Group Board

Agenda

Meeting in Public on Thursday, 06 March 2025, 09:45 – 12:50

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

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:45					

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

Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:50	2.1	Quality Committees-in-Common Report	Committee Chair	Assure	Report
11:00	2.2	Finance Committees-in-Common Report	Committee Chair	Assure	Report
11:10	2.3	People Committees-in-Common Report	Committee Chair	Assure	Report
11:20	2.4	Audit Committees-in-Common Report	Committee Chair	Assure	Report
11:30	2.5	Infrastructure Committee-in-Common Report	Committee Chair	Assure	Report

Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:40	3.1	Maternity Services Report	GCNO	Review	Report
11:50	3.2	Integrated Quality and Performance Report	GDCEO	Review	Report
12:00	3.3	Finance Report (Month 8, 2024/25)	GCFO	Review	Report
12:10	3.5	Public Sector Equality Duty Report	GCPO	Approve	Report
12:20	3.6	Gender Pay Gap Report	GCPO	Approve	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
-	4.1	Healthcare Associated Infection Report	GCNO	Note	Report
	4.2	Group Accountability Framework	GCCAO	Note	Report
	4.3	Equality, Diversity and Inclusion Action Plan	GCPO	Note	Report
	4.4	Safeguarding Annual Report 2023-24	GCNO	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
12:20	5.4	Patient / Staff Story	GCNO	Review	Verbal
12:40	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
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
Pankaj Dave	Non-Executive Director SGUH	PD
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	Associate Non-Executive Director - SGUH	CSH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
In Attendance		
Lizzie Alabaster	Site Chief Financial Officer – ESTH	CFO - ESTH
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDDCA
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications Officer	GCCEO
Ralph Michell	Group Director of Strategy	GDOS
Apologies		
Natalie Armstrong	Non-Executive Director ESTH / SGUH	NA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Observers		
John Hallmark	SGUH Governor	
Hann Latif	SGUH Governor	
Sir Mark Lowcock	Chair Designate	
Jackie Parker	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, 09 January 2025, 10am–12.30pm

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Natalie Armstrong	Non-Executive Director	NS
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
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
Arlene Wellman	Group Chief Nursing Officer	GCNO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Victoria Smith*^	Chief People Officer	CPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
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
John Dela Luna	Head of Nursing	HoN
APOLOGIES		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director – ESTH / SGUH, Vice Chair SGUH	AB
Yin Jones	Non-Executive Director – SGUH	YJ

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

		Action
	FEEDBACK FROM WARD VISITS	
	The Board provided the following feedback from their respective visits to a number of wards at SGUH:	

Haematology and Oncology Outpatients – Group Chair and MD-SGUH

The MD-SGUH advised that the staff are limited with their space for taking a break, which can cause an issue when trying to eat meals and so discussions are ongoing to identify an alternative space.

A member of staff with a disability reported that they feel well-supported which was very pleasing to hear.

McEntee Ward (Clinical Infection) 1st Floor, St James Wing – GCPO, PW

PW advised they were warmly welcomed to the ward by a matron.The key issue they discussed was regarding managing sickness absence; the ward is currently having difficulty with staff returning from sick leave and the GCPO took this feedback away to review further with occupational health.

An MDT took place at 9am and PW was impressed with the organisation and punctuality of all members of staff attending the meeting.

Departure Lounge (Cavell Ward) – GCMO, GCCAO

The GCMO advised that the majority of staff spoken to raised that they would value more nurses on the ward. Staff were extremely positive regarding the pharmacy support which they received. With regards to fire safety, all staff knew who the fire Marshall was and seemed to have a full understanding of the fire safety procedure.

William Drummond (Hyper Acute Stroke) – MD-ESTH, GCFIEO

MD-ESTH advised that all members of staff spoken to were positive about their working life and felt very well supported within the organisation. The flow of stroke patients through the system was discussed, as this system is not working as efficiently across London as a whole, as it could be.

Cardiac Intensive Care – GDCEO, AM

AM noted that the member of staff who escorted them round was very welcoming and informative, which was well received, especially due to this unit being so busy. AM welcomed the news that the team is at full establishment and does not require agency staff. GDCEO and AM also looked at medicines management, and noted very good processes for managing medicines, particularly controlled drugs. A pharmacist attends the unit daily and undertakes checks on controlled drugs and so AM took assurance that this was being managed effectively.

Amyand Ward - GCNO, TW

TW and GCNO was taken through the ward by the ward manager who was generous with her time and provided them with lots of information. All 28 beds were occupied, and the ward manager advised that there were no particular problems with staffing. The GCNO noted that there were unlocked and unattended computers on the wards and this is a point of detail which she will be working to improve across the organisation as part of the quality governance work.

	Hand Unit – GCFO The GCFO advised that the unit was clean and tidy, with all the paperwork relating to fridge temperatures in order and up to date, The Unit itself has limited space for equipment and desk areas. The Unit welcomed the visit from the GCFO and noted it was the first visit from the Board.	
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
1.1.1	The Chairman welcomed everyone to the meeting, welcoming Dr Natalie Armstrong to her first meeting in her role of Non-Executive Director. Apologies were received from Jaqueline Totterdell, Ann Beasley and Yin Jones.	
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	The Minutes of the Group Board meeting on 7 November 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. PUBLIC20240905.1 – This was covered in agenda item 4.1 PUBLIC20240905.2 – This was covered in agenda item 3.5 PUBLIC20240905.3 – This was covered in agenda item 3.5 PUBLIC20241107.1 - Vaccination Track is used to support delivery of Covid and Flu vaccinations and is able to collect 3 reasons for declination – does not want the vaccine, declined due to allergy and declined due to other contraindications. The remaining actions are not yet due.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
1.5.1	The DGCEO updated the Group Board on the following issues: 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.	
1.5.2	Launch of Martha's Rule - Pilot at SGUH: To enhance the quality and safety of care, we are piloting Martha's Rule across selected 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.	
1.5.3	Planning for Winter: 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 have exacerbated the situation. Recently, NHS England revealed that 2,500 patients require hospital treatment for the virus.	
1.5.4	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.	
1.5.5	PW noted that as there are a high number of patients admitted to hospital as a result of flu, should the Board now start thinking about preparing for next winter with regards to increasing the flu jab uptake. The GDCEO advised that there is learning year-on-year with regards to this, explaining that whilst there is undoubtedly fatigue in the community with regards to receiving a vaccination. work is constantly ongoing to improve the culture and awareness on the benefits of vaccines. **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 in November and December 2024:	
2.1.2	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.	
2.1.3	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.	

2.1.4	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.	
2.1.5	CSH asked if work is being done to determine the underlying themes of never-event to ultimately improve the learning from these incidents. The GCMO advised that the group has seen repeated never-events on the skin cancer pathway, along with retained pieces of equipment in patients. These issues can be hard to mitigate, and the learning implemented as a result of these incidents is usually quite specific to the type of never-event which occurred. However, staff do have an understanding of the pattern of the never-events which are occurring, and teams continue to work through the different measures of safety netting required to reduce the risk of these incidents taking place in the future. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in November and December 2024.**	
2.2	**Finance Committees-in-Common Report**	
2.2.1	Peter Kane, on behalf of 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 November and December, including:	
2.2.2	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.	
2.2.3	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).	
2.2.4	CIP update CIP progress was being made but not at the required level to get to a fully developed programme by year end.	
2.2.5	**The Board noted the issues considered by the Finance Committees-in-Common at its meeting in November and Decemberm2024.**	
2.3	**People Committees-in-Common Report**	
2.3.1	Tim Wright, on behalf of Yin Jones, Joint Chair of the People Committees-in-Common, set out the key issues discussed and considered by the Committees in December 2024. These included:	
2.3.2	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.	
2.3.3	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.	
2.3.4	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. The Board **noted** the issues considered by the People Committees-in-Common at its meeting in December 2024.	
2.4	**Audit Committees-in-Common**	
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 December 2024. These included:	
2.4.2	External Audit – although the auditor had yet to be appointed, internal arrangements were on track.	
2.4.3	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.	
2.4.4	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 too (SGH/ESTH).	
2.4.5	The Group Board **noted** the issues escalated to the Group Board and the wider issues on which the Committees received assurance in December 2024.	
2.5	**Infrastructure Committees-in-Common**	
2.5.1	Tim Wright, on behalf of Ann Beasley, Chair of the Infrastructure Committees-in-Common, set out the key issues discussed and considered by the Committees in December 2024. These included:	
2.5.2	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.	

2.5.3	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.	
2.5.4	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.	
2.5.5	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.	
2.5.6	The Chair asked for more detail on the water hygiene position at ESTH. The GCFIEO advised that the water compliance at ESTH has historically not been at a high standard. However, there is now a senior leader in place, Chris Rivers, who has an excellent understanding of water hygiene. Chris is working with the Infection Prevention and Control Team to ensure that water hygiene compliance is at a high standard, and a Water Safety Committee has been established to monitor this. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in December 2024.**	
3.1	**Integrated Quality and Performance Report**	
3.1.1	The GDCEO presented the report, which provided 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.	
3.1.2	TW asked if there is an update on the progress and development of the use of virtual wards, the MD-IG advised that work is ongoing to enhance the pathway, including introducing it to patients who have returned home from elective surgery.	
3.1.3	**The Group Board noted the report.**	
3.2	**6 Month Strategy Review**	
3.2.1	The GDCEO presented the report, noting that the strategy describes how we will achieve our vision through the delivery of: - 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.	
3.2.2	The GDCEO requested the following action from the Board: - **Agree** that for 2025/26, we should roll over our existing 'board to ward priorities' and focus our energies on embedding them into ways of working.	

	- **Agree** that for the strategic initiatives, as they plan for 25/26 the Executive should set ~3 key deliverables for each strategic initiative:
	  - with a stronger emphasis than in 2024/25 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

2.2.2	PK welcomed a review in 6 months-time, suggesting that a dashboard displaying RAG ratings against the key factors of progressing the strategy would be beneficial to monitor the progress.
2.2.3	CSH advised that she felt it difficult to triangulate the position of the strategy review and the assurance framework, noting that it would be helpful going forward if the two documents spoke to each other.
2.2.4	The NEDs asked if the Board can be confident that progress will be made on the key priorities in the strategy, asking if the deliverables will be identified before the new financial year begins to ensure there is enough time to actually deliver against them. The GDCEO advised that the deliverables are updated for 25-26, but the four key priorities relating to the CARE framework are rolled over as they are. It was agreed that a proposal for the key metrics to be monitored in the IQPR will be presented to the Board at the March meeting. **Action: A proposal for the key metrics to be monitored in the IQPR will be presented to the Board at the March meeting. (GDCEO)** **The following was agreed by the Board:** - It was a**greed** that for 2025/26, the Board will roll over the existing 'board to ward priorities' with a focus on evolving these as appropriate given the external environment with regards to elective care. - It was a**greed** that for the strategic initiatives, as they plan for 2025/26 the Executive should set ~3 key deliverables for each strategic initiative as listed in point 3.2.2. This will be done in the context of the current uncertainty to the wider system workings and its potential to evolve as we move forward.
3.3	**Finance Report (Month 8, 2024/25)**
3.3.1	The GCFO presented the report, advising that 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.
3.3.2	**The Group Board noted the report.**
3.4	**Fire Safety Review**
3.4.1	The GCFIEO presented the report, advising that 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.	
3.4.2	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.	
3.4.3	TW noted that the buildings in the estate were built at a time when the standards of fire safety were not at the level that it is today, and therefore in the context of those limitations, what areas should the Board focus on to ensure maximum fire safety is achieved. The GCFIEO noted that ensuring there are identified and trained fire wardens across the site is a key aspect of fire safety, as they will be able to respond to fire alert systems to ascertain if there is a real risk of fire and then also how to react to this risk. The Fire Safety team are currently working with individual departments on their local fire safety risk assessments, such as ensuring that fire exits are clear and combustible materials are removed from these areas.	
3.4.4	The Board welcomed this report being presented to the Public part of the meeting, agreeing that the Infrastructure Committees-in-Common must regularly review the progress of the identified Fire Safety mitigations and make it a key part of their agenda going forward, escalating issues to the Board as required. **The Group Board noted the report.**	
3.5	**Board Assurance Framework**	
3.5.1	The GCCAO presented the report, advising that 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.	
3.5.2	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.	
3.5.3	CSH noted that were a few points throughout the report which she found difficult to engage with due to the formatting and choice of graphs. She offered to meet with the GCCAO for further discussion.	
3.5.4	The Board discussed how the risk scores are generally high, and it would be helpful if there was a clear plan for each SR setting out the plan to reduce the risk scores. The GCCAO advised that this document is a work in progress and will continue to become more comprehensive as time goes along, advising that whilst some of the SR risks are quire complex, he would like identified mitigations to reduce the score to be detailed in a crisp manner.	

3.5.5	**The Group Board reviewed and agreed 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".**	
3.6	**Group Freedom to Speak Up Report**	
3.6.1	The GCCAO presented the report, advising the following: SGUH: - 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%). ESTH - 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%).	
3.6.2	The GCCAO noted that with the departure of Martin Kirke, he asked the Board to endorse Yin Jones to become the Freedom to Speak Up Lead for ESTH as well as SGUH.	
3.6.3	PK noted that number of concerns raised at ESTH are higher than those at SGUH, and given the relative scale of the two trusts, this isn't the result you may expect to see. PK asked if GCCAO has thoughts on what the reason may be for the higher reporting at ESTH. The GCCAO noted that it cannot definitively be said what the cause for the difference in numbers is, however, historically the two trusts have taken a different approach to the FTSU function. In April 2024, the approach was standardised across the group and this change was felt more keenly at ESTH.	
3.6.4	The Chair noted that there is a differential standard across the group with relation to Freedom to Speak Up mandatory training, highlighting that this training in mandatory at SGUH but not at ESTH. The Chair advised that she would welcome this being a standardised requirement across the group. The MD-ESTH advised that a Mandatory Training Group has been established to review the current requirements, however the package needs to be reviewed in the round to ensure the timing required to complete the package is appropriate. **Action: The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)**	
3.6.5	**The Group Board noted the report and endorsed the recommendation that Yin Jones become the Freedom to Speak Up Guardian for both ESTH and SGUH.**	
3.7	**Group Maternity Services Quality Report**	
3.7.1	The GCMidO presented the report, advising that 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. .	
3.7.2	The Group Board was asked to do the following: • 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. • 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	
3.7.3	AM referred to slide 21 of appendix 1, which states that there are no current NHS Resolution concerns. AM advised that as a point of accuracy this report should be updated as NHS Resolution have reported a concern which is focused on CTG.	
3.7.4	The Chair noted that the initial feedback from the CQC visit would suggest that some of the areas of 'Must Dos' which are rated as green in their compliance rating in this report, may in fact not be green following the inspection which was a cause of concern.	
3.7.5	**The Group Board agreed the following:** • **Supported 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.** • **Amended the proposed delegated sign off of the Board declaration of compliance against the CNST MIS year 6 Safety Actions to initially be reviewed by the Chair of the Quality Committee in Common, but for the final sign-off to sit with the Group Chair the Group Chief Executive Officer.**	
4.0	**ITEMS FOR NOTING**	
4.1	**Fairness and Equity in Managing Concerns about Doctors and Dentists**	
4.1.1	**The Group Board noted the report.**	
5.0	**CLOSING ITEMS**	
5.1	**Any new risks and issues identified**	
5.1.1	No new risks were formally identified.	
5.2	**Any other business**	
5.2.1	**End of NED Terms** The Chairman noted that this would be the last meeting for TW, she advised that his contribution to the Board has been greatly valued over the last seven years. The Group Board wished TW well in his future endeavours.	
5.3	**Reflections on meeting**	

5.3.1	The Chairman asked TW to give his reflections of the meeting. The following observations and reflections were offered: • The Board visits at the start of the day is a really powerful process for the Non-Executive Directors to help to focus minds on what the NHS actually delivers for the public. • The IQPR is a crucial document to frame conversations and provide key performance data at the Board and its Sub-Committees • The fire safety of the estate is an enormous challenge to the group and the oversight of this at the Board is of most importance going forward.	
5.4	**Patient Story**	
5.4.1	The Board were presented with a story detailing a patient, booked for termination of pregnancy due to a foetal defect, who had a poor and emotionally distressing experience at the Day Surgery Unit. Upon arrival, she was informed that her husband would not be allowed to accompany her inside the unit during the procedure. This decision was made despite her expressed need for emotional support.	
5.4.2	The patient felt that the staff were unsympathetic and lacked compassion, further intensifying her distress during an already challenging time. The absence of her husband, who was her primary source of emotional support, left her feeling isolated and unsupported during the procedure also expressing the impact on her recovery, psychological and mental health.	
5.4.3	There are two different pathways to book a patient into the Day Surgery Unit for termination of pregnancy: Surgical Management of Miscarriage (SMM) A patient booked in for this procedure isaccompanied by their partner throughout the whole perioperative process, Surgical termination of pregnancy (STOP) A patient booked in for this procedure is not accompanied.	
5.4.4	The patient was incorrectly listed for surgery without considering her specific emotional and support needs. If listed for SMM, the flexibility of partner support would be automatically accommodated. Pre-procedure counselling or assessment regarding the patient's emotional readiness, for a highly sensitive and personal procedure was not completed. Upon arrival the DSU staff did not adequately engage with the patient about her emotional state or explain the reasoning behind the policy restricting her husband's presence, alongside a failure to review emotional support requirements as part of the pre-procedure assessment (standard practice for all patients undergoing terminations for medical reasons).	
5.4.5	HoN advised the following Learning points raised by the Day Surgery Unit are to be supported by Matron Adwoa Anim-Botchway 1. Introduce more flexible guidelines that allow for emotional support patient and relatives, with consideration of individual patient needs. Working with Gynae team and PPC to review the terminology of listing STOP/SMM on the operating list 2. Conduct mandatory training for all Day Surgery Unit staff on providing compassionate care, with a particular focus on supporting patients during	

	emotionally difficult procedures such as pregnancy loss or terminations for medical reasons. 3. Working with Gynae team to establish clear, compassionate communication pathways between patients, their families, and staff to ensure that patients' concerns and emotional needs are heard and always addressed. 4. Provide post-procedure follow-up calls or counselling services to assess the patient's emotional well-being and ensuring patients have access to mental health support if needed. Updating our information leaflets to include bereavement support	
5.4.6	PW asked if learning from this could be shared to other trusts. The GCNO advised that learning from this is being implemented at ESTH. The issue is that the space in which this surgery has taken place is in a multi-use space which on reflection isn't appropriate for this type of case. The fundamental change going forward is that patients will have emotional support and access to bereavement teams regardless of whether the surgery is elective or not.	
5.4.7	The Group Board thanked the GCNO and the HoN for presenting this story and learning.	

CLOSE

QUESTIONS FROM MEMBER OF THE PUBLIC AND SGUH GOVERNORS

The following questions were asked by SGUH Governors in attendance:

Q. Sarah Forester noted that the in the Group Chief Executive's Report (item 1.5), the launch of Martha's Rule is referred to as a pilot. She noted she would hope it to be a roll-out rather than pilot and asked when this will be launched in paediatrics.

A. The MD-SGUH advised that it should be described as an early implementation rather than roll-out. The MD-SGUH advised that she did not have the full schedule for the launch but will send to Sarah Forester outside of this meeting.

Q. Sarah Forester noted that never-events were discussed with relation to wrong-site surgeries, she asked what the patients' role in this is as she finds it hard to believe that a patient would not be able to identify the correct area for surgery on their body.

A. The GCMO advised that the key mitigations put into place for these events involve confirming with patients that the correct site has been identified to operate on, however, this is not always straight forward as there are instances when a patient may have multiple lesions on their back and a surgeon has to identify which lesion to remove. A mitigation for this is to ensure a mirror is available in all skin clinics. The patient's role in their surgery is always at the top of the hierarchy and the mitigation in place helps to ensure this.

The meeting closed at 12.50 pm

Group Board (Public) - March 2025

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20240905.1	05-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.	09-Jan-25	GCFIEO	Paper on the agenda item 3.4	CLOSED
PUBLIC20241107.2	07-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.	03-Jul-25	GCCAO	This will orginally proposed as an action for the March meeting but to be brought to the Group Board for review alongside the draft FTSU strategy for the Group, this would be the July meeting.	NOT YET DUE
PUBLIC20250901.1	09-Jan-25	3.6	Group Freedom to Speak Up Report	The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)	04-Sep-25	GCPO		NOT YET DUE

Group Board

Meeting in Public on Thursday, 06 March 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 Group 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 as a group
- 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, 06 March 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 and the wider NHS landscape.

2.0 National Context and Updates

New Hospitals Programme

2.1 On 20 January 2025, the Government announced the outcome of its review of the New Hospitals Programme (NHP). The review had been commissioned by the Secretary of State for Health and Social Care "to provide a realistic and affordable timetable for delivery" of the programme. The Government has said that it is committed to delivering all schemes that were previously part of the NHP. The seven hospitals constructed primarily using reinforced autoclaved aerated concrete (RAAC) will be prioritised. The NHP will now be delivered through consecutive waves of investment. Each wave sets construction start dates for schemes over a five-year period. The first wave of 16 schemes has been assigned a start date of 2025-30, the second wave of 9 schemes a start date of 2030-35, and the third wave of 9 schemes a start date of 2035-40.

2.2 The construction of the Specialist Emergency Care Hospital (SECH) at Sutton, and the upgrade for Epsom and St Helier Hospitals, has been allocated to the second wave and will be delayed until 2033. Main construction is now scheduled to start between 2033 and 2035 and would be expected to conclude between 2037 and 2039. The delay to the building of the SECH is very disappointing for colleagues and patients who have campaigned for a new hospital for decades. We are working through the detail of what the announcement means for our patients, colleagues and local communities and will continue to work to secure vital investment to improve our estate sooner than the timescales given. A key area of our focus now is on how we mitigate the significant risks we face given the current condition of the St Helier estate.

Government plans for reducing waiting lists

2.3 The Prime Minister, Sir Kier Starmer, announced a new plan to end waiting list backlogs and provide millions of additional appointments across the NHS during a visit to Epsom Hospital on 6 January 2025. As part of the announcement, the Prime Minister, the Secretary of State for Health, and the Chief Executive of NHS England toured the South West London Elective Orthopaedic Centre (SWLEOC), hearing from staff about the service's success in reducing length of stay for patients needing procedures such as hip and knee replacements.

2.4 The Government's plan, *Reforming Elective Care for Patients*, sets out measures to reform elective care and return to the constitutional standard of 92% of patients receiving treatment within 18 weeks of referral by March 2029, as well as to improve performance against the cancer waiting time standards. Under the plans, by March 2026 the percentage of patients waiting less

than 18 weeks for elective treatment will be 65% nationally. Every trust is expected to deliver a minimum 5% improvement by March 2026, after which there will be an expectation of sufficient increases annually to reach 92% by March 2029 (with exact figures for trusts to be set out in planning guidance).

2.5 The Government's plans involve empowering patients by giving them more choice and control; reforming delivery by working more productively, consistently and differently to deliver more elective care, including establishing 17 new and expanded surgical hubs by June 2025 and offering 40,000 additional appointments a week; promoting greater out of hospital care; and aligning finance, performance oversight and delivery standards with clear responsibilities and incentives for reform, including a capital incentive scheme for providers that improve the most in meeting Referral-to-Treatment Time (RTT) standards. The plans also include a measures to ensure that improvements in the RTT standard are done equitably, inclusively and with a focus on health inequalities, with trusts and Integrated Care Boards expected to set a clear vision for how health inequalities will be reduced as part of elective care reform.

2.6 In setting out its vision for establishing new and expanding existing surgical hubs, the Government's plans highlight SWLEOC as an example of how surgical hubs can improve quality of care and performance, with excellent outcomes, high patient satisfaction rates and low complication rates for high volumes of activity over a sustained period. The fact that the Government's plans were announced at Epsom Hospital, home of SWLEOC, shone a spotlight on the vital work our staff do to reduce waiting lists and tackle the elective care backlog.

Leadership changes at NHS England

2.7 On 3 March 2025, Dr Penny Dash was confirmed by the Secretary of State for Health and Social Care as the new Chair of NHS England. Dr Dash is currently the Chair of the NHS North West London Integrated Care Board and is leading a review into the regulation of health and social care quality in England. Dr Dash is a former NHS doctor, senior partner at McKinsey and Company, and a former official at the Department of Health and Social Care (DHSC). Dr Dash, whose confirmation follows a pre-appointment hearing by the House of Commons Health Select Committee on 19 February, succeeds Richard Meddings as Chair of NHS England on 1 April 2025. Her appointment will be for an initial 4-year term of office.

2.8 In addition to a new Chair, NHS England will have a new Chief Executive from 1 April 2025. Amanda Pritchard announced that she would be standing down from her role at the end of March 2025, having served as NHS England CEO since August 2021. Amanda Pritchard will be succeeded by Sir James Mackey, who will take on the role on a secondment basis from his substantive role as CEO of Newcastle Hospitals NHS Foundation Trust with a remit to "radically reshape how NHS England and DHSC work together". I wanted to pay tribute to Amanda, with whom I have worked closely for many years, for her leadership and support, and as a role model as the first female Chief Executive of the NHS.

Reforms to the GP contract

2.9 The Department of Health and Social Care has announced a new agreement between the Government and the British Medical Association to reform the GP contract. The agreement, announced on 28 February 2025, is billed by the Department as helping to "fix the front door" of the NHS to make it easier for patients to book appointments with their GP, "bring back the family doctor", and "end the 8am scramble for appointments". Under the reforms, the Government has announced that "burdensome red tape on GPs will be reduced" by scrapping "unnecessary targets" and enable patients to request GP appointments online. The GP contract reforms will

be accompanied by an additional £889 million, bringing the total spend on the GP contract in England to £13.2 billion in 2025/26.

3.0 Our Group

Launch of our new gesh People Strategy

3.1 On 28 January 2025, we launched our new Group People Strategy, which aims to make gesh a better place to work. Our vision is that, by 2028, gesh will be among the top five acute trusts in London for staff engagement.

3.2 The strategy sets out how we will achieve this, through a focus on: getting the basics right for all of our staff; improving staff learning opportunities and wellbeing; ensuring our culture is inclusive and driven by our values; developing our workforce fir the future; and embracing integrated ways of working. Our strategy sets out the actions we will take over the next two years to help us achieve our vision, with our focus in 2024-25 on "making our team a great and inclusive one to work in".

3.3 As part of our plans, we are redesigning the HR function to become one integrated department across our hospital Group and having a big focus on developing and training our managers, leaders and teams across the group to improve the quality of line management and leadership behaviours. We will also be developing a single, shared set of values across the gesh Group, building on what is currently in place at both Trusts as well as delivering on our Group-wide culture and diversity and inclusion programme.

CQC 'well led' inspection at St George's

3.4 The Care Quality Commission (CQC) undertook a planned "well led" inspection at St George's between 25 and 27 February 2025. The inspection followed previous CQC service inspections of maternity, Emergency Department and Theatres at St George's and Queen Mary's Hospitals in recent months. It is likely to be a few months before we find out the CQC's findings and conclusions. I am very grateful to everyone who took part in and supported the inspection.

4.0 Appointments, Events and Our Staff

Our new Chair

4.1 As the Group Board is aware, Sir Mark Lowcock KCB has been appointed as Chair of gesh from 1 April 2025, as Gillian's term of office comes to an end in March. Sir Mark is a committed public servant and joins gesh after a distinguished career in both the Civil Service and international humanitarian leadership. He previously served as Permanent Secretary of the Department for International Development between 2011 and 2017, and at the United Nations as Under Secretary General for Humanitarian Affairs and Emergency Relief Coordinator between 2017 and 2021. I am delighted to welcome Sir Mark to gesh. He joins at a time of opportunity as we strengthen our ties with our partners such as City St George's, University of London, and as we build one of the biggest specialist renal units in the country to improve care for our sickest patients. I am looking forward to working with Sir Mark.

Farewell and thank you to Gillian Norton

4.2 I also want to pay tribute to Gillan Norton, who stands down after eight years as Chairman at the end of March. Gillian's warmth, compassion and leadership has helped us become a more inclusive and collaborative organisation where every voice is valued. This is why she is so highly regarded by everyone at gesh and we will miss her dearly. Gillian has been a huge personal support to me and, on behalf of everyone at gesh, I would like to say thank you to Gillian for the enormous difference she has made.

Farewell and thank you to James Marsh

4.3 As well as saying goodbye to Gillian, we also say goodbye to James Marsh, who stands down as Group Deputy Chief Executive on 7 March 2025. James has served for more than 21 years at Epsom and St Helier and, later, gesh.

4.4 James joined St Helier Hospital in 2003 as a renal physician. He later became the lead consultant for transplantation and clinical director for renal services before being appointed as Deputy Medical Director of Epsom and St Helier in 2011. In 2013, James became joint Medical Director before being appointed Group Deputy CEO in February 2022. During his career, James has helped create seven-day services, supported rapid change in the covid pandemic and established clinical networks in South West London. More recently, he led on the development of our gesh strategy to give outstanding care together, helped integrate both clinical and corporate teams across the Group, and supported me as CEO when I have needed to take time away. James will be sorely missed but I know he is taking this decision for the right reasons and that he is ready for a different phase in his life. We will announce plans for how we will fill the gap created by James' departure in due course.

Re-accreditation for the St George's Anaesthetic Department

4.5 St George's Anaesthetics Department has secured Anaesthesia Clinical Services Accreditation (ACSA) re-accreditation for the third time in a row, placing St George's among an exclusive group of hospitals to earn such a recognition. ACSA, a programme run by the Royal College of Anaesthetists (RCoA), allows departments to showcase excellence in crucial areas such as patient experience and safety. St George's was the fourth hospital in the country to receive ACSA accreditation when it was first launched in 2015, highlighting the department's long-standing commitment to delivering the best care to our patients. I would like to pay tribute to the department for this outstanding and well-deserved achievement.

Events

4.6 This week, we are celebrating International Women's Day, with our Women's staff networks hosting a series of events throughout the month. This year's #Accelerate Action theme is all about taking bold steps towards gender equality. We are holding a gesh International Women's Day celebration event at St George's on 5 March as well as pop-up events and stands at St Helier and Epsom Hospitals on 4 March and 21 March respectively.

4.7 In February, we marked LGBTQ+ history month, a time to reflect on the rich history, struggles and achievements of the LGBTQ+ community. At gesh, we recognise the importance of this month in fostering inclusivity, raising awareness and celebrating diversity within our workplace. This year, we launched a new permanent wall display at St George's Hospital celebrating St George's LGBTQ+ network members.

4.8 During March, many of our staff and patients are also observing the month of Ramadan, one of the holiest months in the Muslim calendar. As a group, we are well placed to support our staff and patients who are observing Ramadan who are fasting to improve their wellbeing, productivity and sense of belonging.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 06 March 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 January and February 2025 and the matters the Committees wish to bring to the attention of the Group Board. These include:

- **Updates on the CQC Section 29A Warning Notices relating to the Emergency Department and Maternity Services at SGUH**. The Committees received confirmation that the responses to the CQC were made on time. They reviewed progress on the resulting actions plans, noting that a number of immediate actions had been completed. The Committees received an update on the work of medicines management which had been an area of concern raised in both notices.

- **Never Events**. The Committees received a report focussed on Never Events. It described the action being taken to learn from Never Events and prevent a recurrence. The Committees felt that the report was of high quality and demonstrated increased grip and appropriate action being taken and as such the level of assurance was tentatively increased from limited to reasonable. Never Events will remain an area of focus at CQIC at each full meeting.

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 January 2025 and February 2025.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name

Appendix 1	Never Events

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, 06 March 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 January and February 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 30 January 2025 and the 27 February 2025 the Committees considered the following items of business:

January 2025 (Focus Session)	27 February 2025
• Deep Dive Dementia and Delirium • SGUH CQC Section 29A – Emergency Department • SGUH CQC Section 29A – Maternity	• Group Quality Performance Report • Group Maternity Services Update • Group Patient Safety Incident Review Framework Update • SGUH – Never Events • Medicines Management / Optimisation • Group Infection Prevention and Control update • Patient Transport concerns at ESTH • Group – Human Tissue Authority Annual Report • Group update on Quality Priorities 2024/5 • Group update on continuing to approve approach to Quality Governance • Annual Committees Effectiveness Review

2.2 The Committee was quorate at the meetings in January and February 2025.

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) Maternity Services Update

At the February 2025 meeting of the Committees an update on various aspects of Maternity Services was presented. This included:

Risks

ESTH: there are two extreme (red) risks on the risk register, namely the lack of a 2nd operating theatre at Epsom and general environmental issues that were highlighted in the 2023 CQC inspection. The MD-ESTH confirmed that the work on having a second theatre ready for use would be completed shortly.

SGUH: has one extreme risk on the risk register relating to the laser stack in the fetal medicine unit which is out of its life span and manufacturer maintenance contract. As a tertiary referral centre for fetal medicine the equipment and procedure it supports is essential and critical to business continuity. The stack has been requisitioned, however, the laser has not yet been requisitioned, due to difficulty in finding a replacement. Trials need to be carried out once a potential device is sourced pushing this into the 2025/26 financial year. While the plans to replace are worked through, the service has carried out a risk assessment in the event of a failure.

CNST (Year 6)
It was confirmed that ESTH met all requirements for CNST Year 6 but SGH had one unmet safety action (see below).

An area of concern at ESTH had been training compliance amongst the Neonatal Team but this had been completed prior to the end of January 2025 deadline. Plans were in place to try and complete training compliance earlier in the year during 2025/26.

There was an unmet Safety action at SGUH: Safety Action 1 (Perinatal Mortality Review Tool – PMRT): two neonatal deaths in the neonatal unit were reported late, breaching the 7-day reporting criteria. Historical compliance has been strong, and additional safety netting has been implemented, which includes recruitment to the vacant administrative post in the neonatal unit which supports submission of cases to PMRT, and a Standard Operating Procedure outlining roles and responsibilities for those involved with the PMRT process. It was therefore hoped that this would be favourable when SGUH compliance was considered by CNST.

Surveillance model data
The chair raised concerns about the high number of post-partum haemorrhages being recorded at SGUH. The explanation given was the fact that the service was run at a tertiary level and therefore cared for more complex patients, however the Committees were not satisfied with this answer and requested further investigation and benchmarking having excluded placenta excreta cases. Audit work will be undertaken to investigate the concerns.

Fill rates
Work was continuing across both trusts to support teams around managing rosters as short notice sickness and leave was continuing to affect fill rates. The chair raised concerns about ongoing shortfalls in midwifery fill rates at SGH and the lack of data from neonatal teams at ESTH.

Midwifery Leadership
It was confirmed that the plan for Maternity Leadership across the group were near to being finalised. The MSSP were now supportive of the plans and these would be shared with NHS London and SWL ICB. The importance of being clear how the roles would work were stressed so that they had the best chance of success possible. It was noted that the plans fitted within the Group Accountability Framework.

The chair received approval from the Committees that he and the group chair should meet with relevant executives to review the Maternity Leadership proposals prior to any final decisions being taken.

The Committees agreed that the assurance rating for Maternity should remain at limited. This was due to the need for more traction and pace in making improvements and evidence of better leadership.

b) SGUH – CQC Section 29A – Maternity Services

In January 2025, an update was shared regarding the quality and safety concerns raised by the Care Quality Commission (CQC) in the Section 29A Warning Notice to the Trust following their inspection of Maternity Services at SGUH in October 2024. A comprehensive action plan to respond to the concerns raised in the Warning Notice was submitted, as required, on the 21 February 2025. This was shared with the Committee.

Four areas of concern were raised within the Warning Notice:

1. **Maternity Helpline** – this service operates between 08.00 to 20:00h. Previously, when the helpline closed at 8pm, calls were diverted to delivery suite. However, this practice had changed and the telephone helpline now diverts to maternity triage when the helpline closes for lunchbreak and after 8pm.

2. **Approach to Foetal Monitoring** – the CQC felt that there was an inconsistent approach to foetal monitoring. Representation back to the CQC had been undertaken by the Trust.

3. **Concern raised around grading of harm** - 3rd and 4th Degree Tears - One of the biggest issues raised was around concerns relating to grading of harm, particularly on 3rd and 4th degree tears. The CQC had accessed the new learning from patient safety events system. Unfortunately, there is a recognised national issue with updates made after the initial grading was input to the system. The Trust undertakes a daily review of these gradings, and this usually results in a change. This is not currently drawn through to the system and the CQC are not taking account of this issue.

4. **Medicines Management –** there were ongoing issues relating to this within the department and teams were working closely within the pharmacy team, making sure stock is correct and expired drugs were not available.

The Committee sought clarification on the implementation of the “Fresh Eyes” approach for the monitoring of labour, particularly CTGs, since it had been agreed at the November QCIC meeting to move from the local policy to follow the NICE Guidance where they were reviewed once per hour by a different member of staff. This change would be put in place from 1 February 2025.

The Committees are expecting the unified Maternity Improvement Plan (drawing together all the recommendations and actions arising from the various external reviews of Maternity) to be presented to the April QCIC.

The Committees agreed that as a result of the update the overall level of assurance for maternity at SGUH remained limited.

c) SGUH: CQC Section 29A – Emergency Department

At the focus session, which took place at the end of January 2025, the meeting received details of the Section 29A notice received from the inspections undertaken at SGUH in the Emergency Department (ED) in March and November 2024. The Committee focused on reviewing the action plan which was submitted as a result of the Section 29A notice received. The main areas of concern related to:

Streaming and triage of walk-in patients at the front door of the ED: Issues were identified with both patients waiting to be streamed and then patients waiting to be triaged following streaming. At the time of the visit patients were waiting up 45-50 minutes to be streamed and there were also many patients waiting for triage. Further resources were placed in the department to help support streaming and triage and standard operating procedures reinforced, as to when to escalate concerns with flow with triage.

Medicines Management - These concerns included:

- Missed doses of medicines
- Discrepancies in Controlled Drugs
- Self-Administration – need to ensure safety.
- It was confirmed that immediate actions had been put in place to resolve these issues.
- A wider piece of work was required, around how to manage medications for patients who should only be in the department for between 4 and 8 hours but end up being there for over 24hrs. The trust's self-administration of medicines policy had been reviewed and had been deemed not fit for purpose for the ED as it had been written for inpatient areas. The ED did not have the facilities for patients to self-administer medications. Therefore, a statement had been issued to say patients should not self-administer medication until it was determined that it was safe to do so.

Documentation: The standards required for documentation were reinforced. Clear standards were in place for staff and audits were being undertaken which would be carried out on a daily basis.

Information Governance: Lack of confidentiality through staff leaving computers open. Immediate steps taken to resolve this had been to reduce the lock down times on computers.

The meeting acknowledged that it was seeing a high-level action plan but asked for assurance that the actions which were being put in place were embedded and impactful. The Committee queried how patient waiting times for triage would be captured and tracked. Similar questions could be asked about falls prevention work being undertaken within the department. The Committees reinforced the need for appropriate auditing and collation of evidence in relation to the action and improvement plans.

The Committees agreed that it was important to see ongoing evidence of completion of actions and improvements in order to monitor progress. To conclude the discussion the Committees confirmed that the overall level of assurance for ED at SGUH with the Section 29A remained limited.

At the February 2025 meetings the Committees reviewed the action plan and received details of improvement work that had been completed. Notable was a reduction in the time to triage from an average of 27 mins down to 5 mins. It was confirmed that the majority of the actions relating to medicines management had been completed however the Committees would need ongoing assurance of the effectiveness of immediate actions.

The Committee agreed that some of the actions within the improvement plan would take longer to complete, with some taking in the region of 9 to 12 months. They requested further updates as progress was made.

4.0 Key issues on which the Committees received assurance

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

a) Group Patient Safety and Incident Report - update on Patient Safety Incident Review Framework (PSIRF) and Never Events

The Group Patient Safety Incident Report received at the February 2025 meeting of the Committees covered the period of November and December 2024 and provided an overview of patient safety incidents, Never Events, and learning initiatives across the group.

During this reporting period, three Never Events were declared at SGUH**:** One wrong site surgery and two cases of retained swabs.

At ESTH, while no new Never Events were declared in this period, three previous Never Events remain under investigation—two under the Serious Incident (SI) framework and one as a Patient Safety Incident Investigation (PSII). Immediate learning and actions have been identified and shared previously.

Across SGUH and ESTH, a number of incidents and safety concerns have been identified and addressed**:**

- Medication safety remains a key theme at ESTH, with a SWARM learning response implemented following a wrong medication dispensing incident in the Sexual Health Clinic Actions include a revised ID verification process and updated prescription filing system**.**
- Patient transport issues at ESTH continue to contribute to treatment delays and poor patient experience, particularly in the Renal Division. Patients have reported considering discontinuing dialysis due to ongoing transport challenges.
- Handover and escalation challenges in Cardiac Surgery at SGUH were reviewed after a series of incidents on a ward. Improvements are being made to handover processes and escalation pathways to Intensive Care**.**
- Aortic dissection diagnostic delays contributed to an unexpected patient death at SGUH. A thematic review of aortic dissection cases is being conducted in alignment with the national 'Think Aorta' campaign.

The Patient Safety Incident Response Framework (PSIRF) continues to be embedded across the group, with a focus on disseminating learning from Never Events and critical safety incidents**:**

- Monthly Theatres Protected Teaching Time has been implemented at SGUH, bringing together theatre teams to discuss safety and human factors issues. Attendance has improved, especially among surgeons, and the CQC has acknowledged this initiative positively**.**
- A Theatre Improvement Project at ESTH is working to enhance patient safety through improved WHO checklists, LocSSIPs, and consent processes**.**
- Medical and dental training compliance remains below target for PSIRF training. Divisional teams have been provided with staff-specific training compliance data to improve.

Never Events

The Committee received details in February 2025 of the work being undertaken across SGUH to try and reduce the number of Never Events taking place. The report received aimed to provide the Committee with more detailed sources of assurance to evidence improvements made and highlight any areas of ongoing focus or concern.

There had been 17 Never Events between January 2023 and January 2025 at the SGUH site: 10 in 2023 and 7 in 2024. There were currently 9 active Never Events under investigation, 5 of which are being investigated as a cluster. In line with national guidance all Never Events are investigated as a Patient Safety Incident (PSI). However, to ensure timely and responsive learning, some more recent incidents have also been initially investigated using an alternative learning response.

It was confirmed that overall, there was evidence of improvement over the 2 years, especially in relation to retained guidewires and wrong site blocks, and in Never Events in a theatre setting. However, concern remained regarding the risk of further wrong skin lesion surgery. Although, this was the most common type of Never Event reported nationally, SGUH was a negative outlier in April 2023 to March 2024. More recent data showed an early improvement and the team were continuing to ensure that the barriers in place are fully effective at preventing these incidents. Work was also needed to continue engaging with the wider safety work within the plastic surgery team.

It was confirmed that sharing of learning regarding Never Events continued between the two trusts.

The Committees felt there was reasonable assurance regarding PSIRF across the Group. In respect of Never Events the level of assurance was increased to reasonable. The report on Never Events is appended to this report for the information of the Board.

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.

Patient Transport concerns at ESTH

In February 2025 the Committee received a briefing from the team at ESTH relating to the third-party patient transport service, EMed, commissioned through Surrey Heartlands ICB.

It was noted that there were serious issues for patients who required Renal Dialysis. Often delays with transport meant that the patients time for dialysis had to be cut short so that the next patient booked into the “chair” could receive their treatment. This clearly caused both physiological and psychological distress. Enhanced support from ESTH’s own transport services was being used to try and ease some of the concerns and EMed were providing financial support for this. This funding had been agreed until the end of March 2025.

The MD-ESTH shared the details of how the service was being monitored within the trust and the escalation which was being undertaken. It was confirmed that SWL ICB would soon be undertaking a procurement exercise for patient transport services and the ESTH experience and learning would be shared with them.

The Committees agreed that ESTH was being as proactive as possible in trying to resolve the concerns. A request for further updates as necessary was made by the Committee.

d) Group update on Infection Prevention and Control

In February 2025 the Committees received the regular Group wide update on Infection Prevention and Control (IPC). this highlighted high rates of Clostridium Difficile infections but the Committees were assured that the Trusts were not outliers and that appropriate action was being taken. Two further areas of concern were discussed:

Infections in long bone fractures – these concerns were being audited and until this information was available no firm conclusions could be drawn. However, it needed to be recognised that SGUH was a major trauma centre dealing with some of the most severe injuries and this could be having some effect.

Ventilation – concerns with ventilation due to old estates. These continued to be an area of concern on all sites. Both trusts have Ventilation Safety Groups were Estates and IPC Teams worked together on areas of concern. Regular monitoring is undertaken.

e) Medicines Management/ Optimisation

The Chief Pharmacist for SGUH joined the meeting in February 2025 and updated on the work in relation to the two Section 29A CQC Inspection Warning notices received by SGUH regarding medicines management.

It was confirmed that receiving the Warning Notices had felt to have been of benefit for the work of the pharmacy and wider teams, as there had been a real focus from a range of areas. Details of the improvement work undertaken by the multidisciplinary teams would be shared with ESTH and the wider system.

e) Dementia and Delirium

At the focus session in January 2025, the Committees received a deep dive into the work across the group on Dementia and Delirium. The report received described the detailed work taking place across both trusts and the integrated approach being adopted to ensure service improvements.

Although a large number of positive initiatives being undertaken to support both patients with Delirium and or Dementia were described by the site teams, it was clear from both local group data and information from National Audit data that improvements were still needed in the following areas:

- Improvements in discharge planning. SGUH was below the national average with only 55% of patients with a known dementia diagnosis having their potential discharge planning begun within 24 hours of admittance.
- Need to improve compliance with Tier Two Dementia Training.
- Continuing need to improve the screening rates for possible dementia, for eligible patients being admitted to acute care. The care and completion of assessments for dementia was the responsibility of the multidisciplinary team and all staff should work together to ensure that tasks were completed. It was the responsibility of all staff groups to ensure that assessments, whether they be for delirium, dementia or VTE be undertaken.
- Improvement was needed in the unwarranted variation in the way that the initial assessments are undertaken, and work was underway to make these changes.
- There needed to be systems in place to have an easy way of drawing out how many patient safety incidents were directly or substantially attributable to the way that the trusts manage dementia or delirium.

Positive work being undertaken included: The Forget Knot scheme similar to the one being used at ESTH was being introduced at SGUH from the 1 April 2025; Carers campaigns were being relaunched; more open visiting being enabled; Launch of a Carers Survey; Increased use of Care Passports and, at ESTH, being able to record the assessments appropriately should become easier once Electronic Patient Record becomes operational across the Trust in May 2025.

It was confirmed that with the new group structure more work would be undertaken on comparing data and being to explain any apparent discrepancies. Thought also needed to be given to ways to give a better assessment of what the experience was for patients with dementia and their carers.

The Committees agreed that the discussion had highlighted areas of good practice but also the challenges. It was acknowledged that there was a need for more engagement in care across the whole of the multidisciplinary team. Some concerns were voiced as to the number of points within action plans. The question was raised whether perhaps there was too wide a focus, with too many actions and if narrowed there may be greater success.

f) Human Tissue Authority Annual Report

In February 2025 the Group Human Tissue Authority Annual Report was received. The HTAs regulate, monitors and inspects organisations of the licensable activities carried out against set recommended standards.

After the inspections on 5 and 6 August 2024, it was found to be mostly compliant with just two minor shortfalls. Corrective and Preventative Actions (CAPA) have been agreed with HTA and closed within the given deadline last 29 November 2024.

On 2 August 2024, the procurement and testing of Procurement and testing of PBMC (peripheral blood mononuclear cell) as starter product for CAR-T (chimeric antigen receptor, T cell) has been officially added to the list of activity that is conducted in SGUH. The recent HTA inspection was included within the report.

Both ESTH and SGUH have the appropriate licence to run mortuary services on site. During the most recent inspection at ESTH a number of issues were highlighted with the estate. These require capital funding and should be addressed within the next financial year. It was noted that both mortuaries had full implemented and embedded previous recommendations relating to monitoring access to the services.

It was agreed that there was reasonable assurance in relation to the provision of services within the remit of the Human Tissue Authority.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to by the Quality Committees -in-Common to the Group Board and the wider issues on which the Committees received assurance in January and February 2025.

Quality Committees-in-Common

Meeting on Thursday, 27 February 2025

Agenda Item	3.1	
Report Title	**Never Events at the SGUH site: update on progress**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Luci Etheridge, Site CMO Thomas Duggan, Patient Safety Manager	
Previously considered by	Choose an item.	-
Purpose	**For Assurance**	

Executive Summary

This paper reports on the progress made to reduce the number of Never Events at the SGUH site and provides the Committee with more detailed sources of assurance to evidence improvements made and highlight any areas of ongoing focus or concern.

There have been 17 Never Events between January 2023 and January 2025 at the SGUH site: 10 in 2023 and 7 in 2024. There are currently 9 active Never Events under investigation, 5 of which are being investigated as a cluster. In line with national guidance all Never Events are investigated as a Patient Safety Incident (PSI). However, to ensure timely and responsive learning, some more recent incidents have also been initially investigated using an alternative learning response.

Benchmarking with nationally reported data is shown, for overall Never Events and by category of incident. Areas of improvement are described and evidenced and areas of ongoing concern, with the actions being taken to address these, are outlined.

Overall, there is evidence of improvement over the 2 years, especially in relation to retained guidewires and wrong site blocks, and in Never Events in a theatre setting.

However, concern remains regarding the risk of further wrong skin lesion surgery. Although this is the commonest type of Never Event reported nationally, SGUH was a negative outlier in April 23 to March 24. While more recent data shows an early improvement, it is not yet clear that the barriers that have been put in place are fully effective at preventing these incidents, and there is limited engagement with wider safety culture work within the plastic surgery team. The sources of assurance around this particular type of incident are detailed.

Action required by People Committees-in-Common

The Committee is asked to:

a. Note the steps being taken to reduce Never Events on the SGUH site and the initial impact of this work

b. Consider the sources of assurance provided and whether further assurance is required

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Prep Stop Block audit results
Appendix 2	NatSSIPs 2 pilot audit results
Appendix 3	Plastic surgery LocSSIP audit results

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

Avoidable harm may have financial consequences for the Trust

Legal and / or Regulatory implications

None identified

Equality, diversity and inclusion implications

None identified

Environmental sustainability implications

None identified

Never Events at the SGUH site: update on progress

Quality Committees-in-Common, 27 February 2025

1.0 Purpose of paper

1.1 This paper reports on the progress made to reduce the number of Never Events at the SGUH site and provides the Committee with more detailed sources of assurance to evidence improvements made and highlight any areas of ongoing focus or concern.

2.0 Background

2.1 As outlined in previous papers, Never Events are defined as *"Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies….". (Revised Never Events policy and framework, 2018).* The types of incidents that are reported as Never Events are outlined in this policy.

2.2 NHSE publishes a summary of Never Events reported nationally on a 6 monthly basis, broken down by type of incident and reporting Trust.

2.3 The Central Incident Review Group of the SGUH site provides a regular update to the Committee on the management of, and learning from, safety incidents through the Patient Safety Incident (PSI) paper. Over the last two years, this has reported an increase in Never Event incidents across the Group, with a more pronounced increase at the SGUH site. An improvement action plan was presented to the Committee in 2023, following a cluster of 8 Never Events at SGUH and 3 at ESTH since April 2023.

3.0 Analysis

3.1 Between January 2023 and January 2025 SGUH has reported a total of 17 Never Events: 10 in 2023 and 7 in 2024. These are outlined in Table 1 below.

Table 1: Overview of Never Events at SGUH by type Jan 2023 to Jan 2025

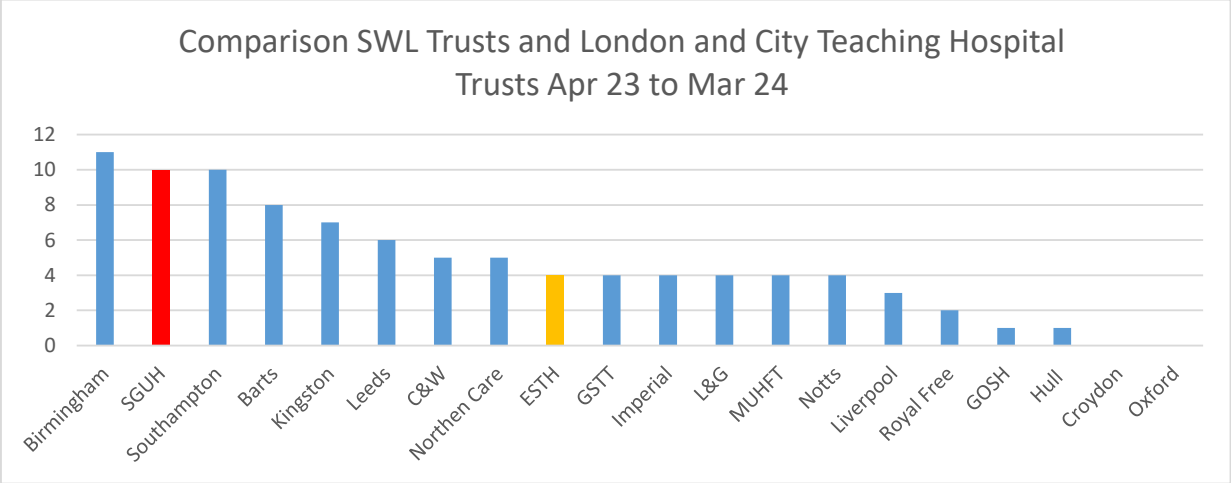
SGUH NEVER EVENTS JAN 23 TO JAN 25							
RETAINED FOREIGN OBJECT (n =7)			**WRONG SITE SURGERY (n =9)**			**WRONG PATIENT SURGERY (n =1)**
Guidewire (1)	**Part of surgical instrument (3)**	**Swab (3)**	**Wrong site block (2)**	**Wrong skin lesion (6)**	**Other (botox) (1)**	
Apr 23 NITU DW187382	Nov 23 Cath lab DW199106	Feb 23 Del suite DW185135	May 23 PCT theatres T&O DW188676	Sep 23 (Jun 22) DSU plastics DW187307	Nov 24 OMFS clinic DW217414	May 23 SJW theatres gynae DW189101
	Feb 24 Vascular theatre DW203146	Nov 24 Cardiac theatre DW219305	Jul 23 PCT theatres T&O DW193118	Oct 23 DSU plastics DW197445		
	Jul 24 OMFS theatre DW212844	Dec 24 Del suite DW219352		Nov 23 DSU plastics DW199446		
				Nov 23 Derm clinic DW199069		
				Mar 24 DSU plastics DW206322		
				Jul 24 DSU plastics/nuclear med DW212336		

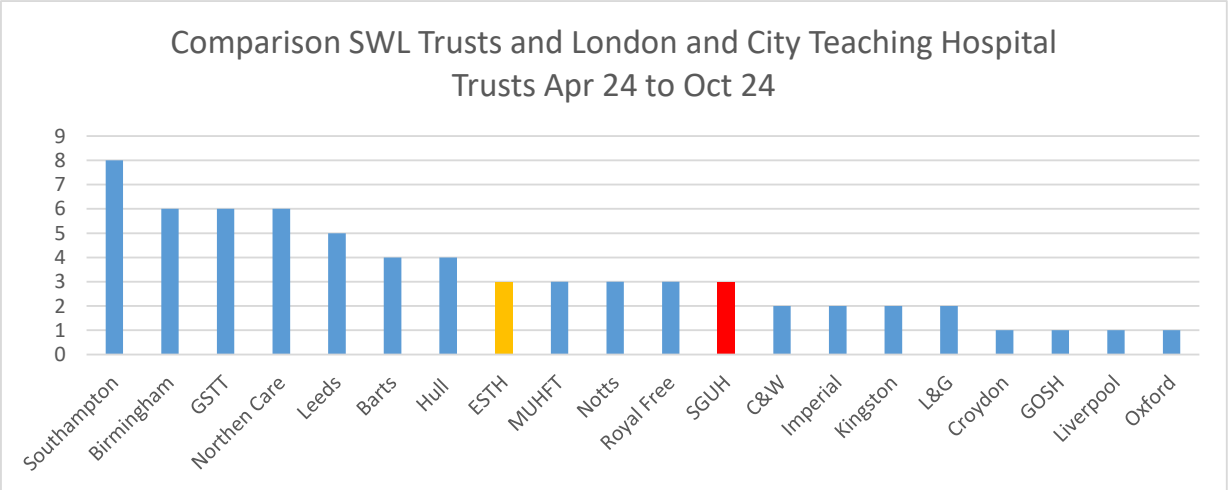
3.2 Comparison of this data with the NHSE dataset is outlined in Table 2 and Graphs 1 and 2.

Table 2: Comparison of main incident categories with NHSE nationally reported dataset

		Apr 23 to Mar 24		Apr 24 to Oct 24	
Category	**Subcategory**	**National**	**SGUH**	**National**	**SGUH**
Retained foreign object	Guidewire	23	1	14	0
	Part surgical instrument	15	2	10	1
	Swab	15	0	13	1
	Vaginal swab	20	1	23	1
	TOTALS	**81**	**4**	**67**	**3**
Wrong Site Surgery	Wrong site block	34	2	24	0
	Wrong skin lesion	52	5	21	1
	TOTALS	**179**	**7**	**101**	1

Graphs 1 and 2: Ranking of Trusts in terms of Never Events reported Apr 23 to Oct 24





3.3 Review of this overall picture demonstrates a number of areas of focus that will be discussed further:

- Overall, there is evidence of improvement over the 2 years, especially in relation to retained guidewires and wrong site blocks. It will be important to capture the learning from this for dissemination across the Group and ensure that we maintain the focus on ongoing assurance that this continues. Both sites continue to share summary details of incidents as they are reported and the outcomes of learning responses as well as work closely on improvement in areas such as LocSSIPs.
- Wrong skin lesion surgery – although this is the commonest type of Never Event reported nationally, SGUH was an outlier in April 23 to Mar 24. While more recent data shows an early improvement, it is not yet clear that the barriers that have been put in place are fully effective at preventing these incidents. There are a number of variables across both sites that continue to be explored in reducing the risk of these incidents.
- Retained vaginal swabs in a delivery suite setting – two incidents have been reported, one in each year, which indicates that there are not yet effective barriers. Review is underway of work processes in delivery suite, using PSIRF methodologies, to better understand the most effective ways of reducing risk in this particular setting, drawing on some of the learning from theatres.

4.0 Sources of Assurance

4.1 The approach to addressing these themes and the sources of assurance for each of the approaches is described.

4.2 Theatre safety:

4.2.1 Protected Theatres Teaching Time (PTTT): The main approach to addressing the cluster of serious safety incidents in theatres has been the institution of the PTTT sessions. Seven sessions have taken place over the last year. All planned theatre activity across the seven theatre suites at the Trust is suspended for the morning, with only CEPOD and emergency surgery taking place. The whole theatre teams from each theatre (anaesthetist, ODP, scrub staff and surgical staff) are required to attend the training, which is run jointly between the theatres practice education team, the theatres triumvirate and the organisational development team. All sessions are attended by a member of the Divisional senior team and the site or executive leadership team. The programme begins with an interactive session focused on incidents that have occurred in theatres at the Trust and draws out the learning and actions from these for discussion amongst smaller teams and the whole group. This is then followed by human factors simulation training in smaller groups.

For the first four sessions attendance by surgical staff was poor. Since the Summer the Site CMO has been writing to all doctors listed to attend the sessions making clear the expectation that they attend. This has led to an improvement in attendance from 17% of expected surgeons attending in February 24 to 83% of expected surgeons attending in November 2024. This had dropped slightly in January 25 to 63%. For the first year, the focus has been on fostering global engagement and adopting a broader approach to enhance overall performance and culture change. As this progresses into the second year, the programme will shift, based on feedback, towards learning from successful improvements and showcasing where things have gone well, as well as targeting specific underperforming areas, to identify gaps, implement targeted interventions, and drive change.

In January 2025 the CQC undertook an inspection of surgical services. In the initial feedback provided the inspectors commented on the positive learning culture evident in theatres and that there was evidence this was embedded across the Trust, with staff they spoke to able to able to describe the Never Events and steps that had been taken to improve safety.

4.2.2 Prep Stop Block: In 2018 the Health Safety Investigation Branch (HSIB) investigated the causes of wrong side regional anaesthetic block and invited the Safe Anaesthesia Liaison Group to formulate a standard, national policy. A specific ask was to review the status of 'Stop Before You Block' to assess if any improvements could be made. This resulted in a new standardised approach, 'Prep Stop Block', which was endorsed by all major bodies in 2022. However, this had not been rolled out at St George's. Since 2023 the focus of work on preventing further wrong site blocks has been to embed this approach across all theatres through dedicated posters, QR codes and training and audit compliance (see Appendix 1).

The majority of blocks happen in Paul Calvert theatres, followed by Day Surgery and Queen Mary's. Audit of 86 blocks undertaken since the campaign started showed 100% compliance with the 'Stop' moment, with no delay between the check and block delivery and 100% complete documentation. However, in 13% of cases the blocker did not return the needle to the assistant to keep it out of reach. A survey of anaesthetists is taking place to understand the barriers to this. However, there have been no further instances of wrong site block.

4.2.3 Accountable items: This policy has been updated in November 24 following the recommendation of the Association for Perioperative Practice and the learning from the Never Events involving fragmentation of surgical instruments/material, including an MDT review. The main changes are standardisation of practices across all areas, incorporating the counting and checking of any surgical components or instruments eg screws and guidewires, inserted during the procedure and then removed, and updating information on imaging. The last audit on accountable items was undertaken in 2018. The audit is now being revised and will be established across all theatres this year and report back through SNCT Divisional Governance Board by Summer 2025.

A key factor in managing accountable items safely is the minimising of distractions in theatres. Some immediate changes, including the nationally recommended 'pause for gauze' – a mandatory stop moment for the surgical count – have also been incorporated. The role of distraction has formed part of the human factors training in the PTTT.

4.2.4 Mandatory training: compliance with Patient Safety Level 1 and Safety Standards for Invasive Procedures MAST training is shown below. The Trust target is 90%.

Table 3: MAST compliance for core safety topics

	Patient Safety Level 1	**Safety Standards Invasive Procedures**
Trust	93.1%	90.4%
SNCT Division	92%	92%
Anaes & theatres directorate	96.5%	95.7%
Surgery directorate	90.7%	87.6%
Surgery and anaesthetics medical staff (cross Divisional)	75%	69%

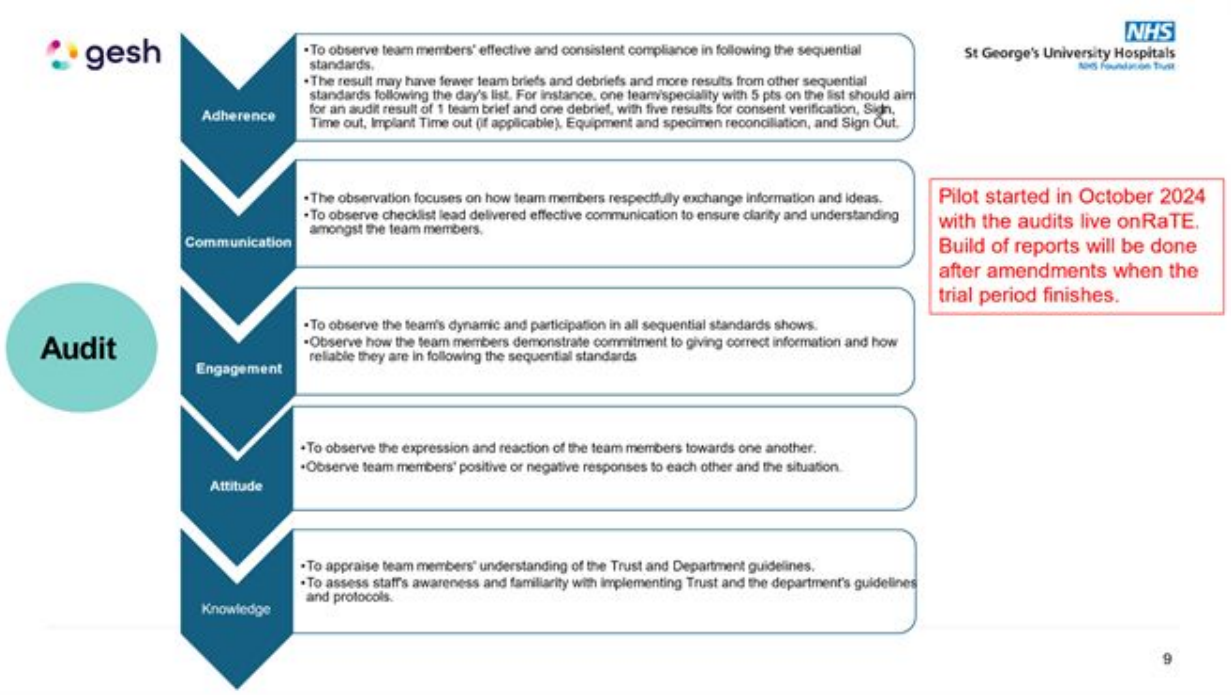
The Divisions have been asked to focus on improving compliance with training for medical and dental staff by April 2025, and to use the PTTT sessions to highlight the importance of ensuring all staff demonstrate competence in the basic elements of patient safety.

