births (Rolling 12 mths)	<2.6	5.4	5.8	6.0	<2.6	6.2			4.28	5.12	4.85		4.06	
Neonatal deaths per 1000 births (Rolling 12 mths)	<1.5	3.0	3.2	3.9	<1.5	2.9			1.34	1.08	1.08		1.48	
HIE (Hypoxic ischaemic encephalopathy rate	<2.2	0.00	0.00	1.70	<2.2	0.35			0.00	0.00	0.00		0.30	

Please note VTE Risk Assessment performance is reported a month in arrears due to data quality
Patient Safety Incident Investigations being implement at ESTH hence no data
SHMI – 12 month rolling

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

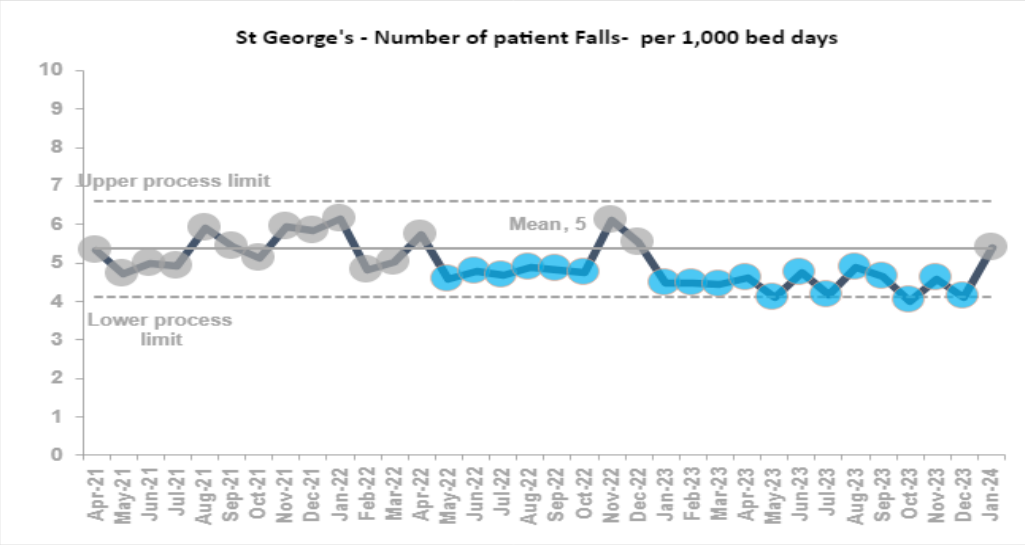
St George's, Epsom and St Helier University Hospitals and Health Group

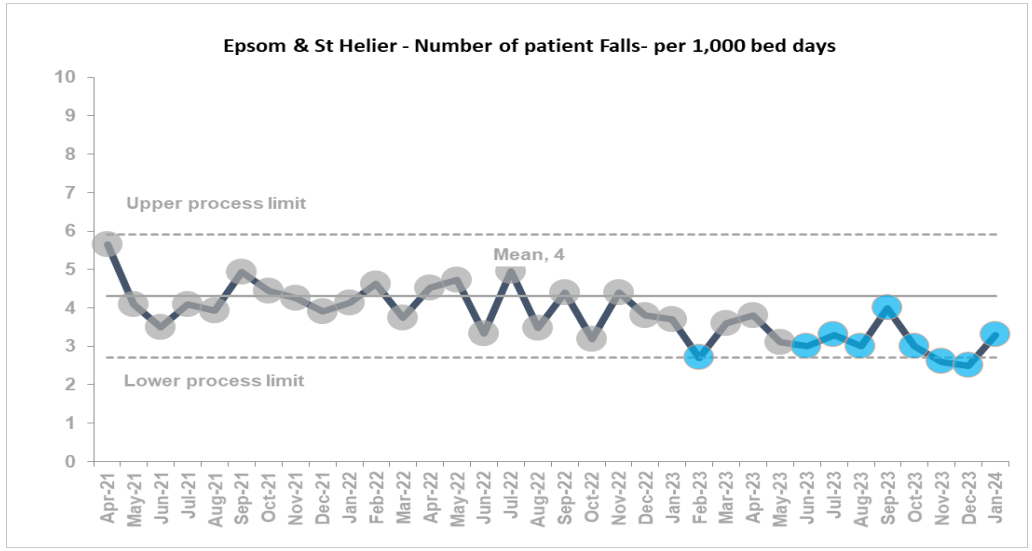
	St George's							Epsom and St. Helier						
Patient Experience	**Monthly Target / Threshold**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Number of Complaints Received	NA	77	68	67	NA	647		NA	46	39	63	NA	434	
Complaints responded to in 25 days	85%	87%	96%	100%	85%	98%		85%	39%	32%	33%	85%	49%	
Percentage of complaints acknowledged within 3 working days		100.0%	100.0%	100.0%		94.6%								
Friends and Family Test - Inpatients Respose Rate	20%	31%	29%	29%	20%	29%		20%	21%	25%	24%	20%	19.9%	
Friends and Family Test - Inpatients Score	90%	98%	98%	99%	90%	98%		90%	95%	96%	95%	90%	94.9%	
Friends and Family Test - Emergency Department Respose Rate	20%	11%	10%	8%	20%	11%		20%	6.0%	6.0%	7.0%	20%	6.6%	
Friends and Family Test - Emergency Department Score	90%	80%	76%	81%	90%	81%		90%	80.0%	83.0%	85.0%	90%	83.8%	
Friends and Family Test - Outpatients Respose Rate	20%	6%	4%	3%	20%	5%		20%	3.3%	3.9%	3.3%	20%	3.1%	
Friends and Family Test - Outpatients Score	90%	94%	94%	95.8%	90%	94%		90%	93.0%	93.0%	93.0%	90%	93.5%	
Friends and Family Test - Maternity Response Rate	20%	22%	7%		20%	18%		20%	4%	6%	6%	20%	7%	
Friends and Family Test - Maternity Score	90%	92%	78%		90%	90%		90%	95.0%	94.0%	98.0%	90%	95.9%	

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

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

Target: TBC	SGH: 5.38	ESTH: 3.3





SGH updates since last month

Falls per 1,000 bed days shows common cause (normal) variation.

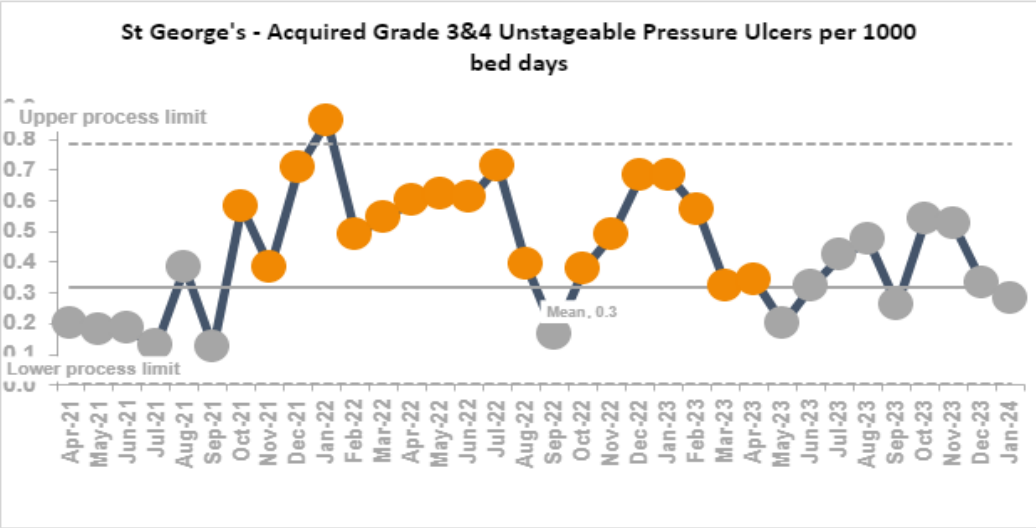
ESTH updates since last month

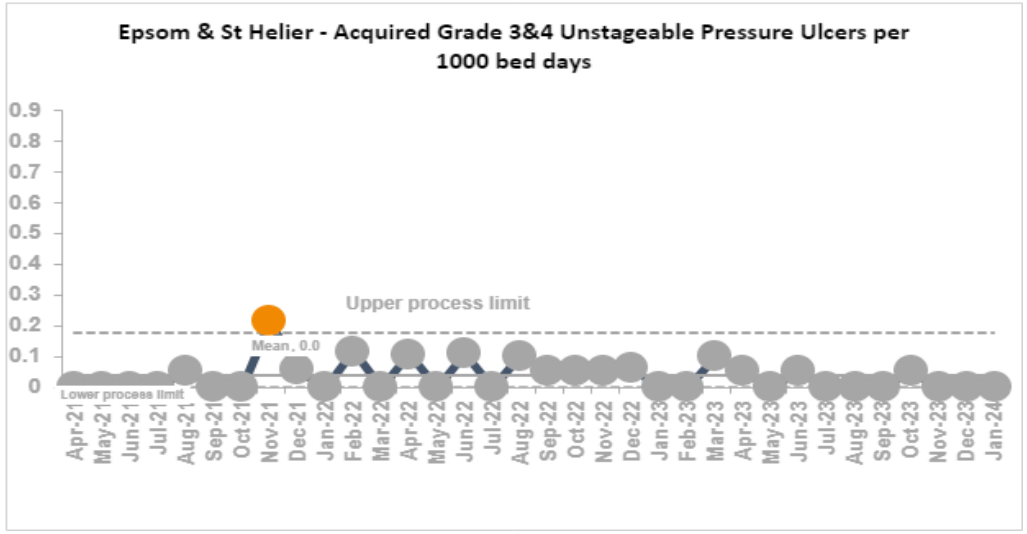
In January 2024 the Acute Services reported 91 incidences (4.2 falls per 1000 OBDs), Of these 64 occurred in inpatient wards which equates to 3.0 falls per 1000 OBDs and shows special cause variation from the average. The percentage of unwitnessed falls continue to show a reduction with 58% in January, which is far below the Trusts average of 67%. 2 incidents with moderate levels of harm occurred in the Acute Services Inpatient wards, both on the same escalation ward. Investigations are under way and support has been provided by the Falls Service.

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: 0.28	ESTH: 0.00





SGH updates since last month

There were a total of 7 category 3, 4 and unstageable pressure ulcers in January 2024. The rate continues within the upper and lower control limits showing common cause variation.

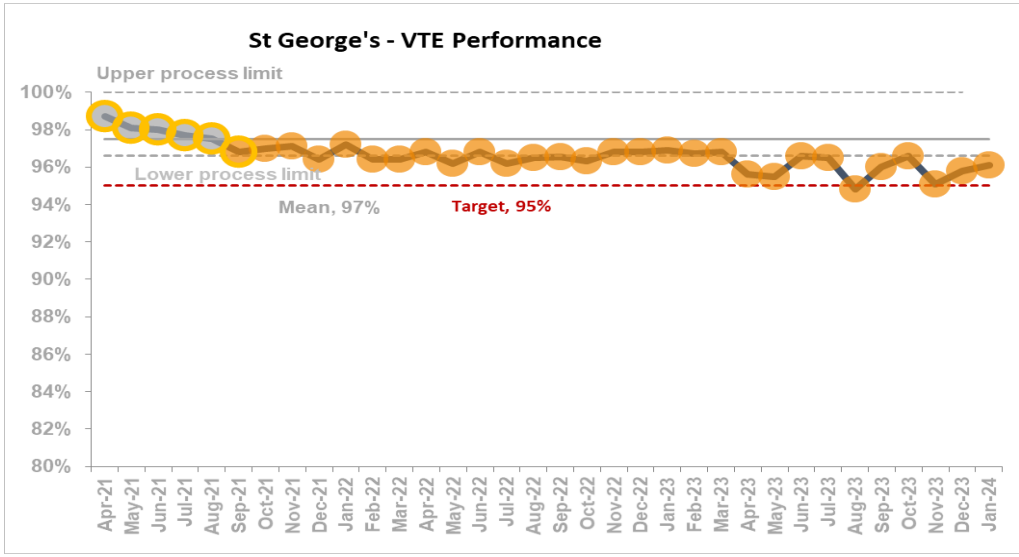
ESTH updates since last month

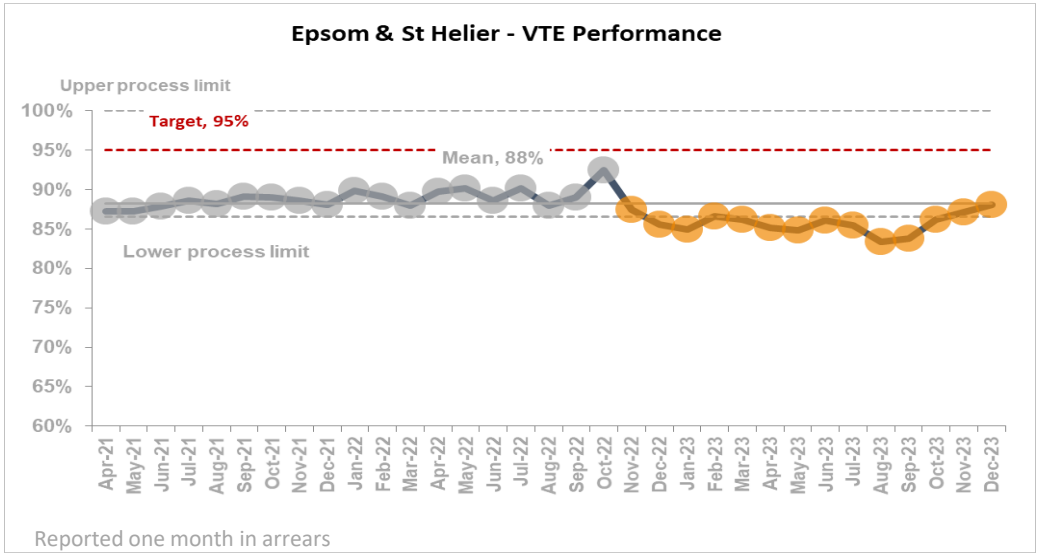
One unstageable pressure ulcer was reported in January 2024. Rapid review completed and treated as moderate harm. 8 Hospital-acquired pressure ulcers; 4x category 2, 1x unstageable and 3x deep tissue injuries.

VTE Risk Assessment

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

Target: 95%	SGH: 96.1%	ESTH: 88.1%





Reported one month in arrears

SGH updates since last month

VTE risk assessment compliance is above the 95% target in January 2024. Performance is varied and shows special cause variation of deterioration with the target being missed on occasions.

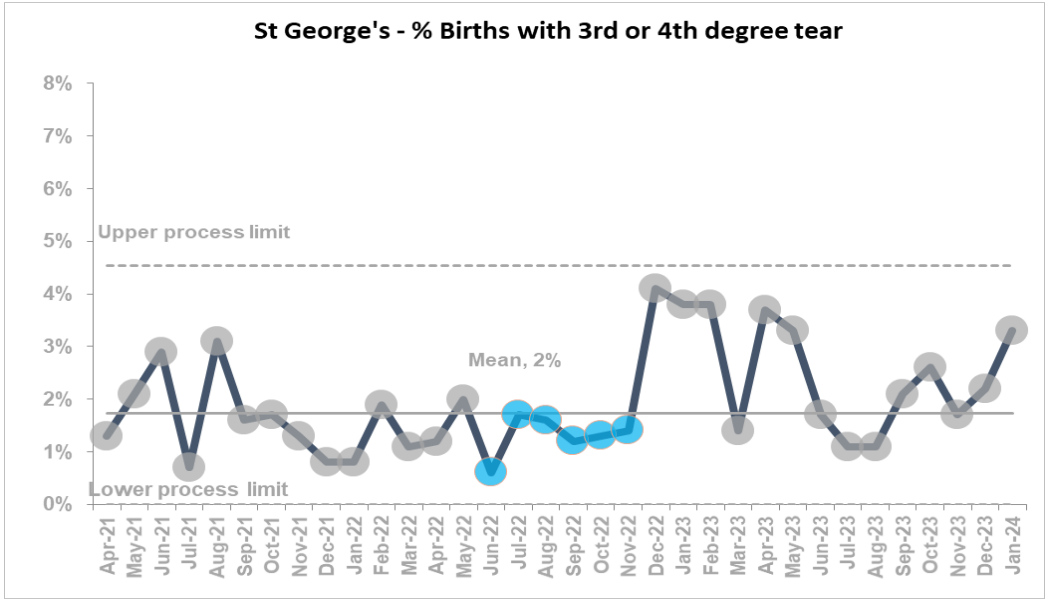
ESTH updates since last month

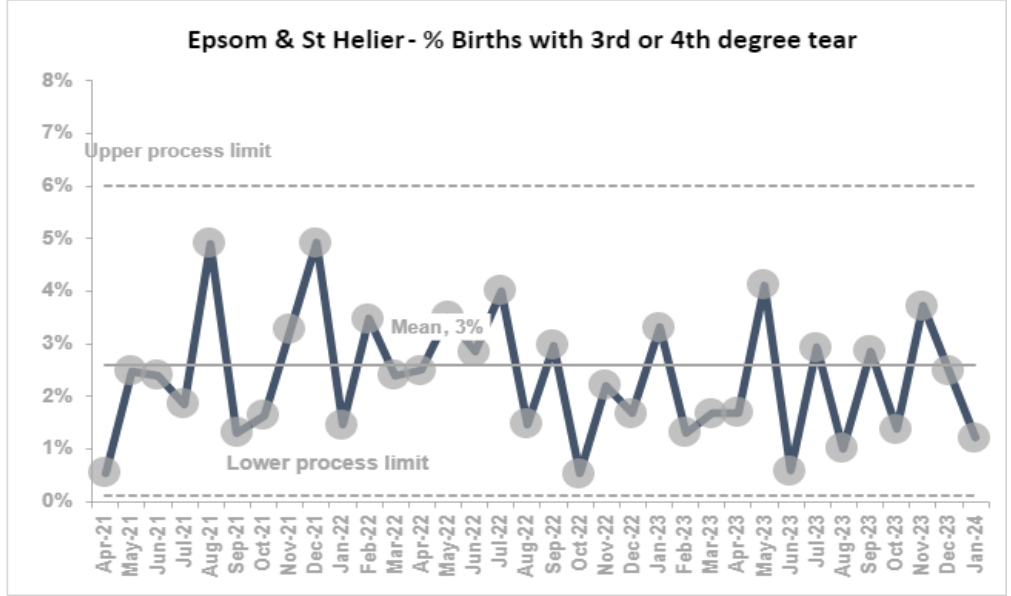
VTE risk assessment was 88% in January 2024. Improvement in the number of areas achieving 100% (16 areas) with a 50% decrease in the in the number of Hospital acquired Thrombosis this month.

% Births with 3rd or 4th degree tear

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

SGH Target:	SGH: 3.3%	ESTH Target:	ESTH: 1.2%





SGH updates since last month

The rate of 3rd or 4th degree tears in January 2024 is 3.3%, which equates to 12 cases - Data suggests common cause variation with the national average being 2.5%

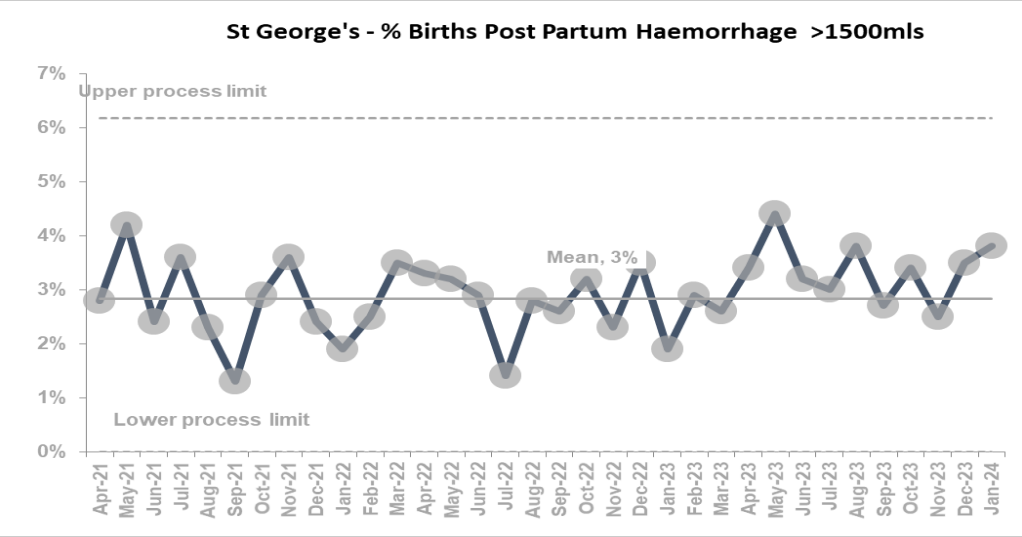
ESTH updates since last month

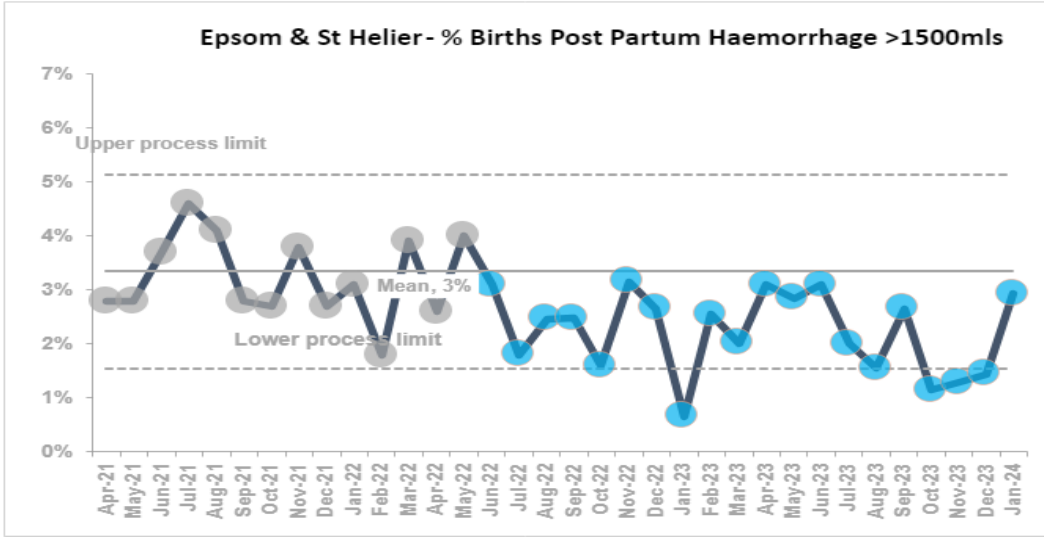
The number of cases remain below target and showing common cause variation.

% Births Post-Partum Haemorrhage >1500mls

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

SGH Target:	SGH: 3.8%	ESTH Target: <3%	ESTH: 2.9%





SGH updates since last month

Rate of PPH >1500mls in January 2024 of 3.8% which equates to 14 cases. The national average is less than 3.0% but this does not differentiate between complexity of case load thus local target is set at 4%.

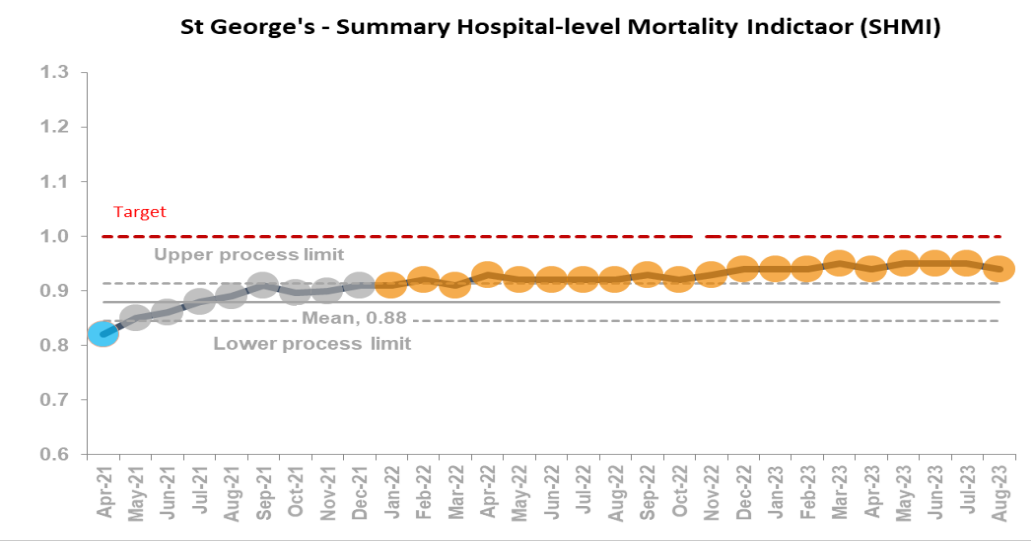
ESTH updates since last month

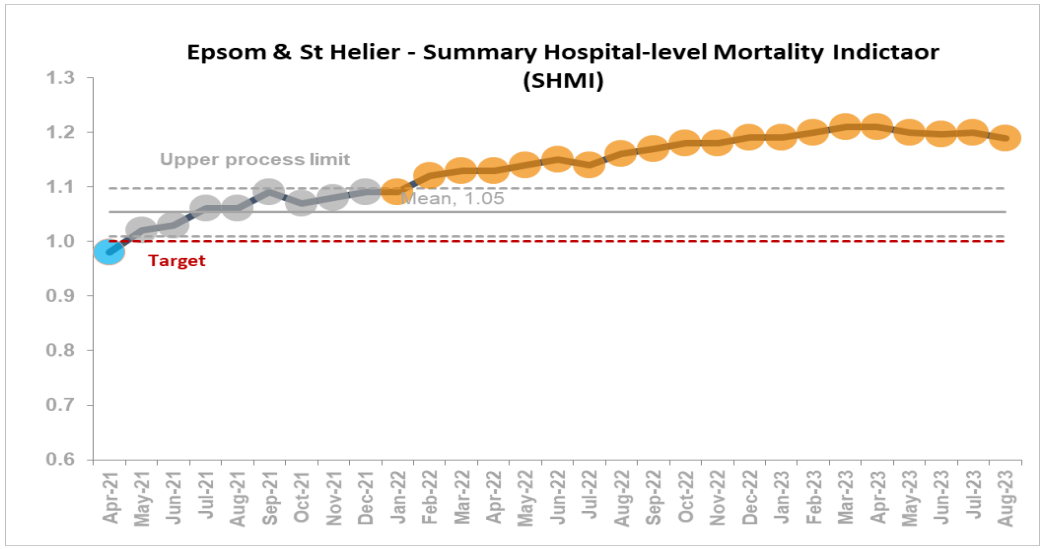
The number of cases continues within target and below national average.

Mortality – SHMI

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

Target: <1	SGH: 0.94	ESTH: 1.19





SHMI data based on rolling 12 months-September 2022 to August 2023

SGH updates since last month

SGH performance remains below expected rates at 0.94.

Source :NHS England

ESTH updates since last month

The latest SHMI data for the rolling 12-month period from September 2022 to August 2023 was 'higher than expected' at a value of 1.1896 It's a slight decrease from the previous value which was 1.2. The positive drop observed in the Crude Mortality Rate (CMR) and Hospital Standardized Mortality Ratio (HSMR) in September is anticipated to be reflected in the SHMI as more data becomes available.

Source: NHS England

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. The Summary Hospital-level Mortality Indicator (SHMI) includes patients admitted to hospitals in England who died either during their hospital stay or within 30 days after discharge. Deaths related to COVID-19 are not considered in the calculation. It's also important to note that the SHMI methodology does not include adjustments for patients documented as receiving palliative care. SHMI Source NHS Digital data based on rolling 12 months- October 2022 to September 2023

Quality - Analysis and Action

St George's, Epsom and St Helier

SGH current issues –

- **Never Event/ Serious Incidents**: 3 SIs declared in January 2024. The integration of PSIRF in all divisions by end of March 2024.
- **Falls**: 5 moderate harm falls were reported in January 2024, this is an increase from previous months. The overall number of falls reported also increased in January 2024 with a total of 135.
- **Pressure Ulcers**: Urinary catheters continue to be the cause for the greatest (1/3) proportion of medical device related pressure ulcers
- **Infection Control**: The Trust continues to be over the NHSE set trajectory for C. difficile and E. coli.
- **Friends and Family** – Response rates for Outpatients and Emergency Department continue below target.
- **Mortality:** SHMI performance remains as expected at 0.94. The Mortality Monitoring Group (MMG) continues to monitor and considers mortality at diagnosis and procedure group level. Cardiology investigation proceeding to inform areas for greater focus.
- **Maternity:** Financial Investment has been approved to support compliance with CNST Safety Actions. This includes investment in midwifery staffing, administrative support and Transitional care workforce.

SGH future action –

- **Falls:** Support from falls prevention nurse provided to areas with increases in falls rate. Quality improvement project focused on continence care underway in Senior Health areas.
- **Pressure Ulcers:** Urinary catheter working group has drafted new guidance on selection of catheter fixation devices with the aim of sign off and launch by the end of 2023/24.
- **Infection Control:** All wards where positive hospital acquired C. difficile cases are identified undergo a Period of Increased Surveillance and Audit.. Feedback is provided via the Divisions. 'Gloves off Campaign' soft launch planned for February 2024.
- **Friends and Family** – Review response rates and source of survey to determine where improvements can be made to engage with our patients and realign according to national targets.
- **Mortality:** M&M priorities for 2024/25 have been set by MMG. Focus will be on key requirements and common outputs so we can use the central function to understand the quality of meetings and begin to harness learning.
- **Maternity**: Ongoing monitoring, quarterly reviews against CNST SA's will drive compliance and address emerging issues

ESTH current issues –

- **Infection Control:** C. difficile YTD cases have reached 51 exceeding local and national trajectory.
- **Falls**: 3 Falls with moderate harm this month.
- **VTE:** Risk Assessment Screening remains a challenge. Lack of ownership by the appropriate health professionals.
- **Mortality**: The RADAH (Reducing Avoidable Death and Harm) Committee continues to review overall and diagnosis-level mortality statistics, and crude mortality rates. 12-month rolling SHMI value, although exhibiting a decrease from previous figures, remains classified as 'higher than expected.' The crude mortality rate for January is documented at 2.2% and is close to the same month last year. The pattern reflects the challenges imposed by winter pressures. 167 Structured Judgement Reviews (SJR) were conducted in Q3 2023/24 and six of them received a 'poor' rating. However, there is a positive shift in the 'concerns in care' percentage, which is now at 31.9%.

ESTH future action –

- **Infection Control:** Compliance per Division has been shared with the Site CNO and CMO for accountability. Face-to-face training has been targeted in Divisions with low compliance.
- **VTE**. Submitted report to Quality Committee in Common. Recommendation that the Senior Leadership team have oversight of progress and holds the division to account in collaboration with colleagues nationally to exchange ideas. Finalise job plans with VTE CNS'
- **Pressure Ulcers:** Continue Task and Finish Group work with areas of concern.
- **Falls Prevention and Management:** The second cohort of the Falls Champion Programme will launch in February, delivering additional education and mentoring on falls prevention strategies. Champions to be equipped with the required level of knowledge and skills to support the reduction of preventable falls within their clinical area of work.
- **Mortality**: Deep dives and thematic analyses are ongoing, with a focus on ensuring safe patient care. An in-depth review of themes from SJRs has identified a list of actions being implemented, including audits on ED mortality and readmissions. Interim findings were presented to the RADAH committee, with formal reports for necessary action soon to be available. Proactive measures are being implemented to prevent deaths due to winter pressures. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. SOP for the transfer of deteriorating surgical patients has been completed and is set to be implemented. The Patient Safety Incident Response Framework (PSIRF) is 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.

