Group Board

Agenda

Meeting in Public on Thursday, 02 May 2024, 10:00 – 12:55

Tooting and Balham Rooms, Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ

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

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:15	2.1a	Quality Committees-in-Common Report	Committee Chair	Assure	Report
	2.1b	Quality Committees-in-Common Annual Report to the Group Board	Committee Chair/GCCAO	Approve	Report
10:35	2.2a	Finance Committees-in-Common Report	Committee Chair	Assure	Report
	2.2b	Finance Committees-in-Common Annual Report to the Group Board	Committee Chair/GCCAO	Assure	Report
10:55	2.3a	People Committees-in-Common Report	TW	Assure	Report
	2.3b	People Committees-in-Common Annual Report to the Group Board	TW/GCCAO	Approve	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:15	3.1a	Group Maternity Services Quality Report February - March 2024 data	GCNO	Review	Report
	3.1b	Maternity and Neonatal Safety Champions	GCNO	Review	Report
11:30	3.2	Integrated Quality and Performance Report	GDCEO	Review	Report
11:45	3.3	Group Financial Performance Year End 23/24	GCFO	Review	Report

Items for Decision					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:55	4.1	Our priorities for 2024/25	GDCEO	Approve	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:05	5.1	GESH Gender Pay Gap Report	GCPO	Note	Report
12:10	5.2	GESH Learning from Deaths Quarterly Report: Q2 (July -Sept) and Q3 (Oct – Dec) 2023/24	GCMO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:15	6.1	New Risks and Issues Identified	Chairman	Note	Verbal
	6.2	Any Other Business	All	Note	Verbal
	6.3	Reflections on the Meeting	Chairman	Note	Verbal
12:25	6.4	Patient / Staff Story	GCNO	Review	Verbal
12:55	-	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
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Derek Macallan	Non-Executive Director - ESTH	DM
Andrew Murray	Non-Executive Director – ESTH / 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
Tim Wright	Non-Executive Director – SGUH	TW
In Attendance		
Patricia Morrissey	Interim Deputy Director Corporate Affairs	IDDCA
Anna Macarthur	Group Chief Communications & Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy	GDOS
Apologies		
Yin Jones^	Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – SGUH & ESTH	PK
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Observers		
John Hallmark	Public Governor - Wandsworth	JH

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, 08 March 2024, 09:45 – 13:00

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director – ESTH / SGUH, Vice Chair SGUH	AB
James Blythe^	Managing Director – ESTH	MD-ESTH
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Martin Kirke	Non-Executive Director – ESTH and Vice Chair	MK
Derek Macallan	Non-Executive Director – ESTH	DM
Ralph Michell	Group Director of Strategy *(deputising for the GDCEO)*	GDS
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Angela Paradise*^	Group Chief People Officer	GCPO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – St George's	MD-SGUH
Phil Wilbraham*	Associate Non-Executive Director	PW
IN ATTENDANCE		
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Patricia Morrissey	Interim Deputy Director of Corporate Affairs	IDDCA
Carolyn Cullen	Interim Corporate Governance Manager (Minutes)	ICGM
APOLOGIES		
Tim Wright	Non-Executive Director - SGUH	TW
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
OBSERVERS		
Alfredo Benedicto	SGUH Appointed Governor, HealthWatch Merton	AB
Fay Greenway	Consultant Neuro-Surgeon SGUH	FG
John Hallmark	SGUH Public Governor Wandsworth	JH
Julian Ma	SGUH Appointed Governor, St George's University of London	JM
Jackie Parker	SGUH Public Governor, Wandsworth	JP
Cllr Peter McCabe	Merton Council	PMcC

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

Feedback from Board Visits

Board members provided feedback from visits undertaken across St George's Hospital. These included: the Neurological Day Unit, Cavell Medical Ward, Florence Ward, Neurological Intensive Care Unit, Majors A and B in the Emergency Department and the Medical Physics Department.

Neurological Day Unit (Jenny Higham and MD-ESTH)

JH described the ward as well organised and welcoming. The ward saw 40-50 patients a day, undergoing a mix of planned and emergency care. Patients attending for planned care would sometimes need to wait when emergencies came in. Issues around pre-operative checks were highlighted as sometimes leading to cancellations and inefficiencies. The MD-ESTH agreed that the pre-operatives checks for lists that day should, if possible, be done the day before an operation, to improve list efficiency. The MD-SGUH stated that she would look into how pre-operative checks were being managed and scheduled.

Cavell Medical Ward (Martin Kirke and MD-IC)

MK stated that, although staffing was stable, the ward relied on the Staff Bank to cover shifts. The patient cohort that the ward treated required a high proportion of one-to-one nursing care. An improvement over the last year has been deployment of mental health nurses on the ward, which had greatly improved the standard of care. The MD-IC commented that many of the patients would be better placed in the community, but there was a lack of community placements available. Delayed discharge was an issue on the ward, with one patient still on the ward who had been ready for discharge in January.

Florence Ward – Head & Neck (Chairman, GCMO and GCCAO)

The GCMO reported that Board members had spoken to two international nurses on the ward about their experience in joining and working in the Trust. The nurses had commented on the welcome and support they had received and felt that had assimilated well onto the ward. Nurses referred to excellent support from Macmillan Cancer Support, psychologists and speech and language specialists who worked with patients on the ward. The atmosphere was positive and multi-disciplinary appeared to be working well. The Chairman had talked to a healthcare assistant on the ward and reported that HCAs enjoyed their work. However, with only two HCAs on the ward when a patient required intensive support, the other HCA needed to cover the rest of the ward. The Chairman had also spoken to first year medical students working on the ward, who had been were very positive about the experience. The GCCAO commented that staff had highlighted discharge as one of the biggest challenges and Board members had spoken to a local authority social worker who was visiting the ward that morning.

Neurological Intensive Care Unit (Ann Beasley, GCEO and GCNO)

AB observed that the unit was very calm and professional. The visit had been unannounced which AB felt was unfair on the unit, but commented that the staff were very welcoming and open. The GCNO explained that all CQC visits were unannounced, so this was a good way of preparing staff for the CQC. The Chairman stated that the merits of announced versus unannounced visits would be debated at a forthcoming Group Board Development session. The GCEO commented that nurse staffing on the ward was stable with a low turnover. Overall, the unit was impressive and well managed.

Majors A and B, Emergency Department (Yin Jones, Andrew Murray)

AM stated that Majors A and B were well managed if high pressure areas. One patient had been waiting 30 hours for a bed which highlighted some of the intense pressures patients and staff were facing. AM had observed a staff huddle and commented on the calibre of the leadership. YJ added that staff had commented on there being insufficient computers as well as problems with wifi. There were also issues with lighting (making the area dark) which had been reported to Estates as high priority but which had not yet been rectified.

Medical Physics Department (Derek Macallan and GCPO)

Derek Macallan explained that the Medical Physics was where hospital equipment was repaired. Staff working in the department were highly skilled engineers and craftsmen. The department saved the hospital many thousands of pounds per annum in keeping medical equipment safely in service. Of concern was the amount of work and storage space that was available. The GCPO was impressed by the expertise but concerned about the working conditions in this cramped area. Staff had raised the implications of the Group model for working with counterparts in ESTH, which represented an opportunity, although the SGUH service was considerably larger than their ESTH equivalent.

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies from Tim Wright, Non-Executive, and James Marsh, Group Deputy Chief Executive Officer. Ralph Michel was deputising for the GDCEO for items relating to strategy. The Chairman drew attention to it being International Women's Day and took the opportunity to highlight the work of Alicia Erauncetamurguil, the current chair of the SGUH Women's Staff Network. Alicia would be standing down from her role on the Network after Easter and the Chairman acknowledged and thanked Aliciafor her significant contribution in supporting women at the Trust. The Chairman informed the Board that Jenny Higham, Non-Executive Director and Vice Chancellor of St George's University of London (SGUL), would be taking up the post of Vice Chancellor of the University of Suffolk later in the year. The Chairman congratulated Jenny on her new appointment and thanked her for leading SGUL through its merger with City University and for her significant and longstanding contribution to the SGUH Board.	
1.2	**Declarations of Interests**	
	The outstanding interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Angela Paradise and Arlene Wellman as Executive Directors. There were no additional declarations of interest.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 12 January 2024 were approved as a true and accurate record, subject to recording that AM had commenced his appointment as a Non-Executive Director at ESTH on 1 February 2024 alongside his role at SGUH.	
1.4	**Action Log and Matters Arising**	
	The three items included on the action log were not yet due for action.	

1.5	**Group Chief Executive's Officer (GCEO) Report**
	The GCEO updated the Group Board on the following: • **Two-year anniversary of gesh:** February marked the two-year anniversary of the St George's, Epsom and St Helier University Hospitals and Health Group. Work on integration of Group-wide corporate services was progressing. Communications, Corporate Affairs and the Deputy Chief Executive's functions had implemented integrated structures. Phase one of the nursing consultation was progressing and corporate medical, people, finance, information technology, and parts of estates and facilities would developed integrated corporate teams over the course of the next year. • **Martha's Rule:** Implementation of the new nation-wide initiative would commence in April. Patients and their families in England would have the right to request a rapid second opinion if they were concerned about a condition worsening. The Group Board welcomed and supported the initiative. • **Principal Treatment Centre for Paediatric Cancer in South London :** NHS England (NHSE) had advised that a decision would be made on 14 March on the future of paediatric cancer services in south London, following the public consultation which had closed on 18 December 2023. • **ESTH CQC Maternity Inspection:** The overall rating for maternity services at both Epsom Hospital and St Helier Hospital had been lowered from 'Good' to 'Requires Improvement', following the CQC inspection in August 2023. Reasons for the rating were related to staffing, triage and governance processes and the hospital's ageing estate, particular at St Helier. In contrast, results from the 2023 CQC Maternity Experience Survey showed that maternity teams across the Group had scored very highly for the patient experience of the care given to women and their babies. • **Staff news:** Natilla Henry had been appointed as the first Group Chief Midwifery Officer. Andrew Ashbury, Group Chief Infrastructure, Facilities and Infrastructure Officer had moved to another role outside the organisation and Ian Robinson had been appointed to cover the role on an interim basis while a recruitment to fill the position substantively was undertaken. **The Group Board noted the Group Chief Executive's Report.**
2.0	**ITEMS FOR ASSURANCE**
2.1	**Quality Committee-in-Common Report**
	Andrew Murray, Chair of the Quality Committees-in-Common, presented the key issues considered by the Committee at its meeting in January 2024 and drew particular attention to the following: • **Maternity Services**: The Committee had reviewed the two Trusts' compliance against the 10 Safety Actions in the Maternity Incentive Scheme (MIS), prior to review by the Group Board and final submission to NHS Resolution in January 2024. ESTH was able to demonstrate full compliance with the MIS and would qualify for the rebate on its Clinical Negligence Scheme for Trusts (CNST), estimated to be worth around £1.2m. SGUH was unable to demonstrate compliance with Safety Action 5

	(midwifery workforce), but with approval of investment by the Group Board, would be able to demonstrate compliance in relation to Safety Action 3 (transitional care). This meant that the Trust was non-compliant with the MIS for 2023/24 and was at risk of not qualifying for the CNST rebate. • **Surgical Pathway Never Events**: The Committee reviewed Never Events in surgical pathways since 2021 and were assured that the remedial actions take in response to wrong site nerve blocks at ESTH had been addressed. The Committee heard that a review at SGUH by the Association for Perioperative Practice (AfPP), which had been commissioned by the GCMO following Never Events in theatres, had identified a number of areas where significant improvements were needed. The Trust had recently received the report from the AfPP and the Committee would review the report and action plan at its meeting in April 2024 and would seek assurance that appropriate actions were being taken. • **Complaints:** The Committee reviewed bi-annual report on complaints and the Patient Advice and Liaison Service. While commending SGUH performance in its timeliness of responding to complaints, the Committees were concerned at ongoing performance challenges at ESTH. The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion: • The GCMO stated that a number of actions had already been taken to address the issues identified in the AfPP report. The Quality Committee Would monitor the progress and impact of the action plan. • PW asked how the progress to transition from the Serious Incident (SI) Framework to the Patient Safety Incident Response Framework (PSIRF) was going. AM stated that the first incident reporting using PSIRF would be considered at the March meeting of the Quality Committees-in-Common. PSIRF reporting would be included in IQPR reports from April onwards. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in January 2024.**	
2.2	**Finance Committees-in-Common**	
	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committee at its meetings on 26 January and 1 March 2024, and highlighted the following: • **Financial Planning 2024/25:** Committee members noted that financial planning guidance had not yet been issued. • **Ambulance handover at 45 minutes:** Committee members noted the patient safety risks associated with the 45 minute handover arrangements given the intense pressures on emergency departments across the Group. • **Integrated Quality and Performance Report:** Non-elective pathways continued to be under significant pressure at both Trusts. ESTH achieved the revised 4-hour ED standard in January 2024, reporting 76.1% compliance. At SGUH, 4-hour performance declined to 69.1% which reflected a challenging month and a high number of patients waiting for beds in both the emergency department and in inpatient areas. Both Trusts reduced the numbers of patients waiting for more than 52 weeks to	

	commence definitive treatment. However, the 65-week wait at ESTH was increasing due mainly to industrial action and delays to insourcing plans for Gynaecology and Community Paediatrics. At SGUH, the number of patients waiting over 65 weeks was exceeding plan. Neurosurgery was a specialty of particular concern. AB assured Board members that all potential 65-week breaches were being scrutinised weekly by management. The Chairman commented that industrial action had had an impact on the length of waiting lists, on patients and on staff. The GCEO added that administrative and clerical staff, who were responsible for re-arrange appointments cancelled due to industrial action, were under particular pressure and had received verbal abuse from patients. The GCEO stated that she wanted to take this opportunity to thank all staff for stepping-up and keeping the Group's hospitals functioning and safe. **The Group Board noted the issues escalated by the Finance Committees-in-Common and noted the wider issues on which the Committees received assurance at their January and March meetings.**	
2.3	**People Committees-in-Common**	
	Yin Jones, Joint Chair of the People Committees-in-Common, set out the key issues considered at its meetings in January and February 2024 and highlighted the following issues: • **Workforce Race Equality Standard (WRES) / Workforce Disability Equality Standard (WDES):** YJ stated that action plans continued to be monitored quarterly to ensure focus on equality, diversity, and inclusion (EDI). The Committee reviewed initial plans to prioritise work across the Group on EDI to maximise impact, as well as to bring together what had, until now, been separate Trust-specific WRES and WDES action plans into a single Group-wide action plan. The Group Board had been clear that it wanted to ensure actions were focused on the areas of highest impact and Group Board development discussion would be held later in the month to discuss this in more depth. • **Bullying and Harassment**: The Committee undertook a deep dive into actions being taken to address bullying and harassment, which had been recurrent themes in staff surveys. The Committee endorsed the introduction of a resolution pathway based on four stages from informal local resolution to formal investigation and action. • **Tackling Domestic Abuse and Sexual Violence Update:** The Committee was briefed on the actions being taken across the Group to tackle domestic abuse and sexual violence following the publication of the new Charter by NHS England. The Committees noted the national deadline for fully implementing the 10 pillars, outlined in the Charter, was July 2024. The Chairman asked whether the Trust would meet the deadline for implementing the new Charter and the GCNO stated that she was confident about meeting it. YJ asked the Board to delegate authority to the People Committees to approve both the annual Gender Pay Gap Report for publication on the Trust website by the end of March and the Equality Delivery System Report which were in the process of being collated and analysed.	

	The Chairman expressed concern that, for the second successive year, the Group Board was being asked to delegate authority to the People Committee authority to review and approve statutory reports that should be presented to the Board prior to publication. The Chairman added that the People Committee forward plan had scheduled a review of these reports in January 2024 and that delays in preparing the reports had created this situation. She asked that a publication timetable be drawn up for 2024/25 for all statutory people-focused reports so that the People Committee and Group Board could consider them in good time prior to publication. **The Group Board:** • **Noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in January and February 2024.** • **Agreed to delegate authority to the People Committees to approve the Gender Pay Gap and the Equality Delivery System were in the process of being collated and analysed for publication in March 2024.** • **Requested that a schedule of statutory people-focused reports be developed for the coming year so as to ensure time for appropriate consideration by the People Committee and Group Board prior to publication deadlines.**	**GCPO**
2.4	**Infrastructure Committees-in-Common**	
	Ann Beasley, Chair of the Infrastructure Committees-in-Common, set out the key issues considered at the meeting held on 18 February: • **Electronic Patient Record (EPR) implementation:** A progress update on implementing the shared EPR programme was given. The Committee discussed the assurances that would be required to agree a plan and timetable for go-live. • **Group Green Plan:** The Committee received an update on the Green Plan and welcomed the momentum and engagement with wider plans and partners across South West London. Members welcomed the imminent publication of the ESTH decarbonisation plan which would inform decarbonisation priorities across the Group. • **Capital restraints and impact on Estates and ICT programmes:** The Committee discussed how reduced levels of capital funding could be stretched to address the backlog of legacy maintenance issues and historical underinvestment in ICT and digital infrastructure. Both Trusts were undertaking a risk-based approach to prioritise how monies were invested. **The Group Board noted the issues escalated by the Infrastructure Committees-in-Common and the wider issues on which the Committees received assurance in February 2024**	
2.5	**SGUH Audit Committee**	
	Peter Kane, Chair of the SGUH Audit Committee, set 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 reviewed the process for the preparation of the 2023/24 Annual Report and Accounts.	

	The Group Communications Team would be coordinating the work on the Annual Report and would seek to align the style and content of the Annual Report for both trusts, recognising the differences in reporting requirements between NHS Trusts and NHS Foundation Trusts. The external audit had commenced in early February and no issues or concerns had been raised by the external auditors in their preliminary audit work. • **Internal Audit:** The Committee welcomed the significant progress on following up outstanding management actions from previous audits. However, the Committee noted that a number of planned internal audit reviews had been delayed, creating a backlog of reviews to be considered at its next meeting. The Committee 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 was subsequently been agreed by the Group Board in February 2024. **The Group Board noted the report of the Committee's meeting held on 1 February 2024.**	
2.6	**ESTH Audit Committee**	
	Peter Kane, Chair of the ESTH Audit Committee, set out the key issues discussed and agreed by the Committee at its meeting on 1 February 2024: • **Annual Report and Accounts:** The Committee noted the process for the preparation of the 2023/24 Annual Report and Accounts. The preliminary audit work for the annual audit of the Trust accounts had commenced in early February. • **Internal Audit:** The Committee welcomed progress in delivering the 2023/24 internal audit plan 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. • **Audit Committee meetings in 2024/25:** The Committee considered and endorsed a proposal for the ESTH Audit Committee to work as a Committees-in-Common with the SGUH Audit Committee, a recommendation which had subsequently been approved by the Group Board in February 2024. **The Group Board noted the report of the Committee's meeting held on 1 February 2024.**	
3.0	**ITEMS FOR REVIEW**	
3.1	**Integrated Quality and Performance Report**	

	Highlights from the Integrated Quality and Performance Report (IQPR) were provided for the month of January 2024. In relation to quality, there were no new MRSA infections in-month, bringing year-to-date cases to zero for SGUH, and two at ESTH. There were No Never Events reported in January 2024. SGUH declared 3 Serious Incidents (SIs) in January 2024: two in Obstetrics and one in Medicine (failure to monitor). The SI investigations were being undertaken to determine learning and what further actions can be taken to mitigate risks. Seven SI's were reported at ESTH in this period. In relation to operational performance, both Trusts continued to exceed trajectories to reduce the numbers of patients waiting for more than 52 weeks to commence treatment. ESTH had 830 patients waiting for more than 52 weeks at the end of December 2023, however this had reduced by 9% compared with November 2023. At SGUH, the number of patients waiting over 65 weeks was exceeding plan and was likely to remain challenged due to planned industrial action. Neurosurgery was a specialty of particular concern in this respect. Diagnostic performance at SGUH remained strong with 97.3% of patients receiving their diagnostic test within 6 weeks of referral in January 2024. ESTH continued to have many unplaced patients remaining in the emergency department, increased ambulance delays and high numbers of mental health patients requiring admission. Despite this, ESTH had achieved the revised 4-hour ED standard in January 2024, reporting 76.1% performance. At SGUH, 4-hour performance had declined to 69.1% which reflected 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. The 2-hour Urgent Community Response (UCR) was being maintained above the national standard (70%) for both Sutton Health and Care and Surrey Downs Health and Care. **The Group Board noted the report.**	
3.2	**Finance Report (Month 10, 2023/24)**	
	The GCFO set out the financial performance for Month 10 for each Trust. ESTH was reporting a deficit of £36.2m at the end of January, which was in line with plan. Cost Improvement Plan (CIP) delivery was £29.7m which was also on target while the cash balance was £14.88m. SGUH was reporting a deficit of £32.1m at the end of January, which was £11.3m adverse to plan. The shortfall was due to shortcomings in CIP delivery, baseline pressures and the impact of industrial action in December and January. At the end of Month 10, SGUH's cash balance was £7.1m so a cash request to NHSE for Quarter 4 had been submitted. **The Group Board noted the financial performance in month 10.**	
3.3	**NHS Staff Survey 2023**	
	The GCPO provided an overview of the results from the 2023 NHS Staff Survey at both Trusts, which had been conducted between 2 October and 24 November 2023. SGUH had recorded a 38% response rate and ESTH had achieved 49% at Epsom & St Helier. At SGUH, the initial results showed improvements in aspects of the Trust's Big 5 programme, for example, improvements in staff not experiencing physical violence from patients & colleagues, positive interest in staff health and well-being, respect from colleagues, constructive handling of disagreements and open communication with managers. It was a similar position	

	at ESTH where initial results showed that the Trust had seen improvements in almost all areas of its Big 5 programme. At ESTH, safer working was the workstream that showed the least improvement. In terms of areas which required further focus, at SGUH there was work to be done on values, flexible working, addressing incivility, promoting psychological safety, and developing compassionate and inclusive teams (especially teams with shared purpose and objectives). At ESTH, work was required to embed all elements of the Big 5 as well as in addressing development opportunities for administrative and clerical staff. The GCPO stated that the results would be analysed and local reporting developed so that teams could reflect on their own scores and develop priorities, interventions and action plans. The Chairman invited comments and questions from Group Board members and the following points were raised and noted in discussion: • The GCEO expressed disappointment with the low response rates, particularly at SGUH. However, she was pleased that there were improvements in in areas which had been a focus of the Big 5. The results demonstrated that the areas within the culture programme continued to be relevant to staff. • MK stated that, as part of the action planning, the Trusts should look at best practice across the NHS. The Picker analysis of the survey was very useful in identifying which trusts tackle specific issues well, and it was important the Group learned from good practice elsewhere. • The Chairman added that, in order to have the biggest impact, the action plans should focus on a smaller number of high impact initiatives than was the case last year. • While it was important to provide teams locally with their results, AM cautioned about the risks of breaking the data down below directorate level given there were a low response rates in some areas. **The Group Board:** • **Noted the high-level survey results** • **Noted the evaluation of the Big 5 of the Culture Programme** • **Noted the next steps**	
4.0	**Items for Decision**	
4.1	**Group Board Assurance Framework 2023/24**	
	The GCCAO introduced the new Group Board Assurance Framework (BAF) which set out the key risks to the delivery of the Group strategy, and the controls, sources of assurance, and actions to address gaps in control. The Group Board had developed its new Group BAF through a series of Group Board development sessions during 2023/24 and had approved the strategic risks at its meeting in November 2023. Other than strategic risks 1 to 3, which were reserved to the group Board, these risks had subsequently been reviewed by the relevant Board Committees ahead of the presentation of the full iteration of the Group BAF. For each strategic risk, the Group BAF set out: a current risk score and current assurance rating, alongside proposed target risk scores and assurance ratings which had been developed using the risk appetite statement that had been approved by the Group Board in November 2023. Significant work had been focused on the development of the Group BAF during 2023/24. The position	

	presented was an opening position, and the controls, assurances, gaps and actions would be iterated through the year following Committee review. Risks on the Corporate Risk Registers of the two Trusts had been aligned to the new Group BAF and a significant piece of work had recently commenced to align risk management processes and policies across the Group and undertake a fundamental review of the two Trusts' Corporate Risk Registers. The Chairman thanked the GCCAO for leading the Group Board through the process of agreeing the new Group BAF, which she considered to be a good document that reflected the agreed position of the Group Board. JH asked what reflections the GCCAO had about the process of developing the Group BAF. The GCCAO commented that one of the key areas of recognised good practice was engaging the Board in the development of strategic risks so that the BAF was owned by the Board. The process of developing the strategic risks through a series of Group Board development sessions had worked well. They key now was for the Group BAF to be a living document, regularly reviewed by the Group Board and Board Committees, and for this to help shape Board and Committee agendas. AB suggested that health inequalities represented the most important partnership risk. The GCMO responded that the Quality Committee would be considering the Trust's plans to play its role in tackling health inequalities at its next meeting and would review this on a regular basis over the coming year. **The Group Board:** • **Agreed the current risk scores and target scores for each strategic risk on the Group BAF.** • **Agreed the current and target assurance ratings for each strategic risk.** • **Noted the risks that have been reviewed by the relevant Committees.** • **Agreed the current and target risk scores, current and target assurance ratings, and actions to address gaps in control for the risks reserved to the Board.**	
5.0	**CLOSING ITEMS**	
5.1	**Any new risks and issues identified**	
	No new risks were identified.	
5.2	**Any other business**	
	There was no other business.	
5.3	**Reflections on meeting**	
	The Chairman asked YJ to give her reflections on the Board meeting, who offered the following observations: • The ward visit feedback had been useful in giving context to the discussions at the Board meeting. The ward visits were valuable. • The GCEO in her report had reminded the Group Board that it was two years since the formation GESH. YJ observed that the Group Board was working together well as a single entity, able to discuss items that related	

	to one trust or both with more knowledge and wisdom. YJ commented that she wanted to see more impetus towards Group-wide integration. At present, staff identifed with one trust more than another, but there is staff recognition of the Group. • The results of the NHS Staff Survey were important for the year ahead. YJ noted that Board members wanted to assess best practice from other trusts to frame the work about to be undertaken on action planning and this was welcome. • Overall, YJ thought it a well-balanced and effectively chaired meeting, giving appropriate time to matters of concern and for opinions and comments to be welcomed and heard.	
5.4	**Patient / Staff Story**	
	The Group Board welcomed Geoff Thomson to the meeting. Mr Thompson was a patient at SGUH who received surgery for prostate cancer. He was accompanied by Hassan Qazi (the surgeon who operated on him) and Kerry (a nurse from the ward on which he was treated). Mr Thomson outlined the course of his illness, from initial cancer diagnosis to surgery and finally to his recovery and ongoing monitoring. Mr Thomson explained that when initially diagnosed he thought his operation, if successful, would be the end of his journey. But after his operation, he explained that he emerged into a dark world. Challenges were not only physical but psychological. He emerged with difficulties with continence and erectile disfunction, which impacted on his relationship. Mr Thomspon spoke powerfully about the psychological impact of encountering incontinence. Although he had received support from a McMillan nurse who was well meaning, he said that as an ex-boxer from an Afro-Caribbean culture he found that he could not open up to her as he felt she could not understand his world. Mr Thomson became suicidal, but by chance met a friend who was struggling with the same diagnosis and side effects. Talking together provided Mr Thomson with the impetus to start a self-help group for men recovering from prostate cancer. This had grown to a network of circa 9,000 men who support one another. The Chairman asked Hassan and Kerry if they would like to give their perspective. Hassan stated that although operations such as Mr Thompson's were lifesaving, they were also life changing. For effective support during recovery and remission, it was important for patients to be with people who had the same lived experiences. Kerry recognised the issues that Mr Thompson described. Improvements had been made. All nursing staff now received psychological training to be better equipped to support patients. However, there were not enough male nurses, and particularly male nurses of ethnic origin, for all the patients that presented with this diagnosis. The Chairman thanked Mr Thomson for attending and telling his very powerful story and asked Board members for questions and comments. The GCMO thanked Mr Thomson for speaking so candidly and added that medics increasingly realised that recovery was dependent on effective psychological support. However, it was difficult to match people to support when there was not enough support of the right kind. The challenge was to ensure that the universal professional service offered was matched with community specific support to get the best outcome.	

	AM was uncertain as to how clinicians would know what support groups are out there and how to put their patients in touch with that support. The Chairman agreed and stated that it was a real challenge for local authorities and Integrated Care Boards (ICBs) to map all support groups active in an area. It was important that if there was no direct funding for such groups, support in kind (such as making meeting rooms available and publicising on websites) could be equally important. On behalf of the Group Board, the Chairman thanked Mr Thompson for presenting his story.	

CLOSE

The meeting closed at 12:45 pm

QUESTIONS FROM MEMBER OF THE PUBLIC AND SGUH GOVERNORS

The following questions had been received from members of the public:

Questions from Councillor Peter McCabe, Merton Council:

1. ***"Following the recent publication of the CQC report on maternity services at St Helier Hospital, what action will the Board be taking to assure Merton residents that the service is safe, well-led and of a satisfactory standard?"***

   In response, the GCEO stated that following the CQC inspection the Trust had taken a number of immediate actions. These included: strengthened oversight to ensure training and care records were up to date; reinvigorating strict protocols to ensure all clinicians used shared care records to improve safety, reduce variation and prevent families from having to repeat their medical histories; 90% of women were now triaged within 15 minutes of arrival to improve risk assessments, with a new dedicated helpline for women to talk directly with our midwifery team if they had concerns; estates work had been fast tracked with new doors and blinds fitted to improve privacy and dignity; and regular spot checks ensured facilities and equipment were kept clean within the challenging environment in which the service operated. The GCEO explained that she hoped that all users of the service across Epsom and St Helier would be assured by the positive outcomes from the most recent CQC patient experience survey in which ESTH midwives and maternity teams were rated number one in London for the care they gave to women and their babies. Additionally, the Trust was strengthening its services by investing more than £2m over two years to increase staffing levels by 8% to help achieve the Trust's ambition for every family to be happy with their care at Epsom and St Helier as we welcome their child into the world. The GCEO agreed that the Trust's buildings were not fit for purpose, which was why the Trust was pleased the Government had promised a new hospital and upgrades to our existing facilities by 2030.

2. ***"Does the Board still believe that a new hospital in Belmont will be "fully funded and built by 2030" despite all the risks identified in the National Audit Report on the New Hospital Programme?"***

   The MD-ESTH stated that the Trust was working closely with the NHS New Hospitals Programme to deliver the scheme and had recently had additional fee allocations confirmed to work on the design and planning requirements for the Specialist Emergency Care Hospital. The Government had expressed ongoing support for the scheme in a debate in Parliament last week.

3. ***"If the new hospital in Belmont is built, how many Merton residents for whom St Helier Hospital currently provides emergency care, will be displaced to St George's Hospital, Kingston Hospital and Croydon University Hospital? Please provide an estimated***

number for each hospital. How will these Emergency Departments cope with the increased number of patients?"

The MD-ESTH stated that the pre-consultation business case for the *Improving Healthcare Together* consultation identified that the Sutton option for major acute services would lead to the following changes for the overall Trust catchment:

- St George's: 1,700 additional ED attendances and 2,000 additional emergency admissions per year
- Kingston 1,800 additional ED attendances and 1,400 additional emergency admissions per year additional emergency admissions per year
- Croydon 5,100 fewer ED attendances and 700 fewer emergency admissions per year.

This data was not currently available at borough level. However, the integrated impact assessment, which was based on the same data set, saw that no Merton resident would see an increase of greater than 10 minutes in blue light travel time. The Building Your Future Hospital scheme included capital provision for the impact of these changes which had been agreed with these providers.

The following questions were received from members of the St George's Council of Governors:

Questions from Chelliah Lohendran, SGUH Governor

1. ***"Since 2010 there has been many consultations taking place with regard to the building of a new hospital. It's been 14 years and there is yet to be any firm design. Can the Board please let me know when will a design go to planning. To date how much has it cost in consultations. When is the next finishing project date."***

   The MD-ESTH undertook pre-planning engagement on a hospital design for the Specialist Emergency Care Hospital in 2021. However, this was paused to align with the New Hospitals Programme. The Trust was in the process of agreeing a timescale for a planning application. The Government had committed to the scheme being completed in 2030. The *Improving Healthcare Together* consultation was run by local CCGs and the Trust does not hold data on costs.

2. ***"Is the Springfield Hospital a part of gesh?"***

   The GCEO responded that the Springfield Hospital was not part of gesh; it was part of South West London and St George's Mental Health NHS Trust.

3. ***"Is it possible to have a breakdown on the number of Physicians Associates and Health Care Assistants working at ESTH and St Georges?"***

   The GCEO stated that there were 627.8 FTE (Full Time Equivalent) and a headcount of 692 Health Care Assistants employed at ESTH. There were 23.2 FTE and a headcount of 24 Physician Associates employed at ESTH. At St George's, there were 690 FTE and head count of 732 Health Care Assistants, and 56 FTE and a headcount of 58 Physician Associates.

4. ***"Are patients sent home late at night due to transport issues? If so, what social care is in place?"***

   The MD-IC stated that while the Group's hospitals try to avoid sending patients home late at night, this does sometimes happen. However, where a patient requires a care package, the discharge would be cancelled and rescheduled for the following day to ensure that the package was in place to meet the patient's needs.

Questions from Alfredo Benedicto, SGUH Governor:

1. ***"It is unacceptable that staff are subject to violence but is the root cause of aggression against hospital staff a perceived lack of care"***

   The GCEO replied that NHS England was clear that no violence is acceptable against staff. The Trust supports staff in tackling aggressive patients, and an increasing number of relatives or friends of patients who are aggressive to staff."

2. ***"Are our Trusts seeing an increase in the number of Never Events; and are our Trusts doing enough to prevent Never Events?***

   AM replied that nationally there was an increase in Never Events, which was perhaps the result of more open reporting and was a positive development. The Quality Committee monitored all Never Events across the Trusts and ensured that learning is captured, and procedures and training are reviewed.

Group Board (Public) - 2 May 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.	Mar-24	GCNO	The Quality Committees-in-Common considered an update on Quality and Safety within the Group's emergency departments at its meeting in March 2024. The Quality Committee will continue to monitor the situation and in light of this it is proposed that this action is moved to the Quality Committee action log.	PROPOSED FOR CLOSURE
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.	May-24	GCIFEO	The Board considered the escalation of issues to the Group Executive and Group Board as part of its Ward to Board discussion at the April Board Development Session. A detailed protocol will be considered by the Board in June/July and has been added to the forward work programme.	PROPOSED FOR CLOSURE
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 a Group Board development session following a detailed discussion at GEM on 7 May.	DUE
PUBLIC20240308.1	08-Mar-24	2.3	People Committees in Common report	Publication timetable to be drawn up of statutory people-focused reports.	04-Jul-24	GCPO	In progress.	NOT YET DUE

Group Board

Meeting in Public on Thursday, 02 May 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	02 May 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 at 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. Since the last update, the Group, together with the collective effort of our dedicated staff, has seen many achievements. For example, we have entered into Phase 2 of corporate nursing integration, with positive feedback from staff. Phase 1 integration of corporate medicine is also underway. These programmes have collectively laid the groundwork for the remaining integration services and informed our refreshed timelines for the integration of the remaining programmes.

While we celebrate our achievements with staff, in the last few weeks, our conversations have focused on setting a GESH vision that fosters high-performing teams. This is crucial in driving our vision of improving the experience and health of our patients, a mission that lies at the heart of our organisation. We also aim to be innovative while reducing costs and enhancing the work life of our workforce.

Like most other hospitals nationwide, we face operational and financial challenges. The combination of inflation, increased demand for our services, and stretched capacity - in part due to industrial action and junior doctor strikes - has put considerable pressure on our services and has also impacted patient experience.

In response to growing system challenges, we have been given a clear mandate by NHS England (NHSE) to reduce our deficit. While the work ahead will not be easy, we are prepared to maintain a high standard of quality care while being innovative in meeting new stretching targets, addressing financial pressures, and fostering a workforce that remains committed to our vision. We continue to find opportunities to expand our partnerships across South London with Councils, NHSE and others to support meaningful and coordinated action.

This report highlights national priorities of impact to us, our achievements to date and the ambitions we are working toward.

4. National Context and Updates

4.1. NHSE Agency Rules

The NHSE agency rules sets out guidance for trusts on agency expenditure, collectively known as 'agency rules.' It sets out conditions for procuring agency staff through approved 'Framework Arrangements' and ensures charge rates are aligned with a set of caps related to the 'Agenda for Change' pay scales.

In February 2024, new agency rules were enacted to help ease the financial pressure facing the NHS. The new rules require formal sign-off at the Executive level for:

- Off Framework agency bookings;
- Agency bookings that exceed NHSE caps ("break glass"). There is a "break glass" provision for Trusts that need to override these rules on exceptional patient safety grounds; and,

- Any agency bookings over £100 per hour.

NHSE will monitor Trust/System compliance against these agency rules and expenditure limits. A GESH approach has been developed to ensure compliance with this recent guidance.

4.2. 2024/24 Priorities and Operational Planning Guidance

On 27 March 2024, NHSE released its operational planning guidance for 2024/25, outlining the priority areas and objectives for the service. The priorities are focused on recovering (i) core services, (ii) productivity (e.g., increase diagnostic and elective activity and reduce waiting times), (iii) quality and safety of services (particularly maternity and neonatal services), and (iv) patient experience (e.g., maximise primary and community services to reduce health inequalities and deliver patient-centred care through integrated care systems).

NHSE will report on productivity metrics at a national, Trust, and ICB level from the second half of 2024/25.

5. Our Group

5.1. Principal Treatment Centre (PTC) for Paediatric Cancer in South London

For the past 25 years, St George's University Hospitals (SGUH), in partnership with the Royal Marsden, has been the primary provider of children's cancer services for South London and large parts of the South East of England.

In September 2023, NHSE launched a public consultation on the proposed future location of the PTC in our catchment. Two options were considered: SGUH in concert with the Royal Marsden and the Evelina London Children's Hospital.

Following a public consultation and options-appraisal process, on 14 March 2024, NHSE selected Evelina London Children's Hospital as the future PTC location for children's cancer services. This move will take effect in October 2026 at the earliest.

There has been significant public opposition to NHSE’s decision. Our local councils and MPs have written to the Secretary of State for Health, highlighting their concerns.

We continue to work alongside the Royal Marsden to provide outstanding care to children and young people with cancer.

5.2. Quality

Following the CQC inspection at SGUH, we reflected on how we can make substantive improvement, consolidate how we provide assurance, and effectively track and report back on actions generated from various quality visits.

We plan to establish an Evidence Assurance Panel to oversee all regulatory requirements (e.g., CQC, NHSE, Royal College) to ensure a comprehensive grip on compliance and risks. We also observed from others who have taken a coordinated approach to quality that there are benefits to this approach. For example, all levels of staff have insight into the work and can actively contribute to good practices, there is a ready-made repository of evidence available for future visits, and from this, there will be increased clarity from board to ward on actions taken to improve and enhance our service.

If benefits and efficiencies are realised, we may consider expanding this approach for other services across the Group.

5.3. Performance

Our ambition is to be at the top quartile of key performance targets. While we are not where we want to be, GESH, and South West London (SWL) are doing well relative to overall national performance.

Key highlights from the past month:

- ED Visits: SGUH and ESTH achieved the national A&E 4-hour target of 76% in March 2024, with performance of 81.3% and 76.8% respectively. At SGUH, the discharge profile improved which supported flow.
- Diagnostic: Against the 5% maximum national ambition for diagnostic waits over 6 weeks, SGUH achieved 3%, and ESTH reported 3.8%.
- Cancer Wait: ESTH delivered against all three national cancer standards in February 2024.
- Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in March 2024. Sutton Health & Care achieved 90.7% and Surrey Downs Health & Care, 86.7%, with a continued focus on encouraging more referrals.

However, there is room for improvement. For example, our RTT waiting lists are higher than planned at both ESTH and SGUH due to capacity constraints and industrial actions. Additionally, both ESTH and SGUH are not meeting current trajectories to reduce the number of patients waiting for more than 52 weeks to commence definitive treatment. Urgent and emergency care services at both trusts continue to experience significant pressures, however we have mitigating actions in place to address our challenges and improve our performance targets.

5.4. Financial Position

We're determined to take action to tackle our financial deficit and work towards a balanced financial position. We are committed to achieving this in a multi-pronged approach, including but not limited to overall cost reductions, significant reductions in bank and agency costs, and scrutinised vacancy control processes. It is our priority to ensure that whatever measures taken to improve our financial position does not adversely affect our quality of care.

6. Appointments, Events and Our Staff

6.1. Appointments

- Victoria Smith will join us in July as Group Chief People Officer (GCPO). My thanks to Angela Paradise, interim CPO for her hard work and supporting Victoria with handover.
- Mark Bagnall will join us in August as the Group Estates and Facilities Officer and will start by working one day a week from 29 April until he joins full time.
- Nicola Shopland joined earlier this month as the SGUH Chief Nursing Officer, on a one-year secondment.

6.2. Events

6.2.1. GESH100 Leadership Forum

We hosted our second GESH 100 Leadership Forum on Friday, 26 April, with over eighty senior leaders coming together to exchange ideas and views. The first Forum focused on individual and collective leadership practice. This second event examined what it takes to build, lead, and contribute to effective teams. This event was timely, given our renewed focus on leading resilient teams that can help meet our ambitions of performing well while saving money.

6.2.2. Executive Question Time

Our Executive Question Time (EQT) is an opportunity to connect with all staff members — 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 22 April, focused our discussion on our financial position and our plans to deliver 5.5% savings that drive efficiency, reduce waste, and boost productivity. We discussed our plans to do more with less – not compromising quality and staff wellness.

We were thrilled to see such a positive response from our staff during the EQT. A record-breaking 660 people tuned in for the discussion, a clear indication of staff interest and engagement.

Over the next few weeks, I will begin roadshows across our three sites to discuss our plans further.

6.3. Our Staff

6.3.1. Ensuring a Safe Workplace for Staff

We developed 'Big 5' commitments in response to feedback from staff through various forums (e.g., our staff survey and culture improvement work). One of these commitments is to ensure a safe workplace for staff and is represented as the 'E' in our CARE objectives to have "empowered and engaged staff."

Some steps we have taken to address staff feedback include:

- Establishment of a Violence and Aggression Task Force, which aims to produce a revised violence prevention and reduction policy, including information on procedures and processes for sanctions and guidance. I chair the Task Force, which has a membership of twenty-four staff across our Group.
- Establishment of a Sexual Safety Steering Group—GESH has signed up for the NHS Sexual Safety Charter, which sets out how we will enforce a zero-tolerance approach to unwanted, inappropriate, and/or harmful sexual behaviours in the workplace. The steering group's goal is to ensure the framework is in place to deliver the Charter's ten principles by July 2024.
- Monthly meetings with the Metropolitan Police as part of Operation Cavell – the London wide operation to improve safety of NHS staff. This will be extended across the Group.

6.3.2. Visits

We welcomed Sir Julian Hartley, Chief Executive of NHS Providers, to St Helier Hospital on Wednesday, 10 April 2024. The visit aimed to discuss local issues and pressures, share best practices and identify areas where NHS Providers can offer support. We discussed the deteriorating estate at St. Helier Hospitals and our ability to provide safe and effective care despite challenges while noting the increasing impracticalities of doing so. Sir Julian met various staff as we toured the ED department, ITU, and other high-priority areas relevant to our discussion.

6.3.3. Chat with the Chair and Chief Executive

The Chairman and I had our first chat with staff earlier this month with tea and cake. We intentionally keep these chats to a small group of people (a maximum of six people join us for an hour) to encourage open and honest dialogue about the organisation. It's also an opportunity to speak to staff about what our organisational priorities are and inspire teams to take collective ownership of our ambitions. These conversations help me anticipate and address issues relating

to the organisation's culture - it's a fantastic way to connect with teams more intimately, and we look forward to the next conversation.

7. Closing

7.1. We have achieved many things in a short time, but there is still more to do. We are focused on leading as a high-performing Group that (i) leverages the individual and extraordinary strengths of our people, providers, and partners, (ii) creates an environment where everyone can thrive at work through fulfilling roles, career progression opportunities, and an inclusive working environment, and (iii) adopts a streamlined and efficient organisation with resources focused on those areas that matter the most.

Group Board

Meeting in Public on Thursday, 02 May 2024

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

Executive Summary

This report sets out the key issues considered by the Quality Committees-in-Common at their meetings in March and April 2024 and the matters the Committee wish to bring to the attention of the Group Board. The key issues the Committee wished to highlight to the Board are:

- **Cardiac Surgery (SGUH):** The Committee received its quarterly report on quality and safety in Cardiac Surgery and was assured by the continuing outcomes data for the service which demonstrated that outcomes are in line with other similar units across the country and that the actions to improve quality and safety within the service had been embedded and sustained. The Committee endorsed proposals to step down the service-specific reporting on Cardiac Surgery in the context of the assurances received, and consider such updates as part of a new structure of quality and safety reporting on specialised services as a whole.
- **Head and Neck Service (SGUH):** The Committee requested and received a progress update on the actions being taken to address the RCS recommendations and was assured that good progress was being made. The Committee will keep the implementation of the remaining actions under close review and will receive a further update at its meeting in June.
- **Interstitial Lung Disease (ESTH):** The Committee reviewed a report about the treatment of Interstitial Lung Disease (ILD) at ESTH and the actions being taken by the Trust to address quality and safety concerns in the treatment of ILD. An external review by an independent panel of assessors and a separate review of culture and ways of working within the ESTH Respiratory Medicine Department have been commissioned by the Trust and the Committee will consider the outcomes of these reviews and the actions being taken by the Trust.
- **Association of Perioperative Practice (AfPP) report and Theatre Safety (SGUH):** The Committee reviewed the findings of the report, which had been commissioned by the Trust in response to a cluster of Never Events, and an update on the actions being taken by the Trust to address these.
- **Independent Review of Maternity Governance:** The Committee received the report which had been commissioned by the Group Board on governance within Maternity Services. It noted that next steps which were for the Executive Team to review the recommendations and to formally respond. The report will be reviewed in further detail at the private meeting of the Board.

Action required by Group Board
The Group Board is asked to: • Note the issues escalate by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in March and April 2024. • Agree to step-down the Committee's arrangements for quarterly oversight of cardiac surgery on the basis of the sustained improvements in the governance and safety of the service.

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

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

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

Quality Committees-in-Common Report
Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees-in-Common at its meetings in March and April 2024 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 28 March 2024 and 25 April 202, the Committees considered the following items of business:

March 2024	April 2024
• Group Update on Health Inequalities • Update on the review of Head and Neck Services (SGUH) • Group Serious Incident Report and update on Patient Safety Incident Review Framework (PSIRF) • Update on quality and safety within the Group's Emergency Departments • Group Maternity Services Report • Group Maternity Workforce Update • Interstitial Lung Disease (ESTH) • Group update from Mortuaries – assurance around Safeguarding • Group Integrated Quality and Performance Report • Group Caldicott Guardian Annual Report • Clinical Ethics Committee Annual Report (SGUH)	• Draft Group Quality Strategy • Group Serious Incidents Report and Update on Patient Safety Incident Review Framework (PSIRF) • CQC Emergency Department visits (SGUH) • Cardiac Surgery Update (SGUH) • Independent Review of Maternity Services Quality Governance • Group Maternity Services Report* • Group Learning from Deaths Report Q2 & Q3 2023/24* • Association for Perioperative Practice Report – Theatre Safety (SGUH) • Integrated Care Services: Challenges in Diabetic Care • Group Integrated Quality and Performance Report* • CQC Self-Assessment • Quality Committees-in-Common – Annual Report and Committee Effectiveness Review

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

2.2 The meeting was quorate in both March and April 2024.

3.0 Key issues for escalation to the Group Board

3.1 The Committees wish to highlight the following matters for the attention of the Group Board at its meeting in public.

a) <u>Cardiac Surgery Update (SGUH)</u>

The Committees received an update on the Cardiac Surgery Service at SGUH at its meeting in April 2024, and was assured by the continuing outcomes data for the service which

demonstrated that outcomes are in line with other similar units across the country and that the actions to improve quality and safety within the service had been embedded and sustained.

The most recent NICOR (National Institute for Cardiovascular Outcomes Research), GIRFT (Getting It Right First Time) and Health Education England reviews and benchmarking had all been satisfactory or positive. The Unit had greatly strengthened its internal governance processes, with active and engaged departmental leadership and broad participation, and the service had recently re-joined the South London Aortic Dissection rota, and the outcomes for this had been fully in line with expectations.

The Committees have received regular reports on the quality and safety of the service since 2018, including quarterly reports since the publication of the Independent Mortality Review in March 2020. The Committees noted that in the half decade the Committees had received such reports, the assurance on the quality and safety of the service had improved significantly. The Committees heard that the principal challenges facing the service had evolved and were no longer about quality and safety but about operational performance, including ITU bed capacity. Over the previous few months the ongoing SGUH Operational Improvement Programme had led to significant and sustained improvement in patient flow, increased elective case numbers and reduced cancellations, as well as an improvement in recruitment to cardiac anaesthesia posts.

In this context, the Committees considered and endorsed a recommendation from management that it would be an appropriate point to revise the arrangements for oversight of Cardiac Surgery, step down the service-specific reporting on quality and safety in Cardiac Surgery, and instead consider such updates as part of a new structure of quality and safety reporting on specialised services as a whole, which would be defined over the coming months. The Committees agreed to propose this change to reporting on Cardiac Surgery to the Group Board, subject to the views of NHS England London Region.

b) Head and Neck Service (SGUH)

In January 2024, the Committees updated the Group Board on its review of the report of the Royal College of Surgeons (RCS) invited review of the Head and Neck Service at SGUH. The Committees informed the Group Board that the RCS report had highlighted concerns in a number of areas, with 11 urgent recommendations to address patient safety risks, 3 important recommendations for service improvement, and 2 additional recommendations. In January, the Committees had heard that significant work had already been undertaken prior to the Trust's receipt of the RCS report to improve the service and further actions were being taken to address the recommendations from the RCS. At its meeting in March 2024, the Committees requested and received a progress update on the actions being taken to address the RCS recommendations and was assured that good progress was being made. Actions relating to the pre-operative pathway, on-call arrangements for free flaps, submission of data for review, review of safety of the service, implementation of best practice multi-disciplinary team meetings and effective morbidity and mortality meetings, and actions to address learning across the service had all been completed, with other actions in progress. The Committees will keep the implementation of the remaining actions under close review and will receive a further update at its meeting in June.

c) Interstitial Lung Disease (ESTH)

At their meeting in March 2024, the Committees reviewed a report about the treatment of Interstitial Lung Disease (ILD) at ESTH. This followed concerns raised through a number of

avenues that indicated possible departures in recognised best practice in the treatment of ILD that may have led to harm as a result of patients not receiving disease modifying treatment in a timely way. The Committees heard that the Trust is continuing to investigate the concerns and has taken action to identify and follow-up with those patients who may not have received timely care. Further action will be needed but will be guided by findings from initial reviews. In addition, the Trust had commissioned an external review by an independent panel of assessors and a separate review of culture and ways of working within the ESTH Respiratory Medicine Department. The Committees will discuss ILD and the planned response at its informal meeting in May and will receive a further update in the June committee meeting. The Committees will receive the outcomes of the two reviews on completion and will continue to monitor closely the actions being taken by the Trust.

d) Association of Perioperative Practice - Theatre Safety (SGUH)

In its report to the Group Board in March 2024, the Committees highlighted its work in reviewing surgical pathway Never Events across the Group. It informed the Group Board that while the Committee was assured that the remedial actions in relation to wrong site surgery nerve blocks at ESTH had been addressed, a review at SGUH by the Association for Perioperative Practice (AfPP), which had been commissioned by the Surgery, Neurosciences, Cancer and Theatres Division in response to a cluster of Never Events in theatres, had identified a number of areas where significant improvements were needed, including in relation to strengthening processes, clinical governance and culture.

At their meeting in April, the Committees reviewed the findings of the AfPP report and an update on the actions being taken by the Trust to address these. The Committees heard that the AfPP report had been highly critical of many aspects of perioperative practice, including adherence to, and audit of, the nationally recognised Five Steps to Safer Surgery, the quality of the estate, the adherence to infection prevention and control rules, the safety governance of operating list changes, and the culture and behaviours of staff. Some areas of good practice were also noted, and the AfPP reviewers found staff welcoming and engaged with the review.

The report received by the Committees outlined a summary of the findings, the recommendations, the actions taken and the outcomes of these actions to date. These were presented using a Systems Engineering Initiative for Patient Safety (SEIPS) approach, in line with the Group Patient Safety Incident Response Framework. The key actions included those directed towards theatre team training and development along with a focus on team working and behaviour. The Division had moved this year to a morning a month set aside for this work, and the SGUH Simulation Team was delivering a programme of safety development work based around teamwork and human factors. The Committees agreed it will receive updates on the action plan on a regular basis in order to seek assurance that the necessary actions have been implemented and embedded and are having the appropriate impact on improving quality and safety.

e) Independent Review of Maternity Governance

At their meeting in April 2024, the Committees reviewed the findings of the independent review of maternity governance, which had been commissioned by the Group Board following the outcome of the Care Quality Commission (CQC) inspection of maternity services at SGUH,

which had highlighted a number of issues including the robustness of ward-to-Board reporting on maternity. Having commissioned the report, the Group Board will formally receive the review and discuss the findings in full at a subsequent meeting. The Committees would, at this stage, simply highlight that they found the review to be helpful in highlighting the factors which had led to a disconnect between the assurances the Board felt it had received and the findings the CQC reached. The review highlighted the need to improve both the quality of reporting on maternity, drawing on appropriate data, to simplify reporting structures and reporting burdens on teams, to be clearer about the threshold for assurance particularly in relation to the impact rather than the completion of actions, and to improve psychological safety. A second stage of the quality governance review will commence shortly which is focusing on quality governance beyond maternity services, and a terms of reference for this work is currently being developed.

4.0 Key issues on which the Committees received assurance

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

a) Quality and Safety with the Group's Emergency Departments

In March 2024, the Committees received an update on the quality and safety work which was taking place in the Emergency Departments (EDs) across the Group. It was widely recognised that there was intense and sustained pressure on the EDs with the number of attendances, the acuity of patients and also concerns about the length of time patients were having to stay within the hospital until they could be admitted.

It was confirmed that there had been two fatal patient falls in the ED at SGUH and concerns with these had triggered an unannounced CQC inspection. At the April meeting, the Committees received an update on the enhanced falls prevention work including greater focus on undertaking risk assessments being undertaken within the department. Cross-Trust and cross-Group learning on falls prevention was being shared.

The Committee received assurance that the falls action plan for SGUH had clear actions to deal with the risks around falls within the ED. The impact of these actions would be monitored and would include local weekly audits and spot checks and there would be increased training put in place for staff. Monthly assurance updates would continue to be provided to the Committees.

b) Patient Safety Incident Review Framework (PSIRF)

The Committees have previously provided updates to the Group Board on their work in seeking assurance on the implementation of the new national Patient Safety Incident Response Framework (PSIRF), which replaces the current Serious Incident (SI) Framework. At their meetings in both March and April, the Committees received updates on PSIRF implementation and heard that over the next three months the Group will complete transition to PSIRF. The current monthly Serious Incident report to the Quality Committees—in-Common will be replaced by a Patient Safety Incident Response report, which will provide the Committees with assurance that both Trusts are meeting safety standards and learning from patient safety incidents. Until the transition is implemented in full, the Committees will receive hybrid SI and PSIRF reports to ensure appropriate oversight of both.

The Committee heard that the future PSIRF reports will outline:

- Patient safety incidents requiring further investigation for the most recent reporting period and compliance against current NHSE, ICB and internal reporting/investigating standards. Concise clinical details of individual incidents will continue to be provided in the appendices.
- Any immediate learning and actions identified as incidents occur, as well as broader safety themes that are emerging from incident review and the actions being taken to address these.
- Progress with the Group PSIRF implementation plan, including staff training and governance.
- The approach being taken to ensure there is wide dissemination of system learning, including exchange of learning between ESTH and SGUH, and triangulation with other sources of assurance that learning is leading to action and sustained improvements.
- The approach being taken to improve the involvement and support of staff as part of a just safety culture.

It was confirmed at the meeting in April that compliance with PSIRF training had made progress over the previous couple of months with 86% of eligible staff across the Group having now completed Level 1 training. There remained some issues with staff being able to complete the enhanced training which would allow them to undertake investigations.

In March, the Committees discussed in some detail the move from the current transactional structure for investigating and reporting SIs to the new system of the PSIRF which gives Trusts more freedom to describe themes. The Committees raised concerns that PSIRF allowed for interpretation, which could potentially lead to ambiguity. It was confirmed that the GCMO and GCNO would undertake greater oversight of the implementation process to assure that any concerns were addressed. In addition all incidents would be considered by a panel - not just those that were considered to be of moderate harm or above. The challenge for the Group would be to build systems which maintained oversight of concerns at every level.

The Committees confirmed that they were aware of the risks within the transition period and until the new practices were embedded. It was suggested that the Committees should receive an update each month until the transition period was completed. This would include a particular focus on assurance around training and that the PSIRF approach was ensuring learning from themes.

c) <u>Group Learning from Deaths Reports Quarter 2 & 3 2023/24</u>

The report on learning from deaths is on the Group Board agenda in May 2024, and so the Committees wish only to highlight a few key points. The Committees noted that overall mortality at ESTH appeared to be improving, but both measures for mortality (SHMI and HSMR) remained "*higher than expected*". Overall mortality at SGUH remains "*as expected*" as measured by SHMI, and "*lower than expected*" as measured by HSMR. The Committees expressed concern that the mortality figures for ESTH still appeared to be high and asked for clarification as to when the national changes in data recording which may positively impact the Trust's scores were expected to come into operation. The Committees were reassured that the ESTH team were not assuming that the high SHMI was a data issue and that analysis and action continued to be taken to understand any causes of high mortality and to address these. The Committees acknowledged the positive learning from each Trust in respect of reviewing mortality which was being shared across the Group. The Committees also received an update on plans to bring together, on a Group-wide basis, the learning from deaths teams across the two Trusts and this was welcomed as a means of developing a consistent Group-wide approach and avoiding unwarranted variation across the Group.

d) Safeguarding within the Group's Mortuaries

In March 2024, the Committees received an update on the work being undertaken across the Group to ensure appropriate safeguarding and security controls were in place within each Trusts' mortuaries to fully comply with the requirements of NHS England and the Human Tissue Authority (HTA). This particularly related to the requirements for the publication of the Phase 1 Report of the David Fuller Independent Inquiry. The GCMO confirmed that both ESTH and SGUH were fully compliant with the majority of the relevant recommendations of the Phase 1 Report of the Fuller Inquiry. The area in which greater assurance was still needed in both Trusts was with the regular monitoring of access to restricted areas. This assurance was provided at the April meeting. With this confirmation, the Committee confirmed that it felt assured that the appropriate security controls were in place within the Trusts' mortuaries and that processes were in place to ensure that they were regularly monitored.