4.3 Theatre and non-theatre invasive procedures:

4.3.1 NatSSIPs 2 audit: In January 2023 the Centre for Perioperative Care published revised National Safety Standards for Invasive Procedures (NatSSIPs 2), designed to reduce misunderstandings or errors and to improve team cohesion. These cover invasive procedures both inside and outside theatres. Training has taken place with theatre teams around NatSSIPs 2 over the last year, with updated posters and QR codes in all theatres.

The infographic below demonstrates the change in approach from the original WHO audit, which did not adequately capture information relevant to safety.

Picture 1: NatSSIPs 2 audit programme



Initial results are being reviewed and then an improvement action plan will be produced by the theatres team. In summary the pilot audit shows the following (see Appendix 2):

- Over 95% of teams complete the Team Brief as a whole team in a private and uninterrupted space (theatre or anaesthetic room).
- However, there is room for improvement in the full use of the briefing guide (88.9%) and the use of Surginet to confirm accurate patient details (74.1%).
- There is also room for improvement in the Debrief, with only 87.7% of whole teams participating. This was lowest in CEPOD theatre (33%) and paediatric theatres (50%).
- There is >98% compliance with steps to ensure accurate consent and procedural verification.

- There was >98% compliance with the Sign In checklist by the whole team, although in some theatres there was lower compliance with the step of final patient and procedure confirmation by the anaesthetist and ODP. This was most noticeable in vascular and maxfax theatres.
- There are high standards of effective communication, team engagement and attitude, with >90% compliance with specific measures eg active listening, specifically checking for concerns, remaining in the room.
- There was some room for improvement in minimising distractions, with 17% of teams completing other tasks while the checklist was happening.

4.3.2 Local Safety Standards for Invasive Procedures (LocSSIPs): The development of LocSSIPs is based upon the high-level safety principles identified in the NatSSIPs and promotes local safe practice. The lack of consistency and application of LocSSIPs was identified as a key factor in a number of Never Events and a task and finish group has been established to drive forward standardisation and embed use and monitoring across the Trust, with this group working closely with ESTH on the same issue.

Work has completed to centralise standards and templates for LocSSIPs to prevent local variation. The three separate incidents of retained guidewires in ITU in 2022 and 2023 identified that all ITU areas had different LocSSIPs for central line insertion, which caused confusion. This has now been standardised, training implemented for all resident doctors, and there have been no further incidents. A Quality Improvement project is running across all three adult ITUs involving nursing and medical staff, with an emphasis on two-person technique. There is clear consultant leadership for LocSSIPs and a focus on competency and passporting for resident doctors.

Audit of LocSSIP compliance does not yet take place uniformly across the Trust. However, critical care, paediatrics, cardiology, cardiac surgery and plastic surgery have been the focus to date and now have well established LocSSIP documents and are auditing their practice. Further detail on plastic surgery can be found in section 4.4 below. The critical care audit is now contained within a wider Central Line Associated Blood Stream Infection Quality Improvement project. In the most recent audit of 40 cases the LocSSIP was completed in 39/40 cases. However, in only 13/40 was it completed contemporaneously, as intended. The main reason for this is the difficulty in allocating two staff members for every line insertion, especially out of hours when there is reduced staffing. Therefore, the focus of the QI project continues to be good awareness and training of the risks associated with line insertion, local competency sign-off for resident doctors, and active risk assessment when a decision is made to insert a central line. A QR code is also being developed that will bring up the LocSSIP on a mobile phone, so it is easier for every operator to view the pre-procedure checklist.

4.4 Excision of the wrong skin lesion

4.4.1 A cluster Patient Safety Incident Investigation (PSII) methodology has been used to investigate these incidents on the skin cancer pathway. This is now at reporting stage. It has drawn on the findings from DW187307 in 2023, where a Serious Incident investigation was completed under the old Serious Incident Framework. Due to the length of time taken for the PSII to conclude, the most recent incident (DW212336) also had an After Action Review (AAR) completed to ensure immediate learning was captured, and this has fed into the PSII at the analysis stage. PSIIs from other Trusts which have reported high numbers of these

incidents are also being reviewed to ensure that all the barriers available, or potentially available, are explored.

This has found that there is a pre-existing high risk of excising the wrong skin lesion, as reported by the British Association of Dermatologists (BAD) in 2022 (*Skin cancer surgical never events, learning from 85 cases occurring in English hospitals between April 2018 and 2022).* To minimise this risk, a number of mitigations have been put in place locally. However, none of these is completely effective and they must all be used in combination, and consistently, to reduce the risk. This relies on a strong safety culture, but also on an effective operational pathway where patient 'handoffs' between team members are reduced.

Table 2: BAD findings of the main causes for Never Events 2018-2022

Main and secondary causes	2018-2019	2019-2020	2020-2021	*2021-2022	Grand Total
Incorrect documentation			4		4
No photo of site lesion	5	4	7		17
Photo of lesion site ignored	1	1	2		4
Lack of communication between staff	1	2	3		6
Lesion site not checked with patient prior to surgery	2	2	5		9
No mirror for patient to check lesion site	2	1	2		4
WHO and safety checklist not followed correctly	8	1	9		17
Incorrect skin lesion site marked		3	4		7
No lesion marking recorded	1	2	6		9
Site marking smudged by face mask			1		1
Patient confirmed benign lesion without checks			1		1
Patient confirmed wrong site in mirror			1		1
Unknown		4			4

4.4.2 The first mitigation is to ensure that the patient is involved in the identification of the correct lesion. To help this, all outpatient clinics and procedure areas now have long length wall mirrors to help identify lesions. Audit in 2023 confirmed these are present in all areas. Local audit in November 2024 has shown a high compliance with the added step in the LocSSIP asking for the patient to confirm the lesion. Despite this, in our cluster, two Never Events occurred when the patient confirmed the wrong lesion. Patient factors, such as age, eyesight, and the high number of suspicious lesions presenting on the head, neck or back area, mean that this mitigation has been found by the BAD to be unreliable and unsafe without other mitigations in place.

4.4.2 BAD recommend that there is improvement in site marking and supporting documentation, including clear descriptions accompanied by imaging. SGUH implemented a 'no photo, no surgery' policy following the incidents in 2023. Audit in November 2024 showed that all patients who had surgery had a photo uploaded in their electronic record. However, there have been issues with image quality as images are now taken by clinicians rather than by a

dedicated medical photography service, as the contract for this service with SGUL ended in 2023 and has not been replaced. This is especially problematic when there are multiple lesions or when patient position or posture can affect lesion location. The most recent incident occurred despite imaging being available and checked. In addition, audit has shown little consistency in documentation regarding the lesion to be excised. The PSII panel has recommended improvements in the eTCI form when referrals are made for excision, and a new clinical note to link the image, description and LocSSIP.

4.4.3 Audit of this pathway is well established in plastics and all incidents are discussed at their governance meeting quarterly (Appendix 3). The use of the LocSSIP is now a routine part of induction for plastic surgery resident doctors. However, the most recent audit did show a 35% decline in completion of the LocSSIP. There has been further communication across the team, and this will be re-audited in February for review in March 2025.

4.4.4 The MAST data for the plastics service shows overall compliance of 79.2% for Patient Safety Level 1 and 83% for Safety Standards for Invasive Procedures against a target of 90%. However, this drops to 57% and 50% respectively for medical staff in the care group. The attendance of plastic surgery medical staff at the recent PTTT sessions has only been between 0 and 33%.

4.4.5 The main risks at SGUH continue to be in the high volume of patients coming through the service with multiple and complex skin lesions. Clinics take place across multiple sites and referrals come in from a variety of sources, some through the local dermatology service but many directly to plastic surgery from other skin clinics. There are clear efficiencies that can be introduced into this pathway to minimise the number of 'handoffs' between clinicians, especially for higher risk patients, but this will require significant service reconfiguration and may require initial investment. This is being assessed by the Division along with the findings of the PSII.

4.4.6 There is a clear need for more to be done to ensure there is a strong culture of patient safety in dermatology and plastics, with clear clinical leadership of work to improve safety in the service, and an ongoing focus on the risk of this type of incident. The medical directorate will be working with the Division to address this with the service and outline a clear and directive plan for improvement.

4.5 Retained swabs

4.5.1 The most recent incident happened in December 24 in delivery suite and the learning response is ongoing. A decision has been made to complete an After Action Review initially to more rapidly identify learning and any immediate actions, prior to a PSII reported externally. As part of this, an analysis is taking place of the investigation and action plan from the retained swab in delivery suite in February 23 to ensure that actions have been completed. This identified that the risk of retained swabs in maternity is higher in delivery suite than obstetric theatres, because different packs of swabs are used at different times. The most recent incident occurred in the context of a major post-partum haemorrhage, when the emergency response leads to a very busy environment, and both delivery and suture swab packs were opened, and different clinicians have signed for swab count at the beginning and end of suturing. Following the February 23 incident a pilot took place of a new combined swab pack with larger swabs. However, these were significantly more expensive and feedback by

practitioners was mixed so they were not continued. Further work will focus on what learning from theatre settings can be applied in delivery suite and the learning response will include theatre team members. This will include the role of the SafeSwab tray, which is well established in theatres but has not been well embedded outside of theatres. Induction and training of obstetric staff is also being reviewed to incorporate safety in delivery suite practices.

4.5.2 A swarm huddle has taken place following the retained swab in cardiac theatres in November 24. This identified that the count was reported as correct, and it has not been possible to identify where the error occurred. Therefore, work is focusing on understanding distractions in cardiac theatres and ensuring that all stages of the process for accountable items are managed to minimise distraction – the 'pause for gauze' programme described in section 4.2.3. There is good engagement of all teams in this work.

5.0 Recommendations

5.1 The Committee is asked to:

a. Note the steps being taken to reduce Never Events on the SGUH site and the initial impact of this work
b. Consider the sources of assurance provided and whether further assurance is required

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	2.3.1	
Report Title	**Quality Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Chief Medical Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Barbara Mathieson, Corporate Governance Officer Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	Quality Committee-in-Common	27 February 2025
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the Quality Committees-in-Common report to the Group Board and updates on the proposed forward plan of business for the Committees in 2025/26. After review, no changes are recommended to the terms of reference.

The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year. Most notably, we wish to make sure that there is the correct flow of reporting to the Board so that approvals. We plan to share the updated forward plan with Committee members for input via email with a view to ratifying this at the next Quality Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

Action required by Group Board

The Board is asked to

a. Review the Quality Committees-in-Common annual report and effectiveness review.
b. Review the Committee terms of reference and recommend to the Board that no changes are made.
c. Note the update on the forward workplan for the Committee for 2025/26.

Committee Assurance

Committee	Quality Committees-in-Common

Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Quality Committees-in-Common Annual Report 2024/25
Appendix 2	Committee Effectiveness Report 2024/25
Appendix 3	Committee Terms of Reference

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

There are no specific EDI implications of this report.

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

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

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the Board with a report of the work of the Committees in 2024/25, which includes a review of the Committees' terms of reference, an update on the draft forward plan of business for 2025/26, and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.2 With the Quality Committees of both Trusts having operated as Committees-in-Common in 2024/25, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

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

2.4 Annual Reports to the Group Board were submitted in May 2024 but this year, we have been brought the timelines forward so that reporting can be made to the last Board meeting of the year in March. This allows for any changes to terms of reference to be implemented at the start of the new cycle in April.

3.0 Quality Committees-in-Common Annual Report

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

- the operation of each Committee as a Committees-in-Common in 2024/25
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Committees in 2024/25

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

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed. No changes are proposed this year.

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

5.0 Committee Forward Workplan 2025/26

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

5.2 The forward plan has undergone significant revision to ensure that we are taking the right items at the right time and frequency throughout the year. A draft of the revised plan is being developed but requires further refinement to ensure that the timeline for any statutory reporting is properly timed within the Group Board meeting cycle. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Quality Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Group Board understands the outcomes of the Committees' annual effectiveness survey, it is proposed that summary of the Committee effectiveness review is attached as an appendix to the Committee Annual Report. This is attached at Appendix 4. Overall, respondents to the effectiveness review considered that the Committee was working well and that the quality and timeliness of papers, though showing some improved, remained a concern.

7.0 Recommendations

7.1 The Board is asked to:

a. Review Quality Committees-in-Common annual report and effectiveness review
b. Agree that there are no changes to the Committee terms of reference.
c. Note the update on the forward workplan for the Committee for 2025/26.

Quality Committees-in-Common Annual Report 2024/25

1 April 2024 – 28 February 2025

Contents

Quality Committees-in-Common Annual Report 2024/25

1. Introduction

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

This report sets out a high level overview of the work of the Quality Committees-in-Common in 2024/25. It provides an integrated report on the key matters considered by the Committees, and highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The Quality Committees of the two Trusts have adopted common terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference agreed by the Trust Board's in May 2022 respectively. Minor amendments have been made to the original Terms of Reference on annual basis since 2022.

2.1 Purpose

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

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

3. Struture of meetings

During the year the Committees ran a series of “Focus sessions” on alternative months. These sessions typically covered between three and four key topics and therefore allowed greater time for a more in depth focus and discussion of key topics. These included maternity services, concerns with the Group’s Emergency Departments and "Fundamentals of Care” – Dementia and Delirium.

Governance of these sessions have been reviewed and continue to be refined over the year and final proposals are due to the meeting of the Committee taking place at the end of February 2025 for formal approval.

4. Membership and attendance

4.1 Members and attendees

During the reporting period (April 2024 to February 2025), the following were members or regular attendees of the Quality Committees-in-Common:

St George’s Quality Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Committee Chair - Non-Executive Director	1 April 2024 – 28 February 2025
Jenny Higham	Member	Non-Executive Director	1 April 2024 – 31 July 2024
Yin Jones	Member	Associate Non-Executive Director	1 April 2024 – 28 February 2025
Peter Kane	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
Kate Slemeck	Member	Managing Director – St George’s	1 April 2024 – 28 February 2025
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2024 – 28 February 2025
Natilla Henry	Attendee	Group Chief Midwifery Officer	1 April 2024 – 28 February 2025
Stephanie Sweeney	Attendee	Group Director of Quality and Safety Governance	1 April 2024 – 28 February 2025
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025
Nicola Shopland	Attendee	Site Chief Nursing Officer	1 April 2024 – 28 February 2025

Epsom & St Helier Quality Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Committee Chair, Non-Executive Director	1 April 2024 – 28 February 2025
Peter Kane	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Derek Macallan	Member	Non-Executive Director	1 April 2024 – 31 December 2024

Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2024 – 28 February 2025
Thirza Sawtell	Member	Managing Director – Integrated Care	1 April 2024 – 28 February 2025
Rebecca Suckling	Attendee	Site Chief Medical Officer - ESTH	1 April 2024 – 28 February 2025
Theresa Matthews	Attendee	Site Chief Nursing Officer - ESTH	1 April 2024 – 28 February 2025
Alison Benincasa	Attendee	Group Director of Compliance	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025
Simon Littlefield	Attendee	Site Chief Nursing Officer – Integrated Care	1 April 2024 – 28 February 2025

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

3.2 Committee meeting attendance

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

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

Attendance			
Name	**Role**	**Trust**	**Attendance**
Andrew Murray **	Committee Chair	SGUH	
Jenny Higham	Member	SGUH	
Peter Kane	Member	ESTH	
Yin Jones	Member	SGUH	
Derek Macallan	Member	ESTH	
Richard Jennings	Member	Both	
Arlene Wellman	Member	Both	
James Blythe	Member	ESTH	
Kate Slemeck	Member	SGUH	
Thirza Sawtell*	Member	ESTH/IC	
Alison Benincasa	Attendee	Both	
Rebecca Suckling	Attendee	ESTH	
Luci Etheridge	Attendee	SGUH	
Nicola Shopland	Attendee	SGUH	
Natilla Henry	Attendee	SGUH	
Stephen Jones	Attendee	Both	
Theresa Matthews	Attendee	ESTH	
Stephanie Sweeney	Attendee	Both	

Simon Littlefield	Attendee	ESTH/IC	

**Thirza Sawtell was represented by Simon Littlefield at the majority of the meetings of the Committee.*

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

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

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

Representatives of South West London Integrated Care Board, June Okochi and Justin Roper, also attended meetings of the Committee throughout the year.

4. Committee activity and focus

One of the key areas relating to patient quality and safety which the Committee considered during the year was the development and adoption of the Group Quality Strategy. The aspiration for the strategy was " **Our aspiration by 2028 is to deliver outstanding care together":**

- waiting times among the best in the NHS,
- lower than expected mortality rates and a reduction in avoidable harm,
- improved outcomes and patient experience
- a reduction in health inequalities.

Within this the strategic priorities are:

- **STRONG GOVERNANCE -** *We will strengthen governance & oversight of quality and safety.*
- **BETTER FLOW / SHORTER WAITS -** *We will improve flow through our services, so that patients get the right care, in the right place, more quickly.*
- **A LEARNING ORGANISATION -** *We will embed a culture of psychological safety, continuous improvement, learning from mistakes and learning from others.*

The Committee will continue to monitor progress on the strategy through receiving regular updates.

Another key area of work which has taken place was the adoption and embedding of the new NHS Patient Safety and Incident Review Framework (PSIRF). All clinical areas within the Group had gone live within this new way of work over the past year. PSIRF sets out the NHS's approach to developing and maintaining effective systems and processes for

responding to patient safety incidents for the purpose of learning and improving patient safety. There is now a focus on recognising themes from incidents and have overarching action plans for similar areas of concerns, eg falls, nosocomial infections etc. New ways, and often quicker ways of undertaking investigations using national guidance are in operation, such as MDTs and the use of swarms. The Committee received regular updates on the compliance of staff having completed their PSIRF Training. This improved over the year.

The occurrence of Never Events continued to be an area of concern for the Quality Committees in Common and it received regular updates on the work being undertaken across the Group in response to this. Most Never Events which occurred over the year could be detailed under two categories:

- Wrong site surgery – particularly in Plastics and Dermatology
- Retained objects – post surgery (e.g. swabs or small pieces that had broken off instruments being used during surgery)

Details of the improvement work being undertaken by the plastics / dermatology teams and within surgery where regularly received by the Committee, ensuring there was a positive culture within theatres and to ensure that staff felt empowered and confident to speak up if they had concerns.

Maternity

A key focus for the Committees at each meeting during the year was maternity services at both Trusts. The Committees monitored a range of metrics to seek assurance regarding the quality and safety of maternity services, including perinatal quality surveillance measures and the safety actions within the Maternity Incentive Scheme.

At each meeting of the Quality Committee in Common it receives an update report as 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, at every meeting. The report updates on significant changes, emerging safety concerns, new risks and successes, and assurance where available. The report also includes, as appendices, the Maternity and Perinatal Incentive Scheme (CNST) update for each Trust (incorporating any Board reporting requirements as set out in the NHS Resolution Technical Guidance and Audit Tool) and the mandated measures required as part of the NHS England Perinatal Quality Oversight Model - Perinatal Quality Surveillance Model data

During 2024/25 the Quality Committee continued its detailed scrutiny of the Trust's action plan to respond to the issues identified by the CQC in their inspections of the service across both trusts in 2023.

Following the inspection, the Board recognised that the issues identified highlighted potential weaknesses in quality governance and ward to Board reporting. The Board commissioned an independent external review of quality governance, this review considered maternity services at both SGUH and ESTH and the outcomes was presented to the Committee in June 2024. The review then looked more widely at quality governance structures, processes and controls in a second phase.

Also, as a result of notification of outlying maternity data at SGUH a NHS Resolution Thematic Review of cases referred by the trust to the Early Notification Scheme between 2017-2024, and a Review of MBRRACE findings of 2020,were commissioned.

A further unannounced inspection took place of SGUH Maternity Service October 2024, from which as Section 29A notice was received by the Trust.

The Committee scrutinised the updates from the various reviews, considered whether the actions were being completed in a timely manner and whether sufficient progress was being made. A deep dive focus session on Maternity Services was held by the Committee in November 2024.

As of February 2025, the expectation in relation to CNST 6 were:

- **ESTH:** Expect to declare full compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6 and would therefore receive 10% rebate of their contribution to CNST.
- **SGUH:** Expect to declare 9/10 compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6, which would result in none or less than 10% rebate of Trust Contribution.

Emergency Departments

Concerns relating to both the quality and safety of the Group's Emergency Departments (ED) given the continuing high operational pressures were the subject of items discussed at both the main Committee meetings and the focus sessions.

The Committee received regular updates on the improvements being made within the EDs to try and improve both quality and safety. These included outlining improved triage practices, establishment of frailty units which could be directly assessed by GPs to try and stop admittance, development and use of standard operating procedures around escalation, improved risk assessment and improved patient services such as provision of meals for long waiters etc. The Committee also learnt of the work being undertaken with the local mental health trusts to try and reduce the number of patients coming to acute services.

Infection Control

During the year there has been a continued focus on Infection Prevention and Control (IPC). The benefits of collaboration and beginning to bring together the IPC teams from the two trusts to enable Group wide learning were seen across the year. There continued to be areas of concern relating to IPC relating to the ageing infrastructure across the sites. Oversight of IPC / infrastructure is also monitored via the Infrastructure Committees-In-Common.

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

The Committees reviewed the Group annual Patient Experience report which provided an overview of key achievements for the year. Of note to both trusts were the Patient Experience Priorities and the outcomes of the various patient experience surveys.

Clinical Governance and Clinical Effectiveness

A key area of focus for the Committees was clinical governance and this will continue in 2025/26. For the current period the Committees reviewed the outcomes of the external review of quality governance within the Maternity Service along with the outcomes of the CQC inspections and the action plans developed by the Trusts. The Committees continue to seek assurance that robust clinical governance structures, systems, processes and controls are in place to ensure effective ward to Board reporting.

The Committees continued to receive updates and assurance relating to concerns which had been identified within individual services. This was the case for the Head and Neck Service at SGUH and the Interstitial Lung Disease Service at ESTH.

General

The Quality Committees-in-Common have reviewed the quality and safety-related risks on the Corporate Risk Register and continued to review the strategic risks on the Group Board Assurance Framework. The Committee will be reviewing the strategic risks on the Group BAF regularly throughout 2025/26.

The Quality Committees-in-Common prioritised throughout the year receiving assurance that the two trusts were sharing learning with each other. This was felt to be an improving picture and related in particular to sharing learning from the new PSIRF work, details from the various CQC Inspections and trying to resolve the concerns within the Emergency Departments alongside. It was agreed that more sharing of learning could take place in some services and Medicines Management was an example where this was the case.

5. Committee Effectiveness

The Quality Committees-in-Common conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. The full report is attached in Appendix 1. Overall, the results of the effectiveness review suggest that there are clear benefits from the new Committees-in-Common approach on quality issues. Respondents felt that the Quality Committee-in-Common was working well, with scope to make further improvements. The main issues highlighted in the effectiveness review are set out below:

- **Overall effectiveness of the Committee:** The majority at 54% (7) felt the Committee was very effective, with 38% (5) expressing that the Committee was somewhat effective. 8% (1) said that the Committee was extremely effective. The quality of papers was commented on as impacting on the view of the effectiveness. One commented that there could be better joining up of medical and nursing perspectives in papers.
- **Membership, skills and experience of Committee:** All respondents agreed or strongly agreed that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. However, one respondent commented that the composition of NEDs may need to be reviewed as there was uncertainty over whether they could all contribute meaningfully, with an over reliance on the Chair. Other comments

on attendees suggests that this needs further review to ensure that everyone is adding value.

- **Quality and timeliness of papers:** There were mixed views on the quality and timeliness of papers with 46% (6) agreeing or strongly agreeing that the papers were timely and of good quality, 23% (3) being neutral and 31% (4) disagreeing. All 11 comments made reference to either all, or combination of, the lateness of papers, the length and the variability in quality – although some improvement was noted in some comments. Two comments noted a lack of standardisation in the reporting by the two trusts.
- **Discussions and assurance:** 8% (1) strongly agreed and 77% (10) agreed that there was sufficient time to consider issues in depth, 15% (2) were neutral. 6 respondents commented that there move to bi-monthly focus sessions was aiding with this. However, 2 commented on the length of the agenda, with a lot to get through, and 1 person felt that the meetings are too long. 92% (11) strongly agreed, or agreed, that the Committee provided insight and appropriate constructive challenge on the matters within its remit escalating and cascading issues as necessary. The 'very good' triangulation by the Chair was highlighted with one comment that this had improved immeasurably under the Chair but was very dependent on him.

6. Committee Forward Plan and Terms of Reference

No changes are proposed to the Terms of Reference (Appendix 2) the paper on the focus meetings (5.2) provide clarity on how those sessions will operate but do not require changes to the Terms of Reference. The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year, most notably to ensure that the content of the focus sessions is captured and to map against board reporting. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

7. Conclusion

Overall, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference, carrying out robust reviews of key areas of quality and patient safety to provide assurance to the Board. The effectiveness review highlights that there have been improvements in the ways of working over the year, with the focus sessions being a welcome addition by Committee members. However, the lateness and the variability in the quality of papers is an area of concern to members. For all Board and Committee meetings it has been agreed that the majority of papers will be issued on the Friday before the meeting, with it being an exceptional case for a paper to be delayed – this should address concerns around timeliness of papers and the impact this has on committee discussion.

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

gesh

Quality Committee-in-Common

Committee Effectiveness Review 2024/25

Summary Report for Group Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

February 2025

1. Introduction
Purpose, context and recommendations

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

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Quality Committees-in-Common in 2024/25. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2025/26.

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

Summary
A total of 14 people responded to the effectiveness survey, although for some questions only 13 responses were given. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective during a challenging year and were continuing to develop and improve. The key issues highlighted were: the timeliness of papers, though seen as improving; the quality and consistency of papers, variable but improving, and, on occasion an over ambitious agenda. The high quality of the Chairing of the meeting was noted by several respondents.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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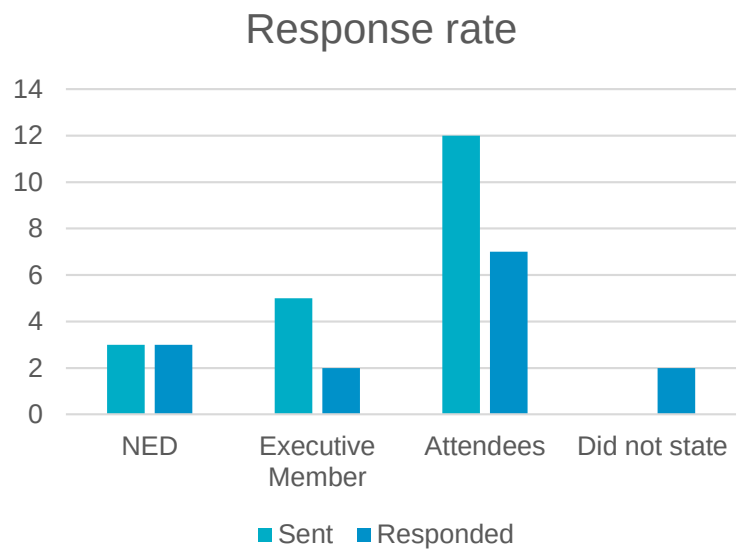
2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Committee
- Executive members of the Committee
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference

In total, 20 people were invited to participate in the survey. Of these a total of 14 people provided responses, a response rate of 70%.



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3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** 78% (11) of respondents agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. 22% (3) neither agreed nor disagreed. 7 respondents made comments on this question. The long delay in agreeing the Terms of Reference for the split between standard meetings and focus sessions was felt to result in a lack of structure and ineffective planning with last minute items being added that had not had proper oversite. One respondent commented that the behind the scenes organisation needed to improve. The deep dives were felt to be helpful but one correspondent added that they were of variable quality.

- **Membership, skills and experience of Committee:** All respondents agreed or strongly agreed that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. However, one respondent commented that the composition of NEDs may need to be reviewed as there was uncertainty over whether they could all contribute meaningfully, with an over reliance on the Chair. Other comments on attendees suggests that this needs further review to ensure that everyone is adding value.

- **Chairing of meetings:** 65% (9) strongly agreed that the meetings are chaired effectively, with 14% (2) agreeing and 7% (1) disagreeing. 7% (1) could not comment. 7 comments were received on this question, 6 of which can be summarised by 1 respondent as '*Meetings are chaired extremely effectively by the current Chair. Forward planning is given to allocating time appropriately for the amount of discussion needed for each item. The discussion is effectively supported but never constrained by the clear chairing. When the committee is asked to choose its level of assurance, the Chair is very disciplined in clarifying what the Committee is being asked if it is assured about. The Chair models good manners and courtesy, which does not prevent strong and clear challenge when this is needed.'* The 7th comment raised that the size of the agenda are too ambitious and more items should be for noting.

3. Key findings

Overall effectiveness

- **Quality and timeliness of papers:** There were mixed views on the quality and timeliness of papers with 46% (6) agreeing or strongly agreeing that the papers were timely and of good quality, 23% (3) being neutral and 31% (4) disagreeing. 11 comments were made with some improvement in timeliness and quality of papers of late noted. All comments made reference to either all, or combination of, lateness of papers, the length and the variability in quality. The length of the narrative in some papers, making it more difficult to highlight key themes and assurance was noted by two respondents. Two comments noted a lack of standardisation in the reporting by the two trusts and how this could impact on the group as a learning organisation. It was suggested that more use could be made of the Reading Room for non-core papers.

- **Discussions and assurance:** 8% (1) strongly agreed and 77% (10) agreed that there was sufficient time to consider issues in depth, 15% (2) were neutral. 6 respondents commented that there move to bi-monthly focus sessions was aiding with this. However, 2 commented on the length of the agenda, with a lot to get through, and 1 person felt that the meetings are too long. 92% (11) strongly agreed, or agreed, that the Committee provided insight and appropriate constructive challenge on the matters within its remit escalating and cascading issues as necessary. 8% (1) neither agreed or disagreed. Two people commented that there could be more challenge. The 'very good' triangulation by the Chair was highlighted with one comment that this had improved immeasurably under the Chair but was very dependent on him.

- **Overall effectiveness of the Committee:** The majority at 54% (7) felt the Committee was very effective, with 38% (5) expressing that the Committee was somewhat effective. 8%(1) said that the Committee was extremely effective. The quality of papers was commented on as impacting on the view of the effectiveness. One commented that there could be better joining up of medical and nursing perspectives in papers.

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4. Next steps

"So what" and "what now"?

The Committee moved to a bi-monthly rhythm of full meetings and focus sessions in 2024/25 and from the comments, it appears that this is changed is supported but more work is needed to embed this and ensure the right flow of topics and attendees. The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2025/26:

- **Terms of Reference and Forward Work Plan:** The Forward Work Plan for 2025/26 should be carefully structured to give greater clarity to the use of the focus sessions and to ensure that agenda are not overloaded.

- **Quality and timeliness of papers:** Ensure greater consistency in the quality of papers – papers to be more concise, focus on assurance and on the "so what" and "what now". Greater use of appendices for necessary detail, and use of reading room for supplementary / optional reading. Greater efforts should be made for papers to be submitted on time.

- **Membership, skills and experience of Committee:** The dependence on the Chair, particularly on medical issues, was a theme that came out in the comments. Future NED appointments to the Committee should bear this in mind but the Committee agreed that the aim should be for the quality of the narrative in the papers to inform all committee members equally, regardless of professional background or expertise.

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Quality Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

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

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

3. Purpose

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

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

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

4. Duties

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

Patient Safety

- Seek assurance that services are safe and high quality, and review action plans to address concerns regarding safety and quality.
- Review and seek assurance regarding the effective and consistent delivery of the fundamentals of care.
- Receive regular reports in relation to the safety and quality of maternity services, including perinatal quality surveillance measures and compliance with the safety actions in the Maternity Incentive Scheme.
- Seek assurance in relation to actions being taken in response to concerns about patient safety raised by staff and to foster psychological safety in staff feeling able to raise concerns about quality of care.
- Seek assurance on the effectiveness of the systems and processes in place to assess the quality impact of Cost Improvement Plans and other significant service changes.
- Review the effectiveness of systems and processes in relation to safeguarding and mental capacity.

Quality Governance and Clinical Effectiveness

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

Patient Experience

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

Health Inequalities

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

Research and Development

- Providing strategic oversight to the Trust's research and development programme, ensuring it is effective and meets the needs of the Trust and the wider Group.

General

- Seeking assurance on quality and safety risks on the Corporate Risk Register and Group Board Assurance Framework.
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, independent reviews, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response, as requested by the Audit Committee.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall under the Committee's areas of interest.
- Reviewing any relevant Trust strategies prior to approval by the Group Board (if required) and monitor their implementation and progress.
- Seeking assurance that the Trust is compliant with the requirements of its registration with the Care Quality Commission (CQC) and oversee any remedial action that may be required and monitor progress against any must and should do actions identified by the CQC.
- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.

5. Membership and Attendance

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

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

Membership of the Committee comprises:

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

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

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

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

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

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

6. Quorum

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

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

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

7. Accountability and Reporting Arrangements

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

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

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

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

8. Meeting Format and Frequency

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

9. Declarations of Interest

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

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

10. Meeting Arrangements and Secretariat

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

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

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

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

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

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

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

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

Document Control

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

Group Board

Meeting on Thursday, 06 March 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 January and February 2025 and sets out the matters the Committee wishes to bring to the attention of the Board.

This Assurance rating of Limited reflects the current adverse financial performance at the Trusts.

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, 06 March 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance Committee at its meetings in January and February 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 31st January and 28th February 2025, the Committee considered the following items of business:

31st January 2025	28th February 2025
PUBLIC MEETING • Update from Group Recovery Board • Finance Report (M9) • CIP Update (M9) • Costing update • Planning guidance 25/26 • Business Planning 25/26 • Productivity update • Business Cases • Spec Comm delegation • Financial Policies • SWL Procurement Partnership update	**PUBLIC MEETING** • Update from Group Recovery Board • Finance Report (M10)* • CIP Update (M10) • Forecast and mitigations • Cash update Q1 • Business Planning 25/26 • Productivity update • IQPR • Procurement policy • Annual Report to committee 24/25 • Self-assessment of the Committee • Workplan 25/26 • SWL Pathology update

**items marked with an asterisk are on the Group Board agenda as stand alone items in March 2025*

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 achieve financial savings in 25/26.

b) Finance Report M10

Both trusts are showing an underlying adverse position to plan at M10 (ESTH £7.0m and SGH £9.8m), showing baseline pressures and CIP shortfalls in addition to cyber attack support impact at SGH (£0.9m).

c) CIP update

CIP delivery was improved from the reclassification of recovery actions as CIP in M10. Both Trusts are now expecting to fully deliver against CIP targets in 24/25.

d) Forecast and mitigations

In January executive leads updated on individual workstreams including scope and resourcing requirements. Committee members welcomed this.

e) Costing update

In January the committee was updated on the latest with costing for the group.

f) Business Planning 25/26

The GCFO noted the latest financial plan values submitted to NHSE for the February draft position. Committee members discussed actions proposed to improve CIP identification ahead of the full submission at the end of March.

g) Planning Guidance 25/26

The GCFO highlighted the key headlines from the published planning guidance in January.

h) Cash update for Q1

The GCFO outlined what cash requirements could be for each organisation based on current assumptions and noted that more work was required on the detailed cash positions ahead of the final plan submission.

i) Productivity update

The SGH DFS updated on the latest productivity information and how the group was planning to use it.

j) Business cases

The SGH DFS noted the latest with big projects across the group.

j) 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.

k) Spec Comm delegation

The SGH SCFO noted latest understanding of the impact of devolution from NHSE to ICSs.

l) Financial Policies

The GCFO introduced the paper and proposed changes to group wide finance policies.

Committee members:

- **Approved the updated SGH Private Patients Debt Recovery and SGH Transactions Management policies**
- **Approved the removal of the SGH Financial Planning, SGH Credit Management and ESTH Virement policies as covered elsewhere**
- **Approved the 1 year roll forward requests for:**
  - **SFIs/Scheme of Delegation (both organisations)**
  - **Overseas Visitors debt recovery (ESTH only)**
  - **Private patients debt recovery (ESTH only)**
  - **Business expenses (ESTH only)**

m) Procurement Policy

Committee members approved the updated Procurement policy

n) Annual Report to committee 24/25

Committee members approved the Annual Report to Group Board subject to minor changes outlined by the Committee Chair.

o) Committee Effectiveness 24/25

Committee members endorsed the suggestions of the committee effectiveness survey, including meetings closing at 11.15 and 12.15 in alternate months.

p) Workplan 25/26

Committee members approved the new workplan for 2025/26.

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

a) SWL Procurement partnership report

The SWLPP Director of Commercial Procurement highlighted performance against breaches and waivers, as well as CIP progress.

b) SWL Pathology report

The GCFO noted latest highlights of the SWLP financial performance. There is an urgent need to resolve the location of the GP Hub given delays to the Sutton Emergency Care Hospital.

5.0 Implications

5.1 The Committee received an update on 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 noted no reason to change the current 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 January and February 2025.

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	2.2	
Report Title	**Finance Committees-in-Common Annual Effectiveness Review**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the Finance Committees-in-Common report to the Group Board, describes the plan to review the Committees' current terms of reference, and updates on the proposed forward plan of business for the Committees in 2025/26.

The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year, co-ordinating with the Board and other committees. We plan to share the updated forward plan with Committee members for input via email. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

Action required by Group Board

The Board is asked to:

a. Review the annual report and effectiveness review
b. Note the plan for the review of the annual workplan and terms of reference

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Finance Committees Annual Report
Appendix 2	Committee Effectiveness Report

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications relating to this report.

Legal and / or Regulatory implications

There are no legal or regulatory implications to this report.

Equality, diversity and inclusion implications

There are no equality, diversity or inclusion implications to this report.

Environmental sustainability implications

There are no environmental sustainability implications to this report.

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

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the Group Board with a report of the work of the Committees in 2024/25, which includes a review of the Committees' terms of reference, an update on the draft forward plan of business for 2025/26, and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.2 With the Finance Committees of both Trusts having operated as Committees-in-Common in 2024/25, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

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

2.4 Reports to the Group Board were submitted in July 2024 but this year, we have been brought the timelines forward so that reporting can be made to the last Board meeting of the year in March. This allows for any changes to terms of reference to be implemented at the start of the new cycle in April.

3.0 Finance Committees-in-Common Annual Report

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

- the operation of each Committee as a Committees-in-Common in 2024/25
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Committees in 2024/25

3.2 The purpose of the annual report is to provide a high-level overview of the Committee's work and how it has delivered against its purpose and duties as set out in its agreed

terms of reference. It is not, and does not seek to, describe all issues addressed by the Committee over the past year.

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed but further consideration is needed.

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

5.0 Committee Forward Workplan 2025/26

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

5.2 The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year, and that it is co-ordinated with the Board and other committees. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Group Board understands the outcomes of the Committees' annual effectiveness survey, a summary of the Committee effectiveness review is provided as an appendix. Overall, respondents to the effectiveness review considered that the Committee was working well, with effective Chairing but that improvements in relation to the timeliness of papers would be of benefit. The length of papers and of the meetings was also commented on.

7.0 Recommendations

7.1 The Board is asked to:

a. Review the Finance Committees-in-Common annual report.
b. Note the update on the terms of reference and forward workplan for the Committee for 2025/26.

Finance Committees-in-Common Annual Report 2024/25

1 April 2024 – 28 February 2025

Contents

Finance Committees-in-Common Annual Report 2024/25

1. Introduction

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

This report sets out a high level overview of the work of the Finance Committees-in-Common in 2024/25. It provides an integrated report on the key matters considered by the Committees, but highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

Membership

2. Committee purpose and duties

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

2.1 Purpose

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

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its annual financial targets and uses public funds.
- Approving the annual operational plan and reviewing performance to ensure the Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance that key risks relating to finance, performance, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Overseeing the implementation of strategies and other frameworks and risks to their delivery.

The full terms of reference, including proposed changes, are at Appendix 1.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2024 to February 2025), the following were members or regular attendees of the Committee:

St George's Finance Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2024 – 28 February 2025
Peter Kane	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Pankaj Dave	Member	Non-Executive Director	1 February 2025-28 February 2025
Claire Sunderland Hay	Member	Associate Non-Executive Director	1 November 2024 – 28 February 2025
Tim Wright	Member	Non-Executive Director	1 April 2024 – 31 January 2025
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2024 – 28 February 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
Kate Slemeck	Member	Managing Director – St George's	1 April 2024 – 28 February 2025
Vicky Smith	Attendee	Group Chief People Officer	1 July 2024 – 28 February 2025
Angela Paradise	Attendee	Group Chief People Officer	1 April 2024 – 30 June 2024
Thirza Sawtell	Attendee	Group Executive Director of Integrated Care	1 April 2024 – 28 February 2025
Tara Argent	Attendee	Site Chief Operations Officer	1 April 2024 – 28 February 2025
Mark Bagnall	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 September 2024 – 28 February 2025
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025
Helen Jameson	Attendee	SWL Chief Financial Officer	1 April 2024 – 28 February 2025
Andy Stephens	Attendee	Site Director of Financial Strategy	1 April 2024 – 28 February 2025
George Harford	Attendee	Site Chief Financial Officer	1 April 2024 – 28 February 2025

Epsom & St Helier Finance Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	1 April 2024 – 28 February 2025
Peter Kane	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Martin Kirke	Member	Non-Executive Director	1 April 2024 – 31 December 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2024 – 28 February 2025

Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2024 – 28 February 2025
Vicky Smith	Attendee	Group Chief People Officer	1 July 2024 – 28 February 2025
Angela Paradise	Attendee	Group Chief People Officer	1 April 2024 – 30 June 2024
Thirza Sawtell	Attendee	Group Executive Director of Integrated Care	1 April 2024 – 28 February 2025
Alex Shaw	Attendee	Site Chief Operations Officer	1 April 2024 – 28 February 2025
Mark Bagnall	Attendee	Group Chief Infrastructure, Facilities & Environment Officer	1 September 2024 – 28 February 2025
Ed Nkrumah	Attendee	Group Director of Performance & PMO	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025
Lizzie Alabaster	Attendee	Site Chief Financial Officer	1 April 2024 – 28 February 2025
Helen Jameson	Attendee	SWL Chief Financial Officer	1 April 2024 – 28 February 2025
Alastair Haggart	Attendee	Site Deputy Director of Finance - Operations	1 April 2024 – 28 February 2025

3.2 Committee meeting attendance

The quorum for each Committee meeting was a minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 13 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees-in-Common were quorate for both Trusts.

Attendance			
Name	Role	Trust	Attendance
Ann Beasley	Committee Chair	Both	13/13
Peter Kane	Member	Both	12/13
Pankaj Dave	Member	SGUH	1/1
Claire Sunderland Hay	Member	SGUH	4/6
Tim Wright	Member	SGUH	10/12
Martin Kirke	Member	ESTH	7/11
Andrew Grimshaw	Member	Both	13/13
Richard Jennings	Member	Both	10/13
Arlene Wellman	Member	Both	8/13
Kate Slemeck	Member	SGUH	10/13
James Blythe	Member	ESTH	12/13
Vicky Smith	Attendee	Both	7/9
Angela Paradise	Attendee	Both	3/4
Mark Bagnall	Attendee	Both	6/7
Thirza Sawtell	Attendee	Both	11/13
Alex Shaw	Attendee	ESTH	5/13
Tara Argent	Attendee	SGUH	5/13
Stephen Jones	Attendee	Both	2/13

Andy Stephens	Attendee	SGUH	12/13
Alastair Haggart	Attendee	ESTH	13/13
Ed Nkrumah	Attendee	Both	9/13
Helen Jameson	Attendee	Both	9/13
George Harford	Attendee	SGUH	12/13
Lizzie Alabaster	Attendee	ESTH	10/13

In addition to the above, the Group Chairman, Group Chief Executive Officer and Group Deputy Chief Executive Officer regularly attended meetings of the Finance Committees-in-Common during the reporting period. The Chairman attended 11 meetings, the Group Chief Executive Officer 9 meetings, and the Group Deputy Chief Executive Officer 8 meetings.

4. Committee activity and focus

4.1 Finance and Business Planning

In 2024/25 the committee increased emphasis on working within the South West London Integrated Care System (SWL ICS) with the attendance of the SWL CFO at committee and discussion on transformational change at a sector level.

In the recovery plan work for 2024/25 the Group took a proactive approach and engaged with Deloitte LLP to support in the delivery of financial improvements. Colleagues from Deloitte have assisted in setting up workstreams with executive leads to support the organisations in financial performance for 2024/25 and into 2025/26.

The Committee received monthly updates on iterations of the Group financial plans for 2024/25 in the early part of the year, before turning attention to 2025/26 in the autumn. Discussions focussed on the planning and delivery of CIPs, as well the impact of industrial action, supporting the cyber security attack in South East London, inflation (in view of the cost of living challenge nationally) and exit run rates from the previous year.

In addition, greater emphasis was placed on contractual negotiation and the delivery of Elective Recovery Fund targets. As the Group heads into 2025/26 there will also be additional scrutiny on cash management, and capital expenditure.

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

The Group delivered a financial deficit for 2023/24 of £8.1m, (with SGH at (£3.6m) and ESTH at (£4.5m)), which is in line with the forecast agreed with SWL and NHSE after the M11 monitoring returns. At the time of writing the Committee was reviewing financial values ahead the proposed 1st draft submission for 2025/26 although this does not require Boards' approval. 2024/25 forecasts are for a deficit of £17.5m at SGUH and £14.9m at ESTH at M10 reporting.

4.2 Financial Strategy and Management

As the year has progressed, the Committee has reviewed progress on the Building Your Future Hospitals (BYFH) project as part of the New Hospitals Programme. Unfortunately this project has been put on hold and the Trust is waiting for clarity on other linked projects such as the Renal development. The ITU build at SGH is expected to open in Summer 2025.

The Committee receives annual assurances from the refresh of SGUH Financial policies, with all policies now part of a forward plan to incorporate the group. The Committee agreed updated Petty Cash and Business Expenses policies in June 2024, Private patient and Transaction Management policies in January 2025 with other policies due in March 2025.

The management of cash remains a key topic of discussion with PDC revenue drawdown a possibility in 2025/26. The Group is monitoring the impact of the 2025/26 plan and forecast for cashflow changes that may require the use of PDC drawdown.

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

4.3 Procurement

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

- Provision of 3 x MRIs at St George's (St James Wing), Queen Mary Hospital (QMH) and the Wilson Hospital
- Security services at Epsom & St Helier
- Document storage evaluation at Epsom & St Helier
- SWLP Blood Sciences Managed Service
- SWL Digital Pathology – Hardware and Maintenance
- SWL Digital Pathology – Storage
- Outsourced Teleradiology (ESTH)
- Immunology (SWL Pathology)
- Back up Solution (ESTH)
- SBS financial systems contract
- ESTH MRI business case
- ESTH incontinence services

4.4 Business Cases, Benefits Realisation and Return on Investment

The Committees in Common received regular updates on major group business cases, including in this financial year including the SWL PACS, EPR, Digital Pathology, Pathology GP Hub and the Renal build.

4.5 Operational Performance

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

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

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

5. Committee Effectiveness

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

- **Terms of Reference and forward work plan:** 50% (5) strongly agreed and 40% (4) agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work – 10% (1) was neutral. 1 respondent commented that there was an ongoing challenge on the balance between finance and performance items.
- **Membership, skills and experience of Committee:** 70% (7) strongly agreed and 30% (3) agreed that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. Two comments were made on attendees – with the non finance senior staff being consistent and good, with another comment that there was a good balance between NED, non executives and site leadership. One respondent commented that digital/IT skills would be important in the future. Another comment was made that the meetings are sometimes too long and have too many attendees.
- **Chairing of meetings:** 100% (10) agreed that the meetings were effectively chaired. The good framing of the discussion and how the Chair was effective in drawing out questions and clarifications was highlighted. Another respondent commented that there is deliberate and clear planning by the Chair around what issues and agenda items require the most focus and that *'Members and attendees are invariably treated with courtesy and respect by the Chair'.*
- **Quality and timeliness of papers:** Respondents had mixed views on the quality and timeliness of papers. 20% (2) agreed that papers are circulated in a timely way and provide clear, concise and sufficient information for the Committee to take informed decisions, fully sighted on the risks and implications. 60% (6) neither agreed nor disagreed and 20% (2) disagreed. 7 comments were received on the timeliness of papers. Although sometimes this was for good reason, and sometimes not, one commented that this impacted on the meeting. The length of some of the papers also received comment.
- **Discussions and assurance:** 90% (9) respondents agreed or strongly agreed that there was sufficient time for issues to be explored in depth.10% (1) neither agreed nor disagreed. Two respondents commented on the 4 hour length of the meetings. In addition, 30% (3) of respondents agreed and 70% (7) strongly agreed that the Committee provide insight and appropriate constructive challenge on the matters within its remit and effectively escalate and cascade issues, risks and assurance to the relevant forums. One comment was made that '*the size of the papers sometimes mean we take too long. It's the only committee we have every month and maybe we could be more succinct'.*

- **Overall effectiveness of the Committee:** The majority at 70% (7) felt the Committee was very effective, with 20% (2) expressing that the Committee was extremely effective. 10% (1) felt the Committee was somewhat effective. One comment was received that the Committee could be even more effective if there were fewer, shorter papers, with a clearer steer on areas for discussion and the decisions required.

6. Committee Forward Plan and Terms of Reference

An updated terms of reference will be produced in time for the June 2025 Committee and the Committees' proposed forward work plan for 2024/25 has been agreed at the meeting in February. The nature of the Committees' work means that it does cover a broad scope of matters on behalf of the Boards. The proposed work plan for 2025/26 sets out the matters for consideration by the Committee. It may be necessary to adjust this (subject to operational pressures) to focus on areas of immediate priority.

7. Conclusion

The year 2024/25 was the third year in which the Finance Committees of the two Trusts worked together as a Finance Committees-in-Common, with a shared agenda and a common forward plan of business. Overall, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated the value members and attendees attach to this new way of working and to the potential benefits of this approach. However, the experience of the third year of operation has also highlighted areas in which the Committees' ways of working will need to evolve in the year ahead to further strengthen its operation and effectiveness. The Committee's forward work plan for 2025/26 and review of agenda items and reporting arrangements to the Boards will help strengthen the operation of the Committees.

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Finance Committee-in-Common

Committee Effectiveness Review 2024/25

Summary Report for Group Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

February 2025

1. Introduction
Purpose, context and recommendations

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Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Finance Committees-in-Common in 2024/25. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2025/26.

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

Summary
A total of 10 people responded to the effectiveness survey. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective during a challenging year and were continuing to develop and improve. The key issues highlighted were: the timeliness of papers, although sometimes for good reason, impacted on meeting, as well as the length of some of the papers and meetings. The quality of the chair was seen as a strength.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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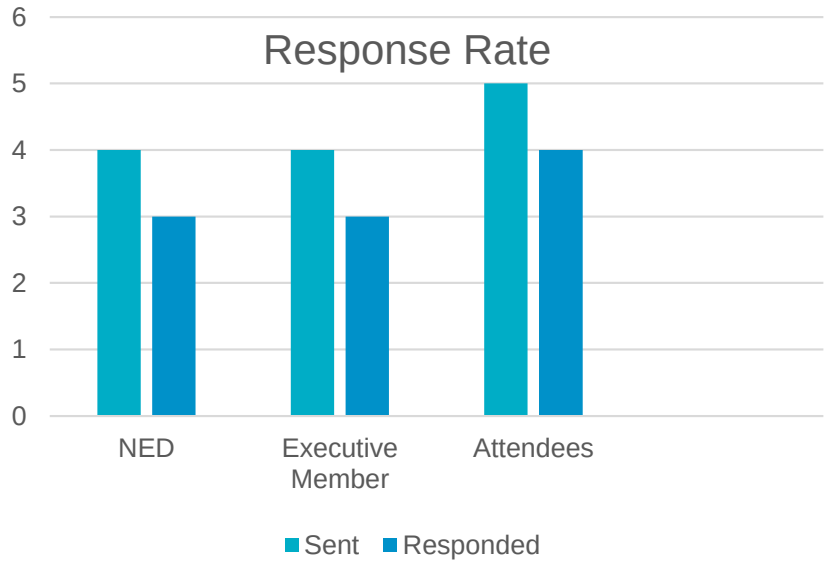
2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Committee
- Executive members of the Committee
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference

In total,13 people were invited to participate in the survey. Of these a total of 10 people provided responses, a response rate of 77%.



3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** 50% (5) strongly agreed and 40% (4) agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work – 10% (1) was neutral. 1 respondent commented that there was an ongoing challenge on the balance between finance and performance items.

- **Membership, skills and experience of Committee:** 70% (7) strongly agreed and 30% (3) agreed that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. Two comments were made on attendees – with the non finance senior staff being consistent and good, with another comment that there was a good balance between NED, non executives and site leadership. One respondent commented that digital/IT skills would be important in the future. Another comment was made that the meetings are sometimes too long and have too many attendees.

- **Chairing of meetings:** 100% (10) agreed that the meetings were effectively chaired. The good framing of the discussion and how the Chair was effective in drawing out questions and clarifications was highlighted. Another respondent commented that there is deliberate and clear planning by the Chair around what issues and agenda items require the most focus and that *'Members and attendees are invariably treated with courtesy and respect by the Chair'.*

- **Quality and timeliness of papers:** Respondents had mixed views on the quality and timeliness of papers. 20% (2) agreed that papers are circulated in a timely way and provide clear, concise and sufficient information for the Committee to take informed decisions, fully sighted on the risks and implications. 60% (6) neither agreed nor disagreed and 20% (2) disagreed. 7 comments were received on the timeliness of papers. Although sometimes this was for good reason, and sometimes not, one commented that this impacted on the meeting. The length of some of the papers also received comment.

3. Key findings

Overall effectiveness

- **Discussions and assurance:** 90% (9) respondents agreed or strongly agreed that there was sufficient time for issues to be explored in depth.10% (1) neither agreed nor disagreed. Two respondents commented on the 4 hour length of the meetings. In addition, 30% (3) of respondents agreed and 70% (7) strongly agreed that the Committee provide insight and appropriate constructive challenge on the matters within its remit and effectively escalate and cascade issues, risks and assurance to the relevant forums. One comment was made that '*the size of the papers sometimes mean we take too long. It's the only committee we have every month and maybe we could be more succinct'.*

- **Overall effectiveness of the Committee:** The majority at 70% (7) felt the Committee was very effective, with 20% (2) expressing that the Committee was extremely effective. 10% (1) felt the Committee was somewhat effective. One comment was received that the Committee could be even more effective if there were fewer, shorter papers, with a clearer steer on areas for discussion and the decisions required.

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4. Next steps

"So what" and "what now"?

The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2025/26:

- **Terms of Reference:** That the name of the Committee be changed to the Finance and Performance Committee to better reflect its work.

- **Timeliness and Quality of Papers:** For authors to ensure greater consistency in the quality of the papers, focusing on the length of the narrative and ensuring that the 'ask' of the Committee is clear. Papers should, wherever possible be issued in line with the agreed timeline with the aim being that all papers will be issued the Friday before the meeting, with advance approval needed from the Chair if there are exceptional reasons for a delay, in which case the paper must be circulated on the Tuesday.

- **Overall Effectiveness:** To consider whether, as monthly sessions, these meetings could be reduced from 4 hours.

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Group Board

Meeting in Public on Thursday, 06 March 2025

Agenda Item	2.3	
Report Title	**People Committees-in-Common Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committee Chair, SGUH & ESTH	
Report Author(s)	Yin Jones, People Committee Chair, SGUH & 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 February 2025 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 introduced the new team members, including the People Director for GESH, the Group Director of OD and Culture, and the Director of Workforce Transformation. She provided an update on the integration of the People Function, highlighting the consultation for integrating the Heads of Service and the TUPE transfer of Epsom and St Helier HR colleagues to St George's. The key intent behind these changes was to create a single point of contact for key HR processes and improve efficiency.
- The 2024 NHS Staff Survey showed an improvement in staff engagement, but there was still work to be done to reach the top five London acute trusts for engagement. A further update on the staff survey and people strategy implementation would be provided to the Committees at a later date.
- Committee Governance Review (Annual Review, Terms of Reference and Committee Effectiveness): The Committees reviewed the annual committee governance review and noted the key themes from the effectiveness survey and areas for improvement. No changes were made to the Committees' terms of reference.

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 February 2025.

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	People Committees-in-Common Annual Report
Appendix 2	People Committees-in-Common Annual Effectiveness Review
Appendix 3	People Committees-in-Common Terms of Reference

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 paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committees-in-Common Report
Group Board, 06 March 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 February 2025 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 20 February 2025, the Committees considered the following items of business:

February 2025
• Group Chief People Officer Report • Medical Revalidation Responsible Officer Report Q3 2024/25 • Guardian of Safe Working Q3 2024/25 • Job planning update for 2025-26 • NHS Staff Survey 2024 • Gender Pay Gap Report to recommend to the Board for approval • Public Sector Equality Duty (PSED) Report to recommend to the Board for approval • Workforce KPI Performance Report • Talent Management Strategy • Committee Governance Review (Annual Review, Terms of Reference and Committee Effectiveness). • Covid and Flu Vaccination Programme Update

2.2 The Committees are now meeting every two months as agreed by the Group Board, and the chairing of the meetings is done by Yin Jones who became the joint Non-Executive Director for both ESTH and SGUH and the joint Chair of the People Committees-in-Common in January 2025. An informal meeting between the Chair 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) Group Chief People Officer Update:

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

- Three new senior team members joined gesh recently, including the People Director for GESH, the Group Director of OD and Culture, and the Director of Workforce Transformation.
- Preparations for the CQC Well-led inspection in February 2025 were progressing well.
- A new executive group called the gesh People Group was introduced.
- The integration of HR policies was another key area of work, with six integrated policies being signed off and a new policy on managing close personal relationships at work.
- The importance of reflecting on the past year's achievements and shaping objectives for 2025/26.

The Committees noted the verbal update and requested a lessons learned report in relation to the 2024 NHS Staff Survey and an update on establishment controls which are crucial for managing and maintaining the accuracy of staffing information, particularly in relation to financial budgeting.

b) NHS Staff Survey 2024

The Committees welcomed the fact that there had been an increase in response rates and notable improvements in key areas such as role clarity, patient care prioritisation, and communication and requested an action plan designed to address challenges in areas including resource availability, staff recognition, and support for health and well-being.

c) Committee Governance Review (Annual Review, Terms of Reference and Committee Effectiveness)

The Group Deputy Director of Corporate Affairs & Head of Corporate Governance presented the annual committee governance review, highlighting key themes from the effectiveness survey and areas for improvement. The review focused on the timeliness of papers and consistency of narrative. The Committee members commented that the Committee was working well but that it would benefit from a single Chair. Yin Jones became the only Chair after the departure of one of the Co-chairs at the end of December 2024 when their term finished.

4.0 Key Issues on which the Committees received assurance

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

a) Medical Revalidation Responsible Officer (RO) Report Q3 2024/25

CMO-SGUH presented the St George's RO report. The report showed that the number of connected doctors was stable, but the rate of appraisal completion had slightly dropped due to operational pressures. There was a discussion about the challenges with locally employed doctors, particularly with obtaining evidence from previous organisations and securing appraisers. The work was in progress to train specialist appraisers and expand the appraisal pool.

GCMO presented the ESTH RO report, which showed a continued increase in the number of doctors with prescribed connections to the organisation. The report also indicated a high level of compliance with appraisal expectations, with 94% of connected doctors meeting the requirements. GCMO highlighted the need for more focus on doctors with deferred appraisals, particularly in medicine, and discussed initiatives to improve the process. The Committees noted the reports and requested standardisation of reports and metrics for future reports.

b) Guardian of Safe Working Q3 2024/25

Kirsty Le Doare, the new Guardian of Safe Working, presented the report for quarter 3, 2024/25. The report showed a decline in overall exception reporting, but highlighted increases in trauma, orthopaedics and neurology due to rota gaps. The Committees noted the efforts to improve the working lives of resident doctors, including spending well-being funds and meeting with resident doctor groups to encourage exception reporting.

c) Gender Pay Gap Report to recommend to the Board for approval

The Committees queried the potential impact of reducing the number of Clinical Excellence Awards on the gender pay gap, as male consultants historically received more awards than female consultants. The DGCEO explained that, while the removal of the competitive process for these awards in 2019 had led to a more even distribution, the legacy issue of older male consultants having received more awards in the past meant that this would take more time to resolve. The Committees recommended the report to the Board for approval.

d) Public Sector Equality Duty (PSED) Report

The Committees reviewed the report and requested the equality objectives to be refined, particularly the maternity objective, before the Committees could recommend the report to the Board for approval. This needs to be done in consultation with clinical leads, ensuring they are SMART and clearly address the issues raised. The EDI team were asked to ensure that the final PSED report accurately reflected the systemic challenges faced by BME staff and the actions that the organisation was taking appropriate action to address these challenges.

e) Workforce KPI Performance Report

The Committees noted the regular updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. Vacancies and turnover remained positive overall, while sickness and appraisal rates were areas requiring further attention. An update was also provided on the action log item regarding vacancies in estates and facilities, outlining the steps being taken to address this issue.

f) Talent Management Strategy

The GCPO presented the Talent Management Strategy, outlining the key priorities and projects aimed at improving career development, recruitment, succession planning, and leadership development. The Committees welcomed the report and highlighted the importance of embedding talent management into everyday conversations and appraisals, rather than treating it as a separate initiative.

5.0 Other issues considered by the Committees

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

a) Job planning update for 2025-26

The CMO-SGUH presented the St George's job planning report, which highlighted significant progress in completing job plans, with 94% signed off, just below the NHS target of 95%. She also discussed the controls in place linked to job planning and medical workforce transformation, and outlined expectations based on the NHS standards published in 2024. The upcoming internal audit into job planning and the next steps for improving the process was also mentioned.

The GCMO presented the ESTH job planning report, which showed that they had met the 95% target for consultants with signed-off job plans. He also outlined the breakdown of programmed activities between direct clinical care and supporting professional activities and highlighted a potential policy change regarding the appeal process for job plans.

b) Covid and Flu Vaccination Programme Update

The Committees noted the update on the Autumn Vaccination Campaign (2024/2025) at St George's and Epsom and St Helier hospitals (the Group), outlining progress in vaccinating staff against seasonal influenza and COVID-19

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 February 2025.

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	2.3.1	
Report Title	**People Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Victoria Smith, Group Chief People Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	People Committee-in-Common	20 February 2025
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the People Committees-in-Common report to the Group Board and the annual effectiveness review and updates on the proposed forward plan of business for the Committees in 2025/26. After review, no changes are recommended to the terms of reference.

The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year. Most notably, we wish to make sure that there is the correct flow of reporting to the Board so that approvals. A draft of the revised plan has been developed with the Group Chief People Officer but requires a co-ordinated review alongside the Group Board forward planner. This will then be reviewed and ratified at the next People Committee meeting.

Action required by Group Board

The Board is asked to:

a. Review the People Committees-in-Common annual report and effectiveness review
b. Approve the terms of reference for 2025/26, unchanged from the current year
c. Note the update on the forward workplan for the Committee for 2025/26.

Committee Assurance

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	People Committees-in-Common Annual Report 2024/25
Appendix 2	Committee Effectiveness Report 2024/25
Appendix 3	Committee Terms of Reference

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

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

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the Group Board with the annual report of the work of the Committees in 2024/25, which includes a review of the Committees' terms of reference, an update on the draft forward plan of business for 2025/26, and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.2 With the People Committees of both Trusts having operated as Committees-in-Common in 2024/25, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

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

2.4 Reports to the Group Board were submitted in May 2024 but this year, we have been brought the timelines forward so that reporting can be made to the last Board meeting of the year in March. This allows for any changes to terms of reference to be implemented at the start of the new cycle in April.