Operational Performance

Monthly Overview – Elective Care

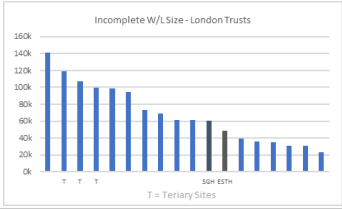
St George's, Epsom and St Helier University Hospitals and Health Group

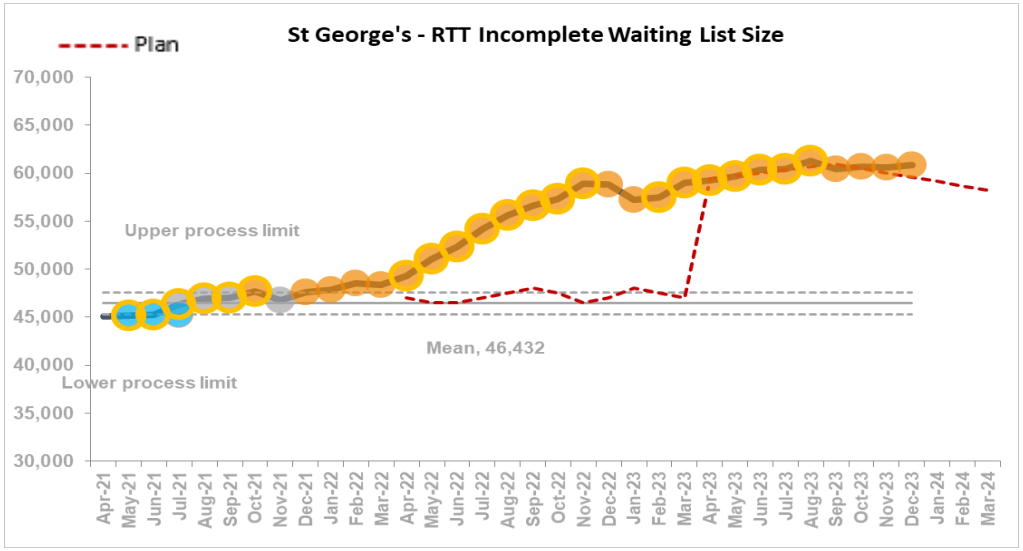
	Responsive and Productive Services - Elective Care	St George's Monthly Target	St George's Nov-23	St George's Dec-23	St George's Jan-24	St George's YTD Target	St George's YTD Actual	St George's 13-Month Trend	Epsom and St. Helier Monthly Target	Epsom and St. Helier Nov-23	Epsom and St. Helier Dec-23	Epsom and St. Helier Jan-24	Epsom and St. Helier YTD Target	Epsom and St. Helier YTD Actual	Epsom and St. Helier 13-Month Trend
ACTIVITY	Outpatient activity	66,072	76,939	59,324	72,565	620,858	697,180		53,886	57,538	43,867	55,438	511,914	517,317	
	Elective and day case activity	5,765	5,959	4,500	5,539	54,156	51,773		3,938	4,108	3,281	3,985	37,411	37,257	
	Diagnostic activity (DM01)		19,058	16,441	19,430		183,466			19,267	16,534	18,207		174,918	
PRODUCTIVITY	Patient Initiated follow ups (Number)		306	261			1,464			2,096	1,310			15,298	
	Patient Initiated follow ups % of OP Activity	5%	0.4%	0.4%					5%	3.4%	2.8%				
	Advice and Guidance Total Processed		1,854	1,109			14,740			1,729	1,040			13,559	
	Advice and Guidance (Utilisation rate) per 100 First Outpatient Attendances	16	5.8	4.6					16	10.8	8.8				
	Outpatient DNA rates	8%	11.5%	11.1%	10.9%	8%	11.1%		8%	4.7%	5.1%	4.8%	8%	5.0%	
	New to follow up outpatient ratios		2.1	2.2	2.2		2.15			2.8	2.9	2.7		2.8	
	Elective Day case rates	78%	80.9%	79.8%	81.9%	78%	79%		82%	84.0%	83.3%	83.2%	83%	83.1%	
	Theatre Utilisation (Capped)	85%	79.4%	78.0%	79.0%	85.0%	77%		85%	80.7%	79.9%	81.7%	85%	77.4%	
	Theatre Average Cases per Session		1.69	1.65	1.69		1.66			4.28	4.26	4.39		3.90	
ACCESS TARGETS	Diagnostic performance	5%	0.77%	2.40%	2.70%				5%	4.1%	6.1%	4.9%			
	On the day cancellations for Non Clinical Reasons not re-booked within 28 Days	0	1	2	2	0	37		0	2	2	2	0	20	
		Monthly Target	Oct-23	Nov-23	Dec-23	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Oct-23	Nov-23	Dec-23	YTD Target	YTD Actual	13-Month Trend
	RTT – total size of waiting list	59,585	60,656	60,579	60,838				46,630	48,679	47,785	48,303			
	RTT -Incomplete Median Waiting Times		11.8	11.6	12.2					11.9	11.9	12.0			
	RTT - Waits over 52 weeks	319	516	489	559				337	956	913	830			
	RTT - Waits over 65 weeks	51	54	27	45				185	230	218	229			
	RTT – Performance	92%	68.6%	68.2%	65.7%				92%	66.5%	66.2%	65.5%			
	Cancer – 28 day Faster Diagnosis Standard	75%	64.0%	63.8%	67.3%	75%			75%	79.1%	75.8%	79.3%	75%		
	31-day decision to treat to treatment standard	96%	96.2%	96.2%	96.9%	96%			96%	100.0%	100.0%	99.0%	96%		
	62-day referral to treatment standard	85%	78.7%	74.1%	80.1%	85%			85%	85.3%	86.3%	86.7%	85%		
	No. of patients over 62 days	105	131	94	107				60	40	64	47			

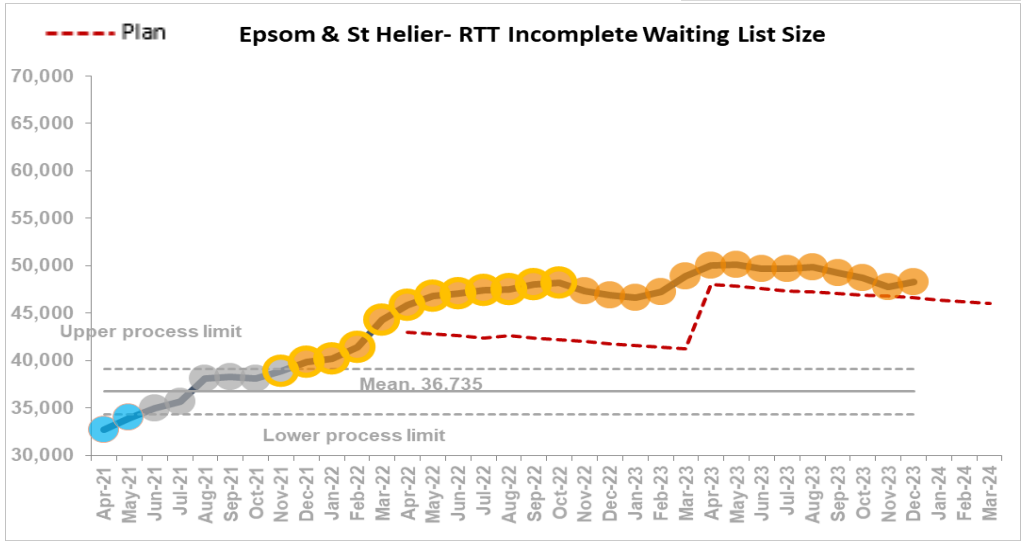
RTT – Total Waiting List Size

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

SGH Plan: 59,585	SGH: 60,838	ESTH Plan: 46,630	ESTH: 48,303







SGH updates since last month

PTL volume at the end of December 2023 was above plan by 1,253 pathways. Compared to the previous month the waiting list size has seen a slight increase of 0.4%, however maintaining a steady trend. 20,856 patients were waiting for more than 18 weeks for treatment an increase of 8.2%. This has resulted in 18 week performance reducing from last month (from 68.2% to 65.7%), ongoing industrial action is one of the largest contributors.

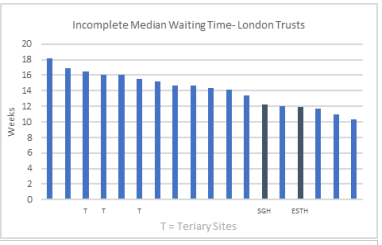
ESTH updates since last month

PTL volume at the end of December 2023 was above plan by 1,253 pathways. PTL volume has increased slightly (by 1.1%), but (18w) breach numbers have also increased, and at a higher rate (by 493 pathways (3.1%)). This has resulted in 18w performance dropping from last month (from 66.1% to 65.5%).

RTT – Median Waiting Times

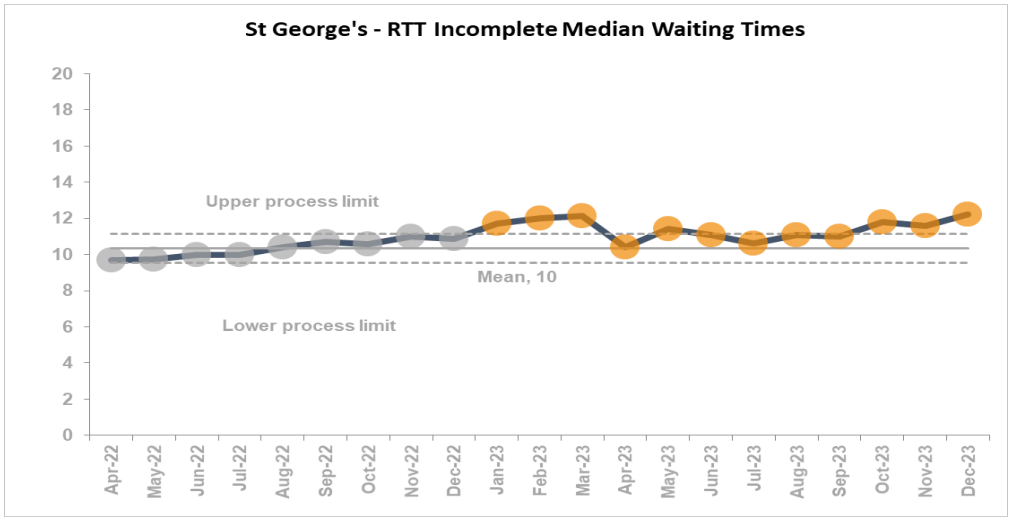
St George's, Epsom and St Helier University Hospitals and Health Group

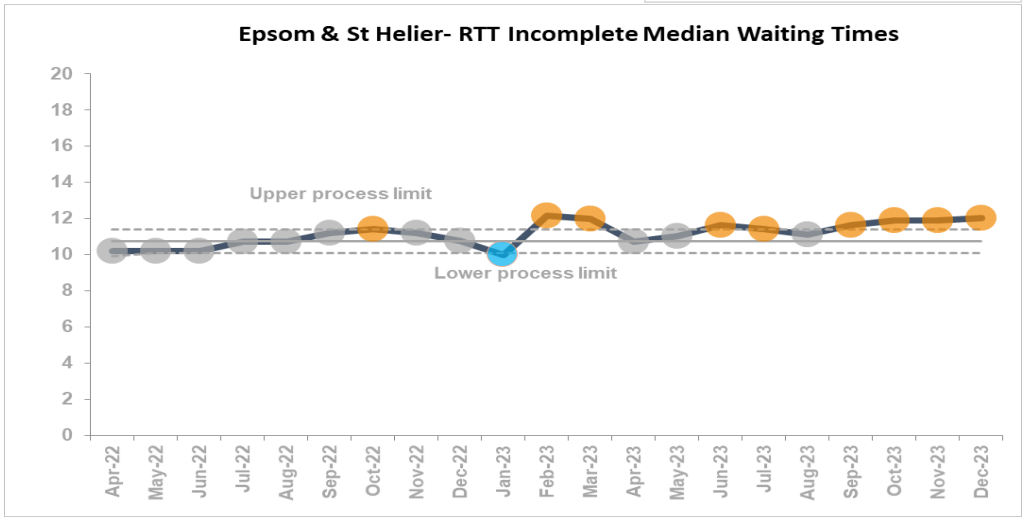
Average (median) waiting time (in weeks)
This is the mid-point of the RTT waiting times distribution. The median is the 50th percentile. It's the time that 50% of patients waited less than, e.g. the waiting time of the middle patient if you lined them up from shortest wait to longest wait.



SGH: 12.2 Wks

ESTH: 12 Wks





SGH updates since last month

The median waiting time for the RTT incomplete waiting list has steadily increased over the last three month period increasing to 12.2 weeks in December 2023, (with waits increasing across all specialties with the exception of Urology and Neurosurgical Service). The highest weeks wait are within General Surgery Service and Ophthalmology.

Ophthalmology is a service provided by Moorfields and Kingston on behalf of St Georges. Kingston have given us notice so we are exploring opportunities for future service provision.

ESTH updates since last month

The median waiting times on the RTT incomplete PTL has seen a steady increase over the past four month period increasing to 12 weeks through December seeing waits increase over multiple specialties, particularly Elderly Medicine and Plastic Services. Cardiology, Gynae and Plastic Services have the highest waiting times (+17 weeks).

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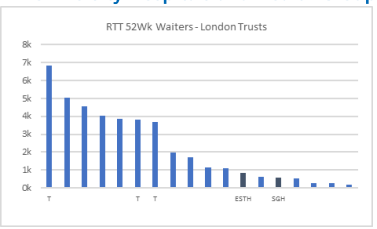
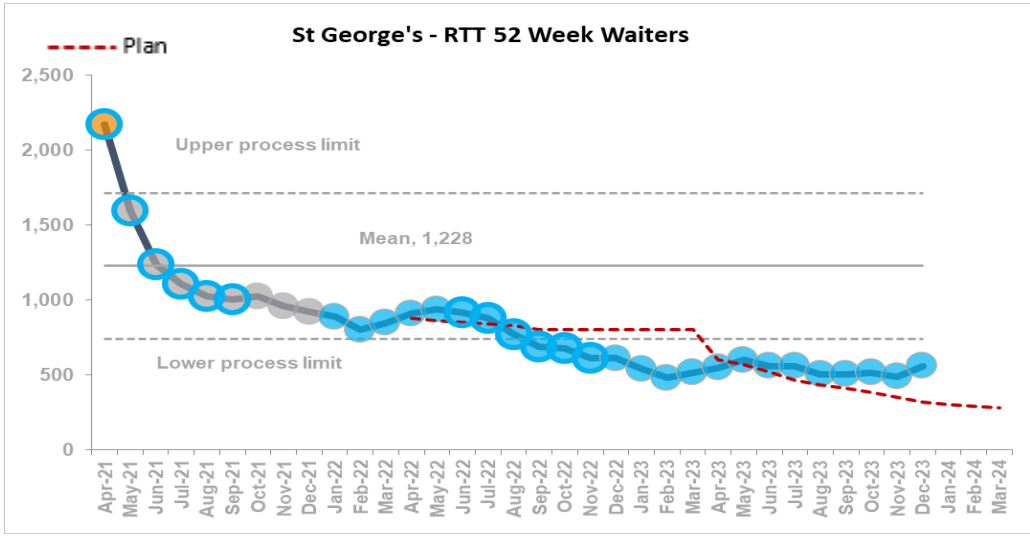
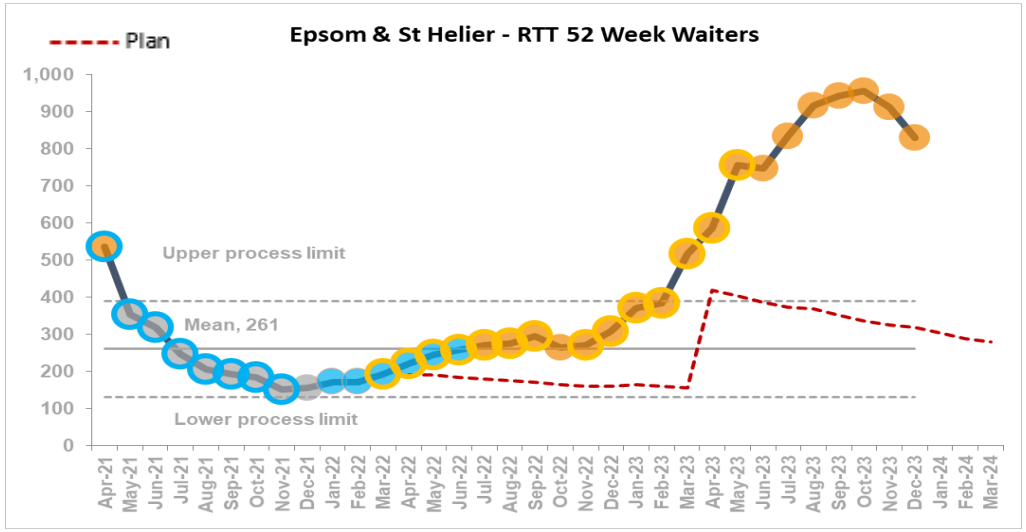
RTT – 52 Week Waiters

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



SGH Plan: 319	SGH: 599	ESTH Plan: 319	ESTH: 830





SGH updates since last month

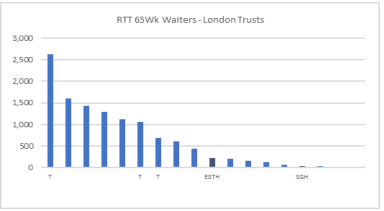
At the end of December 2023, 599 patients were waiting over 52-weeks on an incomplete pathway compared to 489 at the end of November (above plan by 280 pathways). Recovery plans for those specialties not meeting trajectory (highest volume of waits are within Cardiology (101) followed by Neurosurgery [100])are being managed by the divisional teams and are monitored through weekly Elective Access meetings.

ESTH updates since last month

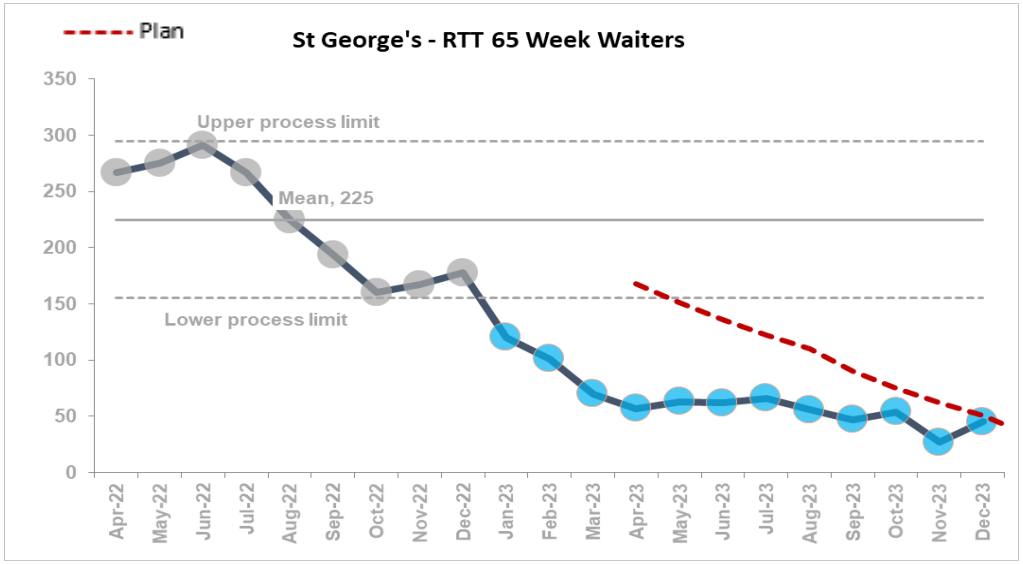
The month-end 52-week waits at the end of December have decreased by 83 pathways (-9.1% compared to November) driven by Gynae and Paediatric Services, however the highest proportion of breaches remain within these areas.

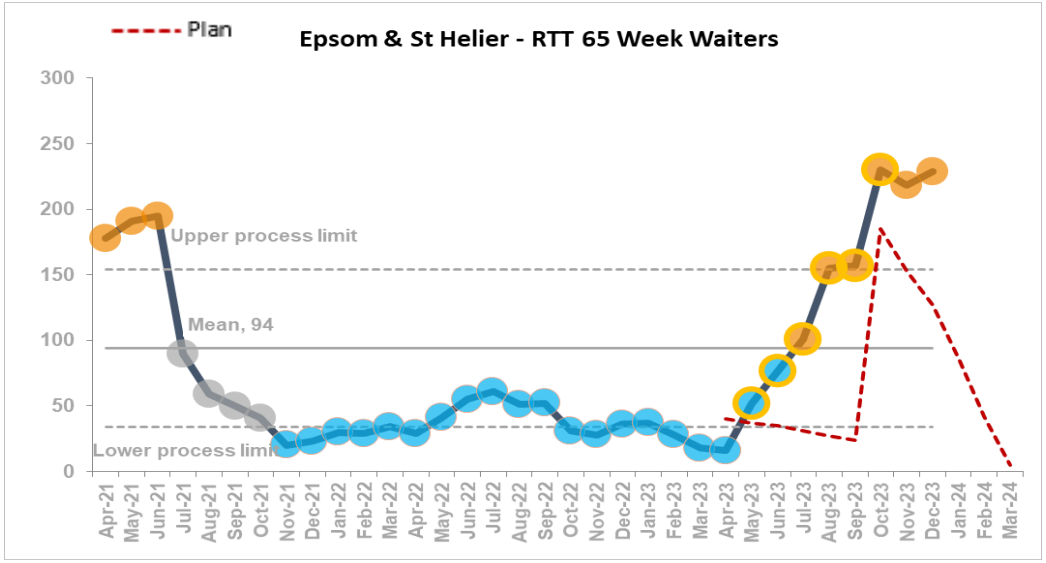
RTT – 65 Week Waiters

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



SGH Plan: 51	SGH: 45	ESTH Plan: 127	ESTH: 229





SGH updates since last month

The Trust remain ahead of plan however did see an increase in the number of 65 week waiters at the end of December 2023. Industrial action (IA) has been the largest contributor, future planning for IA's we are trying to prioritise >65 weeks where clinically appropriate when booking available capacity during industrial action.

ESTH updates since last month

At the end of December 2023, 229 patients were waiting for more than 65 weeks for treatment against a plan of 127. The specialties with the highest number of 65ww are Gynaecology (95), Community Paediatrics (55) and Cardiology (28).

Elective / RTT Analysis and Action

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

SGH current issues –

- January 2024 saw an improved position for Capped Theatre Utilisation, showing 79% compared to 78% in December 2023 (industrial action and holiday periods have impacted).
- Outpatients activity remains above plan, although daycase and inpatients has been reduced due to industrial action and holiday periods.

SGH future action -

- The focus areas for SGUH to improve elective productivity and performance continue to be:
  - Increase theatre productivity to >80% (now looking at cases per list)
  - Reduce DNA rate closer to the national average
  - Increase accuracy in the counting and coding of outpatient procedures
- The 65 week position is monitored daily by Site Associate Director of Performance. Discussed at patient level detail with General Managers with actions reviewed and updated twice weekly.
- A 52 week trajectory position has been shared with divisions for 2024/25. Showing modelling based on current activity levels. This will be worked through to a detailed trajectory to support target delivery of zero 52 weeks by March 2025 although we do not believe that this is achievable without significant WLI's.
- A revamp of the Patient Initiated Follow Up process (PIFU) is currently in process. In an effort to increase current performance from 0.4% towards the national target of 5%

ESTH current issues –

- Patients waiting over 65 weeks for treatment increased from 218 in November 2023 to 229 in December 2023. The specialties with the highest number of 65ww are Gynaecology (95), Community Paediatrics (55) and Cardiology (28). Patients waiting over 78 weeks for treatment increased from 17 in November 2023 to 20 in December 2023, the majority of which were Gynaecology. This increase is due mainly to industrial action in December 2023 and the insourcing approval delay for Gynaecology and Community Paediatrics. A further increase is expected in January 2024 due to the January 2024 industrial action and the flood on 10th January, with some appointments reschedule to February 2024.
- Referrals from GP to a consultant led service remain significantly above BAU (19/20) levels within a number of key specialities such as Gynaecology (+35%) and Paediatrics (+18%) year to date (April 2023-January 2024).

ESTH future action –

- All patients over 12 weeks who have not been seen or contacted in the past 12 weeks continue to be contacted using the DoctorDr platform to confirm if they still wish to be seen. Zesty is due to come online shortly.
- Local action/recovery plans in place for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology.
- Private capacity for Gynae continued throughout January 2024, with plans to increase the private capacity throughout Q4.
- Private capacity for Community Paediatrics start date still TBC.
- Theatre capacity at QMH (Roehampton) increased from 22nd January 2024 (4 lists per week).
- 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+ and an end of Mar24 65wk+ clearance list is being circulated to divisions to increase visibility of pathways needing additional focus.
- Further funding required within the RTT Performance Team to track patients below 30weeks and expedite next steps much earlier. Included within business planning.

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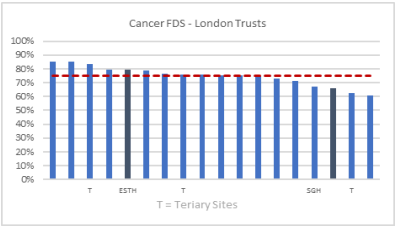
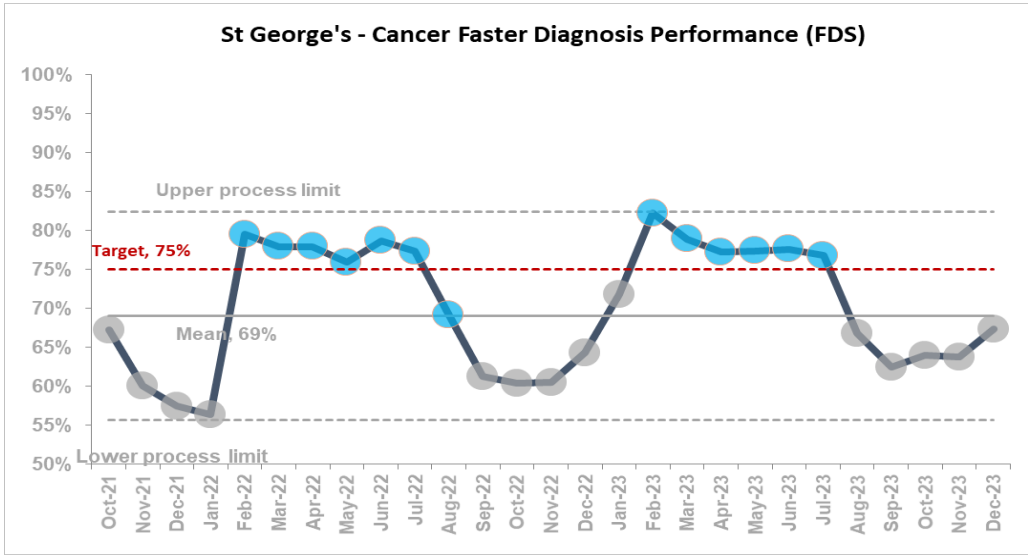
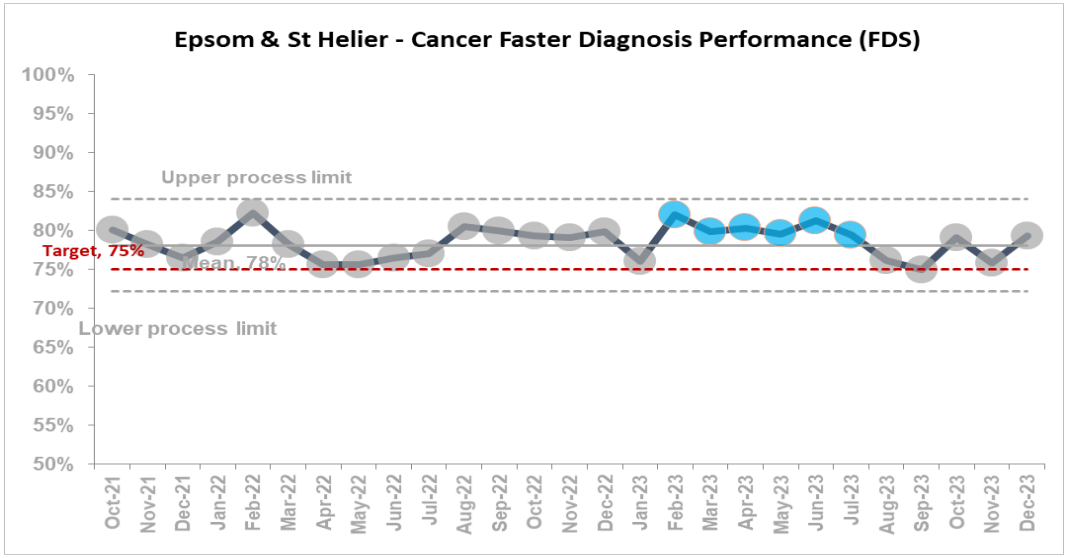
Cancer – Faster Diagnosis Standard

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

Target: 75%	SGH: 67.3%	ESTH: 79.3%







SGH updates since last month

Faster Diagnosis performance remained non-complaint in December 2023 reporting 67.3%, although an improvement on previous months. Challenges are driven by Skin who continue to have the largest proportion of patients waiting for more than 28 days with a performance of 35% in December. Compliance was seen in breast, H&N and Upper GI. There is a business case in progress to support sustainable recovery.

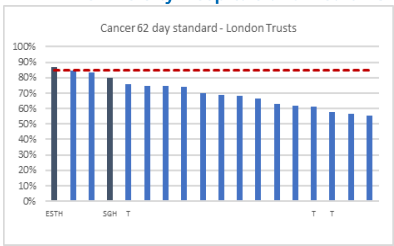
ESTH updates since last month

The Trust continues to meet the FDS standard of 75%, achieving 79.3% in December 2023. The Trust expects to maintain overall performance whilst addressing FDS non-compliance drivers, particularly the challenges within Gynaecology and Lung.

Cancer –62 Day Referral to Treatment Standard

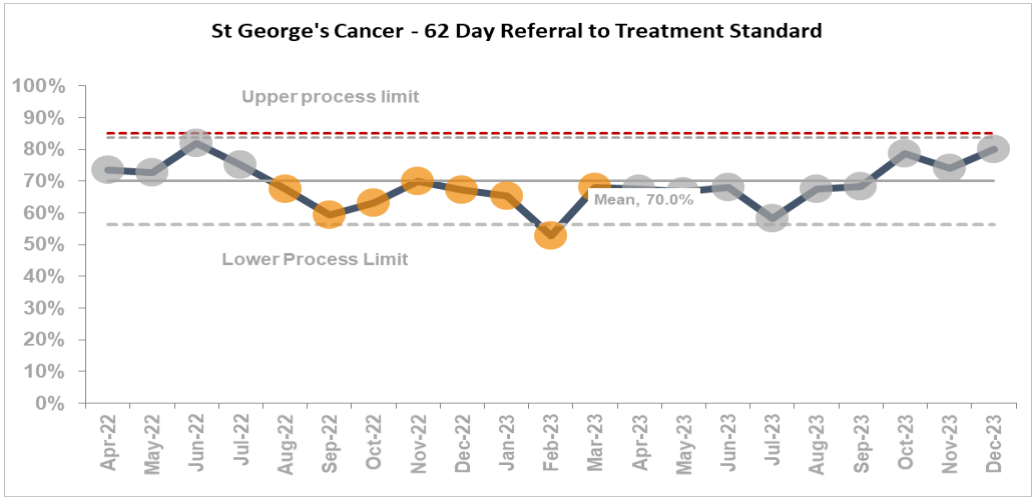
Patients urgently referred by; GP, following screening, consultant upgrade

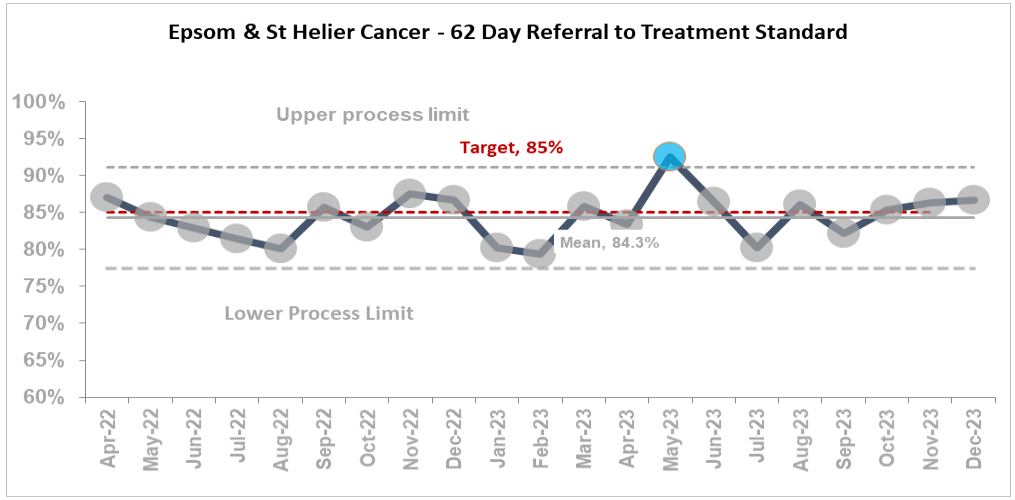
St George's, Epsom and St Helier University Hospitals and Health Group



Target: 85%	SGH: 80.1%	ESTH: 86.7%

From Oct23 the new cancer standards were implemented with one headline indicator for 62 day standard. Performance trend in the charts below show a historic trend of the amalgamated performance of screening, consultant upgrade and GP referral.





SGH updates since last month

In December 2023 the combined performance (GP Referral, screening and consultant upgrades) was 80.1%, increasing from 74.1% in November 2023. In total 30.5 patients breached the target with the largest proportion being reported with the Lung, Breast and LGI pathway.

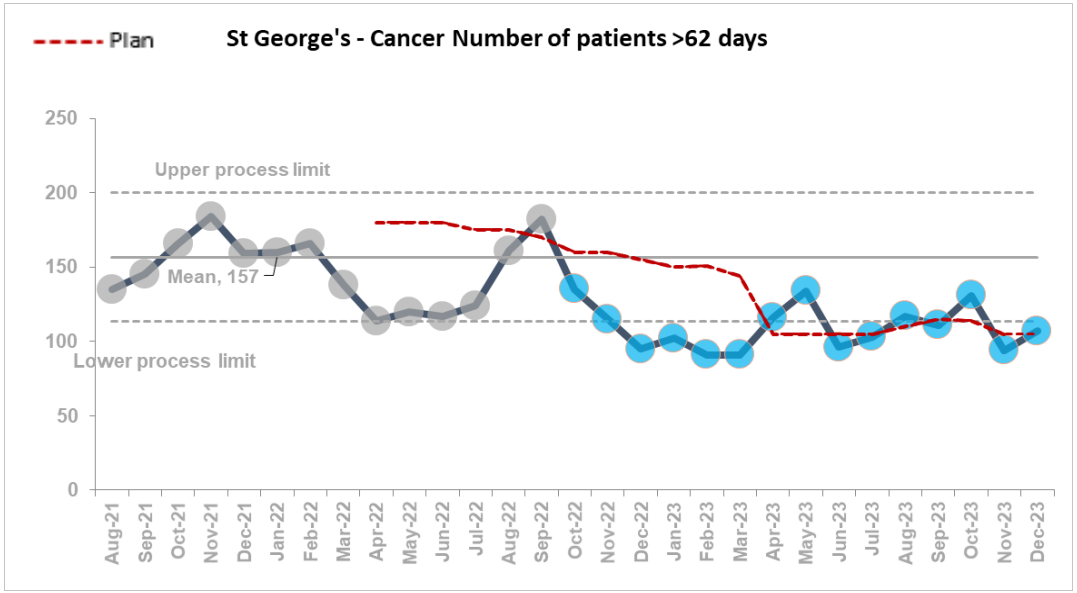
ESTH updates since last month

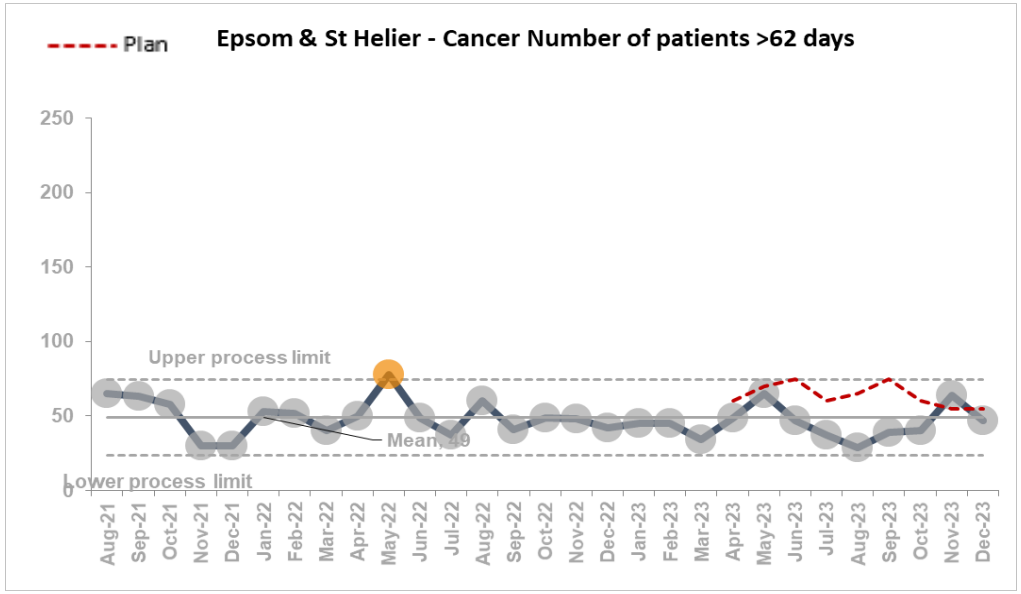
Performance against the 62 day standard continues to be achieved at 86.7% in December 2023 with 14.5 breaches.

