Group Board

Agenda

Meeting in Public on Thursday, 09 January 2025, 10:00 – 12:30

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

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

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

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:15	2.1	Quality Committees-in-Common Report	Committee Chair	Assure	Report
10.25	2.2	Finance Committees-in-Common Report	Committee Chair	Assure	Report
10.35	2.3	People Committees-in-Common Report	Committee Chair	Assure	Report
10.45	2.4	Audit Committees-in-Common Report	Committee Chair	Assure	Report
10.55	2.5	Infrastructure Committee-in-Common Report	Committee Chair	Assure	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:05	3.1	Integrated Quality and Performance Report	GDCEO	Review	Report
11.15	3.2	6 Month Strategy Review	GDCEO	Approve	Report
11:25	3.3	Finance Report (Month 8, 2024/25)	GCFO	Review	Report
11:35	3.4	Fire Safety Review	GCFIEO	Review	Report
11.45	3.5	Board Assurance Framework	GCCAO	Review	Report
11.55	3.6	Group Freedom to Speak Up Report	GCCAO	Review	Report
12.05	3.7	Maternity Services Report	GCNO	Review	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	4.1	Fairness and Equity in Managing Concerns about Doctors and Dentists	GCMO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	5.1	New Risks and Issues Identified	Chairman	Note	Verbal
	5.2	Any Other Business	All	Note	Verbal
	5.3	Reflections on the Meeting	Chairman	Note	Verbal
12:15	5.4	Patient / Staff Story	GCNO	Review	Verbal
12:30	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones^	Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – SGUH & ESTH	PK
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Victoria Smith*^	Group Chief People Officer	GCPO
Claire Sunderland Hay	Non-Executive Director - SGUH	CSH
Philippa Tostevin	Non-Executive Director - SGUH	PT
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
In Attendance		
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications & Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy	GDOS
Becky Suckling	Site Chief Medical Officer – ESTH	SCMO-ESTH
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDDCA
Kelly Brown	Senior Corporate Governance Manager (minutes)	KB
Apologies		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Observers		
Jackie Parker	SGUH Governor	
Sarah Forester	SGUH Governor	

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

** Denotes non-voting member pf the Group Board (Epsom and St Helier)*

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

Minutes of Group Board Meeting

Meeting in Public on Thursday, 07 November 2024, 10am–12.30pm

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director – ESTH / SGUH, Vice Chair SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Derek Macallan	Non-Executive Director – ESTH	DM
Arlene Wellman	Group Chief Nursing Officer	GCNO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Yin Jones	Non-Executive Director – SGUH	YJ
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Victoria Smith*^	Chief People Officer	CPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Philippa Tostevin	Non-Executive Director - SGUH	PT
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
Claire Sunderland-Hay	Associate Non-Executive Director - SGUH	CSH
IN ATTENDANCE		
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy and Integration	GDSI
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
Kelly Brown	Senior Corporate Governance Manager (minutes)	SCGM
APOLOGIES		
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC

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

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	

1.1.1	The Chairman welcomed everyone to the meeting, noting that Claire Sunderland-Hay was present for her first formal meeting as an Associate Non-Executive Director. Apologies were received from James Marsh and Thirza Sawtell.	
1.2	**Declarations of Interests**	
1.2.1	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Mark Bagnall, Andrew Grimshaw, Richard Jennings, Stephen Jones, Victoria Smith as Executive Directors.	
1.2.2	There were no other declarations other than those previously reported.	
1.3	**Minutes of the Previous Meeting**	
1.3.1	Subject to the addition of Kate Slemeck and James Blythe being listed as attending the ward visits, the Minutes of the Group Board meeting on 5 September 2024 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
1.4.1	The Group Board reviewed and noted the Action Log. PUBLIC20240502.1: It is proposed that Network Chairs are provided with administrative support to help support them in their roles. A GESH culture forum will also be established, chaired by the GCEO, to which all Networks Chairs will be invited and therefore allow networks to contribute to the organisations' EDI agenda PUBLIC20240502.2: The ED risks for SGUH were considered by the SGUH Patient Safety and Quality Group meeting in October 2024, and a proposal to create a new risk on the CRR for ED safety is to be considered by the SGUH Site team and then the Group Executive, and - subject to this - will go through the Quality Committees-in-Common in December 2024. The ESTH ED risk on the CRR is currently being reviewed by the ESTH Site team and any changes will be presented following Site review to the Executive and Quality Committees-in-Common in December 2024. The remaining actions are not yet due.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
1.5.1	The GCEO updated the Group Board on the following issues: 2024 Autumn Budget: On 30 October, the Chancellor presented a one-year budget, referred to as Phase 1, which outlines the updated spending for 2024/25 as well as the planned funding for the following year. A longer-term Spending Review, known as Phase 2, is expected to follow in late spring. As part of this two-phased Spending Review, the Chancellor announced a £22 billion increase in total revenue and capital funding for health and social care. 10 Year NHS Plan: The Government plans to consult the public on its 10-Year NHS Plan, with the first face-to-face meeting for CEOs set for November 5, 2024. This	

	follows the publication of the Darzi Review, which provided a preliminary assessment of the NHS since the current Government assumed office. The NHS Sexual Safety Charter: In September 2023, NHS England launched its first Sexual Safety Charter, which aims to enhance staff safety and improve the workplace environment. This Charter includes ten principles that align with the upcoming amendments to the Worker Protection Act, set to take effect in late October 2024.	
1.5.2	PK referred to the 10 Year NHS Plan and the consultation process which will be undertaken as part of that plan. He asked whether it would be beneficial for the group to write to the Government to detail its views on the transition from acute care settings towards more community-focused health and care services The Board agreed that there should be a submission from the group expressing itsviews.	
1.5.3	PW asked how the group is preparing for winter. The GCNO advised that in terms of vaccinations, 4,250 flu vaccines and 1092 covid vaccines have been administered as of 4th November 2024. The Board noted that the covid figures are particularly disappointing but recognised that gesh is not an outlier in this regard and the figure is low nationally. The MD-ESTH advised that ESTH is ensuring there is appropriate resourcing in the correct areas to enable proactive flow throughout the organisation. Action cards have been issued to guide staff on protocol when the trust is experiencing significant pressure in activity. The MD-SGUH noted that the approach for that site is very similar, again focusing on flow and refreshing the full capacity protocol.	
1.5.4	YJ referred to the NHS Sexual Safety Charter, asking if gesh has an assurance framework to follow to ensure it is delivering against this. The GCNO confirmed there is a national framework which launched last week, which enables the group to demonstrate that it is compliant against this workstream.	
1.5.5	**The Group Board noted the Group Chief Executive's Report.**	
2.0	**ITEMS FOR ASSURANCE**	
2.1	**Quality Committee-in-Common Report**	
2.1.1	Andrew Murray, Chair of the Quality Committees-in-Common, presented the key issues considered by the Committees since the last Group Board meeting in October:	
2.1.2	**Interstitial Lung Disease (ESTH):** The Committees discussed this item, which is also on the Group Board agenda for this meeting. **Concerns regarding Safety in the Group's Emergency Departments:** There continue to be concerns relating to safety within the Group's Emergency Departments. These were multifaceted and although much mitigation was in a place some challenges were difficult to resolve and required action outside of the department and with system partners **gesh Learning from Deaths Quarterly Report:** Overall mortality at ESTH appears to be improving. However, both measures (Summary Hospital Mortality Indicator (SHMI) and Hospital Standardised Mortality Ratio (HSMR)) remain "higher than expected". Overall mortality at SGUH remains "as expected" as measured by SHMI, and "lower than expected" as measured by HSMR.	
2.1.3	AB referred to page 8 of the report which stated, 'NHS Blood and Transplant (NHSBT) has informed the Renal Transplant Service that they will be carrying out	

	an external visit due to an outcomes alert. As a preliminary step NHSBT has been sent internal reviews.' She asked if the group were aware of this alert internally before it was picked up externally. The GCMO advised that the point of these alerts is to give an early warning that more scrutiny into outcomes is required to determine if there is an issue. The team is working with the appropriate external quality control colleagues to determine if there is in fact a concern and will report back to the Quality Committees-in-Common on this. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in October 2024.**	
2.2	**Finance Committees-in-Common Report**	
2.2.1	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in October, including: **Financial Recovery Board update:** The GCFO noted the key topics covered in the Financial Recovery Board and encouraged discussion on how the Group should improve its financial performance. **IQPR:** Against the 4-hour ED waiting time standard, SGUH delivered 78.3% in September 2024 exceeding target and demonstrating continuous improvement alongside other urgent and emergency care metrics including length of stay and ambulance handover times. ESTH length of stay also continues to see an improving trend with revised boarding processes implemented on Monday 2nd September successfully incorporating additional areas to board patients.	
2.2.2	The GCEO noted that the group needs to get a grip on the workforce for both organisations, along with looking at the long-term issues such as admin and clerical processes. The Executives are also looking at the estates across the organisation and reviewing the running costs for this. The Board noted that the Finance Committees-in Common will have an additional meeting next week to review the latest plans in development with regards to cost savings and recovery. **The Board noted the issues considered by the Finance Committees-in-Common at its meeting in October 2024.**	
2.3	**People Committees-in-Common Report**	
2.3.1	Yin Jones, Joint Chair of the People Committees-in-Common, set out the key issues discussed and considered by the Committees in October 2024. These included: **Group Chief People Officer Report:** The Committees received a verbal update from the GCPO who outlined the new target operating model for the People function, including an update to our group employment contract, industrial relations issues and workforce planning. **Workforce Race Equality Standard (WRES) Report**: Following delegated, authority from the Board who had reviewed the draft documents the report was presented to People Committees-in-Common on 24th October 2024 to approve. The deadline for publication was 31 October 2024. **Workforce Disability Equality Standard (WDES) Report:** As with WRES, the WDES report was presented to People Committees-in-Common on 24th October	

	2024 to approve on behalf of the Group Board ahead of the deadline for publication of 31 October 2024.	
2.3.2	The Board agreed that whilst WRES and WDES were approved at the People Committees-in-Common on the Boards' behalf this year, given the importance of this subject matter, these reports must be presented to the Board for approval next year.	
2.3.3	MK asked if the Board could be presented with data which details the reasons why some staff choose not to be vaccinated. The GCNO advised that the group already collects data on whether or not staff choose to be vaccinated, and although they currently do not collect information on the reasons, she will find out if there is an option to do so. **Action: The GCNO to determine if data can be collected detailing the reasons why staff may choose not to receive vaccinations. (GCNO)** **The Board noted the issues considered by the People Committees-in-Common at its meeting in October 2024.**	**GCNO**
2.4	**Audit Committee**	
2.4.1	Pete Kane, Chair of the Audit Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in September 2024. These included: **Internal Audit:** The Committee reviewed four internal audit final reports, two for SGUH and two for ESTH. The Committees discussed, in particular, those which had receive 'partial' assurance conclusions; Cyber Assessment Framework at ESTH and Pressure Ulcers at SGUH. The Committee agreed that all internal audits which received partial assurance must be brought back to the Committee within 6 months for a progress update. **Information Governance:** Both Trusts have successfully completed and published their 2023/24 Data Security Protection Toolkits (DSPT) as "standards met". For the 2024/25 DSPT A 'Baseline' Assessment of the 2024/25 DSPT is required to be submitted by 31st December 2024 and the final full, submission by end of June 2025. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in September 2024.**	
3.1	**Interstitial Lung Disease at ESTH**	
3.1.1	The GCMO opened the item by apologising to the patients and their families who had been impacted by this issue. He presented the report, advising that at various points in time, first from within the ESTH respiratory department in November 2019, just before the Covid pandemic, and later in 2023, from the same department and from different internal and external sources, there were reports of apparent departures from recognised best medical practice in the management of patients with Interstitial Lung Disease. This related to a single respiratory consultant who was primarily based at St Helier Hospital until leaving the Trust in 2023. The key concerns related to patients not being referred to a specialist ILD Multidisciplinary Team Meeting (MDT) for consideration of the best treatment	

	options, and patients not being offered potentially disease modifying treatments as these evolved and became recognised in best practice guidelines.	
3.1.2	All patients with ILD who were looked after by the respiratory consultant in the last five years had now had an initial internal review of their care and the patients with ILD who required any change or correction to their treatment had been offered and attended an appointment (either face-to-face or virtually) with a Consultant. The Trust has commissioned the Royal College of Physicians to undertake an Invited Review to assess whether the management of some patients has led to harm, and if so, to determine the degree of harm.	
3.1.3	The Board apologised to the patients and their families who have been adversely affected by this issue.	
3.1.4	The Board noted the importance of whistleblowing, agreeing that there was learning to be taken from this issue. The GCCAO advised that the individual whistleblower in this case has provided some extensive feedback on their experience and how they felt the organisation acted in response to the whistleblowing. Since the whistleblowing concerns were raised, the Freedom to Speak Up Function across the organisation has been strengthened, and the Executives have set up a Raising Concerns Oversight and Triangulation Group which helps ensure concerns are heard at the top of the organisation.	
3.1.5	**Action: The Board requested that a report detailing the timescales of when systems and functions to support whistleblowing and FTSU are to be embedded into the organisation, be presented at a future meeting to allow the Board to track the progress of this.**	**GCCAO**
3.1.6	AM noted that this issue stemmed from an individual consultant who unfortunately was not following best practice with regards to multidisciplinary meetings and latest treatment. ILD was one part of this consultant's practice and so he asked if the Board could be assured that there were no other patient groups with respiratory conditions where this issue could also have occurred. The GCMO advised that when undertaking a review of the consultant's practice, there were concerns identified which did not relate to ILD; these being oxygen prescribing practices and vaccination advice. As a result, the terms of reference agreed with the Royal College of Physicians gave them the freedom to comment on any concerns they identify not just in ILD management, but lung management overall.	
3.1.7	The GCFIEO noted that one concern over the consultant's practice was the lack of involvement with the MDT when discussing patient care, he asked if the outcome in patient care would have been different had the MDT been given the opportunity to be involved. The GCMO advised it is difficult to be specific of the impact the MDT would have had as a whole, but it would have meant there would have been a discussion to ensure that either the treatment was inline with national guidance, or that there was a collective agreement by the MDT that a patient's care should not follow a certain practice, and this reason would have been documented.	
3.1.8	**The Board reenforced its apology to the patients and their families who were affected by this issue and as a result did not receive the standard of care expected.**	
3.2	**Maternity Services Report**	

3.2.1	The GCNO presented the report, highlighting the following for each trust: **ESTH:** There has been an increase in stillbirth/neonatal death cases (8 cases, 6 were below 28 weeks gestation and 2 above 30 weeks gestation) that meet the criteria for reporting to MBRRACE-UK. All cases are being investigated through the nationally mandated Perinatal Mortality Review Tool process. **SGUH:** There has been one episode of significant staffing challenge over the Bank Holiday weekend, 23-26 August. This resulted in delays in care, particularly for women requiring an induction of labour, as well as stress and distress to both patients and staff throughout the weekend. An MDT After Action Review (AAR) into the events took place on 25 September 2024	
3.2.2	The GCNO advised that CQC had completed an inspection in the maternity department at SGUH on the 16th and 17th October. An update will be given to the Board once a report is received.	
3.3.3	**The Board agreed the request to reframe the Midwifery staffing risk graded 16 at SGUH and replace with two new staffing risks.**	**GCNO**
3.3	**Integrated Quality and Performance Report**	
3.3.1	**The Group Board noted the report.**	
3.4	**Finance Report Month 6**	
3.4.1	The GCFO presented the report to the Board, advising that both ESTH and SGUH are now off plan on an underlying basis by £1.4m and £2.0m respectively. This excludes the impact of industrial action and cyber attack support. In addition, there continue to be pressures in both plans that are being managed with non-recurrent resources and delivery of the plan by year end is at risk. **The Group Board noted the report.**	
4.0	**ITEMS FOR NOTING**	
4.1	**Group Learning from Deaths Report, Q4 2023/24 and Q1 2024/25**	
4.1.1	**The Group Board noted the report.**	
4.2	**Healthcare Associated Infection Report**	
4.2.1	**The Group Board noted the report.**	
4.3	**Equality, Diversity and Inclusion:**	
4.3.1	**WRES Action Report and WDES Action Report** The Group Board noted the Reports for both trusts.	
5.0	**CLOSING ITEMS**	
5.1	**Any new risks and issues identified**	
5.1.1	No new risks were formally identified, however the GCCAO noted that as discussed earlier in the meeting, the issue of whistleblowing may need to be articulated and added to the risk register.	GCCAO
5.2	**Any other business**	

5.2.1	**End of NED Terms** The Chairman noted that MK, Vice Chair of ESTH, DM, NED for ESTH and TW, NED for SGUH would shortly reach the end of their term of office and this was their last public meeting as members of the Board. The Chair and the Board as a whole thanked all three for their commitment to the organisation.
5.3	**Reflections on meeting**
5.3.1	The Chairman asked MK to give his reflections of the meeting. The following observations and reflections were offered: • The Board worked efficiently and covered a huge breadth of issues which were all handled well • Whilst accepting that the majority of issues covered at the Board meetings are done so as a requirement, the Board should reflect on what issues could be covered which are of particular interest to the public and its stakeholders. • The Executives have immense ability to cope with and deliver against the various challenges the organisation often faces.
5.4	**Patient Story**
5.4.1	The Board were presented with a story detailing the experience of Charles McKenzie and his mother Georgia. Charles is a 2-year-old surviving twin boy, born at 35+ 1 weeks at Croydon University Hospital. He was transferred as an inpatient to St George's for specialist paediatric respiratory input and was established on non-invasive ventilation. He also has other medical complexities such as gastrostomy feeding, and developmental delay requiring multiple therapies input. Charles spent the next 1 year and 4 months in Paediatric Intensive Care, receiving specialist treatment and input from the whole multi-disciplinary team. The paediatric Respiratory Team managed his care and during his admission he was also referred for a second opinion from the Evelina Children's Hospital Respiratory Team and the radiological team at the Brompton. To this date, there is unfortunately no unifying respiratory diagnosis for Charles. This has been a difficult journey in every aspect for Charles and his mum, who is his sole caregiver. On discharge from the St George's paediatric intensive care unit in February 2024, Charles required 16 hours per day of non-invasive ventilation as well as suction, oxygen and tube feeding. He was able to be discharged home with these ongoing requirements. Georgia was fully trained to care for his complex medical needs by the long-term ventilation clinical nurse specialist team using simulation technology in London's first Well Child Better at Home Training suite which is based at St George's Hospital. Charles has just celebrated his second birthday and is absolutely thriving at home.
5.4.2	Learning points identified by the team and family: - **Keyworker:** Before a keyworker was introduced, there was much frustration and anxiety with the family due to the need to talk to multiple professionals. The Family Liaison Nurse (keyworker) is now included in MDT ward rounds on paediatric intensive care.

	- **Agency representation at discharge meetings:** Liaison with the family highlighted that good representation from all agencies at discharge meetings improves planning and holistic care, therefore increasing the likelihood of successful discharge. Follow on action: Internal team to work with the multi-disciplinary team to raise awareness of the importance of multi-agency representation. - **Regular meetings with family:** Staff recognise that regular meetings with parents encourage continuity of care by providing families with the opportunity to raise any concerns at an early stage and improve the relationship between staff and family. Action in progress: A new meeting forum has been suggested to include the key worker and relevant agencies, which is currently under consideration. - **Continuity of psychologist:** The service does not have a dedicated psychologist working in the team, therefore the support provided can be from different psychologists. Action in progress: The team are exploring whether earlier psychologist involvement/intervention might be beneficial.	
5.4.3	AM asked if the organisation helped Georgia with regards to identifying appropriate housing for her. Georgia confirmed that staff at the hospital did write letters of representation and support for her situation, but unfortunately there were delays on the Council's part due to identifying suitable property.	
5.4.4	The Board thanked Georgia for sharing her story, noting it was a pleasure to meet her and Charles in person and to see that Charles is doing so well.	
CLOSE		
The meeting closed at 12.50 pm		
QUESTIONS FROM MEMBER OF THE PUBLIC AND SGUH GOVERNORS		
There were no questions from members of the public or the SGUH Governors who were in attendance at the meeting.		

Group Board (Public) - 7 November 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20240905.1	5-Sep-24	6.1	Any new risks and issues identified	The GCIFEO was asked to review the fire safety risks for both SGUH and ESTH.	9-Jan-25	GCFIEO	Paper on the agenda item 3.4	PROPOSED FOR CLOSURE
	4-Jul-24	4.1	Board Assurance Framework	Review the strategic risk score for SR2 prior to the next scheduled Board review of the BAF	9-Jan-25	GCCAO	The risk score for SR2 has been reviewed and the Group BAF is on the agenda at item 3.5 for the Group Board to consider and agree the risk score	DUE
	4-Jul-24	4.1	Board Assurance Framework	Consideration to be given to how partnership working comes through the Board in a more explicit way	9-Jan-25	MD-IC	To be considered as part of the December Board development session on community services. Update to be given to Publix Board in January.	DUE
PUBLIC20241107.1	7-Nov-24	2.3.3	People Committee in Common Report	The GCNO to determine if data can be collected detailing the reasons why staff may choose not to receive vaccinations.	9-Jan-25	GCNO	We use Vaccination Track to support delivery of Covid and Flu vaccinations so are able to collect 3 reasons for declination – does not want the vaccine, declined due to allergy and declined due to other contraindications.	PROPOSED FOR CLOSURE
PUBLIC20241107.2	7-Nov-24	3.1.5	Interstitial Lung Disease at ESTH	The Board requested that a report detailing the timescales of when systems and functions to support whistleblowing and FTSU are to be embedded into the organisation, be presented at a future meeting to allow the Board to track the progress of this.	6-Mar-25	GCCAO	To be brought to the Group Board for review alongside the draft FTSU strategy for the Group	NOT YET DUE

PUBLIC20 2401012.2	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.	CLOSED
PUBLIC20 2401012.3	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	May-24	GCIFEO	The Board considered the escalation of issues to the Group Executive and Group Board	CLOSED
	2-May-24	4.1	Our priorities for 2024/25	The GDCEO agreed to review the document to incorporate these suggestions		GDCEO		CLOSED
PUBLIC20 2401012.4	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.	8-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.	CLOSED
2-May-24		Quality Committees-in-Common Annual Report to the Group Board	The section on health inequalities would be added to the Quality Committees-in-Common Annual Report as per the previous discussion at item 2.1a.			GCCAO		
PUBLIC20 240308.1	8-Mar-24	2.3	People Committees in Common report	Publication timetable to be drawn up of statutory people-focussed reports.	5-Sep-24	GCPO	Propose for closure and transfer to the	CLOSED
	2-May-24	6.3	Reflections on meeting	The Chairman asked that further consideration be given on how to better support the staff networks as these were not being fully utilised	7-Nov-24	GCPO	GCPO to provide verbal update at meeting.	CLOSED
	2-May-24	6.1	Any new risks and issues identified	The risk related to ED was flagged for recalibration, while this was not a new risk and was one of the central quality problems nationally, there had been a shift with much more corridor care taking place than had been the case previously.	7-Nov-24	GCCAO	The ED risks for SGUH was considered by the SGUH Patient Safety and Quality Group meeting in October 2024, and a proposal to create a new risk on the CRR for ED safety is to be considered by the SGUH Site team and then the Group Executive, and - subject to this - will go through the Quality Committees-in-Common in December 2024. The ESTH ED risk on the CRR is currently being reviewed by the ESTh Site team and any changes will be presented following Site review to the Executive and Quality	CLOSED

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	1.5	
Report Title	**Group Chief Executive Officer's Report to Group Board**	
Non-Executive Lead	Jacqueline Totterdell, Group Chief Executive Officer	
Report Author(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

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

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

Action required by Group Board

The Group Board is asked to note the report.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

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

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

Group Chief Executive Officer's Report

Group Board, 09 January 2025

1.0 Purpose of paper

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

2.0 Overview

2.1 Reflecting on 2024, I take pride in highlighting several key developments that demonstrate our commitment to providing outstanding care together. Our maternity services were rated the best in London by our patients, with over 6,000 babies delivered. We pioneered a technique for sickle cell patients, allowing them to leave the hospital more quickly and resume their everyday lives. Additionally, we launched a new Cancer Hub, creating a dedicated space for our exceptional Cancer Clinical Nurse Specialists to collaborate effectively.

We have successfully integrated critical aspects of our corporate services, and our staff continue to excel in delivering excellent healthcare to our patients - every step we have taken this year, whether large or small, deserves recognition and celebration.

None of these achievements would have been possible without the support of our Board, partners, and the public. I am especially grateful to our dedicated staff, who consistently go above and beyond to provide quality patient care.

We have more work ahead of us to enhance the patient experience and improve the health of the communities we serve, all while staying within our financial means. I look forward to what we can achieve together in 2025.

3.0 National Context and Updates

3.1 **New Hospital Programme:**

In December, we welcomed Ben Spencer from the Sunday Times to St Helier Hospital. During his visit, Ben interviewed several staff members, including consultants from the emergency department, professionals in the reablement unit, and frailty nurses. He also spoke with patients who praised the care they received.

The resulting article, titled "Inside St Helier Hospital, Staff Fear a 'Quad-Demic'," effectively describes our challenges - a deteriorating estate and insufficient capacity for patients. These issues are worsened by winter pressures, including rising flu rates and other infections, which lead to increased attendance at the A&E department. The article emphasises our collaboration with partners to manage these challenges and encourages the public to help by getting their flu vaccinations and taking precautions.

The article also positively highlights the new Sutton Health and Care Reablement Unit, an 18-bed facility established last year. This unit is designed to care for patients who no longer require medical monitoring but are not yet stable enough to be discharged. Since its launch, the unit has successfully freed up 700 beds.

3.2. Amanda Pritchard, Chief Executive of NHS England, filmed her festive video message to NHS staff at the Sutton Health and Care Reablement Unit. The Christmas message, which has garnered over 44,000 views, reflects on her visit and highlights that the service is "a great example of how the NHS is constantly innovating, with staff always striving to modernise care, support more people in the community, and deliver better value for money."

Planning for Winter

3.3. Multiple news outlets are reporting an increase in flu cases, resulting in a growing number of people being admitted to intensive care. There are concerns that festive gatherings will exacerbate the situation. Recently, NHS England revealed that 2,500 patients require hospital treatment for the virus. During our last Executive Question Time and through email communications, I have urged everyone to get vaccinated. This is essential to protect themselves, their families, and especially the most vulnerable individuals this winter.

4.0 Our Group

4.1 Launch of gesh Quality and Safety Strategy

The NHS is currently facing significant challenges, including overcrowded emergency departments, increasing demand for services, difficulties in transferring patients back to the community from hospitals, and long waiting lists. Our newly launched Quality and Safety Strategy outlines our plans for the next four years to strengthen our governance and oversight of quality and safety, improve patient flow through our services, and foster a culture of psychological safety and continuous improvement.

We want staff across the NHS to feel safe when raising concerns, confident that their voices will be heard and that appropriate actions will be taken in response. For patients, our aim is to ensure they can move safely through our hospitals and experience timely discharges, all while reducing overall system costs.

This initiative is part of our overarching CARE strategy, which aims to deliver outstanding care together.

4.2 Launch of Martha's Rule - Pilot at SGUH

To enhance the quality and safety of care, we are piloting Martha’s Rule across select adult wards and the adult Emergency Department at SGUH. Martha's Rule is an initiative by NHS England that empowers patients and their families to request an urgent review of their condition or that of a loved one if they believe that serious deterioration is occurring and their concerns are not being adequately addressed.

According to NHS England, almost one out of every eight phone calls made under the Martha's Rule scheme has resulted in a potentially life-saving change in treatment. Out of 573 calls received in September and October, 286 (50%) led to a critical-care review. This resulted in changes to treatment—such as the administration of antibiotics, oxygen, or other medications—in 57 cases, and 14 patients were transferred to intensive care.

This initiative reinforces our commitment to patient safety and compassionate care. Posters will be displayed in relevant clinical areas along with a phone number for patients and relatives to contact.

5.0 Appointments, Events and Our Staff

5.1 Our Staff

Violence and Aggression Task Force

The Violence and Aggression Task Force that I lead has made important recommendations that have informed changes to our existing policies and identified additional resources necessary to protect and support staff from violent and aggressive incidents. These resources include, but are not limited to, training sessions, additional escalation methods, and executive-issued warning letters.

We are currently implementing the recommendations and plan to launch our updated plans by March 2025. I will provide a further update and next steps in my next report.

5.2 Events

GESH CARE Awards

In December, we hosted our first-ever gesh CARE Awards. This event is linked to our CARE strategy, which aims to sustain an organisation of 'Engaged and Empowered' staff.

Nearly 400 guests attended the event to celebrate the dedication and achievements of our teams, while nearly 300 people watched online.

We heard firsthand from patients about the impact our staff at gesh have had on their lives. Sky News presenter Jacquie Beltrao spoke movingly about her care and cancer treatment, while our celebrity host, Myleene Klass, shared stories about her mother, an NHS nurse, highlighting the compassion, empathy, and commitment required to care for others. The evening included a standing ovation for our emergency departments and security teams, who strive to keep our patients and staff safe and cared for, even amid record demand.

This is one of several initiatives we have launched to reflect our CARE strategy and respond to the feedback received from our Staff Survey. While there is still more work to be done this year, I am proud of our staff and everything we have accomplished.

Christmas at gesh

5.3 This Christmas season, our wards were filled with festive cheer as patients, staff, and local football clubs came together to celebrate. Fulham FC, AFC Wimbledon, and Chelsea FC Under-21s all visited to deliver presents and spread joy among our younger patients and the dedicated teams in the Paediatrics wards at St George's, Epsom, and St Helier hospitals.

Additionally, the maternity bereavement team SGUH received a special gift last week: a crate of Lindt chocolates. A bereaved patient, who works for Lindt, sent the chocolates as a gesture of gratitude for the care they received from the Bereavement Team, the Fetal Medicine Unit and the Delivery Suite.

6.0 Recommendations

6.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 09 January 2025

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

Executive Summary

This report sets out the key issues considered by the Quality Committees-in-Common (QCIC) at their meetings in November and December 2024 and the matters the Committees wish to bring to the attention of the Group Board. These include:

- **Concerns regarding Maternity Services:** Despite a focus session on Maternity in November, assurance remains limited with particular ongoing concern about maternity leadership and intrapartum monitoring.

  Concerns regarding Never Events: There have been further Never Events along the themes of wrong site skin surgery and retained foreign objects post-surgery (small parts of equipment and swabs). Assurance remains limited since actions taken to date do not appear to have stopped Never Events from occurring.
- **Concerns regarding safety in the Group's Emergency Departments:** This remains a significant concern. Much action continues to take place and risks are being actively mitigated but assurance on safety remains limited.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in December 2024.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

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

Quality Committees-in-Common Report
Group Board, 09 January 2025

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 November and December 2024 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meeting on 19 December 2024 the Committees considered the following items of business:

December 2024
• Group Key Issues Report • Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF) • Group Update on Emergency Departments – and Patient Flow – current progress on tackling issues • Group Maternity Services Report • Maternity Staffing • South West London Pathology Report • Group Update on Quality and Safety Strategy • Group Update on Quality Impact Assessment process of Cost Improvement Programme • Group Board Assurance Framework • Interstitial Lung Disease (ESTH) • Group Integrated Quality and Performance Report* • Group Annual Volunteers Report 2023/24

** Items marked with an asterisk are on the Group Board agenda as standalone items in January 2025.*

2.2 The meeting was quorate.

2.3 A Focus Session of the Committees was held on 28 November 2024 which looked in detail at maternity services across the group.

3.0 Key issues for escalation to the Group Board

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

a) Quality and Safety within the Group's Emergency Departments (EDs) – Patient Flow

Following on from reports received at the most recent Committee meetings a verbal update was given. It was agreed that the outcomes form the recent CQC Inspection at SGUH would be covered at the January 2025 focus session. At this time consideration would be given to any learning from the inspection which could be shared with ESTH.

Key points from the update included:

General

- The key areas within both trusts continued to include – unplanned care in the EDs, overcrowding and outflow block to admitting patients. These areas continued to represent highest risk and safety concerns across both trusts. A subset of these concerns related to the arrangements in place for caring for mental health patients.
- There were continuing concerns with overcrowding particularly relating to the increase in cases of respiratory viruses including Covid and Flu.
- Review of guidelines relating to the use of masks was being undertaken and an update would be shared with staff in due course.

At SGUH

- At SGUH the full capacity protocol was now in place and actions were being activated as required. A meeting was planned with local authority and community partners as to what actions would be required from them and how they could support the trust at different levels of Opal Action.
- The discharge lounge was now open every night – this was acting as a holding place for people who were expected to be discharged the next day.
- Increased work was taking place around frailty with the London Borough of Sutton.
- Work was also taking place on accurately capturing details of patients with no criteria to reside.
- In respect of the recent CQC inspection work to ensure proposals around making improvements to documentation were embedded was underway.

At ESTH

- There had been improvements in all of the following metrics: Length of stay; Super stranded patients; Patients with no criteria to reside. However, this was against a background of ever increasing attendance.
- The London Ambulance Service requirement to off load patients within 30 mins was having an ongoing impact on the performance within both trusts.
- There continued to be particular concerns regarding the estate of the ED at St Helier and the ongoing impact on both patients and staff.
- The staffing levels had been reviewed and formalised. This will allow more substantive recruitment to take place rather than relying on temporary staff. This included strengthening decision making capacity in the form of additional doctors and ACPs.
- There had been minimal additional funding for the winter of 2024/2.
- Boarding was being adopted across the trust where necessary.
- An overnight standard operating procedure had been established.
- Transfer of Care policies were in the process of being simplified.
  This is part of our health and social care flow programme in Sutton which has multi agency links.

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) <u>Maternity Services Update</u>

The Committees received a deep dive on Maternity Services across the Group, at the focus session which had taken place at the end of November 2024. Areas covered included:

- Updates on actions following CQC Inspections of Maternity 2023/24
- Maternity Safety Support Programme (MSSP)
- Clinical Negligence Scheme for Trusts (CNST) – 2024 Submission
- NHS Resolution – feedback from their assessment and issues / actions arising
- Maternity Governance Review
-

The Committees discussed progress on the action points from the CQC inspection and the areas where it had been expected that faster progress could have been made, with it being explained that the aim was to have sustained improvements that were retained beyond a rapid response. Where CQC 'must do' actions were not yet complete it was reiterated that mitigations should be in place and that embedding improvements, the impact of the quality of the estate and staffing levels should be triangulated as part of business planning. It was agreed there should be a single, group maternity improvement strategy that captured all relevant information from the various external reviews which would then give greater clarity on progress and support assurance processes.

The MSSP report provided an update on staffing and leadership of the maternity service and consideration of a group maternity governance approach which, once in place, should support rapid improvements across both trusts. The MSSP actions would be included in the consolidated group maternity improvement strategy.

It was noted that both trusts anticipated being compliant with all elements in the 2024 CNST submission, although there was a caveat relating to SGUH PMRT as there were two cases which were reported outside the seven day period. Ways of reducing the impact of the time pressures around the submissions were discussed.

The meeting also received the findings of the NHS Resolution Thematic review of the Early Notification Scheme (ENS) cases submitted by SGUH Maternity Services between 1 April 2017 and 31 March 2024. It was agreed that there needed to be a greater assurance that where CTGs are undertaken that the information is recorded appropriately and correctly to provide an audit trail as this was an area highlighted in the report for strengthening. Local policies on this would be reviewed against the NICE guidelines.

The maternity governance review was also received with many areas rated green or amber but with a large number of actions to be considered. Greater use of a multi disciplinary team approach, which was already happening for some projects/areas, particularly at ESTH, was recommended. It was noted that there were bi-monthly meetings with the Executive and Non-Executive Maternity Safety Champions and that the Group now had QI Midwives whose role was to focus on innovation and to take service provision to a place of improved delivery and involving others with this.

It was a helpful session in terms of understanding the current position with maternity services, but it did not increase the level of assurance, which remains limited.

At the meeting in December 2024 the Committees noted the following points:

- As both Trusts prepare for the self-assessment of CNST and the Board declaration of compliance against the CNST Maternity and Perinatal Incentive Year 6, there are several action plans to be reviewed by the Maternity Safety Champions to provide assurance to enable Board sign off.
- It was proposed that the Committees delegate the review of the September and October 2024 PMRT data and themes and the supporting action plans required to be compliant with the CNST year 6 requirements to the Maternity Safety Champions. The outcome of this review will then be included in the assurance to the Board. This was agreed by the Committees.
- The Maternity Safety Champions will meet to review all items in advance of the January Group Board, where the Board declaration of CNST compliance will be considered. At this stage, prior to the evidence assurance review, both Trusts have stated they are on track to meet be fully compliant with all CNST safety actions.

Maternity Staffing

This item was deferred from the November 2024 Focus Session and consisted of analysis of maternity rosters across the Group. It provided insights into staffing patterns.

Recommendations included:

- Accelerate recruitment and onboarding for permanent roles.
- Implement predictive analytics for better planning of high-demand periods.
- Enhance bank staff participation through targeted incentives and flexible scheduling.
- Regular review meetings to address gaps and optimise workforce planning.
- Education on roster management for the senior team in maternity as a priority

b) <u>Group Patient Safety and Incident Report - update on Patient Safety Incident Review Framework (PSIRF) and Never Events</u>

The Patient Safety Incident Response reports for September and October 2024 were received along with an update on Never Events. Also received were two Prevention of Future Deaths notices. One of these was directed to the Secretary of State for Health and Social Care but related to a SGUH case. It highlighted the concerns that lack of Social Care leads to overcrowding with hospitals.

Key points from the report included:

- Four Never Events occurred during this reporting period. It was confirmed that two further Never Events were declared after the reporting period.

- The two further Never Events declared in December 2024 were described in a briefing note to Board members.

- In a continuation of the existing trends the four Events declared in September and October were all either retained foreign objects or wrong site surgery. This included a retained swab in cardiac surgery at SGUH. It was noted, given the historical concerns that previously surrounded this service, that cardiac surgery had not had a retained swab, or any other Never Event, for more than five years.

- The wrong site surgery events were skin surgery and a Botox injection. Although, again in continuation of the existing trend, none of the patients suffered long-lasting harm from any of these Never Events.

- The Never Events show, therefore, that the Group do not yet have sufficiently robust safeguards and practices in place to prevent them.

- Actions aimed at lessening the risk of Never Events continue. Programmes of work to improve safety culture and practices in Theatres are underway at both ESTH and SGUH. Engagement with these programmes has been good (engagement from consultant surgeons at SGUH has greatly improved after an initially disappointing start). Some examples of learning and improving were given in the paper, but it was clear that further work is still needed, and skin surgery (dermatology and plastics) is an area in which there is still opportunity for further learning and improvements. The more general programmes of work on Theatre culture in both Trusts are ongoing and they will continue to receive proactive Site Leadership and Executive support.

- The report provided a number of other examples, unrelated to Never Events, of learning being disseminated and change being made. This highlights the increasing roles of the Divisions in providing safety and quality governance and oversight within the new PSIRF framework, and in contributing to the identification of key themes. Training in PSIRF continues, with Medical and Dental training the priority area.

The Committees felt there was reasonable assurance regarding PSIRF across the Group. In respect of Never Events the level of assurance remained limited.

c) Update on Interstitial Lung Disease - ESTH

Previous regular updates to the Committees had described the concerns about Interstitial Lung Disease (ILD) management by a respiratory consultant at St Helier Hospital. Assurance was received that all patients with ILD who needed any intervention or course-correction to their treatment have now been seen.

It was agreed that the next update to the Committees would be provided when the report from the Royal College of Physicians Invited Review had been completed. Exception reporting to the Committees would continue if necessary.

The Committees discussed the “Whistleblowing” which had taken place in relation to this case and the need to ensure that staff were well protected. It was agreed by the Executive Team that there was a need to improve whistleblower protection at a departmental level, or local level, before concerns have been escalated to a senior leadership or executive team.

Whistleblowing was a focus of the key messages relating to the Group Quality and Safety Strategy which had recently be launched. It was important to acknowledge how difficult it can be personally for people to raise concerns and how much everyone has to think about how staff who raise concerns are protected. Actions were also in place to gather the experience of whistleblowers collectively and to learn from individual cases.

5.0 Other issues considered by the Committees

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

a) Group Annual Volunteers Service Report 2023/24

The Committee received an update on the role which volunteers play across the Group. It covered the period November 2023 to October 2024.

The past year has been exceptionally productive for Voluntary Services, with a significant increase in volunteer recruitment. Since November 2023, the team had welcomed 209 new volunteers across various roles (115 at SGUH and 94 at ESTH), with 100 individuals currently undergoing the onboarding process (35 at SGUH and 65 at ESTH). It is estimated that this equates to 68,600 voluntary hours given to the Group in the year (32,200 at SGUH and 36,400 at ESTH). Following a question from the Committee, it was noted that there was capacity to recruit more volunteers, however it takes time to ensure that they receive proper training and the appropriate checks are carried out.

Volunteers had undertaken a very wide range of roles across the two trusts including :

- Emergency Department (ED) Support:
- Dementia Support and Mealtime Assistance:
- Chaplaincy Support/Volunteer Chaplains
- Pets As Therapy (PAT)
- Marie Curie Companion Service:
- PLACE Assessments:
- Veteran Engagement:
- George's Green Club:
- Breastfeeding Peer Support:
- Career Support for the Homeless:
- Gardening Volunteers:
- Expanded Ward Volunteer Roles:

The Committee acknowledged the important role that volunteers undertake across the Group. They were pleased to see how the volunteers were thanked by the wider Group.

b) SW London Pathology Quality Report

The Committee received a regular Quality Report from SW London Pathology (SWLP). The report aims to provide assurance about the services received from SWLP.

Previously there had been some concerns highlighted to the Committees relating to the response time for ESTH receiving some test results. It was noted that this issue had largely been resolved within the most recent period.

The key issues highlighted in the update included:

- SWLP continues to be accredited by UKAS to the standards of ISO15189. These standards have been revised and updated. SWLP is in the process of being assessed in our five pathology specialties over six laboratory sites during the next year.
- A number of significant service improvements have been made since the last report.
- There was a Group specific issue of date and time faecal samples for *C. difficile* arriving in the laboratory and being incorrectly recoded leading to the misclassification of "hospital onset" and "community onset", resulting in incorrectly showing increased numbers of hospital acquired cases of *C. difficile* infection. Action had been undertaken to address this concern.
- Whilst immunology samples take longer than they used to, the ESTH clinical services have adapted to this and are able to obtain faster turnaround on the few occasions that

this is clinically indicated. There is a plan to resolve the IT issues causing this after the go-live of ESTH EPR.

c) Group Board Assurance Framework

The Committees received and noted the update on the Group Board Assurance Framework and reviewed the four strategic risks which were overseen by the Quality Committees-in-Common. It was agreed that risk scores remain unchanged:

SR7: Developing new treatments through innovation and research
The Group and City St George's have commissioned an external consultant to review the benefits and opportunities of closer collaboration. A Group-wide restructure of research leadership and management has been approved by the Group Executive and a consultation will start in the new year.

SR9: Improving patient safety and reducing avoidable harm

The Group Quality and Strategy approved by the Group Board in July 2024 was launched across the Group in December 2024. Progress continues to be made in implementing the recommendations of the Phase 1 Quality Governance Review. As previously reported, a report on Phase 2 will be considered by the Group Executive in January 2025. The Raising Concerns Oversight and Triangulation Group is fully established.

SR10: Improving patient experience
A single Group-wide complaints function has been established as part of the Corporate Nursing restructure.

SR11: Tackling health inequalities

A Health Inequalities Steering Group and a Community of Interest Forum have been established. The reporting to the Quality Committees-in-Common on progress on tackling health inequalities has matured and regular reporting is now in place. A focus in the coming months is on improving data quality on health inequalities and developing areas of focus for gesh.

d) Group update on Quality Impact Assessment of the Cost Improvement Programme

The Committees received an update on the Group-wide Quality Impact Assessment (QIA) process, noting that a revised process had been in place since October 2024. The QIA reviews options for financial savings that are put forward by Group Executives and Site Leadership teams. It was confirmed that proposals for consideration were now invited at an earlier stage of development which supports strategic discussion amongst the Executive and Site Leadership teams and reduces inefficiency.

Additionally, the new process follows NHS best practice by integrating the QIA with equality, diversity and inclusion assessments, creating a process that enables new ideas to be considered alongside quality, safety and EDI principles in one holistic decision-making process.

The Group QIA meeting is Co-Chaired by Richard Jennings Group Chief Medical Officer and Arlene Wellman Group Chief Nursing Officer.

e) Quality and Safety concerns raised by staff

The aim of this new report was to provide the Committees with an overview of any patient safety concerns raised by staff and the actions taken to address them. The concerns highlighted within the report had been discussed and reviewed at the monthly Raising Concerns Oversight and Triangulation Group, which reports to the Group Executive.

At its most recent meeting in November 2024, the Raising Concerns Oversight and Triangulation Group reviewed a total of 9 concerns that related to patient safety, 5 at ESTH and 4 at SGUH. A number of the concerns highlighted in this report had previously been reported to the Committees as stand-alone agenda items (for example Emergency Department overcrowding, Interstitial Lung Disease at ESTH, Head and Neck Service at SGUH).

Going forward the Committees would receive quarterly report with the aim of ensuring that they are assured that safety concerns are being addressed appropriately.

It was further noted that the Executive Team was continuing to develop an Insights Report and a systematic process for identifying and disseminating learning from concerns.

f) Update on the Group Quality and Safety Strategy

An update which outlined the proposed implementation plan for the Group wide Quality and Safety Strategy (2024 -2028) which was approved by the Board in June 2024 was received. It was confirmed that the Strategy had recently been officially launched across the Group with a series of communications highlighting the importance of speaking up with the aim of continuing to build a positive safety culture.

6.0 Recommendations

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

Group Board

Meeting in Public on Thursday, 09 January 2025

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

Executive Summary

This report sets out the key issues considered by the Finance Committee at its meetings in November and December 2024 and sets out the matters the Committee wishes to bring to the attention of the Board.

Action required by Group Board

The Board is asked to: Note the paper

Committee Assurance

Committee	Finance Committees-in-Common
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that whilst the system of internal control is adequate and operating effectively, significant improvements are required to deliver the current financial deficit plan.

Appendices

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

Appendix 2	Add Appendix Name – delete line if not needed
Appendix 3	Add Appendix Name – delete line if not needed

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance Committee-in-Common Report
Group Board, 09 January 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in November and December and sets out the matters the Committee wishes to bring to the attention of the Board.

2.0 Background

2.1 At its meetings on 29th November and 20th December 2024, the Committee considered the following items of business:

29th November 2024	20th December 2024
PUBLIC MEETING • Update from Group Recovery Board • Finance Report (M7) • CIP Update (M7) • Forecast and mitigations • NHSE Briefing • Business Planning 25/26 • SWL Pathology report • IQPR by exception • Strategic Initiative Update - Strengthening Specialised Services	**PUBLIC MEETING** • Update from Group Recovery Board • Finance Report (M8)* • Capital Assurance M8 • Forecast and mitigations • BAF Finance risk update • Business Planning 25/26 • Business case update • IQPR • EPRR Assurance report • BAF Operational risk update

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Recovery Board update

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

b) Finance Report M8

Both trusts are showing an underlying adverse position to plan at M8 (ESTH £4.2m and SGH £6.1m), showing baseline pressures and CIP shortfalls in addition to cyber attack support impact at SGH (£0.9m).

c) CIP update

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

d) Capital assurance

The GCFO noted the request to provide assurance as to the accuracy of the M8 capital forecast to NHSE which was noted by the committee, albeit it was also noted that with the knowledge and agreement of the system the position would change at M9.

e) Forecast and mitigations

Executive leads updated on individual workstreams including scope and resourcing requirements. Committee members welcomed this.

f) NHSE Briefing

In November the GCFO outlined key learnings from NHSE on the Investigation and Intervention process which was noted by committee members.

g) Business Planning 25/26

The GCFO noted the requirement for a draft financial plan to be submitted on 20th January 2025 which he noted would likely be similar to the draft position presented to the committee in November. Committee members asked for detail to be provided once submitted, whilst recognising that this draft submission would not be formally signed off by the Group Board.

h) Business Case update

The SGH DFS noted the changing landscape of the New Hospitals Programme, in which many of the workstreams were on hold whilst the NHP review is being undertaken.

i) IQPR

The GDCEO introduced the paper outlining the successes and challenges in elective and non-elective care. Committee members reflected on the excellent care provided to patients under very difficult circumstances.

j) Strategic Initiative Update – Strengthening specialist services

The SGH MD noted good progress by the group in specialist services. Committee members welcomed progress being made.

k) EPRR Assurance statement

Committee members welcomed the assurance statements provided on the Emergency Preparedness, Resilience and Response report.

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

a) SWL Pathology report

The GCFO noted latest highlights of the SWLP financial performance as well as progress on the GP Hub location.

5.0	Implications
5.1	The Committee considered the BAF operational-related risk SR 8 – Reducing Waiting Times and recommended no changes to the score of ‘20’ and limited assurance.
5.2	The Committee considered the BAF finance risk SR4 - Achieving financial sustainability and recommended no changes to the score of ‘25’ and limited assurance.

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 November and December 2024.

Group Board

Meeting in Public on Thursday, 09 January 2025

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

Executive Summary

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

- Group Chief People Officer Report: The Committees received a verbal update from the GCPO who reported about the progress with the integration of the People function as well as the preparations for the CQC Well-led inspection in February 2025.

- Fairness and Equity in Managing Concerns about Doctors and Dentists: The Committees noted the report which highlighted that, both nationally and at gesh, doctors with protected characteristics were at increased risk of investigation for concerns and referral to the General Medical Council (GMC). The data from the General Dental Council (GDC) (Fitness to Practice Statistical Report 2023) suggested a similar trend for dentists. The Committees approved the GCMO's recommendation to provide a biannual report that outlines the NHS Employers dataset and provides ongoing assurance of the fair and equitable application of processes.

- Group Board Assurance Framework (BAF) – People Risks: The Committees noted that there were no changes proposed to the headline risk scores for People risks (SR12, 13 and 14) or to the assurance ratings (limited) as of December 2024. The GCPO explained that her aspiration was to make improvements that would have an impact on the assurance rating in particular, and potentially the risk scores over the coming months.

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 December 2024.

Committee Assurance	
Committee	People Committees-in-Common

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

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

Implications

Group Strategic Objectives

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

Risks

The Committees noted that there were no changes proposed to the headline risk scores for People risks (SR12, 13 and 14) as of December 2024.

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 the paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in the paper.

Environmental sustainability implications

N/A

People Committees-in-Common Report
Group Board, 09 January 2025

1.0 Purpose of paper

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

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

2.0 Items considered by the Committees

2.1 At its meeting on 12 December 2024, the Committees considered the following items of business:

December 2024
• Group Chief People Officer Report • Freedom to Speak Up Report • Fairness and equity in managing concerns about doctors and dentists • Equality, Diversity & Inclusion (EDI) Action Plan • NHS Staff Survey Evaluation • Domestic Abuse and Sexual Violence update • Investigation & Intervention Findings • Workforce KPI Performance Report • Area of Focus: Appraisals • Group Board Assurance Framework – People Risks

2.2 The Committees are now meeting every two months as agreed by the Group Board, and the chairing of the meetings rotates between the respective Chairs of the Committees at ESTH and SGUH. An informal meeting of the Chairs and GCPO takes place between Committee meetings.

3.0 Key issues for escalation to the Group Board

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

a) <u>Group Chief People Officer Update:</u>

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

- The gesh CARE awards event on 10 December 2024 went very well. Recognising colleagues for their achievements and contributions was an important part of the People Strategy. A guide for managers on how to recognise team members was in preparation and would be finalised soon.
- Three new senior members of the People Team had been appointed and would be starting in December 2024 or January 2025.

- The integration of the People function was in progress, it would not be a revolution but more an evolution. Discussions with the staff side were being held and this would be followed by a consultation.
- Preparations for the CQC Well-led inspection in February 2025 had started. Demonstrating and providing evidence of strong leadership, governance, and management would be the key for ensuring that the organisation was well-led and that it provided a high-quality service to patients. This included delivering the actions outlined in the recent I&I (Investigation and Intervention) report.

The Committees noted the verbal update and requested that the introduction of the training passport be considered to avoid duplication.

b) Fairness and Equity in Managing Concerns about Doctors and Dentists:

The Committees noted the report which highlighted that, both nationally and at gesh, doctors with protected characteristics were at increased risk of investigation for concerns and referral to the General Medical Council (GMC). The data from the General Dental Council (GDC) (Fitness to Practice Statistical Report 2023) suggested a similar trend for dentists. The Committees approved the GCMO's recommendation to provide a biannual report that would outline the NHS Employers dataset and provide ongoing assurance of the fair and equitable application of processes.

c) Group Board Assurance Framework (BAF) – People Risks

The Committees noted that there were no changes proposed to the headline risk scores for People risks (SR12, 13 and 14) or to the assurance ratings (limited) as of December 2024. The GCPO explained that her aspiration was to make improvements that would have an impact on the assurance rating in particular, and potentially the risk scores over the coming months.

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) Freedom to Speak Up Report Q1-Q2 2024/25:

The Committees noted the number of concerns reported to the FTSU Guardians in Q1-Q2 2024/25 for both SGUH and ESTH and the staff groups reporting and received Reasonable Assurance about the strength of the Freedom to Speak Up process. The Committees requested that timeliness of resolutions be added to future Freedom to Speak Up reports.

b) EDI Action Plan

The Committees approved this draft Diversity & Inclusion Action Plan 2025-2027 and noted that next steps would be moving forward with wider stakeholder engagement, followed by final refinements and publication in early 2025. The action plan included the priority areas which were identified with Staff Network leads as part of Board Development days.

c) Domestic Abuse and Sexual Violence (DASV) update

The Committees noted the progress and challenges in implementing the Sexual Safety Charter principles and supported the next steps, including the launch of policies, training, and

reporting tools. The GCNO reported that an online tool for anonymous reporting would be piloted in 2025 to encourage disclosures and bolster staff confidence in the system.

d) Investigation & Intervention (I&I) Findings

The Committees discussed the People aspects of the I&I report and noted that, whilst not every recommendation from the report would be implemented, some, for instance the recruitment freeze and rostering of medical staff, would be.

5.0 Other issues considered by the Committees

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

a) NHS Staff Survey Evaluation

The Committees welcomed the news that the 2024 NHS Staff Survey campaign for SGUH and ESTH successfully engaged staff and improved response rates compared to 2023. The SGUH's response rate improved by 7.6 percentage points, rising from 38.0% in 2023 to 45.6% in 2024 and the ESTH's response rate improved by 3.4 percentage points which demonstrated a substantial boost in staff engagement. The Committees endorsed the next steps approach that supported engagement and continuous improvement and requested a report with full results in February 2025.

b) Area of Focus: Appraisals

The Committees noted that the Appraisal processes between the two trusts differed but that both trusts had found it very difficult to get above 75%-78% compliance and 80% presented a threshold which neither trust had reached in recent times. The GCEO highlighted the importance of aligning the appraisal templates with gesh strategy and values and bringing them into focus for both the manager and appraisee so that they can have a helpful conversation leading to performance improvement.

c) Workforce KPI Performance Report (M7 2024/25)

The Committees continued to receive regular updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance.

The Committees welcomed the news that additional training would be rolled out to managers to help them deal with sickness rates.

6.0 Recommendations

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

Group Board

Meeting in Public on Thursday, 09 January 2025

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

Executive Summary

The report sets out the key issues discussed and agreed by the Audit Committees-in-Common at its meeting on 11 December 2024:

- External Audit – although the auditor had yet to be appointed, internal arrangements were on track.
- Internal Audit: The Committee reviewed four internal audit final reports, three for SGUH and one for ESTH. The Committees discussed, in particular, the audit which had received 'partial' assurance conclusions; Venous thrombosis (VTE) Data Quality at SGUH. The Committee agreed that the audit would be brought back to the Committee within 6 months for a progress update.

- Information Governance: At both Trusts, overall compliance of servers and desktops/laptops has positively increased over the month: Patching compliance for desktops/laptops has increased (SGH/ESTH); the number of Unsupported Operating System (Servers) has improved to (SGH/ESTH).

Action required by the Board

The Board is asked to note the report of the Audit Committees-in-Common meeting held on 11 December 2024.

Committee Assurance	
Committee	Audit Committees-in-Common
Level of Assurance	Not applicable

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Report of the Audit Committees-in-Common

Group Board, 09 January 2025

1.0 Purpose of paper

1.1 The Audit Committees-in-Common met on 11 December 2024. They noted that work on the external audit, internal audit and counter fraud plans was being progressed well. The Committees agreed to bring the following matters to the attention of the Group Board.

2.0 Audit Committee Report

2.1 External Audit 2024-25 Update

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

2.2 Internal Audit Progress Report

The Committees received a report, noting that for SGUH, since the last audit committee meeting, three medium actions relating to Data Security and Protection Toolkit (2) and Pressure Ulcers (1) have been implemented. Two medium actions related to Pressure Ulcers and DSPT are completed, but are awaiting evidence from management to close the actions. There are 4 actions (one high and three medium) in progress with revised implementation dates agreed with management. Three medium actions are overdue without a management response. The Committee asked for early updates where no response had been received and welcomed the continuing efforts to ensure recommendations are completed and appropriate management responses received in a timely way.

2.3 Final Internal Audit Reports

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

- Data Quality for Maternity (reasonable assurance) – ESTH): The Committee welcomed the feedback that during the audit, many areas were identified where the controls in place are well designed and operating effectively. The Committee noted that as a result of the audits, actions have been agreed between the auditors and management and welcomed the helpful recommendations to further strengthen controls.

- Procurement (reasonable assurance - SGUH): This audit received reasonable assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. As part of the audit, five 'Medium' and one 'Low' priority actions for management were raised. The Committee received assurance from the management that the majority of these actions will be completed within their assigned timeframe.

- Data Quality for VTE (partial assurance -SGUH): This audit received partial assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. The GCNO advised this report reenforced existing concerns, which was partly why this internal audit was requested. The team has now been integrated across gesh and work has begun to align the process of reporting. A report will be presented to the Committee in 6 months' time to provide an update on the progress of implementing the management actions for this audit.

- CIP Programme (reasonable assurance – SGUH): This audit received reasonable assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. The Committee welcomed the report that several areas of good control were identified, including relevant policies and procedures, sufficient planning processes, and clear review and approval processes for schemes.

2.4 Information Governance and Cyber Security Update

The Committee noted that for the 2024/25 DSPT, a 'Baseline' Assessment of the 24/25 DSPT is required to be submitted by 31st December 2024 and the final full submission by end of June 2025. The Committee received assurance that the group is on track to submit their assessments against this deadline. The Committee requested that trend data be included in a cyber security dashboard at the next meeting.

2.5 Counter Fraud

The Committees received an update from the counter fraud specialists, who advised they had received 13 new fraud referrals combined since the September Audit Committee for ESTH and SGUH, indicating staff remain vigilant to fraud and bribery risks. During the reporting period, 11 referrals have been closed, with 20 remaining ongoing for both Trusts.

2.6 Group Breaches and Waivers Quarterly Report

The Committees received a report setting out the latest no PO no PAY position

- Phase 1 of the policy implementation has been completed, this equates to £23.2m of spend across gesh.
- Actions planned for phase 2 across Q4 24/25 to ensure this is rolled out in all possible areas.
- Regular reports on progress are provided to the SWL Procurement Steering Board which includes all the CFOs for the 4 acute trusts

3.0 Recommendation

3.1 The Board is asked to note the report of the Committee's meeting held on 11 December 2024

Peter Kane
Audit Committee Chair, NED

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	2.5	
Report Title	**Infrastructure Committees-in-Common Report to Group Board**	
Non-Executive Lead	Ann Beasley, Chair of Infrastructure Committees-in-Common Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	
Report Author(s)	Ann Beasley, Chair of Infrastructure Committees-in-Common Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meetings on 22 November 2024 (Estates & Facilities focus) and 13 December 2024 (IT focus). The key issues the Committee wished to highlight to the Board are:

1. **Workforce**: The Committees noted that engagement levels amongst Estates staff had improved and that sickness levels had reduced. The NHS staff survey response indicated good morale.

2. **Compliance:** Issues were identified in Estates, particularly concerning statutory and regulatory compliance levels which were variable across sites. Of specific concern at St Helier was fire and water safety, asbestos, and electrical safety. It was also noted that policies were missing or needed updating in some areas. Group-wide assurance forums were being established to address these compliance issues.

3. **London Fire Brigade (LFB):** During a recent LFB visit, concerns about fire compartmentation and the quality of fire risk assessments at ESTH were raised. Potential enforcement action due to these issues was anticipated.

4. **Quality**: Challenges were identified, particularly in non-emergency patient transport (NEPT) services and hard FM (e.g. sewage leakage, standby power generation) issues, where significant infrastructure failures could impact clinical services. A 6-facet survey is overdue at SGUH.

5. **Financial performance**: the Committee noted the focus in Estates on managing efficiencies and addressing misallocated expenditures (some expenditure had been wrongly coded). The plan was to achieve a financial net zero by the end of the 2024/25 financial year.

Action required by Group Board
The Group Board is asked to note the issues escalated by the Infrastructure Committees-in-Common to the Group Board and the wider issues on which the Committees received assurance in November and December 2024.

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

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

Implications

Group Strategic Objectives

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

Risks

1. The Committees requested a review of the ESTH water safety risk.
2. The Committees recommended the updated Strategic Risk 5 (Modernising Our Estate) and 6 (Adopting Digital Technology) to the Group Board, which would review the full Group BAF at its meeting on 9 January 2025.

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 the paper.

Legal and / or Regulatory implications

As set out in the paper.

Equality, diversity and inclusion implications

As set out in the paper.

Environmental sustainability implications

As set out in the paper.

Infrastructure Committees-in-Common
Group Board, 09 January 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees-in-Common at its meetings on 22 November 2024 and 13 December 2024 and includes matters the Committee specifically wishes to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 22 November 2024 and 13 December 2024, the Committees considered the following items of business:

November 2024 (Estates & Facilities focus)	December 2024 (IT focus)
• Group Estates Strategy Update • ESTH Fire Update • ESTH Water Hygiene • Premises Assurance Model (PAM) • 2023/24 ERIC Submission • Group Green Plan Update • Overview of the Capital Programme – combined report • Board Assurance Framework (BAF) Risk on Estates	• Digital Strategy Development • Digital Delivery Update • Digital Risk Management Update • EPR Programme update • PACs Update

2.2 The Committee was quorate for both meetings.

3.0 Key issues for escalation to the Group Board

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

3.1 **Group Estates Strategy Update**

The Committee received a written update from the Group Chief Infrastructure, Facilities and Environment Officer (GCIFEO) on the next steps in relation the Group Estates Strategy (GES). The GES is an important planning document that will support the clinical delivery of services across the Group into the future by identifying the types of estate, locations, size of buildings and property that the Group would need in order to provide clinical services to our patients. It was estimated that it would cost c.£300,000 in 2025/26 to produce the Development Control Plans (DCPs) required for the Group Estates Strategy and that the Strategy could be finalised between October and December 2025.

3.2 **Digital Strategy Development**

The Committee received a report on the development of the gesh Digital Strategy. The group is operating in a very challenging environment with increasing national and regional demands

as well as from on-going support of the BAU digital infrastructure and internally from clinical services. The Digital Strategy will set realistic goals that would make a difference and define what that difference would look like in practice. The core drivers included the NHS Long Term Plan, Government Change (with potential investment opportunities) and alignment with SW London strategic objectives. The next steps include capacity adjustments based on 'form follows function' and producing a funded and resourced Digital Plan for the next 2 (+3) years.

3.3 **EPR Programme update**

Overall, the EPR programme was progressing well across all of the workstreams. The technical aspects of the programme were stabilised, and the programme was switching focus to organisational readiness as they progressed towards the May 2025 go-live date. The programme was working through the various assurance asks and had positive feedback from the latest programme review from the DHSC (Department of Health and Social Care) teams.

3.4 **Strategic Risks 5 (Modernising Our Estate) and 6 (Adopting Digital Technology)**

The Committees reviewed the risk scores and assurance ratings for Strategic Risks 5 and 6 on the Group Board Assurance Framework and noted the updates on the controls, assurances and actions, and agreed to recommend the updated position to the Group Board.

4.0 Key Issues on which the Committees received assurance

4.1 The Committee wishes to report to the Group Board the following matters on which they received assurance:

4.2 **Group Green Plan**

The gesh Group Green Plan Strategy was formally launched in September 2024 and the 18-month milestone plan and a governance and reporting structure now in place was noted. The importance of identifying available funding before setting expectations was discussed. The Committee requested the development of a dashboard including agreed KPIs to support the reporting of future progress.

4.3 **Digital Delivery Update**

The Committees received an update on a shared IT operating model for the group which would optimise resource allocation and ensure consistent service delivery across both Trusts. The plan to achieve a single data warehouse post Cerner EPR go-live in May 2025 (which will support a unified reporting platform) was discussed. The Committees noted the risks associated with too great a dependency upon external, interim experts and the progress that had been made to reduce the number of interim contracts.

5.0 Other issues considered by the Committees

5.1 **Digital Risk Management Update**

The Committees noted the report which provided an update on the Group-wide risk management process status, specifically relating to the Digital Risk Review. There was a discussion about the need for a more efficient process for closing down risks and ensuring that risk assessments are aligned with latest updates.

5.2 **ESTH Fire Update**

A programme of formal Fire Safety meetings has begun with the London Fire Brigade (LFB) who visited ESTH on 18 November 2024. The plan was to make significant progress by the next fire safety audit in the summer of 2025.

5.3 **ESTH Water Hygiene**

The Committees received a report and noted that the levels of compliance in relation to Water Safety at both ESTH sites continued to be of concern. The strong partnership between the Estates team and IPC (Infection Prevention and Control) teams in addressing water safety issues was noted. The Committee requested a review of the water safety risk on the central risk register.