3.0 People Committees-in-Common Annual Report

3.1 The People Committees-in-Common Annual Report at Appendix 1 sets out:

- the operation of each Committee as a Committees-in-Common in 2024/25
- the purpose of the Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Committees in 2024/25

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

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed and are attached at Appendix 3. No changes are proposed this year.

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

5.0 Committee Forward Workplan 2025/26

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

5.2 The forward plan has undergone significant revision to ensure that we are taking the right items at the right time and frequency throughout the year. A draft of the revised plan has been developed with the Group Chief People Officer but requires further refinement to ensure that the timeline for any statutory reporting is properly timed within the Group Board meeting cycle. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next People Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

5.3 The proposal is for the Committee to continue to meet bi-monthly in 2025/26.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Group Board understands the outcomes of the Committees' annual effectiveness survey, the summary of the Committee effectiveness review is attached at Appendix 2. Overall, respondents to the effectiveness review considered that the Committee was working well but would benefit from a single Chair (this is now in place) and that the quality of papers, though improved, remained variable.

7.0 Recommendations

7.1 The Board is asked to:

a. Review the People Committees-in-Common annual report and effectiveness review.

b. Accept the Committees recommendation that no changes to the Committee terms of reference.
c. Note the update on the forward workplan for the Committee for 2025/26.

People Committees-in-Common Annual Report 2024/25

1 April 2024 – 28 February 2025

Contents

People Committees-in-Common Annual Report 2024/25

1. Introduction

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

During 2024-25, Yin Jones, Non-Executive Director for SGUH and Martin Kirke, Non-Executive Director for ESTH, served as Co-Chairs of the People Committees-in-Common until Martin Kirke's departure in December 2024. From January 2025, Yin Jones has become the only Chair of the Committee when she also became a Non-Executive Director for ESTH.

In this period, People Committees-in-Common continued to oversee the implementation of the people aspects of the new Group strategy and its role in providing assurance to the Group Board. In April 2024, the Committee produced the annual People Committee report for 2023/24, reviewed its terms of reference, and considered the outcomes of the Committee effectiveness review it had undertaken at year-end. These reports were then presented to the Group Board agenda for the meeting on 2 May 2024.

The Group Board endorsed the Committee's proposal to move to a bi-monthly (every other month) cycle of meetings in 2024/25, holding meetings immediately prior to Group Board meetings. In the months between meetings, it had been agreed that the GCPO would meet informally with the two Committee Chairs to discuss any emerging issues.

This report sets out a high-level overview of the work of the People Committees-in-Common in 2024/25. It provides an integrated report on the key matters considered by the Committees but highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The People Committees of the two Trusts have adopted identical terms of reference in order to ensure that there is consistency of purpose and duties across the two Committees. The Committees' purpose and duties are set out in the terms of reference (appendix 1)

2.1 Purpose

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

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

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2024 to February 2025), the following were members or regular attendees of the People Committees-in-Common:

St George's People Committee			
Name	**Role**	**Designation**	**Period**
Yin Jones	Member	Non-Executive Director, Committee Co-Chair (from 1 April 2024 to 31 December 2024), Committee Chair (from 1 January 2025)	1 April 2024 – 28 February 2025
Andrew Murray	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Tim Wright	Member	Non-Executive Director	1 April 2024 – 31 January 2025
Angela Paradise	Member	Interim Group Chief People Officer	1 April 2024 – 26 July 2024
Victoria Smith		Group Chief People Officer	1 July 2024 – 28 February 2025

Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2024 – 28 February 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
Kate Slemeck	Member	Managing Director – St George's	1 April 2024 – 28 February 2025
Luci Etheridge	Attendee	Site Chief Medical Officer	1 April 2024 – 28 February 2025
Natilla Henry	Attendee	Site Chief Nursing Officer	1 April 2024 – 28 February 2025
Nicole Porter-Garthford	Attendee	Deputy Chief People Officer (HR Operations)	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025

Epsom & St Helier People Committee			
Name	**Role**	**Designation**	**Period**
Martin Kirke	Member	Committee Chair, Non-Executive Director	1 April 2024 – 31 December 2024
Andrew Murray	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Phil Wilbraham	Member	Associate Non-Executive Director	1 April 2024 – 28 February 2025
Angela Paradise	Member	Interim Group Chief People Officer	1 April 2024 – 26 July 2024
Victoria Smith		Group Chief People Officer	1 July 2024 – 28 February 2025
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2024 – 28 February 2025
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2024 – 28 February 2025
Richard Jennings	Member	Group Chief Medical Officer	1 April 2024 – 28 February 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2024 – 28 February 2025
Rebecca Suckling	Attendee	Site Chief Medical Officer	1 April 2024 – 28 February 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 28 February 2025
Theresa Matthews	Attendee	Site Chief Nursing Officer	1 April 2024 – 28 February 2025
Nicole Porter-Garthford	Attendee	Deputy Chief People Officer (HR Operations)	1 April 2024 – 28 February 2025
Steve Russell	Attendee	Site Director of People	1 April 2024 – 28 February 2025
Thirza Sawtell	Attendee	Managing Director – Integrated Care	1 April 2024 – 28 February 2025

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

3.2 Committee meeting attendance

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

The Committee held a total of 6 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of SGUH People Committee were quorate. Five meetings of the ESTH People Committee were quorate with one, 24 October 2024, inquorate.

Attendance			
Name	**Role**	**Trust**	**Attendance**
Yin Jones	Member/Committee Chair	SGUH	5/6
Martin Kirke	Committee Chair	ESTH	4/5
Andrew Murray	Member	Both	4/6
Phil Wilbraham	Member	ESTH	3/6
Tim Wright	Member	SGUH	5/5
Angela Paradise	Member	Both	1/2
James Blythe	Member	Both	6/6
Andrew Grimshaw	Member	Both	3/6
Richard Jennings	Member	Both	3/6
Kate Slemeck	Member	SGUH	6/6
Arlene Wellman	Member	Both	5/6
Rebecca Suckling	Attendee	ESTH	4/6
Luci Etheridge	Attendee	SGUH	5/6
Stephen Jones	Attendee	Both	3/6
Nicole Porter-Garthford	Attendee	Both	4/6
Thirza Sawtell	Attendee	Both	?/6

In addition to the above, the Group Chairman, Group Chief Executive Officer and Group Deputy Chief Executive Officer regularly attended meetings of the People Committees-in-Common during the reporting period. The Chairman attended 5 meetings, the Group Chief Executive Officer 5 meetings, and the Group Deputy Chief Executive Officer 5 meetings.

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

SGUH Governors observing		
Name	Role	Attendance
Khaled Simmons	Public Governor, Merton	1
John Hallmark	Public Governor, Wandsworth	2
Chelliah Lohendran	Public Governor, Merton	3
Dympna Foran	Staff Governor	1

4. Committee activity and focus

4.1 Workforce strategy and planning

In August 2024, the new GCPO outlined the implementation plan for the gesh People Strategy (2024-26). The plan included the key pillars and underpinning activity the

People/HR function will be responsible for delivering, working collaboratively with other teams across gesh. The Strategy will seek to support delivery of the gesh vision for 2028 – Outstanding Care, Together. The Committees approved the delivery milestones that have been identified and requested regular updates to ensure they are met.

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

4.2 Workforce performance themes and trends

The People Committees-in-Common regularly reviewed workforce performance and trends in both Trusts, comparing and learning from performance across the Group. In this, the Committees were supported by the presentation of a wide range of workforce metrics across the Group including vacancy rate, turnover, stability score, sickness absence, statutory and mandatory training (MAST), and appraisal rates. Sickness absence rates at both Trust remained above the KPI targets. Despite improvements in the turnover rate at both Trusts, they narrowly missed their 12 months targets. An area of concern for both Trusts was non-compliance with appraisal rate targets. In August 2024, the combined vacancy rate for the group was 9.84% with ESTH's vacancy rate showing as 11.96% and SGUH vacancy at 8.25%. Further work was being conducted to identify the causes and to apply any relevant learning.

The Committees have supplemented these regular workforce performance reviews and updates on the workforce improvement plan with a range of 'deep dives', the purpose of which was to explore the underlying trends, drivers and actions in more detail. These deep dives, which the Committee has taken an active role in commissioning, have included: Sickness Absence (June 2024); Investigation and Intervention Findings (December 2024); Employee Relations (August 2024); and Talent Management (February 2025). These deep dives have supported the Committee in reviewing in depth current performance and actions to improve performance.

4.3 Staff engagement and wellbeing

Throughout 2024/25, the People Committees-in-Common received regular updates on staff engagement and wellbeing, as well as on actions being taken to address themes emerging from the previous staff survey.

In December 2024, the Committees reviewed the initial results of the 2024 NHS Staff Survey. The 2024 NHS Staff Survey campaign for St George's University Hospitals (SGUH) and Epsom and St Helier (ESTH) successfully engaged staff to improve response rates compared to 2023. The survey ran from 7th October 2024 to 29th November 2024 and a range of strategies were deployed to encourage participation. The number of respondents rose significantly at SGUH, from 3,644 in 2023 to 4,758 in 2024 - a 30.57% increase in survey participation. ESTH's response rate improved by 3.4 percentage points, from 50.0% in 2023 to 53.4% in 2024, reflecting consistent progress in staff engagement.

The quarterly guardian of safe working reports are another form of engagement with junior doctors. The reports were presented by the guardians from each Trust. At ESTH, three immediate exception reports in Q2 were escalated to management teams. Both related to working conditions on general medical wards.

The Committees received reports on Staff Health and Wellbeing and Staff Counselling and Mediation Services in October 2024. The initiatives and services on offer to staff were in high demand and oversubscribed. Feedback from staff was positive.

4.4 Culture, Equality, Diversity and Inclusion

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

The draft People Strategy, which was on the agenda of the Group Board meeting on 2 May 2024, had been previously considered by to the Committees in March 2024 ahead of review at a Group Board development session in April 2024. The Committees welcomed the draft People strategy and provided feedback on the themes and priorities and endorsed the strategy for presentation to the Group Board. It was noted that an Equality, Diversity and Inclusion (EDI) plan was also being developed to prioritise actions to affect a step change in the Group's approach and maximising impact. This EDI action plan would complement the People Strategy.

The Committees reviewed and approved the Public Sector Equality Duty (PSED) reports in February 2025, for both Trusts, for onward submission to the Group Board for approval. The Trusts are required to achieve compliance in 3 areas – workforce; patient services and care; and health inequalities. The Committees also received delegated authority from the Group Board to review and approve a number of reports that the Trusts have a statutory duty to publish or is required to publish by NHS England which included the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) action plans.

In October 2024, when the WRES and WDES reports were presented for approval, the Committees noted the positive progress in a number of WRES indicators at both ESTH and SGUH. However, despite the fact that the proportion of BAME staff had increased, both Trusts continued to grapple with disparities, particularly in senior leadership roles where BAME representation remained low. At their meeting on 24 October 2024, the People Committees-in-Common approved the WRES and WDES reports on behalf of the Group Board.

The Committees received the Freedom to Speak Up reports in June and November 2024. The annual report highlighted that the timely resolution of concerns and effective communication with the Guardian remained issues group-wide. The Committees welcomed the proposal for the Guardian to regularly meet with HR Business Partners (HRBPs) to progress concerns. The new Raising Concerns Oversight and Triangulation Group assisted with further identifying and addressing barriers to timely resolution. A new case management system to manage FTSU cases had been implemented which assisted with tracking the progress of cases and identifying concerns that had not moved forward so that these could be addressed in a more timely manner with the key stakeholders.

In terms of promoting a culture that is safe for staff, the Committees received reports on sexual safety and violence and aggression against staff at their meeting on 12 December 2024. The Committees praised the progress that had been made in embedding the principles of the Sexual Safety Charter within gesh but expressed a concern about higher-than-average reporting rates of unwanted sexual behaviours at SGUH (5.58%) compared to national averages and requested targeted interventions.

In December 2024, the Committees received a 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.

4.5 Education and Organisational Development

Over the past year, the People Committees-in-Common have reviewed and sought assurance in relation to the Trusts' education, training and development plans, particularly for leadership training and organisational development.

In October 2024, the Committees received an update about actions taken following the outcome of the MBBS Quality Assurance Visit on 1st March 2023 by St George's University of London (SGUL) to the Trust Undergraduate Medical Education Team. The Committees were reassured by the positive feedback from the inspection team on the preparation work for the inspection. The main actions identified were around challenges in estates, ensuring there was consistency in clinical teaching fellows and admin support across the teaching areas and greater transparency in the capacity of consultants to provide education. The SGUH Committee received reasonable assurance on the inspection and actions being taken forward. The Quality Assurance Visits are carried out every four years and the next one is scheduled for March 2027.

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

4.6 General

Throughout the year, the People Committees-in-Common have reviewed the people-related risks on the Corporate Risk Registers and the strategic risks relating to people on the new Group Board Assurance Framework. In December 2024, the Committees reviewed the Group Board Assurance Framework risks in relation to people and recommended risk scores and assurance ratings for each of the three risks within its remit. This followed the Group Board's approval of the new strategic risks at its November 2023 meeting. There were three strategic risks relating to people; SR12: Putting staff experience at the heart of what we do; SR13: Fostering an inclusive culture that celebrates diversity; and SR14: Developing tomorrow's workforce. The Committee also endorsed the risk scores and assurance ratings for each of the people related strategic risks and stretch targets for March 2025.

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

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

5. Committee Effectiveness

The People Committees-in-Common conducted a review of its effectives in February, which sought the views of both members and regular attendees. A total of 9 people responded to the survey giving positive feedback on the effectiveness of the Committees. The main issues highlighted in the review are set out below:

- **Terms of Reference and forward work plan:** All respondents agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. One respondent comments that as there is more stability in the team, and in the strategy delivery plan, what comes to the Committee can be more intentional in 2025/26.
- **Membership, skills and experience of Committee:** The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. One respondent felt that not all the NEDs had the same level of engagement.
- **Chairing of meetings:** The respondents agreed, or strongly agreed that the meetings were effectively chaired, with one commenting that the meetings occasionally over ran. Yin Jones was commended as an excellent Chair with another respondent commenting that the Committee will benefit from having a single Chair.
- **Discussions and assurance:** All agreed, or strongly agreed, that there was sufficient time to consider issues in depth. 89% (9) agreed or strongly agreed that the Committee provided insight and appropriate constructive challenge on the matters within its remit escalating and cascading issues as necessary.
- **Quality and timeliness of papers:** Generally, the respondents felt that the quality of papers had improved recently, particularly since the arrival of the new GCPO. The majority at 89% (8) agreed that the papers were timely and provided clear, concise and sufficient information for the Committee to take informed decisions. However, there was 1 comment that the quality of the papers was varied and another that the papers were are very detailed and do not always highlight the key issues which resulted in long discussions. It should be noted that similar comments were made last year. There were no comments made on the timeliness of papers.
- **Overall effectiveness of the Committee:** The majority at 78% (7) felt the Committee was very effective, with 22% (2) expressing that the Committee was somewhat effective. On respondent added that the Committee had improved considerably - they felt 'very effective' was too generous but it was more than 'somewhat effective'. One comment noted that the Committee is well-chaired with the Chair(s) having given room for full discussion and debate of important issues, usually in a very clear and constructive way. The preference for a single Chair was noted by another respondent. The many issues covered in a professional way was also noted.

6. Committee Forward Plan and Terms of Reference

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

The forward plan is undergoing review as part of a co-ordinated process with the other committees and the Group Board. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

Following the outcome of the effectiveness survey and a review of the work of the Committees during the year, no changes are proposed to the Terms of Reference for 2025/26.

7. Conclusion

In the year 2024/25, the People Committees established a new rhythm for meetings which were held bi-monthly with informal meetings attended by the Committee Chairs and the GCPO in between the formal meetings. The Committees lost one Co-Chair whose term finished in December 2024 and gained a new Group Chief People Officer (GCPO) who started in July 2024. Despite this, the Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated that the Committees were broadly effective during a challenging year and were continuing to develop and improve.

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

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People Committee-in-Common

Committee Effectiveness Review 2024/25

Summary Report for Group Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

March 2025

1. Introduction
Purpose, context and recommendations

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

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the People Committees-in-Common in 2024/25. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2025/26.

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

Summary
A total of 9 people responded to the effectiveness survey. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective during a challenging year and were continuing to develop and improve. The key issues highlighted were: the timeliness of papers, though seen as improving; quality of papers, variable but improving; and that having alternating Chairs was not as effective as it could be.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Committee
- Executive members of the Committee
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference

In total, 18 people were invited to participate in the survey. Of these a total of 9 people provided responses, a response rate of 50%.

3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** All respondents agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. One respondent comments that, as there is more stability in the team, and in the strategy delivery plan, what comes to the Committee can be more intentional in 2025/26.

- **Membership, skills and experience of Committee:** The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. One respondent felt that not all the NEDs had the same level of engagement.

- **Chairing of meetings:** The respondents agreed, or strongly agreed that the meetings were effectively chaired, with one commenting that the meetings occasionally over ran. Yin Jones was commended as an excellent Chair with another respondent commenting that the Committee will benefit from having a single Chair. Note: from January 2025 the Committees have a single Chair.

- **Discussions and assurance:** All agreed, or strongly agreed, that there was sufficient time to consider issues in depth. 89% (9) agreed, or strongly agreed that the Committee provided insight and appropriate constructive challenge on the matters within its remit escalating and cascading issues as necessary.

3. Key findings

Overall effectiveness

- **Quality and timeliness of papers:** Generally, the respondents felt that the quality of papers had improved recently, particularly since the arrival of the new GCPO. The majority at 89% (8) agreed that the papers were timely and provided clear, concise and sufficient information for the Committee to take informed decisions. However, there was 1 comment that the quality of the papers was varied and another that the papers were are very detailed and do not always highlight the key issues which resulted in long discussions. It should be noted that similar comments were made last year. There were no comments made on the timeliness of papers.

- **Overall effectiveness of the Committee:** The majority at 78% (7) felt the Committee was very effective, with 22% (2) expressing that the Committee was somewhat effective. On respondent added that the Committee had improved considerably - they felt 'very effective' was too generous but it was more than 'somewhat effective'. One comment noted that the Committee is well-chaired with the Chair(s) having given room for full discussion and debate of important issues, usually in a very clear and constructive way. The preference for a single Chair was noted by another respondent. The many issues covered in a professional way was also noted.

NHS
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University Hospitals and Health Group

4. Next steps

"So what" and "what now"?

The Committee formally moved to a bi-monthly rhythm of meetings in 2024/25 – there is no suggestion in the survey responses or comments that this has a negative impact on the work of the Committee and was not mentioned by any respondent which would indicate it is working well and does not need to be reviewed at this time. The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25:

- **Quality of papers:** Ensure greater consistency in the quality of papers – papers to be more concise, focus on assurance and on the "so what" and "what now". Greater use of appendices for necessary detail, and use of reading room for supplementary / optional reading.
- **Membership, skills and experience of Committee:** Action on the above may address the comments that not all NEDs seem equally engaged.
- **Chairing:** There is now a single Chair so no action is required in response to comments regarding dual chairing.

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NHS
St George's University Hospitals
NHS Foundation Trust

People Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

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

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

3. Purpose

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

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

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

4. Duties

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

Workforce Strategy and planning

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

Workforce performance, themes and trends

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

Staff engagement and wellbeing

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

Culture, Equality, Diversity and Inclusion

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

Education and Organisational Development

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

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

General

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

5. Membership and Attendance

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

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

Membership of the Committee comprises:

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

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

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

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

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

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

6. Quorum

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

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

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

7. Accountability and Reporting Arrangements

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

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

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

8. Meeting Format and Frequency

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

10. Declarations of Interest

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

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

11. Meeting Arrangements and Secretariat

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

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

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

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

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

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

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

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

Document Control

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

Group Board

Meeting in Public on Thursday, 06 March 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 inaugural meeting on 19 February 2025

- Internal Audit: The Committee reviewed four internal audit final reports, four for SGUH and one for ESTH. The Committees discussed, in particular, those which had receive 'partial' assurance conclusions; Complaints Management at ESTH and Violence and Aggression, IT Assets and Maintenance and Job Planning – Consultants 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. The Committee also reviewed the draft internal audit plan for 2025-26.

- External Audit: The Committee met with Grant Thornton, the newly appointed external auditors for the first time. Grant Thornton presented a report detailing the risk assessment procedures which are undertaken to obtain an understanding of the Groups management processes.

- Group-Wide Policy Framework: The Committee reviewed the newly developed Group-Wide Policy Framework and approved the Policy on the Development, Approval and Governance of Policy and Procedural Documents

- Group-Wide Risk Management Framework: The Committee endorsed the Group-Wide Risk Framework and formally recommend its approval by the Group Board.

- Information Governance: The Committee noted that the Trusts continue to see increased threats sent via email. Our email security controls have effectively blocked most of these threats, with the remaining being investigated by our IDT security and third-party security operations centre.

Action required by the Board

The Board is asked to:

a) Note the report of the Audit Committees-in-Common meeting held on 19 February 2024

b) Approve the Group Risk Management Policy, following review and endorsement by the Audit Committee.

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, 06 March 2025

1.0 Purpose of paper

1.1 The Audit Committees-in-Common met on 19 February 2025. 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 Committee met with Grant Thornton, the newly appointed external auditors for the first time. Grant Thornton presented a report detailing the risk assessment procedures which are undertaken to obtain an understanding of the Groups management processes.

2.2 Internal Audit Progress Report

The Committees received a report, noting that since the last audit committee meeting, for SGUH, 36 actions (seven high, 22 medium and seven low) have been implemented and internal audit have reviewed evidence where relevant. One medium action is overdue without a management response. This action relates to Data Security Protection Toolkit. For ESTH, 29 actions (one high, 22 medium and six low) have been implemented and internal audit have reviewed evidence where relevant. One medium action is overdue without a management response. This action relates to Infection Prevention and Control.

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:

- Complaints Management (partial assurance) – ESTH: This audit received partial assurance. 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.

- Violence and Aggression (partial assurance) - SGUH: This audit received partial assurance that the organisational controls in place to manage the risk are suitably designed and operationally effective. As a result of the audit, three high, seven medium and one low priority issues have been raised.

- IT Assets and Maintenance (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 Committee noted that as a result of the audit, two high and four medium priority actions were raised for management.

- Job Planning – Consultants (partial assurance) – SGUH: This audit received partial assurance that the organisational controls in place to manage the risk are suitable designed and operationally effective. As a result of the audit, one high and three medium priority actions were issued to management as a result of the audit.

- Discharge Management (reasonable assurance) – SGUH: The Committee noted that this audit received reasonable assurance. Two high, four medium and one low priority management actions were raised as a result of the audit.

2.4 Internal Audit Plan 2025/25
The Committee noted that draft internal audit plan for 2025/26, a few changes were sure suggested with regards to the timings of certain audits. RSM agreed to consider these suggestion and present a revised plan.

2.5 Information Governance and Cyber Security Update
The Committee noted that the Trusts continue to see increased threats sent via email. Our email security controls have effectively blocked most of these threats, with the remaining being investigated by our IDT security and third-party security operations centre.

2.6 Counter Fraud
The Committees received an update from the counter fraud specialists, who advised that LCFS received 14 new fraud referrals since the December Audit Committees in Common for ESTH and SGUH, indicating staff remain vigilant to fraud and bribery risks. During the reporting period, 17 referrals have been closed, with 16 remaining ongoing across both Trusts.

2.7 Group-Wide Policy Framework
The Committee reviewed the newly developed Group-Wide Policy Framework and approved the Policy on the Development, Approval and Governance of Policy and Procedural Documents

2.8 Group-Wide Risk Management Framework
The Committee approved the Group Wide Risk Management Framework, formally recommending its approval to the Group Board.

2.9 Committee Effectiveness Review
The Committee reviewed the results of the Committee Effectiveness Survey, noting positive feedback for the Chairing of the Committee. The Committee agreed it would be useful to receive feedback from the Internal Auditors and invited colleagues to complete the survey.

3.0 Recommendation

3.1 The Board is asked to:

a) Note the report of the Audit Committees-in-Common meeting held on 19 February 2024

b) Approve the Group Risk Management Policy, following review and endorsement by the Audit Committee.

Peter Kane
Audit Committee Chair, NED

Risk Management Policy

Policy Summary	
Policy Number	GESH/POL/0002
Version	1.0
Document Type	Policy
Policy Type	Corporate
Ownership	
Lead Executive Director(s)	Group Chief Corporate Affairs Officer
Lead Site Director(s)	N/A
Lead Author(s)	Group Head of Risk Management
Scope and application	
Applies to *(Select as appropriate)*	Group-wide (All Staff): This policy applies to all staff who are employed by or work at St George's University Hospitals NHS Foundation Trust and / or Epsom and St Helier University Hospitals NHS Foundation Trust
Approval	
Approval Group	Group Board
Date Approved	-
Ratification Group *(If required)*	N/A
Date Ratified *(If required)*	-
Date Published *(to Policy Hub)*	-
Next Review Date	-

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Document Control			
Version	**Date Approved**	**New, Update or Full Review**	**Summary of reasons for the changes**
1	TBC	New	New Group-wide policy replacing legacy Trust-specific risk management policies and procedures.

Contents

POLICY ON A PAGE

This policy sets out the risk management framework for the St George's, Epsom and St Helier University Hospitals and Health Group ("the Group"). It establishes a robust framework for identifying, assessing, managing and monitoring risks across the Group and supports the delivery of outstanding care to our patients, staff and the communities we serve.

The Group is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental part of the governance framework and system of internal control across the Group and for each of its constituent Trusts. As a large hospital group operating in complex healthcare environment, where the delivery of services involves multiple interdependencies and potential hazards, risks are an inherent part of the day-to-day delivery of clinical and corporate services. Through this policy, the Group ensures that it has in place a systematic approach for the management of risk which supports the delivery of its strategic objectives.

This policy underscores the importance of embedding risk management practices within the organisational culture of the Group, fostering transparency, and encouraging and supporting accountability at every level. By identifying and addressing risks early, the Trusts within our Group not only comply with their specific legal and regulatory obligations, the Group as a whole strengthens its resilience, enhances its decision-making, and helps promote continuous improvement.

Risk management is not simply a compliance exercise; it is an enabler of innovation and strategic growth. The Group recognises that taking calculated risks is necessary to improve services, embrace new technologies and meet the evolving needs of our patients and the wider community. By implementing this policy, the Group seeks to strike a balance between minimising risks and fostering a forward-thinking approach to the delivery of services.

Risk management is the responsibility of all colleagues across the Group. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational working and service delivery. Specific roles and responsibilities are set out in this policy.

The policy sets out clear processes for the identification, treatment, and escalation of risk across the gesh Group. It also sets out the governance groups responsible for oversight of risks, based on their risk scores.

1. Overview

This policy sets out the risk management framework for the St George's, Epsom and St Helier University Hospitals and Health Group ("the Group"). It establishes a robust framework for identifying, assessing, managing and monitoring risks across the Group and supports the delivery of outstanding care to our patients, staff and the communities we serve.

The Group is committed to the principles of good governance and recognises the importance of effective risk management as a fundamental part of the governance framework and system of internal control across the Group and for each of its constituent Trusts. As a large hospital group operating in complex healthcare environment, where the delivery of services involves multiple interdependencies and potential hazards, risks are an inherent part of the day-to-day delivery of clinical and corporate services. Through this policy, the Group ensures that it has in place a systematic approach for the management of risk which supports the delivery of its strategic objectives.

This policy underscores the importance of embedding risk management practices within the organisational culture of the Group, fostering transparency, and encouraging and supporting accountability at every level. By identifying and addressing risks early, the Trusts within our Group not only comply with their specific legal and regulatory obligations, the Group as a whole strengthens its resilience, enhances its decision-making, and helps promote continuous improvement.

Risk management is not simply a compliance exercise; it is an enabler of innovation and strategic growth. The Group recognises that taking calculated risks is necessary to improve services, embrace new technologies and meet the evolving needs of our patients and the wider community. By implementing this policy, the Group seeks to strike a balance between minimising risks and fostering a forward-thinking approach to the delivery of services.

Risk management is the responsibility of all colleagues across the Group. Managers at all levels are expected to take an active lead to ensure that risk management is a fundamental part of their operational working and service delivery. Specific roles and responsibilities are set out in this policy.

2. Scope

This policy applies to all staff employed across the St George's, Epsom and St Helier University Hospitals and Health Group. This includes permanent and temporary staff, as well as staff on joint appointments with other organisations and those on honorary contracts, working in any of the locations registered by St George's University Hospitals NHS Foundation Trust (SGUH) and Epsom and St Helier University Hospitals NHS Trust (ESTH) with the Care Quality Commission (CQC).

3. Background

The Risk Management Policy describes the principles to be applied across the gesh Group on process, roles and responsibilities for managing risk both at a strategic and operational level. It serves as a guide for staff on the identification, assessment and mitigation of risks. It describes roles and responsibilities in relation to risk management and describes the governance of risk at each level of the Group.

Effective risk management processes are central to providing outstanding care, and to providing the Group Board, and the Boards of Directors of its constituent Trusts, with assurance that all required

activities are taking place to ensure the achievement of the Group's strategic objectives, the delivery of safe, high quality and sustainable services, and compliance with all legislation and regulatory requirements.

4. What is new in this version?

This is the first version (V1) of the Group-wide Risk Management Policy. This policy replaces the following documents:

- Risk Management Policy, St George's University Hospitals NHS Foundation Trust
- Risk Management Policy, Epsom and St Helier University Hospitals NHS Trust
- Risk Management Procedure, Epsom and St Helier University Hospitals NHS Trust

5. Policy

5.1 Statement of Intent

The Group Board is committed to the Group's vision and strategy, providing *Outstanding Care, Together*. The Group's strategy, built around the CARE framework, sets out the following strategic objectives:

- Collaboration and Partnership: To play a leading role in integrating services around the needs of our patients, to be a driving force behind the most integrated health and care system in the NHS and be recognised as a national exemplar for integrated working – working with local partners to keep people well in the community, integrating services across the gesh Group, collaborating with other hospitals in South West London and working through regional networks to integrate our tertiary services with primary and secondary care.

- Affordable healthcare, fit for the future: To make our services sustainable for future generations by taking the difficult decisions to break even each year financially, reduce our carbon footprint, modernise our estate, make major strides in adopting digital technology, and be a thriving centre for research and innovation.

- Right Care, Right Place, Right Time: To offer high quality services to our patients, reduce waiting time, have an outstanding safety culture, improve outcomes and patient experience and work with partners to tackle health inequalities in our communities.

- Empowered, Engaged Staff: To make the best use of our highly skilled workforce, getting the basics right for our staff, putting staff experience and wellbeing at the heart of all we do, fostering an inclusive culture that celebrates diversity and embeds our values, and developing tomorrow's workforce.

The risk management framework outlined in this policy is intended to support the Group in achieving these strategic objectives by integrating effective risk management – the mitigation of hazards and the seizing of opportunities – into our culture and ways of working to support robust governance and decision-making at every level of the Group.

5.2 Aims and Objectives

The key objectives of the Risk Management Policy are to:

- Ensure a proactive and consistent approach to risk management, with a common framework and processes for the management of risk across all Sites
- Ensure effective risk management systems, processes and governance are in place at every level
- Foster a positive risk management culture throughout the Group
- Ensure staff are aware of the process for the management of risk at every level of the Group, including service, directorate, divisional, Site, Executive, and Board level.
- Ensure that staff are fully aware of their roles and responsibilities for the management of risk and the levels of authority in relation to risk approval and escalation.
- Ensure that staff have the required competencies and capabilities to support a proactive approach to risk management.
- Support compliance with required and best practice standards, and with relevant regulatory and legislative requirements
- Support and promote on-going development as a learning organisation and, in doing so, maintain a safe environment for patients, service users, staff and visitors.

5.3 Risk Appetite

The Group Board recognises that risk is inherent in the provision of health and care, and therefore a defined approach is necessary to ensure that the Group understands and is aware of the risks it is prepared to accept in the pursuit of the delivery of its objectives.

The long-term sustainability of the Group, and its constituent Trusts, depends on the delivery of its strategic objectives and relationships with patients and service users, public and strategic partners. The gesh Group does not accept risks that materially impact on patients or staff safety or compliance with regulatory requirements, but has a higher risk appetite relating to our pursuit of innovation and transformational objectives.

The risk appetite for the gesh Group is set by the Group Board and is reviewed annually. The Risk Appetite Statement sets out the Group Board's expectations in relation to the category of risks it expects management, at every level, to identify and the level of risk that is acceptable. The Board agreed Risk Appetite Statement is set out in **Appendix 1**.

The purpose of stating risk appetite within the Group is to help steer decision-making across the Group by providing a position against which potential decisions can be tested and challenged, and provide guidance and an objective view on our ability to achieve longer term objectives that the Group is striving for, particularly through its strategy.

The risk appetite statement is based on the premise that:

- The lower the risk appetite, the less the Group Board is willing to accept in terms of risk and, consequently, the higher levels of controls that must be put in place to manage the risk

- The higher the appetite for risk, the more the Group Board is willing to accept in terms of risk and, consequently, the Group Board will accept business as usual activity for established systems of internal control and will not necessarily seek to strengthen those controls.

5.4 Risk Management at all levels across the gesh Group

This document describes the local deployment of risk management practices and responsibilities required at all levels across the Group.

All staff have an important role to play in identifying, assessing, recording and managing risk. To support staff in this role, the Group provides a fair and consistent culture of openness, where all staff are encouraged to assess risk and report any situation where things have, or could have, gone wrong. Balanced in this approach is the recognised need for the Group to provide information, counselling, support and / or training for staff, as required in response to any such situation.

At the heart of this policy is the desire to learn from events and situations, to continuously improve management processes, including those related to patient and staff safety. Where necessary, changes will be made to the Group's systems to enable this to happen.

5.5 Categories of Risk

The group is exposed to a range of risks which have the potential to damage or threaten the achievement of the Group's objectives. The categories of risk faced by the Group are set out in **Appendix 2**, but in summary include:

- Strategic risk
- Clinical risk
- Financial risk
- Health and safety risk
- Information security risk
- Infrastructure risk
- Organisational risk
- Operational risk
- Performance risk
- Reputational risk
- Third party risk
- Event risk

Risk owners should refer to the categories of risk in defining risks and inputting risks on the Group's electronic risk management systems (Datix).

5.6 Risk Management Process

The risk management process set out below describes how risks will be identified, assessed, recorded, and managed at all levels across the gesh Group, and within its constituent Trusts, including where the Group contributes to the provision of integrated care and services delivered locally and at system level.

5.6.1 Risk Identification

Risk identification involves systematically examining all sources of potential risk and uncertainty to which the gesh Group, and its two constituent Trusts, may be exposed. The process of risk identification is the foundational step in the broader framework of risk management and required an understanding of the Group's internal and external environment. The goal of risk identification is to pinpoint all potential risks – whether strategic, clinical, operational, financial, reputational or other – that could hinder the Group's ability to achieve its objectives.

Risk identification lays the basis for subsequent risk management steps, such as risk analysis, evaluation and mitigation, ensuring the Group is better equipped to navigate uncertainty. If a risk is not accurately identified, it cannot be assessed, mitigated or monitored. Effective identification of risks allows for more informed decision-making and helps prevent unexpected disruptions and adverse impacts. It also supports statutory and regulatory compliance and good governance.

Risk identification is not a one-time activity but an ongoing process that must adapt to changes in the organisation's internal and external environment.

When identifying potential risk, there are two key approaches: a top-down approach; and a bottom-up approach. Both are essential to ensuring an effective and holistic approach to risk management and to ensure all risks are appropriately identified.

Top down risk identification (Identifying strategic and organisational-wide risks)	Principal risks to the delivery of the gesh Group's strategic ambitions and objectives are identified by the Group Board, Board Committees and the Group Executive and are approved by the Group Board for inclusion in the Group Board Assurance Framework.
Bottom up risk identification (Identifying operational risks)	Operational risk management is deployed at all levels throughout the Group. Operational risks are identified from, but not limited to, risk assessments, incident and near-miss reporting, complaints and claims management and patient feedback. Risk assessments are to be completed by all service/department managers, these must consider key factors such as: environment, equipment, staffing/resources, digital and IT and any clinical safety concerns as described above. All new and emerging risks are to be added to the Group's electronic risk management system (Datix) for appropriate management and escalation.

Risk can be identified from a wide range of sources, both internal and external. Some examples of risk identifiers include:

- Results of clinical, external and internal audits
- Findings of health and safety inspections
- Reports and assessments / inspections by external bodies
- Incidents, complaints, claims and PALS reporting
- Central Alerting System (CAS) alerts
- Performance metrics
- Outcomes of Coroners' inquests, including Regulation 28 report recommendations
- Freedom to Speak Up concerns
- Changes in legislation or regulatory requirements
- Requirements of professional bodies
- National reports, such as investigations into care failures in other organisations
- Surveys and questionnaires from patients, service users, staff and stakeholders
- Exit interviews
- Observation

5.6.2 Risk Title, Description, Category and Ownership

Once the risk has been identified, it needs to be recorded in a clear and comprehensive way, with a clear risk title, a full risk description, and with a risk owner, Site / Corporate Service Lead, and Executive Director Lead assigned:

- **Risk Title:** Risks must be titled in a clear and concise way, and assigned to a particular service, if relevant, to avoid confusion with similar risks elsewhere in the organisation.

- **Risk Description:** Risks must be described in a clear, concise and consistent manner to ensure common understanding by all. Risk can be more effectively understood and managed if it is clearly articulated. Good quality risk statements must be able to answer the following questions:
  - What could happen?
  - Why could it happen?
  - Why does it matter?

  Based on this, an effective risk description should adopt the following structure and format:

[Event] **caused by** [cause(s)] **results in** [consequence(s)]

  For example:

Overcrowding in the Emergency Department [event] **caused by** rising demand and blocks in flow through the hospital [causes] **results in** poorer outcomes, increased mortality and lower patient experience [consequences]

- **Risk category:** All risks must be assigned a risk category. More than one risk category can be selected. This aids the monitoring and analysis of risk stored within the Group's electronic risk management systems (Datix). The risk categories are: Strategic, Clinical, Financial, Health and Safety, Information Security, Infrastructure, Organisational, Operational, Performance, Reputational, Third Party, Event.

- **Risk Ownership:** All risks must have two named leads to ensure that they are managed appropriately:

  - **Risk Owner**: This is the operational lead for the risk, and is responsible for:
    - Any actions, controls or assurances associated with improving the position of the risk
    - Keeping the risk entry on Datix up-to-date within review date deadline
    - Ensuring that all risk KPI data is complete

  - **Site Director / Corporate Services Lead / Executive Director:** This is the senior leader who has responsibility to which the risk relates, for overseeing the effective management of the risk.

5.6.3 Risk Assessment

Having identified, described, categorised, and assigned the risk, the next steps are to assess and score the risk. This allows for the risk to be assigned a Risk Score which determines at what level the risk will be managed within the organisation.

Through this Risk Management Policy, the gesh Group has established a standardised approach to risk assessment across the Group to ensure consistency. The risk assessment should be detailed on the electronic risk assessment form. The Risk Assessment Form is at **Appendix 3**.

Assessing risks will involve looking at:

- What controls do we have in place to prevent a risk from occurring?
- What is the likelihood of a risk being realised, taking into account the controls in place?
- What is the impact (consequence) if the risk is realised?
- What is the current level of risk (risk profile score) in light of these considerations?
- What additional controls do we need to put in place to prevent the risk occurring?
- What actions do we need to take to reduce the either the impact (consequence) of the risk or the likelihood of the risk occurring, or both? Which of these actions can be implemented by the Trust / Group, and / or where is joint action needed with system partners?
- What is the level of risk (target risk profile score) that we would accept once further controls have been implemented? This is the target risk score, and should reflect the risk score necessary to bring the risk within the Board-approved risk appetite (set out in section 5.3 and in Appendix 1).

Risk Scoring

Scoring a risk determines its overall significance, the level at which the risk will be managed and monitored within the Group, and assists in prioritising remedial action. The risk scoring matrix is set out in **Appendix 4**.

Each risk must have three Risk Scores:

- **Initial Risk Score:** This is the score when the risk was originally identified, and reflects the level of risk before steps to control and mitigate the risk are put in place.
- **Current Risk Score:** This is the score at the time the risk was last reviewed. It is expected that the current risk score will reduce and move towards the Target Risk Profile Score as actions identified to control and mitigate the risk are implemented.
- **Target Risk Score:** This is the score that is intended to be achieved after the identified actions to control and mitigate the risk have been fully implemented. This score should reflect the Group's established risk appetite; the target risk score should be a score that aligns with the risk appetite for the type of risk identified.

Step 1: Identifying a Risk Likelihood Score

The likelihood score is based on the probability of the risk occurring and the timeframes in which the risk might occur. Consideration should also be given to the effectiveness of the current controls in place to mitigate the risk and the assurances about the effectiveness of these controls. A risk's likelihood must be given a score between 1 and 5, in which 1 represents a rare probability of occurrence and 5 represents an almost certain occurrence.

In most cases, likelihood should be determined by reflecting on the extent and effectiveness of the controls in place at the time of the risk assessment, and using the relative probability where this is appropriate. The effectiveness of the controls identified to manage, mitigate and treat the risk should be assessed using the Control Effectiveness Framework set out at **Appendix 5**. Using this approach, each control should be assessed for its effectiveness in treating the risk, and the risk as a whole should be allocated an overall control effectiveness score.

Step 2: Identifying a Risk Consequence Score

The consequence score reflects the impact of the risk occurring. The consequence score is based on several factors, for example:

- the financial implications
- the number of service users or colleagues potentially affected
- the level of harm potentially caused
- the extent of any statutory or regulatory breach
- the extent of service or business interruption
- the ability of the Trust to achieve its objectives
- the effect on the Trust's reputation.

The risk is given a consequence score between 1 and 5, in which 1 represents the least amount of harm and 5 represents catastrophic harm or loss. Each level of severity looks at either the extent of personal injury, total financial loss, damage to reputation or service provision that could result.

Step 3: Calculating the Risk Profile Score

Once the likelihood and consequence scores have been calculated, each risk is then given a Risk Profile Score, which is the multiplication of the "Likelihood Score" and the "Consequence Score":

Based on their score, risks are assigned a risk category as follows:

Risk Score Categories	
Risk Category	**Risk Score**
Extreme	**≥ 15**
High	**10 - 12**
Moderate	**8 - 9**
Low	**4 - 6**
Negligable	**1 - 3**

5.6.4 Risk Recording – Risk Registers

Once a risk has been identified, assessed, scored and recorded on the Group's electronic risk management system, the system can be used to establish and generate operational risk registers at local, Site and Corporate levels.

Local Risk Registers

Datix provides the facility for managers of services, directorates, and divisions to manage and monitor risk registers for their areas of responsibility (local risk registers).

Each Corporate Directorate led by an Executive Director will maintain a local risk register for their respective directorate for which they are responsible.

Site Risk Registers

Each of the three Sites within the gesh Group maintain a Site Risk Register on the electronic risk management system, which contains the highest scored risks on the Divisional Risk Registers for the Divisions that fall within the responsibility of the Site (those risks scored 12 and above).

There may be risks that affect more than one division, or risks that are considered to have a Site-wide impact. Similar risks from Divisional Risk Registers may be aggregated into a single risk for the purpose of the Site Risk Register.

Corporate Risk Register

A Corporate Risk Register (CRR) is also produced from the electronic risk management system for each Trust within the Group and includes risks with a Risk Profile Score of 15 and above, which have been agreed for escalation to the Corporate Risk Register by the Group Executive.

Similar risks proposed for escalation to the CRR from Site-level will be aggregated into one single risk for the purpose of the CRR.

The CRR is a Trust-wide risk register and includes the most significant operational risks facing each of the Trusts within the gesh Group as distinct legal entities. A separate CRR is produced for St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust.

The CRR for each Trust is fully aligned with the Group Board Assurance Framework.

Alignment with strategic objectives

All risks recorded on the electronic risk management system will be aligned to the strategic objectives of the Trust and the wider Group, where appropriate.

Newly created risks

All newly created risks will remain "unapproved" on the electronic risk management system until they have been reviewed and approved and the appropriate level, as set out in Section 5.6.6 below. The approval process will ensure that:

- the risk has been described appropriately
- the controls and assurances are accurate and complete

- the scoring is a true reflection of the current position, taking into account the effectiveness of the controls currently in place
- the actions defined to further mitigate the risk and bring it within the agreed risk appetite are appropriate

5.6.5 Management and Treatment of Risk

All risks identified and recorded on risk registers must have a Risk Treatment Plan in order to ensure risks are reduced to acceptable levels and aligned to the Group's agreed risk appetite. Risk treatment is the process of developing, selecting and implementing strategies and controls to modify and mitigate risks. This process aims to reduce the likelihood or impact of identified risks, ensuring they do not impede the Group's ability to achieve its objectives.

The 4 Ts Framework

The Group follows the 4 T's Framework as a structured approach to treat risks:

Approach	What it means
Treat	• Actions are identified and taken to reduce the likelihood or impact of risks to an acceptable level. Examples include introducing new controls, enhancing existing processes, or implementing safety measures. • Risk treatment plans must be specific, measurable, achievable, realistic and time-bound (SMART)
Tolerate	• Some risks may be accepted when they fall within the Group's agreed risk appetite. These risks should be regularly monitored to ensure they remain at acceptable levels. • An example includes low impact risks that do not justify the cost of implementing additional controls.
Terminate	• Activities or processes that pose unacceptable risks are discontinued or restructured to eliminate the associated risk. • An example would include ceasing a high risk project or process that does not align with the Group's goals.
Transfer	• Risks may be transferred in full or in part to a third party, such as through outsourcing, contracting or purchasing insurance. • This approach ensures that financial or operational risks are managed by parties equipped to handle them.

Risk Treatment Plans

For all risks requiring treatment, a Risk Treatment Plan must be created. The key aspects to consider when developing a Risk Treatment Plan are summarised below:

- What are the existing controls?
- Are there any gaps?

- What further controls are practical and sustainable? What can we do within the Group and where may we need the support of external partners?
- Is the design of the control right? Is it helping you achieve your objectives?
- What further actions are needed to manage the risk?
- How will you assure that the control measures implemented will remain effective and not result in the risk re-emerging?

A Risk Treatment Plan should:

- Clearly identify the risk being treated
- Outline the chosen treatment method (i.e. treat, tolerate, terminate or transfer)
- Specify the controls, measures or actions to be implemented
- Assign responsibilities for managing the risk and implementing the plan to named individuals
- Establish a timeline for completion and review
- Ensure the treatment plan is appropriate to the level of the current risk

All treated risks must be subject to ongoing monitoring to:

- Assess the effectiveness of the risk treatment actions
- Ensure the risks are brought within, or maintained at, acceptable thresholds
- Adapt treatment strategies in response to changes in the internal or external environment

Risk treatment activities, decisions and outcomes must be documented in the risk entries stored on the electronic risk management system. The identified risk owner is responsible for ensuring the successful implementation of the Risk Treatment Plan.

Assurance

Assurance is the process of gaining confidence, based on documented evidence, that controls are in place to mitigate risks and that they are effective in practice. There are three types of assurance, which are referred to as the three lines of defence, and all documented risks must have a level of assurance assigned:

Assurance: Three lines of defence	
Assurance Level	**What it means**
Departmental ***(First Line of Defence)***	The first line of defence relates to functions that own and manage risk. Staff and managers working in departments and divisions have direct ownership, responsibility, and accountability for identifying, managing, and controlling risks to their objectives. Assurance is provided through the monitoring and reporting of risk and control activities through senior leadership and management team meetings. This is ongoing.
Corporate ***(Second Line of Defence)***	The second line of defence relates to functions that oversee or specialise in risk management and compliance. They guide, support, and challenge the first line by bringing expertise and subject matter knowledge to help ensure risks and controls are effectively managed and assured. The corporate governance team and other internal oversight teams such as divisional risk teams, digital, performance and business planning, finance, and workforce and organisational development, among others, form the second line of defence and are

	responsible for coordinating, facilitating, and overseeing the Trusts' effectiveness and integrity.
Independent / External ***(Third Line of Defence)***	The third line of defence relates to functions that provide independent assurance. It provides assurance to senior management and the Group Board over both the first- and second-lines' efforts. It is independent of the design, implementation, control, and operation of control activities, and they are not permitted to perform management or operational functions. This is a crucial part of the model and helps protect objectivity and independence.

Every effort should be made to identify sources of assurance from all three lines of defence for every risk identified.

5.6.6 Escalating and De-escalating Risks

An integral part of effective risk management is ensuring that risks are escalated through the established governance of the Group. This ensures visibility of risks, the appropriate level of management oversight, and effective prioritisation of resources.

Some risks, or the actions needed to mitigate them, can be such that it is necessary to escalate the risk to a higher management level, for example from Directorate to Divisional level, or from Site level to Executive level. Some risks, because of their nature, may require the support of partner organisations and may need to be considered through the Acute Provider Collaborative and / or Integrated Care Board governance structures.

Risks are escalated according to their Risk Profile Scores as follows:

Escalation of risks			
Score	**Risk grading**	**Action**	**Reporting**
1-3	**Negligible**	The majority of control measures are in place. Harm / other impact not identified or is very limited in nature. Action may be long-term.	To be managed at local/specialty level.
4-6	**Low**	The majority of control measures are in place. Harm / other impact severity is limited in nature. Action may be longer-term.	To be escalated to local/specialty level.
8-9	**Moderate**	The majority of control measures are in place. Harm / other impact severity is moderate in nature. Action may be longer-term but some shorter-term actions may be required.	To be escalated to Directorate level.

Escalation of risks			
Score	**Risk grading**	**Action**	**Reporting**
10-12	**High**	Some control measures are in place but are not sufficient to mitigate the risk to an acceptable level. Harm / other impact severity is high in nature. High probability that harm / other impact will occur if control measures are not implemented. Actions are required to limit the risk.	To be escalated to Divisional level – Divisional Management / Governance meeting, or Corporate Directorate meeting for corporate service functions. All risks scored as 10 and above across the Clinical Divisions reporting to the Site Leadership Team (for the ESTH and Integrated Care Sites) and the Trust Management Group (for the SGUH Site). A report will be prepared by the Group Risk Management Team.
15-25	**Extreme**	Some control measures may be in place, but are not currently sufficient to mitigate the risk to an acceptable level. Harm / other impact severity is extremely high. Significant probability that major harm / other impact will occur if control measures are not implemented. Significant and / urgent actions are required. Activity may require limiting.	Risks from Clinical Divisions scoring 15+ to be escalated to the Site Leadership team for review, and potential recommendation to the gesh Risk and Assurance Group Executive for inclusion on the respective Trust Corporate Risk Registers. Site leadership team may also consider aggregating similar risks across into a single Site-level risk. Risks from corporate services to be reviewed by the gesh Risk and Assurance Group for potential inclusion on CRR. The Risk and Assurance Group to review all 15+ risks, agreed risks for inclusion on Trust Corporate Risk Registers and alignment of CRR risks with Group Board Assurance Framework. Risks scored 15+ to be reported to the relevant Board Committees and Board for assurance.

As risks are escalated through the governance of the Group, there is an expectation that robust review and challenge will take place and that moderation and / or de-escalation of risks will occur, if appropriate.

Extreme Operational Risks (Scored ≥ 15)

Operational risks assessed as “extreme” (with a risk score of 15 and above) are to be reported, via the relevant Site or Group Corporate Service, to the gesh Risk and Assurance Group for review. In escalating risks scored 15+, Sites and Group Corporate Services may propose to aggregate similar risks across the Divisions into a single risk.

The gesh Risk and Assurance Group will review all risks scored ≥15 and review proposals for escalation of risks to and de-escalation of risks from the relevant Trust Corporate Risk Register. The gesh Risk and Assurance Group will consider whether any risks reviewed should be aggregated into a single risk and will align any risks proposed for escalation to the CRR of either Trust to the Group Board Assurance Framework. The Group Risk Management Team will prepare a report for the gesh Management Group on all ≥15 risks, which will also set out recommendations in relation to the Trust Corporate Risk Registers.

The Group Executive Committee will ratify the decisions of the gesh Risk and Assurance Group in relation to risks escalated to or de-escalated from the relevant Trust Corporate Risk Register. This will take the form of a report from the gesh Risk and Assurance Group to the Group Executive Committee. Following ratification by the Group Executive Committee, any changes to the Corporate Risk Register of the two Trusts will be actioned on Datix by the Group Risk Management Team.

Following ratification by the Group Executive, “Extreme” risks (15+) are referred to the relevant Board Committee for assurance. Risk reports to Board Committees will follow a common format and will be prepared by the Group Risk Management Team, working in partnership with the risk leads and relevant Site and / or Executive Directors, and will typically be presented as part of a regular review by the Committee of extreme risks within the Committee’s remit.

Extreme operational risks that are reviewed and reassessed as having a risk score of less than 15 are subsequently removed from the Corporate Risk Register (if escalated to the CRR) and managed at the appropriate level of governance as set out above.

Escalation of Risks to Site level (Risks scored 10 +)

All risks scored as 10 and above (10+) across the Clinical Divisions reporting to the Site are to be reviewed and confirmed by the Site Leadership Team (ESTH and Integrated Care Sites) or Trust Management Group (SGUH Site). A report on 10+ risks will be prepared for the Site Leadership Team by the Group Risk Management Team.

The Site Senior Leadership Team will review how the risk has been defined, the appropriateness of the risk scores, and will review the effectiveness and completeness of the actions identified to mitigate the risk to a level consistent with the agreed risk appetite.

The Site Senior Leadership Team will also consider whether any risks reviewed should be aggregated into a single risk where similar risks are held across a number of Divisional risk registers.

Escalation of Risk by Corporate Functions

Executive Directors with responsibility for corporate functions (e.g. Digital, Estates, Human Resources, Communications, Corporate Affairs) are responsible for risk management within these areas. This includes the management of risk registers and the reporting and escalation processes as seen with Site teams in line with this policy. Extreme risks scoring 15+ are to be escalated in a

timely manner to the gesh Risk and Assurance Group via the individual corporate functions' senior leadership teams.

Where risks relating to corporate functions are directly relevant to the delivery of services by the Sites, these risks should also be presented at Site Senior Leadership Team meetings (ESTH and IC) or Trust Management Group meetings (SGUH) for visibility and input, and will be incorporated into the risk report to the Site Senior Leadership Team prepared by the Group Risk Management Team. However, risk scoring and escalation will be the responsibility of the responsible Executive Director responsible for that corporate function, with risk scores reviewed and confirmed by the gesh Risk and Assurance Group.

5.7 Reviewing and escalating risks within the gesh Governance Structure

The governance structure of the gesh Group supports the effective management and escalation of risk across the Group and its constituent Trusts. The key roles of the principal governance forums responsible for reviewing risk registers across the Group are summarised below:

- **Trust Boards of ESTH and SGUH:** Ultimately accountable for the effectiveness of risk management across the Trust. The Trust Boards will receive and approve the Annual Governance Statement for their respective Trust, which includes provisions and judgements about the effectiveness of the systems of risk management and internal control for each Trust. Escalation of risks which have a system-wide impact are to the Integrated Care Board.

- **Group Board:** Operates with delegated authority from the two Trust Boards for oversight of the effectiveness of risk management across the Group, responsible for approval of the Group-wide Risk Management Policy and for the agreement of risks on the Group Board Assurance Framework. The Group Board will receive the Group Board Assurance Framework and the Corporate Risk Register dashboard on a quarterly basis, review the Risk Appetite Statement on an annual basis, and review and approve the Group-wide Risk Management Policy every three years. Escalation of risk is to the Trust Board.

- **Audit Committee:** Operates with delegated authority from the two Trust Boards to seek assurance on behalf of the Boards that the processes in place for the management of risk are fit for purpose. The Committee will receive a report from the internal auditors assessing the effectiveness of each Trust's risk management framework and processes, and will review the Group Board Assurance Framework and Corporate Risk Registers biannually. Escalation of risk is to the Group Board and / or Trust Board.

- **Board Committees:** Responsible for seeking assurance on behalf of the Board for the strategic risks on the Group Board Assurance Framework which have been delegated to each Committee by the Group Board and will review the relevant entries on the Group board Assurance Framework quarterly. Board Committees are also responsible for seeking assurance on extreme risks on each Trust's Corporate Risk Register within the remit of the Committee. Escalation of risk is to the Group Board.

- **Group Executive Committee:** Responsible for ratifying the escalation of risks to, and de-escalation of risks from, the Corporate Risk Register of each Trust, and reviewing proposed changes to the Group Board Assurance Framework ahead of submission to the Board and Board Committees, following review by the gesh Risk and Assurance Group. The Group Executive Committee will receive a report from the gesh Risk and Assurance Group

following each meeting. Escalation of risk is to the relevant Board Committee and / or the Group Board.

- **gesh Risk and Assurance Group:** Responsible for reviewing the Group Board Assurance Framework, and agreeing proposed updates to risks, risk scores and assurance ratings, prior to ratification by the Group Executive Committee and review by the Board and Board Committees. The Group seeks assurance that risks scored 15+ are being effectively managed and mitigated, that new risks scored 15+ are accurately identified and scored, and that risks are being consistently reviewed, with timely action being taken in mitigation by Sites, Divisions and Corporate Services. The gesh Risk and Assurance Group will review the Group Board Assurance Framework, Corporate Risk Registers, and risk dashboard at each meeting. It will also review risks scored 10+ by Corporate Services and Divisions on a rolling quarterly basis. Escalation of risk is to the Group Executive Committee.

- **Site Leadership Team (ESTH and Integrated Care Sites) / Trust Management Group (SGUH Site):** Responsible for seeking assurance that risks scoring 10+ are being effectively managed and mitigated by the Divisions, with timely action being taken in mitigation by the relevant Division, and for ensuring new risks scored 10+ are accurately identified and scored by Divisions. The Site Leadership Teams (for the ESTH and IC Sites) / Trust Management Group (for the SGUH Site) are also responsible for recommending to the gesh Risk and Assurance Group risks from the Site for potential escalation to, or de-escalation from, the relevant Trust Corporate Risk Register. Escalation of risk is to the gesh Risk and Assurance Group.

- **Divisional Management Boards:** Responsible for ensuring that risks held by the Division scoring 10+ are being effectively managed and mitigated, and that new risks scoring 10+ are accurately identified and scored, and that risks are being consistently reviewed, with timely action being taken in mitigation by the directorates and specialty for which the division is responsible. Divisional Management Boards will receive a Divisional Risk Register report at each meeting. The Group Risk Management team will provide a report on escalation of risk from the Divisions to the Site Leadership Team (for the ESTH and Integrated Care Sites) or the Trust Management Group (for the SGUH Site)

A table setting out the role of each of the principal governance forums across the gesh Group responsible for receiving risk registers, what is expected to be reviewed, and at what frequency is set out at **Appendix 6**.

5.8 Risk Management Training

Risk management training will be provided in various forms and in accordance with the Group's learning and development policies. Risk management training will ensure that staff are given the necessary skills to recognise, report and manage risk, according to their respective role in the organisation. The overall aim is to ensure that the Group's approach to risk management is embedded and staff understand the relevance of risk and how and why it should be managed, treated and mitigated to support the delivery of safe, high quality and sustainable services for patients, staff and local communities.

5.9 Future Developments

The Risk Management Policy represents a developing and improving approach to risk management. Its success will be achieved by building and sustaining an organisational culture that enables and

actively encourages proactive identification and management of risk; and working with system partners to create more integrated arrangements for identifying and managing whole-system risks. This will be supported by:

- the ongoing development of enhanced risk management awareness training across the Group, and
- further development of the Group's Risk Management systems to support the ongoing implementation of the Risk Management Policy.

5.10 Help and Support

The Group Risk Management team is available to support all staff across the Group in the management of risk, and in providing training in risk management. The Group Risk Management team can be contacted at: gesh.riskmanagement@stgeorges.nhs.uk.

6. Roles and Responsibilities

It is important that all staff understand their roles and responsibilities in relation to risk management. This section describes these roles and responsibilities:

Role	Responsibilities
Group Chief Executive Officer	Chief Executive has overall accountability and responsibility for ensuring that both Trusts within the gesh Group meet their statutory and legal duties and adhere to all national and regional guidance for risk management. They are responsible for ensuring that the two Trusts have in place the required systems and processes that support risk management across the organisation and that these systems and processes are approved and monitored by the Board.
Non-Executive Directors	Non-Executive Directors are responsible for providing independent judgement in relation to risk management issues and satisfying themselves that the Group's (and Trusts') systems of risk management are robust and defensible.
Group Chief Corporate Affairs Officer	The Group Chief Corporate Affairs Officer has delegated responsibility from the Group Chief Executive Officer for ensuring the strategic development and operational implementation of the Risk Management Policy across the Group and its two constituent Trusts. The Group Chief Corporate Affairs Officer works closely with the Group Chief Executive, other Executive Directors, and Site Directors to ensure a whole systems approach to the management of risk. The Group Chief Corporate Affairs Officer is also responsible for providing support to the Group Executive and the Group Board in ensuring the Group Board Assurance Framework and the Corporate Risk Registers of the two Trusts are effectively maintained. The Group Chief Corporate Affairs Officer is also specifically accountable to the Group Chief Executive Officer for risks arising from areas linked to their executive responsibilities.

Role	Responsibilities
All other Executive Directors	All other Executive Directors are accountable to the Group Chief Executive Officer for risks arising from areas linked to their executive responsibilities.
Site Managing Directors and Site Leadership Teams (ESTH / IC) and Trust Management Group (SGUH)	Site Managing Directors and their Site Leadership Teams (or Trust Management Group for the SGUH Site) are responsible for: • Local implementation of risk management arrangements set out in this policy at Site level, supported by the Group Risk Management team. • Identifying risks to the achievement of corporate objectives and establish and ensure effective oversight of a Site Risk Register. • Escalating risks with a risk score of 15+ to the gesh Risk and Assurance Group, including making recommendations for the escalation of risks to / and de-escalation of risks from the Trust Corporate Risk Register. • Overseeing the principal risks on Divisional Risk Registers, and ensuring the effective management of risk by Divisions (including ensuring oversight of the timely delivery of actions to address identified gaps in control and providing challenge, where appropriate, to the scoring of risk by Divisions) • Ensuring that there is a robust process in place to effectively escalate, approve and manage risks appropriately through the Site governance structure in line with the requirements set out in this Risk Management Policy • Communicating any escalation / de-escalation of 15+ risks to / by the gesh Risk and Assurance Group back to the Site for appropriate management.
Group Head of Risk Management and Group Risk Management team	The Group Head of Risk Management and the Group Risk Management Team are responsible for: • Implementing the Group's arrangements for risk management in line with this Risk Management Policy. • Managing and maintaining the electronic Risk Management systems at both Trusts and ensuring that they support the management of risk across the Group in line with the Risk Management Policy. • Supporting all staff to assess and report risks in line with the Risk Management Policy. • Providing support in development and management of risks. • Monthly production and analysis of the Corporate Risk Register for both ESTH and SGUH, representing all 15+ risks to the gesh Risk and Assurance Group. • Supporting the Site Leadership Teams in the development and maintenance of the Site Risk Register and preparing monthly reports and analysis of risk for each Site across the Group • Supporting Sites in overseeing effective risk management by the Divisions and the principal risks held at Divisional level • Maintaining a fully functioning KPI dashboard for risk

Role	Responsibilities
	• Supporting Executive Directors, Site Directors and Divisional Directors and Divisional Governance / Quality Managers and Corporate Services teams with the delivery of an effective training programme of risk management • Ensuring adequate training in risk management is provided to staff across the gesh Group.
Risk Owner	A risk owner is responsible for ensuring that the risk is managed, including the on-going monitoring of the risk, ensuring controls and further actions are in place to mitigate the risk and reporting on the overall status of the risk in line with the processes outlined in the document. This may involve coordinating efforts to mitigate and manage the risk with various individuals who may also own parts of the risk. The responsibilities of the risk owner are to ensure that: • Risks are identified, assessed, managed and monitored • Risks are clearly articulated in risk registers • Controls and treatment plans are in place to mitigate the risk to within risk appetite
Divisional, Directorate, Specialty Leadership teams	Divisional, Directorate, Service, Ward and Department Leadership teams are responsible for: • Local deployment and management of risk management processes as set by the Group Board within this Risk Management Policy. • Participating in the identification, assessment, planning and management of threats and opportunities • Ensuring a record of identified risks in their area is maintained on the electronic risk management system • Undertaking a regular review of the risks on their risk register • Escalating risks as appropriate and in accordance with this Risk Management Policy.
Divisional Governance Manager (SGUH) / Divisional Quality Lead (ESTH)	Divisional Governance Managers (SGUH) / Quality Leads (ESTH) are responsible for: • Working with the Group Risk Management team to ensure that the Risk Management Policy is effectively conveyed to all staff and is translated into operational practice. • Supporting the Divisional triumvirate in maintaining a Divisional Risk Register that accurately reflects risks and is up-to-date. • Providing risk reports for Divisional and Directorate management groups and forums, collating risks to support assurance mechanisms and demonstrate compliance with key standards. • Regularly reviewing risk owners and leads to ensure named leads are still in an applicable post and re-assign the risks as required • Ensuring data quality within the risk module on the electronic risk management system for their areas of responsibility.