Cancer – Number of patients > 62 days

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

Plan: 105	SGH:107	Plan: 55	ESTH: 47





SGH updates since last month

The number of patients waiting over 62 days increased through December 2023 and was above plan by 2 pathways as a result of reduced theatre capacity as a direct result of industrial action, annual leave and loss of activity during the festive period.

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.

Cancer Performance Analysis and Action

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

SGH current issues

Faster Diagnosis Standard:

Skin: A deterioration in skin performance has impacted the overall recovery against this metric. Recovery is dependent on skin reducing 1st seen booking profile to below day 28, a business case to support this is I development.

Gynaecology – access to scans and one stop clinic has resulted in non-compliance
Lower GI – There are delays to Nurse Led Telephone assessment clinic with a 2/3 week wait.
Radiology –Capacity for CTC due to patient choice and locality is impacting FDS. There is reduced capacity due to one scanner being out of action, with a view to install a new scanner by the end of March.

62-day GP Performance:

Overall, our time from diagnosis to treatment is good. However, some pathway delays with one stop clinics and timely access to theatres, as well as internal administrative processes has led to 35.5 breaches across 8 tumour sites across all combined 62 day standard. The highest volumes seen in Breast, LGI in the screening pathway and Lung due to access to theatres and the expansion of the targeted lung health checks.

SGH future action –

- 62 Day Cancer Waits Trajectory being reviewed to deliver 70% by March 2024 as per national ask - Trajectory met in December 2023.
- Business planning to support trajectory planning for 2024/25 is in train with a view to meet new national standard of 77% for FDS and 85% for 62 day combined cancer standard (screening, consultant upgrade and GP).
- RMP allocated funding (£150K) in December 2023 to support performance and WLIs through to March 2024. This has been allocated on clinical needs basis across all tumour sites to support waiting list initiatives and performance recovery.
- The targeted Lung health checks program scaled up from the 01 October 2023. A business case has been developed and is being discussed by the site leadership team.
- Working closely with SWLP to improve identification of patients on a suspicion of cancer pathway to help improve turnaround times.

ESTH current issues –

EUS capacity at RMH remains a challenge - current wait is 4-5 weeks. Turn around times have slightly improved with the opening of the Oaks Centre in January 2024.

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. This will also be raised in the SWLP monthly contract meeting.

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 KPI fell in the last six months due to capacity issues with Gynaecology and Dermatology, now mainly in Gynaecology (57.8%). Paediatric Skin capacity is an issue, however, there has never been positive diagnosis for cancer for any of those referrals. The drop in 14 day KPI is a risk to the Trust's 28 day FDS and 62 day standards.

ESTH future action –

Other dermatology initiatives are more medium/long term plans. An overseas consultant who was successfully appointed on a fixed term contract has now withdrawn so the post is back out to advert. The Locum consultant who commenced in November 23 has now started providing cancer capacity from January 2024 and the Clinical Lead is providing additional TWR clinics from April.

Gynaecology also have a new consultant to commence in April and the Clinical Lead is also providing some additional TWR clinics from April.

RMH EUS capacity is under focus at group meetings and additional lists have been added. The Oaks Centre will be providing a 2nd list by the end of February 2024 which will further improve the turnaround times.

EBUS at StG is now an established service and a quality review is ensuing to reassure on its efficacy.

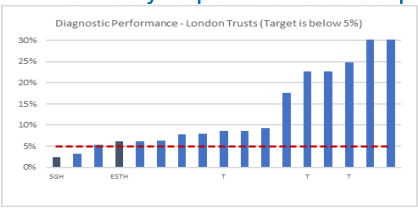
Outpatient Template biopsy (TPPB) work stream continues within Urology with governance oversight by the cancer management team. Acquisition of an outpatient TPPB machine is planned for March 2024.

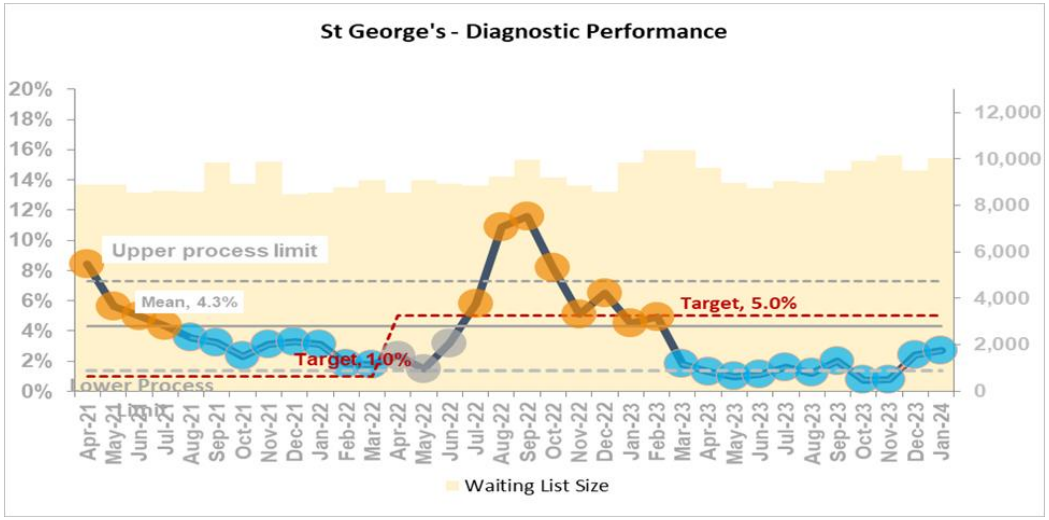
The Cancer Access Policy is planned for review in the next Cancer Strategy Meeting to reflect the New National Cancer guidance (CWTv12).

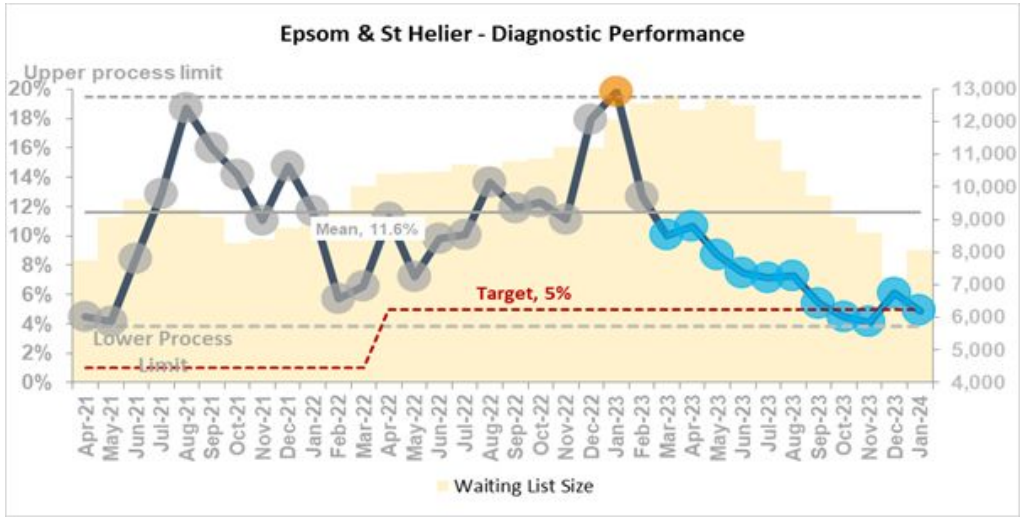
Diagnostic Performance

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

Target: 5%	SGH: 2.7%	ESTH: 4.9%







SGH updates since last month

At the end of January 2024 97.3% of patients were waiting less than six weeks for their diagnostic test, with in total 276 patients waiting for more than six weeks. The Trust continues to exceed the 95% national recovery target. The largest proportion of breaches remains within sleep studies and echocardiography.

ESTH updates since last month

At the end of January 2024 we are reporting 397, which is a drop of 9% from last month. The PTL size has increased from the end of the previous month, and at a fairly significant rate (11%). The impact of both of these changes has meant that our performance has seen a significant increase (from 93.9% to 95.1%).
The modalities with the highest volume of patients waiting over 6 weeks are Urodynamics (94), Endoscopy (91), ECHO (69) and Cystoscopy (63).

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Diagnostic Performance Analysis and Action

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

SGH current issues –

Sleep Studies - Performance in January remained extremely challenged. The Trust continues to see high demand particularly from Croydon and Sutton areas. Performance across the sector has been low.

Staffing challenges impacting Echocardiography has resulted in increased waits through December and January, mainly driven by Stress Echos. Recruitment of physiology posts are extremely challenging to recruit to nationally, and the vacancies are reducing our capacity.

Strike action, sickness and leave through December 2023 impacted waits going into January 2024 within a number of modalities, having to cancel sessions against an already reduced production plan for the seasonal period. This led to more patients waiting for more than six weeks. However, performance continued to be met against the 5% target.

SGH future action –

Sleep Studies - There is CDC funding to create additional capacity, however, this is dependent on staff uptake of sessions. SGH have increased capacity by 70% with extra funding to purchase further sleep diagnostic kit and by increasing outpatient capacity. Clinic template change from February will create more capacity for Pulse Oximetry and this has already had a positive impact through February. SWL Working group proposed to address SWL challenges.

Echo continues to look for support from an insourcing company, however to date they have been unable to supply staff to carry out stress echo tests which is the largest waiting cohort (start date February 2024). The existing team are doing as many additional hours as they are able without impacting their well-being. Bank enhanced rates have been agreed.

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

ESTH current issues –

Imaging: Total diagnostics DM01 breaches for imaging in January 2024 are 52 with the month's **Imaging:** Total diagnostics DM01 breaches for imaging in January are 52 with the month's DMO1 performance for Radiology only showing at 99.1%.

Issues with CT scanner break downs are having an impact on CT Cardiac . Aim to reduce the backlog by the end of February.

Aging equipment within MRI, US and CT are causing frequent breakdowns and impacting waiting lists and performance. Plans are taking place to replace the old equipment and the old PACS servers.

Soliton and Network issues during the last two days of January are affecting the data reports received daily and the monthly submission.

Increased absences due to sickness and other factors across all workforce, including Radiologists

ESTH future action –

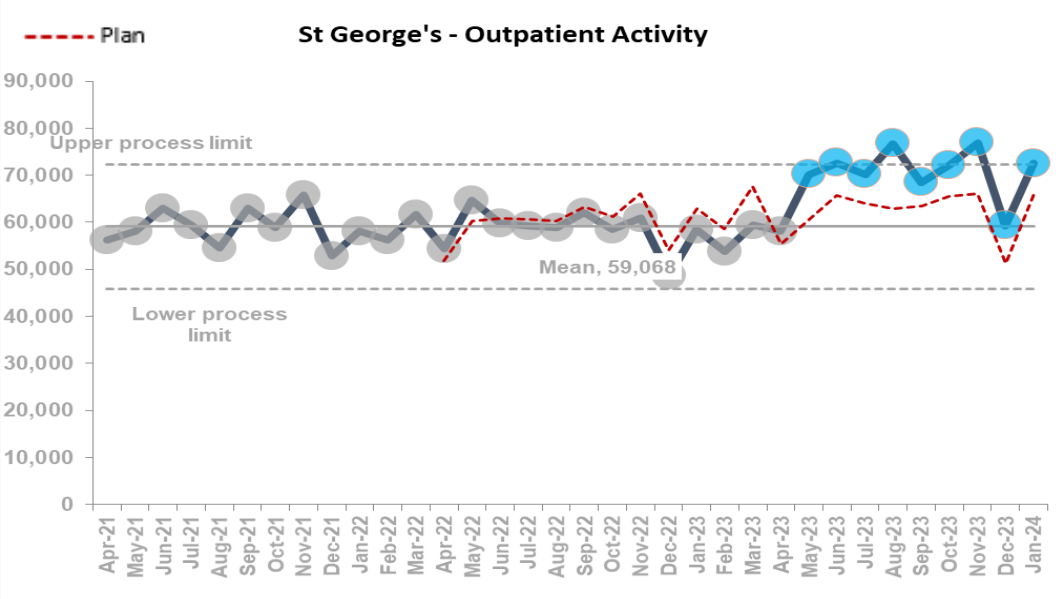
Imaging

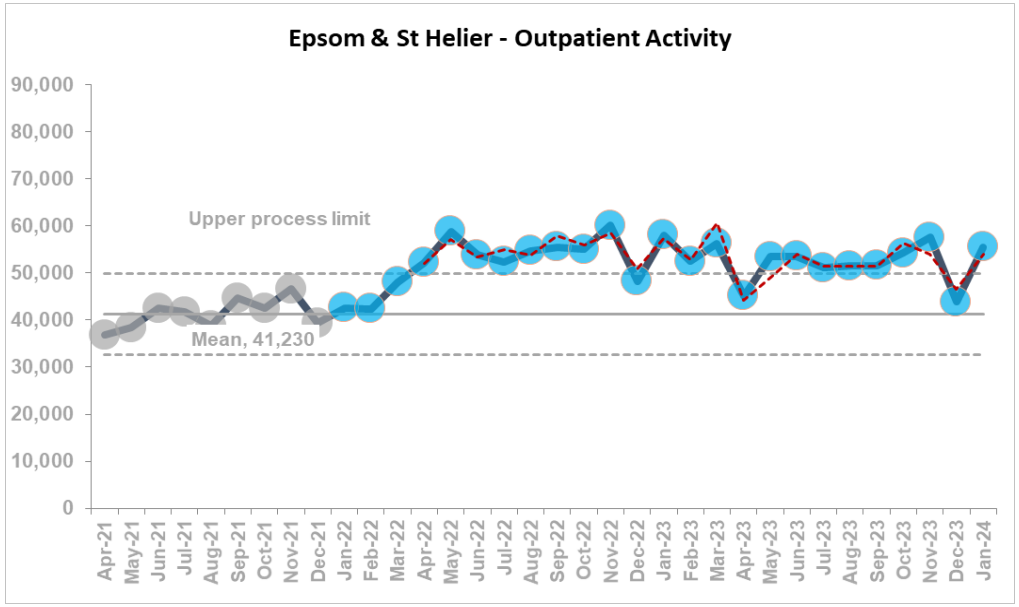
- New chest consultant radiologist and Lead reporting radiographer commencing in February 2024.
- Continuous review of ultrasound, CT and MRI breaches and deep dive of planned waiting list. IR and non key 15 waiting list and breaches improved considerably having reduced the breaches to the minimum.
- Ultrasound Guided injection (USGI) waiting list and breaches reduced considerably (reduced to 7 breaches at the beginning of February).
- Locum working in radiology in January to provide extra CT biopsy and cardiac capacity.
- Daily operational huddles between clerical management and lead superintendents continuing as this is essential in maintaining the DMO1 performance.
- Nuclear Medicine scans outsourced to SGH, RMH and RBH due to camera replacement. Aim is to bring everything back in house in February 2024.
- US outsourcing has ceased from the end of January and the team are managing the demand in house.

Outpatient Activity

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

Plan: 66,565	SGH: 72,565	Plan: 53,886	ESTH: 55,438





SGH updates since last month

Outpatient performance continues above plan and remains consistently above the mean.

ESTH updates since last month

January outpatient activity was ahead of plan and above the upper control limit. YTD activity remains ahead of plan.

Patient Initiated Follow-up (PIFU)

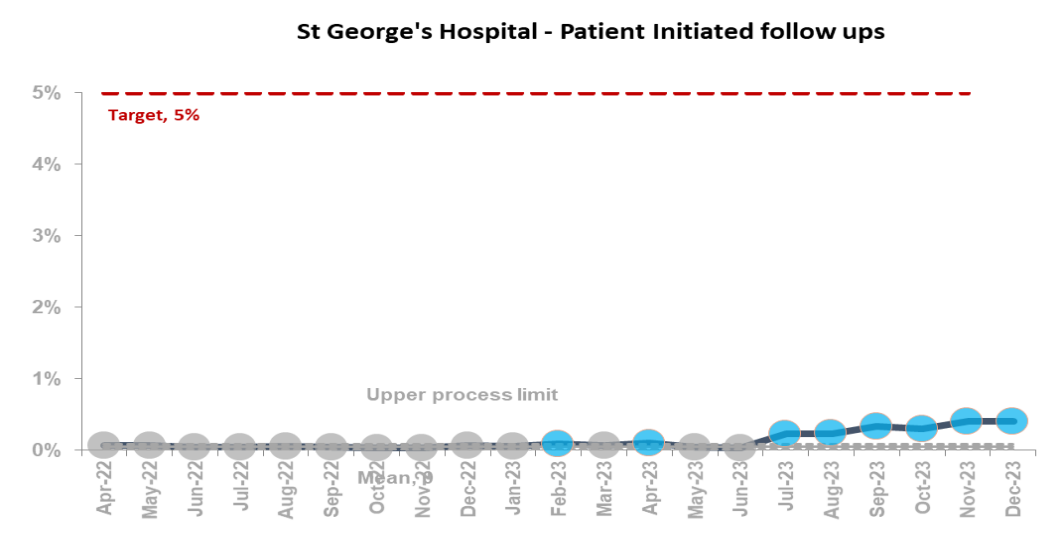
Percentage of episodes moved or discharged to a PIFU Pathway

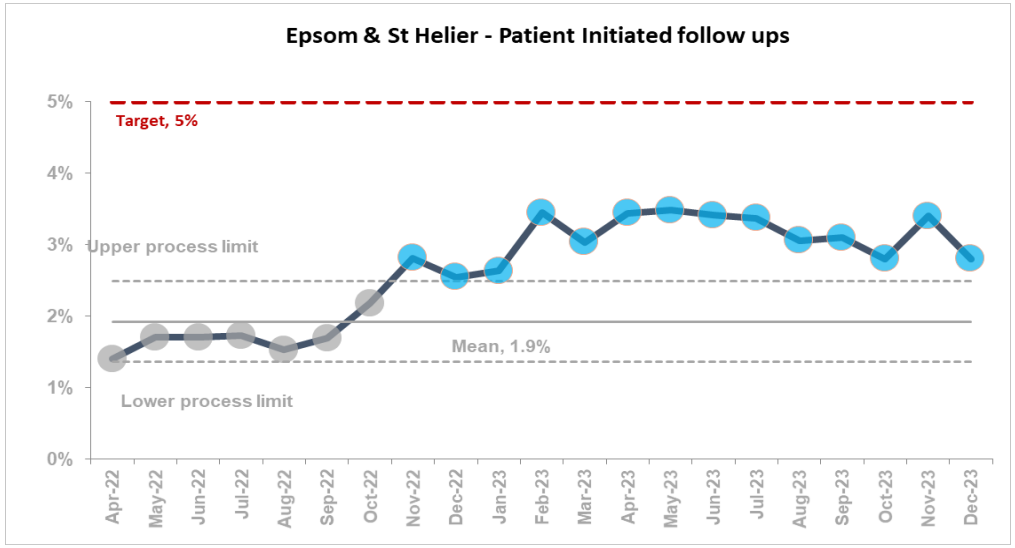
St George's, Epsom and St Helier University Hospitals and Health Group

Target: 5%	SGH: 0.4%

Target: 5%	ESTH: 2.8%

Reported one month in arrears in line with NHSE reporting





SGH updates since last month

Activity continues to increase with the technical solution to PIFU now been designed and rolled out in T&O and Urology. A review of the PIFU process is underway to ensure that we have an IT solution to process and once finalised, will be offered out to all specialties wishing to introduce a PIFU pathway.

ESTH updates since last month

PIFU activity remains above the upper control limit but reduced in December. This is likely due to AL and strikes in December, along with a seasonal reduction in routine activity which is the main sources of PIFU pathway initiation. PIFU continues to be encouraged in specialty business meetings and targeted plans within the OP transformation programme, such as Cardiology, are under way to increase PIFU, initially back to consistently over 3%.

Advice & Guidance

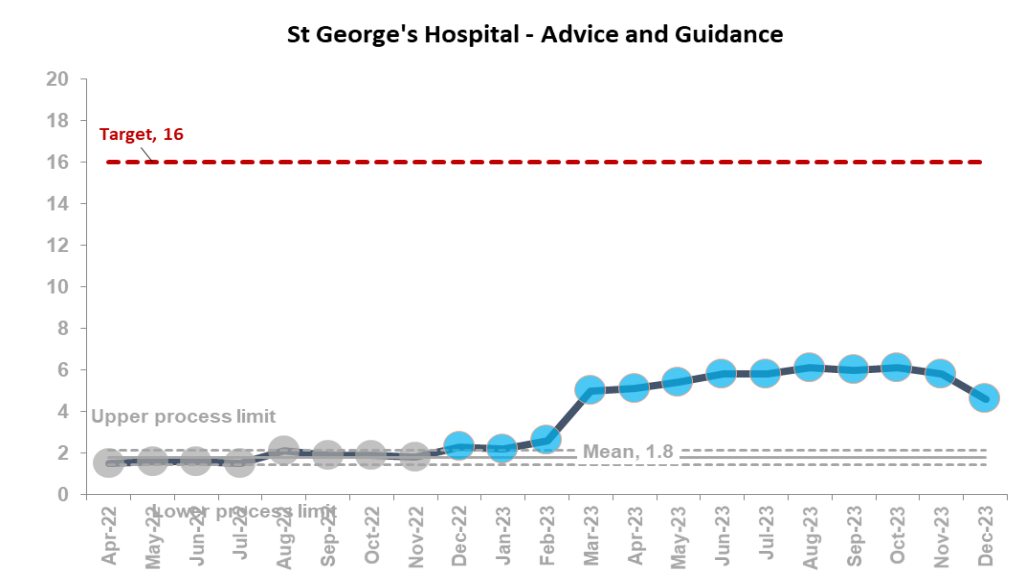
Utilisation of Specialist advice – Number of Processed Requests rate per 100 Outpatient First Attendances

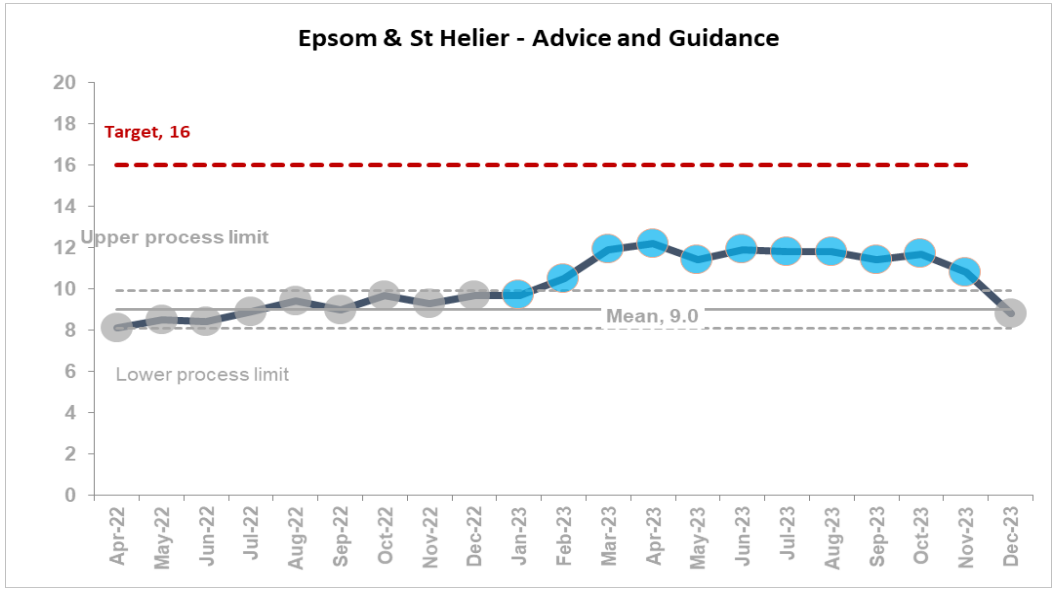
St George's, Epsom and St Helier University Hospitals and Health Group

Target: 16	SGH: 4.6

Target: 16	ESTH: 8.8

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 e-Referrals (ERS) Advice & Guidance portal. Many of the Trust's services provide specialist clinical advice via requests submitted to ERS via alternative referral routes. SWL have now agreed for the inclusion of RAS appointments and this data will be included in the December 2023 submission with activity likely to increase once data has been outcome.

ESTH updates since last month

The above data only counts activity through the e-RS A&G portal. This doesn't take in to account the advice and guidance given as part of triage that takes place for all referrals received through the CAS (clinical assessment service) in e-RS. NHSE have now agreed for the CAS to be included in the submissions. The detail of doing so is being worked up between ESTH and SWL analysts. The inclusion is expected to take ESTH over the 16% target utilisation figure.

Outpatient Activity - Analysis and Action

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

SGH current issues –

- Patient Initiated Follow Up (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. The project team are pulling a plan together to roll out to Physiotherapy, Neurology, Dermatology, ENT, Gastroenterology, Plastic Surgery and Gynaecology which will be presented at the Transformation Steering Group this month. Workshop took place on 6th February with specialities to align and engage new practice. Will be looking to move onto Zesty when ready. Awaiting feedback from Cerner on how soon an auto discharge letters can be generated within the system.
- Advice & Guidance (A&G) – SGH has now received confirmation from SWL that RAS activity can be included in our submission. Some specialities continue to struggle to identify dedicated resource within current job plans to A&G.

SGH future action –

- 12-week validation - We contacted over 90% of patients waiting over 12 weeks ahead of the end of December deadline and provided feedback about the exercise to SWL Outpatient Board
- Outpatient 'MOT' – Check information and configuration of all services is accurate, uses optimal resources and is peer group competitive in 1 year. T&O, Respiratory and Urology all 100% completed – Passed, ENT(90%) and Therapies (95%) –Gastro, Derm, Cardiology and Gynae in motion. No additional progress this month due to capacity constraints
- DNA audits – We are in the process of changing our patient appointment letter to include the QR code which takes patients directly to the appointment rescheduling page and aiming to complete this by end of Feb. Two-way texting has been explored and will be approaching services to support role out of this, will begin with a pilot in speciality services with a higher DNA rate such as Ophthalmology and Audiology.

ESTH current issues –

- PIFU – Testing issues with Zesty for the waiting list validation are a contributing factor in the delay in testing the effectiveness of patient questionnaires via Zesty to support PIFU appointment activation triage.
- A&G – following the agreement to include the CAS data in the utilisation figures, ESTH and SWL analysts are working on the first submission that will include the CAS. There has been an initial discrepancy in figures which being worked through.

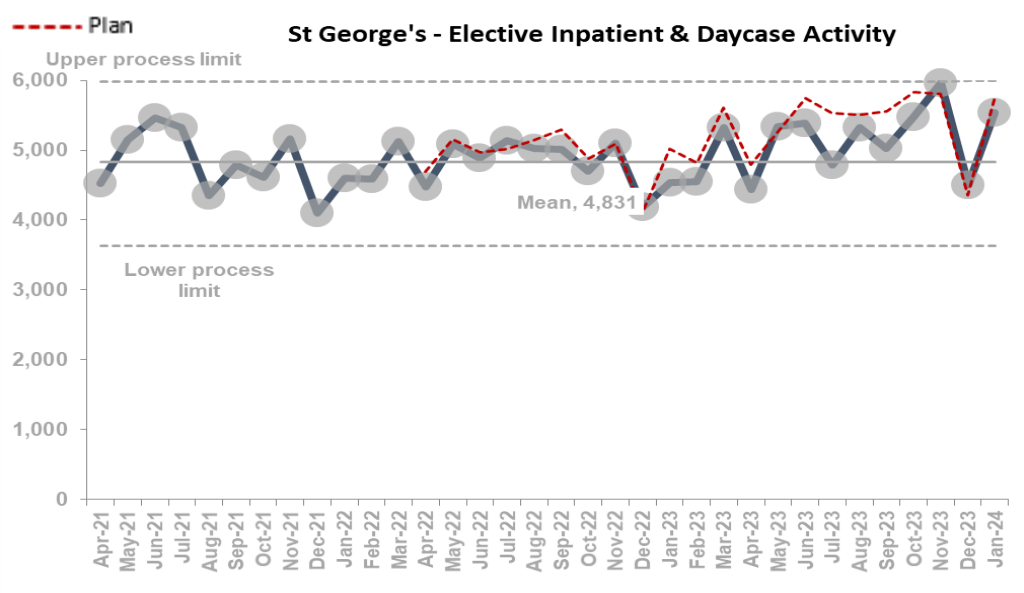
ESTH future action –

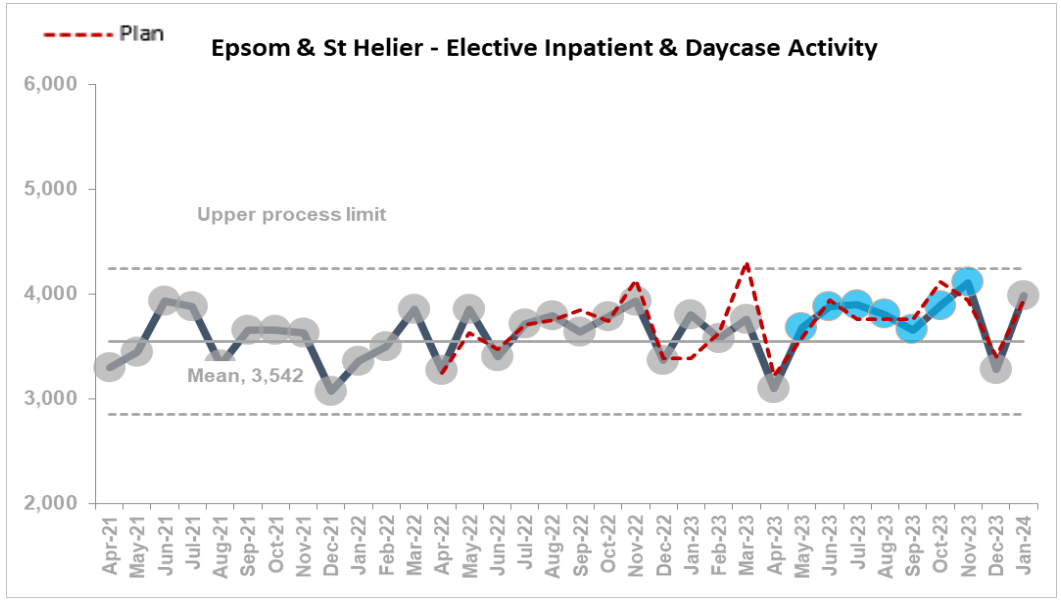
- PIFU – The development of clinical protocols continues within Cardiology. The ILR protocol is drafted and the Arrhythmia protocol is being drafted this month. The admin process in Cardiac Investigations is being considered based on OBC processes. Further opportunities for PIFU in Cardiology are being explored such as Heart Failure (PIFU for long term conditions). Opportunities for PIFU for asthma and COPD continue to be explored in Respiratory. In Neurology, we are sourcing the Croydon PIFU pathway for comparison and learning.
- A&G / Pathway review / Referral Forms -The Quick View programme continues, with Cardiology, and Gastroenterology Quick Views scheduled for OMG. However, cancellation of the meeting is causing delays. An opportunity for review via email is being explored. The Respiratory Quick view has been further edited and is now being shared with the wider Respiratory clinician body.
- Mapping of the Heart Failure pathway – Discharge / PIFU / FU protocol is being developed to support best practice pathways. Now that local community heart failure services locally have defined their referral criteria, a meeting has been scheduled to discuss reduction of duplication in the pathway.
- The task and finish group to look at e-RS attachments identified various factors from both primary and secondary care. A GP site visit in Surrey is now being arranged to support understanding of the primary care process.

Elective Inpatient & Daycase Activity

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

SGH Plan: 5,765	SGH: 5,539	ESTH Plan: 3,938	ESTH: 3,985





SGH updates since last month

Elective and Daycase performance is slightly behind plan for January 2023, this will likely increase with data catch up. Delivery of activity will continue to be impacted by industrial action.