5.0 Other issues considered by the Committees

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

a) Health Inequalities

At their March meeting the Committees received an update on the areas of work being undertaken across the Group to tackle health inequalities. The report described the establishment of the GESH Health Inequalities Steering Group and set out its proposed governance/reporting structure. The report also described the five workstreams through which the Group's health inequalities work was being overseen and managed:

- Community of Practice - Group Community of Practice Forum in which those involved in disparate initiatives could come together to share learning, good practice and resources
- Data - Dataset quality, with a particular focus on improving data collection on ethnicity.
- Proactive Outreach - Health inequalities improvement work with High Intensity Service Users in unplanned care pathways.
- Reasonable adjustments - Health inequalities improvement work in planned care initially on the waiting lists of one or two specialities with a view to roll out group wide. Looking at how to support patients who should attended services regularly but did not attend or frequently cancelled
- Anchor Institution - Developing initiatives that brings most value to the communities of SWL i.e. Employment and education

It was agreed that regular further update reports would be received and these should include deep dives on particular areas as necessary as well as clear timelines and a demonstration of the progress being made. The Committees noted that the work being undertaken in respect of health inequalities across the Group was welcome and important and that it looked forward to receiving further updates in due course.

a) Development of a Group Quality and Safety Strategy

The Committees received a progress update on the development of the new Group-wide Quality and Safety Strategy, which will support the ambitions of the Group Strategy. The current thinking was to have eight strategic domains divided into a number of strategic

priorities for 2024-2028. During discussion, it was agreed that manageable proposals, that could be reviewed in a quantifiable away should be drawn up for the strategic priority areas. This would enable the Committees to consider whether the strategy had achieved what it set out to do. A discussion took place around the differences between quality and safety and the relative emphasis that should be placed on each in the new strategy in the context of the financial pressures on the Group. The Committees agreed that, given these challenges, maintaining patient safety would need be given the greatest weight in any prioritisation of strategic priorities.

Members of the Committees will hold an informal meeting in May 2024 to help inform the further development of the strategy ahead of review at a Group Board development session in June, and Group Board approval in July.

6.0 Recommendations

6.1 The Group Board is asked to:

- Note the issues escalate by the Quality Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in March and April 2024.
- Agree to step-down the Committee's arrangements for quarterly oversight of cardiac surgery on the basis of the sustained improvements in the governance and safety of the service.

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	2.1b	
Report Title	**Quality Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer Arlene Wellman, Group Chief Nursing Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer Barbara Mathieson, Corporate Governance Manager	
Previously considered by	Quality Committee-in-Common	25 April 2024
Purpose	**For Approval / Decision**	

Executive Summary

It is good governance practice for each Committee of the Board to produce an annual report setting out how it has fulfilled its duties and responsibilities as outlined in its established terms of reference. It is also good practice for each Committee to review its terms of reference on an annual basis – making proposals for amendment as necessary to the Board – and agree a forward plan of business for the year ahead. With the establishment of the new Group Board arrangements from May 2023, it was agreed that a single annual report of the work of the Quality Committees-in-Common be provided to the Group Board for consideration, alongside an updated terms of reference.

At its meeting on 25 April, the Quality Committees-in-Common reviewed and approved its annual report to the Group Board, reviewed and agreed to recommend to the Board an updated Terms of Reference and forward plan of business for 2024/25, and reviewed the outcomes of its annual Committee effectiveness review. These reports are attached for consideration by the Group Board.

The Group Board has previously discussed the Quality Committee moving from a monthly meeting to holding meetings bimonthly (every other month). The Committee reviewed proposals on this at its March meeting and agreed in April to recommend this to the Board. The Committee forward plan takes account of this move to a bi-monthly rhythm of meetings.

Action required by Group Board

The Board is asked to:

a. Receive and note the annual report from the Quality Committees-in-Common which sets out how the Committee have fulfilled their terms of reference over 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Review and endorse the proposed forward workplan for the Committees for 2024/25;
d. Receive and note the outcomes of the 2023/24 Committee effectiveness review;
e. Endorse the Committees' proposal to move to bi-monthly meetings in 2024/25.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Quality Committees-in-Common Annual Report 2023/24
Appendix 2	Draft Quality Committee Terms of Reference
Appendix 3	Draft Quality Committee Forward Workplan 2024/25
Appendix 4	Quality Committee Effectiveness Review 2023/24 Summary Report and Full responses

Implications

Group Strategic Objectives

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

Risks

Without appropriate terms of reference and a clear forward workplan for the Committee, there is a risk that each Trust Board may not have sufficiently robust governance arrangements in place for monitoring and seeking assurance on quality-related issues which could result in ineffective assurance or weaknesses in decision-making.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications relating to this report. The Committee's terms of reference and forward workplan set out how the Committee will oversee and provide assurance to the Board that quality plans are aligned with financial and operational planning.

Legal and / or Regulatory implications

There is no legal or regulatory requirement for there to be a quality Committee, but it is good practice to have such a committee in place to oversee and provide assurance to the Board on quality and safety.

Equality, diversity and inclusion implications

The paper sets out how the Quality Committees-in-Common will deal with issues relating to health inequalities over the coming year, both in terms of its remit as set out in the terms of reference and in the forward plan of business for the year ahead.

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

Quality Committees-in-Common Annual Report
Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This paper provides the Group Board with the annual report of the work of the Quality Committees-in-Common in 2023/24, which includes a review of the Committees' terms of reference, a draft forward plan of business for 2024/25, and a summary of the outcomes of the Committees' recent effectiveness review. The annual report, proposed changes to the terms of reference, and proposed forward plan were reviewed and agreed by the Committees at their meeting on 25 April 2024. The Committee also reviewed the outcomes of its annual Committee effectiveness review.

2.0 Background

2.1 It is good governance practice for all committees of the Boards to submit an annual report setting out their key areas of focus over the past year and demonstrating how they have sought to perform their role in accordance with their agreed terms of reference.

2.2 With the Quality Committees of both Trusts having operated as a Committees-in-Common in 2023/24, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

2.3 With the establishment of the new Group Board arrangements from May 2023, the Quality Committees-in-Common annual report continue to be presented to the Group Board for review, which operate with delegated authority from each of the sovereign Trust Boards. Each of the two Quality Committees remains ultimately accountable to the sovereign Board of its respective Trust.

3.0 Quality Committees-in-Common Annual Report

3.1 The Quality Committees-in-Common Annual Report is set out at Appendix 1. The draft report sets out:

- the operation of each Committee as a Committees-in-Common in 2023/24
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2023/24
- key areas of activity and focus by the Committees in 2023/24

3.2 The purpose of the annual report is to provide the Group Board with a high level overview of the Committee's work and how it has delivered against its purpose and duties as set out in its agreed terms of reference. It is not, and does not seek to, describe all issues addressed by the Committee over the past year.

3.3 The draft annual report describes the work of the Quality Committees-in-Common in an integrated way where possible, but where significant Trust-specific items have been considered, the report sets these out as Trust-specific areas of Committee focus and attention.

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed. Given that the terms of reference were redrafted at the start of 2022/23 to coincide with the launch of the new Quality Committees-in-Common the approach adopted to the review has been to revise and update the terms of reference where needed rather than to start again and define an entirely new terms of reference. This is similar to the approach adopted in 2023, when the terms of reference were last reviewed.

4.2 With this in mind, the principal changes to the Committees' terms of reference:

- Simplify and condense the ToR by removing unnecessary detail, repetition and combining some of the duties
- Draw out the focus of the Committee on seeking assurance in relation to learning
- Draw out tackling health inequalities more explicitly as part of the role of the Committee
- Remove the Site COO as a regular attendee of the Committee, reflecting current practice
- Including the Group Chief Midwifery Officer and Group Director of Safety and Governance as regular attendees
- changes to the frequency of the meeting, to be held bi-monthly, before the month of a Group Board

4.3 The changes to the terms of reference are set out at Appendix 2, and the new wording proposed is marked in track changes.

4.4 As in 2022/23, the terms of reference will apply to each Quality Committee, that is it will be the terms of reference for the ESTH Quality Committee and, separately, the terms of reference for the SGUH Quality Committee. The membership and quorum arrangements set out apply, separately, to each Trust's Quality Committee. Each Committee must continue to be quorate in its own right. Any votes at Committee would need to be taken by each Committee and approved separately by each Committee.

5.0 Committee Forward Workplan 2024/25

5.1 It is good practice for each Board Committee to have a clear, and approved, forward plan of business for the year ahead. This enables the Boards to be assured that its Committee is considering the right issues at an appropriate frequency, and ensure it has the scope and capacity to provide effective assurance. A clear forward plan also enables effective planning by report authors and Executive leads, and enables appropriate review at site and / or Executive level prior to issues being presented to the Committees.

5.2 The forward workplan for the Quality Committees-in-Common for 2024/25 is set out at Appendix 3. The draft forward plan was reviewed at the Committee meeting in March 2024 and Committee members and attendees were asked to provide any comments to the Committee Secretary and Group Chief Corporate Affairs Officer ahead of the April Committee meeting. No comments or suggestions were received, and the plan was endorsed by the Committees at its meeting on 25 April 2024. The plan will, however, be a living document and will flex as appropriate during the year to accommodate unforeseen issues.

5.3 The proposal is for the Committee to meet bi-monthly in 2024/25 with informal meetings based on live issues and strategy in between.

6.0 Committee Effectiveness Review 2023/24

6.1 Since the last meeting of the Committee, the Committees have undertaken a Committee effectiveness review. The results of this are set out at Appendix 4. The summary report draws out the key themes from the review.

6.2 The key messages emerging from the effectiveness review are that, overall, the Committee is working effectively, that its effectiveness has improved over the past year, that the new Committee Chair has helped focus the Committee meetings on the right topics, that papers are improving in quality and timeliness albeit with further opportunities to strengthen papers.

7.0 Recommendations

7.1 The Group Board is asked to:

a. Receive and note the annual report from the Quality Committees-in-Common which sets out how the Committee have fulfilled their terms of reference over 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Review and endorse the proposed forward workplan for the Committees for 2024/25;
d. Receive and note the outcomes of the 2023/24 Committee effectiveness review;
e. Endorse the Committees' proposal to move to bi-monthly meetings in 2024/25.

Quality Committees-in-Common Annual Report 2023/24

1 April 2023 – 31 March 2024

Contents

Quality Committees-in-Common Annual Report 2023/24

1. Introduction

In February 2022, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group. In March 2022, the Boards of Directors of the two Trusts agreed that from April 2022 a number of Board Committees would operate as Committees-in-Common across the Group. These included the Quality Committees, Finance Committees and People Committees of the two Trusts. The Quality Committees-in-Common operate with a common terms of reference and a common forward plan of Committee business.

This report sets out a high level overview of the work of the Quality Committees-in-Common in 2023/24. It provides an integrated report on the key matters considered by the Committees, and highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The Quality Committees of the two Trusts have adopted common terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference agreed by the St George's and Epsom and St Helier Trust Boards on 5 and 6 May 2022 respectively.

2.1 Purpose

The purpose of each Committee is to provide assurance to its parent Board on the quality of care provided to the Trust's patients, specifically in relation to patient safety, clinical governance and clinical effectiveness and patient experience, as summarised below:

- Ensuring that the Trust has in place appropriate quality and clinical governance systems, processes and controls in place to achieve consistently high-quality care and to meet the Trust's legal and regulatory obligations.
- Identifying and reviewing themes and trends in key quality indicators, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Seeking assurance that key risks relating to quality of care, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Oversight of the implementation of strategies and other frameworks as listed at Appendix B Review progress against the Trust's quality and safety strategy, quality priorities and any quality improvement plans.

2.2 Duties

Each of the Committees has the following duties:

a. Patient Safety
   i. Seeking assurances that services are safe, and that best practice guidance is being followed, especially in the following areas:
      - Mortality
      - Infection control
      - Pressure ulcers
      - Falls
      - Learning from Deaths
      - Nursing and medical staffing
      - Maternity standards
      - Safeguarding.
      - Identifying the quality impact from any workforce gaps and refer any concerns to the People Committee.
   ii. Review and seek assurance in relation to key risks related to the patient safety.
   iii. The role of reviewing the Integrated Quality Performance Report on a monthly basis will be primarily undertaken by the Finance Committee. The Quality Committee will review key quality indicators as set out above.

b. Patient Experience
   i. Monitoring patient experience through the 'Friends and Family Test', national and local surveys, complaints and compliments.
   ii. Monitoring and overseeing issues relating to equality, diversity and inclusion in relation to all matters of patient safety and quality, including access to care and health inequalities.
   iii. Review and seek assurance in relation to key risks related to patient experience.

c. Clinical Governance and Clinical Effectiveness
   i. Reviewing and providing assurance to the Board in relation to the structures, systems, processes and controls in place to ensure effective and robust clinical governance within the Trust.
   ii. Monitoring clinical effectiveness through a review of the outcomes from the annual clinical audit programme. This activity is aligned with the Audit Committee who also have a responsibility in the clinical audit programme.
   iii. Review and seek assurance in relation to key risks related to clinical governance and effectiveness.

d. Research and Development
   i. Providing strategic oversight to the Trust's research and development programme, ensuring it is effective and meets the needs of the Trust and the wider NHS.
   ii. Review and seek assurance in relation to key risks related to research and development.

e. Health Inequalities

i. Review and seek assurance in relation to work being undertaken across the Group.

f. General

i. Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.

ii. Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to quality and safety with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Board Assurance Framework which relate to the scope of the Committee.

iii. Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response, as requested by the Audit Committee.

iv. Ensuring there is a system in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest

v. Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

vi. Reviewing any Trust strategies prior to approval by the Board (if required) and monitor their implementation and progress.

vii. Seeking assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission (CQC) and oversee any remedial action that may be required and monitor progress against any must and should do actions identified by the CQC.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2023 to March 2024), the following were members or regular attendees of the Quality Committees-in-Common:

St George's Quality Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Committee Chair - Non-Executive Director	1 April 2023 – 31 March 2024
Jenny Higham	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Yin Jones	Member	Associate Non-Executive Director	1 April 2023 – 31 March 2024
Peter Kane	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024

Kate Slemeck	Member	Managing Director – St George's	1 April 2023 – 31 March 2024
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2023 – 31 March 2024
Natilla Henry	Attendee	Site Chief Nursing Officer Group Chief Midwifery Officer	1 April 2023 – 18 February 19 February 2024 – 31 March 2024
Stephanie Sweeney	Attendee	Group Director of Quality and Safety Governance Site Chief Nursing Officer	1 April 2023 – 31 March 2024 1 March 2024 – 31 March 2024
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2022 – 31 March 2023
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2022 – 31 March 2023

Epsom & St Helier Quality Committee			
Name	**Role**	**Designation**	**Period**
Aruna Mehta	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 January 2024
Andrew Murray	Member	Committee Chair, Non Executive Director	1 February 2024 – 31 March 2024
Chris Elliott	Member	Associate Non-Executive Director	1 April 2023 – 31 December 2023
Peter Kane	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Derek Macallan	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2023 – 31 March 2024
Thirza Sawtell	Member	Managing Director – Integrated Care	1 April 2023 – 31 March 2024
Ruth Charlton	Attendee	Site Chief Medical Officer	1 April 2023 – 31 May 2023
Rebecca Suckling	Attendee	Site Chief Medical Officer	1 June 2023 – 31 March 2024
Betty Njuguna	Attendee	Site Chief Nursing Officer	1 April 2023 – 30 September 2023
Theresa Matthews	Attendee	Site Chief Nursing Officer	From 1 October 2023 – 31 March 2024
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2023-31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
Simon Littlefield	Attendee	Site Chief Nursing Officer	1 April 2023 – 31 March 2024

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors also regularly attended to observe meetings of the Quality Committees-in-Common during the period.

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the Quality Committee of each Trust was required to be quorate. The quorum for each Quality Committee was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 9 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees-in-Common were quorate for both Trusts.

Attendance			
Name	**Role**	**Trust**	**Attendance**
Aruna Mehta *	Committee Chair	ESTH	7/8
Andrew Murray **	Committee Chair	SGUH	9/9
Chris Elliott *	Member	ESTH	5/7
Jenny Higham	Member	SGUH	8/9
Peter Kane	Member	ESTH	9/9
Yin Jones	Member	SGUH	4/9
Derek Macallan	Member	ESTH	5/9
Richard Jennings	Member	Both	8/9
Arlene Wellman	Member	Both	8/9
James Blythe	Member	ESTH	8/9
Kate Slemeck	Member	SGUH	8/9
Thirza Sawtell	Member	ESTH	1/9
Alison Benincasa	Attendee	Both	8/9
Ruth Charlton*	Attendee	ESTH	1/1
Luci Etheridge	Attendee	SGUH	9/9
Natilla Henry	Attendee	SGUH	7/9
Stephen Jones	Attendee	Both	8/9
Betty Njuguna*	Attendee	ESTH	3/4
Theresa Matthews	Attendee	ESTH	2/5
Stephanie Sweeney	Attendee	Both	4/9

** No longer members of the Committees-in-Common*

*** Andrew Murray member of both Committees from 1 February 2024*

In addition to the above, the Chairman, Group Chief Executive Officer and Group Deputy Chief Executive Officer regularly attended meetings of the Quality Committees-in-Common during the reporting period. The Chairman attended seven meetings, the Group Chief Executive Officer six meetings, and the Group Deputy Chief Executive Officer nine meetings.

The following members of the St George's Council of Governors observed meetings of the Quality Committees-in-Common also during this period:

John Hallmark	Public Governor Wandsworth
Khaled Simmons	Public Governor Merton
Chelliah Lohendran	Public Governor Merton
Sarah Forseter	Governor Healthwatch Wandwsworth
Alfredo Benedicto	Governor Healthwatch Merton
Huon Snelgrove	Staff Governor SGUH

Representatives of South West London Integrated Care Board – Caroline Pollington and Justin Roper – also attended meetings of the Committee throughout the year.

4. Committee activity and focus

4.1 Patient Safety

A key focus for the Committees at each meeting during the year was maternity services at both Trusts. The Committees monitored a range of metrics to seek assurance regarding the quality and safety of maternity services, including perinatal quality surveillance measures and the safety actions within the Maternity Incentive Scheme. In 2023/24, the Committee reviewed the compliance of the two Trusts against the 10 Safety Actions in the Maternity Incentive Scheme on a regular basis throughout the year. By January 2024, the Committee was pleased to note that, subject to investment later approved by the Group Board in relation to transitional care, ESTH was able to demonstrate full compliance with all Safety Actions and qualified for the rebate on its Clinical Negligence Scheme for Trusts (CNST), estimated to be worth around £1.2m. SGUH was unable to demonstrate compliance with Safety Action 5 (midwifery workforce), but with approval of additional investment by the Group Board, SGUH was able to demonstrate compliance in relation to Safety Action 3 (transitional care), and NHS Resolution later write to the Trust to confirm that the additional investment meant that NHSR judged the Trust to be eligible for the full rebate under the CNST.

The CQC undertook an inspection of the SGUH Maternity Service in March 2023 and the ESTH Maternity Service in August 2023. Following the SGUH inspection, the CQC rated the SGUH service as inadequate. At ESTH the overall outcome was also a rating of requires improvement. The Quality Committee has reviewed the CQC's findings and has undertaken detailed scrutiny of the Trust's action plan to respond to the issues identified by the CQC. Following the inspection, the Board recognised that the issues identified highlighted potential weaknesses in quality governance and ward to Board reporting and the Committee scrutinised plans to commission an independent external review of quality governance. This review has looked maternity services at both SGUH and ESTH and will be looking more widely at quality governance structures, processes and controls in a second phase. The outcome of the review is due to be received by the Committee in April 2024.

Over the year, the Committees have also sought assurance in relation to the preparations and planning for industrial action by junior doctors and Consultants at both Trusts and the learning from this. The Committees were assured that robust planning had been taken to keep patients safe during the successive phases of industrial action. The Committees were also assured that the Trusts had undertaken prompt and comprehensive reviews of the key lessons that could be learnt in order to feed into future contingency planning. At the same time, and while harder to quantify, the Committees recognised the significant disruption caused by the industrial action in terms of the cancellation of elective work and noted that, as had been demonstrated during the Covid pandemic, delays in care carried a significant risk of patient harm. However the Committee was reassured that no cases of immediate harm had been identified over the year as a result of industrial action. The Committees will continue to maintain close scrutiny of the steps being taken across the Group to minimise the risk of patient harm in future phases of industrial action. The Committees acknowledged the hard work and dedication of all staff groups for stepping-up during these periods of industrial action at what was a particularly challenging time. The Committees also recognised that while patients had been kept safe, the measures taken to ensure this could not be sustained on an indefinite basis.

A particular focus for the Committee across the year was reviewing the safety of the Group's Emergency Departments given the continuing high operational pressures. There continued to be significant delays in being able to admit patients due to challenges with flow through the hospitals and delays with being able to discharge patients in a timely way. Many patients who were admitted were often extremely frail and have several comorbidities. They required particular packages of care to be in place before they can be successfully discharged. Another area of focus for the Committee were concerns with the increasing number of adults, children and young people with mental health concerns present to the Group's EDs as they had nowhere else to go to in times of crisis. This put added pressures on the EDs. These patients were not necessarily being treated in the right setting and getting the support they needed for their mental health needs until either a suitable place was found or an assessment by the local mental health team was undertaken and support for them put in place. Dealing with these patients puts extra pressure on the already busy departments. The Committee received regular updates on these concerns including details of the greater involvement of the two local Mental Health Trusts to try and resolve the issues along with input from other system wide partners. Whilst it is acknowledged that progress was beginning to be made and plans were being considered to situate a specialist mental health ED on the SGUH site concern with caring with patients with mental health concerns remained a real concern for the service, including impacting on flow.

The Committees review a monthly report on Serious Incidents (SIs) across the Group, with commentary about immediate actions taken or relevant information about planned investigations and learning identified and embedded from completed SI investigations. While the details of individual SIs are, of course, concerning, the Committees have been assured that there are robust systems and processes in place for identifying, investigating and reporting on SIs. The new Patient Safety Incident Response Framework began to be introduced 2023/24, and is expected to be fully operational across the Group by June 2024. Some incidents were now being investigated using this approach in the pilot Divisions. The Committee has sought assurance around the introduction of PSIRF across the Group, and this has also been the focus of a number of Board development sessions. One area where the Committee continued to devote particular focus was in relation to delays in completing SI investigations and closing SI actions at ESTH. The Committee regularly reviewed actions being taken to tackle these delays and is assured that towards the end of the year progress was being made and steps are being taken to prevent a recurrence. The Committee has also focused on an increase in the number of Never Events, particularly in the surgical pathway and has sought assurance about the steps being taken across the Group to learn from these and prevent further occurrences.

Throughout the year, the Committees have undertaken a series of deep dives in relation to the fundamentals of care and sought assurance in relation to the actions being taken in areas of underperformance. This included considering compliance with undertaking Venos Thromboembolism VTE and Dementia Assessments and reviewing the action plans to increasing compliance where needed. Other Deep Dives included reviewing concerns relating to incidents within the Renal Dialysis at the Units run by ESTH and also Surgical Pathways and Never Events across the Group. The Committees found that holding such deep dives enabled them to draw together and triangulate key themes around quality, safety and patient experience, and were assured that a Group-wide action plans on these areas were appropriate and being followed through.

During the year there has been a continued focus on infection prevention and control (IPC). The benefits of collaboration and beginning to bring together the IPC teams from the two trusts to enable Group wide learning were seen across the year. The Committee maintained continued oversight of rates of Clostridium Difficile (C Diff) at both trusts particularly as there continued to be a rise in the prevelance within the local community. The Committee received a briefing in the autumn of 2023 from two Consultant Microbiologists at ESTH and SGUH, on concerns relating to the number of cases of presenting at the trusts. Actions which were taking place across the Group in terms of reducing the number of hospital acquired in There continued to be concerns with some areas of IPC in relation to the poor and aged estates across the Group but particularly at St Helier. There had been issues with ventilation on the ESTH sites which had led to IPC concerns. Oversight of IPC / Infrastructure cocerns were also monitored via the ESTH Estates Assurance Committee and the Group wide Infrastruture Committee which was formed in year.

Although the lead role in reviewing operational performance rests with the Finance Committees-in-Common, the Quality Committees-in-Common review the Group Integrated Quality and Performance Report at each meeting, looking specifically at the quality metrics and themes and trends in the data.

4.2 Patient Experience

The Quality Committee-in-Common reviewed a bi-annual Patient Experience report for SGUH and ESTH respectively which provided an overview of key achievements for the six months preceding each report. Of particular note to both Trusts were the Patient Experience Priorities and the various patient experience surveys.

The Committee regularly reviews compliance against the metrics for responding to complaints. The required performance was that 85% of complaints were responded to with the required period, which varies depending on the complexity of the concerns. SGUH meet this standard for 11 out of 12 of the most recent months. However ESTH was not compliant for any month. The Committee heard about the work being undertaken to improve the resilience in the ESTH Complaints Team and the Divisions to respond to complaints, It was emphasised that it was important to try and resolve concerns in an informal way.

In the forward plan for 2024/25 the need to receive more regular feedback on patient experience had been recognised and reports would be received to each formal meeting.

4.2 Clinical Governance and Clinical Effectiveness

A key area of focus for the Committees in 2024/25 will be clinical governance. The Committees will review the outcomes of the external review of quality governance within the Maternity Service along with the outcomes of the CQC inspections which were undertaken into both trust's services and any action plans developed by the Trusts. The Committees will seek assurance that robust clinical governance structures, systems, processes and controls are in place to ensure effective ward to Board reporting.

4.4 General

The Quality Committees-in-Common have reviewed the quality and safety-related risks on the Corporate Risk Register and have reviewed the new strategic risks on the new Group Board Assurance Framework ahead of the BAF being agreed by the Group Board in March 2023. The Committee will be reviewing the strategic risks on the new Group BAF regularly throughout 2024/25.

5. Committee Effectiveness

The Quality Committees-in-Common conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. Overall, the results of the effectiveness review suggest that there are clear benefits from the new Committees-in-Common approach on quality issues. Respondents felt that the Quality Committee-in-Common was working well, with scope to make further improvements. The main issues highlighted in the effectiveness review are set out below:

- Overall Effectiveness: 80% of respondents considered the Committee to be "very effective" and 20% of respondents regarded the Committee as "somewhat effective". No respondents rated the Committee as "extremely effective" but neither did any respondents feedback that they considered it either "neither effective nor ineffective" or "not effective". Beyond the overall effectiveness rating, the responses and free text comments on the questions painted a picture of a Committee that had improved considerably over the past year and that it was continuing to improve. The move to bimonthly (every other month) meetings in 2024/25 was seen as an opportunity to further improve the Committee's effectiveness.
- Chairing of meetings: There was very positive feedback on the chairing of meetings, particularly with the move to a single Committee Chair in Common for the Committee. The new Chair was seen to have been very effective in focusing the Committee on assurance and triangulation and ensuring that the Committee focused its time on the right issues. The chairing came through as one of the most significant contributors to the improving effectiveness of the Committee.
- Attendance: This was an area with some variation in responses. Some respondents suggested that too many people attended the Committee and suggested that attendance should be reviewed to reduce the number. One suggestion was that fewer Executive Directors should attend. However, others suggested that attendance should be extended. One suggested this would help with "handing off" issues and ensuring follow up of actions. Another suggested that Divisional Chairs and Clinical Directors should attend the Committee to bring greater insight from services and to assist in ward to Board communication.
- Discussions: While meetings were seen as long the overall view was that they focused on the right issues. Pre-meetings with the Chair were seen to have helped with this. Overall, respondents suggested that the Committee felt unitary in terms of the contributions and challenge. However, one respondent queried the psychological safety at the Committee in terms of crucial feedback.
- Quality and timeliness of papers: The quality of papers was, overall, seen to have improved significantly over the past year and were seen as goof overall though with further scope to improve. The areas in which respondents suggested further improvements could be made were: making papers more concise; providing better executive summaries; bringing greater triangulation into the reporting; and helping

the Committee to 'see the wood from the trees'. Timeliness of papers was seen to be improving but remained an area in which further improvements were needed, particular to help NED members of the Committee perform their roles effectively.

- Committee's Terms of Reference and forward work plan: Overall, there were positive responses to the terms of reference and forward work plan. Adjustments to the terms of reference were seen as necessary to reflect the move to bimonthly meetings and the forward plan would also need to reflect this.
- Committee reports to the Board: It was felt that the quality of the Committee report to the Board was good.

6. Committee Forward Plan and Terms of Reference

The terms of reference for the Committees is set out at Appendix 2 and the Committees' proposed forward work plan for 2024/25 is attached in Appendix 3. The proposed changes to the terms of reference:

- Simplify and condense the ToR by removing unnecessary detail, repetition and combining some of the duties
- Draw out the focus of the Committee on seeking assurance in relation to learning
- Draw out tackling health inequalities more explicitly as part of the role of the Committee
- Updating the membership and attendance

The nature of the Committees' work means that it does cover a broad scope of matters on behalf of the Boards. The proposed work plan for 2024/25 sets out the matters for consideration by the Committee. This builds on the learning from the previous years and supports giving more focus on health inequalities, strategy implementation to align to the proposals for overseeing implementation of the Group Strategy and the development of a new Quality Strategy. The workplan supports the Committee in providing the right level of assurance on key quality and safety matters.

Following discussion at the Board Development Session in December 2023 it had been agreed that the Committee would move to meeting on a formal basis bimonthly (every other month). In the alternate months Committee time would be used to discuss the Quality Strategy for the Group and to review any areas of concern or development in greater detail than the time available at formal meetings would allow.

The Quality Committees-in-Common approved their respective terms of reference at the meeting held in May 2023. The two Boards subsequently approved these terms of reference at the meetings held in June 2023. As the terms of reference were approved 2 years ago, no significant changes are proposed at this time.

6. Conclusion

The year 2023/24 was the second year in which the Quality Committees of the two Trusts worked together as a Quality Committees-in-Common, with a shared agenda and a common forward plan of business. Overall, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. There had been improvements in the ways of working of the Committee over the year. The Committee effectiveness review 2023/24 demonstrated the value members and attendees attach to the Group way of work working and to the benefits of this approach. However, the experience of the year of operation has also highlighted areas in which the Committees' ways of working will need to evolve in the year ahead to further strengthen its operation and effectiveness. The Committee's forward work plan for 2024/25 and review of agenda items and reporting arrangements to the Boards will help strengthen the operation of the Committees.

Quality Committee

Terms of Reference

1. Name

The Committee shall be known as the “Quality Committee”.

2. Establishment and Authority

The Committee is constituted as a committee of the Board of Directors and is authorised by the Board to:

i. Act within its terms of reference
ii. Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
iii. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
iv. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Purpose

The purpose of the Committee is to provide assurance to the Board on the quality of care provided to the Trust’s patients, specifically in relation to patient safety, clinical governance and clinical effectiveness and patient experience, as summarised below:

- Ensuring that the Trust has in place appropriate quality and clinical governance systems, processes and controls in place to achieve consistently high-quality care and to meet the Trust’s legal and regulatory obligations.
- Identifying and reviewing themes and trends in key quality indicators, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Seeking assurance that key risks relating to quality of care, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to quality and safety, specifically the Group strategic objective of right care, right place, right time.
- Overseeing and providing assurance to the Board on progress in the delivery of the strategic initiatives identified in the Group Strategy that relate to quality.
- Overseeing the development and implementation of a quality and safety strategy that supports the new Group Strategy ~~and monitoring progress in the implementation of this~~.

The role of reviewing the Integrated Performance Report on a monthly basis will be primarily undertaken by the Finance Committee. The Quality Committee will review key quality indicators as set out below.

4. Duties

The Committee's duties as delegated by the Trust Board, include:

Patient Safety

- Seek assurance that services are safe and high quality, and review action plans to address concerns regarding safety and quality.
- ~~Seek assurance on actions to deliver continuous reductions in avoidable harm and to ensure mortality rates are lower than expected.~~
- Review and seek assurance regarding the effective and consistent delivery of the fundamentals of care.
- Receive regular reports in relation to the safety and quality of maternity services, including perinatal quality surveillance measures and compliance with the safety actions in the Maternity Incentive Scheme.
- Seek assurance in relation to actions being taken in response to concerns about patient safety raised by staff and to foster psychological safety in staff feeling able to raise concerns about quality of care.
- Seek assurance on the effectiveness of the systems and processes in place to assess the quality impact of Cost Improvement Plans and other significant service changes.
- Review the effectiveness of systems and processes in relation to safeguarding and mental capacity.
- ~~Identifying~~ Reviewing the quality impact of any workforce gaps and refer any concerns to the People Committee.
- ~~Review and seek assurance in relation to key risks related to the patient safety.~~

~~Clinical~~ Quality **Governance and Clinical Effectiveness**

- Review and seek assurance in relation to the structures, systems, processes and controls in place to ensure effective and robust ~~clinical~~ quality governance.
- Review and seek assurance in relation to the full implementation of the Patient Safety Incident Response Framework and the development of an outstanding patient safety and learning culture. ~~This includes actions taken to promote and embed learning within the Trust and across the Group.~~
- Review the development of a Group-wide approach to the promotion and embedding of continuous improvement.
- ~~Monitoring~~ Seek assurance on clinical effectiveness through a review of the key ~~outcomes~~ themes and learning from the annual clinical audit programme.
- ~~Review and seek assurance in relation to key risks related to clinical governance and effectiveness.~~

Patient Experience

- Review the structures, systems, processes and controls in place in relation to patient experience and engagement, with a particular focus on the patient experience aims set out in the Group Strategy.
- ~~Monitoring~~ Seeking assurance in relation to learning from ~~actions to respond to themes and trends in patient experience through~~ the 'Friends and Family Test', national and local surveys, complaints and compliments.
- Monitoring and overseeing issues relating to equality, diversity and inclusion in relation to all matters of patient safety and quality, including access to care ~~and health inequalities~~.
- ~~Review and seek assurance in relation to key risks related to patient experience.~~

Health Inequalities

- Review and seek assurance on the work being undertaken across the Group to deliver the Group's strategic objectives in relation to tackling health inequalities.

Research and Development

- Providing strategic oversight to the Trust's research and development programme, ensuring it is effective and meets the needs of the Trust and the wider Group.
- ~~Review and seek assurance in relation to key risks related to research and development.~~

General

- Seeking assurance on quality and safety risks on the Corporate Risk Register and Group Board Assurance Framework ~~to delivery of the Trust's strategic and corporate objectives in relation to quality and safety with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Group Board Assurance Framework which relate to the scope of the Committee~~.
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, independent reviews, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response, as requested by the Audit Committee.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.
- Reviewing any relevant Trust strategies prior to approval by the Group Board (if required) and monitor their implementation and progress.

- Seeking assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission (CQC) and oversee any remedial action that may be required and monitor progress against any must and should do actions identified by the CQC.
- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.

5. Membership and Attendance

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief Medical Officer and the Group Chief Nursing Officer are the executive leads for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief Medical Officer
- Group Chief Nursing Officer
- Managing Director(s)

The following are expected to attend but will not be counted towards quoracy.

- Site Chief Medical Officer
- Site Chief Nursing Officer
- ~~Site Chief Operating Officer~~
- Group Director of Compliance
- Group Director of Quality and Safety Compliance
- Group Chief Midwifery Officer
- Group Chief Corporate Affairs Officer

Other directors and staff may attend meetings with the prior permission of the Chair.

An attendance register will be held for each meeting and an annual register of attendance will be set out in the Trust's Annual Report.

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

6. Quorum

The quorum for any meeting of the Quality Committee shall be a minimum of four members of the Committee including:

- At least two Non-Executive Directors
- At least two Executive Directors

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

7. Accountability and Reporting Arrangements

The Quality Committee operates under the delegated authority of the Board of Directors and remains ultimately accountable at all times to the Trust Board of Directors.

Under the Group Board arrangements, the Quality Committee, acting as part of a Group-wide Quality Committees-in-Common, will report to the Group Board on the meetings that have taken place since the last Group Board meeting. This will include:

- A list of all items considered by the Committee-in-Common during the relevant period
- Key issues for escalation to the Group Board
- Key issues on which the Committee-in-Common received assurance
- Other issues considered by the Committee-in-Common
- Review of risks assigned to the Committee-in-Common

In addition, the Committee will submit an annual report to the Group Board setting out how it has operated to fulfil role as set out in these terms of reference over the past year.

8. Meeting Format and Frequency

The Committee will meet bimonthly (every other month) and ahead of Group Board meetings so that a report to the Group Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

9. Declarations of Interest

All members of the Committee must declare any actual or potential conflicts of interest. These will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the meeting for the duration of the relevant item.

10. Meeting Arrangements and Secretariat

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Quality Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed in advance with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

11. Review of Committee effectiveness and Review of Terms of Reference

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. Any changes to these Terms of Reference may only be made by the Group Board following review by the Committee.

Document Control

Profile	
Document name	Quality Committee Terms of Reference
Version	1.3
Executive Sponsor	Group Chief Medical Officer and Group Chief Nursing Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	25 April 2024
Date of Trust Board approval	2 May 2024
Date for next review	April 2025

GESH QUALITY COMMITTEES-IN-COMMON: FORWARD PLAN 2024-25

SECTION	ITEM TITLE	LEAD	ACTION	FORMAT	FREQUENCY	Apr-24	Jun-24	Aug-24	Oct-24	Dec-24	Feb-25
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Serious Incidents / PSIRF Report	GCMO & GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Maternity Services	GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Maternity Governance Report	External Lead	Assure	Report	Ad hoc	X					
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Maternity Workforce Update Report	GCNO	Assure	Report	Annual						X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Infection Prevention and Control	GCNO	Assure	Report	x3 per year		X		X		X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Fundamentals of Care Report (alternating focus at each meeting)	GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Safety Concerns	GCMO, GCNO, GCCAO	Assure	Report	x3 per year		X		X		X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Learning from Deaths	GCMO	Assure	Report	Quarterly	X (Q2, Q3)			X (Q4, Q1)		
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Learning from Claims and Inquests Annual Report	GCCAO	Assure	Report	Annual		X				
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Pharmacy	GCMO	Assure	Report	Biannual			X			X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Controlled Drugs Annual Report	GCNO	Assure	Report	Annual						X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Safeguarding Annual Report (inc. MCA, DoLS, LAC)	GCNO	Assure	Report	Annual			X			
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	South West London Pathology Quality Report	SWLP	Assure	Report	Biannual		X			X	
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Cardiac Surgery (SGUH)	GCMO	Assure	Report	Ad hoc	X					
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Head and Neck Review Action Plan Update (SGUH)	GCMO	Assure	Report	Ad hoc			X			
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Association of Perioperative Practice Report & Action Plan (SGUH)	GCMO	Assure	Report	Ad hoc		X				
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Interstitial Lung Disease (ESTH) (External Review; AI)	GCMO / MD-ESTH	Assure	Report	Ad hoc		X				
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Integrated Quality and Performance Report (Quality Metrics)	GCMO & GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Winter Plan 2024/25	GCMO & GCNO	Assure	Report	Annual				X		
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Quality Impact Assessments and Cost Improvement Plan	GCMO & GCNO	Assure	Report	Annual		X			X	
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Clinical Audit and Effectiveness Annual Report and Forward Plan	GCMO	Assure	Report	Annual		X				
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Clinical Ethics Committee Annual Report	GCMO	Assure	Report	Annual						X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Caldicott Guardian Annual Report	GCMO	Assure	Report	Annual						X
IMPROVING SAFETY & REDUCING AVOIDABLE HARM	Human Tissue Authority Compliance Report	GCMO	Assure	Report	Annual					X	
TACKLING HEALTH INEQUALITIES	Health Inequalities and Population Health	GCMO	Assure	Report	x3 per year		X		X		X
IMPROVING PATIENT EXPERIENCE	Patient Experience and Engagement Report	GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
IMPROVING PATIENT EXPERIENCE	Complaints and PALS Report	GCNO	Assure	Report	Biannual			X			X
IMPROVING PATIENT EXPERIENCE	Adult Inpatient Survey Results	GCNO	Assure	Report	Ad hoc	As published through the year					
IMPROVING PATIENT EXPERIENCE	Voluntary Services Report	GCNO	Assure	Report	Annual					X	
IMPROVING PATIENT EXPERIENCE	Chaplaincy Report	GCNO	Assure	Report	Annual						X
DEVELOPING NEW TREATMENTS THROUGH RESEARCH & INNOVATION	Research and Development Strategy (Development & Implementation)	GCMO	Review	Report	x3 per year		X		X (D)		X (I)
STRATEGY, RISK & GOVERNANCE	GESH Quality Group Key Issues Report	GCMO, GCNO	Assure	Report	Every meeting	X	X	X	X	X	X
STRATEGY, RISK & GOVERNANCE	Group Board Assurance Framework (SR7, SR9, SR10, SR11)	GCCAO	Assure	Report	x3 per year		X		X		X
STRATEGY, RISK & GOVERNANCE	Corporate Risk Register (Quality and Safety Risks)	GCCAO	Assure	Report	Biannual			X		X	
STRATEGY, RISK & GOVERNANCE	Quality and Safety Strategy (Development; Implementation)	GCMO & GCNO	Assure	Report	Biannual		X (D)			X (I)	
STRATEGY, RISK & GOVERNANCE	CQC Self Assessment	GCMO & GCNO	Assure	Report	Biannual	X				X	
STRATEGY, RISK & GOVERNANCE	CQC Statement of Purpose	GCNO	Review	Report	Annual						X
STRATEGY, RISK & GOVERNANCE	Draft Quality Account 2023/24	GCNO	Review	Report	Annual	X					
STRATEGY, RISK & GOVERNANCE	Quality Priorities 2024/25(To Set; Update on Progress)	GCMO & GCNO	Review	Report	Annual						X
STRATEGY, RISK & GOVERNANCE	Quality and Safety Policies	GCCAO	Assure	Report	Biannual					X	
STRATEGY, RISK & GOVERNANCE	Committee Effectiveness (inc. ToR review, forward plan and Annual Report)	GCCAO	Approve	Report	Annual	X					

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Quality Committee-in-Common

Committee Effectiveness Review 2023/24

Stephen Jones
Group Chief Corporate Affairs Officer

April 2024

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1. Introduction
Purpose, context and recommendations

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Quality Committees-in-Common in 2023/24. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2023/24.

Background and context
It is good governance practice for all Committees of the Board to hold annual effectiveness reviews and report on these to the Board. The Committee reviewed the plan for this year's effectiveness survey at its meeting in March 2024. Responses were sought via an online survey tool. The anonymised responses to the survey is attached at Appendix 1.

Summary
Overall, 80% of respondents rated the Committee as "very effective" and 20% rated the Committee as "somewhat effective". Stepping back, there was clear feedback that the Committee is working better now than it was a year ago, that the new Committee Chair in Common was having a positive impact on Committee effectiveness and helping to focus the Committee on the right issues and promoting greater triangulation. Meetings were seen as long, but there was a feeling that the focus was on the right issues. The quality of papers was seen as improving, with some high quality, but timeliness of papers, while also improving, remained a challenge. Respondents fed back on the need for more concise papers, with better executive summaries, and better triangulation. There was greater variation in responses on attendance, with some seeing the number of attendees as too large and others proposing an expansion of attendance, including one suggestion to include Divisional Chairs and Clinical Directors to help improve the flow from ward to Board.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2024/25.

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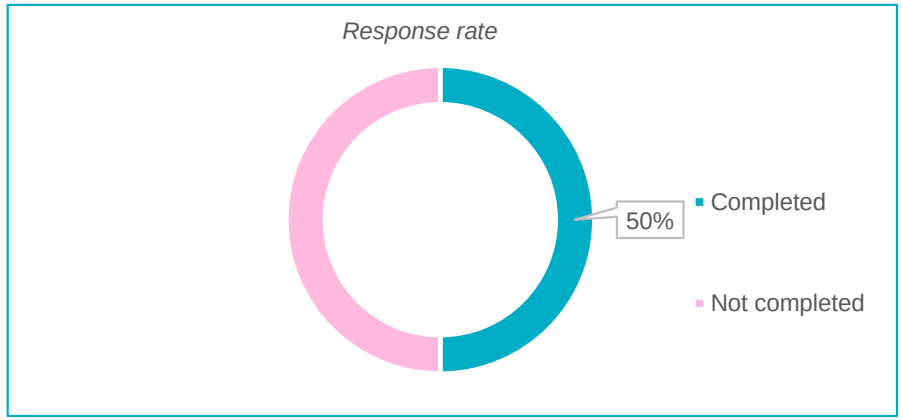
2. Engagement

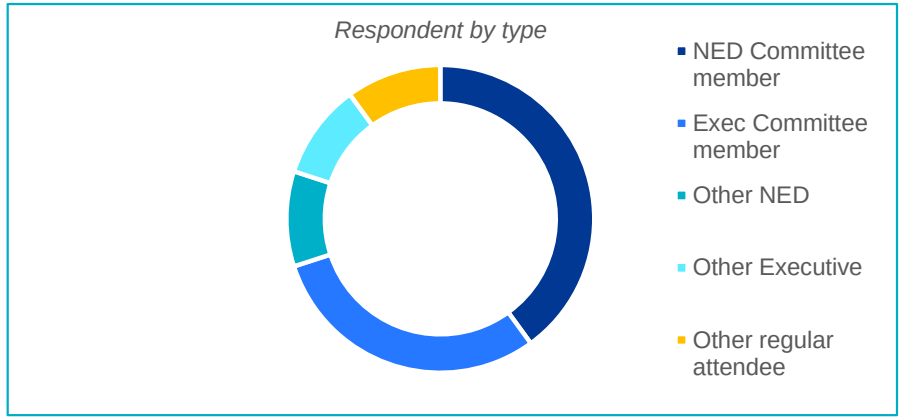
Response rate and respondent types

The following groups were invited to participate in the Committee effectiveness survey:

- Non-Executive members of the Committee
- Executive members of the Committee (Group Chief Medical Officer, Group Chief Nursing Officer)
- Other Non Executive Directors who attend the Committee
- Other Executive Directors who attend the Committee
- Site Managing Directors
- Regular attendees as set out in the Committee's terms of reference (Site Chief Medical Officers, Site Chief Nursing Officers, Site Chief Operating Officers, Director of Quality Governance and Compliance, Group Chief Corporate Affairs Officer)

In total, 20 people were invited to participate in the survey. Of these a total of 10 engaged with and provided responses to the survey, a response rate of 50%.





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3. Key findings

Overall effectiveness

The pages that follow provide a summary of the responses and free text comments provided by respondents to the Committee effectiveness survey. Stepping back from the detailed responses, the following broad themes emerge from the survey:

Overall Effectiveness: 80% of respondents considered the Committee to be "very effective" and 20% of respondents regarded the Committee as "somewhat effective". No respondents rated the Committee as "extremely effective" but neither did any respondents feedback that they considered it either "neither effective nor ineffective" or "not effective". Beyond the overall effectiveness rating, the responses and free text comments on the questions painted a picture of a Committee that had improved considerably over the past year and that it was continuing to improve. The move to bimonthly (every other month) meetings in 2024/25 was seen as an opportunity to further improve the Committee's effectiveness.

Chairing of meetings: There was very positive feedback on the chairing of meetings, particularly with the move to a single Committee Chair in Common for the Committee. The new Chair was seen to have been very effective in focusing the Committee on assurance and triangulation and ensuring that the Committee focused its time on the right issues. The chairing came through as one of the most significant contributors to the improving effectiveness of the Committee.

Attendance: This was an area with some variation in responses. Some respondents suggested that too many people attended the Committee and suggested that attendance should be reviewed to reduce the number. One suggestion was that fewer Executive Directors should attend. However, others suggested that attendance should be extended. One suggested this would help with "handing off" issues and ensuring follow up of actions. Another suggested that Divisional Chairs and Clinical Directors should attend the Committee to bring greater insight from services and to assist in ward to Board communication.

Discussions: While meetings were seen as long the overall view was that they focused on the right issues. Pre-meetings with the Chair were seen to have helped with this. Overall, respondents suggested that the Committee felt unitary in terms of the contributions and challenge. However, one respondent queried the psychological safety at the Committee in terms of crucial feedback.

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3. Key findings

Overall effectiveness

Quality and timeliness of papers: The quality of papers was, overall, seen to have improved significantly over the past year and were seen as goof overall though with further scope to improve. The areas in which respondents suggested further improvements could be made were: making papers more concise; providing better executive summaries; bringing greater triangulation into the reporting; and helping the Committee to 'see the wood from the trees'. Timeliness of papers was seen to be improving but remained an area in which further improvements were needed, particular to help NED members of the Committee perform their roles effectively.

Committee's Terms of Reference and forward work plan: Overall, there were positive responses to the terms of reference and forward work plan. Adjustments to the terms of reference were seen as necessary to reflect the move to bimonthly meetings and the forward plan would also need to reflect this.

Committee reports to the Board: It was felt that the quality of the Committee report to the Board was good.

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4. Next steps

"So what" and "what now"?

The following specific actions are proposed for implementation for the Quality Committee for 2024/25, noting that the overall ways of working agreed for all Committees-in-Common at the Board development sessions in December 2022 and December 2023 also apply:

- **Bimonthly rhythm:** We need to ensure that the new bimonthly rhythm of meetings works effectively, supported with an appropriate forward plan of items that ensures the Committee covers the right issues and provides time for the Committee to have the necessary discussions. The Committee reviewed an initial draft of the forward plan for bimonthly meetings in March and this will be key in ensuring the Committee works effectively as we move to bimonthly meetings.

- **Quality of papers:** Ensure that papers are more concise with high quality executive summaries that give the reader a clear sense of the issues and decision needed. Papers need to avoid unnecessary detail, use appendices appropriately and make use of the Reading Room for information that is of interest and is supplementary to the issue at hand. Greater triangulation to be incorporated into papers.

- **Timeliness of papers:** Publication of papers in a timely manner needed to improve. Default position is that papers not submitted on time will be removed from the agenda, unless specifically agreed by the Committee Chairs and Executive lead

- **Attendance:** The Committee is asked to review the divergent feedback on the issue of attendance. It is not proposed that we include Divisional Chairs and Clinical Directors to attend the Committee, but the Committee reviewing the 'tartan rug' heat map will be key to assisting with ward to Board oversight.

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Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	2.2a	
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 March (actually 5th April) and April 2023 and sets out the matters the Committee wishes to bring to the attention of the Board.

Action required by Group Board

The Board is asked to note the paper.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/a

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☒ Right care, right place, right time	
☐ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
[Summarise the key risks on the Corporate Risk Register and Board Assurance Framework to which this paper relates. Also set out any risks relevant to the content of the paper – set out further detail in the main body of the paper.]				
CQC Theme				
☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☐ People	
☐ Preventing ill health and reducing inequalities			☐ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
n/a				
Legal and / or Regulatory implications				
n/a				
Equality, diversity and inclusion implications				
n/a				
Environmental sustainability implications				
n/a				

Finance Committee-in-Common Report
Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in March (actually 5th April) and April 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 5th and 25th April 2024, the Committee considered the following items of business:

5th April 2024	25th April 2024
PUBLIC MEETING • Finance Report/Forecast (M11) • Cash update • Planning 24/25 • IQPR • Operational risks deep dive • SGH policies update	**PUBLIC MEETING** • Finance Report Year End 23/24* • Cash update • Planning 24/25* • IQPR • Committee Effectiveness 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) Year End 23/24- The GCFO noted both Trusts have delivered their year end forecast deficits (SGH £3.6m; ESTH £4.5m) and have submitted their first draft accounts on time.

b) Planning 24/25- The GCFO introduced an update on financial planning for 24/25, asking the FCIC to approve the respective planned deficit positions. This Committee members **approved these plans for each Trust** and reflected that this was the best financial position that could be achieved based on latest information.

4.0 Sources of Assurance

4.1

a) Cash update

The GCFO introduced the cash update which outlined both Trusts' cash expectations for Q1 and Q2, and best estimates of when drawdown may be needed.

b) IQPR

Urgent and emergency care services at both trusts continue to experience significant pressure. ESTH remain challenged across both sites with many unplaced patients remaining in the Emergency Department, ambulance delays, and high numbers of mental health patients requiring admission. Teams are working with SWL & St Georges Mental Health Trust to explore mental health rapid access clinics for appropriate patients presenting to ED. The service has also undertaken a review of 2023/24 urgent care work programme and have agreed a set of programme priorities for 2024/25. There are high numbers of medically fit patients occupying acute beds on both hospital sites, with many requiring complex discharge planning. The Urgent and Emergency Care (UEC) pathway continues to be a priority for improvement for the Group.

Both ESTH and SGH are not meeting current trajectories to reduce the numbers of patients waiting for more than **52 weeks** to commence definitive treatment. ESTH is particularly challenged with 903 patients waiting for more than 52 weeks at the end of February 2024, primarily in Gynaecology (318), Community Paediatrics (224). The 65-week wait cohort at ESTH remains high due to strike action and delays to insourcing plans for Gynaecology and Community Paediatrics. Recovery plans are in place with private capacity for Community Paediatrics starting on 20th April 2024. At SGH, the number of patients waiting over 65 weeks has now exceeded plan. Neurosurgery is a specialty of concern although all potential 65-week breaches are being scrutinised weekly.

Against the 5% maximum national ambition for **diagnostic waits** over 6 weeks, SGH achieved 3%, and ESTH reported 3.8%.

ESTH delivered against all three national **cancer standards** in February 2024: 28-Day Faster Diagnosis (85.9%), 31-Day Decision to Treatment (100%), and 62-Day Referral to First Treatment (86.3%). SGH reported improved FDS performance, reporting 71.7% (up from 61.8% in January 2024), with Skin performance anticipated to improve in March 2024. Although SGH did not achieving the 62-Day Referral to First Treatment in February 2024 (74.4% vs 85%), the monthly trajectory was met. There are plans in place to reduce backlogs through expansion of tele-dermatology clinics, additional gynaecology clinics, and the installation of a new CTC scanner in March 2024. Work is underway to improve pathology turnaround times also.

Integrated Care Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in March 2024. Sutton Health & Care achieved 90.7% and Surrey Downs Health & Care, 86.7%, with a continued focus on encouraging more referrals. At Sutton, a refresh in data collection logic ensures that we are capturing all referral routes and more accurately reporting our demand.

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

a) SGH Policies

The Committee **approved updated Asset Management, Credit Management and Treasury Management policies.**

b) Committee Effectiveness

Committee members noted the responses following the committee effectiveness survey. Suggestions for improvements included reviewing performance data every two months, to shorten the length of some of the meetings.

5.0 Implications

5.1 The Committee considered the operational-related risks on the SGH and ESTH Trust Corporate Risk Register (CRR).

5.2 The Committee agreed to approve new risks, risk closure and downgrade as suggested, while suggesting further alterations to be considered.

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 March and April 2024.

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	2.2b	
Report Title	**Finance Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

It is good governance practice for each Committee of the Board to produce an annual report setting out how it has fulfilled its duties and responsibilities as outlined in its established terms of reference. It is also good practice for each Committee to review its terms of reference on an annual basis – making proposals for amendment as necessary to the Board – and agree a forward plan of business for the year ahead.

This report introduces and appends the draft Finance Committees-in-Common report to the Group Board.

Action required by Finance Committees-in-Common

The Board is asked to note the Finance Committees-in-Common annual report.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Finance Committees-in-Common Annual Report 2023/24

Implications

Group Strategic Objectives

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

Risks

CQC Theme				
☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes		☐ People		
☐ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☒ Finance and use of resources		☐ Local strategic priorities		
Financial implications				
There are no financial implications relating to this report.				
Legal and / or Regulatory implications				
There is no legal or regulatory requirement for there to be a Finance Committee, but it is good practice to have such a committee in place to oversee and provide assurance to the Board on finance, operational, estates and IDT.				
Equality, diversity and inclusion implications				
The paper has no EDI implications				
Environmental sustainability implications				
There are no specific environmental sustainability implications of this report.				

Finance Committees-in-Common Annual Report to the Group Board

Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This paper provides the Group Board with the annual report of the work of the Committees in 2023/24. The Group Board is asked to note the annual report.

2.0 Background

2.1 It is good governance practice for all committees of the Boards to submit an annual report setting out their key areas of focus over the past year and demonstrating how they have sought to perform their role in accordance with their agreed terms of reference.

2.2 With the Finance Committees of both Trusts having operated as a Committees-in-Common in 2023/24, capturing the work of the Committees and how they have provided assurance to the Group Board is particularly important in supporting effective oversight of the Group governance arrangements.

2.3 With the establishment of the new Group Board arrangements from May 2023, the Finance Committees-in-Common annual report will be presented to the Group Board for review, which operate with delegated authority from each of the sovereign Trust Boards. Each of the two Finance Committees remains ultimately accountable to the sovereign Board of its respective Trust.

3.0 Finance Committees-in-Common Annual Report

3.1 The Finance Committees-in-Common Annual Report is set out at Appendix 1. The report sets out:

- the operation of each Committee as a Committees-in-Common in 2023/24
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2023/24
- key areas of activity and focus by the Committees in 2023/24

3.2 The purpose of the annual report is to provide a high level overview of the Committee's work and how it has delivered against its purpose and duties as set out in its agreed terms of reference. It is not, and does not seek to, describe all issues addressed by the Committee over the past year.

3.3 The draft annual report describes the work of the Committees-in-Common in an integrated way where possible, but where significant Trust-specific items have been considered, the report sets these out as Trust-specific areas of Committee focus and attention.

4.0 Recommendations

4.1 The Group Board is asked to note the draft Finance Committees-in-Common annual report.

Finance Committees-in-Common Annual Report 2023/24

1 April 2023 – 31 March 2024

Contents

Finance Committees-in-Common Annual Report 2022/23

1. Introduction

In February 2022, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group. In March 2022, the Boards of Directors of the two Trusts agreed that from April 2022 a number of Board Committees would operate as Committees-in-Common across the Group. These included the People Committees, Quality Committees and Finance Committees of the two Trusts.

At the Finance Committees-in-Common in March 2023 a forward plan of business for 2023/24 was agreed. The forward plans and terms of reference for the two Committees were approved at the Group Board meeting in July 2023.

This report sets out a high level overview of the work of the Finance Committees-in-Common in 2023/24. It provides an integrated report on the key matters considered by the Committees, but highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The Finance Committees of the two Trusts have adopted identical terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference agreed by the St George's and Epsom and St Helier Trust Boards on 7 and 8 July 2022 respectively.