Role	Responsibilities
Health and Safety lead and team	The Assistant Director of Health & Safety will support and contribute to the development of Risk Registers on all health and safety non-clinical risks and advise on appropriate control strategies. The Health and Safety team has a key role in risk management including providing support and guidance to colleagues undertaking risk assessments and providing advice in the event of a dispute to the validity of a risk assessment.
Senior Information Risk Owner (SIRO) and Information Governance team	The Senior Information Risk Owner (SIRO) and Information Governance team have an important role in the management of confidentiality and security risks to information and records across the Group. These roles and that of the key individuals responsible for information governance are set out in the Information Governance Policy.
All Staff	All staff, including permanent, temporary, locum and honorary staff are responsible for: • Identifying, assessing, reporting and escalating any risks to the delivery of safe, effective and high quality services (clinical and non-clinical) they feel exist within their department/area. • Taking reasonable care for the health, safety and welfare of themselves and others • Ensuring that they comply with all organisation strategies, policies and procedures, including this Risk Management Policy. • Undertaking mandatory training and other relevant training appropriate to their role.
Internal Audit	The internal auditors are responsible for: • Agreeing (with the Audit Committee) a programme of audits which assess the exposures and adequacy of mitigation of the principal risks affecting the two Trusts within the gesh Group • Ensuring that the priorities contained in the internal audit programme reflect the risks identified in the Corporate Risk Registers and the Group Board Assurance Framework • Ensuring internal audit reports and advice inform the management of risk, though responsibility remains with the relevant risk owners. • Preparing an annual report which presents the opinion on the overall adequacy and effectiveness of the risk management, control and governance processes of each of the two constituent Trusts within the gesh Group.

7. Monitoring the Implementation and Effectiveness of the Risk Management Policy

The implementation objectives are to:

- Raise awareness and develop a culture where all risks are identified, understood and managed
- Ensure an appropriate system, process and structure is in place for the identification and control of key risks
- Provide assurance that key processes are in place to provide reliable information and to make appropriate decisions
- Embed risk assessment and risk management into all of our activities, including day-to-day and future ongoing management of the Group

The implementation of the Risk Management Policy will be supported by biannual progress reports to the Audit Committee.

The effectiveness of the Risk Management Policy will be monitored through the following key performance indicators:

Indicator	Compliance Rate	Measurement	Review Period	Monitoring Group
Divisional Risk Registers reviewed in the last quarter by Divisional Management Board	100%	• Divisional Risk Register • Minutes of DMBs	Quarterly	Gesh Risk and Assurance Group
Site-based 12+ risks are reviewed bimonthly (every other month) by the Site Leadership Team	100%	• Minutes of the Site SLT	Bimonthly	gesh Risk and Assurance Group
Risks on the Corporate Risk Register for each Trust are reviewed bimonthly (every other month) by the gesh Risk and Assurance Group	100%	• Minutes of the gesh Risk and Assurance Group	Bimonthly	Audit Committee
Group Board Assurance Framework is presented to the Group Board on a quarterly basis	100%	• Group Board reports	Quarterly	Group Board
Risk Management Policy is reviewed annually by the Audit Committee	100%	• Audit Committee reports	Annual	Audit Committee
Risk Appetite Statement is reviewed by the Group Board annually	100%	• Group Board reports	Annual	Group Board
Internal Audit Opinion on the effectiveness of risk management arrangements to inform the Annual Governance Statement for each Trust	Acceptable level of Assurance	• Annual Internal Audit Review of Risk Management • Annual Head of Internal Audit Opinion	Annual	Audit Committee

8. Abbreviations and Definitions

The following abbreviations are used in this document:

Abbreviation	Meaning
AGS	Annual Governance Statement
APC	Acute Provider Collaborative
BAF	Board Assurance Framework
CAS	Central Alerting System
CRR	Corporate Risk Register
CQC	Care Quality Commission
ESTH	Epsom and St Helier University Hospitals
GEC	Group Executive Committee
gesh	St George's, Epsom and St Helier University Hospitals and Health Group
ICB	Integrated Care Board
KPI	Key Performance Indicator
PALS	Patient Advice and Liaison Service
SGUH	St George's University Hospitals
SIRO	Senior Information Responsible Officer
SMART	Specific, Measurable, Achievable, Relevant, Time-bound
SWL	South West London

The following terms are used in this document:

Term	Meaning
Annual Governance Statement	The Annual Governance Statement (AGS) forms part of each Trust's Annual Report and is a mandatory regulatory requirement. The AGS sets out a high level account of the structures in place to support governance, risk management and the system of internal control.
Assurance	Assurance is an integral part of the Group's governance and risk management processes. Assurance provides the Group board with evidence-based confidence that controls

	(systems, policies, processes, and people) are operating effectively. Assurance can be identified from a number of sources: internal, external or independent sources or a combination of all three. All sources of assurance must be recorded in risk registers to evidence the effectiveness of controls in place. Actions should be identified to address gaps in assurances if the level of risk is above the agreed risk appetite for the category of risk.
Assurance Committee	A Board-level Committee responsible for providing assurance to the Board on the effective management of strategic risks on the Group Board Assurance Framework delegated to it by the Group Board and in relation to extreme risks on the Corporate Risk Register within the remit of the Committee as defined in its terms of reference.
Board Assurance Framework	The Board Assurance Framework sets out the risks the Board has identified that could adversely affect the delivery of the Group's strategy and strategic objectives.
Consequence	The impact of a risk materialising, which could be measured in terms of harm, operational, financial or reputational impact.
Corporate Risk Register	The centralised document used by the Trust to record, manage, and monitor significant risks (scored 15+ and agreed by the Group Executive for escalation) that have the potential to impact the Trust's objectives. It supports the leadership of the organisation to prioritise, track and address risks that require high-level oversight and action.
Electronic Risk Management System	The electronic risk management system is the system used by both Trusts within the Group to record and track the management of risk. This is currently Datix for both Trusts.
External / Independent assurance	Assurance provided by parties external from and independent to the Group, and its constituent Trusts, such as internal and external auditors and regulators.
Gap in control	Absence of sufficiently effective treatments to mitigate and minimise the risk identified.
Gap in assurance	Absence of sufficient evidence that actions to treat risks are operating effectively.
Hazard	Something that may cause harm, damage or loss.
Horizon Scanning	Systematic activity designed to identify, as early as possible, indicators of changes in risk.
Inherent Risk	The exposure arising from a specific risk before any action has been taken to manage it.

Internal Control	Any action originating within the organisation taken to treat the risk. These actions may be taken to manage either the impact if the risk is realised, or the frequency or likelihood of the risk occurring.
Internal Control, System of	The structured framework of policies, procedures, processes and practices designed to ensure that the organisation meets its objectives in an efficient, effective and compliant manner. The system of internal control is overseen by the Board.
Likelihood	Likelihood refers to the probability of a risk materialising and also reflects the effectiveness of the controls in preventing the risk from happening.
Mitigating actions	Individual actions which reduce the likelihood of a risk materialising or reducing the potential impact of a risk.
Principal Objectives	The objectives of the organisation as set out in the Group Strategy.
Principal Risks	The key risks identified by the Group Board to the achievement of the Group Strategy, as set out in the Group Board Assurance Framework.
Residual Risk	The exposure arising from a specific risk after action has been taken to manage / treat it
Risk Acceptance	Risk acceptance is the decision to acknowledge and retain a risk without taking further action to mitigate, transfer or eliminate it. This approach is typically used when the risk falls within the organisation's established risk appetite (the level of risk the organisation is willing to accept) or when the cost of additional mitigation outweighs the benefits of reducing the risk further.
Risk Appetite	Risk Appetite refers to the level and type of risk that the organisation is willing to accept in pursuit of its objectives. It is the amount of risk the Board considers acceptable, tolerable or justifiable to achieve its goals, balancing potential opportunities and threats.
Risk Assessment	Risk Assessment is the overall process of identifying, analysing and evaluating risks to understand their potential impact and likelihood, enabling informed decision-making about how to manage them. It is a core part of the broader risk management process and provides the basis for prioritising and addressing risks effectively.
Risk Avoidance	Risk avoidance refers to a an approach in which the organisation takes deliberate actions to eliminate the possibility of a risk occurring by ceasing or not engaging in

	activities that present the risk. It is used when the potential impact of the risk is deemed unacceptable and cannot be adequately managed or controlled.
Risk Control	Risk controls are measures to reduce the likelihood and / or impact of the identified risk occurring. It involves developing and applying actions to treat or mitigate risks to an acceptable level.
Risk Escalation	Risk escalation is the formal process of reporting or transferring risks from one level of an organisation to a higher level where the risk exceeds the threshold of responsibility, authority, or control at the current level. It ensures that significant risks are addressed by those with the appropriate authority and resources to manage the risks effectively.
Risk Exposure	The consequences, as a combination of impact and likelihood, which may be experience by the organisation if a specific risk occurs.
Risk Identification	Risk identification is the process of identifying the organisation's exposure to uncertainty. The process of risk identification is the foundational step in the broader framework of risk management and requires detailed understanding of the organisation's internal and external environment. The goal is to pinpoint all potential risks – whether strategic, operational, financial, or external – that could hinder the Group's ability to achieve its objectives.
Risk Management	Risk management is the process of understanding, analysing and addressing risk to ensure that individuals and organisations achieve their objectives. It involves the systematic application of management policies, procedures, processes and practices to identify, analyse, evaluate, treat, monitor and review risk.
Risk Reduction	Reducing the probability of the risk occurring or reducing the impact of the risk.
Risk Register	A documented and prioritised log of the overall assessment of a range of risks faced by the organisation, or a Site, Division or Directorate within the organisation.
Risk Transfer	Risk transfer refers to an approach in which the responsibility for bearing the impact of a risk is shifted from one party to another. This is typically achieved through contracts, outsourcing, insurance or other agreements.
Strategic Objectives	These are the principal, long-term objectives of the Group as defined in the Group strategy.

Strategic Risks	Risks to the delivery of the Group's strategy. These are the risks set out in the Board Assurance Framework.
Treatment	Taking action to manage and mitigate the risk. This is the most common approach to responding to risks across the Group.

9. List of Appendices

The following appendices are attached to this policy, and constitute part of the Risk Management Policy:

Appendix number	Appendix title
1	Risk Appetite Statement
2	Categories of Risk
3	Risk Scoring Matrix
4	Control Effectiveness Framework
5	Risk Assessment Form
6	Risk Review and Escalation Framework

Appendix 1 – Risk Appetite Statement

The following Risk Appetite Statement was agreed by the Group Board in January 2024:

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

Risk Appetite Statement

The risk appetite of the gesh Group is grounded in the NHS Constitution. The NHS Constitution sets out rights to which patients, public and staff are entitled, and pledges which the NHS is committed to achieve, together with responsibilities which the public, patients and staff owe to one another to ensure the NHS operates fairly and effectively.

The gesh Group believes that no risk exists in isolation from others and that risk management is about finding the right balance between risks and opportunities to act in the best interests of patients, taxpayers and our staff.

Our approach to risk appetite inevitably involves risk trade-off conversations and a consideration of the counterfactual – giving us a flexible framework within which we can try new things, make agile decisions and find a balance between boldness and caution, risk and reward, cost and benefit. It also aims to provide a balance between an approach which is excessively bureaucratic and burdensome and one which lacks rigour.

When balancing risks, the gesh Group will tolerate some risks more than others. For example, the Group will seek to minimise avoidable risks to patient safety in the delivery of quality care and has a very low appetite for risks in this area. In the case of research and innovation, we are prepared to take managed "moderate to high risks" on the proviso the following has been undertaken:

- An assessment of what and where the current risks are
- That the potential future impact has been understood and agreed
- Rapid cycle monitoring is in place to enable swift corrective action should things go wrong
- Consideration of the position across the SWL and wider systems in which we operate
- Trade-off between risks is understood / assessment of unintended impacts on other risks undertaken (i.e. whether it will lead to an increase or reduction in other categories of risk)
- Cost-benefit analysis and stated preference is undertaken
- Reliability and validity of data used to make the assessment has been considered
- Counterfactual risks have been considered to ensure management apply any learning before taking the risk
- We can demonstrate significant and measurable potential benefits (i.e. enhanced patient care, improved efficiency, and / or value-for-money delivery)

Ranges to guide these trade-off discussions is set out in Figure 1 below:

Risk Category	Risk Appetite Level	Risk appetite score
Patient safety and quality of care	Minimal (Low)	4-6
Operational performance	Cautious (Moderate)	8-9
Financial risk	Cautious (Moderate)	8-9
Estates and physical infrastructure	Open (High)	10-12

Digital and Information Technology	Open (High)	10-12
Research and innovation	Seek (Significant)	15-25
Collaboration across the gesh group	Open (High)	10-12
Collaboration across the Acute Provider Collaborative	Open (High)	10-12
Collaboration across the local system	Cautious (Moderate)	8-9

Appendix 2 – Categories of Risk

Risk category	Description
Strategic Risk	Strategic risks are associated with the Group's ability to implement and deliver its long-term strategic objectives as set out in the Group strategy, and to maintain its long-term viability and sustainability. Strategic risks are risks that could impact the Group's ability to deliver on its core objectives, and will often include external factors (e.g. partnership working across the Integrated Care System, the Acute Provider Collaborative, changes in national policy or the national regulatory framework, or factors relating to service demand such as population growth, demographics).
Clinical Risk	Clinical risks are risks where the causes or effects are primarily related to the health and wellbeing of patients and service users or to the provision of care / services to them. It refers to the potential for harm to patients or the public arising from the provision of health services, clinical decisions, or the delivery of care. It encompasses risks related to patient safety, clinical outcomes, the quality of care, and risks related to the care and treatment of vulnerable groups. Clinical risks can also include risks associated with breaches of clinical guidelines, legal requirements (e.g. consent) or ethical standards which could result in harm or loss of trust.
Financial Risk	Financial risk refers to the potential for financial losses or challenges that could impact the financial sustainability of the organisation or financial impacts which would negatively impact the delivery of healthcare services. Financial risks can include funding risks, risks related to the commissioning of services, risks related to inefficiency, resource allocation, liquidity, demand, and capital and include risks related to weaknesses in financial control.
Health and Safety Risk	Health and safety risks refer to potential hazards or situations which could cause harm, injury, illness or other adverse effects to patients, staff, visitors or the public with any of the sites from which the Group provides services or during the delivery of services. These risks are associated with the physical environment, workplace practices, equipment and behaviours that could compromise the health, safety or wellbeing of those involved. Health and safety risks include risks related to workplace hazards, manual handling, equipment and technology, fire and emergency, environmental risks related to poorly maintained facilities, and violence and aggression against staff.

Information Security Risk	Information security risk refers to the potential for loss, unauthorised access, misuse, damage or disruption to sensitive data, systems and digital infrastructure that could compromise patient confidentiality, operational efficiency, or the delivery of healthcare services. This includes risks associated with protecting electronic patient records, staff information and other critical healthcare data from data breaches (e.g. unauthorised access, hacking, phishing) cybersecurity threats, human error, system downtime risks, third party supplier risks, and risks related to the use of mobile devices and remote access to Group digital and IT systems.
Infrastructure Risk	Infrastructure risk refers to the potential threats, vulnerabilities or failure related to physical facilities, equipment, utilities and systems that are critical to the delivery of services. These risks can include risks relating to aging facilities, maintenance failures, utility disruptions, capacity limitations, environmental and sustainability (e.g. energy efficiency), construction and renovation, medical equipment failures, transport and logistics risks, and to risks relating to the digital infrastructure such as outdated or unreliable technology.
Organisational Risk	Organisational risk refers to potential challenges, threats or uncertainties that could disrupt the ability of the Group, and its constituent Trusts, to achieve its objectives or otherwise relate to the way in which the Trusts, and the Group as a whole, is organised, managed and governed.
Operational Risk	Operational risk refers to the potential for disruption, failure or inefficiencies in day-to-day processes, systems and activities that could negatively impact the delivery of healthcare services, patient safety, staff wellbeing, or organisational performance. These risks can arise from internal or external factors and often relate to how services are planned, managed and delivered. They often relate to inability to meet patient care demand, including delays in treatment, long waiting times, and cancellations.
Performance Risk	Performance risk refers to the ability to deliver safe, high quality services in line with each Trust's annual plan and the standards set by NHS England, the Care Quality Commission and commissioners. It can relate to the potential for failing to meet national operating standards as set out in the NHS Constitution and service delivery standards that affect patient care, staff wellbeing and overall organisational effectiveness.
Reputational Risk	Reputational risk refers to the potential harm to the public's trust, confidence or perception of the Group, and its constituent Trusts, due to adverse events, service failures, poor communication, or negative publicity. Theis risk can impact on the Group's ability to maintain stakeholder

	confidence, attract and retain skilled staff, secure funding or deliver services effectively.
Third Party Risk	Third party risk refers to the potential threats or adverse outcomes that arise from the reliance on external organisations, suppliers, contractors or partners to deliver service, products or support critical to the Group's operations and delivery of services to patients, staff and local communities. These risks can impact patient care, operational efficiency, compliance, financial performance and reputation.
Event Risk	Event risk refers to events outside the direct control of the Group that have potentially significant operational or strategic consequences if not effectively managed. These risks include the potential for specific, unforeseen incidents or occurrences and include, for example: public health emergencies such as pandemics, outbreaks of infectious diseases, or other large scale crises that impact NHS resources and service delivery; natural disasters and environmental events such as floods, extreme weather or heatwaves that can damage infrastructure, disrupt services, or impact patient care; and major incidents such as transportation accidents, industrial disasters, or mass casualty events.

Appendix 3 – Risk Matrix (for Scoring of Risks)

Calculating a Risk Consequence Score		
Consequence score	**Descriptor**	**Examples**
5	Catastrophic	• Harm: Multiple deaths caused by an event. • Service disruption: May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action. • Financial loss: ≥£5m loss • Adverse publicity / Reputation: total loss of public confidence • Business Objective / Project: Incident leading >25 per cent over project budget / schedule slippage; key objectives not met
4	Major	• Harm: Severe permanent harm or death caused by an event. RIDDOR – major injury / dangerous occurrence • Service disruption: Prolonged disruption to one or more Divisions, Extended service closure. • Financial loss: £1m - £5m loss • Adverse publicity / Reputation: National media coverage with <3 days service well below reasonable public expectation • Business Objective / Project: Non-compliance with national 10-25 per cent over project budget / schedule slippage; key objective not met
3	Moderate	• Harm: Moderate harm requiring medical treatment up to 1 year. RIDDOR lost time • Service disruption: Temporary disruption to one or more Division, Service closure. • Financial loss: £100K – £1m loss • Adverse publicity / Reputation: Long-term reduction in public confidence • Business Objective / Project: 5-10 per cent over project budget / schedule slippage
2	Minor	• Harm: Minor harm requiring minor intervention, first aid treatment up to 1 month. • Service disruption: Temporary service restriction • Financial loss: £50K - £100K loss • Adverse publicity / Reputation: Short-term reduction in public confidence • Business Objective / Project: <5 per cent over project budget / schedule slippage
1	Insignificant	• Harm: Minimal injury requiring no/ minimal intervention or treatment. • Service disruption: No disruption, service continues without impact • Financial loss: £0 - £50K loss • Adverse publicity / Reputation: Potential for public concern • Business Objective / Project: Insignificant cost increase / schedule slippage

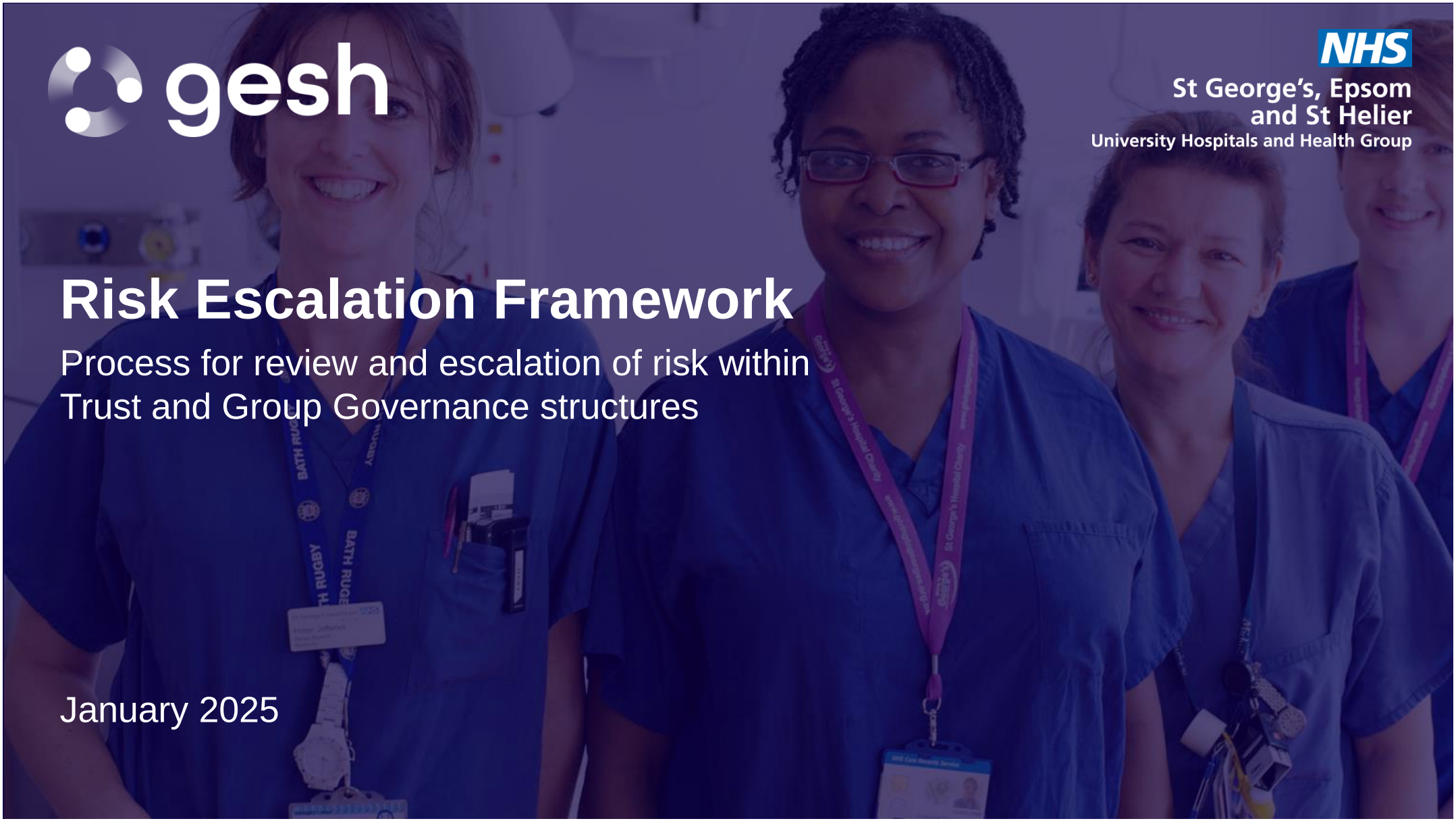
Calculating a Risk Likelihood Score		
Likelihood score	**Descriptor**	**Definition** *How effective are the controls? Or, what is the probability of the risk occurring?*
5	Almost certain	• Effectiveness of controls: No effective controls in place to prevent the risk occurring; or • Probability: This will almost certainly happen / recur – equal to or greater than 1 in 5 chance within 12 months
4	Likely	• Effectiveness of controls: Weak controls to prevent the risk occurring • Probability: This will probably happen / recur – equal to or greater than 1 in 10 chance within 12 months
3	Possible	• Effectiveness of controls: Limited effective controls to prevent the risk occurring • Probability: This might happen / recur – equal to or greater than 1 in 100 chance within 12 months
2	Unlikely	• Effectiveness of controls: Good controls in place to prevent the risk occurring • Probability: This is unlikely to happen / recur – equal to or greater than 1 in 1000 chance within 12 months
1	Rare	• Effectiveness of controls: Very good controls in place to prevent the risk occurring • Probability: This will probably never happen / recur – less than 1 in 1000 chance (or less) within 12 months

Calculating the overall Risk Profile Score						
		Consequence				
		1. Insignificant	2. Minor	3. Moderate	4. Major	5. Catastrophic
Likelihood	5. Almost Certain	**5**	**10**	**15**	**20**	**25**
	4. Likely	**4**	**8**	**12**	**16**	**20**
	3. Possible	**3**	**6**	**9**	**12**	**15**
	2. Unlikely	**2**	**4**	**6**	**8**	**10**
	1. Rare	**1**	**2**	**3**	**4**	**5**

Risk Score Categories	
Risk Category	**Risk Score**
Extreme	**≥ 15**
High	**10 - 12**
Moderate	**8 - 9**
Low	**4 - 6**
Negligable	**1 - 3**

Appendix 4 – Control Effectiveness Framework

Calculating the effectiveness of controls		
	Individual controls	**Overall control effectiveness – all controls linked to a specific risk**
Effective	Indicates the control is fully functional and consistently reduces or mitigates the risk associated with the control. Controls rated effective will not require further actions	Over 70% of the controls are Effective or Partially Effective. Further actions may be taken to strengthen the controls but are not required.
Partially Effective	Indicates that the control is in place but may not consistently mitigate the risk. Controls rated as Partially Effective will require additional actions to strengthen or replace them.	30-70% of the controls are Effective or Partially Effective. Further investigation and targeted remediation is required.
Ineffective	Indicates that the control is insufficient or not functioning adequately to manage the risk associated with it. Controls rated Ineffective will require additional actions to strengthen or replace them.	Less than 30% of controls are Effective or Partially Effective. Immediate further actions are required to manage the risk.



Risk Escalation Framework

Process for review and escalation of risk within Trust and Group Governance structures

January 2025

Risk Escalation Framework

Purpose of this document

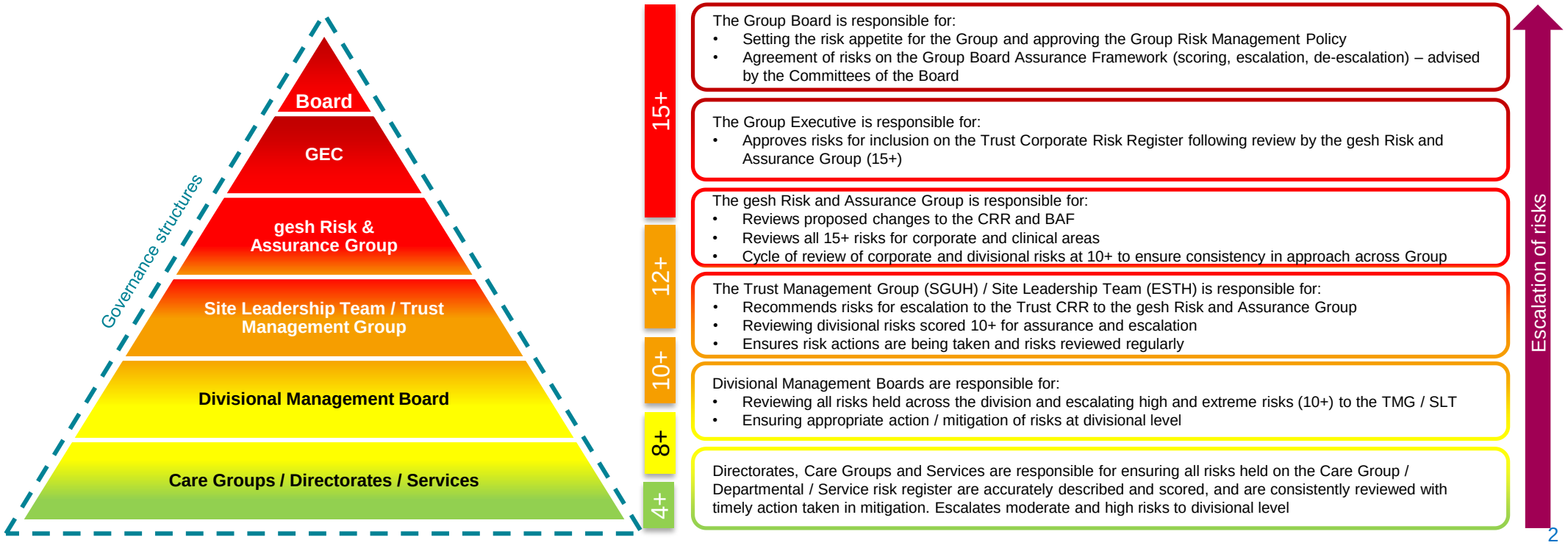
This document sets out the framework and process for the systematic review and escalation of risk within the governance structures of the St George's, Epsom and St Helier University Hospitals and Health Group and its constituent Trusts, in line with the Group Risk Management Policy. It describes the reporting arrangements and relative accountabilities for risk register review at each level, the frequency of risk register review, the route and mechanism for escalation of risks from or onto risk registers and the threshold at which risks are reviewed at each level of the Group's (and Trust's) governance structures.

Risk identification

All staff are accountable for identifying and managing risk. Where a risk can be immediately mitigated, this should be done without delay. Where the risk cannot be immediately mitigated, staff should conduct a risk assessment in accordance with the Group Risk Management Policy and the risk should then be added to the Risk Register. If the staff member feels that they are not able to adequately address the risk themselves, they should report the risk to their line manager.

Risk escalation arrangements

The diagram below sets out the escalation and authority for managing risks across the Group, depending on the risk score assigned:



Risk Escalation Framework

Risk Review and Escalation Mechanisms

The table below sets out the role of each governance forum across the gesh Group responsible for reviewing risk registers, what is expected to be reviewed, and at what frequency. The route of escalation for risk at each level of governance is set out below.

Group	Role	Receiving	Frequency	Route of escalation
Trust Board	• Ultimately accountable for the effectiveness of risk management across the Trust	• Annual Governance Statement (AGS)	• Annual	
Group Board	• Delegated responsibility from the Trust Boards for oversight of the effectiveness of risk management across the Group • Approval of the Group Risk Management Policy • Setting risk appetite for the Group • Agreement of risks on the Group Board Assurance Framework (scoring, escalation, de-escalation)	• Group Board Assurance Framework • Corporate Risk Registers (both Trusts) • Risk Appetite Statement • Group Risk Management Policy	• Quarterly • Quarterly • Annual • Every 3 years	• Trust Board
Audit Committee	• Delegated responsibility to seek assurance on behalf of the Board that the process in place for risk management are fit for purpose	• Group Board Assurance Framework • Corporate Risk Registers (both Trusts) • Risk management internal audit review (both Trusts)	• Biannual • Biannual • Annual	• Group Board • Trust Board (AGS only)
Board Committees	• Seek assurance on behalf of the Board for those strategic risks captured on the Group Board Assurance Framework which have been delegated to each Committee by the Board	• Group Board Assurance Framework (strategic risks relevant to each Committee)	• Quarterly	• Group Board
Group Executive Committee	• Agreement to risks for escalation to the Group Board Assurance Framework • Final approval of risks scored 15+, on the recommendation of the gesh Risk Management Group	• Report from the gesh Risk Management Group	• Monthly	• Relevant Board Committee or Board (by exception)
gesh Risk and Assurance Group	• Recommend risks for escalation to the Group Board Assurance Framework where these have potential to materially impact on the delivery of the Group strategy • Seek assurance that risks scoring 15+ are being effectively managed and mitigated • Ensure new risks scored 15+ are accurately identified and scored • Ensure risks are being consistently reviewed, with timely action taken in mitigation by the Site Leadership Teams and Divisions and / or by Group Corporate Services • Ensure risks are consistently defined, scored and treated so that there is consistency in the management of risk across the Group	• Group Board Assurance Framework • Corporate Risk Registers (both Trusts) • Risk Dashboard • Group Corporate Services risks 10+ • Divisional risks 10+	• Monthly • Monthly • Monthly • Quarterly (rolling cycle)	• Group Executive Committee

Risk Escalation Framework

Group	Role	Receiving	Frequency	Route of escalation
Site Leadership Team (ESTH) **Trust Management Group (SGUH)**	• Recommend risks for escalation to the Trust Corporate Risk Register • Seek assurance that risks scoring 10+ are being effectively managed and mitigated by the Divisions, with timely action taken in mitigation by each Division • Ensure new risks scored 10+ are accurately identified and scored by Divisions	• Site Risk Report (10+ risks) • Site Risk Dashboard	• Monthly	• gesh Risk Management Group
Divisional Management Board	• Satisfy itself that those risks held by the Divisions scoring 8+ are being effectively managed and mitigated • Ensure that new risks scoring 8+ in the Division are accurately identified and scored • Ensure that risks are being consistently reviewed, and timely action is taken in mitigation by each Care Group / Department / Service in the Division	• Divisional Risk Register (8+ risks) • Divisional Risk Dashboard	• Monthly • Monthly	• Site Leadership Team (ESTH) • Trust Management Group (SGUH)
Care Groups / Departments / Services	• Ensure all risks held on the Care Group / Departmental / Service risk register are accurately described and scored, and are consistently reviewed with timely action taken in mitigation	• Care Group / Divisional / Service risk register	• Monthly	• Divisional Management Board

Group Board

Meeting on Friday, 07 March 2025

Agenda Item	2.4	
Report Title	**Audit Committees-in-Common Annual Effectiveness Review**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the Audit Committees-in-Common report to the Group Board, describes the plan to review the Committees' current terms of reference, and updates on the proposed forward plan of business for the Committees in 2025/26.

The minor changes proposed to the Committees' terms of reference relate to making specific reference to fire safety, removing items that are within the purview of other committees and reducing repetition.

The forward plan is undergoing significant revision to ensure that we are taking the right items at the right time and frequency throughout the year, co-ordinating with the Board and other committees. We plan to share the updated forward plan with Committee members for input via email with a view to ratifying this at the next Audit Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

Action required by Group Board

The Board is asked to:

a. Review the annual report and effectiveness review
b. Note the plan for the review of the annual workplan and terms of reference

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Audit Committees Annual Report
Appendix 2	Committee Effectiveness Report

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

There is a statutory requirement for all Trusts to have an audit committee.

Equality, diversity and inclusion implications

There are no equality, diversity or inclusion implications to this report.

Environmental sustainability implications

There are no environmental sustainability implications to this report.

Audit Committees-in-Common Annual Report to the Group Board
Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the Group Board with a report of the work of the Committees in 2024/25, which includes a review of the Committees' terms of reference, an update on the draft forward plan of business for 2025/26, and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.2 With the Audit Committees of both Trusts having operated as Committees-in-Common in 2024/25, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

2.3 With the establishment of the Group Board arrangements from May 2023, and the Audit Committees from February 2024, the Committees-in-Common annual report are presented to the Group Board for review, which operate with delegated authority from each of the sovereign Trust Boards. Each of the two Audit Committees remains ultimately accountable to the sovereign Board of its respective Trust.

2.4 Reports to the Group Board were submitted in July 2024 but this year, we have been brought the timelines forward so that reporting can be made to the last Board meeting of the year in March. This allows for any changes to terms of reference to be implemented at the start of the new cycle in April.

3.0 Audit Committees-in-Common Annual Report

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

- the operation of each Committee as a Committees-in-Common in 2024/25
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Committees in 2024/25

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

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed but further consideration is needed. We expect the changes to be relatively minor but will be recommending that the Committee is renamed the Audit and Risk Committee to better describe its responsibilities.

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

5.0 Committee Forward Workplan 2025/26

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

5.2 The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year, and that it is co-ordinated with the Board and other committees. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Group Board understands the outcomes of the Committees' annual effectiveness survey, a summary of the Committee effectiveness review is provided as an appendix. Overall, respondents to the effectiveness review considered that the Committee was working well, but that improvements in relation to the timeliness of papers would be of benefit.

7.0 Recommendations

7.1 The Board is asked to:

a. Review the Audit Committees-in-Common annual report.
b. Note the update on the terms of reference and forward workplan for the Committee for 2025/26.

Audit Committees-in-Common Annual Report 2024/25

1 April 2024 – 28 February 2025

Contents

Audit Committee Annual Report 2024/25

1. Introduction

This report sets out a high-level overview of the work of the Audit Committees-in-Common in 2024/25. It provides an integrated report on the key matters considered by the Committees but highlights issues that were considered which related solely to either St George's or Epsom and St Helier. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

The Audit Committees have been established to ensure that that each Trust has in place effective mechanisms and systems of internal control and to provide the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee's purpose and duties are set out in its terms of reference as approved by the Trust Board on 7 July 2024. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Provide appropriate challenge and support whilst living the Trust's values.
- Seek assurance that the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2024 to February 2025), the following were members or regular attendees of the Audit Committee:

Other executive directors and senior leaders including the Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Director of Procurement, and the local counter fraud specialist also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews. In addition, internal auditors and external auditors attended each of the meetings.

Epsom and St Helier 's Audit Committee			
Name	Role	Designation	Period
Peter Kane	Member	Committee Chair, Non-Executive Director	1 April 2024 – 31 March 2025
Ann Beasley	Member	Non-Executive Director	1 April 2024 – 31 March 2025
Martin Kirke	Member	Non-Executive Director	1 April 2024 – 31 December 2024
Yin Jones	Member	Associate Non-Executive Director	1 April 2024 – 31 March 2025
Andrew Grimshaw	Attendee	Group Chief Finance Officer	1 April 2024 – 31 March 2025
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2024 – 31 March 2025
Lizzie Alabaster	Attendee	Site Chief Financial Officer	1 April 2024 – 31 March 2025

3.2 Committee meeting attendance

In 2024/25 the quorum for each meeting of the Committee was two members from ESTH and two members from SGUH. For avoidance of doubt only non-executive directors are members of the Committee.

The Committee held a total of 5 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committee were quorate.

Name	Role	Attendance
Peter Kane	Committee Chair	5/5
Ann Beasley	Member	4/5
Yin Jones	Member	2/5
Martin Kirke	Member	2/4
Claire Sunderland Hay	Member	2/2
Tim Wright	Member	4/5

In line with the requirements that the Committee should only comprise non-executive directors as members, the following individuals were not members of the Committee and did not form part of the quorum but regularly attended the Committee during 2023/24:

Name	Role	Attendance
Andrew Grimshaw	Group Chief Finance Officer	5/5
Stephen Jones	Group Chief Corporate Affairs Officer	5/5
George Harford	Site Chief Financial Officer	4/5

4. Committee activity and focus

4.1 External Audit and Year End

During the period the Committees received regular progress updates at each meeting from the external auditors, Grant Thornton LLP, on the preparations for and completion of the external audit of the Trust year-end financial statements, the annual report and the quality accounts during the period. The Committee supported the completion of a successful audit process of the 2023/24 financial year. The Committee reviewed the plans for conducting the 2024/25 audit and agreed to recommend to the Board the audit fee for the 2024/25 audit.

The Committees continued to hold private meetings with the auditors before the start of meetings during 2024/25. There were no issues of material concern raised during these meetings. This is a practice the Committee will continue in 2025/26.

It was agreed to carry out a tender process to appoint a common external auditor for the gesh group. Only one submission was received, from Grant Thornton. A group compromising of three SGUH governors and two members of the ESTH Audit Committee undertook the work of assessing the proposal. Although only one proposal was received, it was agreed to be robust and to meet the needs of both Trusts. A recommendation was therefore made to the SGUH Council of Governors, who are responsible for making the appointment for the Trust, and to the ESTH Audit Committee that Grant Thornton be appointed as auditors for the respective trusts. This recommendation was agreed.

4.2 Internal Audit

RSM UK are the appointed internal auditors for both St George's University Hospitals and Epsom and St Helier University Hospitals. The Committee approved the 2024/25 audit workplan.

At the time of writing this report, the internal auditors are working to deliver their workplan and have issued the following final reports:

Epsom and St Helier University Hospitals NHS Trust

- Complaints and Lessons Learnt – Partial Assurance
- Data Quality - Maternity – Reasonable Assurance.
- EPR Project – Advisory.
- PACS Project – Advisory
- Data Security and Protection Toolkit – Moderate Assurance.
- Cyber Assessment Framework – High Level Review – Partial Assurance

SGUH:

- Job Planning – Consultants – Partial Assurance.
- Transformation/CIP Programme – Partial Assurance
- Staff Safety / Violence and Aggression – Partial Assurance.
- Discharges – Reasonable Assurance
- Data Quality – VTE – Partial Assurance
- Transformation/CIP Programme – Reasonable Assurance

- Procurement – Reasonable Assurance.
- Data Security and Protection Toolkit – Moderate Assurance
- Pressure Ulcers – Partial Assurance

The Committee's scrutiny of the internal audit recommendation tracker, with the support of Executive leads, resulted in the outstanding recommendations being proactively progressed. The Committee will continue to monitor the implementation of the remaining outstanding recommendations over the coming year.

Given the appointment of a common internal auditor across the St George's, Epsom and St Helier University Hospitals and Health Group, the Committees have approved a framework to ensure internal audit reviews undertaken at one Trust within the Group are shared with the 'other' Trust, and that appropriate learning is taken from these reports across the Group. All internal audit reports are shared with members of both Trust's Audit Committees. The Committee also seeks assurance from management that reviews have been shared and have been reviewed by the 'other' Trust – with a short summary of actions taken or assurance as to why existing controls are considered effective and how areas of good practice have been disseminated.

The Committee have also approved the draft internal audit workplan for 2025/26, developed in accordance with the five-year internal audit strategy with input from the Group Executive. The workplan reflects the greater integration and alignment at Group level with the programme including audits which test Trust-specific controls; audits to be taken at both SGUH and ESTH as well as mandatory audits which would be undertaken at both Trusts. The plan also ensures a consistent release of final audit reviews over the next year.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditors, a core element of the Committee's focus in 2024/25 was monitoring corporate governance, compliance and systems for internal control both at trust and group level.

The Committee reviewed the newly developed Group-Wide Policy Framework and approved the Policy on the Development, Approval and Governance of Policy and Procedural Documents along with a new Group Wide Risk Management Framework at its meeting in February 2025, formally recommending its approval to the Group Board.

The Committees received quarterly reports on use of waivers, as well as providing oversight of the management of losses and special payments.

In addition, the Committee reviewed counter fraud arrangements and considered issues and themes raised by the Local Counter Fraud Specialist.

4.4 Trust Annual Report and Accounts

In June 2024, the separate Audit Committees of ESTH and SGUH endorsed the final draft annual report, annual accounts and quality accounts for 2023/24 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2023/24. The report was prepared in line with NHS Foundation Trust Annual Reporting Manual. The Annual Report and Accounts were received by the ESTH

Trust Board ESTH and the SGUH Trust Board on 25 June 2024 and were subsequently submitted to NHS England.

The Value for Money (VfM) Reports for 2023/24 highlighted the challenges facing the Trusts on financial sustainability. The report identified the criticality of achieving sufficient Cost Improvement (CIP) Plan savings to meet challenging CIP targets to meet achieve its forecast deficit plan. Over 2024/25 the Trust has engaged with its system partners in developing a financial recovery plan to return the system to a balanced position.

In February 2025, the Committee reviewed and agreed plans for the production of the 2024/25 annual report and accounts and also agreed both the accounting policies and the external audit plan and fees for 2024/25.

4.5 Cybersecurity

The Committees received regular reports on cybersecurity resilience and how well the group is prepared to respond to potential cybersecurity threats. The Committees continued to receive regular updates on the development of a cybersecurity dashboard, as well as updates on how digital and information teams are increasingly aligned and taking a Group-wide approach to matters of shared interest and concerns. The Committees also received updates on the work underlying the annual submission of its Data Security and Protection Toolkit.

5. Committee Effectiveness

The Audit Committees-in-Common conducted a review of its effectiveness in February 2025, which sought the views of both members and regular attendees. The full report is attached in Appendix 2. Overall, albeit on a low response rate, respondents to the survey scored the performance and effectiveness of the Committee as either extremely effective or very effective.

6. Committee Forward Plan and Terms of Reference

The forward plan will be kept under continuing review to ensure that the right items are being considered at the right time and frequency throughout the year. Risk deep dives will be incorporated into the cycle. The updated forward plan will be circulated to Committee members ahead of sign off at the next Committee meeting.

Proposals to amend the terms of reference are being reviewed, with no significant changes expected. It will, however, be proposed that the names of the Committees are changed to the Audit and Risk Committee to better reflect their work.

7. Conclusion

During 2024/25, the Committee worked hard to deliver its duties as set out in its terms of reference and to embed the Committees-in-Common approach. Its overall effectiveness is reflected in the Committee effectiveness review for 2024/25. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give a reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

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Audit Committee-in-Common

Committee Effectiveness Review 2024/25

Summary Report for Group Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

February 2025

1. Introduction
Purpose, context and recommendations

NHS
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University Hospitals and Health Group

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Audit Committees-in-Common in 2024/25. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2025/26.

Background and context
It is good governance practice for all Committees of the Board to hold annual effectiveness reviews and report on these to the Board. Responses were sought via an online survey tool. A full set of anonymised responses is at Appendix 2.

Summary
A total of 6 people responded to the effectiveness survey. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective during a challenging year and were continuing to develop and improve. The key issues highlighted were: the timeliness of papers and the need to review the membership after the term of office ended for some NEDs.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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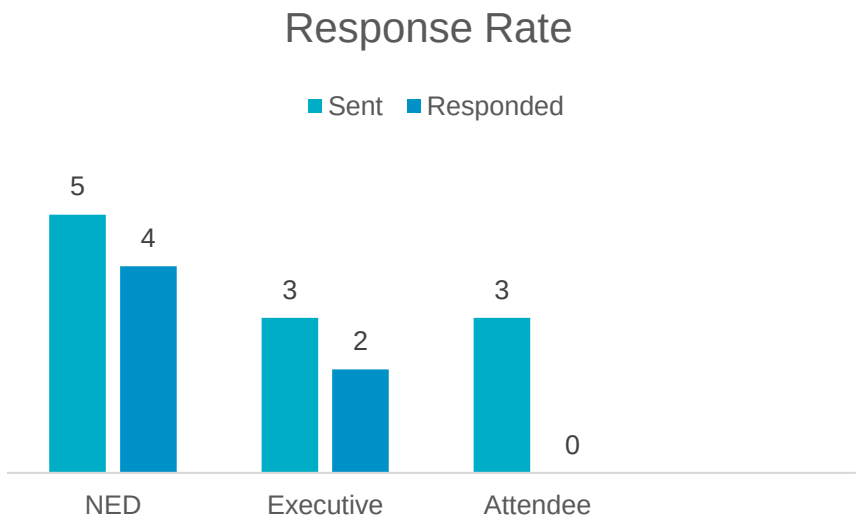
2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Committee
- Executive members of the Committee
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference

In total,10 people were invited to participate in the survey. Of these a total of 6 people provided responses, a response rate of 60%.



3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** 67% (4) strongly agreed and 343% (2) agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. Note: Minor revisions are to be proposed to the Terms of Reference as part of the Annual Report: change the name of the Committee to Audit and Risk Committee, remove reference to clinical audit and update working on Freedom to Speak Up.

- **Membership, skills and experience of Committee:** 67% (4) strongly agreed and 343% (2) agreed that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. One respondent commented that the membership will need to be reviewed with a number of NEDs having reached the end of their term of office recently.

- **Chairing of meetings:** 67% (4) strongly agreed and 343% (2) agreed that the meetings were effectively chaired. One respondent commented that Peter Kane was an effective Chair with an inclusive approach.

- **Discussions and assurance:** All respondents agreed or strongly agreed that there was sufficient time for issues to be explored in depth with the opportunity to explore them in depth. In addition, all respondents agree or strongly agreed that the Committee provide insight and appropriate constructive challenge on the matters within its remit and effectively escalate and cascade issues, risks and assurance to the relevant forums.

3. Key findings

Overall effectiveness

- **Quality and timeliness of papers:** Respondents had mixed views on the quality and timeliness of papers. 50% (3) agreed that papers are circulated in a timely way and provide clear, concise and sufficient information for the Committee to take informed decisions, fully sighted on the risks and implications - 17% (1) neither agreed nor disagreed and 33% disagreed. Two commented that papers were often late, with one adding that this made it difficult to review them appropriately. One respondent commented that the cover sheet was variable in the quality of the information.

- **Overall effectiveness of the Committee:** The majority at 84% (5) felt the Committee was very effective, with 16% (1) expressing that the Committee was extremely effective.

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4. Next steps

"So what" and "what now"?

The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25:

- **Terms of Reference:** That the name of the Committee be changed to the Audit and Risk Committee to better reflect its work, and the Group Head of Risk added as a possible invited attendee. In line with the other Committees these no longer make specific reference to an individual trust but are common to both ESTH and SGUH. Other minor amendments have been made for consistency or clarity.

- **Timeliness and quality of papers:** For authors to ensure greater consistency in the quality of the cover sheets. Papers should be issued in line with the agreed timeline with the aim being that all papers will be issued the Friday before the meeting, with advance approval needed from the Chair if there are exceptional reasons for a delay, in which case the paper must be circulated on the Tuesday.

- **Membership, skills and experience of Committee:** For the Committee membership to be reviewed to ensure that the recent departures of not negatively impacted on the skills available to the Committee

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Group Board

Meeting in Public on Thursday, 06 March 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 24 January 2025 (Estates & Facilities focus) and 21 February 2024 (IT focus). The key issues the Committee wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment Update**

   The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer (GCOFIE) including the news about the planning permission that had been granted for the renal building at SGUH; £3.1 million that had been awarded for LED lighting replacements across the group and a fire enforcement notice regarding fire safety deficiencies at St Helier Hospital issued by the London Fire Brigade.

2. **ESTH Asbestos Update**

   The Committees expressed concern over the non-compliant rating and requested an update about the costs associated with completing and ongoing annual review of the asbestos management survey.

3. **Committee Governance Review**

   The Committees reviewed the draft Infrastructure Committees-in-Common annual report and approved its submission to the Group Board for its meeting in March 2025. They also reviewed and approved the proposed changes to the Committees' terms of reference for recommendation to the Board and noted an update on the forward plan for the Committees for 2025/26.

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 January and February 2025.

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

The Committees noted the closure of the data warehouse and PACS risks and the upcoming new risk management process from March 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, 06 March 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 24 January 2025 and 21 February 2025 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 24 January 2025 and 21 February 2025, the Committees considered the following items of business:

January 2025 (Estates & Facilities focus)	February 2025 (IT focus)

• Group Chief Officer - Facilities, Infrastructure & Environment Update
• ESTH Asbestos Update
• SGUH Private Finance Initiative (PFI) Update
• Capital Programme Update
• Electronic Patients Record (EPR) Update
• Picture Archiving and Communication System (PACS) Update
	• Digital Strategy Development
	• Digital Delivery Update
	• Digital Risk Management Update
	• EPR Programme update
	• PACS Update
	• Committee Governance Review
	  ○ Infrastructure Committees-in-Common Annual Report 2024/25
	  ○ Proposed Committee Terms of Reference
	  ○ Committee Effectiveness Report 2024/25.

2.2 The Committees were quorate for both meetings.

3.0 Key issues for escalation to the Group Board

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

3.1 **Group Chief Officer - Facilities, Infrastructure & Environment Update**

The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer (GCOFIE) on the following key developments:

- Planning permission had been granted for the renal building at SGUH which was an important step in the overall process of receiving funding for this new facility.
- £3.1 million had been awarded for LED lighting replacements across the group with estimated energy savings of £1.5 - £2 million per year.
- Following GCOFIE's meeting with the London Fire Brigade (LFB) on 16 January 2025, it was anticipated that LFB would issue a fire enforcement notice regarding fire safety deficiencies at St Helier Hospital.

The Committees noted the importance of a comprehensive estate strategy and GCOFIE explained that this would depend on securing funding for its production. The level of assurance was discussed and agreed that "reasonable assurance" for GESH infrastructure as a whole was appropriate given the circumstances.

3.2 ESTH Asbestos Update

The Committees expressed concern over the non-compliant rating and asked how long it would take to complete the asbestos management survey. Fortunately, the team would not be starting from scratch as a lot of the information was already available. The Committee requested an update about the costs associated with completing and ongoing annual review of the asbestos management survey.

3.3 EPR Programme update

The Committees welcomed the fact that the EPR programme was progressing well across all of the workstreams. The technical aspects of the programme were stabilised, and the programme switched 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 PACS Update

The Committees noted that, whilst concerns remained about the system wide PACS project, the rectification process was underway, and the final meeting of the project group at the end of January 2025 resulted in recommendations on the way forward. The Committees requested a lessons learned report once the agreement with Sectra (the provider) was finalised so that avoidable mistakes were not repeated in the future.

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 SGUH Private Finance Initiative (PFI) Update

The Committees noted that the PFI Contract for the Atkinson Morley Wing at SGUH started in the year 2000 and that the 10-year countdown to the repatriation of the building was approaching. The multi-faceted nature of repatriation was discussed and the need for specific resources to manage this process emphasised. Next steps include establishing a dedicated PFI management team.

4.3 Digital Strategy Development

The Committees received an update on the Digital Strategy development and noted the progress. Next steps include organising a series of internal and stakeholder workshops scheduled for February and March 2025. It was noted that the digital strategy aligned with the South West (SW) London strategy, particularly in digital information systems and ensuring uniform standards and system integration. The Committees would receive specifics on the SW strategy versus their organisational-centric approach at the next meeting.

4.3 **Digital Delivery Update**

The Committees noted an update on business-as-usual activities, including the significant Maternity project that went live recently. It was noted that, despite funding constraints, the project launch, which addressed CQC identified issues and reduced risks to patients, was a success.

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 challenges of People risks, particularly in recruitment and retention and the Committees welcomed the fact that there had been some progress in these areas. The Committees noted the closure of the data warehouse and PACS risks and the upcoming new risk management process from March 2025.

5.3 **Committee Governance Review**

The Committees reviewed the draft Infrastructure Committees-in-Common annual report and approved its submission to the Group Board for its meeting in March 2025. They also reviewed and approved the proposed changes to the Committees' terms of reference for recommendation to the Board and noted an update on the forward plan for the Committees for 2025/26.

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 January and February 2025.

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	2.5	
Report Title	**Infrastructure Committees-in-Common Annual Report to the Group Board**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer Mark Bagnall, Group Chief Officer, Facilities, Infrastructure and Environment	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	Infrastructure Committees-in-Common	14 February 2025
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the Infrastructure Committees-in-Common report to the Group Board, describes the changes proposed to the Committees' current terms of reference, and updates on the proposed forward plan of business for the Committees in 2025/26.

The minor changes proposed to the Committees' terms of reference relate to making specific reference to fire safety, removing items that are within the purview of other committees and reducing repetition.

The forward plan is undergoing significant revision to ensure that we are taking the right items at the right time and frequency throughout the year, most notably to capture the new structure of having alternating meetings focusing on estates and IT. A draft of the revised plan has been developed with the Group Chief Officer, Facilities, Infrastructure and Estates but requires further refinement. We plan to share the updated forward plan with Committee members for input via email with a view to ratifying this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

Action required by Group Board

The Board is asked to

a. Review the Infrastructure Committees-in-Common annual report.
b. Review and approve the proposed changes to the Committee terms of reference.

c. Note the update on the forward workplan for the Committee for 2025/26.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Infrastructure Committees-in-Common Annual Report 2024/25
Appendix 2	Committee Effectiveness Report 2024/25
Appendix 3	Proposed Committee Terms of Reference

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

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

Legal and / or Regulatory implications

There is no legal or regulatory requirement for there to be an Infrastructure Committee, but it is good practice to have such a committee in place to oversee and provide assurance to the Board on facilities, infrastructure and environment matters.

Equality, diversity and inclusion implications

Environmental sustainability implications

The role of the Committee in environmental sustainability and the related elements of the Group strategy are set out in the terms of reference.

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

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the Group Board with a report of the work of the Committees in 2024/25, which includes a review of the Committees' terms of reference, an update on the draft forward plan of business for 2025/26, and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.2 With the Infrastructure Committees of both Trusts having operated as Committees-in-Common in 2024/25, capturing the work of the Committees and how they have provided assurance to their respective Boards is particularly important in supporting effective oversight of the Group governance arrangements.

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

2.4 Reports to the Group Board were submitted in May 2024 but this year, we have been brought the timelines forward so that reporting can be made to the last Board meeting of the year in March. This allows for any changes to terms of reference to be implemented at the start of the new cycle in April.

3.0 Infrastructure Committees-in-Common Annual Report

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

- the operation of each Committee as a Committees-in-Common in 2024/25
- the purpose and duties of Committees
- membership of the Committees and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Committees in 2024/25

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

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Committee have been reviewed.

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

- To emphasise the assurance role of the Committee in relation to fire safety.
- Removal of clauses relating to non emergency patient transport, which is reviewed by the Quality Committee, and the policy approval process which is overseen by the Audit Committee.
- To tidy up, simplify and condense the terms of reference, removing unnecessary repetition.

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

5.0 Committee Forward Workplan 2025/26

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

5.2 The forward plan has undergone significant revision to ensure that we are taking the right items at the right time and frequency throughout the year. A draft of the revised plan has been developed with the Group Chief Officer - Facilities, Infrastructure and Environment but requires further refinement following discussion with relevant Executive Leads. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

5.3 The proposal is for the Committee to continue to meet monthly in 2025/26 – alternating between an Estates and IT focus.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Group Board understands the outcomes of the Committees' annual effectiveness survey, a summary of the Committee effectiveness review is provided as an appendix. Overall, respondents to the effectiveness review considered that the Committee was working reasonably well, but that improvements in relation to the timeliness of papers and the link between BYFH and the current estates issues in 2025/26.

7.0 Recommendations

7.1 The Board is asked to:

a. Review the draft Infrastructure Committees-in-Common annual report.
b. Review and approve the proposed changes to the Committee terms of reference.
c. Note the update on the forward workplan for the Committee for 2025/26.

Infrastructure Committees-in-Common

Annual Report 2024/25

1 April 2024 – 31 January 2025

Contents

Infrastructure Committees-in-Common Annual Report 2023/24

1. Introduction

In February 2022, Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Foundation Trust formed a hospital group, the St George's, Epsom and St Helier University Hospitals and Health Group. Since April 2022 a number of Board Committees have operated as Committees-in-Common across the Group. This includes the People Committees, Quality Committees and Finance Committees of the two Trusts. The Infrastructure Committees-in-Common had some meetings in 2023/24 with a full meeting cycle in 2024/25.

During 2024/25, the Infrastructure Committees-in-Common reviewed its ways of working and agreed that to ensure its two main areas of responsibility received the appropriate level of focus, and that the right attendees were present, meetings would alternate between an estates and an IT focus – this change was introduced in October 2024. There has also been a change of executive lead with Mark Bagnall replacing the interim Director, Andrew Asbury in October 2024.

This report sets out a high level overview of the work of the Infrastructure Committees-in-Common in 2024/25. The purpose of this report is not to provide a detailed account of all matters considered by the Committees but to give an overview of how the Committees have discharged their responsibilities as set out in their terms of reference over the past year.

2. Committee purpose and duties

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

2.1 Purpose

The purpose of the Committee is to provide assurance to the Board on the safe and effective operation of the Trust's estates, facilities, information, digital and technology infrastructure, systems, processes and controls including:

- Overseeing and providing assurance to the Board on the implementation of the Group Strategy in relation to facilities, infrastructure and environment, specifically the Group strategic objectives of environmental sustainability and buildings that fit for 21st century healthcare.
- delivering on the commitments in the Group strategy in respect of estates, facilities and information technology.
- maintaining the safety of the Trust's estates and facilities for patients, visitors and staff.
- overseeing action to deliver against the Trust's commitments in relation to environmental sustainability.

2.2 Duties

The duties of the Committee are set out in the terms of reference at appendix 2. This also includes the proposed revisions for 2025/26.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2024 to January 2025), the following were members or regular attendees of the Infrastructure Committees-in-Common:

St George's Infrastructure Committee			
Name	**Role**	**Designation**	**Period**
Ann Beasley	Member	Committee Chair, Non-Executive Director	
Andrew Murray	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Tim Wright	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Peter Kane	Member	Non-Executive Director	1 April 2024 – 31 January 2025
Ian Robinson	Member	Group Chief Infrastructure, Facilities and Environment Officer	1 April 2024 – 31 August 2024
Mark Bagnall	Member	Group Chief Officer - Facilities, Infrastructure and Environment	1 September 2024 – 31 January 2025
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
Kate Slemeck	Member	Managing Director – St George's	1 April 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024

Epsom & St Helier Infrastructure Committee			
Name	**Role**	**Designation**	**Period**
Andrew Murray	Member	Non-Executive Director	1 February 2024 – 31 March 2024
Phil Wilbraham	Member	Associate Non-Executive Director	1 April 2023 – 31 March 2024
Peter Kane	Member	Non-Executive Director	1 April 2024 – 31 January 2025
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2023 – 31 March 2024
Ian Robinson	Member	Group Chief Infrastructure, Facilities and Environment Officer	1 April 2024 – 31 August 2024
Mark Bagnall	Member	Group Chief Officer, Facilities, Infrastructure and Environment	1 September 2024 – 31 January 2025
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Arlene Wellman	Member	Group Chief Nursing Officer	1 April 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024

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

3.2 Committee meeting attendance

Under the Committees-in-Common arrangements, the Infrastructure Committee of each Trust was required to be quorate. The quorum for each Infrastructure Committee was a

minimum of four Committee members, including two Non-Executive Directors and two Executive Directors.

The Committee held a total of 7 meetings, plus 2 EPR briefing sessions during the reporting period. By the end of the 2024/25 meeting cycle 2 further meetings would have been held. The attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committees-in-Common were quorate for both Trusts.

Attendance			
Name	Role	Trust	Attendance
Ann Beasley	Committee Chair	SGUH	7/9
Peter Kane	Member	Both	8/9
Andrew Murray	Member	Both*	6/9
Phil Wilbraham	Member	ESTH	7/9
Tim Wright	Member	SGUH	6/9
James Blythe	Member	Both	8/9
Andrew Grimshaw	Member	Both	9/9
Kate Slemeck	Member	SGUH	7/9
Arlene Wellman	Member	Both	6/9
Ian Robinson	Member	Both	2/4
Mark Bagnall	Member	Both	3/5
Stephen Jones	Attendee	Both	4/9

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

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

SGUH Governors observing		
Name	Role	Attendance
John Hallmark	Public Governor, Wandsworth	2/9
Chelliah Lohendran	Public Governor, Merton	2/9
Alfredo Benedicto	Appointed Governor, Healthwatch Merton	1/9

4. Committee activity and focus

4.1 Group Estates Strategy

The timeline for the production of a group estates strategy was modified with launch now anticipated in Spring 2025. The strategy, which is being developed by the GCO-FIE in consultation with key stakeholders, will incorporate the findings of the various assurance reports, the 6 facet reports and capital plans to support the group strategy of providing buildings fit for 21st century healthcare and an estate that is environmentally sustainable.

The new renal unit at SGUH received planning permission in January 2025 and the new ICU building at SGUH making progress. These projects will continue to be monitored during 2025/26.

The maintenance backlog across the groups is similar to that of trusts of a similar size and reflects the national under investment in capital projects over many years. There are significant concerns over some areas of St Helier which are in disrepair and at risk of failure. The estates team are working with site leadership on mitigations and options to relocate some services if needed. An initial discussion on this was held at the December 2024 Board Development session. The impact of the delay to the BYFH project until at least 2032 on the use of the current estate is being worked through and the Committee will continue to seek

assurance on site safety and how funding could be secured to address the maintenance backlog and key capital projects.