ESTH updates since last month

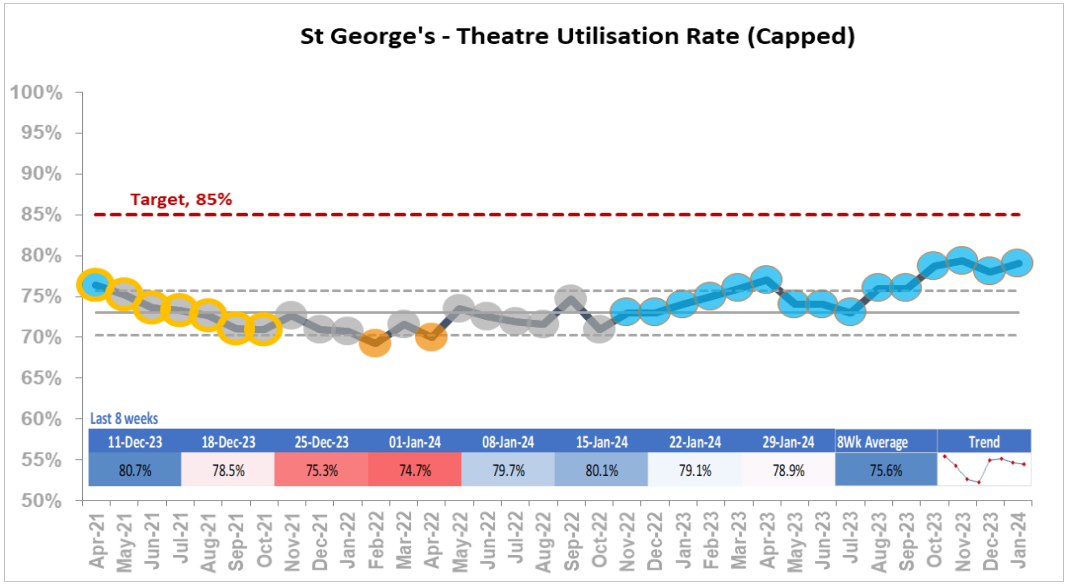
January activity was above plan by 47 cases, this is likely to increase further once data catch up is completed.

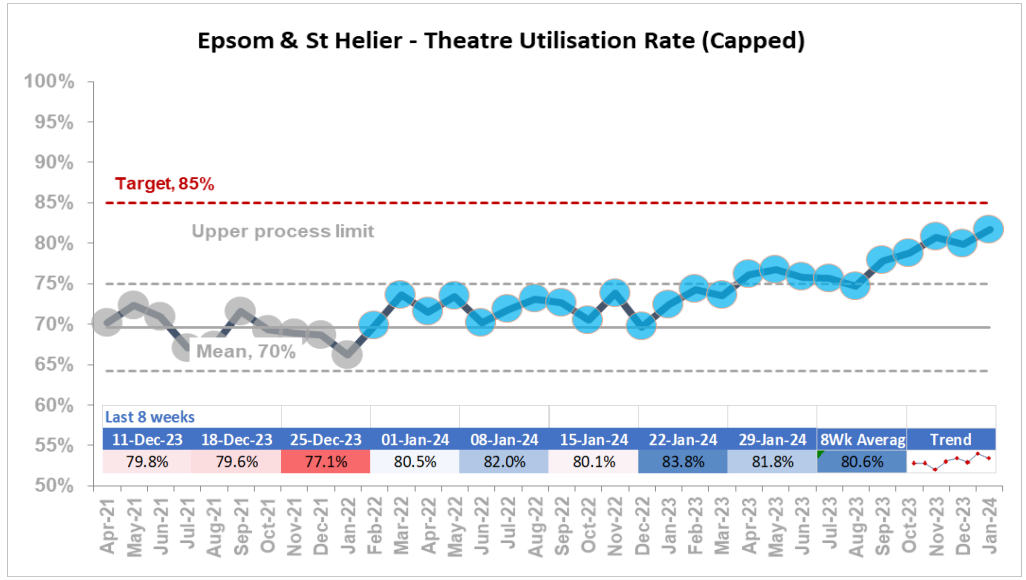
Theatre Productivity – Capped Utilisation

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

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

Target: 85%	SGH: 79%	Target: 85%	ESTH: 81.7%





SGH updates since last month

Capped theatre utilisation rates remain above the upper control limit in January, reporting 79.5% with plans to improve further across all theatre suites to meet the target of 85%.

ESTH updates since last month

Capped utilisation performance remains positively above the upper control limit with an upward trend reporting 81.7% in January showing special cause variation of improvement.

Internal Trust data is being used to calculate utilisation performance. Current data quality issues with Model Hospital data means that the Trust is performing better than being reported externally, this is not due to be resolved until February 24. Any changes to internal reports that may be required are being made and will be reflected in our internal reporting

Theatre Productivity - Analysis and Action

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

SGH current issues –

In January 2024, our capped theatre utilisation was 79% (and 81% so far in February 2024). This remains above the yearly average position of 76% capped utilisation.

Adherence to 642 booking principles is variable, with multiple specialties delivering low booking profile for weeks 1-2. A new theatre performance meeting has been established to ensure lists are fully optimised and booking rules adhered to.

Forthcoming Junior Doctor IA inadvertently impacting theatre utilisation and the number of cases completed.

SGH future action -

Further work is required to ensure ESTH, Moorfields and Dermatology sessions delivered at QMH STC are excluded from utilisation reports.

Scheduling: continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. Weekly deep dives into sessions capped utilisation below 65%.

Continued focus on avoidable cancellations, with specialty specific deep dives to understand scope for improvement.

Data quality issues are being addressed which will impact performance against BADS (British Association of Daycase) procedure to bring us nearer to the target of 85%.

ESTH current issues –

The Trust has seen an on-going overall improvement in Theatres utilisation currently achieving the planned trajectory targets. However, HVLC T&O and Pain injection lists and Urology Template Biopsy lists continue to impact overall performance due to the required downtime between cases for clinical administration and estates constraints (limited admitting and recovery space to accommodate high volume injection lists).

To mitigate, capital investment is required to create a minor ops procedure room and additional consenting rooms, without capital investment to support the throughput of the HVLC Pain & T&O injection lists, there is a risk the Trust will be unable to achieve the year end 85% trajectory.

ESTH future action –

Action: Explore plans to relocate T&O and Pain injections lists into a minor ops procedure room, in line with GIRFT Right Procedure, Right Place (RPRP) recommendations: ***(Key measures for success: Theatres Utilisation, early finishes)***

- Relocate Template Biopsy lists to the Urology Outpatient Centre, by March 2024. *TO NOTE: Approximately 30% of patients requiring a TPPB will still need to be carried out under a GA in theatres.*
- Create a bespoke injection theatre for the appropriate procedures *(Medium term: scope use DCU Theatre 2. Long Term: Well wing redevelopment, proposed 2024/25)*

Action: Creating additional admissions and recovery space: *(Key measures for success: Theatres Utilisation, early finishes, late starts, day case rates)*

- T&F group established to explore our ability to accommodate cases that require extended post operative recovery on Swift Ward. (*This will unlock additional capacity in day case to manage high volume / low complexity lists).* **Current next step:** Deep dive analysis in progress to identify opportunity to further improve BADs day case rates, to support re-profile Swift ward bed base, with the aim to increase day case recovery space and reduce overnight stays.
- T&F group established to scope opportunity to create additional admissions space via Well wing redevelopment, proposed 2024/25.

Action: Reducing avoidable on the day cancellations: *(Key measures for success: On the day cancellation rate)*

- RCA deep dive exercise supported by the use of the Health insights dashboard currently underway, to further analyse reasons for OTDC to understand scope for additional opportunity to mitigate.
- Scope pilot to provide additional 3 day pre TCI 2 way text reminder as a further opportunity for pts to notify they no longer wish to proceed (aimed at pts who have become unwell post 7 day pre TCI call)

➢ **Action: Introduction of a Daily Theatre Huddle and weekly Theatres performance meeting *(Key measures for success: Theatres Utilisation, early finishes, late starts, Utilisation)***

- Highlight any lists that are under 85% booked to ensure services have plans in place to fully utilise lists
- Identified opportunities to ensure case numbers per list are maximised to fully utilise available theatre capacity via a Review of planned vs actual utilisation by surgeon
- Booking rules developed and shared with speciality teams to support accuracy of scheduling

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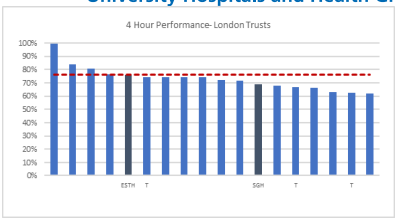
Monthly Overview – Non Elective Care

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

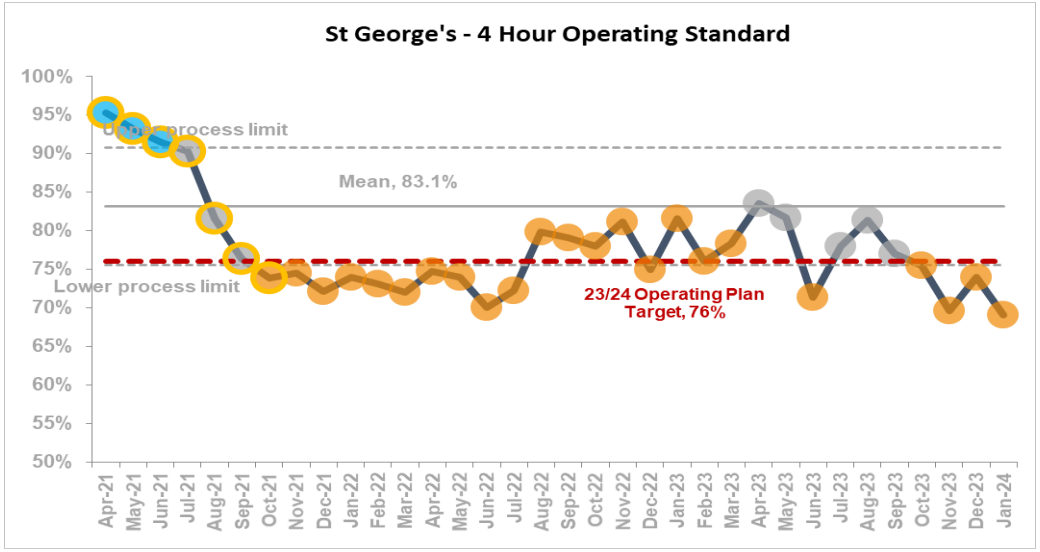
Responsive and Productive Services - Non Elective Care	St George's							Epsom and St. Helier						
	Monthly Target	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend
4 Hour Operating Standard	76%	69.6%	73.9%	69.1%	76%	76.0%		76%	73.7%	73.4%	76.1%	76%	75.9%	
Emergency Department LOS >12 Hours (% of attendance)		13.4%	9.2%	9.5%		8.7%			10.6%	11.1%	11.7%		9.4%	
Ambulance handover Performance 30 minutes	0	205	115	74	0	765		0	501	447	620	0	3656	
Ambulance handover Performance 60 minutes	0	28	25	31	0	525		0	69	45	73	0	940	
Non elective length of stay		7.4	6.8	6.9		6.93			7.3	7.4	8.0		7.50	
Mental health delays 4 Hour Breaches		127	91	104		1153								
Redamission Rate - Non Elective		11.2%	11.2%	12.3%		11.1%			5.7%	5.6%	5.3%		5.4%	
Length of stay > 7 days (stranded)		369	348	363		367			320	328	365		314	
Length of stay > 21 days (super stranded)	172	161	157	164	172	161		130	127	127	152	130	130	
Overnight G&A beds occupancy - Adults	92.0%	97.1%	94.6%	96.4%	92.0%	95.7%		92.0%	93.6%	89.9%	88.4%	92.0%	90.9%	
Number of patients not meeting criteria to reside	83	118	159	171				104	176	175	188			

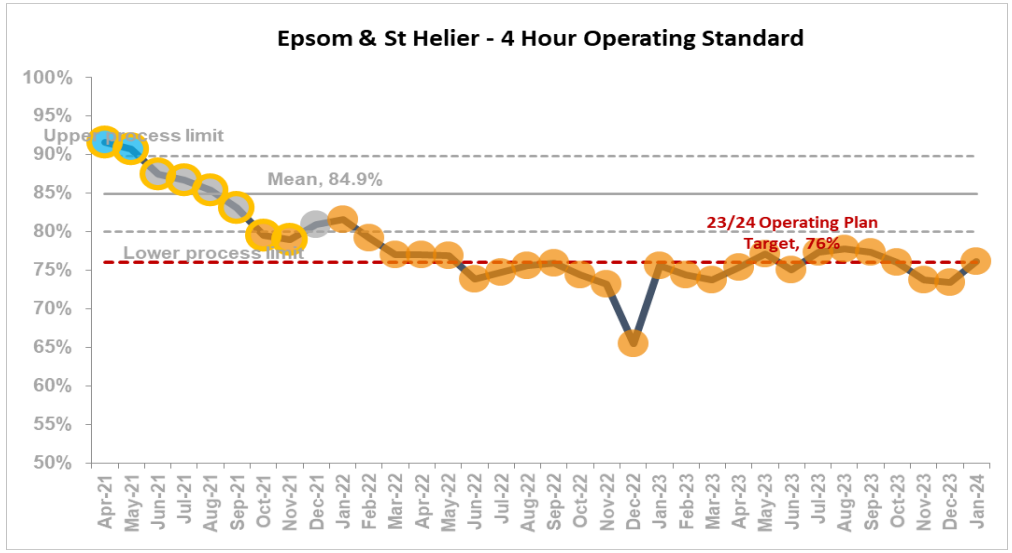
4 Hour Operating Standard

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



Target: 76%	SGH: 69.1%	ESTH: 76.1%





SGH updates since last month

January was very challenged, with four hour performance decreasing to 69.1%. Attendances have been significantly higher including ambulance conveyances and admissions to hospital during January.

We have undertaken an audit of our (data) daily breaches and have identified that there are issues that have artificially reduced performance. We are planning to undertake a retrospective review of the last months data which we will expect to bring our year to date position above 76%.

ESTH updates since last month

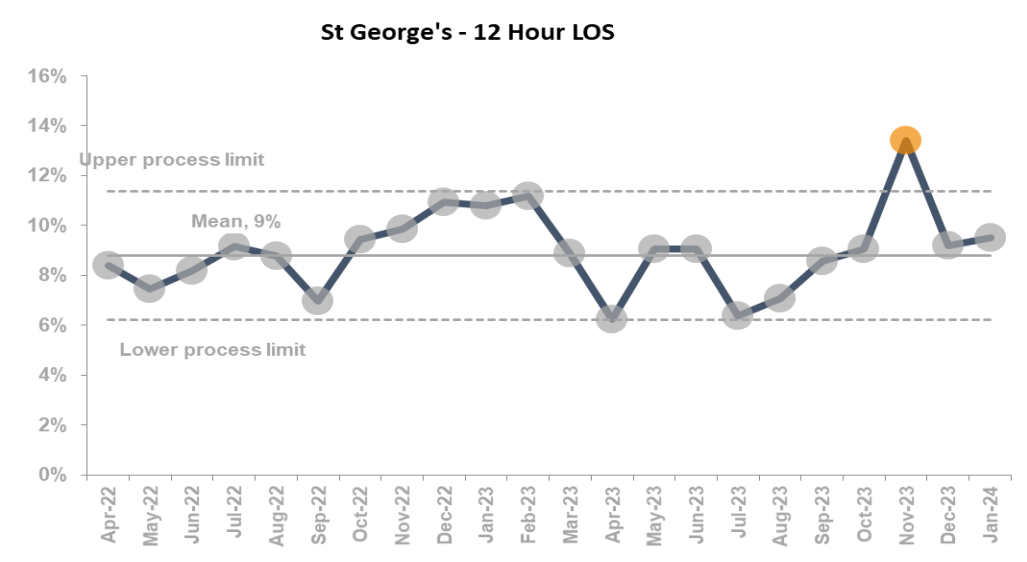
Across January, 76.1% of patients attending the Emergency Department were either admitted, discharged or transferred within 4 hours of their arrival an increase from 73.4% reported in December and comparable to last years performance. Performance remains incredibly challenged across both sites.

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

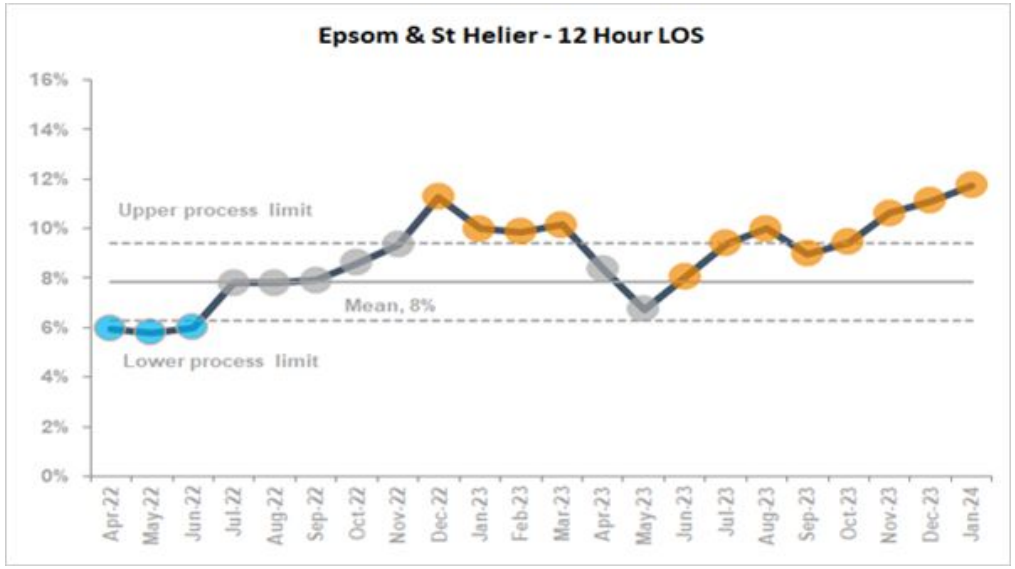
Target: TBC	SGH: 9.5%



SGH updates since last month

Across the month 9.5% of all attendances 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. Also this is a focus for the UEC improvement group and site flow.

Target: TBC	ESTH: 11.7%



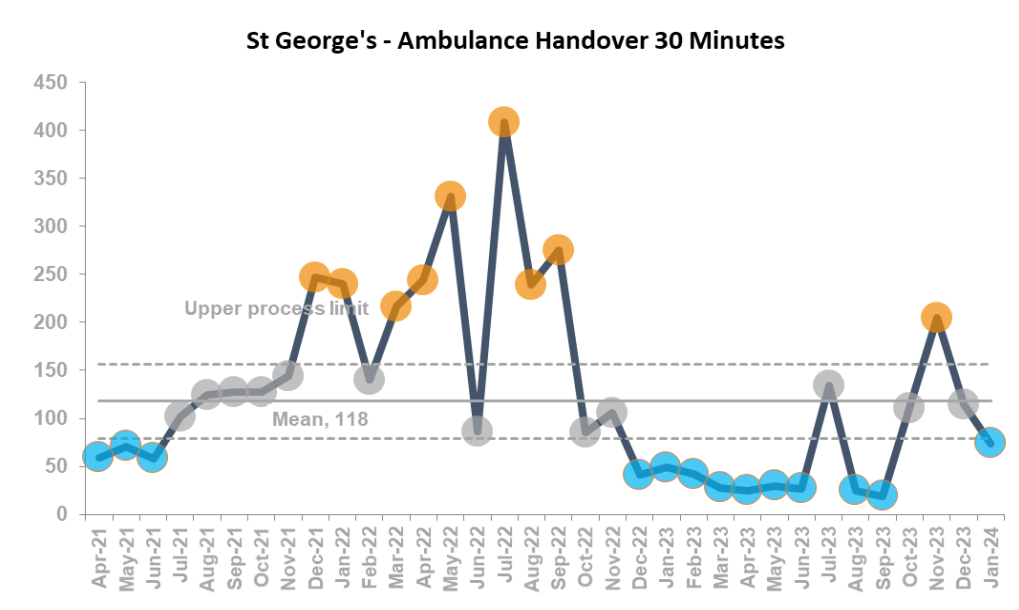
ESTH updates since last month

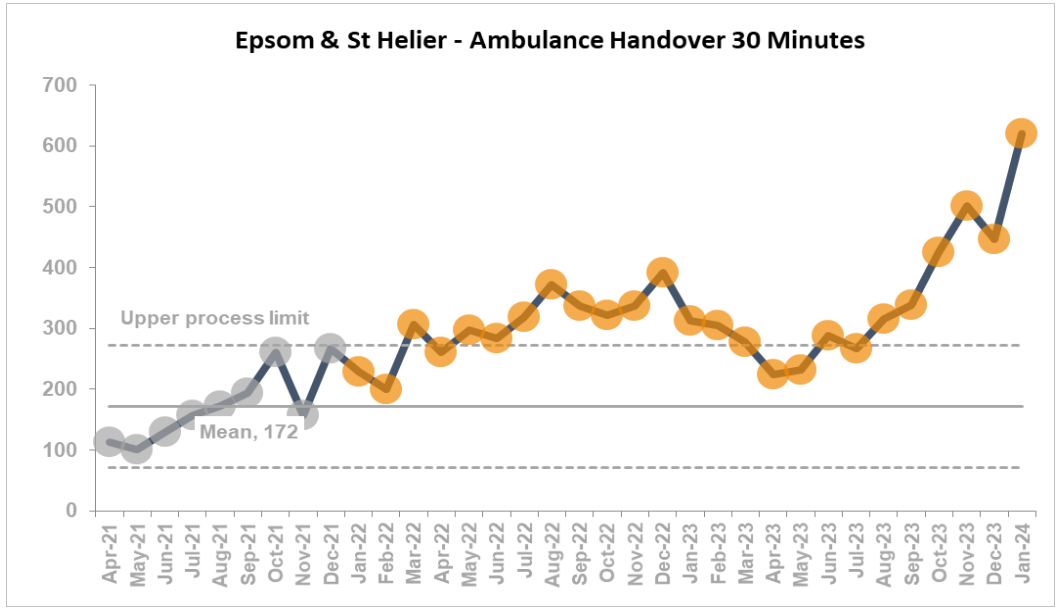
LOS remains high and above the upper control limit reporting 11.7% of patients spending more than 12 hours in our emergency departments. We continue to experience challenges in reducing length of stay in ED, with a significant number of patients waiting for an inpatient bed remaining in the emergency department, as well as patients presenting with mental health conditions.

Ambulance Handover Delays 30-60 minutes

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

Target: 0	SGH: 74	ESTH: 620





SGH updates since last month

Performance against 30-60 minute handover delays improved compared to December, performing below the lower control limit. Waits remain varied and not as stable as the same period last year, some of this is influenced by the “immediate handover” by London Ambulance Service (LAS).

ESTH updates since last month

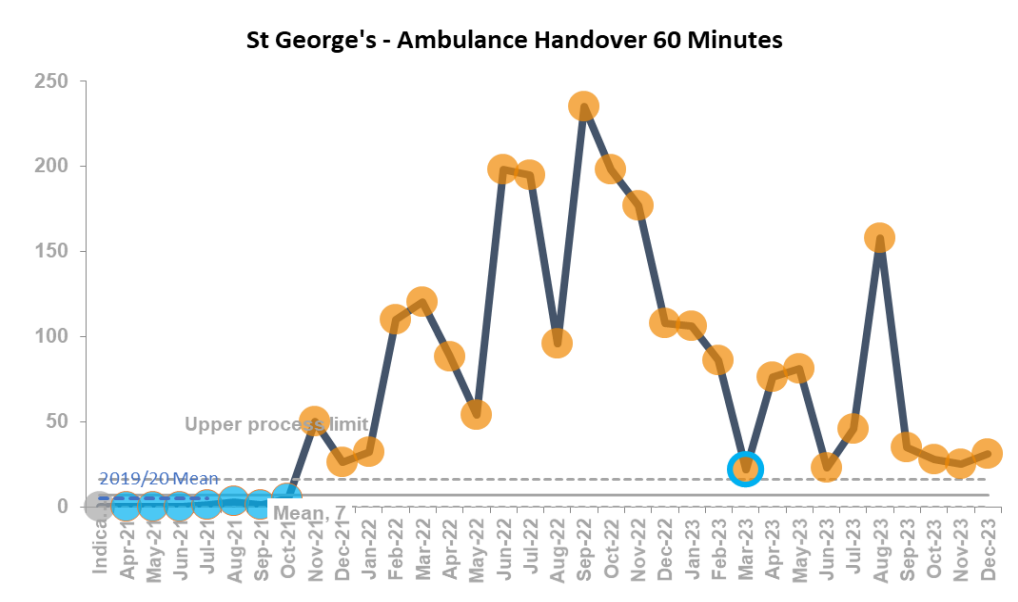
Performance against 30-60 minute handover delays remains significantly high, increasing further through January.

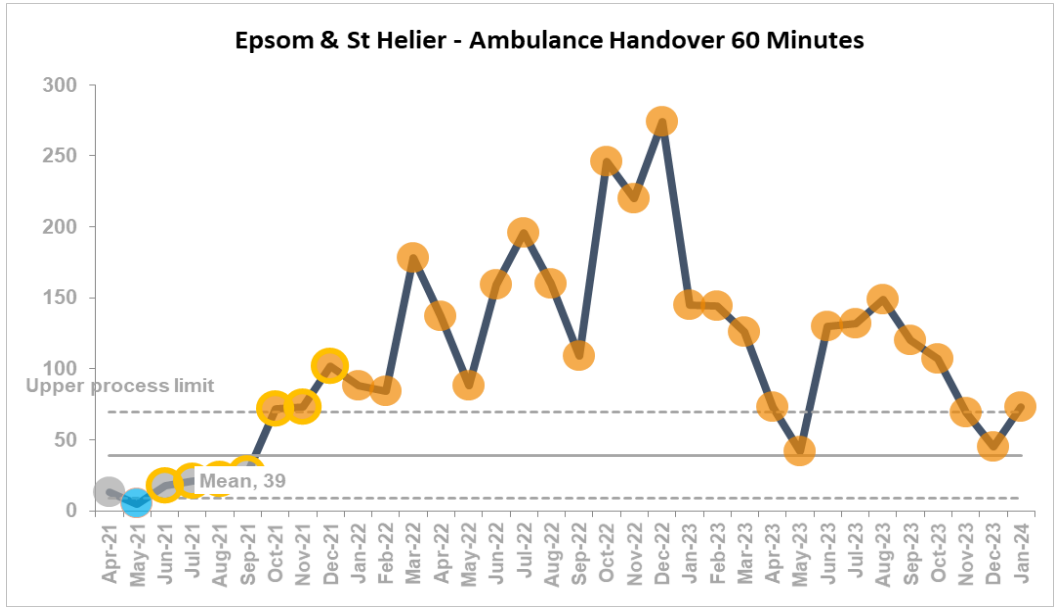
39

Ambulance Handover Delays 60 minutes

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

Target: 0	SGH: 31	ESTH: 73





SGH updates since last month

The number of handover delays over 60 mins is above the upper control limit but has seen some stabilisation over the last four months. Compared to the same period last year performance is much improved.

ESTH updates since last month

60 minute handover delays increased through January with at total of 73 delays compared to 45 through December.

Emergency Performance

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

SGH current issues –

- Overall 4-hour performance (all Types) January 2024 was a challenging month with a 5% decrease in performance compared to December, closing the month at 69%. This placed SGH 15th in London and 94th nationally for all type performance.
- In January we achieved >90% non-admitted performance for 4 days.
- 28% of non-blue light LAS arrivals were off loaded <15 minutes. Work will continue with LAS to improve offload times, and reporting in line with the departments LAS SOP and surge team continues.
- Throughout January the department's ability to see patients in a timely way was extremely challenged, majority of the month the department have had a high number of DTA's, ED saw >30 attendances per hour consecutively over several periods. 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 impacting on the Trusts ability to flow.

SGH future action –

- Maintain Extended Emergency Care Unit (EECU) to facilitate waiting of results
- Maintain in and out spaces to improve performance and capacity within the department.
- Work ongoing with LAS to improve the timely PIN allocations ensuring factual breach and handover data for both LAS and the Trust.
- Further work with LAS to improve conveyances to SDEC, UTC, fit to sit areas.
- ED have support from the Trust for corridor nursing where LAS have declined cohorting.
- Front of house clinician continues to assist with streaming patients to appropriate alternative pathways, improving timely investigations and analgesia.
- Additional EP to front of house for UTC to improve wait times for investigations
- Navigator at front of house to redirect patients to more suitable healthcare settings.
- Patient Flow Co-Ordinator based in UTC to assist with non-admitted pathway.
- 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.
- High numbers of Mental Health patients in ED continues to be challenging

ESTH current issues –

- We remain challenged across both sites with a large number of unplaced patients remaining in ED. Despite that we delivered the 4-hour ED standard in January 2024, reporting 76.1% performance.
- Whilst we have seen improvements in the number of >60-minute ambulance handover delays compared to the previous months; we did see a deterioration in performance in January 2024 reporting 73 > 1-hour ambulance delays. We continue to manage patients in the reverse queue and nurse led cohort areas, however, this remains incredibly challenging with the requirement to provide additional staff to safely manage these patients.
- Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively. However, time to triage continues to remain within the 15-minute standard at 12 minutes in January 2024, providing assurance that patients are seen soon after arrival in the department.
- The number of patients spending >12hrs in ED remains high, increasing to 11.7% in January 2024 compared to 11.1% in December 2023.
- We continue to see high numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.

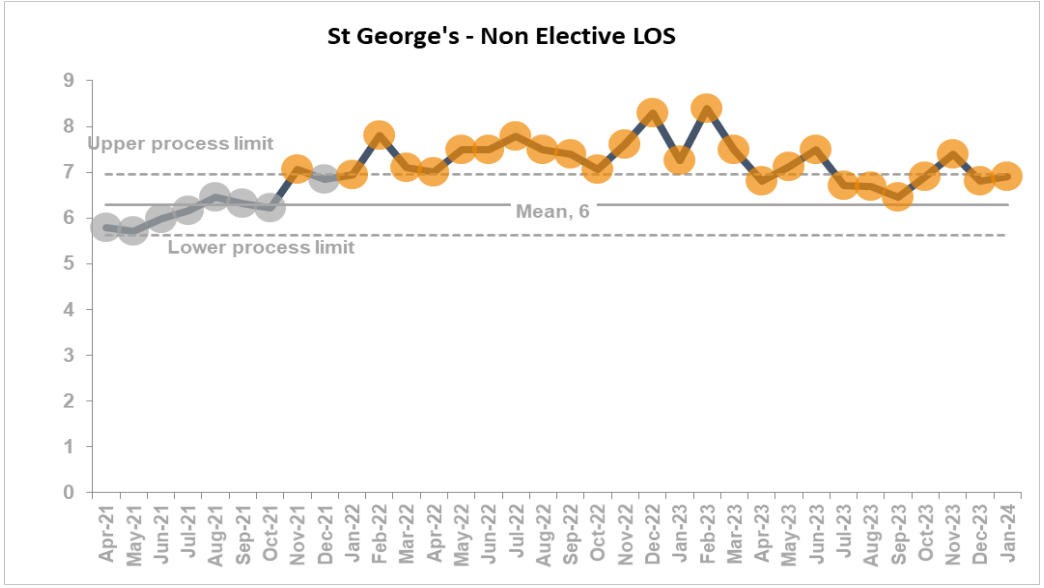
ESTH future action –

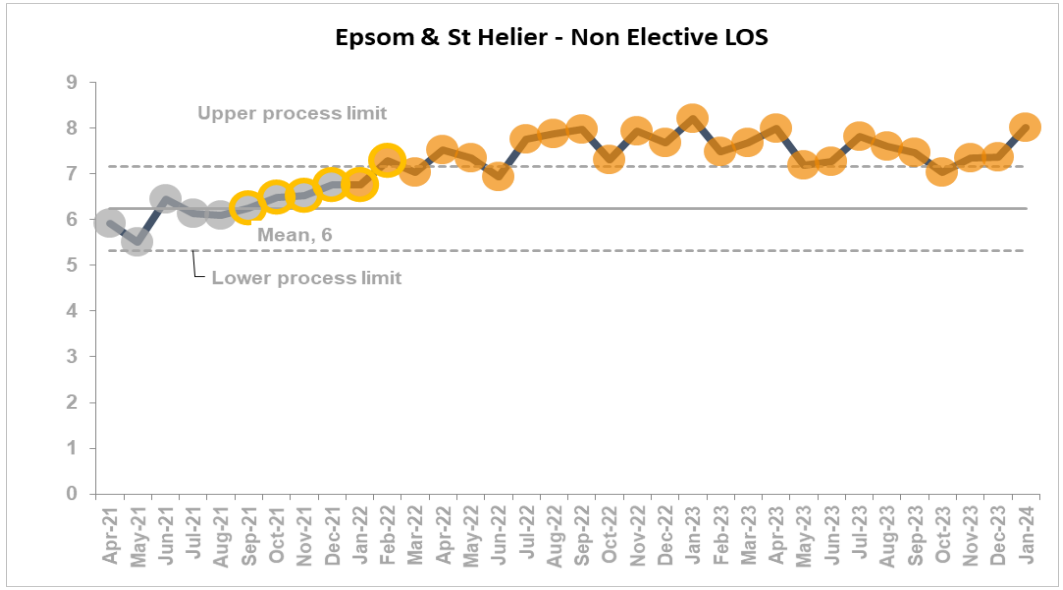
- We continue to progress our ED action plan following a listening event with ED staff. We held a successful urgent care workshop in January 2024 to agree urgent care priorities for 2024/25 with a focus on how we balance risk across both hospital sites. Winter pressure funding continues to support additional doctors and nurses in both emergency departments, and we have reviewed our internal boarding process to support early flow from ED , with boarding routinely in place from 0800-hours onwards.
- Alongside internal trust actions to support the urgent care pathway, the Emergency Care Intensive Support Team (ECIST) undertook an on-site review on Friday 26th January 2024. We are now in receipt of the final report highlighting key areas of focus. We will include the ECIST recommendations in our 2024/25 urgent care work programme.
- We are focusing on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC.
- Our focus remains on listening to and acting on feedback from our staff re. additional actions required to support the emergency care pathway.

Non Elective Length of Stay

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

Target: TBC	SGH: 6.9	ESTH: 8





SGH updates since last month

Non-Elective length of stay although above the mean, is within the upper and lower control limit with on average patients staying in an hospital bed for 6.9 days increasing slightly compared to December whilst also seeing an increase in bed occupancy. Both stranded LOS (>7 days) and super stranded LOS (> 21 days) increased across the month.