6.0 Recommendations

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

Group Board

Meeting on Thursday, 09 January 2025

Agenda Item	3.1	
Report Title		
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	James Marsh, Group Deputy Chief Executive Officer	
Previously considered by	Finance Committee-in-Common	20 December 2024
Purpose	**For Review**	

Executive Summary

This report provides an overview of the key operational performance information, and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data. The report highlights successes achieved throughout the month and operational challenges affecting performance, which are listed below and summarised in the executive summaries of the report.

The metrics and targets covered in this report are based on gesh strategic priorities relating to CARE and are aligned with national priorities outlined in the following documents:

- NHS Priorities and Operational Planning Guidance
- NHS System Oversight Framework
- NHS Constitution and National Standard Contract
- Annual Quality Accounts

The data is presented using statistical process control with benchmarking information where available. The data quality status of metrics is also noted in the reported.

Action required by Group Board

The Group Board is asked to:

a) Note the progress update, key risks, and mitigating actions.

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

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

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

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

Group Integrated Quality & Performance Report

November 2024

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 22 November 2024

gesh CARE Board

Board to Ward Improvement Priorities for 2024/25

C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
Deliver 78% 4-hr A&E Performance: SGUH – 76.1% vs. trajectory of 75.4% ESTH – 72.3% vs. trajectory of 76.5%	**Deliver Financial Plan**: SGUH – Please refer to finance report ESTH – Please refer to finance report	**Improvement in fundamentals of care as per Quality Priorities** – **Falls** – progress under review **Pressure Ulcers** – Not achieving **VTE Risk Assessments** – plans in place to standardise reporting **Dementia Assessments** – under review	**Staff Turnover Rates*: Target 13%** SGUH – Achieving Target ESTH - Achieving Target
Maintain ED 12hr Waits at 23/24 Level or below: SGUH – 9.3% (upward trend) vs. baseline (23/24) of 8.8% ESTH - 13.5% (upward trend) vs. baseline (23/24) of 9.6%	**Deliver 5% Productivity (ERF)** SGUH – Please refer to finance report ESTH – Please refer to finance report	**Achieve Mortality Ratios (SMHI) of 1 or less**: SGUH – 0.91 (below expected) upcoming SDEC reporting likely to adversely impact reported performance ESTH - 1.17 (above expected) (*partly attributable to coding changes)*	**Staff Sickness Rates***: SGUH - 5.1% vs. target of 3.2% ESTH – 5.1% vs. target of 3.8% Sutton – 7.3% vs. target of 3.8% Surrey Downs – 4.6% vs target of 3.8%
Deliver 1.5 Days LOS Reduction with partners: SGUH – 9.3%, improving trend ESTH - 10.7%, improving trend	**Deliver 5.5% CIP** SGUH – Please refer to finance report ESTH - Please refer to finance report	**Eliminate RTT 65-week waits by September 2024:** SGUH – 30 patients ESTH - 98 patients	**Improvement in WRES and WDES Metrics**: 2023/24 WRES and WDES Reports were published in October 2024. Highlights, key next steps and progress to follow.
Deliver 80% Virtual Ward Utilisation Rate: Sutton – 75.3.% vs. target of 80% Surrey Downs – 89% vs. target of 80%		**Deliver 62- Day Cancer Waiting Times Operational Plan Targets**: SGUH –80.5% Exceeding Plan ESTH - 81.1% Below Plan	**Improvement in % of staff saying they would recommend the organisation as a place to work** - Improvement on previous year (results based on 2023/24 compared to 2022/23- under review * Proxy for Staff engagement whilst detailed metrics are developed

Executive Summary

Safe, High-Quality Care

St George's Hospital

Successes

Complaints: SGUH continues to meet the targets for the percentage of complaints responded to in 35 days and acknowledged within 3 working days.
Mortality: SHMI performance remains classified as "As expected". It is important to note that the inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set at SGUH in the coming months is likely to adversely affect reported performance.

Pressure Ulcers: There were zero category 4 pressure ulcers and zero category 3 & 4 pressure ulcers were related to medical devices in November 2024.

Challenges

Never Events: One wrong site surgery Never Event was reported in November2024.
Patient Safety Incident Investigations (PSII): SGUH declared 4 PSIIs in November 2024 which includes a Never Event. The 3 PSIIs (2 Maternal deaths and 1 neonatal death). All are being externally investigated by the Maternity and Newborn Safety Investigation (MNSI) programme

Falls Prevention and Management: 3 falls with moderate harm and 1 with high harm that occurred in inpatient areas in November 2024. The high harm fall resulted in an acute right subdural haemorrhage; the patient is now receiving palliative care. The 3 patients that sustained moderate falls had injuries including tooth loss, subdural haemorrhage and epidural haematoma. 1 high harm fall was also reported in the community when an SGUH patient sustained poly-fractures after falling out of a transport vehicle at their off-site dialysis hub; they are recovering well.

VTE: 61.9% of VTE risk assessments in November 2024 were within 14 hours of admission (as per NICE guidance). Work is underway to standardise reporting and to review the VTE prevention strategy across gesh.

Pressure Ulcers: There were 6 Acquired Category 3 pressure ulcers in November 2024, this is down from previous months. The slow mattress replacement and intensive care medical devices related pressure ulcer prevention projects continue.

Readmission: Readmission rates are elevated and performance will continue to be monitored.

Infection Control: There were 3 hospital acquired C. difficile infections in November, total of 44 YTD. Despite having breached the set threshold of 43, performance remains within the top 25% of 135 NHS Trusts. There were 15 cases of E. coli bacteraemia during November; 12 have been classified as Hospital-Onset Healthcare-Associated (HOHA) and 3 classified as Community-Onset Healthcare-Associated (COHA. Actions around the appropriate management of urinary catheters has been put in place - focus on urinary catheter simulation training for healthcare assistants.

Epsom & St Helier

Successes

Never Events: There were no Never Events reported in November 2024.

Patient Safety Incident Investigations (PSII): ESTH declared 0 PSIIs in November 2024.

Falls Prevention and Management: There were 0 moderate or above harm falls in November 2024. The Falls CNS and Service Lead for Moving and Handling Practices are collaborating to review flat lifting equipment, including access and training. New equipment will be made available for Multi-Disciplinary Team (MDT) consideration. A total of 76 falls was reported in November 2024, this is a 14% reduction from a total of 88 falls in October 2024. This equates to 3.8 per 1,000 occupied bed days (OBDs); of these incidences, 56 occurred on adult inpatient wards.

Pressure Ulcers: The total number of pressure ulcers remains low for November 2024. Currently there are 13 pressure ulcers recorded for November 2024; 5 category 2 and 8 deep tissue injuries (vulnerable skin).

Challenges

Complaints: ESTH were unable to maintain the target for the percentage of complaints responded to within 35 days due to unplanned staff absence in the complaints team Target for the percentage of complaints acknowledged within 3 working days was also impacted and dropped to 98%

VTE: The Trust VTE performance for November 2024 is 83% . This is 1% less than the Trust's reported monthly average. Chuter Ede AMU remains high risk location with only 33% of assessments completed on time.

Mortality: The SHMI remains elevated, partly due to the inclusion of SDEC data in the Emergency Data Set, but it is showing a downward trend.

Infection Control: The Trust continues to experience an increase in C. difficile infections across the health group. The ESTH team is conducting a prospective audit of all cases in 2024/25 to better understand the surge and implement appropriate actions. Additionally, two COVID-19 outbreaks have occurred on the Sutton Reablement Unit. The IPC team has delivered comprehensive training to address gaps in IPC practices

Executive Summary
Operational Performance

St George's Hospital

Successes

- First and procedure outpatient (OP) attendances as a percentage of total OP attendances continues to exceed target achieving 52.3% (above the national ask of 49%).
- Patient Initiated Follow-up (PIFU) uptake is increasing across all divisions. Plan to achieve 2% for October 2024 on track to be delivered.
- Diagnostic performance remains within the 5% recovery target despite current challenges.
- Cancer 62-day performance continues to exceed plan achieving 80.5% in October 2024 Breast, Skin and Urology reporting a compliant position.
- Faster Diagnosis Performance (FDS) Performance improved and exceeded trajectory in October 2024 achieving 80.5%.
- Overall improvement observed in non-elective length of stay (LOS) with an average of 9.3 days in November 2024. The number of Super Stranded patients continues to decrease aiding flow and also a reduction seen in the number of ambulance arrivals breaching 30 minutes.

Challenges

- The number of RTT 52-week pathways remains above plan with increases seen across October 2024 with 832 patients waiting , driven by General Surgery, Gynaecology and Pain.
- Did Not Attend (DNA) Rates continue to be above target with 10.1% of patients through November 2024 not attending their scheduled appointment compared to peer median of 9.9%. Specialities have actions in place via Elective Access Meeting and making changes to call centre options acting on recent patient feedback.
- Continued PTL growth in October by 918 pathways (1.4%)
- Theatre Capped Utilisation rates remain below 85% however seeing an improving trend particularly in Day Surgery Unit and Inpatient. Continued emphasis on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. Deep dives into daycase rates underway through Recovery Meetings.
- Demand for diagnostic tests is now outstripping capacity and November performance at risk driven by Ultrasound.
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside

Epsom & St Helier

Successes

- Theatre utilisation (capped) remains above 80% with 82.1% in November 2024.
- Cancer performance achieved in October 2024: 28-day Faster Diagnosis standard (91.3%) and 31-day standard (97.8%).
- EBUS pathology service was successfully transferred from SGUH to ESTH.
- Reduction in DNA rate to 6.2%
- RTT 52 and 65 week waits reduced again in October 2024 compared to the previous month.
- Diagnostic performance improved again in October 2024, mainly due to significant backlog reductions in ECHO and Urodynamics.
- ESTH are demonstrating a LOS reduction of 0.8 days since April 2024. Super stranded patients (>21 days) have reduced month on month from 174 days in May 2024 to 151 days in November 2024.
- There were 196 patients not meeting criteria to reside in November versus 216 in May 2024.

Challenges

- October GP 62-day standard (81.1%) was challenged due to high number of breaches and low treatments (notably in urology). The breach reasons were a combination of complex pathways and patient choice delays at various points in the pathway.
- Endoscopic Ultrasound Staging (EUS) capacity for Upper GI cancer patients is limited; current wait of 3-4 weeks. Delays in diagnosing lung cancer are increasing due to increased referrals to Navigational Bronchoscopy at the Royal Brompton; an alternative to CT-guided biopsy.
- Delays in Deep Sedation capacity due to theatre availability. Additional funding provided to Endoscopy by 'Cancer Demand' RMP and yearly resilience fund, to create additional lists.
- Ongoing capacity issue in booking patients on the Telephone assessment clinic (TAC) exclusion criteria for an outpatient appointment within 7-days (ESTH local target) specifically for urology, dermatology and lower GI.
- A&E waits and timely ambulance handovers were a challenge in November 2024 due to an increase in attendances and acuity on both sites.
- Many mental health patients continue to experience prolonged waits in emergency departments for transfer to inpatient mental health beds.
- Reducing 65 week waits to 0 remains challenging, however plans are in place across the specialities with long waiters and regular monitoring on progress is in place.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

- Referrals to virtual wards continue to increase to support patient flow. The main referrer is ESTH.
- Service consistently achieves the 2 -hour UCR target - 80.3% in November 2024 against a target of 70%.
- 100% occupancy rate in bedded care was maintained.
- The number of children waiting longer than 52 weeks for therapy services reduced from 75 in April 2024 to 4 in November 2024.

Challenges

- The waiting list and waiting times for children's therapy services remain high, in line with national rising trends for children's speech and language services.

Surrey Downs Health & Care(SDHC)

Successes

- The service maintained its target of discharging of patients through Transfer of Care hub within 2 days on average to support patient flow.
- Service consistently achieves the 2 -hour UCR target while managing high levels of referrals - 86% in November 2024 against a target of 70%.
- Improvements in waiting list management were maintained across all services with no 52+ week waiters and reduction total number of patients waiting over 18 weeks.
- 88% occupancy rate in bedded care was maintained.
- High levels of Mandatory and Statutory Training (MAST) being maintained at 94.3% (Oct 2024).
- Reduction in agency rates to 2.9% (Oct 2024)

Challenges

- Increase in the number of adults waiting longer than 18 weeks due to recruitment difficulties in podiatry.
- Vacancy rate is at 18.5 (October 2024) against a target of 10%. There is an ongoing focus on recruitment.
- Non-Medical appraisal rate is dropped to 82% (October 2024), plan is in place to improve the performance.
- Sickness rate continues to exceed target with current rate of 4.6% (October 2024) against a target of 3.8%

Quality & Safety

Safe, High-Quality Care

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Nov 24	0	1	0				Nov 24	0	0	0			
Patient Safety Incidents Investigated	Nov 24	0	4	0				Nov 24	0	0	0			
Number of Falls With Harm (Moderate and Above)	Nov 24	1	4	1				Nov 24	4	0	1			
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Nov 24	0.04	0.17	0.12				Nov 24	0.19	0.00	0.03			
Pressure Ulcers - Acquired category 3	Nov 24	7	6	8				Nov 24	0	0	7			
Pressure Ulcers - Acquired category 4	Nov 24	2	0	0				Nov 24	0	0	0			
30-Day Readmission Rate	Oct 24	13.3%	12.9%	-				Oct 24	5.8%	5.2%	-			
Infection Control - Number of MRSA	Nov 24	0	0	0				Nov 24	0	0	0			
Infection Control - Number of Cdiff - Hospital & Community	Nov 24	6	3	4				Nov 24	6	7	5			
Infection Control - Number of E-Coli	Nov 24	12	15	10				Nov 24	5	8	5			
VTE Risk Assessment	Nov 24	61.6%	61.9%	95.0%				Nov 24	83.0%	83.0%	95.0%			
Mortality - SHMI	Jul 24	0.91	0.91	1.00				Jul 24	1.17	1.17	1.00			
% Births with 3rd or 4th degree tear	Nov 24	3.6%	2.9%	-			3.1%	Nov 24	1.7%	3.3%	-			3.2%
% Births Post Partum Haemorrhage >1.5 L	Nov 24	3.6%	2.6%	-			2.9%	Nov 24	2.5%	3.7%	-			3.2%
Stillbirths per 1,000 births	Nov 24	3.0	3.3	-				Nov 24	6.1	7.4	-			
Neonatal deaths per 1,000 births	Nov 24	0.0	3.3	-				Nov 24	3.1	0.0	-			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Nov 24	0.0	3.3	-				Nov 24	0.0	0.0	-			

New VTE guidance implemented from Q1 2024 to monitor VTE assessment completed within 14 hours.

- SGUH previously monitored against no time frame and are using Decision to Admit date / time as the clock start for ED patients
- ESTH monitored against 24 hours and are using admission date / time as clock start

Mortality: SDEC reporting will be introduced over the next few months and likely to have an adverse impact on SHMI performance

*Never Events are a subset of PSIIs

Safe, High-Quality Care

Overview Dashboard | Patient Experience

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
	St George's							Epsom & St Helier						
Complaints responded to in 35 days	Nov 24	100.0%	93.6%	85.0%				Nov 24	100.0%	74.5%	85.0%			
Percentage of complaints acknowledged within three working days	Nov 24	100.0%	100.0%	100.0%				Nov 24	100.0%	98.0%	100.0%			
Number of complaints not completed within 6 months from date of receipt	Nov 24	2	1	-				Nov 24	9	6	-			
Friends and Family Test - Inpatients Score	Nov 24	97.4%	97.4%	90.0%			Top Quartile	Oct 24	95.0%	95.5%	90.0%			3rd Quartile
Friends and Family Test - Emergency Department Score	Nov 24	80.3%	79.2%	90.0%			2nd Quartile	Oct 24	82.0%	81.9%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	Nov 24	92.3%	94.1%	90.0%			2nd Quartile	Oct 24	94.0%	94.0%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Nov 24	100.0%	86.2%	90.0%			2nd Quartile	Oct 24	80.0%	94.1%	90.0%			2nd Quartile
Watch List Metrics														
Number of Complaints Received	Nov 24	74	91	-				Nov 24	44	49	-			
Number of re-opened complaints in month	Nov 24	4	3	-				Nov 24	2	0	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Nov 24	0	0	-				Nov 24	1	3	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Nov 24	0	0	-				Nov 24	0	0	-			

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

Safe, High-Quality Care

Overview Dashboard | Integrated Care

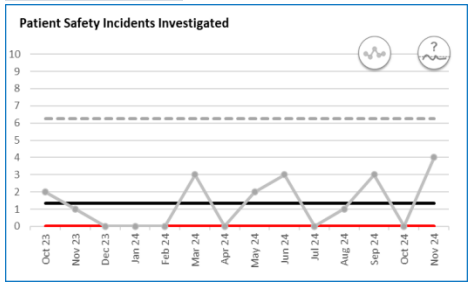
KPI	Sutton Healthcare Latest month	Sutton Healthcare Previous Month Measure	Sutton Healthcare Latest Month Measure	Sutton Healthcare Target	Sutton Healthcare Variation	Sutton Healthcare Assurance	Surrey Downs Latest month	Surrey Downs Previous Month Measure	Surrey Downs Latest Month Measure	Surrey Downs Target	Surrey Downs Variation	Surrey Downs Assurance
Patient Safety Incidents Investigated	Nov 24	0	0	-			Nov 24	0	0	-		
Number of Falls	Oct 24	3	5	-			Nov 24	9	11	-		
Pressure Ulcers Category 3	Nov 24	2	2	0		?	Nov 24	1	3	0		?
Pressure Ulcers Category 4	Nov 24	0	0	0	L	?	Nov 24	1	0	0		?
Infection Control - Number of Cdiff	Nov 24	0	0	-	L		Nov 24	1	1	-		
Complaints	Oct 24	0	0	-	L		Nov 24	2	2	-	H	
Community FFT	Oct 24	96%	95%	90%		?	Oct 24	98%	96%	90%		P

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

Safe, High-Quality Care

Incident Reporting

St George's

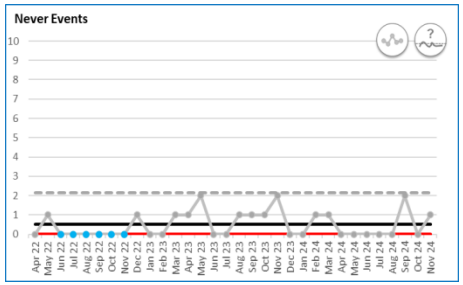


Summary & Actions

4 Patient Safety Incident Investigations (PSIIs) were declared in November 2024, including one Never Event.

2 Maternal deaths and 1 neonatal death. All of which are being externally investigated by the Maternity and Newborn Safety Investigation (MNSI) programme.

1 Wrong site surgery (injection) Never Event.



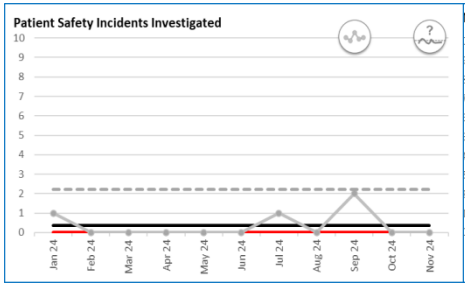
Summary & Actions

One Never Event was declared in November 2024.

Wrong site surgery (injection): of a patient who attended for a routine course of botulinum toxin (botox) to their LEFT lower lip for facial asymmetry secondary to a facial deformity. Unfortunately, this was injected to their RIGHT lower lip in error.

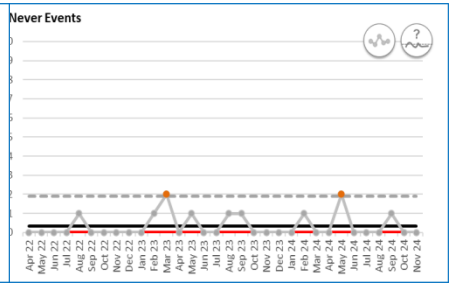
This incident is being investigated as a PSII

Epsom & St Helier



Summary & Actions

No Patient Safety Incident Investigations (PSIIs) were declared in November 2024.

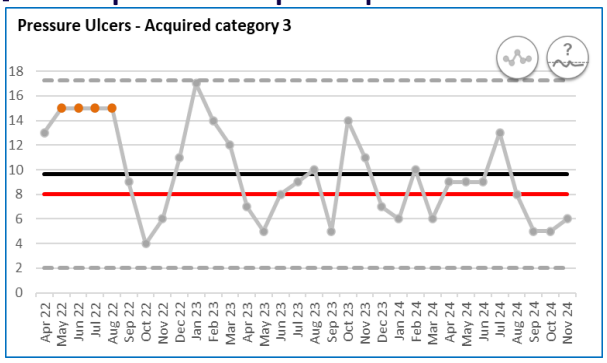


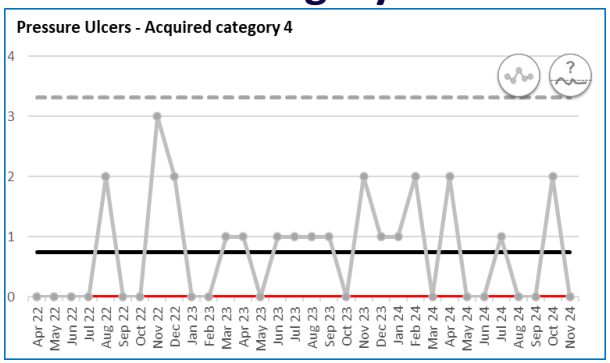
Summary & Actions

No Never Events were declared in November 2024.

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers Category 3 & 4





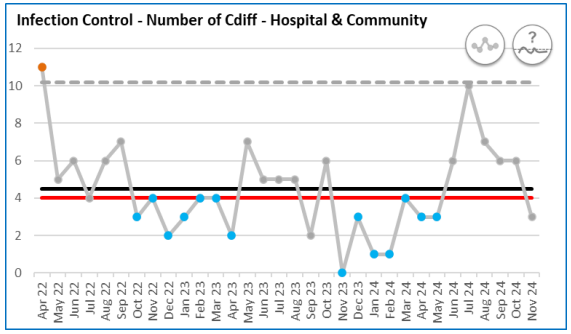
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

SGUH
 	
Pressure Ulcers Grade 3
 	
Normal variation and ambition to achieve 10% reduction is not been met consistently.
	• There were 6 Acquired Category 3 & 4 pressure ulcers in November 2024, this is similar to October 2024 and down from previous months, zero were category 4 or related to medical devices.
	• 5 of the 6 pressure ulcers were acquired in general inpatient areas and were located on the coccyx or sacrum
	• A medical physics audit of mattresses in general ward areas in June/July 2024 showed that 47% did not have optimal function. Patients cared for on sub-optimal mattresses are more likely to develop pressure ulcers in areas such as the sacrum, coccyx and heals
	• 1 pressure ulcer was acquired in an adult ICU, this was also on the sacrum but likely due in part to the poor clinical condition of the patient
		• Dynamic Healthcare and Medical Physics team to continue slow mattress replacement programme with the aim of completion by August 2025. 25% of stock has been replaced to date including mattresses in all priority areas.
		• Stop the pressure event took place in November 2024 to focus on medical devices; urinary catheters in particular
		• Tissue Viability Team to work with procurement to ensure correct catheter fixation devices are available on stock lists by January 2025
		• On-going mandatory and induction teaching sessions as well as e-learning modules (not currently mandated)
		• Site Chief Nurse and fundamentals of care team to work collaboratively to but resources in a place to improve continence care with the hope of reducing moisture associated skin damage including a new:
		  ○ Continence product formulary
		  ○ Group policy including a formalised risk assessment and nursing care plan
		• Review of pressure ulcer incident process to ensure this aligns with PSIRF; focusing more on system improvement and less on investigation
			March 2025 achieve 10% reduction compared to 2023/24	Sufficient for assurance

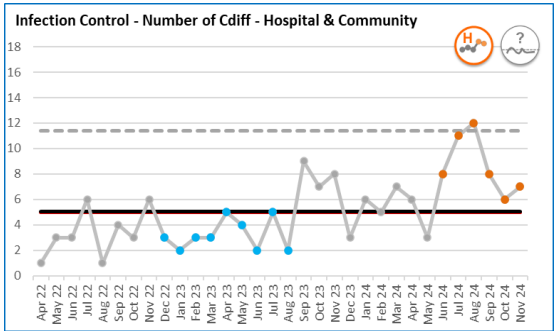
Safe, High-Quality Care

Exception Report | SGUH & ESTH - Infection Prevention and Control

St George's



Epsom & St Helier

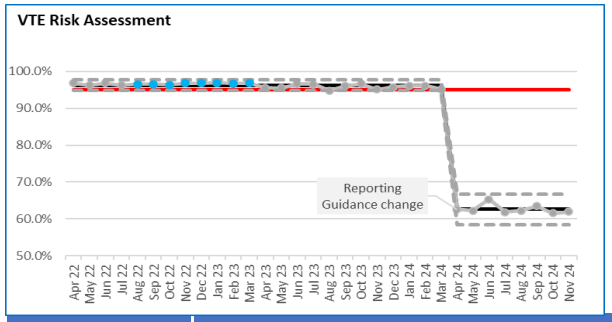


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH and ESTH C.difficile Infections (CDI) There has been an increase in the number of healthcare acquired CDI infections across the group.	Healthcare Associated CDIs: • SGUH: 3 new C diff cases taking us above the trajectory of 43. A total of 44. YTD. • ESTH: 6 new C diff cases A total of 63 YTD. Mortality rate is 14% which is below the national average of 18%. • Both sites: All samples are sent to the reference laboratory for ribotyping and there has been no similar typing suggesting there is no same strain that is circulating in our hospitals or evidence of cross infection.	• SGUH: performance remains within the top 25% of 135 NHS Trusts with a rate of 15.37 per 100,000 bed days • ESTH: The Trust continues to experience an increase in C. difficile infections across the health group. The ESTH team is conducting a prospective audit of all cases in 2024/25 to better understand the surge and implement appropriate actions. • A separate detailed Infection Prevention Report goes to the Board	March 2025 achieve aim to achieve a downward trend in line with national trajectories	Sufficient for assurance

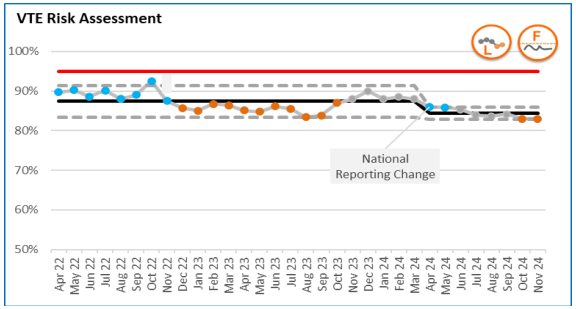
Safe, High-Quality Care

Exception Report| SGUH & ESTH VTE Risk Assessment

St George's



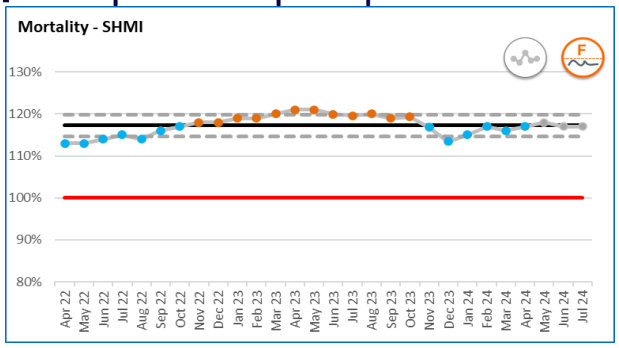
Epsom & St Helier

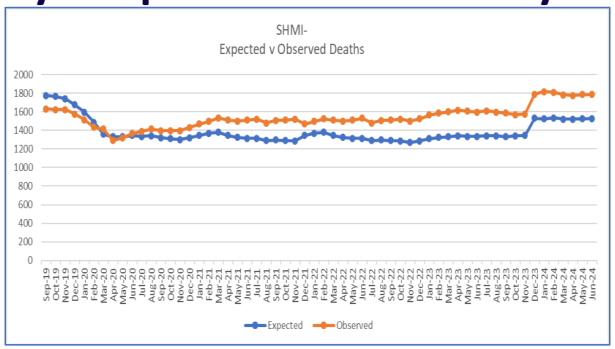


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE Performance – 61.9%. Not meeting target of 95%	National reporting of VTE risk assessments, which had been paused due to the pandemic, has now been reinstated. Previously, the guidance did not specify a time frame for completion. However, it now states that risk assessments should be completed within 14 hours, in line with NICE standards. As a result, reported performance has been affected.	• The Hospital Thrombosis Group and Clinical Informatics are working alongside ESTH to standardise reporting across gesh and have agreed on using DTA (decision to admit time) for patients admitted via ED. Further discussions are also planned to ensure various patient groups are cohorted in the same way for reporting. • A gesh-wide review of VTE risk assessment forms and the rules applied to the alerts on iCLIP is underway, to encourage higher completion rates. • Targeted training and education will be provided to under-performing areas as identified on Tableau.	Aim of incremental improvement: 10% by end of March 2025 and review progress.	Sufficient for assurance.
ESTH: VTE Performance – 81%. Not meeting target of 95%	The Trust VTE performance for November 2024 is 83% . Chuter Ede AMU remains high risk location with only 33% of assessments completed on time, compared to STH AMU's 70% and STH SAU's 96%. Comparison of VTE performance across the divisions show SWLEOC at 100%, Planned Care at 85%, Renal 84%, Women and Children 81% and finally, Medicine with 53% To note ESTH are using Ward Admission Time as the starting point for patients admitted via ED. Discussions are ongoing to align across gesh.	• VTE CNS's have met with medical colleagues from Chuter Ede at MDT meetings and safety huddles with a view to agree an improvement plan by January 2025. • Updated VTE policy approved at Policy Review Group at the beginning of October 2024 and awaiting final SLT approval • Increased VTE Clinical Nurse Specialist ward visibility to monitor VTE prevention practice, advise, support and engage patients and staff directly with both risk assessment completion and prevention strategies	March 2025	Sufficient for assurance.

Safe, High-Quality Care

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



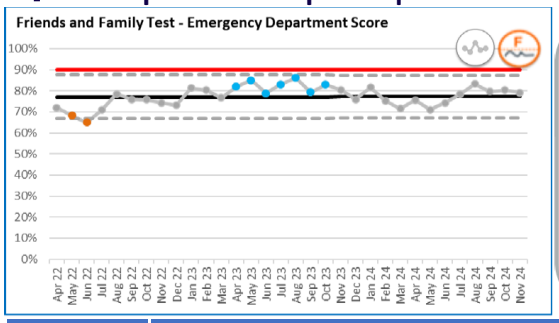


SHMI Source NHS Digital data based on rolling 12 months- June 2023 to May 2024 reported in October 2024

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently above expected rate	ESTH's mortality index is classified as 'higher than expected', but it shows a decreasing trend. In 2020, Epsom and St Helier University Hospitals NHS Trust (ESTH) stopped categorizing Same Day Emergency Care (SDEC) as inpatient activity. As a result, this change has led to a decrease in the total spell count used in the Summary Hospital-level Mortality Indicator (SHMI) model. Consequently, the expected number of deaths has fallen, which has been noticeable since that time. Other Trusts were expected to adopt a similar reporting approach by July 2024. However, national data indicates that by the end of September 2024, only 48 Trusts had submitted data, compared to just 18 at the end of the previous year. NHSE has recently extended the deadline for Trusts to implement this change in reporting to July 2025.	Deep dives and thematic analyses of outlying areas have been completed which included electrolyte imbalances, UTI, COPD and pneumonia and did not show any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has identified areas of improvement and cases where care concerns are identified are reported and investigated. Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. Clinician-Coder collaboration will be extremely beneficial to improve the recording. Coding has improved and is continuing to be reviewed but in areas such as UTI and Acute Bronchitis needs more improvement. There are several enhanced monitoring workstreams including mortality reviewer and medical examiner scrutiny	Under review	sufficient for assurance

Safe, High-Quality Care

Exception Report | SGUH Emergency Department Patient Experience

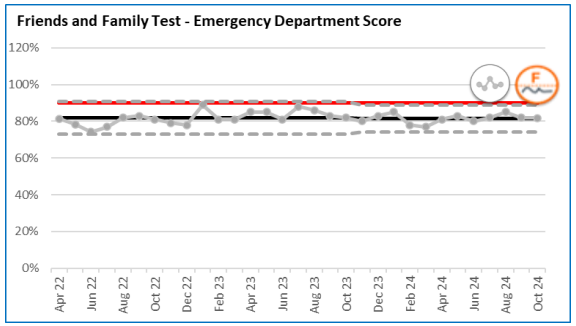


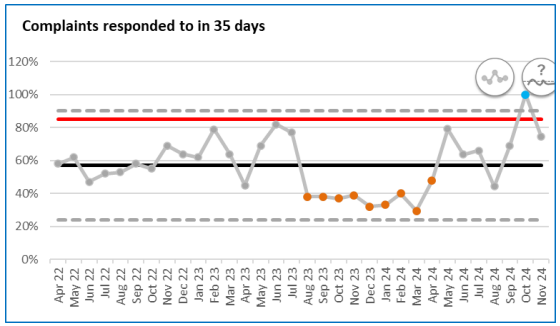
The staff were wonderful - kind and efficient. They were constantly busy and under enormous pressure because there were a lot of people in A and E. They needed to keep me in for observation overnight because they thought that I might have had a heart attack. There weren't enough beds but the doctor seeing me went out of her way to make sure that I could have one and would be able to sleep. I have nothing but admiration for them. I could see how difficult the conditions are under which they are working but everyone - the doctors, the nurses, and the support staff - everyone was helpful and pleasant. They are heroic.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score Special case concerning variation Consistently failing target	The ED survey response rate continues to be well above the national average with **1,479** patients responding to the survey in November2024. The number of patients that would recommend the department to friends and family was 79**%** for November 2024, on par with the national average for EDs of 79% (data from September2024). During November 2024 , the number of ED attendances and patients awaiting a bed in the department continued to be high with the most consistent theme for negative responses being waiting times.	**Actions for improving patient experience whilst waiting in ED include:** 1. Since August, we can now see the FFT score and response rate by area, including Children & Young People Emergency Department, Urgent Treatment Centre and Enhanced Primary Care Hub. This will enable us to review the patient feedback from each area with the relevant leads, share with the teams and make it easier to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing standardised documentation template for use by RNs when looking after patients in the corridor – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments. We are also offering all patients a comfort pack, consisting of eye masks and ear plugs - ongoing 3. Nurse In Charge (NIC) checklist on RATE – quality checklist to be completed by NIC at the start of each shift to identify safety checks completed within the department - ongoing 4. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles - ongoing 5. Consultant Referral and Triage (RAT) rota ongoing. Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary - ongoing 6. Same Day Emergency Care (SDEC) ongoing - 10 new clinical pathways for medical SDEC launched 15th May to redirect patients to medical service if more appropriate. Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic - ongoing	TBC	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH - Patient Experience (Satisfaction & Complaints)





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Normal variation Consistently failing target	In October 2024, 82% of patients surveyed in our emergency departments at both Epsom and St Helier responded positively to the overall question of, how was your experience of our service. 81 patients responded negatively. 629 patients were surveyed (93% via SMS / Text) this is a response rate of 6% against a national average of 11% and SWL average of 8.8%. *FFT data for ESTH has been suspended this month due to a change in supplier. This will be resolved by next month.	• Improve Response rates across both hospital sites • Understand themes and trend of patients that respond negatively . • suggestions for volunteers to be used in ED at ESTH to help gather feedback including FFT but have not successfully recruited any to date. • Medical division working to support patient experience during periods of extreme demand for emergency care services, including additional staffing and patient flow to release inpatient capacity		sufficient for assurance
ESTH Complaints responded to in 35 Days Target not met	Target was not met in November 2024, due to staff shortages within the complaints team. There have been varying ownership levels between the complaints and divisional teams, with most of the responsibility sitting with the complaints team. This is a result of the complaint process that had been in place.	Several actions as part of the complaint's improvement work stream are underway to support improving this metric and are ongoing and previously reported. A review and re-allocation of current cases has taken place within the complaints team to support completion of complaint responses and staffing support will be reviewed again at the end of December 2024.	April 2025	Not sufficient for assurance

Operational Performance

Operational Performance

Overview Dashboard | Elective Care

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
St George's							
Elective Ordinary Activity % of plan	Nov 24	84.5%	92.3%	-			
Elective Daycase Activity % of plan	Nov 24	98.9%	96.5%	-			
Outpatient first attendances without a procedure - ERF scope % of plan	Nov 24	137.2%	138.8%	-			
Outpatient procedures - ERF scope % of plan	Nov 24	90.0%	78.0%	-			
Diagnostic Activity	Oct 24	20268	22041	21345			
BADS All Daycase & Outpatient Procedures % of total procedures	Aug 24	80.0%	79.7%	83.6%			Lowest Quartile
Theatre Utilisation (Capped)	Nov 24	79.7%	80.7%	85.0%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Sep 24	1.0%	1.3%	5.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Nov 24	52.8%	52.3%	49.0%			
Outpatients Missed Appointments (DNA Rate)	Nov 24	10.0%	10.1%	8.0%			Lowest Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Sep 24	21.2	17.9	16.0			2nd Quartile
RTT - Waits over 65 weeks	Oct 24	10	30	0			Top Quartile
RTT - Waits over 52 weeks	Oct 24	743	832	444			3rd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Oct 24	70.4%	80.5%	77.0%			
Cancer 31 Day Decision To Treat to Treatment Standard	Oct 24	96.1%	94.3%	96.0%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Oct 24	81.9%	80.5%	70.0%			Top Quartile
Diagnostics - 6 Week Waits	Oct 24	3.9%	4.3%	5.0%			2nd Quartile
Watch List KPIs							
RTT - Total Size Incomplete Waiting List	Oct 24	66562	67480	64494			2nd Quartile
RTT - Percentage within 18 weeks	Oct 24	63.6%	63.2%	92.0%			2nd Quartile
RTT - Median Waiting Time	Oct 24	12.9	13.0	-			Top Quartile
On the Day Cancellations not re-booked within 28 days	Oct 24	5	4	0			2nd Quartile

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Epsom & St Helier						
Nov 24	92.9%	90.2%	-			
Nov 24	93.5%	101.8%	-			
Nov 24	98.3%	106.1%	-			
Nov 24	96.1%	103.6%	-			
Oct 24	17230	18962	16691			
Aug 24	77.8%	76.1%	83.6%			Lowest Quartile
Nov 24	81.1%	82.1%	85.0%			Top Quartile
Sep 24	5.0%	4.7%	5.0%			Top Quartile
Nov 24	44.8%	46.3%	49.0%			
Nov 24	6.5%	6.2%	6.0%			2nd Quartile
Sep 24	56.4	51.6	16.0			Top Quartile
Oct 24	117	98	0			2nd Quartile
Oct 24	844	754	750			2nd Quartile
Oct 24	87.9%	91.3%	77.0%			
Oct 24	97.1%	97.8%	96.0%			2nd Quartile
Oct 24	86.2%	81.1%	85.0%			
Oct 24	7.8%	5.7%	5.0%			2nd Quartile
Oct 24	51219	50296	46104			2nd Quartile
Oct 24	65.2%	64.5%	92.0%			Top Quartile
Oct 24	12.5	12.5	-			
Nov 24	0	0	0			

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

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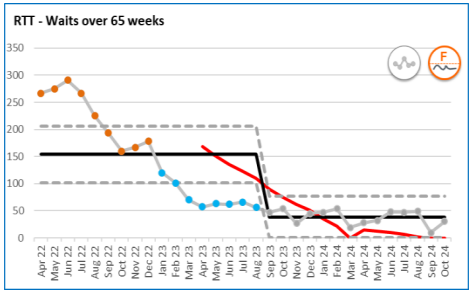
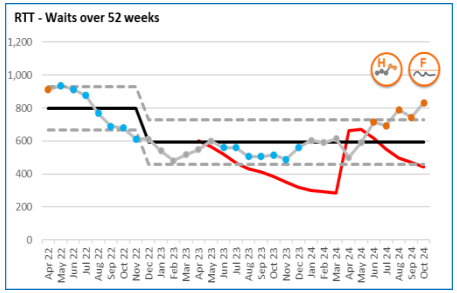
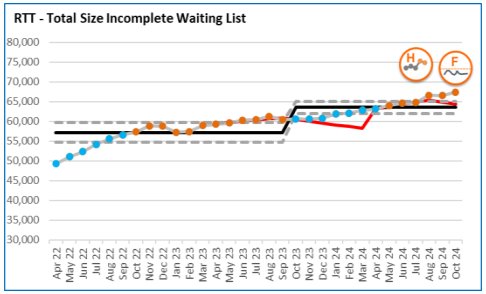
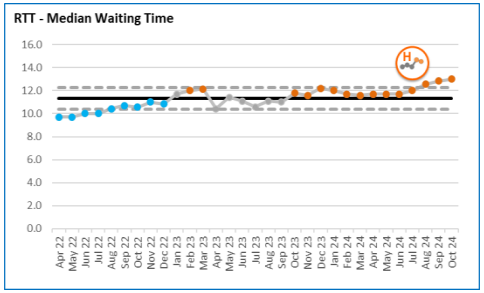
Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)





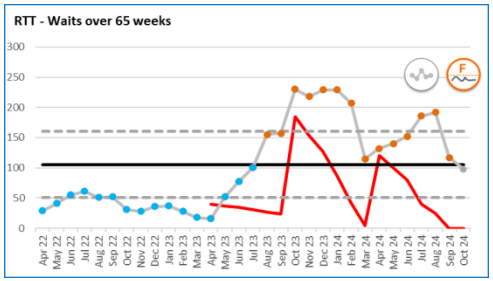


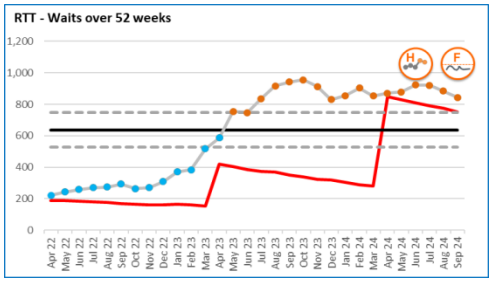


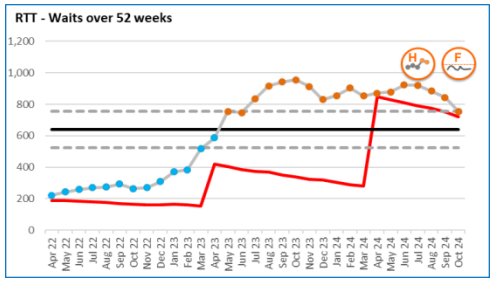
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 0 52 week waits behind plan of 444 Waiting list size behind plan increasing trend	• 65 week waits reporting 30 open pathways, highest three specialties Vascular 7, Gynaecology 5, Neurosurgery 4. • Waiting List size has seen an increase through October 2024 by 918 pathways (1.4%) • Admitted pathway waiting list increased by 482 pathways (6.6%) driven by General Surgery • Outpatient pathway waiting list continues to grow seeing an increase of 0.7% (436 pathways) • 832 patients >52 weeks compared to 743 at the end of September seeing an increase of 89 patients (12%) driven by General Surgery, Gynaecology and Pain • At the end of November, number of patients over 40 weeks un-booked 1,772	**Revised approach to managing long waits:** The elective access meeting has adopted some processes and principles around the management of long waits and this is now a priority agenda item on the weekly meeting. Ensuring that long waiting patients are target booked and considered in capacity plans going forward. **Target booking:** Specialties are now focusing on a targeted booking approach to ensure long waiting patients are treated in chronological order. **eRS Triage process implementation:** Specialties will move to triage on eRS which will help to improve Advice & Guidance numbers and record more accurate waiting list data **Patient Communications:** Improving our communication with patients from point of receipt of referral to point of treatment and discharge. This will ensure there is better engagement and reduce DNAs	**Phased approach Completion March 2025** **January 2025** **March 2025**	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



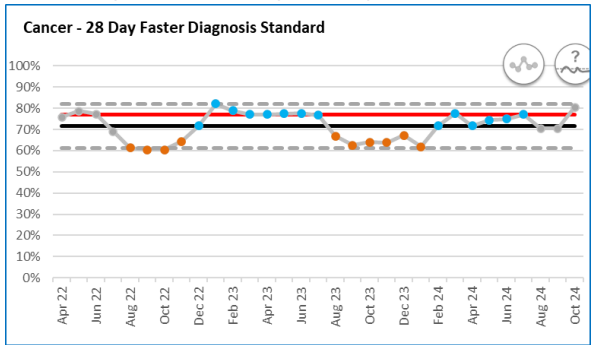


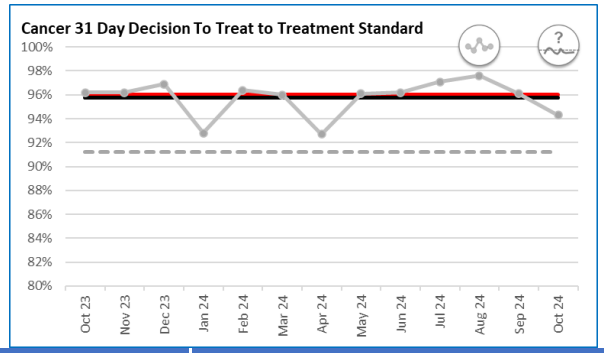


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan 52Wk & 65Wk waits not meeting plan special cause variation	• 52 week waits remained above the ambition of 720 in October 2024 with a total of **754** patients waiting more than 52 weeks. The specialties with the highest cohort were Gynaecology (210), Trauma & Orthopaedics (70) and Vascular (61). • 65 week waits also remained above the ambition in October 2024 with a total of **98** patients waiting more than 65 weeks. The specialties with the highest cohort were Gynaecology (48), Cardiology (8) and Vascular (8). • Gynaecology remains the most challenged specialty at ESTH with several actions being taken to mitigate. • Challenges within several other specialties including T&O, Vascular, Dermatology, Respiratory, Gastroenterology and Cardiology for a variety of reasons, all of which have recovery plans in place.	• Recovery plans in place and ongoing for the most challenged specialties. • Gynaecology patients waiting more then 52 weeks for treatment continue to reduce with additional weekend theatre capacity and additional outpatient insourcing recently approved. Gynaecology theatre scheduling action plan also in place to support theatre productivity and maximise utilisation. • Planned Care's main challenge is Vascular. An additional locum consultant and insourcing was approved for November 2024 to support backlog clearance. • Medicine - mitigations in place including additional consultant support approved in dermatology, cardiology and gastro; mutual aid being provided by Croydon for echo and lung function tests; and insourcing in place for Dermatology, Respiratory and Neurology. • T&O's main cause of increase in long waiters is lack of capacity (referrals from partners outpacing their capacity, with exception of a few consultants) and continuation of referrals being sent to SWLEOC at high RTT waits. EOC are working with Partners to raise issues regarding particular consultants capacity and reviewing options for internal pooling for patients who are happy to have surgery under a different consultant. Where internal pooling is not possible, if clinically appropriate patients are contacted by SWLEOC team and offered transfer of care to a consultant from a different Partner/SWLEOC. • Divisions and performance team continue to work in collaboration to manage 52 week waits daily and expedite next steps. Updates being provided to South West London on a weekly basis for patients 60weeks+. 65wk+ and 78+ clearance lists are also circulated to divisions to increase visibility and focus on long waiting pathways.	52 week recovery date to plan is expected in November 2024. ESTH are expected to have less than seventy-five 65 week waits by the end of November 2024, and less than fifty by the end of December 2024.	Sufficient for assurance

Operational Performance

Exception Report | SGUH Cancer Performance



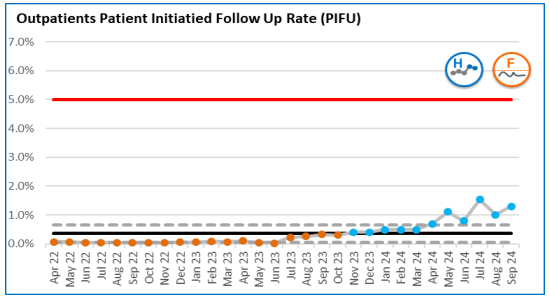


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS Target met Oct24 variable performance 31 Day Target not met Oct24	**Faster Diagnosis performance of 80.5% meeting trajectory** • Gynaecology performance improved to 69.7% driven by timely triage and access to one stop clinics and scans. • Breast performance improved to 92%. • H&N and Urology met the standard at 86.7% and 82.6% respectively • Skin performance improved to (75%), outpatient capacity management has been an issue • Radiology reporting turnaround times are impacting diagnostic waits. CT replacement program continued with one scanner down. • Pathology delays to turnaround times are impacting all pathways including urology. This is a workforce challenge which is currently being addressed. ***31-day Standard performance of 94.3% against target of 96%*** • Increase in breaches within Urology and Lung with a combined performance of 86.4% with 11 patients breaching target (Compared to 1 in Sep-24) this is driven by limited theatre capacity	• £101K NHSE funding granted to support resilience funding and to support non recurrent initiatives. Governance and NHSE reporting in place to monitor spend. • Gynaecology: continued focus on PTL management and one stop capacity. The £20K NHSE funding will be used for WLIs to support one stop WLIs. • Breast has an ongoing recovery plan. • Lung Thoracic: £18.5K funding for 10 consultant WLIs in place to support theatre capacity. • Haem Oncology demand & capacity review on going. £31,560K awarded to support recruitment of a Locum consultant for 3 months to deliver WLIs clinics /MDT. • Clinical Haematology: awarded £4,357K to appoint a band 8a Pharmacist to deliver clinics under consultant supervision to support clinic capacity. • Skin: Pathway group set up to support pathway improvement work. Process mapping of current process under progress. • Urology: £50K RMP funding awarded to urology to support theatre capacity. • RMP Resilience funding in place to support H&N pathway and WLIs. • LGI: £13,400K awarded to support WLI and theatre capacity for 3 months. • Radiology: £13,258K awarded to support admin workforce gaps and provide band 4 cover for 4 months.	Recovery time scales are dependent on Resources.	sufficient for assurance

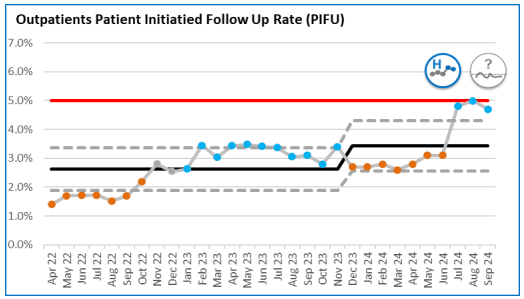
Operational Performance

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

St George's



Epsom & St Helier



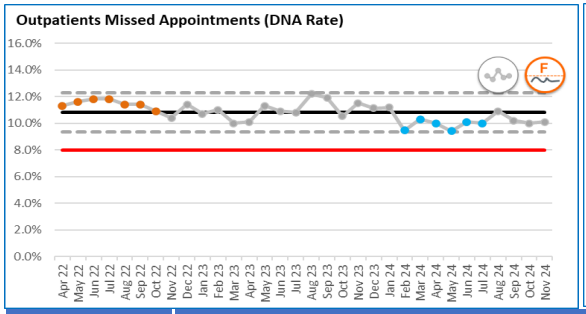
Rate reported one month in arrears in line with Model Hospital reporting

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend	In month performance for September was 1.3% - as per Model Hospital.	• We have 4179 patients on an open PIFU pathway (+1179 since previous month) • Top 3 specialities include: Podiatric Surgery (23%),Trauma and Ortho(3.4%) and Physiotherapy (2.91%) All GIRFT specialties now live. Planned go live for several more specialties ensuring they are PIFU ready [leaflet in place, clinician understand the process, local SOP In place.	2% planned for October 2024 – post launch of PIFU order for all specialities	sufficient for assurance
ESTH PIFU Rate achieved in August 2024	Compliant in August 2024 having achieved the 5% target. Slight reduction in September, however internal data suggests a return to compliance in October.	• In September there was a slight reduction in PIFU but the PIFU rate is still in a positive position. • The Transformation team are working with the service teams and working through plans and any support needed for teams were the PIFU rate has dropped.	3.5% Trust target and 5% national target achieved in August 2024	sufficient for assurance

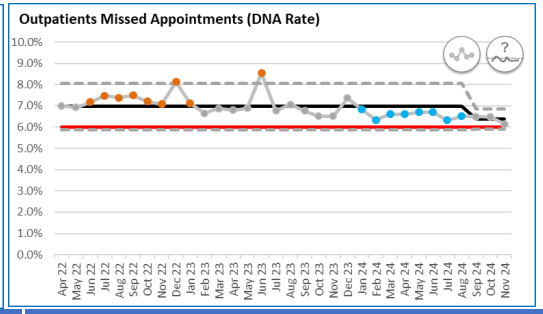
Operational Performance

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

St George's



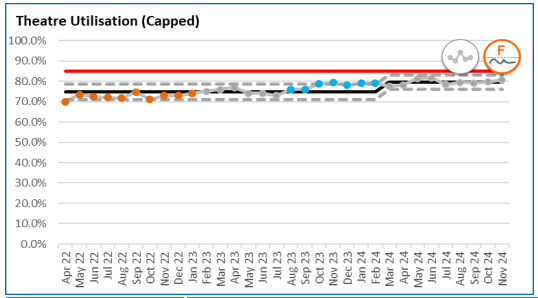
Epsom & St Helier

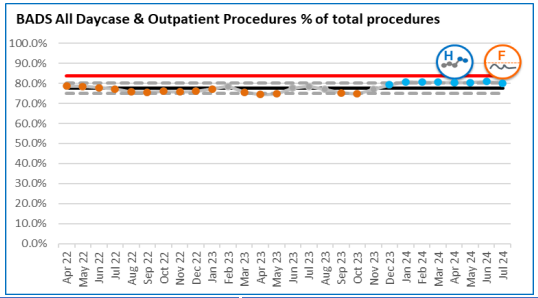


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	• Current DNA rates of 10.2% approx. 241 patients per day • Peer median performance 9.9% • Highest levels of DNA rates remain in our new / first outpatient appointments	• Speciality DNA weekly performance presented to all operational leads in Elective Access Meeting. • Ask all Divisions to include DNA reviews within their Divisional reporting (if not already), prompting services to take ownership of their position and drivers behind this • Working group has commenced to review and cease booking to first available and 7 out of 9 specialities have been met with so far, next planning meeting will be held on 11 December. • One piece of feedback from patients have been they have struggled with the 'decision tree' options at the call centre. As a result, we have undertaken a full review and have a new mapping of this. It will be much clearer now for patients who need to cancel/reschedule their appointments. We are awaiting approval from our call centre provider – NetCall – to put this in place. This is being chased weekly.	TBC	sufficient for assurance
ESTH Normal variation, no significant change Failing target of 6%	DNA rates are still above target but have reduced to 6.2%	• Nurse clinics continue to be added to the text reminder service to support reduction of rates in these clinics. • Work continues to understand the impact of Health Inequalities on DNA rates. In Cardiology and Gastroenterology, patients with multiple DNAs recorded are being reviewed and teams have reviewed and identified patients which can be safely discharged. • The implementation of the access policy is also being reviewed with specialty teams to ensure robust application of it.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH Theatre Utilisation & Daycase Procedure Rates





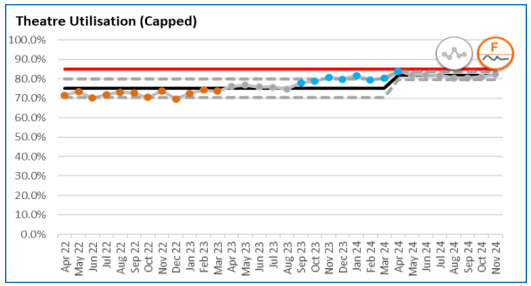
Model hospital recently updated capped utilisation methodology introducing additional exclusions which improves performance for both Trusts. Internal reporting to be updated to align.

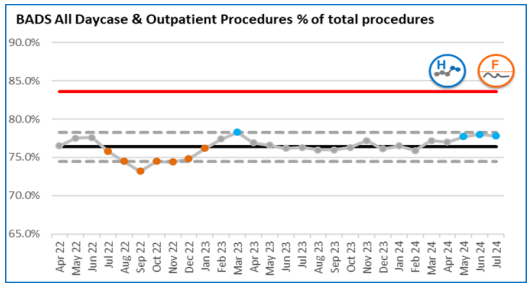
Please note Model Hospital have updated BADS methodology now including outpatient procedures.
The calculation now measures the number of Outpatient Procedure and Day case Procedures as a proportion of all Procedures (Outpatient, Daycase and Inpatients). This is not comparable to previous data.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation (Tableau): 81% 82%- IP 83%-DSU 67%- QMH	• Model Hospital (MH) recently updated its methodology, introducing several exclusions that have improved our performance. The updated MH rules have inadvertently increased the number of rejected sessions in national data submissions, as they are now higher compared to the previous methodology. • November's Tableau data shows an upward trend in capped utilisation across the Trust, particularly in DSU and IP, seeing an improvement of 1% and 4%, respectively. HealthInsights data shows that the Trust-wide utilisation was 81.8% (82.6% for SGH and 71.2% for QMH). • In November, 35 OTDCs were reported.	• Ongoing work to rollout ePOA across specialties as part of the Theatre Transformation Programme, which will improve access to service and subsequently reduce On The Day Cancellations due to clinical reasons. • Redesign of Tableau Theatre Dashboards to reflect the new Model Hospital rules. • Continued emphasis on scheduling, particularly 6-4-2 escalation processes • "Perfect Morning" workshops underway to optimise theatre productivity, with Vascular and Gynae as the pilot surgical group. • Lists not booked to more than 75% utilisation with 2 weeks' notice are being reviewed and stood down. Unless there is a clinical exception to this standard. • QMH Surgical Treatment Centre: Work has started to define the operational model beyond February 2025, with a new scheduling template aimed at improving efficiency.	TBC	sufficient for assurance
SGUH: Improving trend however performing below benchmark of 83.6%	• Effects of data correction and improved recording continues to support an improving trend. • Procedures normally coded as daycase often booked as an intended management of elective overnight due to the complexity of patients referred to SGUH. • Opportunity to convert some elective inpatient work to daycase and outpatient which is being reviewed	• BADS compliance is being discussed with all surgical specialities within theatre transformation deep dives to explore opportunity. • Undertaking a significant piece of work on QMH which includes expanding the inclusion criteria at QMH which will increase throughput. • Deep dive into BADS metric to understand opportunity for improvement, data shared with Breast team to review and determine whether intended management code is being used correctly and plans to correct if required (particular outlier).	TBC	Sufficient for assurance

Operational Performance

Exception Report | ESTH Theatre Utilisation & Daycase Procedure Rates





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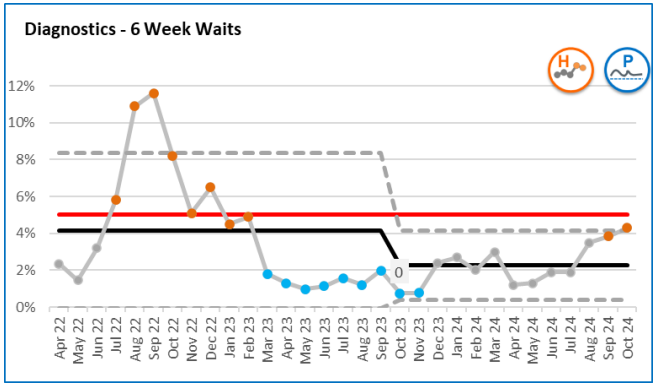
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%) BADS performance Not meeting target, Improving trend	• The Trust has seen an on-going overall improvement in Theatres utilisation, since the Programme commenced in November 2023. • Whilst maintaining over 80% utilisation, ESTH were starting to see a dip in performance from April, so **it is reassuring to see a rise again for October and November**, this is due to a reduction in on the day cancellations. • **Late starts** remain well under target (30 mins) at 17 mins for November. • **Under runs** remain slightly under average (30 mins) at 26 mins.	**Perioperative Care pathway and processes:** • Following the success of the initial pilot, the Group are working through plans to roll out the initiative to ENT and T&O at Epsom, in Jan. This will support a growing pool of 'green' patients, who can be declared *'fit'* on the same day they are listed for surgery. **Day Case Rates (BADs):** • ESTH's performance has seen a decrease of on average -6% (77.7%), following changes to MH's methodology. ESTH are addressing this in three ways: 1. The Introduction of x2 robust SOPs to reduce the top failed day case reasons (escort/urine). 2. To improve the Day Case rate for certain Specialties that have a pattern of procedures being scheduled as an inpatient, but discharged like a day case (zero LoS). 3. EOC process changes (hips & knees). This should have the biggest impacting, taking the Trust back to 82/83%. **On The Day Cancellations:** • Patient cancellations are now the leading reason (39%), Non-Clinical cancellations are now second (32%), Clinical have fallen to third place (28%) • *'Unfit'* is the top cancellation reason for both *'Patient' & 'Clinical'* Cancellations . For patient cancellations, the top reason for unfit was *'cough/cold'*. For Clinical cancellations, the top reason for unfit is *'UTI',* followed closely by *'High Blood pressure'*. • To help tackle this, a short notice booking script has been drafted for approval at Tri, this will help ensure patients are fit and well at the point of being scheduled. • The Group is working hard with Urology on a patient focused solution for those with an identified UTI.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH Diagnostic Performance

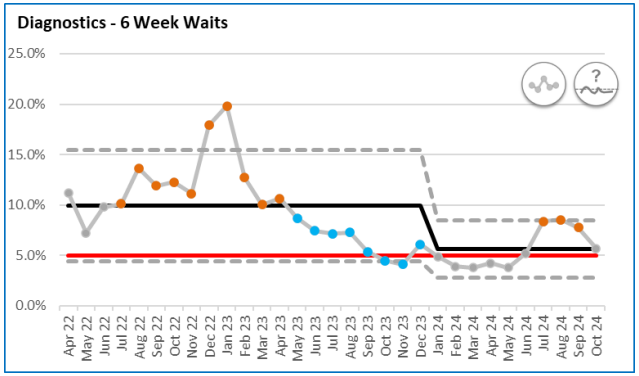


Modality	Waits >6Wks	% within 6 Weeks
Magnetic Resonance Imaging	1	99.9%
Computed Tomography	39	97.0%
Non-obstetric ultrasound	338	95.0%
Barium Enema		
DEXA Scan	0	100.0%
Audiology - Audiology Assessments	0	100.0%
Cardiology - echocardiography	0	100.0%
Cardiology - electrophysiology		
Neurophysiology - peripheral neurophysiology	0	100.0%
Respiratory physiology - sleep studies		
Urodynamics - pressures & flows	12	81.5%
Colonoscopy	84	75.1%
Flexi sigmoidoscopy	14	89.4%
Cystoscopy	13	90.2%
Gastroscopy	49	87.9%
Total	550	95.7%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Target continuing to be met but at risk with Special cause variation of a concerning nature.	At the end of October 2024, 4.3% of patients were waiting for more than six weeks for a diagnostic test, continuing to meet 5% recovery target, however November performance at risk due to increased demand. The main drivers for non-compliance is within imaging where an increase in referrals for both Gynae ultrasounds and Cardiac CTs exceeds the capacity available. At month 6 the department had scanned the equivalent of the 23/24 total cardiac scans. The department are investigating this increase in referrals. (July was up 68% on July 23/24) There has also been a steady increase in demand for Transvaginal ultrasound scan (TVUS) driven mainly by the GPs which has been seen across the whole of SWL. Again, this is hindered by a lack of capacity to scan. A piece of work is being carried out by SWL Diagnostics team to lead on management of US referrals.	The department is utilising the Community Diagnostics Centre to mitigate any capacity mismatches it can. With an extra 400+ scans being delivered in November and an additional 800+ scans due to be delivered in December through this route. Recovery for CT Cardiac is currently predicted to be in February 2025, however working with the cardiology teams, and stress echo team the department is hopeful referrals for CT will be minimised. There is an overall requirement for demand management to be reviewed across all imaging specialities which will be carried out starting Q4 2025 and incorporate Royal College sustainability guidance	TBC	Assured

Operational Performance

Exception Report | ESTH Diagnostic Performance



Modality	Waits >6Wks	% within 6 Weeks
Magnetic Resonance Imaging	1	99.9%
Computed Tomography	3	99.5%
Non-obstetric ultrasound	12	99.8%
Barium Enema		
DEXA Scan	2	99.5%
Audiology - Audiology Assessments	25	90.8%
Cardiology - echocardiography	317	76.3%
Cardiology - electrophysiology		
Neurophysiology - peripheral neurophysiology	2	98.9%
Respiratory physiology - sleep studies		
Urodynamics - pressures & flows	81	51.2%
Colonoscopy	36	89.9%
Flexi sigmoidoscopy	11	89.0%
Cystoscopy	93	59.2%
Gastroscopy	33	88.5%
Total	616	94.3%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 5.7% not meeting target of 5% Improved position	At the end of October 2024 there are 616 patients waiting more than 6 weeks for their diagnostic (DM01), which is a 23.7% reduction compared to September 2024. However, the PTL size has seen a slight increase from the end of the previous month and as a result of both of these changes, our performance has increased to 94.3%. Largest proportion of 6 week breaches are within Echocardiology with 317 patients waiting >6weeks at the end of October 2024. The modalities with the next highest volume of patients waiting >6 weeks at the end of October 2024 are Cystoscopy (93) & Urodynamics (81)	• **ECHOs** -Following the removal of external funding in April 2024, the plans in place to bring Echocardiography back under control (through additional CDC/ERF funded capacity and mutual aid from Croydon University Hospital) , are coming to fruition. In September 2024 there were 478 patients waiting more than 6 weeks, up from 467 at the end of August 2024. However, there has been a significant improvement in October 2024 which has seen the backlog reduce to 317 and work is continuing to sustain this improved position in November 2024. Recruitment is going well for the 2wte cardiology physiologists with a likely start date of January 2025 (if recruitment is successful). • **Urodynamics:** Demand for Gynaecology urodynamics remains high with plans to increase core capacity in the new year by adding nurse-led clinics and weekly urodynamics fellow clinics from February 2025, contributing an additional 32 slots per month. • **Cystoscopies:** The backlog in Gynaecology is being addressed by having the Urogynae fellow running extra clinics in December 2024 and consultants providing adhoc videodynamics in January 2024. A recent demand and capacity review highlighted the need to standardise the video-urodynamics clinic template and there are on-going discussions to address scheduling challenges linked to radiology and afternoon clinic timings. The Cystoscopy backlog in Urology is mainly due to patient choice or patient fitness, with the small number due to capacity being booked into adhoc capacity.	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	Nov 24	78.3%	76.1%	78.0%			2nd Quartile	Nov 24	74.7%	72.3%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%)	Nov 24	9.0%	9.3%	8.8%			2nd Quartile	Nov 24	13.5%	13.5%	9.6%			3rd Quartile
Ambulance handover Performance 30 - 60 minutes	Nov 24	170	54	0				Nov 24	394	407	0			
Ambulance handover Performance 60+ minutes	Nov 24	4	1	0				Nov 24	49	50	0			
Non Elective Length of Stay	Nov 24	10.0	9.3	-				Nov 24	11.3	10.7	-			
Length of stay > 21 days (super stranded)	Nov 24	158	146	117				Nov 24	160.0	151.0	123.0			
Overnight G&A beds occupancy - Adults	Nov 24	96.8%	96.2%	90.8%				Nov 24	89.9%	90.0%	89.0%			
Number of patients not meeting criteria to reside (Daily Avg)	Nov 24	129	124	86				Nov 24	206	196	123			
Watch List KPIs														
Mental health delays 4 Hour Breaches	Nov 24	139	115	-				Nov 24	227	267				