The backlog of maintenance is of real concern, as were reports that not all training within the team was up to date. The Committee were assured that the new GCO-FIE is addressing the latter at pace.

4.2 Electronic Patient Records

The Committee spent significant time reviewing the project for a shared Electronic Patient Record (EPR) programme to create a common EPR across gesh on a shared domain. With the work focused on ESTH, the SRO for the project is Alex Shaw, COO at ESTH. The Go-live date in May 2025 was brought forward by one week to 9 May 2025 to avoid potential capacity issues caused by the May half-term holidays and late May bank holiday.

A number of reports were commissioned to provide assurance on the governance and progress of the programme – two of these were required to release the remaining tranches of funding from NHSE, which was approved. Action points from these reviews have been incorporated into the project plan and the Committee have reasonable assurance that it will be delivered on time.

Regular, detailed reports have been provided to the Board on the project.

4.3 Digital Strategy and Digital Delivery

Demand for new projects has put pressure on delivery of BAU (maintenance, incident management and optimisation) which are necessary for the proper daily function of the Trusts. The Committee sought, and received, assurance on cyber security measures, noting that gesh worked closely with the SWL system, and had been part of the national response to support trusts that had been impacted by a cyber attack.

The Committee discussed reports on the digital delivery programme and the early planning for 2025/26 that sought to address the needs off site leadership and divisions. The challenges of aligning with wider systems was highlighted due to different timelines and objectives of potential partner organisations.

Securing funding for digital innovations has been noted as key and the finance team are supporting with identifying opportunities for capital support, either directly for the group or as part of South West London.

The Committee have sought assurance about how digital risks are aligned across the group and captured within the group corporate risk register. A report on this is due in March 2025.

4.4 Group Green Plan

The gesh Group Green Plan Strategy was approved by the Group Board in early July 2024 following consultation with site leadership teams and discussion at the Group Board development session, it was discussed again at the Board Development Session in December 2024. The Strategy was formally launched across the group in September 2024.

The Committee supported the clarification of priorities for 2024/25 which aligned the Green Plan with other corporate functions and added reporting on the financial benefits and challenges of the Plan. An 18-month milestone plan and a governance and reporting structure is now in place and the Committee emphasised the importance of identifying available funding before setting expectations. The Committee requested the development of a dashboard including agreed KPIs to support the reporting of future progress.

Other works continue across gesh on projects delivering carbon reduction schemes at both ESTH and St George's.

4.5 SWL Picture Archive and Communication system (PACs) Update.

The Committee has kept the SWL Picture Archiving Communication Systems (PACs) project under review. The plan faced significant challenges with the failure of the new supplier to deliver an acceptable product on time. Some progress was being made towards the end of the calendar year, but concerns remain about the project - a report is due to the Committee in February 2025.

4.6 Reporting

During the year the Committee received assurance reports relating to:

- Fire Safety: fire safety assessments were reported on during the year with the new GCO-FIE working to bring a common approach. A plan has been developed to address actions required following an inspection by the London Fire Brigade at St Helier to bring the site up to the latest standards. Some of these matters will be addressed as part of normal maintenance or capital projects but some will take many years to be resolved. Assurance was received by the Committee, and the Board, that the site remains safe for patients, visitors and staff with appropriate mitigations in place.
- Water Hygiene: water hygiene remains a concern, with disparity across the trusts on how this is approached. The Committee received assurance from the GCO-FIE that a new group wide water hygiene group was being established which would bring commonality of approach and improve standards.
- Asbestos: the Committee were concerned at the non-compliant rating for ESTH in asbestos management but received assurance that this related to the lack of a policy rather than practice. Effective and timely policy updates and record keeping are a key part of the estates assurance and governance process that will be kept under review by the Committee in 2025/26.
- Other annual reports received included: Medical Physics, Premises Assurance Model, Violence and Aggression Against Staff and the 6 facet survey.

4.7 General

Throughout the year, the Infrastructure Committees-in-Common have reviewed the facilities, infrastructure and environment related risks on the Corporate Risk Registers and the strategic risks relating to people on the new Group Board Assurance Framework. In January 2025, the Committees reviewed the Group Board Assurance Framework risks in relation to people and recommended risk scores and assurance ratings for each of the three risks within its remit.

5. Committee Effectiveness

The Infrastrucutre Committees-in-Common conducted a review of its effectiveness towards the end of the reporting period, which sought the views of both members and regular attendees. The full report is attached in Appendix 1. A total of 9 people responded to the effectiveness survey. Overall, the results of the effectiveness review were broadly positive. The main issues highlighted in the effectiveness review are set out below:

Terms of Reference and forward work plan: The majority agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. Comments received were that having alternate meetings focused on IT and Estates had led to improvement. One respondent commented that further review of the terms of reference would be needed in light of the BYFH decision.

Membership, skills and experience of Committee: The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. However, one respondent noted that the NED membership may need review as NEDs reached the end of their term of office.

Chairing of meetings: All respondents either agreed, or strongly agreed, that the meetings were chaired effectively.

Discussions and assurance: All respondents agreed that the Committee provides insight and appropriate constructive challenge on the matters within its remit. With matters escalated or cascade to the relevant forums including appropriate risk and assurance matters being passed to the Group Board.

Timeliness and quality of papers: The response was somewhat mixed, with the majority agreeing papers are circulated in a timely way provide clear, concise and sufficient information for the Committee to take informed decisions, but with the remaining respondents being neutral or disagreeing. It was noted that some papers were late, and although there were signs that this had improved recently, having insufficient time to review papers made it more difficult to engage. The new overview report from the Group Chief Officer, Facilities, Infrastructure and Environment was noted as a helpful addition.

Overall effectiveness of the Committee: The majority at 67% (6) felt the Committee was very effective, with 22% (2) expressing that the Committee was somewhat effective and 11% (1) thought the Committee was extremely effective. One respondent felt that as a new Committee there was more to be discussed given the estates challenges at both trusts. Another respondent suggested that there was more to be done on the connectivity between BYFH and the current estate.

6. Committee Forward Plan and Terms of Reference

An updated terms of reference for the Committees is set out at Appendix 2. The minor changes proposed to the Committees' terms of reference relate to making specific reference to fire safety, removing items that are within the purview of other committees and reducing repetition.

The forward plan is undergoing revision to ensure that we are taking the right items at the right time and frequency throughout the year, most notably to capture the new structure of having alternating meetings focusing on estates and IT. A draft of the revised plan has been developed with the GCO-FIE but requires further refinement. We plan to share the updated forward plan with Committee members for input via email with a view to ratify this at the next Infrastructure Committee meeting. We will clearly set out in our communication with the Committee the rationale for our revised plan and make it clear where changes have been made.

7. Conclusion

In the year 2024/25 the Infrastructure Committees began to establish a new rhythm for meetings to alternate the focus between estates and IT, which has had a positive response, although there is more to be done to ensure the correct flow of information, and that the Committee has an opportunity to review relevant reports before submission to the Board. The Committees gained a new Group Chief Officer - Facilities, Infrastructure and Environment (GCO-FIE), during the course of the year, which is supporting the forward planning. The Committees have worked hard to deliver against their responsibilities as set out in their terms of reference. The Committee effectiveness review demonstrated that the Committees were broadly effective and were continuing to develop and improve.

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Infrastructure Committee-in-Comm

Committee Effectiveness Review 2024/25

Summary Report for Group Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

February 2025

1. Introduction
Purpose, context and recommendations

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

Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Infrastructure Committees-in-Common (ICiC) in 2024/25. As a new Committee, the ICiC did not take part in this process in 2023/24. The report highlights the key themes that emerged and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2025/26.

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

Summary
A total of 9 people responded to the effectiveness survey. Overall, the results of the effectiveness review were generally positive while highlighting areas for further focus in the year ahead. The Committee effectiveness review demonstrated that the Committees were reasonably effective. The key issues highlighted were: the improvement seen since the decision was made to alternate meetings between an IT and Estates focus; that the lateness of papers make it difficult to engage.

Recommendation
The Committee is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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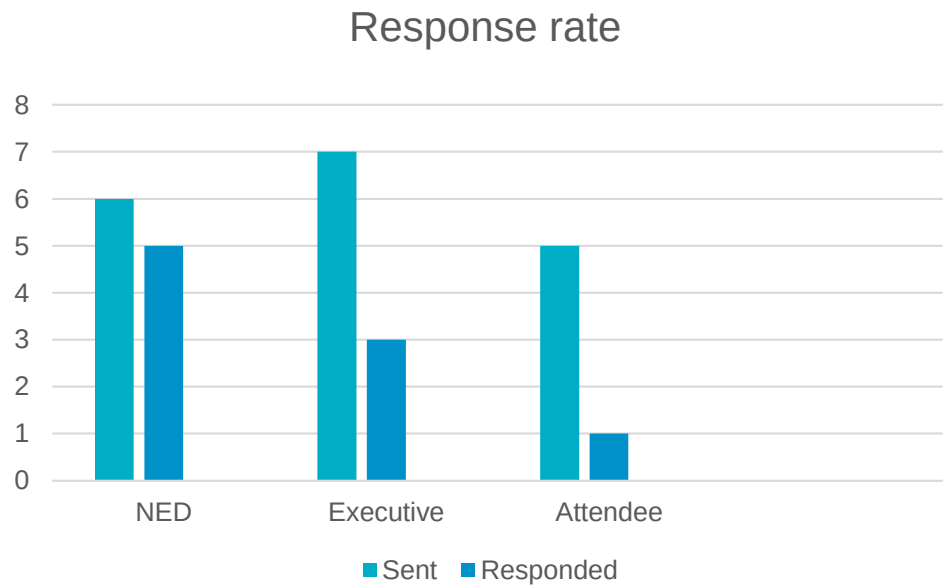
2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Committee
- Executive members of the Committee
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Committee's terms of reference

In total, 18 people were invited to participate in the survey. Of these a total of 9 engaged with and provided responses to the survey, a response rate of 50%:



3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** The majority agreed that the terms of reference were fit for purpose and that the forward plan adequately reflected the programme of work. Comments received were that having alternate meetings focused on IT and Estates had led to improvement. One respondent commented that further review of the terms of reference would be needed in light of the BYFH decision.

- **Membership, skills and experience of Committee:** The respondents felt that the Committee had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. However, one respondent noted that the NED membership may need review as NEDs reached the end of their term of office.

- **Chairing of meetings:** All respondents either agreed, or strongly agreed, that the meetings were chaired effectively.

- **Discussions and assurance:** All respondents agreed that the Committee provides insight and appropriate constructive challenge on the matters within its remit. With matters escalated or cascade to the relevant forums including appropriate risk and assurance matters being passed to the Group Board.

3. Key findings

Overall effectiveness

- **Timeliness and quality of papers:** The response was somewhat mixed, with the majority agreeing papers are circulated in a timely way provide clear, concise and sufficient information for the Committee to take informed decisions, but with the remaining respondents being neutral or disagreeing. It was noted that some papers were late, and although there were signs that this had improved recently, having insufficient time to review papers made it more difficult to engage. The new overview report from the Group Chief Officer, Facilities, Infrastructure and Environment was noted as a helpful addition.

- **Overall effectiveness of the Committee:** The majority at 67% (6) felt the Committee was very effective, with 22% (2) expressing that the Committee was somewhat effective and 11% (1) thought the Committee was extremely effective. One respondent felt that as a new Committee there was more to be discussed given the estates challenges at both trusts. Another respondent suggested that there was more to be done on the connectivity between BYFH and the current estate.

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4. Next steps

"So what" and "what now"?

The change to the alternate IT and Estates focus meetings has been positive and so no change to the frequency or split of meetings is recommended However, timeliness of papers and interconnectivity between BYFH, the current estate and the work of this Committee should be captured in the forward planner at an appropriate time . The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25:

- **Forward plan:** Review the forward plan, which focuses on fewer core issues in depth, with the frequency of retained items revised. Forward plan attached to each circulation of papers to ensure everyone know what is due when.
- **Timeliness of papers:** Reinforce expectation that papers are circulated on the Friday before the Committee, with any late papers agreed in advance with the Committee chairs. Introduce a hard cut off deadline of 48 hours before the meeting for any agreed late papers.
- **Committee membership:** That the skill mix of NEDs be kept under review as they reach the end of their term of office.
- **Terms of Reference:** The terms of reference have been refreshed for clarity.

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Infrastructure Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

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

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

3. Purpose

The purpose of the Committee is to provide assurance to the Board on the safe and effective operation of the Trust’s estates, facilities, information, digital and technology infrastructure, systems, processes and controls by seeking assurance in relation to:

- delivering on the commitments in the Group strategy in respect of estates, facilities and information technology.
- maintaining the safety of the Trust’s estates and facilities for patients, visitors and staff, in particular through reviewing the Premises Assurance Model.
- overseeing action to deliver against the Trust’s commitments in relation to environmental sustainability.
- maintaining the highest standards of health and safety and ensuring the Trust is compliance with all relevant statutory and regulatory requirements.
- ensuring appropriate governance arrangements are in place in relation to infrastructure and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

4. Duties

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

Estates and Facilities

- Oversee and provide assurance to the Board on the implementation of the Group Strategy in relation to estates and facilities, specifically the Group strategic objective of 'affordable services fit for the future', and associated strategic initiatives and corporate enablers:
  - Buildings fit for twenty-first century healthcare
  - Environmental sustainability
- Oversee the development of Group-wide relevant strategies in relation to estates and facilities that support the new Group Strategy and monitor progress in the implementation of these, in the context of the local Integrated Care System(s) and financial and operational plans.
- Seek assurance in relation to the safe operation and performance of the Trust's estates and facilities, including security management of the Trust's assets and estates.
- Review the Trust's Premises Assurance Model to ensure it provides an accurate and comprehensive assessment of the safety and effectiveness of the Trust's estates and facilities.
- Undertake a programme of proactive deep dives in agreed areas within the Premises Assurance Model to ensure the assurances provided are appropriately robust, and undertake further deep dives on areas where the Committee feels the need for further assurance.
- Oversee and seek assurance in relation to land and property appraisal by reviewing the outcomes of six-facet surveys and any associated action plans.
- Review and agree the approach to capital prioritisation for estates and facilities issues, recognising the ongoing role of the Finance Committee in respect of overall oversight of the capital programme in in relation to approving individual business cases.
- Review and seek assurance in relation to the coordination of estates maintenance with emerging capital projects and the Epsom and St Helier Building Your Future Hospitals Programme.
- Review the Trust's Green Plan and actions to deliver against agreed actions and priorities in relation to environmental sustainability.
- Review and seek assurance in relation to the Trust's arrangements for the safe, effective and efficient provision of non-emergency patient transport.
- Review risks on the Corporate Risk Register and Group Board Assurance Framework in relation to estates and facilities and seek assurance that these are being appropriately managed.

Health and Safety

- Seek assurance that the Trust has in place the systems, processes and controls necessary to ensure compliance with the Health and Safety at Work Act 1974 and all other relevant health and safety legislation and regulations, including – but not limited to – fire safety, via regular reports from the lead for health and safety.
- ~~Receiving regular reports from the Associate Director and Executive lead for Health and Safety.~~
- Review the outcome of inspections by the Health and Safety Executive and scrutinise any associated action plans developed by the Trust.
- Oversee and seek assurance in relation to the Trust's performance in relation to the NHS Violence Prevention and Reduction Standard, coordinating oversight with the work of the People Committee where appropriate.
- Review risks in relation to health and safety and seek assurance that these are being appropriately managed.

Information, digital and technology

- Oversee and provide assurance to the Board on the implementation of the Group Strategy in relation to information technology, specifically the Group strategic objective of 'affordable services fit for the future', and associated strategic initiatives and corporate enablers, specifically the development of an electronic patient record system across the Group.
- Oversee the development of Group-wide relevant strategies in relation to information technology that support the new Group Strategy and monitor progress in the implementation of these, in the context of the local Integrated Care System(s) and financial and operational plans.
- Seek assurance in relation to the safe, secure and effective operation and performance of the Trust's information technology infrastructure, systems and processes through review of internal processes and controls as well as mandated reviews such as the Digital Security and Protection Toolkit.
- Receive assurance on the operation of the Trust's information management and reporting environment to ensure it is appropriate and fit for purpose.
- Undertake a programme of risk-based, proactive deep dives in relation to information technology, and undertake further deep dives on areas where the Committee feels the need for further assurance.
- Review risks on the Corporate Risk Register and Group Board Assurance Framework in relation to information technology and seek assurance that these are being appropriately managed.

General

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

Commented [ED1]: Proposed for consolidation.

- ~~Obtaining assurance on the strategic risks to delivery of the strategic objectives in relation to estates, facilities, patient transport, health and safety, information~~
- ~~Ensuring there is a system in place to review and approve relevant policies and procedures that fall within the remit of the Committee.~~
- Reviewing any Trust strategies prior to approval by the Board (if required) and monitor their implementation and progress.

Commented [ED2]: Repetition - proposed for removal.

Commented [ED3]: Proposed for removal as this is within the remit of the Audit Committee.

5. Membership and Attendance

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

The Group Chief Officer, Facilities, Infrastructure and Environment ~~Infrastructure, Facilities and Environment Officer~~ is the executive lead for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief Officer, Facilities, Infrastructure and Environment ~~Infrastructure, Facilities and Environment Officer~~
- Group Chief Finance Officer
- Group Chief Nursing Officer and Director of Infection Prevention and Control
- Managing Director(s)

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

- Site Director of Estates and Facilities
- Group Head of Health and Safety / Assistant Director of Health and Safety
- Group Chief Digital Officer
- Chief Information Officer / Director of ICT
- Group Chief Corporate Affairs Officer

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

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

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

6. Quorum

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

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

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

7. Accountability and Reporting Arrangements

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

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

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

8. Meeting Format and Frequency

The Committee will meet ~~bi-monthly~~every month, alternating between IT and Estate & Facilities focused meeting (~~six~~ twelve times a year) and ahead of Group Board meetings so that a report to the Group Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances.

9. Declarations of Interest

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

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

10. Meeting Arrangements and Secretariat

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

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

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

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

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

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

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

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

Document Control

Profile	
Document name	Infrastructure Committee Terms of Reference
Version	1.2~~1~~
Executive Sponsor	Group Chief Officer ~~Infrastructure,~~ Facilities, Infrastructure - and Environment Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	TBC
Date of Trust Board approval	TBC
Date for next review	TBC

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	2.6	
Report Title	**BYFH Programme Board Annual Report to the Group Board**	
Executive Lead(s)	James Blythe, Managing Director - Epsom and St Helier Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs Barbara Mathieson, Corporate Governance Officer	
Previously considered by	BYFH Programme Board	21 February 2025
Purpose	**For Assurance**	

Executive Summary

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

This report introduces and appends the BYFH Programme Board Annual report and the annual effectiveness review.

At this time, we are not proposing that the terms of reference or the workplan for 2025/26 be reviewed and proposed. This will be done once the level of activity within the project for the year ahead is clearly established which will then inform any work needed by the Programme Board.

Action required by ESTH BYFH Programme Board

The Board is asked to:

a. Review the draft BYFH Programme Board annual report and approve its submission to the Group Board for its meeting in March 2025.
b. Note that that the forward workplan for the Committee for 2025/26 and terms of reference will be reviewed in due course.

Committee Assurance

Committee	ESTH BYFH Programme Board
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name

Appendix 1	BYFH Programme Board Annual Report 2024/25
Appendix 2	Committee Effectiveness Report 2024/25
Appendix 3	n/a

Implications

Group Strategic Objectives

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

Risks

n/a

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications relating to this report.

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

ESTH BYFH Programme Board Annual Report
Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This paper provides the ESTH Board with an annual report of the work of the BYFH Programme Board work in 2024/25 and a summary of the outcomes of the Committees' recent effectiveness review.

2.0 Background

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

2.0 ESTH BYFH Programme Board Annual Report

3.1 The BYFH Programme Board Annual Report is set out at Appendix 1. The draft report sets out:

- the operation the Programme Board in 2024/25
- the purpose of the Programme Board
- membership and attendance by named regular attendees
- attendance record for members and regular attendees in 2024/25
- key areas of activity and focus by the Programme Board in 2024/25

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the Programme Board have been reviewed but no changes are proposed until the activity for the project during 2025/26, and the role the Programme Board would have in this are defined.

5.0 Committee Forward Workplan 2025/26

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

5.2 The workplan for the Programme Board will be proposed once the activity for the project during 2025/26, and the role the Programme Board would have in this are defined.

6.0 Committee effectiveness Review 2024/25

6.1 In order that the Board understands the outcomes of the annual effectiveness survey, the summary of review is attached as an appendix to the Programme Board Annual Report. Overall, respondents to the effectiveness review considered that the Programme Board was working well. The lateness of some papers was commented on, but the reasons for this understood. The strong chairing and input from attendees were also noted by survey respondents.

7.0 Recommendations

7.1 The Group Board is asked to:

a. Review the ESTH BYFH Programme Board annual report and effectiveness review
b. Note that that the forward workplan for the Programme Board for 2025/26 and terms of reference will be reviewed in due course.

Building Your Future Hospitals Board

Annual Report 2024/25

1 April 2024 – 28 February 2025

Contents

Building Your Future Hospitals Programme Board 2024/25

1. Introduction

The Building Your Future Hospital Programme Board, originally known as the Improving Healthcare Together (IHT) Programme Board, was established in April 2020.

This Annual Report outlines activity of the BYFH Programme Board for the period 1 April 2024 to 28 February 2025.

2. Committee purpose and duties

2.1 Purpose

The role of the BYFH Programme Board is to set the direction and framework for the Building Your Future Hospital (BYFH) programme, oversee implementation of the programme, and provide assurance on this to the Board. It will do this by overseeing the BYFH Delivery Group and providing assurance in relation to Executive decision making to the programme. As appropriate, it will draw the attention of the Board to relevant issues and make recommendations to the Board around key decision making.

The BYFH Programme Board is a formal Committee of the ESTH Trust Board of Directors.

3. Membership and attendance

3.1 Members and attendees

The membership comprises:

- Three Non-Executive Directors including the Chair of the meeting (although all NEDs are eligible to attend meetings)
- BYFH Programme Senior Responsible Officer (the Chief Executive)
- Group Chief Finance Officer
- Managing Director for Epsom & St Helier
- BYFH Programme Director & ESTH Director of Estates, Facilities and Capital Projects
- ESTH Chief Medical Officer
- A representative from NHS England and NHS Improvement *(NHSE/I continues to have a joint regulatory role with DHSC (of which New Hospital Programme is part) in respect of review, assurance and recommendations)*
- Two representatives from SWL Integrated Care Board
- A representative from the National Hospital Programme (NHP)

3.2 Committee meeting attendance

The quorum for each BYFH Board meeting is as follows:

- At least two Non-Executive Directors are required to be in attendance (including Associate Non-Executive Directors), of whom one must be the Chair of the Finance Committee
- Group Chief Finance Officer
- BYFH Senior Responsible Officer- ESTH Managing Director
- BYFH Programme Director

The Board held a total of 9 during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below.

BYFH Board			
Name	**Role**	**Designation**	**Period**
Phil Wilbraham	Member	Board Chair, Non Executive Director	1 April 2024 – 28 February 2025
Ann Beasley	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Peter Kane	Member	Non-Executive Director	1 April 2024 – 28 February 2025
Martin Kirke	Member	Non-Executive Director	1 April 2024 – 31 December 2024
Derek Macallan	Member	Non-Executive Director	1 April 2024 – 31 December 2024
Andrew Grimshaw	Member	Group Chief Finance Officer	1 April 2024 – 28 February 2025
James Blythe	Member	Managing Director – Epsom & St Helier	1 April 2024 – 28 February 2025
Rebecca Suckling	Member	Site Chief Medical Officer	1 April 2024 – 28 February 2025
Tim Wilkins	Member	BYFH Programme Director	1 April 2024 – 28 February 2025
Anna Macarthur	Attendee	Group Director of Communications and Engagement	1 April 2024 – 28 February 2025

Attendance			
Name	**Role**	**Trust**	**Attendance * (jan25)**
Phil Wilbraham	Board Chair	ESTH	9/9
Ann Beasley	Member	ESTH	7/9
Peter Kane	Member	ESTH	6/9
Martin Kirke	Member	SGUH	6/8
Derek Macallan	Member	ESTH	4/8

James Blythe	Member	ESTH	9/9
Tim Wilkins	Member	ESTH	8/9
Andrew Grimshaw *	Member	Group	5/9
Rebecca Suckling	Member	ESTH	3/9
Anna Macarthur	Attendee	Group	3/9

*The Group Chief Finance Officer was represented by the Group Director of Financial Planning at the remainder of the meetings

In addition to the above, the Group Chairman, attended three meetings of the BYFH Board during the period.

4. Committee activity and focus

Each meeting of the Board followed a similar pattern with regular updates received on the following items :

- Updates from the NHP Team
- The Programme Directors Report for the month which outlined meetings which had taken place with various partners and activity which had been completed. This included progress on enabling schemes, discussion with the respective planning teams, updates from consultants on activity such as design, demand and capacity. It also outlined activity with key stakeholders such as the Royal Marsden Hospital and the London Cancer Hub regarding the overall plans for the site at Sutton
- Finance updates – including requests for fees, fees approvals and monthly budget reports
- Updates from the Communication and Engagement Team, including media coverage, plans for further public engagement.
- Risks and Issues Report.

During the year the Board also received detailed updates on these areas :

- Smart Buildings
- Digital Transformation
- Demand and Capacity Modelling
- Clinical Engagement
- Planning for the delayed release of funds

The whole team working on the BYFH are to be commended for their continued enthusiasm and hard work which had been maintained throughout 2024/25. There had been a great deal of uncertainty and delays at times, particularly relating to the release of fees from NHP. This had meant that the stop and start nature of the project which had been present over many years had to continue, resulting in complications and ongoing concerns relating to work with partners and stakeholders.

In July, the following the General Election, the new Government announced that the Secretary of State for Health and Social Care would be undertaking a review of the funding available for the whole of the New Hospitals Programme. The outcome of the review was shared in parliament on Monday 20 January 2025 and the trust learnt that the start of the

build of the Special Emergency Care Hospital would not be able to start until 2032, several years later than planned. It was recognised that this further delay meant that the trust would need to keep services going on the existing sites, with all the issues relating to poor infrastructure and estates for many years longer than planned.

The implications of this further delay to the BYFH Project were shared with and discussed at the Group Board Development Day held at the beginning of February 2025. At the time of producing this report the detail of the next steps, and the impact that this will have on the Programme Board are still being worked through.

5. Committee Effectiveness

It is good governance practice for all Committees of the Board to hold annual effectiveness reviews and report on these to the Board. Responses were sought via an online survey tool and the summary is provided at Appendix X and the full survey results at Appendix x.

- **Terms of Reference and forward work plan:** The majority agreed that the terms of reference were, in 2024/25, fit for purpose. The need to fully review the terms of reference and the difficulties in setting an annual workplan in light of the uncertainty and now delay, to the scheme was noted in the comments.
- **Membership, skills and experience of Programme Board:** All respondents agreed, or strongly agreed, that the Programme Board had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board.
- **Chairing of meetings:** 86% (6) respondents strongly agreed, and 14% (1) agreed that the meetings were chaired effectively.
- **Discussions and assurance:** All respondents agreed that the Programme Board provides insight and appropriate constructive challenge on the matters within its remit. Matters are escalated or cascaded to the relevant forums including appropriate risk and assurance matters being passed to the Board as required. 86% (6) agreed and 14% (1) strongly agreed that the Programme Board was effective in this area.
- **Timeliness and quality of papers:** 72% (5) agreed, and 14% (1) strongly agreed that the papers were circulated in a timely way and provided clear, concise and sufficient information to enable the Programme Board to take informed decisions, fully sighted on the risks and implications - 14% (1) was neutral. Three respondents commented on the lateness of papers, with it being acknowledged by one that there was usually good reason for this, and another that this was due to the unpredictability of the NHP. All respondents agreed, or strongly agreed, that there was sufficient time on the agenda to cover all items in appropriate depth. One respondent commented that the Chair allocated time sensibly.
- **Overall effectiveness of the Committee:** 28% (2) felt the Committee was extremely effective, 57% (4) expressing that the Committee was every effective and 14% (1) thought the Committee was somewhat effective.

6. Committee Forward Plan and Terms of Reference

The forward plan 2025/26 and terms of reference will be formally reviewed once the future activity for the programme is confirmed.

7. Conclusion

Despite the ongoing uncertainty over the timelines for the project, the Programme Board have been effective in meeting their duties and through their discussions have monitored the individual aspects, whilst maintaining the interconnectivity of the workstreams.

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University Hospitals and Health Group

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Building Your Future Hospitals Board

Committee Effectiveness Review 2024/25

Summary Report for ESTH Board

Elizabeth Dawson
Group Deputy Director of Corporate Affairs

February 2025

1. Introduction
Purpose, context and recommendations

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Purpose
This paper presents the outcomes of the Committee effectiveness survey for the Building Your Future Hospitals Programme Board (BYFH), which is a sub committee of the ESTH Board, in 2024/25. The report highlights the key themes that emerged and summarises the feedback received and proposes areas for the BYFH Board to consider in how it can further improve its effectiveness in 2025/26.

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

Summary
A total of 7 people responded to the effectiveness survey. Overall, the results of the effectiveness review were very positive The Committee effectiveness review demonstrated that the BYFH Programme Board were effective. The key issues highlighted were the changes that will be needed following the announcement on the New Hospitals Programme and how the uncertainty over the programme has had some impact on the work of the Committee. Lateness of papers was also raised, but it was noted that this somewhat to do with the uncertainties of the programme. The strength of the Chairing was commented on in a number of areas of the survey.

Recommendation
The Programme Board is asked to review the outcomes of the Committee effectiveness survey and consider actions that may improve its effectiveness in 2025/26.

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

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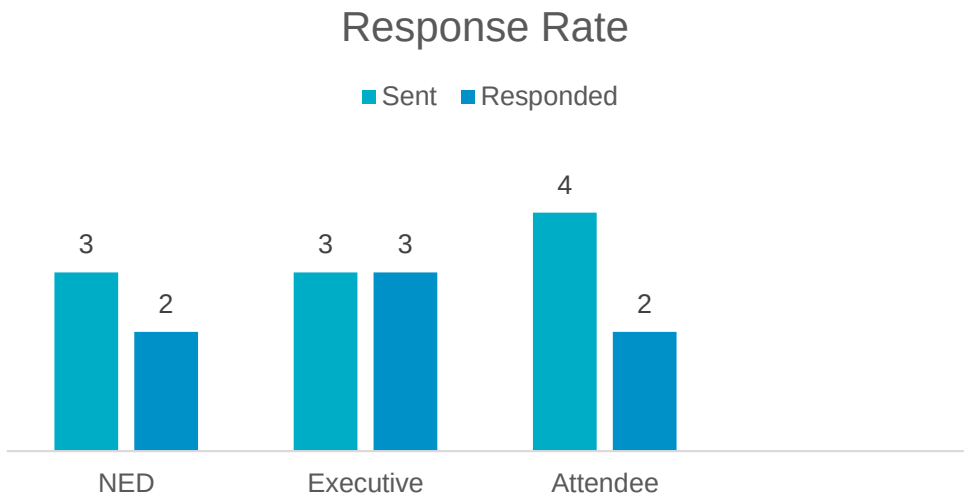
2. Engagement

Response rate and respondent types

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

- Non-Executive members of the Programme Board
- Executive members of the Committee Programme Board
- Trust Chairman and Chief Executive Officer
- Regular attendees as set out in the Programme Boards terms of reference

In total, 10 people were invited to participate in the survey. Of these a total of 7 engaged with and provided responses to the survey, a response rate of 70%.



3. Key findings

Overall effectiveness

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

- **Terms of Reference and forward work plan:** The majority agreed that the terms of reference were, in 2024/25, fit for purpose. One respondent commented that a major review the terms of reference would be needed in light of the recent announcement on the delay to the programme. Another commented that given the uncertainty over the programme, it was difficult to put an annual workplan in place.

- **Membership, skills and experience of Programme Board:** All respondents agreed, or strongly agreed, that the Programme Board had the appropriate range of skills and experience to discharge its duties and provide assurance to the Board. The wider attendance of the multi disciplinary team was noted by one respondent. Another respondent commented that the chairing was excellent with good contributions from all attendees.

- **Chairing of meetings:** 86% (6) respondents strongly agreed, and 14% (1) agreed that the meetings were chaired effectively. One respondent that the chairing was very well done.

- **Discussions and assurance:** All respondents agreed that the Programme Board provides insight and appropriate constructive challenge on the matters within its remit. Matters are escalated or cascaded to the relevant forums including appropriate risk and assurance matters being passed to the Board as required. 86% (6) agreed and 14% (1) strongly agreed that the Programme Board was effective in this area.

3. Key findings

Overall effectiveness

- **Timeliness and quality of papers:** 72% (5) agreed, and 14% (1) strongly agreed that the papers were circulated in a timely way and provided clear, concise and sufficient information to enable the Programme Board to take informed decisions, fully sighted on the risks and implications - 14% (1) was neutral. Three respondents commented on the lateness of papers, with it being acknowledged by one that there was usually good reason for this, and another that this was due to the unpredictability of the NHP. All respondents agreed, or strongly agreed, that there was sufficient time on the agenda to cover all items in appropriate depth. One respondent commented that the Chair allocated time sensibly.

- **Overall effectiveness of the Committee:** 28% (2) felt the Committee was extremely effective, 57% (4) expressing that the Committee was every effective and 14% (1) thought the Committee was somewhat effective.

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4. Next steps

"So what" and "what now"?

The detail of the impact of the Government announcement to delay the programme until 2032-34 is still being worked through. It is therefore recommended that:

- **Terms of Reference:** A detailed review of the terms of reference for the Programme Board be carried out once the above activity is completed.
- **Forward plan:** Once the revised terms of reference are drafted, a forward plan to support delivery of the terms of reference will be developed.
- **Timeliness of papers:** That on the basis that fewer papers will now be dependent on NHP activity, the aim should be for papers to be circulated as set out in the terms of reference.

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University Hospitals and Health Group

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	3.1
Report Title	**Group Maternity Services Quality Report** **November and December 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 Annabelle Keegan, Director of Midwifery and Gynaecology Nursing, ESTH Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH Manjit Roseghini, Interim Director of Midwifery and Gynaecology and Nursing (Outpatients), SGUH Emily Kaliwoh, Lead Midwife for Governance SGUH
Previously considered by	Quality Committees in Common – 27 February 2025 ESTH Women and Children's Divisional Management Team ESTH Senior Leadership Team - 19 Feb 2025 SGUH Maternity Governance Meeting - 3 February 2025 SGUH Women and Children's Divisional Management Senior Leadership Team - 10 Feb 2025
Purpose	**For Assurance**

Executive Summary

1.0 Purpose

The Group Board receives this report as part of the requirements under the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM) (December 2020). These frameworks mandate the presentation of specified monthly indicators, maternity metrics, and information to monitor maternity and neonatal safety, are discussed by the Group Board at every meeting.

This report provides Perinatal Quality Surveillance Model data for November and December 2024 and an update on the CNST compliance status for both trusts under Year 6 of the Maternity Incentive Scheme.

Additionally, it includes:

- A progress update on actions arising from the NHS Resolution Thematic Review of cases referred by SGUH to the Early Notification Scheme between 2017-2024.
- Findings from the 2020 MBRRACE report, which was commissioned for review by the QCiC in 2023, and the subsequent progress on resulting actions.
- An update on the maternity-specific actions stemming from the Care Quality Commission (CQC) inspection of SGUH in October 2024.

Action required by Quality Committee-in-Common
The Group Board is asked to: a) Note the information provided in the Perinatal Quality Surveillance Model (PQSM) and that trend data for quality outcomes does not indicate any special cause for concern for either trust. b) Note the progress against the action plan for the NHSR thematic review of Early Notification Scheme (ENS) cases for SGUH. c) Note the progress against the actions arising from the review of the 2020 MBRRACE findings. d) Note that the immediate safety actions from the SGUH CQC inspection (October 2024) have been completed and all longer-term actions from the inspection have been incorporated into a wider improvement plan.

Appendices	
Appendix No.	**Maternity**
Appendix 1	ESTH Perinatal Mortality Review/ Board report
Appendix 1a	SGUH Perinatal Mortality Review/Board report
Appendix 2	ESTH Perinatal Quality Surveillance Model data (PQSM)
Appendix 2a	SGUH Perinatal Quality Surveillance Model Data (PQSM)
Appendix 3	**READING ROOM** ESTH Maternity and Neonatal Incentive Scheme Year 6 update
Appendix 3a	**READING ROOM** SGUH Maternity and Neonatal Incentive Scheme Year 6 update
Appendix 4	**READING ROOM** SGUH NHS Resolution Thematic review of cases REPORT SUMMARY
Appendix 4a	**READING ROOM** SGUH NHS Resolution Thematic review of cases action plan
Appendix 5	**READING ROOM** Review of MBRRACE findings 2020 – Report
Appendix 5a	**READING ROOM** Review of MBRRACE findings 2020 – Action Plan
Appendix 6	**READING ROOM** SGUH Section 29A Warning Notice
Appendix 6a	**READING ROOM** SGUH Section 29A Warning Notice – Action Plan

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

ESTH: declared full compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6 and therefore expect to receive 10% rebate of Trust contribution to CNST.

SGUH: declared 9/10 compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6, which would result in none or less than 10% rebate of Trust contribution to CNST.

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 inspections across gesh maternity services in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

Equality, diversity and inclusion implications

The Lead Midwife for Transformation (ESTH) and the Consultant Midwife for public health (SGUH) continue to undertake Focus Groups with women from the Global Majority to understand their experiences, and influence service development.

Environmental sustainability implications

ESTH: There are several environmental issues which have an impact on service development and business continuity, detailed in the risk register.

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Group Maternity Services Quality Report

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 The Group Board receives this report as part of the requirements under the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM) (December 2020). These frameworks mandate the presentation of specified monthly indicators, maternity metrics, and information to monitor maternity and neonatal safety, are discussed by the Group Board at every meeting.

1.2 The report also informs the Group Board of significant changes, emerging safety concerns, new risks and successes within gesh maternity services, and assurance where available. The report provides Perinatal Quality Surveillance Model data for November and December 2024 and an update on the CNST compliance status for both trusts under Year 6 of the Maternity Incentive Scheme

1.3 Appendices 3 and 3a, details our compliance with the Maternity and Perinatal Incentive Scheme (CNST) Year 6 and includes information that is required to be presented to the Trust Board for noting in the minutes. This includes the Board Report generated from the Perinatal Mortality Review Tool (Appendices 1 and 1a).

1.4 Additionally, it includes a progress update on actions arising from the NHS Resolution Thematic Review of cases referred by SGUH to the Early Notification Scheme between 2017-2024 (appendix 4a). Findings from the 2020 MBRRACE report, which was commissioned for review by the QCiC in 2023, and the subsequent progress on resulting actions appendix 5, and an update on the maternity-specific actions stemming from the Care Quality Commission (CQC) inspection of SGUH in October 2024 appendix 6a.

2.0 Content

2.1 The report data covers the position for November and December 2024, and includes:

- The perinatal quality surveillance model (PQSM) (READING ROOM appendixes 2 and 2a)
- The maternity quality and safety dashboard trend data in relation to outcomes for birthing people and babies (Appendices 2 and 2a, slide no.3)
- Perinatal mortality by exception (full details available in the PQSM slide deck, appendices 2 and 2a ESTH and SGUH respectively)
- The Maternity and Neonatal Incentive Scheme Year 6 update (READING ROOM, appendices 3 and 3a)
- Patient Experience
- Risk register – by exception
- Key risks/emerging concerns
- NHS Resolution thematic review of cases SGUH referred to the early notification scheme between 2017-2024
- Review of MBRRACE findings 2020, report and action plan (appendices 5 and 5a)
- Action plan from the Care Quality Commission inspection of SGUH in October 2024 (appendices 6 and 6a).

3.0 Context and Overview

3.1 Perinatal Quality Surveillance Model (PQSM) data

3.1.1 Outcomes

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 2 and 2a, slide 3.

3.1.2 Risk register

ESTH: there are two extreme (red) risks on the risk register, namely the lack of a 2nd operating theatre at Epsom and general environmental issues that were highlighted in the 2023 CQC inspection. Work is underway to address both concerns, e.g., an existing room has been identified which will be converted to a 2nd theatre, and sounding proofing of the bereavement room is complete.

SGUH: has one extreme risk on the risk register relating to the laser stack in the fetal medicine unit which is out of its life span and manufacturer maintenance contract. As a tertiary referral centre for fetal medicine the equipment and procedure it supports is essential and critical to business continuity. Medical Physics has advised that the stack and the laser both needs replacing. The stack has been requisitioned, awaiting order number, however, the laser has not yet been requisitioned, due to difficulty in finding a replacement laser, which means it won't be requisitioned in financial year 2024/25, since trials need to be carried out once a potential device is sourced.

While the plans to replace are worked through, the service has carried out a risk assessment and identified mitigations in the event of a failure.

3.1.3 MBRRACE-UK Perinatal Mortality Report 2022

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

3.1.4 Moderate and above harm cases

ESTH: had a total of 14 moderate harm outcomes across November (8) and December (6), all cases have undergone a review and an appropriate learning response (appendix 2 slide 7)

SGUH: had a total of 41 moderate harm outcomes across November (21) and December (20), which are all reviewed through the moderate case review meetings and actions and learning responses applied as appropriate. 22/41 moderate harm outcomes were for post-partum haemorrhages, (appendix 2a slide 10). Following discussions at the February's Quality Committees in Common, the Chair has requested further information:

- The underlying factors driving the high PPH rates
- The actions being taken to address these rates
- Benchmarking position and opportunities for learning from others
- The governance and oversight mechanisms in place to monitor and manage this issue

3.1.5 Training Compliance

ESTH: As of 30 November 2024, training compliance exceeded 90%, ensuring the Trust remains compliant with the CNST Maternity Incentive Scheme Year 6 reporting period. However, improvements are needed to ensure that neonatal service training data, is more readily available. This issue is being addressed by the Site Leadership Team. (Appendix 2, slides 11 and 12).

SGUH: As of 30 November 2024, training compliance was at or above 90%, except for junior doctors, who reported 83% compliance due to three doctors who started in October 2024. The Maternity Incentive Scheme Year 6 guidance acknowledges that attendance gaps may occur and requires a plan to be in place in such cases. Accordingly, these doctors were booked onto the earliest available training, 24th January (2 completed) and 28th February 2025 (1 completed), ensuring the Trust remains compliant with this safety action for the reporting period (Appendix 2a, slide 13).

3.1.6 CQC inspection of SGUH maternity services (October 2024)

An unannounced CQC inspection of SGUH maternity services took place on 16–17 October 2024. Initial high-level feedback was provided at the end of the inspection, followed by written post-inspection feedback on 31 October 2024. Subsequently, on 19 December 2024, the Trust received a **Section 29A Warning Notice**, outlining areas requiring significant improvement (see READING ROOM Appendix 6).

The Trust was invited and made representations regarding some of the evidence cited in the warning notice. Some of the representations were accepted by the CQC, but the Section 29A notice was upheld and will be published.

An Immediate Safety Actions plan (Appendix 6a) was developed with immediate actions to be completed from mid- December to the end of January to address key areas of concern, while a more detailed action plan was developed, to include systems to test how the actions have ben embedded.

SWL ICB was invited to support the improvement efforts by conducting a review visit to SGUH's maternity unit on 29 January 2025, assessing the Trust's response to the Section 29A Warning Notice and specifically whether the immediate action plan had been implemented. Their findings and feedback is as below:

''it was clear that significant progress had been undertaken by the Trust in meeting the requirements, with key areas demonstrating completion. For maternity, key areas were: triage and helpline systems and processes; triage documentation, specifically around escalation review times; CTG - evidence that the Trust had reviewed their Fetal monitoring guideline, moving from 2 hourly fresh eyes review to hourly, this was going live in February; from a walk around in triage, no out of date medication found in the cupboards, and we discussed systems in place for monitoring medicines; and equipment checks now part of the handover process. A number of medicine management actions remained in progress at the time of our visit, for example the IV additive label switch to white labels, the Trust were looking at a co-ordinated communication to effect the change. In terms of the incident grading, we were unsure why CQC used LFPSE when it is not fully operational and were happy to support the Trust in appealing this finding when the regrading of incidents had taken place. In addition, the environment appeared organised and clean. In summary, as highlighted actions had been taken to address the warning notice and staff were able to articulate clearly the changes, and learning, that had taken place, and for many of the actions we saw concrete evidence of the change having been introduced''.

The Trust's formal response to the CQC, detailing the required improvements, was submitted on 21 February 2025.

3.1.7 Executive and Non-Executive Board Safety Champion Engagement

An update of Executive and Non-Executive Board-Level Safety Champions' activity is included in the PQSM slide deck.

4.0 Key issues for noting and or consideration

4.1 ESTH Appraisal and midwifery fill rate

A risk has been identified with the automatic system for recording appraisals via Power BI, as it is not functioning correctly in several cases. Additionally, when staff change teams or managers, these updates are not always reflected in a timely manner, affecting the accuracy of appraisal records. As a result, the ESTH maternity service maintains parallel manual records and request manual updates from the Appraisal Team, which can lead to delays in the accuracy of appraisal compliance, inefficiencies, Trust-wide implications and potential risks for future regulatory inspections.

The maternity establishment is currently under review to ensure it accurately reflects the service's needs following the recent reconfiguration of community services across both sites. A November 2024 paper to the focussed session of Quality Committee, highlighted a reduction in maternity roster fill rates between January and June 2024; however, this data was based on pre-reconfiguration rosters. The current planned fill rate meets minimum safer staffing levels for each shift, with significant progress being made to align rosters with the establishment and budget. This will enable real-time scrutiny and review of maternity rosters. A timescale for the completion of this work will be included in the next report.

4.2 Birthrate Plus review – SGUH

SGUH is currently midway through a full Birthrate Plus review, which is recommended every three years (last reported in 2021). The review has been delayed due to missing data from a snapshot audit (June & November 2024). During validation, it was identified that the dataset used was outdated (2023 data).

To address this, support from the data manager has been enlisted to ensure accuracy. These measures will mitigate risks and ensure the service is working with current and reliable data. The team is now reviewing January 2025 birth data, which will be submitted to Birthrate Plus on 14 March 2025. The service expects to receive the outcome report in April 2025.

4.3 Clinical Negligence Scheme for Trusts, Year 6 Maternity Incentive Scheme

The Maternity Incentive Scheme requires compliance with 10 safety actions, which is further broken down into 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 declaration must be signed by the Trust Chief Executive Officer and the Accountable Officer of the Integrated Care System. The deadline for the Board Declaration Form to be sent to NHS Resolution is 12:00 midday on 3rd March 2025.

ESTH: declared compliance with 10/10 safety actions

SGUH: declared compliance with 9/10 safety actions and subsequently have submitted an action plan in line with MIS requirement.

SGUH unmet Safety Action: Safety Action 1 (Perinatal Mortality Review Tool – PMRT): two neonatal deaths in the neonatal unit were reported late, breaching the 7-day reporting criteria. Historical compliance has been strong, and additional safety netting has been implemented, which includes recruitment to the vacant administrative post in the neonatal unit which supports submission of cases to PMRT, and a Standard Operating Procedure outlining roles and responsibilities for those involved with the PMRT process.

The two late cases occurred in May 2024, with NHS Resolution being informed of the situation in June 2024 as soon as it came to light. NHS Resolution has advised the Trust to report non-compliance against this safety action and to submit an action plan outlining the steps that will be taken to prevent further occurrences. They have also indicated that, since all other actions related to the PMRT process have been completed, compliance is still likely to be approved by MBRRACE.

Where allowed under the MIS scheme, action plans have been developed to address areas of non-compliance, and these plans will be monitored at Divisional Governance and reported up to Site SLT and the GESH Quality Group.

Due to reporting 9/10 compliance, there is a risk that SGUH may not receive the full 10% rebate for their CNST contribution to the Maternity Incentive Scheme for year 6.

The review of evidence through internal governance processes and the ICS Quality Team took place ahead of submission to the Trust Board and ICS Accountable Officer, as required by MIS.

Note: The **Board declaration form** for each Trust was submitted on **3 March 2025**, completing the Maternity Incentive Scheme (MIS) Year 6 process, pending confirmation of the outcome from the NHS Resolution team. The Group Board will be updated as soon as this information becomes available.

4.4 Maternity Leadership

Midwifery: there have been changes in the midwifery leadership structure at both ESTH and SGUH.

- The SGUH Director of Midwifery and Gynaecology Nursing left the Trust in December 2024.
- The SGUH Deputy Director of Midwifery has been seconded to ESTH as the interim Director of Midwifery and Gynaecology Nursing for one year since 4 November 2024.
- Both posts at SGUH have been appointed to and the Deputy DOM commenced in role on 6 January 2025. The Director of Midwifery is expected on 10 March 2025. While the arrival of the new DOM is awaited, an interim Director of Midwifery is in place until 31 March (extendable as required) to mitigate the leadership gap.

Obstetrics: the Clinical Director for SGUH maternity will step down from the role at the end of March 2025. The role has been successfully recruited to, with an expected start date of March 2025, to allow for a handover period.

ESTH has a new Divisional Medical Director for Women's and Children's, due to the previous postholder taking up a Trust-wide role.

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, with a final agreed structure expected by end of March 2025. Following discussions at the Quality Committees in Common, the Chair has emphasised the urgent need to expedite the process and establish substantive, robust leadership, given the ongoing challenges faced by the service.

4.5 Maternity Safety Support Programme

The SGUH maternity service has been challenged in relation to driving ongoing improvements due to the recent CQC inspection, which has diverted resources to the organisational response.

While the pace of improvement has been slow, progress has been recognised, particularly with the additional midwifery leadership resources now in place. There is improved oversight and assurance in areas such as equipment checks and medicines management, and the development of a single perinatal improvement plan is underway. This plan will provide the service, and the wider organisation with clearer visibility of outstanding actions aligned with national objectives, identifying where additional support may be needed to embed and sustain improvements.

There remains a need to understand the obstetric staffing model that is being used across the service at SGUH, with particular reference to the out of hours rota as well as the potential impact the current model could have on the service's ability to safely implement an effective triage service utilising the RCOG Best Practice Paper to benchmark against.

The MSSP team have offered the opportunity to support a review of triage services across all three sites in collaboration with midwifery and obstetric staff. This review would ensure that the Board is fully informed of the challenges in implementing BSOTS, which includes estate constraints, and alternative options. It would also allow for the formal documentation of current mitigations, supported by robust policies and audit processes, in response to both service needs and CQC concerns.

4.6 Unified maternity improvement plan

During the November 2024 Quality Committee meeting, which was a focused session on maternity services, the Committee Chair requested the development of a unified improvement plan for maternity services across gesh. Initial discussions with key stakeholders have taken place, with a template (sourced by MSSP) and key workstreams agreed upon. Additionally, support from the Transformation Team has been secured to assist in developing the template.

However, work on the plan has been temporarily paused to allow the maternity team to prioritise the Section 29a response and the launch of the digital transformation programme (iClipPro) on 8 February 2025. It is expected that the improvement plan will be ready for review by the Quality Committees in Committee in April 2025.

4.7 Review of MBRRACE findings 2020

For St George's University Hospitals NHS Foundation Trust (SGUH), the annual figures published by MBRRACE-UK indicated that the 2020 stillbirth and neonatal death rates, based on a total of 4,679 births, had changed compared to the last published figures from 2019. SGUH was now classified in the 'more than 5% higher than average for type of hospital' category, with a stillbirth rate of **3.92 per 1,000 births**, a neonatal death rate of **2.52 per 1,000 births**, and an

extended perinatal mortality rate (combined stillbirth and neonatal death) of **6.41 per 1,000 births**.

For Epsom and St Helier University Hospitals NHS Trust (ESTH), the 2020 extended perinatal mortality rate was comparable to similar Trusts. However, the neonatal death rate was higher than in similar Trusts. Notably, none of the six affected babies died within the Trust; they were born at ESTH but were transferred out before their deaths, therefore were not included in the review.

To support the Group Board in understanding factors contributing to stillbirths and neonatal deaths in 2020, and to identify potential areas for improvement, the GCNO and GCMO commissioned an external review of the MBRRACE findings on behalf of the Trust. This review began in July 2023 and was completed in January 2024, and the report shared with the service in March 2024. It resulted in **nine recommendations**, which were addressed through an action plan—all of which have now been completed (appendices 5 and 5a).

The Trust has also commissioned a review of the **2021 MBRRACE findings**, which is currently ongoing. A timeframe for completion has not yet been confirmed by the reviewers.

4.8 NHS Resolution Thematic Review of SGUH cases submitted to the Early Notification Scheme (ENS)

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.

The Early Notification arm of NHS Resolution wrote to SGUH maternity in June 2024, 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.

The Trust submitted its response to NHS Resolution on 24 January 2025, an agreed revised submission date from the previous date of 27 December 2024, which was not met due to several competing factors. An action plan is in place (see Appendix 4a, and summary report at Appendix 4 READING ROOM). The action plan will be monitored at Maternity Governance Meeting (MGM) Business and Divisional Governance, with progress reports to the Site Leadership Team and gesh Quality Group.

5.0 Successes

5.1 ***MBRRACE-UK:*** The MBBRACE-UK Perinatal Mortality Report for 2022 has confirmed that neither ESTH nor SGUH are negative outliers for either stillbirth or neonatal death.

5.2 The ESTH and SGUH 2024 CQC National Maternity Survey has continued to show positive feedback from service users for the 2nd year in a row.

5.3 The preferred outcome is for ESTH and SGUH to receive the 10% rebate from their CNST contribution.

6.0 Actions and what success will look like

6.1 Final agreed leadership structure for Maternity Services across gesh and successful recruitment to substantive posts.

6.2 Timely submission of the Trust response to the CQC Section 29A warning Notice for SGUH

6.3 Submission of the CNST Board declaration for each Trust by 12 noon on 3 March 2025

7.0 Next steps

7.1 Development of a unified maternity improvement plan by April 2025.

7.2 To receive the report of the MBRRACE review of findings from 2021.

8.0 Recommendations

8.1 Group Board is asked to:

a) Note the information provided in the Perinatal Quality Surveillance Model (PQSM) and that trend data for quality outcomes does not indicate any special cause for concern for either trust.

b) Note the progress against the action plan for the NHSR thematic review of Early Notification Scheme (ENS) cases for SGUH.

c) Note the progress against the actions arising from the review of the 2020 MBRRACE findings.

d) Note the progress against the action plan for the NHSR Thematic review of ENS cases for SGUH.

e) Note that the immediate safety actions from the SGUH CQC inspection (October 2024) have been completed and all longer-term actions from the inspection have been incorporated into a wider improvement plan.

Appendix 1

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Epsom and St Helier University Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/9/2023 to 31/12/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *23*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
24	6	5	12	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
7	3	2	2	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Laura Rowe
Date report generated: 30/01/2025 13:24

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 14)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	3	1	5	3	12
Antepartum stillbirths	*0*	*0*	*3*	*1*	*5*	*1*	*10*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*2*	*2*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	1	0	2
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	3	1	6	3	14
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	2	0	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	1	0	0	1
Not Applicable	0	1	3	0	4	3	11
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	3	1	6	3	14
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	1	3	1	6	3	14
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	1	0	2
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	1	0	0	1	0	2

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

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Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 14)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	3	1	5	3	12
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	3	1	5	3	12
Hospital post-mortem declined	0	0	0	0	3	2	5
Hospital post-mortem carried out:							
Full post-mortem	0	0	2	1	2	1	6
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	1	0	2
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	1	0	1
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	1	0	0	1	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	1	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	3	1	2	1	7
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	3	1	2	1	7
No	0	0	0	0	3	2	5

*Includes coronial/procurator fiscal post-mortems

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Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 12)

Role	Total Review sessions	Reviews with at least one
Chair	13	66% (8)
Vice Chair	13	66% (8)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	16	100% (12)
Community Midwife	0	0%
External	6	50% (6)
Management Team	2	16% (2)
Midwife	94	100% (12)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	6	50% (6)
Obstetrician	40	100% (12)
Other	1	8% (1)
Risk Manager or Governance Team	40	100% (12)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 2)

Role	Total Review sessions	Reviews with at least one
Chair	2	100% (2)
Vice Chair	2	100% (2)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	2	50% (1)
Community Midwife	0	0%
External	3	100% (2)
Management Team	2	50% (1)
Midwife	19	100% (2)
MNVP Lead	0	0%
Neonatal Nurse	1	50% (1)
Neonatologist	2	50% (1)
Obstetrician	6	100% (2)
Other	2	50% (1)
Risk Manager or Governance Team	9	100% (2)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 14)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	2	0	2	1	5
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	1	3	2	7
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	1	0	3	3	7
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	2	1	2	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	1	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	1	0	2
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 14)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**12 causes of death out of 12 reviews**
	Intrauterine death of an appropriately grown and developed third trimester male fetus. Findings of hypoxia ischaemic injury on examination of the brain. Placental findings of maternal vascular malperfusion and a retroplacental haematoma.
	Likely infection as evidenced by the placental histology and maternal condition.
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	Intra-uterine death of an appropriately grown and developed late trimester male fetus, the cause of which is attributed to the placental findings of acute chorioamnionitis (infection) with fetal inflammatory response (necrotising funisitis) and high grade fetal vascular malperfusion.
	Placental Abruption
	The PM report found features of an acute hypoxic mode of death, the cause of which is attributed to cord entanglement, which corresponds to the clinical findings at delivery where the cord was around Raed's neck twice.
	Intra-uterine death of an appropriately grown and developed third trimester male fetus, the cause of which is attributed to the placental findings of a tight true umbilical cord knot with associated delayed villous maturation and high-grade chronic villitis with avascular villi.
	The cause of death was undetermined
Neonatal deaths	**2 causes of death out of 2 reviews**
	Late miscarriage and extreme prematurity (22+0).
	Respiratory failure secondary to multiple dysmorphic facial features and undiagnosed congenital abnormalities as described by the post mortem examination.
Post-neonatal deaths	**0 causes of death out of 0 reviews**

Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
During resuscitation the baby required intubation but this was not achieved	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Date report generated: 30/01/2025 13:24

Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	8	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	6	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother's progress in labour was not monitored on a partogram	5	This has been added to the risk and documentation mandatory training session.
		To add to mandatory risk training that when the labour assessment pro-forma on BadgerNet is completed the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. In addition this will be fed back at labour ward huddle and in the risk newsletter.
		No action entered
		Clinicians to be reminded that the partogram gives an overview of progress in labour and maternal wellbeing. When caring for a mother with an intrauterine death who is in labour, maternal observations must be documented in the labour assessment on BadgerNet, (this should include an hourly pulse) so the partogram is populated. If the mother has commenced analgesia and/or is contracting this information must also be documented on the partogram. All antenatal inpatient women must have 4 hourly observations. On daily ward round the frequency of observations must be reviewed. This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.
		This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.