2.1 Purpose

The purpose of each Committee is to assist the Board in maximising the Trust's healthcare provision within available financial constraints by:

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its annual financial targets and uses public funds.
- Approving the annual operational plan and reviewing performance to ensure the Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance in relation to the management of the Trust's estates, facilities and IT services (which from autumn 2023 was transferred to the Infrastructure Committee)
- Seeking assurance that key risks relating to finance, performance, IT and estates, as included on the Board Assurance Framework and the Corporate Risk Register, are

being effectively managed and mitigated (IT and estates from autumn 2023 move to Infrastructure Committee).

- Overseeing the implementation of strategies and other frameworks and risks to their delivery.

2.2 Duties

Each of the Committees has the following duties:

Finance and Business Planning

- Assessing the timeliness and robustness of the annual business planning process.
- Reviewing and recommending the annual financial plan, including capital plan, for approval by the Board.
- Approving cost improvement and income plans and seeking assurances that any resulting service changes are safe and do not have an adverse effect on the quality of patient care.
- Approving returns and submissions on behalf of the Board.
- Reviewing productivity, profitability and efficiency metrics.

Financial Strategy and Management

- Reviewing all aspects of financial performance against plan in order to provide assurances to the Board.
- Approving policies in relation to cash management and ensuring they are effective.
- Reviewing arrangements for effective compliance and reporting in respect of loan covenants in place or other requirements relating to borrowed funds.
- Reviewing and seek assurance in relation to key risks related to the operation of the Trust's financial systems and processes and the delivery of the financial plan.

Procurement

- Overseeing the implementation of the Trust's Procurement Strategy.
- Approving the annual procurement plan and receiving progress reports on their implementation.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.

Business Cases, Benefits Realisation and Return on Investment

- Reviewing and approving business cases, tenders and bids for new business opportunities and investment required in service developments in line with approved limits in the Trust's financial Scheme of Delegation.
- Considering any significant infrastructure investment prior to proposals being put to the Board for consideration/approval.
- Reviewing benefits realisation and return on investment of major projects.

Operational Performance

- Reviewing the performance of the Trust on a monthly basis across the range of performance indicators within the Integrated Performance Report prior to consideration by the Trust Board, including NHS Constitutional Standards.
- Scrutinising key indicators where performance is deteriorating and/or is off trajectory and seeking assurance that appropriate actions are being taken to bring performance back to trajectory.
- Reviewing the Trust's performance against any other key metrics and performance indicators included in the NHS System Oversight Framework and seeking assurance that appropriate actions are being taken to bring performance back to trajectory where applicable.
- Reviewing the development of the Trust's operational plan and other relevant regulatory submissions, including the winter plan, prior to submission to the Trust Board for approval.
- Overseeing the Trust's arrangements for, and compliance with, national standards in relation to Emergency Preparedness Resilience and Response (EPRR), and reviewing the annual EPRR submission to NHS England and NHS Improvement.

Estates, information technology, and health and safety (from autumn 2023 this transferred to the Infrastructure Committee)

- Seeking assurance in relation to he safe operation and performance of the Trust's estates and facilities, including security management of the Trust's assets and estates.
- Providing oversight and seek assurance in relation to the Premises Assurance Model.
- Making recommendations to the Board about any estate disposal, acquisition or estate change of use in accordance with the Trust's Strategy.
- Seeking assurance in relation to the operation and performance of the Trust's information technology infrastructure, systems and processes.
- Ensuring the Trust has robust processes for complying with health and safety legislation and that all relevant risks are identified, mitigated and reported.

General

- Referring any matter to any other Board Committee and responding to items referred to the Committee from other Board Committees and / or the Board.
- Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to finance, performance, estates and IT with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Board Assurance Framework which relate to the scope of the Committee. (IT and estates from autumn 2023 move to Infrastructure Committee).
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seeking assurance that appropriate actions are taken in response, as requested by the Audit Committee.

- Ensuring there is a system in place to review and approving relevant policies and procedures that fall under the Committee's areas of interest.
- Receiving and reviewing reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, and seeking assurance that appropriate action is being taken to address these.
- As required, reviewing any Trust strategies within the remit of the Committee prior to approval by the Board (if required) and monitor their implementation and progress.

3. Membership and attendance

3.1 Members and attendees

The Committees-in-Common continue to meet 'virtually' as in previous years since the pandemic.

During the reporting period (April 2023 to March 2024), the following were members or regular attendees of the Finance Committees-in-Common:

St George's Finance Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 March 2024
Gillian Norton	Member	Chairman-in-Common, Non-Executive Director	1 April 2023 – 31 March 2024
Peter Kane	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Stephen Collier	Member	Non-Executive Director	1 April 2023 – 30 September 2023
Tim Wright	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Jacqueline Totterdell	Member	Group Chief Executive Officer	1 April 2023 – 31 March 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
James Marsh	Member	Group Deputy Chief Executive Officer	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
Kate Slemeck	Member	Managing Director – St George's	1 April 2023 – 31 March 2024
Paul da Gama	Attendee	Group Chief People Officer	1 April 2023 – 31 December 2023
Angela Paradise	Attendee	Group Chief People Officer	1 January 2024 – 31 March 2024
Peter Davies	Attendee	Group Chief Digital Officer	1 April 2023 – 31 July 2023
Thirza Sawtell	Attendee	Group Executive Director of Integrated Care	1 April 2023 – 31 March 2024
Tara Argent	Attendee	Site Chief Operations Officer	1 April 2023 – 31 March 2024
Andrew Asbury	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 April 2023 – 28 February 2024
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 September 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
Helen Jameson	Attendee	SWL Chief Financial Officer	
Andy Stephens	Attendee	Site Director of Financial Strategy	1 April 2023 – 31 March 2024
George Harford	Attendee	Site Chief Financial Officer	1 April 2023 – 31 March 2024

Epsom & St Helier People Committee

Name	Role	Designation	Period
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 March 2024
Gillian Norton	Member	Chairman-in-Common, Non-Executive Director	1 April 2023 – 31 March 2024
Peter Kane	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Martin Kirke	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Jacqueline Totterdell	Member	Group Chief Executive Officer	1 April 2023 – 31 March 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
James Marsh	Member	Group Deputy Chief Executive Officer	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2023 – 31 March 2024
Paul da Gama	Attendee	Group Chief People Officer	1 April 2023 – 31 December 2023
Peter Davies	Attendee	Group Chief Digital Officer	1 April 2023 – 31 July 2023
Thirza Sawtell	Attendee	Group Executive Director of Integrated Care	1 April 2023 – 31 March 2024
Alex Shaw	Attendee	Site Chief Operations Officer	1 April 2023 – 31 March 2024
Andrew Asbury	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 April 2023 – 28 February 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 September 2023 – 31 March 2024
Lizzie Alabaster	Attendee	Site Chief Financial Officer	1 April 2023 – 31 March 2024
Helen Jameson	Attendee	SWL Chief Financial Officer	1 October 2023 – 31 March 2024
Alastair Haggart	Attendee	Site Deputy Director of Finance - Operations	1 April 2023 – 31 March 2024

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors can attend if they wish to observe meetings of the Finance Committees-in-Common.

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the Finance Committee of each Trust was required to be quorate. The quorum for each Finance Committee was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 11 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees-in-Common were quorate for both Trusts.

Attendance			
Name	Role	Trust	Attendance
Ann Beasley	Committee Chair	Both	11/11
Gillian Norton	Member	Both	9/11
Peter Kane	Member	Both	11/11
Stephen Collier	Member	SGUH	6/6
Tim Wright	Member	SGUH	9/11
Martin Kirke	Member	ESTH	11/11
Jacqueline Totterdell	Member	Both	5/11

Andrew Grimshaw	Member	Both	11/11
James Marsh	Member	Both	11/11
Richard Jennings	Member	Both	9/11
Arlene Wellman	Member	Both	6/11
Kate Slemeck	Member	SGUH	10/11
James Blythe	Member	ESTH	10/11
Paul da Gama	Attendee	Both	5/9
Angela Paradise	Attendee	Both	2/2
Peter Davies	Attendee	Both	3/4
Thirza Sawtell	Attendee	Both	6/11
Alex Shaw	Attendee	ESTH	8/11
Tara Argent	Attendee	SGUH	9/11
Andrew Asbury	Attendee	Both	7/11
Stephen Jones	Attendee	Both	3/11
Andy Stephens	Attendee	SGUH	10/11
Alastair Haggart	Attendee	ESTH	10/11
Ed Nkrumah	Attendee	Both	5/6
Helen Jameson	Attendee	Both	4/5
George Harford	Attendee	SGUH	11/11
Lizzie Alabaster	Attendee	ESTH	11/11

No members of the St George's Council of Governors observed meetings of the Finance Committees-in-Common during this period.

4. Committee activity and focus

4.1 Finance and Business Planning

The Committee received monthly updates on iterations of the Group financial plans for 2023/24 in the early part of the year, before turning attention to 2024/25 in the autumn. Discussions focussed on the planning and delivery of CIPs, as well the impact of industrial action, inflation (in view of the cost of living challenge nationally) and exit run rates from the previous year.

In addition, greater emphasis was placed on contractual negotiation and the delivery of Elective Recovery Fund targets as the NHS moves to new business rules following the global pandemic. As the Group heads into 2024/25 there will also be additional scrutiny on cash management, and capital expenditure.

The Committee now regularly receives updates on Group Productivity following metrics published nationally, which comments on the validity of results obtained. As well as this, there is a quarterly update on costing and the performance against national benchmarks.

The Group delivered a financial deficit for 2023/24 of £8.1m, (with SGH at (£3.6m) and ESTH at (£4.5m)), which is in line with the forecast agreed with SWL and NHSE after the M11 monitoring returns. At the time of writing the Committee approved the proposed financial plans for 2024/25 and agreed to recommend them to the Boards in Common, with a final agreed plan of (£55.0m) for ESTH and (£60.4m) for SGH, a total group deficit of £115.4m.

4.2 Financial Strategy and Management

As the year has progressed, the Committee has reviewed progress on the Building Your Future Hospitals (BYFH) project as part of the New Hospitals Programme. Updates will continue to be received in 24/25 as this is another important year for this development.

The Committee receives annual assurances from the refresh of SGUH Financial policies, with an emphasis on moving to Group level financial policies in the near future. The Committee agreed updated Petty Cash and Business Expenses policies in June 2023, Private and Overseas patient policies in September 2023 and Treasury Management, Asset Valuation and Credit Management policies in March 2024.

The management of cash is now a key topic of discussion with loan financing accessed in 2023/24. The Group is monitoring the impact of the 2024/25 plan and forecast for cashflow changes that may require the use of new loan financing.

Financial risk remained a crucial part of discussions during the year. The Committee agreed to recommend a score of 20 for ESTH and 25 for SGH under the new strategic (BAF) risk 4 related to financial sustainability.

4.3 Procurement

On a quarterly basis throughout the year, the Committees-in-Common received regular updates on Procurement progress, including updates on CIP plans, as well as the latest on breaches and waivers. The Committee recommended procurements for:

- SWL Pathology contracts in Cellular Pathology, Blood sciences and Courier services
- Dialysis contracts at Kingston and Epsom & St Helier
- Prosthetics and Orthotics Managed Service

4.4 Business Cases, Benefits Realisation and Return on Investment

The Committees in Common received regular updates on major group business cases, including in this financial year including the ITU build, the ESTH Bank Insourcing, Digital Pathology and the Renal build.

The EPR project was also regularly brought to committee in the IDT section (before moving to the Infrastructure Committee in autumn 2023).

4.5 Operational Performance

Over the past year, the Finance Committees-in-Common have reviewed and sought assurance in relation to the delivery of key operational metrics, namely the Emergency Care Operating Standard, the suite of national Cancer targets, RTT performance (specifically number of 65 and 52 week waits), Diagnostic performance and Activity levels (related to the financial ERF target).

The Committee have also received assurance on the Operational risk associated with delivering these targets, especially following the impact of industrial action.

4.6 Estates, information technology, and health and safety

The committee considered the risks associated with these areas before it was transferred to the infrastructure committee in autumn 2023.

4.7 General

During the year, the Finance Committees-in-Common also reviewed the position of each Trust's finance-related Trust-wide policies. The Committees sought assurance that plans were being developed to harmonise finance-related policies across the Group and looks forward to receiving further updates in the coming months.

The Committees also regularly highlight areas of escalation as appropriate to the Group Board.

5. Committee Effectiveness

The Finance Committees-in-Common conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. Respondents felt that the Finance Committee-in-Common was working well, with scope to make further improvements. The main issues highlighted in the effectiveness review are set out below:

- **Chairing:** Committee members praised the effective chairing, although there was a comment that disciplined questioning would shorten a long meeting.
- **Scope and timing:** Members noted that the inception of the Infrastructure Committee had assisted with timings but an approach of reviewing performance every two months may assist in reducing committee time for a meeting that can still last 4 hours.
- **Timeliness of papers:** It was noted that late papers were submitted to committee and this was seen as impacting negatively on Committee effectiveness. It was noted that this is sometimes unavoidable due to external pressures.
- **Executive Leadership:** Respondents noted the high quality of financial leadership and asked for more input from non-finance executives to the financial challenges being experienced.
- **Constructive challenge:** It was noted that the impact of the challenge made at committee was not always known, and whether more challenge on making difficult decisions would assist the committee effectiveness.

The Finance Committees-in-Common discussed the results of the effectiveness review at its meeting in April 2024. The Committees discussed the feedback regarding the length of meetings but agreed that with the scale of the financial challenges both across the Group and the wider NHS it was not an appropriate time to reduce the finance content of meetings. However, it agreed to incorporate the operational review every two months rather than monthly. The Committee agreed to build in the other areas of feedback from the review into its ways of working and forward plan for the year ahead.

6. Committee Forward Plan and Terms of Reference

An updated terms of reference will be produced in time for the June 2024 Committee and the Committees' proposed forward work plan for 2023/24 has already been approved by Committee in March. The nature of the Committees' work means that it does cover a broad scope of matters on behalf of the Boards. The proposed work plan for 2024/25 sets out the matters for consideration by the Committee. It may be necessary to adjust this (subject to operational pressures) to focus on areas of immediate priority.

7. Conclusion

The year 2023/24 was the second year in which the Finance Committees of the two Trusts worked together as a Finance Committees-in-Common, with a shared agenda and a common forward plan of business. Overall, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated the value members and attendees attach to this new way of working and to the

potential benefits of this approach. However, the experience of the second year of operation has also highlighted areas in which the Committees' ways of working will need to evolve in the year ahead to further strengthen its operation and effectiveness. The Committee's forward work plan for 2024/25 and review of agenda items and reporting arrangements to the Boards will help strengthen the operation of the Committees.

Group Board

Meeting in Public on Thursday, 02 May 2024

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

Executive Summary

This report sets out the key issues considered by the People Committees-in-Common at its meetings in March and April 2024 and sets out the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- People Strategy: The draft People Strategy, which is on the agenda of the Group Board meeting on 2 May, was considered by to the Committee in March 2024 ahead of review at a Group Board development session in April. The Committee welcomed the draft strategy and provided feedback on the themes and priorities and endorsed the strategy being presented to the Group Board, subject to any further feedback from Group Board members. It was noted that an Equality, Diversity and Inclusion plan was also being developed to prioritise actions to effect a step change in the Group's approach and maximising impact. This would complement the people strategy.

- Gender Pay Gap Report: The Committees received delegated authority from the Group Board to review and approve for publication the annual Gender Pay Gap reports for the two Trusts, which capture data from 31 March 2023. The Gender Pay Gap reports are on the Group Board agenda for 2 May. The Committees discussed the key elements of the reports. At SGUH, there had been an improvement in the mean gap reducing by £1.33 but an increase in the median pay gap by 26p. Male consultants were paid on average £3.45 more per hour than females. The mean bonus gap had reduced year on year, from 34.17% to 32.10%. At ESTH, the mean pay gap had increased by 5p to £3.26 since March 2022 and male median pay was 24p lower than females. Male consultants were paid on average £4.48 more per hour than females. The number of male staff being paid bonuses was 6 times higher than female staff at ESTH. Across the Group, females were over-represented in the lower bands with male colleagues over-represented at 8b and above. The Committees were assured that the actions necessary to address the findings of the reports were already incorporated into the work being taken forward to develop an EDI plan for the Group. Regarding the requirement to analyse available data on pay gaps across the protected characteristics and implement an improvement plan for race and sex by 2024, it was noted that the Group may struggle to meet the deadline.

- Equality Delivery System (EDS) Report: The Committees received delegated authority from the Group Board to review and approve the EDS report for publication on the Trust websites. The Committees reviewed the EDS report in April 2024, which covered 3 domains: Commissioned or provided services completed for both Trusts (SGUH reviewed Cancer and Maternity Services and ESTH reviewed Cancer, Diabetes and Maternity); Workforce health and well-being completed for both Trusts; and Inclusive leadership, pending further discussion with Trust Board.

  The Committees reviewed the reports in detail and considered that further work was necessary before the reports would be ready for publication. In particular, the Committees highlighted concerns regarding the actions arising from the report which needed to feed into overall EDI action planning in a clear and coherent way. The Committees also highlighted that the proposed actions set out in the report had not been costed or incorporated into the 2024/25 financial plan for either Trust and costs would need to be defined, following which consideration could be given as to how best to proceed. The Committees agreed that the EDS report could not be approved, based on the need for further work on the actions and the need for thorough review from the Group Executive. The Committees agreed that the EDS report would come back to the next Committee meeting ahead of consideration by the Group Board. The Committees recognised that this decision would mean that the Trusts would not meet the deadline for publishing the reports this year.

Action required by Group Board

The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in March and April 2024.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

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

People Committees-in-Common Report
Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meetings in March and April 2024 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

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

2.0 Items considered by the Committees

2.1 At its meetings on 22 March and 18 April 2024, the Committee considered the following items of business:

March 2024	April 2024

• Group Chief People Officer Report
• People Strategy*
• Gender Pay Gap Report*
• Group Workforce Key Performance Indicators Report with metrics
• 6 months progress update on ESTH Bank Service Insourcing
• Job planning update for 2024-25
• Medical Revalidation Responsible Officer Q3 Update
• Guardian of Safe Working Q3 Report
• People Management Group Report
	• Group Chief People Officer Report
	• Equality Delivery System Report
	• Staff Health & Wellbeing Report
	• Staff Support Counselling & Mediation
	• Certificates of Sponsorship Update
	• NHS Staff Survey Summary
	• Covid and Flu Vaccination Programme Update
	• People Committees-in-Common Annual Report to the Group Board 2023/24, including*:
	  ○ People Committee Annual Report 2023/24
	  ○ Terms of Reference review
	  ○ Committee Effectiveness Report 2023/24

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

2.2 The Committees have been meeting on a monthly basis, and the chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH.

3.0 Key issues for escalation to the Group Board

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

a) People Strategy: The draft People Strategy, which is on the agenda of the Group Board meeting on 2 May, was considered by to the Committee in March 2024 ahead of review at a

Group Board development session in April. The Committee welcomed the draft strategy and provided feedback on the themes and priorities and endorsed the strategy being presented to the Group Board, subject to any further feedback from Group Board members. It was noted that an Equality, Diversity and Inclusion plan was also being developed to prioritise actions to effect a step change in the Group's approach and maximising impact. This would complement the people strategy.

b) Gender Pay Gap Report

The Committees received delegated authority from the Group Board to review and approve for publication the annual Gender Pay Gap reports for the two Trusts, which capture data from 31 March 2023. The Gender Pay Gap reports are on the Group Board agenda for 2 May. The Committees discussed the key elements of the reports.

At SGUH, the mean hourly pay for males was £2.56 higher than that of females, a gap of 12.9%. The mean gap had reduced by £1.33 from March 2022. Male median pay was £2.46 higher than females, a gap of 10%. The median gap had increased by 26p since 2022. Male consultants were paid on average £3.45 more per hour than females. The mean bonus gap had reduced year on year, from 34.17% to 32.10%. The percentage of staff receiving a bonus increased significantly due to clearing overdue clinical excellence awards (CEAs). If medical staff were removed from the overall total, the gender pay gap at SGUH would be in favour of females by 1.9%.

At ESTH, the mean hourly pay for males was £3.26 higher than that of females, which means on average male staff receive 13.1% more than female staff. The mean gap had increased by 5p since March 2022. Male median pay was 24p lower than females, a gap of -1.2%.
Male consultants were paid on average £4.48 more per hour than females. The mean bonus gap dropped in 2023 but was still at 18.7%. The number of male staff being paid bonuses was 6 times higher than female staff at ESTH. Bonus pay had been decreasing in the last 4 years for both males and females.

Across the Group, females were over-represented in the lower bands with male colleagues over-represented at 8b and above.

The Committees were assured that the actions necessary to address the findings of the reports were already incorporated into the work being taken forward to develop an EDI plan for the Group. Regarding the requirement to analyse available data on pay gaps across the protected characteristics and implement an improvement plan for race and sex by 2024, it was noted that the Group may struggle to meet the deadline.

The Committees concluded they would have liked to have seen more analysis and insight into whether the actions taken last year had had the desired impact, including an analysis of what had been successful and the current concerns and issues. The Committees suggested utilising resource and intelligence within the Staff Networks, particularly in setting and delivering the action plans. The Committees also concluded that actions to develop effective talent management arrangements across the Group would be a key factor in helping to address some of the issues raised within the report.

c) Equality Delivery System (EDS) Report

The Committees received delegated authority from the Group Board to review and approve the EDS report for publication on the Trust websites. The Committees reviewed the EDS report in April 2024, which covered 3 domains: Commissioned or provided services completed

for both Trusts (SGUH reviewed Cancer and Maternity Services and ESTH reviewed Cancer, Diabetes and Maternity); Workforce health and well-being completed for both Trusts; and Inclusive leadership, pending further discussion with Trust Board.

The Committees reviewed the reports in detail and considered that further work was necessary before the reports would be ready for publication. In particular, the Committees highlighted concerns regarding the actions arising from the report which needed to feed into overall EDI action planning in a clear and coherent way. The Committees also highlighted that the proposed actions set out in the report had not been costed or incorporated into the 2024/25 financial plan for either Trust and costs would need to be defined, following which consideration could be given as to how best to proceed. The Committees agreed that the EDS report could not be approved, based on the need for further work on the actions and the need for thorough review from the Group Executive. The Committees agreed that the EDS report would come back to the next Committee meeting ahead of consideration by the Group Board. The Committees recognised that this decision would mean that the Trusts would not meet the deadline for publishing the reports this year.

4.0 Key Issues on which the Committees received assurance

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

a) Medical Revalidation Responsible Officer Q3 (October-December 2023)

The Committees received the Q3 report from the Responsible Officers (ROs) for medical revalidation at each Trust at its meeting in March 2024. Both Trusts reported that the number of doctors with a prescribed connection had increased in Q3. At 93%, the appraisal compliance rate was above the 90% target at ESTH, whereas SGUH had remained consistently below the target for the last 6 months at 88%. For ESTH, there were no revalidation deferrals during the period and at SGUH deferrals remained static at 10 and included a few locally employed doctors (LEDs). This was mainly due to lack of evidence and catching up on appraisals from the past few years that had been impacted by the pandemic.

The Committees heard that, at ESTH, the Medicine Directorate would benefit from increased appraiser numbers to enable a fairer distribution of appraisee/appraiser ratio across the directorate. Appraiser refresher courses were encouraged for all appraisers whose appraisal training had expired. The quality of appraisals was reviewed by the RO using a grid to validate an appraisal and there was a feedback loop for the appraisee to provide feedback on the appraiser. At SGUH, significant improvement had been made in reducing the number of doctors who were more than 6 months overdue on appraisals, due to intensive work with those doctors. The focus at SGUH was on improving the quality of appraisals; support for appraisers; training and ongoing continuous professional development (CPD); working with care groups to ensure LEDs were supported through appraisals and robust data on protected characteristics and employment groups.

The Committees discussed whether the Trusts would consider introducing non-medical appraisers. ESTH has 120 appraisers and are able to recruit appraisers. ESTH had considered senior specialist doctors who were not consultants, who could be appraisers. The Committees agreed that they could take reasonable assurance from the reports.

b) Guardian of Safe Working (GOSW) Q3 Report

The Committees received the GOSW Q3 report for October-December 2023. Both Trusts reported a reduction in exception reports in Q3, compared with the same quarter last year and it was reported that this could be attributed to the ongoing industrial action. LEDs were continuing to submit exception reports. The majority of the exception reports for both Trusts were in acute medicine where there were particular operational pressures and a high number of rota gaps. There were no immediate safety concerns raised at SGUH. One safety concern had been raised at ESTH in Same Day Elective Care (SDEC) regarding care given and lack of senior support. The Health Education England steering group was monitoring this. The Committees received reasonable assurance on the GOSW Q3 reports.

c) 6 months progress update on ESTH Bank Service Insourcing

The Committees received a 6 month progress update on the ESTH bank service insourcing which had gone live in August 2023. The Committees were pleased to note that the insourcing had been successful, as all staff expected to TUPE to ESTH had done so and there was low turnover. There had been improvements in the fill rates and KPI targets. A lot of work had been conducted with the temporary staffing team and operational teams on reducing the use of 'off framework' agencies. There was more control and good quality fill rates. Improvements had mainly been in the acute setting and more work was required in the community. Financial savings had been achieved. The Committees were reasonably assured with the update.

d) Job planning update for 2024-25

The Committees received the annual job planning update for 2024/25 for both Trusts. Overall, 94% of consultants at ESTH having job plans signed off and the Trust had opened 2024/25 job plans in January 2024 with the aim of completing as many plans as possible by the end of the financial year. Job planning was audited externally and good assurance had been received. The job planning process at ESTH was well supported by the medical workforce team.

The Committees acknowledged the significant improvement SGUH had made over the past year in relation to consultant job planning, which had increased from 0% job plans being signed off in 2022/23 to 67% by the end of the financial year in 2023/24. The Committees commended the Site CMO-SGUH for her hard work and dedication in driving the work forward. It was reported that there were more consultant Specialty and Specialist (SAS) doctors with job plans in the system. Clinician engagement had been a challenge and was a focus for the team, emphasising the importance of job planning in line with the job planning policy. They were continuing to struggle with the capacity of the divisional teams to challenge job plans effectively and in a timely manner and move job plans through the system. Fortnightly medical finance recovery meetings were being held, where divisions were held to account for their job plans. SGUH was on track with the 3-year cycle of improvement. The plan for 2024/25 (third year of the cycle) was to close down job plans and start team job planning with the aim to have job plans signed off by the end of Q2. This would get SGUH back to a position of prospective job planning, rather than retrospective job planning. The cost resulting from the discrepancy in pay versus signed off Professional Activities (PAs), as of end February 2024 was estimated at a total net cost from 171.52 PAs (c £2.3m). Any under/overpayments would be paid/recovered. The Committees received reasonable assurance on job planning for 2024-25.

5.0 Other issues considered by the Committees

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

a) Industrial action

The Committees continued to receive regular updates on industrial action. In March, the Committees were informed that 62% of British Medical Association (BMA) junior doctors voted for strike action. The new mandate would run from 3rd April to 19th September 2024. The consultants accepted a pay deal in early April 2024.

b) Group Workforce Key Performance Indicators (KPI) report

The Committees continued to review key workforce performance metrics and the themes and trends in these. In March, the Committees reviewed the workforce KPIs with data from January 2024. The ESTH vacancy rate remained above the 10% target at 11.78%, whereas the SGUH vacancy rate was at 6.27%. The combined Group vacancy rate for month 10 was 8.58%. It was noted that although SGUH performance was good, the report needed to pick out any hotspots and departments of concern. The disparity between the vacancy rates was attributed to ESTH's location (SGUH was closer to central London with better transport links), ESTH was a high cost living area but staff did not receive the high cost area allowance and SGUH was a designated university/training hospital which attracted more people.

Turnover was low at both Trusts with ESTH reporting a monthly turnover at 0.90% and SGUH reporting a monthly turnover at 1.10%. The monthly KPI threshold was 1%. The overall turnover had decreased and improved over the course of the year, at both Trusts.

Both Trusts reported a monthly sickness absence rate (ESTH 5.15%, SGUH 4.67%) above the respective Trust KPI targets of 3.80% and 3.20%. The sickness rate had remained above the targets throughout the year and it was felt that it would be unlikely that the rate would fall to pre-pandemic levels.

ESTH core skills compliance fell from 85% to 83% and remained below target. SGUH had consistently reported above the 85% target and was at 91%.

Appraisal compliance with the exception of the Nursing and Midwifery staff group at ESTH, both Trusts and the Group overall was not meeting the 90% appraisal compliance target, with compliance rates at ESTH at 73% and SGUH at 76%, although ESTH had improved over the year. The Committee agreed that compliance with appraisals – and the quality of appraisals – needed more focus.

The Committees discussed whether the sickness absence KPI targets should be increased. The HR team would review all the KPI targets and align them across the Trusts. It was felt by some Committee members that the focus should be on supporting staff back to work, rather than increasing the target. The Committees also felt that appraisals should be spread across the year.

The Committees considered whether the vacancy controls were having an impact on the vacancy rates and whether a higher vacancy was preferred to control costs.

c) Staff Health & Wellbeing Report

The Committees received a summary of Health and Wellbeing (HWB) activity for Q3-Q4 2023/24. The activity considered was based on the four pillars of wellbeing: Mental, Physical, Social, and Financial. The work of the Health and Wellbeing team aimed to support the Group strategic objective of supporting 'empowered and engaged staff'. The Trust HWB teams were working as a Group. It was noted that there were gaps between the two Trusts and the next steps were to align the services at the Trusts.

The Committees noted that there was more activity in SGUH than ESTH but this was not reflected in the staff survey results, as ESTH scored better. Overall, there was a concern that take-up of some of the interventions was low, despite some increases from the previous year. Greater staff awareness was needed on the services and interventions available, as it was felt that the offer was good. The HWB team was asked to consider removing the transaction fee for the Wagestream service. The awareness of HWB Champions also needed to be elevated.

d) Staff Support Counselling & Mediation

The Committees received an update on the counselling and mediation services. Both Trusts deliver NICE interventions. The presentations from staff have included trauma, post-traumatic stress disorder (PTSD), anxiety, depression and suicidal ideation. At SGUH, there had been an increase in reflective practice which involved talking about what is going on. It was reported that, at both Trusts, work was being undertaken to support staff who had expressed suicidal ideation and the Counselling teams were looking after these staff, with regular contact and 'safety plans' in place for them but there were delays in the community. SGUH provides the mediation service and reported that the number was low and that the themes were around micro-management, impoliteness and workload. It was noted that the Teams were proactive and visited wards, although there was less capacity at ESTH to do this as regularly as they would like to. Overall, it was felt that the services were valued and making a difference to staff.

e) NHS Staff Survey Summary

The Committees received a further update on the Staff Survey, having previously received a detailed report on the initial findings in January 2024. The divisions at the Trusts had now received their results at divisional level. The detailed results and data would be considered at Group Board at a future meeting, following review by the Committee in June 2024. The team was working on identifying and targeting specific areas. The Committees requested to see the 10 top and lowest performing areas within the next report to the Committee, which was regarded as a key piece of insight which could be triangulated with other data to identify challenged services and teams and plan interventions to support them. It was generally felt that the Big 5 – the Group's approach to targeting action on key themes emerging from the staff survey – needed to be developed at a divisional level and linked to in action plans.

f) Covid and Flu Vaccination Programme Update

It was reported to the Committees that 2023/24 was the first year to have a Group-wide approach to the Influenza (Flu) and Covid-19 vaccination campaigns, led by the Group Chief Nursing team. The Flu Autumn campaign had taken place between 1 September 2023 and 31 March 2024. The SWL Hospital Hub sites were St George's Hospitals, Epsom and St Helier Hospitals and Croydon University Hospital.

The Flu vaccination uptake in frontline health care workers had seen a decreasing trend over the last five campaigns. Each site in the Group was given a Commissioning for Quality and

Innovation (CQUIN) target for Flu. This had been set at the national target of 75%. ESTH achieved 49.9% while SGUH vaccinated 46.7%. Of the 35 Trusts in the London region, both acute hospitals were noted to be in the upper quartile, with ESTH 3/35 and SGUH 6/35.

There was no national target for the Autumn Covid-19 booster vaccination. Despite this, each Trust site continued to promote the booster vaccination to support staff health and wellbeing. Uptake for frontline health care workers had also decreased each season, mainly due to the changes to the response to the pandemic. At ESTH, the take up was 29.7% and at SGUH it was 24.1%. This placed ESTH in the second quartile (12/35) and SGUH in the third quartile (23/35), when compared to other London Trusts.

Work on the 2024/25 campaign had already commenced.

g) People Committees-in-Common Annual Report to the Group Board 2023/24

The Committees received the annual People Committee report for 2023/24, reviewed its terms of reference, and considered the outcomes of the Committee effectiveness review it had undertaken at year-end. These reports are on the Group Board agenda for the meeting on 2 May. The Committees endorsed a proposal to move to a bi-monthly (every other month) cycle of meetings in 2024/25, holding meetings immediately prior to Group Board meetings. In the months between meetings, it had been agreed that the GCPO would meet informally with the two Committee Chairs to discuss any emerging issues. The forward plan was in the process of being finalised and would be shared with the Committees.

The Committees discussed the outcome of the committee effectiveness review and noted that there were recurrent themes from the previous year. Getting a balance of assurance and operational detail and the right level of detail to understand the assurance and have the right discussions. Other themes were timeliness of papers; the quality of papers which was improving; being clear on the focus of the committee and having the right level of information. The Committees noted that the Group Board had agreed that reducing the frequency of Committee meetings to every other month came with the quid pro quo that papers would be submitted on time, a week before the meeting, and this would be important in making the new rhythm of meetings work effectively.

In relation to the terms of reference, the Committee endorsed the proposed changes, which made some minor changes to strengthen explicitly the Committee's focus on assurance as well as to tidy up the terms of reference. The Committees also agreed to include the Group Chief Communications and Engagement Officer in the list of regular attendees and to remove the Site Chief Medical Officers and Site Chief Nursing Officers from the list of regular attendees agreeing that these should attend the Committee when there were relevant agenda items. The Committees requested that the Group Executive consider whether the Group Chief Finance Officer should continue to be a member of the Committee given the pressures on his time, but suggested that in the event that the GCFO ceased to be a member it would be important to have a senior finance representative among the regular attendees.

The Committees reviewed and approved the People Committee Annual Report 2023/24 for submission to the Group Board and endorsed the proposed changes to the Committees' Terms of Reference, subject to further amendments regarding the membership of the GCFO, for submission to the Group Board.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in March and April 2024.

Group Board

Meeting in Public on Thursday, 02 May 2024

Agenda Item	2.3b	
Report Title	**People Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Angela Paradise, Interim Group Chief People Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

It is good governance practice for each Committee of the Board to produce an annual report setting out how it has fulfilled its duties and responsibilities as outlined in its established terms of reference. It is also good practice for each Committee to review its terms of reference on an annual basis – making proposals for amendment as necessary to the Board – and agree a forward plan of business for the year ahead. With the establishment of the new Group Board arrangements from May 2023, it was agreed that a single annual report of the work of the People Committees-in-Common be provided to the Group Board for consideration, alongside an updated terms of reference.

At its meeting on 18 April, the People Committees-in-Common reviewed and approved its annual report to the Group Board, reviewed and agreed to recommend to the Board an updated Terms of Reference, and reviewed the outcomes of its annual Committee effectiveness review. These reports are attached for consideration by the Group Board. The Committee is currently developing its forward plan of business for 2024/25 and this will be shared with the Group Board at the July 2024 meeting following review by the Committees in June.

The Group Board has previously discussed the People Committees moving from a monthly meeting to holding meetings bimonthly (every other month). The Committees endorsed the proposal to move to a bimonthly rhythm of meetings in 2024/25 and seeks the formal approval of the Group Board for this.

Action required by Group Board

The Group Board is asked to

a. Receive and note the annual report from the People Committees-in-Common which sets out how the Committees have fulfilled their terms of reference over 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Receive and note the outcomes of the 2023/24 Committee effectiveness review;
d. Endorse the Committees' proposal to move to bi-monthly meetings in 2024/25.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	People Committees-in-Common Annual Report 2023/24
Appendix 2	Proposed Committee Terms of Reference
Appendix 3	Committee Effectiveness Report 2023/24

Implications

Group Strategic Objectives

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

Risks

Without appropriate terms of reference and a clear forward workplan for the Committee, there is a risk that each Trust Board may not have sufficiently robust governance arrangements in place for monitoring and seeking assurance on people-related issues which could result in ineffective assurance or weaknesses in decision-making.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications relating to this report. The Committee's terms of reference and forward workplan set out how the Committee will oversee and provide assurance to the Board that people plans are aligned with financial and operational planning.

Legal and / or Regulatory implications

There is no legal or regulatory requirement for there to be a People Committee, but it is good practice to have such a committee in place to oversee and provide assurance to the Board on people, culture and organisational development.

Equality, diversity and inclusion implications

The paper sets out how the People Committees-in-Common will deal with issues relating to EDI over the coming year, both in terms of its remit as set out in the terms of reference and in the forward plan of business for the year ahead.

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

People Committees-in-Common Annual Report to the Group Board

Group Board, 02 May 2024

1.0 Purpose of paper

1.1 This paper provides the Group Board with the annual report of the work of the People Committees-in-Common in 2023/24, which includes a review of the Committees' terms of reference, and a summary of the outcomes of the Committees' recent effectiveness review. A forward plan of business for the Committees is being developed and will be shared with the Group Board at its meeting in July 2024 following review by the Committees in June.

2.0 Background

2.1 It is good governance practice for all committees of the Boards to submit an annual report setting out their key areas of focus over the past year and demonstrating how they have sought to perform their role in accordance with their agreed terms of reference.

2.2 With the People Committees of both Trusts having operated as a Committees-in-Common in 2023/24, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

2.3 With the establishment of the Group Board arrangements from May 2023, the People Committees-in-Common annual report will be presented to the Group Board for review, which operate with delegated authority from each of the sovereign Trust Boards. Each of the two People Committees remains ultimately accountable to the sovereign Board of its respective Trust.

3.0 People Committees-in-Common Annual Report

3.1 The draft People Committees-in-Common Annual Report is set out at Appendix 1. The draft report sets out:

- the operation of each Committee as a Committees-in-Common in 2023/24
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2023/24
- key areas of activity and focus by the Committees in 2023/24

3.2 The purpose of the annual report is to provide a high level overview of the Committee's work and how it has delivered against its purpose and duties as set out in its agreed terms of reference. It is not, and does not seek to, describe all issues addressed by the Committee over the past year.

3.3 The annual report describes the work of the People Committees-in-Common in an integrated way where possible, but where significant Trust-specific items have been considered, the report sets these out as Trust-specific areas of Committee focus and attention.

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed. Given that the terms of reference were redrafted at the start of 2022/23 to coincide with the launch of the new People Committees-in-Common the approach adopted to the review has been to revise and update the terms of reference where needed rather than to start again and define an entirely new terms of reference. This is similar to the approach adopted in 2023, when the terms of reference were last reviewed.

4.2 The changes to the terms of reference are set out at Appendix 2, and the proposed amendments to the existing wording is marked in tracked changes. The proposed amendments to the Committee's terms of reference are largely a tidying up exercise rather than fundamental changes to the role, purpose of scope of the Committee. In summary, the key changes proposed are:

- To emphasise the assurance role of the Committee in seeking and providing assurance to the Board. While this has always been the role of the Committee, the changes proposed seek to make this far more explicit throughout. This is, in part, to reflect some of the comments in the Committee effectiveness review.
- On workforce performance, to make more explicit that the Committee's role is to review themes and trends in the data, seeking assurance on actions, and considering the "so what" issues.
- To clarify the Committee's role in relation to overseeing the Group Strategic Initiative in relation to collaboration across the Group refers specifically to the integration of Group Corporate Services, reflecting the focus of the Committee in 2023/24.
- To removing the role of the Committee in relation to receiving reports and action plans in relation to independent reviews to address significant cultural issues. This is (a) to reflect the fact that this is not something the Committee currently does in any case, (b) to reflect the fact that most such reviews have a quality dimension and are already reviewed by the Quality Committee, and (c) to recognise the role of the Executive in relation to this.
- To update the list of regular attendees at the Committee to remove the reference to Director of People, Strategy and Planning (a role previously envisaged but not ultimately introduced), to remove the Site Chief Medical Officers and Site Chief Nursing Officers and instead invite them for relevant agenda items as needed, and to include the Group Chief Communications and Engagement Officer.
- To update the meeting frequency to bi-monthly (every other month), reflecting the previous discussions at the Committee and Group Board.
- To tidy up, simplify and condense the terms of reference, removing unnecessary repetition.

4.3 The terms of reference will apply to each People Committee, that is it will be the terms of reference for the ESTH People Committee and, separately, the terms of reference for the SGUH People Committee. The membership and quorum arrangements set out apply, separately, to each Trust's People Committee. Each Committee must continue to be quorate in its own right. Any votes at Committee would need to be taken by each Committee and approved separately by each Committee.

4.4 The Committees propose to the Group Board that they meet bimonthly (every other month) in 2024/25. The rationale for this is to ensure the right frequency of meetings to enable the Committee to receive effective, evidenced-based assurance on key people issues. The currently monthly rhythm was considered too frequent to enable the preparation of effective assurance reporting, with appropriate management oversight on some issues prior to Committee review. It is proposed that the Committees meet every other month, with the Committee Chairs holding informal meetings with the Group Chief People Officer in the months without a Committee meeting to keep abreast of live issues.

5.0 Committee effectiveness Review 2023/24

5.1 Since the last meeting of the Committee, the Committees have undertaken a Committee effectiveness review. The results of this are set out at Appendix 3. The summary report draws out the key themes from the review.

5.2 Overall, respondents to the effectiveness review considered that the Committee was working reasonably well, but that improvements in relation to the timeliness and quality of papers and a focus on assurance would support further improvements in 2024/25.

6.0 Recommendations

6.1 The Group Board is asked to:

a. Receive and note the annual report from the People Committees-in-Common which sets out how the Committees have fulfilled their terms of reference over 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Receive and note the outcomes of the 2023/24 Committee effectiveness review;
d. Endorse the Committees' proposal to move to bi-monthly meetings in 2024/25.

People Committees-in-Common Annual Report 2023/24

1 April 2023 – 31 March 2024

Contents

People Committees-in-Common Annual Report 2023/24

1. Introduction

In February 2022, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group. Since April 2022 a number of Board Committees have operated as Committees-in-Common across the Group. This includes the People Committees, Quality Committees and Finance Committees of the two Trusts.

Following its first full year of operation, in April 2023 the People Committees-in-Common reviewed and approved an updates to its terms of reference to reflect the role of the Committees in overseeing the implementation of the people aspects of the new Group strategy and its role in providing assurance to the new Group Board, which started operating from May 2023. At the same meeting, the Committee also approved its forward plan of business for 2023/24, which introduced an alternating monthly focus of workforce performance one month and culture, diversity and inclusion the next, with the intention of reducing the frequency of reporting on issues and easing the burden on the people function. As in its first year of operation, the chairing of meetings alternated between the respective Chairs of the People Committees at St George's University Hospitals and Epsom and St Helier University Hospitals. The long serving St George's Non-Executive Director Committee Chair (Stephen Collier) left the organisation in October 2023, as his term of office came to an end. Yin Jones, previously a member of the Committee as an Associate Non-Executive Director, was appointed as a full voting Non-Executive Director at St George's on an interim basis from October 2023. For the duration of her interim appointment Yin is also serving as Chair of the People Committee, working closely with the Epsom and St Helier People Committee Chair through the Committees-in-Common arrangements.

This report sets out a high level overview of the work of the People Committees-in-Common in 2023/24. It provides an integrated report on the key matters considered by the Committees but highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The People Committees of the two Trusts have adopted identical terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference.

2.1 Purpose

The purpose of each Committee is to provide assurance to its parent Board – through the Group Board arrangements – on the development and delivery of the Trust's strategy and plans for a sustainable workforce that supports the provision of safe, high quality, patient-centred care by:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people, specifically the Group strategic objective of engaging and empowering staff.
- Overseeing and providing assurance to the Board on progress in the delivery of the strategic initiatives identified in the Group Strategy that relate to people.
- Overseeing the development of relevant people, culture and organisational development strategies that support the new Group Strategy and monitoring progress in the implementation of these, in the context of the local Integrated Care System(s), the Trust's financial and operational plans, and the national NHS People Plan.
- Monitoring workforce key performance indictors and identifying and reviewing themes and trends, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Overseeing the development of a culture that empowers and supports staff to deliver to their best, including in relation to equality, diversity and inclusion, raising concerns, and staff health and wellbeing.
- Overseeing education, training and development plans.
- Monitoring the Trust's engagement with staff and work to improve engagement.
- Seeking assurance that key risks relating to workforce, culture, equality, diversity and inclusion, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Providing assurance that legal and regulatory requirements relating to the workforce are met.
- Ensuring appropriate governance arrangements are in place in relation to people, culture and organisational development issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

2.2 Duties

Each of the Committees has the following duties:

a. Workforce Strategy and planning

   i. Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people, specifically the Group strategic objective of engaging and empowering staff by:

      - Getting the basics right in payroll, recruitment, employee relations, good people management practice;
      - Putting staff experience and wellbeing at the heart of what we do;
      - Fostering an inclusive culture that embeds our values;
      - Developing tomorrow's workforce; and
      - Working differently ('flexible by default', digitally-supported working, leaders, and continuous improvement).

   ii. Overseeing and providing assurance to the Board on progress in the delivery of the strategic initiatives identified in the Group Strategy that relate to people, in particular in relation to:

- Supporting a continuous improvement approach through high performing teams and leaders; and
- Transforming our culture and making our workplaces more diverse and inclusive.
- Pursuing collaboration across our GESH Group.

iii. Overseeing the development of relevant people, culture and organisational development strategies that support the new Group Strategy and monitoring progress in the implementation of these, in the context of the local Integrated Care System(s), financial and operational plans, and the national NHS People Plan.

iv. Reviewing and seeking assurance in relation to risks to the delivery of the Group's workforce strategy and related Trust plans.

b. Workforce performance, themes and trends

i. Receiving reports relating to the Trust's workforce performance indicators and providing assurance that any necessary corrective plans and actions are in place. This includes indicators relating to: recruitment and retention, vacancy, turnover, sickness absence, use of bank and agency staff, appraisal rates, education and training, employee relations, and diversity and inclusion metrics.

ii. Overseeing and reviewing key themes and trends in relation to workforce performance and improvement, and escalating these to the Board as appropriate.

iii. Overseeing the working hours of junior medical staff and actions to drive improvements, including receiving reports from the Guardian of Safe Working.

c. Staff engagement and wellbeing

i. Providing oversight of plans to improve engagement by the Trust with its staff, with the aim of securing increasing levels of staff engagement.

ii. Reviewing the results of the annual NHS staff survey and overseeing the development and implementation of action plans to address issues identified.

iii. Monitoring staff health and wellbeing, including the Trust's plans to ensure that staff are supported to deliver to their best.

d. Culture, Equality, Diversity and Inclusion

i. Overseeing the development and delivery of the Trust's action plans to strengthen culture, equality, diversity and inclusion and monitoring performance in relation to equality indicators drawing relevant issues to the attention of the Board.

ii. Monitoring and providing assurance to the Board on the actions taken by the Trust to comply with the Equality Act 2010 in relation to its staff. The Quality Committee will monitor the Trust's compliance with the Equality Act 2010 in relation to patients.

iii. Overseeing actions taken by the Trust to comply with relevant regulatory frameworks relating to equality, diversity and inclusion.

iv. Receiving regular reports relating to equality, diversity and inclusion in the Trust, and reviewing prior to consideration by the Board:

- the Workforce Race Equality Standard (WRES) and improvement action plans.

- the Workforce Disability Equality Standard (WDES) and improvement action plans.
- The Trust's performance in relation to the gender pay gap and the ethnicity pay gap.

v. Overseeing actions taken by the Trust to raise the profile of equality, diversity and inclusion across the Trust.

vi. Overseeing and seeking assurance in relation to the Trust's plans for organisational development.

vii. Reviewing the key trends and themes arising from concerns raised by staff, and receiving regular reports from the Freedom to Speak Up Guardian.

viii. Receive reports and action plans relating to independent reviews commissioned by the Trust, or externally, to address significant cultural challenges within teams / services across the Trust.

e. Education and Organisational Development

i. Overseeing and seeking assurance in relation to the development and implementation of strategies and plans for education, training and development across the Trust and in partnership with other organisations.

ii. Overseeing performance on staff appraisal rates (clinical and non-clinical).

iii. Overseeing performance in relation to statutory, mandatory and other training.

iv. Overseeing and seeking assurance in relation to the Trust's plans for leadership and organisational development.

f. General

i. Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.

ii. Obtaining assurance on the risks to delivery of the Trust's corporate objectives in relation to workforce, organisational development, culture, and equality and diversity with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee.

iii. Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response.

iv. Ensuring there is a system in place to review and approve relevant policies and procedures that fall within the remit of the Committee.

v. Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

vi. Reviewing any Trust strategies prior to approval by the Board (if required) and monitor their implementation and progress.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2023 to March 2024), the following were members or regular attendees of the People Committees-in-Common:

St George's People Committee			
Name	**Role**	**Designation**	**Period**
Stephen Collier	Member	Committee Chair, Non-Executive Director	1 April 2023 – 11 October 2023
Yin Jones	Member	Associate Non-Executive Director / Committee Chair, Non-Executive Director (from 12 October 2023 to 31 March 2024)	1 April 2023 – 31 March 2024
Andrew Murray	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Tim Wright	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Paul da Gama	Member	Group Chief People Officer	1 April 2023 – 31 December 2023
Angela Paradise	Member	Interim Group Chief People Officer	2 January 2024 – 31 March 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
Kate Slemeck	Member	Managing Director – St George's	1 April 2023 – 31 March 2024
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2023 – 31 March 2024
Jonathan Head	Attendee	Deputy Chief People Officer (Culture and Organisational Development)	1 April 2023 – 29 February 2024
Natilla Henry	Attendee	Site Chief nursing Officer	1 April 2023 – 18 February 2024
Nicole Porter-Garthford	Attendee	Deputy Chief People Officer (HR Operations)	1 April 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024

Epsom & St Helier People Committee			
Name	**Role**	**Designation**	**Period**
Martin Kirke	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 March 2024
Aruna Mehta	Member	Non-Executive Director	1 April 2023 – 31 January 2024
Andrew Murray	Member	Non-Executive Director	1 February 2024 – 31 March 2024
Phil Wilbraham	Member	Associate Non-Executive Director	1 April 2023 – 31 March 2024
Paul da Gama	Member	Group Chief People Officer	1 April 2023 – 31 December 2023
Angela Paradise	Member	Interim Group Chief People Officer	2 January 2024 – 31 March 2024
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2023 – 31 March 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Richard Jennings	Member	Group Chief Medical Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
Ruth Charlton	Attendee	Site Chief Medical Officer	1 April 2023 – 31 May 2023
Rebecca Suckling	Attendee	Site Chief Medical Officer	1 June 2023– 31 March 2024
Jonathan Head	Attendee	Deputy Chief People Officer (Culture and Organisational Development)	1 April 2023 – 29 February 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
Betty Njuguna	Attendee	Site Chief Nursing Officer	1 April 2023 – 30 September 2023
Theresa Matthews	Attendee	Site Chief Nursing Officer	1 October 2023 – 31 March 2024

Nicole Porter-Garthford	Attendee	Deputy Chief People Officer (HR Operations)	1 April 2023 – 31 March 2024
Saskia de Vries	Attendee	Site Director of People	1 April 2023 – 31 May 2023
Steve Russell	Attendee	Site Director of People	1 July 2023 – 31 March 2024
Sam Gooden	Attendee	Site Director of People	1 July 2023 – 31 March 2024
Thirza Sawtell	Attendee	Managing Director – Integrated Care	1 April 2023 – 31 March 2024

Members of the St George's University Hospitals NHS Foundation Trust Council of Governors also regularly attended to observe meetings of the People Committees-in-Common during the period.

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the People Committee of each Trust was required to be quorate. The quorum for each People Committee was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 10 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees-in-Common were quorate for both Trusts.

Attendance			
Name	**Role**	**Trust**	**Attendance**
Stephen Collier	Committee Chair	SGUH	5/5
Yin Jones	Member/Committee Chair	SGUH	10/10
Martin Kirke	Committee Chair	ESTH	8/10
Aruna Mehta	Member	ESTH	4/8
Andrew Murray	Member	Both**	9/10
Phil Wilbraham	Member	ESTH	7/10
Tim Wright	Member	SGUH	8/10
Paul da Gama	Member	Both	7/7
Angela Paradise	Member	Both	3/3
James Blythe	Member	Both	8/10
Andrew Grimshaw	Member	Both	1/10
Richard Jennings	Member	Both	4/10
Kate Slemeck	Member	SGUH	8/10
Arlene Wellman	Member	Both	9/10
Ruth Charlton*	Attendee	ESTH	0/2
Rebecca Suckling	Attendee	ESTH	4/8
Luci Etheridge	Attendee	SGUH	10/10
Jonathan Head*	Attendee	Both	8/9
Natilla Henry*	Attendee	SGUH	9/9
Stephen Jones	Attendee	Both	8/10
Betty Njuguna*	Attendee	ESTH	0/5
Theresa Matthews	Attendee	ESTH	0/5
Nicole Porter-Garthford	Attendee	Both	9/10
Saskia de Vries*	Attendee	ESTH	1/2
Steve Russell	Attendee	ESTH	7/7
Sam Gooden	Attendee	SGUH	6/7
Thirza Sawtell	Attendee	Both	8/10

** No longer members of the Committees-in-Common*

*** Both Committees from 1 February 2024 (SGUH only prior to this).*

In addition to the above, the Group Chairman, Group Chief Executive Officer and Group Deputy Chief Executive Officer regularly attended meetings of the People Committees-in-

Common during the reporting period. The Chairman attended 8 meetings, the Group Chief Executive Officer 4 meetings, and the Group Deputy Chief Executive Officer 9 meetings.

The following members of the St George's Council of Governors observed meetings of the People Committees-in-Common during this period:

SGUH Governors observing		
Name	Role	Attendance
Patrick Burns	Public Governor, Merton	6
Richard Mycroft	Public Governor, South West Lambeth	2
Huon Snelgrove	Staff Governor, Non-Clinical	7
Chelliah Lohendran	Public Governor, Merton	2

4. Committee activity and focus

4.1 Workforce strategy and planning

The Committees received regular updates on the industrial action taken by various staff groups throughout the year. The Committees have sought assurance that appropriate actions are being taken to plan for the action in terms of business continuity, staff welfare and support, while the Quality Committee has separately sought assurance in relation to how the Trusts have maintained patient safety during periods of industrial action. Junior doctors carried out the longest strike action of 6 days in January 2024. By February 2024, it was reported that although consultants had been supportive in stepping in to cover junior doctor strike action, consultants had reported that they were fatigued, with no resolution in sight and that they were losing their Supporting Professional Activities (SPAs) time and training. The consultants accepted a pay deal in early April 2024.

The Chief Medical Officers for both Trusts provided an annual update on job planning for medical staff in March 2024. Epsom and St Helier consultants had 94% of their job plans signed off for 2023/24 and had opened the job planning process for 2024/25. St George's had not met the 85% of total job plans signed off. This was mainly attributed to delays in ongoing discussions and resolutions with individuals. The Committees acknowledged that St George's had made significant improvements in 2023/24. The cost resulting from the discrepancy in pay versus signed off PAs, as of end February 2024 was estimated at a total net cost from 171.52 PAs (c £2.3m). Any under/overpayments would be paid/recovered.

The Committees also sought assurance in relation to the insourcing of the bank service at ESTH. The 'go live' date was delayed by a month, from 1 July 2023 to 1 August 2023, to implement the necessary IT. The Committees received an update six months after implementation in March 2024. The feedback was positive with a successful TUPE process; low rate of turnover; and improved KPIs in fill rates. There had also been financial savings by insourcing the service and improved control in filling bank shifts.

The Group Corporate Services integration programme, a key enabler of the Group Strategy, has been presented on a regular basis at a confidential session of the Committee, since May 2024. The Committee has monitored the progress and delivery of the programme and key risks.

4.2 Workforce performance themes and trends

The People Committees-in-Common regularly reviewed workforce performance and trends in both Trusts, comparing and learning from performance across the Group. In this, the Committees were supported by the presentation of a wide range of workforce metrics across the Group including: vacancy rate, turnover, stability score, sickness absence, statutory and mandatory training (MAST), and appraisal rates. Sickness absence rates at both Trust remained above the KPI targets. Despite improvements in the Turnover rate at both Trusts, they narrowly missed their 12 months targets. An area of concern for both Trusts was non-compliance with appraisal rate targets. The Committees received a deep dive on appraisals and were assured that targeted work with specific teams had been successful and wider actions based on the learning from this was being rolled out. St George's vacancy rate dropped to 6.27% in January 2024, against a target of 10%. Further work was being conducted to identify the cause of this and, subject to this, to apply any relevant learning to Epsom and St Helier.

Alongside the workforce performance reports, the Committees received three progress reports on the Workforce Improvement Plan during the year, which set out key actions being taken across the Group to improve performance in six key areas: recruitment and retention; sickness absence management; temporary staffing; rostering and annual leave management; health and wellbeing; and, staff support. The impetus for this focus was the need to make significant savings through improved workforce and people practices across the two Trusts, though wider people-related issues were also an important driver. A significant change from the previous year was a shift from the financial savings being realised by the People Directorate to the Divisions, as it was recognised that the improvements would have an impact at a local level.

The Committees have supplemented these regular workforce performance reviews and updates on the workforce improvement plan with a range of 'deep dives', the purpose of which was to explore the underlying trends, drivers and actions in more detail. These deep dives, which the Committee has taken an active role in commissioning, have included: turnover/recruitment and retention (May 2023); ; Temporary staffing (SGUH only) (July 2023); Employee Relations (October 2023); and Appraisals (February 2024).These deep dives have supported the Committee in reviewing in depth current performance and actions to improve performance.

4.3 Staff engagement and wellbeing

Throughout 2023/24, the People Committees-in-Common received regular updates on staff engagement around the 'Big 5' priorities. The 'Big 5' were themes identified from previous staff survey results and culture diagnostics work. The first area of focus was 'Civility and Psychological Safety'. The Committee was briefed on the actions being taken and heard that the HR team had held lunch and learn sessions and other activities and had engaged with around 2000 staff. Feedback from staff had been positive. The Committee heard that a range of workforce information and performance metrics were being developed, the purpose of which would be to measure progress with strengthening culture. In February 2024, the focus shifted to the second workstream 'Safe place to work', which includes bullying and harassment.