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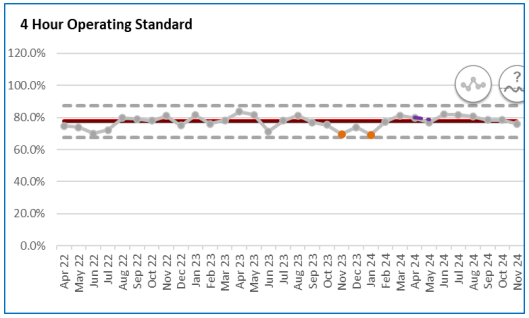
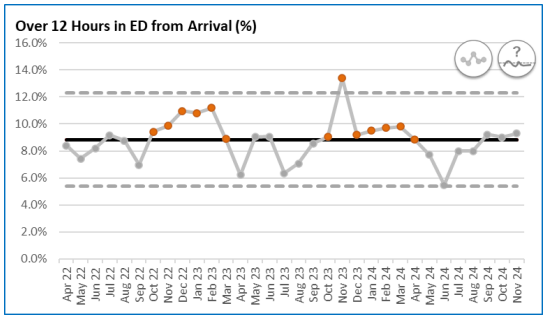
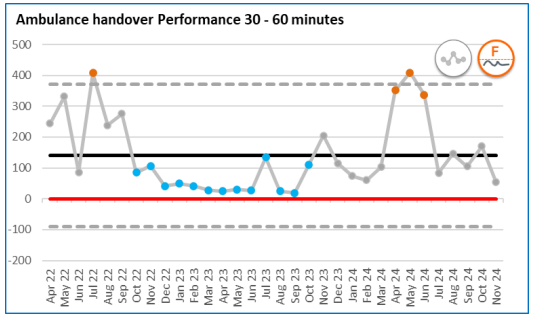
Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



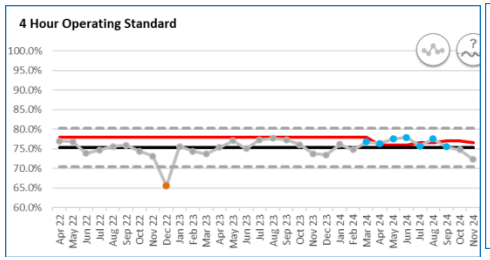


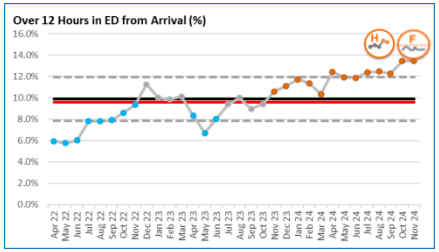


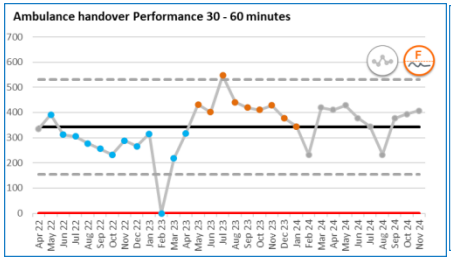
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH **4 Hour Target not met** LAS Target consistently not met showing common cause variation.	Four Hour Performance in November 2024 was 76.01%, a slight decrease from last month's 78%. The key drivers of operational pressures and delays are: •High volume of DTA's in department •High number of complex mental health patients spending >24hrs in department •Increased hours of corridor care 85.5% of 2,680 LAS arrivals were off-loaded <15 minutes	• Dedicated Treatment pod for faster delivery of IVs • Dedicated investigation cubicle to reduce time to finding equipment • Maintaining in-and-out spaces to aid flow • RAT rota fully established to redirect patients where appropriate • Continue to work with 111 to optimise UTC utilisation • Further development of SDEC inclusion criteria • Direct access to Paediatric clinics for UTC plastic patients. • Enhanced boarding and cohorting continue to be business as usual across site • Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced • Increased discharge lounge capacity allowing for increased criteria of patients that were previously rejected. • Full Capacity Protocol launched 5th Nov • Frailty SDEC to pilot from 25th Nov • LAS Winter plan including 30W started 18th Nov	TBC	Internal validated figures

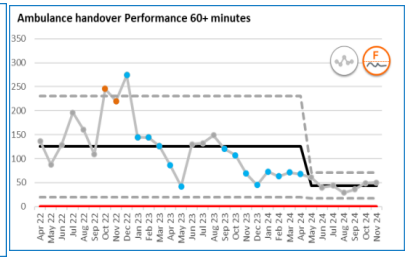
Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers





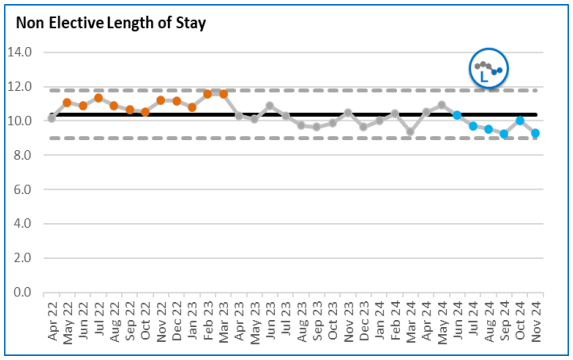


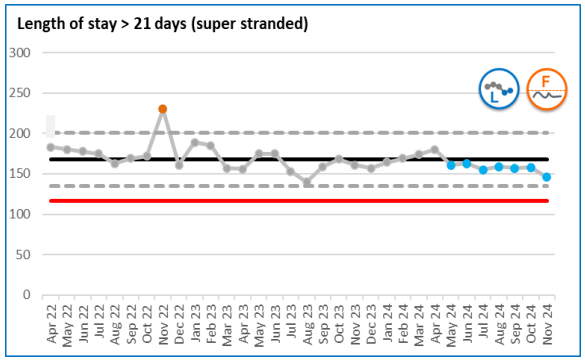


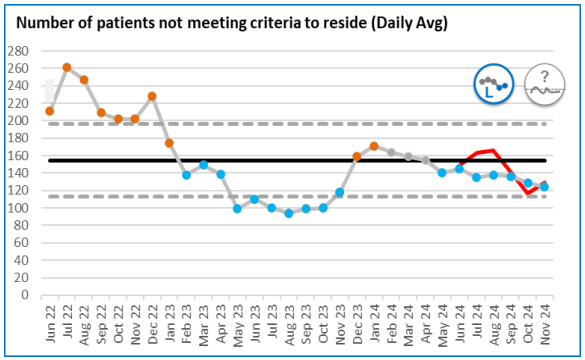
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 77% ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 30-60 Min Consistently not meeting target	• Deterioration in ED performance in November 2024 reporting 72.3% versus 74.7% in October 2024. • Patients spending longer than 12-hours in ED remains challenging with 13.5% of patients spending longer than 12-hours in the department in November. However, we continue to see a month on month increase in Type 1 attendances reporting the highest in November since March 2024. 60-minute ambulance handover delays remain static in November (50), which is contributed by a continuing increase in both ambulance attendances and high acuity in the month of November. • Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively, however time to triage performance remains within the 15-minute threshold. • High numbers of MH patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• The Trust's Urgent Care Transformation programme hosts an agreed set of priorities for 2024/25 which includes PLACE deliverables. This includes key outputs and supporting metrics, including but not limited to, the electronic streaming/redirection and direct booking of patients to UTC/SDEC/GP for patients who attend ED but do not require acute care to support alleviation of ED capacity and admission avoidance and a reduction of Trust LOS by 1.5 days. • Work continues to support LAS direct conveyances to UTC, GP, SDEC, SACU, and timely internal surgical transfers from Epsom to St Helier. Activity within these areas continues to increase month on month with the highest reported activity for both UTC and SDEC in November 2024. • SWL winter money allocation is supporting the collaboration of Sutton PCN GP colleagues to support additional GP resource in ED over winter. This initiative commenced 18th November supporting the assessment and treatment of patients presenting to the department. A review of utilisation is undertaken weekly on shift fill and patient demand and capacity. • The launch of our Same Day Acute Frailty response service took place in April 2024. The provision is supported by a dedicated space and frailty MDT to ensure early specialty assessment and treatment with clear exit pathways supporting direct/early flow from ED for appropriate patients, supporting admission avoidance and reduced LOS. Winter monies supporting enhanced clinical medical support to the frailty hub over the weekend to include senior clinical in-reach/reviews to the frailty hub. • Focussed work with Surrey & Borders Mental Health Trust continues to progress the development of a proposal/business case for a mental health CDU on the Epsom site. We are also working with SWL & St Georges Mental Health Trust to explore rapid access clinics for appropriate patients presenting to ED.	TBC	sufficient for assurance

Operational Performance

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



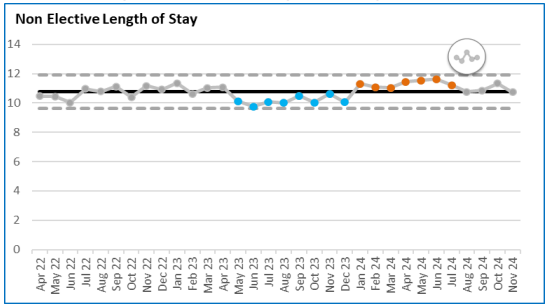


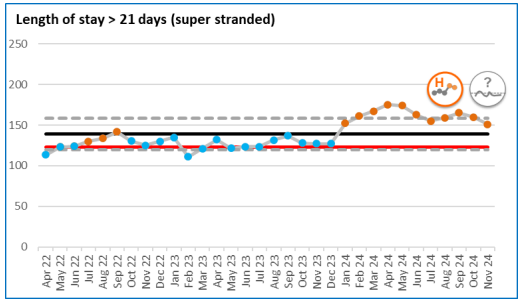


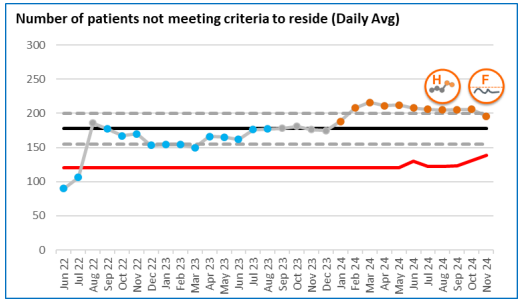
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR LOS Los>21days: Consistently not meeting target, all showing performance below mean	• Now adopted the SWL methodology for calculation of non-elective average length of stay (*i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties*). • Non-Elective Length of Stay below the mean for the sixth consecutive month • Largest cohort of patients with LOS>21 days Geriatric Medicine (avg. 31 beds per day) and Neurology (avg. 19 beds per day). • NCTR Delays – on average 124 beds per day across October • Hospital and Social Care Interface process highlighted as highest reason for delay. In particular, we see a significant number of patients awaiting Packages of Care, as well as beds in mental health institutions.	• The Emergency floor and the Integrated Care Transfer Hub continue to review if Social Workers & CLCH partners can attend on site. • Increase in bedding in SDEC / AAA overnight impacting ED exit flow • Good improvement in earlier discharges • MADE "style" Events has resumed given increased operational pressure • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • The Trust has replaced Red2Green with the National Criteria to Reside tool for daily electronic tracking patients' readiness for safe and timely discharge to improve patient flow and reduce length of stay. • Focussed sessions with ward teams to improve NCTR data capture • The division has agreed, with support from Senior Leadership Team to close one bay (6 beds) on MSW over the summer, planned for July – November inclusive. • Significant improvement in the number of NCTR forms completed prior to 9.30am daily, reflecting a more accurate number of patients NCTR. This is being reviewing in the daily 10.30am bed meetings.	TBC	sufficient for assurance

Operational Performance

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

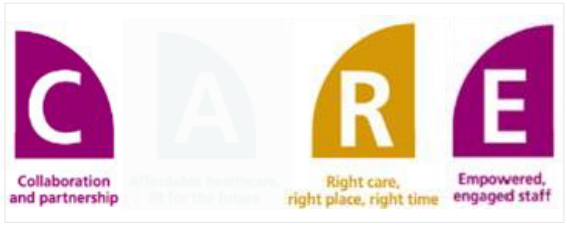






Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation not meeting plan Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties). Numbers of medically optimised patients on both hospital sites remain above the ambition with many patients requiring complex discharge planning to support discharge in those patients holding a LOS in excess of >7 days, >14 days, >21 days. All cohorts are reporting their lowest since November 2023 despite revised bed base. A significant cohort of our medically fit patients are requiring on-going acute therapy prior to discharge. This is also reflected in our non-CTR patient cohort which remains above the ambition of 123 with a reported 196 in the month of November, however, we continue to see a month-on-month reduction, reporting lowest levels since November 2023.	• Daily reports in place identifying those patients who are medically fit for discharge shared with internal and external stakeholders, including our therapy team. • Revised boarding process was implemented on Monday 2nd September successfully incorporating additional areas. • Highest utilisation of our discharge lounge to support flow on both sites. • The complex paediatric discharge panel meeting for complex patients who require additional support/escalation to progress discharge arrangements. • Weekly DMT led 14 day + LOS review continue, this has been complemented this month by a review of all patients with a LOS of 1-14 days in collaboration with the virtual wards and supporting pathways. • The Trust's complex discharge panel has now progressed to reviewing all patients with a LOS of > 35 days as opposed to the initial >45 days due to volume of patients that have been discharged from this patient cohort. The meeting includes key internal stakeholders, including CNO/deputy representation and relevant system partner(s) as appropriate. • Our Urgent Care KPI dashboard has been updated to reflect ED metrics including SDEC and UTC activity which shows increased redirection and utilisation in both areas alleviating unnecessary activity in ED. LOS metrics at ward/department level continue to receive ongoing scrutiny enabling us to monitor areas reporting an increased LOS or patients holding no CTR. • The review of individual patient flow/LOS work streams and attributed improvement trajectories continue to be monitored closely to ensure progression and impact on wider 1.5 days LOS reduction. • Patients on pathway 3 - focussed piece of work undertaken to understand delays in deciding lead provider for discharge. This has been shared with ICB and LA.	TBC	sufficient for assurance

Integrated Care



Integrated Care Performance

Overview Dashboard | Elective and Urgent & Emergency Care

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Nov 24	4	3	-			
Reablement Unit Bed Occupancy	Aug 24	100.0%	100.0%	100.0%			
Reablement Unit Length of Stay (Average)	Aug 24	10.0	10.0	5.0			
Two hour UCR performance	Nov 24	85.4%	80.3%	70.0%			
Two hour UCR referrals received	Nov 24	473	376	-			
Virtual ward - Admissions	Nov 24	326	379	-			
Virtual ward - Bed Occupancy	Nov 24	84.7%	75.3%	80.0%			
Virtual ward Length of Stay (Average)	Nov 24	7.1	6.1	-			
Total Waiting List Size Adult	Nov 24	1634	1633	-			
Total Waiting List Size Adult 18-52wks	Nov 24	16	56	-			
Total Waiting List Size Adult >52wks	Nov 24	1	3	-			
Total Waiting List Size Children	Nov 24	649	715	-			
Total Waiting List Size Children 18-52wks	Nov 24	289	291	-			
Total Waiting List Size Children >52wks	Nov 24	6	4	-			

Surrey Downs

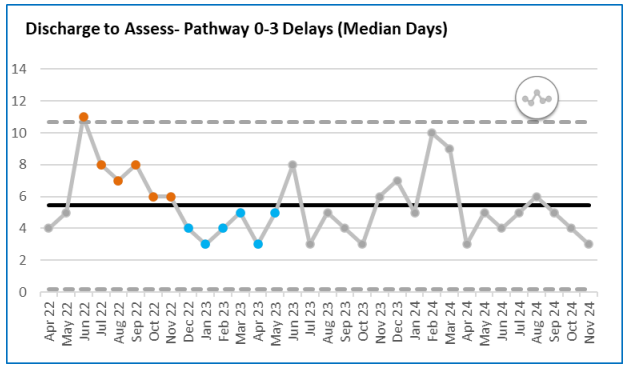
KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Nov 24	2	1	2			
Community Hospitals Bed Occupancy	Nov 24	89.0%	88.4%	80.0%			
Community Hospitals Length of Stay (Average)	Nov 24	25	24	21			
Two hour UCR performance	Nov 24	89.5%	86.0%	70.0%			
Two hour UCR referrals received	Nov 24	524	512	-			
Virtual ward - Admissions	Nov 24	261	257	-			
Virtual ward - Bed Occupancy	Nov 24	83.0%	89.0%	80.0%			
Virtual ward Length of Stay (Average)	Nov 24	8.4	8.7	-			
Total Waiting List Size Adult	Nov 24	5567	5684	-			
Total Waiting List Size Adult 18-52wks	Nov 24	254	248	-			
Total Waiting List Size Adult >52wks	Nov 24	0	0	-			

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

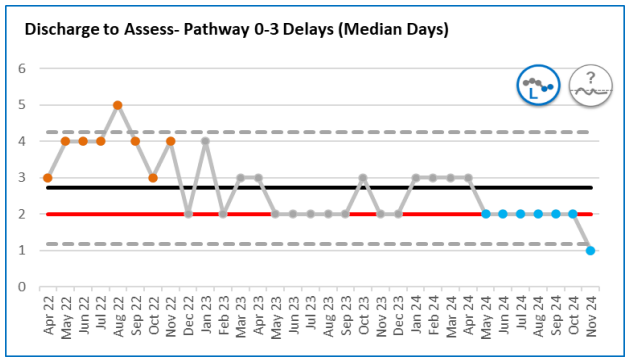
Integrated Care

Exception Report | HomeFirst Delayed Discharges (median days)

Sutton Healthcare



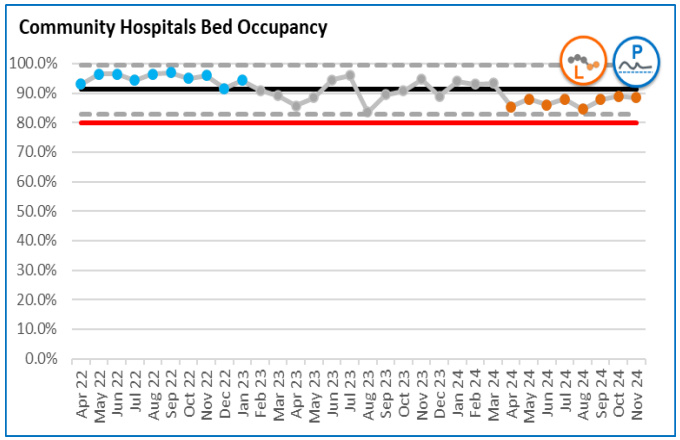
Surrey Downs

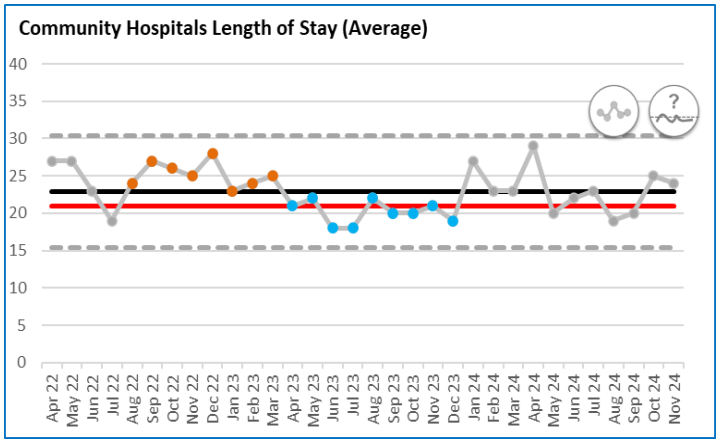


Site & Metric	Cause of variance/ non-compliance / challenges	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	• Normal variation only with median days across November at 3 days., showing a downward trend • Increased referrals through October and November 2024 (+20% compared to November 2023) • Patients not meeting criteria to reside – Recent increase, on average 8 patients per day. Main delays 1) Transport 2) Awaiting availability of resource 3) Awaiting community equipment	• Focus on improving referral to discharge time. • Focus on Transfer of Care Hub process. • Length Of Stay reduction programme with ESTH and Sutton Alliance in progress.	N/A	Sufficient for assurance
Surrey Downs Health & Care	• Median days LOS below mean reducing through November 2024 • Referral numbers to HomeFirst consistent (247 through November 2024) • Highest delays in pathway 3 (mainly patients discharged to a care home as new admission)	• Length Of Stay reduction programme in development	N/A	Sufficient for assurance

Integrated Care

Exception Report | Surrey Downs Bed Occupancy & Length of Stay

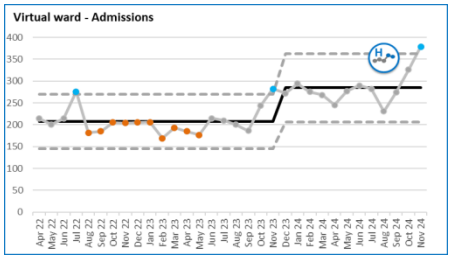
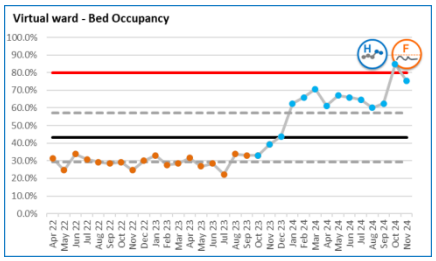
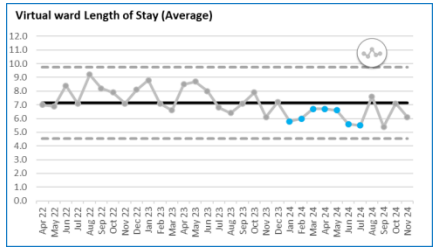
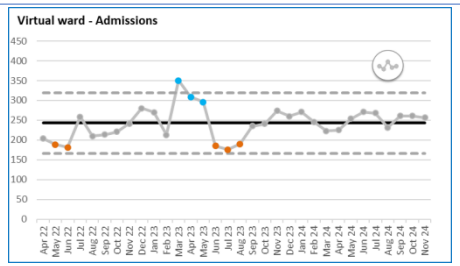
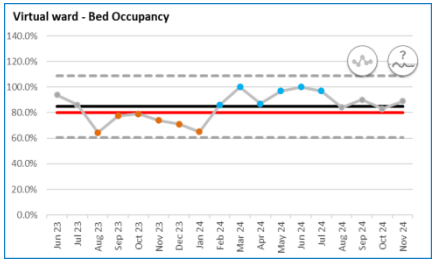
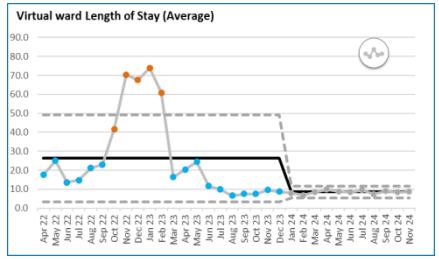




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs Health & Care	Bed occupancy continues to exceed target of 80% Average length of stay showing normal variation overall however LOS has increased through the month at Dorking Hospital Admission numbers – normal variation	• Process for escalations of delays is in place • Choice policy is implemented • Flex criteria during escalation	TBC	Sufficient for assurance

Integrated Care

Exception Report | **Virtual Wards**

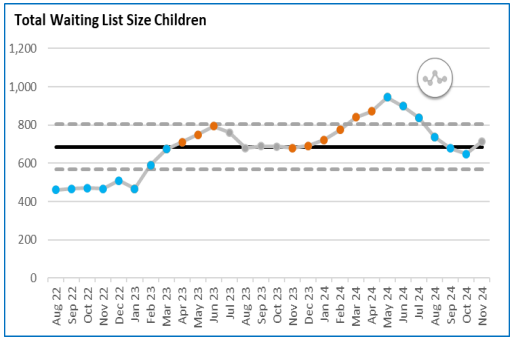
Sutton Healthcare			
Surrey Downs			

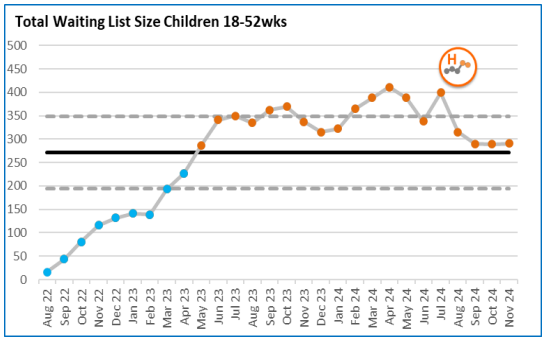
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Admissions continue to increase, rising above the upper control limit, seeing an increase across all PCN's Occupancy rate just below target of 80%	• SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. • LoS reduction programme with ESTH and Sutton Alliance is in progress. • Engagement work with appropriate wards and with clinicians continues. • Work to explore additional pathways into virtual ward in development.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Occupancy Rate continues to exceed target of 80%. Admissions / referrals remain consistent, however proportion of ED and hospital referrals increasing	• On-going development of enhanced care in Virtual Wards.	N/A	Sufficient for assurance

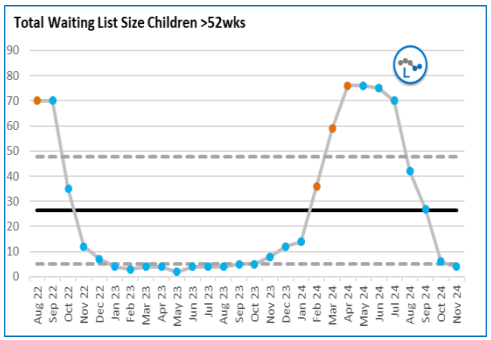
Integrated Care

Exception Report | **Children's Waiting List Performance**

Sutton Healthcare







Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	The growth in children requiring NHS therapy services has been a national issue recognised at SWL/PLACE. SWL ICB programme is taking this forward with providers across SWL. There has been significant progress at Sutton in reducing waiting list size however in November 2024 we saw an increase of 57 pathways for SALT Service At the end of November, 4 children waiting for 52+ weeks, a decrease from 6 in the previous month.	• PLACE/SWL Programme of work under way. • SHC Review of harms with Integrated Care CNO. • SHC additional triage/ support for parents • SHC additional clinic sessions run (note decrease in waiting lists) • Improvements also made in triage, priority clinics (productivity /efficiency). • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Sufficient for assurance

gesh

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

Appendices

39

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Oct 24	4.6%	5.1%	3.2%			
Agency rates	Oct 24	1.5%	1.0%	-			
MAST	Oct 24	90.8%	90.7%	85.0%			
Vacancy Rate	Oct 24	7.7%	7.2%	10.0%			
Appraisal Rate Medical	Oct 24	80.4%	80.3%	90.0%			
Appraisal Rate Non Medical	Oct 24	73.8%	73.6%	90.0%			
Turnover	Oct 24	12.4%	11.9%	13.0%			
Percentage BAME staff band 6 and above	Oct 24	46.2%	46.4%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Oct 24	4.9%	5.1%	3.8%			
Oct 24	2.3%	1.8%	-			
Oct 24	86.8%	87.6%	85.0%			
Oct 24	12.3%	12.1%	10.0%			
Oct 24	95.2%	93.7%	90.0%			
Oct 24	78.5%	75.2%	90.0%			
Oct 24	11.1%	11.1%	12.0%			
Oct 24	39.3%	39.4%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	Oct 24	6.8%	7.3%	3.8%		
Agency rates	Oct 24	6.1%	4.5%	-		
MAST	Oct 24	91.2%	93.1%	85.0%		
Vacancy Rate	Oct 24	20.3%	20.5%	10.0%		
Appraisal Rate Medical	Oct 24	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	Oct 24	78.6%	76.4%	90.0%		
Turnover	Oct 24	1.4%	1.8%	12.0%		
Percentage BAME staff band 6 and above	Oct 24	35.8%	36.1%	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Oct 24	4.5%	4.6%	3.8%			
Oct 24	5.4%	2.9%	-			
Oct 24	93.3%	94.3%	85.0%			
Oct 24	18.5%	18.5%	10.0%			
Oct 24	100.0%	100.0%	90.0%			
Oct 24	90.1%	82.0%	90.0%			
Oct 24	1.2%	0.9%	12.0%			
Oct 24	20.5%	19.8%	-			

Statistical Process Control (SPC)

Interpreting Charts and Icons

	Variation/Performance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	Common cause variation, NO SIGNIFICANT CHANGE.	This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.	**Consider if the level/range of variation is acceptable**. If the process limits are far apart you may want to change something to reduce the variation in performance.
	Special cause variation of a CONCERNING nature.	**Something's going on!** Something a one-off, or a continued trend or shift of numbers in the wrong direction	**Investigate** to find out what is happening/ happened. Is it a one off event that you can explain? Or do you need to change something?
	Special cause variation of an IMPROVING nature.	**Something good is happening!** Something a one-off, or a continued trend or shift of numbers in the right direction. Well done!	Find out what is happening/ happened. **Celebrate** the improvement or success. Is there **learning** that can be shared to other areas?

	Assurance Icons		
Icon	***Technical Description***	***What does this mean?***	***What should we do?***
	This process will not consistently HIT OR MISS the target as the target lies between the process limits.	The process limits on SPC charts indicate the normal range of numbers you can expect of your system or process. If a target lies **within** those limits then we know that the target may or may not be achieved. The closer the target line lies to the mean line the more likely it is that the target will be achieved or missed at random.	Consider whether this is acceptable and if not, you will need to change something in the system or process.
	This process is not capable and will consistently FAIL to meet the target.	If a target lies **outside of those limits in the wrong direction** then you know that the target cannot be achieved.	**You need to change something in the system or process if you want to meet the target.** The natural variation in the data is telling you that you will not meet the target unless something changes.
	This process is capable and will consistently PASS the target if nothing changes.	If a target lies **outside of those limits in the right direction** then you know that the target can consistently be achieved.	**Celebrate the achievement**. Understand whether this is by design (!) and consider whether the target is still appropriate; should be stretched, or whether resource can be directed elsewhere without risking the ongoing achievement of this target.

Appendix 2

Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 31 Day Decision to Treat Standard	The proportion of patients beginning their treatment within 31 days of deciding to treat their cancer. Applies to anyone who has been diagnosed with cancer, including people who have cancer which has returned.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Referral to Treatment Waiting Times	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	National Framework for Reporting and Learning from Serious Incidents	Local Data
Serious Incidents	An incident that occurred in relation to NHS-funded services and care resulting in one of the following: Acts or omissions in care that result in; unexpected or avoidable death. injury required treatment to prevent death or serious harm, abuse.	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	Gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	Gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
Mental Capacity Act and Deprivation of Liberty (MCADoL)	The Deprivation of Liberty Safeguards are a part of the Mental Capacity Act and are used to protect patients over the age of 18 who lack capacity to consent to their care arrangements if these arrangements deprive them of their liberty or freedom. Percentage of staff receiving MCA Dols Level 2 Training	Gesh Priority	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital

Glossary of Terms

Terms	Description
A&G	Advice & Guidance
ACS	Additional Clinical Services
AfPP	Association for Perioperative Practice
AGU	Acute Gynaecology Unit
AIP	Abnormally Invasive Placenta
ASI	Appointment Slot Issues
CAD	computer-assisted dispatch
CAPMAN	Capacity Management
CAS	Clinical Assessment Service
CATS	Clinical Assessment and Triage Service
CDC	Community Diagnostics Centre
CNS	Clinical Nurse Specialist
CNST	Clinical Negligence Scheme for Trusts
CQC	Care Quality Commission
CT	Computerised tomography
CUPG	Cancer of Unknown Primary Group
CWDT	Children's, Women's, Diagnostics & Therapies
CWT	Cancer Waiting Times
D2A	Discharge to Assess
DDO	Divisional Director of Operations
DM01	Diagnostic wating times
DNA	Did Not Attend
DTA	Decision to Admit
DTT	Decision to Treat
DQ	Data quality

Terms	Description
EBUS	Endobronchial Ultrasound
eCDOF	electronic Clinic Decision Outcome Forms
E. Coli	Escherichia coli
ED	Emergency Department
eHNA	Electronic Health Needs Assessment
EP	Emergency Practitioner
EPR	Electronic Patient Records
ESR	Electronic Staff Records
ESTH	Epsom and St Helier Hospital Trust
EUS	Endoscopic Ultrasound Scan
FDS	Faster Diagnosis Standard
FOC	Fundamentals of Care
GA	General Anaesthetic
H&N	Head and Neck
HAPU	Hospital acquired pressure ulcers
HIE	Hypoxic-ischaemic encephalopathy
HTG	Hospital Thrombosis Group
HSMR	Hospital Standardised Mortality Ratios
ICS	Integrated Care System
ILR	Implantable Loop Recorder
IPC	Infection Prevention and Control
IPS	Internal Professional Standards
IR	Interventional Radiology
KPI	Key Performance Indicator
LA	Local anaesthetics

Terms	Description
LAS	London Ambulance Service
LBS	London Borough of Sutton
LGI	Lower Gastrointestinal
LMNS	Local Maternity & Neonatal Systems
LOS	Length of Stay
N&M	Nursing and Midwifery
MADE	Multi Agency Discharge Event
MAST	Mandatory and Statutory Training
MCA	Mental Capacity Act
MDRPU	Medical Device Related Pressure Ulcers
MDT	Multidisciplinary Team
MHRA	Medicines and Healthcare products Regulatory Agency
MMG	Mortality Monitoring Group
MRSA	Methicillin-resistant Staphylococcus aureus
MSSA	Methicillin-resistant Staphylococcus aureus
MSK	Musculoskeletal
NCTR	Not meeting the Criteria To Reside
NEECH	New Epsom and Ewell Community Hospital
NHSE	NHS England
NMC	Nursing and Midwifery Council
NNU	Neonatal Unit
NOUS	Non-Obstetric Ultrasound
O2S	Orders to Schedule
OBD	Occupied Bed Days
OPEL	Operational Pressures Escalation Levels

Terms	Description
OT	Occupational Therapy
PIFU	Patient Initiated Follow Up
PPE	Personal Protective Equipment
PPH	postpartum haemorrhage
PSIRF	Patient Safety Incident Response Framework
PSFU	Personalised Stratified Follow-Up
PTL	Patient Tracking List
QI	Quality Improvement
QMH	Queen Mary Hospital
QMH STC	QMH- Surgical Treatment Centre
QPOPE	Quick, Procedures, Orders, Problems, Events
RAS	Referral Assessment Service
RADAH	Reducing Avoidable Death and Harm
RCA	Root Cause Analyses
RMH	Royal Marsden Hospital
RMP	Royal Marsden Partners Cancer Alliance
RTT	Referral to Treatment
SACU	Surgical Ambulatory Care Unit
SALT	Speech and Language Therapy
SDEC	Same Day Emergency Care
SDHC	Surrey Downs Health and Care
SGH	St Georges Hospital Trust
SHC	Sutton Health and Care
SHMI	Summary Hospital-level Mortality Indicator
SJR	Structured Judgement Review

Terms	Description
SLT	Senior Leadership Team
STH	St Helier Hospital site
STG	St Georges Hospital site
SNTC	Surgery Neurosciences, Theatres and Cancer
SOP	Standard Operating Procedure
TAC	Telephone Assessment Clinics
TAT	Turnaround Times
TCI	To Come In
ToC	Transfer of Care
TPPB	Transperineal Ultrasound Guided Prostate Biopsy
TVN	Tissue Viability Nurses
TWW	Two-Week Wait
UCR	Urgent Community Response
VTE	Venous Thromboembolism
VW	Virtual Wards
WTE	Whole Time Equivalent

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	3.2	
Report Title	Group Strategy Update	
Executive Lead	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Zahra Abbas, Group Strategy and Planning Manager Annastacia Emeka-Ugwuadu, Head of PMO	
Previously considered by	n/a	
Purpose	**For Approval / Decision**	

Executive Summary

This is the latest 6-monthly update to the Board on progress delivering our Group strategy.

Our strategy describes how we will achieve our vision through the delivery of:

1. **Local improvements**: against a framework of annual priorities aligned to our CARE objectives.
2. **Corporate enablers**: corporate departments, working with clinical teams developing and implementing enabling strategies.
3. **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work.

This report:

- Describes how the external environment is changing
- Gives a progress update on:
  - local improvement,
  - corporate enablers, and
  - strategic initiatives.
- Describes where we are now vs our 2028 ambitions.

Action required by Group Board

Group Board is asked to:

- Note the update, and relevant accompanying papers (BAF on risks to delivery of the strategy, and IQPR on board-to-ward priorities)
- Agree, given that we will be c. half-way through the lifespan of the group strategy, and should have greater clarity on both the New Hospital Programme and the NHS Ten Year Plan, that the next 6-month report to Board on the strategy should take the form of a more in-depth stock-take.

- Agree that for 25/26, we should roll over our existing 'board to ward priorities' (shown on slide 7) and focus our energies on embedding them into ways of working.
- Agree that for our strategic initiatives, as we plan for 25/26 the Executive should set ~3 key deliverables for each strategic initiative:
  - with a stronger emphasis than in 24/25 on delivering financial benefit
  - reviewing/prioritising carefully to ensure that the totality is deliverable
  - ensuring close alignment across the culture and high-performing teams initiatives, such that there is a coherent ask of our workforce re 'the gesh way of doing business'
  - ensuring close alignment across the Group integration, BYFH and APC initiatives, such that they move us coherently towards one future view of acute provision in SWL

Committee Assurance	
Committee	NA
Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy Update

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

As per report
Environmental sustainability implications
As per report

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Group Strategy Update

Board

James Marsh
Group Deputy Chief Executive Officer

Report Authors:
Zahra Abbas, Strategy and Planning Manager
Annastacia Emeka-Ugwuadu, Head of PMO

9 January 2025

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Introduction

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This is the latest 6-monthly update to the Board on progress delivering our Group strategy.

Our strategy…	This report…
Was based in part on an analysis of our external operating environment	Describes how the external environment is changing
Describes how we intend to achieve our vision for 2028, through: • **Local improvements**: against a framework of annual priorities aligned to our CARE objectives. • **Corporate enablers**: corporate departments, working with clinical teams developing and implementing enabling strategies. • **Strategic initiatives**: nine large, complex, long-term, Board-led, transformational programmes of work.	Gives a progress update on • local improvement, • corporate enablers, and • strategic initiatives
Sets out where we want all this work to take us by 2028 – our vision for "outstanding care, together"	Describes where we are now vs our 2028 ambitions

Based on this update, slide 20 makes some proposals for the 25/26 planning round to support delivery of the strategy.

Board is asked to:
- Note the update
- Agree the proposals for action in 25/26 to support delivery of the strategy.

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Changing environment for gesh (1)

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The environment in which gesh operates is evolving rapidly, with significant shifts occurring at local, regional, and national health system levels.

National Policy landscape	Regional developments
• Nationally, the NHS is undergoing strategic shifts with the introduction of the 10 Year Plan and the ongoing review of the New Hospital Programme (NHP). • Work on the NHS 10 Year Plan is underway. It intends to set out how we achieve the transformational change our health system needs focusing on three "shifts": hospital to community, analogue to digital and sickness to prevention. This will be published in Spring 2025. • The SECH scheme remains part of the New Hospital Programme's ongoing review into the national programme for the new Government. • Aligning with the priorities, once clear, will be crucial to securing investment and shaping services in line with national expectations.	• The delegation of many specialised services from NHSE to ICSs will take place from 1 April, 2025. • Governance and staffing arrangements are due to be confirmed to providers by ICB commissioners early in 2025. • In parallel, there is a proposed move to population-based allocation of funding for specialised services based on ICB-areas. • The South London Office of Specialised Services has begun a review of specialised services. This could prompt system level, i.e. South London and South East region opportunities to re-configure specialised services • These developments could have significant implications for St George's and its role as a regional provider of specialised services.

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Changing environment for gesh (2)

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South-West London ICS	Surrey Heartlands ICS	Local Place: Surrey Downs, Sutton, Merton, Wandsworth
• Within the SWL Integrated Care System (ICS), financial pressures mean the appetite to collaborate on radical transformation may grow • The ICB is now led by a relatively new chair, and will have a new CEO in 2025 – with a potentially different perspective/approach • The Acute Provider Collaborative's work programme currently remains more evolutionary than revolutionary. In parallel, gesh and Kingston have begun some bilateral work on collaboration in surgery.	• In Surrey, acute providers are increasingly collaborating, creating a more cohesive network within the county. Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust are progressing a proposal to form a group model, which would lead to closer working between the two organisations. • This could strengthen the sense of SWL and Surrey as two increasingly integrated but separate systems, which could impact cross-regional collaboration and integration. For gesh, it will be important to maintain connectivity across both ICSs.	• In Surrey Downs and Sutton, ESTH's collaboration with system partners continues to be recognized locally and nationally as an example of good practice • At the local level, the Group has positioned itself more actively in Merton and Wandsworth, particularly in the design/delivery of integrated working across acute/community services. • The recommissioning of community services in Merton and Wandsworth has been delayed, creating some uncertainty in discussions on how to deliver more joined up care for patients.

See annex for more detail

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Our approach to delivering our strategy

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Local improvement

Local improvement pursued by teams across the Group, against our CARE framework. In May, the Board agreed 2024/25 'board to ward priorities' to support this. The Board receives updates against these priorities through the Integrated Quality & Performance Report (IQPR).

Corporate enablers

Action led by corporate teams, against a set of enabling corporate strategies. The Board has agreed 24/25 objectives for corporate teams, and has also approved a People Strategy, Quality and Safety Strategy and a Green Plan to date. Progress reports on delivery of the Implementation Plans are being reported, by executive SROs, to Board Sub-Committees (CiCs) a minimum of three times per year.

Strategic initiatives

Nine complex, multi-year, Board-led programmes of work. Each of our nine strategic initiatives have been set up as programmes of work, led by an Executive SRO. These initiatives report to the relevant board subcommittee, and the Board receives a progress report on these initiatives on a 6-monthly cycle (via this report).

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Local improvement

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A range of work is underway to embed local improvement against our CARE objectives, and our 2024/25 'board to ward priorities' (shown below).

C	A	R	E
Collaboration & Partnership	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered, engaged staff
Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in

- Individual teams are continuing to articulate their priorities/purpose using the CARE framework, with the offer of facilitation available from corporate teams (some examples shown here).
- CARE strategy presented as part of the gesh Senior Leadership Programme, supporting leaders to align individual team objectives to CARE
- Through our High-Performing Teams strategic initiative, we continue to train staff in improvement methodologies, explicitly linked to the CARE strategy
- The CARE awards took place on 10 December. The achievements and contribution of our colleagues in hospital and community services were recognised across 12 awards linked to the ambitions of our CARE strategy
- In Q1 2024/25, we anticipate launching a revised version of the ward accreditation programme, which will be explicitly linked to the CARE framework
- The 2024/25 "Board to Ward priorities", linked to the CARE framework, are now embedded in regular progress reporting to Board via the Integrated Quality and Performance Report (IQPR) (see separate report).
- As we plan for 25/26, the proposal is to roll over the 2024/25 'board to ward priorities', and focus energy on continuing to embed them in ways of working across gesh.

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Corporate enablers

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The Board has previously agreed that six corporate enabling strategies should be developed:

Strategy	Update
People strategy	Approved by Board in May 2024. An implementation plan will be taken to the People Subcommittee.
Quality & Safety strategy	Approved by Board in July 2024. The implementation plan was agreed at Quality Committee in Common in December.
Green plan	Approved by Board in July 2024. The implementation plan has been agreed.
Estates	The new Group Director for Estates is the SRO for the Estates Strategy development. Scoping is underway, with market engagement and workshops to refine lines of enquiry being planned for January to March and securing technical support for master planning activities including SDPs from April 2025. This will inform the development of the Strategy, ready for Board approval in the Autumn 2025. This should enable the Board to approve a strategy informed by a Government decision on the New Hospital Programme.
Digital	Scoping work is being led by the IT department and SRO, Andrew Grimshaw. An update at a Board development session is being planned for spring 2025 with Board approval planned for the autumn, retaining the flexibility to agree a strategy at greater pace if needed to support a large estates/capital scheme such as renal or BYFH. This should enable the Board to approve a strategy informed by the national 10 year plan, expected to have a significant focus on shifting the NHS 'from analogue to digital'
Research & Innovation	We are targeting summer 2025 for board approval. The corporate medicine department (which include leadership positions overseeing clinical research) at the two Trusts are currently being restructured, and the Group is in the relatively early stages of exploring how its strategic partnership with the newly-merged University might change. This timeline will enable the strategy to be developed under the leadership of a new Group-wide lead for research, and in dialogue with the University.

For strategies that have been approved, the relevant Board Subcommittee are receiving updates 3 times per year on progress vs deliverables, except for the Green Plan, where the Board Subcommittee are receiving updates 4 times a year.. These updates are being prepared by the relevant corporate team, with the Group Performance & PMO team providing a common format for reporting (e.g. single-slide dashboard) and supporting with independent assurance.

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Strategic initiatives

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- Significant progress has been made across several initiatives since the last board update. Further advancements have been achieved in three key areas regularly assessed by the group PMO team: planning, delivery, and impact. The most notable improvements have been in planning and delivery. Despite limited human and financial resources, numerous initiatives have navigated the challenging landscape to progress towards the objectives set for 2024/25. In line with the delivery plan, it is anticipated that further progress will be made before the end of the financial year, facilitating the release of anticipated benefits.
- It is important to note that the recent general election has impacted the progress of several initiatives, particularly BYFH, as many elements of the National Hospital Programmes are directly influenced by the political landscape.
- Although programme management resources continue to be a challenge for many initiatives, with competing priorities impacting the pace of delivery, the Group PMO continues to provide delivery and PMO support. This support has been crucial in establishing and embedding best practice tools and processes for managing the portfolio
- To facilitate the implementation of the governance framework, the group PMO has collaborated with programme management teams to establish and align to the board approved governance framework. This includes supporting the smooth running of established steering group meetings and aligning the nine strategic initiatives with key sub-committees. Robust processes have been put in place to enable periodic updates to the sub-committees.
- Quarterly assessments against foundational best practices have been conducted, with the outcomes shared with group executives and wider programme management teams to facilitate useful feedback, actions, and continuous improvement. The group PMO teams have worked with programme management teams to ensure the standardisation of programme management practices and the development of key programme documentation and tools to enable delivery, risk management, stakeholder engagement, monitoring and assurance reporting of programmes.
- Risk management practices across the portfolio have been tightened to ensure the early identification and management of any threats to the delivery of planned objectives.

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Building Your Future Hospitals

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview - Dec 24 (inc Key Achievements)	Next Period Key Priorities --Dec 24
James Blythe	**Objective 1**: Submit Outline Business Case	Full review of the New Hospital Programme was announced by the government in Jul 24, despite the delay this has caused, planned work to deliver the strategic elements of this programme of work has progressed. Further update regarding the outcome of the review is being expected.	• Work on the OBC has progressed, however, NHP schemes have been on partial hold since August 2024 due to the government review, outcome now expected by the end of January 2025. • Programme and phasing for BYFH will be determined following the government announcement. • The new H2.0 SECH design approach has been completed to Stage 2 & agreed both internally & externally, with clinical engagement ongoing. • Work has formally commenced on creating the RMH Haem design brief for SECH to progress the determination of updated capital costs for RMH elements. • The OBC Readiness Review concluded successfully in September 2024. D&C modelling is progressing in collaboration with ICBs; this will need to align with the SWL recovery plan, with the intention of concluding by early 2025. • The Clinical Advisory Group was stood up as part of the new design approach, with the next meeting tentatively scheduled for 17/01	• Await outcome of Govt review end of Jan '25 • Conclude RMH Haematology design brief as planned • Continue internal clinical engagement on functional brief • Continue close liaison with NHP on next steps ahead of Govt review output • Review and refresh fee proposal for next stage of design and OBC development once outcome is known • Prepare pre-mobilisation plan with illustration of key governance and assurance requirements as part of the above
	Objective 2: Submit Planning application		• Refreshed version of Head of Terms received from RMH in Nov '24 • Notable updates included RMH changing plan for Theatres to Haematology wards, inclusion of MSCP for Sutton site but exclusion of RMH capital contribution to the scheme • This is being progressed through the Haematology & RMH scope design brief to understand capital cost prior to formally responding and ahead of any joint agreement • Initial pre-application engagement with LBS was successfully concluded in the summer • Progress since has been development of site wide joint travel strategy with LCH partners & RMH.	• LCH travel planner to continue further junction modelling to inform phase 1 of LCH development & wider joint strategy • Continue to progress RMH design brief development as well as solution for the Sutton MSCP solution • Pending outcome of govt review, refresh plan for Q4 activities in relation to travel and planning strategy as well next step of developing joint agreement with RMH
	Objective 3: Progress SECH site enabling works		• Significant progress made on Power Upgrade, Demolition and Malvern Centre enabling schemes with Demolition application submitted and tender documentation for Power upgrade completed • Short Form Business Cases (SFBCs) in progress & completed drafts will be shared internally early Jan '25.	• Await any initial feedback from LBS on demolition planning application • Initial review of District refurbishment programme • Recommence progress on enabling schemes once review outcome is known

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Collaboration across GESH

SRO	*Objective* (up to Top 3) *for 2024-2025*	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
James Marsh	**Objective 1**: Integrate most corporate services	• Substantial progress has been made across all three key areas. • The integration of corporate services has allowed quality benefits and some cost savings • However, the new Government's review of the New Hospital Programme means the renal integration programme has been delayed • Integration of corporate services has also slipped vs plan	• Structural integration completed for deputy CEO, corporate affairs, comms, and nursing departments. • Structural integration of corporate medicine department on track to be completed in Q1 2025/26. • Structural integration of HR underway: Senior team restructured (phase 1), and design for phase 2 (heads of service) approved by Executive, aiming for implementation by 30 March. Timeline for phase 3 in development. • Tracked £1.77m of financial benefit for services whose integration redesign has been signed off. • Estates and facilities integration design work is currently underway – with timeline agreed by Executive for first two phases. • Finance integration timeline agreed in October 2024 is off track and no longer deliverable, options to refresh this and agree a new timeline are being explored. • IT integration timeline currently being reviewed with the group executive as part of a wider review of the challenges in this space.	• Medicine (phase 3) due to launch consultation in February 2025 and teams expected to fully integrated in May 2025. • HR (phase 2) heads of services integration expected to be complete by end of March 2025. • Pharmacy strategy draft implementation plan developed – to be reviewed in GEM January 2025. • Paediatrics strategy Board development session scheduled for February 2025. • Agree plan and timetable for Finance re-structure. • Executive team exploring potential to set out more directly our vision for integration across clinical services (via a "Group Roadmap") • Identify and focus on target areas for clinical integration following the roadmap development. • Clarify impact of New Hospital Programme review on renal integration
	Objective 2: Submit full business case for renal build		• Full business case drafted and shared informally with NHSE. • However, Government review of New Hospital Programme (part funder of the renal build) means the renal integration programme has been delayed • Inflationary pressure on building costs continues to be a significant risk	
	Objective 3: Agree three Group-wide clinical strategies, and begin implementation		• Pharmacy strategy approved. • Discussion re surgery strategy at December board development session, with approval due early Q1 2024/25. • Group children's services strategy under development and due to be approved Q1 2024/25. • A range of other clinical integration work ongoing, including in urology, community paediatrics, anaesthetics, respiratory physiology.	

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Collaboration across SWL hospitals

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
James Marsh	**Objective 1:** Deliver agreed transformation programmes (e.g. PACS)	• Range of transformation programmes underway, however the delivery of joint PACS remains challenging. • Work to strengthen APC partnerships hosted by gesh ongoing • Some new partnership programmes are underway which could lay the foundations for greater collaborative working, including along lines of 'hub' models – but the task in 2025/26 will be to ensure these programmes reflect the scale of the financial challenge our system faces	• Significant advancements are being made across key focus areas, including elective recovery, diagnostics, outpatient transformation, and workforce. • The delivery of the joint PACS remains challenging.	• Extend the existing PACS at SGUH as a mitigation measure due to the supplier's inability to meet the required timeframe. Negotiations for this extension are being led by the Group's GCFO
	Objective 2: Strengthen hosted APC partnerships (SWLEOC; SWL Procurement; SWL Pathology)		• Work aimed at strengthening the Acute Provider Collaborative partnerships hosted by GESH continue to progress under the leadership of executive directors.	• Maintain engagement to strengthen formal APC partnerships • This will need to align with internal work within the Group on governance/management of Group-wide clinical services (such as pharmacy).
	Objective 3: Develop new partnership programmes to support long-term financial sustainability (e.g. hubs)		• Following rapid review of opportunities for collaboration in elective care, the APC is pursuing projects aimed at ensuring SWL providers deliver better outcomes & VFM through collaboration – e.g. through piloting women's health hubs and developing a single point of access in ENT and ophthalmology. • Additionally, Kingston Hospital NHS Foundation Trust and GESH have initiated strategic collaboration efforts in general surgery. • These projects will have positive benefits, but they will not in themselves make a significant dent in the system's very significant financial challenges.	• Ongoing engagement at CEO level with ICB and ACP partners on potential further collaboration for long-term financial sustainability. • Complete joint work with Kingston on strategic framework for collaboration in surgery

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Collaboration with Local Partners (Surrey, Sutton, Merton & Wandsworth)

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
Thirza Sawtell	**Objective 1:** Develop gesh-wide approach to frailty	• Progress is being made with the re-launch of the Steering Group in the new year to drive group-wide objectives. • Ongoing reporting to the Integrated Care - Interface & Recovery Meeting and the Finance Committee ensures continuous alignment and accountability	• Scoping session for the Integrated Acute Frailty Service successfully completed with the identification of key areas for development with input from frailty consultants.	• Develop communities of practice around agreed best practice • Develop benefits realisation dashboard
	Objective 2: Work with local partners to reduce length of stay		• The Community of Practice is actively working to reduce non-elective length of stay by 1.5 days, facilitating shared learning among operational teams. • A robust Group LOS dashboard with agreed metrics and methodology that supports the evaluation of LOS reduction performance and trends has been established. • A group view of site project plans for managing LOS has been convened. • A unified approach to measurable performance metrics has been successfully developed. • Initial engagement with SWL on the Group approach has begun.	• Share Insights across operational teams on progress against plans and performance • Developing areas of work that can be advanced at the Site vs. Group level • Further refine Group level LOS metrics for accuracy and consistency with other reporting lines and performance metrics reviewed across SWL program
	Objective 3: Work with partners on redesign of community services in Merton & Wandsworth		• Provider Alliance Working Groups in Merton and Wandsworth have been established, with a focus on stimulating collaboration and developing alliance care models. • Focus now on testing new models for winter pathways in Merton, refining performance metrics for accuracy and consistency, and strengthening partnerships with provider partners and the SWL ICB.	• Conduct a Provider Alliance opportunity analysis for winter testing of the focused pathway to be developed through the Alliance model in Merton. • Develop delivery model strategies for integrated community services in scope for procurement • Explore different options for the Alliance Governance model. • Strengthen provider partner relationships across Merton and Wandsworth through Alliance OD • Engage with SWL ICB to test and align to overall ICB strategy

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Strengthening our Specialist Services

SRO	*Objective* (up to Top 3) *for 2024-2025*	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
Kate Slemeck	**Objective 1:**Get gesh ready for devolution of specialised service budgets	• Increased focus on delegation implications for services funded by Spec Comm, ready for 1 April, 2025 transfer from national to system level commissioning • Focus on financial analysis and market share of all specialised services to guide decision making re future service provision.	• New Director of Specialised Commissioning for pan London hub to oversee delegated services recruitment underway. The devolution of spec comm set for 1 April 2025 is on track • Ongoing dialogue with South London Office of Specialised Services (SLOSS), NHSE and partner ICBs to prepare for the upcoming delegation.	• Work continues to prepare for the delegation of specialised services funding from NHSE to the local system (ICBs). Use the Group oversight framework and risk register to mitigate, and escalate as appropriate, risks in Q4 of 2024-25 • A new system wide transformation group has been established for South London.
	Objective 2: Strengthen the services we want to be renowned for		• The programme has been re-scoped after a 'light touch review', with a focus on strengthening of Neurosciences, Major Trauma, Renal, Cardiac surgery, and children's services. Highlights include: • Range of actions taken to strengthen cardiac surgery, including increased theatre capacity, enhanced care capacity, and focus on recruitment/retention of surgical & anaesthetic workforce. • 'Model of care' for Major Trauma currently under development, to codify & strengthen our approach to delivering the service • Ongoing programme to integrate renal services (see update under Group collaboration) • Ongoing discussion with NHSE on how to strengthen paediatric services, particularly in the context of NHSE's decision to move paediatric cancer to the Evelina	• Complete the Major Trauma model of care in early 2025. • Agree strategic intent for strengthening paediatric services with NHSE
	Objective 3: Improve oversight of our specialised service portfolio		• New risk/oversight framework has been developed and is currently being reviewed by Service Leads, this will enable proactive management of the risks associated with the delegation of the majority of spec comm funded services from national (NHSE to system (ICBs) commissioning leadership arrangements • Detailed analysis of (including of financial data such as SLAM and PLICS) underway to enable definition of services where there are opportunities to collaborate	• Contribute to the South London Office of Specialised Services (SLOSS) sustainability review, combining this with implementing the recommendations from the GESH review of the opportunities to collaborate, network or consolidate services.

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High Performing Teams & Leaders

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
James Marsh	**Objective 1**: Support our teams to develop shared goals, linked to our strategy		• Progress is being made with the rollout of our gesh CARE framework, accelerating strategy deployment through the effective use of CARE boards. • A number of senior leadership teams have successfully adopted the use of CARE boards. Learning and feedback will be used to further refine and enhance this approach	• Conduct an executive-led workshop to explore adoption strategies, enhance executive involvement, and facilitate learning from others. • Finalise areas to pilot the new Quality Management System approach in targeted segments across the group. • Finalise and agree on the implementation plan for the Quality Management System. • Strengthen the alignment with the people strategy, quality and safety strategy, and cultural initiatives to ensure a consistent approach
	Objective 2: Support teams to use continuous improvement habits and tools against these goals		• Significant progress has been made in enhancing staff and leadership skills through dynamic improvement programs and forums for sharing best practices. • Programme has leveraged partnerships to develop leadership and continuous improvement culture by learning from other trusts. For example, collaboration with Royal Free London NHS Foundation Trust on the 'What Matters to You' program. • Improvement capability continues to develop across gesh, while team continues to work with teams to identify, harness, and celebrate existing strengths	
	Objective 3: Align our approach to performance		• The programme has successfully established 6 design and delivery groups and 2 enablers to support the development and launch of a group wide Quality Management System (QMS) has been mobilised. The QMS will enable teams identify, plan, control and assure activities undertaken to improve access, quality, experience and outcomes. • Design and delivery groups have developed initial plans to pursue the definition and development of our group wide collaborative quality management system. • A framework to define the operational ambitions based on a co-design and review approach has been agreed at GEM in December 2024. To test this framework, targeted 'slices' of the organisation are being selected at this stage	

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Transforming Our Culture, Diversity & Inclusion)

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
Victoria Smith	**Objective 1**: Implement sexual safety charter	• Progress has been made on implementing the sexual safety charter and through the violence and aggression taskforce, but more actions are planned – work is ongoing • The EDI action plan is drafted and has been reviewed by People Committee, with sign off due early 2025. • The People Strategy includes a range of activities which are designed to improve our culture, including integrated values and behaviours and a focus on people management capability – these will likely form the basis of activity under this strategic initiative in 2025	• Sexual safety charter and steering group has been successfully established. • Working group formed with reps from all workforces with progress achieved across all workstreams. • Policy and toolkit currently in development. • Divisional leadership and staff networks collaborating and contributing.	• Finalise the development of data gathering platform for anonymous concerns. • Finalise and launch sexual safety policy and toolkit.
	Objective 2: Develop and implement plan to tackle violence & aggression against staff .		• Violence and aggression taskforce, co-creating solutions to issues experienced has been successfully established with Group CEO as chair, and meetings in progress to oversee activity. • A gesh-wide Violence and aggression policy is being drafted which adopts a clear violence prevention, reduction and response process. • Closer collaboration between Trust and the police as part of Operation Cavell across all sites. • Working towards compliance with the violence and aggression reduction standard. Noting that NHS England has just launched (Dec. 2024) an updated standard which includes a new RAG rating to support continuous improvement • Violence and aggression face to face staff awareness training at has been launched at each site and online.	• Launch gesh-wide policy violence and aggression policy which includes toolkit resources for staff. • Launch the use of more supportive incidence response letters. • Progress targeted work with intranet updates. • Review of additional resources for violence prevention and reduction training based on a training needs analysis. • Review and report on status against the updated violence prevention and reduction standard.
	Objective 3: Deliver our diversity & inclusion plan		• Gender Pay Gap, EDS, WRES and WDES reporting complete. • 2024-26 D&I Action Plan drafted and aligned to NHSE High Impact Action Plan and has been presented at People Committee for review and feedback. • Introduction of Neurodiversity in the workplace training. • Review of workplace adjustment process and ramp up of the Disability Advice Line. • Gesh Culture Forum launched including recognising and celebrating awareness events.	- Secure sign off of the EDI Action Plan and continue to progress with planned actions. Define governance and resource requirements. - Conclude scoping introduction of sensory pods (including securing partial funding from Charity). - Develop a positive action pathway to proactivity prepare colleagues from ethnic minority backgrounds for leadership

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Shared Electronic Patient Records (EPR)

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview- Jan 25 (inc Key Achievements)	Next Period Key Priorities - Jan 25
Alex Shaw	**Implement an EPR domain share for ESTH by May 2025**.	Positive progress across the programme. • Steady progress made across all streams of testing and Go-Live timeline of May 2025 remains on track. • The ongoing work to conclude the financial process with finance director to release the additional funding • Some slippage with some workstreams due to delayed activities or identified risks or issues currently impacting on delivery milestones. Programme team continues to work through mitigations to each arising challenge.	• On track for maternity iclip launch in Feb at SGH • Successful launch of new ICLIP branding. • Successful End User Testing sessions have completed across all planned clinical and admin areas with good level of engagement and consistent positive feedback. • Successful conclusion and exit of the TL4 and IT3 cycles, and final underway towards upcoming trial load (TL5) and testing cycle (IT4). • Formal organisational readiness oversight structure stood up with the development of activity reduction plans and opportunities for sign off. • Domain copy (PROD to MOCK2) successfully completed to schedule. Handover to Trust and Oracle Cerner teams to commence TL5 activities w/c 02/12 • Training prep is underway with progressive movement on the training needs analysis being undertaken across all the divisions	• Submit financial Addendum to regional Eprib committee for review and to release additional funding • Develop and socialise digital and operational BAU models • Sign off Go and No-Go criteria, aligned to operational readiness plans. • Sign off organisational readiness plans • Bolster communications strategy launch familiarisation sessions from mid-January • Roll out training plan • Focus on rapid completion on required build configuration ahead of the next domain copy to aid TL5.
			• Development of cut over plan in progress. • Checklist to support operational readiness complete and in circulation • Activity planning on track for January completion • Programme assurance reviews have been successfully completed; this includes the audit of robustness of future plans, and previous historic management of programme. Outcome to be discussed with group executives in Dec 24. Work on actions following two external reviews continues, focusing on: • Onboarding critical friends • Launching refreshed governance structure in January • Collaborating with ICS colleagues to assemble a team of experts • Finalising BAU structures post go-live	• Finalise actions plan which incorporates key recommendations following review to improve programme outcome including the refresh governance framework and oversight • Sign off cut over plan. • Continue to work on FBC addendum to secure additional funding.

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Transforming Outpatients

SRO	Objective (up to Top 3) for 2024-2025	Overall Assessment	Status Overview (inc Key Achievements)	Next Period Key Priorities
Richard Jennings	**Objective 1:** Redesign pathways with primary care, e.g. more advice & guidance for GPs **Objective 2:** Offer more Virtual & telephone Clinics **Objective 3:** Expand use of Patient Initiated Follow-Up pathways	Ongoing improvement in site-led transformation programmes, with a more focused approach to group level deliverables, workstreams and priorities. Refreshed governance and meeting cadence introduced, with a Steering Group established overseeing 4 workstreams with Design & Delivery groups set up for each. Continued work with both sites, aligning reporting metrics, and further scoping of the financial benefits of outpatient transformation work.	• Regular and more structured interface with primary care colleagues have been successfully established. These regular meetings have helped to boost relationships and improve the advice and guidance utilisation rate. Both SGUH and ESTH are now consistently achieving this NHSE national target. • Engagement with key stakeholders in GESH and the broader health system is progressing well. The SRO of the Transforming Outpatients Strategic Initiative is chairing the Tackling Health Inequalities meeting, fostering the cross-fertilisation of ideas. • Ongoing collaboration with SWL partners to identify best practice in reducing the impact of health inequalities for patients on waiting lists. • Detailed discussions around the use of automation, with options appraisal and a framework drafted – focusing on the benefits and group alignment • Exploring the use of AI and the multitude of benefits it can bring – understanding the need for clear direction, oversight, exec buy in and a change in culture along with training and guidance • Both site teams continue to aim to increase PIFU performance and exploring further PIFU opportunities. ESTH - 3.5% Trust target and 5% national target achieved in August 2024. SGUH- Patient Initiated Follow-up (PIFU) uptake is increasing across all divisions. Plan to achieve 2% for October 2024 on track to be delivered.	• Ongoing collaboration with Site teams, including oversight of 'get the basics right' transformation programmes at Site, and providing Group-wide strategic direction and 5-year goals. • Identification of further cost savings, financial benefits and CIP's within Outpatients. • Continued scoping of design and delivery groups to prioritise workstreams delivering most benefits to outpatients transformation. • Continued development of processes to support Group-wide transformation goals, including through technology adoption principles.