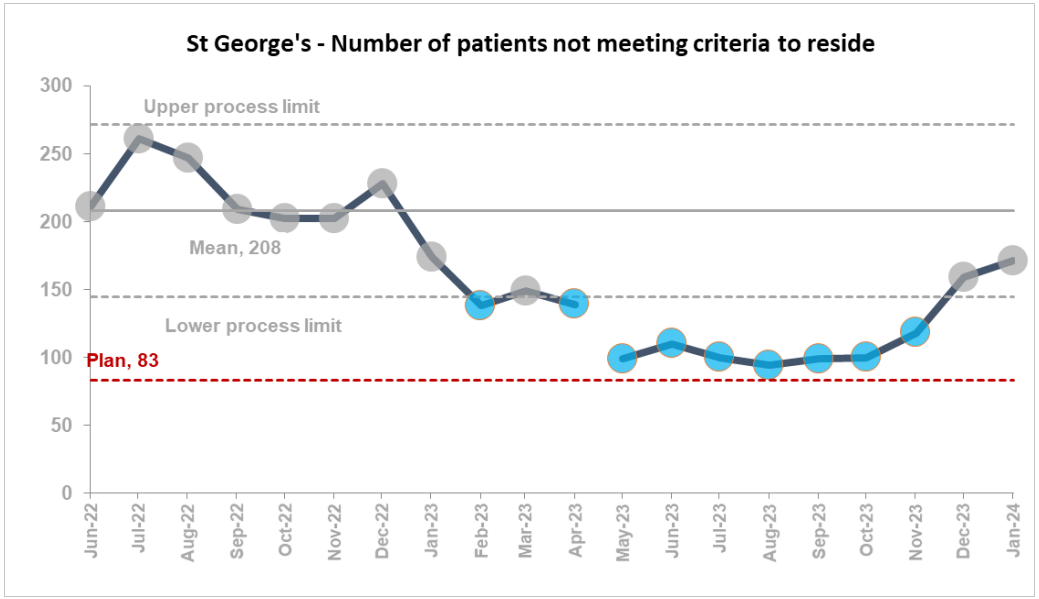
ESTH updates since last month

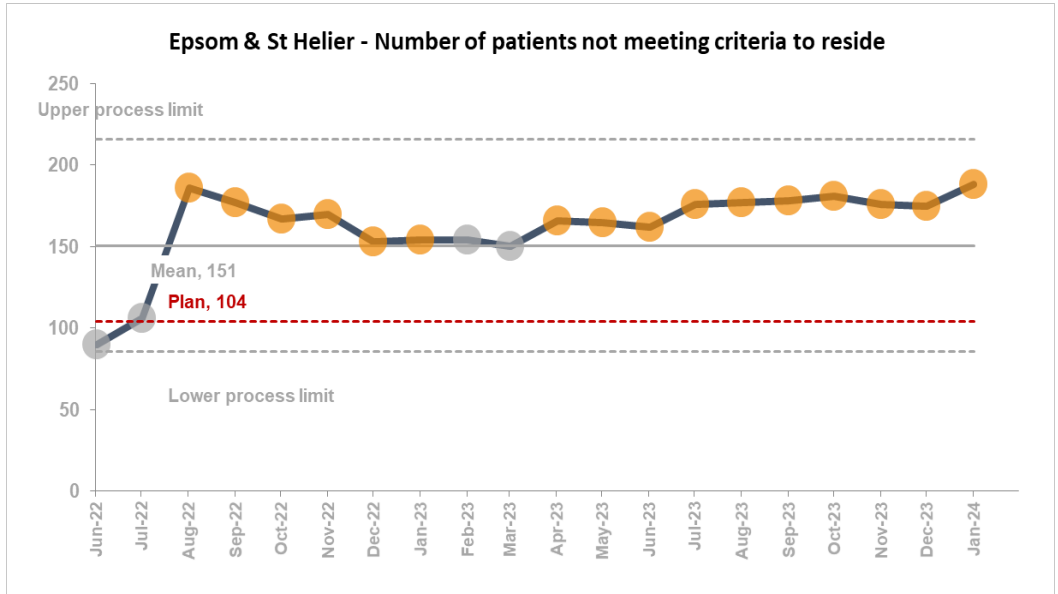
On average across December, patients admitted on non-elective pathways stayed for 8 days compared to 7.3 days through December. Both the daily stranded (7 day LOS) and super stranded patients (21 day LOS) as well as an increase in patients not meeting criteria to reside.

Patients not meeting criteria to reside

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

SGH Plan: 83	SGH: 159	ESTH Plan: 104	ESTH: 188





SGH updates since last month

January shows a further increase in the number of patients not meeting the criteria to reside with on average 171 patients daily. The Trust has replaced 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 has improved the recording and reporting of this metric showing a more accurate state, therefore it is not possible to accurately determine if the increase in NCTR is a true increase or as a result if improved monitoring.

ESTH updates since last month

The number of patients not meeting criteria to reside remains above the mean. On average there were 188 patients daily not meeting the criteria to reside in a hospital bed compared to 175 through December.

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.
- In January 2024 Junior Doctor industrial action took place for 6 days.
- Cavell Ward continues to provide 28 winter escalation beds and has supported decompressing the Emergency Department. The STG teams continue to work with local partners to reduce delays in onward care to mitigate this reduction.
- There has been significant flow constraints due to infectious outbreaks, for example Flu, Covid and Norovirus. This at times has lead to the need to open up additional escalation areas such as Brodie to support decompressing the Emergency Department.

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 January the Transfer of Care team also provided vital in-person support on the wards to facilitate discharge and from march will launch a new format of meetings, improving focus on plans, greater connection with ward and social care.
- An updated Trust Regularising Flow Standard Operating Procedure (SOP) is in place with the implementation of boarding of inpatients as business as usual 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.
- CLCH to be part of the Transfer of Care (TOC) hub to challenge discharge pathways and take more direct discharges.

ESTH current issues –

- We continue to see high numbers of medically optimised patients on both hospital sites, with many patients requiring complex discharge planning to support discharge. A particular challenge relates to those patients on pathway 3 who require discharge to a nursing/residential home with many patients waiting in excess of 3-weeks from their medically fit date to discharge.
- A significant cohort of our medically fit patients are those requiring on-going therapy prior to discharge. We circulate a daily report for both hospital sites to ensure that we focus on this patient cohort with engagement from our therapy senior leadership team.
- We continue to focus on our reporting of patients who do not meet the criteria to reside with a weekly checking mechanism in place to ensure accuracy.
- Patients with a > 7day, > 14day, and >21day length of stay have remained static over recent months, although there was a noticeable increase in January. However, the Trust are working with divisional teams to support twice weekly reviews of those patients holding a length of stay of 14+ days. We are looking to set up a complex discharge panel with relevant stakeholders for the escalation of patients who have a particularly complex discharge pathway.
- 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 –

- The Sutton Health and Care Reablement Unit is now open on the St Helier Hospital site providing an additional 18-beds to support those patients who require on-going therapy prior to discharge. We have a good mechanism in place for identifying appropriate patients for the unit and have been operating at full capacity.
- 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.
- Our urgent care programme will focus on improvements in our internal processes commencing with a ward-based process mapping exercise to highlight areas for further focus
- An additional 24 beds are now open on Alex Ward on the Epsom Hospital site. These beds opened fully directly after the Christmas period and have remained at full capacity.

Integrated Care

Monthly Overview – Integrated Care

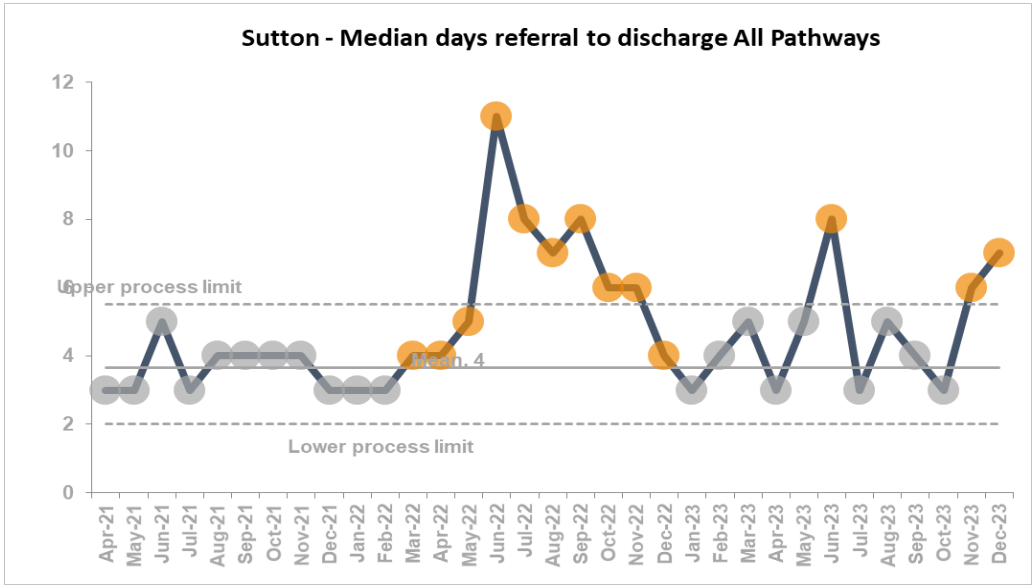
St George's, Epsom and St Helier University Hospitals and Health Group

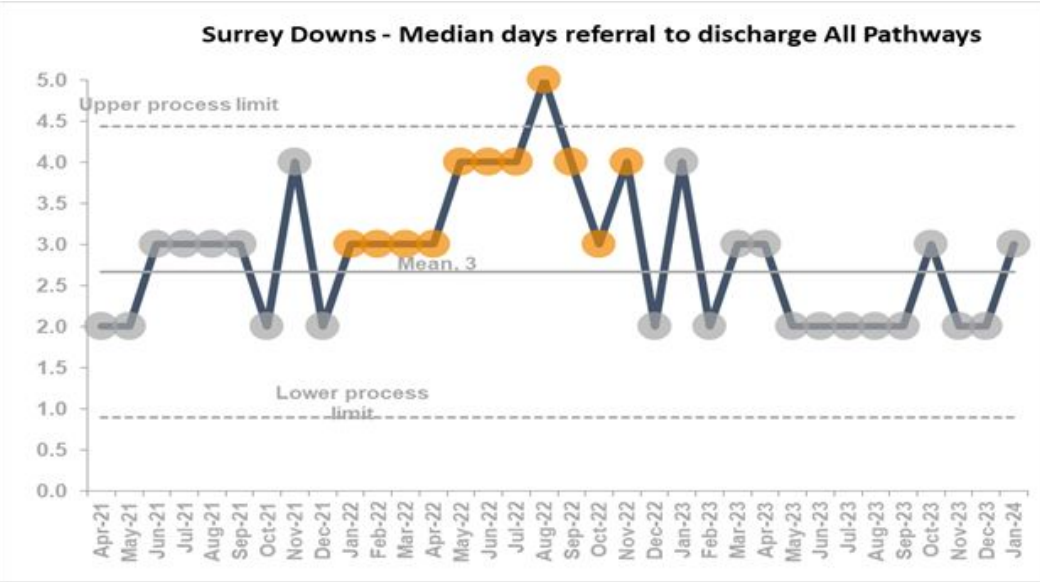
Integrated Care	Sutton Health & Care							Surrey Downs Health & Care						
	Monthly Target	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend	Monthly Target	Nov-23	Dec-23	Jan-24	YTD Target	YTD Actual	13-Month Trend
Median days referral to discharge All pathways		6	7	TBC		5			2	2	3		2	
Median days referral to discharge Pathway 1		4	4	TBC		4			2	2	3		2	
Median days referral to discharge Pathway 2		12	17	TBC		11			1	1	2		1	
Median days referral to discharge Pathway 3		20	21	TBC		14			15	15	15		16	
Two hour UCR performance	70%	76.9%	80.9%	76.0%	70%	81%		70%	84.2%	79.3%	82.1%	70%	82.5%	
Two hour UCR referrals received		251	246	271		2182			588	527	630		4836	
Community hospitals bed occupancy									95%	89%	94%		91%	
Community hospitals LoS									18	12	17		17	
Virtual ward - Admissions		282	272	294		2265			274	260	271		2437	
Virtual ward - Bed Occupancy	80%	39.2%	43.8%	62.4%				80%	74.0%	71.0%	65.0%			
Virtual ward LoS		2	3	3		2.1		14	3	4	7		6.6	
Total RTT Waiting List Size		1,008	1,008	919					594	592	541			
Total number of RTT patients waiting over 18 weeks		3	3	3					5	10	7			
Sickness Rate	3.2%	5.8%	5.5%	4.9%	3.2%	5.2%		3.8%	6.1%	6.3%	4.8%	3.8%	5.8%	
Agency rates		4.2%	5.2%	3.4%		3.5%			7.9%	9.9%	8.0%		9.0%	
MAST	85%	89.6%	88.7%	87.4%	85%	88.8%		85%	93.0%	93.5%	91.8%	85%	92.1%	
Vacancy	10%	11.4%	20.1%	19.0%	10%	15.2%		10%	19.2%	19.0%	19.6%	10%	19.1%	
Appraisal Rate Medical	90%	100%	100%	100%	90%	100%		90%	100%	100%	100%	90%	95.0%	
Appraisal Rate Non Medical	90%	66.4%	67.7%	70.2%	90%	67.1%		90%	68.0%	70.7%	73.6%	90%	77.6%	
Turnover	13%	0.3%	0.6%	0.3%	13%	1.1%		12%	0.7%	1.7%	1.3%	12%	1.1%	
Percentage BAME staff band 6 and above		35.7%	35.6%	36.3%		36.0%			18.3%	18.9%	18.9%		18.6%	

Median days referral to discharge All Pathways

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

Target: TBC	Sutton: tbc	Surrey Downs: 3 days





Sutton Health & Care updates since last month

Median days from referral has seen a increase through November and December performing above the upper control limit. Pathway 2 increased to 17 days and Pathway 3 increased by 1 day (at 21 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 through January, seeing an increase compared to December. Pathway 3 continues to have the highest referral to discharge time of 15 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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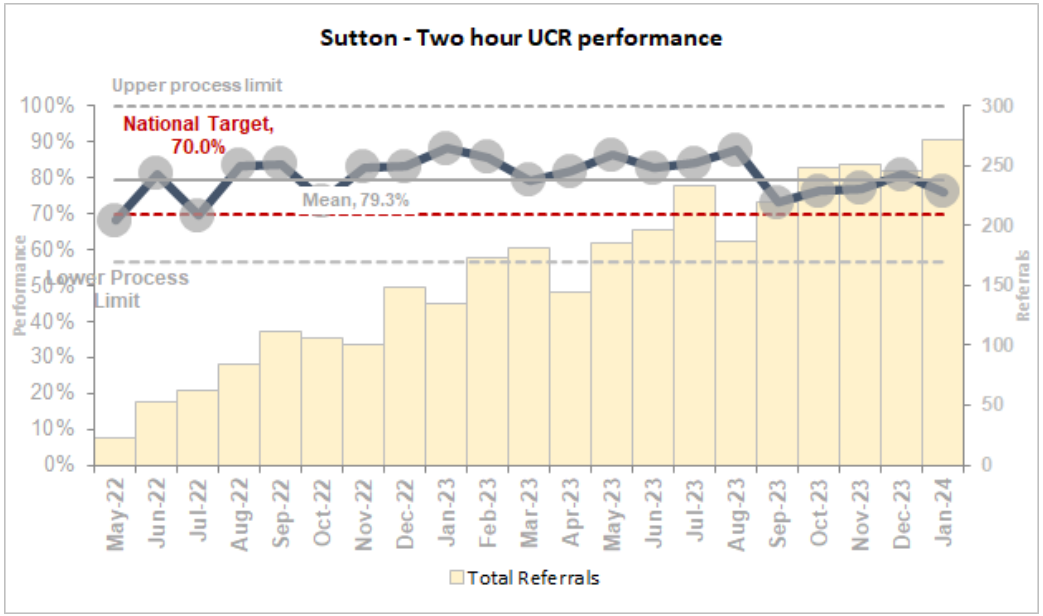
Ageing Well

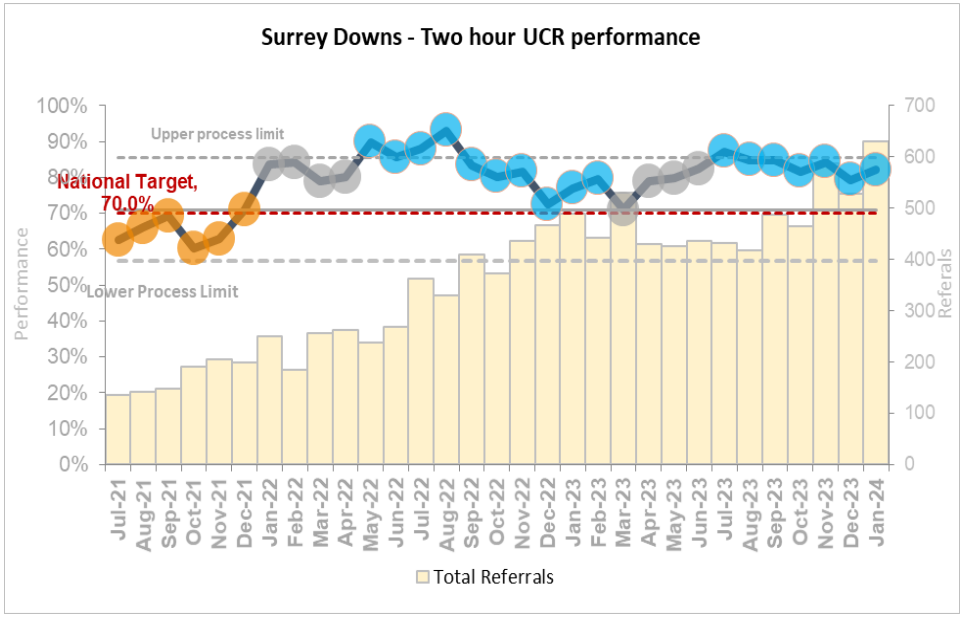
2-Hour Urgent Community Response (UCR)

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

Sutton Target: 70%	Actual: 76%



Surrey Downs Target: 70%	Actual: 82.1%



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 2022. Performance continues to exceed target, with a performance of 76% through January 2024.

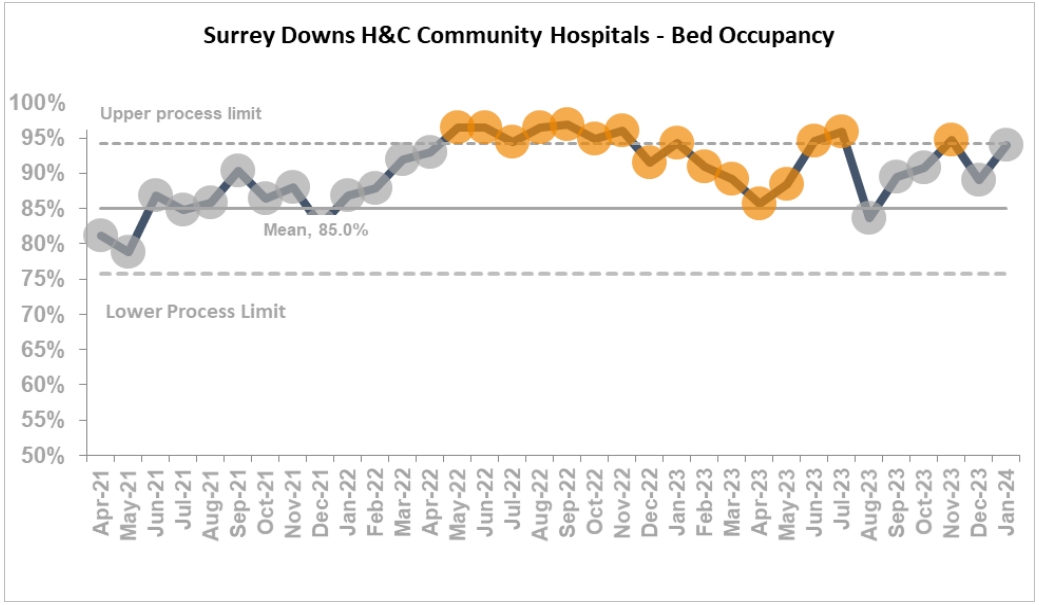
Surrey Downs Health & Care updates since last month

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 target, with a performance of 82.1% through January 2024.

Surrey Downs Health & Care
Bedded Care

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

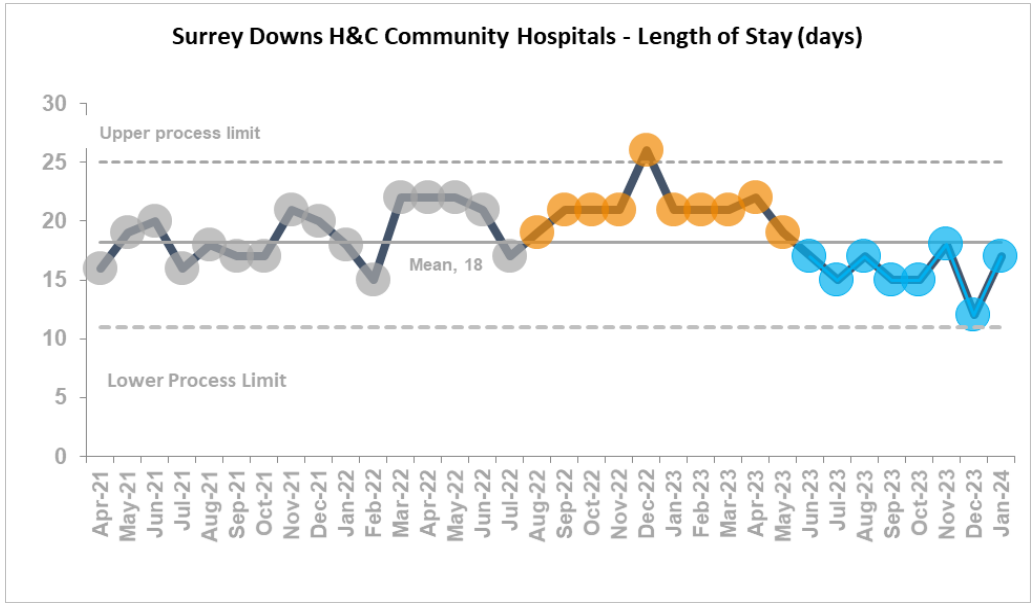
Bed Occupancy	Actual: 94%



Surrey Downs Health & Care updates since last month

SDHC runs 3 bedded units. Bed occupancy increased to 94% in January showing common cause variation.

Length of Stay	Actual: 17 days



Surrey Downs Health & Care updates since last month

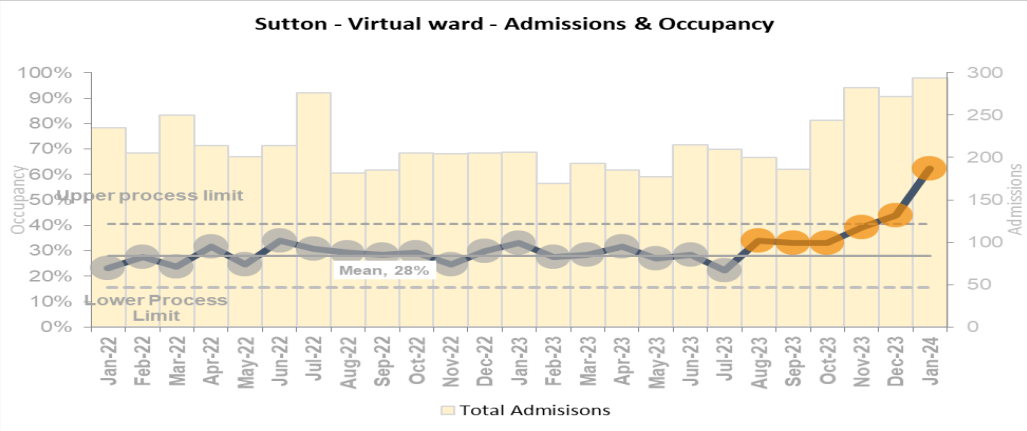
Length of stay continues to show a recent reduction with the last eight month period below the mean. Through January the average length of stay was 17 days compared to 12 days in December.

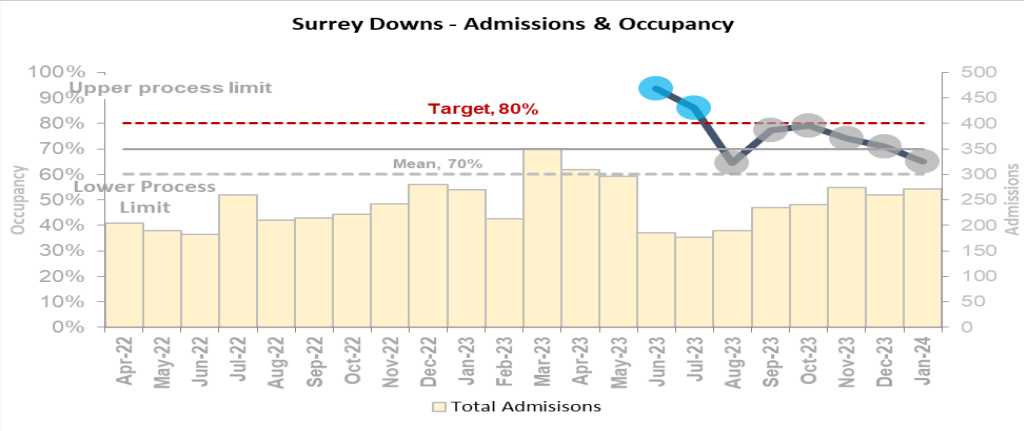
Virtual Ward
Admissions, Occupancy & Length of Stay

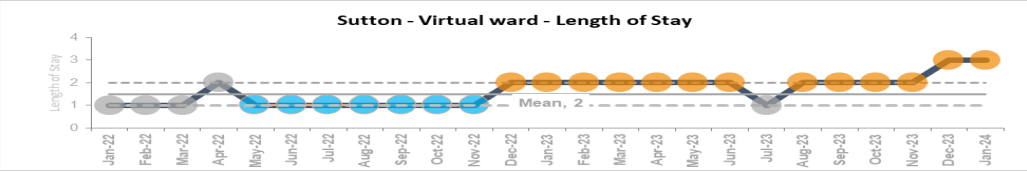
St George's, Epsom and St Helier
University Hospitals and Health Group

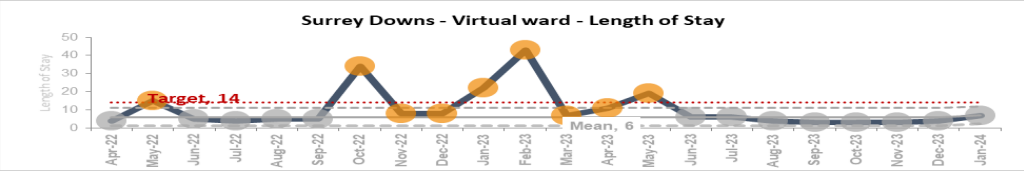
Sutton Occupancy Target: >80%	Actual: 62.4%

Surrey Downs Occupancy Target: >80%	Actual: 65%









Sutton Health & Care updates since last month

Service target occupancy rates amended from December 2023. The number of admissions remain higher than recent trend with occupancy rates continuing to increase.

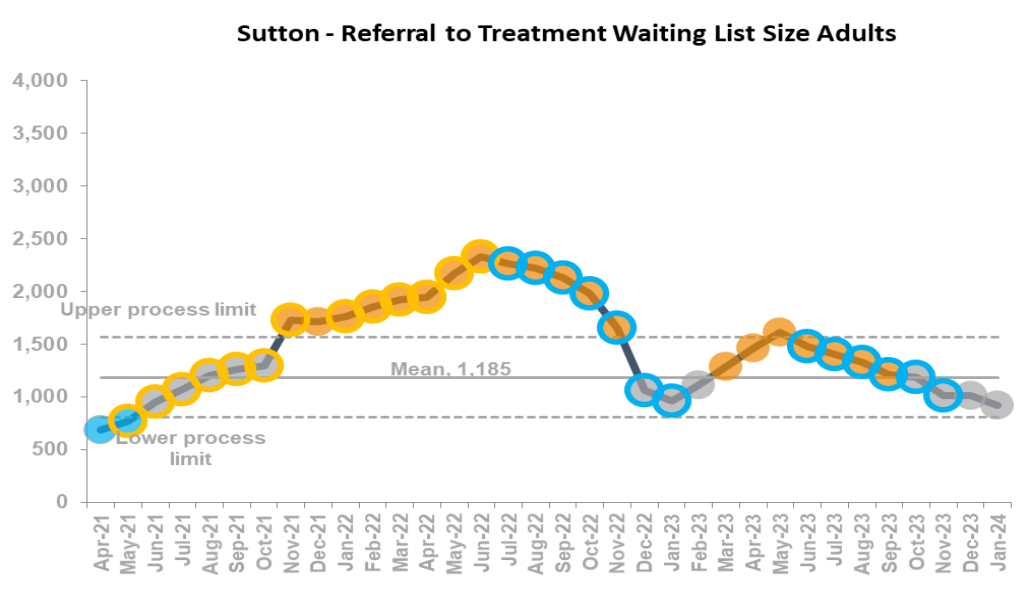
Surrey Downs Health & Care updates since last month

Service started September 2021. Occupancy rates continues to show only common cause variation however the last four months has seen a downward trend. Admissions remains stable with a slight increase in length of stay through January.

Referral to Treatment Waiting List Size

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

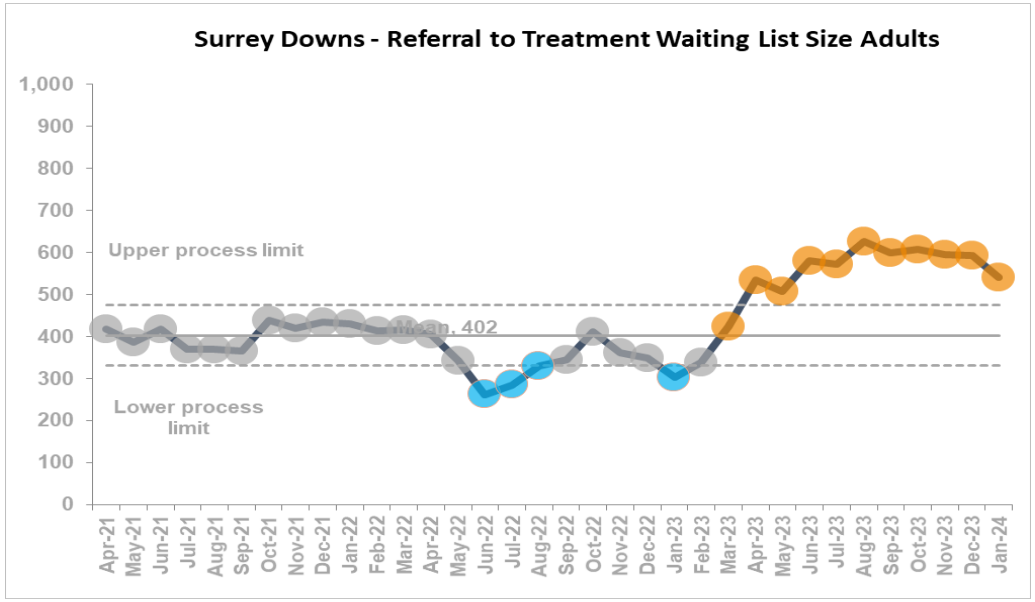
Sutton	Actual: 919



Sutton Health & Care updates since last month

The number of patients on a RTT pathway continues on a downward trend and below the mean for a third consecutive month. There were three patients waiting for more than 18 weeks for treatment.

Surrey Downs	Actual: 541



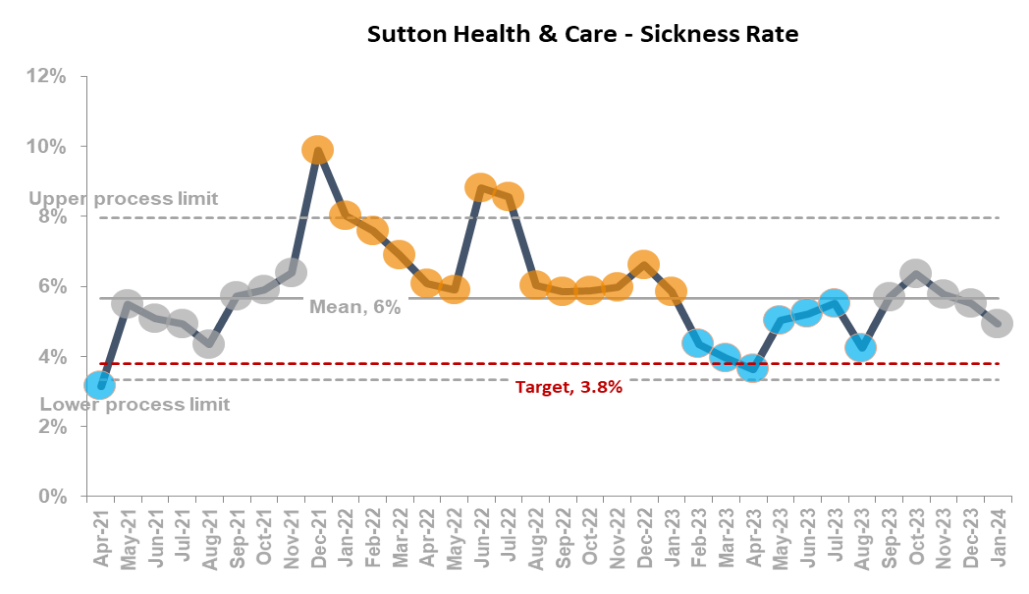
Surrey Downs Health & Care updates since last month

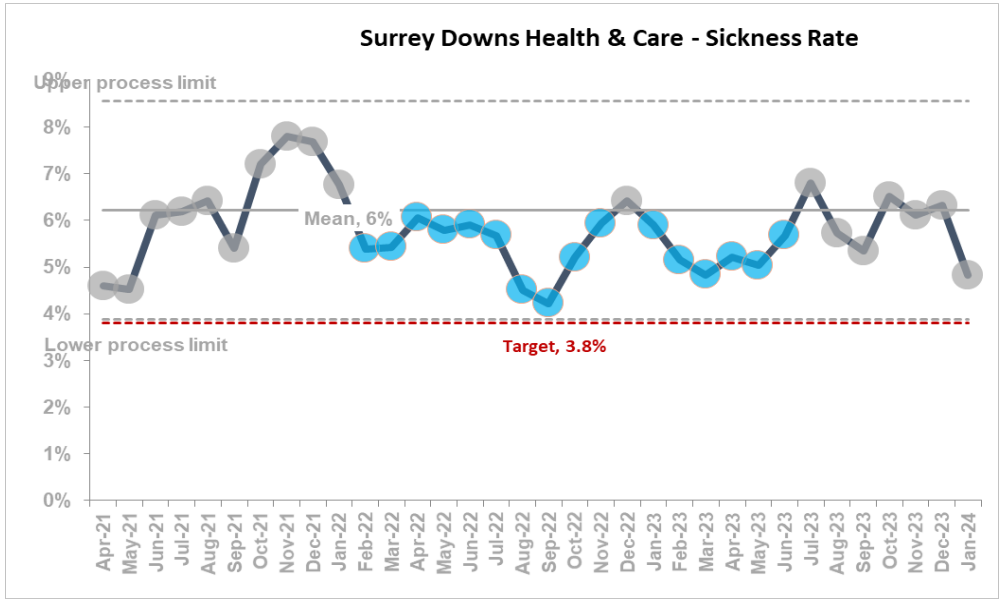
The number of patients on the RTT waiting list remains above the upper control limit however has seen a recent decrease. There were 7 patients waiting for more than 18 weeks for treatment compared to 10 pathways in December.