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During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	4	To add to mandatory risk training that when the labour assessment proforma on BadgerNet is completed, the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. This will also be fed back at the labour ward huddle and an item placed in the risk newsletter.
		Article in risk newsletter to outline PCA observations. Huddle and handover reminder of observations in labour.
		Observations should be 4 hourly for every woman who is admitted with an IUD/ threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted in a message of the week circulated to all staff, via the handovers and huddles and in the band 7 meetings.
		Clinicians to be reminded that observations should be 4 hourly for every woman who is admitted with an intrauterine death/threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted at daily labour ward huddle, message of the week, at Band 7 meetings.
This mother had poor/no English and an interpreter was not used on every occasion when she was seen for her antenatal care	2	No action entered
		CardMedic to be be discussed at huddle, at the doctors induction and at yearly mandatory risk training for midwives.
This mother had poor/no English and arrangements other than an interpreter were made during her labour and birth	2	Since this case the Trust has implemented the use of the cardmedic system.
		CardMedic to be be discussed at huddle, at the doctors induction and at yearly mandatory risk training for midwives.
This mother smoked during pregnancy but was not offered referral to smoking cessation services	2	No action entered
		The smoking in pregnancy guideline requires review to include referral of women who live with smokers or who exclusively vape to be referred to smoking cessation service for advice.
During the early bereavement period the baby was not cared for in a cold cot because the cold cot was not offered	1	The Bereavement Midwife to highlight at yearly mandatory training, the importance of using a cold cot.
It was highlighted that there is no robust and prompt process in place for requesting notes from the Trust a woman was formerly booked at. This also raises issues of resource available to review notes if they are obtained.There are also issues with GDPR which need considering.	1	Review guideline with regard to requesting notes from previous Trusts, with due regard for GDPR. LR to take to LMNS to discuss possible centralised solutions.
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	1	Matron for community to explore this with the community team and ensure equipment now working and being used at all booking appointments

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Procedural or Task Design	1	During resuscitation the baby required intubation but this was not achieved

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Appendix 1a

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

St George's University Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

8/12/2023 to 31/12/2024

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *48*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
41	13	9	19	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
26	1	7	18	2

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Melissa Claridge
Date report generated: 18/02/2025 15:45

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 37)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	4	--	--	--	--	4
Stillbirths total (24+ weeks)	0	0	5	2	5	3	15
Antepartum stillbirths	*0*	*2*	*4*	*2*	*5*	*2*	*15*
Intrapartum stillbirths	*0*	*2*	*1*	*0*	*0*	*1*	*4*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	5	0	1	1	8
Late neonatal deaths (8-28 days)*	0	2	2	0	2	2	8
Post-neonatal deaths (29 days +)*	0	0	2	0	0	0	2
Total deaths reviewed	0	7	14	2	8	6	37
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	1	1	2
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	7	14	2	7	5	35
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	7	12	2	8	6	35
No	0	0	2	0	0	0	2
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	7	14	2	8	6	37
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	4	0	2	3	10
Mother transferred before birth	0	1	1	0	0	0	2
Baby transferred after birth	0	2	5	0	1	0	8
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	3	2	0	1	0	6

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

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Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 37)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	4	4	2	5	3	18
No	0	0	1	0	0	0	1
Hospital post-mortem offered	0	4	5	2	5	3	19
Hospital post-mortem declined	0	0	4	1	2	3	10
Hospital post-mortem carried out:							
Full post-mortem	0	4	1	0	2	0	7
Limited and targeted post-mortem	0	0	0	1	0	0	1
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	1	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	3	9	0	3	2	17
No	0	0	0	0	0	1	1
Death discussed with the coroner/procurator fiscal	0	1	3	0	2	1	7
Coroner/procurator fiscal PM performed	0	0	1	0	0	1	2
Hospital post-mortem offered	0	3	8	0	3	1	15
Hospital post-mortem declined	0	2	6	0	3	1	12
Hospital post-mortem carried out:							
Full post-mortem	0	1	2	0	0	0	3
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	1	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	4	1	1	2	0	8
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	4	4	2	5	3	18
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

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Date report generated: 18/02/2025 15:45

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 19)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	5	21% (4)
Community Midwife	0	0%
External	2	10% (2)
Management Team	0	0%
Midwife	63	78% (15)
MNVP Lead	0	0%
Neonatal Nurse	4	21% (4)
Neonatologist	31	78% (15)
Obstetrician	52	78% (15)
Other	15	68% (13)
Risk Manager or Governance Team	18	73% (14)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 18)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	3	16% (3)
Ambulance Team	0	0%
Bereavement Team	25	72% (13)
Community Midwife	0	0%
External	12	44% (8)
Management Team	0	0%
Midwife	104	100% (18)
MNVP Lead	0	0%
Neonatal Nurse	10	27% (5)
Neonatologist	95	100% (18)
Obstetrician	55	100% (18)
Other	22	72% (13)
Risk Manager or Governance Team	27	83% (15)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 37)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	2	2	1	2	2	9
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	2	2	1	3	1	9
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	1	0	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	4	5	2	2	2	15
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	3	1	4
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	1	3	0	0	3	7
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	2	2	0	1	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	4	0	0	0	4
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	2	0	2
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	3	0	3	3	10
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	2	4	0	0	0	6
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	2	0	0	0	2
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	2	8	0	1	3	14
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	1	0	2	0	3
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	1	0	0	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 37)

Timing of death	Cause of death
Late fetal losses	**4 causes of death out of 4 reviews**
	The cause of death was undetermined
	The post-mortem showed second trimester female baby with severe acute necrotising chorioamnionitis, and funisitis, with acute villitis and intervillositis.
	Acute chorioamnionitis with a fetal inflammatory response.
	Spontaneous miscarriage of a normally grown 22-week gestation male baby with the placental findings of distal villous hypoplasia, high-grade fetal vascular malperfusion and retroplacental haematoma formation.
Stillbirths	**15 causes of death out of 15 reviews**
	The cause of death was undetermined
	Acute hypoxia attributed to SARS-CoV-2
	The placenta was small for gestation but conversely shows areas of delayed villous maturation and chorangiomatosis
	An acute hypoxic mode of death, the cause of which is attributed to the placental finding of high-grade chronic villitis with avascular villi; screening of the mother for autoimmune conditions and close follow up in subsequent pregnancies is advised. • Additional placental finding of basal plate myometrial fibres.
	The cause of death was undetermined
	Maternal and fetal vascular malperfusion leading to the growth restriction.
	Placenta Findings: Twin 1 Accelerated villous maturation, avascular villi, thrombi within chronic vessels; severe acute necrotising chorioamnionitis with a fetal inflammatory response and features of maternal vascular malperfusion. Twin 2: early acute chorioamnionitis, patchy early chorioamnionitis with no fetal inflammatory response
	1. Early third trimester macerated male baby. 2. Linear body measurements in keeping with 30 weeks' gestation. 3. No dysmorphic features. 4. Genotypically male with no identified abnormalities on Array CGH. 5. A placenta showing early acute chorioamnionitis.
	Acute chorioamnionitis with a fetal inflammatory response
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	Chronic Haemosiderosis with a single infarct with thrombosed spiral artery, ? maternal vascular malperfusion.
	Acute Chorioamnionitis with fetal inflammatory response. Maternal vascular malperfusion.
	Acute Chorioamnionitis with fetal inflammatory response. Maternal vascular malperfusion.
Neonatal deaths	**16 causes of death out of 16 reviews**
	a. Right tension pneumothorax b. Extreme prematurity (27 weeks gestation); IUGR (intra uterine growth restriction) e. Congenital bowel obstruction
	Intracranial Haemorrhage Extreme prematurity Placental Abruption
	1a Spontaneous brain haemorrhage, spontaneous pulmonary haemorrhage 2 Extreme Prematurity
	1a. Spontaneous intracranial haemorrhage b. Extreme prematurity (26 weeks gestation) c. In utero twin to twin transfusion
	Extreme prematurity

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	a) Severe perinatal hypoxia b) Prematurity (32 weeks) c) Bilateral pulmonary emboli
	1A Hypoxic brain injury, prematurity 1B In utero hypoxia following maternal collapse with PE.
	1a) Multiorgan failure 1b) spontaneous small bowel necrosis and intra-abdominal sepsis 1c) extreme prematurity (23 weeks gestation)
	The pathologist stated that this case is best classified as Sudden Unexpected Death in Infancy (SUDI) and proposed the following natural cause of death: 1a. Sudden Unexpected Death in Infancy.
	1a. Bilateral pneumothoraces. 1b. Bronchopulmonary dysplasia and pulmonary interstitial emphysema. 1c. Extreme prematurity (born at 25 weeks gestation). 2. Intra-uterine growth restriction.
	1A. Chronic Lung Disease and Pulmonary hypertension 1B. Extreme prematurity
	1a. Pulmonary hypertension 1b. Trisomy 21
	1a. Intra-abdominal haemorrhage following abdominal surgery (Date of surgery 21.5.24) 1b. Perforated necrotizing enterocolitis 1e. Extreme prematurity 26 weeks gestation, intracerebral bleed, pulmonary haemorrhage.
	1a Spontaneous Intracranial Haemorrhage and Spontaneous intestinal perforation 1b Extreme prematurity - 23 weeks gestation
	Pulmonary Hypoplasia secondary to Left sided Congenital Diaphragmatic Hernia
	Trisomy 13 (Patau's Syndrome)
Post-neonatal deaths	**2 causes of death out of 2 reviews**
	1a Klebsiella pneumoniae septicaemia Extreme prematurity (Twenty five weeks gestation)
	1A Multiple Organ Failure 1B Recurrent NEC 1C Extreme prematurity and Congenital CMV 2 Extremely low birthweight

Table 7: Top 10 issues** raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Did this affect her care?	3	No action entered
		No action entered
		No action entered
This mother had poor/no English and language line was used to interpret during her labour and birth	3	No action entered
		No action entered
		No action entered
During the transfer to another neonatal/specialist unit the baby's temperature was not maintained within an appropriate range	2	No action entered
		The referring unit has identified and discussed learning - To follow the thermoregulation guideline and use Cosytherm to aid with maintaining temperature in the desired range.
The opportunity to take their baby home was not offered to the parents as this was logistically too complicated to organise	2	No action entered
		No action entered
The thermal management of the baby during the first 24 hours of arrival on the neonatal unit was not appropriate	2	No action entered
		No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	2	No action entered
		No action entered
This mother's progress in labour was not monitored on a partogram	2	No action entered
		No action entered
A completed bereavement checklist was not in the notes	1	Reminder to staff to complete
During the move to the neonatal unit the baby's temperature was not maintained within an appropriate range	1	No action entered
During the transfer to another neonatal/specialist unit cardiovascular support for the baby was not managed appropriately	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Report Generated by: Melissa Claridge
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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
This mother's progress in labour was not monitored on a partogram	14	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks	13	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
This mother booked late. Are there any organisations to consider in relation to her booking late?	7	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered

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		No action entered
This mother booked late. Did this affect her care?	5	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		Remain the booking office to prioritize late referral and to schedule the booking appointment at the next available space.
The opportunity to take their baby home was not offered to the parents	5	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Fundal height measurements had not been plotted on a chart	4	No action entered
		No action entered
		No action entered
		No action entered
The opportunity to take their baby home was not offered to the parents as there is no local policy for this	4	No action entered
		No action entered
		No action entered
		No action entered
A completed bereavement checklist was not in the notes	3	No action entered
		The team has been reminded to please complete the bereavement checklist.
		No action entered
It is not possible to tell from the notes if the parents were offered the opportunity to take their baby home	3	No action entered
		No action entered
		No action entered
NICE guidance recommends carbon monoxide testing for all mothers at booking; this mother was not screened	3	No action entered
		No action entered
		Key message to be sent to all midwifery staff to ensure CO testing is being carried out in all booking appointments

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

Report Generated by: Melissa Claridge
Date report generated: 18/02/2025 15:45

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Organisational - Priorities	1	This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks
		This mother's progress in labour was not monitored on a partogram
		This mother has a history of an endocrine problem (other than thyroid disease or diabetes) which was not managed appropriately in her pregnancy
		This mother had poor/no English and language line was used to interpret during her labour and birth
Communication - Communication Management	1	It was not possible to ask this mother about was not asked about domestic abuse at booking as she was seen remotely and was not alone
		This mother had poor/no English and family members were used as interpreters on occasions during her antenatal care
		This mother had poor/no English and language line was used to interpret during her labour and birth
Patient Factors - Clinical Conditions	1	During the transfer to another neonatal/specialist unit the baby's temperature was not maintained within an appropriate range
		The opportunity to take their baby home was not offered to the parents as this was logistically too complicated to organise
Education and Training - Competence	1	This mother had twin to twin transfusion syndrome/twin anaemia polycythemia sequence during her pregnancy and there was a delay in the diagnosis
		This mother had twin to twin transfusion syndrome/twin anaemia polycythemia sequence during her pregnancy which was not managed according to national or local guidelines
Team Factors - Leadership - Ineffective leadership – clinically	1	During the transfer to another neonatal/specialist unit the baby's airway was not appropriately secured
		During the transfer to another neonatal/specialist unit respiratory support for the baby was not managed appropriately

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Date report generated: 18/02/2025 15:45

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Appendix 2

ESTH Perinatal Quality Surveillance Model Data, November and December 2024

Group Board – March 2025

Presented by:
Natilla Henry
Group Chief Midwifery Offer

06 March 2025

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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.

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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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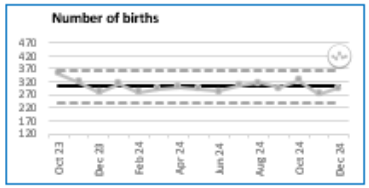
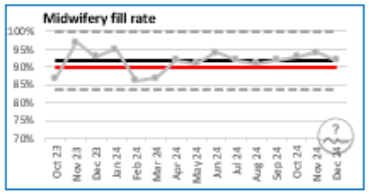
Outcomes Dashboard

Maternity overview | ESTH

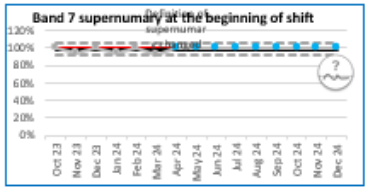
Latest month 01/12/24
Number of birth 297
No significant change



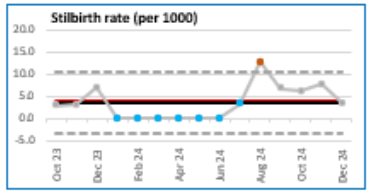
Latest month 01/12/24
Midwifery fill rate 90%
No significant change



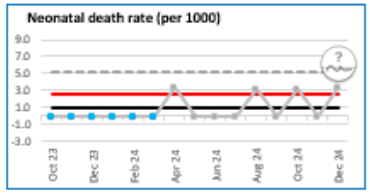
Latest month 01/12/24
Supernumary status 100%
Significant Improvement



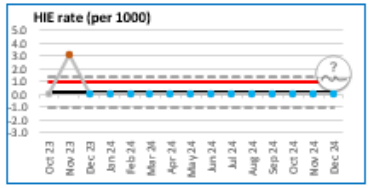
Latest month 01/12/24
Still birth rate/1 3.4
No significant change



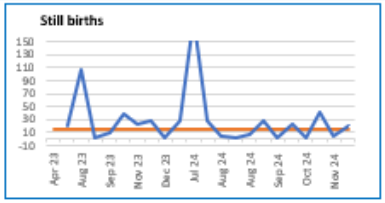
Latest month 01/12/24
Neonatal Death 3.4
No significant change



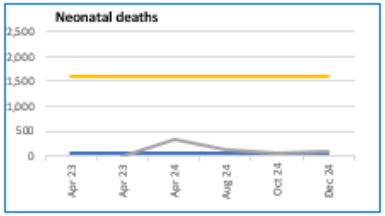
Latest month 01/12/24
HIE rate/1000 0.0
Significant Improvement



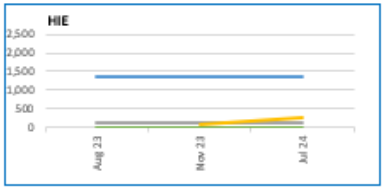
Date of last stillbirth 15/12/24
Average days between 15.9
No significant change



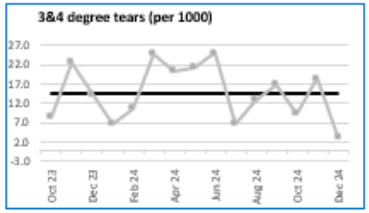
Date of last neonatal death 29/12/24
Average days between 69.2
No significant change



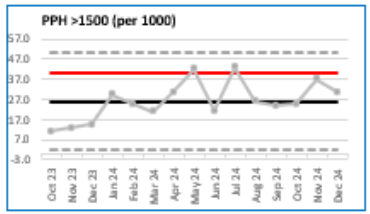
Date of last HIE 22/07/24
Average days between HIE 148.7
No significant change



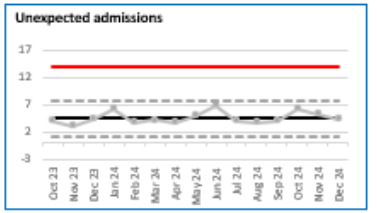
Latest month 01/12/24
3&4 degree tears (per 1000) 3.4
No significant change



Latest month 01/12/24
PPH >1500 (per 1000) 30.6
No significant change



Latest month 01/12/24
Unexpected admissions to NNU ATAIN 4.4
No significant change



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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	31/03/2025	Work has now started to convert Rose Room into a 2nd theatre	Extreme	Annabelle Keegan
General environmental issues were highlighted during the 2023 CQC inspection	30/04/2025	Work to sound-proof the STH bereavement room has been completed; work to increase the unit footprint to accommodate triage is planned.	Extreme	Kathryn Hughes
Maternity lift breakdowns restricting access to labour and maternity wards and risk of entrapment for staff and patients	31/03/2025	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	31/03/2025	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. Work to increase the unit footprint to accommodate MAU is planned.	High	Annabelle Keegan

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Perinatal Mortality

- **ESTH Data from the PMRT data tool**

	Dec 2023 – Nov 2024	Jan 2024 – Dec 2024
Antepartum stillbirths	13	12
Intrapartum stillbirths	0	0
Stillbirth (unknown timing	1	1
Early neonatal death	3	4
Late neonatal death	1	1
	(18)	(18)
<24 weeks	1	2
24 – 27 weeks	4	5
28 – 31 weeks	2	2
32 – 36 weeks	5	4
37 – 41 weeks	6	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 Nov/Dec 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
ESTH: 2 panel meetings held (22/11/2024 and 06/12/2024 with an external panel member at the November meeting)	INC-158919 INC-159199 INC-158848 INC-159754 INC-159354 INC-161247 INC-162505	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 INC-151063	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.*** 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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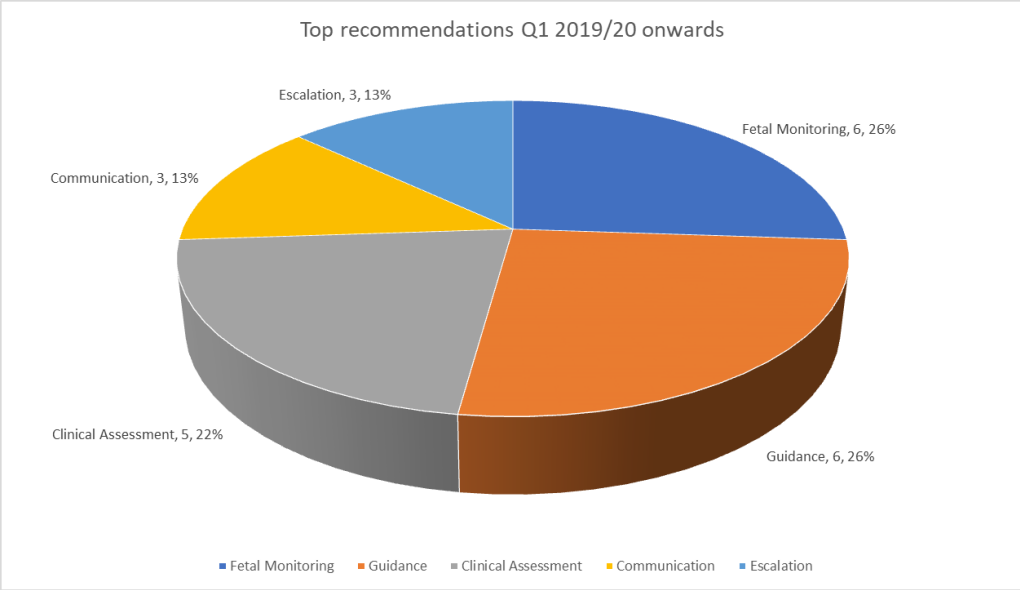
MNSI Cases

- 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 Nov/Dec 2024.
- There are no open action plans in relation to MNSI reports.



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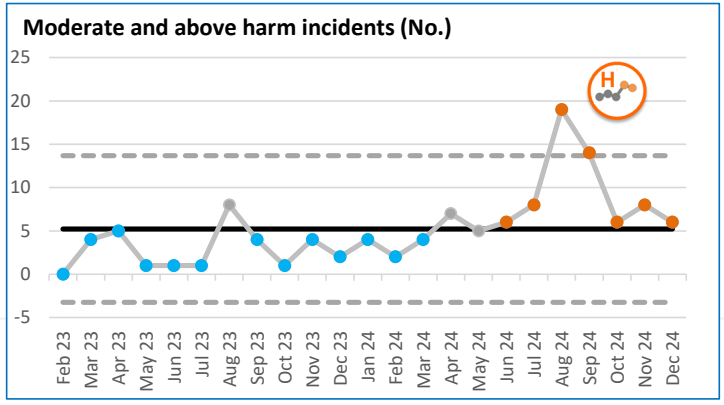
Moderate and above Harm Outcomes

In November 2024 there were 8 moderate harm outcomes identified; these related to:

- Postpartum haemorrhage (1)
- Massive obstetric haemorrhage (3)
- 3rd/4th degree tear (2)
- Stillbirth (2)

One the 8 incidents, 3 have been closed with PSI or learning response identified and 5 are currently under review. Stillbirth occurred at 30/40 and 38+3/40 and both cases are currently undergoing an MDT panel review using the Perinatal Mortality Review Tool.



In December 2024 there were 6 moderate harm outcomes identified; these related to:

- Post-partum haemorrhage (1)
- Massive obstetric haemorrhage (1)
- Bladder injury at caesarean section (1)
- Neonatal injury following forceps delivery (1)
- Stillbirth (1)
- Neonatal death (1)

The neonatal death occurred at 21+3/40 following a late miscarriage and this case has been reviewed and closed with no PSI identified; all other cases are currently under review. The Stillbirth which occurred at 25+2/40 is undergoing an MDT panel review using the Perinatal Mortality Review Tool.

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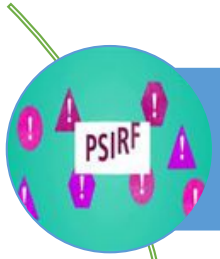
PSIIs/Learning/Themes



There are currently no open actions from PSIIs/legacy SIs.

During November and December 2024 7 investigations were closed, 6 of which were closed through review by the PMRT panel (see separate PMRT report on the CNST update slides). One AAR was completed and identified actions in relation to escalation and documentation.

There are currently 10 open investigations/learning responses; 6 cases are being reviewed by the PMRT panel; 1 PSII is currently with the family for comments on the draft report, 2 are being investigated by MNSI and 1 is subject to an MDT review.

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Incident themes (PSIRF)

Top 5 Incidents November 2024

The majority of incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in November 2024 were:

- Readmission of baby (19)
- Term baby admitted to the neonatal unit (11)
- Blood loss >1500mls (10)
- Guidelines not followed(7)
- Antenatal delay in care or procedure (6)

Top 5 Incidents December 2024

- Readmission of baby (17)
- Blood loss >1500mls (9)
- Guidelines not followed (6)
- Term baby admitted to the neonatal unit (4)
- Postnatal delay in care (4)
- Maternal readmission (4)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slide 3).

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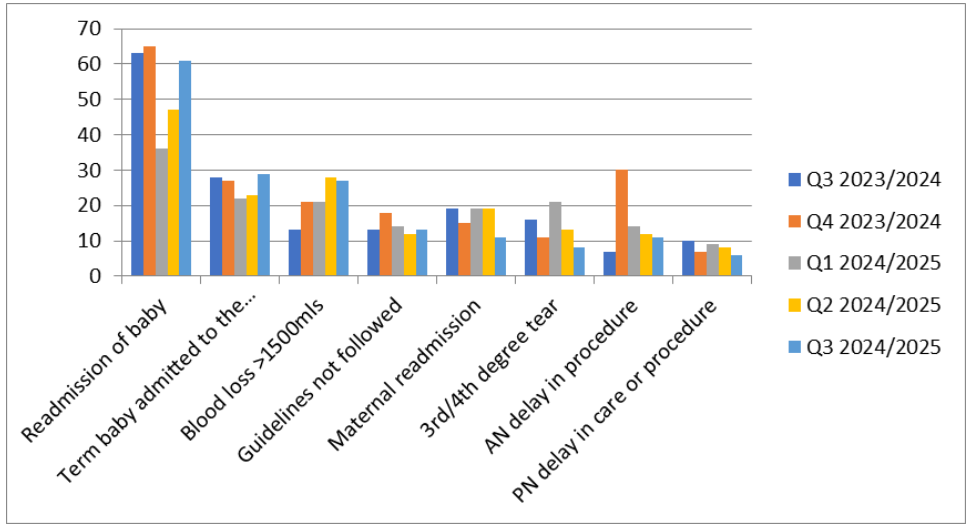
Incident themes Quarterly analysis/QI (PSIRF)



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; we have only showed as above the national average on 2 of the last 15 months (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 with no themes or trends identified.

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Training Compliance

Type of Training and % compliance	Staff Group	ESTH Oct 24	ESTH Nov 24	ESTH Dec 24
PROMPT 90%	Midwifery Staff	94%	96%	94%
	Maternity Support Workers	93%	97%	93%
	Consultant Obstetricians	90%	94%	97%
	Trainee and Staff Grade Obstetricians	96%	97%	100%
	Anaesthetics	87%	95%	100%
CTG Training 90%	Midwifery Staff	95%	95%	95%
	Obstetricians	97% Cons/100% MG	97% Cons/100% MG	97% Cons/95% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	94%	96%	95%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	94%	98% Nurses/100% ANNP	Requested
NLS (Newborn Life Support) 90%	Neonatal Medical Staff		100%	100%

Training compliance as at 30/11/2024 (01/12/2023 – 30/11/2024) was 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	Oct 2024		Nov 2024		Dec 2024	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		94%	92%	94%	94%	92%	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 was submitted to QCiC in October 2024.

Neonatal nursing and medical fill rates requested but not supplied.

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Service User Feedback (complaints, FFT, PALS, MNVP and actions)

COMPLAINTS

There were 9 complaints in Q3 2024/2025. We received 4 complaints in November and December 2024; these related to general/multiple issues around the management of care and listening to concerns and delays in care. There was one allegation of 'visible' racism, although from review of the notes there is no evidence to suggest that care was not as expected.

PALS

During November and December 2024 there were 26 contacts; most contacts were regarding confirmation of appointments/self-referral and requesting birth debrief appointments. Other recurring themes included positive comments about care (4), waiting time for debrief appointments (4) and antenatal care concerns (3).

FFT (112 responses in October 2024) - positive feedback:

- ✓ Personalised care
- ✓ Maternity vaccination service
- ✓ Being seen in a timely manner
- ✓ Infant feeding
- ✓ General comments about the excellence of the service and staff

FFT - YOU SAID/WE DID

There were comments around visiting hours, community midwifery care, waiting times in MAU.

We are reviewing MAU to ensure there is medical cover in place to reduce waiting times. Staff have been reminded to ensure woman are give the ***'Welcome to the Maternity Unit'*** leaflet which explains the visiting policy.

ACTIONS – There have been a number of general reminders issued to staff in response to complaints.

To ensure women reinforce to women the need to bring their own formula milk if they wish to artificial feed. Also, actions to remind staff to use professional language at all times and sign-post women to information leaflets.

MNVP – Positive feedback for antenatal care/support and women could not speak highly enough of care in labour. There were lots of positive comments around care on the Birth Centre. There were mixed comments around breastfeeding support on the postnatal ward. More information is required around induction of labour, specifically around timescales, and there were some instances where women felt decision making was taken out of their hands.

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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)

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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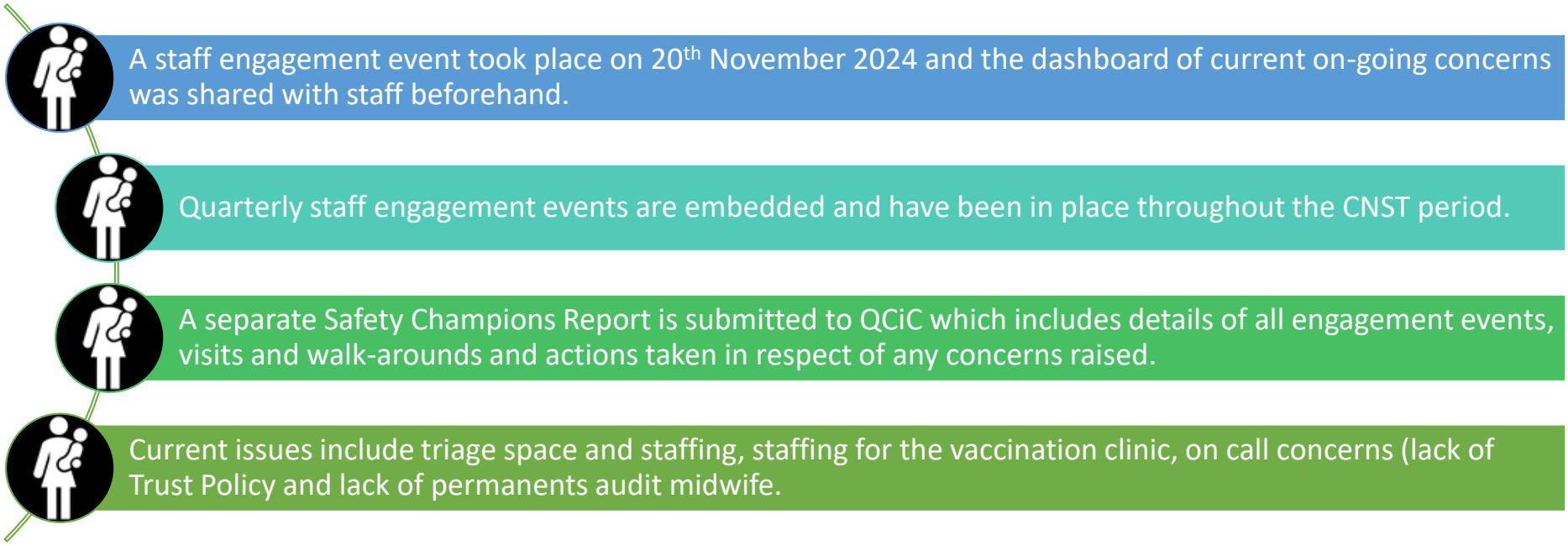
Safety Champions (staff engagement/feedback/walk-arounds etc.)



- 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.
- Current issues include triage space and staffing, staffing for the vaccination clinic, on call concerns (lack of Trust Policy and lack of permanents audit midwife.

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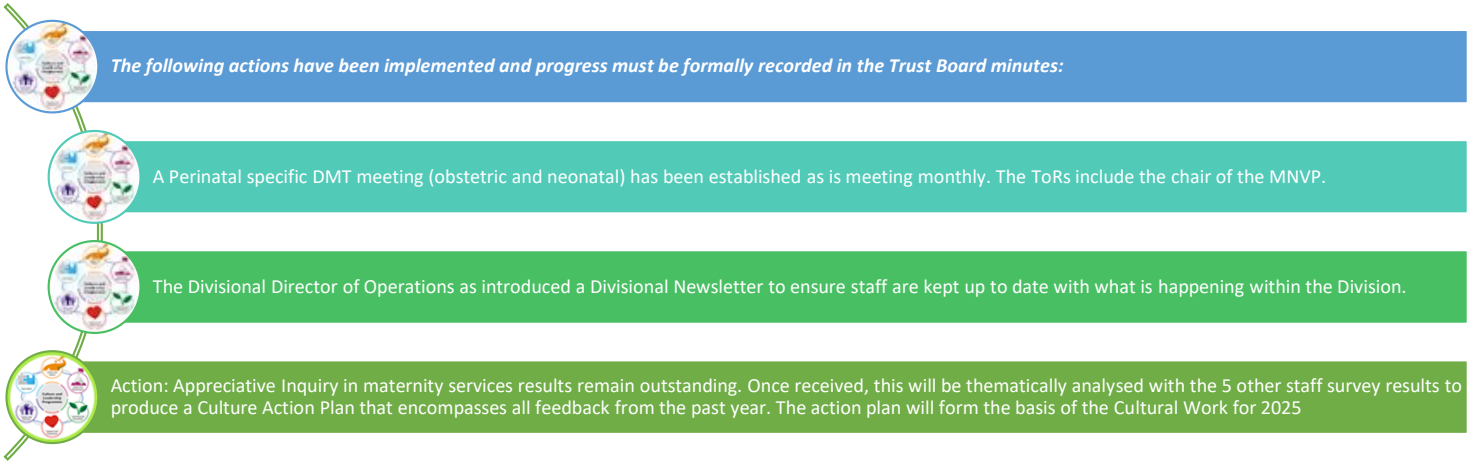
Include cultural improvement plans/survey/SCORE survey



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:

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Appendix 2a

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SGUH Perinatal Quality Surveillance Model Data, November and December 2024

Group Board - March 2025

Presented by:
Natilla Henry
Group Chief Midwifery Officer

06 March 2025

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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.

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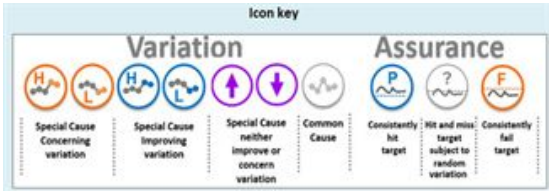
Outcomes dashboard



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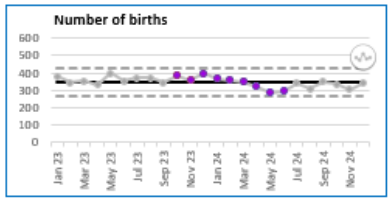
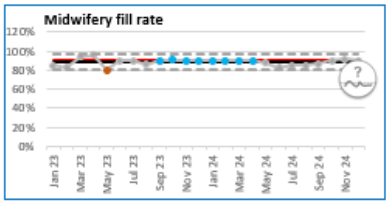
Maternity overview — St Georges Maternity Unit

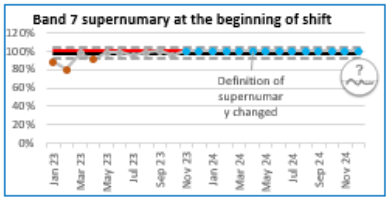
Latest month 01/12/24
Number of births 341
No significant change



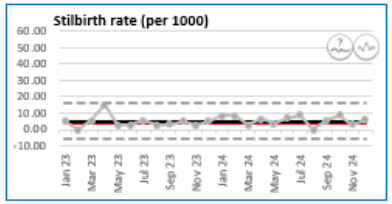
Latest month 01/12/24
Midwifery fill rate 90%
No significant change



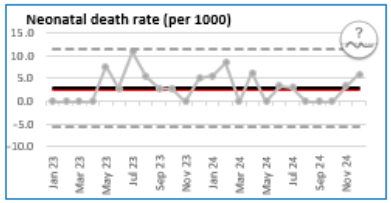
Latest month 01/12/24
Supernumary status 100%
Significant Improvement



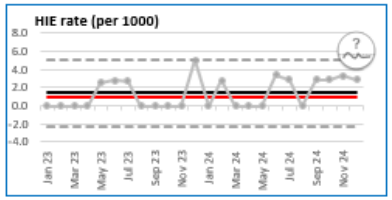
Latest month 01/12/24
Still birth rate/10 5.9
No significant change



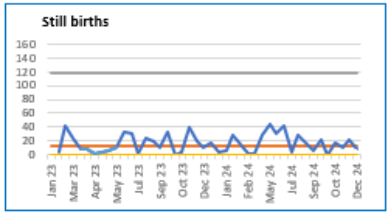
Latest month 01/12/24
Neonatal Death rate/1000 5.9
No significant change



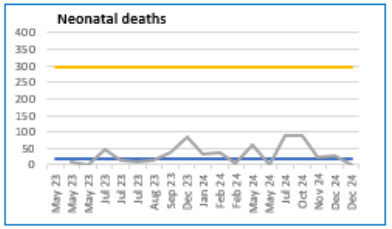
Latest month 01/12/24
HIE rate/1000 2.9
No significant change



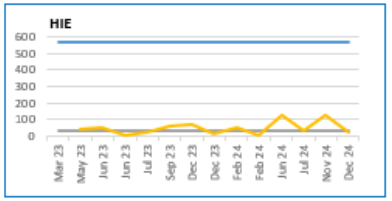
Date of last stillbirth 10/12/24
Average days between 12.1
No significant change



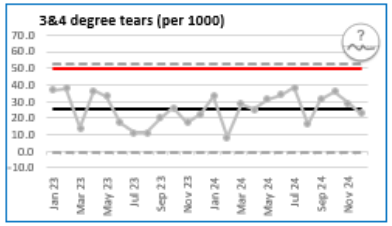
Date of last neonatal death 22/12/24
Average days between 20.9
No significant change



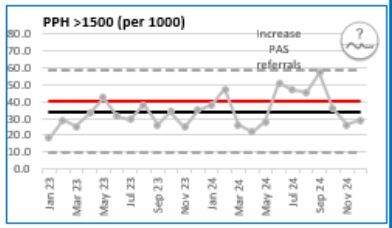
Date of last HIE 20/12/24
Average days between HIE 35.1
No significant change



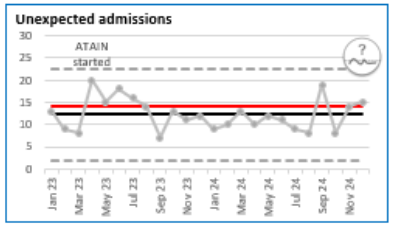
Latest month 01/12/24
3&4 degree tears (per 1000) 23.0
No significant change



Latest month 01/12/24
PPH >1500 (per 1000) 29.0
No significant change



Latest month 01/12/24
Unexpected admissions to NNU ATAIN 15.0
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
FMU Laser Stack	18/12/2024	FMU laser stack out of its life span and manufacturer maintenance	Extreme	Cheryl Stewart
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

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Risks – Moderate and above

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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**

	Dec 2023 – Nov 2024	Jan 24-Dec 2024
Antepartum stillbirths	21	21
Intrapartum stillbirths	1	1
Stillbirth (unknown timing	3	3
Early neonatal death	15	12
Late neonatal death	7	8
	(47)	(45)
<24 weeks	9	9
24 – 27 weeks	15	12
28 – 31 weeks	3	3
32 – 36 weeks	9	9
37 – 41 weeks	11	12
≥ 42 weeks	0	0

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Perinatal Mortality

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- **Cases discussed, themes and open**

PMRT Panel	Cases reviewed November and December 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
During the period of November/December 2024, SGH held 3 meetings in which 8 cases were discussed. 2 out of the 8 cases were re-discussion and in out of the 8 cases, an external panel member was present for 2 cases.	• ID:94950-IUD • ID:92175-IUD • ID:87434-NND • ID:90977-NND • ID:93934-NND • ID:94937-NND • ID:995210-IUD • ID:95304-IUD During this period, the SOP for PMRT was reviewed and updated to make it more suitable for a tertiary unit. The SOP was ratified and published in January 2025.	No new clear emerging themes were identified to date that contributed to the deaths of the cases reviewed. Case ID: 95210 was reported as After Action Review and case ID: 95304 was reported as Patient Safety Incident Investigation. Both cases were discussed at PMRT meetings however we are waiting for the outcome of these cases for recommendations.	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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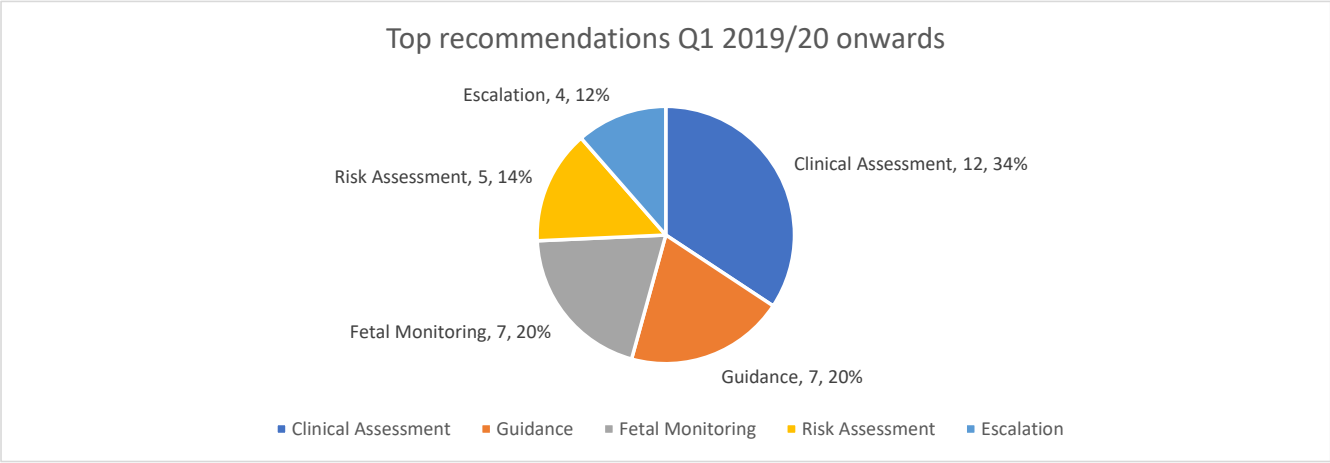
Perinatal Mortality (MBRRACE-UK Perinatal Mortality Report)

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2022 birth has shown that SGUH 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 8 cases open with MNSI; 6 ongoing cases and 2 new cases.
- 2 cases related to stillbirths, and 2 cases related to therapeutic cooling
- 2 maternal deaths

3 cases were closed during November/ December2024.



Moderate and above Harm Cases

In November 2024 there were 21 moderate harm outcomes identified; these related to:

- Postpartum Haemorrhage (13)
- 3rd degree tear (4)
- 4th degree tear (1)
- Stillbirth (1)
- Staff violence by patient (1)
- Unexpected admission to NNU

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 December there were 20 moderate harm outcomes identified; these related to:

- Post-partum haemorrhage (9)
- 3rd degree tear (6)
- Unexpected admission to NNU (2)
- IUD (2)
- Retained swab- Never event (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 5 open investigations, 3 PSII and 2 AAR

During November and December 2024 2 investigations were closed. 1 AAR and 1 case investigated by MNSI and there were no safety recommendations.

10

Incident themes (PSIRF)

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Top 5 Incidents November 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 (unexpected postnatal admission)
- 2 instruments used for delivery (e.g. forceps following failed Kiwi)

Top 5 Incidents December 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
- Diabetes clinic capacity

Incident types- November and December 2024

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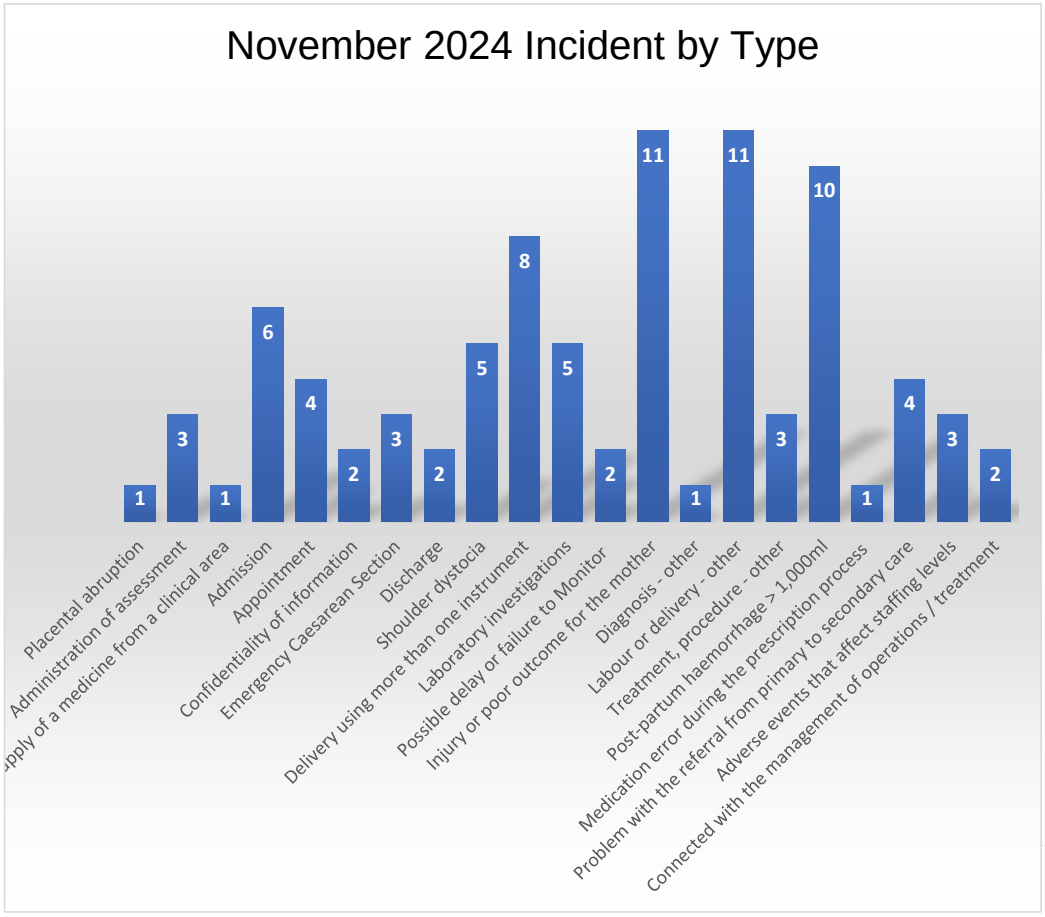

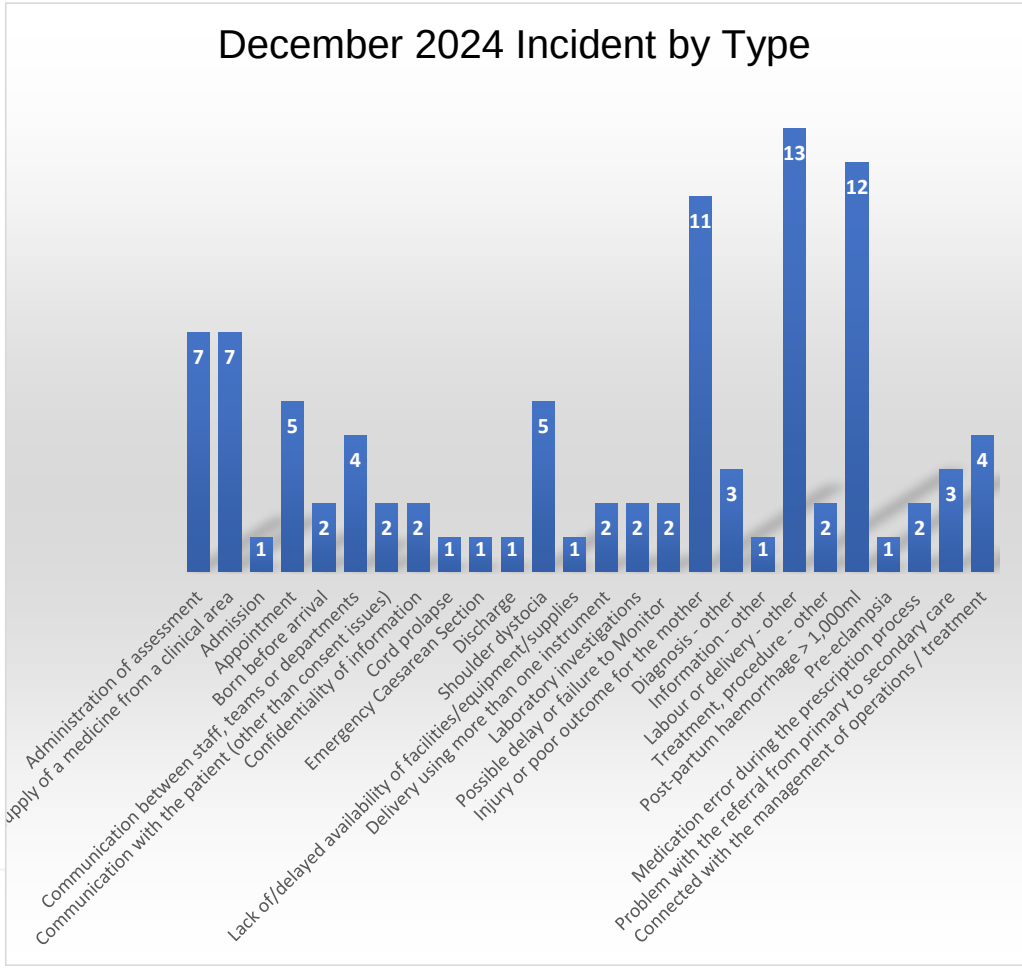

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Training Compliance

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Type of Training and % compliance	Staff Group	SGH Oct 24	SGH Nov 24	SGH Dec 24
PROMPT 90%	Midwifery Staff	90%	90%	87%
	Maternity Support Workers	90%	90%	92%
	Consultant Obstetricians	95%	100%	95%
	Trainee and Staff Grade Obstetricians	78%	83%	87%
	Anaesthetics	88%	94%	94%
CTG Training 90%	Midwifery Staff	89%	98%	92%
	Obstetricians	84%	100%	89%
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	93%	88.2%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	90%	90%	88%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

In PROMPT there are 3 junior doctors who require SGH training - 2 of these Junior Drs started at St George's in October 2024.

They are booked to attend PROMPT in January and February 2025 , so we are compliant as per MIS year 6 April 2024 amendment.

13

Safe Staffing

St George's University Hospitals NHS Foundation Trust

Safer Staffing-Nov- 2024

Ward name	Day				Night				Overall %
	Registered Nurses/ Midwives		Care Staff		Registered Nurses/ Midwives		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	720	540	349	349	679	380	333.5	322	76%
Delivery Suite	5153	4287	1061	886	4,669	4411	1,035	1,012	89%
Gwillim Ward	2188	1985	735.5	588	1380	1,290	690	689	91%

St George's University Hospitals NHS Foundation Trust

Safer Staffing-Dec- 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	705	572	81%	379	300	79%	702	554	79%	357	355	100%	83%
Delivery Suite	5,185	4,733	91%	1,143	943	82%	4888	4520	92%	1,070	1,047	98%	92%
Gwillim Ward	2,224	2,095	94%	712	634	89%	1415	1357	96%	702	690	98%	95%

	Nov 2024		Dec 2024	
Band 7 supernumerary MW allocated at start of shift	100%		100%	
Triage Staff Day 2 RM & 1 MSW	100% 1 MW & 1MSW	85% 2 MW & 1 MSW	100% 1 MW & 1 MSW	53% 2 MW & 1 MSW
Triage Staff Night 1 RM & 1 MSW	100%		100%	

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Service User Feedback (complaints, FFT, PALS,MNVP and actions)

Complaints

There were 7 complaints received in November and December 2024 for Maternity. 6 Complaints related to Birthing and Midwifery. 1 complaints related to Safeguarding on information shared with Social Services.

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 an 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 actions

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Action Log development for current 2024 survey results is in progress with new MNVP maternity Lead & area leads. It will follow below format.

National CQC Maternity Survey 2023 Action Log

Where experience could improve	Action: Responsible person	Progress
Providing women with information about feeding their baby during pregnancy	Annual training for all midwives to ensure they are giving consistent advice and sign-posting to all available resources ie local & national breastfeeding support, Infant feeding resources, social media updates on weekly local community -based classes. Babybuddy App promoted (e -redbook discontinued): **Matron for AN clinic & Community/ Consultant Midwife - Public Health / PDM team**	Annual eLfH training for all midwives, 10hrs online study allocated - AN classes offered F2F by all teams; gap analysis of specialist teams due Jan 25.
During antenatal checks, being asked about mental health by midwives	Ensure all women can identify their named midwife. Whooley questions are used at booking; DV questions (AQ) in private: **Perinatal Mental Health Lead Midwife/DV & Substance misuse Lead Midwife**	Audit 30 notes Dec 24 due. Whooley questions & 'AQ' embedded/ mandatory at booking to trigger referral or close f/up – achieved.
Being able to get support or advice about feeding their baby during evening, nights or weekends if needed Implementation of a new values -based ward round (midwife led)	Ensure all women are aware of the contact details (QR coded postnatal leaflet) highlighting: **Matron - PN ward** • Maternity helpline, 7 day a week, 8am -8pm (this started in June 22 and sustained to date, Dec 24) • National Breastfeeding helpline contact details up until 9.30pm – social media and PN leaflet • 24-hour postnatal ward contact. Maternity proposal for 24 -hour reception cover to ensure dedicated person answering the phone. • Upskill HCA to MSW which involve infant feeding role and daily group discharge talks in parents' room on ward.	Two cohorts of HCAs upskilled to MSW level. Plan for next cohort in discussion. Website development to Padlet version for easier accessibility. Social media Instagram account updated with infant feeding classes and support groups.
Receiving help from a midwife or health visitor about feeding in the 6 weeks after birth	HV team details clear on discharge leaflet and community midwife team contact details with in -house/community Infant Feeding team support details: **Matron for Community**	Matron liaised with HV Leads to ensure that contact details are up -to-date – achieved.
Asking women about their mental health during their care after birth	Implementation of 1. A Midwife -led Values -based ward round: **Matron PN ward** 2. The Birth Satisfaction Scale (UK -BSS-R, 2014/ up -dated 2023): **MNVP Lead/Con Midwife**	Training attended (03.10.24) by Consultant Midwife who will pilot in Jan 2025, Launch - April 2025

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Maternity and Neonatal Voices Partnership Actions

MNVP-led ACTIONS

- A new MNVP maternity Lead has been recruited and appointed Mrs Amena Ahmed started in Jan 2025 and is currently developing (in conjunction with the operational leads) a workplan draft based on user feedback, Whose Shoes actions, and is awaiting the 2024 CQC maternity survey results. The MNVP Neonatal Lead is currently being appointed via the First Touch charity and NNU Leads. The 2 Leads will co-chair the MNVP.
- MNVP maternity Lead is working with SWL ICS core connector to prioritise communities to direct targeted antenatal and postnatal information language/deprivation/greatest risk e.g., a user recorded a talk on postnatal depression for an Islamic Radio station with the Consultant Midwife.
- The Whose Shoes event in 2024, attended by 49 users, stakeholders and MDT staff, resulted in 14 Actions for the maternity/neonatal services and 20 Pledges from staff which will result in service improvements.
- The key themes included: linguistic and cultural differences, supporting refugee and asylum seekers, improving communication with patients, continuity of care and documentation, improving multi-agency and cross-team conversations and collaboration, listening to patients and providing person-centred care, services under pressure and staff morale, technology-enabled care, and improving access to services and support both antenatally and postnatally.
- 15-steps in Maternity due to be led by MNVP Lead on 29th January.
- Review of website and social media channels in progress by MNVP maternity Lead. Comms request for changes Jan 25.

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Birth trauma and birth experience

- In order to evaluate the birth experiences of our parents on an ongoing basis, the Birth Satisfaction Scale-Revised version (UK-BSS-R) will be piloted in January and February 2025.

- Full roll-out for all women on 1st April 2025 once training has been given to area Leads to calculate the satisfaction score according to the scoring criteria. Results to be presented to staff quarterly at the unit meeting and discussed at senior team meetings and at Governance Days.

- This will enable a quantitative measurement of Birth Satisfaction.

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Cont....

Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern.
There are no current NHS 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	• Signed off at EAP in 4th February 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))		85% compliant	• To be presented at EAP in Feb 2025	Action plan with 3-month audit data for Environment audit (MITIE) to be complete Band 7 compliance for daily equipment 100% compliance for monthly audits on RATE
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))		100 % compliant	• To be presented at EAP in Jan 2025 deferred to 4th Feb 202	
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 Feb 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 in Feb 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

Summary of Safety Champions visits, as presented at the gesh Maternity Triangulation Meeting on 18 November 2024

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Executive Summary

Maternity and Neonatal Safety Champions play a crucial role in ensuring the safety and quality of maternity and neonatal care within our trusts, facilitating effective relationships, providing strong leadership and ensuring robust governance processes are in place.

Board Level Maternity Safety Champion: their role is to promote unfettered communication from 'ward-to-board', by working with maternity and neonatal safety champions to ensure that maternity and neonatal issues are communicated and championed at board level.

Board safety champions should ensure that safety in its broadest sense is a priority item at board meetings, with the board taking action where needed, as well as regularly monitoring quality and safety outcomes, by drawing on data from e.g. MBRRACE-UK reports, National Maternity and Perinatal Audit reports, Saving Babies' Lives Care Bundle and feedback from women and birthing people, as well as friends and family tests.

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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.

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gesh Maternity and Neonatal Champions Staff Engagement Events

Action Log

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Staff Engagement session – 20 November 2024

Issues/Concern	Actions	Lead	Due
Expired Drugs and Equipment Following CQC inspection expired drugs and equipment was picked up	GCNO asked that you go around, check and bring to the attention of the department any issues you can see with a fresh pair of eyes!	**All clinical staff**	December 2024
LMNS Maternal Deaths Piece of work presented to Quality Group/Committee looking at maternal deaths over the last few years and identified common learning.	Antoinette is pulling together a plan to share the findings and will update GCNO	**Antoinette Johnson**	April 2025

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Freedom to Speak Up (FTSU)

The FTSU team confirmed that there have not been any FTSU concerns raised for maternity in November or December.

There was however one query raised regarding Bank rates of pay.

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Thank you.

For any other information, please see:

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	3.2	
Report Title	**Group IQPR**	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Group Director of Performance & PMO, ESTH & SGUH Site COOs, Group Chief Nursing Officer, Group Chief Medical Officer	
Previously considered by	Finance Committees-in-Common Quality Committees-in-Common	-
Purpose	**For Review**	

Executive Summary

This report provides an overview of the key operational and quality 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 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 People Committees-in-Common

The Committee is asked to:

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

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Report
Appendix 2	

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Group Integrated Quality & Performance Report

January 2025

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 21 February 2025

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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: - ESTH – 74.7% vs. trajectory of 77% - SGUH – 78.3% vs. trajectory of 77%	**Deliver Financial Plan**: - ESTH Deficit of £15m forecast against target of £5m (adverse to plan). - SGUH Deficit of £17m forecast against target of £4m (adverse to plan)	**Improve Fundamentals of Care:** – **Falls** –ESTH and SGUH not achieving targets – **Pressure Ulcers** – ESTH achieving, SGH not achieving targets. – **VTE Risk Assessments** – ESTH and SGUH not achieving – **Delirium/Dementia Assessments** – 4AT (delirium detection tool) is now available at ESTH	**Staff Turnover Rates*: Target 13%** - ESTH - Achieving Target - SGUH – Achieving Target
Maintain ED 12hr Waits at 23/24 Level or below: - ESTH - 14.2% vs. baseline (23/24) of 9.6% - SGUH – 9.5% vs. baseline (23/24) of 8.8%	**Deliver 5% Productivity (ERF)** - ESTH target of 107.4%, forecast outturn 110.4% - SGUH target 105.0% forecast outturn 112.8%	**Achieve Mortality Ratios (SMHI) of 1 or less**: - ESTH - 1.16 (above expected) *(partly attributable to SDEC reporting change)* - SGUH – 0.89 (below expected) *upcoming SDEC reporting likely to adversely impact reported performance*	**Staff Sickness Rates***: - ESTH – 5.83% vs. target of 3.8% - SGUH - 5.3% vs. target of 3.2% - Sutton H&C – 7% vs. target of 3.8% - Surrey Downs H&C– 6.4% vs target of 3.8%
Work with partners to deliver 1.5 Days average Non-Elective LOS Reduction: - ESTH - 10.7%, maintained improvement - SGUH – 10.4%, increase January 2025	**Deliver 5.5% CIP** - ESTH fully delivered target CIP inclusive of mitigations. - SGUH fully delivered CIP inclusive of mitigations.	**Eliminate RTT 65-week waits by September 2024:** - ESTH - 63 patients (decreasing trend) - SGUH – 24 patients (decreasing trend)	**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 H&C – 71.2% - Surrey Downs H&C – 80%		**Deliver 62- Day Cancer Waiting Times Operational Plan Targets**: - ESTH - 85.3% Achieving Plan - SGUH –77.4% Achieving 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. New results due 13th March 2025

* Proxy for Staff engagement whilst detailed metrics are developed

IQPR Development
Proposed Changes for 2025-26

Refresh CARE Board of priorities metrics for 25/26

Update metrics to 2025/26 priorities – national and local

- Performance against the RTT 18 weeks standard (5% pt improvement) and proportion waiting over 52 weeks (<1%)
- Outpatient waits to first appointment (5% pt improvement)
- UEC – 4 hour waits (78%)
- Cancer Standards – Faster Diagnosis and Start of Treatment
- Operational Productivity measures – refine and refresh reporting

Update metrics to 2025/26 priorities – national and local

- Distinction between key metrics and watch metrics
- Enhance reporting of rare events e.g. reporting time between events instead of cases per month

Further incorporate the Integrated Care into the report.

Executive Summary
Safe, High-Quality Care

St George's Hospital

Successes

- **Mortality:** Mortality rates, measured using the Summary Hospital-level Mortality Indicator (SHMI), remain below expected levels. However, the inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set at SGUH is likely to negatively impact reported performance**.**
- **Complaints:** SGUH consistently meets the targets for responding to complaints within 35 days and acknowledged within 3 working days.

Challenges

- **Never Events and Patient Safety Incident Investigations (PSII):** There was one Patient Safety Incident Investigation in January 2025, with no Never Events recorded.
- **Pressure Ulcers:** Two category 4 pressure ulcers were reported in January 2025: one related to a medical device in the General Intensive Care Unit (GICU) Unit secondary to a endotracheal tie, and a sacral category 4 in Cardiothoracic Intensive Care Unit . There were 11 category 3 pressure ulcers acquired in January 2025 compared to 6 in December 2024. Improvement work on pressure ulcer prevention is ongoing in adult Intensive Care Units and has been expanded to include Mouth Care Matters.
- **Falls Prevention and Management:** In January 2025, there were four moderate harm falls and one high harm fall. The high harm incident involved a left hip fracture, with the patient continuing rehabilitation. One moderate fall involved rib fractures, and the patient is receiving rehabilitation at Queen Mary's Hospital. Two other moderate falls resulted in subdural haematomas, with one patient discharged home and the other still an inpatient on the neurosurgical ward. The fourth moderate fall involved an acromioclavicular joint disruption (shoulder), which is being managed conservatively. These incidents are being reviewed within Divisional Governance meetings and clinical areas for actions.
- **VTE:** In January 2025, only 60.2% of VTE risk assessments were completed within 14 hours of admission, falling short of the 95% target as per NICE guidelines. Actions being taken include a trust-wide review of VTE risk assessment forms and a review of the VTE prevention strategy at SGUH and across the trust.
- **Readmission**: Readmission rates have been steadily increasing, primarily driven by patients returning to Same Day Emergency Care (SDEC) areas due to the expansion of surgical SDEC. Readmissions to non-SDEC areas have remained steady at around 7%. A pathway and patient-level review is underway, and while this has not been identified as an emerging theme in patient safety, it will continue to be monitored.
- **Infection Control:** There were four hospital-acquired C. difficile infections in January 2025, and year-to-date cases have surpassed the annual threshold of 43. Despite this, performance remains within the top 25% of 135 NHS Trusts. All samples sent for ribotyping showed no similar strain, suggesting there is no evidence of cross-infection or a circulating strain in the hospital.

Epsom & St Helier

Successes

- **Complaints:** ESTH met the target for the percentage of complaints responded to within 35 days for December 2024.

Challenges

- **Pressure Ulcers:** The total number of pressure injuries remains low but has increased with eight acquired in January 2025 compared to five in December 2024 One case progressed to a Category 3 injury from a deep tissue injury and has been escalated for an After-Action Review. Of the remaining seven cases, five were Category 2 pressure ulcers, including two linked to medical devices.
- **Falls Prevention and Management:** In January 2025, there were two falls resulting in moderate or severe harm within Acute Services. These included a hip fracture (severe harm) in Epsom SDEC and a humeral fracture (moderate harm) in St Helier's ED. A total of 92 falls were reported, with 63 occurring in inpatient areas (2.9 per 1,000 bed days). This represents an increase from December 2024 (2.5 per 1,000 bed days) but remains below the national average of 6.6 per 1,000 bed days).
- **VTE:** The Trust's VTE performance for January 2025 was 83%, a slight decrease from 83.2% in December 2024. This remains below the national target of 95%. Compliance with completing risk assessments within 14 hours of admission continues to be a challenge, particularly in areas impacted by winter pressures. Efforts are underway to standardize processes and reporting across GESH.
- **Mortality:** SHMI remains high and stable, partly due to the inclusion of SDEC data in the Emergency Data Set, over the past few months.
- **Infection Control:** The Trust continues to see a rise in C. difficile infections, with five hospital-acquired cases in the latest reporting period, bringing the year-to-date total to 68—exceeding the trajectory of 63. In December 2024, the UK Health Security Agency (UKHSA) issued a briefing note highlighting the increase in C. difficile infections across England. In response, a UKHSA C. difficile Technical Group has been established, with further surveillance and recommendations planned for 2025.

Executive Summary
Operational Performance

St George's Hospital

Successes
- Cancer performance standard trajectories were met in December 2024: 28-Day Faster Diagnosis standard (86.1%) and 62-Day Treatment Standard (77.4%).
- First and procedure outpatient (OP) attendances as a percentage of total OP attendances continues to exceed target, achieving 51.8% (above the national ask of 49%).
- Significantly reduced the number of patients waiting for more than six weeks for a diagnostic test by providing additional capacity through the month, further actions in place to further improve performance to within 5%
- Performance against the 4-hour standard continues to exceed national ask achieving 78.3% through January 2025 performing within the top quartile in London.
- SDEC (Same Day Emergency Care) activity continues to increase, demonstrating a sustained step change in improvement, currently piloting Frailty SDEC.

Challenges
- Patient Initiated Follow Ups (PIFU) rates are below the target of 5%, although improving and now live within 14 services, with Audiology going live in February 2025 and two Cardiology pathways in March 2025.
- Further increase in the number of patients on a referral to treatment pathway waiting for more than 52 weeks, 906 patients at the end of January, driven mainly by Neurosurgery and Bariatric Surgery. Specialties have been given detailed actions to mitigate growth of wait times and a continued focus on eliminating 52 week waits by March 2026.
- Overall Theatre utilisation rates across the month was 79% impacted by QMG Closure, reduced 4-hour sessions. Higher on the day cancellations due to patients being unwell and issues related to patient flow, this has also impacted on our ability to re-date patients within 28 days.
- A high proportion of beds continue to be occupied by patients who do not meet the criteria to reside, increasing through January 2025. Programme support for the IMPOWER initiative is currently being identified.
- High attendances and acuity in ED remain a challenge, along with a high number of complex mental health patients. The number of patients seen in ED cohort areas has increased steadily and is being closely monitored and mitigated as necessary.

Epsom & St Helier

Successes
- Theatre utilisation (capped) remains high at 81.27% in January 2025, and top quartile, nationally.
- Cancer performance standards were achieved in December 2024: 28-day Faster Diagnosis standard (81.9%), 31-day standard (97.8%) and 62 Day Standard (85.2%)
- Successful business case to substantively recruit a second H&N CNS that will solidify ESTH's position as the leading H&N service in SWL, providing all H&N patients with nurse-led clinical assessment and triage.
- DNA rates returned to below 7% after a seasonal increase in December.
- The Trust achieved the ambition to be below 715 in December 2024 for RTT 52-week waits, with 631 patients waiting more than 52 weeks, the second consecutive month that the ambition has been achieved in 2024/25.
- Average Length of Stay (LOS) reduction remained at 0.8 days in January 2025 compared to April 2024. This is due to the continued progression of our complex patients with extended long LOS who were discharged in the month of January.
- SDEC (Same Day Emergency Care) activity continues to increase month on month, with January demonstrating a further increase and reporting the highest activity to date.

Challenges
- Increasing delays in cancer pathways due to extended waiting times for external diagnostics, including a 3-4 week wait for Endoscopic Ultrasound Staging (EUS). Delays in lung cancer diagnoses are rising due to higher referrals for Navigational Bronchoscopy, an alternative to CT-guided biopsies, at the Royal Brompton. Additionally, PET scans at RMH are delayed due to F-18 FDG supply issues. Discussions with RMP are underway to reduce diagnostic wait times.
- Ongoing capacity issues impacting the ability to book outpatient appointments within the 7-day ESTH local target, particularly in urology, dermatology, gynaecology, and lower GI. Cancer Team collaborating with service teams on Demand and Capacity modelling to identify areas for improvement.
- A&E waits and timely ambulance handovers remained a challenge in January 2025 due to a combination of high attendances and acuity on both sites. However, there was an improvement in A&E performance in January 2025 (74.7%) compared to December 2024 (71.8%).
- Mental health patients continue to experience prolonged waits in the 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 to regularly review and monitor progress.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

- 2-Hour UCR Service performance of 74.1% remains above response target (KPI 70%). Referral numbers continue to increase with activity at 545 in month.
- Occupancy rate for the reablement unit remains at 100%.
- High levels of MAST maintained.