As well as understanding the actions being taken through the Big 5 to address themes emerging from the previous staff survey, the Committee also reviewed the initial results of the 2023 NHS Staff Survey, which were presented to the Committees in January 2024. There had been a decline in the response rate at SGUH from 48% to 39%. The ESTH response rate was static at 50%. For SGUH, aside from a disappointing level of engagement the results were broadly favourable, compared to 2022, as 77 questions showed no significant difference, 2 worse results and 18 had improved. However, SGUH had dropped when compared with comparator organisations with 74 questions significantly worse. For ESTH, 36 questions were significantly better than 2022, 61 questions had no significant difference. However, ESTH had 38 questions that were significantly worse against the comparator organisations, 46 no change and 16 significantly better. In October 2023, the Committees reviewed the top 10 and lowest 10 performing teams from the 2022 survey. Although the data had been shared with and made available to divisions, directorates, care groups and culture boards, the Committees were not assured that enough analysis on the learning had taken place to impact change. The culture programme was a key driver for the staff survey results. A dashboard scorecard was being developed as a reassurance mechanism. The metrics would also help with the development of the evaluation of the culture programme.

The quarterly guardian of safe working reports are another form of engagement with junior doctors. The reports were presented by the guardians from each Trust. The exception reports tended to increase in Q2, due to the rotation of junior doctors and the new intake of junior doctors. The areas with the highest exceptions reports at both Trusts were acute and general medicine because of the workload and high rota gaps. Junior doctors were encouraged to submit exception reports through various communications i.e. at junior doctor forums and team meetings. The Committees were encouraged to see locally employed doctors engaged and submitting exception reports. The Committees received reasonable assurance throughout the year from the guardians at both Trusts. The Committees also received a report on the learning from the junior doctors experience which triangulated the guardian of safe working reports, GMC National Training Survey (NTS) feedback, Health Education England (HEE) visits and reports and other information. Although there had been some improvements for junior doctors, challenges remained in ongoing industrial action, high rota gaps, working additional hours and operational pressures.

The Committees received reports on Staff Health and Wellbeing and Staff Counselling and Mediation Services. The initiatives and services on offer to staff were in high demand and oversubscribed. Feedback from staff was positive.

4.4 Culture, Equality, Diversity and Inclusion

Culture, equality, diversity and inclusion was a key area of focus for the Committees throughout the year. The Committees have received regular updates from the Group Culture, Equality and Inclusion Board.

The Committees reviewed and approved the Public Sector Equality Duty (PSED) reports in June 2023, for both Trusts, for onward submission to the Group Board for approval and publication on the Trust websites by 31st July 2023. It was the first time SGUH had publishing a PSED report and learning was shared from ESTH, as staff worked collaboratively. The Trusts are required to achieve compliance in 3 areas – workforce; patient services and care; and health inequalities. The Committees also received delegated authority from the Group Board to review and approve a number of reports that the Trusts

have a statutory duty to publish or is required to publish by NHS England which included the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans in October 2023 which saw a decline in some of the indicators and the Gender Pay Gap report in March 2024 which reported some improvements in the mean and median pay gaps.

Although there is no requirement to publish, the Ethnicity Pay Gap was reviewed by the Committees in May 2023. The Committees had requested a further analysis on Ethnicity Pay Gap data be undertaken. The analyses for ESTH and SGUH focused on male Black/Black British colleagues and demonstrated that there is a disparity in earnings for colleagues from that background in comparison to their white counterparts. The Committees emphasised that this disparity needed to be addressed and discussed how this could be achieved by focussing on certain aspects of the WRES action plans and implementing them through working with leaders in the areas where this was a particular issue, for example ESTH Estates and Facilities, and HR Business Partners.

In October 2023, when the WRES and WDES reports and action plans were presented for approval, the Committees were disappointed by the lack of improvement and decline in some of the indicators, despite the investment and effort that had been put into the culture programme. The Committees heard that the lack of progress in delivering the agreed action plans was mainly due to resourcing issues. The Committee also reviewed, in November 2023, the Trusts' positions against the six high impact actions in the national EDI Plan published by NHS England in June 223. The Group Board discussed the culture programme and wider work to make progress on equality, diversity and inclusion at its development sessions in December 2023 and March 2024. A list of EDI priorities were identified and an EDI strategy was developed, which will form part of the overall People Strategy. The People Strategy was presented to the Committees for review in March 2024 and will be presented at the May 2024 Group Board for approval.

The Committees received the annual report on Freedom to Speak Up 2022/23 in June and the Q1/Q2 reports in November 2023. The annual report highlighted that the concerns raised continued to increase and that the majority were raised by nursing and midwifery staff. At SGUH, the main theme of concern was Trust systems and processes which included recruitment and at ESTH it was management conduct, bullying and harassment. The Q1/Q2 reports revealed an increase in concerns raised at SGUH by 8.6% whereas ESTH reported a decrease when compared to the same quarters the previous year. Both Trusts reported that the majority of the concerns were raised by admin and clerical staff. The main themes raised were consistent with the 2022/23 report. It was encouraging to see an increase in the reporting of patient safety the concerns at ESTH, which could be seen as an indication that staff felt more secure in speaking up about safety issues. Both Trusts reported issues with the timeliness and delays in resolving concerns. The Committees agreed that they received reasonable assurance, with the introduction of the newly formed Raising Concerns Oversight and Triangulation Group to monitor and progress cases and a new case management system.

In terms of promoting a culture that is safe for staff, the Committees received reports on sexual safety and violence and aggression against staff. Regarding sexual safety, a national in-depth study revealed the extent of sexual misconduct by colleagues, including sexual harassment, sexual assault, and rape within the UK surgical workforce in the last five years. The team found that two thirds of women (63.3%) had been the target of sexual harassment from colleagues, along with almost a quarter of men (23.7%). The Committee heard that NHS England had launched its first ever sexual safety charter on 4 September 2023, with 10

pledges including commitments to provide staff with clear reporting mechanisms, training, and support. The Group signed up to this charter. The Committees were presented with a progress update on the 10 pillars and heard that a steering group had been set up with nurses, clinicians and HR to review how the 10 pillars would be addressed. The deadline to declare that the Trusts were working towards the pillars was the end of March 2024 and the national deadline to fully implement the 10 pillars was July 2024. The Committees noted that the challenge was around getting people to speak up about sexual abuse/harassment and communicating to staff that the Trusts will hold staff to account for their actions. Also, the SGUH had seen an increase in violence and aggression against staff and the Committees were assured that SGUH had interventions in place, such as Operation Cavell. SGUH had also increased its overall NHS Violence Prevention and Reduction Standard (VPRS) compliance from 35% to 47%.

Linked to the culture programme, onboarding was one key element of the Group talent management strategy. The loss of talent through turnover within the first 12-18 months of service was high. The approach to onboarding would be to introduce it at a number of levels across the group and through a range of actions and interventions. The goal was to create a new positive experience throughout the new joiner pathway at gesh. The onboarding schedule for roll out in SGUH would be replicated in ESTH from September 2023. The Committee agreed it could take reasonable assurance in terms of onboarding.

4.5 Education and Organisational Development

Over the past year, the People Committees-in-Common have reviewed and sought assurance in relation to the Trusts' education, training and development plans, particularly for leadership training and organisational development. The Committees received an update on the first GESH100 Senior Leadership Forum. It involved around 100 leaders across the two Trusts, including clinical/operational and corporate colleagues. The main theme was culture and there was a lot of engagement and enthusiasm during the sessions. The Committees also heard about the Compassionate and Inclusive Leadership programme delivered by NHS Elect. Priority was given to staff with people management responsibilities and covered multi-disciplinaries of staff. The response had been positive and there was a lot of enthusiasm for the training. In addition, open days were provided for middle managers on employee relations related policies and conflict resolution. On apprenticeships, the Committee heard that the Apprenticeship Strategy was a joint strategy on progressing the apprenticeship levy spend and a joint process on how to recruit external apprentices, as well as putting existing staff on apprenticeship programmes. A south-west London Apprenticeship Hub had been set up. There was currently an underspend of around 70% of the apprenticeship levy. The Committees discussed including apprenticeships within the business planning process; offering apprenticeships to local residents; and reviewing the barriers to and supporting teams to release staff. Regarding Mandatory and Statutory Training (MAST), the Committee was told that a review of MAST was underway to streamline the training offer and requirements. There was limited scope with statutory training and some opportunities to reduce local mandatory training. Work was underway to align MAST across the Group which could take up to a year to bring together.

In addition to the above, the Committees received the outcome of the quality assurance visit on 1st March 2023 by St George's University of London (SGUL) to the Trust Undergraduate Medical Education Team. The Committees were reassured by the positive feedback from the inspection team on the preparation work for the inspection. The main actions identified were around challenges in estates, ensuring there was consistency in clinical teaching fellows and

admin support across the teaching areas and greater transparency in the capacity of consultants to provide education. The SGUH Committee received reasonable assurance on the inspection and actions being taken forward.

For both the nursing and medical workforce, the Committees reviewed and were able to provide assurance to the Boards regarding nursing and medical revalidation.

4.6 General

Throughout the year, the People Committees-in-Common have reviewed the people-related risks on the Corporate Risk Registers and the strategic risks relating to people on the new Group Board Assurance Framework. In January 2024, the Committees reviewed the Group Board Assurance Framework risks in relation to people and recommended risk scores and assurance ratings for each of the three risks within its remit. This followed the Group Board's approval of the new strategic risks at its November 2023 meeting. There were three strategic risks relating to people; SR12: Putting staff experience at the heart of what we do; SR13: Fostering an inclusive culture that celebrates diversity; and SR14: Developing tomorrow's workforce. The Committee also endorsed the opening risk scores and assurance ratings for each of the people related strategic risks and stretch targets for March 2025. The Committees also reviewed the people-related risks on both Corporate Risk Registers (CRR). There were 14 people risks on the SGUH CRR and 13 on the ESTH CRR. The Committees received a deep dive into the bullying and harassment risk, as it had been on the CRR for 14 years at SGUH and were assured by the new pathway to manage bullying and harassment.

The Committees received regular assurance on the Certificate of Sponsorship (CoS) issue at SGUH and reviewed the action plan.

During the year, the People Committees-in-Common also reviewed the position of each Trust's people-related Trust-wide policies. The Committees sought assurance that plans were being developed to harmonise people-related policies across the Group and looks forward to receiving further updates in the coming months.

Throughout the year, the Committees received regular highlight reports from each of the two Trusts' People Management Groups, setting out the issues considered by each Trust at an operational level.

5. Committee Effectiveness

The People Committees-in-Common conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. A total of 12 people responded to the effectiveness survey. Overall, the results of the effectiveness review were broadly positive. The main issues highlighted in the effectiveness review are set out below:

- **Terms of Reference and forward work plan:** The majority agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. One of the 12 respondents felt that the forward plan contained a lot of topics and felt that there was potential to review what were Executive accountabilities and what should be discussed at the Committees – though the issue

of scope also relates to the nature of the discussions (see below on focus on assurance).

- **Membership, skills and experience of Committee:** The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. One respondent felt that there was scope to further reduce the number of attendees at the Committee, while it was also noted the pressures in expecting the GCNO and GCMO to attend meetings. Comments also highlighted that, typically, the GCPO took on many of the actions arising from the Committee and queried whether these could appropriately be shared between Executives. One respondent proposed inviting a patient representative to the Committee.
- **Chairing of meetings:** The respondents acknowledged the different styles and variability in chairing the meetings but felt that both chairs were effective. Some respondents highlighted that meetings could become too operational in focus or get 'taken down rabbit holes' and that the Committee risked 'going over old ground repeatedly'.
- **Discussions and assurance:** Linked to the above, the majority of respondents felt that there was generally good challenge but some flagged that actions were not always entirely clear and that meetings could become too operational in focus and insufficiently focused on assurance. The respondents felt that generally there was enough time for discussions, but some highlighted that three hours was a long time for a meeting. Another respondent felt too much time was spent on one item and that the discussions felt like Executive discussions rather than Board level discussions.
- **Timeliness of papers:** The response was somewhat mixed. It was acknowledged that some papers were late, but that there were signs that this had improved recently, aided by shorter agendas, but remained an issue. Respondents felt that papers should be circulated a week before the meeting (as per terms of reference). There was an acknowledgement that sometimes there may be legitimate reasons for a late paper and one proposal was to introduce a hard deadline of 48 hours before the meeting for any late papers. Some respondents also felt that the GCPO should push back at times when there were requests for unnecessary information or papers.
- **Quality of papers:** Generally, the respondents felt that the quality of papers had improved recently. Some felt the papers were too long, repetitive, lacked clarity on risks, triangulation and actions. Cover sheets could be improved to provide a better and more rounded Executive Summary of the paper and be clearer on what the Committee is asked to do.
- **Overall effectiveness of the Committee:** The majority at 45% (5) felt the Committee was very effective, with 36% (4) expressing that the Committee was somewhat effective and 18% (2) thought the Committee was extremely effective. One respondent felt that the right issues were discussed but change was slow. Another felt more consideration was needed to be given to what information should be available and what time should be spent on.

6. Committee Forward Plan and Terms of Reference

An updated terms of reference for the Committees is set out at Appendix 2. The amendments to the Committee's terms of reference are intended to reflect the new cycle of bi-monthly (every other month) meetings, drawing out explicitly the assurance focus of the Committee, and revising the list of regular attendees.

The forward plan has undergone significant revision to ensure that we are taking the right items at the right time and frequency throughout the year. A draft of the revised plan has been

developed with the Group Chief People Office but requires further refinement following discussion with relevant Executive Leads. The plan is to share the updated forward plan with Committee members for input via email with a view to ratify this at the next People Committee meeting. This is intended to ensure that the Committee is able to discharge its responsibilities under its terms of reference in the bi-monthly cycle of meetings. The workplan will support the Committee in providing the right level of assurance on key workforce matters. Over the coming months, while it will work to the agreed plan, it may be necessary to adjust this (subject to operational pressures) to focus on areas of immediate priority.

7. Conclusion

In the year 2023/24 the People Committees established a new rhythm for meetings to alternate the focus between Culture and OD and Workforce performance/operational. The Committees also gained a new Chair and a new GCPO, during the course of the year. Despite this, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated that the Committees were broadly effective during a challenging year and were continuing to develop and improve. Going forward, the proposal is for the Committees to be held bi-monthly, before the month of a Group Board and to hold informal meetings between the Committee Chairs and the GCPO, in between the formal meetings.

People Committee

Terms of Reference

1. Name

The Committee shall be known as the “People Committee”.

2. Establishment and Authority

The Committee is constituted as a committee of the Board of Directors and is authorised by the Board to:

i. Act within its terms of reference
ii. Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
iii. Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
iv. Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. Purpose

The purpose of the Committee is to provide assurance to the Board on the development and delivery of a sustainable, engaged and empowered workforce that supports the provision of safe, high quality, patient-centred care by:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people.
- Overseeing and providing assurance to the Board on progress in the delivery of the strategic initiatives identified in the Group Strategy that relate to people.
- Overseeing the development of relevant people, culture and organisational development strategies that support the new Group Strategy and monitoring progress in the implementation of these, in the context of the local Integrated Care System(s), the Trust’s financial and operational plans, and the national NHS People Plan.
- Monitoring workforce key performance indictors and identifying and reviewing themes and trends, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Overseeing the development of a culture that empowers and supports staff to deliver to their best, including in relation to equality, diversity and inclusion, psychological safety and raising concerns, and staff health and wellbeing.

Deleted: , specifically the Group strategic objective of engaging and empowering staff

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- Seeking assurance in relation to education, training and development plans.
- Seeking assurance in relation to improving staff engagement.
- Seeking assurance that key risks relating to workforce, culture, equality, diversity and inclusion, as included on the Group Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Providing assurance that legal and regulatory requirements relating to people issues are met.
- Ensuring appropriate governance arrangements are in place in relation to people, culture and organisational development issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

4. Duties

The Committee's duties as delegated by the Trust Board, include:

Workforce Strategy and planning

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to people, specifically the Group strategic objective of engaging and empowering staff by:
  - Getting the basics right (payroll, recruitment, employee relations, good people management practice);
  - Putting staff experience and wellbeing at the heart of what we do;
  - Fostering an inclusive culture that embeds our values;
  - Developing tomorrow's workforce;
  - Working differently ('flexible by default', digitally-supported working, leaders, continuous improvement).
- Overseeing and providing assurance to the Board on progress in the delivery of the strategic initiatives identified in the Group Strategy that relate to people, in particular in relation to:
  - Supporting a continuous improvement approach through high performing teams and leaders; and
  - Transforming our culture and making our workplaces more diverse and inclusive.
  - Pursuing collaboration across our GESH Group in relation to the development of Group Corporate Services.
- Monitoring the implementation of relevant people, culture and organisational development strategies that support the new Group Strategy, in the context of the local Integrated Care System(s), financial and operational plans, and the national NHS People Plan.
- Reviewing and seeking assurance in relation to risks to the delivery of the Group's people strategy and related Trust plans.

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Workforce performance, themes and trends

- Reviewing themes and trends in relation to relevant workforce performance indicators and seeking assurance on actions to improve performance, and escalating issues to the Board as appropriate. This includes: recruitment and retention, vacancy, turnover, sickness absence, use of bank and agency staff, appraisal rates, mandatory and statutory training (clinical and non-clinical), and employee relations.
- Seeking assurance in relation to the experience of junior medical staff and actions to drive improvements, including receiving reports from the Guardian of Safe Working.

Staff engagement and wellbeing

- Seeking assurance on plans to improve engagement with staff, with the aim of securing increasing levels of staff engagement.
- Reviewing the results of the annual NHS staff survey and seeking assurance in relation to the development and implementation of action plans to address issues identified.
- Monitoring staff health and wellbeing.

Culture, Equality, Diversity and Inclusion

- Seeking assurance in relation to development and delivery of action plans to strengthen culture, equality, diversity and inclusion and monitoring performance in relation to equality indicators drawing relevant issues to the attention of the Board.
- Monitoring and providing assurance to the Board on the actions taken to comply with the Equality Act 2010 in relation to staff. The Quality Committee will monitor the compliance with the Equality Act 2010 in relation to patients.
- Overseeing actions to comply with relevant regulatory frameworks relating to equality, diversity and inclusion.
- Receiving regular reports relating to equality, diversity and inclusion, and reviewing prior to consideration by the Board:
  - the Workforce Race Equality Standard (WRES) and improvement action plans.
  - the Workforce Disability Equality Standard (WDES) and improvement action plans.
  - The Trust's performance in relation to the gender pay gap and the ethnicity pay gap.
- Reviewing the key trends and themes arising from concerns raised by staff, including receiving regular reports from the Freedom to Speak Up Guardian.

Education and Organisational Development

- Overseeing and seeking assurance in relation to the development and implementation of strategies and plans for education, training and development across the Trust and in partnership with other organisations.

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Deleted: that any necessary corrective plans and actions are in place

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Deleted: education and training,

Deleted: <#>Overseeing and reviewing key themes and trends in relation to workforce performance and improvement, and escalating these to the Board as appropriate.¶
Overseeing the working hours of

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Deleted: <#>Receiving reports and action plans relating to independent reviews commissioned by the Trust, or externally, to address significant cultural challenges within teams / services across the Trust.¶

- Overseeing and seeking assurance in relation to the Trust's plans for leadership and organisational development.

General

- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.
- Obtaining assurance on the strategic risks to delivery of the strategic objectives in relation to workforce, organisational development, culture, and equality and diversity with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall within the remit of the Committee.
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Reviewing any Trust strategies prior to approval by the Board (if required) and monitor their implementation and progress.

5. Membership and Attendance

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief People Officer is the executive lead for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief People Officer
- Group Chief Nursing Officer
- Group Chief Medical Officer
- Managing Director(s)
- Group Chief Finance Officer

The following are expected to attend but will not be counted towards quoracy.

- Deputy Chief People Officer – Culture and Organisational Development
- Deputy Chief People Officer – HR Operations
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- People Director (Site)
- Group Chief Corporate Affairs Officer
- Group Chief Communications and Engagement Officer

Deleted: <#>Overseeing performance on staff appraisal rates (clinical and non-clinical).¶
Overseeing performance in relation to statutory, mandatory and other training.¶

Deleted: Director of People Strategy, Planning and Change…

Other directors and staff may attend meetings with the prior permission of the Chair.

An attendance register will be held for each meeting and an annual register of attendance will be set out in the Trust's Annual Report.

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

6. Quorum

The quorum for any meeting of the People Committee shall be a minimum of four members of the Committee including:

- At least two Non-Executive Directors
- At least two Executive Directors

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

7. Accountability and Reporting Arrangements

The People Committee operates under the delegated authority of the Board of Directors and remains ultimately accountable at all times to the Trust Board of Directors.

Under the Group Board arrangements, the People Committee, acting as part of a Group-wide People Committees-in-Common, will report to the Group Board on the meetings that have taken place since the last Group Board meeting. This will include:

- A list of all items considered by the Committee-in-Common during the relevant period
- Key issues for escalation to the Group Board
- Key issues on which the Committee-in-Common received assurance
- Other issues considered by the Committee-in-Common
- Review of risks assigned to the Committee-in-Common

8. Meeting Format and Frequency

The Committee will meet bi-monthly (every other month) and ahead of Group Board meetings so that a report to the Group Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

10. Declarations of Interest

All members of the Committee must declare any actual or potential conflicts of interest. These will be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the meeting for the duration of the relevant item.

11. Meeting Arrangements and Secretariat

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the People Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed in advance with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

12. Review of Committee effectiveness and Review of Terms of Reference

The Committee shall undertake an annual review of effectiveness, the results of which will be considered by the Committee and will be presented, in summary, to the Group Board.

These Terms of Reference shall be subject to an annual review. Any changes to these Terms of Reference may only be made by the Group Board following review by the Committee.

Document Control

Profile	
Document name	People Committee Terms of Reference
Version	1.3
Executive Sponsor	Group Chief People Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	18 April 2024
Date of Trust Board approval	2 May 2024
Date for next review	April 2025

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

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People Committee-in-Common

Committee Effectiveness Review 2023/24

Summary Report for Group Board

Stephen Jones
Group Chief Corporate Affairs Officer

May 2024

1. Introduction
Purpose, context and recommendations

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

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the People Committees-in-Common in 2023/24. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2024/25.

Background and context
It is good governance practice for all Committees of the Board to hold annual effectiveness reviews and report on these to the Board. Responses were sought via an online survey tool. A full set of responses and anonymised responses is at Appendix 1.

Summary
A total of 12 people responded to the effectiveness survey. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective during a challenging year and were continuing to develop and improve. The key issues highlighted were: the timeliness of papers, though seen as improving; quality of papers, variable but improving; that action/changes were slow; more consideration needed to be given to the information and papers presented; need to agree actions at the end of each item; and ensuring that discussions were focused on assurance.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2024/25.

Next steps
The Committee's discussion, actions to improve the Committee's effectiveness will be incorporated into the workplan and terms of reference.

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

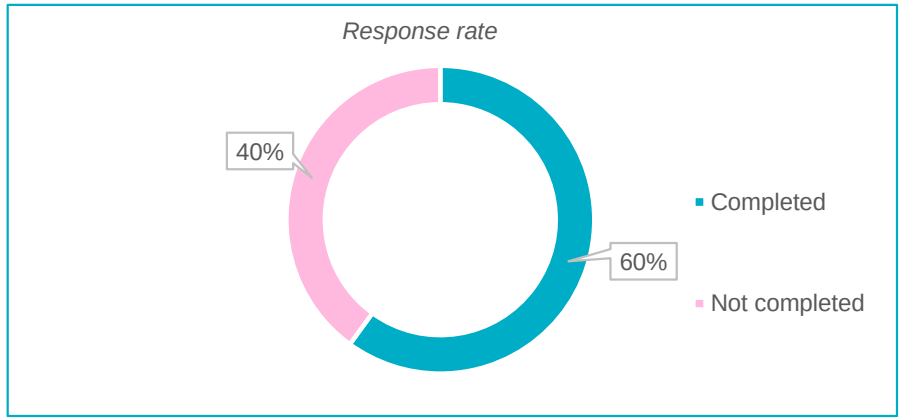
2. Engagement

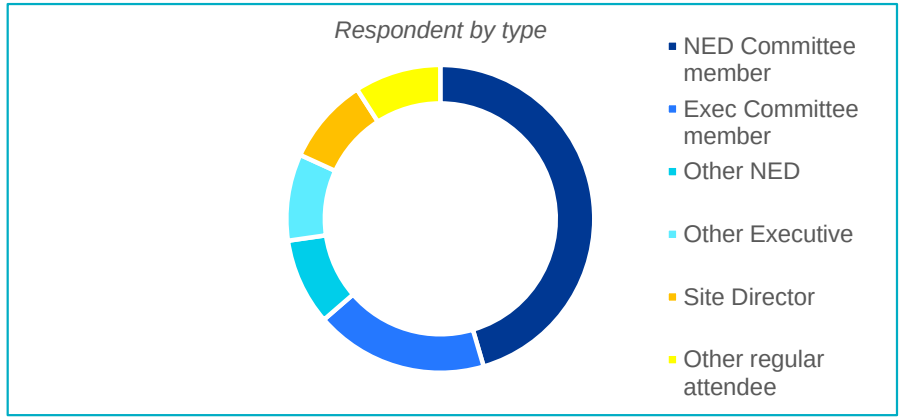
Response rate and respondent types

The following groups were invited to participate in the Committee effectiveness survey:

- Non-Executive members of the Committee
- Executive members of the Committee (Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Managing Directors, Group Chief Finance Officer)
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference (Deputy Chief People Officers, Site People Directors, Site Chief Medical Officers, Site Chief Nursing Officers, Group Chief Corporate Affairs Officer)

In total, 20 people were invited to participate in the survey. Of these a total of 12 engaged with and provided responses to the survey, a response rate of 60%:





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3. Key findings

Overall effectiveness

The pages that follow provide a summary of the responses and free text comments provided by respondents to the Committee effectiveness survey. Stepping back from the detailed responses, the following broad themes emerge from the survey:

- **Terms of Reference and forward work plan:** The majority agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. One of the 12 respondents felt that the forward plan contained a lot of topics and felt that there was potential to review what were Executive accountabilities and what should be discussed at the Committees – though the issue of scope also relates to the nature of the discussions (see below on focus on assurance).

- **Membership, skills and experience of Committee:** The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. One respondent felt that there was scope to further reduce the number of attendees at the Committee, while it was also noted the pressures in expecting the GCNO and GCMO to attend meetings. Comments also highlighted that, typically, the GCPO took on many of the actions arising from the Committee and queried whether these could appropriately be shared between Executives. One respondent proposed inviting a patient representative to the Committee.

- **Chairing of meetings:** The respondents acknowledged the different styles and variability in chairing the meetings but felt that both chairs were effective. Some respondents highlighted that meetings could become too operational in focus or get ‘taken down rabbit holes’ and that the Committee risked ‘going over old ground repeatedly’.

- **Discussions and assurance:** Linked to the above, the majority of respondents felt that there was generally good challenge but some flagged that actions were not always entirely clear and that meetings could become too operational in focus and insufficiently focused on assurance. The respondents felt that generally there was enough time for discussions, but some highlighted that three hours was a long time for a meeting. Another respondent felt too much time was spent on one item and that the discussions felt like Executive discussions rather than Board level discussions.

3. Key findings

Overall effectiveness

- **Timeliness of papers:** The response was somewhat mixed. It was acknowledged that some papers were late, but that there were signs that this had improved recently, aided by shorter agendas, but remained an issue. Respondents felt that papers should be circulated a week before the meeting (as per terms of reference). There was an acknowledgement that sometimes there may be legitimate reasons for a late paper and one proposal was to introduce a hard deadline of 48 hours before the meeting for any late papers. Some respondents also felt that the GCPO should push back at times when there were requests for unnecessary information or papers.

- **Quality of papers:** Generally, the respondents felt that the quality of papers had improved recently. Some felt the papers were too long, repetitive, lacked clarity on risks, triangulation and actions. Cover sheets could be improved to provide a better and more rounded Executive Summary of the paper and be clearer on what the Committee is asked to do.

- **Overall effectiveness of the Committee:** The majority at 45% (5) felt the Committee was very effective, with 36% (4) expressing that the Committee was somewhat effective and 18% (2) thought the Committee was extremely effective. One respondent felt that the right issues were discussed but change was slow. Another felt more consideration was needed to be given to what information should be available and what time should be spent on.

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4. Next steps

"So what" and "what now"?

The Committee has previously discussed moving to a bimonthly rhythm of meetings, and this has been endorsed by Board members, and may wish to reflect on the feedback from the Committee effectiveness review in the context of this planned change to the rhythm of meetings. The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25:

- **Frequency of meetings:** Formally review and recommend to the Board moving to bi-monthly meetings.
- **Forward plan:** Review the forward plan, which focuses on fewer core issues in depth, with the frequency of retained items revised. Forward plan attached to each circulation of papers to ensure everyone know what is due when.
- **Focus:** Agendas, papers and discussion need to focus on the big strategic issues and not on unnecessary operational detail – focus on operational detail where this relates to exposing / exploring an important issue of assurance
- **Timeliness of papers:** Reinforce expectation that papers are circulated a week before the Committee, with any late papers agreed in advance with the Committee chairs. Introduce a hard cut off deadline of 48 hours before the meeting for any agreed late papers.
- **Quality of papers:** Ensure greater consistency in the quality of papers – papers to be more concise, focus on assurance and on the "so what" and "what now". Greater use of appendices for necessary detail, and use of reading room for supplementary / optional reading. Workforce data presented less frequently but with a focus on trends, themes and actions.
- **Discussion:** Questions to focus on exploring assurance and the implications. and agree actions at the end of each item.
- **Chairing:** Summing up at the end of each agenda item, including agreement of the level of assurance received, any actions and any next steps. Questions of interest to be dealt with off line.

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University Hospitals and Health Group

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	3.1a	
Report Title	**Group Maternity Services Quality Report** **February - March 2024 data**	
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Dr Benedicta Agbagwara - Osuji, Director of Midwifery and Gynaecology Nursing ESTH Laura Rowe, Lead Midwife for Clinical Governance and Risk ESTH Dr Ramesh Ganapathy, Divisional Director, Women and Children's Services ESTH Janet Bradley, Director of Midwifery and Gynaecology Nursing SGUH Emily Kaliwoh, Interim Lead Midwife for Governance SGUH Dr Jessica Moore, Clinical Director Women's Health, SGUH	
Previously considered by	ESTH Women and Children's Divisional Management Team ESTH Senior Leadership Team SGUH CWDT Divisional Management Team SGUH Senior Leadership Team]	
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

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

The purpose of the report is therefore to inform the Quality Committee in Common (designated sub-committee of the Trust Board) of progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns and activity to ensure safety within maternity units across the Group.

The report data covers the period February and March 2024. The report format and style has evolved, and this is the first report in the format recommended by the Improvement Director who was commissioned by the Trust Board to undertake a review of governance at gesh, starting with maternity.

2.0 Significant changes since the last report

The Maternity and Perinatal Incentive Scheme for Year 6 was published on 2nd April 2024 and is currently being reviewed.

ESTH will now be part of the Maternity Safety Support Programme (MSSP), with a Diagnostic Review by the NHSE MSSP team taking place 7-9 May 2024.

Both ESTH and SGUH were successful in achieving full compliance for all ten safety actions against Year 5 of the Maternity Incentive Scheme. The value of the CNST contribution that will be awarded to ESTH and SGH is not yet known, however, the committee will be updated with this information as soon as it is known.

SGUH launched the digital transformation project, which will replace Euroking with Cerner.

3.0 Successes

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

Maternity teams across the group scored as the top two in London for care given to women, birthing people and their babies. This is positive when viewed against the national picture and when compared to the 2022 results.

ESTH was ranked top / 1st in London in the NHS Maternity Survey 2023 and made improvements in several areas.

SGH was ranked 2nd in London in the NHS Maternity Survey 2023 and showed an improved picture.

Awards: SGH has been awarded the NHS Pastoral Care Quality Award for internationally recruited nurses and midwives.

4.0 Concerns and new risks

ESTH and SGUH: PMRT external panel member; both services are aware of the recommendation for the presence of an external panel members for PMRT reviews, which remains challenging to fulfil. However, the requirement for an external panel member is not mandatory, rather, the MIS guidance stipulates that reviews should be undertaken by a multidisciplinary team, and the focus for CNST is that PMRT reviews are completed in a timely manner, and a selective approach applied regarding which case would benefit most from having an external member as part of the panel.

> ***What does "multidisciplinary reviews" mean?***
> *To be multi-disciplinary the team conducting the review should include at least one and preferably two of each of the professionals involved in the care of pregnant women and their babies. Ideally the team should also include a member from a relevant professional group who is external to the Trust who can provide 'a fresh pair of eyes' as part of the PMRT review team. It may not be possible to include an 'external' member for all reviews and you may need to be*

selective as to which deaths are reviewed by the team including an external member. Bereavement care staff (midwives and nurses) should form part of the review team to provide their expertise in reviewing the bereavement and follow-up care, and advocate for parents. It should not be the responsibility of bereavement care staff to run the reviews, chair the panels nor provide administrative support.
Source: technical guidance of MIS year 6, MIS-Year-6-guidance.pdf

ESTH and SGUH: both services offer shared care to women and birthing people with the midwife and their GP, a recommendation was made by the external team who conducted the MBRRACE-UK 2020 review of cases across gesh maternity services, that the service needs to gain assurance that GPs who provide antenatal care undertake saving babies lives care bundle and fetal monitoring training. The Group Chief Midwifery Officer has taken an action to liaise with the SWL GP lead and the NHS Resolution Trust link to clarify the requirements. Any resulting actions that must be taken to ensure gesh maternity services are complaint with national guidance in this aspect will be addressed.

An update will be provided at the next committee meeting.

ESTH:
Workforce: maternity workforce configuration is underway, which will see a reduction in midwifery continuity of care teams 10 to 2 teams.
Risks: new risk regarding the environment, transitional care and the homebirth service was added to the risk register. Extreme risks regarding CNST compliance and transitional care have been reviewed and the risk rating and scores reduced in line with the resolution of the risk (Met CNST compliance) and mitigations in place for transitional care
Staff experience: the service has seen a deteriorating position in the SCORE and NHS Staff surveys. The maternity and neonatal team are undertaking the Perinatal Culture and Leadership programme to support them in addressing the concerns locally

SGUH:
Clinical safety: the service has identified a theme of increasing number of Caesarean Sections taking place at full dilatation for which a review is underway to identify any contributory factors, and safety concerns.
Equipment: several essential equipment that have either reached their 'end of life' or have been decommissioned or defunct, has not had their replacement supported through routine asset management e.g., cardiotocograph (CTG machines to monitor fetal heart rate), and birthing pools
Staff Experience: the service has seen a deteriorating position in the SCORE and NHS Staff Survey. This feeds into the Perinatal Culture and Leadership programme, which the maternity and neonatal quad are undertaking, to help the team identify and address aspects of the service that has bene highlighted as requires improvement.

5.0 Training compliance related to the Core Competency Framework (Jan-March 2024)

Type of Training and % compliance	Staff Group	ESTH January 24	ESTH February 24	ESTH March 24
PROMPT 90%	Midwifery Staff	95%	96%	96%
	Maternity Support Workers	87%	91%	88%
	Consultant Obstetricians	89%	93%	93%
	Trainee and Staff Grade Obstetricians	72%	100%	100%
	Anaesthetics	87%	91%	90%
CTG Training	Midwifery Staff	95%	91%	92%

90%	Obstetricians	77% (89% Consultant and 45% middle grades)	92%	92%
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	96%	96%

Type of Training and % compliance	Staff Group	SGUH January 24	SGUH February 24	SGUH March 24
PROMPT 90%	Midwifery Staff	90%	87%	91%
	Maternity Support Workers	85%	83%	96%
	Consultant Obstetricians	70%	90%	95%
	Trainee and Staff Grade Obstetricians	80%	100%	100%
	Anaesthetics	54%	83%	92%
CTG Training 90%	Midwifery Staff	93%	84%	92%
	Obstetricians	80%	78% (75% consultant and 80% middle grade)	96% (100% consultant and 94% middle grades)
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	89%	91%

Safe staffing

Staff Group	Measure	January 2024		February 2024		March 2024	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		97%	93%	94%	77%	93%	80%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

Staff Group	Measure	January 2024	February 2024	March 2024
Midwifery	Fill rate (target >94%)	SGUH 90.3%	SGUH 92.6%	SGUH 92.1%
Obstetric	Expected v Fill	100%	100%	100%
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	94%	98.3%	92%
Triage Staff SGUH, 2.0 wte per shift	Shift allocation 100%	100%	100%	100%

ESTH: Midwifery fill rates were lower across February and March 2024 due to high levels of annual leave as well as an increase in both short and long term sickness on the Epsom site. Recruitment has been successful with 6 WTE midwives progressing to substantive posts. In the interim, 2 WTE midwives have been seconded to EGH from STH to help improve staffing. There has been an increase in off-framework agency use; however, the measures above have been implemented to reduce this, with fill rates on both sites predicted to improve over the next rosters.

SGUH: Midwifery fill rates remained below the threshold of >94% across February and March 2024 due to short-, and long-term sickness. The midwifery matrons are working with both the HRBP and ER teams to manage their sickness levels. The teams are also supporting flexible working requests to

support retention and well-being of staff and are in the process of reviewing regular rotation of all clinical staff to maintain midwifery competencies and skills.
Following the establishment review and supported investment, the corresponding posts are now out to advert and will serve to maintain and enhance quality and safety across the service.

6.0 Current or upcoming plans/reviews/Quality Improvement
There is a requirement under CNST for the maternity and neonatal team to jointly register and undertake a QI project relating to transitional care and minimising the separation of mothers and babies. This applies to all gesh maternity and neonatal service and plans are in development to undertake.
ESTH: Healthwatch are planning to do a qualitative research project looking at patient experience of maternity services at ESTH. This was already in planning and is unrelated to the CQC report or survey.
SGUH: the Equality Delivery System (EDS) scoring of maternity services is underway during April, with a presentation to an MDT that includes SWL ICB colleagues.
ESTH and SGUH: there is need to review the arrangements for midwifery manager on call. This will be taken through an options appraisal in collaboration with ESTH and SGUH, ER and HR. The outcome will be shared at a future Quality Committee

Action required by Group Board

The Board is asked to:

a) Note the successful outcome against the CNST year 5 and the publication of CNST year 6.
b) Note the key areas of success, risks, and mitigations.
c) Make recommendations for any further action.

Appendices

Appendix No.	Maternity
Appendix 1	**READING ROOM** ESTH Perinatal Mortality Review/ Board report
Appendix 2	**READING ROOM** SGUH Perinatal Mortality Review
Appendix 3	**READING ROOM** ESTH SCORE survey
Appendix 4	**READING ROOM** ESTH Staff Survey
Appendix 5	**READING ROOM** SGUH PMRT Board report
Appendix 6	**READING ROOM** SGUH Score Survey

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and /or Regulatory implications

ESTH and SGUH: ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

Equality, diversity and inclusion implications

As set out in the paper.

Environmental sustainability implications

No issues to consider.

Group Maternity Services Quality Report

Group Board, 02 May 2024

1.0 Purpose of paper

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

The purpose of the report is therefore to inform the Quality Committee in Common (designated sub-committee of the Trust Board) of progress against the local and national agreed safety measures for maternity and neonates and of any emerging safety concerns and activity to ensure safety within the maternity units across the Group.

2.0 Background

2.1 The report data covers the period February and March 2024. The report format and style has evolved, and this is the first report in the format recommended by the Improvement Director who was commissioned by the Trust Board to undertake a review of governance at gesh, starting with maternity.

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

Currently the report includes:

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

Feedback to the authors of the report about what works well and what needs development in terms of the report will be welcomed.

3.0 Analysis

3.1 Maternity and Perinatal Incentive Scheme (CNST)

The Trust have been notified that the Maternity Service at ESTH and SGUH were assessed as compliant with all 10 safety actions in the Year 5 Maternity Incentive Scheme; the amount of the incentive element that will be awarded has not yet been announced.

Note: at the point of the original submission on 1st February 2024, SGUH declared compliance with 9/10 safety actions (SA), due to not meeting safety action 5, midwifery staffing – 100% supernumerary status of the delivery suite coordinator. On 28 February 2024, NHS Resolution asked SGUH to re-evaluate the submission surrounding SA5. Following re-submission of evidence which demonstrated the robust mitigations in place when the coordinator is non-supernumerary, NHS Resolution confirmed that SGUH were compliant with 10/10 SA.

The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. There are 84 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2024). The deadline date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2025.

ESTH and SGUH, as in previous years, will convene a working party within the Women and Children's Health Division and CWDT Division respectively, to monitor compliance with the requirements, gather evidence, and complete the Excel Audit and monitoring tool (new) which has been provided for Trusts to use for assurance purposes.

The audit tool with progress to date, will be shared as an Appendix in reports from June 2024 onwards.

3.2 Perinatal Quality Surveillance

This report includes all the elements required to be reported in accordance with the Perinatal Quality Surveillance data (CNST Safety Action 9).

ESTH - Perinatal Mortality Reviews

3.2.1 The Perinatal Mortality cases reported and reviewed during the period 1st March 2023 to 31st March 2024 can be found in Appendix 1.

3.2.2 The table below shows a summary of cases discussed, themes and open actions in relation to Perinatal Mortality Reviews (PMRT) undertaken and should be read in conjunction with the summary Board report (3.2.1 above).

PMRT Panel	Cases reviewed February 2024/ March 2024	Emerging Themes	Open Actions from previous reviews, year to date	
ESTH: 2 panel meetings held (09/02/2024 and 08/03/2024)	INC-142169 (2nd panel – no external attendance) ***Grading: B,B*** INC-144107 (1st panel – external attendance) ***Review not yet complete***	**3 Cases reviewed during this period (1 case in March 2024 was a SGUL reported case so appears on their PMRT but we contributed to the antenatal factual questions).** No new clear emerging themes identified to date that contributed to the deaths but the panel has noted that there is a trend of not completing partograms in labour for cases of intrauterine death. There was one case reviewed at the meeting in February 2024 where the panel considered there were care and service delivery that ***would not*** have made a difference to the outcome, including lack of written information on reduced fetal movements and lack of partogram use in labour. There was 1 ESTH case reviewed in March 2024; this related to a stillbirth in the 3rd trimester and a further panel is required to conclude the review.	INC-138602 INC-132938 INC-141041	1. Review to be undertaken by the obstetric team, in conjunction with the regional team, of the blood tests required following a stillbirth. ***This action has been extended as regional review is recommended.*** 2. Roll out the use of the SBAR facility in BadgerNet (29/02/2024). 3. RCOG Pre-labour rupture of membranes leaflet to be included on BadgerNet for women to access and guidance to be updated (31/01/2024). 4. Diabetes guideline to include the management of women on Metformin post steroid administration (31/01/2024). 5. Process for following up results for women discharged before the results are available (29/02/2024). 6. Review the guidance on following-up MSU samples (31/03/2024) 7. Signs and symptoms of infection following SROM to be discussed at the safety huddle.

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

3.2.4 There have been no clear themes emerging from the review of stillbirths and neonatal deaths. Of the 2 PMRT panel meetings held, 1 had an external panel member. The service is aware of the recommendation for the presence of external panel members for PMRT reviews, which remains challenging to fulfil. However, the requirement for an external panel member is not mandatory, rather, the MIS guidance stipulates that reviews should be undertaken by a multidisciplinary team, and the focus for CNST is that PMRT reviews are completed in a timely manner and a selective approach applied regarding which case would benefit most from having and external member as part of the panel.

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

3.2.6 **MNSI Cases**

There are currently 2 cases open with MNSI. One case was closed in February 2024, and this was presented to the Trust SI Panel in April 2024. There was one safety recommendation in relation to the report closed in February 2024; ***"The Trust to ensure that staff are supported to maintain holistic oversight when there is evidence of deteriorating fetal wellbeing requiring a change in the urgency of birth".***

Since this incident, the maternity service has strengthened their performance in undertaking CTG reviews and peer reviews in line with Saving Babies Lives Care Bundle v3 (now over 80% in line with the target) and a meeting is planned for April 2024, to consider if any further actions are required. This will continue to be monitored quarterly by the ICB in line with the review requirements for SBLCBv3.

SGUH Perinatal Mortality Reviews

3.2.7 The perinatal mortality cases reported and reviewed during March 2014 can be found at Appendix 2

3.2.8 The following tables provides a summary of cases discussed in February and March 2024, the PMRT grading, themes and actions.

PMRT Panel	9 Cases reviewed in February and March 2024	External panel member present Y/N	PMRT grading of cases (A-D)	Emerging Themes	Open Actions from previous reviews, year to date	
SGH: 3 panel meetings	ID 90419 ID 89718 ID 90962 ID 90535 ID 90801 ID 90462	N	A, A A, B (Frimley), A C (Croydon), C (Croydon), A A, A A, A, A B, A	**9 Cases reviewed during this period** No new clear emerging themes identified to date. There were two case reviewed at the meeting in February 2024 where the panel considered there were care and service delivery that ***would not*** have made a difference to the outcome, including an opportunity was missed to do a blood gas and perhaps administer antibiotics sooner. There was 1 cases reviewed in March 2024 where the panel considered there were care issues that ***would have*** made a difference to the outcome: an opportunity for cerclage was missed as delayed booking. This could have potentially avoided preterm delivery.	ID 89718 ID 90962	1. Frimley will be revising their guidelines around further investigations when a baby has an increasing Fi02 - further education to team. 2. Midwifery and team leader at Croydon aware of delay in appointments due to capacity. Discussed with POD and plan made for appropriate escalation.

PMRT Panel	9 Cases reviewed in February and March 2024	External panel member present Y/N	PMRT grading of cases (A-D)	Emerging Themes	Open Actions from previous reviews, year to date	
SGH: 3 panel meetings	ID 81289 ID 90805 ID 90977	Y	C, C B, B A, C, B	There were two cases reviewed in March 2024 where the panel considered there were care issues that ***would have*** made a difference to the outcome: the panel recognised that given the hypotensive episode, it is unlikely the baby could have survived. There was a significant delay in administering medication to stabilise blood pressure. There was a missed opportunity to have contacted the obstetric team. There were two cases reviewed at the meeting in March 2024 where the panel considered there were care and service delivery that ***would not*** have made a difference to the outcome, the panel felt that correct referrals, policies and protocols were followed in ID 90805 case. However, the grading reflects the panel's acknowledgement of how the family felt of their experience.	ID 90977	1. The neonatal team have developed an intubation checklist which is in use on the Neonatal Unit. The neonatal unit is currently developing a guideline for use of the video laryngoscope. There may be later recommendations and actions following an SI panel.

3.2.9 There were three cases (of the nine reviewed) where the panel considered that there were care issues that would have made a difference to the outcome. In one case, an opportunity for cerclage was missed due to delayed booking, which could have potentially prevented a preterm delivery. Other care issues identified, related to missed opportunity to administer anti-hypertensive treatment to stabilise the woman's blood pressure and a missed opportunity to contact the obstetric team for review.

3.2.10 Of the 3 panel meetings held, only 1 had an external panel member. The service is aware of the recommendation for the presence of external panel members, which remains challenging to fulfil. However, the requirement for an external panel member is not mandatory, rather, the MIS guidance stipulates that reviews should be undertaken by a multidisciplinary team, and the focus for CNST is that PMRT reviews are completed in a timely manner and a selective approach applied regarding which case would benefit most from having and external member as part of the panel.

However, it is recognised that having an external panel member where possible is good practice and solutions are being explored to address, e.g., cross-site panels.

3.2.11 The MBBRACE-UK Perinatal Mortality Report for 2022 shows that the Trust is not a negative outlier for either stillbirth or neonatal death.

3.3 Incidents logged as moderate harm and above.

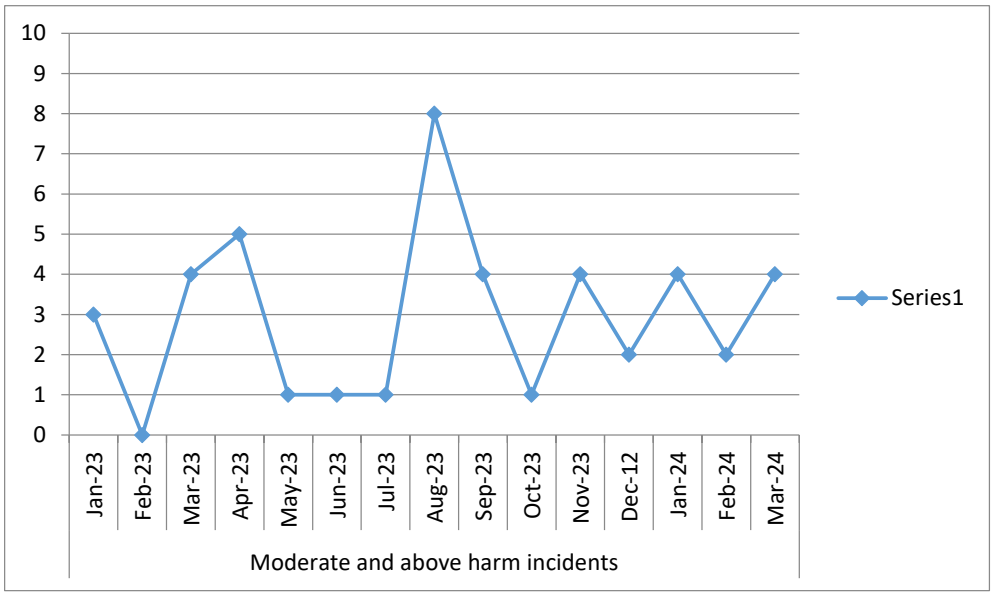
3.3.1 'Harm' relates to the degree of harm caused as a result of a patient safety incident and NHS England Guidance (maternity example) states that a harm grading should only be applied to maternity incidents if it is considered that a patient safety incident, such as an omission or error in care has led to, or contributed to the harm (NHS England, 2019).

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

ESTH

In February and March 2024, there were 7 incidents which were reported as resulting in moderate harm and above; 1 related to a readmission (appropriate care was given), 4 related to 3rd degree tears and 2 related to obstetric haemorrhage >1500mls. The cases are currently being reviewed by the obstetric team to determine if there were any patient safety incidents which contributed to the outcome, but currently, no cases are proceeding to a Patient Safety Incident Investigation.

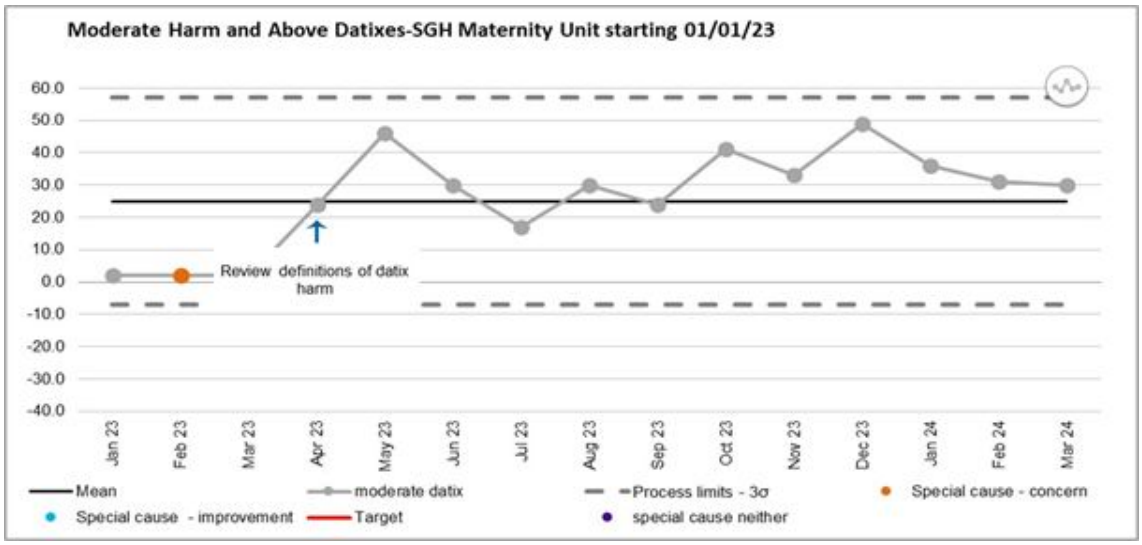
The table below shows the trend of moderate harm grading over the last 15 months, with the caveat that this does not relate to harm caused by the organisation (which we cannot determine due to the policy of reporting outcomes as harm by default). This shows a stable position over time.



SGUH

In February and March 2024, there were 32 incidents reported as resulting in moderate harm. Of these, there were 23 incidents relating to post-partum haemorrhages of 1.5 litres and above, or of lesser volumes where a transfusion was required. These cases have all been discussed in an MDT meeting and quarterly themes will be reported and discussed at the Maternity Governance Meeting. Feedback has been given to medical and midwifery staff about the importance of completing clear postnatal plans and the Post Partum Haemorrhage (PPH) proforma. The PPH guidelines have been reviewed and a PPH awareness week was completed in February.

If we consider a rise in the number of datixes submitted to be improvement, then this SPC chart shows following a review of the definitions of patient harm in April the number of datixes increased from 2 per month to a mean of 25. The variation seen between the numbers of moderate datixes submitted month on month can be attributed to common cause and is of no positive or negative significance.



3.3.2 **Patient Safety Incident Investigations (PSII)/Themes**

3.3.2 **ESTH:** there are currently 10 open Patient Safety Investigations in progress, 2 of which are being investigated by MNSI, and one is awaiting sign-off by the Division. There are no clear themes emerging however, this will continue to be reviewed during and post transition to PSIRF. The maternity service transitioned to the PSIRF model on the 2nd April 2024.

3.3.3 There were no Serious Incidents/PSIIs completed in January or February 2024. Completion of actions from MNSI/PMRT/SI/PSII are monitored centrally via a tracker by the Maternity Risk Team. There is currently one action in progress as a result of a SI/PSII and this relates to updating the guidance for the administration of antenatal steroids to bring this in line with RCOG guidance. There are no overdue actions.

3.3.4 **SGUH:** There is one open patient safety investigation, a preterm twin birth with cord occlusion. A date for the 1st panel meeting is being arranged.

3.3.5 Three cases were closed in February and March.

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3.4 Training compliance related to the Core Competency Framework (Jan - March 2024)

ESTH

Type of Training and % compliance	Staff Group	ESTH January 24	ESTH February 24	ESTH March 24
PROMPT 90%	Midwifery Staff	95%	96%	96%
	Maternity Support Workers	87%	91%	88%
	Consultant Obstetricians	89%	93%	93%
	Trainee and Staff Grade Obstetricians	72%	100%	100%
	Anaesthetics	87%	91%	90%
CTG Training 90%	Midwifery Staff	95%	91%	92%
	Obstetricians	77% (89% Consultant and 45% middle grades)	92%	92%
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	96%	96%

3.4.1 Safe Staffing

Staff Group	Measure	January 2024		February 2024		March 2024	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		97%	93%	94%	77%	93%	80%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

3.4.2 Midwifery fill rates were lower across February and March 2024 due to high levels of annual leave as well as an increase in both short and long term sickness on the Epsom site. Recruitment has been successful with 6 WTE midwives progressing to substantive posts. In the interim, 2 WTE midwives have been seconded to EGH from STH to help improve staffing. There has been an increase in off-framework agency use; however, the measures above have been implemented to reduce this, with fill rates on both sites predicted to improve over the next rosters.

3.4.3 The following red flags were reported during this period, with the main issue relating to delays in induction of labour. We are currently undertaking a deep dive review into induction of labour as a trend has emerged in relation to delays.

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

3.4.4 Training compliance related to the Core Competency Framework (Jan – March 2024)

SGUH

Type of Training and % compliance	Staff Group	SGUH January 24	SGUH February 24	SGUH March 24
PROMPT 90%	Midwifery Staff	90%	87%	91%
	Maternity Support Workers	85%	83%	96%
	Consultant Obstetricians	70%	90%	95%
	Trainee and Staff Grade Obstetricians	80%	100%	100%
	Anaesthetics	54%	83%	92%
CTG Training 90%	Midwifery Staff	93%	84%	92%
	Obstetricians	80%	78% (75% consultant and 80% middle grade)	96% (100% consultant and 94% middle grades)
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	89%	91%

3.4.5 Safe staffing - SGUH

Staff Group	Measure	January 2024	February 2024	March 2024
Midwifery	Fill rate (target >94%)	90.3%	92.6%	92.1%
Obstetric	Expected v Fill	100%	100%	100%
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	94%	98.3%	92%
Triage Staff SGUH, 2.0 wte per shift	Shift allocation 100%	100%	100%	100%

3.4.6 Red flags - SGUH

Red Flag Category	SGUH
Coordinator not supernumerary	5
Delay in time critical activity	14
Delayed induction of labour	9
Delayed pain relief	4
Delayed or cancelled care	0
Number of cancelled incidents related to red flag	0

3.4.7 Midwifery fill rates remained below the threshold of >94% across February and March 2024 due to short-, and long-term sickness. The midwifery matrons are working with both the HRBP and ER teams to manage their sickness levels. The teams are also supporting flexible working requests to support retention and well-being of staff and are in the process of reviewing regular rotation of all clinical staff to maintain midwifery competencies and skills.