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What Next for our strategic initiatives?

1. **Outline Deliverables for 2025/26**: Support programme management teams to define the deliverables for the 2025/26 period and support the development of robust plans to drive the delivery of agreed deliverables at pace.
2. **Align Strategic Initiatives with Business Planning**: Align deliverables for strategic initiatives in 2025/26 with business planning activities. This will facilitate the identification of key schemes, drive the delivery of efficiencies and significant financial and non-financial benefits to the organisation and stakeholders. It will also help identify and address resource implications.
3. **Review and Prioritise Delivery Support**: Continuously review the delivery support required by each initiative and prioritise available capacity accordingly.
4. **Strengthen Risk Management**: Enhance the risk management process to ensure clear understanding of all potential risks, ensuring compliance and accountability at all levels of portfolio management. This will include enabling a clear escalation process to ensure appropriate actions are taken to address threats to stakeholders and the successful implementation of strategic initiatives and the Group's long-term goals.
5. **Improve Assurance Reporting**: Adapt the reporting process following recent review of GEM operating model. Enhance the assurance reporting mechanisms to support robust escalation and provision of timely updates. This will facilitate the right discussions at governance meetings and informed decision-making.

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Our ambitions for 2028

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Is all the activity above contributing to our 2028 ambitions in the way that we intended?

	Collaboration & partnership	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered, engaged staff
Ambition for 2028	"By 2028 gesh will be a driving force behind the most integrated health and care system in the NHS"	"By 2028, we will have taken the difficult action required to break even each year financially"	"In 2028, waiting times for our services will be among the best in the NHS (top quartile), and we will have an outstanding safety culture, delivering lower than expected mortality rates and a reduction in avoidable harm."	"By 2028 gesh will be among the top five acute trusts in London for staff engagement"
Where are we now	**Mixed progress**. Growing number of trusts across the NHS pursuing Group model – we have made progress but much further to go. At place level, recognised good practice in Surrey Downs/Sutton but further to go in Merton/Wandsworth. A relatively mature APC by national standards but the test will be delivering radical change needed for sustainable provision in SWL.	**Extremely challenging**. Despite delivering very significant cost improvement YTD, we are forecasting a deficit for 24/25, and future years likely to be extremely challenging across the NHS.	**Mixed progress.** Waiting times generally compare well to the rest of the NHS (top or 2nd quartile), but are not where we would want them to be – incl. high concern re pressures on A&E. Mortality rates lower than expected at SGUH but higher at ESTH (partly due to coding issues), & mixed progress on reducing avoidable harm - see IQPR report for detail.	**Mixed progress.** Initial results from latest staff survey suggest engagement scores slightly improved (SGUH) and static (ESTH), in both cases above NHS trust average. But getting to top 5 in London by 2028 will be challenging. Fuller analysis of latest staff survey to follow.

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Recommendations

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The Board is asked to:

1. Note the update, and relevant accompanying papers (BAF on risks to delivery of the strategy, IQPR on board-to-ward priorities)

2. Agree, given that we will be c. half-way through the lifespan of the group strategy, and should have greater clarity on both the New Hospital Programme and the NHS Ten Year Plan, that the next 6-month report to Board on the strategy should take the form of a more in-depth stock-take.

3. Agree that for 25/26, we should roll over our existing 'board to ward priorities' (shown on slide 7) and focus our energies on embedding them into ways of working.

4. Agree that for our strategic initiatives, as we plan for 25/26 the Executive should set ~3 key deliverables for each strategic initiative:
   a) with a stronger emphasis than in 24/25 on delivering financial benefit
   b) reviewing/prioritising carefully to ensure that the totality is deliverable
   c) ensuring close alignment across the culture and high-performing teams initiatives, such that there is a coherent ask of our workforce re 'the gesh way of doing business'
   d) ensuring close alignment across the Group integration, BYFH and APC initiatives, such that they move us coherently towards one future view of acute provision in SWL

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Annex A:
Regional and local update / horizon scanning

Changing environment for ICSs – national context

With the election of the new Labour government, there have been a number of strategic shifts in the health and care landscape

Darzi Investigation of the NHS in England	Review into the operational effectiveness of the CQC
• On 12th September 2024, Lord Darzi published a report on the state of the National Health Service in England. The independent investigation was commissioned by the Secretary of State for Health and Social Care in July 2024. • It found that the NHS is in a "critical condition," with significant underfunding and rising demand leading to deteriorating services. Since the 2010s, the NHS has spent £37 billion less than peer countries on health assets, resulting in outdated infrastructure and equipment. • It suggested shifting a larger proportion of the budget towards primary, community, and mental health services to enhance preventive care and reduce hospital admissions, investing in technology and addressing health inequalities.	• In May 2024, Dr Penny Dash conducted a review on behalf of the Department of Health and Social Care on the operational effectiveness of the Care Quality Commission (CQC). The full report was published on 15 October 2024 outlining the necessary changes to start improving CQC. • The review identified a significant reduction in inspection activities, with only 6,700 inspections conducted in 2023 compared to 15,800 in 2019. • Delays and inconsistencies in inspection reports were highlighted, with reports described as poorly structured and lacking clarity, leading to diminished trust among providers. • Furthermore, organisational restructuring led to inspectors operating outside their areas of expertise, eroding credibility within the health and social care sectors.

Changing environment for ICSs – national context

The NHS 10 Year Plan in particular will set the strategic direction for the NHS and set out how we achieve transformational change.

Review of patient safety across the health and care landscape	NHS 10 Year Plan	New Hospitals Programme (NHP)
• A review considering the wider landscape for quality of care, with an initial focus on safety, will be published in early 2025. The review will: • map the broad range of organisations that impact on quality (and therefore have links to safety); • focus on six key organisations overseen by the Department of Health and Social Care, which have a significant impact on safety.	• A new 10 Year Plan for the NHS is underway. It intends to set out how we achieve the transformational change our health system needs. This will involve three strategic shifts in how care is delivered, moving care from: ○ hospital to the community ○ analogue to digital ○ sickness to prevention • There are 11 working groups supporting policy development. The plan will be published in Spring 2025. • gesh submitted a response to the NHS 10 Year Plan consultation on 2 December.	• A review of the New Hospitals Programme has been requested by the Chancellor of the Exchequer and the Secretary of State for Health and Social Care. • The review intends to assess the appropriate schedule for delivery for schemes in the New Hospital Programme in the context of overall constraints to hospital building and wider health infrastructure priorities. • We are waiting for the outcome of the review.

Changing environment for ICSs – specialised services

NHSE Board decision

• NHSE Board on 5 December approved delegation to the four remaining regions (including London) from 1 April 2025. NHSE London region are currently in the process of forming a Specialised Services Shared Commissioning Team (SSSCT) to support ICBs across London in their commissioning of the delegated services.

Retained operating model

• London Region hosted a workshop with SE and SW Regions on 9 Dec to flesh out details for those services whose commissioning will be retained at a regional level. We are in regular contact with the South London Office of Specialised Services on what this will mean to our services.

Risks and issues

The delegation of specialised services introduces three main categories of risk, which are managed by SLOSS in collaboration with ICBs and providers, and reviewed on a quarterly basis at the SLOSS Executive Management Board (EMB), or which has gesh representation:

- *Finance:* Whilst initial 25/26 allocations have been set to cover the current cost of commissioning the delegated services, demand for specialised services is growing and future growth allocations are likely to be very constrained. This could be further impacted by convergence towards new 'needs-based' allocations.
- *Commissioning support:* The capacity and structure of the Specialised Services Shared Commissioning Team (SSSCT) is still unknown. This cannot be finalised until staff consultations within the current NHSE team are complete.
- *Existing service risks and issues:* ICBs will inherit existing risks and issues relating to specialised services that are currently managed by NHSE, from April 2025.These include capacity constraints, provider finance pressures, and capital replacement issues.

South London specialised sustainability review

The sustainability review was discussed at the SLOSS CEO Strategic Oversight board on 2 December and received support to proceed. The key three themes of the programme deliverables will be:

- *Compendium of opportunities:* Drawing together existing known issues and opportunities by programme of care and specialty, to understand what projects are already in the pipeline or are being developed.
- *Data review and analysis:* A holistic data review, looking at trends in activity, out of area flows, efficiency metrics, patient demographics and inequalities, and finance. This will begin very broadly across the entire portfolio of services but narrow down once validation and input from clinicians / networks has been received.
- *Outputs and project proposals:* Validated outcomes and variation from data review are prioritised and turned into proposals for change, which are brought to EMB and other forums.

Implications for gesh:

- GESH will need to continue to work with SLOSS/SW ICB and NHSE, through the gesh Specialised Services Steering Group, to work through the future commissioning arrangements following delegation of Specialised Commissioning.
- GESH will need to continue working closely with SLOSS to work through the key risks that have been identified in the new model of commissioning arrangements.

South West London ICB, ICS and ICP - key updates

SWL ICB Finances:

South West London has an agreed financial plan for 24/25, delivering a small surplus with regional support. At month 6 the SWL system is reporting a £7.7m adverse position to plan largely due to industrial action and efficiency delivery shortfall. The financial plan is extremely challenging and an update to the ICS November Board noted there remains significant risk to the delivery of the financial plan and the savings programme included within it.

Delegation of specialised commissioning

From April 2025, approximately £366m of specialised commissioning budgets will be delegated to the ICB with the aim of integrating commissioning to achieve service, pathway, and population health benefits. The ICB, working with colleagues from across London and the South London Office of Specialised Services (SLOSS), are working to complete final preparations including relevant assurance processes with NHSE, and expect to seek ICB Board approval for delegation in January 2025 with final confirmation by the NHSE Board in February 2025.

SWL ICS Digital Strategy 2025-2028:

A refreshed SWL ICS Digital Strategy was presented for approval at the November 2024 ICS Board meeting. This strategy outlines how quality of care will be improved through digital innovation and should inform ongoing development of the gesh Digital Strategy.

New ICP Co-chair announced:

South West London Integrated Care Partnership (ICP) has appointed Kingston Council leader, Andreas Kirsch as its new co-chair. Andreas will work alongside fellow co-chair Mike Bell to lead health and care across the six boroughs through the ICP.

Implications for gesh: gesh will need to continue supporting the financial recovery of the system. The Group will also need to liaise with the ICB as they continue to work through assurance processes related to the delegation of specialised commissioning budgets. The appointment of a new ICB chair could offer a fresh perspective and renewed energy for regional collaboration.

Surrey Heartlands ICB, ICS - key updates

System sustainability plan
As a system, Surrey Heartlands continues to work hard to improve the financial position and to progress system-wide sustainability plans which covers the rest of this current financial year and future years.

This work includes several specific efficiency programmes, such as medicines optimisation, and wider cost improvement plans across partners. This work is supported by a dedicated Efficiency Delivery Unit with a programme management approach to oversee and assure our system-wide efficiency programme.

Surrey Heartland plans have been positively received by NHS England who have recognised the good work undertaken across the organisation, noting that there is still a lot to do to ensure the system achieves the agreed deficit position of c. £40m.

Ashford and St Peter's and Royal Surrey group model
Following recent discussions, Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey NHS Foundation Trust are progressing a proposal to form a group model, which would lead to closer working between the two organisations.

The Boards and Council of Governors of both trusts have agreed recommendations to form a group model and appoint a group chief executive and group chair. They have also agreed that the chief executive should be the current chief executive of Royal Surrey, Louise Stead who, subject to some formal processes and final decisions by both Trust's Council of Governors, will take up the new role in January 2025. Both Trusts have also agreed to form a joint transformation committee which will set the strategic direction for the group and agree priorities and key areas for collaboration

Implications for gesh:
- GESH will need to continue to work with Surrey Heartlands on their sustainability plans particularly given implications this may have on Epsom.
- Developments in the group model development between Ashford and St Peter's and the Royal Surrey may have implications to patient pathways that come from Surrey Heartlands to gesh. Gesh should ensure it is aware of the strategic direction of the group.

South West London Acute Provider Collaborative

Governance & leadership

The Terms of Reference for the APC Collaborative Board have been refreshed clarifying the APC Collaborative Board as the decision-making Board and key group for providing update and assurance of all activities within the Acute Provider Collaborative. The Board will approve business cases prior to ICB approval or individual statutory Trust Boards. Both the Shared Services Board and the Elective Transformation Board report into the APC Collaborative Board. A new managing director for the APC (Lucy Clements) has been recruited.

Elective care collaboration

As one of the 4 major cross-system programmes of work agreed by the ICS to support financial recovery, the APC is leading a piece of work to explore opportunities for greater collaboration in elective care. The APC is taking this forward with input from directors of strategy/COOs from the four trusts through a rapid diagnostic process, which is due to conclude in the coming weeks. More detailed work will follow on this as opportunities to support longer term financial sustainability are clarified.

Clinical Networks

Following the reduction in the number of clinical networks to nine, the priority focus remains on major workstreams of Ophthalmology, Dermatology, Audiology, ENT & Gynae (Women's Health Hubs), as well as continued shaping of new gastroenterology network arrangements, aligned with endoscopy and cancer programmes. Alongside this, there is a continued focus on Outpatient transformation, specifically looking at ways to reduce demand, and wait times for first time appointments.

Implications for gesh:
Particularly in the context of the challenging financial environment, the Group will need to continue support/ input to the APC work on elective collaboration to successfully drive longer term financial benefits at system level.

Surrey Heartlands Provider Collaborative

The Surrey Heartlands Trust Provider Collaborative Strategic Committees in Common met in July and September to agree the following:

- The proposed Trust Provider Collaborative Vision and Principles
- To re-commit to the following clinical transformation programmes: Acute Paediatrics, Mind and Body, Endoscopy, Maternity and Neonates, Surrey Heartlands Elective Centre and Anti-Systemic Cancer Therapy
- To adopt the Emotional Wellbeing Mental Health Project as a new clinical transformation programme, subject to project management resource being identified
- To stop the Stroke clinical transformation programme
- To support a total of four clinical sessions (one from each Trust) to support the Acute Paediatric Programme (Including the Emotional Wellbeing Mental Health Project)
- The revised SCIC Terms of Reference
- The proposal that the three acute provider members of the TPC take responsibility for the Elective Delivery function and team from the Integrated Care Board
- The Elective Delivery Function Partnership Agreement for the three acute provider members

gesh Group to:

- Continue engagement with the Provider Collaborative particularly on the identified areas for clinical transformation
- Continue to engage in the Mind and Body programme of work
- Stay abreast of the ongoing development of the provider collaborative, and the direction in which chair/NED discussions might go

Wandsworth and Merton Place-Based Developments- key updates

Wandsworth:

- **Emergency Department Pressures**

There is a significant focus on reducing avoidable hospital admissions during the winter season by adopting alternative care pathways. This includes the promotion of same-day emergency care, virtual wards, and strengthened urgent community response teams.

- **Vaccination Campaigns and Public Engagement**

With flu and COVID-19 vaccination uptake lower than desired, significant efforts are being directed toward community engagement, particularly in areas of high deprivation and vaccine hesitancy.

- **SW London Community Services Contract**

The Merton Place Partnership is contributing to the development of a new community services contract to standardise core services across South-West London, with flexibility for borough-specific customisation.

- **Winter Communications Plan**

A proactive communications strategy is being developed to inform residents about when and where to seek care and to encourage responsible use of NHS services.

- **Virtual Wards**

The current virtual ward model in Merton is under review, with a focus on optimising performance and increasing patient throughput. The Place Partnership recently held a stakeholder workshop to identify barriers and opportunities for improvement.

- **Health Inequalities**

A fund is being explored to address health disparities, with a focus on targeted interventions in areas of high deprivation or low service uptake.

Merton:

- **Winter Planning**

Focusing on addressing system-wide pressures including managing demand, addressing inequalities and providing targeted support. There has been a targeted vaccination campaign and behavioural change campaign to help reduce ED attendance.

- **Provider Alliance Working Group**

The Merton Provider Alliance (MPA) Working Group was recently established. In the first six months, the Group will focus on identifying its purpose and working arrangements, determining the agreed focus areas for service transformation and delivering these projects include proactive frailty Multi-Disciplinary Teams (MDTs) and streamlined frailty pathways.

- **Health Inequalities**

There was a mid-point evaluation of Merton Health Inequalities Projects 2023-25. The overriding message was that all projects have done well. The current funding stream for these projects has now stopped, so there is a focus on identifying alternative sources of funding for future projects. Findings from a recent Healthwatch report highlight challenges in healthcare access for Polish and Eastern European communities.

- **Quality and Performance Monitoring**

The creation of a Merton-specific Quality and Performance Group to oversee key metrics and risks, including Uptake of Serious Mental Illness (SMI) and Learning Disability (LD) health checks.

Implications for gesh:

- Continue to engage in system-wide Winter Planning
- Continue to engage in the Provider Alliance Working Group to strengthen relationships and increase scope for integration.

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Sutton and Surrey Downs Place-Based Developments- key updates

Surrey Downs:

Transformation Plan
Following engagement with local people and partners over the past few months, the Surrey Downs Place Board formally approved our two-year transformation plan at its November seminar. The board was assured that the plan was in line with the emerging national direction and move towards enhancing the neighbourhood health service.

Virtual wards
The Surrey Downs Virtual Ward was highlighted as a case study of good practice in a letter sent to all providers from Amanda Pritchard, CEO of NHSE. The case study highlighted the strength of the integrated service in both preventing acute admissions and facilitating earlier hospital discharge. The model mirrors the Surrey Heartlands specification for virtual wards.

Sutton:

Anchor development:
Integrated Care Systems (ICSs) are increasingly acting as 'Anchor Systems' working with partner members across health and care to support their Anchor/civic ambitions and collaborating across the system to facilitate joint action to support social and economic development. SWL Integrated Care Board (ICB) and South London Partnership (SLP) have mapped their 99 current activities by Borough.

In Sutton there is ongoing work with NHS Trusts and large local employers to create to internships and apprenticeships for local people and implement the London Living Wage.

Through the development of the Integrated Neighbourhood Programme Sutton Place is collaborating with PCN's, voluntary and charity sector to develop a collective neighbourhood response to identified issues.

Implications for gesh:

ESTH continues to work closely as an active partner at Place. It is important the Trust remains engaged in shaping, and actively contributing to the development of the transformation plan.

Gesh should continue to work with Sutton in the development as an anchor institution particularly around in the creation of internships and apprenticeships for local people.

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	3.3	
Report Title	**Finance report Month 08 (November) PUBLIC**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	20 December 2024
Purpose	**For Review**	

Executive Summary

Both trusts are reporting underlying positions adverse to plan at M8 (ESTH £4.2m and SGH £6.1m), driven by baseline pressures and CIP shortfalls and in addition a £0.9m income loss from cyber attacks at SGH.

Delivery of the plan by year end is at material risk, with both trusts forecasting adverse variances to plan for the end of the year. Action to identify ways to mitigate this continue.

The assurance is rated 'limited' as based on the YTD variance from the agreed financial plan

Action required by Group Board

The Board is asked to note this paper

Committee Assurance

Committee	Finance Committees-in-Common
Level of Assurance	Limited Assurance: The report and discussions did not provide sufficient assurance that the system of internal control is adequate and operating effectively and significant improvements are required and identified and understood the gaps in assurance

Appendices

Appendix No.	Appendix Name
	None

Implications

Group Strategic Objectives

☒ Collaboration & Partnerships

☒ Right care, right place, right time

☒ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks

BAF SR4.				
CQC Theme				
☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes		☒ People		
☐ Preventing ill health and reducing inequalities		☒ Leadership and capability		
☒ Finance and use of resources		☐ Local strategic priorities		
Financial implications				
IN support of delivering the Group financial plans.				
Legal and / or Regulatory implications				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

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Group Board (Public): 9th January 2025
24/25 M8 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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Group M8 position

GESH

	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• **Both trusts are reporting underlying positions adverse to plan at M8 (ESTH £4.2m and SGH £6.1m), driven by baseline pressures and CIP shortfalls and in addition a £0.9m income loss from cyber attacks at SGH.** • The M8 in month adverse positions is favourable to M7 at both Trusts due to mitigating the previously reported adverse position from income loss from Industrial action. • **Brought forward NR benefits** from later in the year (SGH £1.8m, ESTH £0.8m). • **Delivered mitigations** this is SGH £11.0m, ESTH £9.2m.	• Based on current performance the trust will not deliver the financial plan in full	• Continued focus on cost control and the development and delivery of CIPs through the Financial recovery Board and site management meetings.
Workforce costs and WTE plan	• Pay expenditure is overspent in both trusts. • WTE at ESTH is 123 adverse to plan, an improvement from the 211 adverse to plan reported at M7. This is a result of an additional 42 WTE delivered CIP in M8, mainly relating to enhanced care and roster efficiencies and some phasing benefits on WTE on winter plans that are expected to deliver to plan in M9. • WTE at SGH is adverse to plan by 453 due to the step up in CIP delivery planned for in M4/7 and Junior Doctor rotation of 30 WTE.	• M4 had a step change at both Trusts in the planned reduction in WTE as a result in step change in plan CIP. • Both Trusts have been unable to mitigate the adverse performance in full at M8	• Increased focus on control actions in key areas notably agency controls all staff groups, medical temporary staff costs, nursing rota management and continued challenge through vacancy control.
CIP delivery	• ESTH delivery £3.0m adverse to plan. Recurrent CIP £5.9m adverse and non recurrent £2.9m favourable. Slippage in WTE reduction recurrent planned CIP (WTE CIP 156 adverse) whilst an improvement from M7 has continued to be mitigated by non recurrent efficiency. • SGH £4.3m adverse to plan (although this includes b/f £0.8m benefit) with £6.6m less recurrent than plan.	• Underlying recurrent CIP performance at both Trusts not in line with plan driven by slippage on WTE reduction plan as per the workforce costs and CIP.	• Continued focus on CIPs identification and delivery within the Trust. • Work actively with SWL groups to identify other opportunities and system wide actions, including estates, medical staffing and agency.

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Group M8 position

GESH

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	Overview	What does this tell us?	What actions/mitigations are required?
Capital	• ESTH M8 performance behind the PFR plan but in line with internal plan which built in slippage for delays in agreeing the SWL capital plan. • ESTH: EPR funding now secured. • SGH M8 YTD position is behind plan mainly due to SECH enabling unlikely to be drawn down in year and slippage in ITU • SGH: Minor delays in ITU could attract NHSE attention. • NHSE sought assurance statement on capital forecasts at M8. Detail presented to FinCom. Position will change at M9 following further capital allocations and uncertainty on NHP funding streams.	• ESTH and SGH: Key risk and uncertainty remain on BHYH and renal NHP programme schemes. • Need for continued focus on capital forecast through to year end.	• Careful monitoring and forecasting of capital will be required in both trusts across the year. • Continued engagement with National and SWL ICB on funding mechanism for EPR. • Continue focus on key projects.
Cash	• No significant issues since M7. • Cash flow forecasts continue to be produced to ensure effective management.	• Whilst the cash implication of the deficit and adverse variance to plan is mitigated, the pressure on cash is still significant and will need to be monitored closely into 25/26.	• Take steps to reduce the deficit in 25/26. • Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management.

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Site summary I&E

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	Head line I&E YTD	Key issues	Key actions
ESTH Acute	• £4.4m adverse to plan • £3.0m adverse to CIP plan	• Adverse position to plan driven by net costs and lost income associated with Industrial Action and financial baseline /CIP pressures. • These have been partially offset in the acute position by non recurrent items.	• Review and QIA of baseline pressures. • Review of CIP mitigations and stretch.
ESTH IC	• £0.2m favourable YTD • On plan for CIP	• Pay costs and WTE reducing month on month across Integrated Care.	• Ongoing review of CIP plans in progress and actions to move to fully developed and delivery
SGH Acute	• £4.2m adverse YTD	• Impact of Industrial action, Cyber, CIP and Ward pressures • These have been partially offset in the acute position by non recurrent items.	• Length of stay and flow action plan review and delivery • Weekly Thursday finance meetings in place to drive divisional delivery on baseline and CIP
Corporate (group)	• £4.1m adverse YTD	• inflationary pressures £1.3m • CIP non-delivery £2.9m	• Progress Corporate CIP development through BAU and Corp consolidation

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ESTH Trust Summary reported position

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		Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	670.2	55.6	56.5	0.9	445.7	450.2	4.5
	Other Op. Income	48.2	4.3	4.0	(0.2)	31.7	31.1	(0.5)
Income Total		**718.4**	**59.9**	**60.6**	**0.6**	**477.4**	**481.3**	**4.0**
Expenditure	Pay	(486.3)	(39.8)	(39.3)	0.6	(325.8)	(330.1)	(4.3)
	Non Pay	(206.4)	(17.2)	(18.7)	(1.5)	(137.5)	(142.4)	(5.0)
Expenditure Total		**(692.7)**	**(57.0)**	**(58.0)**	**(1.0)**	**(463.2)**	**(472.5)**	**(9.3)**
Post Ebitda		(30.7)	(2.5)	(2.8)	(0.2)	(20.6)	(19.5)	1.1
Grand Total		**(5.1)**	**0.4**	**(0.2)**	**(0.6)**	**(6.5)**	**(10.7)**	**(4.2)**

- The Trust is adverse to plan by £0.6m in month and £4.2m YTD. The adverse position YTD is due £1.4m reported adverse in line with previous months offset in month by mitigation of the previously reported £0.8m income loss from Industrial action. It has been clear that no funding will be available for this.
- Patient Care income is above plan by £4.5m at the end of November. This is largely due to the release of income provisions no longer required, additional £2m income from SWL and ERF £0.4m above plan. performance is in line with plan at M8. **It should be noted that the baseline trajectory for ERF income increases by £3m a quarter by Q4 so deliver the ERF CIP in future quarters the Trust needs to deliver a higher level of income before CIP can be booked.**
- Other Operating Income is £0.2m adverse in month and is £0.5m adverse YTD with adverse £1.0m in Clinical Services being partially offset by £0.9m favourable R&D income, however the R&D income is offsetting pay costs in R&D.
- Pay is £0.6m favourable in month and £4.3m adverse YTD. The in month reduction is largely due to a reduction WTE driven by are reduction in enhanced care and release of non recurrent items within pay to offset the pressures within the position in line with the forecast.
- Non pay is £1.5m adverse in month and £5.0m adverse YTD. Cardiology was £0.2m adverse in month but £1.5m adverse on pacemakers and Cath Lab consumables YTD, EOC is £0.2m adverse in month and £0.8m adverse YTD and Planned Care is £0.5m adverse in month and £1.5m adverse YTD with high spend in theatres and endoscopy in month. The YTD position was mitigated by non-recurrent benefits intended for later in the year were released to cover overspends.
- Post EBITDA is £0.2m adverse in month and £1.1m favourable YTD due to interest received above plan and reduction in forecast revenue support.

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

SGH - Summary Reported Position

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		Full Year Budget (£m)	M8 Budget (£m)	M8 Actual (£m)	M8 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	1,065.3	89.6	89.7	0.0	716.9	720.8	3.9
	Other Operating Income	163.2	14.3	14.3	0.0	108.3	111.5	3.2
Income Total		**1,228.5**	**103.9**	**104.0**	**0.1**	**825.2**	**832.3**	**7.1**
Expenditure	Pay	(758.7)	(63.2)	(65.0)	(1.8)	(509.0)	(514.4)	(5.4)
	Non Pay	(448.5)	(39.4)	(38.9)	0.5	(308.1)	(316.9)	(8.8)
Expenditure Total		**(1,207.2)**	**(102.6)**	**(103.9)**	**(1.3)**	**(817.2)**	**(831.3)**	**(14.1)**
Post Ebitda		(25.7)	(0.6)	(0.6)	0.0	(15.2)	(15.2)	0.0
Grand Total		**(4.3)**	**0.7**	**(0.5)**	**(1.3)**	**(7.2)**	**(14.3)**	**(7.0)**

The Trust is reporting a £14.3m deficit YTD in M8, which is £7.0m adverse to plan. The YTD deficit position is driven by baseline pressures (£2.5m), CIP non-delivery (£3.5m) and the impact of the Cyber Attack (£0.9m). The previous variance from the impact of Industrial Action (£0.8m) has been offset by additional NRs in M8.

Income

- Income is £0.1m favourable to plan.

Pay

- Pay is £1.8m adverse to plan. This is driven by a £0.9m negative CIP target variance, £0.5m overspend in medical pay and £0.3m overspend in ward nursing.

Non-Pay

- Non-Pay is £0.5m favourable to plan in month. This is driven by a £0.6m negative CIP target variance partially offset by non-CIP overspend in areas offset by income.

Group Board

Meeting on Thursday, 09 January 2025

Agenda Item	3.4	
Report Title	**Group Fire Risk Assessments**	
Executive Lead(s)	Mark Bagnall Group Chief Officer, Facilities, Infrastructure, Facilities and Estates	
Report Author(s)	Mark Bagnall	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

This report provides an update to the Group Board on the current fire risk assessments at both SGUH and ESTH.

The current fire risk assessments show that at ESTH the risk is assessed at 20, and at SGUH the risk is currently assessed as 15. The SGUH risk has reduced slightly following implementation of the mitigating actions and is currently having this new rating assessed by the SGUH risk team.

The higher risk at ESTH reflects the increased risk to areas where adequate fire compartmentation needs repairing, some emergency lighting needs to be upgraded and a number of areas where adequate planned preventative maintenance is not currently undertaken.

The lower risk at SGUH arises from smaller number of areas where fire compartmentation risks exist and some emergency lighting needs to be upgraded.

Both Trusts have identified that stronger oversight is required in this area.

Both Trusts have up to date Trust level fire risk assessments and it is felt that they provide a realistic assessment of the risks currently present at each Trust. Both Trusts have action plans in place and SGUH is generally up-to-date in implementing the mitigating actions. However, ESTH have a number of actions listed that would mitigate the risk although no completion dates have been stated as to when these actions have been completed.

The risk assessments are a core part of managing risks at each Trust and they are used to prioritise backlog maintenance funds within the capital allocation. Sustained capital investment is required for the foreseeable future in order to mitigate the risks that have been identified.

Further work is required particularly at ESTH to ensure that the levels of mitigation that are currently in place to minimise the risk associated with fire safety are in place and working effectively. This is a detailed piece of work and will involve clinical colleagues as well as external advisors.

A new Group level fire safety forum is in the process of being established in order to provide ongoing assurance that fire safety measures are being undertaken at both Trusts or identify where further work is required.

Action required by Group Board

The Board is asked to:

a. Note this report.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	SGUH Risk of fire starting within the Trust and developing into a major fire.
Appendix 2	ESTH Overarching Trust Fire Risk Assessment

Implications

Group Strategic Objectives

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

Risks

Fire safety

CQC Theme

☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

In order to improve the levels of fire safety at both Trusts and reduce the risks of a major fire spreading, continued capital expenditure will be required at both Trusts. This will mean that fire safety will need to be prioritised so that reasonable progress can be made in achieving the required levels of overall fire safety assurance. Investment will be needed for the foreseeable future to ensure that reasonable progress is made.

Legal and / or Regulatory implications

Fire safety is governed by legislation called the Regulatory Reform Order (Fire Safety)2005. All NHS premises are required to conform to HTM 05.

Equality, diversity and inclusion implications
NA
Environmental sustainability implications
NA

Group fire risk assessments.

Group board 09 January 2025

1.0	Issue
1.1	The Group Board is aware of the concerns regarding fire safety at both Trusts which have been going back over a number of years. As more information comes to light it is important that the Trust level risk assessments are reviewed and updated based on any rectification works undertaken or any deterioration in fire safety measures within our premises.
1.2	Each Trust has its own fire safety team and the risk assessments for each Trust have been undertaken by the respective teams and are attached as an appendices to this document.
1.3	Both Trusts fire safety risk assessments indicate that the current risks are above the target scores.
1.4	In order to continue to make progress in achieving the target scores, backlog maintenance capital funding will be required to address fire safety systems and building fabric issues over a number of years.
1.5	Both Trusts are working with London Fire Brigade to ensure that fire safety across the Group is at an acceptable level.

2.0	Background
2.1	Fire safety at both Trusts is an important issue and is fundamental to the safety of all users of all of our hospitals.
2.2	The Group has a statutory responsibility to ensure that our premises are as safe as reasonably practicable from the consequences of a fire. The main piece of legislation that governs this is the Regulatory Reform (fire safety) Order 2005. The Group is also required to comply with the NHS HTM 05 Firecode.
2.3	Both Trusts have undertaken a Trust level fire safety risk assessment which are included as appendices. These risk assessments are up to date and are kept under regular review due to the overall condition of the estate and the progress of works and mitigating actions that are being undertaken in order to address any fire safety deficiencies that have been identified.
2.4	Both Trusts are indicating that the levels of risk are currently above the target score. It is unlikely that the target score could realistically be set below 10.
2.5	ESTH currently has a risk assessed score of 20. While SGUH currently has a risk assessed score of 15. The score of 15 is subject to confirmation from the SGUH risk team as it has recently reduced from 20 due to mitigation works being completed.

2.6 All NHS trusts are currently working with their local Fire and Rescue Services in order to ensure that hospitals and other NHS premises are at a satisfactory level of fire safety.

2.7 The London Fire Brigade have visited St Helier Hospital in November 2024 and whilst a follow up meeting was due to take place in December 2024, this was postponed to the new year due to a high workload within the LFB. It is anticipated that LFB will visit SGUH and other premises within London area over the next 12 months.

2.8 There are no active LFB notices currently in place within the Group.

3.0 Main Content and Analysis

3.1 The assessment of risk at our hospitals have been reached after reasonable consideration of the condition of the hospitals.

3.1 A number of hospitals in London and across the country have indicated that they have significant fire safety concerns. Given the age and long periods of under investment it is the case that ESTH has a significant amount of work that is needed in order to bring the Trust buildings up to the stipulated standards. Whilst SGUH also has challenges it has benefited from comparatively greater investment in fire safety and hence is assessed to be a lower risk than ESTH.

3.2 Given the constraints on space at both Trusts, it is not feasible to permanently close areas of the hospital that are affected by these building shortcomings. However, a long term programme will be required in order to ensure that the premises are brought up to a satisfactory level over a number of years. This is consistent with the approach that is being undertaken at other Trusts.

3.3 Planning for the works that will be necessary to improve the levels of compliance are currently underway and this will give an indication of any implications on clinical capacity that will arise as part of this programme. This may require mitigation for the temporary loss of capacity whilst works are undertaken.

3.4 It is evident that the approach in assessing risk at each Trust has been different. Within the next 6 months it is anticipated that a standardised format will be used in order to manage the risk at each Trust going forward. This will enable a more consistent approach to be taken and it will also enable prioritisation of work to be done in a way that ensures that capital investment is directed in the most effective why.

3.5 A new Group wide fire safety forum is in the process of being set up which will be chaired by the GCOFIE. This will ensure that the overall levels of fire safety are reviewed on a quarterly basis to ensure that progress is being made in order to reach the target risk score of 10.

3.6 A general review of mitigations is being undertaken to ensure that notwithstanding the building related fire safety concerns, that the hospitals remain safe for continued delivery of clinical care. This has already started and is ongoing. It is anticipated that this will be completed by June 2025.

3.7 Both SGUH and ESTH have appointed external fire Authorising Engineers who undertake assessments of fire safety and provide action plans for any areas that

require remedial works. The Authorising Engineers undertake regular checks on the progress of any mitigating actions.

4.0 Implications

4.1 The group has a statutory responsibility to ensure that both Trusts operate within a satisfactory level of fire safety. The current risk assessments indicate that work is required across both Trusts to ensure that this is the case.

4.2 In order to ensure that the premises remain safe for clinical use, a high level of priority will need to be allocated within the capital programme to ensure that funds are invested to achieve the required levels of fire safety.

4.3 LFB have yet to give us feedback on the fire inspection that took place at St Helier hospital in November 2024. However, we can expect LFB to continue their programme of inspections and we anticipate that they will visit our other sites over the next 12 months.

4.4 We will work with LFB to present a transparent picture of fire safety across the Group and we will listen to feedback that they provide in a constructive way. We will also consult with our colleagues at NHS England who have fire safety expertise and can provide advice.

5.0 Recommendations

5.1 The Board is asked to:

a. note the contents of this report and attached appendices.

Group Board

Meeting on Thursday, 09 January 2025

Agenda Item	3.4	
Report Title	**Group Fire Risk Assessments**	
Executive Lead(s)	Mark Bagnall Group Chief Officer, Facilities, Infrastructure, Facilities and Estates	
Report Author(s)	Mark Bagnall	
Previously considered by	n/a	-
Purpose	**For Noting**	

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Group board 09 January 2025

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5.0 Recommendations

5.1 The Board is asked to:

a. note the contents of this report and attached appendices.

Alan Clark*

DATIX Risk Form*

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Risk Description	
ID	2036
Ref When entering a new risk please add 'NEW' into the Ref Or Click on the ? above to see how to give the final ref	CRR-2036
Title	Risk of fire starting in the Trust and developing into a major fire
Description **Describe the risk event, the cause and the effect.** When wording the risk it is helpful to think about: Nature of the uncertainty …… This is caused by…… Would lead to an impact/effect on …… The risk should be articulated clearly and concisely, with acronyms spelt out in the first instance.	If a fire starts in the Trust that is not detected early and extinguished it could develop into a serious fire. This is caused by compartmentation breaches and defects, condition of the fire doors, and lack of maintenance and provision of fire dampers on SGUH site (exc. PFI). This could result in the evacuation of wards: mass evacuation; the loss of wards and healthcare facilities due to fire and water damage; the potential loss of life and casualties. This risk is mostly applicable to those areas that we have not yet completed the compartmentation remedials, fire damper upgrades and fire repairs.
Source of the risk how was the risk identified?	Fire risk assessments; fire compartmentation surveys carried out by the Fire Protection Association (FPA) in May – June 2015; the British Research Establishment (BRE) fire strategy reports in 2018; the Interserve (P22) fire compartmentation, fire door and emergency lighting surveys carried out in 2019; and the resent (2018) fire damper maintenance survey reports Please note this revised risk is intended to supersede and replace risk reference 1561.

Controls - What is in place to manage the risk: Prevention - Detection - Contingency					
Prevention (What we routinely do to stop hazards or problems from occurring)	**Policies, procedures, guidelines, processes, training, use of equipment, checklists, computer systems, PPE, care pathways**	**Detection (How we get to know if controls are not working effectively)**	**Alarms, audit, inspection, monitoring, investigation, incident reporting, complaints, surveys, compliance routines**	**Contingency (What we do if controls fail, to minimise impact and stay resilient)**	**Escalation procedures, emergency / back-up plans, specialist advice, spillage kits, reserve funds, insurance**

Value
Fire Risk assessment programme
Fire alarm system maintained and tested via specialist fire alarm contractor

Compartmentation and fire remedial work carried out on ground, first and second floor (plant rooms) LSW in 2017. Third, fourth and fifth floor LSW main compartmentation lines, fire dampers and fire doors remedial work completed 2021. St James Wing first floor main compartment lines and fire doors only and fifth floor main compartment lines completed in 2022
Fire wardens and ongoing programme of fire warden training
Provision of first aid fire fighting equipment
Formal appointment of an Authorised Engineer Fire to provide additional professional advice and support as well as carrying out an annual fire safety management audit - New Authorised Engineer (Fire) appointed March 2023 – DRLC Ltd.
Trust's ward accreditation programme records local fire safety issues
Operational Fire Safety management Group
Fire training on MAST – system prompt staff to attend face-to-face training
Fire remedial works on levels 3,4 and 5 LSW completed (main compartment lines, fire dampers and fire door remedials).
Main compartment lines remedial only completed in SJW and 1st floor LSW
Fire safety remedial work prioritised for in-patient areas only since 2019

Gaps in controls
What is not in place to manage the risk

Value
Capital funding - sustainable year on year capital funding to progress fire safety infrastructure back-log to bring the SGUH building stock up to condition B.
Fire dampers require replacement in St James Wing and some parts of LSW on the main fire compartmentation lines to enable and support a safe means of escape and progressive horizontal fire evacuation strategy.
Lack of full emergency lighting within LSW and SJW
Fire door repairs and maintenance is not currently funded via the back-log maintenance programme and will continue to be a significant revenue pressure
No process in place to confirm that enough trained fire wardens are on duty at all times
Adequate planned preventative maintenance programmes are not in place, for all the critical fire safety passive and active measures and equipment, that result in all remedial action being taken within an agreed risk based timescale
Lack of assurance that all infrastructure fire safety fire safety remedial actions identified are completed within agreed timescales
Progress with risk adjusted back-log maintenance in-line with allocated funding
Fire safety surveys and remedial infrastructure work to ensure that all Trust building stock's 'protected means of escape' in all other areas including out-patient, administration and commercial areas blocks are adequate and maintained
Known fire safety infrastructure risks and use of modular buildings inside LSW light wells

Assurances

Assurances on effectiveness of controls. Assurance sources can be Internal and/or External

How do we know that risks are being managed effectively? where do we get assurance from?

Please state: Source of the Assurance, date of the assurance, what the assurance indicates. **Example on how to state your assurance:**		Audit *'name of audit'* carried out in June 2019 indicates *'level of compliance'* compliance with...

Source	Value
	AE (Fire) audit reports for 2023 submitted Oct/November 2023 – overall assurance for SGUH site 'Comprehensive
	PAM submitted for 2023 showing overall fire safety management rating 'requires minimal improvement'
	PAM submitted for 2023 shows that risk assessment; maintenance; and resilience/Emergency & BC Planning requires moderate improvement

Gaps in assurances

Source	Value
	Any new or existing breaches in compartmentation from infrastructure work are remediated to the appropriate standard as part of the work plan. (Service runs, IT cables, fire alarm installations etc.).
	Assurance from Estates Engineering needed to confirm fire dampers in the LSW (Ground and first floor) and SJW are of the right type, location and are maintained and working as required
	All the remedial actions from, for example, the fire risk assessments are not being fully actioned within an appropriate and realistic timescale
	Fire Damper surveys carried out in 2022/23 via Estates have identified that a significant number of fire dampers require replacement
	Known fire spread risk with modular buildings inside light wells in LSW (ref BRE 2018 report)Condition survey completed in the old MRImodular building (Feb 2024) – not safe to put back in use until fire safety remedial works are carried out

Risk Grading

Initial

Initial risk:

Exposure arising from a specific risk before any action has been taken to manage / mitigate it.

	Consequence (initial)				
Likelihood (initial)	**1. Insignificant**	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain	○	○	○	○	○
4. Likely	○	○	○	○	◉
3. Possible	○	○	○	○	○
2. Unlikely	○	○	○	○	○
1. Rare	○	○	○	○	○
	Rating (initial): 20		**Risk level (initial):** Extreme		

Current (Residual)

Current risk:

The risk remaining after risk treatment.

The Current risk score should be reviewed each time new mitigating controls are implemented.

	Consequence (current)				
Likelihood (current)	**1. Insignificant**	**2. Minor**	**3. Moderate**	**4. Major**	**5. Catastrophic**
5. Almost Certain	○	○	○	○	○
4. Likely	○	○	○	○	◉
3. Possible	○	○	○	○	○
2. Unlikely	○	○	○	○	○
1. Rare	○	○	○	○	○
	Rating (current): 20		**Risk level (current):** Extreme		

Target

	Consequence (Target)

Likelihood (Target)	1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
5. Almost Certain	○	○	○	○	○
4. Likely	○	○	○	○	○
3. Possible	○	○	○	○	○
2. Unlikely	○	○	○	○	◉
1. Rare	○	○	○	○	○
	Rating (Target): 10		Risk level (Target): High		

Target date Target date is when the risk will either be closed or the identified target risk score / level is achieved, meaning the risk owner considers the risk to be at a tolerable level to be considered as part of the business as usual. If the risk is not closed, this does not mean the risk is removed or gone but the controls are considered sufficient and practicable against any further cost benefits of additional mitigation measures.	
Please state the changes to the risk score: 1) Date risk score changed 2) Committee /meeting group where change of risk score was agreed 3) Which change was agreed – i.e. from (CxL=RS) to (CxL=RS)	Levels 3,4 and 5 have had fire doors repaired and or replaced, fire compartmentation reinstated/repaired on the main fire compartmentation lines and new automatic fire dampers installed as par to the P22 fire compartmentation works. Main fire compartmentation lines in SJW and level 1 one LSW completed. This needs to go the the Estates Assurance Group, H&SNCRG and Infrastructure Committee to agree a change of risk score from likely to possible (4 to 3). Target is to move from extreme to high (managed risk).

Risk Location

Level of Risk ≤6 Care Group level ≥8 Directorate level ≥10 Divisional level ≥15 Escalation to CRR	CRR (To be used only by Risk Team)
Division	Corporate
Directorate	Estates & Facilities Directorate
Care Group	Estates & Facilities
Specialty	Estates - St Georges

Risk ownership/responsibility

Handler	Clark*, Alan - Assistant Director of Non-Clinical Risk and Assurance
Manager	Clark*, Alan - Assistant Director of Non-Clinical Risk and Assurance

Sub-category

Risk Sub-category	Estates / infrastructure

Key Dates

Opened (dd/MM/yyyy)	04/02/2020
Last updated	Alan Clark* 03/01/2025 14:49:20

Approval Status

Current approval status	Open

Actions

ID	Directorate (Contacts)	Synopsis	Progress	Assigned by ('From')	Responsibility ('To')	Due date	Done date	Module
4413	Estates & Facilities Directorate	Set up a Strategic Fire Safety Management Group chaired by an executive lead to drive forward, monitor and report on fire safety initiatives including general awareness; prevention; training; emergency evacuation and contingency	Initial meeting set up for 07 February 2020 with draft TOR	Alan Clark*	Jenni Doman*	28/02/2020	06/03/2020	Risk Register
4411	Estates & Facilities Directorate	Repair or replace all damaged fire doors in-line with the main compartment lines as part of the P22 Capital programme	Fire door remedial and repair work completed within the the P22 fire door task order only. O&M, passed over to estates for ongoing maintenance	Alan Clark*	Alan Clark*	29/05/2020	31/03/2021	Risk Register
4410	Estates & Facilities Directorate	Fire compartmentation capital remedial work (via P22) commencing on the 5 to 3 floor of Lanesborough wing in the first instance, ensuring that the main compartmentation evacuation lines (walls and floor slabs) are in place to contain a fire and facilitate progressive horizontal evacuation.	Final stages of remedial work on levels 3,4 and 5 now planned to be completed by end of September 2021 - as of 29/09/21 final 3 dampers being installed in Caesar Hawkins Ward	Alan Clark*	Alan Clark*	30/11/2020	20/06/2022	Risk Register
4412	Estates & Facilities Directorate	For all fire dampers to be installed, working on the main compartment lines as part of P22	75 new fire dampers being installed LSW as part of 2020-21 capital plan - planned to be completed and	Alan Clark*	Alan Clark*	30/09/2021	30/09/2021	Risk Register

		capital programme.	commissioned September 2021					
4414	Estates & Facilities Directorate	Assure and confirm capital funding for all the remaining fire safety back-log works and adequate revenue funding for lifecycle maintenance within the Estates budgets.	Capital back-log funding for fire safety infrastructure for 2021-22 as of 20/09/21 has been allocated £1 million. Fire compartmentation and fire doors work completed in St James Wing high dependency areas 1st floor - no fire damper work included	Alan Clark*	Andrew Asbury	31/03/2022	31/05/2022	Risk Register
5162	Estates & Facilities Directorate	Full review/survey of fire safety infrastructure with regard fire compartmentation and fire dampers in levels Ground, 1st and 2nd floors	New action created to supersede this one ref 5378.	Alan Clark*	Alan Clark*	31/03/2022	29/09/2021	Risk Register
5163	Estates & Facilities Directorate	Full review of 2018 British Research Establishment report findings in Lanesborough Wing to inform risk adjusted back-log maintenance capital plan	Focus for 2021/22 capital plan is to survey High dependency areas on level 1 LSW - survey completed by Trust Fire Team.	Alan Clark*	Sydin Siwela*	31/03/2022	31/03/2022	Risk Register
6409	Estates & Facilities Directorate	Review the training provision	Fire training on MAST, since 2021 The system prompt staff to attend face-to-face fire training	Maria Prete*	Sydin Siwela*	30/03/2023	10/01/2023	Risk Register
6713	Estates & Facilities Directorate	Alfor Fire terminated their services as AE Fire in March 2022	Procurement process to appoint new AE Fire Safety commenced in 2022. New AE fire (DRLC Ltd - David Butler) appointed in March 2023. Fire safety audit of all Trust sites to be completed in Qtr 1 2023	Alan Clark*	Sydin Siwela*	31/03/2023	31/03/2023	Risk Register
6714	Estates & Facilities Directorate	New Fire Safety audit of all Trust Sites to be completed by newly appointed AE Fire (DRLC Ltd). This included community sites and AMW PFI.	AE appointed and dates for audit confirmed with responsible persons. Full report, level of assurance and recommendations expected by Sept 2023. Full reports received and approved by the Trust in October 2023	Alan Clark*	Sydin Siwela*	30/09/2023	27/10/2023	Risk Register

6473	Estates & Facilities Directorate	Confirmation of full planned preventative maintenance in place for all critical fire (passive and active) infrastructure. Evidence of Estates PPM's and remedial work to maintain fire infrastructure to and acceptable standard required as a matter of urgency. (i.e. fire doors, compartmentation and fire dampers)	Progress to be reported to Estates Assurance Group and Fire Infrastructure Group. Progress reported and monitored by the Fire Safety Infrastructure Group	Alan Clark*	RNAGEN	30/03/2024	21/02/2024	Risk Register
5378	Estates & Facilities Directorate	Full compartmentation audit and survey of Grd, 1st and 2nd floor LSW compartmentation required which included the fire wall infrastructure and integrity and the location, suitability and maintenance of fire dampers - initial priority to be given to high dependency patient areas - This is part of the risk adjusted back-log capital programme.	June 2024 Fire Compartmentation of main fire lines (60min) completed as part of 2023/24 fire safety capital prograrmme. No dampers installed d2023/24 due to constraints with funding Fire Alarm cause and effect and device addressing issues not progressed in 2023/24 due to constraints with funding Feb 2024 Survey information forwarded to Capital Project to be progressed subject to available Capital funding in 2023/24. This will be progressed in-line with available capital funding as detailed above Priority in 2021/22 will be to survey level 1 in LSW which contains all the High Dependency Areas - Survey of 1st floor completed by Trust Fire Team in 2022. Survey information forwarded to Capital Project to be progressed subject to available Capital funding in 2023/24	Alan Clark*	RNAGEN	31/03/2024	22/02/2024	Risk Register
7995	Estates & Facilities	Full fire safety back-log capital	All back-log fire remedial works	Maria Prete*	Alan Clark*	27/12/2024		Risk Register

	Directorate	reported required to identify and cost out requirement to bring building infrastructure up to estate code condition B. This will need to include: Fire dampers (auto fire dampers to replace mechanical heat only, and where fire dampers are missing); fire doors; compartmentation and protected means of escape; emergency lights; SJW fire alarm system cause & effect and device addresses.	currently estimated via ERIC 2024/25 returns at £10m. As stated, we will continue to set and prioritise infrastructure back-log maintenance requirements in business case for future capital funding.					
6474	Estates & Facilities Directorate	Confirmation and assurance that all infrastructure fire safety remedial actions identified are completed within agreed timescale or, where appropriate, added to the fire safety back-log programme.	Work in progress to review outstanding fire safety actions by Estates supported by Fire Safety Team. All back-log and new fire safety jobs taken out of Planet (CAFM) and transferred to project team to action subject to funding. Need assurance and confirmation that all other revenue maintenance works are being completed within agreed KPI timescales	Alan Clark*	Fradreck Ricky Mujaji*	30/12/2024		Risk Register
7519	Estates & Facilities Directorate	Evidence of Estates PPM's and remedial work to maintain fire infrastructure to and acceptable standard required as a matter of urgency. (i.e. fire doors, compartmentation and fire dampers)	Progress to be reported to Estates Assurance Group and Fire Infrastructure Group. Work in progress, fire damper maintenance contract procured (March 2024), fire door maintenance, compartmentation audits and emergency lighting still to progress	Maria Prete*	Fradreck Ricky Mujaji*	30/12/2024		Risk Register
6712	Estates & Facilities Directorate	Replacement of fire dampers automatic (linked to fire alarms system) to meet fire safety	June 2024 - Business case for replacement fire dampers required to inform future fire risk adjusted	Alan Clark*	Fradreck Ricky Mujaji*	31/12/2024		Risk Register

		condition B requirements	back-log maintenance capital requirements Feasibility options currently being explored by Estates. Any progress will be subject to available capital funding being made available					
7996	Estates & Facilities Directorate	Review of fire safety infrastructure and use of modular building inside LSW light wells (Ref: BRE 2018 report); including local fire risk assessment and management arrangements		Maria Prete*	Alan Clark*	30/01/2025		Risk Register
7811	Estates & Facilities Directorate	No Capital funding allocated for 2024/25 - Continue to review, set and prioritise future fire safety infrastructure back-log maintenance capital requirements in a detailed business case for future capital funding bids	Full review of fire safety back-log requirements for SGUH site Trust owned and managed buildings is ongoing.	Alan Clark*	Alan Clark*	30/03/2025		Risk Register
6410	Estates & Facilities Directorate	To assure that trained fire wardens are on duty at all times	Board in each department to identify fire warden on duty and their deputy. Fire warden audit to assess compliance. Divisions reminded of need of compliance. Further assurance required by Division that adequate number of trained fire wardens on duty and that they are carrying out their sole for the day to day management of fire safety within there ward and department. Review for fire warden audit process a key fire safety objective for 2023/24 Improve fire training KPIs and	Maria Prete*	Sydin Siwela*	30/03/2025		Risk Register

			reporting especially regarding providing assurance fire wardens on duty. (noting in the last 2 years we have trained 2265 fire wardens)					
6446	Estates & Facilities Directorate	Confirmation that adequate year on year capital funding is identified and resourced to secure investment in fire compartmentation, fire dampers and fire door upgrades to remediate all the fire compartmentation and fire infrastructure issues on SGUH site issues Assure and confirm capital funding for all the remaining fire safety back-log works and adequate revenue funding for lifecycle maintenance within the Estates budgets. Fire Back-Log funding to bring estate up to condition B is currently estimated at between £5 to £8 million.	20 Feb 2024 £ 700k allocated in 2023/24 This year, 2023/24 (700K) we are able to: • Make good main compartment lines and upgrade on the LSW first floor. • Progress, in line with funding, the fire alarm device replacement and up-grade in STJ wing and the • Cost up the fire damper upgrade (mechanical to au tomatic smoke) in St James Wing and LSW first floor) • Due to financial constraints, we will not be able to progress with SJW cause and affect and any fire damper replacements on 1st Floor LSW - Work completed in 2024 as stated above. Noting that significant year on year investment in fire safety back-log is still required to bring St Georges critical fire infrastructure up to building stock up to estate code condition B (est, £5m - £10m) No capital funding allocation for fire safety infrastructure back-log in 2024/25	Alan Clark*	Jenni Doman*	31/03/2025		Risk Register
6003	Estates & Facilities Directorate	Implement sustainable fire door repair and maintenance programme, which provides reports and assurance that all fire doors are maintained in good working order.	Some fire door maintenance remedial work has been carried out in 2023, however, there continues to be a significant number of fire doors which require urgent maintenance and repair. Fire Safety	Claudine Bond	Dean Gornall	31/03/2025		Risk Register

			and Estates Engineering continue to work together to support progress with fire door maintenance. Going forward they will prioritise maintenance and repair to the main compartmentation and protected means of escape doors subject to availability of funding. New fire door maintenance engineer employed directly, fire door repair programmed ongoing. Full condition survey off all fire doors planned, and implementation of a fire door PPM programme still required.					
7809	Estates & Facilities Directorate	Estates project and infrastructure team to manage and action all outstanding and new fire infrastructure back-log (capital) and new work fire safety requests, subject to the availability of funding.	Update to be reported to the Fire Safety Infrastructure Group	Alan Clark*	Bharat Kapoor	31/03/2025		Risk Register
7520	Estates & Facilities Directorate	Undertake further fire safety surveys and remedial infrastructure work to ensure that all Trust building stock's 'protected means of escape' in all other areas including out-patient, administration and commercial areas blocks are adequate and maintained	No infrastructure remedial action can be taken/ planned until capital funding made available. Review of local risk assessments and fire safety mitigations continue to be kept under review This is included as part of the Trust's risk based ongoing fire safety infrastructure priorities from 2023. Note: to date the Trust has only been able to prioritise the sleeping risk (in-patient) areas as part of the capital funding made available since 2019 as described above Confirmation from	Maria Prete*	Alan Clark*	30/04/2025		Risk Register

			Finance and Estates Capital, May 2024, that no new capital funding will be available for fire safety back-log in 2024/25					
5379	Estates & Facilities Directorate	Emergency lighting upgrade of LSW to be progressed in-line with back-log maintenance capital funding. Awaiting allocation of capital funding via risk adjusted back-log maintenance programme	Feb 2024 This was put on – hold due to awaiting allocation of capital funding Emergency lighting upgrades pulled out of 2020/21 capital plan due to lack of available funding. Full new review of emergency lighting commenced, April 2024, to appraise current status and advise for upgrade priorities based on risk as part of any future allocation of fire safety back log capital funding.	Alan Clark*	Fradreck Ricky Mujaji*	29/09/2025		Risk Register

Communication and feedback

Recipients

Message

Message history

Date/Time	Sender	Recipient	Body of Message	Attachments
05/01/2023 14:15:20	Clark*, Alan	Asbury, Andrew	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Nagendra, Rathan	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Siwela*, Sydin	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Prete*, Maria	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Brind, James	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Doman*, Jenni	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for comments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	
05/01/2023 14:15:20	Clark*, Alan	Clark*, Alan	This is a feedback message from Alan Clark*. The Risk reference is 2036. The feedback is: Corporate Fire risk updated for co	

			mments Please go to http://stg1datixapp01/Datix/Live/index.php?action=risk&recordid=2036 to view it.	

Documents

No documents.

Progress notes

Bond, Claudine - Group Risk Officer 20/06/2022 14:24:54	20/06/2022: Risk updated taken from the BAF
Bond, Claudine - Group Risk Officer 29/11/2021 12:30:34	RMCG 10/11/2021 Risk CRR-2036, Risk of a fire starting in Lanesborough Wing - risk score 20(5x4). Progress has been made: level 3, 4 and 5 are now up to standards. Further work is expected to be completed by March 2022. The deputy director thanked the staff for their collaboration during the works
Nakasala, Martin - Information Governance Officer 26/02/2020 14:31:06	February 2020 RME Minutes Risk EF2036 – Risk of a fire starting in Lanesborough Wing developing into a major fire (5x4=20) – If a fire were to break out in Lanesborough Wing and were to go undetected, there is a risk that it could spread quickly throughout the building due to poor compartmentation, bad state of fire doors and fire dampers. This would require a full floor evacuation. Current preventative mitigations are: fire alarm systems which would detect a fire should this not be immediately detected by staff, regular fire alarm testing and maintenance, staff fire training, fire wardens for each shift, firefighting equipment, Authorised Engineer to provide support and advice, a Strategic Fire Safety Management group has been established which will review and monitor all fire safety issues. RME queried whether the risk score (likelihood = 4) was accurately reflecting the risk. RME was advised that the controls that have already been implemented are mitigating the risk such that fire incidents that have occurred in the last 3 months have been immediately detected; however more work is needed to improve their effectiveness, as well as addressing all identified gaps in controls (the fire assessment report presented at Trust Board gave a reasonable assurance that the Trust had identified the issues and has a programme to implement mitigating actions). This work will be monitored by the Strategic Fire Safety Management group. The divisional triumvirate were advised to nominate a representative from their areas to attend the group. The risk will be escalated to the CRR.

Epsom and St Helier University Hospitals NHS Trust

Risk Assessment Title:	Overarching Trust Fire Risk Assessment		
Name & Post of Person Completing:	Enos Mugadzaweta- Head of Health and Safety	**Date Of Risk Assessment:**	09/05/2024
Ward / Unit / Team / Department:	Estates, Facilities and Capital Projects	**Risk Assessment Approved By: (Name & Post)**	Health and Safety Risk Committee
Service:	Fire Prevention	**Date Risk Assessment Approved:**	
Hospital / Site:	Trust Wide	**Division / Director Approved: (Name & Date)**	Ian Robinson

Introduction / Background

There is currently an inadequate Fire Safety Management system. This has been identified through the completion of a third-party fire audit. That found the following:

*The overall level of assurance given by the audit report is **Limited**: Governance, Internal control and the Management of Risk display a general trend of unacceptable residual risk and weaknesses that must be addressed within a reasonable timescale, appropriate resourcing will be required.*

The report generated by the third-party audit reflected the findings of the internal review undertaken by the Fire Safety Team. In particular the audit concluded the following:

1. Effective Fire Safety Management: *This section of audit demonstrated several areas of significant weakness that require immediate attention to redress.*

2. Fire Safety Passive & Active Measures, Testing and Maintenance: *This area of audit demonstrated several areas of significant weakness that require immediate redress.*

CURRENT POSITION	FORECAST

Risk Description • Identify the hazard • Identify the risk • Identify who may be affected • Identify the possible outcome/impact	**Current Controls** • What current controls are in place to mitigate the risk?	**Current Risk Rating** (consequence x likelihood)			**Further Action Required** • What additional controls/measures can be introduced? • What actions will be taken to further mitigate the risk? • Remember to include future reviews and maintenance etc.	**Target Date for completing further action** (DD/MM/YY)	**Review Date** (DD/MM/YY)	**Responsible Person**	**Predicted Residual Risk Rating** (consequence x likelihood)		
		C	**L**	**RR**					**C**	**L**	**RRR**
Lack of trust wide Fire strategy:	Fire Risk Assessment regime are done periodically to identify risks. Site risk profiles are currently being undertaken to rank fire risks	**5**	**4**	**20**	To procure a company to develop a fire strategy for Trust buildings	Sept 25	Dec 25	CR	5	2	10
Significant backlog maintenance liabilities and poor condition of the Estate eg fire doors compartmentation and Escape routes	Door Survey is completed Refurbishments underway are guided by the fire team to rectify non conformities	**5**	**4**	**20**	Complete replacement of high risk fire doors Complete compartmentalisation and dampers surveys	June 25 March 25	Dec 25 Dec 25	CR CR	5 5	2 2	10 10
Inability to evidence completion of statutory Planned Preventative Maintenance	Asset register is being completed and will PPM	**5**	**3**	**15**	Once asset register is complete SFG 20 compliant PPM regime can be uploaded onto CAFM	June 25	Dec 25	CR	5	2	10

Inadequate Fire Safety measures Trust wide:	Recent audits conducted by LFB have identified housekeeping issues resulting in enforcement action	**5**	**4**	**20**	Action completed to remove catering ovens from ward corridors Action completed to remove clutter from evacuation routes	Mar 25 Mar 25	Jun 25 Jun 25	CR CR	5 5	2 2	10 10
Some existing fire RA's are no longer compliant with HTM following update	Following LFB audit a number of existing fire risk assessments need to be reviewed as revisions to HTM 03 require enhanced engagement with operational services	**4**	**4**	**16**	Review process underway and will be completed within 6 months	Jun 25	Dec 25	CR	3	2	6

Note –Press Tab on the keyboard at the end of each line to produce a new line for each risk as appropriate.

During review, if further actions have eliminated the risk, then the task/hazard can be removed from the risk assessment, but must remain historical for 7 years.

Action to be taken to further reduce risk	Person responsible for completing action	Target completion date (Prioritized on risk, using risk rating)		Action closure	
		Date	Priority	Signature	Date
To procure a company to develop a fire strategy for Trust buildings	**CR**	**Sept 25**	**High**		
Complete replacement of high risk fire doors	**CR**	**June 25**	**High**		
Complete compartmentalisation and dampers surveys	**CR**	**March 25**	**Med**		
Complete asset register is complete SFG 20 compliant PPM regime can be uploaded onto CAFM	**CR**	**March 25**	**High**		
Complete removal of catering ovens from ward corridors Completed removal of clutter from evacuation	**CR** **CR**	**March 25** **March 25**	**High**		
Complete review of Fire RA's within 6 months	**CR**	**June 25**	**Med**		

	Date	Employee name & signature	Manager name & signature
Initial risk assessment completed:			
Proposed date for next assessment:			
Assessment reviewed on:			

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	3.5	
Report Title	**Group Board Assurance Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Finance Committees-in-Common	20 Dec 2024
	Quality Committees-in-Common	19 Dec 2024
	Infrastructure Committees-in-Common	13 Dec 2024
	People Committees-in-Common	12 Dec 2024
Purpose	**For Approval / Decision**	

Executive Summary

At its meeting in November 2023, the Group Board reviewed and approved the new strategic risks on the Group Board Assurance Framework. The Group Board defined a series of 14 strategic risks, each aligned to one of the four themes set out in the Group Strategy, *Outstanding Care, Together 2023-28.* The first full iteration of the Group BAF was agreed by the Group Board in March 2024. For each strategic risk, the BAF sets out:

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

All Strategic Risks have been reviewed by the relevant Board Committee ahead of the presentation of the full BAF to the Group Board. The Strategic Risks relating to collaboration and partnerships (strategic risks 1-3) are reserved to the Group Board.