Challenges

- The Childrens therapy waiting list has increased in month to 798 from 753. This has been raised with the ICB and is on their risk register across SWL. Plans are in place to address the SWL cohort. The service have put in place robust mitigations, noted 1 child remains on the waiting list for 52+ weeks. .

Surrey Downs Health & Care(SDHC)

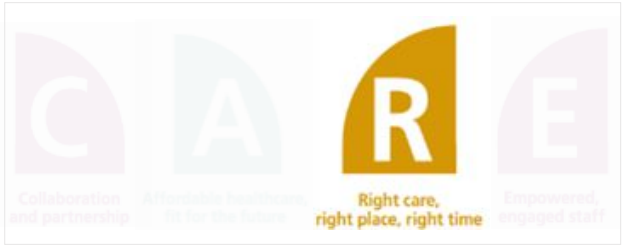
Successes

- The service maintained its target of discharging of patients through Transfer of Care hub supporting patient flow.
- Service consistently achieves the 2 -hour UCR target while managing high levels of referrals – 84.4% in January 2025 against a target of 70%.
- Increase in number of patients accepted to VW
- Occupancy rate in bedded care was maintained meeting target of 80%.
- Reduction in number of patients waiting 18+
- High levels of MAST maintained
- Improvements in agency usage rate to 3.9%

Challenges

- Increase in Absence rate to 6.4% due to Winter season.
- Reduction in non-medical appraisal rate- staff support offered to improve this

Quality & Safety



Safe, High-Quality Care

Overview Dashboard

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KPI	St George's Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark	Epsom & St Helier Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Never Events	Jan 25	2	0	0				Jan 25	0	0	0			
Patient Safety Incident Investigations	Jan 25	3	1	0				Jan 25	0	1	0			
Number of Falls With Harm (Moderate and Above)	Jan 25	5	5	1				Jan 25	0	2	1			
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Jan 25	0.20	0.20	0.12				Dec 24	0.00	0.00	0.03			
Pressure Ulcers - Acquired category 3	Jan 25	6	11	8				Jan 25	1	1	7		P	
Pressure Ulcers - Acquired category 4	Jan 25	0	2	0				Jan 25	0	0	0			
30-Day Readmission Rate	Dec 24	12.1%	13.5%	-	H			Dec 24	5.9%	5.9%	-			
Infection Control - Number of MRSA	Jan 25	0	0	0		P		Jan 25	0	0	0			
Infection Control - Number of Cdiff - Hospital & Community	Jan 25	4	4	4				Jan 25	5	4	5			
Infection Control - Number of E-Coli	Jan 25	13	17	10	H			Jan 25	3	2	5			
VTE Risk Assessment	Jan 25	57.7%	60.2%	95.0%		F		Jan 25	83.0%	83.2%	95.0%	L	F	
Mortality - SHMI	Sep 24	0.91	0.89	1.00	L	P		Sep 24	1.16	1.16	1.00		F	
% Births with 3rd or 4th degree tear	Jan 25	2.3%	1.5%	-			3.1%	Jan 25	0.6%	4.1%	-			3.2%
% Births Post Partum Haemorrhage >1.5 L	Jan 25	2.9%	3.3%	-			2.9%	Jan 25	3.1%	3.0%	-			3.2%
Stillbirths per 1,000 births	Jan 25	5.9	6.1	-				Jan 25	3.4	0.0	-			
Neonatal deaths per 1,000 births	Jan 25	5.9	3.0	-				Jan 25	3.4	0.0	-			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Jan 25	3.0	3.0	-	H			Jan 25	0.0	0.0	-	L		

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

* Maternity data not received due to impact of Maternity "Go- Live"

Safe, High-Quality Care

Overview Dashboard | Patient Experience

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Complaints responded to in 35 days	Jan 25	100.0%	100.0%	85.0%				Dec 24	74.5%	97.9%	85.0%			
Percentage of complaints acknowledged within three working days	Jan 25	97.0%	100.0%	100.0%				Dec 24	98.0%	100.0%	100.0%			
Number of complaints not completed within 6 months from date of receipt	Jan 25	2	2	0				Dec 24	6	6	0			
Friends and Family Test - Inpatients Score	Jan 25	97.9%	98.6%	90.0%			Top Quartile	Jan 25	99.0%	98.8%	90.0%			3rd Quartile
Friends and Family Test - Emergency Department Score	Jan 25	77.0%	80.2%	90.0%			2nd Quartile	Jan 25	0.0%	72.7%	90.0%			3rd Quartile
Friends and Family Test - Outpatients Score	Jan 25	93.5%	94.3%	90.0%			3rd Quartile	Jan 25	98.0%	100.0%	90.0%			2nd Quartile
Friends and Family Test - Maternity Score	Jan 25	69.2%	79.3%	90.0%			3rd Quartile	Jan 25	N/A	N/A	90.0%			N/A
Watch List Metrics														
Number of Complaints Received	Jan 25	75	70	-				Dec 24	49	31	-			
Number of re-opened complaints in month	Jan 25	6	5	-				Dec 24	0	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Jan 25	0	0	-				Dec 24	3	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Jan 25	0	0	-				Dec 24	0	1	-			

*Community FFT is a subset of Epsom and St Heliers FFT data.
FFT at ESTH delayed due to migration to a new reporting system

Safe, High-Quality Care

Overview Dashboard | Integrated Care

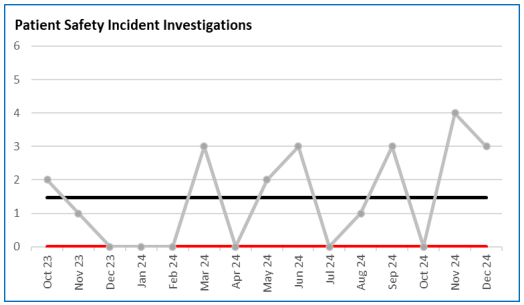
KPI	Sutton Healthcare Latest month	Sutton Healthcare Previous Month Measure	Sutton Healthcare Latest Month Measure	Sutton Healthcare Target	Sutton Healthcare Variation	Sutton Healthcare Assurance	Surrey Downs Latest month	Surrey Downs Previous Month Measure	Surrey Downs Latest Month Measure	Surrey Downs Target	Surrey Downs Variation	Surrey Downs Assurance
Patient Safety Incidents Investigated	Jan 25	0	0	-			Jan 25	0	0	-		
Number of Falls	Jan 25	7	7	-			Jan 25	6	17	-		
Pressure Ulcers Category 3	Jan 25	1	4	0		?	Jan 25	5	8	0	H	?
Pressure Ulcers Category 4	Jan 25	0	0	0		?	Jan 25	1	0	0		?
Infection Control - Number of Cdiff	Jan 25	1	0	-			Jan 25	0	0	-		
Complaints	Jan 25	0	0	-			Jan 25	0	1	-		
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

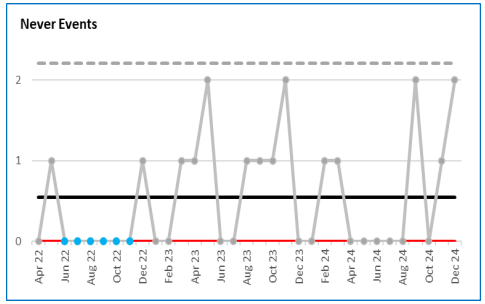
Incident Reporting

St George's



Summary & Actions

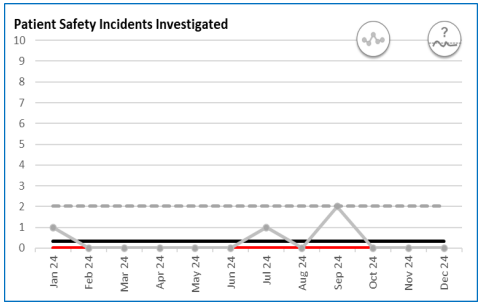
One Patient Safety Incident Investigation (PSII) was declared at SGUH in January 2025, related to an unexpected admission to the Neonatal Unit (NNU) in Obstetrics.



Summary & Actions

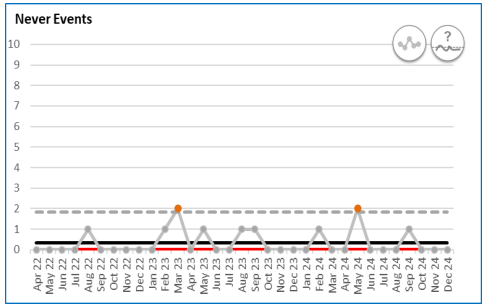
No Never Events were reported at SGUH in January 2025

Epsom & St Helier



Summary & Actions

One Patient Safety Incident Investigation (PSII) was declared at ESTH in January 2025, relating to the provision of care for adult and paediatric patients in the Emergency Department, while awaiting a mental health placement.

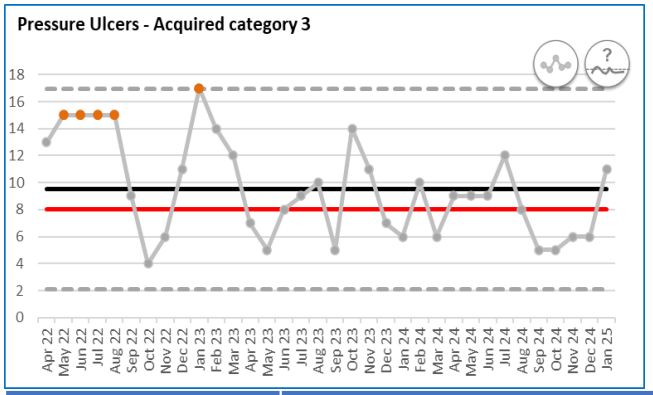


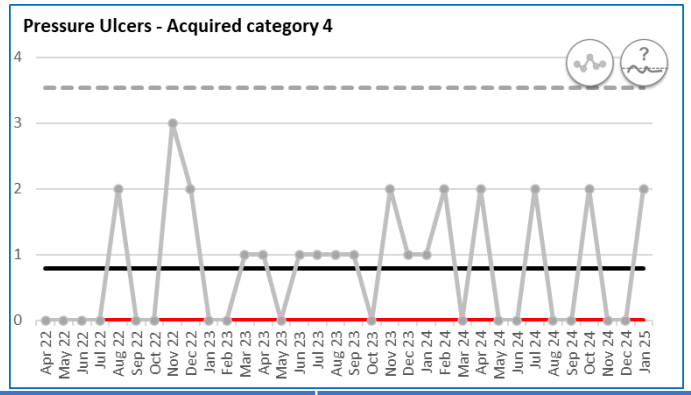
Summary & Actions

No Never Events were reported at ESTH in January 2025

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers Category 3 & 4





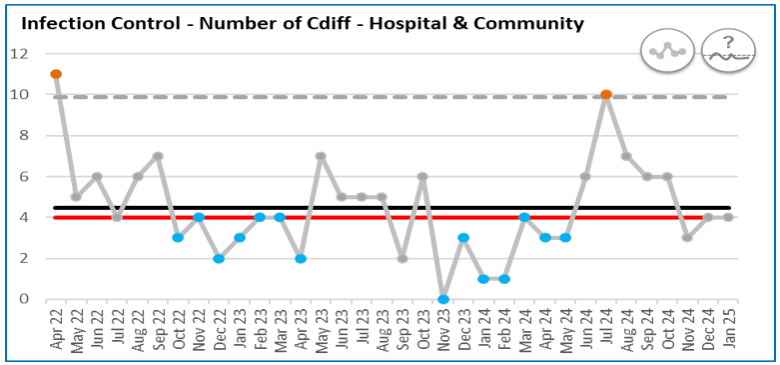
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

SGUH
 	
Pressure Ulcers Category 3 Quality Priority - 69 YTD against Ambition of 89 currently achieving YTD
 	
Pressure Ulcers Category 4 Quality Priority 8 YTD against Ambition of 0
	• There were 2 category 4 pressure ulcers cases reported in January 2025, one was related to a medical device in the General Intensive Care Unit (GICU) Unit secondary to a endotracheal tie, and the other was a sacral C4 in Cardiothoracic Intensive Care Unit. There were 11 category 3 pressure ulcers acquired in January 2025 compared to 6 in December 2024.
	• All patients that acquired a pressure ulcer in January 2025 were frail and acutely unwell
	• Two pressure ulcers were caused by the same type of oxygen delivery device. An investigation was conducted to ensure there were no issues with the product, and it was determined that the ulcers were due to user placement errors, rather than any problems with the product itself.
	• A large proportion of the pressure ulcers could have potentially been identified at an earlier stage (category 1 or 2)
		• The Dynamic Healthcare and Medical Physics teams will continue the gradual mattress replacement program, aiming for completion by August 2025. To date, 30% of the stock has been replaced, including mattresses in all priority areas.
		• The Tissue Viability Team has worked with procurement to ensure that the correct catheter fixation devices are available on stock lists, and this was completed by January 2025.
		• The Site Chief Nurse and Fundamentals of Care Team will collaborate to put resources in place aimed at improving continence care, with the goal of reducing moisture-associated skin damage. This will include the development of a new:
		  ○ Continence product formulary
		  ○ Group policy, including a formalized risk assessment and nursing care plan.
		• The adult critical care pressure ulcer prevention initiative continues and has now been expanded to include the "Mouth Care Matters" programme.
			March 2025 achieve 10% reduction compared to 2023/24	Sufficient for assurance

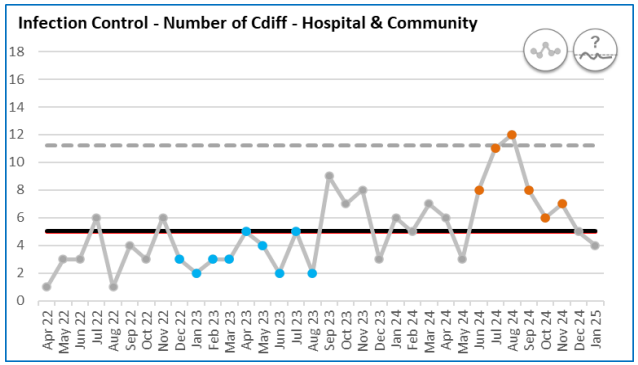
Safe, High-Quality Care

Exception Report | SGUH & ESTH - Infection Prevention and Control

St George's



Epsom & St Helier

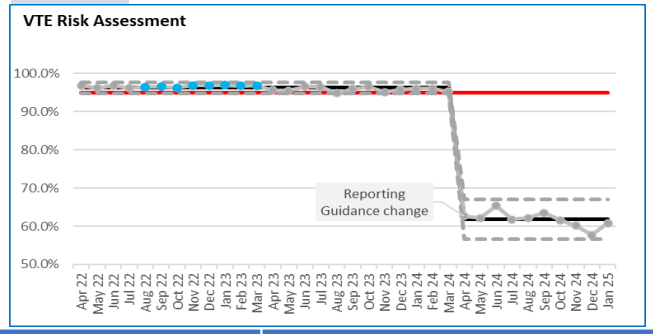


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH and ESTH <u>C.difficile Infections (CDI)</u> We continue to see an increase of healthcare acquired CDI infections across the group and above monthly ambition. Increased Norovirus activity across both sites (similar trend seen nationally)	Healthcare Associated CDIs: • SGUH: 4 new C diff cases. YTD 52, trajectory 43 • ESTH: 4 new C diff cases YTD 72, trajectory 63. • Increase in cases at both sites is resulting in bay/ward closures	• SGUH: performance remains within the top 25% of 135 NHS Trusts with a rate of 15.37 per 100,000 bed days • ESTH: No new learning from the reviews, no outbreaks or evidence of cross transmission. • A separate detailed Infection Prevention Report goes to the Board and at group IPC Strategy meeting. • Increased enhanced cleaning/use of UV light disinfestation if necessary • Incident/outbreaks meetings to help manage and maintain patient flow • Daily IPC reviews and updates including weekends	March 2025 achieve aim of a downward trend. April/May 2025 (seasonal downward trend nationally)	Sufficient for assurance

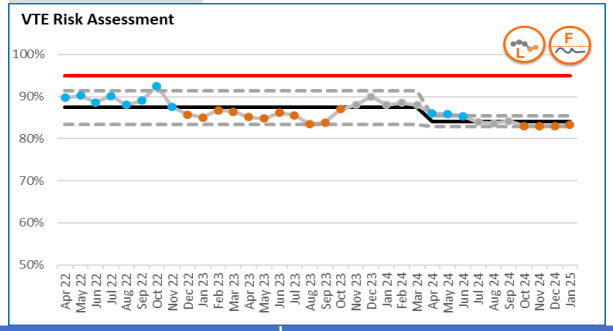
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



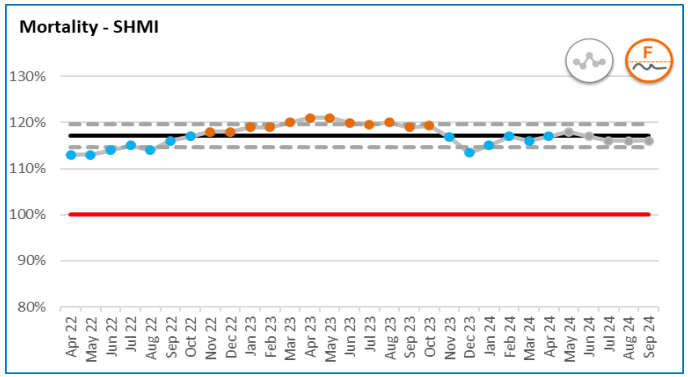
Epsom & St Helier

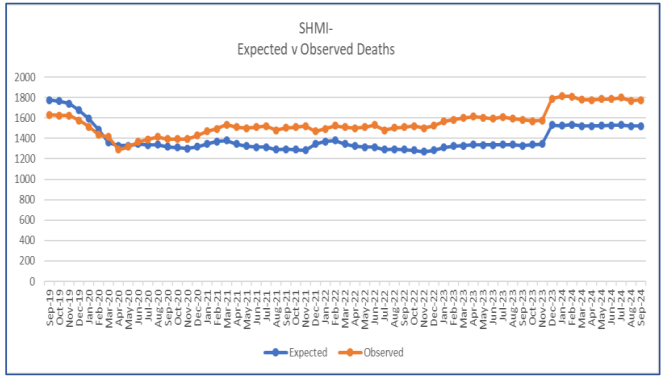


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE Performance 60.8%. Not meeting target of 95%	The VTE risk assessment data submission to NHS England Digital now requires assessments to be completed within 14 hours, in line with NICE standards. As a result, performance has been impacted. In January 2025, St George's continued to fall below the 95% target, with a performance rate of 60.2%, which is higher than the rate in December 2024.	• Targeted training and education are being implemented for underperforming areas identified through Tableau analytics. • The ongoing GESH task group is reviewing the VTE risk assessment form to enhance completion rates. • The Hospital Thrombosis Group and Clinical Informatics are collaborating with ESTH to standardize reporting across the GESH Group.	Aim of incremental improvement: 10% by end of Quarter 3 and review.	Not sufficient for assurance.
ESTH: VTE Performance – 83%. Not meeting target of 95% 1st Qtr national VTE risk assessment performance results published by NHS England: ESTH: April 84.09%, May 83.85%, June 83.18% (National target 95%)	At ESTH, performance remains below target, with underperformance affected by: • Wards below average performance for the Trust include STH CCU 56%, C5 56%, B3 T&O 55%, B1 53%, A5 52%, C1 51%, Northey 50%, C4 48%, C3 46%, B5 42%, EGH CCU 37%, Gloucester 35%, Chuter Ede 31%, Britten 23%: • Above average trust performance: STH labour ward 89%, A3 hip fracture 90%, EGH Birth centre 91%, EGH Delivery suite 92%, STH Birth centre 97%, PACU (SWLEOC) 100%, Oaks ward (SWLEOC) 100%, Buckley escalation ward 100% To note ESTH are using Ward Admission Time as the starting point for patients admitted via ED. Discussions are ongoing to align across gesh.	• The updated VTE policy was approved by the Policy Review Group in October 2024 and is awaiting final approval from the Senior Leadership Team (SLT). • The VTE Service held a meeting with Clinical Leads on January 16, 2025, followed by a follow-up meeting with SGH counterparts • Alignment of VTE processes across gesh • Thrombosis committee meeting • HA-VTE investigation process to be streamlined with divisional ownership/discussion with quality managers	Aim of incremental improvement: 10% by end of March 2025 and review progress.	Not sufficient for assurance.

Safe, High-Quality Care

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



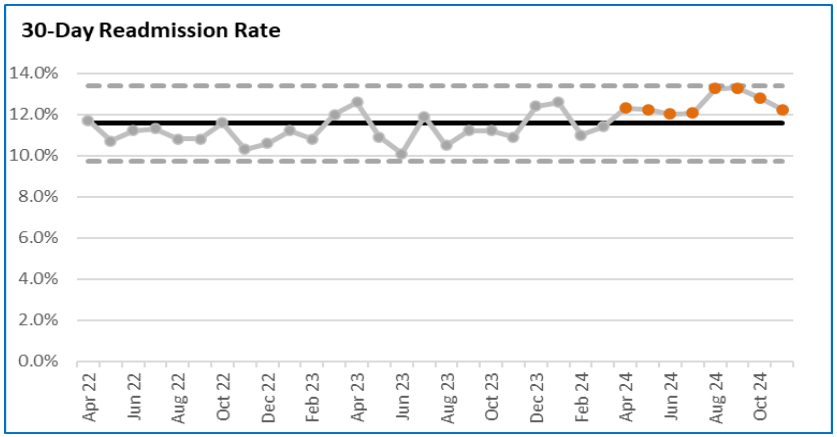


SHMI Source NHS Digital data based on rolling 12 months- August 2023 to September 2024 reported in February 2025

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, ESTH reclassified Same Day Emergency Care (SDEC) activity as non-inpatient activity. This change reduced the total spell count used in the Summary Hospital-level Mortality Indicator (SHMI) model, leading to a decrease in the expected number of deaths, a trend that has been evident since then. Other Trusts were initially expected to adopt a similar reporting approach by July 2024. However, national data shows that by the end of September 2024, only 48 Trusts had submitted data, up from just 18 at the end of the previous year. As a result, NHSE has extended the deadline for Trusts to implement this reporting change to July 2025.	Comprehensive deep dives and thematic analyses of outlying areas have been conducted, covering electrolyte imbalances, UTIs, COPD, and pneumonia. The findings did not indicate any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has highlighted areas for improvement. Any identified care concerns are reported and thoroughly 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. Collaboration between clinicians and coders will be highly beneficial in improving record accuracy. While coding has improved and continues to be reviewed, further enhancements are needed in areas such as UTI and Acute Bronchitis Several enhanced monitoring workstreams are in place, including mortality reviews and medical examiner scrutiny	Under review	sufficient for assurance

Safe, High-Quality Care

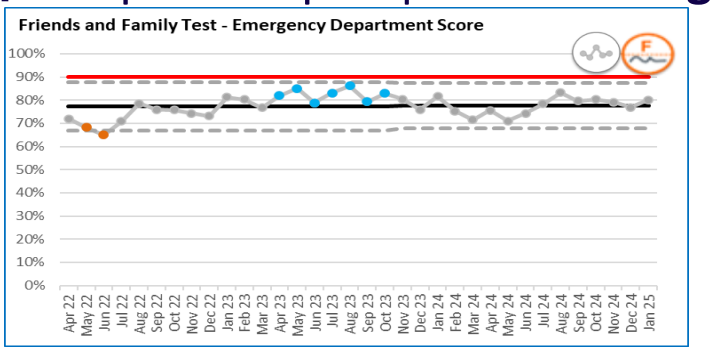
Exception Report | SGUH Emergency Readmission Rates



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: Upward trend in Emergency readmissions within 30 days of a prior inpatient spell.	The overall rate saw a slight increase between 2022/23 and 2023/24; however, the quarterly rate for this year has risen significantly. Analysis indicates that this increase is driven by patients being readmitted to SDEC areas, with a notable rise in activity, particularly following the expansion of surgical SDEC Readmission rates this month remains elevated with a further increase from 12.12% to 13.5% Readmissions to non-SDEC areas are very steady around 7%.	• Reviewing Same Day Emergency Care (SDEC) pathways to assess and optimize patient flow and service efficiency • CCU readmissions appear to be a pathway recording issue rather than a significant increase in patients returning after care. A detailed review of pathways and patient-level data is currently underway. • This has currently not been identified as an emerging theme within patient safety but will be monitored.		sufficient for assurance

Safe, High-Quality Care

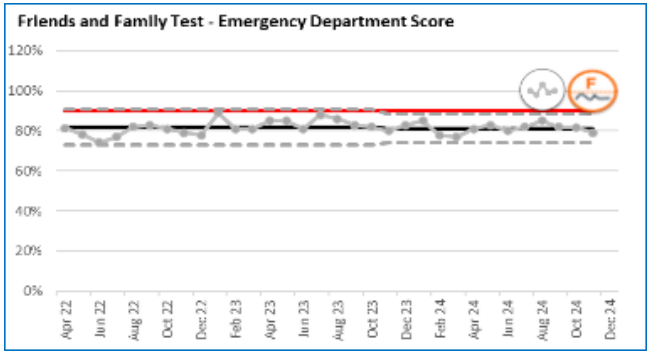
Exception Report | SGUH Emergency Department Patient Experience

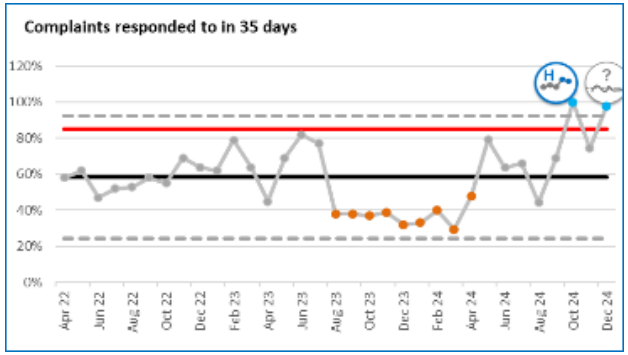


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score Special case concerning variation Consistently failing target	The ED survey response rate continues to be well above the national average with 1,490 patients responding to the survey in January 2025. The number of patients that would recommend the department to friends and family was 80% for January 2025 - a slight improvement on the previous month. During January 2025 , the number of ED attendances and patients waiting for a bed in the department remained high with the most consistent theme for negative responses being waiting times.	**Actions for improving patient experience whilst waiting in ED include:** 1. Review of patient feedback by each area with the relevant leads to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 3. 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 4. 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 5. 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 6. 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 7. Additional streamer at FOH to help keep the queue to check in down from January 2025. 8. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 9. Same Day Emergency Care (SDEC) ongoing - 10 new clinical pathways for medical SDEC launched to redirect patients to medical service if more appropriate. Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic - perfect week started 10th Feb	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	The FFT contract at ESTH has ended, and steps are being taken to secure a replacement as soon as possible. ESTH is transitioning to the system currently used at St George's. While technical solutions are ready, IG approval is still pending, as is the setup and registration of the new product through procurement. External data reporting continues, though it isn't directly comparable to previous months and shows some variations, especially in services where surveys are conducted via text. The reported numbers remain lower for certain services (e.g., ED), pending IG approval for the proposed text messaging service.	• Improve Response rates across both hospital sites • Analyse the themes and trends of patients who provide negative feedback. • Suggestions have been made to involve volunteers in the ED at ESTH to help gather feedback, including FFT, but recruitment efforts have not been successful so far. • The Medical Division is focused on improving patient experience during peak periods of emergency care demand by increasing staffing levels and optimizing patient flow to create more inpatient capacity.	TBC	Not sufficient for assurance
ESTH Complaints responded to in 35 Days Target met in Dec 2024	The target was surpassed in December and there is a strong commitment to maintain this level of performance moving forward. Ownership of responsibilities has varied between the complaints and divisional teams, with the majority of the responsibility resting with the complaints team. This is due to the structure of the complaint process that was previously 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.	April 2025	Not sufficient for assurance

Operational Performance

Operational Performance

Overview Dashboard | Elective Care

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National 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
Elective Ordinary Activity % of plan	Jan 25	88.5%	86.2%	-				Jan 25	85.6%	82.8%	-			
Elective Daycase Activity % of plan	Jan 25	106.0%	92.2%	-				Jan 25	92.4%	100.0%	-			
Outpatient first attendances without a procedure - ERF scope % of plan	Jan 25	145.8%	144.0%	-				Jan 25	96.8%	101.0%	-			
Outpatient procedures - ERF scope % of plan	Jan 25	94.6%	72.6%	-				Jan 25	98.3%	102.0%	-			
Diagnostic Activity	Dec 24	98.8%	106.0%	-			2nd Quartile	Dec 24	109.0%	102.0%	-			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Oct 24	79.7%	80.2%	83.6%			Lowest Quartile	Oct 24	76.5%	75.9%	83.6%			Lowest Quartile
Theatre Utilisation (Capped)	Jan 25	76.2%	78.5%	85.0%			2nd Quartile	Jan 25	81.6%	81.2%	85.0%			Top Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jan 25	1.6%	1.7%	5.0%			Lowest Quartile	Jan 25	5.0%	4.5%	5.0%			Top Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jan 25	53.4%	51.8%	49.0%			2nd Quartile	Jan 25	45.4%	46.5%	49.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Jan 25	10.2%	10.2%	8.0%			Lowest Quartile	Jan 25	7.2%	6.9%	6.0%			3rd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Dec 24	17.9	16.1	16.0			3rd Quartile	Dec 24	50.2	52.9	16.0			Top Quartile
RTT - Waits over 65 weeks	Dec 24	31	24	0			2nd Quartile	Dec 24	72	63	0			3rd Quartile
RTT - Waits over 52 weeks	Dec 24	858	906	410			2nd Quartile	Dec 24	692	631	715			2nd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Dec 24	84.5%	86.1%	77.0%			Top Quartile	Dec 24	87.0%	81.9%	77.0%			Top Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Dec 24	96.1%	94.6%	96.0%			2nd Quartile	Dec 24	98.8%	97.8%	96.0%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Dec 24	76.9%	77.4%	70.0%			2nd Quartile	Dec 24	86.0%	85.3%	85.0%			Top Quartile
Diagnostics - 6 Week Waits	Jan 25	11.8%	5.4%	5.0%			2nd Quartile	Dec 24	5.8%	8.6%	5.0%			2nd Quartile
Watch List KPIs														
RTT - Total Size Incomplete Waiting List	Dec 24	67362	68291	63826			Highest 25%	Dec 24	50386	50537	45632			2nd Quartile
RTT - Percentage within 18 weeks	Dec 24	62.6%	62.1%	92.0%			2nd Quartile	Dec 24	65.4%	65.4%	92.0%			Top Quartile
RTT - Median Waiting Time	Dec 24	12.7	13.5	-			2nd Quartile	Dec 24	12.5	11.9	-			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Jan 25	3	8	0			2nd Quartile	Jan 25	0	2	0			Top Quartile

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

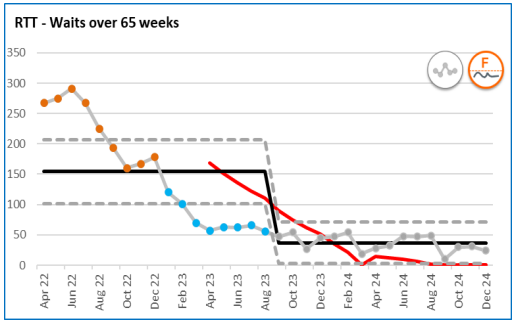
Operational Performance

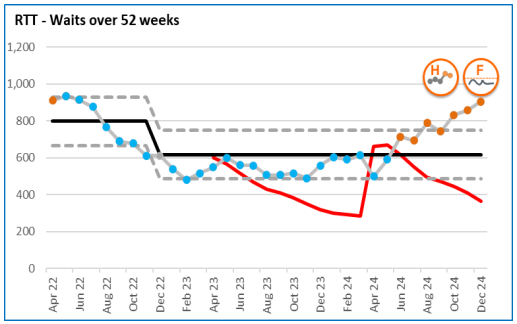
Overview Dashboard | Urgent and Emergency Care

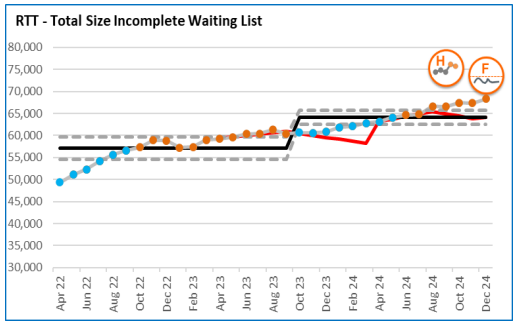
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
4 Hour Operating Standard	Jan 25	79.7%	78.3%	78.0%			Top Quartile	Jan 25	71.8%	74.7%	78.0%			2nd Quartile
Over 12 Hours in ED from Arrival (%)	Jan 25	9.1%	9.5%	8.8%			Top Quartile	Jan 25	14.4%	14.2%	9.6%	H	F	3rd Quartile
Ambulance handover Performance 30 - 60 minutes	Jan 25	31	37	-		P		Jan 25	541	480	-	H		
Ambulance handover Performance 60+ minutes	Jan 25	1	2	0	L			Jan 25	64	65	0	H	F	
Non Elective Length of Stay	Jan 25	9.4	10.4	-				Jan 25	10.7	10.7	-			
Length of stay > 21 days (super stranded)	Jan 25	151	161	117		P	3rd Quartile	Jan 25	141.0	180.0	123.0	H		Lowest Quartile
Overnight G&A beds occupancy - Adults	Jan 25	94.7%	94.6%	90.8%		F	2nd Quartile	Jan 25	88.0%	88.8%	89.0%	L	P	2nd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Jan 25	128	137	86	L		2nd Quartile	Jan 25	180	211	123	H	F	3rd Quartile
Watch List KPIs														
Mental health delays 4 Hour Breaches	Jan 25	124	125	-	H			Jan 25	209	214		H		

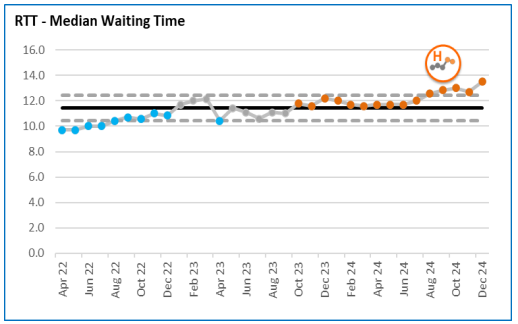
Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)





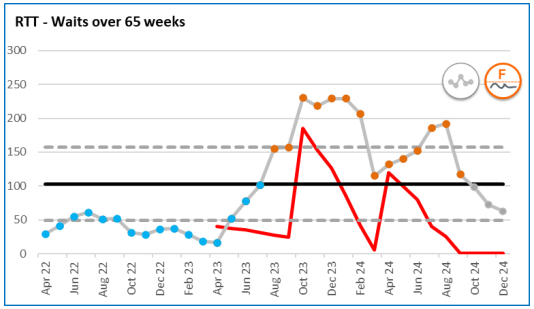


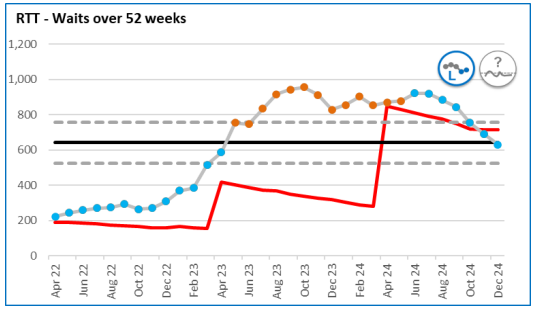


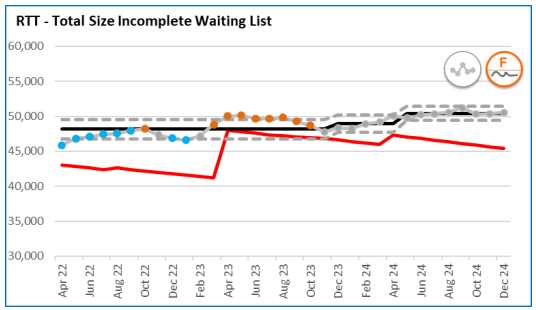
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 0 52 week waits behind plan of 364 Waiting list size behind plan by 9%	At the end of December 2024; • 65 week waits – Further reduction 24 open pathways - Admitted 17 and Non-Admitted 7, Top 3 Gynae, Neurosurgery, Vascular Surgery. • 52 week waits – Overall increase (5.6%) 906 open pathways, driven by Neurosurgery and General Surgery – There are recovery plans in place to reduce wait times in each specialty. Already showing improvements in many specialties inc Pain and Cardiology. Focusing on ensuring national guidance is met to ensure no more than 1% of patients on the waiting list are waiting more than 52 weeks for treatment • Waiting List size remains above the upper control limit with continued growth in non-admitted PTL. Total referrals were approximately 10,000 more in 2024 than in 2023. In comparison, the total PTL grew by 7,000 waiters from Oct23 to Oct24	**March 2025 – Long wait reduction approach** Specialty level PTL meetings being held weekly to go through plans for long waiting patients. **Revision of booking process:** The Trust is focusing on ensuring patients are not booked so far ahead. To reduce the risk of patients not attending and to promote chronological booking. **Firebreak clinics:** Introducing firebreak clinics to reduce the impact on wait times as a result of clinic cancellations **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 Action plan being developed to support delivery of 2025/26 Elective Recovery and target metrics to improve RTT performance	**March 2025** **Phased approach Completion March 2025** **Phased approach – completion June 2025** **March 2025** **March 2026**	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



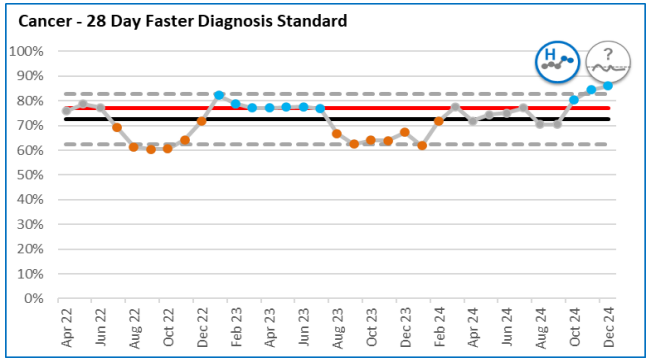


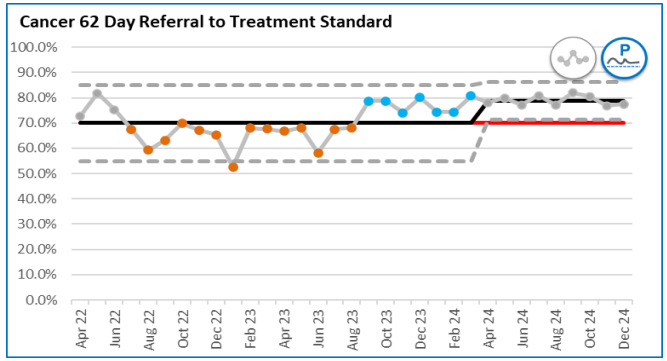


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan 65Wk waits not meeting plan special cause variation	• 52 week waits achieved the ambition to be below 715 in December 2024 with a total of **631** patients waiting more than 52 weeks, the second consecutive month that the ambition has been achieved in 2024/25. The specialties with the highest cohort were Gynaecology (133), Dermatology (73) and General Surgery (53). • However, 65 week waits continues to be above the ambition of zero in December 2024 with a total of **63** patients waiting more than 65 weeks. The specialties with the highest cohort were Gynaecology (18), Gastroenterology (13) and Respiratory (7). • Gynaecology and Dermatology are the most challenged specialties at ESTH with several actions being taken to mitigate. • Challenges within several other specialties including T&O, Vascular, Respiratory and Gastroenterology 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 capacity being funded. • Vascular service remains a challenge. An additional locum consultant and insourcing is in place to support backlog clearance, as well as recently agreed support from SGUH. • Medicine - mitigations are in place including additional consultant support approved in dermatology, cardiology and gastro. Mutual aid is being provided by Croydon for echo and lung function tests; and insourcing in place for Dermatology, Respiratory and Neurology. The onboarding of Virtual Lucy, an Innovative digital healthcare platform, is also supporting with the Dermatology demand. • T&O's main cause of increase in long waiters is a 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. SWLEOC are working with partners to raise issues regarding a consultant's 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 and 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. Weekly updates are being provided to SWL ICS for assurance. The clearance list of 65 plus and 78 plus week waiters are closely monitored by Divisions.	ESTH are expected to have fewer than twenty 65-week waiters by the end of February 2025 and 0 by the end of March 2025.	Sufficient for assurance

Operational Performance

Exception Report | SGUH Cancer Performance



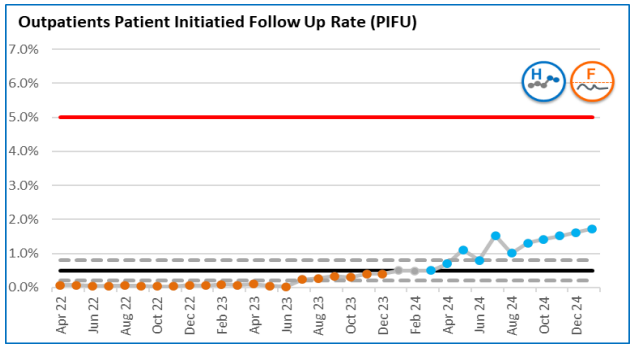


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS Target being met 62 Day Standard Meeting System Wide Target	The Trust recorded a further improved Faster Diagnosis performance in December 2024 achieving 86.1%, surpassing the previous month's figure of 84.5% meeting target for the third consecutive month. Various tumour groups have experienced a month-on-month improvement in performance, which can be credited to recovery plans that are positively impacting the overall performance of the Trust. It's great to see such significant improvements across the board. Breast and Gynae have particularly impressive results with 97% and 88.9% respectively. Skin (90%), H&N (89%), and Urology (77%) also performed well. 62 Day Performance – continues to meet system wide target of 70% achieving 77.4% in December 2025.	• £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. • Lung Thoracic: £18.5K funding for 10 consultant WLIs in place to support theatre capacity. • Haem Oncology demand & capacity review on going. £31K awarded to support recruitment of a Locum consultant for 3 months to deliver WLIs clinics /MDT. • Clinical Haematology: awarded £4K 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: £13K awarded to support WLI and theatre capacity for 3 months. • Radiology: £13K awarded to support admin workforce gaps and provide band 4 cover for 4 months.		sufficient for assurance

Operational Performance

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

St George's

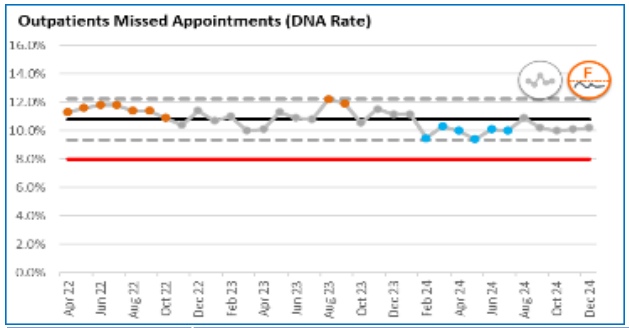


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend	In month performance for January 2025 continues to see a positive increase at 1.7%. PIFU orders continue to rise with 5,284 (+17%) patients currently on a PIFU pathway. Top 3 specialities include: Therapies, Trauma & Orthopaedics and Dermatology.	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure for more specialties are ready to go live - patient leaflets, clinician understand the process, and local SOP. • Of 22 services, we have officially gone live with 14, with Audiology officially going live on 10/02/2025. Conversations are ongoing with General Managers for Resp Med, Diabetes and Endocrine and Cardiology are aiming to go live with two pathways (General Cardiology and ICC) in mid March. We continue to reach out to services to support their transition to PIFU with no agreed go-live dates at present.	3.5% Trust target for end of 24/25	sufficient for assurance

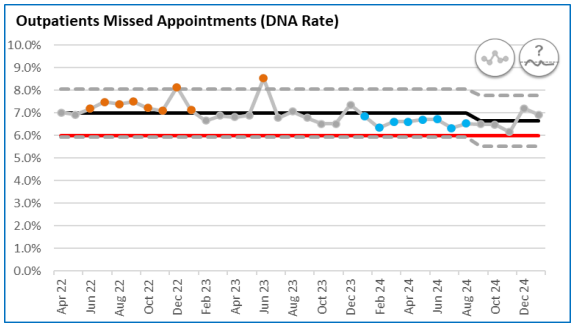
Operational Performance

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

St George's



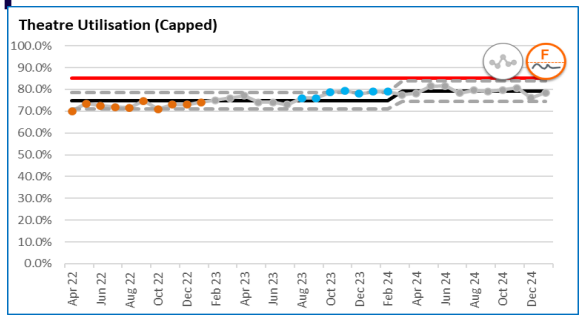
Epsom & St Helier

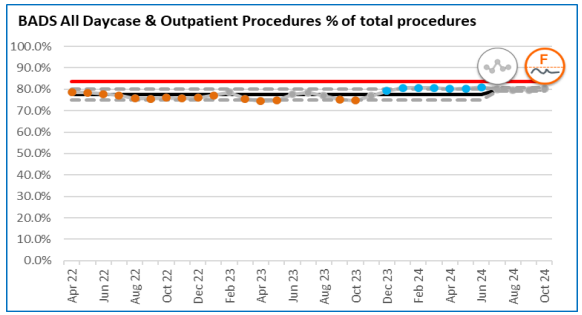


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	• Current DNA rates of 10.2% compared against Peer average performance 8.6% • First appointment DNA Rate 11% highest DNA volume; - Physio 17.5% - Audio 16.4% - Dermatology 10.5% • Follow-up DNA Rate 9.8% - Physio 13.2% - Dermatology 9.5% - Rheumatology 13.7%	• Speciality DNA weekly performance presented to all operational leads in Elective Access Meeting. • Divisions to include DNA reviews within their Divisional reporting prompting services to take ownership of their position and drivers behind this, also monitored via CARE board by SLT weekly. • Feedback from patients have been they have struggled with the 'decision tree' options at the call centre. The Call Centre went live with the new call mapping on 10/02/2025 which will make it much clearer now for patients who need to cancel/reschedule their appointments to get through to the right team to complete their request, it should also reduce waiting times for the call centre overall. • Reviewing Model Hospital data – Reviewing and reaching out to top 10 specialties with high volume DNA rates alongside Model Hospital Analysis and opportunity to reduce DNAs, services to investigate reasons for high rates with support from Outpatient Services and actions to be formulated and progress tracked.	TBC	sufficient for assurance
ESTH Normal variation, no significant change Failing target of 6%	The DNA rate returned to below 7% in January after a seasonal increase in December. Areas of non-compliance with the 5% target are being targeted with deep dives and targeted mitigations tried as a result.	• The automation of text reminders where nurse clinics have specific reasons that currently prevent them being added to the main text reminder are expected to go live in March to support DNA reduction. • Following a deep dives into Paediatric Dermatology, a slight change was made to short notice booking processes and 2-way texts using DrDoctor are being introduced from March. In Respiratory, a detailed review of nurse clinics highlighted short notice cancellations as a likely factor that the project team are now working on mitigating. In Gynaecology clarification of and improved robustness of communication routes for patients needing to cancel or rebook are being tested. • The next deep dive is underway in adult Ophthalmology.	TBC	sufficient for assurance

Operational Performance

Exception Report| SGUH Theatre Utilisation & Daycase Procedure Rates





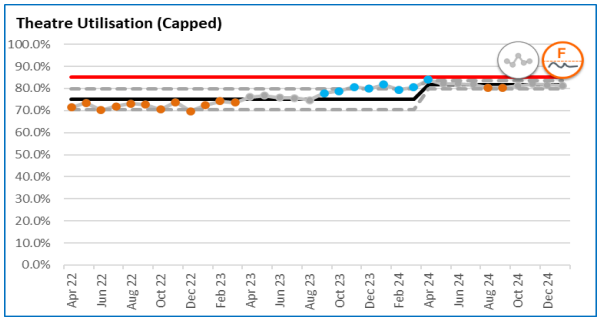
Model hospital recently updated capped utilisation methodology introducing additional exclusions which improves performance for both Trusts. Internal reporting to be updated to align.

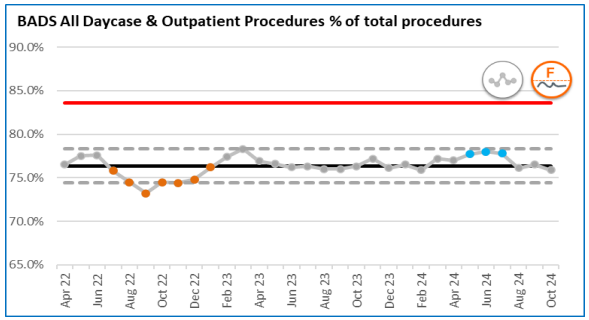
Please note Model Hospital have updated BADS methodology now including outpatient procedures.
The calculation now measures the number of Outpatient Procedure and Day case Procedures as a proportion of all Procedures (Outpatient, Daycase and Inpatients). This is not comparable to previous data.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation (Tableau): 79% 79%- IP 75%-DSU	• Capped Theatre Utilisation: 78.5% across the month of January 2025 • Most specialties have theatre utilisation between 75% and 80% • Latest weekly Model Health data (wk ending 26/01/2025) saw a positive increase with SGUH performing in the upper quartile (High 25%) • QMH Surgical Treatment Centre was closed for refurbishment works • Average cases per session decreased from 1.59 (Dec) to 1.32 (Jan). • Higher on the day cancellations due to patients being unwell and issues related to patient flow, this has also impacted on our ability to re-date patients within 28 days.	• e Pre-Op Assessment being introduced to help reduce cancellations and increase cohorts of patients available for scheduling • Adherence to 6-4-2 escalation processes being implemented to improve theatre capped utilisation and improve scheduling standards • QMH Surgical Treatment Centre: Work has started to define the operational model beyond February 2025, with a new scheduling template aimed at improving efficiency. Also focusing on case mix and start / finish times	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 reporting a rate of 80.2% in latest Model Hospital Data (peer average 84%). • Number of planned daycases that have a length of stay >0 days – if this is a case of incorrect data issue, we could improve further • Daycase proportion of total procedures at 66% below peer average of 75%. Opportunity to move more procedures away from inpatient elective: Breast surgery, Vascular surgery, Oral and MaxFax, ENT which is being reviewed • Model Hospital data uses Intended Management Code- Procedures normally coded as daycase often booked as an intended management of elective overnight due to the complexity of patients referred to SGUH (under counting actual DC).	• BADS compliance is being discussed with all surgical specialities within theatre transformation deep dives to explore opportunity. “Right Procedure, Right Place” data at procedure level is being shared across divisions. • 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 at specialty and procedural level – investigating whether intended management code is being used correctly and plans to correct if required (particular outlier). Test for change instigated in Breast • Continued opportunity to improve data quality and correction.	TBC	Sufficient for assurance

Operational Performance

Exception Report | ESTH Theatre Utilisation & Daycase Procedure Rates





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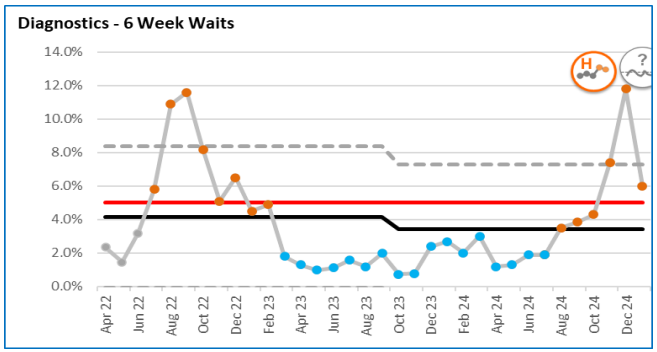
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%) BADS performanc e Not meeting target, Improving trend	• **Utilisation** continues to consistently perform over 80% throughout Quarter 3 of 24/25. ESTHs Average Case Per List (ACPL) number for January 2025 was 3.92. • **Late starts** remain under the 30-minute target at 18 minutes. Further improvement to scheduled timings is anticipated when new consenting rooms open in March 2025. • **On The Day Cancellations (OTDC)** were high again in January 2025 at 7.97% against a target of 6.5% . Reminder calls continue at 7 & 3 days before TCI. Cancelled Ops due to No Theatre Time was a theme in January which is being reviewed at patient level data for learning and to identify possible mitigations.	**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 January. 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 DC rate is **76.5**% overall including EOC. Day case rate has been impacted by the recent inclusion of hip and Knee procedures into the national calculations If we were to exclude EOC activity on Model Hospital ESTH revised day case rate would be **89.3%** in January. • We are introducing 2 SOPs to reduce the top failed day case reasons ('No one at home policy/post –op urinary retention SOP). • EOC commenced process changes for recording hips/knee procedures in Nov 24 and the impact of this should be seen cumulatively in the coming months. • **On The Day Cancellations:** • 'Patient unfit' (cough/cold) continues to be the top cancellation reason for both *'Patient'* & *'Clinical'* Cancellations • Pre-TCI-Calls are being launched for T&O. Currently patients receive a reminder text message, but we are seeing high numbers of OTDC due to patient being unfit with common illnesses. • The Working Group is meeting twice monthly to review deep dive audits with the aim of identifying possible mitigation processes to support the reduction cancelled Ops on the Day. • Working with the Theatre Network to compare rates of OTDC and implement any shared learning. **Queen Marys Paediatric Day Case Theatre Utilisation** ➢ There are multiple factors currently compromising theatre utilisation. A Task and Finish Group has been set up to review: • Confirm the current capacity in the paediatric day-case unit and identify unused capacity within the existing resource. • Review the staffing and estate resource required to enable the unit to run 5 days a week with extended days	TBC	sufficient for assurance

Operational Performance

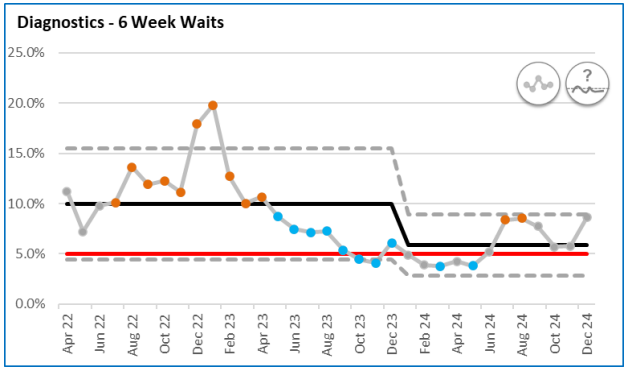
Exception Report | SGUH Diagnostic Performance



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Target not met	At the end of January 2025, 94.6% of patients waited less than six weeks for a diagnostic test compared to 88.2% at the end of December 2024, showing an improved position. The main drivers for non-compliance in November and December 2024 were within Imaging where an increase in referrals for both Gynae ultrasounds and Cardiac CTs exceeds the capacity available. Highest proportion of waits greater than six weeks at the end of January 2025 are within Endoscopy and CT. At month 6 the department had scanned the equivalent of the 23/24 total cardiac scans. Another challenge is Kingston are offering a recruitment and retention bonus to encourage recruitment, we have seen a reduction in our staffing as a result which in turn is impacting capacity. Number of Endoscopy planned patients returning to active DM01 list as not seen by planned TCI date.	The department is utilising the Community Diagnostics Centre to mitigate any capacity mismatches it can. An extra 400+ scans were delivered in November and an additional 800+ scans delivered through December and January which significantly reduce the backlog. Recovery for CT Cardiac is currently predicted to be in February 2025, Working with the cardiology and stress echo teams to refine Cardiac CT demand criteria. A piece of work is being carried out by SWL Diagnostics team to lead on management of US referrals. 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 Saturday Endoscopy lists continue to be utilised to reduce backlog. Planned Endoscopy waiting list being clinically reviewed / validated.	TBC	Assured

Operational Performance

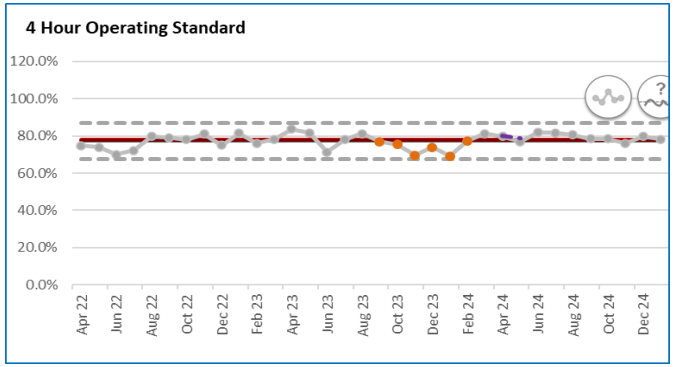
Exception Report | ESTH Diagnostic Performance

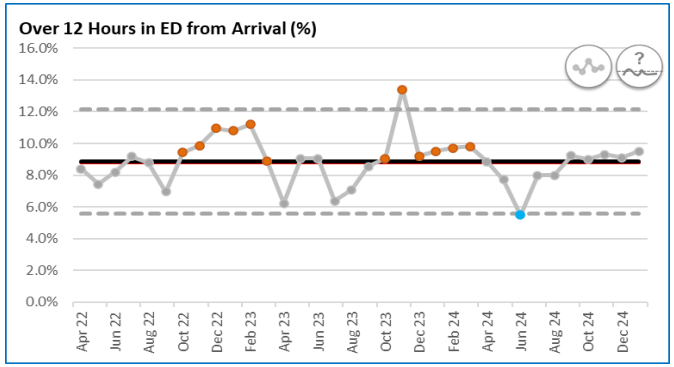


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 8.6% not meeting target of 5%	At the end of December 2024 there are 905 patients waiting more than 6 weeks for their diagnostic (DM01), which is a significant increase compared to November 2024 (632). As a result performance has deteriorated to 91.38% compared to 94.21% in November 2024. The modalities with the next highest volume of patients waiting >6 weeks at the end of December were 2024 were ECHO (347), Endoscopy (277) & Urodynamics (74).	• **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. 1 x WTE physiologist started in January 2025; recruitment ongoing for 2nd post; Capacity increased in February with agency staff, DM01 expected <200 • **Urodynamics:** Demand for Gynaecology urodynamics remains high with plans to increase core capacity with weekly fellow clinics from February 2025. Mutual aid has also been requested to support with reducing the backlog. • **Endoscopy:** We have seen a significant but steady increase over time in the number of patients that either require deep sedation or a general anaesthetic (in main theatres) and are in the process of submitting a business case with our colleagues in anaesthetics to secure additional permanent anaesthetist and ODP support as at present we predominantly rely on ad hoc arrangements to meet demand. We have also had a significant shortfall in our scheduling team which has resulted in some lists being taken down however additional funding has been secured and we are in the process of recruiting which will support an improvement in performance.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers

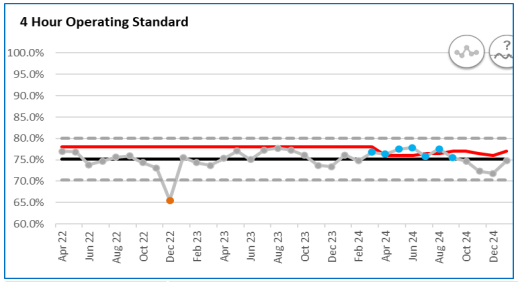


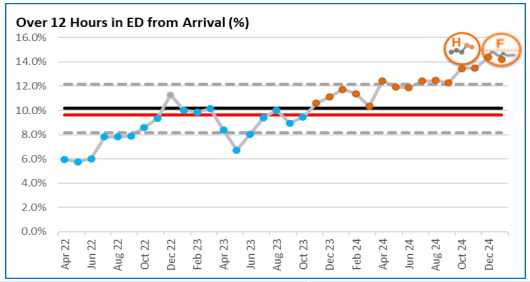


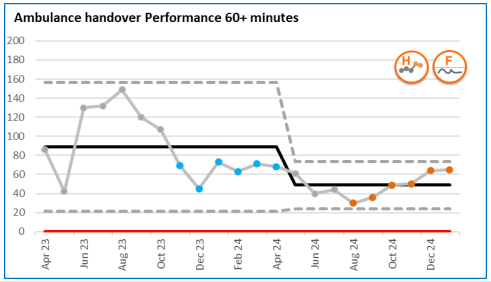
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in January 2025 – variances in performance	Four Hour Performance in January 2025 was 78.3% Admitted performance continues to be challenged with average daily performance of 38% against 4 hour standard. ED Capacity main driver in 4 hour breaches, with DTAs, increasing 12 hour waits and Mental Health workload being the main driver. 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	• 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 Urgent Treatment Centre (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 London Ambulance Service (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 November 2024 • Frailty Same Day Emergency Care (SDEC) to pilot in progress. • South West London (SWL) Chief Operating Officer's have agreed an LAS escalation Standard Operating Procedure for any direct requests. • Additional Emergency Practitioner on duty in peak hours to manage patients in the streaming queue. • Team trialling ambient AI solutions for real time documentation, trial began 9th January and will continue throughout February.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers



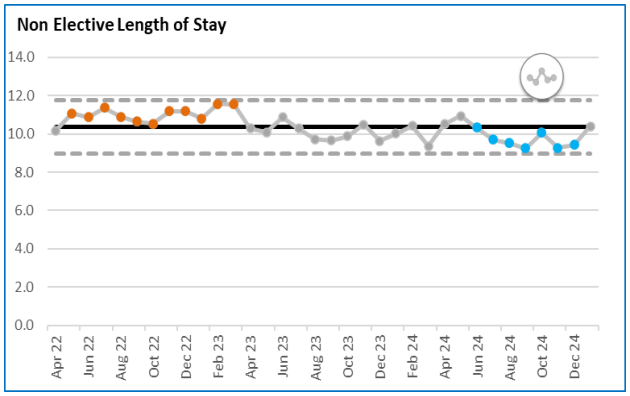


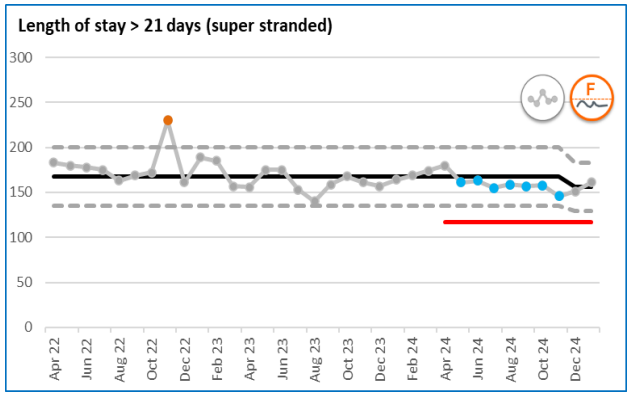


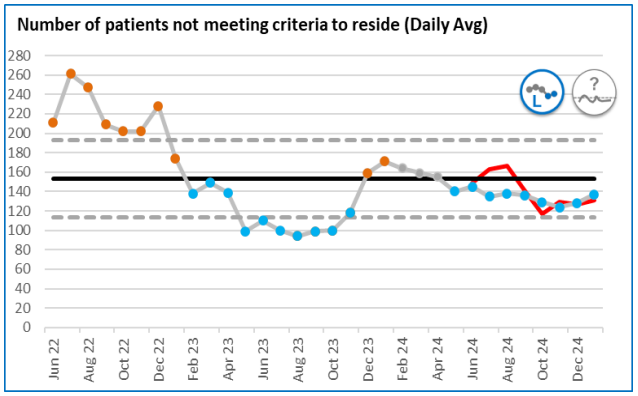
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 75% ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 30-60 Min Consistently not meeting target	A&E waits and timely ambulance handovers remained challenging in January 2025 due to a combination of high attendances and acuity on both sites. However there is an improvement in A&E performance in the month of January from 71.8% in December to 74.7% in January. Patients spending >12-hours in ED remains challenging with 14.8% in January. 60-minute ambulance handover delays remain high in January (65). This is due to a continued increase in ambulance attendances throughout January, with 24% of overall ED attendances by ambulance which is the highest reported since March 2021. Whilst above the ambition there was a marked reduction in 30-60 min ambulance handovers, reducing from 541 in December 2024 to 480 in January 2025. Time to first assessment and decision to admit remain above the ambition of 60 minutes and 180 minutes respectively, however, time to triage reduced to 14 minutes in January achieving the 15-minute ambition. High numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• The ESTH Urgent Care Transformation programme hosts an agreed set of priorities for 2024/25 which includes PLACE deliverables. Key outputs and KPIs include but are 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 treatment in the major's area 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. UTC and SDEC activity continues to increase month on month, with January demonstrating a further increase in activity. • SWL winter funding in collaboration with Sutton PCN GP colleagues continues to support additional GP resource in ED for appropriate patients. The initiative includes the treatment of all patients within SWL to alleviate pressure within the ED footprint at St Helier. Available funding will support extending the service to 7-day cover from February 2025 with shifts actively out for fill. In addition, Sutton PCN will also be increasing community GP clinics. A further review is underway to scope additional clinics for appropriate paediatric attendances and support delivery of the 78% standard. • The Same Day Acute Frailty response service launched in April 2024, supported by a dedicated space and frailty MDT for early assessment, treatment, and clear exit pathways. This enhances ED flow, admission avoidance, and reduces LOS. Winter funding provides additional weekend clinical support, including senior in-reach and reviews at 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.	TBC	sufficient for assurance