Following the establishment review and supported investment, the corresponding posts are now out to advert and will serve to maintain and enhance quality and safety across the service

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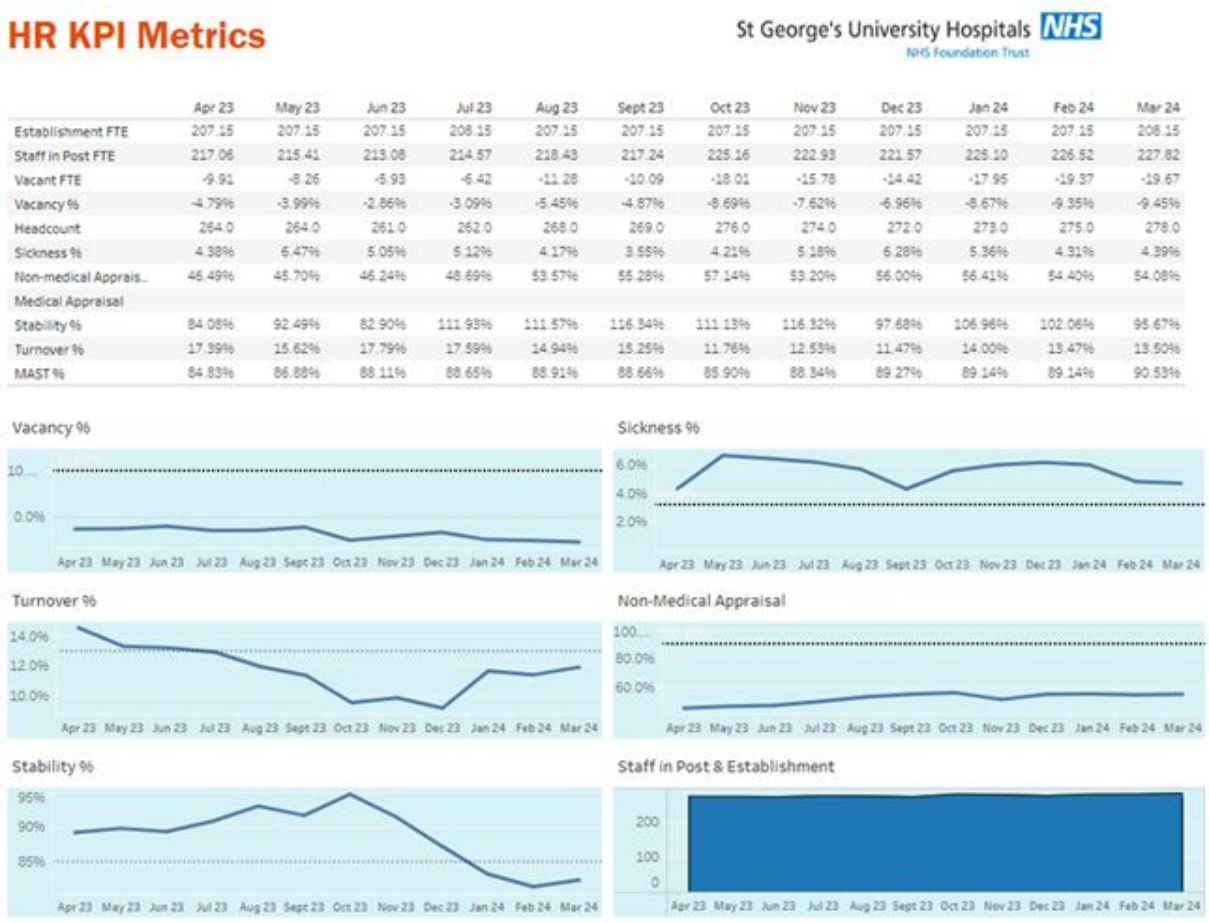
3.5 Workforce Performance

3.5.1 ESTH workforce performance:

Division	Vacancy %	Turnover (1m) %	Turnover (12m) %	Absence %	Appraisal %	Core Skills %
343 3 Women & Children's Services	4.66%	0.00%	7.98%	5.35%	85.29%	82.37%
Total	**4.66%**	**0.00%**	**7.98%**	**5.35%**	**85.29%**	**82.37%**

3.5.2 SGUH workforce performance



	Apr 23	May 23	Jun 23	Jul 23	Aug 23	Sept 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24
Establishment FTE	207.15	207.15	207.15	208.15	207.15	207.15	207.15	207.15	207.15	207.15	207.15	208.15
Staff in Post FTE	217.06	215.41	213.08	214.57	218.43	217.24	225.16	222.93	221.57	225.10	226.52	227.82
Vacant FTE	-9.91	-8.26	-5.93	-6.42	-11.28	-10.09	-18.01	-15.78	-14.42	-17.95	-19.37	-19.67
Vacancy %	-4.79%	-3.99%	-2.86%	-3.09%	-5.45%	-4.87%	-8.69%	-7.62%	-6.96%	-8.67%	-9.35%	-9.45%
Headcount	264.0	264.0	261.0	262.0	268.0	269.0	276.0	274.0	272.0	273.0	275.0	278.0
Sickness %	4.38%	6.47%	5.05%	5.12%	4.17%	3.55%	4.21%	5.18%	6.28%	5.36%	4.31%	4.39%
Non-medical Apprais..	46.49%	45.70%	46.24%	48.69%	53.57%	55.28%	57.14%	53.20%	56.00%	56.41%	54.40%	54.08%
Medical Appraisal												
Stability %	84.08%	92.49%	82.90%	111.93%	111.57%	116.34%	111.13%	116.32%	97.68%	106.96%	102.06%	95.67%
Turnover %	17.39%	15.62%	17.79%	17.59%	14.94%	15.25%	11.76%	12.53%	11.47%	14.00%	13.47%	13.50%
MAST %	84.83%	86.88%	88.11%	88.65%	88.91%	88.66%	85.90%	88.34%	89.27%	89.14%	89.14%	90.53%

3.5.3 ESTH: Maternity Continuity of Carer (MCoC)

Maternity Workforce reconfiguration work is currently underway in order to reduce the current Maternity Continuity of Carer teams from 10 to 2 teams to ensure minimum safe staffing in each area. The two teams will focus on areas of social deprivation. There was a national requirement to reconfigure maternity services into teams providing continuity of care to women throughout the antenatal, intrapartum and postnatal periods; ESTH had reconfigured their services to meet this

requirement, however, this initiative was suspended nationally, in view of the fact that maternity services in England were struggling to implement against a backdrop of national staffing challenges

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

3.5.4 ESTH SCORE survey

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

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

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

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

3.5.5 ESTH NHS Staff Survey 2023

In the latest staff survey, within the Division, 58% would recommend the organisation as a place to work and 65% would be happy for a friend/relative to be cared for by the organisation. This is a deterioration from the last staff survey, which showed 59.3% would recommend the division as a place to work and 67.2% would be happy for a friend or relative to receive treatment. A detailed breakdown can be seen in Appendix 4

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

3.6 Patient and staff experience and engagement

3.6.1 ESTH: Friends and Family (FFT) feedback

There were 80 responses in total of which 100% were positive, with compliments on the efficiency of the antenatal pathway and appointment scheduling, friendliness of all staff and swift

discharge. The Infant Feeding, Home Birth and Vaccination teams were highlighted as providing excellent care.

3.6.2 **ESTH: CQC maternity patient survey published February 2024**

The NHS Maternity Services 2023 Benchmark Report was published in early 2023 (Appendix 1). The survey, which is commissioned by the CQC, collects feedback on maternity care and the CQC use this data as part of their on-going monitoring or services.

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

- The Trust fell within the top five trusts in London in all measures (1st place).
- The Trust scored highest in London for care during pregnancy, labour and birth, care in the ward after birth and care at home after birth.
- Areas where we could improve includes care in the six weeks after birth (largely falling outside the ESTH service as women are discharged to the HV/GP usually at Day 10 postnatal), being aware of user's medical history during antenatal appointments, personalised care and asking about mental health issues.

Action plans for areas of improvement are currently being co-produced with the MNVP.

3.6.3 The ESTH MNVP had an away-day in March 2024, which included a workshop on areas of improvement noted in the CQC Maternity Survey.

There are several additional requirements for MNVP Leads in the coming year in relation to the Maternity and Perinatal Incentive Scheme and further updates will be given in future reports.

3.6.4 **SGUH: from the CQC maternity patient survey published February 2024**

The Trust feel in the top five trusts in London (2nd place)

There were five 'better than expected' scores and two 'somewhat better' scores. No score was worse or much worse than expected.

Better than expected scores in the following areas:

- Advice on the benefits associated with an induced labour
- Advice on the risks associated with an induced labour
- Was involved in the decision to be induced
- Partner being able to stay as much as they wanted
- Pain management after birth

Somewhat better scores as follows:

- Respect and dignity in antenatal care
- Personal circumstances being taken into account by the midwife

3.6.5 Board Safety Champions/Engagement Event/Walkabouts

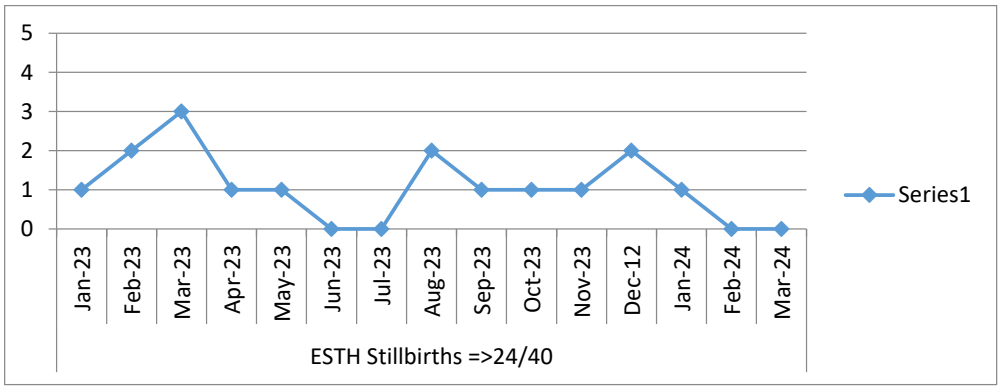
The Board Executive and Non-Executive safety champions have carried out walkarounds and held engagement sessions at all maternity services across gesh, e.g., staff engagement session for ESTH staff held on 25 March 2024, in relation to the recently published CQC report and

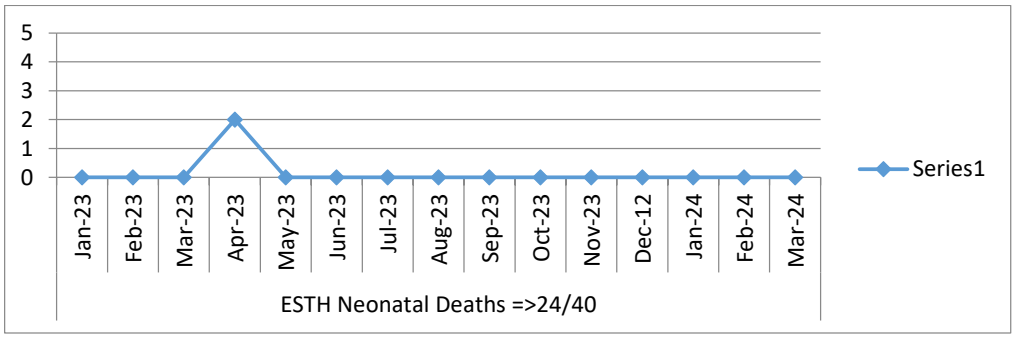
listening sessions with matrons and birth centre midwives at the SGUH site during February 2024. A separate Board Safety Champions report was tabled at the Quality Committees in Common meeting, on 25th April 2024 and is at item 3.1b on the agenda.

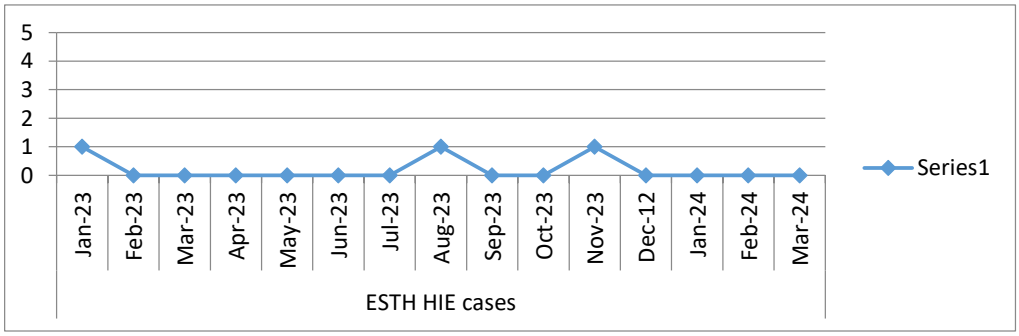
3.6.6 The Year 6 Technical Guidance for the Maternity and Perinatal Incentive Scheme includes the requirement for engagement events to be held with maternity and neonatal staff within each service every two months, which is an increase from the Year 5 guidance, which was quarterly. This should be in place by 1st July 2024. Issues raised and the progress made against them should be shared with all maternity and neonatal staff.

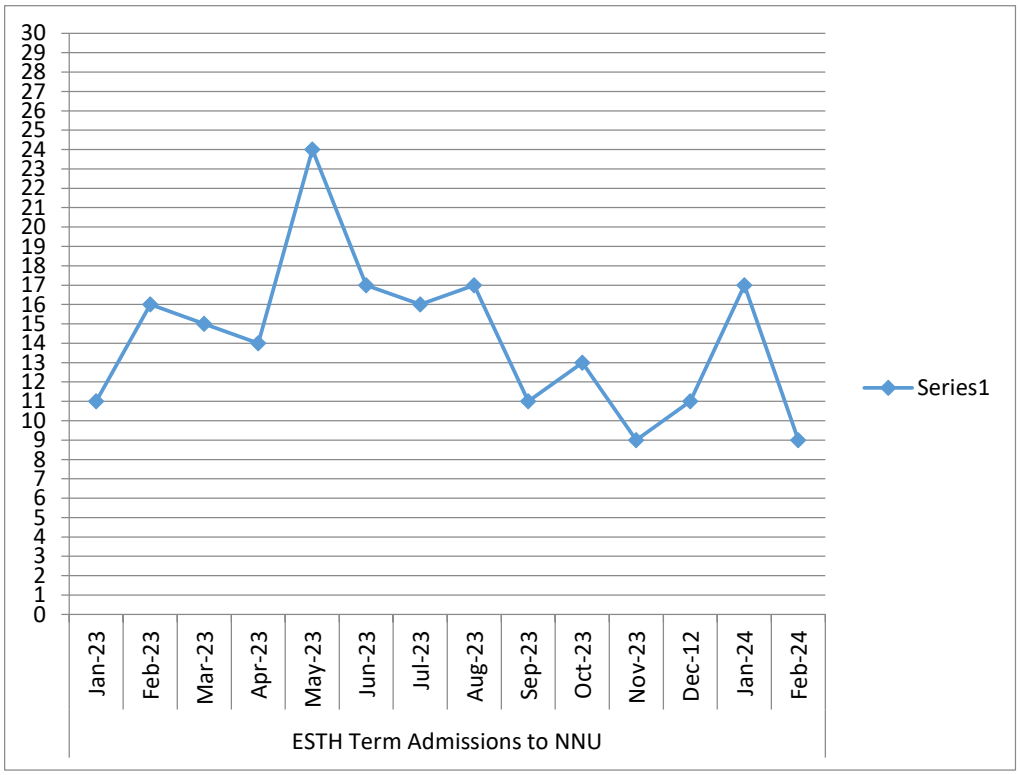
3.7 Outcomes/Trends

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





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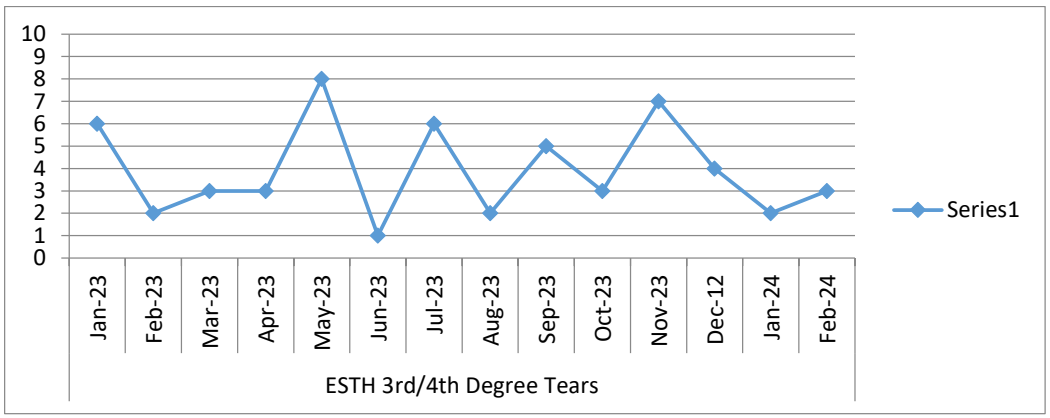
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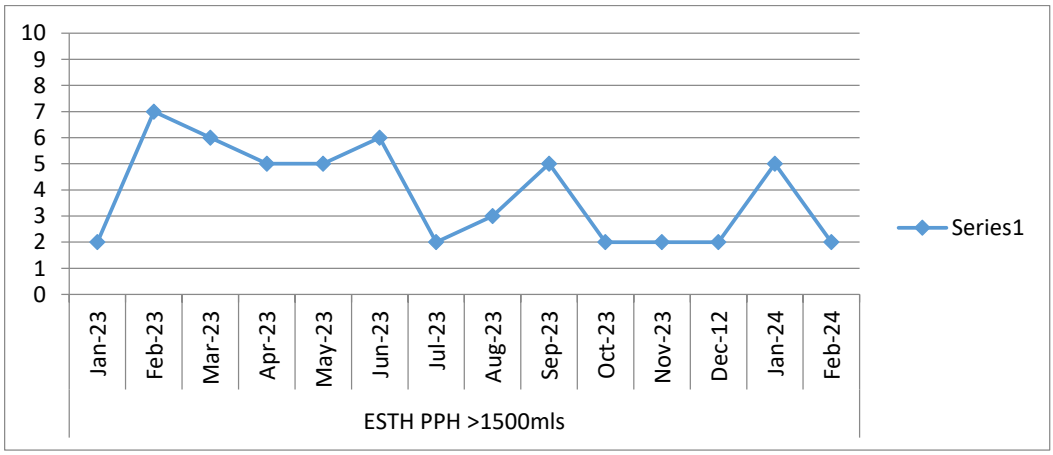
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3.8 Risk Register

3.8.1 ESTH

Title of Risk	Review Date	Risk Level
Lack of 2nd Obstetric Operating theatre at EGH	31/10/2024	Extreme Risk
Multiple environmental issues (triage, recovery, bereavement room soundproofing (the latter is part of our capital bids)	31/03/2025	Extreme Risk
Storage of Ultrasound images	31/10/2024	High Risk
Maternity Block Lifts (breakdown)	31/12/2024	High Risk
Documentation of blood results in BadgerNet (currently a manual transcribe for some results with no mitigations possible)	30/09/2024	High Risk
Staffing establishment following Birthrate+ (staffing plan in place)	31/08/2024	High Risk
Location of the Maternity Assessment Unit at Epsom (in a separate building to Labour Ward)	31/10/2024	High Risk
CAM line closures (regional working party considering the scope of the line as demand has outstripped capacity)	31/12/2024	High Risk
Homebirth Service (lack of resource to cover on-calls)	31/07/2024	High Risk
Babies falling out of bed	30/06/2024	Moderate Risk
Lone working in the community for midwifery staff	30/06/2024	Moderate Risk
Flooding in ANC EGH	30/04/2024	Moderate Risk

3.8.3 The risk scores associated with the two extreme risks are to be reviewed. It is anticipated that the risk scores will reduce to reflect the mitigations in place.

The following extreme risks were reviewed, and the risk level and rating were amended to reflect the mitigations in place or resolution of the risk.

- CNST year 5- risk of non-compliance – full compliance with all 10 safety actions were achieved.
- Transitional Care (to meet BAPM) standards – the service has a plan in place to address.

3.8.4 SGUH

Title	Risk level (current)	Rating (current)
Shortage of Midwifery staffing	Extreme	16
Infrastructure damage/sewage risk in relation to flooding	High	12
Multiple information system	High	12
Closure of birth centre	High	12
Provision of homebirth service	High	12

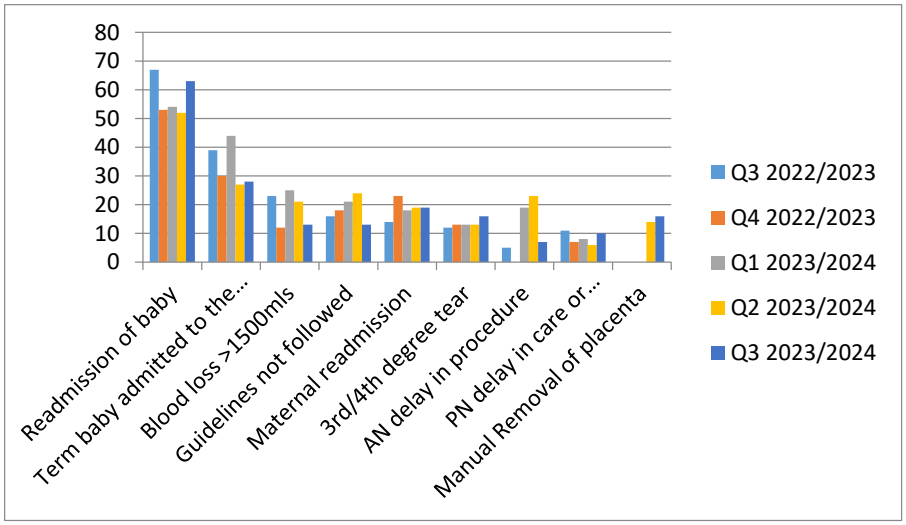
Euroking backcopying and forward copying IT risk	High	12
Maternity Unit security risk	Moderate	8
Maternity Helpline 24 hr cover	Moderate	8
Poor compliance with training requirement	Moderate	9
Provision of continuity of care	Moderate	9
Inability to provide transitional care	Moderate	9
Midwifery manager on call rota	Moderate	9

3.8.5 The risk score associated with the extreme risk overleaf (shortage of midwifery staffing) is to be reviewed. It is anticipated that the risk score will reduce to reflect the mitigations in place.

3.9 Triangulation of complaints/claims/PSIs

3.9.1 **ESTH:** work is on-going to triangulate incidents, complaints (feedback) and claims and no clear themes have emerged.

The following table shows an analysis of incidents reported over the last 5 quarters and this has been relatively stable with the exception of an increase in delay of induction of labour, and a deep dive is planned to look at the reasons associated with the induction, and the gestation, as this is an indicator of the likely success. The deep dive will also consider national guidance, with a plan to make recommendations.



3.9.2 Complaints - ESTH

Since 01/01/2023 the Maternity Service as received 47 complaints, of which 30 were either partially or not upheld; the only theme that has emerged is staff attitude (medical, midwifery and sonography), which featured as a theme in around 7 complaints. General communication is also often a theme, but this relates to a variety of scenarios, such as:

- Consent
- Maternal concerns not taken seriously enough
- Following up test results

The complaints received are often complex and specific and relate to the management of clinical care throughout the antenatal, intrapartum and post-partum period. Whilst delay in care has been mentioned, this has not been emerging as a theme in complaints.

3.10 Audit

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

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

At the last quarterly assessment of ESTH's compliance undertaken by the ICB, which took place in January 2024, ESTH were 81% compliant with all of the requirements of the 70 interventions; the next quarterly assessment will be taking place on 15th April 2024 and the service have self-assessed as now being 96% compliant. Quarterly assessments will continue to take place and re-audits against element to demonstrate continuing compliance are required every 6 months.

A regular programme of audits is being formalised (including named leads, frequency and presentation) in response to the CQC inspection and any associated information requests going forward.

3.10.2 The SGUH Maternity Service must undertake audits for SBLCB vs3 as part of the CNST requirements. These include:

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

At the last quarterly assessment of SGUHs compliance undertaken by the ICB, which took place in January 2024, SGUH were 71% compliant with all of the requirements of the 70 interventions: the next quarterly assessment will be taking place on 16th April 2024, and SGUH have self-assessed as now being 87% compliant. Quarterly assessments will continue to take place and re-audits against elements to demonstrate continuing compliance are required every 6 months.

4.0 Sources of assurance

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

2020 was during the height of the COVID-19 pandemic and the standards around PMRT (CNST) had been suspended.

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

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

5.0 Implications

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

- The publication of new Technical Guidance for the Maternity and Perinatal Incentive Scheme Year 6.
- There are no clear themes emerging in respect of the ESTH Maternity Service.
- ESTH - the impact of the aging estate on ability of the service to provide a modern Maternity Service in line with national guidance.
- ESTH trends of outcomes have remained stable over the last 15 months.
- Consideration needs to be given to completion dates for actions, particularly around PMRT, to ensure that they are achievable.
- A programme of safety champions engagement sessions has been re-established
- ESTH - the CQC inspection report was published 14 February 2024 and there is a deterioration in the overall rating – changing from GOOD to Requires Improvement
- SGUH has noted an increase in caesarean sections at full dilatation and are undertaking a review of cases.

6.0 Recommendations

6.1 The Board is asked to:

a) Note the successful outcome against the CNST year 5 and the publication of CNST year 6.
b) Note the key areas of success, risks and mitigations.
c) Make recommendations for any further actions.
d) Provide feedback and recommendation regarding the format of the report.

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	3.1b	
Report Title	Maternity and Neonatal Safety Champions	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer & DIPC and Maternity Safety Champion Dr Andrew Murray, Non-Executive Director, Quality Committee Chair & Maternity Safety Champion	
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

Maternity and Neonatal Safety Champions are the ambassadors for safety improvements in maternity and neonatal services, driving the 'halve it' campaign, which aims to make measurable improvements in safety outcomes for women, babies, and families.
The role of the Board and frontline Maternity and Neonatal Safety Champions is to facilitate effective relationships, provide strong leadership and ensure robust governance processes are in place.

Board Level Maternity Safety Champion: role is to promote unfettered communication from 'ward-to-board', by working with maternity and neonatal safety champions to ensure that maternity and neonatal issues are communicated and championed at board level. Board safety champions should ensure that safety in its broadest sense is a priority item at board meetings, with the board acting where needed, as well as regularly monitoring quality and safety outcomes by drawing on data from e.g., MBRRACE-UK reports, National Maternity and Perinatal Audit reports, Saving Babies Lives Care Bundle and feedback from women and birthing people.

Governance: the governance arrangements and roles and responsibilities have been reviewed and updated and can be seen in appendix 1

Themes from 'walk the floor': The Non-Executive Board Safety Champion conducted a walkaround (at SGH) on 6 February 2024, which revealed general themes across the Neonatal Unit, Day Assessment Unit and Foetal Medicine Unit.

- Perceived lack of clarity and excess complexity to the process for getting approval for replacement equipment
- Feedback to those requesting an update on progress of an application was either slow or non-existent

- There seemed to be a lack of clarity on how investment is prioritised and where and how those decisions are made
- Instances where staff did not feel empowered or psychologically safe to raise concerns related to the prioritisation of investments also emerged
- Staff on NNU were aware of the funding that was approved for transitional care and expressed how pleased they were about it
- Staff cited long delays in getting IT dependent equipment operationalised due to delays with Trust IT team capacity/resource
- Difficulty recruiting and retaining juniors in NNU

The Executive Board Safety Champion (EBSC) has done several visits around the units and has also met with maternity staff across all three sites. The Executive Board Safety Champion also organised maternity-specific meetings with midwifery matrons, birth centre and continuity of care midwives, the safeguarding and bereavement midwives, Fetal Medicine and Day Assessment Unit midwives and B7 midwives all on the St. George's site. In addition, the EBSC has conducted exit interviews with senior midwives who have left the organisation, at their request.

Themes from these walk the floor and meetings include:

- Senior midwives not feeling listened to and/or excluded from decision-making
- Fear of reprisals from speaking up/raising concerns
- Disbanding of the Continuity of Care ("CoC") team without engagement of staff working in those teams
- Senior Midwifery team on-call being handed over to the site team
- Lack of administrative support for some teams
- Lack of visibility of the senior midwifery leadership team (generally and day-to-day)
- Environmental concerns including midwives needing to clean and restock clinics.
- Utilisation of midwifery resource effectively across the unit
- Lack of transparency/ communication regarding doctor availability for clinics resulting in midwives needing to chase to find out if there was cover available.

Action required by Group Board

The Board is asked to:

- Note the contents of the report for assurance.
- Make any recommendation for further action.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Governance

Implications				
Group Strategic Objectives				
X Collaboration & Partnerships			X Right care, right place, right time	
X Affordable Services, fit for the future			X Empowered, engaged staff	
Risks				
• Inappropriate staffing levels on the Maternity Unit • Non-compliance with national and regulatory requirements for continuity of care provision • Recruitment, retention and skill mix of doctors in training (junior doctors) in NNU				
CQC Theme				
X Safe	X Effective	☐ Caring	X Responsive	**x** Well Led
NHS system oversight framework				
x Quality of care, access and outcomes			x People	
☐ Preventing ill health and reducing inequalities			x Leadership and capability	
x Finance and use of resources			☐ Local strategic priorities	
Financial implications				
N/A				
Legal and / or Regulatory implications				
Safer Maternity Care: next steps towards the national maternity ambition Saving Babies Lives Care Bundle (MIS Safety Action 6) Each Baby Counts				
Equality, diversity and inclusion implications				
No issues to consider				
Environmental sustainability implications				
No issues to consider				

Maternity and Neonatal Safety Champions

Group Board, 02 May 2024

1.0 Purpose

The purpose of the report is to inform and assure the Board of the engagement activities carried out by the Maternity and Neonatal Safety Champions to gain insight and views on all aspects of safety related issues or concerns, including operational and or structural challenges that may adversely impact safety, and the actions that have been taken to address them to ensure continued safety and outcomes in maternity and neonatal services.

2.0 Themes, issues, and concerns

2.1 Walkaround at St George's

The Non-Executive Board Safety Champion conducted a walkaround in the Neonatal Unit, Day Assessment Unit and Foetal Medicine Unit at St George's Hospital on 6 February 2024, which revealed some cross-cutting themes.

- Perceived lack of clarity and excess complexity to the process for getting approval for replacement equipment, e.g., new computer for the Foetal Medicine Unit and a Cardiotocograph (CTG) machine for the Day Assessment Unit
- Feedback to those requesting an update on progress of an application was either slow or non-existent
- There seemed to be a lack of clarity on how investment is prioritised and where and how those decisions are made, e.g., NNU needing IT input/resource to implement electronic milk labelling system
- Instances where staff did not feel empowered or psychologically safe to raise concerns related to the prioritisation of investments also emerged
- A mock CQC inspection was underway in the neonatal unit during the walkaround, which was good to see and demonstrates staff commitment to quality and safety, and making improvements
- Staff on the neonatal unit were aware of the funding that was approved for transitional care and expressed how pleased they were about it
- Staff cited long delays in getting IT dependent equipment operationalised due to delays with Trust IT team capacity/resource, e.g., SGH provides a milk bank for other SWL hospitals, and a milk bank tracking system was bought two years ago but it is not yet in use due to compatibility issues with existing software, which needs input from IT

to resolve, but it has not happened. This clinical risk has been placed on the risk register

- Difficulty recruiting and retaining doctors in training (juniors) in NNU

2.2 Executive Board Safety Champion walkaround and meetings at St George's and ESTH

The Executive Board Safety Champion (EBSC) has done several visits around the units and has also met with maternity staff across all three sites. The Executive Board Safety Champion also organised maternity-specific meetings with midwifery matrons, birth centre and continuity of care midwives, the safeguarding and bereavement midwives, Fetal Medicine and Day Assessment Unit midwives and B7 midwives all on the St. George's site. In addition, the EBSC has conducted exit interviews with senior midwives who have left the organisation, at their request.

- Senior midwives not being listened to has been a recurring theme in the team meetings, exit interviews and 1:1 conversations/meetings with various grades of midwives. In one particular meeting several midwives were very tearful about how they felt when changes to the service are made without any discussions with them. Examples cited included:
  - removing equipment from the department (in preparation for CQC visit) during a weekend, with no discussion with the matron so she was not able to be involved or contribute
  - disbanding the CoC teams (Juniper and Maple) with no discussions with the midwives affected to seek their views on how the service could be safely decommissioned
  - 'rotation' of midwives from CoC teams to departments with no vacancies without discussions with the department leads and matrons. No discussion with the matrons as to where the roles could be best used to support the service
  - reconfiguring triage to implement a pathway where women/birthing people are required to self-present on DAU after being seen in triage

- Several midwives also reported being 'told off' for speaking up in meetings during the establishment review process. Similarly, other midwives reported that they were treated badly (ignored, not spoken to, avoided) after raising concerns via email regarding how a service was being pulled.

- The potential issue with CoC was highlighted in a meeting with the birth centre and CoC midwives which was called to listen to feedback on how they were affected by the changes that were necessary during the immediate post CQC inspection period where the decision was made to close the Birth Centre in order to relieve staff to go to Delivery Suite and/or triage. At that meeting, the midwives highlighted that they were only made aware that their service was changing when they saw it on future rosters. They were clear that they had not been consulted, included in any conversations, and felt quite upset by how they found out. They recounted that they spoke to their manager and then matron who were also not aware of the plan.

- The issue of changing the on-call cover for maternity to the site team was highlighted in another meeting. The midwife raising the issue expressed concern regarding the safety of women/birthing people if the on-call cover was provided by non-midwifery staff. Other midwives raised this issue and reported that they were not included in discussions and did not feel that they had been listened to when they raised any concern

- Lack of administrative support (particularly for Foetal Medicine Unit - FMU) was highlighted in a meeting with the FMU and Day Assessment Unit (DAU) midwifery team, along with concerns that midwives were having to undertake cleaning and restocking of the unit, book appointments and answer the telephones

- Several midwives also highlighted the lack of visibility of the senior midwifery team across the unit on a day-to-day basis and not having visibility of which senior midwife was in or not if escalation is required.

- Birth centre pools need updating/refurbishing

2.3 Actions taken

Several actions have been taken to address the issues highlighted to the Executive and Non-Executive Board Safety Champion.

These include,

- The General Manger has been tasked with obtaining quotations for the pool repair/ refurbishments with a view to the GCNO exploring streams of funding to support
- A visit to the milk bank to review the current processes used for recording to ensure that current systems are safe, while the general manager reviews what the issues are with the IT solution
- The GCNO continues to meet with staff to listen and address any immediate concerns raised as appropriate
- Funding for administrative support has been included in the establishment review and funding agreed
- The issues with the CoC team decommissioning were addressed with the senior midwifery team and affected staff were engaged with, prior to finalisation of the process
- The on-call issue has been raised at the Site Maternity Improvement meeting and the process is being worked through collaboratively

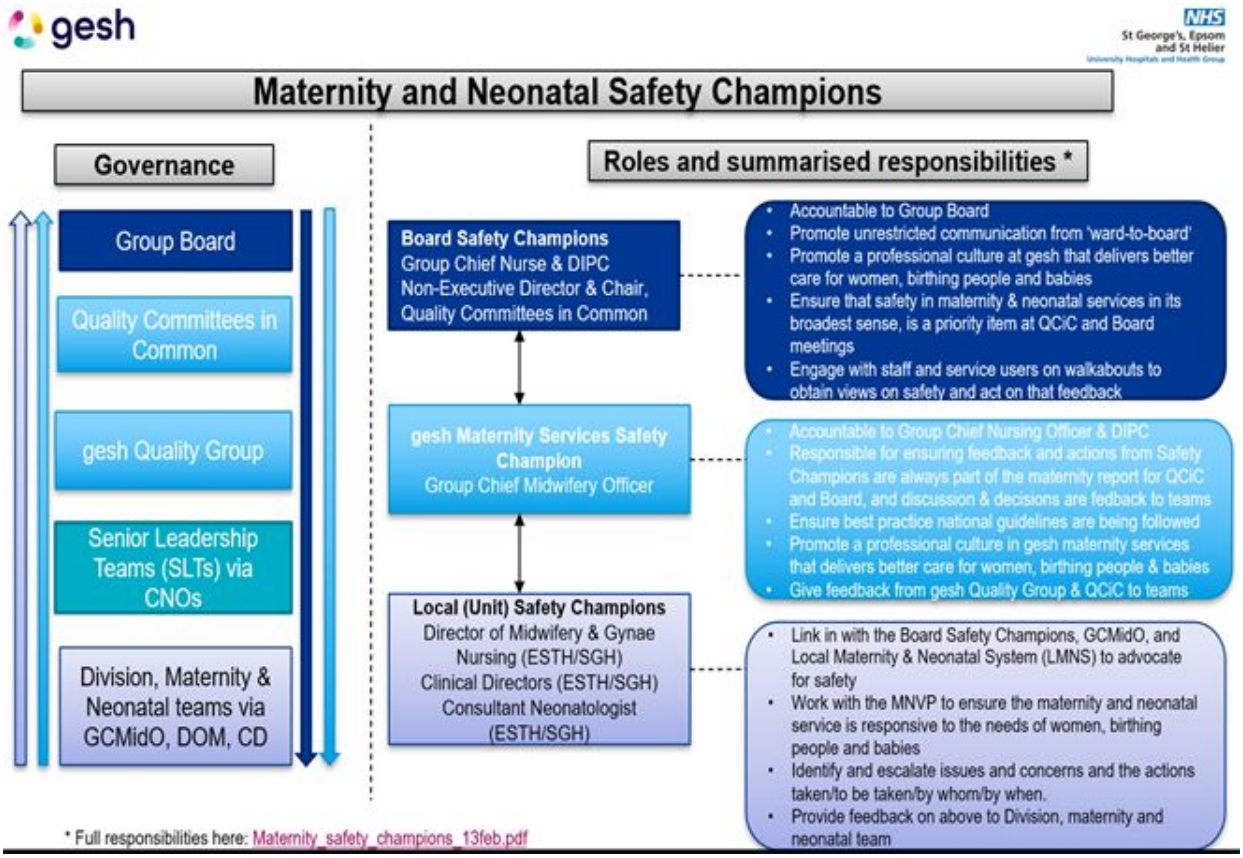
3.0 Action Plan

Issue/Concern	Action	Lead	Due
Approval process for replacement equipment	Establish process in place to replace equipment and	GCMidO	17 May 2024

	communicate it to maternity/neonatal team		
Lack of clarity on decision making process for investment in services	Clarify the process in place, including rules and prioritisation for investments and communicate it	GCNO	17 May 2024
Two-year delay in getting the software compatibility issues resolved with the milk bank	Establish the reason for delay with the IT team Identify solutions and timescale to resolve via e.g., working group with appropriate stakeholder input	CWDT DDO and GCMidO	30 June 2024
Recruitment and retention and skill mix of doctors in training in NNU	Review the medical establishment required to safely staff the neonatal unit, and act on findings	CWDT Divisional Chair, CWDT DDO	30 September 2024

4.0 Appendix

Maternity and neonatal safety champion: governance, roles, and responsibilities.



Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	3.2
Report Title	**Integrated Quality and Performance Report**
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer
Report Author(s)	Group Director of Performance & PMO, 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 key operational performance and quality measure information, and improvement actions across St George's Hospitals (SGH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

Action required by Group Board

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

Committee Assurance

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

Appendices

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

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
As set out in the report.				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access, and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
Legal and / or Regulatory implications				
• Enforcement undertakings applicable to St George's and Epsom and St Helier Hospitals • Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations				
Equality, diversity, and inclusion implications				
No EDI issues to consider.				
Environmental sustainability implications				
No environmental sustainability issues to consider.				

Group Board, 02 May 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 March 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 March 2024 for ESTH. A year-to-date total of 10 at SGH, and 4 at ESTH.
- VTE Risk Assessment is within target for SGH, and improvements seen in recent months at ESTH.
- In 2023/24, SGH reported 41 cases of *C. Diff*, just below the annual ceiling of 42 cases.
- Observed mortality rates (Summary Hospital-level Mortality Indicator or SHMI) continue to track below expected levels at SGH.
- 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 six Serious Incidents (SIs) and three Patients Safety Incidents (PSII) in March 2024. The six SIs included 1 Never Event; a wrong site surgery in Plastics, this will form part of a PSII cluster. Seven SI's were reported at ESTH.
- **Pressure Ulcers:** A decrease was observed in the number of Category 3, 4, and unstageable cases in March 2024 at SGH. Conversely, at ESTH, there was a slight increase in Category 3 pressure ulcers, attributed to changes in definition as recommended by the National Wound Care Strategy Programme. To support improvement, Urinary catheter fixation guidance and pathways have been published, Healthcare Assistant targeted e-learning is being developed, and a Tissue Viability Nurse recruited to support improvement.
- **Friends and Family Test (Patient Experience**) **-** Response rates for Outpatients and Emergency Department continue to track below target at both SGH and ESTH. Improvement actions include FFT reminder on ED screens in the waiting room, posters with QR codes and reminders during nursing handovers to encourage staff to remind patients to complete the survey.

- **Venous Thromboembolism (VTE) Assessment rates:** ESTH is still off target for assessments. The Acute Medical Unit (AMU) at St Helier Hospital continues to demonstrate improvement in screening, while further efforts are required in Medicine, Renal, and Planned care. The Site Senior Leadership Team is leading these improvement initiatives, with support from colleagues from NHS England.

- **Infection Prevention and Control –** ESTH exceeded the nationally set annual ceiling of 38 *C. Diff* cases with 63 cases during 2023/24. Trust wide actions include the launch of 'Gloves Off' campaign, 'Getting back to Basics' working group, and a new Healthcare Assistant Continence and Skills study day.

- **Mortality**: The Summary Hospital-level Mortality Indicator (SHMI) is reported as higher than expected for ESTH, with rates steadily improving. This is being closely monitored with proactive measures in place to prevent deaths.
- **Key challenges in Integrated Care** relate to Estates, staffing (sickness absences and recruitment), and delayed discharge.

3.0 Operational Performance

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

- Outpatient activity exceeded the plan both in the current month and year-to-date at ESTH and SGH. Patient-Initiated Follow-Up rates at ESTH remain relatively high, while activity continues to increase at SGH with the rollout in Trauma & Orthopaedics and Urology.

- Improvements in capped theatre utilisation are being maintained at ESTH and SGH with both sites continuing to aim for the national target of 85% utilisation rate through improvements in day case theatres (ESTH), and scheduling at SGH. Elective activity through March 2024 was impacted by leave and on the day cancellations.

- Against the 5% maximum national ambition for diagnostic waits over 6 weeks, SGH achieved 3%, and ESTH reported 3.8%.

- ESTH delivered against all three national cancer standards in February 2024: 28-Day Faster Diagnosis (85.9%), 31-Day Decision to Treatment (100%), and 62-Day Referral to First Treatment (86.3%). SGH reported improved FDS performance, reporting 71.7% (up from 61.8% in January 2024), with Skin performance anticipated to improve in March 2024.

- SGH and ESTH achieved the national A&E 4-hour target of 76% in March 2024, with performance of 81.3% and 76.8% respectively. At SGH, the discharge profile improved which supported flow.

- Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in March 2024. Sutton Health & Care achieved 90.7% and Surrey Downs Health & Care, 86.7%, with a continued focus on encouraging more referrals. At Sutton, a refresh in data collection logic ensures that we are capturing all referral routes and more accurately reporting our demand.

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

- RTT waiting lists are higher than planned at both ESTH and SGH due to capacity constraints and industrial actions. 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 ESTH and SGH are not meeting current trajectories to reduce the numbers of patients waiting for more than 52 weeks to commence definitive treatment. ESTH is particularly challenged with 903 patients waiting for more than 52 weeks at the end of February 2024, primarily in Gynaecology (318), Community Paediatrics (224). The 65-week wait cohort at ESTH remains high due to strike action and delays to insourcing plans for Gynaecology and Community Paediatrics. Recovery plans are in place with private capacity for Community Paediatrics starting on 20th April 2024. At SGH, the number of patients waiting over 65 weeks has now exceeded plan. Neurosurgery is a specialty of concern although all potential 65-week breaches are being scrutinised weekly.

- Although SGH did not achieving the 62-Day Referral to First Treatment in February 2024 (74.4% vs 85%), the monthly trajectory was met. There are plans in place to reduce backlogs through expansion of tele-dermatology clinics, additional gynaecology clinics, and the installation of a new CTC scanner in March 2024. Work is underway to improve pathology turnaround times also.

- Urgent and Emergency Care (UEC) services at both trusts continue to experience significant pressures. ESTH remain challenged across both sites with many unplaced patients remaining in the Emergency Department, ambulance delays, and high numbers of mental health patients requiring admission. Teams are working with SWL & St Georges Mental Health Trust to explore mental health rapid access clinics for appropriate patients presenting to ED. The service has also undertaken a review of 2023/24 urgent care work programme and have agreed a set of programme priorities for 2024/25. There are high numbers of medically fit patients occupying acute beds at both hospital sites, with many requiring complex discharge planning. UEC pathway continues to be a priority for improvement for the Group.

4.0 Sources of Assurance

4.1 Quality Committees-in-Common

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

4.2 Finance Committees-in-Common

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

6.0 Recommendations

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

gesh

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

Group Integrated Quality & Performance Report

March 2024

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 19 April 2024

Executive Summary

Safe, High-Quality Care

St George's Hospital

Successes

- **Falls:** Reduction in number of moderate and above harm falls in March 2024 , reporting one case compared to five in February 2024.
- **Pressure Ulcers:** 6 Acquired Category 3 & 4 including unstageable in March 2024, down from 12 in February 2024.
- **Infection control**: The Trust continues to report zero MRSA bacteraemia for the year.
- Maternity Services: currently conducting a data quality exercise to review data sources, target/thresholds to ensure there is consistency in data provided to internal and external sources.

Challenges

- **Never Events/ Serious Incidents and PSII:** St George's declared six Serious Incidents (Sis) and three Patients Safety Incidents (PSII) in March 2024. The six SIs included 1 never event; a wrong site surgery in Plastics, this will form part of a PSII cluster.
- **Mental Capacity Act (MCA) training compliance** 85.9% compliant for March 2024, however not consistently meeting the 85% target. There are large numbers of rotating staff and gaps in training posts however Safeguarding and MCA new starters are now onboarding.
- **Infection Control:** There were four C. difficile infection (an increase from one in February 2024) and eight cases of E. coli bacteraemia during March 2024 (up from seven in February 2024), of the eight E. coli cases, six have been classified as Hospital Onset Hospital Acquired.
- **Friends and Family** – Response rates for the Emergency Department continues below the national average of 11%. Departments working to improve rates with introducing online options, FFT reminders posters with a QR code so surveys can be completed whilst in the department. Rates have increased over the past two months.

Epsom & St Helier

Successes

- **Falls Prevention and Management:** The Falls Clinical Nurse Specialist (CNS) met with the Learning & Development Workforce team to progress plans to include the Fundamentals of Care study days to the ESR system as a mandatory training for Registered Nurses, Nursing Associates and HealthCare Support Workers. This will allow better monitoring and increased assurance that this essential training is being delivered. A further 50 staff members received formal Falls training during the month of March. The second cohort of the Falls Champion programme continues; the delegates are currently working on their individual Improvement project ideas (supported by the Falls CNS), they are due to present their plans and outcomes in May. The percentage of unwitnessed falls reduced by 7% from the previous month, reporting 57% of all inpatient falls being unwitnessed.
- **Pressure Ulcers:** The number of pressure ulcers remain consistently low., there was a slight increase in March : eleven Hospital acquired pressure ulcers ; six category 2, three category 3 and two DTI's. No grade 4 pressure ulcers . Reduction in outstanding ward level investigations. New band 6 Tissue Viability Nurse started March 2024 . Task and Finish group started with areas of concern for number of acquired pressure ulcers . Certificates of achievement for wards with zero acquired pressure ulcers for 3-6 months in 2023 were presented to 19 wards/units.
- **VTE:** Slight Increase in screening data over the last quarter. Continued reduction in hospital associated thrombosis incidents with only one with a non-compliance of delayed VTE Risk Assessments.

Challenges

- **Falls Prevention and Management :** In March there was one moderate harm incident reported that occurred on a Surgical ward resulting in a left spiral humeral fracture and one severe harm incident resulting in a hip fracture that occurred in the St Helier Emergency Department. This case was unavoidable and PSIRF falls action plan was applied.
- **Pressure Ulcers:** Sudden increase in Category 3 has been noted but this is mostly associated due to the recent recommendations from National Wound Care Strategy Programme, where all unstageable pressure ulcers are categorised as ''unstageable category 3 pressure ulcers'.' However, the acquired Category 3 pressure ulcers this month resulted in low harm caused to the patients. No severe harm reported over the last 3 months.
- **VTE**: Still off target for assessments. 25 outstanding reports for Hospital Acquired VTE's 2

Executive Summary
Operational Performance

St George's Hospital

Successes

- The number of patients waiting for treatment >65 weeks was 19 at the end of March 2024. This places us in the top ten percentile against the metric nationally.
- The new PIFU process is set to launch on April 24th – with a number of specialties waiting to implement, this will considerably improve our performance and improve our Outpatient value weighted activity as a result
- Diagnostic performance target of 95% continues to be met.
- Positive improvement in performance against the Cancer Faster Diagnosis standard reporting 71.7% compared to 61.8% in January meeting our trajectory. Skin performance is recovering with compliance expected in March. Cancer 62 day backlog is ahead of plan.
- Four Hour performance improved significantly through March achieving 81.3% - Putting us in line to receive some of the capital funding made available by NHSE. The discharge profile improved across the month which supported flow as well as a reduction in infectious outbreaks.
- Reduction in the number of stranded in-patients (LOS 7+ days) and focus on >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.

Challenges

- Increasing waiting list size and long wait positions exceeding trajectory driven by Industrial action with reduced capacity in outpatient clinics and theatre lists. This is in line with the national picture.
- Theatre Productivity (and capped utilisation rate) was impacted by patient flow with a high number of on-the-day cancellations partly due to lack of available post op beds, and patients arriving on the day unfit for surgery.
- Capacity within Breast service for one-stop clinics is becoming challenging. The service has RMP funding to support further Xyla clinics for the next two months. Gynae has seen a decline in FDS performance due to lack of access to scans and one stop clinics. Trajectory for 2024/25 is in line with national ambitions of 77% for FDS, and 70% system level 62-day combined cancer standard.
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside, and Pathway 2A (Merton + Wandsworth) and Pathway 3 awaiting discharge, adversely impacting on flow from ED to wards and DTAs in ED. We continue to work as part of the SWL programme for mental health improvement to reduce long waits in ED for patients presenting with mental health concerns.
- We are focussing on validation of front door "4-hour" data and improving the processes and system interfaces following an audit which identified inaccuracies in performance reporting.

Epsom & St Helier

Successes

- 65 week waits reduced from 229 in January 2024 to 207 in February 2024. The specialties with the highest cohort are Gynaecology (87), Community Paediatrics (42) and Cardiology (28). A further reduction to <120 is expected once March 2024 is submitted.
- DNA rates continue to be under 5% at 4.5% for Mar24. Targeted work continues.
- Updated A&G utilisation data agreed with SWL and first submission made on 9th April which will include CAS activity meaning performance is expected to increase to ~50-55%.
- Theatre utilisation (capped) increased to 80.8% in March 2024, from 79.4% in previous month.
- Day case rates continue to be above the target, at 85.1% for March 2024.
- All key cancer performance standards were achieved in February 2024
- The trust delivered 76.8% performance against the 4-hour ED standard in March 2024. Sutton Health and Care Reablement Unit continues to operate at full capacity with good processes in place to ensure identification of appropriate patients. Good progress in relation to LAS direct to SDEC attendances with 29 reported in February 2024, increasing to 34 in March 2024

Challenges

- Industrial action in February 2024 impacted capacity to support long waiter reduction. 52 week waits increased from 856 in January 20 24 to 903 in February 2024. The specialties with the highest cohort are Gynaecology (318), Community Paediatrics (224), Cardiology (82) and T&O – EOC (64). A reduction to ~860 is expected once March 2024 data is validated. 78 week waits increased from 27 in Jan24 to 35 in February 2024. A reduction to less than 20 is expected once March 2024 data is validated.
- Elective IP/DC activity was below plan in March 2024, mainly due to a high number of annual leave, however Value Weighted Activity for elective IP/DC was above plan.
- EUS capacity at RMH has reduced from 5-6 to 3-4 weeks but is still impacting negatively on cancer performance. RMH Oak Centre has provided an extra weekly list.
- EBUS turnaround time is longer than the 7-day ideal at 7-10 working days. StG histopathology team send ESTH patient samples to ESTH pathology for processing to reduce the reporting turnaround times. Discussions are ongoing.
- UEC pathway and flow remain key challenges with long waits to initial assessment (120 minutes), high proportion waiting more than 12 hrs in department (10.3%), high numbers of unplaced patients including mental health patients remaining in ED for prolonged periods.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

Virtual Ward: Occupancy rates continue to stabilise reaching 70.6% through March 2024. Work is ongoing with St Georges and inreach alongside Central Surrey Health (CSH).

2-hour Urgent Community Response (UCR) target was met at 90.7%.

Reablement bed occupancy 97% with length of stay at seven days. Work is ongoing to improve length of stay to five days.

Mandatory and Statutory Training (MAST) compliance is being maintained exceeding target at 89%.

Challenges

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

Discharge to assess. Pathway delays noted to pathway 2 and 3. This is a system issue across Health and Social Care with robust mitigations and improvement work in place.

Vacancy rates 16.3% remains above target. This is an improvement from the previous month. High rates have been driven by 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 86.7% in March 2024. Winter pressures resources support to manage the increase in activity has stopped at the end of March.

Maintained the Improvement in waiting lists across all services.

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

Non-Medical – appraisal rates continue to increase, with plans in place with line managers to ensure this rate continues to improve.

Increased virtual ward occupancy rate to 100% meeting target of above 80%

Challenges

Sickness rate remains above target, mainly due to long term sickness. Improvement is expected as robust absence management process in place .

High vacancy rate (20.7%), Golden Hello scheme is in place and more recruitment events planned.

2024/25 Priorities and Operational Planning Guidance

Headline Messages: Quality, Workforce, Activity and Performance

The 2024/25 Priorities and Operational Planning Guidance published by NHSE on 28th March 2024 sets out 3 key focus areas for the new financial year, underpinned by a set of objectives listed in the table;

Recovery of core services (elective, urgent, and emergency care) while maintaining a focus on the quality and safety of services, particularly in maternity and neonatal care, and reducing inequalities. This will be achieved through BCF initiatives, outpatient transformation, and productivity, supported by NHS Impact, to create conditions for improvement.

To **support our workforce**, prioritise enhancing staff experience, retention, and attendance, drawing on national retention initiatives. Trusts are required to implement the national policy framework for pregnancy and baby loss support, building on 2023 survey improvements, and implement actions to enhance workplace safety.

Focus on **productivity improvements** including reducing temporary staffing spend, reducing the delayed discharges, compliance with best value frameworks and contracts; and implementing more productive and flexible working practices to make the most of the growth in workforce.