Risk Scores: As at the end of Q3 2024/25, there are no proposed changes to the overall risk scores for any of the Strategic Risks on the Group Board Assurance Framework. Nine months on from the agreement of the 14 Strategic Risks on the Group BAF – which are intended to reflect risks to the delivery of the five-year strategy – there is a substantial amount of work in progress to deliver the Group Strategy and mitigate the identified risks. However, much of this work is in train and is not, at the present time, at a stage where a reduction in the overarching risk scores is considered appropriate.

Assurance Ratings: There is one proposed change to the assurance ratings, in relation to SR2 Working with the APC where the proposal is to move from a "reasonable" assurance rating to a "good" assurance rating. This is on the basis of the extent of collaboration across the APC and the active role of the gesh Group within the APC.

Target Risk Scores: In March 2024, the Group Board established target risk scores for all of the 14 Strategic Risks on the BAF. These target risk scores were intended to be stretching but realistic aims

for the end of 2024/25. As at Q3 2024/25, it is now likely that the target risk scores established will not be achieved.

Action required by Group Board

The Group Board is asked to:

a) Review the current risk scores and assurance ratings for each strategic risk on the Group BAF at the end of Q3 2024/25.
b) Note the risks that have been reviewed by the relevant Committees.
c) For the risks reserved to the Group Board, review and agree the risk scores and assurance ratings at Q3 2024/25, including the proposal to uplift the assurance rating in relation to SR2 (Working with the APC) from "reasonable" to "good".

Committee Assurance

Committee	All Board Committees
Level of Assurance	N/A

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Board Assurance Framework

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

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

gesh

Group Board Assurance Framework

January 2025

Stephen Jones
Group Chief Corporate Affairs Officer

9 January 2025

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

Overview

gesh

Summary
At its meeting in November 2023, the Group Board reviewed and approved the new strategic risks on the Group Board Assurance Framework. The Group Board defined a series of 14 strategic risks, each aligned to one of the four themes set out in the Group Strategy, *Outstanding Care, Together 2023-28.* The first full iteration of the new Group Board Assurance Framework was reviewed and approved by the Group Board at its meeting on 8 March 2024.

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

Review of the Group BAF at Q3 2024/25
Nine months on from the Group Board's approval of the new BAF, the Group Board is asked to consider the latest position, including any changes:

- The Strategic Risks related to finance (SR4) and operations (SR8) have been reviewed by the Finance Committees-in-Common
- The Strategic Risks related to quality (SR7, 9, 10, 11) have been reviewed by the Quality Committees-in-Common
- The Strategic Risks relating to people (SR12, 13, 14) have been reviewed by the People Committees-in-Common
- The Strategic Risks related to estates (SR5) and digital (SR6) have been reviewed by the Infrastructure Committees-in-Common.
- The risks related to Collaboration and Partnership (SR1, 2 and 3) are reserved to the Group Board.

Risk scores

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

Assurance ratings

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

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

Group BAF: Overview at 4 July 2024

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

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

Group BAF: Overview at 9 January 2025

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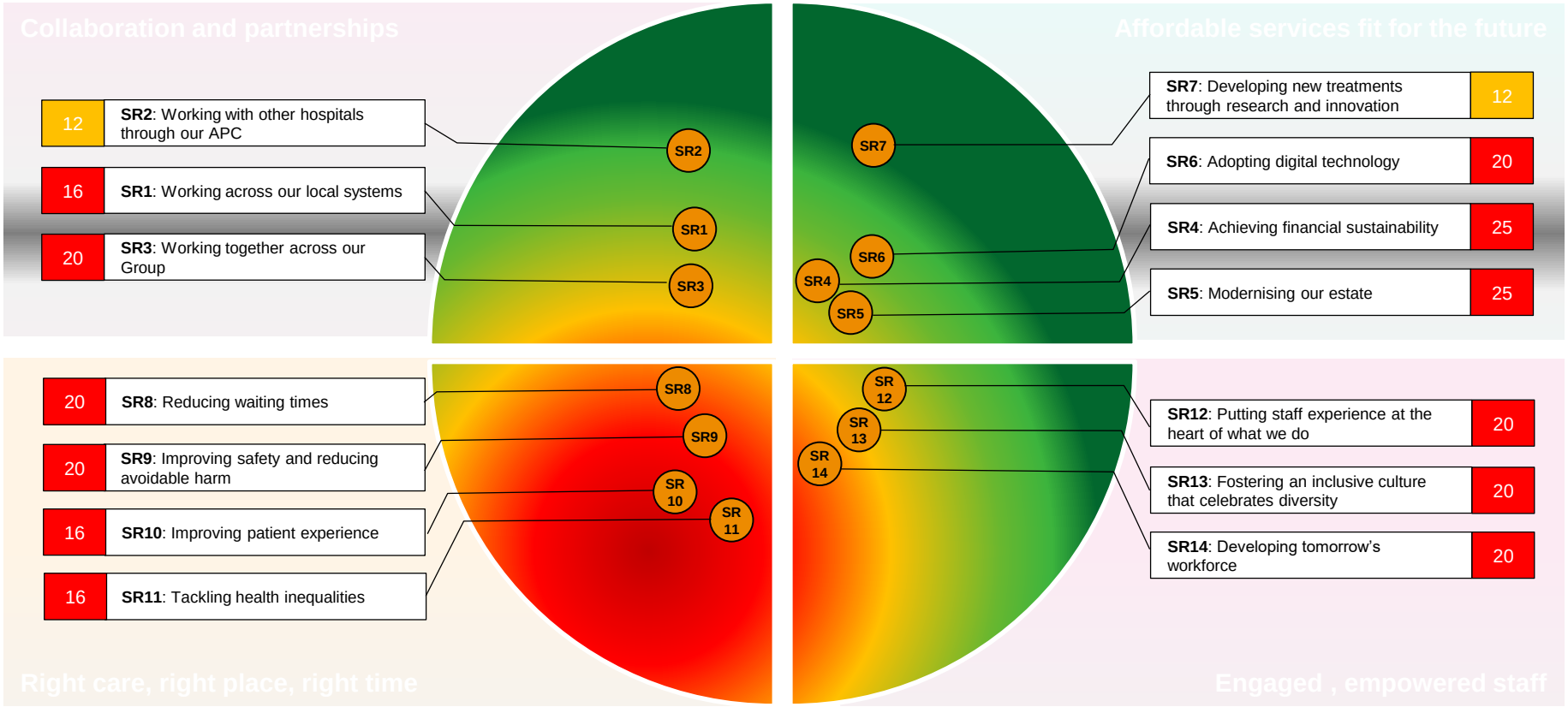

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
SR1: Working across our local system *If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*	16 (4x4)	16 (4x4)	12 (4x3)	Reasonable	Good	No changes to risk score or assurance rating at Q3 2024/25. The risk score continues to represent the level of risk facing the group in the context of system-wide approaches to materially impact operational challenges facing the Group.	The Board has reviewed the plans for the development of new / renewed alliance agreements in Sutton, Merton and Wandsworth and has provided steers in relation to these. Integrated delivery through integrated teams at INT and place level (recognised as best practice nationally) Integrated frailty service across all settings of care (recognised as best practice nationally) Comprehensive Benefits Realisation Dashboard reviewed at place: consistent reduction AE attendances; readmissions
SR2: Working with other hospitals through our APC *If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.*	12	12	8	Good	Good	No changes to risk score at Q3 2024/25. Proposal to increase assurance rating from "reasonable" to "good", in the context of the breadth of collaborative work across the APC and the active role of the Group within the APC. It is a marginal call as to whether the risk score should remain a 12 or be lowered to an 8. It is proposed to maintain the score at 12 both in light of the current challenges across the system, and in light of the fact that there have not been material shifts in the controls since the risk was rated as a 12 in March 2025.	Controls relating to existing formalised collaborations across the APC now integrated into the controls section of the BAF: • Clinical: SWL Pathology; SWLEOC; • Staffing: SWL Recruitment • Back office: SWL Procurement Partnership Controls relating to system-wide clinical networks across the SWL APC also included among the controls for this risk on the BAF: cardiology, neurology, radiology New SWL APC Programme Director (Lucy Clements) appointed and scheduled to commence in March 2025.

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
SR3: Working across our local system *If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.*	16 (4x4)	16 (4x4)	12 (4x3)	Reasonable	Good	No changes to risk score or assurance rating at Q3 2024/25. The risk reflects the current position in relation to the realisation of the Group benefits and the level of collaboration (clinical and non-clinical) at the present time. Corporate integration is behind schedule. Clinical collaboration work has been gathering pace. It is not yet considered to be at a stage where the assurance rating or risk score could move at the current time. Work has progressed with Group Corporate Services Integration. A rebasing of the timelines for delivery was established in October 2024, but there is variance from this rebased plan for Finance, IT, Estates and HR. Progress has been made in relation to clinical collaboration, with the Board having approved a Group Pharmacy Strategy and having reviewed draft proposals to inform a Group Surgical Strategy.	Completion of supporting strategies on: People; Quality and Safety; Green Plan. Revised timelines established for remaining strategies: Estates, Research, Digital. Re-basing of timelines for integration of remaining corporate services: HR, Estates, Finance, IT, Phase 3 Medical. Completion of restructures in following areas: Corporate Affairs; Communications; DCEO; Corporate Nursing; Phase 1 Corporate Medical. In relation to clinical collaboration and integration: • A new Group-wide pharmacy strategy 2024-28 has been agreed by the Group Board (September 2024) which aims to collectively maximise the best of our pharmacy services across gesh. • The Group Board has reviewed initial proposals in relation to the development of a new Group-wide surgery strategy (December 2024), and has endorsed the direction of travel. A final draft strategy is due to be reviewed by the Group Board in March 2025.
SR4: Achieving financial sustainability *If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, then we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients.*	25 (5x5)	25 (5x5)	20 (5x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25.	While progress has happened, it has not been possible to identify a route to deliver the full plan due to pressures as well as the high CIP target. Progress against the CIP target has continued to improve, with mitigating actions possibly moving this close to plan. The financial control environment continues to be strong, and independent work by an external consultancy has confirmed this, as well as identifying some further opportunities. Key gaps are: • Level of non-recurrent actions in the CIP

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Group Board Assurance Framework Summary – January 2025

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

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
							• Other operational pressures above / outside the agreed financial plans • Medium term financial plans at both Trusts as part of wider system plan • Access to capital or the identification of actions to mitigate the need for investment • Address the pressures placed on the finance functions and create a common finance team.
SR5: Modernising our estate *If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services*	25 (5x5)	25 (5x5)	20 (5x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. The key gaps are: developing a Group Estates Strategy; the outcome of new Government's review of the New Hospitals Programme; and capital to address material risks to the hospital estate across STH, EGH and STG.	A Group Green Plan has been agreed by the Group Board (July 2024) – this has been added as a new control A new permanent Group Chief Infrastructure, Facilities and Environment Officer is now in post (since 27 August 2024) Six facet survey for ESTH has been completed The timelines for a number of actions to address gaps in control have been reviewed and adjusted: (i) Developing a Group Estates Strategy – new date of December 2025 (from July 2025); (ii) (longer-term capital plans (from October 2024 to December 2025); (iii) Ensuring the Infrastructure Committee is fully sighted on all matters of infrastructure risk (new date added – March 2025). The control strength relating to external condition surveys has been reviewed and adjusted to "reasonable" from "good" on the basis of the ESTH six-facet surveys and the addition of a new action to commission a new six-facet survey for SGUH The control strength relating to governance through the Infrastructure Committee has also been adjusted to "reasonable" from "good" to reflect the assurance needs of the Committee in relation to the condition of the estate.

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
SR6: Adopting digital technologies *If we do not build a robust digital infrastructure and adopt transformational digital solutions, then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement.*	20 (5x4)	20 (5x4)	15 (5x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25.	No changes to controls. The control in relation to the development of a Digital strategy for the Group has been downgraded to "weak" given the delays to developing the strategy. The plan is to produce the draft strategy by September 2025. New risks are being developed to address gaps in relation to: digital strategy alignment to Group-wide integration; resourcing, given impact of resourcing gap based on current capital plan; and gesh cybersecurity / data centre / storage risk.
SR7: Developing new treatments through research and innovation *If we do not create the right culture, infrastructure and partnerships, then we will not become a thriving centre for research and innovation and not attract sufficient research funding, resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff*	12 (4x3)	12 (4x3)	8 (4x2)	Reasonable	Good	No changes to risk score or assurance rating at Q3 2024/25. Impending merger between St George's University of London and City University represents significant opportunity in relation to research. Need for alignment of research priorities across Group.	New action has been added to reference the plans to bring together the currently separate research leadership and management structures of ESTH and SGUH into a single Group-wide structure as part of the Phase 3 Corporate Medical Directorate restructure. The structure was approved by the Group Executive on 17 December 2024 and the next stage of the process will be to consult with staff on the proposals in the new year. The plan is to develop a truly multi-disciplinary approach to research and innovation, involving doctors, nurses, AHPs, pharmacists and others within a broad team with a multidisciplinary culture and practice. The intention is to appoint a Group-wide Director of Research and Innovation, which will be appointed internally, in Spring 2025. Since the last review of SR7, SGUL has merged with City University to form City St George's The gesh Group and City St George's have jointly commissioned Jillian Lockett to undertake a review to consider the opportunities and benefits of enhanced collaboration between City St George's and gesh, which is also looking at early priorities for an integrated workplan and developing proposals for high level strategic positioning for a joint approach to fundraising and supporter development. The initial outputs of this work are due to submission to the gesh CEO and the President of City St George's in December 2024.

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
							Updated timelines for the development of a Group-wide research strategy – in late 2025. The Quality Committees-in-Common received a detailed update on the current research performance of both SGUH and ESTH at its meeting in August 2024. For SGUH, this highlighted that: in 2023/24 the number of clinical research studies that patients were recruited to was consistent with the previous year but remained lower than before the Covid-19 pandemic; SGUH was 19th in the UK for the number of clinical studies recruited to in 2023/24, one position lower than the previous year; SGUH had secured NIHR Capital Infrastructure funding of £441k and £75k of NIHR BRC funding (as part of a wider award the bid led by Barts Health). For ESTH, the August 2024 update set out that: recruitment to ESTH clinical trials continued to grow year-on-year.
SR8: Reducing Waiting Times *If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, then we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*	20 (5x4)	20 (5x4)	15 (5x3)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Significant operational pressures continue in relation to ED and wider flow. Additional pressures created through presentation of patients at ED with mental health needs. Capacity of social care is limited, impacting on discharge. Work required to set out actions being taken to address identified gaps in controls and timelines for completion.	A significant number of actions have been taken at both Trusts to ensure the safe delivery of care to patients attending the three Emergency Departments across the Group, as well as to decompress ED through boarding on wards, use of virtual wards, and measures to encourage ED avoidance where appropriate. These measures have been reported to the Quality Committees-in-Common at its meeting in August 2024, which reviewed the pressures in the EDs, trends in attendance numbers and acuity, mental health attendances, and the actions being taken to mitigate safety risks. The actions related to improvements in theatre productivity have been implemented, as previously reported to the Finance Committees-in-Common. This has addressed one of the previously identified gaps in control, which has now been removed from the current gaps section. In terms of the gaps in control: • Theatre productivity has been removed as a gap for the reasons set out above. • Ambulance handover times has been added to the ED pressures entry

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
							In terms of the controls in place to manage and mitigate the risk: • OPEL escalation triggers and actions have been reviewed and updated since the last review of SR8 by the Committee. The control strength is judged to be good. • In relation to Long Length of Stay (LLoS), the control has been adjusted to include reference to the 14-day / complex review panel at ESTH. • Assurance on the control related to virtual wards has been reviewed and updated to clarify that Hospital@Home in Wandsworth is being utilised at 100% and that remote capacity is being reviewed, and that the Sutton virtual ward is being used at or near capacity. In terms of related risks on the Corporate Risk Register, the SGUH Emergency Overcrowding Risk (rated as an extreme risk of 20) has been added to the aligned operational risks to the BAF.
SR9: Improving safety and reducing avoidable harm *If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable and harm and mortality and poorer clinical outcomes.*	20 (5x4)	20 (5x4)	15 (5x3)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Emergency Department overcrowding remains one of the highest safety risks across the Group. Evidencing the embedding of learning from Never Events is a key gap in light of number of Never Events across the Group.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July, and launched across Group in December 2024. The PSIRF framework has been fully implemented across the Group and a format and rhythm for regular reporting on PSIRF is now established for the Quality Committees-in-Common, following review by the gesh Quality Group. The Raising Concerns Oversight and Triangulation Group has been fully established and has found a regular rhythm, which is helping to unblock concerns raised by staff to aid with resolving concerns in a timely way. The first report to the Quality Committees-in-Common on patient safety concerns raised by staff has been provided to the December 2024 meeting of the Quality Committees-in-Common, and this is to become a quarterly report to provide Committee and Board level oversight of concerns raised by staff.

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
							Completion of Phase 1 Quality Governance Review with agreed management response. Phase 2 Quality Governance review completed with outputs due to be presented to Group Executive in January 2025, and to the Quality Committees-in-Common in February 2025, and to the Group Board in March 2025.
SR10: Improving Patient Experience *If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, then we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services.*	16 (4x4)	16 (4x4)	12 (4x3)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Work required to refine material actions to mitigate identified gaps in control. Some gaps relate to wider programmes of work: EPR implementation, outpatient transformation.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July, and launched across Group in December 2024. Complaints and PALS teams established on a Group-wide basis through the Group Corporate Services Integration programme. Review of the National Inpatient Survey Results 2023 by the Quality Committees-in-Common at its October 2024 meeting, which showed overall patient experience at ESTH had improved on the previous year, and SGUH as the same as the previous year.

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
SR11: Tackling Health Inequalities *If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, then we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.*	16 (4x4)	16 (4x4)	12 (4x3)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Significant progress in relation to the governance of the Group's work on Health Inequalities has been developed and implemented in recent months. The key areas of focus in the coming months are: improving data quality on HI including through the development of a PowerBI dashboard; EDI team input into the HI Steering Group; and Developing areas of focus for gesh as an Anchor Institution.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July, and launched across Group in December 2024. A new gesh Health Inequalities Steering Group has been established. A Communities of Practice on HI has been established and has held meetings in July and November 2024. Funding for an Equity Lead at SGUH has been secured from the SGH Charity and funding for a similar role at ESTH is currently being pursued. The Sickle Cell team won funding from NHSE for establishing a Sickle Cell Hyperacute Unit at SGUH. A horizon scanning exercise has been undertaken to help inform plans for the gesh Group acting as an "Anchor Institution" Quality Committees-in-Common held a deep diver on HI at its meeting in September 2024 and a further update on HI at Place and in relation to data quality on HI was circulated to the Committee in November 2024.
SR12: Putting staff experience at the heart of what we do *If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, then our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Despite this, there are a number of material actions that have been, or are currently being, taken which we expect to have an impact on the assurance rating in particular, and potentially the risk score over the coming months as these are fully implemented	Development of further proposals in relation to talent management (presented to Group Executive in November 2024) Progress in developing and implementing plans for Group-wide HR restructure

Group Board Assurance Framework Summary – January 2025

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (July 2024)
	Original Mar-24	Current Jan-25	Target Mar-25	Current Jan-25	Target Mar-25		
SR13: Fostering an inclusive culture that celebrates diversity *If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, then our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Despite this, there are a number of material actions that have been, or are currently being, taken which we expect to have an impact on the assurance rating in particular, and potentially the risk score over the coming months as these are fully implemented	Establishment of new Raising Concerns Oversight and Triangulation Group, with established rhythm and reporting to Group Executive and Committees People Committees and Board have approved new WRES and WDES action plans for each Trust Approach to Executive and Site Sponsorship of Staff Diversity Networks has been reviewed and agreed A draft new EDI action plan has been developed and has been reviewed initially by the People Committees.
SR14: Developing tomorrow's workforce *If we do not retain, train and transform our workforce for the future, then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score or assurance rating at Q3 2024/25. Despite this, there are a number of material actions that have been, or are currently being, taken which we expect to have an impact on the assurance rating in particular, and potentially the risk score over the coming months as these are fully implemented	Reduction in agency staffing Progress in developing new Group-wide HR policies.

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Group Board Assurance Framework

Group Board
9 January 2025

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Collaboration and Partnerships

Strategic Risks 1 – 3

- SR1: Working across our local systems
- SR2: Working with other hospitals through our APC
- SR3: Working across our Group

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

Strategic Risk	SR1	Working across our local systems

Current Risk Score: 16

Assurance: Reasonable

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

Strategic objective	Collaboration and Partnerships
Last review date	09 January 2025
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Cautious (Moderate)

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

Change since last review

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Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	16	16	16	16								

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

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

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Renewal of Sutton alliance agreement, and development of alliance agreements for Merton and Wandsworth	MD-IC	Dec-25	On Track
2	Put in place clear processes to ensure structured feedback from ICBs into Group Executive and Board	GCEO	Mar-25	On Track
3	Working across the ICB to prepare for devolution of specialised commissioning	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No risk on CRR relating to cross-system working			

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No specific related risks relating to cross-system working on ICB BAF			

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
No specific related risks relating to cross-system working on ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
No specific related risks relating to cross-system working on ICB BAF	

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

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

Current Risk Score: 12

Assurance: Reasonable

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

Strategic objective	Collaboration and Partnerships
Last review date	09 January 2025
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review

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Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	12	12	12	12								

	Key controls *What are we already doing to manage the risk?*
1	Governance structure for the APC established
2	SWL APC has established an APC Board comprising the Chairs and CEOs of the SWL providers, which meets bimonthly
3	Group CEO is lead CEO of the South West London Acute Provider Collaborative
4	Formal SWL APC partnerships in place for recruitment, orthopaedics, procurement, pathology
5	Agreed set of SWL APC priorities in place for 2023/24
6	A range of elective programmes and clinical networks in place across the SWL APC covering elective recovery, outpatients and diagnostics
7	APC Programme Director in place (new appointment from March 2025)
8	Established collaborative partnerships: SWL Recruitment, SWL Procurement, SWLEOC, SWL Pathology
9	System-wide clinical networks: cardiology, neurology, radiology in place

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Updates from APC presented to Executive team	Reasonable	Second - Management
2	Updates from APC presented to Executive team	Reasonable	Second - Management
3	Updates from APC presented to Executive team	Reasonable	Second - Management
4	Review of key performance metrics of APC partnerships through the Site, Executive and relevant Board Committees	Reasonable	Second - Management
5	Delivery overseen by APC Board	Reasonable	Second - Management
6	Delivery overseen by APC Board	Reasonable	Second - Management
7	Regular meetings with GCEO and updates provided to Executive	Reasonable	Second - Management
8	Reporting integrated into performance reports to Committees and Group Board	Reasonable	Second - Management
9	Reporting through relevant reports to Committees and Group Board	Reasonable	Second - Management

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Approve 3-5 year strategy for the SWL APC	GCEO	Dec-24	On Track
2	Define clear outputs from the networks established across the APC	GCEO	Dec-24	TBC
3	Developing SWL model of surgical hubs with APC support	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
No specific related risks relating to the APC on the CRR			

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
No specific related risks related to the APC on the CRR			

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
No specific related risks relating to cross-system working on ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
No specific related risks relating to cross-system working on ICB BAF	

Strategic Risk	SR3	Working together across our Group

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

Current Risk Score: 20

Assurance: Limited

Strategic objective	Collaboration and Partnerships
Last review date	09 January 2025
Monitoring Committee	Group Board
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Group-wide strategy in place and approved by Boards, with People strategy, Quality strategy, Green Plan approved by Group Board	1	Strategy progress updates reviewed by Group Board bi-annually, and by the Executive on a monthly basis	Good	Second - Management
2	9 strategic initiatives agreed with Executive leads for each identified, and governance of the initiatives agreed by the Group Board	2	Programmes of work for each established, with executive review of Strategic Initiatives on a monthly basis	Reasonable	Second - Management
3	MoU and Information Sharing Agreement in place to support the development of the Group	3	In place and approved by the Boards	Good	Second - Management
4	Group governance arrangements established at Board, Committee and Executive level	4	Group Board and Committees-in-Common established and review effectiveness annually	Good	Second - Management
5	Group Corporate Services programme established, with legal agreements in place to support the operation of Group-wide services	5	Timescales established for integration of corporate functions across the Group. Corporate Affairs, Communications, DCEO, Corporate Nursing and Phase 1 Corporate Medical completed.	Weak	Second - Management
6	Executive Collaboration Group now established to oversee the development of clinical and corporate collaboration and integration across the Group	6	Recently reconstituted and will be providing regular reporting of progress to the Group Executive	Reasonable	Second - Management
7	Performance data reviewed on Group-wide basis	7	Group-wide Integrated Quality and Performance Report presented to Committees and Group Board	Good	Second - Management

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Preparation and Group Board approval of Group People Strategy	GCPO	May-24	Completed
2	Preparation and Group Board approval of Group Quality and Safety Strategy	GCNO/GCMO	Jul-24	Completed
3	Preparation and Group Board approval of Group Green Plan	GCIFEO	Jul-24	Completed
4	Group Board review and approval of governance framework for oversight of Strategic Initiatives	GDCEO	Jul-24	Completed
5	Remaining supporting strategies to be developed, reviewed and approved by the Group Board: Digital, Estates, Research	Exec Leads	Nov-24	Off Track
6	Delivery of the 9 Strategic Initiatives to support the implementation of the Group strategy	GDCEO	Mar-28	Off Track
7	Finalise and approve designs for remaining corporate areas for integration, and complete integration of Group Corporate Services to agreed timeline	GDCEO	Jul-24	Overdue
8	Develop and agree Group-wide clinical strategies in first wave services	GDCEO	Sep-24	Completed
9	Develop and agree Group-wide clinical strategies in second wave services	GDCEO	Mar-25	On Track
10	Develop and agree Group-wide clinical strategies in third wave services	GDCEO	Sep-25	On Track
11	Develop and agree Group-wide Accountability Framework, drawing on Group Operating Model	GCCAO	Feb-25	On Track
12	Develop revised Standing Orders, Scheme of Delegation and Standing Financial Instructions for each Trust, with as much alignment as possible within the existing legal and regulatory framework	GCCAO	Feb-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2963	20	Group Corporate Services

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-652	20	Group Corporate Services

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
No specific related risks on the gesh Group on ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
No specific related risks on the gesh Group on ICB BAF	

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

Affordable Healthcare, Fit for the Future

Strategic Risks 4 – 7

- SR4: Achieving financial sustainability
- SR5: Modernising our estate
- SR6: Adopting digital technologies
- SR7: Developing new treatments through research

Group Board Assurance Framework 2024/25

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

Strategic Risk	SR4	Achieving financial sustainability – Group Assessment

Current Risk Score: 25

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	20 December 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

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

Change since last review

⇔

Risk Score	Mar24	Jun24	Sept 24	Dec 24	Mar 25	Jun 25	Sept 25	Dec 25	Mar 26	Jun 26	Sept 26	Dec 26
	25	25	25	25								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Managing income and expenditure in line with budget.	1	Financial performance is in line with budget/plan	Weak	First - Operational
2	Ensuring there is an effective financial control environment.	2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	CIPs. Identifying and delivering actions to improve the financial position.	3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Reasonable	First - Operational
4	Robust understanding of cost structures and productivity.	4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	Maintaining a five year forward view.	5	A five year "long term financial plan" is in place	Weak	Second - Management
6	Maintaining the capacity and capability of the finance team.	6	Clearly defined statement of how demands on dept are meet by available resources.	Weak	Second - Management
7	Capital: clear view of future capital needs and how to meet them		Detail available of prioritised capital need together with available funding.	Weak	Second - Management
8	Robust processes to forecast and manage cash.	7	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
9	Maintaining an effective procurement environment	8	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Weak	Second - Management
9	External engagement with SWL, London and national finance teams.	9	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

Group Board Assurance Framework 2024/25

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Uncertain planning environment for 25/26. • Scale of financial challenge and time allowed to recover. • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding	• Working across the Group. • Working across the SWL system.

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

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1961	25	Inability to achieve long term financial sustainability
ESTH	CRR-1960	25	Inability to undertake the required capital investment programme with the SWL capital programme CDEL limits

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
20	Financial Sustainability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
16	Failure to deliver the ICB financial plan (breakeven) for 2024/25

Group Board Assurance Framework 2024/25

Strategic Risk	SR5	Modernising our estates

Current Risk Score: 25

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	15 November 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Infrastructure Officer
Risk appetite	Open (High)

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

Change since last review

⇔

Risk Score	Mar24	Jul24	Sept 24	Dec 24	Mar 25	Jun 25	Sept 25	Dec 25	Mar 26	Jun 26	Sept 26	Dec 26
	25	25	25	25								

	Key controls *What are we already doing to manage the risk?*
1	Ensure we have a comprehensive understanding of our infrastructure risks across all sites
2	Having clear, risk based, preventative maintenance schemes that can be flexed based on affordability
3	A clear, transparent, risk-based approach to capital prioritisation
4	Sourcing alternative sources of capital
5	Group Green Plan in place and approved by Group Board
6	Governance of infrastructure issues across the Group through the Infrastructure Committee
7	Use major capital projects to address wider infrastructure risks wherever possible

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	External condition surveys, risk assessments, reporting to Infrastructure Committee	Reasonable	Third - External
2	Internal audits on maintenance undertaken / due. Regular estates reporting to plan to Infrastructure Committee	Reasonable	Second - Management
3	Both Trusts have processes for agreeing collectively the annual capital plans, with clinical, operational and E&F input	Reasonable	Second - Management
4	Limited work done to date, examples include external SALIX funding for green projects and phasing BYFH funds	Weak	First - Operational
5	Group Green Plan approved by Group Board in July 2024. Governance arrangements and KPIs agreed.	Reasonable	Second - Management
6	The Infrastructure Committee is established and is evolving its oversight of estates and facilities issues and risks	Reasonable	Second - Management
7	Whilst projects are always looking to improve wider infrastructure wherever affordable and appropriate,	Weak	First - Operational

Group Board Assurance Framework 2024/25

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

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2036	20	Fire Safety
SGUH	CRR-762	20	Infrastructure backlog
SGUH	CRR-2061	15	Lack of UPD/IPS power supplies site-wide

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
12	Failure to modernise and fully utilise our estates

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
No related estates risk on the ICB BAF	

Group Board Assurance Framework 2024/25

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

Strategic Risk	SR6	Adopting digital technology

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	13 December 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

Risk Score	Mar24	Jun24	Sept 24	Dec 24	Mar 25	Jun 25	Sept 25	Dec 25	Mar 26	Jun 26	Sept 26	Dec 26
	20	20	20									

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

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

Group Board Assurance Framework 2024/25

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-803	20	ICT Disaster Recovery Plan
SGUH	CRR-1395	20	Network Outage
SGUH	CRR-1312	16	Data Warehouse Fragmentation
SGUH	CRR-1292	16	Telephony
SGUH	CRR-810	15	Data Centre

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1958	16	Aging / unsupported IT equipment, systems, platforms; Cybersecurity incidents

Group Board Assurance Framework 2024/25

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
16	Interruption to Clinical and Operational Systems due to Cyber Attack

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
No related Digital / ICT risk on the ICB BAF.	

Group Board Assurance Framework 2024/25

Strategic Risk	SR7	Developing new treatments through innovation and research

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

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Affordable Services Fit for the Future
Last review date	19 December 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Seek (Significant)

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

Change since last review

⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	12	12	12	12								

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

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Approved by Board but to be succeeded by Group-wide research and development strategy in 2025/26	Reasonable	Second - Management
2	Regular meetings of Joint Strategic Board with the University	Reasonable	Second - Management
3	Leadership positions in the Clinical Research Network. Group CEO chairs the CRN Partnership Board	Reasonable	First - Operational
4	TACRI Steering Group reporting to SGUH PSQG currently	Reasonable	Second - Management
5	5-year designation from NIHR	Reasonable	Third - External
6	Reporting on research through to the JRES and Quality Cttee	Reasonable	Second - Management
7	Required wider Group-wide integration of non-medical research support team	Weak	Second - Management
8	Reporting on research through to the Quality Committee	Reasonable	Second - Management

Group Board Assurance Framework 2024/25

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

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

Emerging risks	Emerging opportunities
• Financial pressures impacting on research opportunities • Ability to secure research funding	• Opportunities for wider partnerships with the merged City St George's University • Opportunity for greater research leadership role in SWL

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and secure Group board approval for Group-wide research and development strategy	GCMO	Nov-25	On Track
2	Bring together the delivery arms of research for ESTH and SGUH on a Group-wide basis through the integration of corporate services	GCMO	Jul-25	On Track
3	Explore opportunities for building a wider relationship with City University through its merger with St George's University of London	GCMO	Apr-25	On Track
4	Create more research capacity through job planning	GCMO	Jun-25	On Track
5	Establish research data warehouse	GCMO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
No research and innovation related risks on the CRR.			

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
No research and innovation risks on the CRR.			

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
No research and innovation related risks on the SWL ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
No research and innovation related risks on the SH ICB BAF	

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Right care, Right place, Right time

Strategic Risks 8 – 11

- SR8: Reducing waiting times
- SR9: Improving safety and reducing avoidable harm
- SR10: Improving patient experience
- SR11: Tackling health inequalities

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

Strategic Risk	SR8	Reducing waiting times

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	20 December 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Site Managing Directors
Risk appetite	Cautious (Moderate)

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

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	OPEL escalation triggers updated and revised actions in place	1	OPEL triggers regularly used and associated actions activated	Good	Second - Management
2	Daily surge call in place with system partners to help manage capacity and to escalate delayed patients / discharges/repatriations	2	Used regularly to escalate concerns. Integrated TOCs at SGUH and ESTH means constant updates and escalation. SGUH and ESTH boarding SOPs in place and "live"	Reasonable	Second - Management
3	Boarding arrangements to depressurise ED with SOPs in place	3	ED performance reported to Site, Exec, Committees and Board	Reasonable	Second - Management
4	Transfer of care functions in place to facilitate discharge	4	In place. Integrated TOC team established on site at SGUH.	Good	Second - Management
5	ED overcrowding mitigating actions in place to manage risks of corridor care	5	Actions to mitigate safety risks in ED due to overcrowding reviewed by the Quality Committees-in-Common	Reasonable	Second - Management
6	Validation of PTLs	6	Decrease in number of patients waiting longer than 52 weeks	Good	Second - Management
8	Long length of stay MDT meetings in place (SGUH) Divisional check and challenge of LLoS and 14 day/complex review panel (ESTH)	8	Oversight of LoS by Site Leadership teams. Meetings in place and increased when needed.	Reasonable	Second - Management
9	Regular bed management meetings to help manage flow	9	Oversight of flow by Site Leadership teams	Reasonable	Second - Management
11	QMH Surgical Treatment Centre in place to help reduce waiting times ERF plan at ESTH and use of QMH capacity	11	Activity reviewed by SGUH Site team (improved utilisation and theatre to ESTH). ESTH@QMH plan being mobilised	Good	Second - Management
12	Mutual aid across SWL	12	Reviewed by Site and Executive teams. Managed via ICB.	Reasonable	Second - Management

13	Virtual wards established	13	Hospital@Home capacity used 100% in Wandsworth – remote monitoring capacity being reviewed. Sutton virtual ward now being used at or near capacity	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Volume of patients attending EDs, Reduction in LAS Handover time and large numbers of DTAs
2	Numbers of patient outliers across the hospitals and number of delayed tertiary repatriations
3	Staff concerns regarding pressures in ds
4	Strengthening of arrangements for addressing pressures due to patients with mental health issues attending Eds
5	Delays in local authorities supporting discharge and availability of social care support
6	Availability of alternatives to ED
7	Strengthening mutual aid across Group and across SWL

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

Emerging risks	Emerging opportunities
• Staff burnout, illness and disengagement • Moral injury to staff • Increasing violence and aggression directed at staff • ability to physically accommodate further excess demand in site footprint (ESTH) • Inability to compete on pay with other providers for key staff	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Put in place enhanced arrangements and oversight of ED safety in the context of overcrowding and corridor care	Site MDs	Dec-24	Completed
2	Implementation of actions to respond to staff concerns in Eds	Site MDs	Mar-25	On Track
3	Implementation of electronic patient record system across the Group on a shared domain with SGUH	GCEO and EPR SRO	May-25	On Track
4	Collaboration with South West London & St George's Mental Health Trust and Surrey and Borders Partnership NHS FT in relation to patients with mental health issues attending EDs.	Site MDs	TBC	TBC
5	Strengthening of mutual aid across Group and SWL	MDs	TBC	TBC
6	Work programme to understand health inequalities impact of long waits	GCMO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising flow
SGUH	CRR-2240	20	Long waits for cardiology procedures
SGUH	CRR-2421	16	Personalised stratified follow-up – breast cancer
SGUH	CRR-2903	20	Emergency Department Overcrowding

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Delivering Access to Care (NHS Constitutional Standards)

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
16	Capacity in our Urgent and Emergency Care Services

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

Strategic Risk	SR9	Improving patient safety and reducing avoidable harm

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	19 December 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	GCMO / GCNO
Risk appetite	Cautious (Moderate)

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

Change since last review

⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Quality governance structures and processes	Internal reporting to Site, Executive, Committees, and Group Board; CQC reports	Weak	Third - External
2	Established governance on management of patient serious incidents under outgoing SI framework and new PSIRF framework	Oversight of PSIs and SIs by Mortality Monitoring groups and regular reporting to Quality Committee	Reasonable	Second - Management
3	Safety data established as core part of Integrated Quality and Performance Report	Safety data reviewed regularly by Site, Executive Quality Committee and Group Board	Good	Second - Management
4	Established governance on quality impact assessments of cost improvement plans	QIAs process agreed and individual QIAs reviewed by Site and Executive, with Quality Committee oversight	Reasonable	Second - Management
5	Governance and reporting on learning from deaths established	Regular reporting to Quality Committee and Group Board	Good	Second - Management
6	Established clinical audit plan	Reporting on clinical audit plans to Site quality groups and to Quality Committee	Good	Second - Management
7	Established ward accreditation programme	Reporting on ward accreditation through IQPR	Reasonable	Second - Management
8	Group-wide infection prevention and control governance in place	Regular reporting on IPC to Executive, Quality Committee and	Good	Second - Management
9	Influenza and Covid vaccination programme	External NHS England data on vaccination rates – compliance rates low but among the best compliance rates in London	Weak	Third - External
10	Commissioned external quality reviewed by Royal Colleges and other national bodies	Tracking action plans developed in response to external reviews	Reasonable	Third - External

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

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

Emerging risks	Emerging opportunities
• Increasing financial pressures • Magnitude of ED risks, and pressures of overcrowding	• Closer collaboration with system partners to develop integrated care approaches across primary, secondary, community and mental health settings.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Commence implementation of Patient Safety Incident Response Framework across the Group in phases	GCMO/GCNO	Mar-24	Completed
2	Develop and secure Group Board approval of new Group quality and safety strategy	GCMO/GCNO	Jul-24	Completed
3	Develop PSIRF maturity	GCMO/GCNO	Mar-25	On Track
4	Develop and implement Group-wide approach for dissemination of learning on patient safety	GCMO/GCNO	Dec-24	On Track
5	Develop a plan for improving psychological safety as part of Quality and Safety Strategy	GCMO/GCNO	Mar-25	On Track
6	Bring together and strengthen maternity governance arrangements together across the Group	GCNO	Mar-25	On Track
7	Implementation of Phase 1 Quality Governance Review actions in line with agreed timetable	GCMO/GCNO	Jul-25	On Track
8	Implement strategic initiative on developing a shared electronic patient record across the Group	GCEO	May-25	On Track
9	Implement strategic initiative on strengthening specialised services at SGUH	GCMO/GCNO	Mar-28	Off Track

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising Flow
SGUH	CRR-2240	20	Long wait for elective cardiology procedures
SGUH	CRR-2923	16	Emergency Department Overcrowding
SGUH	CRR-2606	16	Consent
SGUH	CRR-1626	15	Wrong blood in tube

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Delivering Access to Care (NHS Constitutional Standards)
9	System Quality Oversight

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
16	Capacity in our Urgent and Emergency Care Services
15	Operational challenges impacting the safe delivery of maternity care

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

Strategic Risk	SR10	Improving patient experience

Current Risk Score: 16

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	19 December 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Nursing Officer
Risk appetite	Open (High)

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

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	16	16	16	16								

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

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

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Strengthen complaints teams through Group-wide corporate restructure	GCNO	May-24	Completed
2	Develop and secure Group Board approval for quality and safety strategy, including strategic vision for patient engagement	GCMO/GCNO	Jul-24	Completed
3	Deliver strategic initiative on a shared electronic patient record across the Group	GCEO	May-25	On Track
4	Develop staff training and support for managers to gain real time data for their areas to support and promote patient involvement	GCNO	Mar-25	On Track
5	Improve complaints response times	GCNO	May-25	On Track
6	Deliver strategic initiative on outpatient transformation	GCMO	Mar-28	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No patient experience risks on the CRR.			

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No patient experience risks on the CRR.			

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
No research and innovation related risks on the SWL ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
No research and innovation related risks on the SH ICB BAF	

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

Strategic Risk	SR11	Tackling health inequalities

Current Risk Score: 16

Assurance: Partial

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	19 December 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Open (High)

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

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	16	16	16	16								

Key controls *What are we already doing to manage the risk?*	
1	Group strategy identified health inequalities as key priority for Group
2	Analysis of planning guidance and NHSE statement of information on health inequalities
3	Initial analysis of health inequalities in ED and outpatients across the Group completed
4	HI plan in place with short term and longer term workstreams
5	Steering Group established and meetings scheduled

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management
2	Integrated into Group-wide approach to addressing Health Inequalities	Reasonable	Second - Management
3	Reviewed and considered by Quality Committee, and integrated into wider work programme on HI	Reasonable	Third - External
4	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Weak	Second - Management
5	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Improve quality of data collection in relation to ethnicity and other important demographic or protected characteristic information
3	Developing reporting on health inequalities (evidenced-based reporting on impact)
4	Review of patient involvement from health inequalities perspective
5	EDI team input into the Health Inequalities Steering Group
6	Reporting of patient health inequalities in our PSED report is not as clear as staff equality, diversity and inclusion

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
	• Patient elements of EDI included in approach to patient experience • Group-wide integration on patient experience, clinical audit • AI tools to run waiting lists with insight into HI aspects

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Establish a GESH Group Health Inequalities Steering Group reporting into the newly formed GESH Quality Group	GCMO	Apr-24	Completed
2	Take up offer from Optum UK, leading health services and innovation company, to provide free development sessions on health inequalities	GCMO	Dec-24	Completed
3	Establish GESH Community of Interest / Health Inequalities Forum for service areas to share learning, good practice and resources	GCMO	Apr-24	Completed
4	Improve research study recruitment to ensure patients from minority ethnic backgrounds are appropriately represented in clinical research	GCMO	Dec-24	Completed
5	Provide regular health inequalities update report to the Quality Committee	GCMO	Mar-24	Completed
6	Include EDI team input into HI Steering Group	GCMO	Mar-25	On Track
7	Address approach to unplanned and emergency care high intensity service users	GCMO/GCNO	Mar-25	On Track
8	Improve the quality of the data recording by, and data sets used, across the Group, including by developing a PowerBI dashboard	GCMO	May-25	On Track
9	Identify priority areas in planned care waiting lists for initial focus	GCMO	Jul-25	On Track
10	Adapt clinical audit and effectiveness to shed light on health inequalities as manifested by differences in access or outcomes	GCMO	Jun-25	On Track
11	Strengthen patient involvement to recruit service users who can bring particular perspectives on inequalities to help shape services	GCMO	Dec-25	On Track
12	Develop options and plans for gesh acting as an Anchor Institution.	GCMO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No risks related to health inequalities on the CRR.			

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No risks related to health inequalities on the CRR.			

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
No health inequalities focused risks on the SWL ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
No health inequalities focused risks on the SH ICB BAF	

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Engaged, Empowered Staff
Strategic Risks 12 – 14

- **SR12: Putting staff experience at the heart of what we do**
- **SR13: Fostering an inclusive culture that celebrates diversity**
- **SR14: Developing tomorrow's workforce**

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

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

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	12 December 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

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

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Group People Strategy approved by the Group Board	1	Approved by the Group Board in May 2024, with monitoring of progress through the People Committees-in-Common	Good	Second - Management
2	Well developed staff support programmes in place across Group	2	Delivery of staff support is reviewed by People Committee which has taken good assurance on this	Good	Second - Management
3	Board level Wellbeing Guardian in place at both Trusts	3	Approved by the two Boards; Wellbeing Guardian is a member of People Committee	Good	Second - Management
4	Established ESTH and SGUH leadership development programmes	4	Outputs reviewed locally and by HR. Leadership particularly at middle management remains an area of challenge.	Weak	First - Operational
5	GESH 100 leadership forum in place	5	Positive feedback from staff involved in first two GESH100 events.	Reasonable	Second - Management
6	Staff induction in place at both Trusts	6	Programme of induction events monitored by HR	Reasonable	First - Operational
7	Employee Relations Service Improvement Plan in place	7	Ongoing operational challenges for ER functions at both Trusts particularly at SGUH e.g. timeliness of investigations	Weak	Second - Management
8	Group-wide Continuous Improvement team established and in place	8	CI team established.	Reasonable	First - Operational
9	Established ESTH and SGUH Quality Improvement programmes	9	Outputs from QI reviewed at Site, Executive and Committee.	Weak	Second - Management

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
	• Results of 2024 NHS Staff Survey

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy in support of the Group strategy	GCPO	May-24	Completed
2	Implement fully the Employee Relations Service Improvement Plan	GCPO	Jun-24	Off Track
3	Undertake restructure of HR / People Functions at both Trusts to establish Group-wide function	GCPO	Dec-24	On Track
4	Develop People Strategy Implementation Plan	GCPO	Feb-25	On Track
5	Develop Group-wide talent management strategy	GCPO	Feb-25	On Track
6	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff	GCPO	Mar-25	On Track
7	Develop and deliver programme to embed CI at organisational, team and individual level in line with Group Strategy	GDCEO	Mar-25	On Track
8	Implement changes to appraisals and objective setting to align with new Group strategy	GCPO	Dec-25	On Track
9	Deliver Strategic Initiative on High Performing Teams	GDCEO	Mar-28	On Track
10	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2530	16	Appraisal rates
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1929	16	Senior leadership capacity
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-1935	16	Appraisals
ESTH	CRR-150	16	Mandatory and Statutory Training
ESTH	CRR-2072	16	Payroll provision
ESTH	CRR-2071	20	People Directorate

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
12	ICB Workforce Instability

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

Strategic Risk	SR13	Fostering an inclusive culture that celebrates diversity

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	12 December 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

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

Change since last review: ⟺

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Group People Strategy approved by the Group Board	1	Approved by the Group Board in May 2024, with monitoring of progress through the People Committees-in-Common	Good	Second - Management
2	Site-based Culture Equity and Inclusion Boards and Group Culture Forum established	2	Updates reported through Site SLTs and Group Executive	Reasonable	Second - Management
3	Workforce Race Equality Standard Action Plan developed	3	Action Plan in place. Single Group-wide WRES plan in development.	Reasonable	Second - Management
4	Workforce Disability Equality Standard Action Plan developed	4	Action Plan in place. Single Group-wide WRES plan in development.	Reasonable	Second - Management
5	Framework for raising concerns in place with FTSU Guardians in place across the Group and Raising Concerns Group established	5	Regular reporting of concerns raised through FTSU considered at People Committee and Group Board	Reasonable	Second - Management
6	Staff networks in place at both Trusts	6	Networks meet regularly and programme of Board engagement with network chairs. Executive sponsorship refreshed.	Reasonable	Second - Management
7	NHS Staff Survey Results reviewed systematically with action plans developed	7	Review of NHS Staff Survey results through Executive, People Committee and Group Board	Reasonable	Second - Management
8	Established values in place at each Trust	8	Monitored by Site, Executive and People Committee	Reasonable	Second - Management

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and implement a two-year People strategy in support of the Group Strategy	GCPO	May-24	Completed
2	Develop and implement single Group-wide WRES and WDES action plans	GCPO	Oct-24	Completed
3	Clarify Executive sponsorship of staff networks and align networks arrangements across the Group	GCPO	Dec-24	Completed
4	EDI Action Plan approved by Group Board	GCPO	Jan-25	On Track
5	Develop Group-wide Raising Concerns policy in line with new national raising concerns policy	GCCAO	Jan-25	On Track
6	Develop a Group-wide Raising Concerns strategy in line with good practice from NGO building on SGUH FTSU strategy	GCCAO	Feb-25	On Track
7	Develop and implement a Group-wide talent management programme	GCPO	Feb-25	On Track
8	Develop plans for improvement of Trusts' positions in relation to the NHSE Violence Prevention and Reduction Standard	GCIFEO	Mar-25	On Track
9	Undertake forthcoming Board recruitment with focus on diversity	GCEO / Chairman	Mar-25	On Track
10	Develop plan for aligning values across the Group	GCPO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-1967	16	Diversity in senior management positions
SGUH	CRR-881	16	Bullying and harassment of staff
SGUH	CRR-1978	16	Raising concerns
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1933	16	Protected characteristics
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-2070	16	Raising concerns
ESTH	CRR-2073	20	Harmonisation of staff T&Cs following TUPE

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
12	ICB Workforce Instability

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

Strategic Risk	SR14	Developing tomorrow's workforce

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	12 December 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Open (High)

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

Change since last review

⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	Group-wide People Strategy in place and approved by Group Board
2	Existing Trust-based education strategies in place
3	SWL Recruitment established to support recruitment – SLAs in place
4	International recruitment processes in place
5	Corporate induction for all new starters
6	Establishment of Joint Bank
8	Vacancy Control Panels in place to help manage spend and deliver CIPs

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Strategy oversight by Group Executive and People Committee	Reasonable	Second - Management
2	Reporting to People Committee on undergraduate education, training, and MAST compliance	Reasonable	Second - Management
3	Oversight of delivery of SWL Recruitment of key SLAs by APC and Trusts.	Reasonable	First - Operational
4	Local monitoring	Reasonable	First - Operational
5	Monitored locally by HR	Reasonable	First - Operational
6	Monitored locally by HR	Reasonable	First - Operational
8	Oversight by Site and Executive leadership teams	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Implementation Plan for the People Strategy
2	Talent management and succession plans
3	Quality of appraisals
4	Leadership capacity and capability
5	Strengthening rostering particularly for medical staff
6	Supporting the development of new roles

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy as a sub-strategy of the Group strategy	GCPO	May-24	Completed
2	Develop and agree through the People Committee an implementation plan for the People Strategy	GCPO	Feb-25	On Track
3	Develop and implement Group-wide talent strategy	GCPO	Feb-25	On Track
4	Review appraisals process to link appraisals to CARE framework	GCPO	Dec-25	On Track
5	Increase completion rate for and quality of appraisals	GCPO	Dec-25	On Track
6	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	Dec-25	On Track
7	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff	GCPO	Feb-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
12	ICB Workforce Instability

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Scoring the BAF

Risk scores and assurance ratings

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Scoring the Group Board Assurance Framework

(i) Risk scores

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

Risk grading (scoring)

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

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

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

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

Strength of controls

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

Strength of controls

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

(iii) Calculating the overall level of assurance

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

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

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

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	3.6	
Report Title	**Group Freedom to Speak Up Report Q1-Q2 2024/25**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Karyn Richards-Wright, Group Freedom to Speak Up Guardian	
Previously considered by	People Committees-in-Common Group Executive	12 December 2024 2 December 2024
Purpose	**For Review**	

Executive Summary

This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the gesh Group during Q1 and Q2 2024/25. This report was previously considered by the People Committees-in-Common on 12 December 2024.

St George's:

- A total of 78 concerns were raised with the FTSU Guardian over the first half of the year.
- The staff groups which raised the highest number of concerns were: Administrative and Clerical staff (41 concerns – 52.56%; and Nursing and Midwifery staff (15 concerns – 19.23%).
- In terms of concerns raised across the Divisions:
  - 24 concerns (30.76%) were raised from Children's Women's Diagnostics and Therapies (CWDT), the largest Division,
  - 20 concerns (25.64%) were raised from MedCard;
  - 14 concerns (17.94%) were raised from Corporate Division;
  - 8 (10.25%) concerns were raised from Estates and Facilities;
  - SWL Pathology and Research had 2 concerns each raised
- There were a total of 2 anonymous concerns (2.56%) raised to the FTSU Guardian.
- The main types of concern raised were: Bullying and Harassment, 41 concerns (52.56%); inappropriate attitudes and behaviour, 34 concerns (43.58%); worker safety, 23 concerns (29.48%); patient safety, 20 concerns (25.64%); policy/process, 20 concerns (29.48%); discrimination, 3 concerns (3.84%); and detriment, 2 concerns (2.56%).
- A total 92.2 % of workers at SGUH have undertaken the Speak Up training to date.

Epsom and St Helier

- A total of 87 cases were raised with the FTSU Guardian over the same period.
- The staff groups which have raised the highest number of concerns were: Nursing and Midwifery (30 concerns – 34.4%); and Administrative and Clerical staff (22 concerns – 25.28%).
- In terms of concerns raised across the Divisions:
  - 14 concerns (16.9%) were raised by staff within Medicine
  - 13 concerns (14.94%) were raised by staff within Women's and Children's
  - 9 concerns (10.34%) were raised by staff in Surgery
  - 7 concerns (8.4%) were raised by staff within the Corporate, Finance, & Human Resources teams

- 7 concerns (8.4%) were raised by staff within Estates and Facilities
- Surrey Downs Health and Care and Sutton Health and Care together saw 14 concerns (16.9%) raised.
- At present, the Speak Up training at ESTH is not mandatory.

Following the formation of the Group FTSU team, we are in the process of adopting the new national Freedom to Speak Up Policy as one off the first Group-wide policies, in line with national guidelines from NHS England. The draft policy has been reviewed and endorsed at the Raising Concerns Oversight and Triangulation Group, each of the three Site Leadership Teams (ESTH acute, SGUH acute, and Integrated Care), the Group Executive and the People Committees-in-Common. The draft policy is appended to this report for review and approval by the Group Board. As part of our work in building the new Group-wide FTSU team, we have also developed a standardised process, within the team, for triaging concerns raised to the FTSU service to help ensure consistency in the way in which concerns are dealt with and escalated, which includes clarity on how the service escalates immediate patient safety concerns and its process for undertaking an early stage assessment of the risk of concern raisers encountering detriment. In line with national guidance from the National Guardian's Office, our triage process also sets out our process for checking in with concern raisers six and 12 months after raising a concern.

Timely resolution of concerns, confidentiality of concerns and effective communication with the Guardian remain issues Group-wide. We are developing a Toolkit for Managers to support managing in knowing what to do when staff in their areas raise concerns, including some practical advice, sources of support, key "dos" and "don'ts", and scenarios and anonymised worked examples. The Guardian is meeting HR Business Partners (HRBPs) regularly to progress concerns, the new Raising Concerns Oversight and Triangulation Group is assisting with further identifying and addressing barriers to timely resolution.

In line with National Guardian's Office guidance, the report also highlights a number of recommendations from the Guardian to the Trust, based on learning from recent concerns.

Action required by Group Board

The Group Board is asked to:

a. Note the number of concerns reported to the FTSU Guardians in Q1 and Q2 2024/25 for both SGUH and ESTH.
b. Note the themes emerging from FTSU concerns raised in this period.
c. Note the recommendations of the Group FTSU Guardian as set out in section 3 of the report
d. Note the priorities of the new Group FTSU service in the coming months.
e. Approve the draft Group-wide Freedom to Speak Up Policy, which implements the national FTSU policy for the NHS across the gesh Group.

Committee Assurance	
Committee	People Committees-in-Common
Level of Assurance	Reasonable Assurance is proposed for the level of assurance in relation to the resourcing, structuring and operation of the Group Freedom to Speak Up Service. This also reflects the "reasonable assurance" findings of internal audits at both SGUH and ESTH on the FTSU services. However, more broadly, in relation to how confident our staff are in speaking up, the timely resolution of concerns, the ability of our managers to deal confidently and appropriately in handling concerns, and our triangulation of concerns with other metrics to provide insight into areas that may require early support and / or intervention, limited assurance is proposed.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Draft Group FTSU Policy *(as reviewed and endorsed by the People Committees-in-Common)*
Appendix 2	Group FTSU Service Triage Process

Implications

Group Strategic Objectives

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

Risks

Failure to comply with the requirements around Freedom to Speak Up, a regulatory requirement, risks undermining staff confidence in the leadership of the Trust and would be a reputational risk to the organisation.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no specific financial implications relating to this report.

Legal and / or Regulatory implications

NHSE, Freedom to Speak Up Policy for the NHS. Sir Robert Francis QC, Freedom to Speak Up: An independent report into creating an open and honest reporting culture in the NHS, 2015.

Equality, diversity and inclusion implications

There are no specific EDI implications of this report. Through the new case management system, we will be able to report on concern raising by protected characteristic from April 2025.

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

Group Freedom to Speak Up Report, Q1-Q2 2024/25
Group Board, 09 January 2025

1.0 Purpose

1.1 This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the Group during Q1 and Q2 24/25. The report sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues. The report was previously considered by the People Committees-in-Common on 12 December 2024.

2.0 Background

2.1 In February 2015, the independent report into Freedom to Speak Up, by Sir Robert Francis QC set out 20 principles to guide the development of a healthy speaking up culture throughout the NHS. Among these was the recommendation that every NHS trust appoint a Freedom to Speak Up Guardians. As the report stated, “every organisation needs to foster a culture of safety and learning in which all staff feel safe to raise a concern…we need to get away from the culture of blame, and the fear that it generates, to one which celebrates openness and commitment to safety and improvement”.

2.2 Freedom to Speak Up Guardians support workers to speak up when they feel that they are unable to in other ways. Workers can speak up about things such as but not limited to, unsafe patient care, a criminal offence maybe that has been, or is being committed, unsafe working conditions or other breaches of Health and Safety, inadequate induction or training for workers, lack of, or poor response to, a reported patient safety incident, suspicions of fraud, bullying and harassment.

2.3 The importance of speaking up has been reinforced in both the NHS Patient Safety Strategy, published in July 2019, which sees speaking up as a fundamental part of establishing effective patient safety cultures in NHS trusts, and in the new NHS People Plan, published in August 2020, which describes speaking up as essential to building a culture of belonging in the NHS, one in which patients and staff feel safe. The NHS People Plan stated that “making sure staff are empowered to speak up – and that when they do, their concerns will be heard – is essential is we are to create a culture where patients and staff feel safe.”

2.4 In September 2020, the SGUH Board approved the St George’s first Freedom to Speak Up vision and strategy. It set out the following vision for raising concerns:

> *“We aim to create a culture of safety and learning in which all staff feel safe, supported and confident to raise concerns without fear or detriment, and where speaking up is visibly championed as a core part of providing outstanding care every time to our patients, staff and the communities we serve.*
>
> *“We aim to become a leader in establishing a positive speaking up culture by encouraging and supporting staff to speak up, listening to their concerns and acting on them. Staff will not fear speaking up and will be thanked for doing so”.*

It also set out five strategic priorities for Freedom to Speak Up:

1. We will support our staff to feel confident about speaking up
2. We will make it safe for our staff to speak up
3. We will investigate concerns promptly, fully and fairly
4. We will ensure that speaking up makes a difference
5. We will support the positive development of our organisational culture

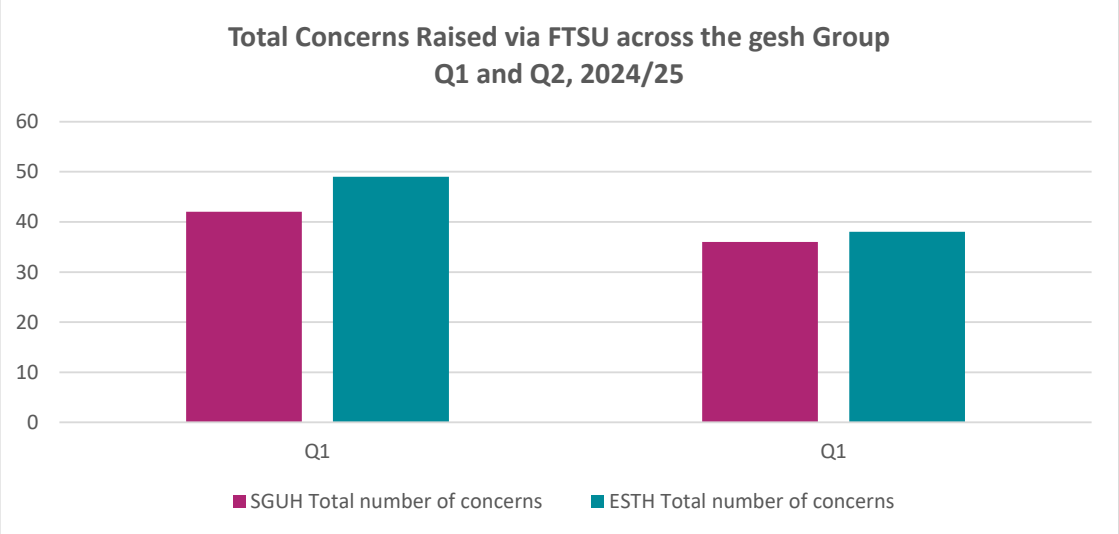
2.5 There is currently no corresponding FTSU vision and strategy approved by the Board for ESTH, but the principles and approach adopted in the SGUH strategy could equally apply at ESTH, and the paper sets out the development of a Group-wide FTSU vision and strategy as an important step in strengthening our approach to speaking up.

3.0 Current SGUH and ESTH FTSU activity and themes

(a) Total number of concerns raised via Freedom to Speak Up in Q1 & Q2 2024/25

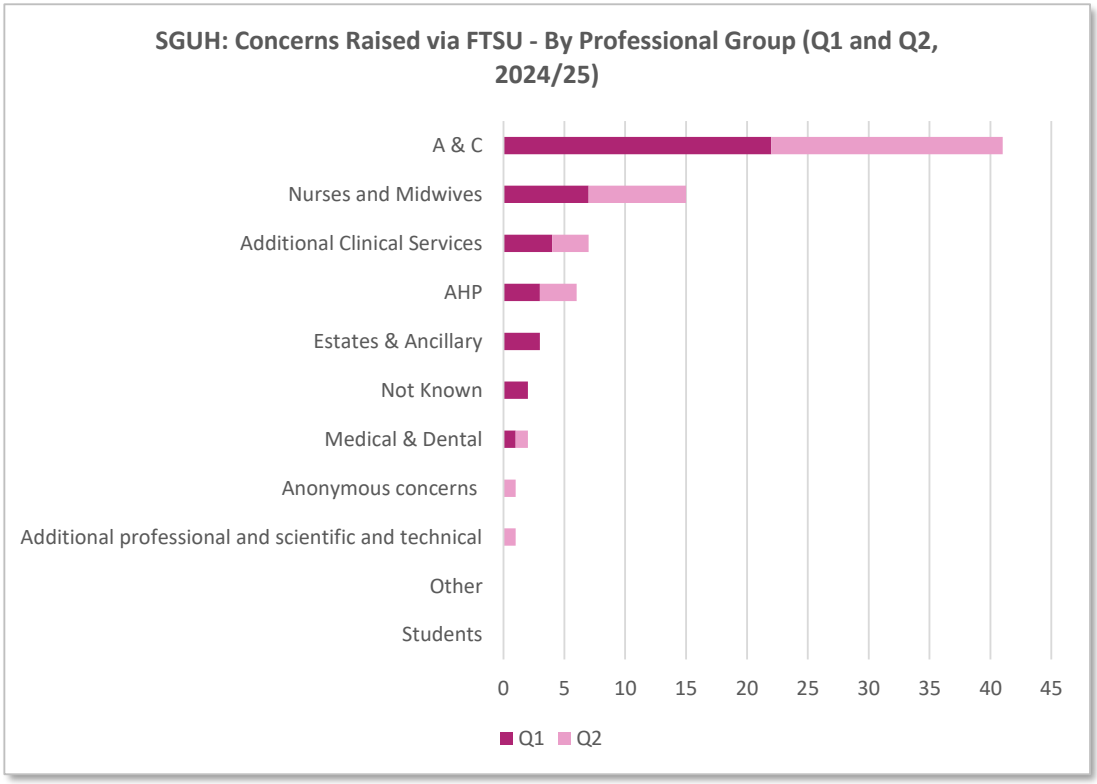
3.1 Between 1 April 2024 and 3, a total of 165 concerns were raised with the FTSU Service across the gesh Group. SGUH staff raised a total of 78 concerns, 42 concerns in Q1 and 36 concerns in Q2. In the same period, 87 concerns were raised from ESTH staff, with 49 concerns raised in Q1 and 38 in Q2.

3.2 As reported previously (June 2024), there were historically differences in the way in which FTSU concerns were recorded at SGUH and ESTH. A common approach to the recording of concerns was adopted from the start of Q4 2023/24 in line with the NGO guidance, which resulted in a 23% reduction in the number of FTSU concerns at ESTH in 2023/24 recording of fewer concerns in Q4 at ESTH. The gesh FTSU team now have an aligned reporting process relating to concerns raised and as such moving forward this more consistent process will give a clearer picture for reporting purposes. Based on the number of concerns raised at the halfway point in 2024/25, the data indicates that at the end of the financial year concerns raised via FTSU across the Group are likely to have reduced by approximately 20%. In part, this reflects the new standardised processes for recording concerns.



(b) Concerns raised by staff group in Q1 & Q2 2024/25 (SGUH)

3.3 The following charts show the concerns raised via FTSU by different staff groups at SGUH, both over the course of Q1 and Q2.