Staff Sickness Absence Rates

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

Target: 3.8%	Sutton Health & Care 4.9%	Surrey Downs Health & Care: 4.8%





Sutton Health & Care updates since last month

The sickness is above the mean with a further improvement in performance from 5.5% to 4.8% in January. The sickness rate continues to show common cause variation.

Surrey Downs Health & Care updates since last month

The sickness absence rate continues to stay within the upper and lower control limits, indicating common cause variation. There was a notable decrease in the sickness rate from 6.3% in December to 4.8% in January.

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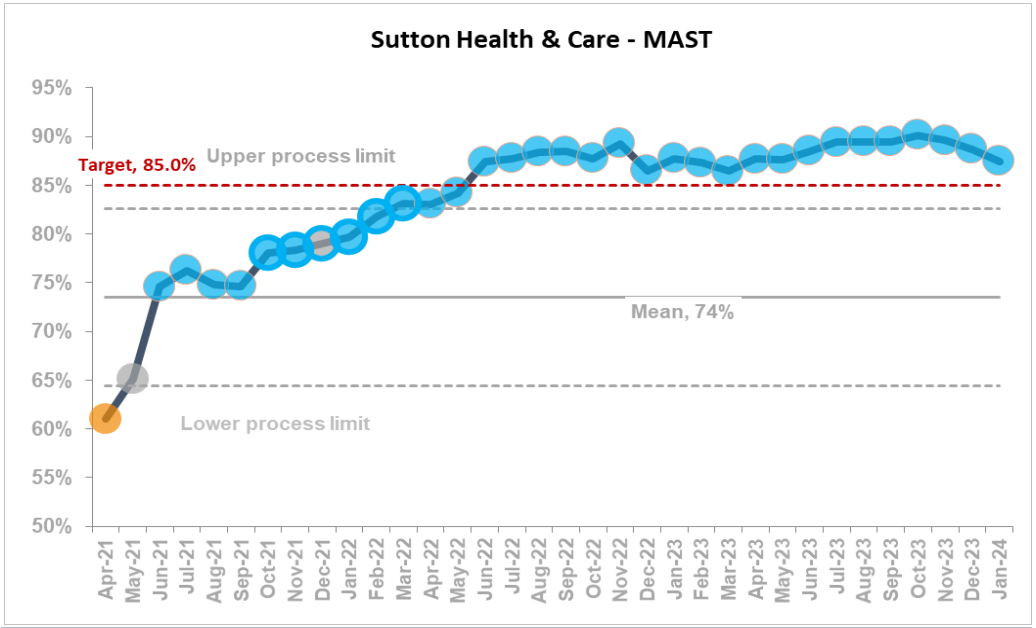
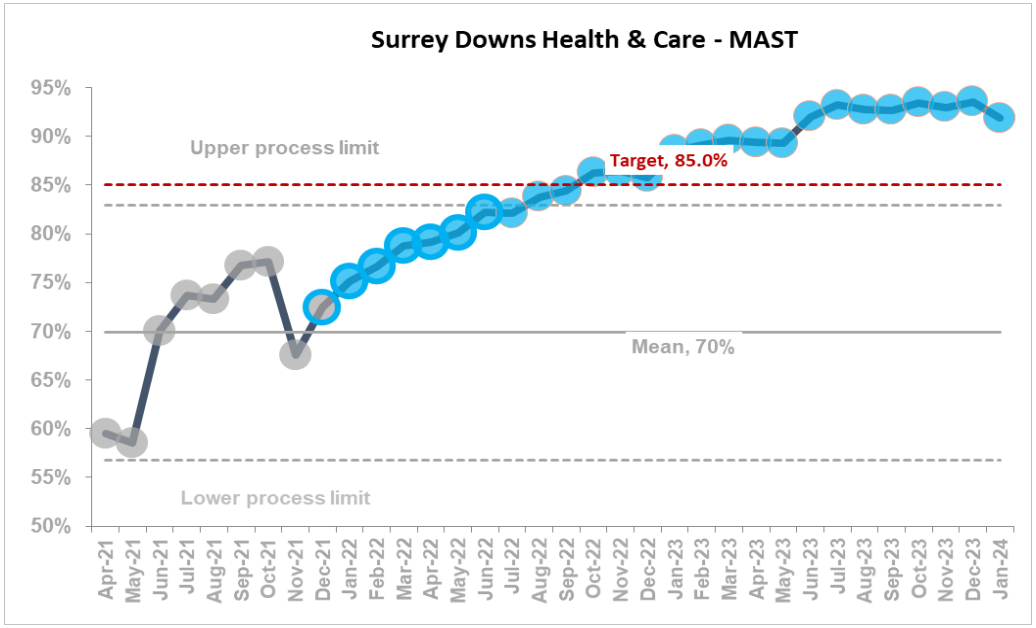
Mandatory and Statutory Training (MAST)

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

Target: 85%	Sutton Health & Care: 87.4%	Surrey Downs Health & Care: 91.8%





Sutton Health & Care updates since last month

There is a robust monthly process in place to monitor MAST within SHC. Performance continues to exceed target with 87.4% of staff complaint at the end of January and shows special cause variation with an improving position.

Surrey Downs Health & Care updates since last month

MAST compliance continues to exceed target and show special cause variation with an improving position, with 91.8% of staff compliant at the end of January.

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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 –

Average waiting lists for SALT and OT Children's Therapy remain high (routine). Mitigations in place.

Virtual Ward in reach -commenced at St Georges Hospital, supporting flow of Sutton patients.

Recruitment Campaign for SHC Reablement Unit. Posts outstanding-6wte. Reablement Assistants remain core focus.

Surrey Downs Health & Care current issues –

High level of vacancies, particularly in nursing.

Agency usage rate is still under the target . This contributed by various funded winter pressures projects.

Drop in Appraisal rate.

Sutton Health & Care future action –

1. Children's Therapy: collaboration with system leads to determine resolution of increased waiting lists across the borough.
2. Continued focus on short term sickness and agency usage
3. Focus on recruitment to SHC Reablement Unit

Surrey Downs Health & Care future action –

Welcome Payment for band 5 & 6 community nurses in place with further recruitment promotion plans in place.

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

Continue to focus on Appraisals.

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Appendices

Monthly Overview – Our People

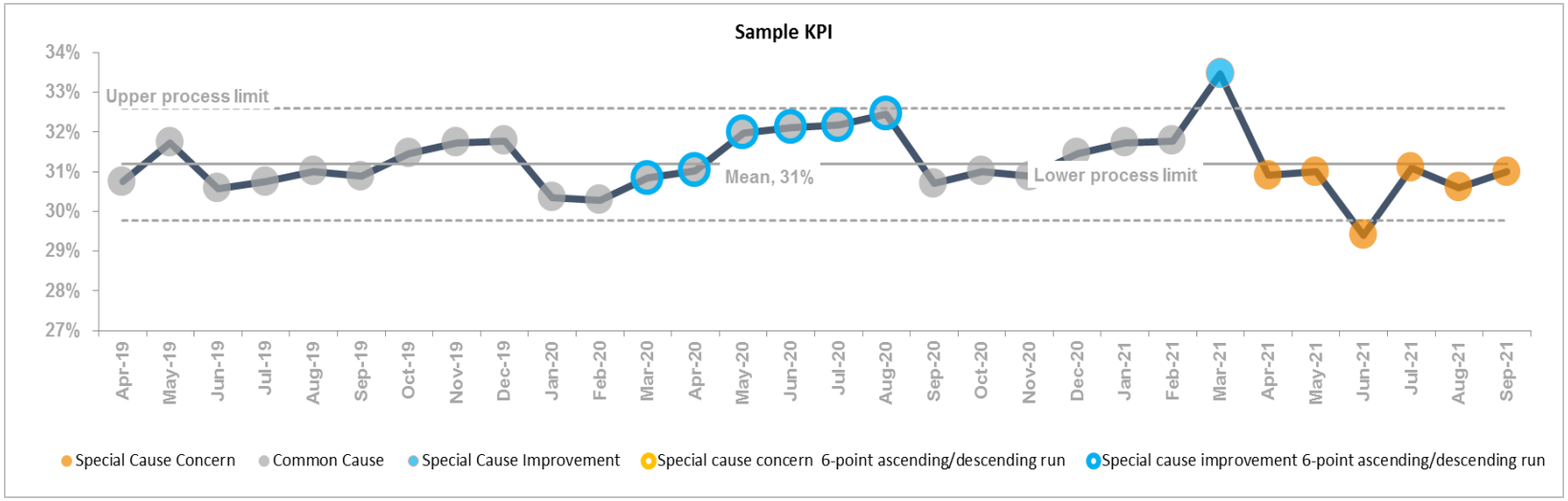
St George's, Epsom and St Helier University Hospitals and Health Group

	St George's							Epsom and St. Helier						
Our People	**Monthly Target**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD Target**	**YTD Actual**	**13-Month Trend**	**Monthly Target**	**Nov-23**	**Dec-23**	**Jan-24**	**YTD Target**	**YTD Actual**	**13-Month Trend**
Sickness Rate	3.2%	4.6%	4.9%	4.7%	3.2%	4.3%		3.8%	5.3%	5.3%	5.2%	3.8%	5.0%	
Agency rates	TBC	3.2%	3.0%	2.4%	TBC	3.0%		TBC	3.6%	5.8%	3.6%	TBC	3.1%	
MAST	85%	90.5%	90.9%	91.0%	85%	90.2%		85%	85.5%	84.7%	82.7%	85%	84.0%	
Vacancy	10%	6.4%	6.6%	6.3%	10%	7.8%		10%	11.4%	12.0%	11.8%	10%	12.5%	
Appraisal Rate Medical	90%	78.7%	79.5%	82.2%	90%	79.8%		90%	99.0%	94.0%	94.6%	90%	84.8%	
Appraisal Rate Non Medical	90%	73.5%	76.8%	75.8%	90%	73.1%		90%	68.4%	69.7%	65.6%	90%	65.4%	
Turnover	13%	14.5%	14.5%	14.2%	13%	14.8%		12%	13.1%	13.1%	14.5%	12%	14.3%	
Percentage BAME staff band 6 and above	TBC	44.7%	44.7%	44.7%	TBC	44.7%		TBC	38.3%	38.5%	38.4%	TBC	38.4%	

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 on Friday, 08 March 2024

Agenda Item	3.2	
Report Title	**Group - Financial Performance M10**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO, SGH Site CFO, ESTH Site CFO	
Previously considered by	Finance Committees-in-Common	01 March 2024
Purpose	**For Review**	

Executive Summary

This paper sets out the financial performance YTD for each Trust and the progress in delivering the financial forecast.

Both Trusts are on forecast in M10, including and excluding industrial action impact.

Action required by Finance Committees-in-Common

The Committee is asked to: Note the financial performance in M10

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	23/24 M10 Financial Performance

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

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University Hospitals and Health Group

Group Board: 8th March 2024
23/24 M10 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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Key Actions

GESH

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	Issue	Action
Summary I&E	• Additional NR deficit funding in process of being confirmed for each trust. This will change cash and I&E positions. • Recent Dec/Jan industrial action has deteriorated ESTH/ SGH forecast by £3.7m/£7.6m respectively. Unclear on how Feb industrial action will be treated in FOT • ESTH is forecasting on plan apart from Dec/Jan/Feb IA. • SGH is forecasting a £15.1m adverse variance apart from Dec/Jan/Feb IA. This is related to 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	• Increased focus on grip and control actions
CIP delivery	• ESTH delivery is £0.3m adverse at M10 • SGH delivery £2.6m adverse at M10 • Both owing to industrial action which will continue to be pressure to year end.	• 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. • SGH have requested PDC support for Q4.	• Continued close management of cash. • Focus on debt recovery at SGH.

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University Hospitals and Health Group

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 £36.2m at the end of January, which is £2.9m adverse to plan. The adverse variance is wholly related to the industrial action by junior doctors in December and January.	£2.9m adverse	£0.9m adverse	There is currently no funding for the December and January industrial action
Income	Overall income is £10.2m favourable to plan. Patient Care income is £5.9m 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 is now £4.3m favourable YTD with an increase of £1.1 in LDA income in month relating to prior periods and the release of deferred income into the position.	£10.2m Fav to Plan	£7.5m Fav to Plan	Risk remains with ERF delivery and Surrey Heartlands growth
Expenditure	Expenditure is £9.0m adverse year to date, of this £4.0m is due to the net costs of the industrial action to the end of January. Additional expenditure above plan is offset by income with a route to deliver the financial plan.	£13.7m Adv to Plan	£9.0m Adv to Plan	Risk to holding run rate
Cost Improvement Plans	The CIP plan has delivered £29.4m to date against a plan of £29.7m. In month the Trust reported £3.4m of CIP against an in month plan of £3.8m. The slippage in month was a result of the industrial action.	£0.3m Adv to Plan	On plan	Industrial action impact of £1.0m on Delivery
Capital	The year to date capex was £24.0m being £16.1m behind plan. The following projects were underspent: Right of use assets £2.6m due to new forecast being £3.9m less than original plan following IFRS16 lease review; BYFH / SECH enablers £0.5m; EPR £6m (slippage mitigations in progress) ; Estates programme £2.9m, backlog maintenance £1.3m, medical equipment £1m.	£16.1m behind plan	£22.7m behind plan	See capital slides
Cash	The Trust's cash balance at the end of January is £14.88m which is in line with plan			

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University Hospitals and Health Group

M10 performance

ESTH

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ESTH have agreed on a financial forecast equal to plan, of a deficit of £37.9m. This excludes the impact of industrial action from December and January which amounts to £3.7m, and takes the forecast to £41.6m deficit. At M10 ESTH is on track to deliver this forecast. It is not clear how February industrial action will be treated in the forecast.

Performance against Budget

Table 1 - Trust Total

		Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	584.1	49.5	49.5	0.0	486.0	492.0	5.9
	Other Op. Income	41.5	3.4	6.1	2.7	34.5	38.8	4.3
Income Total		**625.6**	**52.8**	**55.6**	**2.7**	**520.6**	**530.8**	**10.2**
Expenditure	Pay	(441.5)	(36.8)	(41.2)	(4.4)	(367.8)	(374.3)	(6.5)
	Non Pay	(194.3)	(16.2)	(16.5)	(0.4)	(163.0)	(170.1)	(7.1)
Expenditure Total		**(635.9)**	**(53.0)**	**(57.7)**	**(4.7)**	**(530.8)**	**(544.5)**	**(13.7)**
Post Ebitda		(27.6)	(2.3)	(2.3)	(0.0)	(23.0)	(22.5)	0.5
Grand Total		**(37.9)**	**(2.4)**	**(4.4)**	**(2.0)**	**(33.2)**	**(36.2)**	**(2.9)**

Performance against Forecast

Table 2 - Performance Against Forecast

		Full Year Forecast (£m)	M10 Forecast (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Forecast (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	589.4	48.9	49.5	0.6	489.3	492.0	2.7
	Other Op. Income	45.9	3.8	6.1	2.3	37.3	38.8	1.5
Income Total		**635.3**	**52.7**	**55.6**	**2.9**	**526.6**	**530.8**	**4.2**
Expenditure	Pay	(446.6)	(37.2)	(41.2)	(4.0)	(371.0)	(374.3)	(3.3)
	Non Pay	(198.6)	(15.6)	(16.5)	(0.9)	(165.4)	(170.1)	(4.7)
Expenditure Total		**(645.1)**	**(52.8)**	**(57.7)**	**(4.9)**	**(536.4)**	**(544.5)**	**(8.0)**
Post Ebitda		(28.1)	(2.4)	(2.3)	0.0	(23.4)	(22.5)	0.9
Grand Total		**(37.9)**	**(2.4)**	**(4.4)**	**(2.0)**	**(33.2)**	**(36.2)**	**(2.9)**

- At Trust level both performance against budget and performance against forecast is £2.0m adverse in month and £2.9m adverse year to date. These variances wholly relate to industrial action costs and income lost as a result.
- Against the forecast at M10 pay is £4.0m adverse, £2.0m associated with Industrial Action, £0.7m is associated with the additional cost of winter above forecast and variances in non recurrent movement on pay. This has been offset by the £1.1m of additional LDA income.
- Non pay variances to forecast relate to high cost drugs offset by income and other variances in non recurrent movements.

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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 £32.1m at the end of January, which is £11.3m adverse to plan. The shortfall is due to CIP delivery shortfall, baseline pressures, and industrial action impact in December and January.	£16.7m Adv to Plan	£11.3m Adv to Plan	On track against revised forecast
Income	Income is reported at £19.9m favourable to plan at Month 10. This is due to additional income to cover centralised costs and industrial actions costs between April and October. There is also additional income in Pharmacy, which is offset by Non-Pay costs.	£19.9m Fav to plan	£13.9m Fav to plan	
Expenditure	Expenditure is reported at £36.7m adverse to plan at Month 10, 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.	£36.7m Adv to plan	£25.2m Adv to plan	
Cost Improvement Programme	CIPs are £2.6m adverse to plan.	£2.6m Adv to plan	£2.9m Adv to plan	
Capital	YTD M10 Capital expenditure is £19.8m underspent, c.50% of this is due to the timing for the larger capital schemes being later in the year than expected with the delay of externally funding project accounting for the balance.	£19.8m underspent	£16.2m underspent	
Cash	At the end of Month 10, the Trust's cash balance was £7.1m. Cash request for Q4 submitted to NHSE.	£7.1m which is £51.4m lower than Y/E	£6.5m which is £52.0m lower than Y/E	Cash position remains tight. Requires close management.

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Executive Summary

SGH

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SGH have agreed on a financial forecast £15.1m adverse to plan, a deficit of £30.8m. This excludes the impact of industrial action from December and January which amounts to £7.6m, and takes the forecast to £38.4m deficit. At M10 SGH is on track to deliver this forecast. It is not clear how February industrial action will be treated in the forecast.

Performance Against Budget

Table 1 - Trust Total

		Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	SLA Income	944.6	80.0	83.0	3.0	789.1	805.9	16.8
	Other Income	152.7	12.9	15.9	3.1	127.1	130.2	3.1
Income Total		**1,097.3**	**92.9**	**99.0**	**6.1**	**916.2**	**936.1**	**19.9**
Expenditure	Pay	(687.5)	(57.0)	(63.5)	(6.5)	(574.6)	(606.7)	(32.1)
	Non Pay	(353.9)	(29.9)	(34.9)	(5.0)	(298.2)	(302.8)	(4.5)
Expenditure Total		**(1,041.3)**	**(86.9)**	**(98.4)**	**(11.5)**	**(872.8)**	**(909.4)**	**(36.7)**
Post Ebitda		(71.7)	(6.2)	(6.2)	(0.0)	(58.8)	(58.8)	0.0
Grand Total		**(15.7)**	**(0.2)**	**(5.6)**	**(5.4)**	**(15.4)**	**(32.1)**	**(16.7)**

Year to date the Trust is adverse to plan owing to CIP, baseline pressures, and industrial action impact in December and January. Industrial action impact between April and October has been negated following receipt of compensating income.

Performance Against Forecast

Table 1 - Trust Total

			M10 Forecast (£m)	M10 Actual (£m)	M10 Variance (£m)
Excluding IA Impact	**Income**	SLA Income	82.0	81.9	(0.1)
		Other Income	13.4	15.9	2.5
	Income Total		**95.4**	**97.8**	**2.4**
	Expenditure	Pay	(58.1)	(61.3)	(3.2)
		Non Pay	(35.7)	(34.9)	0.8
	Expenditure Total		**(93.8)**	**(96.2)**	**(2.4)**
	Post Ebitda		(6.2)	(6.2)	(0.0)
	Grand Total		**(4.6)**	**(4.6)**	**0.0**
IA Impact	**ERF**		1.4	1.1	(0.3)
	Expenditure		(2.4)	(2.2)	0.3
	Reported Position		**(5.6)**	**(5.6)**	**0.0**

The Trust is on forecast overall at month 10.

Group Board

Meeting in Public on Friday, 08 March 2024

Agenda Item	4.1	
Report Title	**Group Board Assurance Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Infrastructure Committees-in-Common	28 February 2024
	Finance Committees-in-Common	26 January 2024
	Quality Committees-in-Common	25 January 2024
	Group Executive	16, 23 January 2024
Purpose	**For Approval / Decision**	

Executive Summary

At its meeting in November 2023, the Group Board reviewed and approved the new strategic risks on the Group Board Assurance Framework. The Group Board defined a series of 14 strategic risks, each aligned to one of the four themes set out in the Group Strategy, *Outstanding Care, Together 2023-28.*

This report sets out the first full iteration of the Group BAF. For each strategic risk, the BAF sets out:

- A current risk score and current assurance rating – as at February 2024
- A target risk score and target assurance rating – stretching but achievable ratings to be achieved by March 2025
- Supporting risks as currently set out on each Trust's corporate risk register.

The quality, people and finance risks were reviewed at the Quality, People and Finance Committees in January 2024. The digital and estates risks were reviewed by the Infrastructure Committee at its meeting in February 2024. Risks relating to collaboration and partnerships (strategic risks 1-3) are reserved to the Group Board.

While this is the first full iteration of the Group BAF, the entries will continue to be iterated and refined. In particular:

- Controls and actions will be refined to ensure those most material to the risk are captured
- Timelines for a number of identified actions to control risks need to be defined. This will enable effective plotting of risk reduction schedules
- Supporting risks on the two Trusts' corporate risk registers will require review

Action required by Group Board

The Group Board is asked to:

a) Review the current risk and target scores for each strategic risk on the Group BAF
b) Review the current and target assurance rating for each strategic risk
c) Note the risks that have been reviewed by the relevant Committees
d) For the risks reserved to the Group Board, consider and agreed the current and target risk scores, current and target assurance ratings, and actions to address gaps in control.

Committee Assurance	
Committee	All Board Committees
Level of Assurance	N/A

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Board Assurance Framework

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

Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHS System Oversight Framework, Code of Governance for NHS Providers.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

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Group Board Assurance Framework

March 2024

Stephen Jones
Group Chief Corporate Affairs Officer

8 March 2024

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University Hospitals and Health Group

Overview

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Summary

At its meeting in November 2023, the Group Board reviewed and approved the new strategic risks on the Group Board Assurance Framework. The Group Board defined a series of 14 strategic risks, each aligned to one of the four themes set out in the Group Strategy, *Outstanding Care, Together 2023-28.*

This paper sets out the first full iteration of the new Group Board Assurance Framework across all 14 of the new strategic risks.

The risks relating to quality, finance and people have been reviewed by the Quality, Finance and People Committees respectively in January 2024 and the estates and digital risks were reviewed by the Infrastructure Committee in February 2024. The risks relating to collaboration and partnerships (strategic risks 1-3) are reserved to the Group Board for review.

A Group-wide position

The BAF tracks the risks to the delivery of an organisation's strategy. In the case of GESH, the strategy is a Group-wide strategy. As such, the risks on the BAF provide an overview of the risks to the delivery of that 5-year Group-wide strategy. Where controls, assurances, gaps or actions relate only to one Trust within the Group, this is set out explicitly. In the case of finance, as the Trusts report separately on their financial positions, separate Trust-specific positions have been developed alongside the Group-wide position. The Group position is contained within the main body of the BAF, with the separate financial positions for each Trust attached as appendices to the BAF.

Risk scores

- **2 strategic risks scored at the maximum score of 25:**
  - Achieving financial sustainability
  - Improving our estates
- **7 strategic risks are scored at 20:**
  - Working across the Group
  - Adopting digital technology
  - Reducing waiting times
  - Improving safety and reducing avoidable harm
  - Putting staff experience and wellbeing at the heat of what we do
  - Fostering an inclusive culture that celebrates diversity
  - Developing tomorrow's workforce
- **3 strategic risks are scored at 16:**
  - Working with our local system
  - Improving patient experience
  - Tackling health inequalities
- **2 strategic risks are scored at 12:**
  - Working with other hospitals through our APC
  - Developing new treatments through research and innovation

Assurance ratings

- **11 strategic risks have a limited assurance rating:**
  - Working across the Group
  - Achieving financial sustainability
  - Improving our estates
  - Adopting digital technology
  - Reducing waiting times
  - Improving safety and reducing avoidable harm
  - Improving patient experience
  - Tackling health inequalities
  - Putting staff experience and wellbeing at the heat of what we do
  - Fostering an inclusive culture that celebrates diversity
  - Developing tomorrow's workforce
- **3 strategic risks have reasonable assurance ratings:**
  - Working with our local system
  - Working with other hospitals through our APC
  - Developing new treatments through research and innovation

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Strategic Risks

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Strategic Objective	Strategic Risk	Summary risk description	Full risk description
Collaboration and Partnership	SR1	**Working across our local systems**	*If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*
	SR2	**Working with other hospitals through our Acute Provider Collaborative**	*If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.*
	SR3	**Working together across our Group**	*If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.*
Affordable Services Fit for the Future	SR4	**Achieving financial sustainability**	*If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, then we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients.*
	SR5	**Modernising our estate**	*If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services*
	SR6	**Adopting digital technology**	*If we do not build a robust digital infrastructure and adopt transformational digital solutions, then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement.*
	SR7	**Developing new treatments through innovation and research**	*If we do not create the right culture, infrastructure and partnerships, then we will not become a thriving centre for research and innovation and not attract sufficient research funding, resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff*

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Strategic Risks

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Strategic Objective	Strategic Risk	Summary risk description	Full risk description
Right Care, Right Place, Right Time	SR8	**Reducing waiting times**	*If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, then we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*
	SR9	**Improving patient safety and reducing avoidable harm**	*If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable and harm and mortality and poorer clinical outcomes.*
	SR10	**Improving patient experience**	*If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, then we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services.*
	SR11	**Tackling health inequalities**	*If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, then we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.*
Empowered, Engaged Staff	SR12	**Putting staff experience and wellbeing at the heart of what we do**	*If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, then our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*
	SR13	**Fostering an inclusive culture that celebrates diversity**	*If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, then our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*
	SR14	**Developing tomorrow's workforce**	*If we do not retain, train and transform our workforce for the future, then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.*

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Group BAF: Opening position (February 2024)

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Strategic Objective	Strategic Risk	Summary risk description	Board level oversight	Executive lead	Current risk score (Feb 24)	Target risk score (Mar 25)	Assurance rating (Feb 24)	Target assurance rating (Mar 25)
Collaboration and Partnership	SR1	Working across our local system	Group Board	GCEO	16	12	Reasonable	Good
	SR2	Working with other hospitals through our APC	Group Board	GCEO	12	8	Reasonable	Good
	SR3	Working across the Group	Group Board	GDCEO	20	15	Limited	Reasonable
Affordable Services Fit for the Future	SR4	Achieving financial sustainability	Finance Committee	GCFO	25	20	Limited	Reasonable
	SR5	Modernising our estate	Infrastructure Committee	GCIFEO	25	20	Limited	Reasonable
	SR6	Adopting digital technology	Infrastructure Committee	GCFO	20	15	Limited	Reasonable
	SR7	Developing new treatments through research and innovation	Quality Committee	GCMO	12	8	Reasonable	Good
Right Care, Right Place, Right Time	SR8	Reducing waiting times	Finance Committee	Site MDs	20	15	Limited	Reasonable
	SR9	Improving safety and reducing avoidable harm	Quality Committee	GCMO / GCNO	20	15	Limited	Reasonable
	SR10	Improving patient experience	Quality Committee	GCNO	16	12	Limited	Reasonable
	SR11	Tackling health inequalities	Quality Committee	GCMO	16	12	Limited	Reasonable
Empowered, Engaged Staff	SR12	Putting staff experience and wellbeing at the heart of what we do	People Committee	GCPO	20	16	Limited	Reasonable
	SR13	Fostering an inclusive culture that celebrates diversity	People Committee	GCPO	20	16	Limited	Reasonable
	SR14	Developing tomorrow's workforce	People Committee	GCPO	20	16	Limited	Reasonable

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Group BAF: Opening position (Feb 2024)

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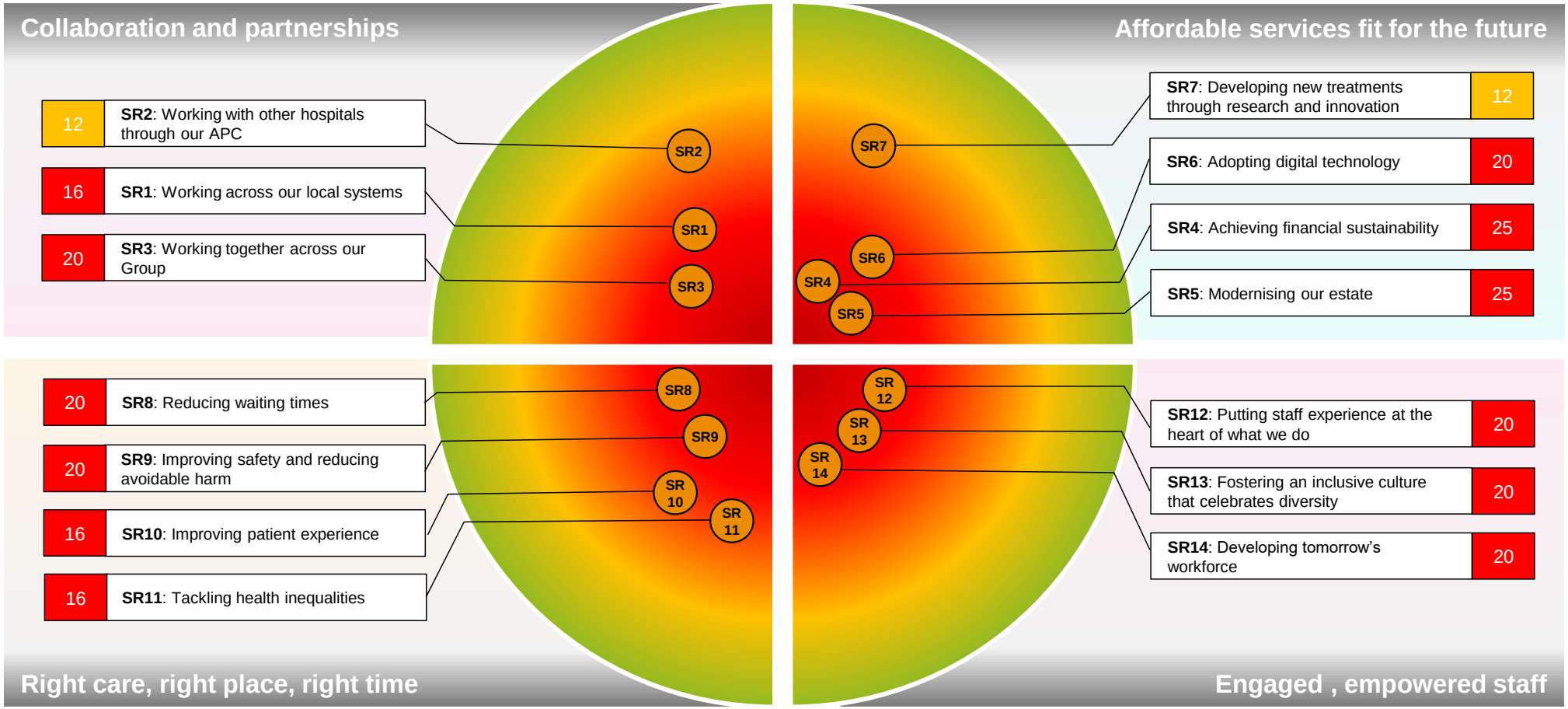

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Scoring the BAF

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Scoring the Group Board Assurance Framework

(i) Risk scores

Although the BAF is not a risk register per se, it is commonplace across the NHS to provide an overall risk score for each strategic risk on the BAF. The scoring methodology for BAF risk scores reflects the scoring methodology for risks on the corporate risk registers, using a 5 x 5 risk scoring matrix calculating the impact of the identified risk should it occur (consequence) by the chances of the risk occurring (likelihood).

Risk grading (scoring)

	CONSEQUENCE INDEX			LIKELIHOOD INDEX*	
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

(ii) Calculating the strength of assurances on the controls in place

Against each strategic risk, the BAF identifies a number of controls (what we are already doing to manage the risk), plots the sources of assurance against these (how we know whether the controls are working), and it offers an assessment of the effectiveness of the controls, as well as setting out which line of defence the source of assurance relates to.

Strength of controls

Control strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Good	The identified control provides a good mechanism for helping to control the risk, albeit there is scope to strengthen this further
Reasonable	The identified control provides a reasonable and partial mechanism for controlling the risk but there are notably weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk.