Themes	Objectives
Quality and Safety	Implement the Patient Safety Incident Response Framework (PSIRF)
Maternity, neonatal and women's health	Continue to implement the Three-year delivery plan for maternity and neonatal services, including making progress towards the national safety ambition and increasing fill rates against funded establishment.
	Establish and develop at least one women's health hub in every ICB by December 2024.
Urgent and emergency care	Headline ambition: 78% A&E 4-Hr performance by March 2025 • Systems are also asked to reduce the proportion of waits over 12h in A&E compared to 2023/24. • Increase productivity (including flow and LoS) • Virtual ward utilisation to be consistently above 80% with a focus on frailty, acute respiratory, heart failure and CYP
	Improve Category 2 ambulance response times to an average of 30 minutes across 2024/25
Elective Care	Deliver ERF value-weighted activity target, unchanged from 2023/24
	Proportion of all outpatient attendances that are first appointment or procedure (ERF scope) should be at least 49%
	Cancer FDS target of 77% by March 2025 at system level
	Cancer 62-day target of 70% by March 2025 at system level
	Diagnostic waits under 6 weeks (DM01) – 95% by March 2025
	Eliminate RTT 65ww by September 2024
	Develop a comprehensive plan by June 2024 to reduce the overall waiting times for community services, including reducing waits over 52 weeks for children's community services.
Workforce	Improve the working lives of all staff and increase staff retention
	Improve the working lives of doctors in training by increasing choice and flexibility in rotas, and reducing duplicative inductions and payroll errors
	Provide sufficient clinical placements and apprenticeship pathways to meet the requirements of the NHS Long Term Workforce Plan

Quality & Safety

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Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Never Events	Mar 24	1	1	0			
Serious Incidents	Mar 24	5	6	0			
Patient Safety Incidents Investigated	Mar 24	0	3	0			
Number of Falls With Harm (Moderate and Above)	Mar 24	5	1	0			
Pressure Ulcers - Acquired category 3&4	Mar 24	12	6	0		F	
Mental Capacity Act & Deprivation of Liberties - Level 2	Mar 24	84.2%	85.9%	85.0%			
Infection Control - Number of Cdiff - Hospital & Community	Mar 24	1	4	4			
Infection Control - Number of MRSA	Mar 24	0	0	0	L		
Infection Control - Number of E-Coli	Mar 24	7	8	7			
VTE Risk Assessment	Mar 24	96.1%	95.0%	95.0%			
Mortality - SHMI	Mar 24	0.96	0.95	1.00	H	P	
% Births with 3rd or 4th degree tear	Mar 24	0.8%	2.8%	-			
% Births Post Partum Haemorrhage >1.5 L	Mar 24	4.7%	2.6%	4.0%			
Stillbirths per 1,000 births	Mar 24	11.2	2.8	2.0			
Neonatal deaths per 1,000 births	Mar 24	8.4	0.0	2.0			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Mar 24	0.0	0.0	2.2			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 24	1	0	0			
Feb 24	7	4	0			
Mar 24	1	2	0			
Mar 24	0	3	0			
Mar 24	88.9%	88.9%	85.0%	H	P	
Mar 24	5	7	4			
Mar 24	0	0	0	L		
Mar 24	9	6	7			
Feb 24	88.0%	88.5%	95.0%		F	
Mar 24	1.19	1.17	1.00	H	F	
Mar 24	2.1%	4.2%	-			
Mar 24	2.5%	2.1%	4.0%			
Mar 24	3.57	0.00	-			
Mar 24	0.00	0.00	-			
Mar 24	0.00	0.00	-	L		

Please note VTE Risk Assessment performance for ESTH is reported a month in arrears due to data catch up

Patient Safety Incident Investigations being implement at ESTH hence no data

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Serious Incidents	Mar 24	0	0	-	L	
Pressure Ulcers Category 3	Mar 24	2	1	-		
Pressure Ulcers Category 4	Mar 24	0	0	-		
Infection Control - Number of Cdiff	Mar 24	0	0	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Mar 24	0	0	-	L	
Mar 24	8	8	-	H	
Mar 24	0	0	-	L	
Mar 24	0	0	-		

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Overview Dashboard | Patient Experience

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Number of Complaints Received	Mar 24	80	88	-				Mar 24	44	28	-			
Complaints responded to in 25 days	Mar 24	95.5%	88.2%	85.0%				Mar 24	33.0%	35.0%	85.0%			
Percentage of complaints acknowledged within three days	Mar 24	100.0%	100.0%	-							-			
Friends and Family Test - Inpatients Respose Rate	Mar 24	31.0%	32.9%	20.0%				Mar 24	25.0%	22.0%	20.0%			
Friends and Family Test - Inpatients Score	Mar 24	98.8%	98.7%	90.0%				Mar 24	95.0%	95.0%	90.0%			
Friends and Family Test - Emergency Department Respose Rate	Mar 24	15.0%	14.0%	20.0%				Mar 24	7.0%	6.0%	20.0%			
Friends and Family Test - Emergency Department Score	Mar 24	75.3%	71.6%	90.0%				Mar 24	78.0%	77.0%	90.0%			
Friends and Family Test - Outpatients Response Rate	Mar 24	5.3%	6.9%	-				Mar 24	3.3%	3.4%	-			
Friends and Family Test - Outpatients Score	Mar 24	95.8%	93.4%	90.0%				Mar 24	94.0%	94.0%	90.0%			
Friends and Family Test - Maternity Response Rate	Mar 24	7.0%	6.4%	20.0%				Mar 24	9.0%	9.0%	20.0%			
Friends and Family Test - Maternity Score	Mar 24	96.2%	92.6%	90.0%				Mar 24	100.0%	95.0%	90.0%			

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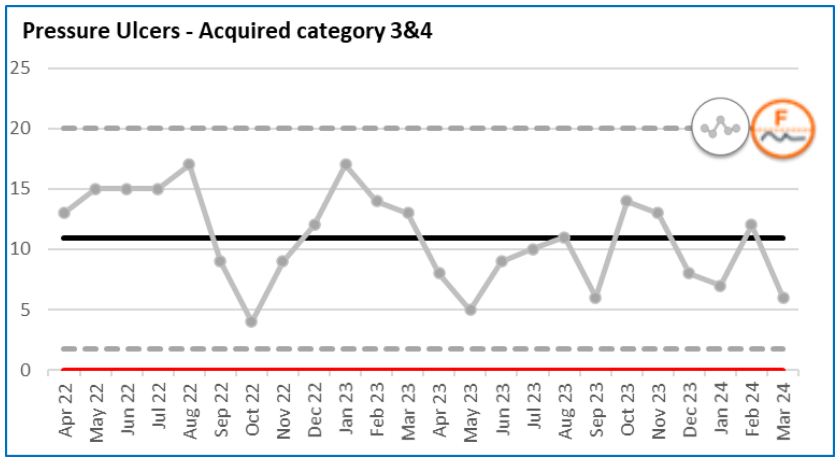
Exception Report | SGH Pressure Ulcers Category 3 and Above



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH Pressure Ulcers Grade 3 and above Common cause variation and consistently not meeting target	A decrease seen in the number of Category 3,4, and unstageable in March 2024 (6) compared to January 2024 (12) 4 Category 3 and above pressure ulcers were reported in the Medicine/Cardiovascular Division, improved rates are likely to be due to better substantive staffing levels in ward areas.	• Services where harm has occurred continue to complete investigations and produce local action plans that are managed with the division • Urinary catheter fixation guidance and pathways published • Healthcare Assistant targeted e-learning developed and awaiting sign-off • Band 6 secondment Tissue Viability Nurse to cover maternity leave started; team now back up to full compliment	TBC	sufficient for assurance

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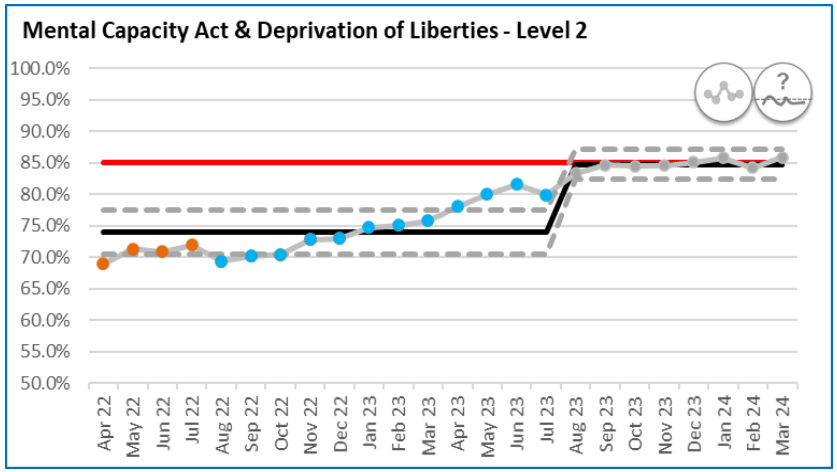
Exception Report | SGH Mental Capacity Act & Deprivation of Liberties Level 2



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality Rating
SGH Mental Capacity Act (MCA) & Deprivation of Liberties Level 2 Common cause variation Target not consistently met	MCA compliance has reached to the target of 85% since Q3 2023/24. There are large numbers of rotating staff and new starters and the online modules are available pre-start. There has been no Practice Educator for Safeguarding and MCA in post since January 2024, and no MCA Clinical Nurse Specialist (CNS) or Practitioner since December 2023.	Dedicated Induction sessions for newly qualified staff, rotating Junior Doctors and speciality specific trainings are offered by the Practitioners within the team. This will be reviewed by the new Practice Educator and MCA Practitioners. The level 1 and level 2 training has been quality edited by the previous Practice Educator and MCA CNS, however is waiting for the MAST team to edit the online modules. This will then be shared with EStH colleagues so that education work can focus on more workshop style training and supervision. Safeguarding and MCA new starters are now onboarding.	August 2024	sufficient for assurance

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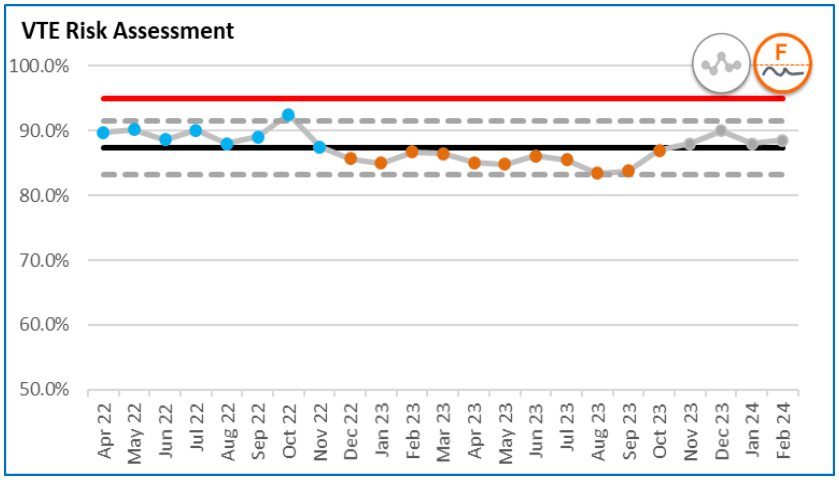
Exception Report | ESTH VTE Risk Assessment



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH VTE Performance Common cause concerning variation and consistently failing target	Risk Assessment Screening remains a challenge. Lack of ownership by the appropriate health professionals.	• 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. • Medicine, Renal and Planned Care need to improve screening. • AMU StHelier continues to show improvement in screening coverage. Shared learning with Epsom hospital to be planned.	Under review	sufficient for assurance Data definitions under review.

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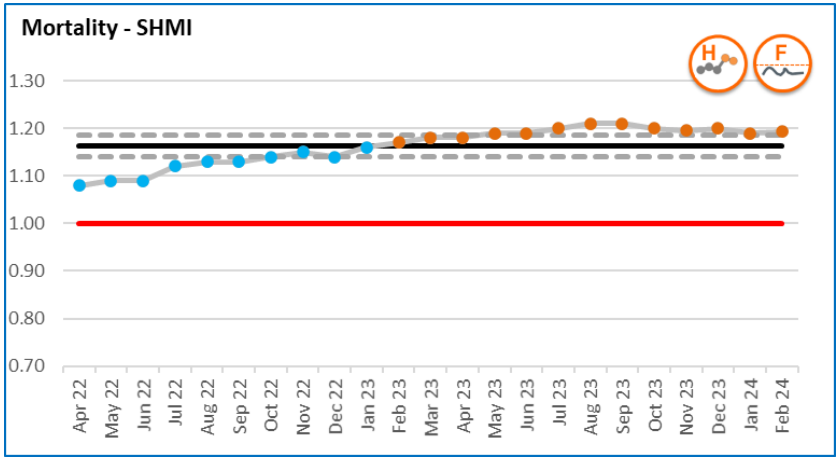
Exception Report | ESTH Summary Hospital- Level Mortality Index (SHMI)

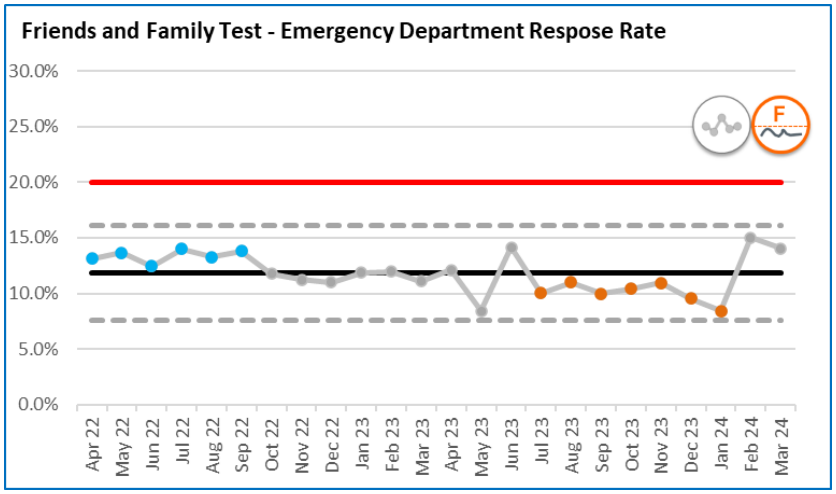


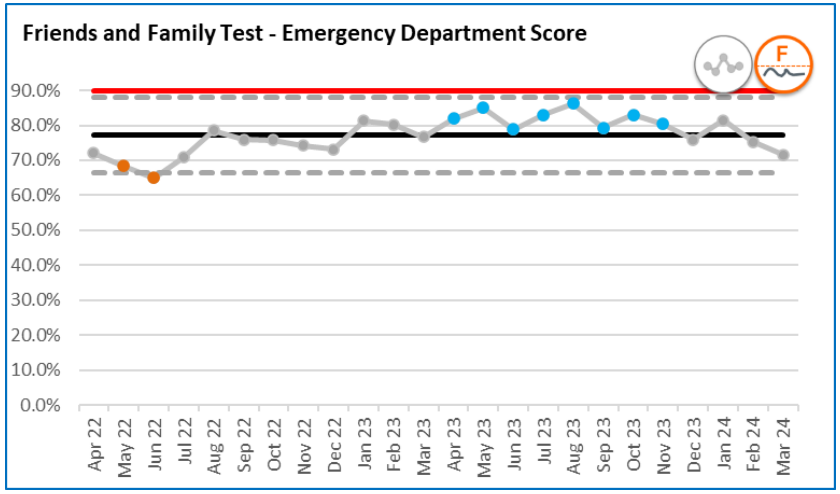
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause concerning variation and consistently exceeding expected rate	Remains classified as 'higher than expected.'	• Deep dives and thematic analyses are ongoing, with a focus on ensuring safe patient care. • An in-depth review of themes from Structured Judgement Reviews (SJRs) has identified a list of actions being implemented, including audits on ED mortality and readmissions. Interim findings were presented to the Reducing Avoidable Death and Harm (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	Under review	sufficient for assurance

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

Safe, High-Quality Care

Exception Report | SGH Patient Experience





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH FFT ED Response Rate FFT ED Score Special case concerning variation Consistently failing target	Response rate of 14% in ED this month which is slightly less than February 2024 but higher than the preceding months. The national average for ED response rate is 11%, this accounts for the high volume of patients. The target rate needs reviewing.	• Review response rates target and realign according to national targets. • Departments working to improve the response rates with introducing an online option, FFT reminder on ED screens in the waiting room and posters with a QR code so surveys can be completed whilst in the department. • Work with FFT data lead to ensure all patients are receiving a text after their visit to complete FFT • In cooperate FFT update into nursing handover update to encourage staff to remind patients to complete the survey when they discharge them	May 2024	sufficient for assurance

Operational Performance

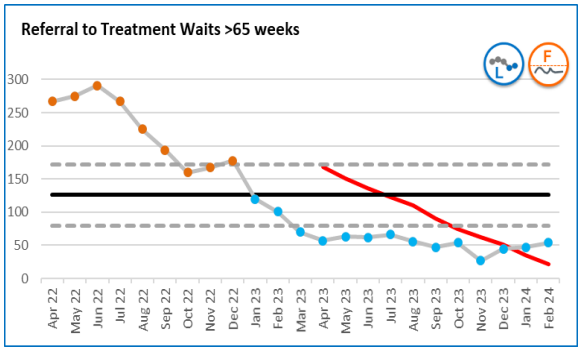
Operational Performance

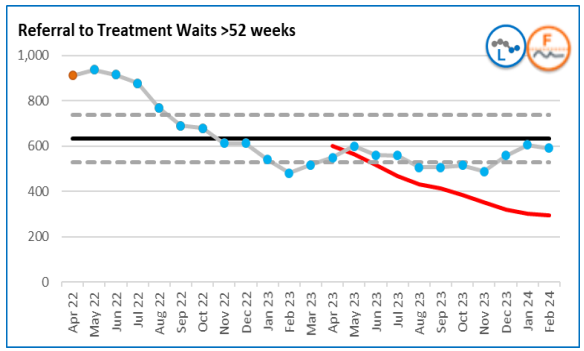
Overview Dashboard | Elective Care

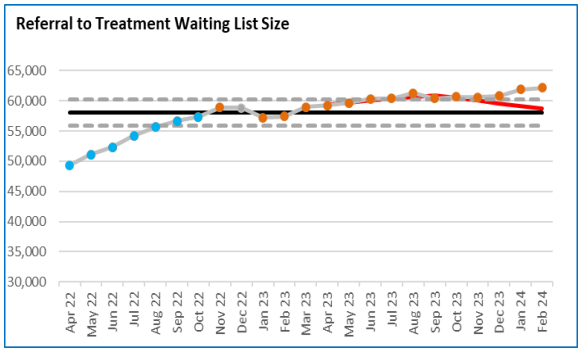
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Referral to Treatment Waits >65 weeks	Feb 24	47	54	35				Feb 24	229	207	86			
Referral to Treatment Waits >52 weeks	Feb 24	605	591	301				Feb 24	856	903	303			
Referral to Treatment Waits >18 weeks	Feb 24	20849	20638	-				Feb 24	16433	16463	-			
Referral to Treatment Median Waiting Time	Feb 24	12.0	11.7	-				Feb 24	12.0	12.0	-			
Referral to Treatment Waiting List Size	Feb 24	61909	62147	59138				Feb 24	48280	48926	46398			
Referral to Treatment Performance	Feb 24	66.3%	66.8%	92.0%				Feb 24	66.1%	66.4%	92.0%			
Cancer - 28 day Faster Diagnosis Standard	Feb 24	61.8%	71.7%	75.0%				Feb 24	76.9%	85.9%	75.0%			
Cancer - 62-day Referral to Treatment Standard	Feb 24	74.4%	74.4%	85.0%				Feb 24	85.9%	86.3%	85.0%			
Cancer - 31-day Decision to Treat Standard	Feb 24	92.8%	96.4%	96.0%				Feb 24	97.8%	100.0%	96.0%			
Cancer - Waiting List Backlog >62 days	Feb 24	104	95	120				Feb 24	36	35	70			
Diagnostic Waits >6 weeks	Mar 24	2.0%	3.0%	5.0%				Mar 24	3.9%	3.8%	5.0%			
Diagnostic Test Activity	Mar 24	18782	18267	-				Mar 24	17280	16757	-			
On the day cancellations not re-booked within 28 days	Mar 24	4	3	0				Mar 24	2	0	0			
Elective Inpatient & Daycase Activity	Mar 24	5369	5173	5341				Mar 24	3677	3715	3759			
Outpatient Activity	Mar 24	70928	65077	61290				Mar 24	52760	49136	51436			
Theatre Utilisation Capped	Mar 24	79.0%	77.5%	85.0%				Mar 24	79.4%	80.8%	85.0%			
Daycase Rates	Mar 24	81.4%	78.0%	80.0%				Mar 24	83.8%	85.1%	80.0%			
Outpatient DNA Rates	Mar 24	9.5%	10.3%	8.0%				Mar 24	4.4%	4.5%	8.0%			
Patient Initiated follow ups (Moved or Discharged)	Mar 24	346	370	-				Mar 24	1592	1355	-			
Patient Initiated follow ups % of OP Activity	Jan 24	0.4%	0.5%	5.0%				Jan 24	2.8%	2.7%	5.0%			
Advice and Guidance Processed per 100 First Outpatient Attendances	Feb 24	6.4	5.1	16.0				Feb 24	10.4	9.1	16.0			
Outpatient New to Follow up Ratio	Mar 24	1.8	2.0	-				Mar 24	2.7	2.6	-			

Operational Performance

Exception Report | SGH Referral to Treatment (RTT)



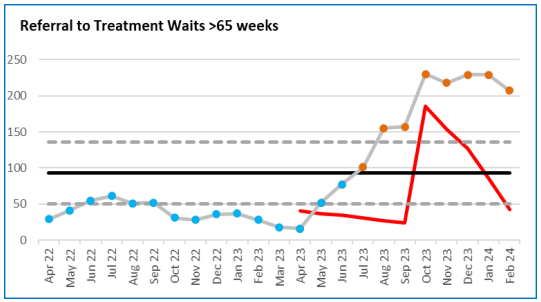


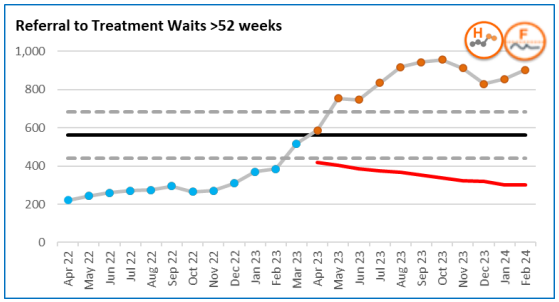


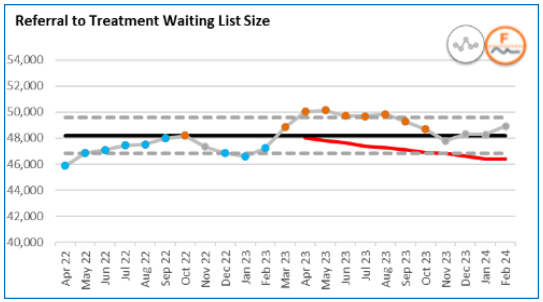
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH Waiting list size behind plan 52 week waits behind plan 65 week waits behind plan	• The common denominator for waiting list growth and long wait positions exceeding trajectory is Industrial Action. As a result of the cumulative impact of IA has seen a number of OP clinics and theatre lists cancelled / postponed / rescheduled. With reduced capacity, divisions needed to reprioritise lists according to clinical need. • Theatre capped utilisation below target in month. A high number of on the cancellations were noted. Some due to lack of available post op G&A beds and patients arriving on day unfit for surgery	**Operational Planning Guidance:** The 2024/25 guidance has now been published and has allowed us to align action and recovery plans to targets and metrics. **Elective Overview and recovery:** An overview of national and local requirements has been developed and circulated to divisions. This includes the Trust's elective priorities, our commitment to activity through annual operational planning and our approach to delivery. **Standardising processes:** A consistent approach to wait list management and patient communication is being implemented. With benefits already evident for DNA rates. **Improvement and action plan:** Elective Access meeting is agreeing a set of action plans with divisions. Setting measurable benefits, timeframes and action owners.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



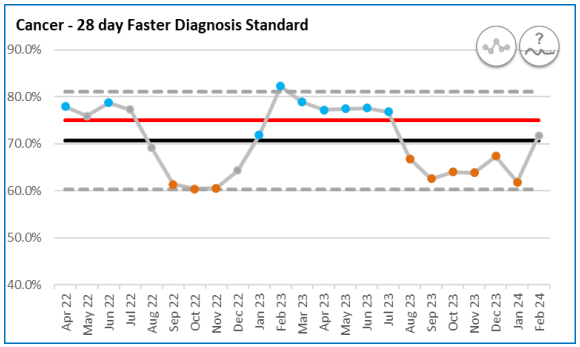


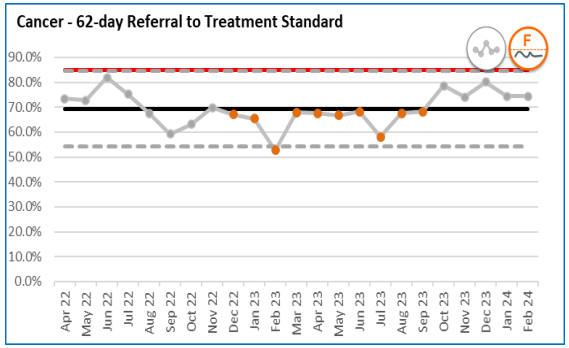


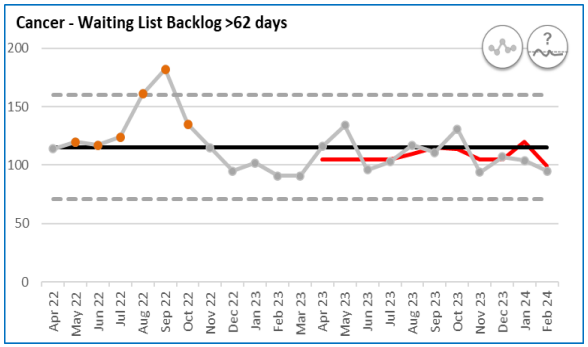
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan Median waiting times – special cause variation 52Wk & 65Wk waits not meeting plan special cause variation	• 52 week waits increased from 856 in January 2024 to **903** in February 2024. The specialties with the highest cohort are Gynaecology (318), Community Paediatrics (224), Cardiology (82) and T&O –EOC (64). However, a reduction to ~860 is expected once March 2024 is submitted. • 65 week waits reduced from 229 in January 2024 to 207 in February 2024. The specialties with the highest cohort are Gynaecology (87), Community Paediatrics (42) and Cardiology (28). A further reduction to <120 is expected once Mar24 is submitted. • 78 week waits increased from 27 in January 2024 to **35** in February 2024. However a reduction to <20 is expected once March 2024 is submitted.	• Recovery plans in place for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology. • Private capacity for Gynae continues. • Private capacity for Community Paediatrics starts on 20th April 2024. • Community Paediatrics locum in post and 65+ waits have reduced in this service since January 2024. • Breach allocation for late referrals to SWL Elective Orthopaedic Centre from the base hospitals has now been agreed as of 1st April 2024. • Theatre capacity at QMH (Roehampton) increased from 22nd January 2024 (4 lists per week). • Divisions and performance team continue to work in collaboration to manage 52WWs daily and expedite next steps. Updates being provided to SWL on a weekly basis for patients 60weeks+ and an end of April 2024 65wk+ and 78+ 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 has been included in business plans. • 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.	Clearance of RTT 52 week waits not yet planned to achieve. RTT 65 Week Waiters Recovery Date- June 2024 (subject to ongoing additional funding in Gynae and Community Paediatrics)	sufficient for assurance

Operational Performance

Exception Report | SGH Cancer Waiting Times





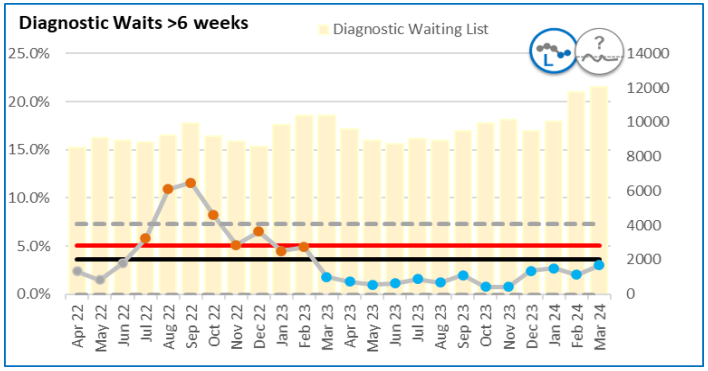


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH FDS – Consistently failing target (75%) 62 Day Combined Consistently failing target (85%)	**Faster Diagnosis performance 71.7%** **Skin** Forward view in March is 75% and compliant. **Breast** forward view is showing a deteriorating position due to capacity for one stop. **Gynaecology** Reduced access to scans and one stop clinics has resulted in a decline in performance. **Lower GI** Delays to Nurse Led Telephone assessment clinic with a 2/3 week wait due to job planning misalignment, currently being worked through. **Radiology** Capacity for CTC due to patient choice and locality reduced capacity due to one scanner being out of action. **62 Day Performance met internal trajectory 74.4% (consultant upgrade achieved 87.8%)** Some pathway delays with one stop clinics and timely access to theatres. The highest volumes seen in Breast (17), Lung (8.5) and urology (5.5) services and the screening pathway and Lung due to access to theatres and the expansion of the targeted lung health checks.	• **Skin** forward view shows a reduction of backlog, resulting in an improved position. • **Breast** has been awarded resilience funding to support further Xyla clinics planed for the next 2 months. 1 senior fellow due to start in April 24 and additional ANP is out to advert. • **Gynaecology** plan to run an all-day one-stop clinic at QMH from June 20203 • **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). • Working closely with SWL Pathology to improve identification of patients via Live Tableau on a suspicion of cancer pathway to help improve turnaround times. • Working with IT to develop a Live Radiology dashboard for tracking of patients against FDS targets. • The targeted Lung health checks program scaled up from 1st October 2023. A business case has been developed and is being discussed by the site leadership team. • RMP allocated funding (£150K) in December 2023 to support performance and Waiting List Initiatives through to March 2024. Further resilience funding will be allocated in April 2024 and will be allocated on clinical need basis across all tumour sites.	TBC	sufficient for assurance

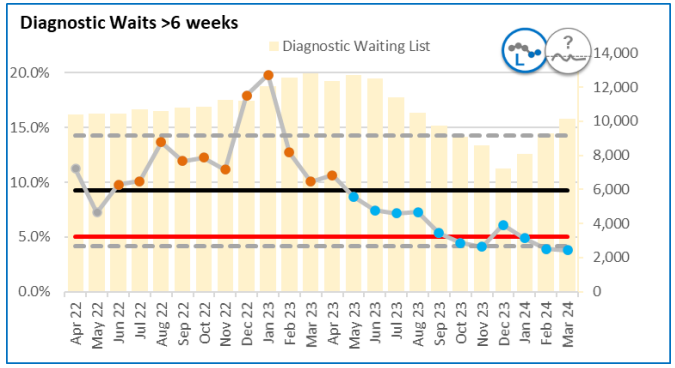
Operational Performance

Exception Report| ESTH & SGH Diagnostic Waiting Times

St George's



Epsom & St Helier

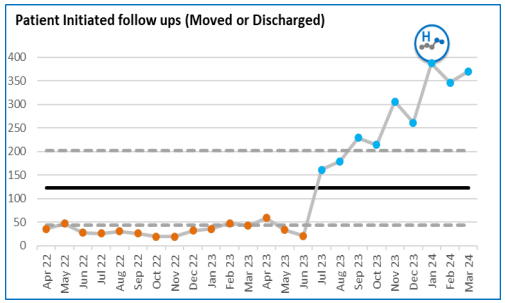


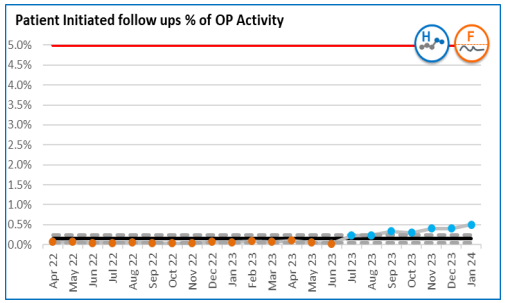
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH Diagnostic waiting times: Consistently meeting target of no more than 5% waiting >6 weeks.	Echocardiography - Staffing challenges impacting the department has resulted in increased waits. Increase in Ultrasound demand has led to increased waits within the service Audiology not fully reporting data in line with national guidance, this is being addressed.	• Echo continues to look for support from an insourcing company to support reducing the backlog, and existing team are doing as many additional hours as they are able without impacting their well-being. Bank enhanced rates have been agreed. • Increased sessions throughout April to reduce waits and reviewing referral pattern to ascertain where demand is coming from, likely impacted due to SWL backlog. • Reviewing of booking processes for Audiology to ensure activity is captured accurately and in line with national guidance	N/A	sufficient for assurance
ESTH Diagnostic waiting times: Met target of no more than 5% waiting >6 weeks and special cause improvement in waiting times.	The modalities with the highest volume of patients waiting over 6 weeks (as of March 2024) are Endoscopy (111) and Urodynamics (86).	• Endoscopy has seen a recent backlog increase in Paediatric Gastroscopy and the division are in the process of working up plans to recover the position. • Gynae urodynamics remain high and Planned Care will be exploring the option of restarting the support previously being provided to bring the waits back down.	N/A	sufficient for assurance

Operational Performance

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

St George's





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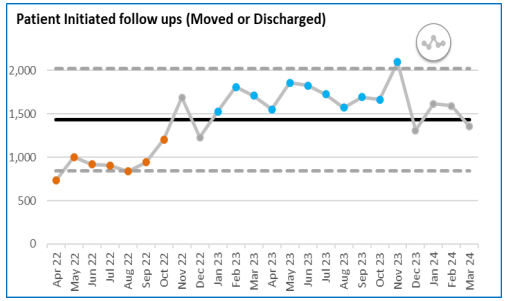
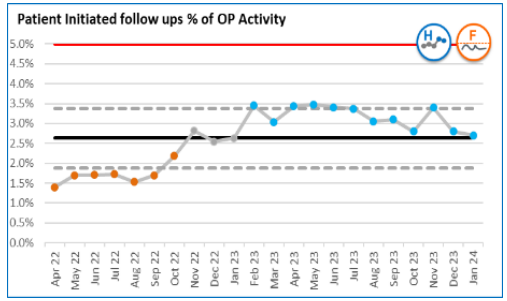




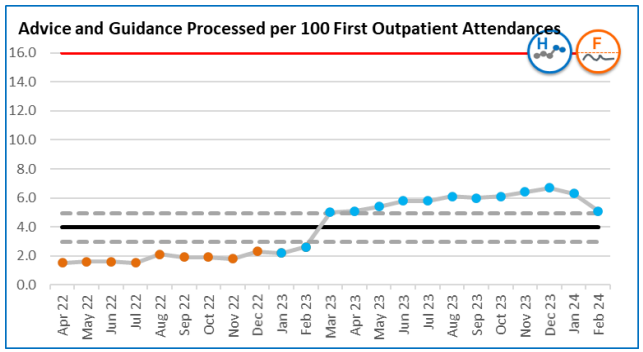
Rate reported one month in arrears in line with Model Hospital reporting

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH PIFU Rate: Consistently not meeting target	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. We hope to switch on PIFU functionality on the Patient Portal on 24th April 2024.	• A revamp of the Patient Initiated Follow Up process (PIFU) is currently under way to increase current performance from 0.4% towards the national target of 5% • We have started PIFU checklists and operational preparedness with 6x GIRFT specialities + Therapies from end of April and beginning of May • 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. • Version 2.5b has now been agreed for PIFU which offers clinicians the opportunity to vary the length of time each patient is placed on a PIFU pathway. Work is ongoing with clinical systems to support this and clinical acceptance testing on Friday 12th April with clinicians • Testing still ongoing with Zesty portal for waiting list validation and PIFU data capture	2% planned for April 2024 (pending IT testing and launch date 22nd April)	sufficient for assurance
ESTH PIFU Rate: Consistently not meeting target	The PIFU rate slightly increased again in March 2024. Engagement with PIFU amongst clinicians varies. But we continue to look for more opportunities for PIFU to Discharge and PIFU to Assess.	• In Cardiology PIFU to Discharge is being piloted now available for use in the Post Ablation Pathway. PIFU to Assess is about to begin in Cardiology with ILR devices in May. • The adult asthma pathway has been discussed and is being mapped. A potential opportunity for PIFU has been identified and this is being discussed.	3.5% planned for Mar25 (National Target 5%) 5% target not yet planned to achieve.	sufficient for assurance

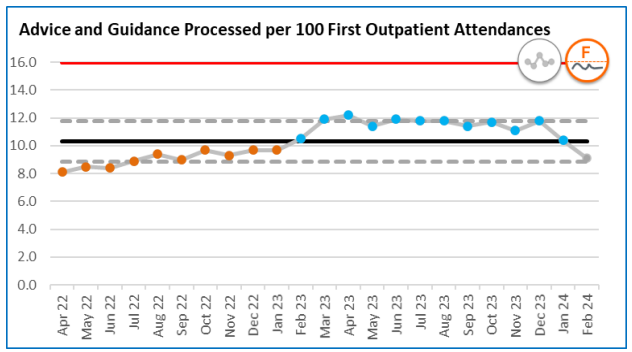
Operational Performance

Exception Report | ESTH & SGH Specialist Advice & Guidance (A&G)

St George's



Epsom & St Helier



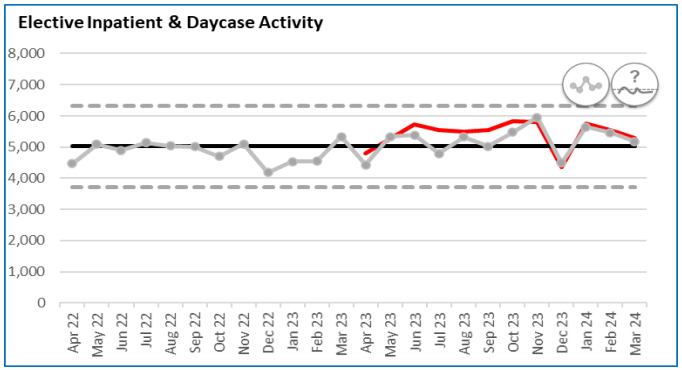
Number of Processed Requests rate per 100 Outpatient First Attendances

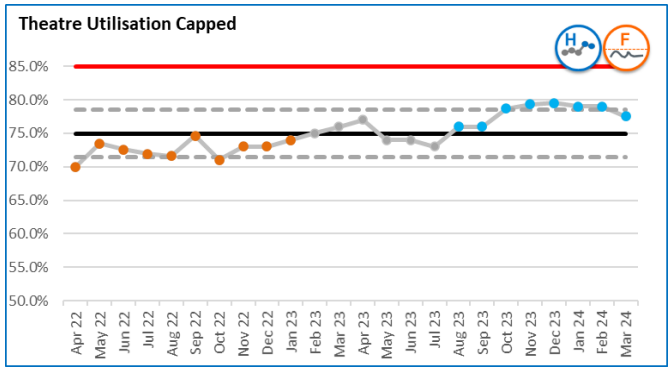
Reported one month in arrears in line with NHSE reporting based on FLEX data, data catch up expected

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH A&G Utilisation Rate: Consistently not meeting target	The above data only counts activity conducted through e-Referrals (ERS) Advice & Guidance portal. However, we are now able to include "referrals rejected with A&G" as part of the return and this will see the percentage double.	• 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. • Working with IT to test new functionality in iCLIP which should encourage clinical buy in for actioning A&G meaning they can triage and complete A&G requests within the same area of the application. Escalations to Oracle as currently this is only with A&G and request is to be with all referrals	TBC	Work in progress to resolve under-reporting
ESTH A&G Utilisation Rate: Consistently not meeting target	The new data agreement is in place to include referrals received via the CAS on e-RS not just via A&G. There was a continued slight reduction in A&G % processed, possibly impacted by the February half term which can delay processing. However, when the CAS is included, this rate increases to 59% which is significantly above the target rate.	• The new agreed data set has been submitted for month 11 (as of 9th April 2024). • The Quick View programme continues. Gastroenterology is now progressing to the clinical leadership forum in Sutton. Respiratory is now progressing to wider Respiratory clinician review. • Standard Editable texts to support A&G responses have now been drafted in Dermatology and Gynaecology. • In Urology, a clinician session to discuss referral triage and A&G has taken place. Monitoring is in place to test any resultant changes in CAS and A&G diversion rates.	TBC	New data set submitted for month 11 (as of 9th April 2024) to resolve under-reporting

Operational Performance

Exception Report | SGH Elective Activity & Productivity

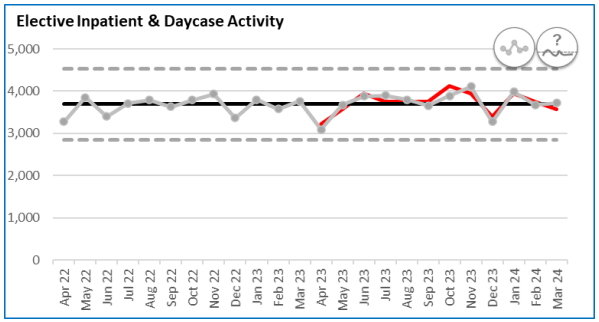


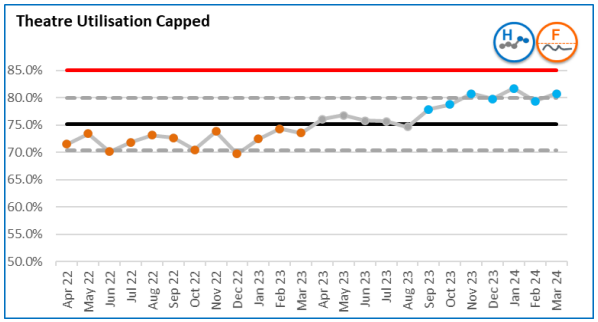


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH Theatre Utilisation (capped): Consistently not meeting target (85%) and special cause improving trend.	Adherence to 642 booking principles is variable, with multiple specialties delivering low booking profile for weeks 1-2. Patient flow remains a contributing factor to Theatre Productivity. To address this, clinical and operational teams continue to focus on early discharges and further embedding of the day-of-surgery admission pathways On day cancellations were high in March due to high occupancy across the bed base and lower than predicted discharges. An extremely high number of repatriation delays especially to Kingston also impacted on our elective performance, as well as patients being unfit for surgery.	Continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. New 642 meeting structure being rolled out in the w/c 29th of April Lists not booked to >75% utilisation with 2 weeks notice will be reviewed and stood down. Unless there is a clinical exception to this standard. A new theatre performance meeting has been established to ensure lists are fully optimised and booking rules are adhered to. Further work is being planned to understand the scope for improvement of ACPS across different specialities. Theatre Transformation support starting in April 2024 to help coordinate the site improvement programme, particularly focusing on productivity.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH Elective Activity & Productivity





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%)	We are currently achieving the planned trajectory targets, and the Trust has seen an overall improvement in utilisation since November. HVLC T&O injection lists &Urology Template Biopsy lists continue to impact overall performance due to the required downtime between cases for clinical administration and estates constraints (limited consenting, admitting and recovery space to accommodate high volume injection lists). March was impacted by a broken laser machine resulting in a number of on the day and short notice cancellations for Urology. This has now been resolved. As we approached the end of the leave year, we also had more 'available' sessions, and less uptake on them, likely due to leave.	**Action: Explore plans to relocate T&O Foot & Ankle injection 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 end of April 2024. *TO NOTE: Approximately 30% of patients requiring a TPPB will still need to be carried out under a GA in theatres.* ▪ The Pain Injection lists are appropriate for a procedure room, and therefore from the 4th March have been excluded from Theatre utilisation. We have created a separate activity dashboard so we can continue to monitor their utilisation. ▪ We are exploring moving T&O injection lists (foot & ankle) to a Procedure room on Derby at EOC. A business plan is being written. **Action: Creating additional admissions and recovery space: *(Key measures for success: Theatres Utilisation, early finishes, late starts, day case rates)*** ▪ Some ENT cases can recover for 4-6 hours, and are currently doing so in Day surgery. We are exploring moving ENT to MT, and admitting/recovering the patients via SWIFT ward to support HVLC lists in day surgery. ▪ A T&F group is being established to focus on creating additional Day Case admissions capacity for specialties utilising SWIFT ward. Within this, there may be an opportunity to consent Day Case patients by their bed which could help reduce late starts. **Action: Reducing avoidable on the day cancellations: *(Key measures for success: On the day cancellation rate)*** ▪ We are strengthening our pre-TCI calls to reduce the number of avoidable cancellations, and ensuring our OTDC SOP is adhered to at all times. ▪ We are trying to support teams grow a pool of patients fit for standby by trying a new approach to early health screening in preoperative assessment (POA) in line with GIRFT. We aim to increase the no. of available slots and reduce cancellations through early optimisation and a wider window between POA & TCI. This will ensure a patient is ready for surgery before being listed. We are challenged with space as we require more OP rooms, but are working closely with our Executive team on this. ▪ We continue to challenge emerging themes for cancellations at our weekly lookback performance meeting, and tackle issues in real time at our daily theatre huddle. ▪ Our staff continue to help us achieve high levels of patient satisfaction. Epsom Day Case received a 5 star rating for March's Friends & Family test, and a positive score or 98.90%. Epsom Pre Assessment, achieved 4.5 stars, with a positive score of 92.86%. We are so proud of our teams!	TBC	sufficient for assurance

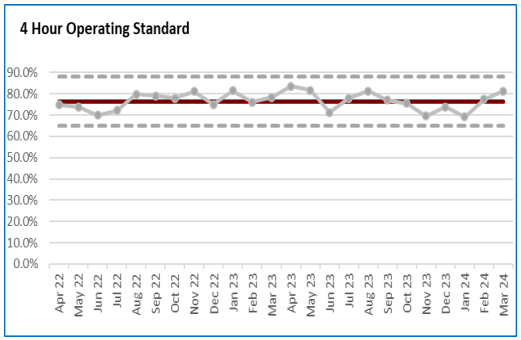
Operational Performance

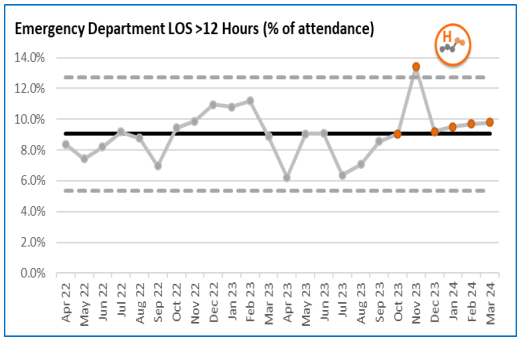
Overview Dashboard | Urgent and Emergency Care

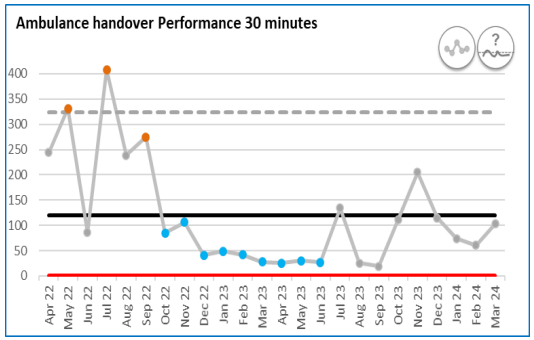
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
4 Hour Operating Standard	Mar 24	77.3%	81.3%	76.0%		?		Mar 24	74.8%	76.8%	76.0%		?	
Emergency Department LOS >12 Hours (% of attendance)	Mar 24	9.7%	9.8%	-	H			Mar 24	11.4%	10.3%	-	H		
Ambulance handover Performance 30 minutes	Mar 24	61	103	0		?		Mar 24	504	490	0	H	F	
Ambulance handover Performance 60 minutes	Mar 24	23	11	0	L	?		Mar 24	63	71	0	L	F	
Non elective length of stay	Mar 24	7.2	6.4	-				Mar 24	7.6	7.7	-			
Mental health delays 4 Hour Breaches	Mar 24	100	91	-							-			
Readmission Rate - Non Elective	Mar 24	12.4%	12.6%	-				Mar 24	5.6%	4.6%	-			
Length of stay > 7 days (stranded)	Mar 24	385	378	-				Mar 24	375	364	-	H		
Length of stay > 21 days (super stranded)	Mar 24	169	174	172		?		Mar 24	161	167	130	H	?	
Overnight G&A beds occupancy - Adults	Mar 24	95.6%	96.2%	92.0%		F		Mar 24	89.3%	88.6%	92.0%		?	
Number of patients not meeting criteria to reside	Mar 24	164	159	83		F		Mar 24	208	216	101	H	F	

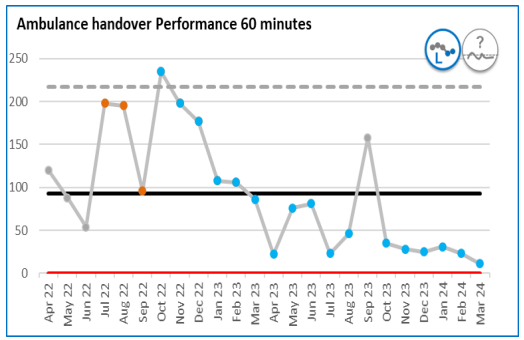
Operational Performance

Exception Report | SGH A&E Waits and Ambulance Handovers





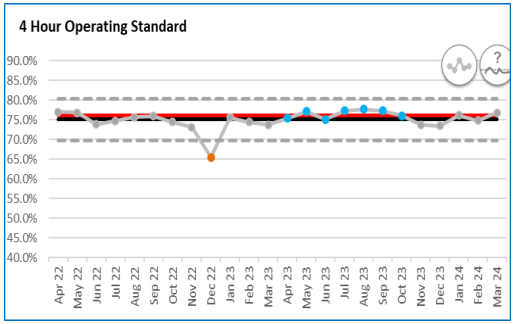


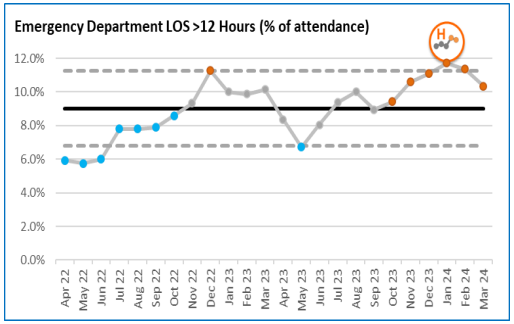


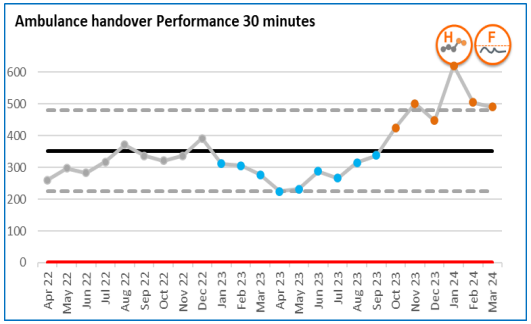
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH 4 Hour Operating Standard Common cause variation with target not being met consistently. ED LOS> 12 Hrs Special cause concerning variation , upward trend	The key drivers of operational pressures are; • High number of DTA's and mental health attendances. • 78% of 2,678 LAS arrivals were off-loaded <15 minutes. March 2024 saw an improvement in performance compared to previous month, with 4-hour performance increasing to 81.3% and 9 days of >95% non-admitted performance. Discharges exceeded admissions on 17 days, aiding flow across the Trust. The discharge profile improved across the month which supported flow.	• Maintaining Extended Emergency Care Unit (EECU) to facilitate waiting of results • Maintaining in and out spaces to improve performance and capacity within the department • 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	TBC	ED Performance: sufficient for assurance LAS: Under review

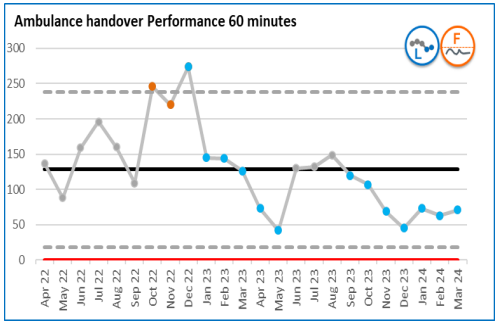
Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers







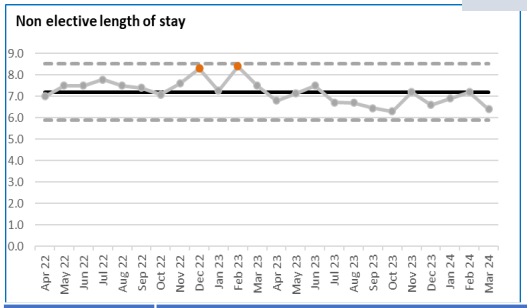


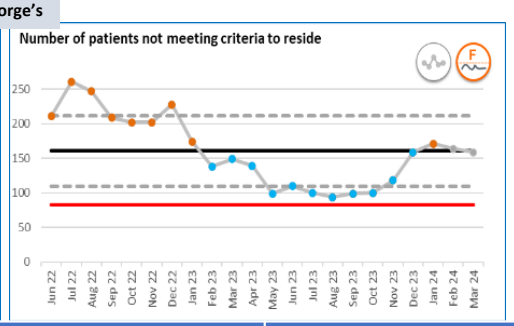
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hour Operating Standard Special cause concerning variation and target not being consistently.	We saw an improvement in ED performance in March 2024, reporting 76.8% performance Patients spending longer than 12-hours in ED also remains challenging with 10.3% of patients spending longer than 12-hours in the department. However, this is a slightly improved position compared to February 2024 when we reported 11.4% > 60-minute ambulance handover delays remain high with 71 reported delays in March 2024, however, an improving trajectory over the last 5 months Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively 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.	• We have undertaken a review of our 2023/24 urgent care work programme and have agreed a set of programme priorities for 2024/25. This includes outputs from our ED listening event, our urgent care workshop event, and the recommendations from the recent ECIST visit. • We are undertaking focussed work with colleagues from Surrey and Borders Mental Health Trust to develop a proposal/business case for a mental health CDU on the Epsom Hospital site. We are also working with SWL & St Georges Mental Health Trust to explore mental health rapid access clinics for appropriate patients presenting to ED. • We are reviewing our front door frailty service at St Helier and looking to develop a front door frailty hub in the existing emergency floor footprint. This will support admission avoidance for appropriate patients and ensure early onward flow from ED to the frailty area. Phase 1 is expected to commence w/c 22nd April • We are focusing on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC. LAS direct to SDEC conveyances have been a priority with increasing numbers of patients being conveyed directly to SDEC • Our focus remains on listening to and acting on feedback from our staff re. additional actions required to support the emergency care pathway.	TBC	sufficient for assurance

Operational Performance

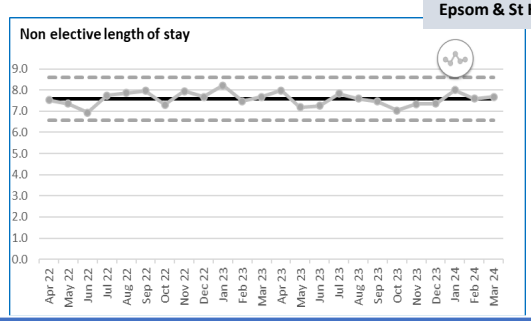
Exception Report | ESTH & SGH Length of Stay (LOS) & No Criteria to Reside (NCTR)

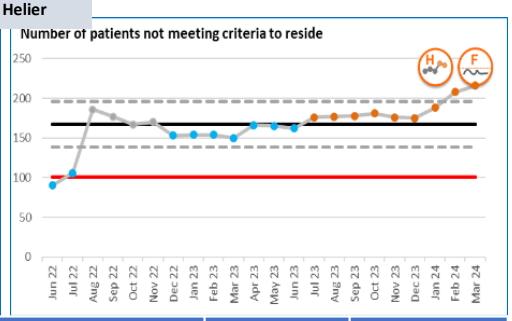
St George's





Epsom & St Helier





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGH NCTR: Consistently not meeting target	High number of patients not meeting the criteria to reside in addition to the high number of patients awaiting Pathway 2A (Merton + Wandsworth) and Pathway 3. Slight improvement in flow compared to January and February, with significantly less infectious outbreaks. However, Cavell Ward continued to provide 28 winter escalation beds and has supported decompressing ED. Cavell will be closing from the 1st May 2024 for the summer months. The Brodie escalation area closed mid-February 2024 and briefly opened in March for a few days.	• MADE "style" Events has resumed given increased operational pressure • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • 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 • CLCH to be part of the Transfer of Care (TOC) hub to challenge discharge pathways and take more direct discharges. • The Trust has replaced Red2Green with the National Criteria to Reside tool for daily electronic tracking patients' readiness for safe and timely discharge to improve patient flow and reduce length of stay.	TBC	sufficient for assurance
ESTH NCTR: Consistently not meeting target	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. A significant cohort of our medically fit patients are those requiring on-going therapy prior to discharge. This is also reflected in our non-CTR patient cohort, with a high number of patients waiting for a hospital-based action prior to discharge being progressed.	• Daily reports in place identifying those patients who are medically fit for discharge by specific discharge pathway, shared with internal and external stakeholders, including our therapy team to enable progression of key actions. Senior level oversight is in place to ensure that key actions are progressed. • Discharge roles and responsibilities document completed and shared with wider trust colleagues providing clarity on who should be responsible for key steps in the discharge process • We are working with Sutton Place colleagues to develop a collaborative length of stay improvement programme, aligning key actions across health and social care. Progress will be reported via the Sutton Alliance Board with phase 1 consisting of 5 priority work-streams for delivery over the next 6 months • The Sutton Health and Care Reablement Unit has been operating at full occupancy with a robust system in place to ensure the early identification of suitable patients to transfer to the unit.	TBC	sufficient for assurance

gesh

Integrated Care

C Collaboration and partnership

A Affordable healthcare, fit for the future

R Right care, right place, right time

E Empowered, engaged staff

Integrated Care Performance

Overview Dashboard | Integrated Care

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Mar 24	10	9	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	Mar 24	7	7	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Mar 24	15	38	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Mar 24	18	29	-			
Reablement Unit Bed Occupancy	Mar 24	97.0%	97.0%	0.0%			
Reablement Unit Length of Stay	Mar 24	7	7	0			
Two hour UCR performance	Mar 24	86.9%	90.7%	70.0%			
Two hour UCR referrals received	Mar 24	459	452	-			
Virtual ward - Admissions	Mar 24	275	268	-			
Virtual ward - Bed Occupancy	Mar 24	65.9%	70.6%	80.0%			
Virtual ward Length of Stay	Mar 24	2	3	-			
Total RTT Waiting List Size	Mar 24	895	921	-			
Total number of RTT patients waiting over 18 weeks	Mar 24	3	2	-			
Sickness Rate	Mar 24	5.2%	4.6%	3.2%			
Agency rates				-			
MAST	Mar 24	89.8%	89.0%	85.0%			
Vacancy	Mar 24	17.2%	16.3%	10.0%			
Appraisal Rate Medical	Mar 24	100.0%	75.0%	90.0%			
Appraisal Rate Non Medical	Mar 24	70.9%	68.3%	90.0%			
Turnover	Mar 24	0.9%	2.1%	13.0%			
Percentage BAME staff band 6 and above	Mar 24	37.9%	37.6%	-			

Surrey Downs

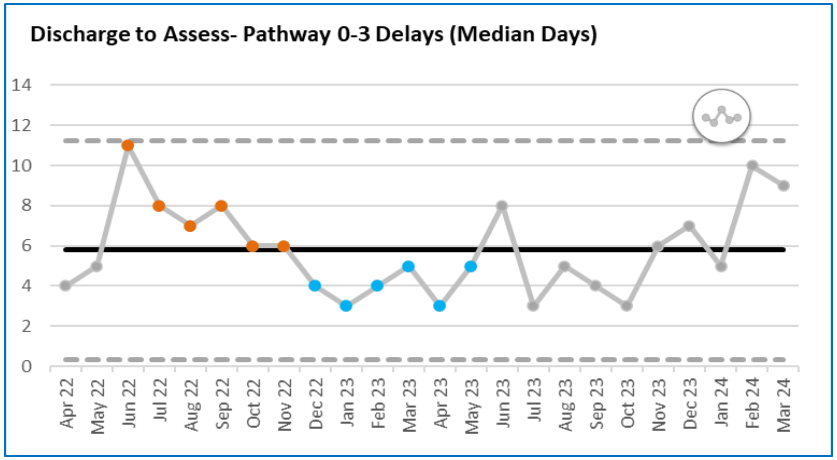
KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Mar 24	3	3	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	Mar 24	2	3	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	Mar 24	1	2	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	Mar 24	14	12	-			
Community Hospitals Bed Occupancy	Mar 24	93.0%	93.4%	-			
Community Hospitals Length of Stay	Mar 24	21	17	-			
Two hour UCR performance	Mar 24	83.7%	86.7%	70.0%			
Two hour UCR referrals received	Mar 24	540	518	-			
Virtual ward - Admissions	Mar 24	246	223	-			
Virtual ward - Bed Occupancy	Mar 24	86.0%	100.0%	80.0%			
Virtual ward Length of Stay	Mar 24	4	5	-			
Total RTT Waiting List Size	Mar 24	409	493	-			
Total number of RTT patients waiting over 18 weeks	Mar 24	5	8	-			
Sickness Rate	Mar 24	4.3%	5.0%	3.8%			
Agency rates	Mar 24	9.2%	7.2%	-			
MAST	Mar 24	92.3%	93.3%	85.0%			
Vacancy	Mar 24	19.4%	20.7%	10.0%			
Appraisal Rate Medical	Mar 24	100.0%	100.0%	90.0%			
Appraisal Rate Non Medical	Mar 24	78.8%	84.4%	90.0%			
Turnover	Mar 24	1.0%	2.0%	12.0%			
Percentage BAME staff band 6 and above	Mar 24	18.9%	18.8%	-			

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

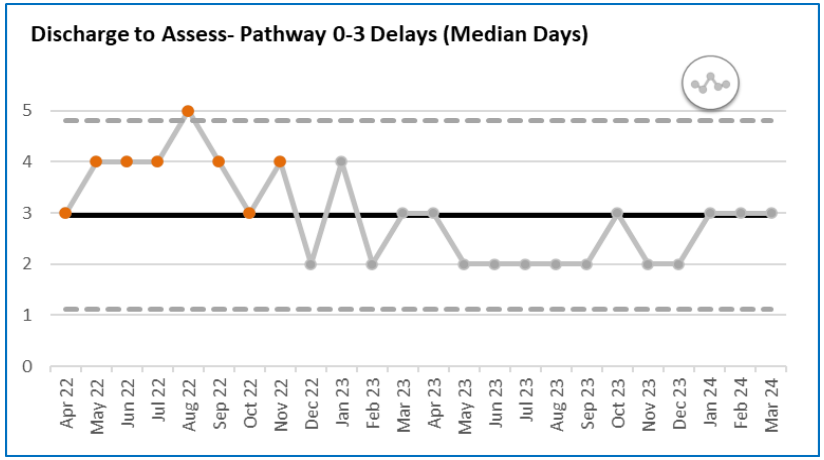
Integrated Care

Exception Report | Median days Discharge to Assess

Sutton Healthcare



Surrey Downs

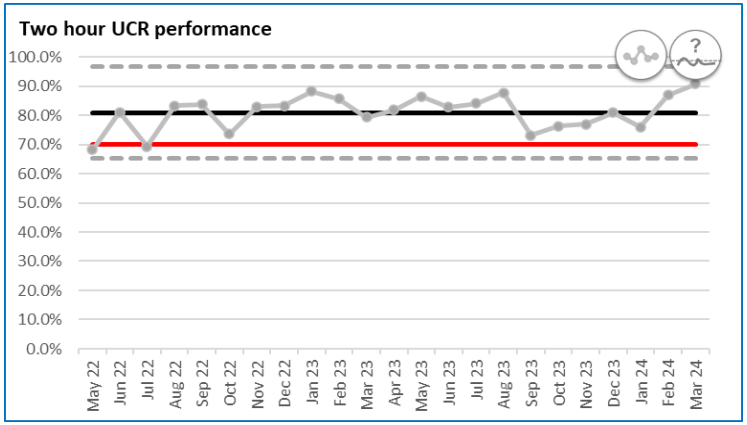


Site & Metric	Cause of variance/ non-compliance / challenges	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Increase seen through February and March driven by pathway 2 and 3 delays.	The data is line with the increase in admissions into ESTH and complex discharges over the Winter Period. P2 and P3 have now decreased in 2024. Work is in place with partners to further mitigate increase.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Common cause variation only with median days at 3 days. Pathway 3 saw a decrease of on average 2 days through March compared to February	Although the individual pathways improved their median days the overall median days is 3. Continued focus on improving referral to discharge time. Home First IT software (pathways to care) live in March which will further streamline the administrative processes.	N/A	Sufficient for assurance