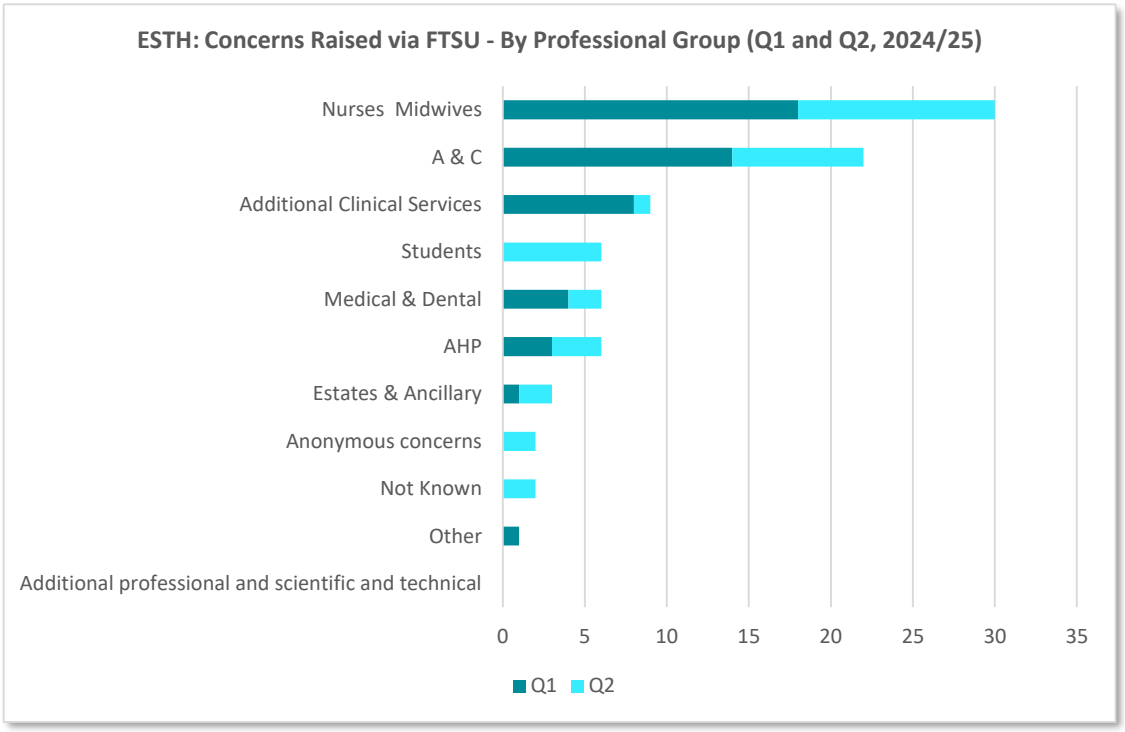
3.4 Staff groups at SGUH who have raised concerns with the FTSU Guardian over Q1 & Q2:

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over the past 2 quarters. A total of 41 concerns (52.56%) were raised by this staff group with 22 concerns raised in Q1 and 19 raised in Q2.
- **Nursing and Midwifery** staff raised the second highest number of concerns in Q1 & Q2 with 15 concerns (19.23%). 7 concerns were raised in Q1 and 8 concerns in Q2.
- **Allied Health Professionals** raised a total of 6 concerns (7.69%), 3 in Q1 and 3 in Q2. **Additional professional, scientific and technical services** had 1 concern raised in Q2 (1.28%).
- **Medical & Dental staff** raised 2 concerns (2.56%) with 1 raised in each quarter .
- There have been 2 "**department unknown**" concerns (2.56%) raised in Q1 and 1 **anonymous concern** raised in Q2 (1.28%).

- **Estates & Ancillary** staff raised 3 concerns in Q1 (3.84%), with **additional clinical services** raised a total of 7 concerns (8.97%) over the 2 quarters with 4 concerns in Q1 and 3 in Q2.

(c) Concerns raised by staff group in Q1 and Q2 (ESTH)

3.5 The following charts show the concerns raised via FTSU by various staff groups at ESTH:



3.6 Staff groups which have raised concerns with the FTSU Guardian at ESTH over the past year shows that:

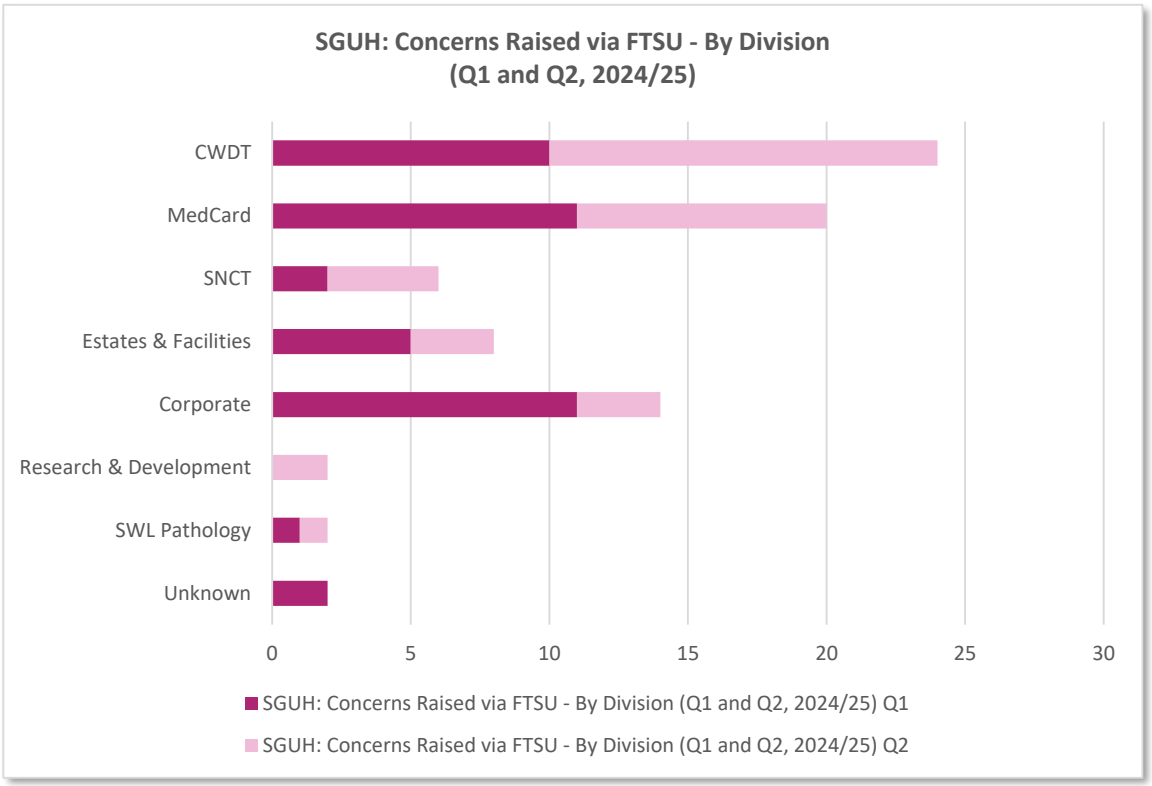
- **Nursing & Midwifery** are the staff group which raised the highest number of concerns to the FTSU Guardian over the past 2 quarters. A total of 30 (34.4%) concerns were raised by this staff group with 18 concerns raised in Q1 and 12 raised in Q2.
- **Administrative and Clerical** staff raised the second highest number of concerns in Q1 & 2 with 22 concerns (25.28%) raised,14 concerns were raised in Q1 and 8 concerns in Q2.
- **Additional Clinical Services staff** raised a total of 10 concerns (11.49%) over the all 10 raised in Q2.
- **Estates, Facilities & Ancillary** staff raised a total of 7 concerns (8.04%) 1 in Q1 and 6 in Q2
- **AHP's** raised 6 (6.89%) concerns over the two quarters 3 in Q1 and 3 in Q2
- Concerns reported from **Medical and dental staff** in Q1 & 2 were 6 (6.89%) with 4 raised in Q1 & 2 raised in Q2.

- There have been 2 **anonymous concerns** in Q2 (2.29%) and 3 (3.44%) **unknown/other,** 1 in Q1 and 2 in Q2.

- There was 1 concern (1.14%) raised in Q2 by **Additional professional, scientific and technical services.**

(d) <u>Concerns raised by Divisions in Q 1 & 2 2024/25 (SGUH)</u>

3.7 The following chart shows the number of concerns raised by Division at SGUH over the 2 quarters:



3.8 An analysis of the concerns raised by Division with the FTSU Guardian over the 2 quarters at SGUH shows that:

- Staff from the **Children's, Women's Diagnostics and Therapies (CWDT) Division (the largest division)** raised a total of 24 concerns out of a total of 78, (30.76%) of total SGUH concerns.

- **Medicine and Cardiovascular Division** staff raised the second highest number of concerns with 20 concerns raised, (25.64%).

- **Corporate Division** accounted for 14 concerns (17.94%).

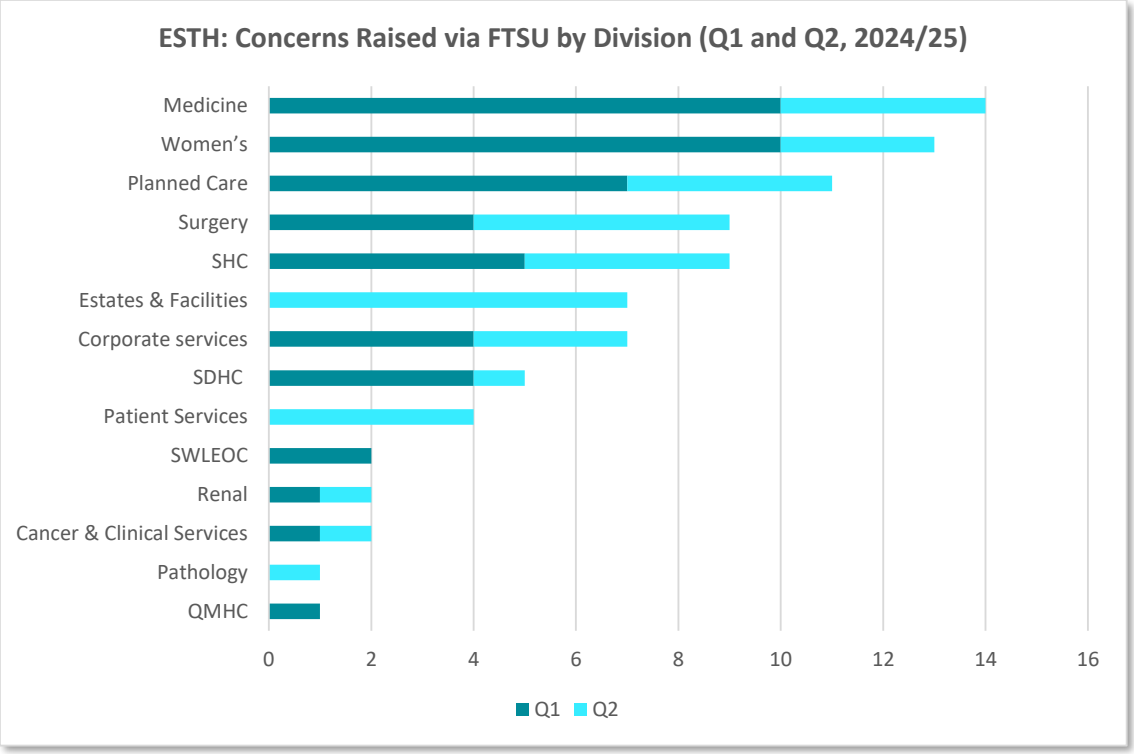
- E**states and Facilities** accounted for 8 concerns (10.25%).

- Staff from **Surgery, Neurosciences, Cancer, and Theatres (SNCT)** 6 concerns, (7.69%)

- **SWL Pathology** accounted for 2 concerns (2.56%).
- Staff from **Research and Development** raised 2 concerns (2.56%).
- There were 2 concerns in which the division was **unknown** (2.56%).

(e) Concerns raised by Division (ESTH)

3.9 The following chart shows the number of concerns raised by Division at ESTH over the past 2 quarters:



3.10 An analysis of concerns raised by directorate at ESTH shows that:

- **Medicine Directorate** staff raised the most concerns, a total of 14 concerns (10 in Q1 and 4 in Q2) out of a total of 87 across the Trust as a whole (16.09%).
- **Women's and Children's Directorate** staff raised the second highest number of concerns, with 13 out of a total of 87 concerns, 10 in Q1 and 3 in Q2 (14.94%).
- **Surgery Directorate** had 9 concerns raised, 4 in Q1 and 5 in Q2 (10.34%).
- Corporate Directorate staff raised a total of 7 concerns, 4 in Q1 and 3 in Q2 (8.04%) whilst **Estates and Facilities** equally has 7 concerns raised all in Q2 (8.04%).
- For the **Planned care Division**, a total of 11 concerns were raised (12.64%),
- **SWLEOC** staff raised 2 concerns (2.29%).

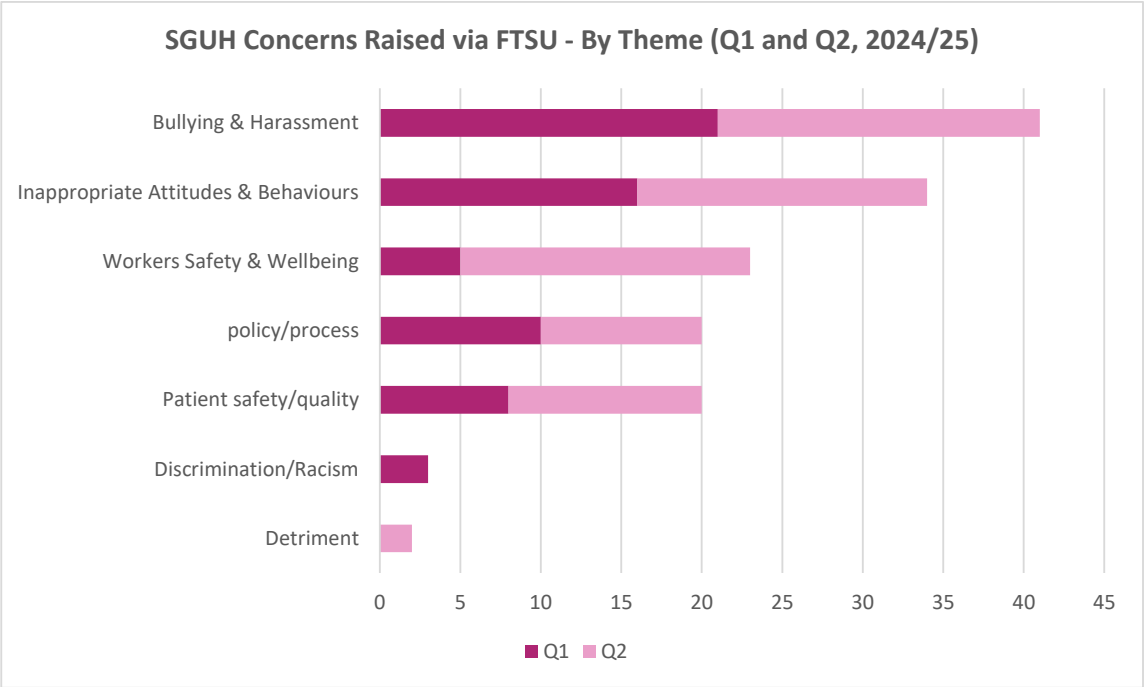
- Staff from **Renal, Cancer and Clinical Services Directorate** raised a total of 4 concerns out of 87 or (4.59%).
- Staff from **QMHC** raised 1 concern (1.14%). **Pathology** 1 (1.14%), **Patient services** amounts to 4 (4.59%).
- Across **Surrey Downs Health and Care** a total of 5 concerns (5.74%) and **Sutton Health and Care** 9 concerns (10.34%).

(f) <u>Themes in concerns raised with the Group FTSU Guardians in 2024/25 to date</u>

3.11 As well as analysing concerns raised by staff group and division, we also look at the types of concern being raised and the themes within these. Across the Group, the key themes in the concerns raised via FTSU in Q1 & Q2 2024/25 are:

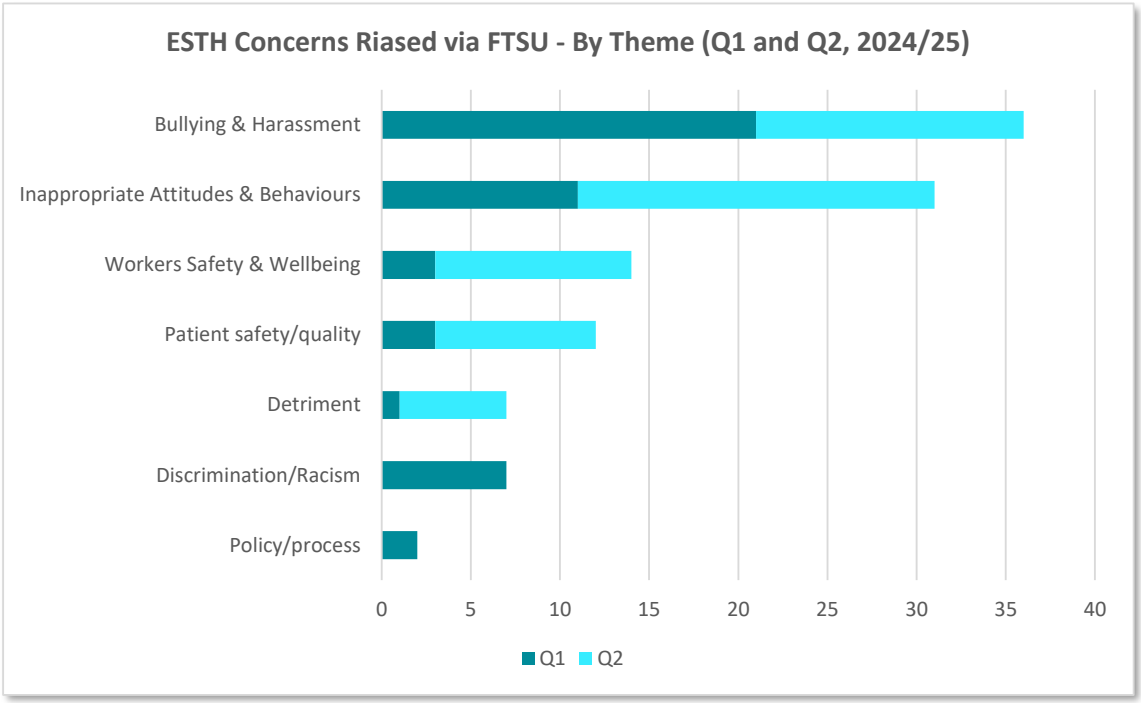
- Trust Systems / Processes
- Staff Safety
- Leadership
- Patient Safety/Quality
- Behavioural / relationship
- Discrimination
- Cultural
- Bullying and harassment
- Infrastructure / environment
- Fraud
- Management conduct
- Detriment

3.12 The charts below illustrate the themes of concerns raised during Q1 & Q2, 2024/25.



(a) Often, concerns raised to FTSU contain more than one theme. In relation to the themes of the 78 concerns raised across the first two quarters at SGUH, concerns around bullying and harassment (41) were a theme in 52.56% of all concerns raised to FTSU. Inappropriate attitudes & behaviour (34) were present in 43.58% of concerns raised. Worker safety (23) was a theme in 29.48% concerns, and patient safety (20) in 25.64%. Concerns around policy/process (20) were a theme in 29.48% of all concerns. Concerns regarding discrimination (3) were an issue in 3.84% of all concerns and detriment (2) a theme in 2.56% of concerns. It should be noted, in terms of the recording of themes, the theme of "patient safety concerns" includes both direct concerns about the safety of patients and concerns raised by workers relating to their wellbeing which the worker feels could impact their care of patients.

(b) In relation to the themes of the 87 concerns raised across the two quarters at ESTH, bullying and harassment (41) was a theme in almost half of all concerns (47.12%), inappropriate attitudes & behaviour (29 concerns - 33.33%); worker safety (21 concerns - 24.13%); patient safety & quality (15 concerns - 17.24%); policy/process (12 concerns - 13.79%); discrimination (7 concerns - 8.04%); and detriment (3 concerns - 3.44%).



Timely resolution of concerns

3.13 The vast majority of concerns raised with the FTSU Guardian are resolved informally and rapidly; concerns raised with the Guardian that are formally investigated are a very small proportion of the total number of concerns raised however the Guardian is seeing more multifaceted concerns which does have an impact on timely resolution. The Guardian continues to have concerns in relation to engagement of managers with FTSU across gesh where concerns are being dealt with at departmental level. Further, over 60% of concerns raised across gesh have already been raised within departments before staff have approached FTSU.

3.14 The Guardian is able to resolve a large number of concerns informally through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising the issue with the relevant team to enable prompt action to be taken to address the concern raised. The Guardian continues to work closely with HR colleagues, Staff Support, Organisational Development and is also a trust mediator so is also able to facilitate resolution of concerns through transparent conversations and negotiation.

3.15 The Guardian has seen improvements in unblocking some barriers since the inception of the Raising Concerns Oversight and Triangulation Group whereby more complex long-standing concerns are brought to this group and actions to enable resolution, or evidence to enable closure of cases are discussed. For example, the last meeting held on 14 November 2024 has facilitated the closing of a number of longstanding concerns.

3.16 The Guardian continues to have concerns relating to the link between concerns being raised and staff going on sick leave citing work related stress and the effect that long-standing cases have on staff wellbeing and productivity.

3.17 The Guardian continues to recommend the organisations urgently review processes and training of workers responsible for investigations surrounding timely resolution of concerns, together with how workers responsible for the concerns will be supported to ensure that the trusts abide by their own policies and good practice guidelines supplied by the National Guardian's Office and NHS England for all Departmental, HR and FTSU concerns. Concerns have been raised in relation to confidentiality especially within departments when concerns have been raised direct to management and confusion as to how the concern is to be addressed. The FTSU team is developing a Toolkit for Managers to support managers in dealing with responding to concerns raised by their staff. This will include practical advice, sources of support, key "dos" and "don'ts", and scenarios and anonymised worked examples.

3.18 The Guardian recommends the organisation pay particular attention to the issues and themes being raised by workers who are raising concerns through the Guardian, particularly those themes relating to trust processes not being followed which are on the increase, concerns pertaining to recruitment practices across gesh continue to rise together with concerns relating to partners/families working together and reporting to each other.

4.0 Speak Up, Listen Up, Follow Up Training

4.1 In late 2021 at SGUH, the Trust incorporated training on raising concerns into its MAST Training programme, meaning it is now a mandatory training module for all staff. It is important that all workers are given protected time to complete the required training to ensure that workers are aware of how to raise concerns and that managers are aware and confident in applying their responsibilities to concerns raised with them. Following a national directive that all organisations should offer all workers regular mandatory training on how to speak up safely, how to respond to concerns and how to learn and reflect from these concerns. All 3 parts of the required training have now been released.

4.3 As 28 November 2024, 92.2.% of staff at SGUH have completed their FTSU training. The FTSU Guardians regularly send reminders through communications and at all training, network meetings, nursing preceptorship training days, wards, and departments team training days. At ESTH, the training is not mandatory and data on current take-up of the optional training in speaking up is not available. However, as at June 2024 only 81 members of staff had completed the training at ESTH. While training alone will not be sufficient to equip staff and managers in raising and responding to concerns, low training levels mean concerns, and particularly complex concerns, are not always being appropriately addressed, with one of the

issues being understanding of Freedom to Speak Up. The Guardian recommends that the training is made mandatory at ESTH in line with current arrangements at SGUH.

MAST Topic Organisation Compliance - Freedom To Speak Up

Date Run: 28/11/2024

200 Children and Women's Diagnostic and Therapy Services Division				Amt. Completions	Required Training	Compliant
		Total:		3173	3333	95%
200 Corporate Division				Amt. Completions	Required Training	Compliant
		Total:		793	981	81%
200 Estates and Facilities Division				Amt. Completions	Required Training	Compliant
		Total:		350	366	96%
200 Medicine and Cardiovascular Division				Amt. Completions	Required Training	Compliant
		Total:		2297	2489	92%
200 Research & Development Division				Amt. Completions	Required Training	Compliant
		Total:		80	85	94%
200 Surgery & Neurosciences Division				Amt. Completions	Required Training	Compliant
		Total:		2013	2220	91%
200 SWL Pathology Division				Amt. Completions	Required Training	Compliant
		Total:		640	658	97%

				Amt. Completions	Required Training	Compliant (%)
Organisation Total:				9346	10132	92.2%

5.0 Resources within the FTSU Service

5.1 The gesh FTSU service has now been in place for six months. This is having a positive impact on the visibility and availability of the team across sites and enables staff to have more flexibility raising concerns.

5.2 The FTSU service continues to be approached by staff who have raised concerns through HR but feel that their concern is not progressing. Staff continue to report a perceived lack of engagement (i.e. slow or no response to emails) and timely resolution of concerns raised directly with HR at both sites. Many of these concerns pertain to grievances which have been raised but are progressing slowly for a variety of reasons. The impact of this is staff frustration and lack of trust in raising concerns/speaking up combined with increased sickness of staff who have raised grievances. Staff associate this with speaking up not being beneficial and increasing the risk of detriment.

5.3 As a new Group-wide service, the team has focused on standardising and strengthening its own internal processes to ensure these are robust and provide timely, impartial and confidential support to concern raisers. Both FTSU functions have previously had informal triage processes in place. However, we have formalised these informal triage processes within the team by developing a FTSU team triage process which sets out clear and consistent processes for the team to follow in receiving, acknowledging, logging, escalating and resolving concerns, as well as in how concern raisers are kept updated. This process also contains provisions for undertaking an initial assessment of the risk of the concern raiser encountering detriment for speaking up, and a process for checking in with concern raisers after six and 12

months following resolution of their concerns. The internal FTSU triage process is attached for information at Appendix 2.

6.0 Priorities for FTSU Service Going Forward

6.1 In terms of the priorities of the Group FTSU Service over the rest of the year and into 2025/26, we are focused on:

a) **Ensuring the timely resolution of concerns:** We are committed to working with managers at all levels to help ensure that concerns are resolved in a timely way. While the FTSU service itself cannot deliver improvements in timeliness of resolution, we are working with the Executive and Site leadership teams through the Raising Concerns Group to seek early resolution and to unblock issues.

b) **Aligning FTSU policies and processes across the Group:** We are keen to ensure that across the Group we develop a consistent policy and approach to managing and promoting FTSU which implements locally the new national FTSU policy. While there is limited scope to amend the policy overall, local variations – such as inserting timescales for resolution – the draft policy is attached at appendix 1 for approval.

c) **Developing a Toolkit for Managers in Speaking Up:** As referenced above, the confidence and awareness of managers in responding to concerns raised by their staff is a key area where the Trusts need to focus. To assist with this, we are developing a Toolkit to support managers, which will include advice, sources of support, and practical guides and worked examples.

d) **Implementing recommendations from the recent internal audit and Board reflection tool completed on 6 June 2024:** Recent reviews by both Trusts' internal auditors reached findings of "reasonable assurance" on the controls in place in relation to FTSU at both Trusts. No urgent recommendations were made, but the audits were helpful in highlighting certain control areas where further strengthening of our processes can be made. Furthermore, the completion of the Board reflection tool has assisted in clarity regarding ongoing priorities and this will help inform the development of a new strategy and plan for raising concerns across the Group.

e) **Group FTSU Vision and Strategy:** Having a group Vision and Strategy further assists in clarity of the function. The current SGUH vision and strategy remains broadly fit for purpose 4 years on from approval by the Board but would benefit from a refresh. ESTH has not historically had a Board approved FTSU vision and strategy place. As such, a Group FTSU Vision and Strategy is being developed, with an ambition to agree and launch this in early 2025.

7.0 Recommendations

7.1 The Group Board is asked to:

a) Note the number of concerns reported to the FTSU Guardians in Q1 and Q2 2024/25 for both SGUH and ESTH.
b) Note the themes emerging from FTSU cases in this period.
c) Note the recommendations of the Group FTSU Guardian as set out in section 3 of the report.
d) Note the priorities of the new Group FTSU service in the coming months.
e) Approve the draft Group-wide Freedom to Speak Up Policy, which implements the national FTSU policy for the NHS across the gesh Group.

Appendix 1: Draft Group FTSU Policy

Executive Summary

Both St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust currently have in place Trust-specific policies on Raising Concerns at Work. Both of these policies require review and updating, and have passed their review dates. In line with the Group's vision of aligning key policies and process to remove unwarranted variation, and following the formation of a Group-wide FTSU service earlier this year, there is a need to have a consistent Group-wide approach to FTSU and to codify this is a new Group-wide policy which reflects new national requirements and expectations.

NHS England has published a new national FTSU policy, which according to NHSE "provides the minimum standard for local freedom to speak up policies across the NHS, so those who work in the NHS know how to speak up and what will happen when they do". NHSE states that the new national policy "is designed to be inclusive and support resolution by managers wherever possible". NHSE requires all NHS organisations to adopt the new national policy, while providing some limited scope for adding in necessary local information as indicated in the model policy (see Appendix 1). Implementing the new national policy is also a key element of Domain 3 of the CQC Well Led Framework, which focuses on NHS organisations' FTSU arrangements.

The Group FTSU Guardian and Executive Lead for FTSU have reviewed the new national policy and a draft FTSU policy for the gesh Group has been developed (See Appendix 2). This very closely follows the national policy and sets out the local information required by the national policy. The draft policy was discussed and reviewed at the Raising Concerns Oversight and Triangulation Group meeting on 17 October 2024, and has been reviewed and endorsed by the three Site Leadership teams in November 2024, the Group Executive on 2 December 2024, and the People Committees-in-Common on 12 December 2024. The comments received related to indicative timelines for resolving concerns – agreement on setting indicative timescales for resolution to help provide clarity to concern raisers on what to expect when speaking up while recognising that complex concerns can take time to resolve.

The scope to diverge from the nationally-mandated policy is limited. The proposed variations to the national policy, discussed at the Raising Concerns Oversight and Triangulation Group, are highlighted in yellow in the attached draft policy. The key points to highlight in adopting the new policy are:

- Name of the policy: Currently, the SGUH and ESTH policies are known as the "Raising Concerns at Work Policy". The new national policy requires the policy to be known as the Freedom to Speak Up Policy. This is helpful as there are a number of other routes and policies locally for raising concerns at work (e.g. grievance policy, dignity at work policy etc.) and the name change helps to clarify that the new policy is about FTSU more widely.

- Timescales for resolution of concerns: The national policy simply states that concerns should be investigated and concluded "within a reasonable timescale" which the concern raiser will be notified of and that "we will tell you how long we expect an investigation to take". The national policy does not mandate specific timescales for investigating and resolving concerns. The National Guardian's Office for FTSU sets out that is it good practice for organisations to resolve FTSU concerns in a timely manner to mitigate risks to patients and staff.

  Timely resolution of concerns has been a challenge at both Trusts, and has been discussed previously by the People Committee and the Board. Resolving concerns in a timely way will

help build staff confidence in speaking up, as well as helping to address safety concerns and promoting wellbeing.

The current SGUH Raising Concerns at Work policy sets a general expectation that straightforward concerns are resolved within 4 weeks and more complex concerns within 12 weeks. This is not an absolute requirement, given that some investigations or interventions, especially those requiring external involvement, can take significantly longer. Having a guide on timeframes, however, does help establish expectations. The current ESTH policy does not contain any timescales.

A recent internal audit review at ESTH of the FTSU process recommended that specific timescales for investigating and responding to concern raisers is added to the policy, and the Trust agreed this with the auditors and with the Audit Committee.

The draft policy proposes the adoption of the 4 and 12 week timescales currently in the SGUH policy as a means of setting expectations and providing a guide to how long concern raisers can expect concerns to take to be addressed, but it is recognised that this is a guide rather than an absolute, and that in some cases it may not be possible to achieve these timescales, particularly for the most complex concerns or those requiring extensive external investigation.

- Detriment: The National Guardian's Office requires NHS organisations to establish processes to explore and investigate allegations from staff about encountering detriment for speaking up. This does not need to form part of the policy and the process for investigating concerns about detriment can sit alongside the policy. However, in contrast to the NGO guidance, the national policy is silent on the issue of detriment. We know that our staff do raise concerns about detriment. We consider that a high level statement setting out the fact that we will not tolerate staff suffering detriment for speaking up is an important policy commitment, even if the detail of the process for investigating allegations of detriment is dealt with separately.

- Training: The national policy states that staff are encouraged to complete the online training in FTSU. At SGUH, staff are required to complete FTSU training as part of the MAST programme, and over 9,000 staff at SGUH have completed this. At ESTH, FTSU training is not mandatory and only 80 staff have completed the training. The internal audit of FTSU at ESTH recommended, and the Trust agreed, to make FTSU training mandatory for all ESTH staff, reflecting the position at SGUH. MAST training requirements across the Group are currently being reviewed by the Executive team and this is expected to conclude in January 2025. Currently the draft FTSU policy necessarily reflects what are very different approaches to FTSU training across the two Trusts. Once a common MAST position has been agreed for the Group, the policy will be updated to reflect the outcome of this.

Freedom to Speak Up Policy

Policy Summary	
Policy Number	GESH/POL/XXXX
Version	1.0
Policy Type	Corporate
Ownership	
Lead Executive Director	Group Chief Corporate Affairs Officer
Lead Author(s)	Group Freedom to Speak Up Guardian
Scope and application	
Applies to *(delete as appropriate)*	Group-wide – All Staff
Approval	
Approving Body	Group Board
Date Approved	TBC
Next Review Date	TBC

Contents

Policy Gateway

Please complete the checklist and tables below to provide assurance around the policy review process.

☒ I have involved everyone who should be consulted about this policy/guidance ☒ I have identified the target audience for this policy/guidance ☒ I have completed the correct template fully and properly ☒ I have identified the correct approval route for this policy/guidance ☒ I have saved a word version of this policy/guidance for future reviews and reference

Please set out what makes you an appropriate person to conduct this review:
Freedom to Speak Up Guardian

Please set out the legislation, guidance and best practice you consulted for this review:
Freedom to Speak Up Policy for the NHS National Guardians Office - Learning from Case Reviews - December 2021

Please identify the key people involved:
In developing the original policy: Freedom to Speak Up Guardian STG, Group Chief Corporate Affairs Officer

Summarise the key changes you have made and why:

Executive Summary

To be completed following engagement on the text.

1. Introduction

Freedom to Speak Up principles encourage and support all staff in raising concerns at the earliest opportunity about safety, malpractice or wrongdoing at work, responding to and where necessary, investigating the concerns raised. The St George's, Epsom and St Helier University Hospitals and Health Group ("gesh", "the Group") is committed to encouraging a culture of openness whereby staff are able to raise any concerns that may be affecting their work and wellbeing or the safety and wellbeing of patients and service users. The Group is committed to promoting a culture in which staff are supported and feel psychologically safe to raise concerns and do not encounter detriment for speaking up.

2. Key Audience

This policy applies to all individuals working for gesh including those working on alternate sites, those individuals providing services through an agency or contractor working primarily for another organisation including students and volunteers.

3. Speak up – we will listen

We welcome speaking up and we will listen. By speaking up at work, you will be playing a vital role in helping us to keep improving our services for all patients and the working environment for our staff.

This policy is for all our workers. The NHS People Promise commits to ensuring that "we each have a voice that counts, that we all feel safe and confident to speak up, and take the time to really listen to understand the hopes and fears that lie behind the words".

We want to hear about any concerns you have, whichever part of the organisation you work in. We know some groups in our workforce feel they are seldom heard or are reluctant to speak up. You could be an agency worker, bank worker, locum, volunteer or student. We also know that workers with disabilities or from a minority ethnic background or the LGBTQIA+ community do not always feel able to speak up. This policy is for all workers and we want to hear all our workers' concerns.

We ask all our workers to complete the online training on speaking up:

- For staff at St George's, this training is mandatory as part of the St George's Mandatory and Statutory Training programme, and is accessible via the Trust's iLearn platform on the SGUH intranet (Course: Freedom To Speak Up (stgeorges.nhs.uk)).
- For staff at Epsom and St Helier, this training is currently not mandatory but staff are strongly encouraged to complete the training, which is accessible via the ESTH intranet at: https://elearning.epsom-sthelier.nhs.uk/course/view.php?id=821

The online module on listening up is specifically for managers to complete and the module on following up is for senior leaders to complete.

4. This policy

All NHS organisations and others providing NHS healthcare services in primary and secondary care in England are required to adopt this national policy as a minimum standard to help normalise speaking up for the benefit of patients and workers. Its aim is to ensure all matters raised are captured and considered appropriately.

5. What can I speak up about?

You can speak up about anything that gets in the way of patient care or affects your working life.

Speaking up is about all of these things.

Speaking up, therefore, captures a range of issues, some of which may be appropriate for other existing processes (for example, HR or patient safety/quality). As an organisation, we will listen and work with you to identify the most appropriate way of responding to the issue you raise.

6. We want you to feel safe to speak up

Your speaking up to us is a gift because it helps us identify opportunities for improvement that we might not otherwise know about.

We will not tolerate anyone being prevented or deterred from speaking up or being mistreated because they have spoken up.

7. Who can speak up?

Anyone who works in NHS healthcare, including pharmacy, optometry and dentistry. This encompasses any healthcare professionals, non-clinical workers, receptionists, directors, managers, contractors, volunteers, students, trainees, junior doctors, locum, bank and agency workers, and former workers.

8. Who can I speak up to?

8.1 Speaking up internally

Most speaking up happens through conversations with supervisors and line managers where challenges are raised and resolved quickly. We strive for a culture where that is normal, everyday practice and encourage you to explore this option – it may well be the easiest and simplest way of resolving matters.

However, you have other options in terms of who you can speak up to, depending on what feels most appropriate to you:

- Senior manager, or director with responsibility for the subject matter you are speaking up about.

- Our HR team:

  - ESTH HR Services – esth.askhr@nhs.net
  - SGUH HR Services – MyHRAdvice@stgeorges.nhs.uk

- Our Freedom to Speak Up Guardians – gesh.ftsu@stgeorges.nhs.uk
  The Freedom to Speak Up Guardians can support you to speak up if you feel unable to do so by other routes. The Guardians will ensure that people who speak up are thanked for doing so, that the issues they raise are responded to and that the person speaking up receives feedback on the actions taken. You can find out more about the Guardian role here

- Local counter fraud teams (where concerns relate to fraud), which are operated independently by RSM UK Ltd: tina.jones@rsmuk.com or heather.greenhow@rsmuk.com

- Our Executive Lead responsible for Freedom to Speak Up, Stephen Jones Group Chief Corporate Affairs Officer. Email: Stephen.Jones@stgeorges.nhs.uk.
  The Executive Lead provides support for our Freedom to Speak Up Guardian, and is responsible for reviewing the effectiveness of our FTSU arrangements.

- Our non-executive director responsible for Freedom to Speak Up. The Non-Executive Director provides support and advice to the FTSU Guardian and oversees speaking up matters regarding Board members:
  - The NED FTSU lead at SGUH is: Chiew Yin Jones
  - The NED FTSU lead at ESTH is: Martin Kirke.

  To contact the non-executive lead for FTSU, please email: gesh.nedftsu@stgeorges.nhs.uk.

8.2 Speaking up externally

If you do not want to speak up to someone within the organisation, you can speak up externally to:

- Care Quality Commission (CQC) for quality and safety concerns about the services it regulates – you can find out more about how the CQC handles concerns here.

- NHS England for concerns about:

  - GP surgeries

  - dental practices

  - optometrists – pharmacies

  - how NHS trusts and foundation trusts are being run (this includes ambulance trusts and community and mental health trusts)

  - NHS procurement and patient choice

- the national tariff

NHS England may decide to investigate your concern themselves, ask your employer or another appropriate organisation to investigate (usually with their oversight) and/or use the information you provide to inform their oversight of the relevant organisation. The precise action they take will depend on the nature of your concern and how it relates to their various roles.

Please note that neither the Care Quality Commission nor NHS England can get involved in individual employment matters, such as a concern from an individual about feeling bullied.

• NHS Counter Fraud Authority for concerns about fraud and corruption, using their online reporting form or calling their freephone line 0800 028 4060.

If you would like to speak up about the conduct of a member of staff, you can do this by contacting the relevant professional body such as the General Medical Council , The Nursing Midwifery & Council , Health & Care Professions Council , General Dental Council , General Optical Council or General Pharmaceutical Council

Appendix C contains information about making a 'protected disclosure'.

9.0 How should I speak up?

You can speak up to any of the people or organisations listed above in person, by phone or in writing (including email).

Confidentiality

The most important aspect of your speaking up is the information you can provide, not your identity. You have a choice about how you speak up:

- **Openly:** you are happy that the person you speak up to knows your identity and that they can share this with anyone else involved in responding.
- **Confidentially:** you are happy to reveal your identity to the person you choose to speak up to on the condition that they will not share this without your consent.
- **Anonymously:** you do not want to reveal your identity to anyone. This can make it difficult for others to ask you for further information about the matter and may make it more complicated to act to resolve the issue. It also means that you might not be able to access any extra support you need and receive any feedback on the outcome.

In all circumstances, please be ready to explain as fully as you can the information and circumstances that prompted you to speak up.

Internal Advice and Support

You can gain support relating to your wellbeing from Staff Support:

- ESTH Staff: esth.staffcounselling@nhs.net

- SGUH Staff: You can contact Staff Support at: staffsupport@stgeorges.nhs.uk.

You can also make a self-referral to occupational health via email:

- ESTH Staff: esth.occhealth@nhs.net
- SGUH Staff: OH.admin@stgeorges.nhs.uk

You can find out more about the local support available to you on the intranet of the two Trusts:

- ESTH Intranet Page
- SGUH Intranet page

External Advice and support

You can access a range of health and wellbeing support via NHS England NHS England » Freedom to Speak Up

- Support available for our NHS people.
- Looking after you: confidential coaching and support for the primary care workforce.

NHS England has a Speak Up Support Scheme that you can apply to for support.

You can also contact the following organisations:

- Speak Up Direct provides free, independent, confidential advice on the speaking up process Speakup Direct
- The charity Protect provides confidential and legal advice on speaking up Protect
- The Trades Union Congress provides information on how to join a trade union TUC: Trades Union Congress
- The Law Society may be able to point you to other sources of advice and support The Law Society
- The Advisory, Conciliation and Arbitration Service gives advice and assistance, including on early conciliation regarding employment disputes ACAS

10.0 What will we do?

The matter you are speaking up about may be best considered under a specific existing policy/process; for example, our process for dealing with bullying and harassment. If so, we will discuss that with you. If you speak up about something that does not fall into an HR or patient safety incident process, this policy ensures that the matter is still addressed.

What you can expect to happen after speaking up is shown in **Appendix A**.

10.1 Resolution and investigation

We support our managers/supervisors to listen to the issue you raise and take action to resolve it wherever possible. In most cases, it's important that this opportunity is fully explored, which may be with facilitated conversations and/or mediation.

Where an investigation is needed, this will be objective and conducted by someone who is suitably independent (this might be someone outside of the organisation or from a different part of the organisation) and trained in investigations. You will be informed of the person assigned to investigate your concerns and will have the opportunity to discuss any potential conflicts of interest relating to the investigating officer with the commissioning manager or the FTSU Guardian before the start of the investigation. In line with national guidance, staff who speak up will have the opportunity to input into the terms of reference for any investigations held into the concerns they have raised. An investigation will reach a conclusion within a reasonable timescale (which we will notify you of), and a report will be produced that identifies any issues to prevent problems recurring.

Any employment issues that have implications for you/your capability or conduct identified during the investigation will be considered separately.

In the event that your concern would be more appropriately managed through another established process, such as an existing HR process, you will be advised of and signposted to this. You will be supported by the guardian to escalate your case to HR who will follow the necessary HR process and timescales.

10.2 Timescales

We aim to ensure that concerns are explored and resolved in a timely manner. This helps to ensure that concerns are dealt with and any resulting actions and learning can be acted on promptly. Timely resolution also builds the confidence of our staff in the fairness and robustness of our speak up processes.

The timescales for resolving concerns will depend on a number of factors, including the complexity of the concerns raised and whether an external investigation is required. However, as a guide, we aim for all concerns raised internally (whether to a manager, senior leader of FTSU Guardian) to be resolved within 4 weeks, or within a maximum of 12 weeks for more complex concerns. Where a concern requires external investigation, or another form of external review (such as an appreciative inquiry or a review by a professional or regulatory body), it may take longer to resolve. You will be kept updated by the person you have raised your concerns with as to how your concerns are being addressed and expected timescales for exploring and resolving your concerns. Upon resolution of your concern, you will receive written feedback from the organisation. Where concerns are raised via the Freedom to Speak Up Guardian, the Guardian will follow-up with you six months after the resolution of your concern to see whether any agreed actions in response to your concerns have been implemented and your concerns have been resolved.

10.3 Communicating with you

We will treat you with respect at all times and will thank you for speaking up. We will discuss the issues with you to ensure we understand exactly what you are worried

about. If we decide to investigate we will tell you how long we expect the investigation to take and agree with you how you wish us to keep you up to date with its progress. Wherever possible, we will share the full investigation report with you (while respecting the confidentiality of others and recognising that some matters may be strictly confidential; as such it may be that we cannot even share the outcome with you).

10.4 How we learn from your speaking up

We want speaking up to improve the services we provide for patients and the environment our staff work in. Where it identifies improvements that can be made, we will ensure necessary changes are made, and are working effectively. Lessons will be shared with teams across the organisation, or more widely, as appropriate.

10.5 Review

We will seek feedback from workers about their experience of speaking up. We will review the effectiveness of this policy and our local process annually, with the outcome published and changes made as appropriate.

10.6 Detriment

Staff should be able to speak up about concerns or make improvement suggestions without experiencing disadvantageous and/or demeaning treatment (often referred to as ‘detriment’). Staff who experience detriment, witness or hear about it happening to others, may hesitate to speak up in the future. Such treatment has a negative impact on staff and potentially on the services that they provide to patients and service users.

Detriment for speaking up will not be tolerated. Action will be taken to prevent detriment occurring and staff who feel that they have come to a detriment after speaking up are encouraged to report this to the Freedom to Speak Up Guardian.

When a concern is raised, the risks of detriment will be assessed and actions will be taken to mitigate these risks. The risk of detriment will continue to be monitored on an ongoing basis until the concerns are resolved.

Cases of alleged detriment will be investigated when they are reported. Investigations into the alleged conduct of staff who have previously spoken up should also seek to identify whether the allegations about the member of staff are motivated by a desire to cause them detriment because they have spoken up. If evidence of detriment is found, appropriate action will be taken.

10.7 Senior leaders’ oversight

Our most senior leaders will receive a report at least twice a year providing a high level thematic overview of speaking up by our staff to our FTSU Guardians.

In addition, the Group's Raising Concerns Oversight and Triangulation Group, chaired at Executive level, oversees the timeliness of processes to investigate, resolve and learn from concerns, and the robustness of the Group's speaking up systems and processes.

12.0 Dissemination and implementation

12.1 Dissemination

This policy is made available to staff via the intranet of the two Trusts and awareness of the available services is raised through line managers and communications department. The Group Freedom to Speak Up Service provides regular drop-in sessions, attends Corporate Induction and all staff briefings in order to raise awareness of speaking up.

12.2 Implementation

Trend information, themes and key learnings are reported by the FTSU Guardian and Executive Lead for FTSU to the Raising Concerns Oversight and Triangulation Group, the Group Executive, and the People Committees-in-Common. The Audit Committees-in-Common oversees the robustness of the Group's arrangements to support staff to speak up.

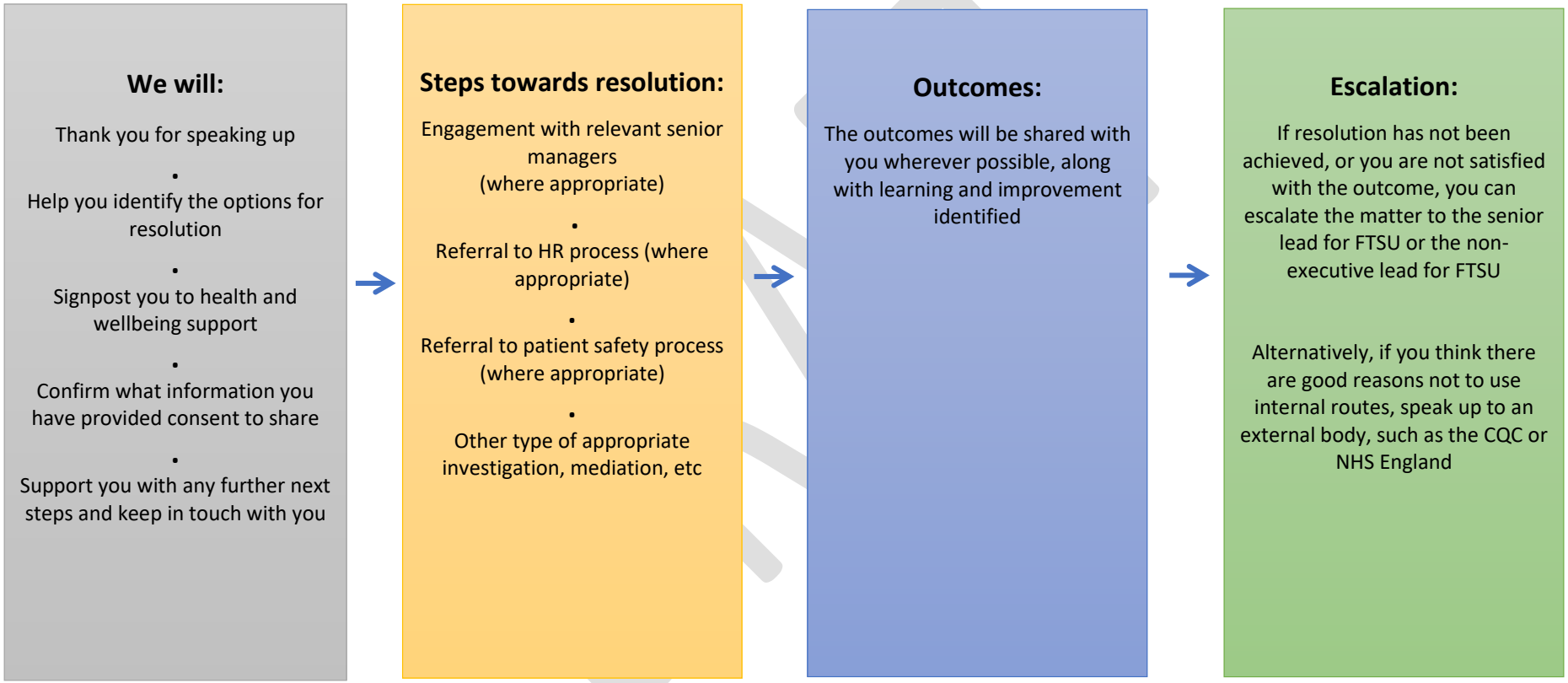
We will review the effectiveness of this policy and local process regularly, with the outcome published and changes made as appropriate.

12.3 Monitoring compliance

The Group Board will be given high level information about all concerns raised through this policy and what we are doing to address any issues. We will include similar high-level information in our annual reports.

APPENDIX A:

What will happen when I speak up?



APPENDIX B:

Making a protected disclosure

Making a 'protected disclosure'

A protected disclosure is defined in the Public Interest Disclosure Act 1998. This legislation allows certain categories of worker to lodge a claim for compensation with an employment tribunal if they suffer as a result of speaking up. The legislation is complex and to qualify for protection under it, very specific criteria must be met in relation to who is speaking up, about what and to whom. To help you consider whether you might meet these criteria, please seek independent advice from Protect or a legal representative.

You can contact them on: 0203 117 2520 or by emailing or clicking: whistle@pcaw.org.uk

Concerns Raised to the Group Freedom to Speak Up Guardian Service:

Triage and Case Management Process

1. Introduction

This document sets out the process for handling concerns raised to the Group Freedom to Speak Up (FTSU) Guardian by staff at the St George's, Epsom and St Helier University Hospitals and Health Group. The process is intended to ensure timely, fair and consistent handling of concerns, and transparency in how concerns will be managed and escalated, particularly where those concerns relate to patient or staff safety.

2. Objectives

The objectives of this triage process are to:

i. Provide a clear, consistent and structured framework for the initial handling of all concerns raised to the Group Freedom to Speak Up Service
ii. Ensure all concerns are treated appropriately and fairly
iii. Facilitate timely and appropriate resolution, escalating concerns where necessary
iv. Help promote a culture in which staff feel psychologically safe and supported to raise concerns
v. Support organisational learning from concerns raised via Freedom to Speak Up

3. Scope

This triage process applies to all concerns raised by staff to the Group Freedom to Speak Up Service.

4. Triage Process

4.1 Receipt of Concern

a) <u>Step 1: Initial Contact:</u>

- Concerns can be raised via email, phone, face-to-face meetings, or the FTSU portal on the intranets of the two Trusts.

- Details of the concerns raised, key data about the concern raiser (staff group, location, department, protected characteristics, date raised, contact information) will be logged using the FTSU contact form on the confidential FTSU database, which is accessible only to members of the FTSU Service.

b) Step 2: Acknowledgement of Receipt

- All concerns raised via email will be acknowledged within 24 hours of receipt and an appointment offered to speak/meet with the concern raiser as necessary to discuss further to gain further clarity/agree next steps.

c) Step 3: Confidentiality Assurance

- The concern raiser will be reassured that their identity will be protected, where possible, in line with the Freedom to Speak Up Policy.

- The circumstances in which it may be necessary to breach confidentiality (e.g. where there is a risk of harm to patients, staff or others, or where there is a legal obligations to disclose information) will be explained to the concern raiser.

d) Step 4: Case Management

- A unique case identification number will be assigned to the concern to facilitate tracking and monitoring.

- A member of the FTSU team will be assigned as the lead for the concern, typically a Deputy FTSU Guardian. The lead will be responsible for liaising with the concern raiser, logging updates on the FTSU case management system, and escalating issues in line with this process.

4.2 Initial Assessment

a) Step 1: Gather Basic Information

Identify key details, including:

- the nature of the concern
- whether the concern relates to patient safety, staff safety or wellbeing, or to issues relevant to wider team or organisational culture
- whether there is any immediate risk to patient or staff safety
- the key individuals, teams and / or departments involved

b) Step 2: Categorise the concern

Classify the concern into one of the following categories:

- “Category 1 – Urgent”: Immediate risk to patient or staff safety requiring urgent action and / or intervention.

- “Category 2 – Serious”: Significant issues requiring – or likely to require – formal investigation. This includes concerns regarding patient and staff safety where there is no immediate risk of harm to patients, staff or others.

- "Category 3 – Standard": Concerns that can be resolved through informal processes, signposting to the appropriate HR or other process, or by providing advice / support.

c) Step 3: Risk Assessment

Proactively identify the risks of detriment associated with raising the concern by:

- Evaluating the concern raiser's workplace context, including relationships with colleagues and managers, sensitivity of the concern, and history of similar issues, drawing on advice from HR where appropriate
- identifying potential risks, such as exclusion, hostility, or changes to workload or duties.
- Document findings and identify immediate mitigation steps, such as enhanced confidentiality or monitoring team dynamics.

d) Step 4: Consultation with relevant teams

Where appropriate, the FTSU Service will liaise with relevant teams (e.g. Patient Safety, Human Resources, or with relevant managers) to assess the severity and scope of the concerns.

4.3 Escalation and referral

a) Category 1: Urgent

For concerns categorised as Category 1 – Urgent (immediate risk to patient or staff safety), the FTSU Service will:

- Escalate immediately to the appropriate senior leader (e.g. Divisional triumvirate, Site Chief Medical Officer, Site Chief Nursing Officer) for action
- If case is received by a Deputy FTSU Guardian, Category 1 concerns must be notified the Group FTSU Guardian and the FTSU Executive Lead
- Ensure immediate patient or staff safety measures taken are logged.
- Confirm by sending file opening and escalation email to the concern raiser that concern has been escalated (including the name of the person/team it has been escalated to) together with confirmation of frequency of updates (4 weekly updates at a minimum, but depends on the nature of the concern).
- Provide regular updates to concern raiser
- Category 1 concerns are to be added to the concern tracker for the Raising Concerns Oversight and Triangulation Group

b) Category 2: Serious

For concerns categorised as Category 2 – Serious (requiring or likely to require formal investigation but no immediate risk), the FTSU Service will:

- Escalate the concern to the relevant senior manager (e.g. General Manager, Head of Service), who will be responsible for commissioning an investigation
- Ensure the relevant investigation team (e.g. Patient Safety / Quality team, HR) is engaged

- If case is received by a Deputy FTSU Guardian, Category 1 concerns must be notified the Group FTSU Guardian
- Confirm by sending file opening and escalation email to the concern raiser that concern has been escalated (including the name of the person/team it has been escalated to) together with confirmation of frequency of updates (4 weekly updates at a minimum, but depends on the nature of the concern).
- Ensure the concern raiser has an opportunity to input into the terms of reference for any investigation, in line with guidance from the National Guardian's Office
- Provide regular updates to concern raiser
- Notify the Executive Lead for FTSU and include in tracker for the Raising Concerns Oversight and Triangulation Group

c) Category 3: Routine

For concerns categorised as Category 3 – Routine (concerns that can be resolved informally or through advice / support), the FTSU Service will:

- Confirm by sending file opening and escalation email to the concern raiser that concern has been escalated (including the name of the person/team it has been escalated to) together with confirmation of frequency of updates (4 weekly updates at a minimum, but depends on the nature of the concern).
- Address the concern through informal channels, such as discussions with line managers or by recommending mediation, where appropriate
- Provide advice, support or signposting to the process or support service

4.4 Action and Monitoring

a) Clarify actions and / or advice

- For Categories 1 and 2 concerns, develop an action plan outlining:
  - Steps to be taken (by the FTSU Service and by the person to whom the concerns have been escalated)
  - Responsible individuals and / or teams
  - Timelines for resolution
  - Log relevant correspondence on the FTSU case management system
- For Category 3 concerns, log relevant correspondence and summary of advice or signposting provided on the FTSU case management system

b) Regular Updates

- Provide the concern raiser with regular updates at agreed intervals, to help ensure transparency and trust in the process

c) Monitor Progress

- Use the FTSU case management system to monitor progress
- Escalate the concern where agreed timescales will not be met
- Conduct regular check-ins with the concern raiser to consider their well-being and any emerging risks of detriment

4.5 Escalation to Group FTSU Guardian and Executive Lead for FTSU

a) Escalation to the Group FTSU Guardian
- Concerns being managed by the Deputy Guardians that have not been resolved by week 8 after escalation to the appropriate manager/department for response should be escalated to the Group FTSU Guardian who will oversee the management of the case. These cases will also be placed within the report for the Raising Concerns Oversight and Triangulation Group.

b) Escalation to the Executive Lead for FTSU
- Concerns that have not been resolved by week 12 will be flagged to the executive lead by the Group FTSU Guardian and agreement as to next steps will be discussed and agreed.

4.6 Resolution and Feedback

a) Final resolution
- Confirm with the identified manager the resolution of the concern, and ensure receipt of confirmation of the actions taken to address the concern, the remaining actions being taken, and any organisational learning identified. This should include completion by the manager of the case closure template to ensure the FTSU team has sufficient evidence and information to be able to appropriately close a case as resolved for the purposes of FTSU.
- Record the outcome / resolution in the FTSU case management system.

b) Feedback to individuals
- Thank the concern raiser for speaking up
- Provide feedback to the concern raiser about the resolution of the concern, outlining a summary of:
  - the actions taken in response to the concern
  - the outcome of any investigation (where relevant)
  - any organisational learning or changes resulting from their concerns
- Discuss with the concern raiser any concerns regarding detriment
- Request the concern raiser completes an anonymised FTSU feedback form, providing details of their experiences of speaking up and any areas where the FTSU Service or organisation could learn and improve.

c) Learning, sharing and communication
- Ensure that lessons learnt from the concerns are identified
- Ensure that any organisational learning from the concerns is shared appropriately (e.g. through staff briefings, team meetings, or updates to policies)
- Maintain anonymity in shared learning unless the concern raiser consents to their identify being shared

4.6 Follow Up

a) Follow-up to Category 1 and 2 concerns:

- For Category 1 and 2 concerns, the FTSU Service will follow-up with concern raisers six months after resolution to ensure that appropriate actions have been taken and that the concerns are not outstanding.
- Where concerns persist, the FTSU will escalate these with the responsible manager.

b) Follow-up for Category 3 concerns:

- For Category 3, the FTSU Service will follow-up with concern raisers one year after resolution to ensure that appropriate actions have been taken and that the concerns are not outstanding.
- Where concerns persist, the FTSU will escalate these with the responsible manager.

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

Group Board

Meeting in Public on Thursday, 09 January 2025

Agenda Item	3.7
Report Title	**Group Maternity Services Quality Report** **September and October 2024 data**
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer and Director of Infection Prevention and Control
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Jan Bradley, Director of Midwifery and Gynaecology Nursing, SGUH Emily Kaliwoh, Lead Midwife for Governance, SGUH Annabelle Keegan, Director of Midwifery and Gynaecology Nursing, ESTH Laura Rowe, Lead Midwife for Clinical Governance and Assurance, ESTH
Previously considered by	ESTH Women and Children's Divisional Management Team ESTH Senior Leadership Team
Purpose	**For Assurance**

Executive Summary

The Group Board is receiving this report as it is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM) (December 2020) that specified monthly indicators, maternity metrics and information to monitor maternity and neonatal safety, is discussed by the Group Board (or a designated sub-committee of the Group Board) at every meeting.

This report provides Perinatal Quality Surveillance Model data for September and October 2024 and an update on the CNST compliance status for both trusts as well as progress against the outstanding. MUST and SHOULD Do actions issued by the CQC 2023 Maternity inspections across gesh maternity services.

Action required by Group Board

The Group is asked to:

a. Discuss and make recommendations for further reports.
b. Support the recommendation for the Executive and Non-Executive Safety Champions to review the CNST evidence and the September and October 2024 data, to provide assurance to the Board that all requirements have been met.

c. Consider the evidence for CNST and delegate the sign off of the Board declaration of compliance against the CNST MIS year 6 Safety Actions to the Chair of the Quality Committee in Common
d. Give an assurance rating.

Appendices	
Appendix No.	**Maternity**
Appendix 1	ESTH Perinatal Quality Surveillance Model
Appendix 1a	SGUH Perinatal Quality Surveillance Model
Appendix 2	ESTH CNST compliance status
Appendix 2a	SGUH CNST compliance status
Appendix 3	READING ROOM – ESTH and SGUH CQC MUST and SHOULD Dos
Appendix 4	READING ROOM – SGUH NHS Resolution Thematic Review

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

SGUH & ESTH: We expect to declare full compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6, which would result in a at least a 10% rebate of Trust Contribution.

Legal and /or Regulatory implications

There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC 2023 Maternity inspections across gesh maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

Within the maternity Service, the issue around the midwifery manager on-call arrangements that contravene the Working Time Regulations 1998/AFC remains unresolved.

Equality, diversity and inclusion implications

The Lead Midwife for Transformation continues to undertake Focus Group with women from the Global Majority to understand their experiences, and influence service development.

Environmental sustainability implications
Please see the risk register in the Perinatal Quality Surveillance Model report. There are several environmental issues which have an impact on service development and business continuity across gesh.

Group Maternity Services Quality Report

Group Board, 09 January 2025

1.0 Purpose of paper

1.1 It is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (December 2020) that specified monthly indicators, 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 and therefore the Perinatal Quality Surveillance Model data has been included on a separate slide deck (ESTH Appendix 1 and SGH Appendix 1a).

1.2 The report seeks to inform the Group Board of significant changes, emerging safety concerns, new risks, and successes within the SGUH and ESTH Maternity Services. The report will also include an update on compliance with the year 6 Clinical Negligence Scheme for Trusts (CNST), Maternity Incentive Scheme (MIS) as appendices, (2 ESTH and 2a SGUH).

The Group Board is requested to delegate review of the evidence to the Board Maternity Safety Champions who will then provide assurance to the Board in order for the Board declaration of compliance against the CNST year 6 safety actions to be signed off for submission on 3rd Match 2025.

2.0 Context and Overview

2.1 The report data covers the position as of September and October 2024.

The Report Includes:

- The nationally mandated Perinatal Quality Surveillance data (Appendices 1 and 1a)
- CNST Maternity Incentive Scheme year 6 compliance status (appendices 2 and 2a)
- The Board Report generated from the Perinatal Quality Surveillance Tool (Appendix 3)
- Trend data over 15 months in relation to outcomes for women and babies (dashboard data)
- Findings of any external reviews, including MBRRACE-UK, CQC, Staff Survey, etc.
- The status of the current risk register
- Key risks/emerging concerns

3.0 Context and overview

3.1 Perinatal Quality Surveillance data

ESTH and SGUH: Trend data has shown that our outcomes have either remained stable or improved over the last 15 months, as demonstrated in the 'outcomes dashboard' appendices 1 and 1a, slide 3.

ESTH: In October, there were six cases of moderate harm which is more than is usually reported (1-2). These have now either been reviewed or undergoing a review to identify learning and the learning response required, appendix 1 slide 7.

Investigations **–** long term sickness absence in the risk team has led to there being 14 open investigations. However, these are now progressing through the appropriate route, (appendix 1 slide 8).

SGUH: Five obstetric doctors at trainee and staff grade level are non-compliant with PROMPT. These doctors started in October 2024 and have been booked to attend PROMPT training in December and January 2025, which will ensure compliance is met for year 6 of the maternity incentive scheme (appendix 1a slide 13).

Fill rate: in September, the fill rate was challenging for registered staff, e.g., Carmen was at 83% and 69% for day and night shift respectively, which is below the target of 90%. However, an improvement was seen across all areas in October, with the lowest fill rate of 81% seen in Delivery Suite. Meeting optimum staffing for triage (2 midwives + 1 MSW) during the day continues to be well below target of 100%. However, triage is staffed with 1midwife and 1maternity support worker 100% of the time.

4.0 Key issues for consideration

4.1 Clinical Negligence Scheme for Trusts, Year 6 Maternity Incentive Scheme

The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) has 89 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS reporting 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.