Strength of controls

Line of Assurance	First Line Assurance	Second Line Assurance	Third Line Assurance
Description	Care Group / Operational Level	Corporate Level	Independent and external
Examples	• Service delivery / day-to-day management • Service level oversight • Divisional level oversight	• Board and Board Committee oversight • Executive oversight • Specialist support (e.g. Finance, Governance, HR)	• Internal audit • External audit • CQC • NHSE • Independent review • Other independent report

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Scoring the BAF

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(iii) Calculating the overall level of assurance

For each of the 14 strategic risks on the Group Board Assurance Framework, an overall assurance rating is provided. This is intended to help the Group Board understand the level of confidence it can have that appropriate controls are in place and that they are working effectively, that any material gaps in control have been identified with clear actions being taken to address these gaps in control with clear timelines for doing so. The following table sets out the definitions of the assurance levels provided.

As many of the risks in the Group BAF are newly defined, with work ongoing to refine the controls, gaps and timelines for implementing actions, many of the assurance ratings in the opening position are limited. However, this is expected to evolve as the controls and actions are refined and honed.

Assurance Levels	
Control strength	**Description**
Substantial	Governance and risk management arrangements provide substantial assurance that the risks are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented. Outcomes are consistently achieved across all relevant areas.
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with some inconsistencies in some areas.
Reasonable	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are achieved, but this is inconsistent across areas and / or there are risks to current performance.
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Limited evidence is available that systems and processes are being consistently applied or implemented.

Further development

Although the BAF presented to the Board is the first full iteration, it is important to note that the BAF will necessarily iterate and develop over the coming months. It is a live document that will be continually updated through reviews at Committee and the Group Board. It is worth, in particular, flagging three areas of focus in this further work:

- Refining and honing the controls, assurances, gaps and actions so that the BAF captures the most material of these. This is important to ensure the BAF is a useful tool for the Group Board and to ensure it is focused on the right areas.

- For the actions to address gaps in control, fully populating these over the coming weeks and months to ensure that the Committees and Group Board can track progress in managing BAF risks. Once these are populated, reporting on the BAF will set out risk reduction schedules that will project how the risk score and assurance ratings are forecast to evolve with the implementation of the material actions identified. This will enable the Committees and Board to see how the material actions will impact the risk and help reduce the risk score over time.

- Relevant risks on the Corporate Risk Registers of both Trusts have been provisionally mapped against the strategic risks on the BAF. This highlights that, in some areas, the Corporate Risk Registers need to be further developed and updated, and this will be a key area of focus in the coming weeks and months in order to ensure that the BAF and CRRs are used in concert in an appropriate way.

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Development of the Group Board Assurance Framework

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Development of the Group Board Assurance Framework

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- Every NHS organisation is required to have a board assurance framework, as part of the organisation's approach to risk management. The Code of Governance for NHS providers, requires Boards to "*establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic aims".*

- There is no definitive definition of, set of requirements for, a Board Assurance Framework in the NHS. However, the following are two of the most helpful definitions:

    - HM Treasury Guidance on Assurance Frameworks (2012): "*An assurance framework is a structured means of identifying and mapping the main sources of assurance in an organisation, and coordinating them to best effect*".

    - Good Governance Institute (2021): "*The Board Assurance Framework is, in GGI's view, the original invest-to-save scheme for Boards. Time spent on getting the various elements of the BAF right will help Bards streamline assurance, locate where and how assurance is tested, and develop proportionately in Board reporting".*

- The BAF starts with an organisation's strategy. The BAF brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives. It acts as the source of evidence that the Board can rely on to be confident that risks of the delivery of the Board's strategic objectives are being managed and controlled effectively.

- The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed. The BAF also provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of strategic risks. Used effectively, the BAF provides a Board with real, evidence-based confidence that it is providing a thorough and effective oversight of risks of the organisation and its strategic objectives.

- The BAF should be a comprehensive means of reporting to the Board that allows for effective prioritisation, focus and management of key strategic risks. It should be the main tool the Board uses to discharge its overall responsibility for internal control and should inform the Annual Governance Statement, and it should help shape the Board agenda.

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Development of the Group Board Assurance Framework

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- The BAF is owned by the Board and is a key tool in enabling it to do its job. It is therefore good practice for the Board to be involved form the outset in developing the BAF through seminars and workshops. The Group Board has been actively involved in shaping the new Group BAF:

    - April 2023: In April 2023, the Group Board discussed the role and purpose of a Board Assurance Framework, considered good practice in the development and design of Board Assurance Frameworks and how BAFs differ from corporate risk registers, and discussed how it could develop and use a Group-wide Board Assurance Framework. The Board considered some of the principal risks the Group might face in delivering each of the four new strategic objectives set out in the new Group strategy, and held break-out groups to think through these risks against each of the four strategic objectives.

    - October 2023: At its development session in October 2023, the Group Board took these discussions on further and considered the framing of each of the risks on the new Group BAF. It discussed which risks should be included for each of the four strategic objectives, considered these in relation to the 'cause-risk-effect' of each, and discussed options around the wording of individual risks. The Group Board reflected on the number of risks on the BAF, and the need to balance the need for the BAF to be comprehensive but also manageable as a tool that is used by the Board. The Group Board also considered the risk appetite for each draft risk on the BAF.

    - November 2023: At its public session in November, the Group Board reviewed and approved the 14 strategic risks on the new Group Board Assurance Framework, approved the risk appetite statement, and governance arrangements for the governance and ownership of the BAF.

- Since the Group Board's approval of the strategic risks, a new BAF template has been developed which seeks to draw out the key areas for review by the Group Board: the risk scores and assurance ratings (current and target), material controls and sources of assurance (including strength of controls), material gaps in control, and principal actions necessary to address those gaps. Each risk on the new BAF has now been populated with this information. Risks relating to quality, finance and people were considered by the relevant Committees in January, and risks relating to infrastructure will be considered by the Infrastructure Committee at its next meeting. The three risks relating to collaboration and partnership are reserved to the Group Board for review.

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Development of the Group Board Assurance Framework

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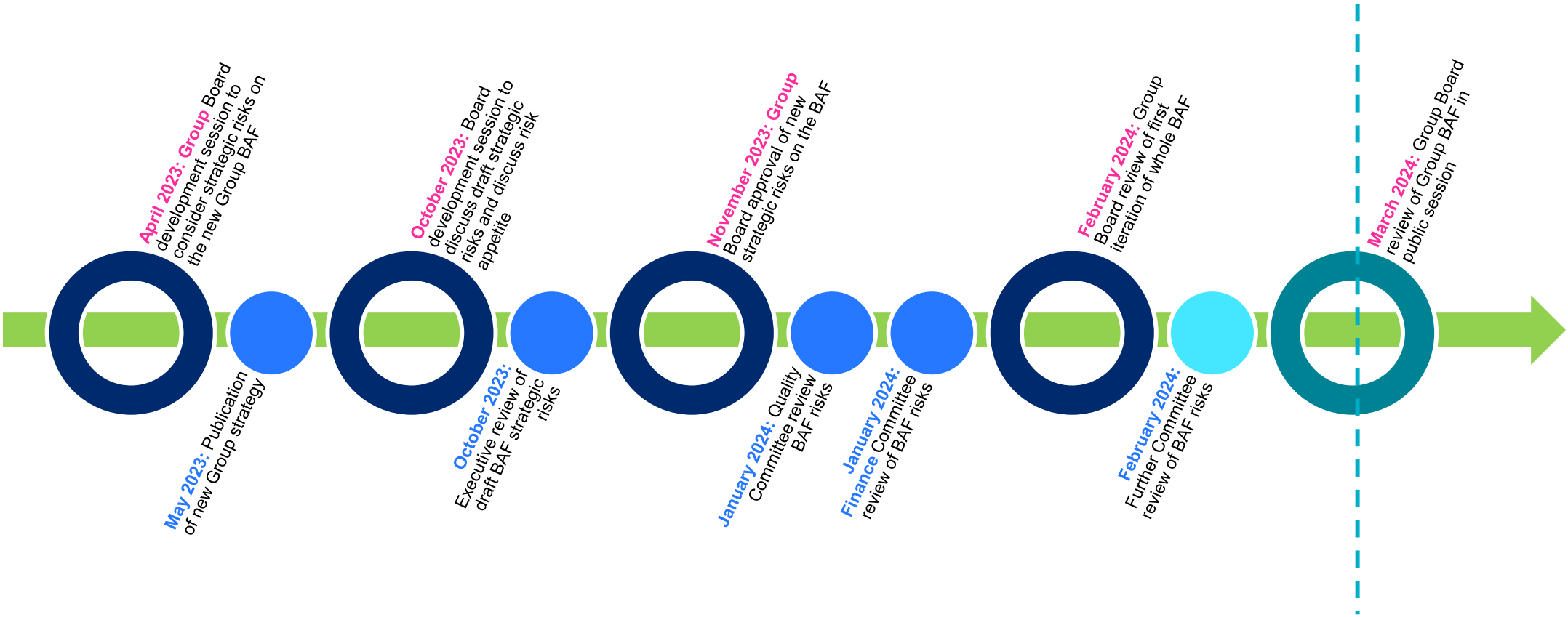

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Group Board Assurance Framework: Governance

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Ownership and management of strategic risks: Roles and responsibilities

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- It is important that there is clarity on roles and responsibilities in relation to the BAF, and that each tier of our corporate governance understands the role they play in relation it.

- **Ownership:** Ultimately, it is the Board which owns the BAF – the Board develops the Trust strategy, agrees the Strategic Risks to the delivery of the strategy, and is responsible for reviewing assurances and ensuring there is a robust process for managing the BAF and risk more generally. With our new Group Board arrangements, it would in practice be the Group Board committees-in-common which would review the BAF, with responsibility delegated from the Board. Board Committees play a role in supporting the Board to manage the BAF and test assurances in their respective areas, with the Audit Committee playing a key role in relation to the effectiveness of assurance systems and internal controls in the management of the BAF. The Executive's role is to manage the strategic risks on behalf of the Board, oversee actions to address gaps in controls and assurance, and propose changes and risk scores. The table on the next slide sets out respective responsibilities.

- **The BAF and the Corporate Risk Register:** We will highlight to the Board the "supporting risks" on the CRR that sit below each BAF risk as it is important that the BAF takes account of the CRR when taking assurance or defining strategic risk scores. But we will report on Strategic Risks in a way that sets out for each the controls, assurances, key indicators, and emerging risks so that the Board can understand the assurances that exist for each Strategic Risk.

- **Scoring the BAF:** The Board is ultimately responsible for scoring the Strategic Risks on the BAF, based on advice from the Executive and the assurances provided by the Board Committees. The Strategic Risks set out in this paper are deliberately not scored at this stage. Once the Strategic Risks are approved by the Group Board, the relevant Board Committees will be asked to review the controls, gaps in control, material actions to be taken to reduce the risk, and the assess the current risk score. This will be undertaken through the next round of Committee meetings, with the fully scored and worked-up Group BAF coming to the Group Board for review at the Q3 2023/24 position in January 2024.

- The pages that follow set out the role of each governance group in relation to the Group Board Assurance Framework, and the ownership at Executive level of each of the Strategic Risks.

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Ownership and management of strategic risks: Roles and responsibilities

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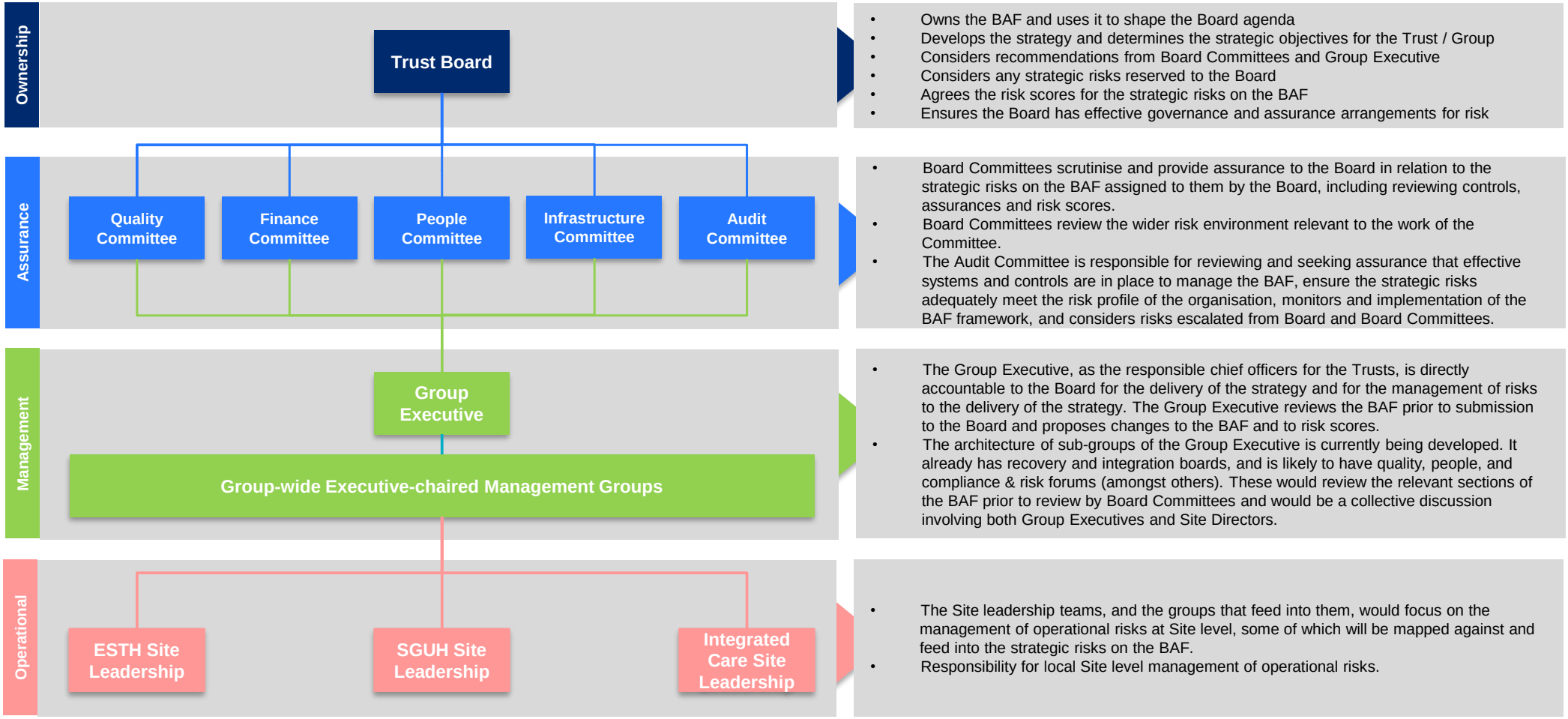

- Owns the BAF and uses it to shape the Board agenda
- Develops the strategy and determines the strategic objectives for the Trust / Group
- Considers recommendations from Board Committees and Group Executive
- Considers any strategic risks reserved to the Board
- Agrees the risk scores for the strategic risks on the BAF
- Ensures the Board has effective governance and assurance arrangements for risk

- Board Committees scrutinise and provide assurance to the Board in relation to the strategic risks on the BAF assigned to them by the Board, including reviewing controls, assurances and risk scores.
- Board Committees review the wider risk environment relevant to the work of the Committee.
- The Audit Committee is responsible for reviewing and seeking assurance that effective systems and controls are in place to manage the BAF, ensure the strategic risks adequately meet the risk profile of the organisation, monitors and implementation of the BAF framework, and considers risks escalated from Board and Board Committees.

- The Group Executive, as the responsible chief officers for the Trusts, is directly accountable to the Board for the delivery of the strategy and for the management of risks to the delivery of the strategy. The Group Executive reviews the BAF prior to submission to the Board and proposes changes to the BAF and to risk scores.
- The architecture of sub-groups of the Group Executive is currently being developed. It already has recovery and integration boards, and is likely to have quality, people, and compliance & risk forums (amongst others). These would review the relevant sections of the BAF prior to review by Board Committees and would be a collective discussion involving both Group Executives and Site Directors.

- The Site leadership teams, and the groups that feed into them, would focus on the management of operational risks at Site level, some of which will be mapped against and feed into the strategic risks on the BAF.
- Responsibility for local Site level management of operational risks.

Group Board Assurance Framework

For review by Group Board

8 March 2024

Strategic Risk	SR1	Working across our local systems

Cause	Risk	Effect
If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system…	*…then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care…*	*…resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*

Current Risk Score: 16

Assurance: Reasonable

Strategic objective	Collaboration and Partnerships
Last review date	23 January 2024
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	4	4	16	Reasonable
Target	Mar-25	4	3	12	Good

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	16											

Key controls *What are we already doing to manage the risk?*	
1	Group is a convenor of two Places (Sutton, Surrey Downs) and part of a third Place Board (Wandsworth and Merton)
2	Integrated Care Boards established for South West London and Surrey Heartlands, with the Group as an active partner
3	Integrated Care Partnerships established for South West London and Surrey Heartlands, with the Group as an active partner
4	South West London Integrated Care Partnership has developed a SWL Integrated Care Strategy identifying priority areas of focus
5	A SWL Joint Forward Plan has bene developed which sets out how NHS partners across SWL will work together over the next 5 years
6	Surrey Heartlands ICS Strategy launched in March 2023, with GESH representation in its Delivery Oversight Committee
7	South London Pathfinder in place (to test how to deliver contracting arrangements under devolution of specialised commissioning)
8	Virtual wards in place via community services to improve discharge and patient flow

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Site MDs actively involved in Place discussions and provide feedback into Group	Reasonable	Second - Management
2	SGUH and ESTH represented on ICB. Regular high-level meetings held with Surrey Heartlands	Reasonable	Second - Management
3	Group Chairman and Finance Committee Chair are members of SWL ICP Board.	Reasonable	Second - Management
4	Regular review of ICS updates at Group Board	Reasonable	Second - Management
5	Regular review of ICS updates at Group Board	Reasonable	Second - Management
6	Regular review of ICS updates at Group Board	Reasonable	Second - Management
7	Regular review of ICS updates at Group Board	Reasonable	Second - Management
8	Reporting through to Board Committees and Group Board	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Preparing for the devolution of specialised services across South London
2	Development of SWL primary care strategy
3	Working though how the Group works most effectively at Place, building on how effectively it operates at system level
4	Strengthening collaborative working relationships with local authorities
5	Strengthening processes for feedback from ICBs into Group governance (Executive and Board)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• TBC	Opportunity to place more of a role at Place in Wandsworth and Merton

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Put in place clear processes to ensure structured feedback from ICBs into Group Executive and Board	GCEO	TBC	TBC
2	Working across the ICB to prepare for devolution of specialised commissioning	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Strategic Risk	SR2	Working with other hospitals through our Acute Provider Collaborative

Cause	Risk	Effect
If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services…	*…then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey…*	*…resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.*

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Collaboration and Partnerships
Last review date	23 January 2024
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	-	4	4	16	Limited
Current	Jan-24	4	3	12	Reasonable
Target	Mar-25	4	2	8	Good

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	12											

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	South West London Acute Provider Collaborative Memorandum of Understanding in place setting our principles of collaboration	1	Updates from APC presented to Executive team	Reasonable	Second - Management
2	SWL APC has established an APC Board comprising the Chairs and CEOs of the SWL providers, which meets bimonthly	2	Updates from APC presented to Executive team	Reasonable	Second - Management
3	Governance structure for the APC established	3	Updates from APC presented to Executive team	Reasonable	Second - Management
4	Group CEO is lead CEO of the South West London Acute Provider Collaborative	4	Updates from APC presented to Executive team	Reasonable	Second - Management
5	Formal SWL APC partnerships in place for recruitment, orthopaedics, procurement, pathology	5	Review of key performance metrics of APC partnerships through the Site, Executive and relevant Board Committees	Reasonable	Second - Management
6	Agreed set of SWL APC priorities in place for 2023/24	6	Delivery overseen by APC Board	Reasonable	Second - Management
7	A range of elective programmes and clinical networks are in place across the SWL APC covering elective recovery, outpatients and diagnostics	7	Delivery overseen by APC Board	Reasonable	Second - Management
8	APC Programme Director in place	8	Regular meetings with GCEO and updates provided to Executive	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Medium-to-long term APC strategy
2	Arrangements for ICB oversight
3	Need for clear outputs from established networks across the APC
4	APC working in the context of the GESH Group
5	Alignment of EPRs across the APC
6	Development of Surrey Heartlands APC with GESH representation via Surrey Downs Health and Care

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• TBC	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Approve 3-5 year strategy for the SWL APC	GCEO	Jul-24	On Track
2	Define clear outputs from the networks established across the APC	GCEO	Dec-24	TBC
3	Clarify way forward in relation to EPRs across the APC	GCIFEO	Dec-24	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

Strategic Risk	SR3	Working together across our Group

Cause	Risk	Effect
If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths…	*…then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities…*	*…resulting in unwarranted variation in care and poorer outcomes for patients.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Collaboration and Partnerships
Last review date	23 January 2024
Monitoring Committee	Group Board
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	4	20	Limited
Target	Mar-25	5	3	15	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Group-wide strategy in place and approved by Boards
2	9 strategic initiatives agreed with Executive leads for each identified
3	MoU and Information Sharing Agreement in place to support the development of the Group
4	Group governance arrangements established at Board, Committee and Executive level
5	Group Corporate Services programme established, with legal agreements in place to support the operation of Group-wide services
6	Group Collaboration Board in place to oversee the development of clinical and corporate collaboration and integration across the Group
7	Group strategy, continuous improvement and project management teams in place to support delivery of Group collaboration
8	Performance data reviewed on Group-wide basis

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Strategy progress updates reviewed by Group Board bi-annually, and by the Executive on a monthly basis	Reasonable	Second - Management
2	Programmes of work for each established, with executive review of Strategic Initiatives on a monthly basis	Reasonable	Second - Management
3	In place and approved by the Boards	Reasonable	Second - Management
4	Group Board and Committees-in-Common established and review effectiveness annually	Reasonable	Second - Management
5	Steering Group meets fortnightly, with reporting to the Executive and review by People Committee on monthly basis	Weak	Second - Management
6	Regular reporting of progress to the Executive	Reasonable	Second - Management
7	All roles fully appointed to	Reasonable	Second - Management
8	Group-wide Integrated Quality and Performance Report presented to Committees and Group Board	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Supporting strategies on quality, people, digital, estates, green plan, research and innovation
2	Clinical supporting strategies in priority areas
3	Completion of Group Corporate Services integration programme – agree funded delivery plan and metrics for success
4	Common systems, processes and policies across the Group
5	Accountability framework
6	Revised governance documentation

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• TBC	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Supporting strategies to be developed, reviewed and approved by the Group Board	GDCEO	Nov-24	On Track
2	Delivery of the 9 Strategic Initiatives to support the implementation of the Group strategy	GDCEO	Mar-28	Off Track
3	Finalise and approve designs for remaining corporate areas for integration, and complete integration of Group Corporate Services to agreed timeline	GDCEO	Jul-24	Off Track
4	Develop and agree Group-wide clinical strategies in pharmacy, surgery, radiology	GDCEO	Sep-24	On Track
5	Develop and agree Group-wide clinical strategies in second wave specialties	GDCEO	Mar-25	On Track
6	Develop and agree Group-wide clinical strategies in third wave specialties	GDCEO	Sep-25	On Track
7	Develop and agree Group-wide Accountability Framework, drawing on Group Operating Model	GCCAO	Jul-24	On Track
8	Develop revised Standing Orders, Scheme of Delegation and Standing Financial Instructions for each Trust, with as much alignment as possible within the existing legal and regulatory framework	GCCAO	Jun-24	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-XXX	20	Group Corporate Services

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-XXX	20	Group Corporate Services

Strategic Risk	SR4	Achieving financial sustainability – Group Assessment

Cause	Risk	Effect
If we do not manage costs effectively, optimise productivity, and ensure our activities are effective…	*…then we will not return to financial balance…*	*The poor use of public funds and unsustainable services for patients.*

Current Risk Score: 25

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	5	25	Limited
Target	Mar-25	5	4	20	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	25											

Key controls *What are we already doing to manage the risk?*	
1	Managing income and expenditure in line with budget.
2	Ensuring there is an effective financial control environment.
3	CIPs. Identifying and delivering actions to improve the financial position.
4	Robust understanding of cost structures and productivity.
5	Maintaining a five year forward view.
6	Maintaining the capacity and capability of the finance team.
7	Capital: clear view of future capital needs and how to meet them
8	Robust processes to forecast and manage cash.
9	Maintaining an effective procurement environment
9	External engagement with SWL, London and national finance teams.

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Financial performance is in line with budget/plan	Reasonable	First - Operational
2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Weak	First - Operational
4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	A five year "long term financial plan" is in place	Weak	Second - Management
6	Clearly defined statement of how demands on dept are meet by available resources.	Reasonable	Second - Management
	Detail available of prioritised capital need together with available funding.	Weak	Second - Management
7	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
8	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Reasonable	Second - Management
9	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Enhance level of financial support and challenge – esp embed at budget holder level
2	Challenge in continued emphasis on the identification and delivery of CIPs.
3	Improve understanding and actions to address variance in benchmarking
4	Improve understanding and actions to address productivity
5	Clear trajectory to return to financial balance
6	Need to revise the five-year model developed as part of BYFH refresh
7	Capital funding is insufficient to meet identified known investment needs; BAU and developmental
8	Review finance team capacity and capability in respect of current agenda
9	Continued focus on cashflow forecasting and engagement with NHSE
10	Increase communication on and integration of finance into wider agenda (not separate)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Uncertain planning environment for 24/25. • Scale of financial challenge and time allowed to recover. • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding	• Working across the Group. • Working across the SWL system.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Continued weekly budget review with SLT leads and divisions underway	MDs	May-24	On Track
2	CIPs, work ongoing to identify new opportunities.	MDs	Apr-24	On Track
3	Detailed review performance against key benchmark data, explain or address variance	GCFO	Apr-24	TBC
4	Detailed review performance against key productivity data, explain or address variance	MDs	Apr-24	TBC
5	Work with SWL and London CFOs to agree trajectory to return to financial balance	GCFO	Mar-26	TBC
6	Develop a 5-year financial model; two stages rapid high-level view and then detailed LTFM. Aligns to refresh for BYFH	GCFO	Sep-24	TBC
7	Explore alternate sources for funds. Where not possible identify non-capital mitigations to known risks	MDs/GCFO	Apr-24	TBC
8	Revised departmental structure for Finance	GCFO	Mar-24	TBC
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management	GCFO	Mar-25	On Track
10	Increase communication on finance maintaining open communication while maintaining engagement	GCFO	Mar-25	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-1085	25	Managing an effective control environment
SGUH	CRR-1865	20	Identifying and delivering CIPs
SGUH	CRR-1411	20	Managing I&E within budget
SGUH	CRR-1414	16	Five-year financial model
SGUH	CRR-1416	15	Future cash requirements are understood
SGUH	CRR-2495	20	Elective Recovery Fund

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1961	25	Inability to achieve long term financial sustainability due to inefficiencies of providing range of services across two 'subscale' acute sites, contributing to an increasing underlying structural deficit
ESTH	CRR-1960	25	Inability to undertake the required capital investment programme with the SWL capital programme CDEL limits

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

Strategic Risk	SR5	Modernising our estates

Current Risk Score: 25

Assurance: Limited

Cause	Risk	Effect
If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans…	*…then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients…*	*…resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services.*

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Infrastructure Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	5	25	Limited
Target	Mar-25	5	4	20	Reasonable

Change since last review

⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	25											

	Key controls *What are we already doing to manage the risk?*
1	Ensure we have a comprehensive understanding of our infrastructure risks across all sites
2	Having clear, risk based, preventative maintenance schemes that can be flexed based on affordability
3	A clear, transparent, risk based approach to capital prioritisation
4	Sourcing alternative sources of capital
5	Aligned estate strategy & green plan
6	Infrastructure Committee / Governance & Communication
7	Use major capital projects to address wider infrastructure risks wherever possible

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	External condition surveys, risk assessments, reporting to Infrastructure Committee	Good	Second - Management
2	Internal audits on maintenance undertaken / due. Regular estates reporting to plan to Infrastructure Committee	Reasonable	First - Operational
3	Both Trusts have processes for agreeing collectively the annual capital plans, with clinical, operational and E&F input	Reasonable	Second - Management
4	Limited work done to date, examples include external SALIX funding for green projects and phasing BYFH funds	Weak	First - Operational
5	A group estate and green plan are currently being produced although these will be difficult to deliver with limited capital, particularly the 80% carbon reduction target by 2032 and Net Zero by 2040, which are NHSE requirements	Reasonable	First - Operational
6	The Infrastructure Committee is proving effective at understanding and reviewing E&F risks	Good	Second - Management
7	Whilst projects are always looking to improve wider infrastructure wherever affordable and appropriate,	Weak	First - Operational

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Develop longer term capital plans (5 yrs+) that are better aligned with our strategies and affordability envelope
2	Communicate estate risks to clinical teams more widely
3	Ensure our business continuity plans are up to date and better reflect our infrastructure risks
4	Be clear on those risks that we are not mitigating and the potential impacts
5	Communicate infrastructure benefits from projects better
6	
7	

Emerging risks and opportunities
What else is relevant to how we managing the risk?

Emerging risks	Emerging opportunities
• Increase in revenue spend caused by worsening infrastructure • Impact on clinical service due to infrastructure unmitigated risks • Inability to deliver NHSE Net Zero commitments	• Working closer with clinical teams to further refine priorities • BYFH • Working across the group • SWL system working

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop longer term capital plans in line with revised estate strategies and conditions surveys	GCIFEO	Oct-24	On Track
2	Ensure clinical engagement on all infrastructure issues; capital planning, risk management etc on an ongoing basis	GCIFEO	Mar-25	TBC
3	Complete six-facet survey at ESTH and commission new survey for STG	GCIFEO	Apr-24	On Track
4	Ensure Infrastructure Committee is fully informed on all matters of infrastructure risk	GCIFEO	Jul-24	On Track

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2036	20	Risk of fire in Lanesborough and St James'
SGUH	CRR-762	20	Infrastructure backlog
SGUH	CRR-2061	15	Lack of UPD/IPS power supplies site-wide

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1951	20	Poor condition of external buildings
ESTH	CRR-1952	20	Electrical infrastructure
ESTH	CRR-1955	20	Risk of failure of air handling and cooling
ESTH	CRR-1956	20	Risk of failure of mechanical bed lifts
ESTH	CRR-1953	16	Fire prevention systems
ESTH	CRR-1954	16	Sewage and drainage systems
ESTH	CRR-1957	16	Renal units meeting statutory requirements
ESTH	CRR-1962	16	Risk that BYFY fails to meet objectives
ESTH	CRR-1941	15	Replacement of medical equipment

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

Strategic Risk	SR6	Adopting digital technology

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not build a robust digital infrastructure and adopt transformational digital solutions…	*…then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently…*	*…resulting in poorer patient outcomes, less efficient services and staff disengagement.*

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	4	20	Limited
Target	Mar-25	5	3	15	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

	Key controls *What are we already doing to manage the risk?*
1	Digital Strategy in development to provide direction
2	Agreed resourcing plan in place for next 3 years but not seen as adequate for current agenda.
3	Governance in place but needs enhancement given challenges
4	Infrastructure. Focus on some areas but ongoing failures causes challenge
5	Resilience in existing systems and plans to renewal/refresh in place but is the pace sufficient given challenges and demands on digital.
6	Disaster recovery plans in place but require further review.
7	Cyber and malware strategies/responses in place and tested.
8	Capacity and capability in Digital team in line with current resources but demands continue to exceed capability.
9	Digital plans to support Group integration in development. Need to be finalised
10	Group effectively represented in SWL collaboration activities. Is GESH clear what it wants and effectively pushing for this.

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Strategy to focus on transformative actions as well as resilience. To be discussed by Trust Board.	Reasonable	Second - Management
2	Resourcing under material pressure due to wider pressures.	Weak	Second - Management
3	Structures in place. Challenges have emerged in key projects such as EPR. Need be better integrated with and engagement by wider group. Ensure focus on transformation	Weak	Second - Management
4	Weaknesses in infrastructure especially at SGUH evident	Weak	First - Operational
5	Requirements understood, delivery of projects challenging. Ensure plans exploit opportunities of new systems.	Weak	First - Operational
6	Plans in place but further work needed to test.	Reasonable	First - Operational
7	Plans in place externally reviewed and reported to Audit Com	Reasonable	First - Operational
8	Current team capabilities strong but demands on both sites large and growing. More consideration of transformative action	Weak	First - Operational
9	Clear plans not in place. Plans need to address not just alignment but also transformative opportunities	Weak	Second Management
10	Good engagement into SWL and beyond. Group needs active engagement and support for system working inc transformation	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Strategy: Agree the strategy ensuring linked to known demands and resources
2	Resourcing: Consider prioritisation against other demands. Seek additional resources
3	Governance: Revised governance in development. Report to Infrastructure Com
4	Infrastructure: Agree key resilience actions with operations as part of resource plans
5	Resilience: Continue to refresh systems as required. Review learning from previous projects
6	Disaster recovery: Continue to refine and test plans. Report to Infrastructure Com
7	Cyber: Maintain focus and ensure plans, systems and processes kept up to date
8	Capacity: Review current resourcing. Match resourcing to agreed plans.
9	Group collaboration: Agree priorities and develop clear plans
10	SWL collaboration: Continue to work closely with system and regional partners.