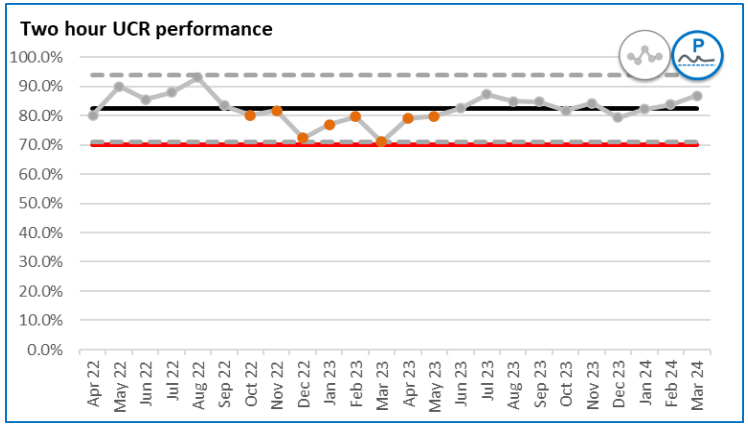
Integrated Care

Exception Report| 2-Hour Urgent Community Response

Sutton Healthcare



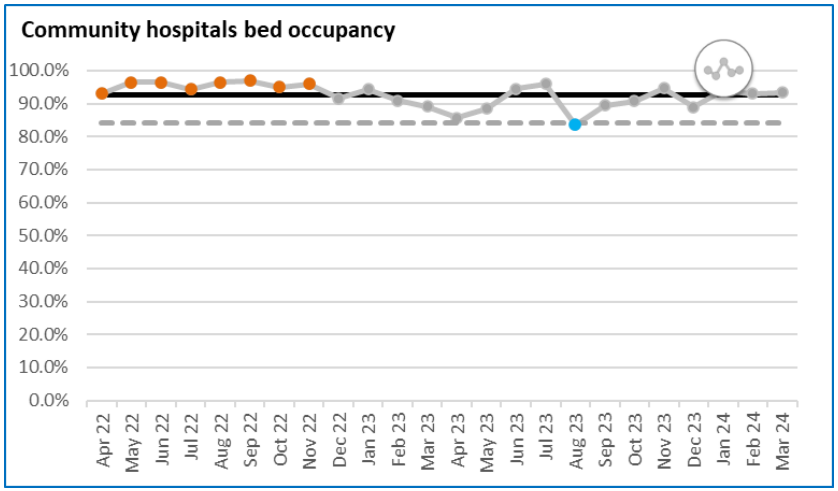
Surrey Downs

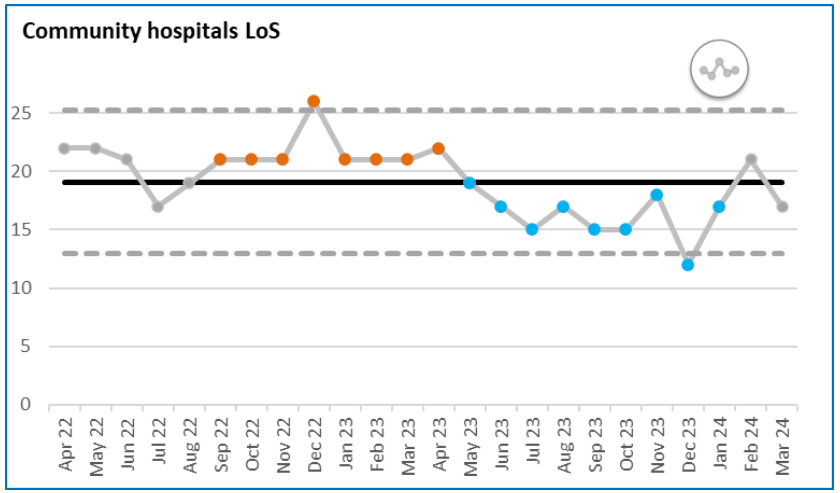


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Compliant - Performance continues to exceed target, with a performance of 90.7% through March 2024.	N/A	N/A	Sufficient for assurance
Surrey Downs Health & Care	Compliant - Performance continues to exceed target, with a performance of 86.7% through March 2024.	Plan to monitor the capacity and demand as winter pressures resources support to manage the increase in activity is now finished	N/A	Sufficient for assurance

Integrated Care

Exception Report| Surrey Downs Bed Occupancy & Length of Stay



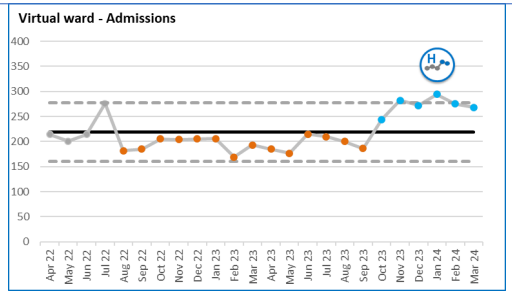


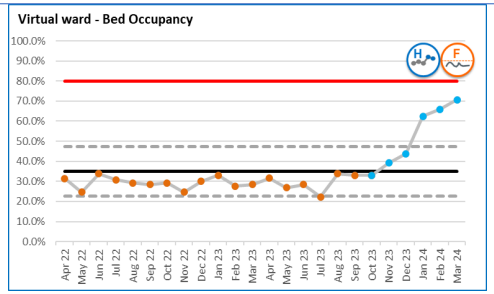
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs Health & Care	Common cause variation. Bed Occupancy trend remains consistent with length of stay reducing after a peak in February 2024.	Increase in length of stay is due to additional escalations beds and complex patients . Process for escalations of delays is in place . Working on Choice policy implementation.	TBC	Sufficient for assurance

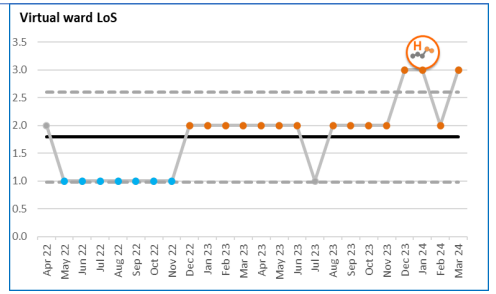
Integrated Care

Exception Report | **Virtual Wards**

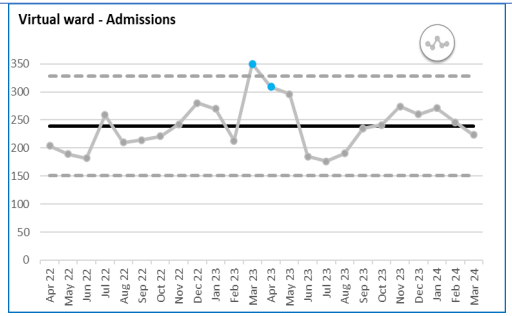
Sutton Healthcare

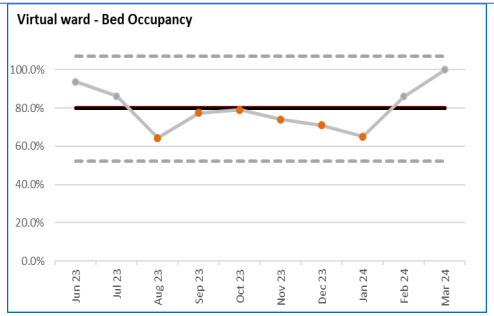


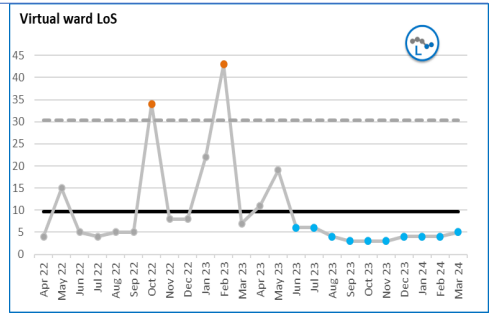




Surrey Downs





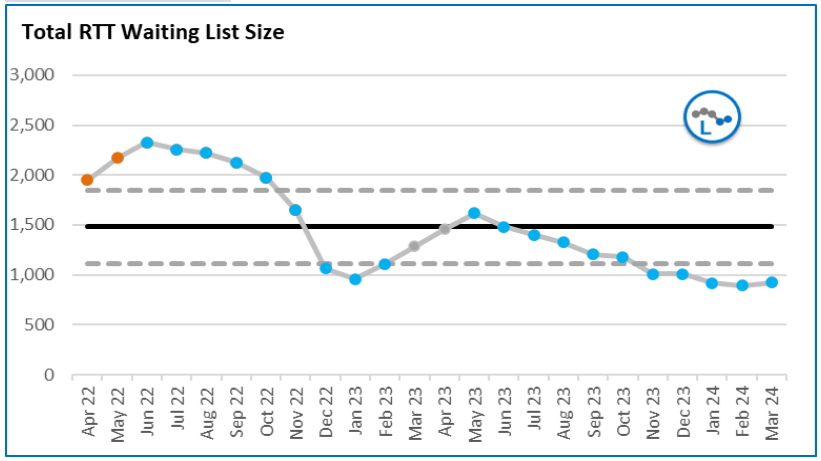


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Service target occupancy rates amended from December 2023. The number of admissions has been above the mean for six consecutive months with occupancy rates approaching target.	SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. Engagement work with appropriate wards and with clinicians continues.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Service started September 2021. Occupancy rates increased above the upper control limit. Admissions remains stable with a slight increase in length of stay through March. Length of stay trend is now much more consistent.	Increase in length of stay is due to development of enhanced care in Virtual Wards. Improvement in occupancy rate. Digital monitoring went live in April	TBC	Sufficient for assurance

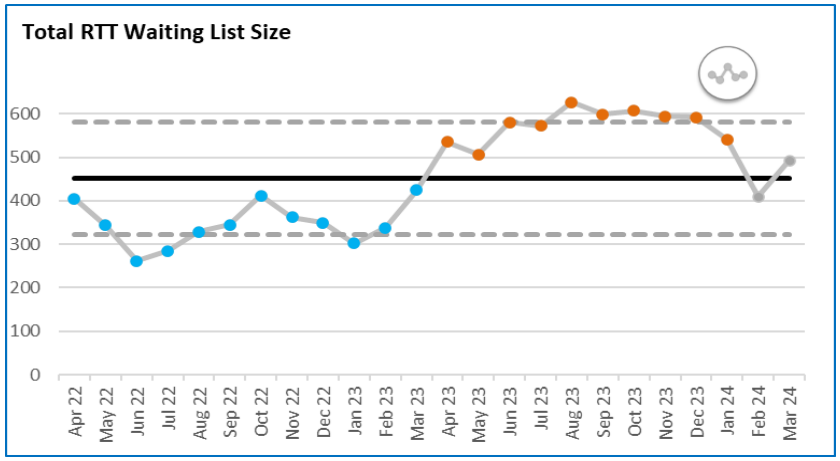
Integrated Care

Exception Report | Referral to Treatment Waiting List

Sutton Healthcare



Surrey Downs

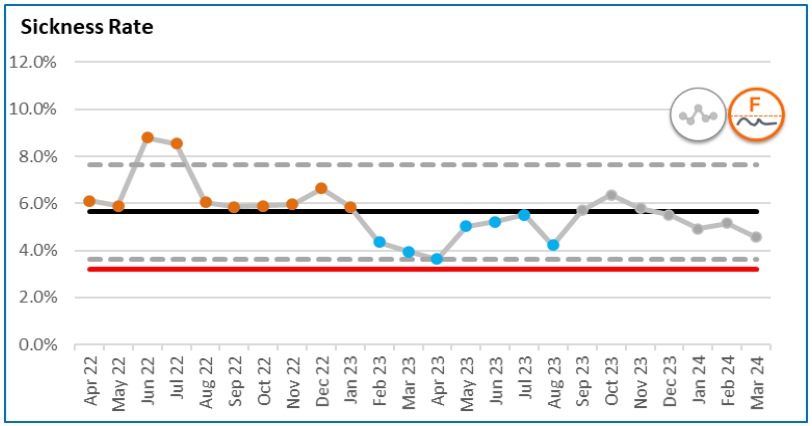


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	RTT waiting list size continues below the lower control limit showing a positive reduction	Data analysis is being completed to further understand this downward trend.	N/A	Work underway to expand scope to include all waiting lists
Surrey Downs Health & Care	Waiting list size although returning within the upper and lower control limits has seen an increase through March.	Service level plans to manage the Waiting List is in place	N/A	Work underway to expand scope to include all waiting lists

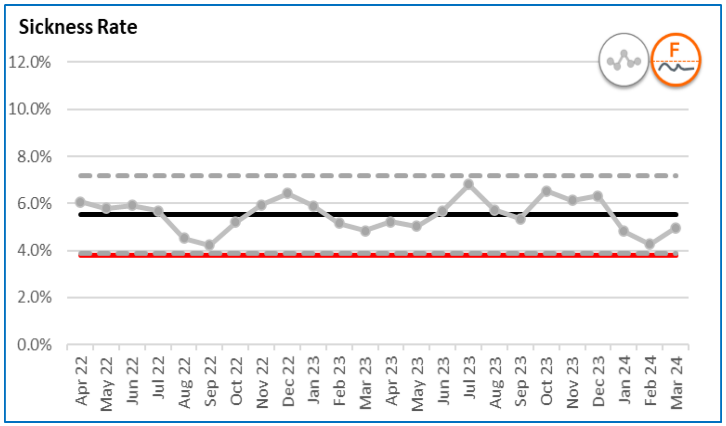
Integrated Care

Exception Report | Staff Sickness Absence Rate

Sutton Healthcare



Surrey Downs

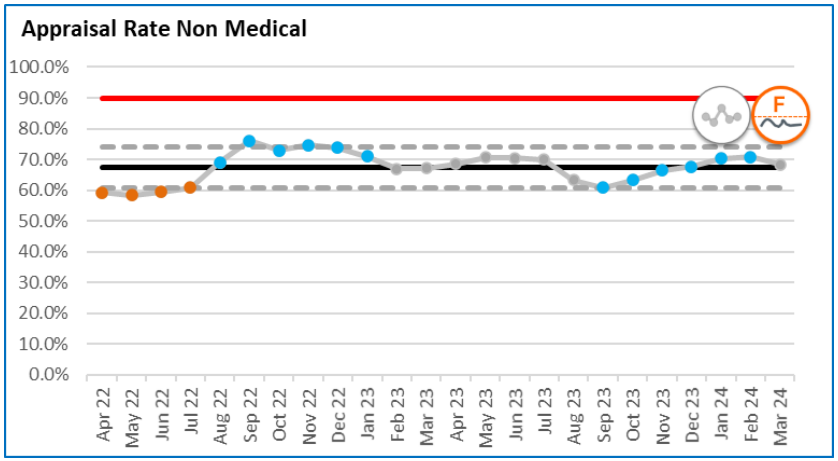


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care: Staff sickness absence rate consistently not meeting target	Short term episodes of sickness over the Winter period, alongside existing long-term sickness	This is being managed robustly in house with Human Resources.	TBC	Sufficient for assurance
Surrey Downs Health & Care: Staff sickness absence rat e consistently not meeting target	Sickness absence rate on a downward/improvement trend. Mainly due to long term sickness.	Further improvement is expected as robust absence management process in place	TBC	Sufficient for assurance

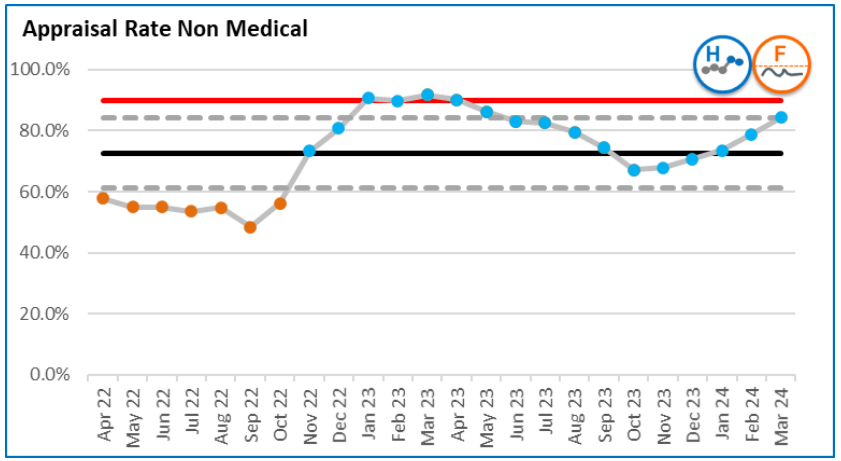
Integrated Care

Exception Report| **Non-Medical Staff Appraisal**

Sutton Healthcare



Surrey Downs



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Although showing improvement rates remain below target.	Work is in place with line managers to ensure this rate continues to improve.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Performance above the mean and showing improvement however remains below target.	Plan in place with continuous improvement noted .	TBC	Sufficient for assurance

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Appendices

Our People

Overview Dashboard | People Metrics

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Sickness Rate	Mar 24	5%	4%	3%		F		Mar 24	5.7%	5.0%	3.2%		F	
Agency rates	Mar 24	2%	3%	-				Mar 24	2.6%	3.4%	-			
MAST	Mar 24	91%	91%	85%	H	P		Mar 24	85.3%	84.2%	85.0%	H	F	
Vacancy Rate	Mar 24	6%	6%	10%	L	P		Mar 24	12.1%	11.4%	10.0%	L	P	
Appraisal Rate Medical	Mar 24	82%	84%	90%	H	F		Mar 24	90.0%	90.0%	90.0%	H	?	
Appraisal Rate Non Medical	Mar 24	76%	76%	90%	H	F		Mar 24	66.0%	71.4%	90.0%	H	F	
Turnover	Mar 24	14%	14%	13%	L	F		Mar 24	13.5%	12.5%	13.0%	L	F	
Percentage BAME staff band 6 and above	Mar 24	45%	45%	-	H			Mar 24	38.1%	39.0%	-	H		

Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Glossary of Terms

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

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

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

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

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

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	3.3	
Report Title	**Group Financial Performance Year End 23/24**	
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	25 April 2024
Purpose	**For Review**	

Executive Summary

This update on the financial year end is brief and based on draft information as the Trusts complete year end processes ahead of submission and external audit.

Both Trusts have achieved their Year End forecast positions for 23/24 and submitted full draft accounts on time.

Action required by Group Board

The Board is asked to note the draft year end positions for each organisation.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/a

Implications

Group Strategic Objectives

☐ Collaboration & Partnerships

☐ Right care, right place, right time

☒ Affordable Services, fit for the future

☐ Empowered, engaged staff

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
[Set out briefly any financial implications relevant to the issues described in the paper]
Legal and / or Regulatory implications
[Set out any legal and / or regulatory issues relevant to the issues described in this paper]
Equality, diversity and inclusion implications
[Set out any equality, diversity and inclusion issues relevant to the issues described in this paper]
Environmental sustainability implications
[Set out any environmental sustainability issues relevant to the issues described in this paper]

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University Hospitals and Health Group

Group Board: 2nd May 2024
Year End 2023/24

GCFO, SGH Site CFO, ESTH Site CFO

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University Hospitals and Health Group

Executive summary

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This update on the financial year end is brief and based on draft information as the Trusts complete year end processes ahead of submission and external audit.

The Trusts have submitted key data returns on 9th and 16th April, and a first draft full accounts submission on 24th April. Key accounts deadline is:

Provider Timetable	Date
Final Agreement of balances and full accounts	28 June 2024

Both Trusts achieved their Year End forecast positions for 23/24, as outlined in the below table:

2023/24 £m	ESTH	SGH	Narrative
Original plan	**-37.9**	**-15.7**	**Plan submission 4th May 2023**
M8 FOT change	0.0	-15.1	SGH deterioration caused by excess Non Pay Inflation, ED and ward pressures
M8 FOT	**-37.9**	**-30.8**	**This included 100% funding for M1-7 IA and excluded any IA impact after M8**
M11 Deficit funding plan change	30.3	24.7	Group share of £81.6m funding set aside by NHSE for SWL planned deficit
M11 Distribution of inflation funding	3.1	2.5	Group share of £8.4m funding from SWL, offset within system position
Year end deficit	**-4.5**	**-3.6**	**This included 100% funding for M8-12 IA**

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SGH Draft Year End 23/24

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The numbers included within this slide are consistent with the numbers included within the key data return on Tuesday 16th April. These remain draft until final account submission 24th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Original Budget £m	Updated Budget £m	Actual £m	Variance £m
Income	1,092.8	1,117.5	1,159.6	42.1
Expenditure	(1,108.6)	(1,108.6)	(1,163.2)	(54.6)
Surplus / (Deficit)	(15.7)	9.0	(3.6)	(12.6)

Capital	Budget £m	Actual £m	Variance £m
Capital Spend	(41.9)	(39.4)	2.5

Cash	2223 Closing Cash £m	2324 Closing Cash £m	Movement £m
Cash Balance	58.6	58.2	(0.4)

Income and Expenditure

- The Trust is reporting a deficit of £3.6m at year end, which is £12.6m adverse to the updated plan and equal to the financial forecast agreed as part of the forecast change protocol with NHSE at M9. The shortfall to plan is due to non-pay inflation excess and pressures in the ED and ward budgets.
- The updated plan is following the deficit funding agreed with SWL ICB and NHSE. Original plan is a £15.7m deficit- and following deficit funding of £24.7m- the updated plan is a £9.0m surplus.

Capital Spend

- The Trust is reporting capital spend of £41.9m, £2.5m under plan.

Cash

- The Trust ended the year with a cash balance of £58.2m which is £0.4m lower than the opening balance for the year.

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ESTH Draft Year End 23/24

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The numbers included within this slide are consistent with the numbers included within the key data return on Tuesday 16th April. These remain draft until final account submission 24th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Original Budget £m	Updated Budget £m	Actual £m	Variance £m
Income	**609.2**	**645.8**	**698.5**	**52.7**
Expenditure	**(647.1)**	**(653.4)**	**(702.9)**	**(49.5)**
Surplus / (Deficit)	**(37.9)**	**(7.6)**	**(4.5)**	**3.1**

Capital	Budget £m	Actual £m	Variance £m
Capital Spend	**(56.9)**	**(45.9)**	**11.0**

Cash	22/23 Closing Cash £m	23/24 Closing Cash £m	Movement £m
Cash Balance	**27.2**	**50.6**	**23.4**

Income and Expenditure

- The Trust is reporting a deficit of £4.5m at year end, which is £3.1m favourable to the updated plan and equal to the financial forecast agreed as part of the forecast change protocol with NHSE at M9.
- The updated plan is following the deficit funding agreed with SWL ICB and NHSE. Original plan is a £37.9m deficit- and following deficit funding of £30.3m- the updated plan is a £7.6m surplus.

Capital Spend

- The Trust is reporting capital spend of £45.9m, £11.0m less than plan. The Trust delivered all its BAU schemes however due to the plan including estimated spend on national schemes, e.g. BYFH, as actual funding received was less than plan.

Cash

- The Trust ended the year with a cash balance of £50.6m which is £23.1m more than the opening balance for the year.

Group Executive Board

Meeting on Thursday, 02 May 2024

Agenda Item	4.1	
Report Title	**Our priorities for 2024/25**	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Ralph Michell, Julie Alexander	
Previously considered by	Group Board	-
Purpose	**For Approval / Decision**	

Executive Summary

In March, the Board discussed emerging priorities for 2024/25 and gave the Executive three challenges: agree what our 'board to ward' people priority is, prioritise ruthlessly and set SMARTer objectives for 24/25 for our strategic initiatives. The Executive presented an update to the Board for discussion at April's Group Board Development Session. This paper is the updated narrative for Board approval.

The purpose of the *'board to ward' priorities* is to provide a clear statement of GESH Group in-year priorities to staff, patients and partners, in support of our strategic 'CARE' objectives:

C: *Work with other teams to reduce delays in patient journeys through our services*
A: *Live within our means: innovating, working more efficiently and cutting costs*
R: *Keep our patients safe – including those waiting for our case*
E: *Make our team a great and inclusive one to work in.*

Against each of these priorities, measures of success in 24/25 will be different for each layer of the organisation (Group, site, division, service etc.). The paper summarises an emerging set of SMART objectives at Group level, which will be translated into a revised IQPR for July Board.

The 'Board to ward' priorities provide a clear framework for teams across the Group (each site, division, service etc.) to agree improvement priorities that will enable delivery of our strategic 'CARE' objectives – our overall aims for 2028.

Action required by Group Board

The Board is asked to:

a. Review and approve the 'plan on a page' for 24/25, including 'board to ward' priorities and priorities for our strategic initiatives and corporate departments.
b. Note the emerging SMART objectives/metrics, which will be translated into a revised IQPR for July Board.

Committee Assurance

Committee	GEM

Level of Assurance	GEM

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	**Our priorities for 24/25 – narrative plan**

Implications

Group Strategic Objectives

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

Risks

As per 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 per paper/Appendix 1

Legal and / or Regulatory implications

As per paper/Appendix 1

Equality, diversity and inclusion implications

As per paper/Appendix 1

Environmental sustainability implications

As per paper/Appendix 1

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Our priorities for 24/25

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Introduction

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In March, the Board discussed emerging priorities for 24/25 and gave the Executive three key challenges to address prior to approval. This paper presents an update of the 24/25 narrative plan for Board approval.

1

Agree what our 'board to ward' people priority is

2

"Prioritise ruthlessly"

3

Set SMARTer objectives for 24/25 for our strategic initiatives

2

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1 'Board to Ward' people priority: options

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The Executive considered options for a 'Board to ward' people priority for the 24/25 narrative plan. The recommended option 5 is set out below for approval by the Board.

Option	Notes
Option 1: make this a great team to work in	Applicable to any team across the organisation, and suitable for continuous improvement approach. Would have an indirect impact on quality/finance. But does not explicitly call for action on diversity & inclusion, where we know we have major challenges.
Option 2: make our team more diverse and inclusive	Reflects a major challenge for the organisation, and could have an indirect impact on quality/ finance. Applicable to any team across the organisation, although on its own potentially less suited than option 1 to the frequent cycle of continuous improvement (regular team huddles etc).
Option 3: Ensure all our colleagues feel able to help improve/transform our service	The Executive were initially attracted to this option given its potential impact on our financial & quality challenges, but on reflection felt it did not sufficiently reflect our desire to look after our staff / make the organisation more inclusive. It also makes a priority of a method (continuous improvement) which we hope to support teams to apply to all 4 board-to-ward priorities.
Option 4: Ensure we are always learning and developing	Reflects an area for improvement in the staff survey, and could have an impact on quality / finance – but potentially better suited to corporate-led action than local improvement.
Option 5: Make our team a great and inclusive one to work in **(recommended option)**	Less focused than options 1-3, but applicable to any team across the organisation, suitable for continuous improvement approach, would have an indirect impact on quality/finance, and reflects our need for action on diversity & inclusion.
Option 6: Make ours a great and inclusive team to work in, where all staff are able to contribute to improving the service	Covers a range of important issues, but not a very ruthless example of prioritisation.

3

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2 "Prioritise ruthlessly"

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By March 2025 we will have…

	C	A	R	E
Option 1	Collaborated across teams/system to improve flow; and delivered a step change in Group collaboration	Delivered our financial plan	Kept/improved our grip on safety; and delivered a reduction in long-waiters	People priority as above
Option 2 **(recommended)**	Collaborated across teams/system to improve flow	Delivered our financial plan	Kept/improved our grip on safety; and delivered a reduction in long-waiters	People priority as above
Option 3	Collaborated across teams/system to improve flow	Delivered our financial plan	Kept/improved our grip on safety	People priority as above

Three options were put to the Group Executive in response to the Board's challenge to "prioritise ruthlessly".

The Group Executive agreed to recommend option 2 to the Board, on the basis option 1 did not go far enough in meeting the Board's challenge, but excluding long-waiters from our priorities could a) send the wrong signal to external partners/regulators, b) have a negative impact on other priorities given the relationship between some long waits and clinical outcomes, c) be easier for the organisation (Board to ward) to do on paper than in reality.

However, the Executive agreed that the ambition should be framed in a way that focuses on avoiding the clinical harms associated with some long waits, and that recognises the financial constraints on delivery.

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Resultant 'Board to ward' improvement priorities for 24/25

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Work with other teams to reduce delays in patient journeys through our services

Live within our means: innovating, working more efficiently and cutting costs

Keep our patients safe – including those waiting for our care

Make our team a great and inclusive one to work in

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Making it SMART

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The proposal is that against each of these priorities, SMART measures of success in 24/25 will be different for each layer of the organisation (Group, site, division, service, etc). Below is an emerging set of SMART objectives at Group level, which would be translated into a revised IQPR for Board. These will iterate further over the coming weeks.

Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
• 78% 4hr standard • 12hr waits in ED as % of total lower than 23/24 • LOS lower than 23/24 • Virtual ward utilisation >80% • SDEC improvement vs 23/24	• Deliver our financial plan, incl: • CIP target • ERF target • Productivity target	• Improvement vs 23/24 on fundamentals of care (e.g. falls, pressure sores, VTE, reduced harm) • Improvement in mortality rate 65-week waits eliminated by sept • Cancer 62 days as per targets in operational plan	• Improvement in % of staff saying they would recommend the organisation as a place to work / look forward to coming to work (staff survey / Pulse) • Improvement vs 23/24 on proxy metrics (turnover rate, sickness rate). • Improvement in WRES/WDES metrics

Note: these objectives will be translated into the IQPR, along with a range of additional 'watch metrics', for July Board

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3 Strategic initiatives – SMARTer priorities

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Electronic patient record
- Progress shared electronic patient record across gesh, for implementation in 2025

Building your future hospitals
- Submit outline business case
- Submit planning application
- Progress enabling works

Group collaboration
- Integrate most corporate services
- Submit full business case for renal build
- Agree 3 Group-wide clinical strategies, and begin implementation

Collaboration with SWL hospitals
- Strengthen hosted APC partnerships
- Deliver agreed transformation programmes – e.g. joint PACS
- Develop new partnership programmes to support long-term financial sustainability – e.g. hubs

Collaboration with local partners
- Develop gesh-wide approach to frailty
- Work with local partners to reduce length of stay
- Work with partners on redesign of community services in Merton & Wandsworth

Specialised services
- Get gesh ready for devolution of specialised service budgets
- Strengthen the services we want to be renowned for
- Improve oversight of our specialised service portfolio.

Culture
- Implement sexual safety charter
- Develop and implement plan to tackle violence & aggression against staff
- Deliver our diversity & inclusion plan

High-performing teams
- Support our teams to develop shared goals, linked to our strategy
- Support teams to use continuous improvement habits and tools against these goals
- Align our approach to performance

Outpatient transformation
- Redesign pathways with primary care, e.g. more advice & guidance for GPs
- Deliver more virtual and telephone clinics
- Deliver more patient-initiated follow-up

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3 SMART objectives – corporate enablers

gesh

People

Bring together one, transformed HR function across the Group, with policies/processes aligned

IT

Improve the performance and resilience of our IT infrastructure

Deliver a programme of major IT projects, with EPR on track for 2025, a new shared PACS, and iClip for Maternity at St George's

Environmental sustainability

Develop a Group-wide Green Plan, with implementation underway

Quality & safety

Integrate corporate medicine and nursing departments, and strengthen quality governance & oversight – including roll-out of PSIRF

Research & Innovation

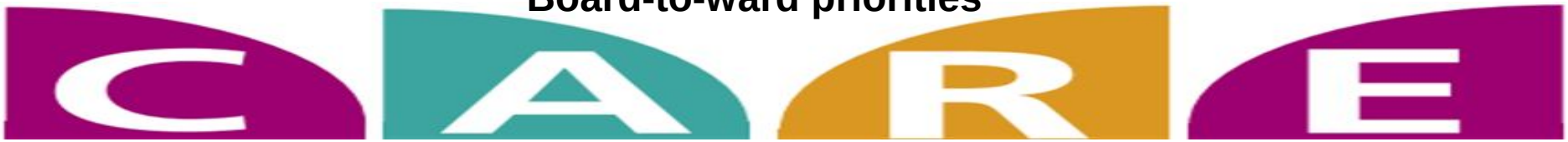
Develop our partnership with the newly merged City St George's University, and recruit 10% more patients to trials than in 23/24

Estates & facilities

Deliver a programme of building projects across both Trusts, including new ICU capacity at St George's

Outstanding care, together: our plan for 24/25

Board-to-ward priorities



Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in

Strategic initiatives

Electronic patient record
- Progress shared electronic patient record across gesh, for implementation in 2025

Building your future hospitals
- Submit outline business case
- Submit planning application
- Progress enabling works

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- Integrate most corporate services
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High-performing teams
- Support our teams to develop shared goals, linked to our strategy
- Support teams to use continuous improvement habits and tools against these goals
- Align our approach to performance

Outpatient transformation
- Redesign pathways with primary care, e.g. more advice & guidance for GPs
- Deliver more virtual and telephone clinics
- Deliver more patient-initiated follow-up

Corporate enablers

People
Bring together one, transformed HR function across the Group, with policies/processes aligned

IT
Improve the performance and resilience of our IT infrastructure.
Deliver a programme of major IT projects, with EPR on track for 2025, a new shared PACS, and iClip for Maternity at St George's

Environmental sustainability
Develop a Group-wide Green Plan, with implementation underway

Quality & safety
Integrate corporate medicine and nursing departments, and strengthen quality governance & oversight – including roll-out of PSIRF

Research & Innovation
Develop our partnership with the newly merged City St George's University, and recruit 10% more patients to trials than in 23/24

Estates & facilities
Deliver a programme of building projects across both Trusts, including new ICU capacity at St George's

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Recommendations

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The Board is asked to:

1. Approve the 'plan on a page' for 24/25, including 'Board to ward' priorities and priorities for our strategic initiatives and corporate departments

2. Note the emerging SMART objectives/metrics, which will be translated into a revised IQPR for July Board.

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	5.1	
Report Title	**GESH Gender Pay Gap**	
Executive Lead(s)	Angela Paradise, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer / Rumiko Yonezawa / Sandra Ovid	
Previously considered by	People Committee-in-Common	22 March 2024
Purpose	**For Review**	

Executive Summary

The Equality Act 2010 Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This report captures data at 31st March 2023.

SGUH employed 9,927 staff – 7,109 were female and 2,818 were male. The mean hourly pay for males is £2.56 higher than that of females, which is a gap of 12.9%. Male median pay is £2.46 higher than females, which is a gap of 10%.9,927 staff.

- The mean pay gap reduced year on year since 2021, from 14.59% to 12.86% in 2023.
- The median pay gap has increased from 9.51% to 10.02%.
- The mean bonus gap has reduced year on year, from 34.17% to 32.10%.
- The median bonus gap remained static between 2020-22, reducing this year to 0%.
- The % of staff receiving a bonus increased significantly due to clearing overdue CEAs.

ESTH employed 7,148 staff – of those, 75% were female. The mean hourly pay for males is £3.26 higher than that of females, which means on average male staff receive 13.1% more than female staff. Male median pay is 24p lower than females, which is a gap of -1.2%.

- The mean pay gap has been reducing year on year.
- The mean bonus gap dropped in 2023 but still at 18.7%.
- The number of Male staff being paid bonus is 6 times higher than female staff.
- Bonus pay has been decreasing in the last 4 years for both male and female.

Work with CMO's to implement NHSE's High Impact Actions which relate to pay gaps, including Mend the Gap recommendations.

Action required by Group Board

The Board is asked to:

a. Review the results across both SGUH and ESTH.
b. Review next steps and approve (implementing relevant NHS High Impact Action Plan actions).

Committee Assurance

Committee	Choose an item.

Level of Assurance	Choose an item.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Gender Pay Gap Report

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

Equality, diversity and inclusion implications

Environmental sustainability implications

gesh Gender Pay Gap Report
Group Board, 02 May 2024

1.0 Purpose of paper

1.1 *To provide an opportunity for the Group Board to consider implications of the reports and consider the direction of future work to address findings.*

2.0 Background

2.1 The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2023.

The NHS has issued guidance on how to calculate the gender pay gap, and that guidance is followed here (see Appendix 1).

At the time of writing, St George's University Hospitals employs 9,927 staff in a number of staff groups, including administrative, medical, nursing, and allied health roles. Epsom and St Helier Hospitals employs 7,148 staff.

All staff St George's University Hospitals except for medical and Very Senior Management (VSM) are on Agenda for Change (AfC) payscales, which provide a clear structure for paying employees equally, irrespective of gender. In addition to Medical, Very Senior Management (VSM) and Agenda for Change (AfC), Epsom and St Helier Hospitals also employs 610 Estates & Facilities staff on locally agreed payscales.

3.0 Analysis

3.1 **Overview of findings**:

SGUH employed 9,927 staff – 7,109 were female and 2,818 were male. The mean hourly pay for males is £2.56 higher than that of females, which is a gap of 12.9%. Male median pay is £2.46 higher than females, which is a gap of 10%.9,927 staff.

- The mean pay gap reduced year on year, from 14.59% to 12.86% in 2023.
- The median pay gap has increased from 9.51% to 10.02%.
- The mean bonus gap has reduced year on year, from 34.17% to 32.10%.
- The median bonus gap remained static between 2020-22, reducing this year to 0%.
- The % of staff receiving a bonus increased significantly due to clearing overdueCEAs.

ESTH employed 7,148 staff – of those, 75% were female. The mean hourly pay for males is £3.26 higher than that of females, which means on average male staff receive 13.1% more than female staff. Male median pay is 24p lower than females, which is a gap of -1.2%.

- The mean pay gap has been reducing year on year.
- The mean bonus gap dropped in 2023 but still at 18.7%.

- The number of Male staff being paid bonus is 6 times higher than female staff.
- Bonus pay has been decreasing in the last 4 years for both male and female.

Next Steps:
This year, the GESH group produced and published our 2024 report - covering the period April 2023 – March 2024.

In the period April-May 2024 we will present the findings to our respective Women's Staff Networks and Chief Medical Officers Offices. These reports will be presented alongside NHSE's High Impact Action Plan which includes several actions relating to reducing pay gaps, see below:

- Implement the recommendations from the Mend the Gap review for medical staff and further develop a plan for implementation for senior non-medical staff
- Implement an effective flexible working policy to be utilised in recruitment campaigns
- Analyse available data on pay gaps and implement an improvement plan by protected characteristic. Plans for race and sex should be in place by 2024, for disability by 2025 and for other protected characteristics by 2026. This will be tracked and monitored by NHS boards.

4.0 Sources of Assurance

4.1 Data for this report was provided by our Workforce Information Teams and reviewed / checked by colleagues in EDI and Business Intelligence. The report has been taken through PMG for review and comment.

Sources of Assurance

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 Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

The table above provides an example of the kinds of assurance that should be described in this section. Please delete the table from the final version of your report.

5.0 Implications

5.1 We are required by law to publish our gender pay gap data each year. Failure to publish or knowingly provide misleading information can result in enforcement or penalty action.

6.0 Recommendations

6.1 The Board is asked to:

a. Review the results across both SGUH and ESTH.
b. Review next steps and approve (implementing relevant NHS High Impact Action Plan actions).

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Gender Pay Gap Report

Snapshot Date: 31/03/2023

March 2024

Gender Pay Gap

Introduction

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2023.

The NHS has issued guidance on how to calculate the gender pay gap, and that guidance is followed here (see Appendix 1).

At the time of writing, **St George's University Hospitals** employs 9,927 staff in a number of staff groups, including administrative, medical, nursing, and allied health roles. **Epsom and St Helier Hospitals** employs 7,148 staff.

All staff St George's University Hospitals except for medical and Very Senior Management (VSM) are on Agenda for Change (AfC) payscales, which provide a clear structure for paying employees equally, irrespective of gender. In addition to Medical, Very Senior Management (VSM) and Agenda for Change (AfC), Epsom and St Helier Hospitals also employs 610 Estates & Facilities staff on locally agreed payscales.

What is the gender pay gap?

The Gender Pay Gap (GPG) is a mathematical calculation based on the difference between the average (or 'mean') hourly earnings of women compared to the average hourly earnings of men. The Gender Pay Gap highlights any imbalance of average pay across an organisation.

For example, if an organisation's workforce is predominantly female yet the majority of higher paid roles are held by men, the average female salary would be lower than the average male salary. The Gender Pay Gap is not the same as equal pay which is focused on men and women earning equal pay for the same / similar jobs or for work of equal value. It is unlawful to pay people unequally because of their gender.

What do we have to report on?

The statutory requirements of the Gender Pay Gap legislation require that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payments.

Who is included?

All staff who were employed across the GESH Group on full pay on 31st March 2022 are included. Bank staff who worked a shift on the snapshot date are also included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded. Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff are not included.

What pay is covered?

Both Basic pay and Bonus pay is covered. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards.

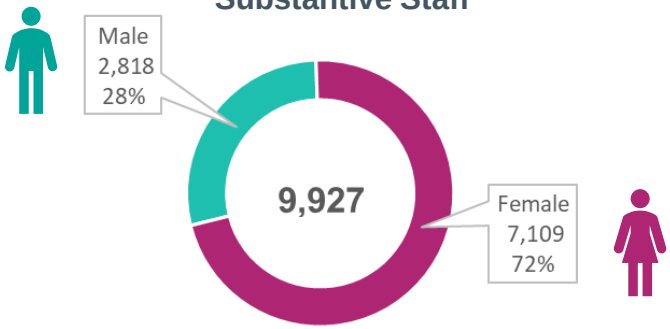
Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, but not if they are continuous. Workplace vouchers that are paid in addition to basic salary are included, unless they take the form of a salary sacrifice arrangement.

For detailed information on how the pay gap is calculated please see Appendix A.

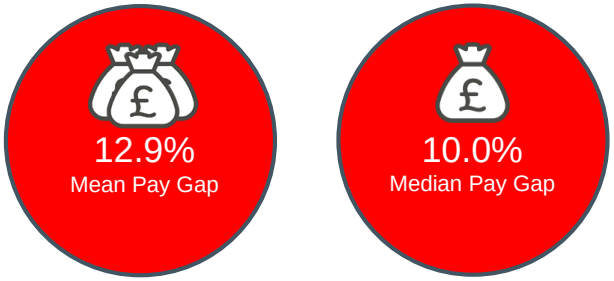
Gender Pay Gap
Overview

St George's University Hospital

Substantive Staff

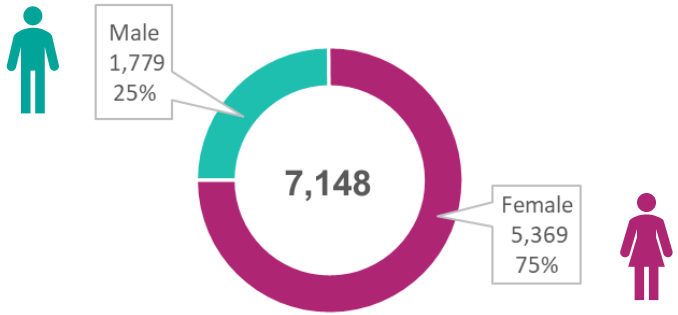


Pay Gap



Epsom and St Helier Hospital

Substantive Staff



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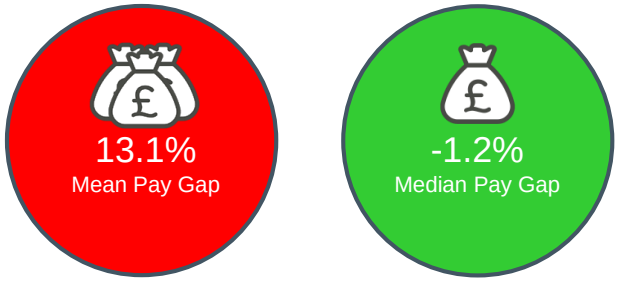


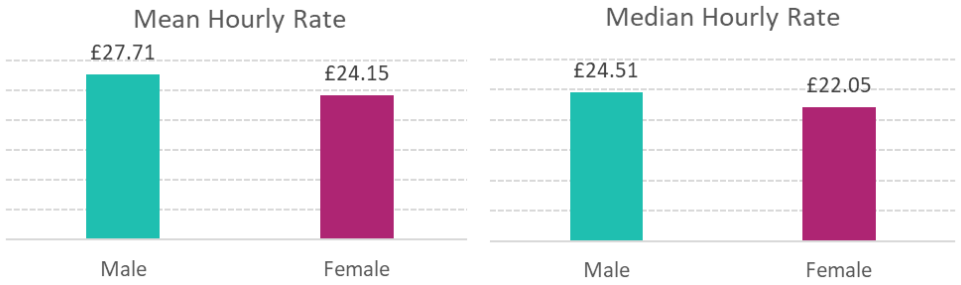
Gender Pay Gap

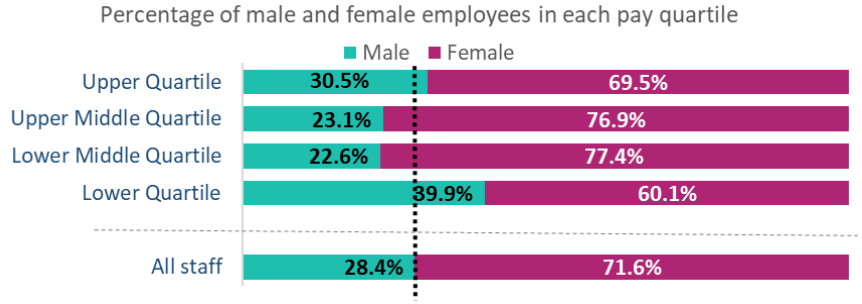
Basic Pay - Mean and Median Gap

Definitions of Pay Gap
The **mean pay gap** is the difference between the average pay of all male employees and the average pay of all female employees.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid

St George's University Hospital

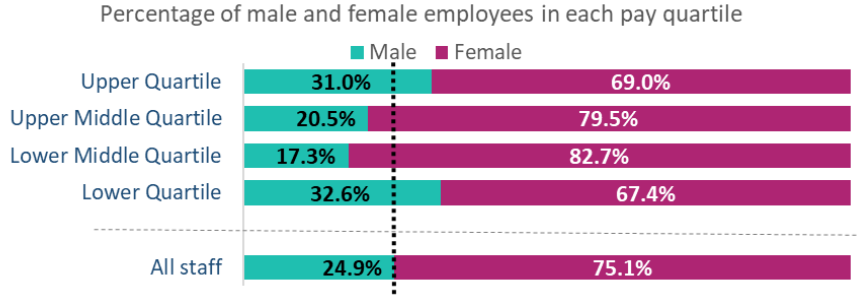




On 31st March 2023 St George's employed 9,927 staff – 7,109 were female and 2,818 were male. The mean hourly pay for males is £2.56 higher than that of females, which is a gap of **12.9%.** Male median pay is £2.46 higher than females, which is a gap of **10%.**

If Medical Staff were removed from STG's overall total, the gender pay gap would be 1.92% in favour of females.

Epsom and St Helier Hospital



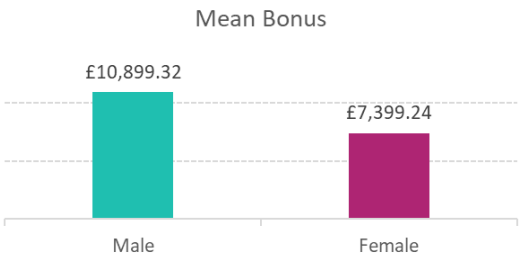
On 31st March 2023 Epsom and St Helier employed 7.148 staff – of those, 75% were female.

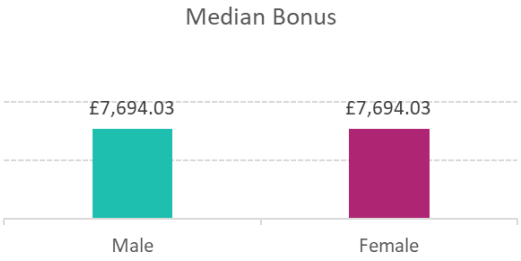
The mean hourly pay for males is £3.26 higher than that of females, which means on average male staff receive **13.1%** more than female staff**.** Male median pay is 24p lower than females, which is a gap of **-1.2%. This means that there are more male staff who are receiving significantly higher pay than the others (outliers).**

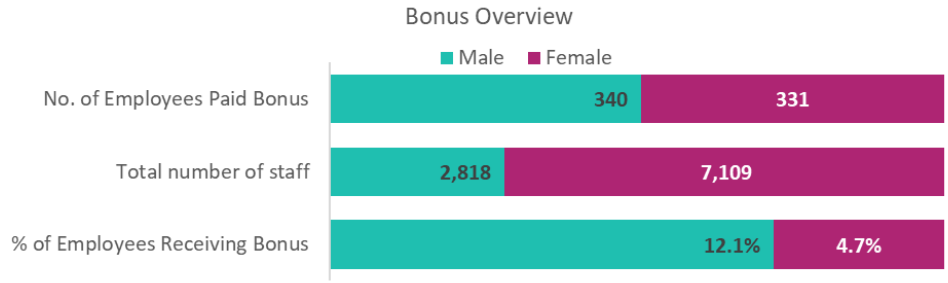
Gender Pay Gap

Bonus Pay - Mean and Median Gap

St George's University Hospital



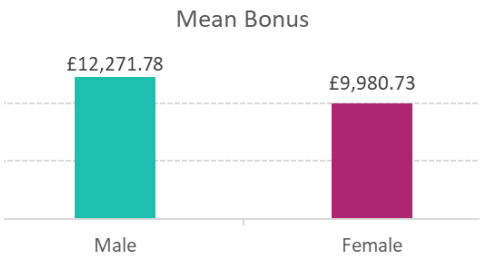


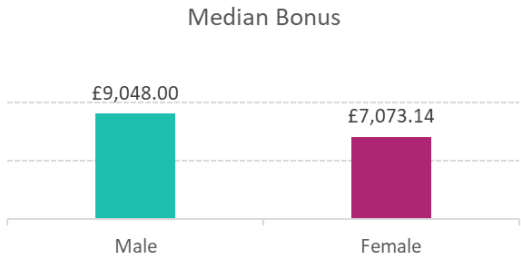


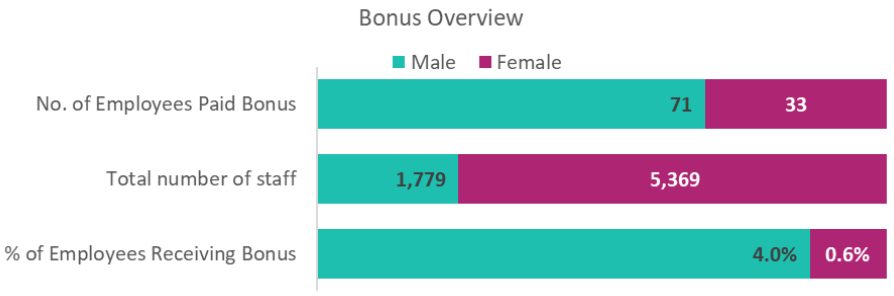
671 members of staff received a bonus this reporting period. On the 671, 331 were female, which is 5% of the female workforce and 340 were male, which is 12% of the male workforce. For LY, 177 members of staff received a bonus, which was 1% of the female workforce and 4% of the male workforce.

The mean bonus pay for males is £3,500.08 higher than that of females, which is a gap of **32.1%**. This reduced from a gap of £4,717.65 in 2022. Male and female median bonus pay was the same at £7694.03, so there is no pay gap.

Epsom and St Helier Hospital







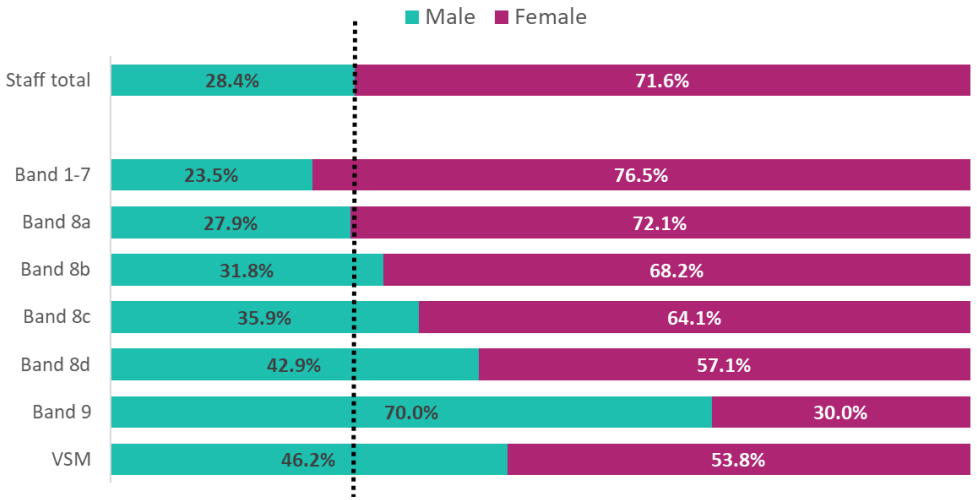
Bonus pay are mainly the CEA payments to consultants. In 2022/23, 104 members of staff received a bonus this reporting period (down from 107 previous year). Of those, 33 were female, which is 0.6% of the female workforce and 71 were male, which is 4% of the male workforce.

Mean pay gap is £2,291.05 (18.7%) and median pay gap is £1,974.86 (21.8%) both in favour of male staff.

Gender Pay Gap

Spotlight on Senior AFC Staff

St George's University Hospital



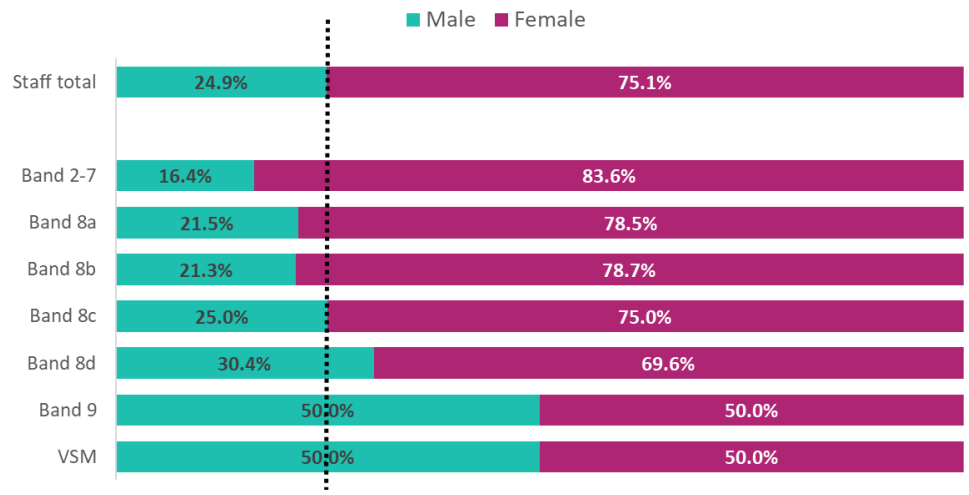
As an organisation, female staff make up 72% of the STG workforce. The workforce composition is representative at Bands 2, 3, 4, 8a and 8b.

There is an over representation of female staff at bands 5-7 (78-82%).

From Band 8c and above female representation reduces and we see a higher proportion of male staff. Female representation is lowest at Band 9 at 30%.

Male staff make up 28% of the STG workforce overall, the highest representation is 70% at Band 9, followed by 46% at VSM.

Epsom and St Helier Hospital



Female staff make up 75% of the ESTH workforce.

Through Bands 2 – Bands 8b we see an over representation of female staff, between 78% - 84%.

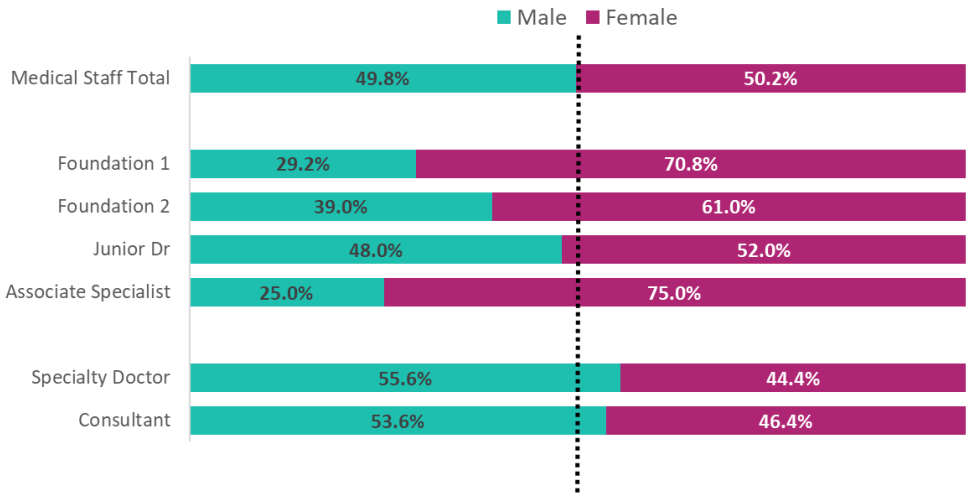
From Band 8d and above female representation starts dropping, and higher the banding the lower female representation.

Male staff make up 25% of the ESTH workforce overall but as much as 50% of the most senior AFC positions (Band 9 and VSM).