Several specific MIS Safety Actions, i.e. safety actions 1, 3, 4, 7, 8 and 9 must additionally be reviewed by and discussed with the Executive and Non-Executive Safety Champions, for them to be able to provide assurance to the Group Board these actions are compliant with CNST requirements. During the MIS reporting period, these actions have been discussed at meetings such as the Bi-monthly Neonatal and Maternity SLT meeting, co-chaired by the Executive Safety Champion and the Group Chief Midwifery Officer) and the bi-monthly Maternity Triangulation meeting chaired by the Executive Safety Champion and attended by the Non- Executive Safety Champion. A final review of the safety actions by the Executive and Non-Executive Safety Champions will be undertaken on 8 January 2025 for final confirmation of compliance.

In line with the required assurance process, meetings have been scheduled with SWL ICB quality leads and the System Director of Midwifery to review and sign off the evidence for MIS year 6.

The Group Board is requested to delegate review of the evidence to the Board Maternity Safety Champions who will then provide assurance to the Board in order for the Board declaration of compliance against the CNST year 6 safety actions to be signed off for submission on 3rd Match 2025.

4.2 Care Quality Commission (CQC) inspection

2023 CQC inspection, Governance and Oversight:
An Evidence Assurance Panel was established with the first of monthly meetings commencing in July 2024. The EAP reviews the action plans and progress of the MUST and SHOULD DO actions from the CQC report of August 2023 (SGUH) and February 2024 (ESTH). The panel evaluates impact of the actions and ensures improvements made are sustainable. The EAP reports progress to the gesh Quality Group and the Quality Committees in Common.

ESTH: Out of **15 total actions** (9 "Must Do" and 6 "Should Do"), 9 actions are completed (Green), and 6 actions remain in progress (Amber).
SGUH: of **21 total actions** (15 ''Must Do'' and 6 ''Should Do''), 16 actions are completed (Green), 5 actions remain in progress (4 Amber and 1 Red)

Both Trusts are projecting full completion of all actions by 31 March 2025, except for the longstanding estate/ premises issues at ESTH ''MUST DO Action 2'' which will resolve with the new hospital build programme.

2024 CQC inspection - SGUH:
There was an unannounced CQC inspection of the SGH maternity service on 16 and 17 October 2024. The inspection team provided high level feedback at the end of day 2, and a written post inspection feedback dated 31 October 2024. The feedback letter highlighted some positive findings, e.g., good MDT working, high standard bereavement suite and documentation, visibility and support of leadership, positive feedback from women and a robust HDU service. Areas for improvement related to knowledge around ligature risk and risk assessments, management of medicines, gaps in daily check of fridge temperatures, medical cover overnight, fetal monitoring and telephone helpline out of hours.

Work is already underway to address the areas for improvement, e.g., a medicines audit and check of all emergency equipment has taken place in all clinical areas and the results shared with staff. The audit found expired medication (one month out of date) were present in all clinical areas, which indicates that a more robust process is required to prevent this happening and this action is being taken forward by the matrons and QI midwives, overseen by the interim Director of Midwifery.

4.3 Maternity Leadership

Midwifery: there have been changes in the midwifery leadership structure at both ESTH and SGUH.

- The Director of Midwifery and Gynaecology Nursing has taken up a regional post at NHSE and left her post in December 2024
- The Deputy Director of Midwifery has been seconded to ESTH as the interim Director of Midwifery and Gynaecology Nursing.
- Both posts at SGUH have been appointed to and while the arrival of the newly recruited staff is awaited, an interim Director of Midwifery is in place for 3-4 months to mitigate the leadership gap.

Obstetrics: the Clinical Director for SGUH maternity has given notice to step down from the role at the end of March 2025. The Divisional Chair has circulated an expression of interest invitation and job description, to recruit to the post.

Gesh maternity leadership structure: considering the move to a Group model, a proposal for a new leadership structure for maternity services across the Group has been developed and

was discussed at the Quality Committees in Common focussed session on maternity services in November 2024. The Committee asked for a revised version to be presented that incorporates the feedback given on the initial paper.

4.4 NHS Resolution Early Notification Thematic (ENS) Review

Babies who meet the criteria to be reported to ENS by NHS Trusts include term babies born following labour (at least 37 completed weeks of gestation) who have had a potential severe hypoxic brain injury confirmed on an MRI scan. Babies who are born by elective caesarean section, and babies who have sadly died within the first week of life (0-6 days) will not be eligible for review under the EN scheme.

SGUH maternity received correspondence in June 2024, from the Early Notification arm of NHS Resolution advising that they will be undertaking a thematic review of cases submitted by the service between April 1, 2017, and March 31, 2024. The review was primarily triggered by concerns raised in the Trust's August 2023 CQC report, which rated maternity services as *Inadequate* and highlighted issues in triage, staffing, governance, and oversight.

Cases Analysed: 10 of 22 cases met the ENS criteria for review.
Exclusions: 12 cases excluded due to incomplete records, lack of family consent, or failure to meet ENS brain injury definitions.
Similar concerns to those raised in the CQC inspection were identified, e.g., fetal monitoring escalation and adherence to guidelines, for which improvement work had already begun (appendix 4 READING ROOM).

The Trust was asked to submit a response to NHS Resolution by 27 December, however, due to several factors, this was not met, and a new deadline of 24 January 2025 has been agreed.

5.0 Actions and what success will look like

5.1 Pending Group Board approval of the MIS year 6 evidence of compliance, the Board declaration will be completed by gesh and SWL ICB CEOs and submitted to NHS Resolution by 12:00 midday on 3rd March 2025.

The expected outcome is for ESTH and SGUH to receive the 10% rebate from their CNST contribution.

5.2 Full compliance with the BAPM standards, as part of CNST, recorded in the Trust Board minutes.

5.3 Completion of all MUST and SHOULD dos issued to ESTH and SGUH by the CQC in the 2023 inspection of maternity services by 31 March 2025.

5.4 Final agreed leadership structure fir Maternity Services across gesh.

6.0 Next steps

6.1 Onboarding of interim staff who have been appointed to the Midwifery Leadership team.
Interim Director of Midwifery – start date tbc.
Deputy Director of Midwifery start date of 06.01.2025.

6.2 The relevant Executives to update the proposal for the maternity leadership structure across gesh and present to the Quality Committees in Common in February 2025.

7.0 Recommendations

7.1 Group Board is asked to.

a. Discuss and make recommendations for further reports.

b. Support the recommendation for the Executive and Non-Executive Board Safety Champions to review the CNST evidence and the September and October 2024 data, to provide assurance to the Board that all requirements have been met.

c. Delegate sign off of the Board Declaration for CNST to the Quality Committees in Common.

d. Give an assurance rating.

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University Hospitals and Health Group

Appendix 1

Perinatal Quality Surveillance Model Data – ESTH

Group Board

September and October 2024 data

Presented by:
Natilla Henry
Group Chief Midwifery Offer

09 January 2025

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

Background and Overview

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) at every meeting.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

Epsom And St Helier University Hospitals NHS Trust

CQC Maternity Ratings	Overall	Safe	Effecti	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Outstanding

Maternity Safety Support Programme	Yes

	2024											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data												
Findings of review all cases eligible for referral to HSIB.												
Report on:												
The number of incidents logged graded as moderate or above and what actions are being taken, serious incidents declared, serious incidents closed and progress on action plans												
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training												
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with		CQC Report published										
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	59%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	70%

RAG Rating	Explanation
Green	All parameters within normal limits, progress being made with action plan within anticipated time period, or action plan created
Amber	Progress with action plans not within anticipated time limit
Red	Issues identified, new reports available

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Outcomes Dashboard

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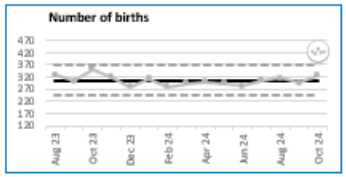
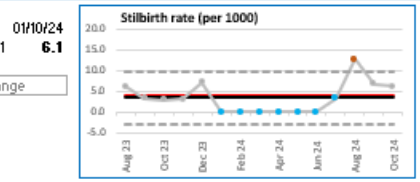
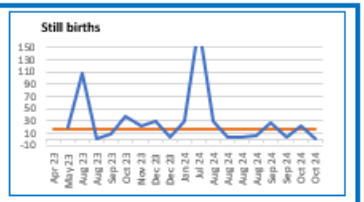
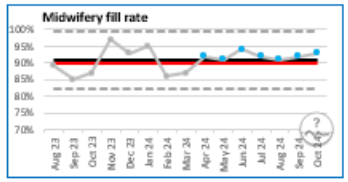
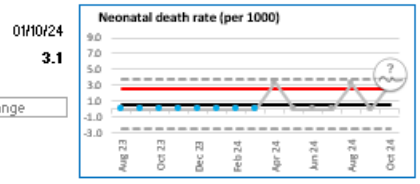
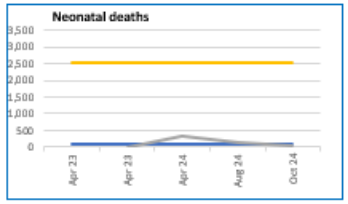
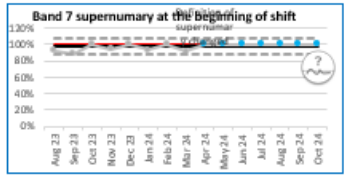
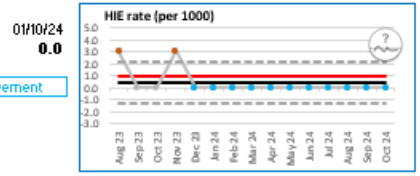
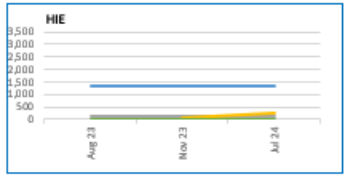
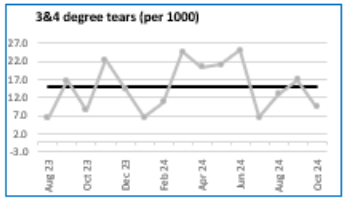
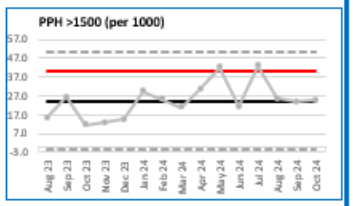
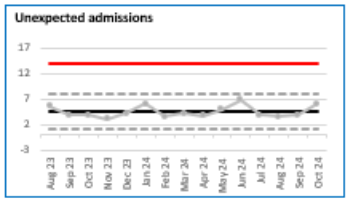
Maternity overview ESTH

Latest month 01/10/24 **Number of birtl** 326 No significant change		**Latest month** 01/10/24 **Still birth rate/1** 6.1 No significant change
	**Date of last stillbirth** 10/10/24 **Average days between** 15.7 No significant change	
Latest month 01/10/24 **Midwifery fill rate** 90%		**Latest month** 01/10/24 **Neonatal Death** 3.1 No significant change
	**Date of last neonatal** 06/10/24 **Average days between** 65.9 No significant change	
Latest month 01/10/24 **Supernumary status** 100%		**Latest month** 01/10/24 **HIE rate/1000** 0.0 Significant Improvement
	**Date of last HIE** ##### **Average days between HIE** 148.7 No significant change	
Latest month 01/10/24 **3&4 degree tears (per 1000)** 9.3 No significant change		**Latest month** 01/10/24 **PPH >1500 (per 1000)** 24.9 No significant change
	**Latest month** 01/10/24 **Unexpected admissions to NNU ATAIN** 6.0 No significant change	

Risks – High and Extreme (10 and above)

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Description of Risk	Review Date	Update	Current Risk Level	Risk Owner
Lack of 2nd obstetric operating theatre at Epsom	31/12/2024	Work is planned to convert Rose Room into a 2nd theatre	Extreme	Annabelle Keegan
General environmental issues were highlighted during the 2023 CQC inspection	31/03/2025	Work to sound-proof the STH bereavement room is currently underway.	Extreme	Kathryn Hughes
Maternity lift breakdowns restricting access to labour and maternity wards and risk of entrapment for staff and patients	31/12/2024	An external lift was installed at STH but this does not give access to the main building (main theatres) as does not go down to basement level. At EGH contingency measures are in place through SWLEOC.	High	Annabelle Keegan
Documentation of blood results into BadgerNet notes is currently a manual process as iCM does not interface. This has led to errors.	30/09/2025	This is likely to be resolved when we move to Cerner.	High	Annabelle Keegan
Nitrous Oxide exposure on Labour Ward	30/11/2024	The second round of room testing is currently underway. The HoM has provided details of the rooms in which Entonox is used to Estates for further action.	High	Annabelle Keegan
Our current staffing establishment only allows backfill for 23 hours of mandatory training and this is not sufficient to cover essential and nationally mandated training. SGUL by contrast have 34 hours per year.	31/03/2025	This is currently unresolved due to financial constraints.	High	Natilla Henry
The maternal assessment unit (MAU) at EGH is located in a separate building to Labour Ward	31/03/2025	There is a SOP and process in place to control the risk but this remains a patient safety concern.	High	Annabelle Keegan

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Perinatal Mortality

- **ESTH Data from the PMRT data tool**

	Oct 2023 – Sep 2024	Nov 2023 – Oct 2024
Antepartum stillbirths	12	13
Intrapartum stillbirths	0	0
Stillbirth (unknown timing	0	0
Early neonatal death	3	3
Late neonatal death	0	1
	(15)	(17)
<24 weeks	1	1
24 – 27 weeks	4	4
28 – 31 weeks	1	2
32 – 36 weeks	6	5
37 – 41 weeks	3	5
≥ 42 weeks	0	0

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.

- **Cases discussed, themes and open actions (please also see Appendix 1)**

PMRT Panel	Cases reviewed Sep/Oct 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
ESTH: 2 panel meetings held (20/09/2024 with an external panel member)	INC-138976, INC-157255, INC-158919, INC-159199, INC-158848, INC-159354 and INC-159754 (external representation for 1 case)	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/observations in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes).	INC-131062 and others	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.***
			INC-151063	Obstetric team to review the pathway of routine midwifery care for women being cared for by the Maternal or Fetal Medicine Team.

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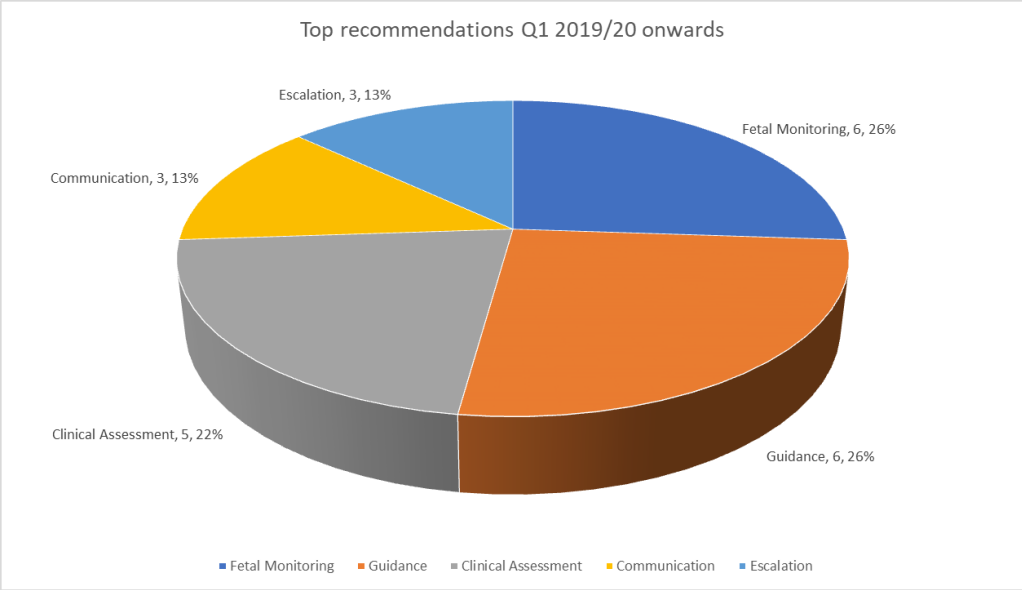
MNSI Cases

- There are currently 2 cases open with MNSI; both of these were reported in July/August 2024.
- One case related to a neonatal death and one case related to a baby who underwent therapeutic cooling.
- There were no cases closed during Sept/Oct 2024.
- There are no open action plans in relation to MNSI reports.



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Moderate and above Harm Cases

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In September 2024 there were 14 moderate harm outcomes identified; these related to:

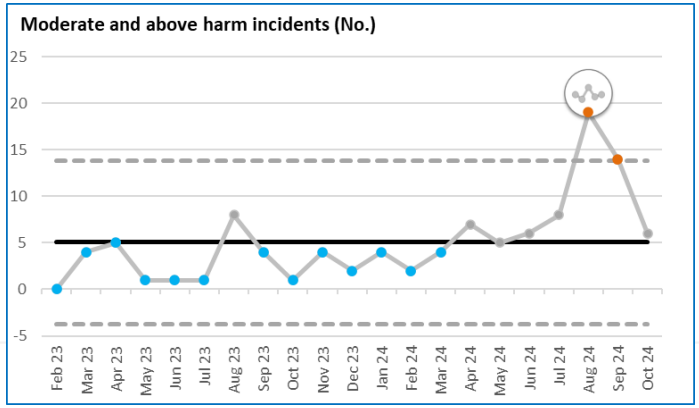
- Intrauterine death (3)
- Neonatal death (termination of pregnancy born with signs of life) (2)
- Massive obstetric haemorrhage (2)
- 3rd/4th degree tear (6)
- Staff injury (1)

One of the IUDs was a late miscarriage at 21/40 and therefore is not reportable to MBRRACE-UK; the other two occurred at 27+1/40 and 34+6/40 and will be reviewed via the PMRT. Six incidents have been reviewed and no PSI or other learning response was identified; one incident of 3rd degree tear is currently under review by the obstetric consultant as it occurred following a forceps delivery.

In October 2024 there were 6 moderate harm outcomes identified; these related to:

- Post-partum haemorrhage (2)
- Intrauterine death (2)
- 3rd degree tear (2)

The IUD which occurred at 28/40 was attributed to a placental abruption. One PPH has been reviewed and no further learning response is required. Three cases are currently under review.



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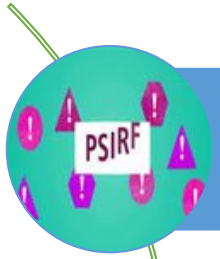
PSIIs/Learning/Themes



There are currently no open actions from PSIIs/legacy SIs.

During September and October 2024 3 investigations were closed; one case reviewed by the PMRT panel with unrelated issues identified (PCA observations not undertaken and previous LLETZ no documented). Two AARs were completed; one AAR had no actions identified and one identified actions around the MDT review of women booked for homebirth).

There are currently 14 open investigations as completion has been impacted by long term sickness absence in the risk team; 3 are awaiting final approval, 8 are subject to PMRT review, 2 are being investigated by MNSI and 1 is and on-going PSII.

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Incident themes (PSIRF)

Top 5 Incidents September 2024

The majority of incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in July 2024 were:

- Readmission of baby (15)
- Term baby admitted to the neonatal unit (9)
- Blood loss >1500mls (8)
- 3rd/4th degree tear (6)
- Maternal readmission (5)

Top 5 Incidents October 2024

- Readmission of baby (25)
- Term baby admitted to the neonatal unit (14)
- Blood loss >1500mls (8)
- Postnatal delay in care (4)
- 3rd/4th degree perineal tear (3)
- Maternal readmission (3)
- Born before arrival (3)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slide 3).

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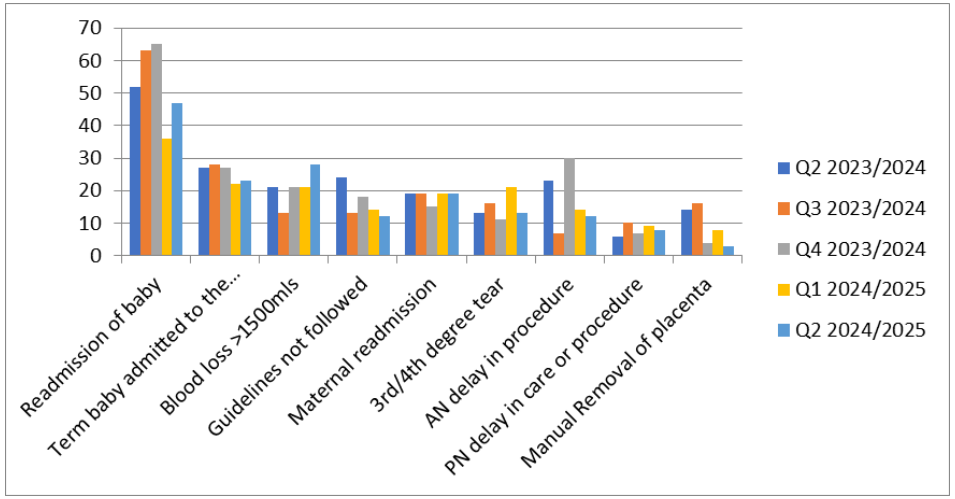
Incident themes Quarterly analysis/QI (PSIRF)



As readmission of babies has consistently been our most frequently reported incident, and has a significant impact on both families and the service, we have commenced a deep dive audit and will present the findings and recommendations when the audit has been completed.

We are currently progressing a maternity-specific PSIRP; an-depth analysis of incidents is currently being undertaken to inform this, but this will include readmission of babies as one of the areas for local focus.

Our current PSIRP (areas for local focus below) now needs to be updated in response to our on-going analysis of incident themes:

1. PPH >1500mls has shown consistency over the last 15 months and we have been below the national average since July 2022 (National Maternity Dashboard).
2. CTG – we have well-embedded processes associated with audit, training and review with a specialist midwife and consultant in post.
3. There have been low numbers of maternal admissions to HDU (4 cases over the last year, none of which were due to care concerns).

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Training Compliance

Type of Training and % compliance	Staff Group	ESTH Sep 24	ESTH Oct 24	ESTH Nov 24
PROMPT 90%	Midwifery Staff	94%	94%	96%
	Maternity Support Workers	94%	93%	97%
	Consultant Obstetricians	90%	90%	94%
	Trainee and Staff Grade Obstetricians	92%	96%	97%
	Anaesthetics	75%	87%	95%
CTG Training 90%	Midwifery Staff	90%	95%	95%
	Obstetricians	93% Cons/100% MG	97% Cons/100% MG	97% Cons/95% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	94%	96%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	86% (provided in November 2024)	94%	98% Nurses/100% ANNP
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	7% Consultants 17% Middle grades	Not Provided	100%

Training compliance as at 30/11/2024 (01/12/2023 – 30/11/2024) is greater than 90% and therefore we are compliant with the CNST Maternity Incentive Scheme Year 6. Figures are still not being routinely provided by the neonatal service and this has been escalated so that a robust process for reporting compliance monthly can be established.

All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

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Safe Staffing

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Staff Group	Measure	Aug 2024		Sept 2024		Oct 2024	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		92%	90%	91%	92%	94%	92%
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%	

The 6 monthly staffing report has been submitted to QCiC in October 2024.

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Service User Feedback (complaints, FFT, PALS, MNVP and actions)

COMPLAINTS

There were 9 complaints in Q2 2024/2025 and we received 5 complaints in October 2024; these related to issues around consent, antenatal diagnosis of fetal anomalies, management in early pregnancy, coercion around pain relief options, unprofessional behaviour, conflicting advice, communication, not listening to concerns and delays in care.

PALS

During September and October 2024 there were 31 contacts; communication issues and general care concerns continue to be a common theme. A number of contacts were regarding confirmation of appointments/self-referral, requesting test result, requesting birth debrief appointments and requesting MatB 1.

FFT (143 responses in August/September 2024) - positive feedback:

- ✓ Infant feeding support
- ✓ Maternity vaccination service
- ✓ Kind and friendly staff
- ✓ Care during labour and birth
- ✓ Care in the Birth Centre at Epsom

FFT - YOU SAID/WE DID

There were comments around short staffing and delays and suspension of the homebirth service.

There are a number of QI initiatives being undertaken to make is easier for women to provide FFT feedback; there is a link on the BadgerNet App and we are giving out congratulations card with the FFT information included.

ACTIONS – There have been a number of general reminders issued to staff in response to complaints. There is a need to ensure that families are aware of the difference between screening and diagnostic tests. We will be developing local guideline for the management of women who have had a stroke.

MNVP – Positive feedback for the Birth Centre, infant feeding support, antenatal care and labour care but some women have reported a lack of information leaflets in hard copy, women not involved in decision making, noisy postnatal ward and lack of drinks provided for partners. Action are already in place to improve information resources.

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Other Quality Improvement work:

- The consultant midwives are working together to improve our antenatal education resources.
- As the demand for postnatal debrief appointments is increasing, we are developing a midwifery-led debrief service. Complex cases will continue to be supported by the consultant midwives and the obstetricians. The aim is to commence this service in January 2025.

Focus groups for maternity patients from black, Asian or mixed ethic background
Focus groups for new mothers from these cultural backgrounds have been established to discuss their pregnancy and birth experiences. The insights and learning identified from these discussions will be shared with staff, with an emphasis on highlighting good practice.

Learning from Complaints

If you are completing a datix and you discuss this with the woman and her family please ensure that you explain that they will only hear from us if we identify anything significant. The governance team do not routinely contact all women for whom a datix has been raised and this can, on occasional, create an issue where women are expecting to hear the outcome of a review.

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Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern

There are no current NSHR concerns

The CQC rating for the Maternity Service is 'Requires Improvement' and an action plan is being progress, and reviewed through the Evidence Assurance Panel – ESTH alongside SGUL have entered onto the Maternity Support Programme

There are no current Regulation 28 Reports (reports to prevent future deaths issued by a Coroner)

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ESTH CQC Action Plan Update – updated from the GESH Evidence Assurance Panel

Must Do	Action assurance	COMPLIANT	NOT YET COMPLIANT
Statutory & Mandatory Training, Must Do 1, The service must ensure all staff are up to date with maternity mandatory and safeguarding modules (Epsom and St Helier sites)	80% actions completed	• To be presented to EAP in Jan 2025	• A baby abduction drill in planned for Jan 2025
Premises and Equipment, Must Do 2, S29A The service must ensure that premises and equipment are suitable and fit for purpose (Epsom and St Helier sites)	100% actions completed	• To be presented at EAP quarterly – next meeting March 2025	• To remain on EAP action plan due to on-going Estates concerns. No specific action required by maternity SLT
Mitigating Risk, Must do 3 The service must ensure it assesses and mitigates risks to women, birthing people, and babies (Epsom and St Helier sites)	100% actions completed	• Signed off at EAP - 4 November 2024	
Triage, Must do 4 The service must ensure that medical staffing for triage is reviewed so there are sufficient numbers of staff to review women and birthing people in a timely manner (Epsom and St Helier sites) The service must operate clear triage processes to ensure the safety of women, birthing people and babies (St Helier)	100% actions completed	• Signed off at EAP - 4 November 2024	
Early Warning Score Documentation, Must do 5 The service must ensure staff accurately complete and document modified obstetric early warning scores in order to identify and escalate women and birthing people at risk of deterioration (Epsom and St Helier sites)	100% actions completed	• Signed off at EAP - 4 November 2024	
Transitional Care, Must do 6 The trust must ensure that staff caring for transitional care babies have the appropriate level of qualifications and additional training (Epsom and St Helier sites)	95% actions completed	• To be re-presented at EAP in Jan 25	• Total number of staff trained for TC required

Must Do	Action assurance	COMPLIANT	NOT YET COMPLIANT
Recovery Practitioner, Must do 7 The Trust must ensure the role of recovery practitioner is a role carried out by staff with the right level of qualification and additional training (Epsom and St Helier sites)	90% actions compliant	• To be presented at EAP in Jan 2025	• Ongoing training for new staff within TC is being developed • Staffing model meets demand – EGH phase 1 completed, STH phase 2 recruitment underway for theatre nurses
Care Records, Must do 8 The service must ensure records of care and treatment provided are accurate, complete and contemporaneous (Epsom and St Helier sites)	100% compliant	• Signed off at EAP on 2nd December 2024	
Oversight of Maternity, Must do 9 The service must ensure it operates effective systems and processes to maintain oversight of maternity services and enable it to assess, monitor and improve the quality and safety of services and mitigate risks to women, birthing people and babies (Epsom and St Helier sites)	85% compliant	• To be presented at EAP in Jan 2025	• Review how risk register information is shared and make adjustments to process

Should Do	Action assurance	COMPLIANT	NOT YET COMPLIANT
Should do 1 – The service should ensure fresh eyes checks of CTG monitoring are carried out hourly (Epsom and St Helier sites)	80% compliant	• SBLCB vs3 assessed as compliant by SWL LMNS	
Should do 2 – The service should ensure staff use the SBAR handover format when handing over care of women, birthing people and babies (Epsom and St Helier sites)	100% compliant	• 10 set of documentation audited per month per site with 100% compliance	
Should do 3 – The service should ensure midwifery staff complete an annual appraisal (Epsom and St Helier sites)	Local data > 90% Trust BI data > 72.5%	• Review of Trust held data compared to local data (accurate) underway to confirm overall %	
Should do 4 – The Trusts should continue to ensure the design and maintenance of the environment allows staff to detect, prevent and control the risk of the spread of infection (St Helier)	100% complaint	• Trust Quality Assurance review confirmed compliance	
Should do 5 – Staff Culture The service should examine its culture and involve staff in improving it, including staff members with protected characteristics	90% Compliant	• Perinatal Culture and leadership Programme completion SCORE survey • REACH network in place • Appreciative Enquiry undertaken awaiting results	Feedback from Appreciative Enquiry not yet received
Should do 6 – Executive oversight The service should improve executive knowledge of and involvement in maternity services, including but not limited to the safety champion role and health inequalities for women and birthing people who use the service	100% compliant	• Planned programme of engagement with Executive and NED safety champions, (gesh and site specific) • MNVP invited to attend gesh Safety Champions Meeting	

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CQC Maternity Survey published November 2024

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NHS

2024 Maternity Survey

Results for Epsom And St Helier University Hospitals NHS Trust

CareQuality Commission

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Postnatal Care: Care in the ward after birth:** Delays to discharge on the day of leaving hospital
- ✓ **Postnatal Care: Care in the ward after birth:** Healthcare professionals doing everything they could to manage service user's pain
- ✓ **Antenatal care: During your pregnancy:** If service users had concerns, they were taken seriously
- ✓ **Labour and Birth: Your labour and birth:** Feeling that healthcare professionals did everything they could to help manage pain

Where service user experience could improve

- o **Labour and Birth: Your labour and birth:** Service users given appropriate information and advice on the associated risks with induction
- o **Antenatal care: During your pregnancy:** Service users given enough support for their mental health
- o **Antenatal care: During your pregnancy:** Service users given information about any warning signs to look out for during pregnancy
- o **Antenatal care: Start of your pregnancy:** Information from midwife or doctor to help service users decide where to have their baby
- o **Antenatal care: Start of your pregnancy:** Service users offered choice about where to have their baby

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2024. Between May and August 2024, a questionnaire was sent to 300 recent service users who gave birth at Epsom And St Helier University Hospitals NHS Trust. Responses were received from 123 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

13 Maternity Survey 2024 | [TRUST CODE] | [TRUST NAME]

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Comparison to other trusts

Much better than expected

- B17. If you raised a concern during your antenatal care, did you feel that it was taken seriously?
- C9. The birth of your baby. If your partner or someone else close to you was involved in your care during labour and birth, were they able to be involved as much as they wanted?
- D2. On the day you left hospital, was your discharge delayed for any reason?

Better than expected

- C8. Do you think your healthcare professionals did everything they could to help manage your pain during labour and birth?
- C12. If you raised a concern during labour and birth, did you feel that it was taken seriously?
- D5. Thinking about the care you received in hospital after the birth of your baby, were you treated with kindness and understanding?
- D7. Do you think your healthcare professionals did everything they could to help manage your pain in hospital after the birth?

Somewhat better than expected

- B7. During your antenatal check-ups, were you given enough time to ask questions or discuss your pregnancy?
- C6. At the start of your labour, did you feel that you were given appropriate advice and support when you contacted a midwife or the hospital?
- D4. Thinking about the care you received in hospital after the birth of your baby, were you given the information or explanations you needed?

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Comparison to other trusts cont.

Somewhat worse than expected

- No questions for your trust fall within this banding.

Worse than expected

- No questions for your trust fall within this banding.

Much worse than expected

- No questions for your trust fall within this banding.

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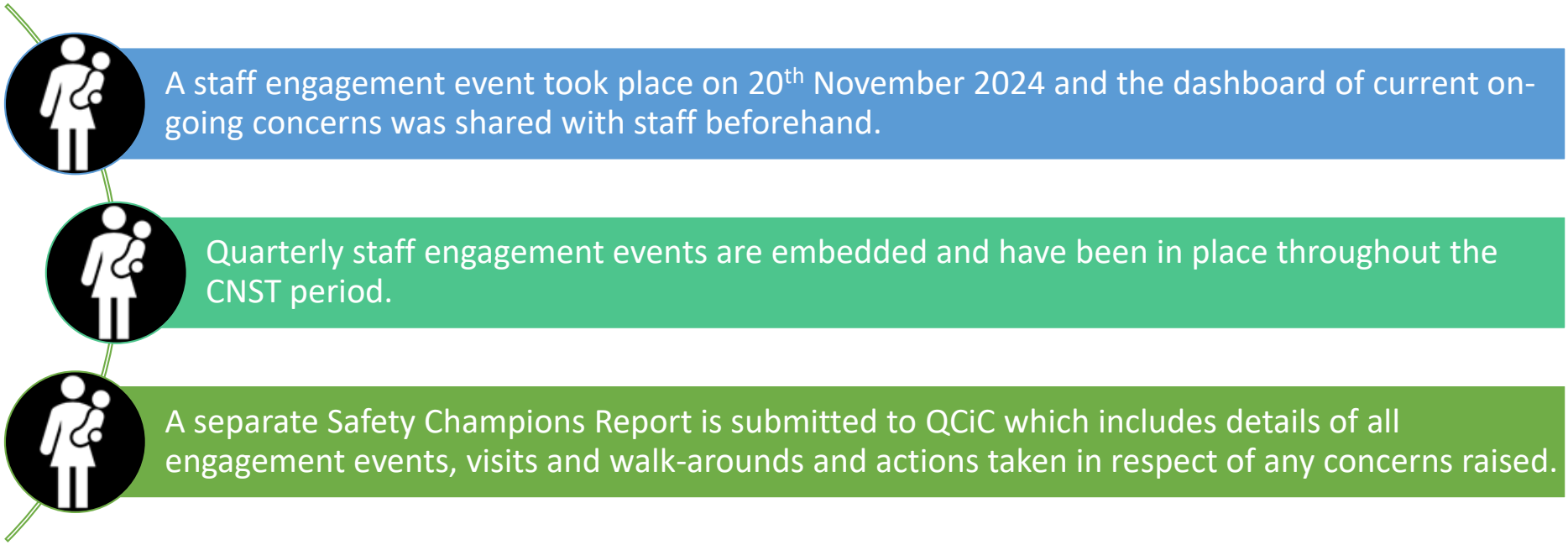
Safety Champions (staff engagement/feedback/walk-arounds etc.)



A staff engagement event took place on 20th November 2024 and the dashboard of current on-going concerns was shared with staff beforehand.

Quarterly staff engagement events are embedded and have been in place throughout the CNST period.

A separate Safety Champions Report is submitted to QCiC which includes details of all engagement events, visits and walk-arounds and actions taken in respect of any concerns raised.

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Include cultural improvement plans/survey/SCORE survey

The following actions have been implemented and progress must be formally recorded in the Trust Board minutes:

A Perinatal specific DMT meeting (obstetric and neonatal) has been established as is meeting monthly. The ToRs include the chair of the MNVP.

The Divisional Director of Operations as introduced a Divisional Newsletter to ensure staff are kept up to date with what is happening within the Division.

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually) – ***70% (2023)***

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Thank you.

For any other information, please see:

Appendix 2a

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

SGH Perinatal Quality Surveillance Model Data, September and October 2024

Quality Committees in Common December 2024

Presented by:
Natilla Henry
Group Chief Midwifery Officer

December 2024

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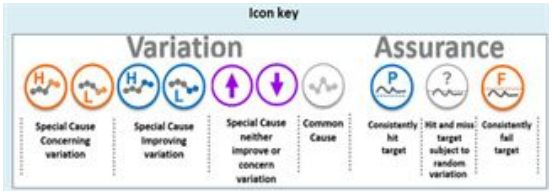
Background

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) at every meeting.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

Outcomes dashboard



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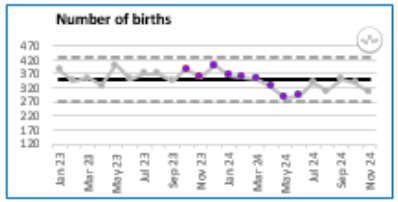
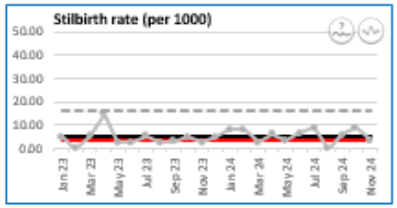
Maternity overview — St Georges Maternity Unit

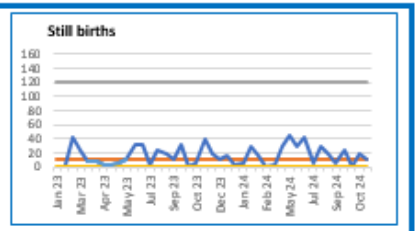
Latest month 01/11/24
Number of birtl 307
No significant change



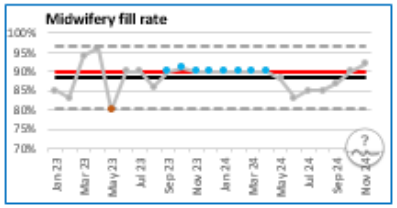
Latest month 01/11/24
Still birth rate/1 3.3
No significant change



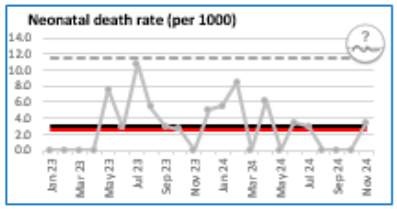
Date of last stillbirth 11/11/24
Average days between 12.0
No significant change



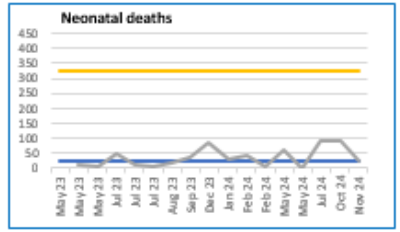
Latest month 01/11/24
Midwifery fill rate 90%
No significant change



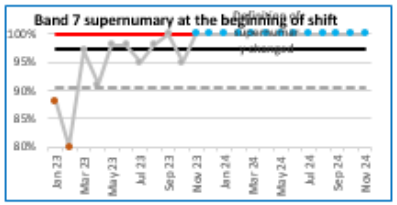
Latest month 01/11/24
Neonatal Death 3.3
No significant change



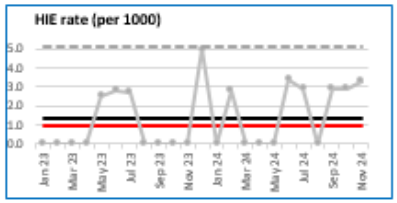
Date of last neonatal 24/11/24
Average days between 23.6
No significant change



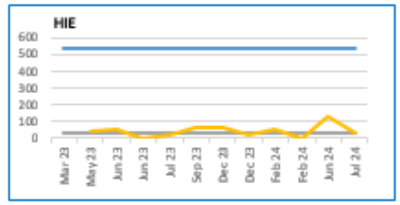
Latest month 01/11/24
Supernumary status 100%
Significant Improvement



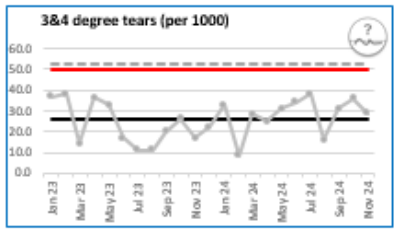
Latest month 01/11/24
HIE rate/1000 3.3
No significant change



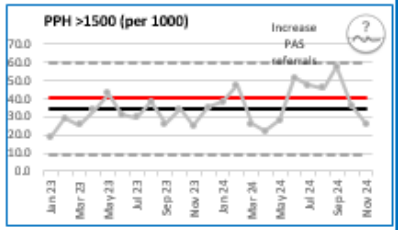
Date of last HIE 21/07/24
Average days between HIE 31.2
No significant change



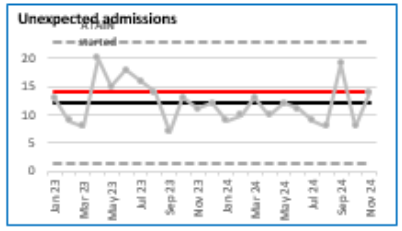
Latest month 01/11/24
3&4 degree tears (per 1000) 29.0
No significant change



Latest month 01/11/24
PPH >1500 (per 1000) 26.0
No significant change



Latest month 01/11/24
Unexpected admissions to NNU ATAIN 14.0
No significant change



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Risks – Moderate and above

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SGH-Title of Risk	Review Date	Update	Current Risk Level	Risk Owner
Closure of Birth Centre	29/08/2024	Risk for de-escalation at next Divisional Governance	High risk	Director of Midwifery
Euroking back copying and forward copying IT risk	29/08//2024	National risk identified. Cerner being launched Feb 2025	High risk	Director of Midwifery
Infrastructure damage/sewerage flooding on the maternity unit	29/08//2024	Action plan in place with Estates. Escalation for any issues logged with estates	High risk	Director of Midwifery
Multiple Information Systems Migrating to a single digital platform. Project underway. To launch Feb 2025	29/08//2024	Migrating to a single digital platform. Project underway. To launch Feb 2025	High risk	General Manager
Provision of Home Birth service	29/08//2024	Risk for de-escalation at next Divisional Governance	High risk	Director of Midwifery
Viewpoint 5 servers and application out-of-support IDT is working with Med Physics and clinical services to transition to V6 Viewpoint and integrate this with iCLIP. Risk description updated to add risk and impact; controls added.	29/08//2024	Awaiting transition to V6 Viewpoint	High Risk	General Manager
Diabetes team seeing 500+/year women with GDM in the same clinic for women with pre-existing diabetes. Provision of pregnancy care for women with pre-existing diabetes in an MDT clinic although this patient group forms a minority within the clinic which includes gestational diabetics and other endocrine patients	June 2024	This service being reviewed with the MDT as currently no facility to expand the clinic. Weekly MDT meeting prior to clinic to support focused care	High Risk	Obstetric Consultant Lead for Diabetes

Risks – Moderate and above

SGH-Title of Risk	Review Date	Update	Current Risk Level	Risk Owner
High level of short-term sickness	26/11/2024	Monitoring process set up. Reports received and discussed at monthly service meeting with senior leaders sharing the impact deficit due to staff sickness shared with Quality Committee in Common, Division and site.	Moderate	Director of Midwifery
Onboarding time laps for recruited midwives	31/10/2024	Recruitment and retention midwives to have 2 touch base meetings with new recruits whilst they are waiting for the pre-employment checks to be completed	Moderate	Director of Midwifery
Maternity Unit Security System	29/08/2024	Not approved during this year's establishment review, will reassess in the establishment review in 2025. Establishment review to include 7/7 security and 7/7 reception cover on the PNW.	Moderate	General Manager
Midwifery Manager on call rota	29/08/2024	Ongoing optimisation of the Midwifery Manager on call roster. Work with division and HR to understand role of MMoC and expand team through HR processes	Moderate	Director of Midwifery

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Perinatal Mortality

- **SGH Data from the PMRT data tool**

	Oct 2023 – Sep 2024	Nov 2023 – Oct 2024
Antepartum stillbirths	21	21
Intrapartum stillbirths	1	1
Stillbirth (unknown timing	4	4
Early neonatal death	14	14
Late neonatal death	7	7
	(47)	(47)
<24 weeks	10	10
24 – 27 weeks	14	15
28 – 31 weeks	2	2
32 – 36 weeks	10	10
37 – 41 weeks	11	10
≥ 42 weeks	0	0

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Perinatal Mortality

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- **Cases discussed, themes and open actions (please also see Appendix 1)**

PMRT Panel	Cases reviewed July/August 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
During the period of September/October 2024, SGH held 4 meetings in which 11 cases were discussed and in out of the 11 cases, an external panel member was present for 7 cases.	• ID:93549-NND • ID:91253-IUD • ID:92631-IUD • ID:94050-IUD • ID:93841-IUD • ID:93789-IUD • ID:93550-NND • ID:94450-IUD • ID:93934-NND • ID:94950-IUD • ID:94533-NND	No new clear emerging themes were identified to date that contributed to the deaths of the cases reviewed.	The actions from the cases discussed for the period of August 2023 to present	Actions: • ID:90977/1 - The guideline for use of the video laryngoscope is currently in development. There may be further recommendations and actions as part of the SI review. • ID: 93934 - Plymouth Hospital: There was no evidence in the notes that this mother was asked about Domestic abuse at booking. Plan: Email to all midwives to ensure that at booking and every appropriate opportunity the domestic abuse question is raised. All remaining actions are closed.

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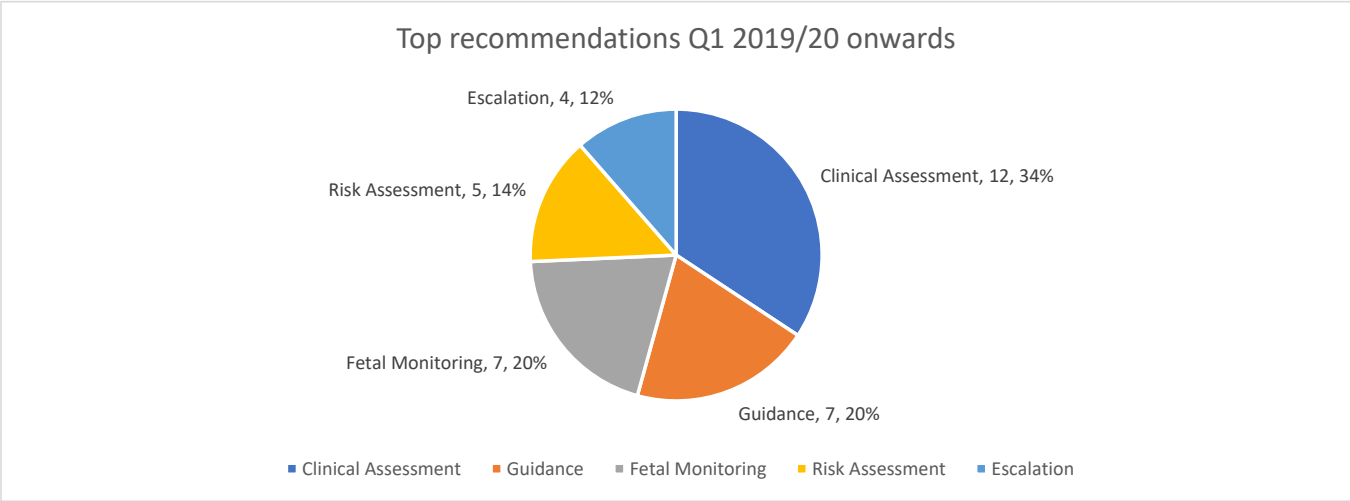
Perinatal Mortality (MBRRACE-UK Perinatal Mortality Report)

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2022 birth has shown that SGUL 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.

MNSI Cases

- There are currently 6 cases open with MNSI; 5 ongoing cases and 1 awaiting discussion at MGM cases and action plan.
- 2 case related to IUD, and 1 cases related to therapeutic cooling
- 2 maternal deaths
- 3 cases were closed during September/October 2024.
- 2 action plans in relation to recent closed MNSI reports.



Moderate and above Harm Cases

In September 2024 there were 29 moderate harm outcomes identified; these related to: • Postpartum Haemorrhage (20) • 3rd degree tear (9) The above incidents are being reviewed through our moderate cases review meetings and actions will be made as appropriate . The baby that required cooling was referred to MNSI and the case has been accepted.	In October there were 23 moderate harm outcomes identified; these related to: • Post-partum haemorrhage (11) • 3rd degree tear (11) • 4th degree tear (1) The above incidents have been reviewed at moderate cases review meetings.

PSIIs/Learning/Themes

There are currently no open actions from PSIIs/legacy SIs. There is currently 2 open investigations, 1 PSII and 1 AAR Antenatal CTG with regards to Dawes Redman Criteria	During September and October 2024 3 investigations were closed; one case was an AI and 2 were investigated by MNSI and there were no safety recommendations.

Incident themes (PSIRF)

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Top 5 Incidents September 2024

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in September 2024 were:

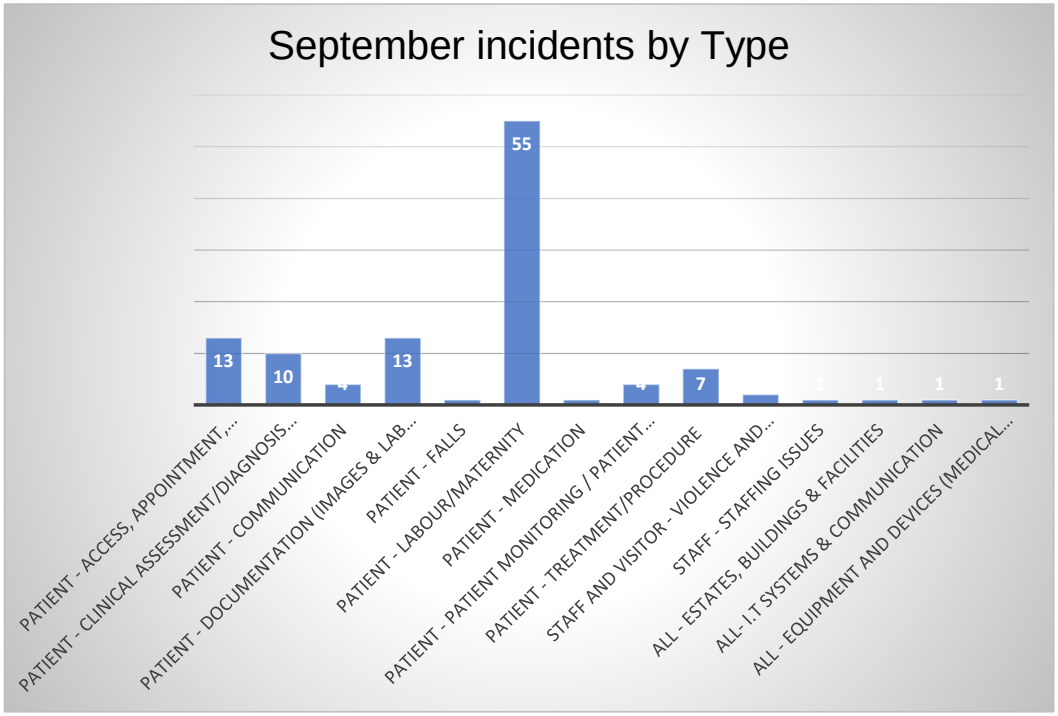
- Postpartum haemorrhage
- 3rd Degree tears
- Unexpected Neonatal Admissions
- Readmissions
- 2 instruments

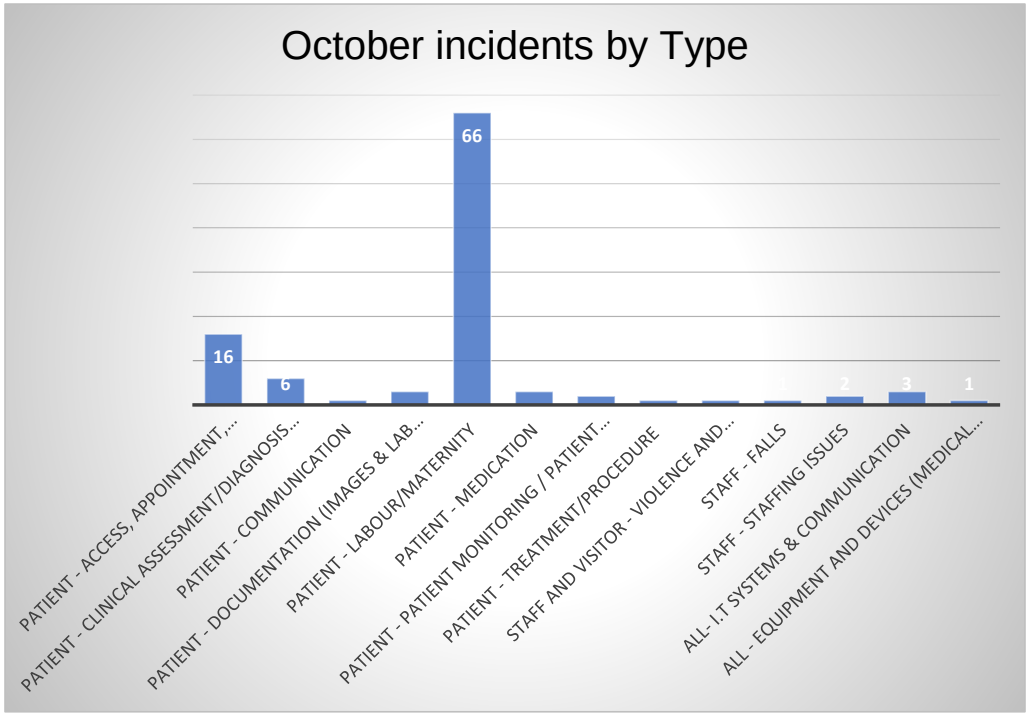
Top 5 Incidents October 2024

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in October 2024 were:

- Postpartum haemorrhage
- 3rd Degree tears
- Unexpected Neonatal Admissions
- Readmissions
- 2 instruments

Incident types- September and October 2024





Training Compliance

Type of Training and % compliance	Staff Group	SGH Sept 24	SGH Oct 24	SGH Nov 24
PROMPT 90%	Midwifery Staff	90%	90%	90%
	Maternity Support Workers	92%	90%	90%
	Consultant Obstetricians	94%	95%	100%
	Trainee and Staff Grade Obstetricians	88%	78%	83%
	Anaesthetics	94%	88%	94%
CTG Training 90%	Midwifery Staff	92%	89%	98%
	Obstetricians	84%	84%	100%
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	96%	93%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	92%	90%	90%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	95%	100%	100%

In PROMPT there are 5 junior doctors who require SGH training - 4 of these Junior Drs started at St George's in October 2024.

They are booked to attend PROMPT in December 2024 & January 2025, so we are compliant as per MIS year 6 April 2024 amendment.

Safe Staffing

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

Safer staffing September 2024

Ward name	Day						Night						Overall %
	Registered Nurses/ Midwives		Average fill rate - registered staff (%)	Care Staff		Average fill rate - care staff (%)	Registered Nurses/ Midwives		Average fill rate - registered nurses/midwives (%)	Care Staff		Average fill rate - care staff (%)	
	Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		
Carmen Suite	686	567	83%	349	338	97%	690	473	69%	334	334	100%	83%
Delivery Suite	5,298	4,027	76%	1,025	896	87%	4690	4082	87%	1,024	1,024	100%	83%
Gwillim Ward	2,221	1,970	89%	696	699	100%	1380	1387	100%	690	667	97%	95%

Safer staffing October 2024

Ward name	Day						Night						Overall %
	Registered Nurses/ Midwives		Average fill rate - registered staff (%)	Care Staff		Average fill rate - care staff (%)	Registered Nurses/ Midwives		Average fill rate - registered nurses/midwives (%)	Care Staff		Average fill rate - care staff (%)	
	Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		Total planned staff hours	Total actual staff hours		
Carmen Suite	725	622	86%	349	334	96%	713	674	95%	355	355	100%	93%
Delivery Suite	5,247	4,288	82%	1,107	897	81%	4922	4336	88%	1,058	1,047	99%	86%
Gwillim Ward	2,309	2,068	90%	760	689	91%	1426	1404	98%	713	701	98%	93%

	Sept 2024		Oct 2024	
Band 7 supernumerary MW allocated at start of shift	100%		100%	
Triage Staff Day 2 RM & 1 MSW	100% 1 MW & 1MSW	50% 2 MW & 1 MSW	100% 1 MW & 1 MSW	23% 2 MW & 1 MSW
Triage Staff Night 1 RM & 1 MSW	100%		100%	

Service User Feedback (complaints, FFT, PALS,MNVP and actions)

COMPLAINTS
There were 7 complaints received in September and October 2024 for Maternity.
3 of the 7 complaints relate to birthing experience and poor communication from midwives.
A historic complaint of incorrect blood type recorded on documentation.
A mental health safeguarding issue.
Incorrect measurement of Cervix.
1 complaint related to waiting times in Antenatal clinic.

PALS
There were 10 PALS queries received in September and October 2024 for Maternity.
4 relate to Birthing experience.
3 general service enquiries.
Patient notes request.
General feedback.

FFT positive feedback

- ✓ Caring and compassionate staff
- ✓ Being seen by the same team of midwives
- ✓ Lots of staff mentioned by name
- ✓ Staff described as amazing
- ✓ Care in labour

FFT - YOU SAID/WE DID

The value of face-to-face classes –

Every team in the community now provides their own antenatal classes.

ANC and the Birth Centre are now launching their own face to face classes to create and equitable opportunity.

ACTIONS

A new MNVP Lead has been recruited and appointed – Mrs Amena Ahmed starting in Dec ‘24 /Jan ‘25.

Working with SLW core connector to prioritise communities to direct targeted classes – language/deprivation/greatest risk

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SGUH – Inpatient Maternity Survey 2024

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SGUH: NHS maternity services survey 2024

The NHS Patient Survey Programme (NPSP) collects patient feedback on various healthcare services, including maternity care. The Maternity Survey, first conducted in 2007, provides insights into the quality and risks of maternity services, informing the Care Quality Commission (CQC) and service organisers.

2024 Survey Overview:

- The eleventh Maternity Survey.
- Covered feedback from maternity care users in February 2024, with January births included for smaller trusts.

Participation:

- Invitations: 46,687 maternity service users across 120 NHS Trusts.
- Responses: 18,951 completed surveys (adjusted response rate: 41.2%).
- Eligibility: Service users aged 16+ who experienced a live birth in an NHS Trust between 1st – 29th February 2024.

Survey Sections:

1. Antenatal Care.
2. Labour and Birth.
3. Postnatal Care.
4. Complaints.

The results contribute to understanding patient experiences and identifying areas for improvement in maternity care services.

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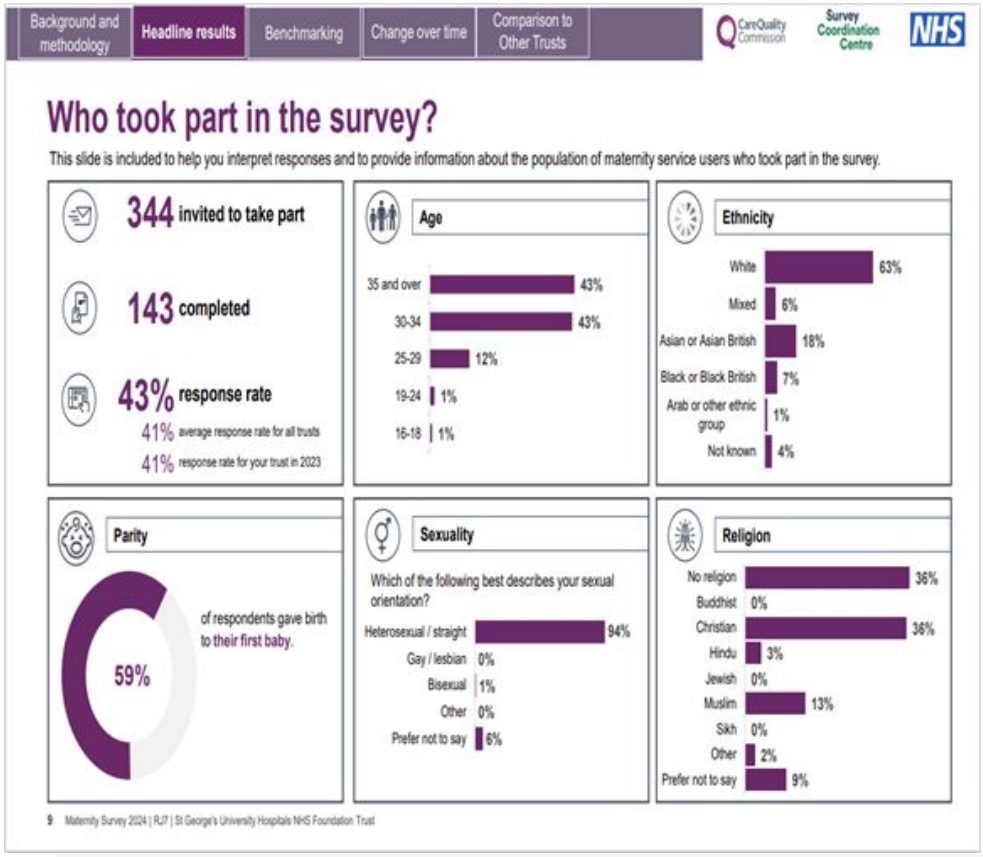
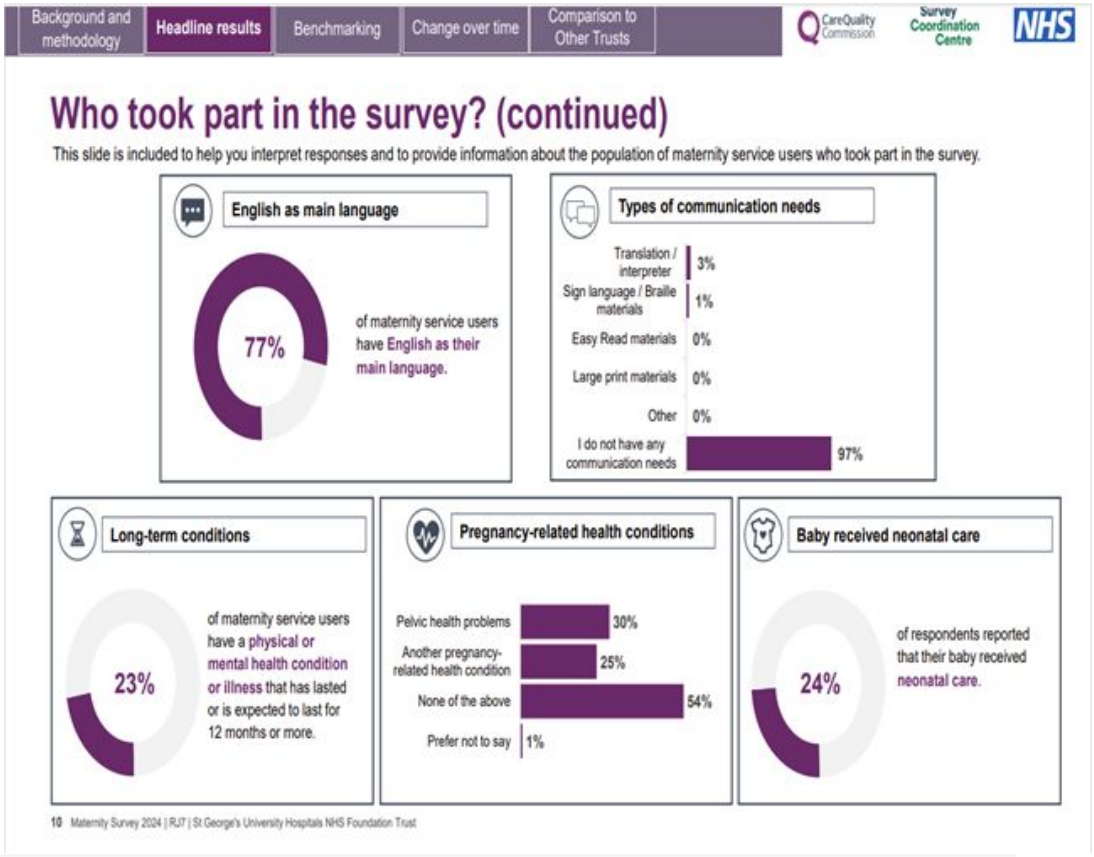
Who took part in the survey





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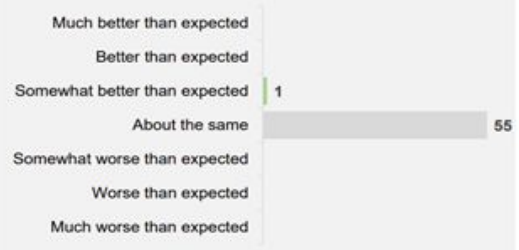
Summary of findings for your trust

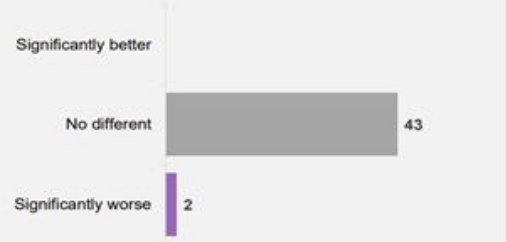
Comparison with other trusts

The **number of questions** at which your trust has performed better, worse, or about the same compared with all other trusts.



Comparison with last year's results

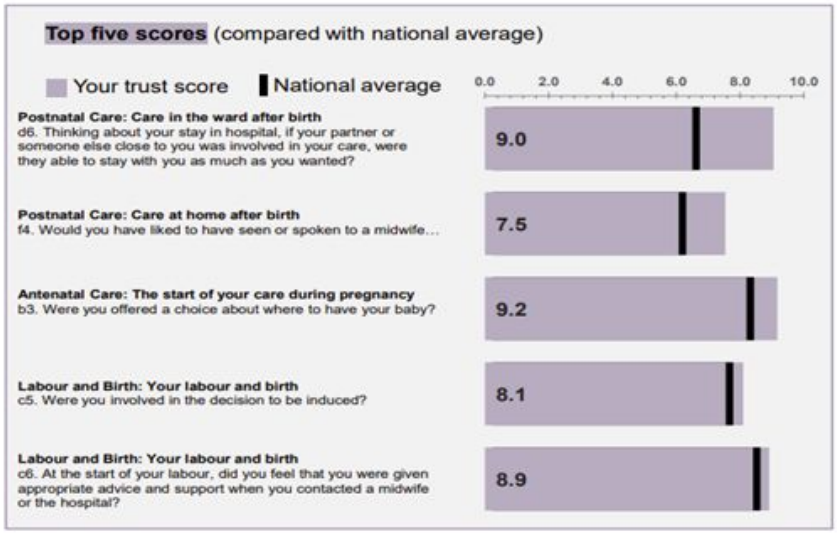
The **number of questions** at which your trust has performed statistically significantly better, significantly worse, or no different than your result from the previous year, 2024 vs 2023.