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Mismatch between needs/plans and available resources. • Greater collaborative working will require understanding and compromise. • Delivery against key projects taking longer than planned	• Closer Group working. • SWL-wide solutions being explored for the medium/longer term. • IDT is major enabler for change, transformation and improvement

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Strategy: Complete strategy and agree at Trust Board	GCFO	Mar-24	On Track
2	Resourcing: Group Executive to recommend resourcing as part of 24/25 planning. This will be challenging given wider NHS pressures. Mitigations need to be considered where funding is limited/not available	GCEO	May-24	On Track
3	Governance: Complete digital governance review and embed from sites through to Board. Ensure governance and plans on key projects assured at Infrastructure Committee, e.g. EPR.	GCFO	Mar-24	On Track
4	Infrastructure: Group Exec to agree key actions within available capacity, capability and interrelationships between actions.	GCEO	Dec-24	TBC
5	Resilience: Agree priorities with clinical and operational colleagues. Review and apply learning from current projects.	GCFO	Dec-25	TBC
6	Disaster recovery: Enhance visibility and further develop horizon scanning.	GCFO	Dec-25	TBC
7	Cyber: Continue vigilance and horizon scanning.	GCFO	Dec-24	On Track
8	Capacity: Agree workforce development programme for next 3 years	GCFO	Dec-24	TBC
9	Group collaboration: Agree prioritisation and work plan for next 3 years in support of wider objectives and practical needs	GCFO	Sep-24	TBC
10	SWL collaboration: Improve visibility of system plans and role/opportunity for GESH within them	GCFO	Sept 24	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-803	20	ICT Disaster Recovery Plan
SGUH	CRR-1395	20	Network Outage
SGUH	CRR-1312	16	Data Warehouse Fragmentation
SGUH	CRR-1292	16	Telephony
SGUH	CRR-810	15	Data Centre

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1958	16	Aging / unsupported IT equipment, systems, platforms; Cybersecurity incidents

Strategic Risk	SR7	Developing new treatments through innovation and research

Cause	Risk	Effect
If we do not create the right culture, infrastructure and partnerships…	*…then we will not become a thriving centre for research and innovation and not attract sufficient research funding…*	*…resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff.*

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Seek (Significant)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	4	16	Limited
Current	Jan-24	4	3	12	Reasonable
Target	Mar-25	4	2	8	Good

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	12											

Key controls *What are we already doing to manage the risk?*	
1	Existing Trust-based research strategies in place for ESTH and SGUH
2	Partnership with St George's University of London well established
3	Key role in London Clinical Research Network
4	Translational and Clinical Research Institute established
5	NIHR Clinical Research Facility designation – St George's
6	Research governance in place
7	Lead for non-medical research in place at SGUH – to become Group-wide role through restructure
8	Research portfolio in renal and commercial portfolio within renal and ophthalmology at ESTH
9	Actions to increase research activity

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Approved by Board but to be succeeded by Group-wide research and development strategy in 2024/25	Reasonable	Second - Management
2	Regular meetings of SGUH/SGUL Joint Strategic Board	Reasonable	Second - Management
3	Leadership positions in the Clinical Research Network. Group CEO chairs the CRN Partnership Board	Reasonable	First - Operational
4	TACRI Steering Group reporting to SGUH PSQG	Reasonable	Second - Management
5	5-year designation from NIHR	Reasonable	Third - External
6	Reporting on research through to the JRES and Quality Cttee	Reasonable	Second - Management
7	Required wider Group-wide integration of non-medical research support team	Weak	Second - Management
8	Reporting on research through to the Quality Committee	Reasonable	Second - Management
9	Continuing growth of research activity	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Group-wide alignment of research priorities and strategic focus
2	Group-wide alignment of research activities and delivery support
3	Relationship with City University
4	Not all major Group clinical activities are yet proportionately reflected in research activity
5	Research IT infrastructure needs strengthening
6	Secure additional NIHR core funding
7	Explore opportunities for collaborative research across the Group
8	Develop non-medical research

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Financial pressures impacting on research opportunities • Ability to secure research funding	• Opportunities for wider partnerships with City University • Opportunity for greater research leadership role in SWL

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and secure Group board approval for Group-wide research and development strategy	GCMO	Nov-24	On Track
2	Bring together the delivery arms of research for ESTH and SGUH on a Group-wide basis through the integration of corporate services	GCMO	Sep-24	On Track
3	Explore opportunities for building a wider relationship with City University through its merger with St George's University of London	GCMO	TBC	TBC
4	Seek investment to allow more clinical academic appointments	GCMO	TBC	TBC
5	Seek investment / work with IT to set up research data warehouse	GCMO	TBC	TBC
6	Seek additional NIHR core funding	GCMO	TBC	TBC
7	Explore opportunities for collaborative research across the Group	GCNO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

Strategic Risk	SR8	Reducing waiting times

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services…	*…then we will not improve flow through our hospitals…*	*…resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	23 January 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Site Managing Directors
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	4	20	Limited
Target	Mar-25	5	3	15	Reasonable

Change since last review

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Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	OPEL escalation triggers and actions in place
2	Daily surge call in place with system partners to help manage capacity and to escalate delayed patients / discharges
3	Boarding arrangements to depressurise ED with SOPs in place
4	Transfer of care functions in place to facilitate discharge
5	Winter plan in place
6	Validation of PTLs
8	Long length of stay MDT meetings in place (SGUH) Divisional check and challenge of LLoS (ESTH)
9	Regular bed management meetings to help manage flow
11	QMH Surgical Treatment Centre in place to help reduce waiting times ERF plan at ESTH and use of QMH capacity
12	Mutual aid across SWL

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	OPEL triggers regularly used and activated	Good	Second - Management
2	Used regularly to escalate concerns. Integrated TOC at SGUH means constant updates and escalation. SGUH boarding SOP in place and "live"	Reasonable	Second - Management
3	ED performance reported to Site, Exec, Committees and Board	Reasonable	Second - Management
4	In place. Integrated TOC team established on site at SGUH.	Good	Second - Management
5	Reviewed and approved by Finance and Quality Committees	Good	Second - Management
6	Decrease in number of patients waiting longer than 52 weeks	Good	Second - Management
8	Oversight of LoS by Site Leadership teams. Meetings in place and increased when needed.	Reasonable	Second - Management
9	Oversight of flow by Site Leadership teams	Reasonable	Second - Management
11	Activity reviewed by SGUH Site team (improved utilisation and theatre to ESTH). ESTH@QMH plan being mobilised	Good	Second - Management
12	Reviewed by Site and Executive teams. Managed via ICB.	Reasonable	Second - Management

13	Virtual wards established	13	Hospital@Home capacity used 100%, remote monitoring capacity underutilised due to lack of demand	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Volume of patients attending EDs and large numbers of DTAs
2	Numbers of patient outliers across the hospitals
3	Staff concerns regarding pressures in EDs
4	Strengthening of arrangements for addressing pressures due to patients with mental health issues attending EDs
5	Increase 'criteria-led discharges' and other advanced discharge tools to support early discharges
6	Delays in local authorities supporting discharge and availability of social care support
7	Availability of alternatives to ED
8	Strengthening mutual aid across Group and across SWL
9	Theatre productivity

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Staff burnout, illness and disengagement • Moral injury to staff • Increasing violence and aggression directed at staff • ability to physically accommodate further excess demand in site footprint (ESTH) • Inability to compete on pay with other providers for key staff	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Work with system partners to pursue mental health trust provision of a dedicated emergency mental health facility outside EDs.	MDs	TBC	TBC
2	Collaboration with South West London & St George's Mental Health Trust and Surrey and Borders Partnership NHS FT in relation to patients with mental health issues attending EDs.	MDs	TBC	TBC
3	Implementation of actions to respond to staff concerns in EDs	MDs	TBC	TBC
4	Optimise discharge planning across the entire week including through 'criteria-led' discharges	MDs	TBC	TBC
5	Implementation of electronic patient record system across the Group on a shared domain with SGUH	GCEO and EPR SRO	TBC	TBC
6	Implementation of actions to improve theatre productivity	MDs	TBC	TBC
7	Recruitment to cardiac anaesthetist vacancies	MD-SGUH	TBC	TBC
8	Strengthening of mutual aid across Group and SWL	MDs	TBC	TBC
9	Work programme to understand health inequalities impact of long waits	GCMO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising flow
SGUH	CRR-2240	20	Long waits for cardiology procedures
SGUH	CRR-2421	16	Personalised stratified follow-up – breast cancer

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1942	20	Waiting times
ESTH	CRR-1946	20	Cancer metrics (waiting times)
ESTH	CRR-1943	16	Emergency department flow
ESTH	CRR-1948	16	Caring for adult mental health patients in ED
ESTH	CRR-1945	16	Diagnostics backlog / waiting time
ESTH	CRR-1936	16	Cardiology (timely access)
ESTH	CRR-1947	16	Covid-19 recovery

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

Strategic Risk	SR9	Improving patient safety and reducing avoidable harm

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning…	*…then we will not deliver safe, effective and responsive care to our patients…*	*…resulting in increases in avoidable and harm and mortality and poorer clinical outcomes.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	23 January 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	GCMO / GCNO
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	4	20	Limited
Target	Mar-25	5	3	15	Reasonable

Change since last review

⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Quality governance structures and processes
2	Established governance on management of serious incidents
3	Safety data established as core part of Integrated Quality and Performance Report
4	Established governance on quality impact assessments of cost improvement plans
5	Governance and reporting on learning from deaths established
6	Established clinical audit plan
7	Established ward accreditation programme
8	Group-wide infection prevention and control governance in place
9	Influenza and Covid vaccination programme
10	Commissioned external quality reviewed by Royal Colleges and other national bodies

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Internal reporting to Site, Executive, Committees, and Group Board; CQC reports	Weak	Third - External
2	Oversight of SIs by Mortality Monitoring groups and regular reporting of SIs to Quality Committee.	Reasonable	Second - Management
3	Safety data reviewed regularly by Site, Executive Quality Committee and Group Board	Reasonable	Second - Management
4	QIAs process agreed and individual QIAs reviewed by Site and Executive, with Quality Committee oversight	Reasonable	Second - Management
5	Regular reporting to Quality Committee and Group Board	Reasonable	Second - Management
6	Reporting on clinical audit plans to Site quality groups and to Quality Committee	Reasonable	Second - Management
7	Reporting on ward accreditation through IQPR	Reasonable	Second - Management
8	Regular reporting on IPC to Executive, Quality Committee and	Reasonable	Second - Management
9	External NHS England data on vaccination rates	Weak	Third - External
10	Tracking action plans developed in response to external reviews	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Flow through hospitals, discharge and pressures on ED
2	Quality governance in maternity at SGUH in response to CQC findings
3	Review our wider quality governance arrangements across the Group to identify strengths, weaknesses and gaps
4	Patient Safety Incident Response Framework implementation
5	Safety culture, including culture of psychological safety and raising concerns
6	Systematic learning from Never Events
7	Visibility of Getting It Right First Time (GIRFT) findings, data and actions
8	Consistent delivery of fundamentals of care
9	Availability of ITU beds
10	Out-of-date clinical policies and inconsistency across Group
11	Paper records at ESTH
12	Quality of the Trusts' estates

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Increasing financial pressures	• Closer collaboration with system partners to develop integrated care approaches across primary, secondary, community and mental health settings.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and secure Group Board approval of new Group quality and safety strategy	GCMO/GCNO	Jul-24	On Track
2	Fully embed Patient Safety Incident Response Framework across the Group and develop PSIRF maturity	GCMO/GCNO	TBC	TBC
3	Develop and implement Group-wide approach for dissemination of learning from incidents	GCMO/GCNO	TBC	TBC
4	Implement strategic initiatives on culture (inc. safety culture, culture of psychological safety)	GCMO/GCNO	Mar-28	TBC
5	Develop plans with system partners for addressing pressures on ED	MDs / GCEO	TBC	TBC
6	Bring together and strengthen maternity governance arrangements together across the Group	GCNO	TBC	TBC
7	Implement improvements to quality governance framework (inc. embedding Group-wide management forums on quality and concerns)	GCMO/GCNO	TBC	TBC
8	Implement strategic initiative on strengthening specialised services at SGUH	GCMO/GCNO	Mar-28	Off Track
9	Implement strategic initiative on developing a shared electronic patient record across the Group	GCEO	Mar-28	Off Track
10	Implement strategic initiative on Building Your Future Hospitals Programme	MD-ESTH	Mar-28	Off Track

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising Flow
SGUH	CRR-2240	20	Long wait for elective cardiology procedures
SGUH	CRR-2681	16	Industrial action
SGUH	CRR-2606	16	Consent
SGUH	CRR-2174	16	Midwifery staffing
SGUH	CRR-1626	15	Wrong blood in tube

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1942	20	Waiting times
ESTH	CRR-1946	20	Cancer diagnostic waits
ESTH	CRR-1937	20	Children & Adolescent Mental Health Services
ESTH	CRR-1943	16	Emergency department flow
ESTH	CRR-1948	16	Caring for adult mental health patients in ED
ESTH	CRR-1938	15	Out of Hours Services

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

Strategic Risk	SR10	Improving patient experience

Current Risk Score: 16

Assurance: Limited

Cause	Risk	Effect
If we do not equip our staff to make improvements in their services and build effective relationships with patient groups…	*…then we will not deliver improvements in the quality, effectiveness and efficiency of our services…*	*…resulting in lower quality of care, increased risk of harm, and less efficient services.*

Strategic objective	Right Care, Right Place, Right Time
Last review date	23 January 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Nursing Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-24	4	4	16	Limited
Target	Mar-25	4	3	12	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	16											

Key controls *What are we already doing to manage the risk?*	
1	Patient involvement and experience groups established at each Trust
2	Established complaints and PALS teams
3	Data on key patient experience metrics gathered and tracked
4	Action plans in response to national patient experience surveys
5	Established focus on support for veterans
6	Patient stories to the Group Board

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Reporting on this through quality management forums and in patient experience reporting to Quality Committee.	Reasonable	Second - Management
2	Reporting of complaints to quality management forums and in complaints and PALS reporting to Quality Committee.	Weak	Second - Management
3	Friends & Family Test and complaints data presented to quality management forums, Quality Committee and Group Board	Reasonable	Second - Management
4	Presented to quality management forums & Quality Committee	Reasonable	Second - Management
9	Veterans Covenant Healthcare Alliance accreditation for ESTH	Good	Third - External
9	Patient story taken at each group Board meeting	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Develop strategic approach to improving patient engagement
2	Improve outpatients experience
3	Improve patient experience through moving to electronic patient records
4	Improve data collection relating to patients with protected characteristics
5	Strengthen staffing of complaints teams and standardise complaints processes across Group
6	Improve complaints performance (timeliness and quality of responses)
7	Recruitment of additional volunteers
8	Secure SGUH veterans accreditation
9	Ensure audit compliance with Accessible Information Standard
10	Raise profile of patient engagement groups
11	Identify and disseminate good practice across teams on patient engagement

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• TBC	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and secure Group Board approval for quality and safety strategy, including strategic vision for patient engagement	GCMO/GCNO	Jul-24	On Track
2	Deliver strategic initiative on outpatient transformation	GCMO	Mar-28	Off Track
3	Deliver strategic initiative on a shared electronic patient record across the Group	GCEO	TBC	TBC
4	Improve the quality of the data recording by, and data sets used, across the Group	GCMO	TBC	TBC
5	Strengthen complaints teams through Group-wide corporate restructure	GCNO	May-24	On Track
6	Develop and implement plans to recruit additional volunteers	GCNO	TBC	TBC
7	Deliver SGUH silver aware for veterans and embed Armed Forces Community Project at ESTH	GCNO	TBC	TBC
8	Develop staff training and support for managers to gain real time data for their areas to support and promote patient involvement	GCNO	TBC	TBC
9	Launch engagement award for teams to celebrate projects codesigned and coproduced with patients	GCNO	TBC	TBC
10	Deliver customer service training to staff	GCNO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Strategic Risk	SR11	Tackling health inequalities

Cause	Risk	Effect
If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution…	*…then we will fail to play our part in improving the health of our local population…*	*…resulting in less equitable access to care and poorer outcomes.*

Current Risk Score: 16

Assurance: Limited

Strategic objective	Right Care, Right Place, Right Time
Last review date	23 January 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-24	4	4	16	Limited
Target	Mar-25	4	3	12	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	16											

Key controls *What are we already doing to manage the risk?*	
1	Group strategy identified health inequalities as key priority for Group
2	Analysis of planning guidance and NHSE statement of information on health inequalities
3	Appointment of lead to undertake initial analysis of health inequalities in ED and outpatients across the Group
4	Recording of data

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Addressing health inequalities incorporated into strategy and focused Board development sessions held Oct-22 and Apr-23	Reasonable	Second - Management
2	Requirements on Trusts in planning guidance presented to Quality Committee in November 2023	Reasonable	Second - Management
3	Health inequalities analysis presented to and discussed by the Quality Committee in November 2023	Reasonable	Third - External
4	Data presented in IQPR but does not include data on health inequalities and ethnicity	Weak	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Improve quality of data collection in relation to ethnicity and other important demographic or protected characteristic information
2	Group-wide governance to support focus on health inequalities
3	Regular reporting on health inequalities
4	Review of patient involvement from health inequalities perspective

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• TBC	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Improve the quality of the data recording by, and data sets used, across the Group	GCMO	TBC	TBC
2	Identify priority areas in planned care waiting lists for initial focus	GCMO	TBC	TBC
3	Address unplanned and emergency care high intensity service users	GCMO	TBC	TBC
4	Establish a GESH Group Health Inequalities Steering Group reporting into the newly formed GESH Quality Group	GCMO	Apr-24	On Track
5	Establish GESH Community of Interest / Health Inequalities Forum for service areas to share learning, good practice and resources	GCMO	Apr-24	On Track
6	Provide quarterly health inequalities update report to the Quality Committee	GCMO	Mar-24	On Track
7	Take up offer from Optum UK, leading health services and innovation company, to provide free development sessions on health inequalities	GCMO	TBC	TBC
8	Improve research study recruitment to ensure patients from minority ethnic backgrounds are appropriately represented in clinical research	GCMO	TBC	TBC
9	Adapt clinical audit and effectiveness to shed light on health inequalities as manifested by differences in access or outcomes	GCMO	TBC	TBC
10	Strengthen patient involvement to recruit service users who can bring particular perspectives on inequalities to help shape services	GCMO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

Strategic Risk	SR12	Putting staff experience and wellbeing at the heart of what we do

Cause	Risk	Effect
If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level…	*…then our staff will be unable to perform to their best and may not feel fairly treated…*	*…resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Empowered, Engaged Staff
Last review date	16 January 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-24	4	5	20	Limited
Target	Mar-25	4	4	16	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Well developed staff support programmes in place across Group
2	Board level Wellbeing Guardian in place at both Trusts
3	Established ESTH and SGUH leadership development programmes
4	GESH 100 leadership forum in place
5	Staff induction in place at both Trusts
6	Employee Relations Service Improvement Plan in place
7	Culture programme in place (including leadership culture, psychological safety, and openness to change)
8	Group-wide Continuous Improvement team established and in place
9	Established ESTH and SGUH Quality Improvement programmes

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Delivery of staff support is reviewed by People Committee	Good	Second - Management
2	Approved by the two Boards; Wellbeing Guardian is a member of People Committee.	Good	Second - Management
3	Outputs reviewed locally and by HR	Weak	First - Operational
4	Positive feedback from staff involved in inaugural GESH100	Reasonable	Second - Management
5	Programme of induction events monitored by HR	Reasonable	First - Operational
6	Delivery of the ER Plan monitored by People Committee	Reasonable	Second - Management
7	Overseen by Group CEI Programme Board, Executive and People Committee	Reasonable	Second - Management
8	CI team established	Good	First - Operational
9	Outputs from QI reviewed at Site, Executive and Committee.	Weak	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Leadership development for managers
2	Capacity of HR services, inc. fragility of Employee Relations functions at SGUH and ESTH
3	Quality of staff appraisals, and linking of appraisals and objectives to Group strategy at every level
4	Quality of the estates infrastructure
5	Quality of IT infrastructure
5	Issues with Payroll
6	Up-to-date and accessible HR policies refreshed on Group-wide basis
7	Group-wide approach to Continuous Improvement and capacity of staff to engage with CI
8	Staff awareness of Group strategy and vision for Continuous Improvement

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Fragility of HR	• Results of 2023 NHS Staff Survey • Group-wide communications approach • Launch of the Disability Advice Line

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy in support of the Group strategy	GCPO	May-24	On Track
2	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	TBC	TBC
3	Develop and implement Group-wide talent management programme	GCPO	TBC	TBC
4	Deliver Strategic Initiative on High Performing Teams	GDCEO	TBC	TBC
5	Implement fully the Employee Relations Service Improvement Plan	GCPO	TBC	TBC
6	Improvements in estate through agreed capital plan	GCIFEO	TBC	TBC
7	Improvements in IT infrastructure through agreed capital plan	GCFO	TBC	TBC
8	Implement changes to appraisals and objective setting to align with new Group strategy	GCPO	TBC	TBC
9	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff	GCPO	TBC	TBC
10	Develop and deliver programme to embed CI at organisational, team and individual level in line with Group Strategy	GDCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2530	16	Appraisal rates
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1929	16	Senior leadership capacity
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-1935	16	Appraisals
ESTH	CRR-150	16	Mandatory and Statutory Training
ESTH	CRR-2072	16	Payroll provision
ESTH	CRR-2071	20	People Directorate

Strategic Risk	SR13	Fostering an inclusive culture that celebrates diversity

Cause	Risk	Effect
If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination…	*…then our staff will not feel valued, empowered or psychologically secure…*	*…resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Empowered, Engaged Staff
Last review date	16 January 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-24	4	5	20	Limited
Target	Mar-25	4	4	16	Reasonable

Change since last review

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Group and Site-based CEI Programme Boards in place
2	Big 5 priorities with clear programmes established and matured
3	Civility and Psychological Safety programme well established
4	Workforce Race Equality Standard Action Plan developed
5	Workforce Disability Equality Standard Action Plan developed
6	Framework for raising concerns in place with FTSU Guardians in place across the Group and Raising Concerns Group established
7	Staff networks in place at both Trusts
8	NHS Staff Survey Results reviewed systematically with action plans developed
9	Established values in place at each Trust

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Groups meeting regularly and monitoring progress	Reasonable	Second - Management
2	Regular reporting of progress against Big 5 to People Committee, and analysis of impact against Staff Survey results	Reasonable	Second - Management
3	Regular reporting of progress against CAPS to People Committee, and analysis of impact against Staff Survey results	Reasonable	Second - Management
4	Regular reporting of progress against WRES action plan to People Committee	Reasonable	Second - Management
5	Regular reporting of progress against WDES action plan to People Committee	Reasonable	Second - Management
6	Regular reporting of concerns raised through FTSU considered at People Committee and Group Board	Reasonable	Second - Management
7	Networks meet regularly and programme of Board engagement with network chairs	Reasonable	Second - Management
8	Review of NHS Staff Survey results through Executive, People Committee and Group Board	Reasonable	Second - Management
9	Monitored by Site, Executive and People Committee	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Focus on high impact equality, diversity and inclusion actions
2	Diversity of the two Boards and senior leadership
3	Clear programme of talent management
4	Differences in values between the two Trusts – need for alignment
5	Strengthen staff networks
6	Strengthening arrangements for raising concerns
7	Reviewing approach to addressing bullying and harassment
8	Improve position in relation to violence and aggression standards

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Compliance against national NHSE EDI Plan • NHS Staff Survey Results 2023	• Board recruitment in 2024/25 • NHS Staff Survey Results 2023

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and implement a two-year People strategy in support of the Group Strategy	GCPO	May-24	On Track
2	Develop and implement single Group-wide WRES and WDES action plans, focused on high impact actions	GCPO	Oct-24	On Track
3	Undertake forthcoming Board recruitment with focus on diversity	GCEO	Dec-24	On Track
4	Clarify Executive sponsorship of staff networks and align networks arrangements across the Group	GCPO	TBC	TBC
5	Develop and implement a Group-wide talent management programme	GCPO	TBC	TBC
6	Develop plan for aligning values across the Group	GCPO	TBC	TBC
7	Develop Group-wide Raising Concerns policy in line with new national raising concerns policy	GCCAO	Apr-24	On Track
8	Develop a Group-wide Raising Concerns strategy in line with good practice from NGO building on SGUH FTSU strategy	GCCAO	Jul-24	On Track
9	Deliver plans for improvement of Trusts' positions in relation to the NHSE Violence Prevention and Reduction Standard	GCIFEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-1967	16	Diversity in senior management positions
SGUH	CRR-881	16	Bullying and harassment of staff
SGUH	CRR-1978	16	Raising concerns
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1933	16	Protected characteristics
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-2070	16	Raising concerns
ESTH	CRR-2073	20	Harmonisation of staff T&Cs following TUPE

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

Strategic Risk	SR14	Developing tomorrow's workforce

Current Risk Score: 20

Assurance: Limited

Cause	Risk	Effect
If we do not retain, train and transform our workforce for the future…	*…then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff…*	*…resulting in lower quality and less efficient services for patients, and higher staffing costs.*

Strategic objective	Empowered, Engaged Staff
Last review date	16 January 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	5	20	Limited
Current	Jan-24	4	5	20	Limited
Target	Mar-25	4	4	16	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Existing Trust-based workforce strategies in place w/retention targets
2	Existing Trust-based education strategies in place
3	SWL Recruitment established to support recruitment – SLAs in place
4	International recruitment processes in place
5	Corporate induction for all new starters
6	Establishment of Joint Bank
7	Policies on flexible working in place
8	Vacancy Control Panels in place to help manage spend
9	Skills gap analysis and review of new roles and the training pathways to implement these

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Recruitment & retention data reported regularly to People Committee	Reasonable	Second - Management
2	Regular reports to People Committee on undergraduate education, training, and MAST compliance	Reasonable	Second - Management
3	Oversight of delivery of SWL Recruitment of key SLAs by APC and Trusts.	Reasonable	First - Operational
4	Monitored by People Management Group	Reasonable	First - Operational
5	Monitored by People Management Group	Reasonable	Second - Management
6	Monitored by People Management Group, Executive and People Committee	Reasonable	Second - Management
7	SGUH IA on homeworking (reasonable).	Reasonable	Second - Management
8	Oversight by Site and Executive leadership teams	Reasonable	Second - Management
9	Monitored by People Management Group	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Leadership capability and capacity
2	Talent management programme
3	Quality of appraisals
4	Strengthening rostering particularly for medical staff
5	Maximising the Apprenticeship Levy
6	Supporting the development of new roles
7	Strengthening Employee Relations

Emerging risks and opportunities
What else is relevant to how we managing the risk?

Emerging risks	Emerging opportunities
• Nationally, 112,000 unfilled job vacancies due to challenging labour market conditions	• Create a competitive advantage through a more engagement people experience • Use workforce analytics to make the most of our talent • Use of HR and technology to improve people experience • Engage easily with flexible talent • Relationship with City University

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy as a sub-strategy of the Group strategy	GCPO	May-24	On Track
2	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	Mar-25	TBC
3	Develop and implement Group-wide talent management programme	GCPO	Mar-25	TBC
4	Increase completion rate for and quality of appraisals	GCPO	Mar-25	TBC
5	Implement fully the Employee Relations Service Improvement Plan	GCPO	Mar-25	TBC
6	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff	GCPO	Mar-25	TBC
7	Apprenticeship Levy	GCPO	Mar-25	TBC
8	GCEO leadership of London-wide programme of work on future workforce	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2533	16	Workforce recruitment
SGUH	CRR-2534	16	Workforce retention
SGUH	CRR-1684	16	Junior doctor vacancies
SGUH	CRR-2344	16	Shortage of anaesthetic consultants
SGUH	CRR-2174	16	Midwifery staffing
SGUH	CRR-2530	16	Appraisal rates
SGUH	CRR-1036	16	Apprenticeship levy
SGUH	CRR-2681	16	Industrial action

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1930	16	Medical staffing
ESTH	CRR-2103	15	Nurse staffing
ESTH	CRR-1935	16	Appraisals
ESTH	CRR-150	16	Mandatory and Statutory Training
ESTH	CRR-2073	20	Harmonisation of staff T&Cs following TUPE
ESTH	CRR-2075	16	Apprenticeship levy
ESTH	CRR-2149	16	Industrial action

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

APPENDIX 1: SGUH Finance BAF Risk

Strategic Risk	SR4	Achieving financial sustainability – St George's University Hospitals

Cause	Risk	Effect
If we do not manage costs effectively, optimise productivity, and ensure our activities are effective…	*…then we will not return to financial balance…*	*The poor use of public funds and unsustainable services for patients.*

Current Risk Score: 25

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jan-24	5	5	25	Limited
Target	Mar-25	5	4	20	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	25											

Key controls *What are we already doing to manage the risk?*	
1	Managing income and expenditure in line with budget.
2	Ensuring there is an effective financial control environment.
3	CIPs. Identifying and delivering actions to improve the financial position.
4	Robust understanding of cost structures and productivity.
5	Maintaining a five year forward view.
6	Maintaining the capacity and capability of the finance team.
7	Capital: clear view of future capital needs and how to meet them
8	Robust processes to forecast and manage cash.
9	Maintaining an effective procurement environment
9	External engagement with SWL, London and national finance teams.

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Financial performance is in line with budget/plan	Reasonable	First - Operational
2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Weak	First - Operational
4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	A five year "long term financial plan" is in place	Weak	Second - Management
6	Clearly defined statement of how demands on dept are meet by available resources.	Reasonable	Second - Management
	Detail available of prioritised capital need together with available funding.	Weak	Second - Management
7	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
8	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Reasonable	Second - Management
9	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Enhance level of financial support and challenge – esp embed at budget holder level
2	Greater emphasis on the identification and delivery of CIPs.
3	Improve understanding and actions to address variance in benchmarking
4	Improve understanding and actions to address productivity
5	Clear trajectory to return to financial balance
6	Build a five-year model
7	Capital funding is insufficient to meet identified known investment needs; BAU and dev
8	Review finance team capacity and capability in respect of current agenda
9	Continued focus on cashflow forecasting and engagement with NHSE
10	Increase communication on and integration of finance into wider agenda (not separate)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Uncertain planning environment for 24/25. • Scale of financial challenge and time allowed to recover. • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding	• Working across the Group. • Working across the SWL system.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Enhanced weekly budget review with SLT leads and divisions underway	MD-SGUH	May-24	On Track
2	CIPs: Plan required to embed CIP development into current range of management meetings	MD-SGUH	Apr-24	TBC
3	Detailed review performance against key benchmark data, explain or address variance	GCFO	Apr-24	TBC
4	Detailed review performance against key productivity data, explain or address variance	MD-SGUH	Apr-24	TBC
5	Work with SWL and London CFOs to agree trajectory to return to financial balance	GCFO	Mar-26	TBC
6	Develop a 5-year financial model; two stages rapid high-level view and then detailed LTFM	GCFO	Sep-24	TBC
7	Explore alternate sources for funds. Where not possible identify non-capital mitigations to known risks	MD/GCFO	Apr-24	TBC
8	Revised departmental structure	GCFO	Mar-24	TBC
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management	GCFO	Mar-25	On Track
10	Increase communication on finance maintaining open communication while maintaining engagement	GCFO	Mar-25	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-1085	25	Managing an effective control environment
SGUH	CRR-1865	20	Identifying and delivering CIPs
SGUH	CRR-1411	20	Managing I&E within budget
SGUH	CRR-1414	16	Five-year financial model
SGUH	CRR-1416		Future cash requirements are understood
SGUH	CRR-2495		Elective Recovery Fund

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

APPENDIX 2: ESTH Finance BAF Risk

Strategic Risk	SR4	Achieving financial sustainability – Epsom & St Helier University Hospitals

Cause	Risk	Effect
If we do not manage costs effectively, optimise productivity, and ensure our activities are effective…	*…then we will not return to financial balance…*	*The poor use of public funds and unsustainable services for patients.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	20	Limited
Current	Jan-24	5	4	20	Limited
Target	Mar-25	5	4	20	Reasonable

Change since last review: ⟺

Risk Score	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24	Dec-24
	20											

Key controls *What are we already doing to manage the risk?*	
1	Managing income and expenditure in line with budget.
2	Ensuring there is an effective financial control environment.
3	CIPs. Identifying and delivering actions to improve the financial position.
4	Robust understanding of cost structures and productivity.
5	Maintaining a five year forward view.
6	Maintaining the capacity and capability of the finance team.
7	Capital: clear view of future capital needs and how to meet them
8	Robust processes to forecast and manage cash.
9	Maintaining an effective procurement environment
9	External engagement with SWL, London and national finance teams.

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Financial performance is in line with budget/plan	Reasonable	First - Operational
2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Reasonable	First - Operational
4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	A five year "long term financial plan" is in place	Reasonable	Second - Management
6	Clearly defined statement of how demands on dept are meet by available resources.	Reasonable	Second - Management
7	Detail available of prioritised capital need together with available funding.	Weak	Second - Management
8	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
9	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Reasonable	Second - Management
10	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Enhance level of financial support and challenge – esp embed at budget holder level
2	Challenge in continued emphasis on the identification and delivery of CIPs.
3	Improve understanding and actions to address variance in benchmarking
4	Improve understanding and actions to address productivity
5	Clear trajectory to return to financial balance
6	Need to revise the five-year model developed as part of BYFH refresh
7	Capital funding is insufficient to meet identified known investment needs; BAU and developmental
8	Review finance team capacity and capability in respect of current agenda
9	Continued focus on cashflow forecasting and engagement with NHSE
10	Increase communication on and integration of finance into wider agenda (not separate)

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Uncertain planning environment for 24/25. • Scale of financial challenge and time allowed to recover. • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding	• Working across the Group. • Working across the SWL system.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Continued weekly budget review with SLT leads and divisions underway	MD-ESTH	May-24	On Track
2	CIPs, work ongoing to identify new opportunities.	MD-ESTH	Apr-24	TBC
3	Detailed review performance against key benchmark data, explain or address variance	GCFO	Apr-24	TBC
4	Detailed review performance against key productivity data, explain or address variance	MD-ESTH	Apr-24	TBC
5	Work with SWL and London CFOs to agree trajectory to return to financial balance	GCFO	Mar-26	TBC
6	Develop a 5-year financial model; two stages rapid high-level view and then detailed LTFM. Aligns to refresh for BYFH	GCFO	Sep-24	TBC
7	Explore alternate sources for funds. Where not possible identify non-capital mitigations to known risks	MD/GCFO	Apr-24	TBC
8	Revised departmental structure	GCFO	Mar-24	TBC
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management	GCFO	Mar-25	On Track
10	Increase communication on finance maintaining open communication while maintaining engagement	GCFO	Mar-25	TBC

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1961	25	Inability to achieve long term financial sustainability due to inefficiencies of providing range of services across two 'subscale' acute sites, contributing to an increasing underlying structural deficit
ESTH	CRR-1960	25	Inability to undertake the required capital investment programme with the SWL capital programme CDEL limits