Gender Pay Gap

Spotlight on Medical Staff

St George's University Hospital

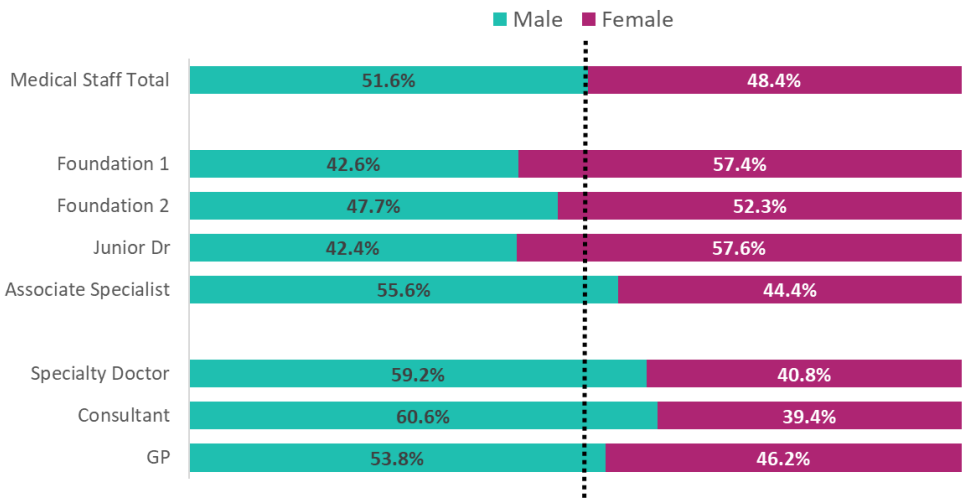


The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles and features the biggest gap in hourly pay, and as with previous years it is this pay gap that is the most significant. The pay gap for the Doctor in Training roles has decreased from 11.29% in 2021/22 to 7.21% in 2022/23.

The pay gap for Medical Staff, as a whole, is 8% (down from 9.83% last year) - males get paid on average £3.45p/h more than females. The proportion of male to female staff is 49.81% to 50.19%.

Male consultants were paid, on average, £2.21 p/h more than their female counterparts in 2022/23, this has decreased from £2.36 p/h in the previous reporting year (2021/22).

Epsom and St Helier Hospital



The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles and features a large gap in hourly pay, and as with previous years it is this pay gap that is the most significant. The pay gap for the Doctor in Training roles has decreased from 1.45% in 2021/22 to 0.62% in 2022/23.

The pay gap for Medical Staff, as a whole, is 10.88% (slightly up from 10.64% last year) - males get paid on average £4.48p/h more than females (an increase from £4.25p/h last year). The proportion of male to female staff is 51.59% to 48.41%.

Male consultants were paid, on average, £1.99 p/h more than their female counterparts in 2022/23, this has increased from £0.42 p/h in the previous reporting year (2021/22)..

Gender Pay Gap

Trend 2019 - 2023

St George's University Hospital

	2019	2020	2021	2022	2023	Line trend
Mean Pay Gap	14.83%	13.71%	14.83%	14.59%	12.86%	
Median Pay Gap	7.85%	9.49%	7.94%	9.51%	10.02%	
Mean Bonus Pay Gap	25.40%	29.23%	35.10%	34.17%	32.10%	
Median Bonus Pay Gap	36.11%	33.33%	33.33%	33.33%	0.00%	
% males getting bonus	4.83%	5.03%	4.57%	4.00%	12.07%	
% females getting bonus	1.15%	1.33%	1.07%	0.94%	4.66%	

- The mean pay gap reduced year on year since 2021, from 14.59% in 2022 to 12.86% in 2023
- The median pay gap has increased from 9.51% to 10.02%.
- The mean bonus gap has reduced year on year, from 34.17% to 32.10%.
- The median bonus gap remained static between 2020-22, reducing this year to 0%. This is due to an increase in CEA paid in 2023.
- The % of males and females receiving a bonus increased significantly in 2023 due to clearing overdue CEA from previous years.
- The % of males receiving bonuses in 2023 is significantly higher than females.

Epsom and St Helier Hospital

	2019	2020	2021	2022	2023	Trend
Mean Pay Gap	21.1%	19.5%	18.5%	14.3%	13.1%	
Median Pay Gap	12.8%	12.3%	10.4%	1.9%	-1.2%	
Mean Bonus Pay Gap	16.5%	15.2%	16.1%	21.6%	18.7%	
Median Bonus Pay Gap	0.0%	0.0%	0.0%	1.3%	21.8%	
% males getting bonus	4.8%	5.9%	5.3%	4.2%	4.0%	
% females getting bonus	0.8%	0.9%	0.7%	0.6%	0.6%	

- The mean pay gap has been reducing year on year
- The median pay gap has dropped in 2022 when a large group of locally paid facilities staff were transferred into the Trust.
- The mean bonus gap dropped in 2023 but still at 18.7%
- Significant increase in the median bonus gap indicates that the higher bonus pay for male staff is not restricted to a handful of outliers
- The number of Male staff being paid bonus is 6 times higher than female staff. Bonus pay has been decreasing in the last 4 years for both male and female.

(Note: historical data could have changed slightly from the previously published data due to validation, such as back dated pay awards and delay in national changes being applied).

Gender Pay Gap

Next Steps

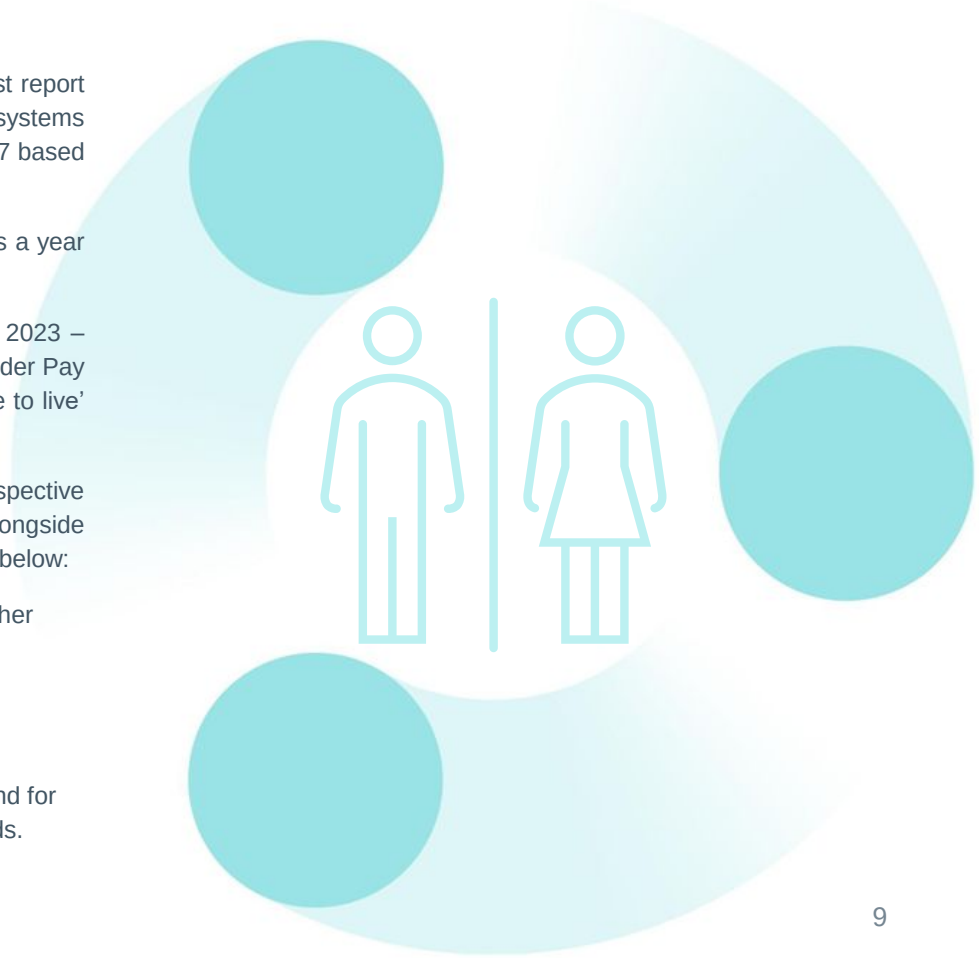
The requirement to produce a Gender Pay Gap report was introduced in March 2016, with the first report not due until the following year, March 2017. This was to allow time for organisations to implement systems to collect the required data on the GPG. Therefore, organisations published a report in March 2017 based on data for the period April 2015 through to March 2016.

This one-year lag has continued nationally and resulted in published reports looking at data that is a year old, and any findings and decisions about next steps may be outdated at the time of publishing.

This year, the GESH group will produce and publish our 2024 report - covering the period April 2023 – March 2024, in real time, shortly after the snapshot date of 31st March 2024. This will bring our Gender Pay reporting in line with the current financial year and ensure our actions are current and in response to live' findings.

Following 31st March 2023 and review of the current data, we will present the findings to our respective Women's Staff Networks and Chief Medical Officers Offices. These reports will be presented alongside NHSE's High Impact Action Plan which includes several actions relating to reducing pay gaps, see below:

- Implement the recommendations from the Mend the Gap review for medical staff and further develop a plan for implementation for senior non-medical staff
- Implement an effective flexible working policy to be utilised in recruitment campaigns
- Analyse available data on pay gaps and implement an improvement plan by protected characteristic. Plans for race and sex should be in place by 2024, for disability by 2025 and for other protected characteristics by 2026. This will be tracked and monitored by NHS boards.



Appendix: A
Calculating the Gender Pay Gap

To calculate the GPG we first determine the average hourly pay for all valid employees within the month of March 2020. For each employee the total pay - including basic salary, high cost allowance, any extra duties etc. – are totalled, and then divided by the number of hours worked that month. This gives an average hourly rate. Note: The figures in this appendix are an **example data** set to show the calculations, they are not the figures for a specific reporting period.

Calculating the '**mean**' (i.e. average) hourly pay for all male employees and all female employees:

- Total the average hourly pay for each gender and then divided this figure by the number of employees in each group.
- A sample of 14 employees is shown below to assist with understanding these calculations:

For each employee their total monthly pay for March is calculated and then divided by the hours worked to determine an average hourly pay.

To get the mean hourly pay for the two genders all the average hourly rates are added together and then divided by the number of employees (in this case, 7):

- Female: (11.87 + 12.14 + 13.85 + 16.73 + 22.52 + 23.97 + 25.7) / 7 = £18.11
- Male: (13.35 + 18.48 + 19.68 + 24.09 + 33.31 + 52.73 + 52.99) / 7 = £30.66

To calculate the Agenda for Change (AFC) staff only, medical staff must be removed before the calculation. In this example there are only male medical staff (indicated by an asterisk * in the table), and so for just agenda for change male staff the calculation is (13.35 + 18.48 + 19.68) / 3 = £17.17.

To get the mean pay gap the calculation is the difference between the male and female hourly rates divided by the male hourly rate:

- 30.66 – 18.11 = 12.55
- 12.55 / 30.66 = 0.4093, which is 40.93%

For AFC only the calculation would be:

- 17.17 – 18.11 = -0.94
- -0.94 / 17.17 = -0.055, which is -5.48%. A minus value indicates that the pay gap favours female.

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
	Receptionist	£3,341.00	£564.75		£3,905.75	162.95	£23.97
	Senior Staff Nurse - Critical Care	£3,105.58	£564.75	£518.03	£4,188.36	162.95	£25.70
Male	Theatre HCA	£1,585.00	£366.67	£224.34	£2,176.01	162.95	£13.35
	Staff Nurse - Acute Medicine	£2,509.33	£501.87	£55.27	£3,066.47	165.95	£18.48
	Anaesthetic Nurse	£2,509.33	£501.87	£235.53	£3,246.73	164.95	£19.68
	Specialty Registrar – Dermatology*	£4,006.25		£180.17	£4,186.42	173.81	£24.09
	Specialty Registrar - A&E*	£4,006.83		£1,782.90	£5,789.73	173.81	£33.31
	Consultant – Radiology*	£8,477.92		£685.84	£9,163.76	173.8	£52.73
	Consultant – Anaesthetics*	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Outstanding care every time

Appendix: A
Calculating the Gender Pay Gap

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Calculating the '**median**' (i.e. middle point) hourly pay for all male employees and all female employees:

- Rank the hourly pay rate of each employee, from smallest to largest, again separated by gender, and take the middle point hourly pay in the ranking. This is your 'median' value.
- In the given example the median hourly rate for both female and male staff is highlighted below:

The calculation for the pay gap remains the same:

- 24.09 – 16.73 = 7.36
- 7.36 / 24.09 = 0.3055, which is 30.55%

Excluding medical staff there is again no change in the female median value, but the median hourly rate for male staff is £18.48:

- 18.48 – 16.73 = 1.75
- 1.75 / 18.48 = 0.094, which is 9.47%

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
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	Consultant - Anaesthetics	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Outstanding care every time

Group Board

Meeting on Thursday, 02 May 2024

Agenda Item	5.2	
Report Title	**GESH Learning from Deaths Quarterly Report: Q2 (July - Sept) and Q3 (Oct – Dec) 2023/24**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Martine Meyer AMD for Quality, ESTH Rumiko Yonezawa Associate Director for Business Intelligence, ESTH Laura Rowe Lead Midwife for Clinical Governance and Risk ESTH Rebecca Suckling, Site CMO, ESTH Ashar Wadoodi, Learning from Deaths Lead, SGUH Kate Hutt, Head of Mortality Services, SGUH Rebecca Paulraj, Senior Business Manager, Medical Directorate, SGUH	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

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

Some key points to note from this Report are:

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

At ESTH:

- A high percentage of deaths (about 40%) continue to be scrutinised through Structured Judgment Reviews.
- Structured Judgment Reviews have highlighted the need to do further work on sepsis – ED overcrowding may be associated with delays in sepsis treatment. A number of steps are being taken to further explore and address this, and the impact of these will be included in the next Learning from Deaths Report (this is discussed in Section 3.1).

- There is an indication from Q3 that a disproportionate number of cardiac arrests may be occurring in ED, and again a concern that ED overcrowding may be contributing to this. Again, an update on this will be included in the next Report (this is discussed in Section 3.1).

At SGUH:

- Dr Foster data shows us – again – that mortality is higher than we would expect in Acute Myocardial Infarction. The Cardiology Care Group is highly engaged with their work to understand and improve this (previous LfD Reports to QCiC have described some of this work already) and updates will continue to be provided (this is discussed in Section 3.2).
- Dr Foster data also suggested higher than expected mortality in people with fractured neck of femur, and this Report describes the improvement work that has been done in response (this is discussed in Section 3.2).
- Mortality & Morbidity Meetings are well-supported, but (disappointingly) an audit showed that less than half these meetings are recording clear minutes and actions. The Site CMO has made it clear to the Care Group Leads and Governance Leads that this is not acceptable, and is overseeing a drive to achieve compliance with safety and learning requirements. An update will be provided in the next Report (this is discussed in Section 3.2).

Group-wide and national issues:

- The Learning from Deaths teams, along with bereavement services, are being brought together in Phase 1 of the Medical Directorate Corporate Restructure – the staff consultation opened on 03 April. The purpose of this is to spread best practice across the Group (e.g. SJRs at ESTH, support for M&Ms at SGUH) and to avoid duplication and unwarranted variation.
- The Medical Examiner system continues to work effectively in both our hospitals and the community setting, and the ME system will be established on a statutory basis on the 9th September 2024 – the implications and benefits of this change are described in Section 5.9

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

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

Appendices
Appendix 1: ESTH Mortality Overview
Appendix 2: ESTH To address QCiC Action Log 1.4 Oct 2023, Row 8

Appendix 3: SGUH LFD Dashboard

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships		☒ Right care, right place, right time		
☐ Affordable Services, fit for the future		☐ Empowered, engaged staff		
Risks				
Failure to achieve high standards in mortality governance presents a risk to the delivery of safe patient care.				
CQC Theme				
☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes		☐ People		
☐ Preventing ill health and reducing inequalities		☐ Leadership and capability		
☐ Finance and use of resources		☐ Local strategic priorities		
Financial implications				
Legal and / or Regulatory implications				
Learning from Deaths' framework is regulated by CQC and NHS Improvement and demands trust actions including publication and discussion of data at Board level.				
Equality, diversity and inclusion implications				
Analysis of the HSMR (Hospital standardised mortality ratio) by age, sex and ethnicity is possible at SGH using the Dr Foster platform. Of these three groups (i.e., selected by protected characteristic), there are none in which mortality is higher than expected compared to the overall mortality. The new medical certificate of cause of death (MCCD) will now include mandatory reporting on ethnicity which will support improved data collection.				
Environmental sustainability implications				
None Identified.				

GESH Joint Learning from Deaths Quarterly Report
Q2 (July – September 2023) and Q3 (October – December 2023)

1.0 PURPOSE

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

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

2.0 NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

ESTH

2.1 There have been 287 in-patient deaths in the period July – September 2023 and 361 in October – December 2023.

Q2 (2023/24)	287
Q3 (2023/24)	361

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS England]

SHMI data for the rolling 12-month period from August 2022 to July 2023 was '*higher than expected*' at a value of 1.20 in Q2. The latest overall mortality for 12-month rolling SHMI covering discharges from January 2023 to December 2023 is 1.13 and remains '*higher than expected*'.

As described in previous reports, Epsom & St. Helier University Hospitals NHS Trust was in a pilot of 10 trusts for removal of the Same Day Emergency Care (SDEC) data from the Admitted Patient Care (APC) dataset and moving it to the Emergency Care Data Set (ECDS) – this change in recording is recognised to have an impact on SHMI. There has been an expectation that all Trusts across England move to this way of recording from April 2024. There will be a delay to any impact of this England-wide change in recording on SHMI due to the time needed for the national data analysis. There has been higher than expected mortality in patients coded as having urinary tract infection, and in patients coded as having acute bronchitis, which has reduced to 'as expected' in Q3. Secondary Malignancy is 'higher than expected' in Q3. There will be a review of the cases that have been coded under these diagnostic groups which will be presented to the Reducing Avoidable Death and Harm (RADAH) meeting so that any appropriate next steps can be identified.

An external coding review found that there needs to be improvement in the quality of coding which requires support from both coding and clinicians.

SHMI for 10 diagnostic group for Q2 and Q3

Diagnosis group description	SHMI value (Q2)	SHMI Value (Q3)	Banding
Septicaemia (except in labour), Shock	1.16	1.12	As expected
Cancer of bronchus; lung	1.33	1.38	As expected
Secondary malignancies	1.45	**1.78**	Q2 – As expected Q3 – Higher than expected
Fluid and electrolyte disorders	1.78	1.59	Q2 – Higher than expected Q3 – As expected
Acute myocardial infarction	0.64	0.81	As expected
Pneumonia (excluding TB/STD)	1.12	1.18	As expected
Acute bronchitis	1.69	1.71	Q2 – Higher than expected Q3 - As expected
Gastrointestinal haemorrhage	1.31	1.37	As expected
Urinary tract infections	1.43	1.30	Q2 – Higher than expected Q3 As expected
Fracture of neck of femur (hip)	0.84	0.83	As expected

**Data published in NHSE SHMI report. Accessible here. bit.ly/shmi-vis-nov22oct23*
Review of mortality analysis at diagnosis and procedure group level is considered at the Mortality Reviewer meeting which reports to the Reducing Avoidable Deaths and Harm Group (RADAH).

2.3 Hospital Standardised Mortality Ratio (HSMR)

[source: Healthcare Evaluation Data (HED)]

The HSMR for the most recent 12-month rolling period spanning from January 2023 to December 2023 is 105.87 and is higher than expected. The HSMR includes individuals with a palliative care outcome. The monthly HSMR has been improving but this may reflect common cause variation in this case as the data is increasing in December (see appendices) although the difference between expected and observed deaths has improved in comparison to 2024.

The elevated national mortality rates form part of the mortality vigilance. The engagement the Medical Examiner's office is vital to support identification of quality concerns from Medical Examiners and families. Whilst a high percentage of deaths are reviewed using SJRs at ESTH, the Medical Examiner input will continue to help us

understand quality of care and identify avoidable deaths, avoidable harm and areas requiring improvement.

Data for Q2 (based on Oct 2022 – Sept 2023) and Q3 (based on Jan 2023 – Dec 2023)

	Q2 HSMR	Q3 HSMR
All admission methods	109.35 Higher than expected	106.07 Higher than expected
Elective admissions	82.36 Lower than expected	84.39 Lower than expected
Non elective admissions	109.75 Higher than expected	106.44 Higher than expected

SGUH

2.4 Deaths at SGUH in Q2 & Q3 2023/24

Q2 (2023/24)	324
Q3 (2023/24)	413

2.5 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
The latest SHMI data covers discharges from October 2022 to September 2023, and at 0.94 our mortality is as expected. This period covers 62,705 spells, with 1,625 deaths observed against an expected 1,725.

Diagnosis group	SHMI value (Q2)	SHMI value (Q3)	Banding
Septicaemia (except in labour), Shock	0.90	0.89	As expected
Cancer of bronchus; lung	0.70	0.75	Q2 - Lower than expected Q3 - As expected
Secondary malignancies	0.81	1.00	As expected
Fluid and electrolyte disorders	0.84	0.77	As expected
Acute myocardial infarction	1.37	1.35	Higher than expected
Pneumonia (excluding TB/STD)	0.89	0.86	As expected
Acute bronchitis	*	*	*
Gastrointestinal haemorrhage	0.75	0.86	As expected
Urinary tract infections	1.28	1.29	As expected
Fracture of neck of femur (hip)	1.62	1.31	As expected

* value not given due to small numbers

2.6 **Hospital Standardised Mortality Ratio (HSMR)** [source: Dr Foster]
The most recent Dr Foster data covers discharges between November 2022 and October 2023. For this period our mortality is lower than expected at 90.2.

	Value (Q2)	Value (Q3)	Banding
HSMR	89.0	90.2	Lower than expected
HSMR weekday emergency admission	85.9	87.4	Lower than expected
HSMR weekend emergency admission	91.4	91.3	As expected

3.0 LEARNING FROM DEATHS OBJECTIVES

ESTH

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

Review of SJR with major/moderate concerns 2022-23:
Thematic review of 38 SJRs with at least one major or moderate concern were reviewed out of the 497 SJRs were undertaken in Q1-4 in 2022-23. The themes identified were communication (7/38), resuscitation (3/38), lack of senior decision-making (3/38), sepsis management (4/38) and inappropriate discharge prior to the patient's final admission (3/38). These have been picked up as themes for further investigation.

Table 1. Priority Work Streams and Signals (ESTH)

Workstream	Priority area	Key updates
Mortality Data	**Raised SHMI**	**Acute Bronchitis Code** Clinicians and Medical Examiners are not using a diagnosis of Acute Bronchitis, but Coders are using this code when they are unable to code more accurately. The use of this code continues to be high and although no longer 'higher than expected' there needs to be further reduction of its use. **Action:** The coding meetings in Acute medicine have not continued due to winter pressures and industrial action reducing the ability of clinicians to find appropriate time. This will be reviewed by the division to ensure that they are reprioritised.

		Secondary Malignancies: A sample of Secondary Malignancy deaths will be subjected to a deep dive to review accuracy of diagnosis, coding and review care delivery. The findings will be presented to RADAH in May 2024.
Learning from Structured Judgement Reviews	**1. Joint working with nursing increase opportunity for learning.**	**Infrastructure:** There are now 2 nurses who undertake reviews on nursing issues within an SJR when appropriate, supported by the lead mortality reviewer. The consultant mortality reviewers and Medical Examiners refer to nurses where they find cause for nursing concern. **Governance:** Supervision from lead mortality reviewer and members of the mortality review group. **Development: To continue to identify nursing and other health professions to increase the MDT approach to mortality review.** .
	2. New anaphylaxis guidelines not followed in Resuscitation	Anaphylaxis module now part of Statutory and Mandatory eLearning (Q2) as part of the Basic Life Support Training.
	3. Sepsis not identified or delayed provision of antibiotics	Sepsis Audit in Q3 showed reduced number of sepsis screening and assessments. In addition there were delays in delivery of antibiotics. The increase in volume of patients remaining in ED after the decision to admit led to delays in antibiotic delivery. Despite these pressures, the majority of unwell patients were escalated appropriately. **Actions:** ED working to pilot the introduction of REDS score. There will be recruitment to the position of Clinical Lead for Sepsis to support the implementation of new NICE guidelines. Further support in ED including additional iv trained nursing staff and increased pharmacy support.
	4. Inappropriate discharge prior	The Trust has reviewed of all patients readmitted within 7 days of discharge between April-June

	to final admission	2023, some of whom then died as in-patients. Initial results highlighted that there was increased risk of death after readmission in those patients who were discharged home or self-discharged against medical advice rather than patients discharged to care homes. **Action:** Previous admission needs to be considered and analysed with the current admission, given that SJR reviews only cover the re-admission. This has been agreed as part of the Clinical Audit Programme for 2024-25
	5. Nursing and medical note-keeping proformas	Development: MR team noting improved quality of clinical content and consistency of use of proformas
	6. Electrolyte balance management	A Working Group (WG) led by a Consultant Biochemist is developing guidance for hypernatraemia. and the medical examiners notify the working group lead of any identified cases of hypo/hypernatraemia to support the improvement program.
	7. Working with the Medical Examiner team to identify quality concerns	The Mortality Reviewers have presented the outline of the Medical Examiner service and mortality review system at Quality Meetings to Critical Care, Anaesthesia, General Medicine and Urology in quarter 3
Resuscitation Team	**Cardiac Arrest Outlier (outlier of cardiac arrests)** **Q1, Q2 and Q3 Data*** *Data for Q3 includes data from 1st April 2023 to 31st December 2023	All unexpected Cardiac Arrests have an SJR. Data for Q3 includes data from 1st April 2023 to 31st December 2023. There has been a reduction in the total number of the cardiac arrests and number of CA on the wards in the Trust between Q3 22-23 an Q3 23-24 but the rates are still higher than similar organisations. The outcomes of resuscitation have improved with increased survival. **NCAA cumulative data for ESTH: Q3 (2022-24) vs. Q3 (2023-24)**

	Q3 2022-23		Q3 2023-24
Total admissions	59425		61664
Total cardiac arrests (CA)	88	↓	67
CA/1000 admissions	1.42	↓	1.09
Ward CA	40	↓	24
Ward CA/1000 admissions	0.67	↓	0.39
ROSC > 20min achieved *(from all CA)*	44.6	↑	53.8%
Survival to discharge *(from all CA)*	14.5	↑	30.8

Q3: Cardiac Arrests in Patients 75+

ESTH: 50.8%
Similar hospitals: 43.1%
All hospitals: 44.0%

ESTH resuscitates more people over 75 than similar hospitals and nationally. This indicates that further work with appropriate resource needs to occur on decisions relating to escalation, resuscitation and completing related documentation. The introduction of 24/7 Nurse Led Critical Care Outreach at both sites will support this work.

Cardiac Arrests within ED Footprint
In Q3 47.8% of Trust cardiac arrests occurred within the ED footprint (including SDEC areas). These are all counted as in-hospital cardiac arrests and not out of hospital cardiac arrests. This is compared to 26.5% from similar hospitals and has increased from 36.4% in Q3 of 22-23 compared to 24.8% at similar Trusts. This increase is being reviewed through case reviews and may be due increased number of patients cared for in ED, longer length of stay in ED

<table>
<tr>
<td></td>
<td></td>
<td>including after decision to admit and reduced monitoring of patients in ED due to department crowding.

Percentage of all in hospital cardiac arrest occurring within the ED footprint Q3 22-23v Q3 23-24

<table>
<tr><td></td><td>Q3 22-23</td><td>Q3 23-24</td></tr>
<tr><td>Our Trust</td><td>36.4%</td><td>47.8%</td></tr>
<tr><td>Similar Hospitals</td><td>24.8%</td><td>26.5%</td></tr>
</table>

Action: Q3: A retrospective audit of patients who died in an ED location (including patients for whom a decision to admit (DTA) had been made) from March to August 2023 is being analysed to look for potential contributing factors including length of stay in ED, clinical team review and timing of senior review and escalation plans. in Q4. This will be presented to RADAH and the actions will be overseen at the medicine divisional quality meeting and reported through the quality report to PSQC. In addition there is a prospective cardiac arrest audit of patients in ED looking at similar themes.</td>
</tr>
<tr>
<td></td>
<td>Surgical Pathway</td>
<td>Transfer of surgical patients from Epsom Hospital to St Helier Hospital for surgical review has in the past led to harm and treatment delay resulting in death, leading to important changes.

Governance: The pathway for surgical referrals from the Royal Marsden Hospital has been improved to ensure that referrals are directed to the St Helier Surgical Department.

An updated SOP for surgical review of patients presenting to the Epsom ED is now in place and its effectiveness is being audited by the Planned Care Division.</td>
</tr>
<tr>
<td>Respiratory Team</td>
<td>Management of Chest Drains</td>
<td>Management of chest drains is not consistent, and delays to chest drain insertion on wards and in ED have been noted. Q3: Training for ED team is being provided by the respiratory team. Guidelines for chest drains are being updated</td>
</tr>
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SGUH

3.2 The Mortality Monitoring Group aims to create an environment where sharing learning becomes routine. This is supported through the learning from deaths model of SJR review, but the M&M review teams have further work to do to improve meeting outputs and learning. Our processes are monitored and ratified through MMG which is chaired by the Site Chief Medical Officer.

Table 2: Priority Work Streams and Signals

Workstream	Priority area	Key updates
Mortality investigations	**Cardiology diagnosis and procedure groups, principally Acute myocardial infarction**	**Benchmarking** Dr Foster has now provided more focused analysis of the AMI data with other Heart Attack Centres (HACs) to allow us to better understand the persistent signal. This has been discussed at the cardiology governance meeting, attended by the LfD lead and Site CMO. **Outcome of Dr Foster Deep Dive** When analysed further it is clear that London HACs overall have higher mortality than other UK HACs. SGH ranks 4/5 for HAC mortality in London, after King's College Hospital. Comorbidity and deprivation do not seem to be any worse at SGH than the other five London HACs. The mortality signal primarily arises from acute myocardial infarction, mainly NSTEMI. Procedure related mortality is also divergent. The cause of this is unclear and is being looked at in more detail by the clinical team, focusing on the areas that are known to improve outcomes. It will continue to be monitored and discussed within the cardiology governance meeting. The clinical team has been asked to formulate a plan to develop understanding better focussing on pathway review. Progress will be monitored by MMG.
	Hip Fracture Mortality	In the first half of the year, we observed a signal suggesting higher than expected mortality in the fractured neck of femur diagnosis group. Clinical coding of the patient group was audited and showed a high degree of accuracy. 96.5% of primary diagnoses and 98.7% of secondary diagnoses were correct. Coding of primary procedures was correct in over 90% of cases. Although the quality of coding was high and did not account for the alert it was agreed that improvements could be made, particularly around

		procedures, and validation processes have been established. Additionally, the clinical team looked at data submitted to the National Hip Fracture Database (NHFD). Opportunities for improvement were identified and data completeness has significantly improved as a result of improved processes and clinician validation. The clinical team focused their investigation on the treatment pathway, looking at key performance indicators, such as prompt specialist review, prompt surgery and best practice treatment post operatively. Performance is now above our major trauma London peers for many of the best practice measures. The clinical team routinely review the data, provide feedback to clinicians and challenge practice that appears to be outside the expected pathway. Our mortality has reduced and in the second half of the year is as expected, when measured by SHMI, and better than then national average as measured by the NHFD.
	30-day mortality after systemic-anti-cancer therapy (SACT)	In February NHS England published case-mix adjusted 30-day mortality post-SACT for prostate cancer and renal cell carcinoma for 2020-2022 and 2019-2022 respectively. This showed that mortality for both tumour groups is in line with expected levels. There is a schedule of reporting for each tumour type over the year. MMG invited the Medical Oncology team to provide an overview of this programme of mortality analysis and reporting and how the service use this data for governance and assurance. Looking at deaths within 30 days of chemotherapy supports clinical teams to evaluate treatment decisions, which must balance the risk of treatment against the potential benefits. For each tumour type there is an estimate of expected mortality and if our rate exceeds that it is essential that data is reviewed. An example was shared of a previous publication that indicated that we were an outlier. Careful review of existing M&M reviews, which are conducted for each patient, provided assurance that the issue was due to data rather than clinical care. It was discovered that our electronic system was not properly recording performance status, which is a measure of how well a patient is, negatively impacting our case-mix adjusted mortality. This has since been resolved so that our data is now representative of the patients that we treat.

		The data review exercise highlighted to the service the importance of their M&M activity and of accurate clinical coding. The oncology team have a long established, robust M&M process and has fully implemented the Trust's core data set and terms of reference for M&M meetings. The service's approach to mortality review is considered an exemplar of best practice, which supports the management, use, understanding and validation of data both internally and externally.
Mortality and Morbidity team activity	A recent audit of M&M quality has taken place. Of 53 clinical services, 47 are now supported by the M&M team (inc from 39). The team are working with the remaining 6 services to build in central support. 20% of M&Ms were cancelled in the audit period. Reasons are currently unknown and will be audited in the next cycle. We note the sustained impact of industrial action and operational pressures this year. Less than 50% of meetings record clear minutes and actions. This will be a key area of focus in the next quarter. We have defined the priorities for 2024/25 as: • To ensure common outputs from meetings to use the central function to better understand the quality of M&Ms across the organisation. • Share best practice across M&Ms. • Ensure joint meetings where necessary. • Ensure that there is a structured process to discuss the right patients at M&Ms. • Ensure people attend and all meetings are minuted, with copies of these minutes circulated and retrievable if needed, while supporting the accountability for acting on decisions made at M&Ms by establishing a formal monitoring process.	
Special focus cases	In Q2, we reviewed all deaths that occurred in the Emergency Department (ED). Twenty-six deaths were examined. In 88% of cases admission and initial management was either good or excellent. End of life care and overall care were assessed as either good or excellent in 69% and 73% respectively. No poor or very poor care was observed in any phase of care. None of the deaths were felt to be due to problems in healthcare. We are now looking at deaths following a wait in ED of over 8 hours for admission. To understand possible logistical consequences of admission delays we are focusing our deep dive on general surgical, vascular and orthopaedic admissions, where there is most likely an intervention that may be delayed due to lack of inpatient beds. This work remains in process.	

4.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

ESTH

4.1 Mortality Review Team

SJRs act as a secondary screening tool rather than a detailed investigation.

Reviews are performed on all cases in cases of:

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

During this quarter, independent reviews using the structured judgement review (SJR), have been completed for 131 deaths in Q2 and 167 in Q3, which represent 40.06% and 40.05% of all deaths respectively. The percentage of overall 'poor/very poor' assessments was 6.87% in Q2 and 3.59% in Q3. The percentage of overall `good/excellent' assessments was 52.27% in Q2 and 65.27% in Q3 out of the rated SJRs.

Quarter 2

Overall care Judgement	Number	Percentage
Excellent care	9	6.87%
Good care	60	45.80%
Adequate care	53	40.46%
Poor care	8	6.11%
Very poor care	1	0.76%
Awaiting rating	0	0%

Total: 131 (100%)

Quarter 3

Overall care Judgement	Number	Percentage
Excellent care	9	5.39%
Good care	100	59.88%
Adequate care	52	31.14%
Poor care	6	3.59%
Very poor care	0	0%
Awaiting rating	0	0%

Total: 167 (100%)

Any concerns identified through the SJR process are assessed as minor, moderate or major. Major concerns are automatically reported through the clinical reporting system (DATIX) by the Mortality Reviewer and where appropriate a Rapid Review Report is recommended. Mortality Reviewers also liaise directly with the responsible consultant for cases where they recommend learning for improvement to be discussed at the relevant specialty-based mortality and morbidity meetings. They provide positive feedback to consultants where there is excellent care.
All SJRs assessed as overall 'poor' or 'very poor' care have a second SJR by another consultant Mortality Reviewer (MR). All overall poor care SJRs were reported (DATIX IDs 2546, 2608, 2617, 2724, 2178, 2677,2775, 2810, 2819, 2837, 2884, 2881, 2931, 3109, 3167)

4.2 **Learning from excellence**

In Q2/3 the following areas were identified by the Mortality Review Team and fed back to individual teams and Divisions:

- The Renal team providing excellent care
- Respiratory team providing good leadership.
- Orthogeriatric team provide consistently good care and management of patients
- AHP teams including physiotherapy, OT, stoma nurses, dietitians, SALT and Tissue Viability Nursing provide excellent advice and detailed documentation.

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

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

The Learning from Deaths teams, along with bereavement services, are being brought together in Phase 1 of the Medical Directorate Corporate Restructure – the staff consultation opened on 03 April. The purpose of this is to spread best practice across the Group (e.g. SJRs at ESTH, support for M&Ms at SGUH) and to avoid duplication and unwarranted variation.

4.4 **Perinatal Mortality:**

The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the quarterly Perinatal Mortality Review Tool reports. In addition to summarising compliance with the safety standard, each report also detailed potential areas for learning and improvement. Over the year there were no clear themes identified.
There was 1 Neonatal and 4 Stillbirths during Q2 and 1 Neonatal and 4 Stillbirth deaths during Q3. Stillbirth and neonatal deaths are reviewed through MBRRACE-UK and reported separately to the Board. All child deaths are reviewed locally by clinical teams and presented at the monthly paediatric Divisional Management Team meeting.

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

There are regular meetings and good communication between St George's and Epsom & St Helier about patients who died either at Epsom & St Helier or St George's but have recently visited the other hospital within the group. Going forward a joint policy will be developed to ensure that all cases where there has been a death of a patient who has crossed both sites within 30 days will be notified to the respective site for local learning.

SGUH

4.6 **Mortality Review Team**

The Mortality Review Team are committed to increasing the proportion and range of deaths reviewed. As the deaths that fall into the categories defined by the Learning from Deaths policy, which is based on the National Quality Board's framework, is consistently below 10 per cent it has been agreed by MMG that each quarter an area of focus will be identified, triangulating with other concerns or areas of focus across the organisation, and those deaths will be selected for review to support enhanced learning.

As detailed in section 3.2 of this report, in Q2 the team reviewed all deaths in ED and in Q3 the focus has been deaths of patients admitted to certain surgical specialties following a wait in ED of over 8 hours. This work will cover the whole of 2023/24 and will be reported following the end of Q4, although if any urgent issues are identified these will be addressed immediately and will be detailed in this report.

In Q2 SJRs, were completed for 59 deaths, which represents 18.2% of all deaths. 32 were referred by the Medical Examiner Office and 27 from other sources. In Q3 the need for SJRs was identified for 45 patients, representing 10.9% of all deaths. 37 of these were referred by the Medical Examiner Office.

The reasons for requesting a review are summarised below. It should be noted that a death may trigger a review for multiple reasons and, therefore, the total number of triggers is greater than the number of reviews. It should be noted that of the 9 LD deaths in Q3, 1 patient had a diagnosis of autism and 4 were paediatric patients.

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

Triggers for SJR

Triggers for review	Q2	Q3
Confirmed learning disability +/- clinical diagnosis of autism	2	9
Significant mental health diagnosis	14	16
ME or clinical team detected possible learning or potential issue with care	5	5
Deaths following elective admission	8	9
Areas subject to enhanced oversight	4	10
Family raised significant concerns	2	0
Safeguarding queries		1
Deaths in ED	26	0

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. In Q2 of the 59 deaths reviewed this quarter problems were identified in relation to 11 (18.6% of the patients reviewed). In total there were 13 problems, as 2 patients experienced more than 1 problem. Most of these problems did not lead to harm.

Of the 45 deaths reviewed in Q3 problems were identified in relation to 15 (33.3% of the patients reviewed). In total there were 19 problems, as 3 patients experienced more than 1 problem.

Although in most instances these problems did not lead to harm, it is a higher rate than typically observed and so has been examined in more detail by the Lead for Learning from Deaths. Although there was a variety of reasons for concerns raised, three cases shared concerns in relation to consent. In one case this was based around the quality of consent as the patient ultimately died and in two cases there was concern about the capacity of patients to fully comprehend the risks that they were taking. This issue has been discussed at MMG previously and informs the ongoing work with the Trust consent lead on improving quality of consent across the Trust.

Table 3: Problems in healthcare identified.

Problem in healthcare	No harm		Possible harm		Harm		TOTAL	
	Q2	Q3	Q2	Q3	Q2	Q3	Q2	Q3
Assessment	0	0	1	1	0	0	1	1
Medication	1	1	0	0	0	0	1	1
Treatment	0	3	2	1	0	0	2	4
Infection control	1	0	0	0	0	0	1	0
Procedure	1	2	1	3	1	1	3	6
Monitoring	0	1	1	0	0	0	1	1
Resuscitation	0	1	0	0	0	0	0	1
Communication	2	3	0	1	0	0	2	4
Other	1	0	1	1	0	0	2	1
Total	6	11	6	7	0	1	**13**	**19**

For the majority of deaths reviewed overall care was adequate, good, or excellent. In Q2 there was one death where care was deemed to be poor. In this case the clinical team reported the incident through Datix (ref DW194149). The reviewer and clinical team identified issues with

timely review of results and clinical assessment. This has now undergone a rapid review with discussion at SIDM and has been declared an SI (STEIS 2023 17735). In Q2 there were no cases where the death was judged to be more than likely avoidable.

In Q3 overall care was adequate, good, or excellent for most cases reviewed. However, one review revealed care that was deemed to be poor and the death was judged to be probably avoidable and there was one death where the reviewer judged there to be strong evidence of avoidability. Both deaths are being investigated through the patient safety incident process and are briefly outlined below.

Datix reference	Status
DW200431	Concerns raised about the delayed placement of chest drain within ED. This case has been discussed at the Trauma and ED M&M meetings, as well as being referred to SIDM.
DW202019	Death following induction of anaesthesia. This is a Coronial case.

Overall care rating

Overall care judgement	Q2		Q3	
	Number	Percentage	Number	Percentage
Excellent care	6	10.2	4	8.9
Good care	41	69.5	33	73.3
Adequate care	11	18.6	7	15.6
Poor care	1	1.7	1	2.2
Very poor care	0	0	0	0
Total	**59**		**45**	

Judgement on avoidability of death is made for all reviews

Avoidability of death judgement	Q2		Q3	
	Number	Percentage	Number	Percentage
Definitely not avoidable	51	86.4	33	73.3
Slight evidence of avoidability	6	10.2	6	13.3
Possibly avoidable but not very likely (less than 50:50)	1	1.7	4	8.9
Probably avoidable (more than 50:50)	0	0	1	2.2
Strong evidence of avoidability	0	0	1	2.2
Definitely avoidable	0	0	0	
Unable to score as death not in hospital	1	1.7		
Total	**59**		**45**	

4.7 **Review processes and cross-site working**

In order to further validate the review process, we are now sharing cases with ESTH to better understand differences in thresholds for care being described as adequate or poor. The Learning from Deaths Lead and Head of Mortality Services continue to meet regularly with the ESTH Learning from Deaths team and have shared our approach to examining the impact of ED waits.

The informal reviewer meetings at St George's now include opportunities for reviewers to discuss any cases where the care has been less than optimal, or the death is judged to be anything other than definitely not avoidable.

We continue to provide reviews to the Patient Safety Team for cases which have been reported locally outside of the learning from deaths process and now receive notification of all deaths discussed at SIDM to triangulate learning.

5.0 MEDICAL EXAMINER SERVICE

ESTH

5.1 Sutton & Epsom (S&E) Medical Examiner (ME) service is hosted by Epsom & St Helier Hospitals (ESTH). The service is funded centrally by the NHS and is independent of the Trust. All ME services report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each quarter all ME services are required to make a return directly to the office of the National ME. The Sutton and Epsom Medical Examiner service has met all the key requirements reviewing 100% (Q2/322 & Q3/413) of all Adult and Paediatric Deaths in the Trust. The ME service is not required to review cases where the death has been recorded as a Stillbirth. [See Table in section 5.5]**.

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

5.3 The medical examiners service works closely with the mortality reviewers to identify individual cases where referral for mortality review is indicated. The number of deaths referred for an SJR by the ME service was 50/Q2 and 63/Q3. Of these, 16/113 (Q2/7, Q3/9) were for review of on-ward cardiac arrests and 12/113 (Q2/4, Q3/8) were for COVID-related deaths. This number has steadily reduced following the significant reduction in COVID cases, the changes in working practices following action provided from previous SJR reviews plus the proportionate scrutiny undertaken by the MEs where the understanding and accuracy of review is now greater.

5.4 In addition to flagging areas where there are potential concerns, the Medical Examiner (ME) service highlights cases where best practice was observed. Positive feedback is shared with the Patient Experience team, Ward teams and individuals on a regular basis.

5.5 The Epsom & St Helier ME service has expanded review of deaths to the community setting. This will be a statutory requirement from 9th September 2024. The Community ME service is now fully established for the Sutton PCN with all 23 practices and the assigned hospice reporting to the service. The service also supports 11 Surrey GP practices; 7 are already on-board. The remaining 4 (Integrated Care Partnership Group of 4 practices) are now engaging with the Medical Examiner Team with training provided. Sutton and Epsom Medical Examiner service has since inception had Primary Care Doctors as medical examiners and this has supported the provision to the wider community. The number of Community deaths scrutinised was 181/Q2 (141 Q1) and 208/Q3

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

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN REVIEWED BY THE ME Q2 & Q3 (2023-24)		
	Q2	**Q3**
Number of in-hospital deaths reviewed (in-patient **and** ED)	**322****	**412**
Adult deaths		
Cases not notified to the Coroner and MCCD issued directly	267	350
Cases notified to the Coroner and MCCD issued following agreement by Coroner	27	24
Cases referred to the Coroner and taken for investigation	25	37
Child deaths		
Cases not notified to the Coroner and MCCD issued directly	0	0
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0	0
Cases referred to the Coroner and taken for investigation (including ED)	3	1
Timeliness and rejections by registration service		
Number of MCCDs not completed within 3 calendar days (NB: no account is taken of BH or weekend and requirement is 5 days)	53	91
Number of MCCDs rejected by registrar after ME scrutiny	0	0
Number of cases where urgent release of body is requested and achieved within requested time	7	12
Number of cases where urgent release of body is requested and NOT achieved within requested time	0	0
Achieving communication with the bereaved		
Number of deaths in which communication did not take place		
Reasons for no communication: Declined	0	0
No response	1	3
No NOK	2	5
Not documented	0	0

Detection of issues and actions		
ME referred for structured judgement review (including COVID related deaths and on-ward cardiac arrests)	50	63
ME referred to other clinical governance processes (including safeguarding, nursing issues)	0	0
ME referred to external organisation for review (including GP practices, LAS)	1	0
Families referred to PALS	1	0

Triggers for SJR by ME service

Triggers for review:	Q2	Q3
Confirmed learning disability +/- clinical diagnosis of autism	8	8
Bereaved raised concerns	5	7
ME or clinical team detected possible learning or potential issue with care	19	14
Unexpected death e.g. following elective admission	1	1
Maternal or neonatal death	0	0
Areas subject to enhanced oversight (learning will inform quality improvement work)	6	15
Provider learning/improvement where there is an unexpected cardiac arrest (OWCA)	7	9
Provider learning/improvement with COVID judged to be likely nosocomial (Covid Infections)	4	8
Death linked to a service specialty/specific diagnosis	0	0

SGUH

MERTON & WANDSWORTH MEDICAL EXAMINER SERVICE

5.6 Merton & Wandsworth (M&W) Medical Examiner (ME) service is hosted by St George's and funded centrally by the NHS and is independent of the Trust. All ME offices report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each quarter all ME offices are required to make a return directly to the office of the National ME. The M&W ME service met all the required KPIs and milestones, scrutinising the deaths that occurred at SGH over Q2 & Q3 2023/24.

Q2 (2023/24)	All 324 deaths
Q3 (2023/24)	412 of 413 deaths

5.7 The ME service continues to work proactively with community providers to scrutinise non-coronial deaths which occur outside of the acute setting. This quarter we received 172 referrals from a total of 39 providers. The service has contacted all practices to

either seek feedback, to reinforce the benefits of the service, or to encourage onboarding before the system becomes statutory. There are three providers that have not engaged at all, and the Integrated Care Board are working alongside the service to make clear the requirement.

5.8 The service continues to work on implementation of the out of hours service that was approved by the National ME in the previous quarter. The principal driver of this extended service is to support requests for rapid release of the deceased, usually to meet faith requirements. This will be essential when the system is statutory.

5.9 The national Medical Examiner system will formally begin on a statutory basis on 09 September 2024.This will represent the most significant changes to death certification processes since the 1950s. Key changes are summarised briefly below. A comprehensive implementation plan will be presented at the next MMG, outlining stakeholder engagement and detailing any potential risks.

- All deaths will be subject to independent review, either through ME or Coroner.
- All MCCDs must be signed by an attending doctor and a ME.
- The MCCD will have several additional fields including ethnicity, pregnancy and the presence of medical devices.
- The registrar will no longer be at liberty to refer to the coroner and will instead revert to the ME with any queries.
- If the coroner does not feel investigation is necessary, they will no longer issue Form 100As allowing the MCCD to be issues and will revert to the ME.
- In exceptional circumstances the coroner can refer a death to the ME for them to issue a Medical Examiner MCCD directly
- It will no longer be necessary for the certifying doctor to have seen the patient within 28 days or after death.

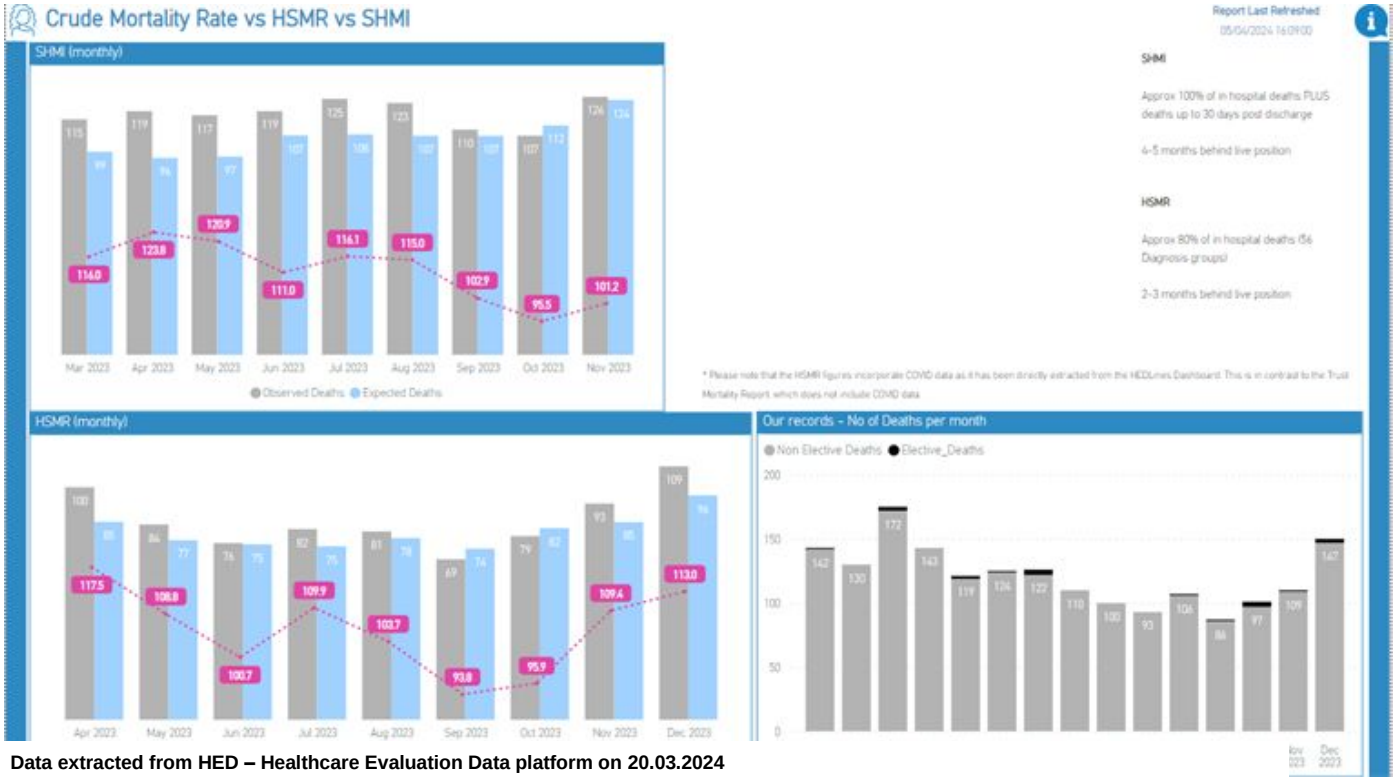
5.10 The ME service remains positively engaged with Trust Learning from Deaths processes and is currently the primary route through which deaths requiring structured judgement review are identified. This quarter the ME service flagged 37 deaths for SJR. The Lead ME is a regular faculty member for national Medical Examiner training and meetings with Coroner leads.

6.0 RECOMMENDATION

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

APPENDIX 1 (ESTH DATA)

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



Data extracted from HED – Healthcare Evaluation Data platform on 20.03.2024

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

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

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

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

These are called protected characteristics.

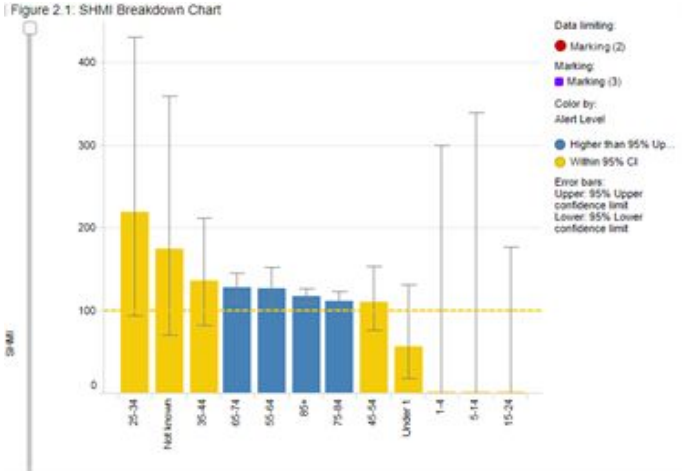
In September 2022, the Quality Committee in Common requested that future Learning from Deaths reports should include analysis of themes by protected characteristics.

In order to provide this analysis, it would be necessary to routinely and reliably collect this data for all patients. Currently, as part of routine data, NHS organisations collect data on age, sex, and race (if taken to be ethnicity). Data is not collected routinely and consistently across all patients for the remaining characteristics, and these are not compulsory fields in the patient management system.

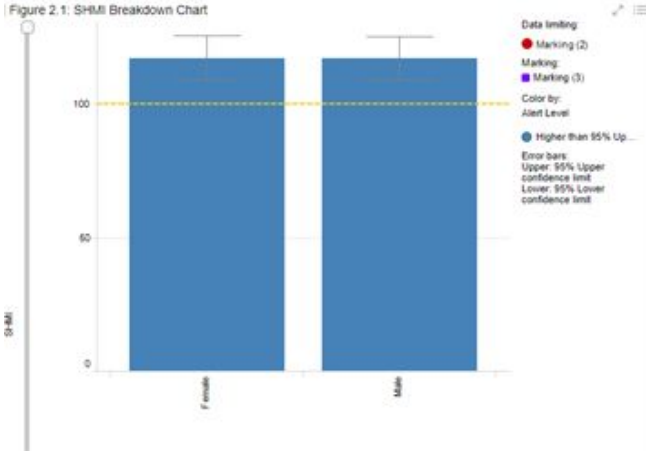
The SHMI (Summary Hospital-level Mortality Indicator) can be analysed by age, sex, and deprivation quintile using the HED platform. Reviewing the most recent reporting period (November 2022 to October 2023) for age, gender, and deprivation quintile, the results indicate expected levels, with exceptions noted in specific categories, as described below (please be aware that metrics exceeding the 95% CI are highlighted in blue in the graphs).

Both male and female categories are significant, as mortality surpasses the 95% upper confidence interval (CI). The age groups of 55-64, 65-74, 75-84, and 85+ stand out, showing mortality rates beyond the 95% upper CI. Deprivation Quintiles Q2 (less deprived), Q4 (less affluent), and Q5 (most affluent) demonstrate mortality levels exceeding the 95% upper CI. Despite these concerns, it's important to highlight that the overall pattern within the SHMI data for other categories continues to align with expected mortality rates.

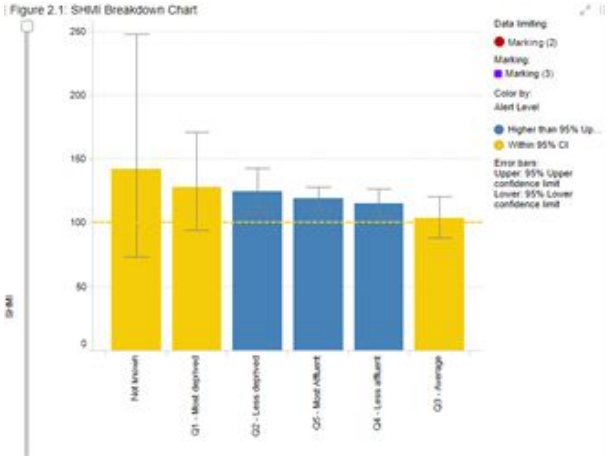
SHMI by Age groups



SHMI by Sex



SHMI by Deprivation Quintile



APPENDIX 3 (SGUH Data)

Learning from Deaths Dashboard

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2023-24

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

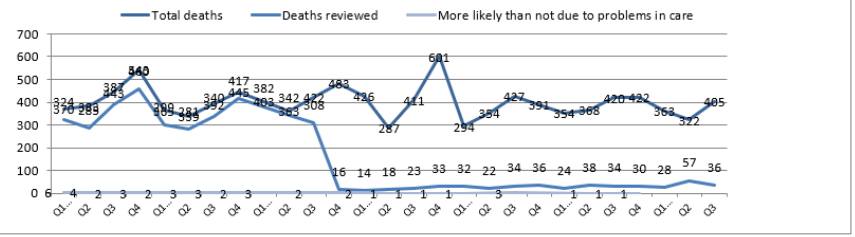
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

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

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
147	133	16	10	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
405	322	36	57	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1090	1564	121	126	0	3

Time Series: Start date 2017-18 Q1 End date 2023-24 Q3

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	1	6.3%	This Month	1	6.3%	This Month	2	12.5%	This Month	3	18.8%	This Month	9	56.3%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.8%	This Quarter (QTD)	1	2.8%	This Quarter (QTD)	4	11.1%	This Quarter (QTD)	6	16.7%	This Quarter (QTE	24	66.7%
This Year (YTD)	0	0.0%	This Year (YTD)	1	0.8%	This Year (YTD)	1	0.8%	This Year (YTD)	11	9.2%	This Year (YTD)	15	12.5%	This Year (YTD)	92	76.7%

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2023-24

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

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

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
4	1				
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
9	2				
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
16	24				

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
4	1	4	1	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
9	2	9	2	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
16	24	7	24	0	0

Time Series:	Start date	2017-18	Q1	End date	2023-24	Q3