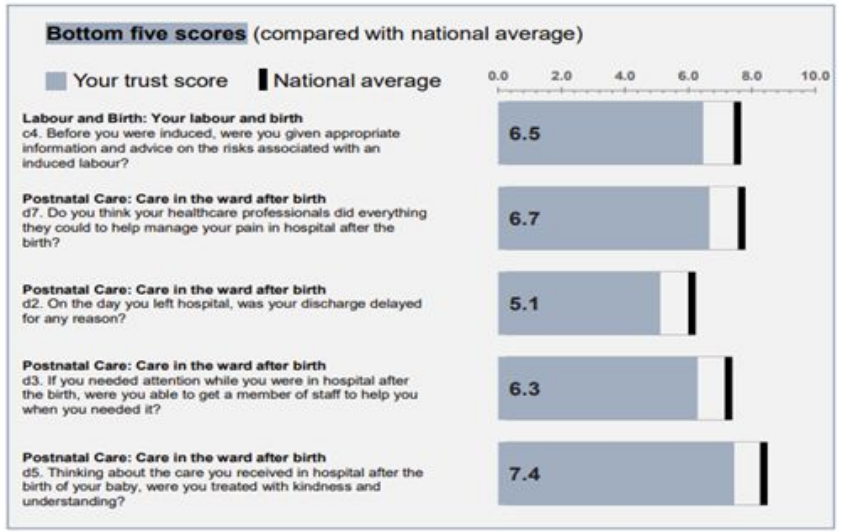


Best and worst performance relative to the national average

These five questions are calculated by comparing your trust's results to the the average trust score across England.

- **Top five scores**: These are the five results for your trust that are highest compared with the national average. If none of the results for your trust are above the national average, then the results that are closest to the national average have been chosen, meaning a trust's best performance may be worse than the national average.
- **Bottom five scores:** These are the five results for your trust that are lowest compared with the national average. If none of the results for your trust are below the national average, then the results that are closest to the national average have been chosen, meaning a trust's worst performance may be better than the national average.





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2024 Maternity Survey

Results for St George's University Hospitals NHS Foundation Trust

CareQuality Commission

Where service user experience is best

- ✓ **Postnatal Care: Care in the ward after birth:** Partner or someone else close to service user was able to stay as much as the service user wanted
- ✓ **Care after birth:** Frequency of seeing or speaking to a midwife
- ✓ **Antenatal care: Start of your pregnancy:** Service users offered choice about where to have their baby
- ✓ **Labour and Birth: Your labour and birth:** Being involved in the decision to be induced
- ✓ **Labour and Birth: Your labour and birth:** Feeling that they were given appropriate advice and support when they contacted a midwife or the hospital

Where service user experience could improve

- o **Labour and Birth: Your labour and birth:** Service users given appropriate information and advice on the associated risks with induction
- o **Postnatal Care: Care in the ward after birth:** Healthcare professionals doing everything they could to manage service user's pain
- o **Postnatal Care: Care in the ward after birth:** Delays to discharge on the day of leaving hospital
- o **Postnatal Care: Care in the ward after birth:** Being able to get help from staff when needed
- o **Postnatal Care: Care in the ward after birth:** Being treated with kindness and understanding

These questions are calculated by comparing your trust's results to the national average. "Where service user experience is best": These are the five results for your trust that are highest compared with the national average. "Where service user experience could improve": These are the five results for your trust that are lowest compared with the national average.

This survey looked at the experiences of service users who gave birth at the trust in January and/or February 2024. Between May and August 2024, a questionnaire was sent to 344 recent service users who gave birth at St George's University Hospitals NHS Foundation Trust. Responses were received from 143 service users at this trust. If you have any questions about the survey and our results, please contact [NHS TRUST TO INSERT CONTACT DETAILS].

13 Maternity Survey 2024 | [TRUST CODE] | [TRUST NAME]

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Cont....

Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern.
There are no current NSH Resolution concerns.

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Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Safe staffing, Must Do 1, S29A The service must ensure staffing levels are safe and there are effective processes in place to escalate and mitigate safe staffing concerns. (Regulation 12)		100% actions completed	• Signed off at EAP September 2024	
Triage, Must Do 2, S29A The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))		100% actions completed	• Partial approval at EAP on 2nd Dec 2024	Review and support medical workforce
Policies and Guidelines, Must do 3 The service must ensure adequate and up-to-date policies, pathways and guidance are in place, including implementation of a standard operating procedure in maternity triage and clear, effective escalation pathways to mitigate for risks of short staffing on women, birthing people, babies and staff. (Regulation 12)		100% actions completed	• Signed off at EAP on 2nd December 2024	
Fetal Monitoring, Must do 4 The service must ensure safe care of women in labour especially in relation to fetal monitoring. (Regulation 12 (2) (a) (b)		100% actions completed	• Signed off at EAP on 4 November 2024	
Statutory Mandatory Training Must do 5 The service must ensure that all staff groups complete mandatory training in a timely way. (Regulation 12)		100% actions completed	• To be presented at EAP in Jan 2025	
Audit Must do 6 The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))		100% actions completed	• Signed off at EAP in Dec 2nd 2024	Audit data requirements embedded into new IT systems and Digital transformation programme (go live Feb 2025) to support full compliance. Ensure further backlog does not occur and monitor this via local governance.
Medicines Safety Must do 7 The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments. (Regulation 12 (2) (g))		100% actions compliant	To be presented at EAP in 2025	

Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Incident Management, Must do 8, S29A The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))		100% compliant	• To be presented at EAP in Jan 2025	
Environment, Must do 9, S29A The service must ensure clinical areas are clean, fit for purpose and equipment is properly serviced and maintained in a timely way, including but not limited to emergency trolleys, resuscitaires and appropriate, timely portable appliance testing. (Regulation 15 (1) (a) (c) (d))		100% compliant	• To be presented at EAP in Jan 2025	
Governance and Communications, Must do action 10 The service must ensure governance processes are effective including but not limited to communication between staff, service leaders and trust executives, clear and up-to-date guidelines in place, acting on audit results, and appropriate incident management. (Regulation 17 (1))		90% compliant	• To be presented at EAP in Jan 2025	Revised gesh structure not yet confirmed; site leadership not yet substantive.
Appraisal, Must do 11 The service must ensure all staff are provided with annual developmental appraisals. (Regulation 12)		69% compliant	• To be presented at EAP in 2025	Sustainability of reaching and maintaining >90% appraisal rates remains challenging.
Standards of documentation, Must do 12 The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))		85% actions completed	• To be presented at EAP in 2025	Maternity Digital Transformation programme launching Feb 2025 Maintaining documentation audit programme, with oversight at Div Gov Meeting
Safeguarding, Must do 13 The service must ensure maternity safeguarding processes are strengthened, including timely staff training, consideration of a maternity safeguarding policy, adequate availability of staff trained in safeguarding concerns, and timely actions to implement safe measures to reduce the potential for baby abduction. (Regulation 13)		100% compliant	• Signed off at EAP 27 September 2024	
Induction of Labour, Must do 14 The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12)		100% compliant	• Signed off at EAP in September 2024 with additional recommendations made to co-produce with MNVP	

Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Bereavement, Must do 15 The service must ensure that documentation in the bereavement suite is completed contemporaneously and in full. (Regulation 17 (2) (c))		100% compliant	• Signed off at EAP - 27 September 2024	
SHOULD DO's				
Should do 1 – Fetal growth The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies		100% compliant	• SBLCB vs3 assessed as compliant by SWL LMNS	
Should do 2 – The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way		100% compliant	• SBLBC vs3 assessed as compliant by SWL LMNS • SQAS review met compliance	
Should do 3 – The service should take account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups			• Capital Midwife anti-racism framework being rolled out • Development and job opportunities open to all staff	Gap analysis against WRES standards to be completed in conjunction with Trust EDI lead
Should do 4 – Second Ward Round on Delivery Suite The service should formalise a second consultant ward round on labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations		100% complaint	• Safety Action 4 CNST meets compliance	
Should do 5 – Staff Culture The service should examine its culture and involve staff in improving it, including staff members with protected characteristics		100% Compliant	• Perinatal Culture and leadership Programme completion SCORE survey and Qi /maternity transformation programme underway	
Should do 6 – Executive oversight The service should improve executive knowledge of and involvement in maternity services, including but not limited to the safety champion role and health inequalities for women and birthing people who use the service		100% compliant	• EDS compliance • Planned programme of engagement with Executive and NED safety champions, (gesh and site specific)	

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Safety Champions (staff engagement/feedback/walk-arounds)

The Board safety champions continues with walkaround of the maternity and neonatal unit, with the latest taking place on 1 October 2024. Triage, delivery suite, birthing centre, bereavement suite and the neonatal unit were visited
Examples of what staff said;

The bereavement suite has been refurbished with the support of charitable funds and is a fantastic facility.
A new midwife told the Exec Board Safety Champion that they felt well supported since moving to the Trust in August.
An MSW also reported being really well supported, very happy to be working in the unit and proud to be part of the team.
In triage - there was a discrepancy between what is reported in terms of staffing numbers and fill rate and how it feels on the ground (staffing should be 2RMs + 1 MSW in the day, but the lived experience is mostly 1RM + 1MSW)
In triage – rota management was highlighted as an issue
Birthing Centre – a complaint that staffing levels were low at the time of the visit, however there were no birthing people at all in the birth centre, with one expected to come in.
Neonatal Unit – the milk bank was visited, which has an IT solution previously procured to track milk, which is still not integrated with the Trust IT. The milk bank is a small fridge and at the time of the visit held 30 small bottles and they are tracked in and out with a logbook. Given the small volumes held, prioritisation for integration will need to be considered in context of all the Trust priorities.

FTSU

The SGH FTSU team confirmed that there have not been any FTSU concerns raised in September or October.

There was however one query raised regarding Bank rates of pay.

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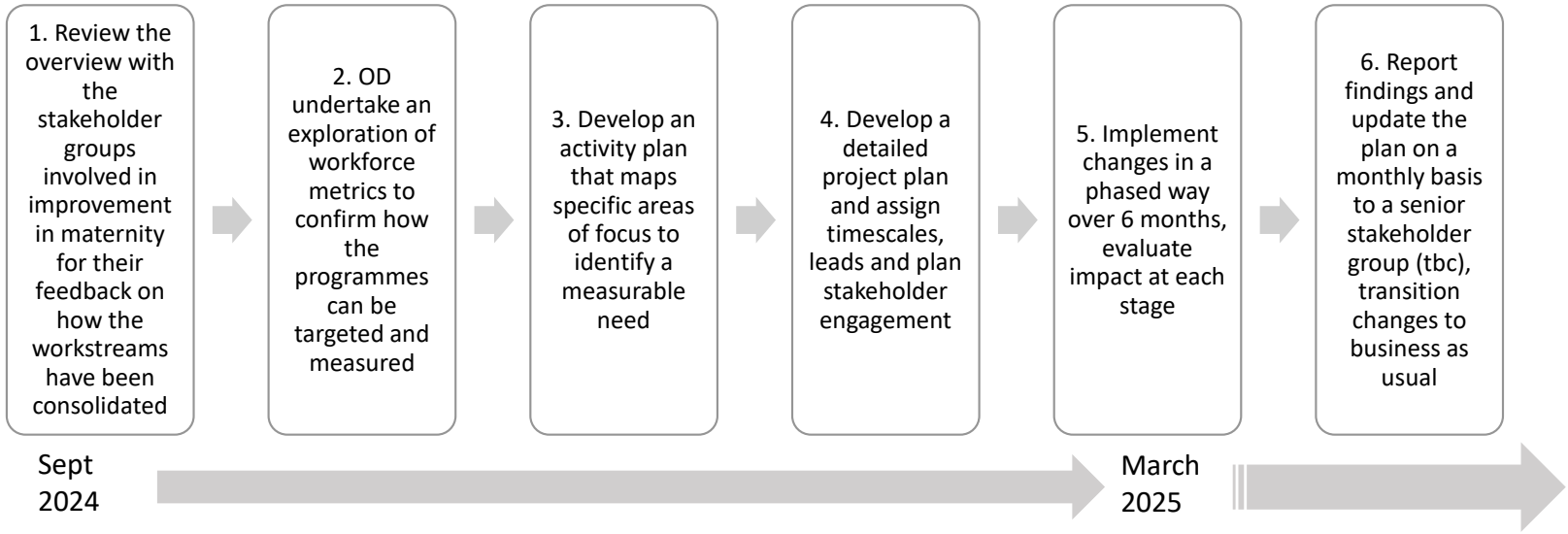
Next steps for planning culture improvement programme delivery - SGH



Assumptions for programme delivery and design

- OD capacity for improvement will be approximately 30% FTE over 6 months from September 2025.
- The programme is designed to be delivered as local initiatives with support of OD and health and wellbeing teams, but led and owned by local leaders at mid and senior level.
- Local Driver leaders will be supported and championed by senior leadership

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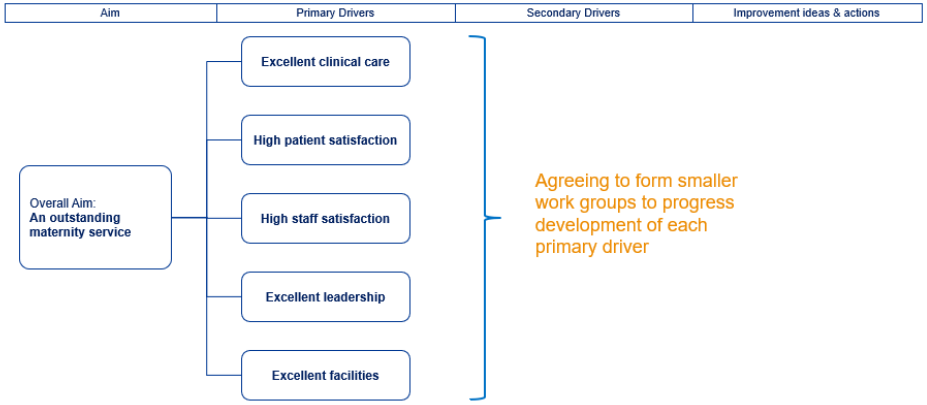
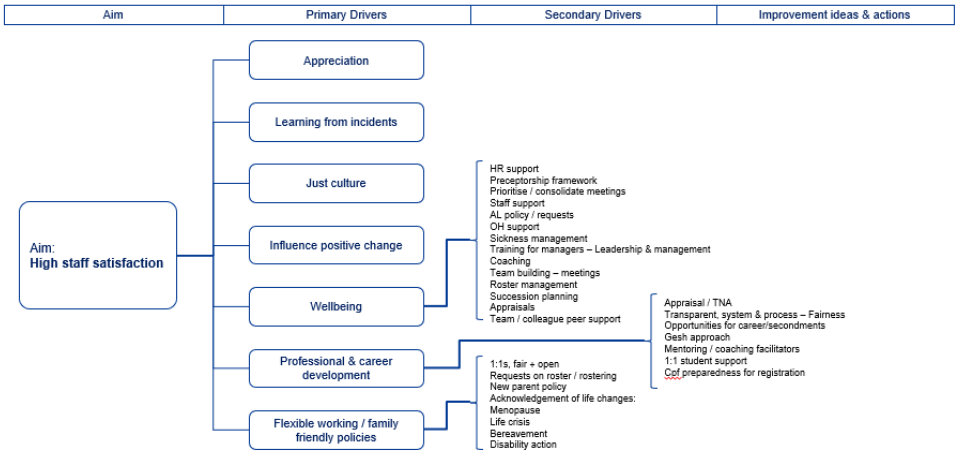
The proposed culture improvement implementation plan based on the drivers and workstreams identified through the continuous improvement driver analysis

An initial high-level vision / driver diagram structure from the 24th & 25th May workshops



Development of 'staff satisfaction' drivers in 17th June workshop



Culture improvement implementation plan proposed to start from Sept 2024

WORKSTREAMS OVERVIEW:				
Mentoring	Health and wellbeing	Appraisal focus	Succession Planning	Team building
Inclusive mentoring is introduced to embed inclusive teamwork, share best practice and break silos	Flexible working conversations are encouraged. Breaks are managed well.	A campaign for good appraisals. Bite size learning for appraisals	Implement the NHS succession planning process – a pilot of the gesh talent management programme	Team building skills developed in team leads and regular opportunities for team development activities planned
Delivery: September 2024 – March 2025				

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Thank you.

For any other information, please see:

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Appendix 2

Maternity and Neonatal Incentive Scheme (CNST) Year 6 - ESTH

Compliance update for the Group Board – 09 January 2025

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Background/Overview

- The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. There are 89 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2024). The deadline date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2025.
- The following slide shows an overview of the current compliance status. Most requirements cannot be assessed as complete until after the end of the MIS period. For the purposes of this report 'red' indicates that we have not yet received any assurance or evidence or that we are compliant, 'amber' indicates that work is in progress and on track, 'green' indicates that the action is complete and evidence has been received and 'blue will be completed once the evidence has been reviewed and signed-off.

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

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Background/Overview - ESTH

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	Safety Action Detail	RAG (Dec 2024)	Projected Submission RAG
1	*Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024?*	On Track – awaiting evidence of Safety Champion Meeting minutes	
2.	*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*	Standard met and all evidence submitted	
3	*Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?*	Transitional Care QI update included below	
4	*Can you demonstrate an effective system of clinical workforce planning to the required standard?*	Evidence of BAPM standard met – to be formally recorded in Board Minutes	
5	*Can you demonstrate an effective system of midwifery workforce planning to the required standard*	Standard met and all evidence submitted	
6	*Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*	Standard met and all evidence submitted	
7	*Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*	On track – evidence pending from Lead Midwife and LMNS	
8	*Can you evidence of 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*	Standard met and all evidence submitted	
9	*Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*	On track - evidence pending from corporate team (minutes)	
10	*Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*	Standard met and all evidence submitted	

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Safety Action 1:

"All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days."

- Since the last report in October 2024 there have been 5 eligible cases for PMRT review and all cases have met the standard.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review Y/N
95161	14/09/2024	16/09/2024	Y
95209	17/09/2024	18/09/2024	Y
95489	06/10/2024	07/10/2024	Y
95532	09/10/2024	10/10/2024	Y
95557	10/10/2024	11/10/2024	Y

"For at least 95% of all the deaths eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months."

Case ID	Review Started	Review Complete	Parents Informed	Notes
92613	Y	Y	Y	
94180	Y	Y	Y	
94559	Y	N	Y	*Standard on track*
94606	Y	N	Y	*Standard on track*
94664	Y	N	Y	*Standard on track*
94724	Y	N	Y	*Standard on track*
94791	Y	N	Y	*Standard on track: MNSI Case*
94809	Y	N	Y	*Standard on track*
95161	Y	N	Y	*Standard on track*
95209	Y	N	Y	*Standard on track*
95489	Y	N	Y	*Standard on track*
95532	Y	N	Y	*Standard on track*
95557	Y	N	Y	*Standard on track*

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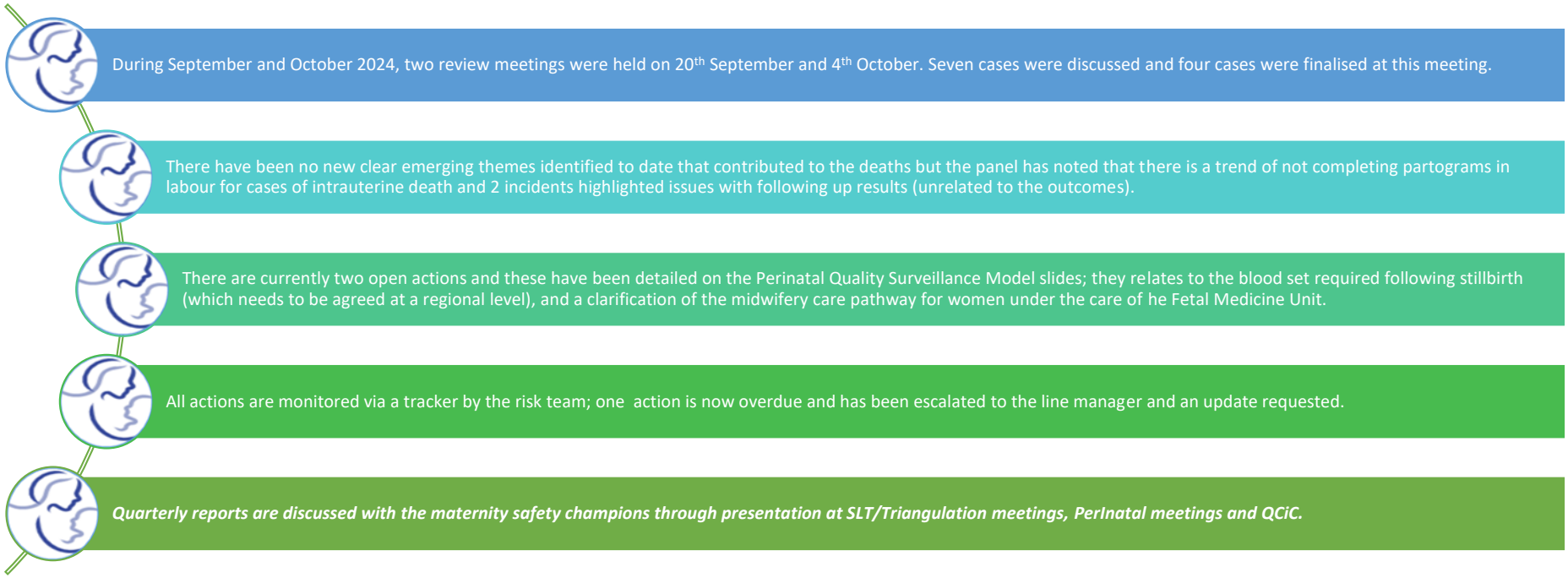
Themes and action plans

Please refer to the Board Report generated from the PMRT (Appendix 1)



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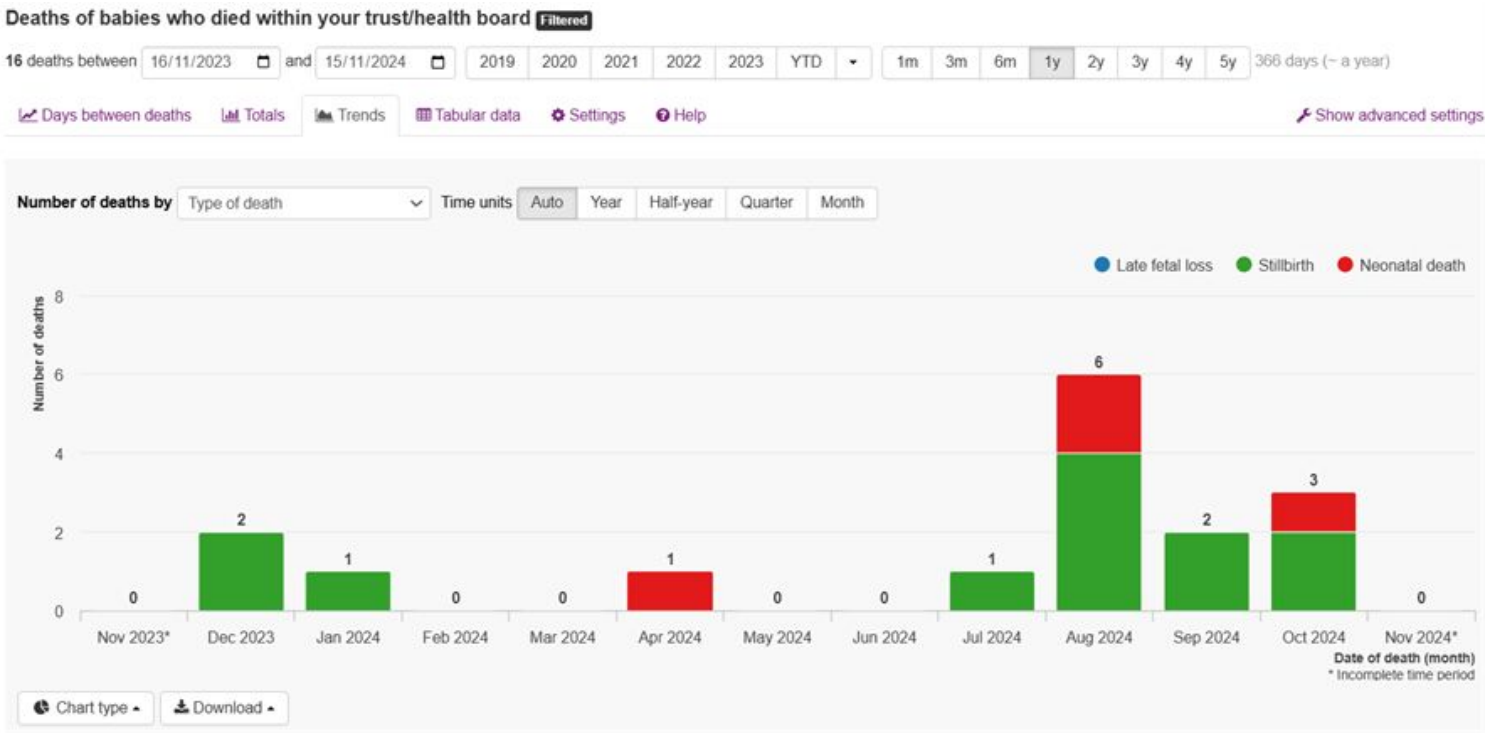
Overview of cases reported to MBBRACE-UK



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Overview of cases reported to MBBRACE-UK

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Safety Action 4: *compliance with BAPM standards needs to be formally recorded in the Trust Board minutes to be compliant with CNST*

Consultant attendance at emergency situations is monitored and audited. 100% compliance with the standard achieved during MIS Year 6.

BAPM

Both the Neonatal Nursing and Medical Teams have confirmed that they fully meet the BAPM standards. This needs to be formally recorded in the Trust Board minutes.

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Safety Action 6: We are required to meet all standards within the Saving Babes Lives Care BundleV3 and compliance is assessed quarterly by the ICB ***We are fully compliant with this safety action***

Trust: **Epsom and St Helier University Hospitals NHS Trust**

ICB: **London**

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5	A
Review Quarter	Baseline	Q1	Q2	Q3	Q4	Q1	
Assurance Review Date	29/09/23	12/10/23	16/01/24	15/04/24	15/07/24	14/10/24	
Element 1	10%	10%	90%	100%	100%	100%	
Element 2	60%	60%	90%	90%	95%	95%	
Element 3	50%	50%	100%	100%	100%	100%	
Element 4	40%	40%	80%	100%	100%	100%	
Element 5	15%	15%	81%	89%	100%	100%	
Element 6	17%	17%	100%	100%	83%	100%	
TOTAL	30%	30%	89%		97%	99%	

At the last quarterly review meeting (Oct 2024) with the LMNS/ICB we were assessed as 99% compliant. The next review is scheduled for January 2025. Improvement trajectories are included on the implementation tool.
Thematic review of incidents is undertaken by the risk team on a monthly basis and a larger review was undertaken between 01/07/2023 and 03/06/2024 and was reported to QCiC in June 2024.

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Safety Action 8:Training Compliance

Type of Training and % compliance	Staff Group	ESTH Sep 24	ESTH Oct 24	ESTH Nov 24
PROMPT 90%	Midwifery Staff	94%	94%	96%
	Maternity Support Workers	94%	93%	97%
	Consultant Obstetricians	90%	90%	94%
	Trainee and Staff Grade Obstetricians	92%	96%	97%
	Anaesthetics	75%	87%	95%
CTG Training 90%	Midwifery Staff	90%	95%	95%
	Obstetricians	93% Cons/100% MG	97% Cons/100% MG	97% Cons/95% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	94%	96%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	86% (provided in November 2024)	94%	98% Nurses/100% ANNP
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	7% Consultants 17% Middle grades	Not Provided	100%

Training compliance as at 30/11/2024 (01/12/2023 – 30/11/2024) is greater than 90% and therefore we are compliant with the CNST Maternity Incentive Scheme Year 6. Figures are still not being routinely provided by the neonatal service and this has been escalated so that a robust process for reporting compliance monthly can be established.

All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

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Safety Action 10: *we are fully compliant with this safety action*

Since 8th December 2023 we have reported 2 cases to MNSI; one case related to a baby who needed therapeutic cooling and one case related to a neonatal death. The cooled baby was also reported to NHS Resolution's Early Notification Scheme (M24CT489/009). We have received confirmation from NHSR that all the relevant reporting has been completed and we are compliant with sub-action 10.8.

All families have received the relevant information regarding MNSI and the ENS/duty of candour. The redacted letters will be presented as evidence.

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Thank you.

For any other information, please see:

Appendix 2a

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

Maternity and Neonatal Incentive Scheme (CNST) Year 6 - SGUH

Compliance update for the Group Board – January 2025

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Background/Overview

- The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. There are 89 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2024). The deadline date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2025.
- The following slide shows an overview of the current compliance status. Most requirements cannot be assessed as complete until after the end of the MIS period. For the purposes of this report 'red' indicates that we have not yet received any assurance or evidence that we are compliant, 'amber' indicates that work is in progress and on track, 'green' indicates that the action is complete, and evidence has been received and 'blue will be completed once the evidence has been reviewed and signed-off.

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	0	6	0	0	6
2	0	0	2	0	2
3	0	0	4	0	4
4	15	5	0	0	20
5	0	3	3	0	6
6	0	6	0	0	6
7	1	3	3	0	7
8	8	13	0	0	21
9	0	6	3	0	9
10	0	8	0	0	8
Total	24	50	15	0	89

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

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Background/Overview - SGH

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	Safety Action Detail	RAG – November 2024	Projected Submission RAG in DEC
1	*Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024?*	On Track (PMRT report included - slide 4)	
2.	*Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*	Compliant	
3	*Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?*	Transitional Care QI update included below	
4	*Can you demonstrate an effective system of clinical workforce planning to the required standard?*	Action plans in place for obstetric consultant attendance at emergencies and Neonatal Nursing.	
5	*Can you demonstrate an effective system of midwifery workforce planning to the required standard*	Midwifery staffing report submitted	
6	*Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*	On track – update provided Slide 10	
7	*Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*	On track	
8	*Can you evidence of 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*	On track-November training stats included below	
9	*Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*	On track – claims scorecard report included slide 13	
10	*Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*	On track	

Safety Action 1: PMRT

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All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days."

Since the last report in August 2024 there have been 2 eligible cases for PMRT review, and all cases have met the standard.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review Y/N
95210	13/09/2024	18/09/2024	Y
95304	20/09/2024	25/09/2024	Y
95656	13/10/2024	17/10/2024	Y
95656	13/10/2024	17/10/2024	Y
95964	31/10/2024	07/11/2024	Y

"*For at least 95% of all the deaths eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months."*

Case ID	Date of Death	Review Started	Review Complete	Parents Informed	Notes
95210	13/09/24	18/09/24	N	Y	PMRT meeting to take place on 11/12/2024
95304	20/09/2024	25/09/24	N	Y	PMRT meeting to take place on 11/12/2024
95656	13/10/24	17/10/24	N	Y	PMRT meeting to take place on 08/01/2025
95656	13/10/24	17/10/24	N	Y	PMRT meeting to take place on 08/01/2025
95964	31/10/24	07/11/24	N	Y	PMRT meeting to take place on 4 29/01/2025

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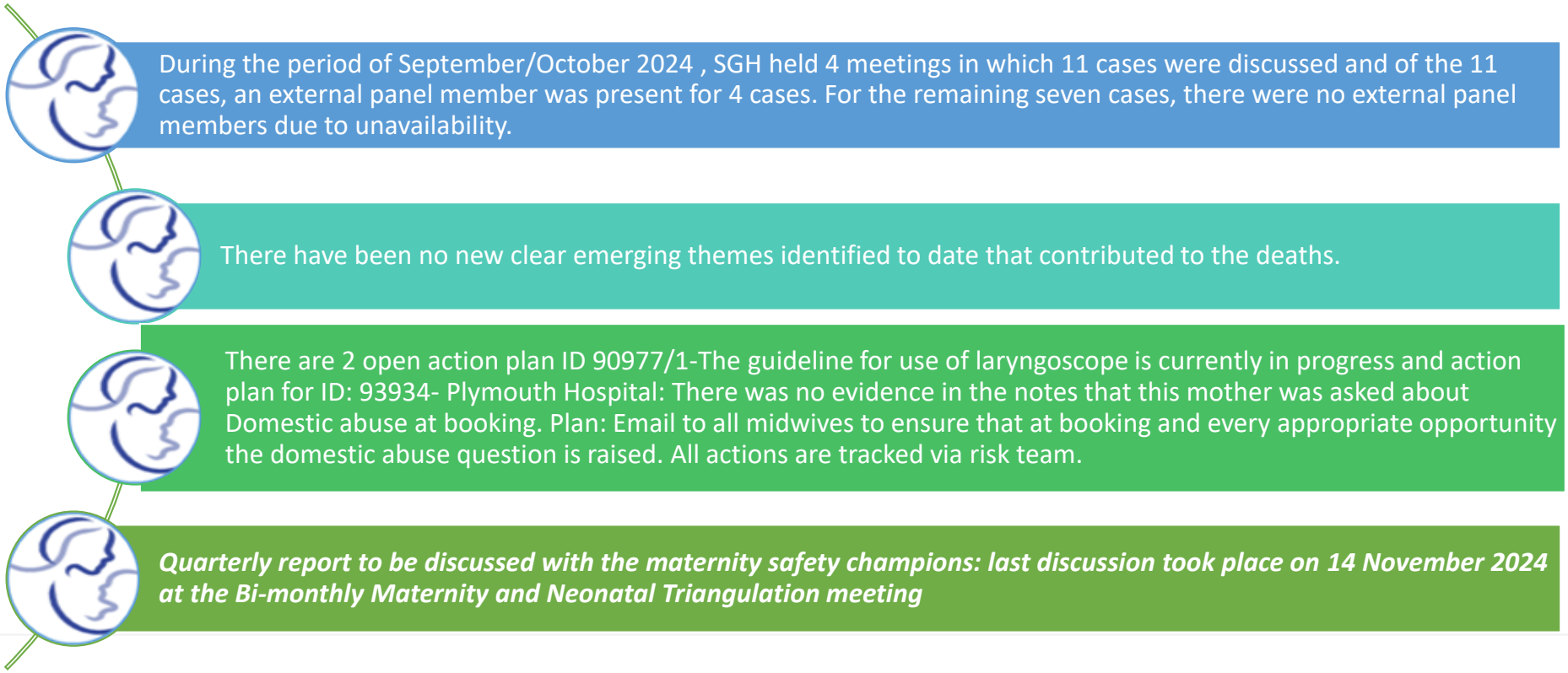
Themes and action plans

Please refer to the Board Report generated from the PMRT (Appendix 1)



During the period of September/October 2024 , SGH held 4 meetings in which 11 cases were discussed and of the 11 cases, an external panel member was present for 4 cases. For the remaining seven cases, there were no external panel members due to unavailability.

There have been no new clear emerging themes identified to date that contributed to the deaths.

There are 2 open action plan ID 90977/1-The guideline for use of laryngoscope is currently in progress and action plan for ID: 93934- Plymouth Hospital: There was no evidence in the notes that this mother was asked about Domestic abuse at booking. Plan: Email to all midwives to ensure that at booking and every appropriate opportunity the domestic abuse question is raised. All actions are tracked via risk team.

Quarterly report to be discussed with the maternity safety champions: last discussion took place on 14 November 2024 at the Bi-monthly Maternity and Neonatal Triangulation meeting

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

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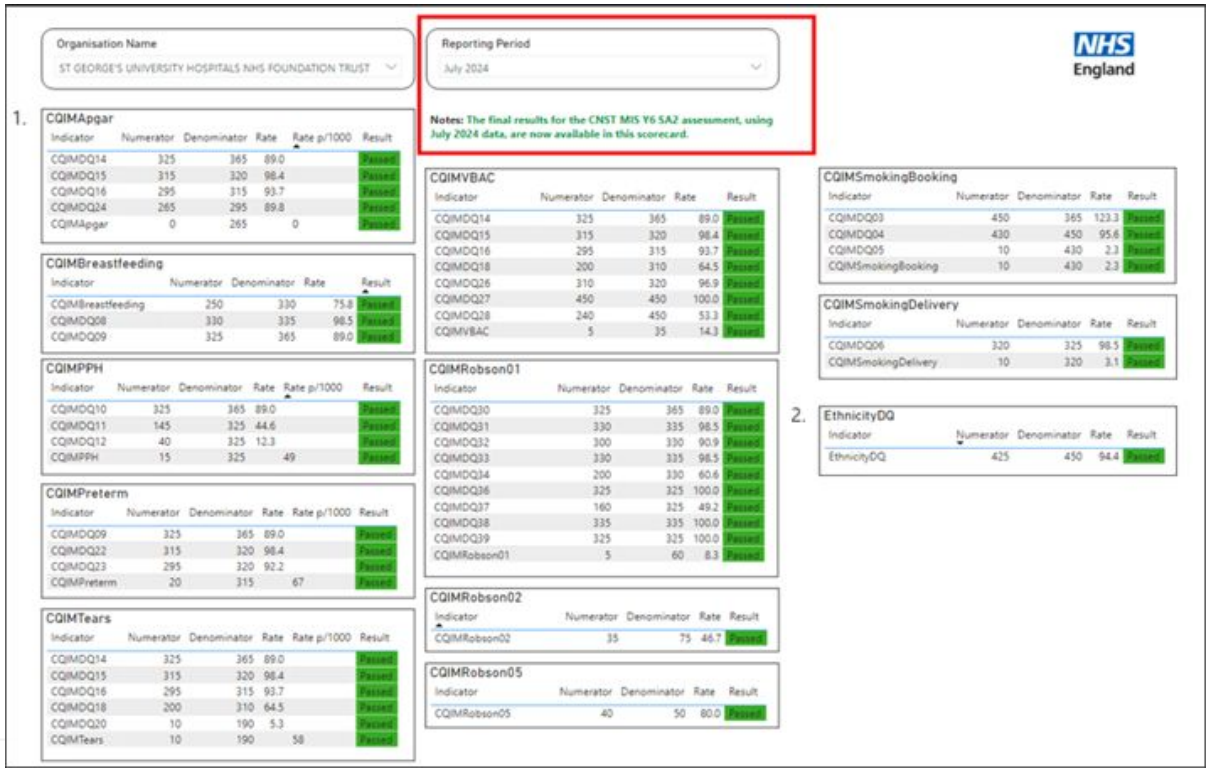
SGH is compliant on the FINAL report for July Data. The final report was published in October 2024.

	Requirement
2.1	Was your Trust compliant with at least 10 out of 11 MSDS-only Clinical Quality Improvement Metrics (CQIMs) by passing the associated data quality criteria in the "Clinical Negligence Scheme for Trusts: Scorecard" in the Maternity Services Monthly Statistics publication series for data submissions relating to activity in July 2024? Final data for July 2024 published in October 2024.
2.2	Did July's 2024 data contain a valid ethnic category (Mother) for at least 90% of women booked in the month? Not stated, missing and not known are not included as valid records for this assessment as they are only expected to be used in exceptional circumstances. (MSD001)



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Safety Action 3: SGH – As part of SA3 we are required to undertake a QIP and provide a progress Report to the Board

SGH – TC QIP Progress Report

- There has been ongoing work to have TC on the postnatal ward to avoid separation of mothers and babies.
- Some babies that require TC are being admitted to NNU as this cannot be provided on the postnatal ward.
- Neonatal staffing required to care for these babies on postnatal ward.
- The business plan was approved to facilitate the provision of TC on postnatal ward.
- QI project for TC has been registered with Trust.

- Recruitment and onboarding of staff for TC is currently in progress and is being led by the neonatal team.
- Recruited Band 7, 5 Band 4s, 2 band 5s.
- Recruitment for 2 more Band 5s in progress.
- Band 4s started in October and are going through Trust and local induction and skills and competencies training.
- Neonatal team currently hold regular MDT meetings discussing TC and how it will be launched. Next TC meeting date TBC
- The neonatal team will invite the postnatal ward team to their next meeting
- TC will be launched Q4 2024/25. This is to allow all staff to go through training to ensure safety.

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Safety Action 4: Evidence of audit of obstetric locum use, of 24/7 obstetric anaesthetist cover and evidence that the neonatal medical and nursing workforce meet the BAPM standards has been requested.

Consultant attendance at emergency situations has been 89.1% against standard of 100% for April to July. 2 cases of 4th degree repairs were not attended by a consultant and 1 case of preterm twins c-section birth >28/40. Evidence of an action plan has been submitted by the consultant body.

Neonatal and anaesthetic medical workforce are compliant with this action. Evidence of rotas submitted. Action plan for Neonatal Nursing submitted as non- compliant with BAPM nursing standards.

Any action plan needs to be signed off by the Trust Board and this information needs to be shared with the LMNS and the Safety Champions.

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

Compliant with this Safety action.

Staffing paper being submitted with this report as evidence of compliance.

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Safety Action 6: We are required to meet all standards within the Saving Babes Lives Care Bundle Version 3 and compliance is assessed quarterly by the ICB.

Trust: **St George's University Hospitals NHS Foundation Trust**

ICB: **London**

% of Interventions Fully Implemented (LMNS Validated)

	Baseline Assessment	Assessment 1	Assessment 2	Assessment 3	Assessment 4	Assessment 5
Review Quarter	**Baseline**	**Q1**	**Q2**	**Q3**	**Q4**	**Q1**
Assurance Review Date	**29/09/23**	**10/10/24**	**18/01/24**	**17/04/24**	**17/07/24**	**16/10/24**
Element 1	0%	0%	60%	70%	84%	60%
Element 2	40%	40%	60%	65%	75%	90%
Element 3	0%	0%	100%	100%	100%	100%
Element 4	0%	0%	60%	80%	80%	80%
Element 5	44%	44%	78%	85%	93%	93%
Element 6	33%	33%	100%	100%	83%	83%
TOTAL	31%	31%	71%	79%	84%	86%

At the last quarterly review meeting (16th October 2024) with the LMNS/ICB SGH were assessed as being 86% compliant. Improvement trajectories are included on the implementation tool.

Evidence of discussion in the form of minutes to be provided by the LMNS/ICB.

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Safety Action 7: Listen to women, parents and families using maternity and neonatal services and coproduce with users.

On track for compliance with this safety action. Comprehensive report from Core Connector on the outcomes of the Whose Shoes event. FMU/MNVP/SANDS project to commence introducing peer supporters. IOL project to transform the user experience.

MNVP expenses reimbursement SOP Dec 2023/MNVP invoice template. Funding support available for maternity and neonatal.

CQC Maternity Survey results 2023 with 2024 action plan. CQC maternity presentation with actions-Trust PPEG meeting

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Safety Action 8: *Can you evidence 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*

Type of Training and % compliance	Staff Group	SGH Sept 24	SGH Oct 24	SGH Nov 24
PROMPT 90%	Midwifery Staff	90%	90%	90%
	Maternity Support Workers	92%	90%	90%
	Consultant Obstetricians	94%	95%	100%
	Trainee and Staff Grade Obstetricians	88%	78%	83%
	Anaesthetics	94%	88%	94%
CTG Training 90%	Midwifery Staff	92%	89%	98%
	Obstetricians	84%	84%	100%
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	96%	93%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	92%	90%	90%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	95%	100%	100%

In PROMPT we can see that 5 'juniors' are not compliant with PROMPT, but 4 of them started at St George's in October 2024. They are booked to attend PROMPT in December 2024 or January 2025, so we are compliant as per MIS year 6 April 2024 amendment.

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Safety Action 9

SGH claims Scorecard April 2014 – March 2024 ***Legal team publish this annually***

Top injuries by volume: Unnecessary Pain (5) Fatality (4) Brain Damage (4) Stillborn (4) Cerebral palsy (3)	**Top injuries by value:** Brain damage (4) Cerebral palsy (3) Incontinence (2) Bowel Damage/Dysfunction (2) Erb's palsy (1)
Top causes by volume: Fail/Delay Treatment (10) Fail to monitor 2nd stage Labour (5) Fail to monitor 3rd Stage Labour (5) Fail/Delay Diagnosis (3) Fail To make Respond to Abnormal FHR (3)	**Top causes by value:** Fail to monitor 1st Stage Labour (5) Fail/Delay Treatment (10) Fail to Monitor 2nd stage of Labour (5) Fail to make Respond to Abnormal FHR (3) Inadequate Nursing Care (1)

Complaints Q2 2024-2025 (complaints)

Birthing experience (3)
Communication (1)
Incorrect blood type (1)
Incorrect measurement of cervix(1)
Antenatal clinic waiting times (1)

Incidents Q2 2024-2025 (moderate and above harm outcomes)

PPH > 1.5 litres
3rd/4th degree tears
Term NNU admission
IUD's

There is a requirement for a Quarterly review of Trust's claims scorecard alongside incident and complaint data and discussed by the maternity, neonatal and Trust Board level safety champions at a Trust level (Board or directorate) quality meeting

Themes Q2 2024-2025

- There are no obvious themes emerging in response to incidents, complaints and claims. The main emerging themes for this period were antenatal computerised CTGs and postnatal readmissions.

Learning Q2 2024-2025

- Interpretation of Antenatal computerised CTGs
- VTE risk assessment in pregnancy

Key Actions in progress

VTE risk assessment awareness	Ongoing	
Antenatal computerised CTG's teaching	Ongoing	
Proposal of wound infection clinic	Ongoing	

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Safety Action 10:

Since 8th December 2023 we have reported 9 cases to MNSI; 4 cases related to babies who needed therapeutic cooling, and three cases related to neonatal deaths and 2 maternal deaths. The cooled babies were also reported to NHS Resolution's Early Notification Scheme.

All families have received the relevant information regarding MNSI and the ENS/duty of candour. The redacted letters will be presented as evidence.

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Thank you.

For any other information, please see:

Group Board Meeting (Public)

Meeting on Thursday, 09 January 2025

Agenda Item	4.1	
Report Title	**Fairness and Equity in Managing Concerns about Doctors and Dentists**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Dr Steve Hyer, Responsible Officer ESTH Dr Elizabeth Rhodes, Responsible Officer SGUH Dr Rebecca Suckling, CMO ESTH Dr Lucinda Etheridge, CMO SGUH	
Previously considered by	People Committees-in-Common	12 December 2024
Purpose	**For Assurance**	

Executive Summary

It is recognised nationally that doctors with protected characteristics are at increased risk of investigation for concerns and referral to the General Medical Council (GMC), and data from the General Dental Council (GDC) (Fitness to Practice Statistical Report 2023) suggests a similar trend for dentists.

Standards to protect against this unfair bias exist and are described by the GMC paper "*Fair to Refer*" (June 2019) and in a letter from Baroness Dido Harding to all Trusts (May 2019).

Not unexpectedly, this organisation has been challenged from time to time, by doctors, their advocates, unions and national associations representing doctors of different ethnic origins, to consider the fairness of our processes in the light of this national picture.

Whilst a regular report on all formal investigations of doctors is provided to the Group Board in Private, and whilst these reports have from time to time provided data on protected characteristics, the Board has not hitherto received regular information to enable it to assess the level of assurance that investigations are conducted as fairly as possible.

This report to People Committees-in Common seeks to begin to provide that information in a structured way that can be continued on a regular basis, and further developed as appropriate.

This paper describes:

- The current approach across gesh to ensuring that the principles of a just culture are embedded throughout our processes for managing concerns about doctors and dentists;
- The challenges to sustaining this and where the risks and gaps are;
- The breakdown by gender and ethnicity of doctors and dentists where concerns have been managed under the Maintaining High Professional Standards (MHPS) framework;
- The approach we will take to improving both our processes in order to improve our assurance that these processes are fair, transparent and equitable.

The picture described in this paper can be summarised as follows:

- Governance arrangements are in place to ensure that the majority of good practice recommendations in GMC guidance, the Baroness Harding recommendations and the national MHPS process are followed.
- There is well-established close working, sharing of good practice and unity of basic processes between ESTH and SGUH, and a Group-wide MHPS Policy is ready to be ratified in the New Year.
- There is established consistent Board level visibility of formal investigations into doctors and dentists
- Data from the last three years shows, however, that of those doctors formally investigated, in common with the national picture, male doctors and doctors of non-white (global majority) ethnic origin constitute a greater proportion than they do of the overall workforce, indicating that more needs to be done to mitigate potential or actual bias and unfairness.
- Areas for improvement have been identified, and will be addressed, to strengthen these mitigations.
- Data will henceforth be provided more consistently and comprehensively to enable a more informed assessment of the level of assurance we can have in the fairness of our investigation processes for doctors and dentists.

Action required by Group Board

The Board is asked to:

a. Note the report, and note the approval by People Committee of the recommendation to provide a biannual report that outlines the NHS Employers dataset and provides ongoing assurance of the fair and equitable application of processes

b. Advise on other key metrics that should be presented to provide appropriate assurance that both Trusts maintain a fair and equitable application of MHPS processes

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

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

Ineffective management of concerns about doctors and dentists carries a high financial burden.

Legal and / or Regulatory implications

Medical and dental practitioners are regulated through the GMC and GDC respectively and action under MHPS may have implications for licence to practise. Unfair application of these processes may result in legal challenge and potential high cost for the Trust.

Equality, diversity and inclusion implications

This is an issue where we know doctors and dentists with protected characteristics are at increased risks of concerns being raised and referrals to the GMC.

Environmental sustainability implications

None.

Fairness and Equity in Managing Concerns about Practising Doctors and Dentists

Group Board Meeting (Public)

1.0 Purpose of paper

1.1 To provide assurance to the Board that both Trusts have embedded processes to ensure fairness, equity, and transparency when addressing concerns about practising doctors and dentists (referred to together as practitioners).

2.0 Background

2.1 Wide ranging evidence has consistently demonstrated that doctors with protected characteristics are at increased risks of investigation for concerns and referral to the General Medical Council (GMC). The GMC's "Fair to Refer?" report in 2019 brought into focus systemic inequities in the referral of doctors to the GMC for fitness-to-practice concerns. In particular, doctors from Black, Asian and Minority Ethnic backgrounds and international medical graduates (IMGs) are disproportionately referred, which could represent potential biases in referral practices.

To address this, the report recommended:

- Providing comprehensive support for doctors new to the UK or the NHS or whose role is likely to isolate them (including SAS doctors and locums).
- Ensuring engaged and positive leadership more consistently across the NHS
- Creating working environments that focus on learning and accountability rather than blame
- Developing a programme of work to deliver, measure and evaluate the delivery of these recommendations

2.2 National Guidelines, including NHS *Just Culture* guide and The NHS People Plan (2019, 2021) emphasise the importance of a more inclusive and supportive NHS workplace when addressing concerns about practitioners. The importance of having a Just culture allows a more balanced approach to accountability and distinguishes between honest mistakes and reckless behaviour. This culture is integral to the development of a supportive working environment for practitioners.

2.3 Baroness Dido Harding, whilst NHS improvement chair, wrote to all NHS Trusts in May 2019 detailing the findings of an independent analysis by an advisory group following the very tragic death of Amin Abdullah, an NHS nurse who took his own life after being dismissed from his job in 2016. The letter includes guidance relating to the management and oversight of local investigation and disciplinary procedures and a call to action to review the guidance against current practice and adjust to ensure it is in line with best practice. The questions Trusts were asked to consider were :

- Is there sufficient understanding of the issues or concerns, and the circumstances relating to them, to justify the initiation of formal action?
- Considering the circumstances, in the eyes of your organisation and others external to it, would the application of a formal procedure represent a proportionate and justifiable response (i.e. have other potential responses and remedies, short of formal intervention, been fully assessed before being discounted)?

- If formal action is being or has been taken, how will appropriate resources be allocated and maintained to ensure it is conducted fairly and efficiently; how are you ensuring that independence and objectivity is maintained at every stage of the process?
- What will be the likely impact on the health and wellbeing of the individual(s) concerned and on their respective teams and services, and what immediate and ongoing direct support will be provided to them? Further, how will you ensure the dignity of the individual(s) is always respected and in all communications, and that your duty of care is not compromised in any way, at any stage.
- For any current case that is concluding, where it is possible that a sanction will be applied, are similar questions being considered?

Baroness Harding's recommendations specifically pointed to the disproportionate impact of disciplinary measures on practitioners from BAME backgrounds.

2.4 The management of concerns about medical and dental practitioners is guided by the nationally agreed Maintaining High Professional Standards (MHPS) framework. This provides a robust, transparent structure for managing concerns about practitioner conduct, performance, and health. Crucially, the MHPS framework promotes fairness by ensuring that decisions are made based on evidence and merit, that all parties involved have a clear understanding of their rights and responsibilities, and that impartiality checks are built in at every stage of the process.

3.0 Gesh approach to ensuring equity, fairness and transparency

3.1 Approach across gesh

3.1.1 Both Trusts manage concerns about practitioners in line with the national MHPS framework and accepted best practice. In 2024, a group MHPS policy was agreed with the Local Negotiating Committees on each site which incorporates the Just Culture guide and Dido Harding principles. Following ratification this will be implemented 2025, with investigator and manager training already ongoing across both sites for clinical leaders and managers. The characteristics of the trained individuals is recorded in order to try to ensure that as far as possible it is representative of the population of doctors and dentists working in the Trust.

3.1.2 The independent Practitioner Performance Advisory Service (PPAS, part of NHS Resolution) supports both Trusts through providing independent, impartial and expert advice for any practitioner where the Trust has a concern. PPAS offer assessment, mediation and remediation services that can allow concerns to be addressed before the initiation of any formal action, in agreement with the practitioner. PPAS also provides both Trusts with benchmarking data that is reviewed at site level (see section 4.1)

3.1.3 Both Trusts hold a regular Decision-Making Group (DMG) in line with MHPS. These groups have a diverse membership, both in terms of professional background and expertise and protected characteristics, to ensure plurality of decision making. Both comprise the Site Chief Medical officer, Responsible Officer, Head of Medical Workforce and Employee relations expertise. Key individuals such as Divisional senior clinicians, Case Managers and Investigators, Non-Executive Directors, Practitioner Performance Adviser, the GCMO or the GMC Employer Liaison Adviser are invited to join the meeting where required. The DMGs review health concerns, clinical concerns and behaviour/misconduct concerns. Decision making is guided by formal discussion of the Dido Harding principles with the outcome of this recorded for each case. Where formal action is considered, the

Responsible Officer or Group/Site Chief Medical Officer will seek advice from PPAS prior to next steps being taken, and this discussion is shared with the practitioner. If there is an urgent patient safety concern and exclusion or restrictions are considered, this discussion will take place urgently, and the group works to ensure that the least restrictive decision needed to maintain patient safety is made. Impartiality checks are built in throughout the process.

3.1.4 A monthly joint medical workforce meeting discusses issues of common interest and areas for development across gesh. This also allows for sharing of relevant information across the group and peer review and challenge of processes and outcomes.

3.1.5 At both sites, practitioners undergoing a formal process are supported through the Staff Support Service, through their professional bodies and medical protection organisations, and through the appointment of a senior mentor allocated by the DMG. Both sites have a named Non-Executive Director for MHPS whose role is to ensure that matters are proceeding properly and in line with reasonable timescales. The practitioner is able to make independent representations to them.

3.1.6 Both sites have a new consultants' group with a programme aimed at supporting new consultants in the Trust, with meetings with key people and information provided on the consultant role in a variety of formats. This is supported by senior consultants who have trained as mentors. However, mentoring is only provided on a voluntary basis.

3.1.7 Both sites also have induction programmes for international Medical Graduate (IMG) doctors which follows the NHS Workforce, Training and Education (WTE) minimum standards for induction to professional practice, with structured support. The group has appointed a Locally Employed Doctor (LED) lead at St Georges, reporting to the Deputy CMO for workforce, who supports and oversees this group and ensures that all services provide adequate local induction and support, including clinical supervision and supernumerary working as required. The lead at ESTH has developed a buddy system to support overseas graduates for their first 3 months, which will be extended to all LEDs for six months. They offer support and guidance on a voluntary basis and are LEDs, Specialty and Specialist (SAS) doctors or doctors in training who have been at the Trust for at least 6 months.

3.2 Variation in practice at Site level

At St George's, the management of concerns about medical and dental practitioners sits with the central Employee Relations (ER) team. A band 7 ER manager has been appointed to specialise in matters relating to doctors and dentists. At ESTH the management of concerns about medical and dental practitioners sits with a specialist Medical Staffing team, who have expertise in all HR matters relating to doctors and dentists.

There are important differences in timescales for MHPS processes at each site and in the way that data is collected, which are felt to be largely due to the differences in the HR support provided at the two sites. At St George's, cases are taking longer for completion than comparable organisations, as evidenced by PPAS benchmarking data whilst at ESTH the time taken is better than peers.

The original Department of Health 2005 document *Maintaining High Professional Standards in the Modern NHS* says (section 1.17) that investigations should be completed within 4 weeks, and a case report should be submitted to the Case Manager within a further 5 days, but it is well recognised

across the NHS that this target timescale, for investigations that are frequently very complex, is often not practicable.

At ESTH feedback from patients and colleagues as part of the "*Your Voice, Your Values*" exercise resulted in the establishing of the RESPECT course, which is open to all staff and runs 3-4 times a year. The RESPECT People Management Programme is aimed at all new managers and as a refresher for more experienced managers. The course sets out Trust values and the behaviours we expect from each other. In collaboration with NHS Elect, there is a further programme for more senior managers. Building on the RESPECT course, the Trust has developed a Cultural and Leadership programme to enhance equality, diversity and inclusivity approaches. St George's currently does not have a similar program to support this aspect.

4.0 Sources of assurance

4.1 St George's

4.1.1 The Responding to Concerns group has been collecting basic data on key demographic details of practitioners discussed and the outcome of discussions. Table 1 shows the breakdown of this data over a three-year period for St George's:

Table 1: St George's Responding to Concerns key performance data Jan 2021- Jan 2024 (61 doctors discussed 71 times)

Type of concern	Number discussed	Number managed formally	Number excluded, restricted or GMC action on registration	Number of BAME origin	Number of female gender
Doctor's health	3	1	2	1 (33%)	2 (66%)
Conduct	50	6	6	25 (50%)	13 (26%)
Capability	18	4	4	11 (61%)	3 (17%)

Of the 10 practitioners managed formally under the MHPS policy in this time:

- 80% are male
- 50% are Asian/British Asian
- 20% are Black/Black British
- 20% are White

This compares to data from ESR which shows that:

- 47% of substantive medical staff are male
- 27% are from an Asian/British Asian ethnic background
- 4% are from a Black/Black British background
- 49% are from a White background

4.1.2 In 2023 PPAS produced their organisation report for St George's 2019-2022 and the key findings were:

- As a large organisation we have discussed a lower-than-average number of cases.
- Our cases stay open for longer than other organisations of a similar size.
- 66% of our cases discussed conduct, 17% discussed clinical concerns, and 17% discussed health concerns.
- 40% of our cases were doctors who were Asian or Asian British (though in 40% of cases ethnicity was unknown /not recorded), and 20% were white.
- 60% of our cases discussed were male.
- 80% of cases discussed were consultant doctors.

4.2 **ESTH:** The Medical Workforce Meeting group has been collecting basic data on key demographic details of practitioners discussed and the outcome of discussions. Table 2 shows the breakdown of this data for the same three-year period for ESTH:

Table 2: ESTH Responding to Concerns key performance data Jan 2021- Jan 2024

Type of concern	Number discussed	Number managed formally	Number excluded, restricted or GMC action on registration	Number of BAME origin	Number of female gender
Doctor's health	4	0	1	3 (75%)	1 (25%)
Conduct	23	5	7	14 (60%)	6 (26%)
Capability	8	0	2	7 (87%)	3 (37%)

Of the 5 practitioners managed formally under the MHPS policy in this time:

- 80% are male
- 80% are Asian/British Asian
- 20% Black/Black British
- 20% are White

This compares to data from ESR which shows that:

- 50% of substantive medical staff are male
- 38% are from an Asian background
- 7% are from an African or Caribbean background
- 33% are from a White background
- 22% are from mixed, unclassified, not stated and other backgrounds.

4.2.2 The PPAS report (April 2019 –March 2024) for ESTH highlighted the following:

- The total number of cases opened is comparable to Trusts of a similar size
- The average duration of cases (4.9 months) was better than Trusts of a similar size (7.4 months)
- 67% of cases related to behaviour or misconduct, 26% clinical concerns and 7% were health concerns

- 46% of cases identified as South Asian, 31% as White, 15% as Chinese or other ethnicity, 8% as Black and 2% as Mixed. These proportions were comparable to Trusts of similar size with a slight increase in the proportion of South Asian ethnicity.
- 54% of ESTH cases were female
- 62% were consultant grade, 15% Trust grade and 8% SAS doctors. The small proportion of trainees reflects their different management of concerns structure through their Local Education and Training Boards.

4.3 NHSE recommend a minimum dataset is collected for all practitioners who have concerns raised to the DMG. Both sites have agreed to collect data according to this minimum dataset and in addition feel that some additional information would usefully provide insight into the organisational impact of our MHPS processes.

The dataset agreed is as follows:

- Total number of practitioners with and without a prescribed connection to the RO
  - Breakdown into contract types
  - Breakdown by gender and ethnicity of practitioners
- Managing Concerns
  - Total open cases
    - Open internal investigations
    - Open GMC investigations
    - External referrals
    - Restrictions
    - Exclusions
    - Ethnicity, age and gender of the above
    - Self-reported disability

4.4 In addition data will be collected by both DMGs of concerns that are managed at a local level before they reach threshold to be escalated to a decision-making group convened under the MHPS policy. As both nationally and locally, data demonstrates that men and practitioners from a BAME background are over-represented in the group that proceed to a formal process under MHPS. Analysis of concerns which are managed at local departmental or divisional level before concerns are discussed at DMG will provide more understanding of the scope of concerns and their character (health, behaviour, clinical), and help us to understand whether there is opportunity to mitigate unconscious bias or any other form of apparent or actual unfairness in the way concerns are managed at this level.

5.0 Challenges, risks and gaps in assurance

5.1 Following an employment tribunal in 2022, a number of recommendations were made for the organisation to consider based on the learning from this case. The Regional Medical Director then sought assurance on our response to these recommendations. The recommended improvements, most of which have been acted upon and met, were in the following key areas:

- Induction and mentoring for new consultants
- Management of anonymous concerns and triangulation of information about a doctor's performance
- Improved sharing of information about concerns between the sites at which a practitioner works
- Improved oversight of appraisers and appraisal quality assurance

- Review of how doctors in difficulty are managed, especially when in dysfunctional teams, with streamlining of processes to make them efficient and effective
- Improved early remedial action when teams are dysfunctional
- Use of risk templates through a decision-making group to enable fair onward referral
- Consistent allocation of skilled supporters for practitioners going through a process
- Increasing trained investigators and case managers
- Improved training for clinical managers to ensure a working knowledge of MHPS

Following receipt, both Trusts undertook a self-assessment and reviewed their structures and processes to make improvements in line with these recommendations. While the majority are now met, both Trusts continue to have challenges in some areas. The following recommendations will address these issues.

1. **New Consultant Induction and Mentoring:**

Both Trusts will jointly review new consultant induction. The demands on the consultant post can often be different to a new consultant's expectations, with non-clinical aspects of the role often being most challenging. Support during this time is vital to ensure both the wellbeing of new consultants and their effective integration with the team. The practice review will cover induction and support as well as how new consultants develop leadership and management skills.

General Medical Council guidance recommends mentoring throughout a doctors career and emphasises the particular support required at transition points. To support new consultants, both Trusts will explore how to increase the trained mentors available from different backgrounds and experience. With no current funding for provision of this time in job plans, there is a reliance on the continued good will and support of senior doctors. Options to place our mentoring programme on a more robust footing will need to be explored.

2. Data collection

Both Trusts will benefit through improvement in the quality and range of data collected, and through the use of this data to further improve processes.

Once collection is embedded this data will be discussed on a regular basis at the Joint Medical Workforce Meeting to inform ongoing action and development and it is proposed that it form part of more comprehensive reporting to People Committees-in-Common in the future.

3. Aligned HR management

Reducing unwarranted variation in investigation outcomes, as evidenced by the PPAS organisational reports, is important for the wellbeing of those under investigation. Work is underway within the People directorate to establish the optimum models as part of corporate services integration.

In addition, while a number of staff at both sites, including clinical leads, have been trained in MHPS, it remains difficult to find internal staff with the time and resource to undertake complex MHPS investigations. Therefore, we remain reliant on expensive external investigators for most cases. It is important to formally evaluate the time requirement to deliver this work and assess if this can be provided internally.

4. **Training**

There is evidence from external reports, including "*Fair to Refer?*", that the way in which concerns are managed at a local level and escalated has a direct impact on the likelihood of later formal action.
More work is required to train clinical leaders and managers in the application of just culture principles, the recognition and management of any bias, and to provide support them to effectively manage concerns informally, working in conjunction with the People function of gesh. Both Trusts have taken some local action to improve training in recognition of bias, for example Grand Rounds at St George's on recognition of neurodiversity and the blended Human Factors and Continuous Quality Improvement (CQI) Programme at ESTH. However, this practice needs to be better embedded in the training of all line managers, with skilled HR support alongside it. To address this gap, gesh is discussing with NHS Resolution the utilisation of NHSR-sponsored recognised training on managing concerns which is free to Trusts.

6.0 Recommendations

6.1 The Board is asked to:

a. Note the report, and note the approval by People Committee of the recommendation to provide a biannual report that outlines the NHS Employers dataset and provides ongoing assurance of the fair and equitable application of processes

b. Advise on other key metrics that should be presented to provide appropriate assurance that both Trusts maintain a fair and equitable application of MHPS processes