Operational Performance

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



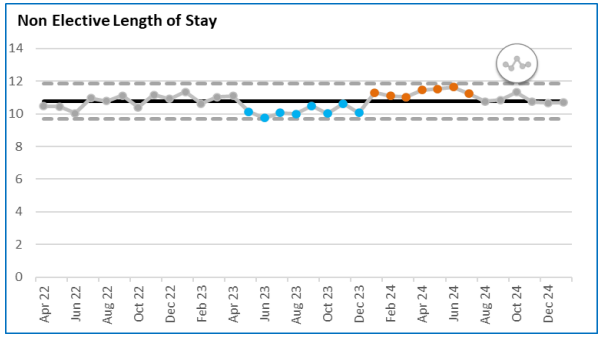


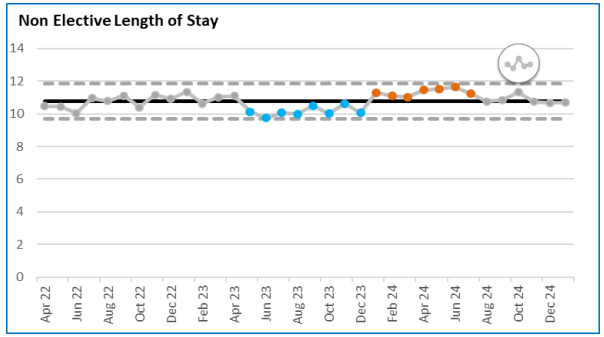


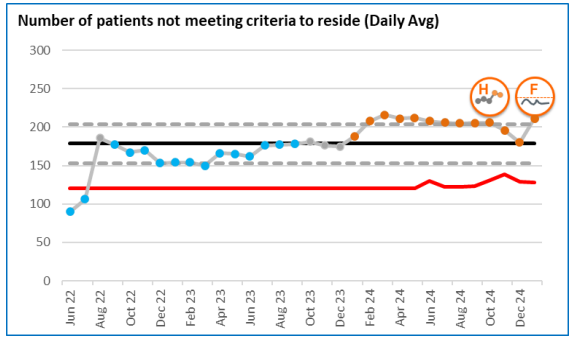
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR LOS Los>21days: Consistently not meeting target, all showing performance below mean	• Non-Elective Length of Stay has seen an increase through January 2025 • Long length of stay patients >21 days has seen an increase with average daily beds occupied 6.6% higher compared to December 2024) • Hospital and Social Care Interface process highlighted as highest reason for delay. In particular, we see a significant number of patients awaiting for 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. • Good improvement in discharges earlier in the day. • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • Focussed sessions with ward teams to improve NCTR data capture • 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. • >21 day LoS meetings embedding lead by MedCard Deputy DDO. • LoS Tri working on further actions to continue to drive down NEL LoS.	TBC	sufficient for assurance

Operational Performance

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

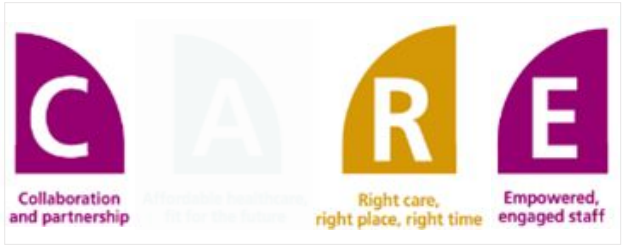






Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation not meeting plan Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Number of medically optimised patients on both hospital sites remain above the ambition with many patients requiring complex discharge planning to support discharge in those patients holding a LOS of more than 7,14, and 21 days. We have seen an increase across all cohorts in January 2025 due to high complexity and acuity and an increased number of patients awaiting new pathway 3 placement. Timely discharge has also been impacted by IPC constraints across both sites. 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 211 in January 2025 compared to 180 in December 2024.	• 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. • 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. • Revised KPI's have been drafted and agreed with partners to support escalation for business as usual in addition to separate KPI's and timelines in the event acute surge and/or to support the compliance of LAS 30 implementation. • 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. • A focused piece of work for those patients requiring progression on a pathway 2 is underway with a focussed piece of work underway to understand patients receiving therapy in an inpatient setting in the absence of capacity or suitability within current provisions working with social care partners on appropriate solutions.	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)	Jan 25	4	4	-			
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	Jan 25	79.0%	74.1%	70.0%			
Two hour UCR referrals received	Jan 25	424	545	-			
Virtual ward - Admissions	Jan 25	387	341	-			
Virtual ward - Bed Occupancy	Jan 25	97.9%	71.2%	85.0%			
Virtual ward Length of Stay (Average)	Jan 25	9.1	6.3	-			
Total Waiting List Size Adult	Jan 25	1603	1835	-			
Total Waiting List Size Adult 18-52wks	Jan 25	0	17	-			
Total Waiting List Size Adult >52wks	Jan 25	2	0	-			
Total Waiting List Size Children	Jan 25	753	798	-			
Total Waiting List Size Children 18-52wks	Jan 25	309	335	-			
Total Waiting List Size Children >52wks	Jan 25	3	1	-			

Surrey Downs

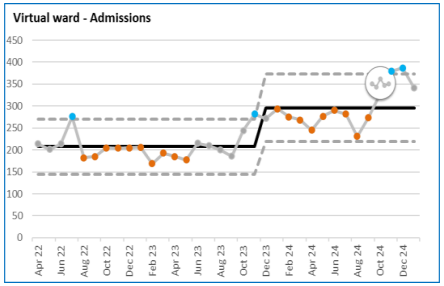
KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Jan 25	1	2	2			
Community Hospitals Bed Occupancy	Jan 25	86.1%	91.2%	80.0%			
Community Hospitals Length of Stay (Average)	Jan 25	21	21	21			
Two hour UCR performance	Jan 25	87.8%	84.4%	70.0%			
Two hour UCR referrals received	Jan 25	538	544	-			
Virtual ward - Admissions	Jan 25	261	290	-			
Virtual ward - Bed Occupancy	Jan 25	80.0%	93.0%	80.0%			
Virtual ward Length of Stay (Average)	Jan 25	8.3	8.2	-			
Total Waiting List Size Adult	Jan 25	5989	5867	-			
Total Waiting List Size Adult 18-52wks	Jan 25	263	223	-			
Total Waiting List Size Adult >52wks	Jan 25	0	0	-			

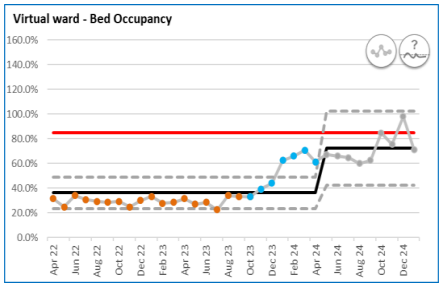
Pathway 0 – Home with self-funded POC / Self funded placement / No support / family support / restart
Pathway 1 – Support to recover at home; able to return home with support
Pathway 2 – Rehabilitation or short term care in 24 hour bed based setting, community hospital
Pathway 3 Requires on-going 24-hour 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

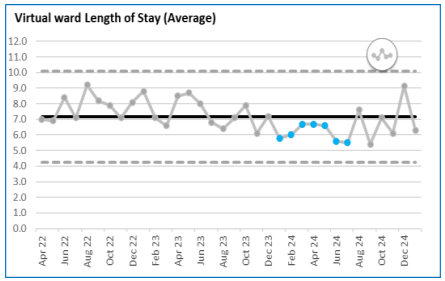
Integrated Care

Exception Report | **Virtual Wards**

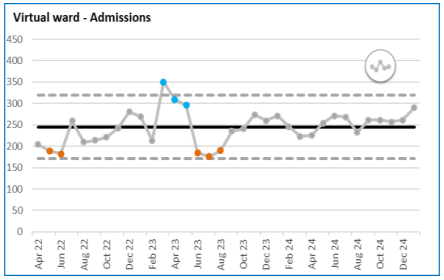
Sutton Healthcare

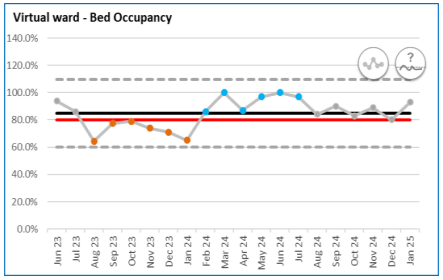


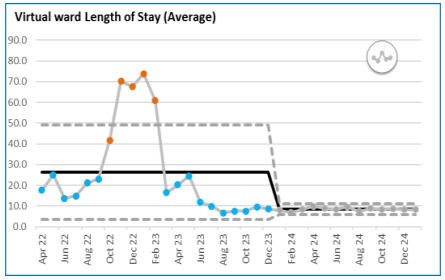




Surrey Downs





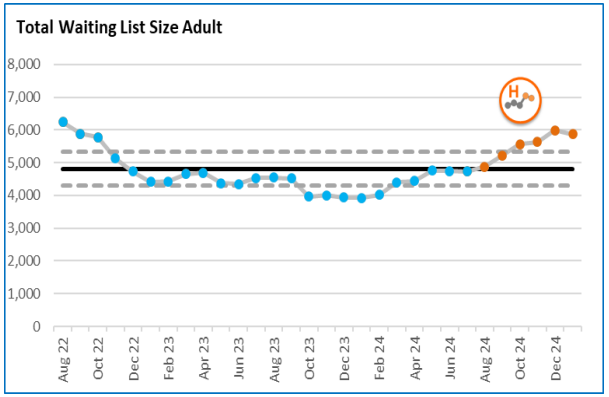


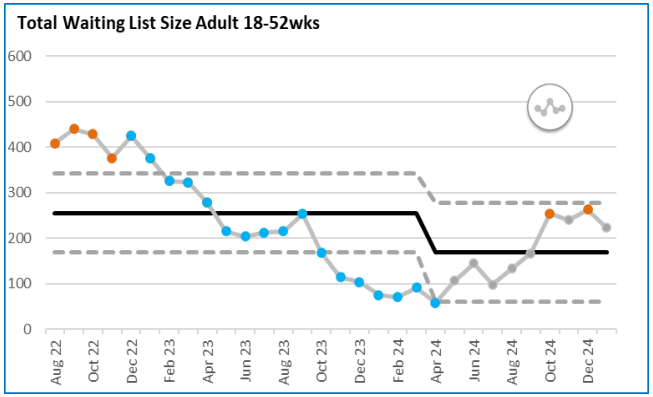
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Admissions number remains above the mean however seeing a slight drop compared to November and December 2024. The service continues to achieve its occupancy target.	• 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 meet target of 80%, increasing to 93% through January 2025. Admissions increased significantly through – 288 admissions which is above the average of 260.	• On-going development of enhanced care and new pathways in Virtual Wards.	N/A	Sufficient for assurance

Integrated Care

Exception Report | **Adult Waiting List Performance**

Surrey Downs



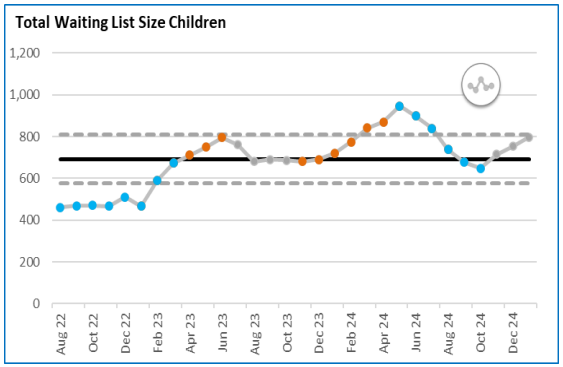


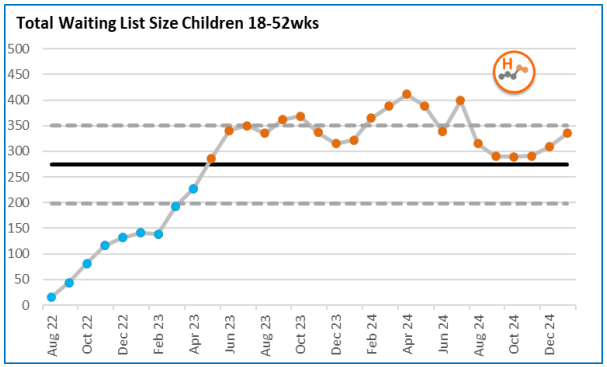
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs	Growth in overall waiting list size – above the upper control limit Patients waiting between 18-52 although above the mean has seen a decrease through January 2025 Increasing driven by Podiatry who have the largest proportion of waits over 18 weeks. Recruitment difficulties in podiatry impacting waiting times	• Review of podiatry service to explore new ways of working- temporary staffing support in place • MSK waits are mainly in hand therapy –liaison with ESTH on increase in demand , business case in progress • Next Community Assessment and Support Day (Waiting List initiative) covering MSK and Podiatry completed in Feb 25.	TBC	Sufficient for assurance

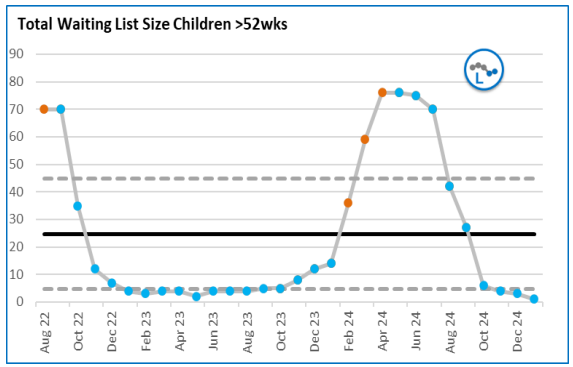
Integrated Care

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 and median waiting times however growth in the waiting list size has been seen within Children's SALT Service. Recording issue on EMIS impacting clock stops within Children's OT Waiting List which has been investigated and a number of actions agreed that will include system changes being implemented which ensure reporting of correct waiting time information and also enabling us to capture our productivity correctly.	• 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 • Improvements also made in triage, priority clinics (productivity /efficiency). • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Insufficient for assurance - waits within Children's OT Service being investigated

gesh

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

Appendices

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Jan 25	5.0%	5.3%	3.2%			
Agency rates	Jan 25	1.4%	0.1%	-			
MAST	Jan 25	90.7%	91.1%	85.0%			
Vacancy Rate	Jan 25	6.8%	6.3%	10.0%			
Appraisal Rate Medical	Jan 25	77.1%	76.4%	90.0%			
Appraisal Rate Non Medical	Jan 25	75.3%	75.1%	90.0%			
Turnover	Jan 25	11.7%	11.1%	13.0%			
Percentage BAME staff band 6 and above	Dec 24	46.6%	46.7%	-			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jan 25	5.7%	5.8%	3.8%			
Jan 25	2.3%	3.3%	-			
Jan 25	87.4%	87.5%	85.0%			
Jan 25	12.5%	10.6%	10.0%			
Jan 25	94.4%	94.5%	90.0%			
Jan 25	79.6%	79.9%	90.0%			
Jan 25	11.0%	10.6%	12.0%			
Jan 25	40.3%	40.9%	-			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Jan 25	7.4%	7.0%	3.8%			
Agency rates	Jan 25	4.3%	4.3%	-			
MAST	Jan 25	91.4%	91.4%	85.0%			
Vacancy Rate	Jan 25	18.5%	18.5%	10.0%			
Appraisal Rate Medical	Jan 25	100.0%	100.0%	90.0%			
Appraisal Rate Non Medical	Jan 25	82.2%	80.1%	90.0%			
Turnover (12-Month)	Jan 25	14.7%	14.7%	12.0%			
Percentage BAME staff band 6 and above	Jan 25	37.6%	37.6%	-			

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Jan 25	6.3%	6.4%	3.8%			
Jan 25	3.9%	6.4%	-			
Jan 25	92.6%	92.3%	85.0%			
Jan 25	18.0%	17.4%	10.0%			
Jan 25	100.0%	100.0%	90.0%			
Jan 25	81.8%	77.9%	90.0%			
Jan 25	16.6%	17.0%	12.0%			
Jan 25	20.1%	22.1%	-			

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
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
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 on Thursday, 06 March 2025

Agenda Item	3.3	
Report Title	**Finance report Month 10 (January) PUBLIC**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	28 February 2025
Purpose	**For Noting**	

Executive Summary

Both trusts are reporting underlying positions adverse to plan at M10 (ESTH £7.0m and SGH £9.8m), 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: 6th March 2025
24/25 M10 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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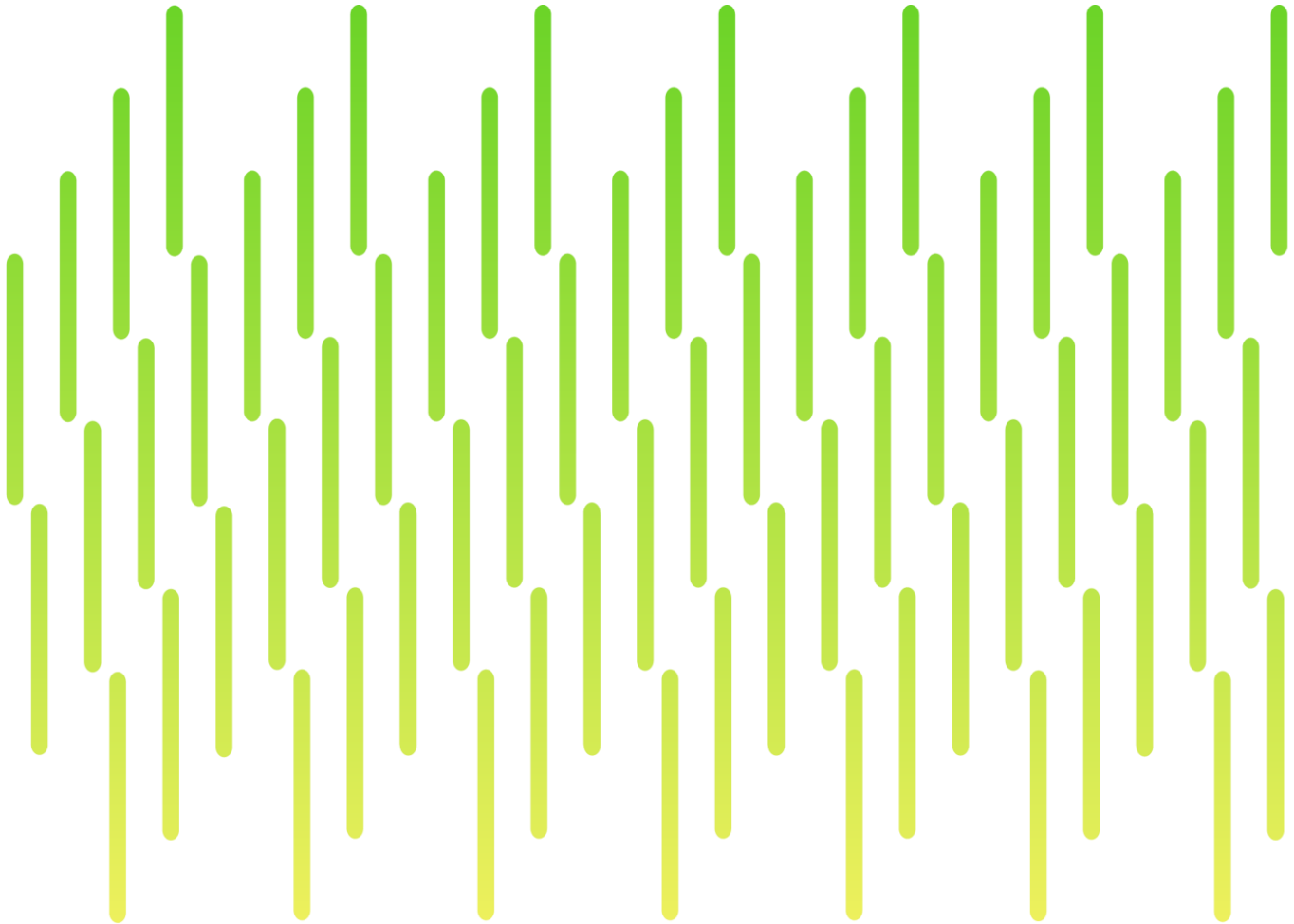
2024-25 M10

Executive Summary



Outstanding care every time

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Group M10 position

GESH

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	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• **The YTD adverse position for both ESTH and SGH reporting adverse to plan of £7.0m and £9.8m for ESTH and SGH respectively. SGH in addition is reporting £0.9m adverse variance as a result of loss of income from Cyber attacks.** • The M10 in month adverse position is in line with forecast actions. • **Brought forward NR benefits** from later in the year (SGH £1.8m, ESTH £0.8m). • **Delivered mitigations** this is SGH £13m, ESTH £10.6m, as outlined in slides 7/8.	• 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 site management meetings. • Costs of escalation capacity costing more than forecast in January.
Workforce costs and WTE plan	• Pay expenditure is overspent in both trusts. • WTE at ESTH is 221 adverse to plan, due to CIP of 189. WTE reported in M10 increased by over 100 in month due to increased winter pressures, sickness above rostered levels and enhanced care (1:1 specials). • WTE at SGH is adverse to plan by 530 due to the step up in CIP delivery planned for in M4/7 and operational pressures of 111.	• 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 M10	• 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. • Costs of escalation capacity costing more than forecast. Paper brought to SLT with focus on reduction of these costs to previous levels.
CIP delivery	• ESTH delivery £7.6m adverse to plan. Recurrent CIP £10.2m adverse and non recurrent £3.8m favourable. Slippage in WTE reduction recurrent planned CIP (WTE CIP 189 adverse) whilst the position has continued to be mitigated by non recurrent efficiency. • SGH £6.6m adverse to plan (although this includes b/f £0.8m benefit) with £9.1m less recurrent than plan. • When the mitigations are included, both trusts have delivered the full value of the original CIP programme in year.	• 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. • CIP delivery for the year has been risk assessed at 100% for ESTH and 94% for SGUH	• 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 M10 position

GESH

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	Overview	What does this tell us?	What actions/mitigations are required?
Capital	• ESTH M10 performance behind the PFR plan owing to the BYFH programme. • SGH M10 YTD position is behind plan mainly due to slippage in ITU	• ESTH and SGH: Key risk remains on BHYH and renal NHP programme schemes	• 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	• As per previous narrative, there is no cash requirement for 24/25 following confirmation of deficit funding. • Challenges outlined in Q1 25/26 are covered by a separate paper.	• Challenges in 25/26 need mitigations plans as outlined in paper.	• Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management. • Review requirements into 25/26.

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Site summary I&E

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	Head line I&E YTD	Key issues	Key actions
ESTH Acute	• £6.0m adverse to plan • £1.1m favourable 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. • Review of costs of escalation capacity as these costing more than forecast in January.
ESTH IC	• £0.3m favourable YTD • £0.8m favourable on 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	• £7.4m 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)	• £5.3m adverse YTD	• inflationary pressures £1.9m • CIP non-delivery £3.4m	• 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)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	670.4	56.2	55.6	(0.6)	557.9	562.3	4.4
	Other Op. Income	48.3	4.1	4.0	(0.1)	39.9	38.8	(1.2)
Income Total		**718.7**	**60.3**	**59.6**	**(0.7)**	**597.9**	**601.1**	**3.3**
Expenditure	Pay	(484.0)	(38.2)	(40.1)	(1.9)	(404.0)	(411.0)	(7.0)
	Non Pay	(209.0)	(19.2)	(19.1)	0.1	(173.9)	(179.6)	(5.6)
Expenditure Total		**(693.0)**	**(57.4)**	**(59.2)**	**(1.8)**	**(578.0)**	**(590.6)**	**(12.6)**
Post Ebitda		(30.7)	(2.5)	(1.5)	1.0	(25.7)	(23.3)	2.3
Grand Total		**(5.1)**	**0.3**	**(1.1)**	**(1.4)**	**(5.8)**	**(12.8)**	**(7.0)**

- The Trust is adverse to plan by £1.4m in month and £7.0m YTD. The adverse position YTD is in line with the £10m risk position identified in September. It has been clear that no funding will be available for this and the Trust has mitigated this as part of the overall forecast and the £10m risk adjusted position.
- Patient Care income is above plan by £4.4m at the end of January. 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 M10. **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 £0.1m adverse in month and is £1.2m adverse YTD. Clinical Services is £1.2m adverse but this is offset by a matching non pay variance; Training income is £0.9m behind plan and R&D income is £1m favourable but offset with matching expenditure
- Pay is £1.9m adverse in month and £7.0m adverse YTD. The in month increase is due to an increase in temporary staff due to winter pressures.
- Non pay is £0.1m favourable in month and £5.6m adverse YTD. Cardiology was on plan in month but £1.6m adverse on pacemakers and Cath Lab consumables YTD, EOC is £0.1m adverse in month and £1.2m adverse YTD and Planned Care is £0.1m favourable in month and £1.8m adverse YTD with high spend in theatres and endoscopy. The YTD position was mitigated by non-recurrent benefits intended for later in the year were released to cover overspends.
- Post EBITDA is £1.0m favourable in month due to reforecast depreciation and £2.3m favourable YTD due to interest received above plan and reduction in forecast revenue support.

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SGH - Summary Reported Position

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Table 1 - Trust Total

		Full Year Budget (£m)	M10 Budget (£m)	M10 Actual (£m)	M10 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	1,073.4	91.7	92.2	0.5	898.7	904.1	5.4
	Other Operating Income	164.7	14.2	16.0	1.8	136.4	141.8	5.3
Income Total		**1,238.1**	**105.9**	**108.2**	**2.4**	**1,035.2**	**1,045.8**	**10.7**
Expenditure	Pay	(761.2)	(63.3)	(64.6)	(1.2)	(635.5)	(644.0)	(8.5)
	Non Pay	(455.5)	(39.6)	(42.5)	(2.9)	(386.6)	(399.6)	(13.0)
Expenditure Total		**(1,216.8)**	**(103.0)**	**(107.0)**	**(4.1)**	**(1,022.1)**	**(1,043.5)**	**(21.4)**
Post Ebitda		(25.7)	(2.2)	(2.2)	0.0	(18.9)	(18.9)	0.0
Grand Total		**(4.3)**	**0.7**	**(1.0)**	**(1.7)**	**(5.8)**	**(16.5)**	**(10.8)**

The Trust is reporting a £16.5m deficit YTD in M10, which is £10.8m adverse to plan. The YTD deficit position is driven by £9.8m of unrealised CIP target and baseline pressures and £0.9m of Cyber Attack impact.

Income

- Income is £2.4m favourable in month driven by hosted services, R&D and clinical services income offset by non-pay costs. income offset by non-pay costs. YTD income is £10.7m favourable of which £7.4m relates to additional income offset by additional costs and £2.8m to additional ICB income.

Pay

- Pay is £1.2m adverse in month driven by an adverse CIP target variance of £1.0m, Medical pay which is £0.4m adverse and Ward Nursing which is £0.2m adverse offset by underspends in corporate non-clinical where costs have been transferred to non-pay. YTD the CIP target is driving a £3.8m adverse variance and IA and Cyber are driving a £1.5m adverse variance resulting in an underlying YTD position that is £3.2m adverse. Wards are driving £2.2m of the YTD variance and Clinical Medical pay £1.3m, partially offset by underspends in other pay categories.

Non-Pay

- Non-Pay is £2.9m adverse in month driven by additional costs offset by income and the transfer of corporate pay costs to non-pay. YTD the CIP target is driving a £3.0m adverse variance resulting in an underlying YTD position that is £9.9m adverse. This adverse variance driven is by additional costs offset by additional income and corporate inflationary pressures.

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	3.4	
Report Title	**2024 Public Sector Equality Duty Report**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Sandra Ovid Head of Equality, Diversity and Inclusion	
Previously considered by	People Committees-in-Common	20 February 2025
Purpose	**For Review**	

Executive Summary

1. Introduction

Public Sector Equality Duty (PSED) and Reporting Requirements

The Public Sector Equality Duty (s.149 of the Equality Act 2010) requires public organisations to have due regard to:

- Eliminating discrimination, harassment, and victimisation.
- Advancing equality of opportunity between individuals with and without protected characteristics.
- Fostering good relations between individuals with and without protected characteristics.

Overview of GESH's compliance and strategic direction in equality, diversity, and inclusion (EDI).

2. GESH Structure & Reporting

- GESH is a collaboration of two NHS Trusts (SGUH & ESTH), sharing best practices, and equality effect but remaining operationally separate.

Each trust independently submits:

- Workforce Race Equality Standard (WRES)
- Workforce Disability Equality Standard (WDES)
- Equality Delivery System (EDS)
- Gender Pay Gap (GPG)
- PSED with a set of Equality Objectives (spanning 4 years)
- Workforce analysis includes:
- Pay distribution, recruitment trends, employment relations, promotions, training, and GPG insights.

3. Health Inequalities & PSED Reporting

- NHS Standard Contract (s13.9.1) does not require health inequalities reporting in PSED.
- Trusts must support commissioners in reducing health disparities.
- Key contributors: Dr. Richard Jennings (CMO) & Prof. Arlene Wellman (CNO).
- Commitment to inclusion via South West London Integrated Care Board (ICB)

4. Equality Delivery System (EDS) 2022-2023 Grading

- Inclusive Leadership (5) needs improvement
- SGUH excels in Services, ESTH leads in Workforce
- **Overall rating:** Developing (20)

5. Workforce Race Equality Standard (WRES) Highlights

Diversity Representation :

BAME staff = 49.66%, but underrepresented at senior levels.

Harassment & Bullying:

- 26.85% experienced public abuse
- 25.95% faced internal harassment
- Career Progression: 47.5% feel they lack equal promotion opportunities.

Leadership Gap:

- 30.5% underrepresentation at Board level
- 37% underrepresentation in executive roles

Workforce Disability Equality Standard (WDES) Highlights

- Underrepresentation: Only 4% of staff identify as disabled

Harassment:

- 34% harassed by patients
- 20% harassed by managers
- 28% harassed by colleagues

Career Progression & Well-being:

- 44% see equal career growth
- 30% felt pressure to work unwell
- 35% feel valued
-

Disability Support:

- 56% report reasonable adjustments are provided
- 20% underrepresentation in Board roles
- Engagement score: 6.3 (needs improvement)

7. Strengthen Staff Networks:

- Post-pandemic revitalisation of staff networks
- Executive sponsors for strategy, site sponsors for local engagement
- Focus: Gender Pay Gap, WRES, WDES

8. Gender Pay Gap (GPG) Analysis

Key Driver:

- Senior male doctors' salaries influence GPG

Excluding medical staff:

- SGUH: Women earn 1.92% more than men
- ESTH: Women earn 0.9% more than men

Bonus Pay Gap:

- Men receive 25.4% higher bonuses
- Driven by Clinical Excellence Awards for senior doctors

9. Strong Governance & Accountability:

- Robust Board Assurance Framework & Committees for oversight
- Continuous improvement via stakeholder feedback, surveys, audits, and external assessments

10. Advancing Diversity, Equity, and Inclusion

- Progress in EDI since group model adoption

Focus areas:

- Better service delivery for health outcomes
- More inclusive workforce
- Diverse and accountable leadership

11. Conclusion & Next Steps

Areas for improvement:

- Leadership representation for BAME & disabled staff
- Workplace culture & harassment reduction
- Gender Pay Gap transparency
- Board to review and endorse strategic actions to accelerate progress

Action required by Group Board
The Boardis asked to: a) The Board is assured that both ESTH and SGUH (GESH) are meeting its statutory duties under the Equality Act 2010. b) The Group Board approves the PSED 2023–2025 report for publication

Committee Assurance	
Committee	People Committees-in-Common
Level of Assurance	Substantial Assurance: The report and discussions assured the Committee that there are robust systems of internal control operating effectively to assure that risks are managed effectively

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Add Appendix Name – PSED Report 1 Compliance
Appendix 2	Add Appendix Name – PSED Report 2 Workforce dataset Analysis
Appendix 3	

Implications	
Group Strategic Objectives	
☐ Collaboration & Partnerships	☐ Right care, right place, right time
☐ Affordable Services, fit for the future	☒ Empowered, engaged staff
Risks	
GESH (ESTH and SGUH) must uphold the Public Sector Equality Duty (PSED) to prevent discrimination, promote equality, and reduce health disparities while managing risks like legal action, reputational damage, and workforce inequality through inclusive policies and data-driven decisions.	

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 direct implications for expenditure related to the content of this report.

Legal and / or Regulatory implications
Compliance with section 149 of the Equality Act 2010 (the Public Sector Equality Duty) and the Equality Act 2010 (Specific Duties and Public Authorities) Regulations 2017

Equality, diversity and inclusion implications
This report is specifically relevant to Equality Diversity and Inclusion and compliance

Environmental sustainability implications
No: The report is provided under the specific statutory requirements of the Equality Act 2010 and related legislation.

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

gesh

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

Group Public Sector Equality Duty, Annual Report 2023-2024

Other formats and languages
If you would like a copy of this report in a different language or a different format, such as large print or Braille, please contact:

Group Communications Team
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University Hospitals and Health
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You can also call us on 020 8266 6128.

Publication for Information

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

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- Introductions to the Report
- Methodology and Purpose of the Joint PSED Report 2024
- Legal Context and Background of the Public Sector Equality Duty
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- gesh: Achievements Highlights of 2023-24 (SGUH and ESTH)
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Chief Executive Officer's Foreword – Jacqueline Totterdell

As the Chief Executive Officer for gesh, I am pleased to introduce our Joint Public Sector Equality Duty (PSED) 2023-2024 Annual Report. This report reflects our on-going commitment to promoting equality, diversity, and inclusion within our organisation and the communities we serve.

Inclusion is important to me, not just as a principle, but as a fundamental driver of our success. We understand that fostering an inclusive environment is essential for unlocking the full potential of our workforce and ensuring that everyone feels valued and respected.

Our commitment to the Public Sector Equality Duty is not merely a regulatory requirement; it is a vital part of our mission to create a workplace that celebrates diversity in all its forms.

This year, we have made significant strides in enhancing our policies, practices, and initiatives aimed at reducing inequalities and promoting equitable access to opportunities within gesh. We have engaged with our employees, stakeholders, and the communities we serve to understand their experiences and perspectives, ensuring that their voices inform our actions.

In this report, you will find a comprehensive overview of our activities, achievements, and areas for improvement. We are proud of the progress we have made, but we recognise that there is always more work to be done.

We are committed to continuously evaluating our practices and recognise that we may not always get it right the first time. However, we are dedicated to learning from our experiences and striving for excellence in our pursuit of equality and inclusion.

I invite you to explore this report and join us on our journey toward a more equitable future for all. Together, we can build a stronger, more inclusive gesh that reflects the diverse society we serve.

I would like to extend my sincere appreciation to all who have contributed to the progress we have made in 2023/24.

What do we want to achieve?

Our vision for 2028 is to provide outstanding care together. With the help of our patients, staff and partners, we have chosen four overall aims for 2028 – our CARE objectives. We care about these things the most, and will be central to achieving our vision.

- **Collaboration and partnership** - *ensures diverse voices are included encouraging an inclusive environment that represents* the needs of all communities.
- **Affordable services fit for the future** - *addresses equitable access to care, aiming to remove financial barriers so that all patients can benefit from services.*
- **Right care, right place, right time** - *prioritises patient-centered care, ensuring that everyone receives timely, appropriate services regardless of background*
- Empowered, engaged staff In all this, everything we do will be driven by our patients - *promotes a culture of inclusivity, ensuring all staff have opportunities to thrive, feel valued, and contribute meaningfully to patient care.*

By centering everything on patient needs, these objectives underscore a commitment to equality and inclusion across all levels, creating a healthcare system that serves everyone fairly and compassionately.

Chief People Officer -Victoria Smith

Joining St George's as Group Chief People Officer in July 2024, I bring with me a deep commitment to fostering a positive and inclusive workplace culture. My background spans the private and public sectors, here in the UK and internationally, and I'm excited to use my experience to serve my local community. I'm passionate about delivering positive change which drive public services forward. I believe that change is only sustainable when it is design and delivered by the front line, in collaboration with those people we are here to serve – our patients and our community.

Our efforts will be judged on the results and I'm delighted to be able to share the data included in this report openly and transparently so that we can be properly accountable. This is an important responsibility under the Public Sector Equality Duty (PSED), which calls for public bodies to publish equality information annually, per section 149 of the Equality Act 2010. My focus is on thoroughly demonstrating our adherence to both the general and specific duties of the PSED.

Our PSED report is more than just a data requirement; it's a foundation for understanding and advancing equalities, both for our patients and our workforce. This report includes critical insights from a range of frameworks not only to ensure transparency but also to actively reflect on the insight this data brings, so that it will continually strengthen our policies and practices.

I am particularly focused on addressing the challenges and opportunities around racial equality within gesh. This area deserves thoughtful, sustained action, and I am committed to driving this work forward with the dedication it requires. I am fully invested in creating a workplace where racial equality is actively promoted and upheld. I also want to support and empower colleagues with disabilities and long-term health conditions. gesh relies on the diversity, dedication, and talent of every single person within our workforce and I believe that colleagues with disabilities and long-term health conditions bring unique perspectives, skills, and experiences that enhance patient care and enrich our teams.

Last year's race riots were a poignant reminder of the urgent need to address systemic inequalities and ensure psychological safety for all staff, especially those from ethnic minority backgrounds. In response, gesh came together as a unified organisation, demonstrating resilience and compassion. The Senior Management Team, led by the CEO and Group Chief Nurse, truly stepped up to the plate where it mattered. They spearheaded initiatives to foster an inclusive and supportive environment and took a brave stand against unwanted racism. Their leadership and commitment to creating a safe space for staff were commendable, setting a clear tone of zero tolerance for discrimination. Through open forums, dedicated support groups, and actionable policies, they prioritised the well-being and psychological safety of affected staff. These efforts highlighted gesh's commitment to equity, diversity, and inclusion as fundamental organisational values.

As we look toward 2025, my commitment is to further enhance inclusivity and equity across gesh. I plan to support and amplify the work of our Staff Network, collaborating to identify meaningful solutions to equality and inclusion challenges. I will also work with Medical and Nursing colleagues to continue to drive forward efforts to address and eliminate health inequalities with our community partners. Through these collaborations, I aim to promote an environment where every individual feels genuinely valued, respected, and supported; ultimately benefiting our workforce, patients, and the communities we serve.

CPO Ambitions for 2025:

- Driving a more inclusive and equitable future for gesh
- Building a sustainable People function for lasting impact
- Ensuring our Employee's physical, mental and financial wellbeing is prioritised and supported
- Designing interventions that support retention with key staff groups
- Creating an inclusive and equitable work environment where diversity and differences are valued and employees feel supported
- Rolling out our Diversity & Inclusion Action Plan to address and eliminate biases and promote a culture of belonging for all
- Improving our Gender Pay Gap
- Delivering improvements across the key metrics included in our Workforce Race and Disability Equality Standards
- Continuing the vital work we have started to safeguard our workforce by bearing down on violence and aggression and ensuring sexual safety in all of our workplaces

Summary of the Methodology and Purpose for the Joint PSED Report 2024

The purpose of the Public Sector Equality Duty (PSED) report is to show how St Georges and Epsom and St Helier hospitals (gesh) is fulfilling its Public Sector Equality Duty to eliminate discrimination, advance equality, and foster good relations among individuals from different backgrounds.

The Joint PSED Report 2024 provides an in-depth analysis and overview of gesh's efforts to promote equality, diversity, and inclusion (EDI) in alignment with legal and regulatory standards. The report is organised into several sections, each serving a distinct purpose in reflecting gesh's, Initiatives, progress, and the legal framework within which it operates.

Structure and Governance of gesh
gesh comprises two trusts St George's and Epsom and St Helier hospitals operating as separate entities unless legally merged with NHS England approval. Shared leadership under a "Group" "Provider Collaborative" streamlines decision-making, reduces duplication, and enhances patient outcomes, but each trust must independently produce audited accounts and reports.

gesh Reporting Obligations
While gesh has a joint board, NHS mandatory contract obligations (WRES, WDES, EDS, and GPG) require separate reporting for each trust. Combined gesh data reporting is not required, and each organisation reports independently under its governance framework.

Joint Initiatives Representation
A red asterisk (*) highlights areas of active collaboration between the two trusts, making joint initiatives, achievements, events, and celebrations easily identifiable. Key points or areas for improvement are emphasised in **bold** for clarity.

Language and Terminology- Some specific points on language
Although NHS England uses the term Black Minority Ethnic (BME) for reporting the Workforce Race Equality Standard, we use Black, Asian, and minority ethnic (BAME) to reflect the significant proportion of Asian and Black staff within our workforce.

The term disability is used as defined in the Equality Act 2010, reflecting its positive and protective intent. We also recognise that disability is a dynamic concept, with evolving terms like neurodivergence and neurodiversity shaping the understanding of its scope and relationship to disability definitions.

The terminology "Gay, Lesbian, and Bisexual" used in this document encompasses all identities and sexual orientations not explicitly referenced. To promote inclusive language, the terms sexual orientation" is also used throughout this document.

Summary of the Methodology and Purpose for the Joint PSED Report 2024-Con'd....

Section 1: gesh People and Culture Report 2024

This section begins with the vision for equality, diversity, and inclusion (EDI) from the Chief Executive and Chief People Officer, setting the tone for gesh's commitment to fostering an inclusive environment. It provides an overview of the purpose of the Public Sector Equality Duty (PSED) Report, explaining its role in guiding gesh's EDI efforts. The section also outlines the Public Sector Equality Duty's legal context, highlighting the relevant frameworks that inform gesh's practices. In the "About Us" sub-section, you are introduced to gesh, the demographic landscape of the communities served by the two trusts, and the governance structures in place to ensure accountability and oversight. Key strategic initiatives are also included, gesh People Strategy (2022–2028), Inclusive Talent Management Strategy, and efforts to drive strategic retention. Highlights from gesh's achievements in 2023–24 and initiatives such as CEO Question Time and executive support are also included.

Furthermore, the section examines the outcomes of gesh staff survey and showcases efforts to celebrate diversity through events, employee networks, executive sponsorships, and support systems like Freedom to Speak Up and Chaplaincy services. Together, these elements reflect gesh's comprehensive approach to achieving equality and promoting an inclusive culture.

Section 2: Equity, Diversity, and Inclusion: Legal and Mandatory Requirements Overview 2024

This section provides an overview of gesh's compliance with key legal and mandatory requirements (NHS contract). It covers important summary reports and standards such as the Gender Pay Gap 2023, the Equality Delivery System, Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES) for 2024 with links to the full report for each perspective Trust (SGUH and ESTH). In addition a High-Level EDI Action Plan is also included to highlight gesh's commitments and planned actions for advancing equality, diversity, and inclusion.

Section 3: Workforce Data Analysis by Protected Characteristics

This section presents a detailed analysis of key workforce data, categorised by protected characteristics (PC). It covers insights into the composition of gesh's workforce, including data on workforce distribution by PC, pay bands, recruitment trends, and starters and leavers by PC. Additionally, the analysis explores employment relations cases (disciplinary and grievance) promotions and training, offering a comprehensive view of workforce dynamics.

By examining this data, the section highlights trends and identifies potential disparities, providing valuable insights to guide gesh's on-going efforts in promoting equality and diversity within the organisation.
When conducting a combined analysis of gesh, such as the Gender Pay Gap (GPG), it is important to consider that data may be skewed by differences in the size, workforce composition, and pay structures of each trust. These variations can significantly impact the overall results. Therefore, we recommend consulting individual trust data sets for a more accurate and nuanced understanding. Links to each trust's specific reports are provided for detailed reference.

Section 4: Reducing Health Inequalities across SWL ICB Systems by St George's, Epsom, and St Helier Trust (gesh)

Reducing health inequalities is a key priority for SGUH and ESTH Trusts (gesh), which serves as a cornerstone of healthcare delivery within the South West London (SWL) Integrated Care Board (ICB) systems. As a key healthcare provider, gesh is committed to ensuring that all populations, regardless of their socio-economic status, ethnicity, or geographic location, have equitable access to high-quality healthcare services.

This section outlines the strategic initiatives and actions that gesh will implement to tackle health inequalities across the SWL ICB. These efforts are designed to address the systemic barriers that contribute to disparities in health outcomes and ensure that vulnerable and underserved populations receive the care and support they need to lead healthier lives. By aligning these initiatives with the broader goals of the SWL ICB, gesh is working towards creating a more inclusive, accessible and effective healthcare system for all.

Section 5: Key Conclusions and Recommendations

This section consolidates key findings and insights from previous sections, offering actionable recommendations to enhance gesh's equality, diversity, and inclusion (EDI) practices and workforce engagement.

It reflects contributions from EDI leads at SGUH and ESTH. The EDI leads from each trust will provide a joint summary of the findings through an equality lens, ensuring a comprehensive perspective on the data and insights presented. The report aligns with gesh's commitment to transparency, legal compliance, and reducing health inequalities. By incorporating both data-driven analysis and qualitative insights, it supports on-going improvement in fostering an inclusive environment.

gesh People and Culture: Legal Framework and Background of the Public Sector Equality Duty

Introduction

Legal Framework and background

This report ensures compliance with the Public Sector Equality Duty (PSED) for 2023/24 at gesh (Trusts). Both SGUH and ESTH University Hospitals NHS Trusts are committed to meeting these requirements. As required by law, the Trust monitors, analyses, and annually publishes data on equality, diversity, and inclusion, in line with the PSED. The data includes protected characteristics from the Equality Act 2010, such as Age, Disability, Gender Reassignment, Marriage and Civil Partnership, Pregnancy & Maternity, Race, Religion & Belief, Sex, and Sexual Orientation. Organisations under the general equality duty must consider these factors in their operations.

1. Eliminate unlawful discrimination, harassment, victimisation, and other conduct prohibited by the Act.
2. Advance equality of opportunity between individuals with protected characteristics and those without.
3. Foster good relations between individuals with protected characteristics and those without.

The Act specifies that advancing equality of opportunity entails giving due regard to the necessity to:

- Remove or minimise disadvantages faced by individuals due to their protected characteristics.
- Address the distinct needs of individuals with specific protected characteristics.
- Encourage the participation of individuals with specific protected characteristics in public life or activities where their participation is disproportionately low.

This report will exemplify gesh's adherence and progress in fulfilling the obligations of the Public Sector Equality Duty (PSED) through:

- Reporting the Gender Pay Gap within the organisation.
- Complying with the General Equality Duty by presenting a breakdown of employee demographics.
- Outlining objectives to further the goals of the PSED.
- Implementing steps to meet the needs of disabled persons that differ from the needs of non-disabled persons, including considerations for disabilities.
- Having due regard to the need to foster good relations by tackling prejudice and promoting understanding.

The report will cover data from April 2023 to March 2024, encompassing staff, service users. Annually, this information is mandated to be published on our public website by January 31st.

The Equality Delivery System

The Equality Delivery System (EDS) serves as a valuable tool for NHS organisations, facilitating improvement in services provided to local communities and fostering discrimination-free working environments within the NHS.

Aligned with the requirements of the Equality Act 2010, the EDS 2022 aims to enhance both service provision and working conditions. Mandated by the NHS Equality, Diversity, and Inclusion Council, the NHS Equality Delivery System (EDS) stands as an optional yet integral tool for NHS organisations. Its purpose is to support both existing and emerging NHS entities in fulfilling their General Public Sector Equality Duties, outlined in Section 149 of the Equality Act 2010, across the nine protected characteristics.

About US: gesh Local Demographics

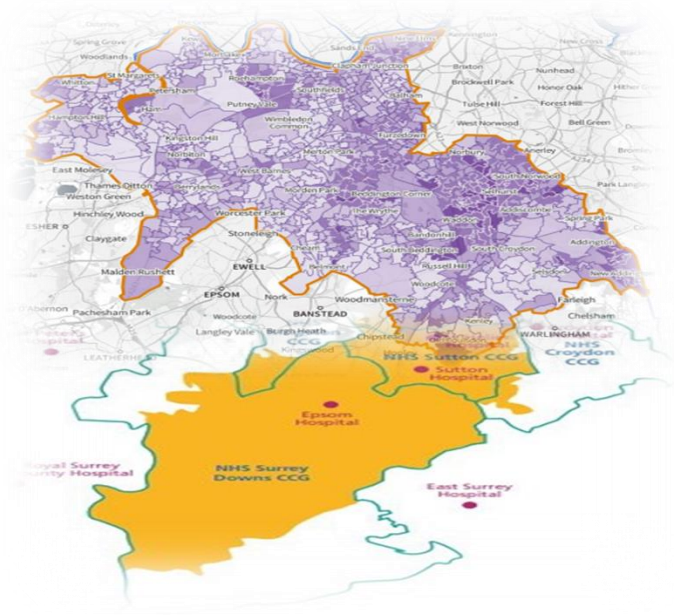
Background Information: St George's University Hospitals NHS Foundation Trust (SGUH) and Epsom and St Helier University Hospitals NHS Trust (ESTH)

St George's University Hospitals NHS Foundation Trust (SGUH)
St George's University Hospitals NHS Foundation Trust (SGUH) is the largest healthcare provider in southwest London, serving a population of approximately 1.3 million people. The Trust operates several key sites, with St George's Hospital being its main facility, offering a comprehensive range of services including emergency, trauma, surgery, and critical care. SGUH is also a leading teaching hospital and a centre for research and innovation.

Other key sites within SGUH include:

- **Queen Mary's Hospital in Roehampton:** Providing urgent care, outpatient clinics, and rehabilitation services.
- **St John's Centre in Battersea** and **Nelson Hospital in Raynes Park:** Offering community-based services and outpatient care.

SGUH extends its services beyond general healthcare, being a provider of specialised tertiary services in neurosciences, paediatrics, and cardiology, with a reach covering Surrey, Sussex, and Hampshire, thus serving a population of around 3.5 million people. The Trust operates within the South West London Integrated Care System (ICS) and collaborates closely with Epsom and St Helier University Hospitals NHS Trust (ESTH) within the St George's, Epsom, and St Helier University Hospitals and Health Group (gesh).



Epsom and St Helier University Hospitals NHS Trust (ESTH)
Epsom and St Helier University Hospitals NHS Trust (ESTH) is a key healthcare provider in southwest London and northeast Surrey, delivering general hospital and community services to over 490,000 residents. The Trust operates within the South West London Integrated Care System (ICS) and the Surrey Heartlands ICS, ensuring comprehensive and integrated care for its diverse patient base.

ESTH's primary hospitals include:

- **Epsom Hospital:** Providing a wide range of general medical services, including surgery and emergency care.
- **St Helier Hospital:** Known for its emergency services, maternity care, and outpatient clinics, along with its specialised renal services.

ESTH collaborates closely with local health and care systems, including Sutton Health and Care and Surrey Downs Health and Care, working to meet the healthcare needs of its local communities. The Trust also participates in strategic partnerships such as the South West London Acute Provider Collaborative, which includes other major hospitals in the region.

Together, SGUH and ESTH form a vital part of the healthcare landscape in southwest London and Surrey, driving improvements in patient care through their on-going collaboration within the gesh framework.

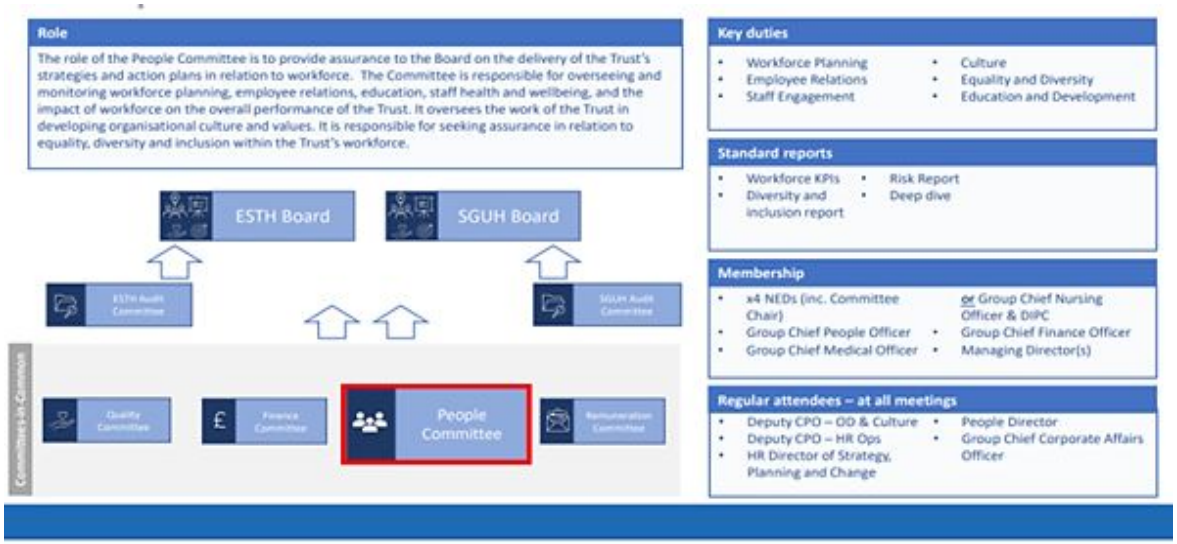
gesh Board Assurance Framework

The Board Assurance Framework provides the Board with evidence that the effectiveness of the controls used to manage the risks to the organisation in achieving its strategic objectives have been regularly reviewed. The Trust's committee structures ensure sound monitoring and review mechanisms to make certain that the systems of internal control are working effectively. Other sources of information include: the views and comments of stakeholders; patient and staff surveys; internal and external audit reports; clinical benchmarking and audit reports and mortality monitoring; and reports from external assessments.

How does the BSF align with EDI?

In the NHS, the Board Assurance Framework (BAF) plays a fundamental role in ensuring equality, diversity, and inclusion (EDI) throughout its operations. Specifically, the BAF incorporates equality-related objectives and assessments to manage risks and ensure compliance with statutory duties related to EDI. key aspects of equality as they relate to the NHS BAF:

1. **Compliance with Equality Legislation**: The BAF ensures that NHS Trusts comply with key legislative frameworks, such as the Equality Act 2010 and the Public Sector Equality Duty (PSED). This includes integrating equality considerations into decision-making processes, policies, and service delivery.
2. **Embedding EDI in Governance**: The BAF supports the inclusion of equality objectives as part of governance and risk management. By aligning EDI with strategic priorities, the BAF ensures that NHS organisations commit to eliminating discrimination, promoting equality of opportunity, and fostering good relations among diverse groups.
3. **Workforce Race and Disability Equality Standards**: The BAF requires regular monitoring and reporting on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES). These standards help track the experience and representation of Black, Asian, Minority Ethnic (BAME) and disabled staff, ensuring that progress is regularly reviewed and any inequalities are addressed.



4. Equality Impact Assessments (EIA): As part of risk management, the BAF includes Equality Impact Assessments (EIAs) to analyse and mitigate potential discriminatory effects of policies or changes within the NHS. EIAs are essential for promoting equitable treatment in both workforce and patient care initiatives.

5. Monitoring Staff and Patient Equality Data: The BAF supports the collection and analysis of workforce and patient data related to protected characteristics (e.g., race, gender, disability) to identify disparities, monitor progress, and guide equality initiatives. This also includes overseeing adherence to the Gender Pay Gap reporting requirements and commitments to closing any identified gaps.

6. Oversight of Culture and Staff Engagement Programs: Through the BAF, the Board monitors the effectiveness of culture change and staff engagement programs to ensure inclusivity in the workplace. This includes promoting a safe, diverse, and supportive environment where all staff feels valued and empowered.

7. Freedom to Speak Up (FTSU): The BAF encourages oversight of FTSU programs, ensuring that staff from diverse backgrounds feel safe to raise concerns without fear of retribution. This fosters a culture of openness and equality within the NHS.

The equality-related elements of the NHS BAF ensure that NHS Trusts continuously prioritise EDI, minimise disparities, and address the needs of both staff and patients across diverse backgrounds. This alignment with equality goals reinforces the NHS's commitment to fairness, inclusivity, and accountability in healthcare.

Governance Joint Committee in Common

Joint People Committee Overview: St George's and Epsom and St Helier University Hospitals NHS Trust

The People Committee operated as a Committee-in-Common with the People Committee of Epsom and St Helier University Hospitals NHS Trust throughout the 2023-24 periods. This collaborative structure allows for shared governance and strategic oversight across both organisations.

The Committee's responsibilities include:

- **Development and delivery of workforce and education strategies:** Ensuring alignment of workforce plans with the strategic goals of the Trusts, as well as the on-going development of education and training programs.
- **Workforce planning and performance oversight**: Monitoring workforce metrics, ensuring optimal staffing levels, and supporting staff development and performance management.
- **Strategic aim delivery:** Ensuring that workforce objectives are aligned with the Trust's broader strategic goals, including enhancing staff wellbeing and ensuring compliance with regulatory workforce requirements.
- **Culture, Equality, Diversity, and Inclusion (EDI):** Overseeing the implementation of the Trust's culture and EDI programs, ensuring that progress is being made, and that corrective actions are taken when necessary.
- The Committee's membership comprises both non-executive and executive directors, ensuring balanced oversight and accountability. Regular attendees include the Group Chief Executive, Group Deputy Chief Executive, and the Group Chief Corporate Affairs Officer, who are involved in steering and supporting the Committee's work.
- In 2023-24, the Committee held approximately 10 meetings, and attendance is recorded and tracked to ensure active participation and engagement in discussions around workforce strategy and performance.

This structure facilitates shared decision-making and ensures that the workforce strategy across both Trusts is aligned, transparent, and focused on the effective delivery of healthcare services, employee wellbeing, and inclusive organisational.

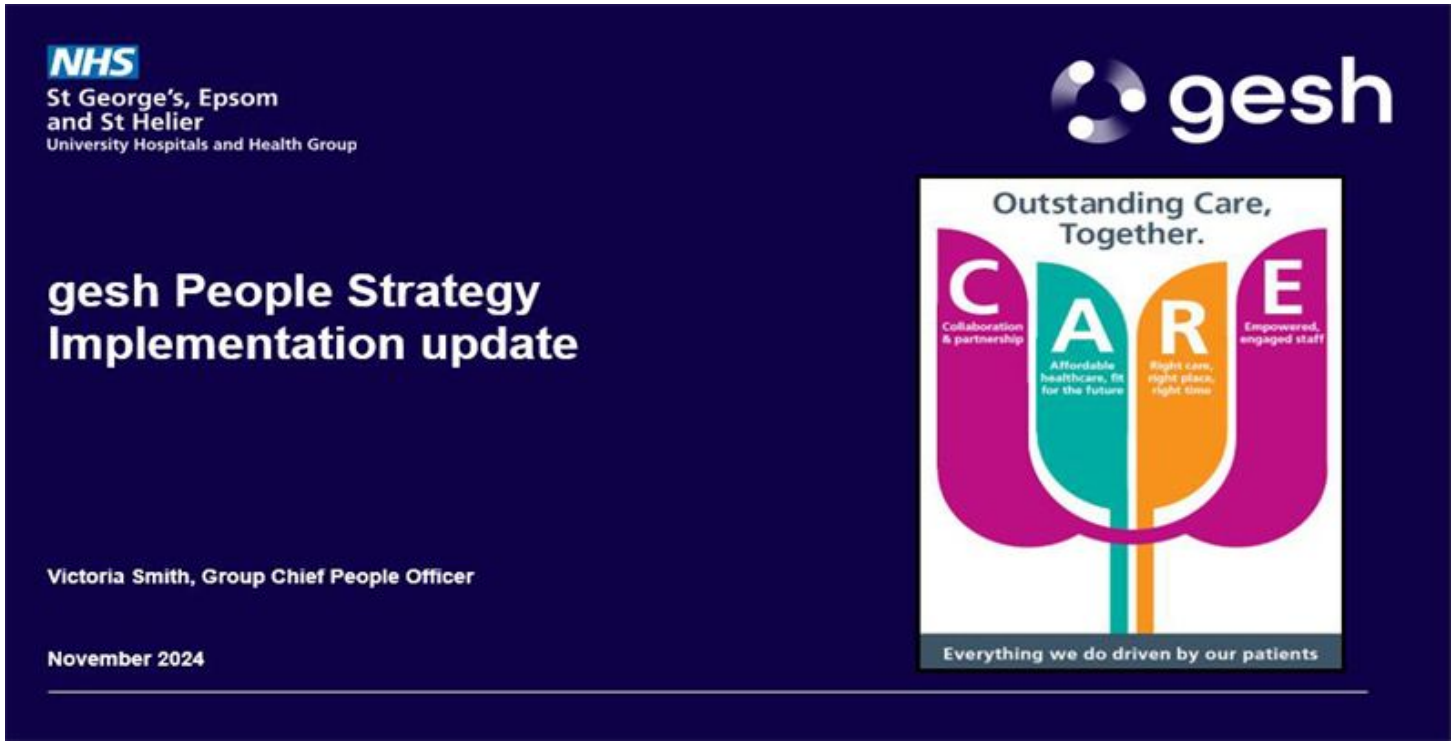
This table provides a clear breakdown of the Committee's activities, demonstrating its role in ensuring the on-going development and oversight of workforce performance and staff wellbeing at the Trust

Activity	Details
Review of Key Workforce Performance Indicators	Included turnover rates, stability, sickness absence, and training, alongside regular updates on the impact of industrial action taken by various staff groups.
Deep Dive Investigations	Focused on areas where the Committee required further assurance or where additional scrutiny was needed.
Monitoring Progress on Culture and Staff Engagement	Reviewed progress on the culture change programme, staff engagement plans, diversity and inclusion initiatives, and the Trust's position on the Workforce Race Equality Standard (WRES) and Workforce Disability Equality Standard (WDES).
Staff Health and Wellbeing Reports	Considered reports on staff health and wellbeing, including staff support services such as counselling and mediation programs.
Annual NHS Staff Survey	Reviewed the Trust's plans for the annual NHS Staff Survey and the results.
General Medical Council National Training Survey	Received reports on the results from the General Medical Council (GMC) National Training Survey.
Freedom to Speak Up and Medical Revalidation Reports	Received reports from the Trust's Freedom to Speak Up Guardian, Guardian of Safe Working, and the Medical Revalidation Responsible Officer.

gesh People Strategy 2024-2026

People Strategy 2024-2026
This section outlines gesh's efforts to achieve its vision for 2028, as part of the new five-year strategy launched in May 2023. The strategy is designed to provide clarity on our future ambitions and to guide the entire group towards achieving outstanding care, together. Central to this vision are our **"CARE objectives"**, which focus on collaboration and partnership, affordable and future-ready services, delivering the right care at the right time and place, and empowering our staff.

Throughout, our patients will remain the driving force behind everything we do. In May 2023 we launched our new five-year strategy for St George's, Epsom and St Helier University Hospitals and Health Group. It is designed to give everyone connected to the group clarity about our ambitions for the future, and what we want to achieve.



Our vision for 2028 is to provide outstanding care, together. We have identified four overall aims for 2028, our CARE objectives. These are the things we care about the most and will be central to achieving our vision. Collaboration and partnership Affordable services, fit for the future Right care, right place, right time Empowered, engaged staff In all this, everything we do will be driven by our patients.

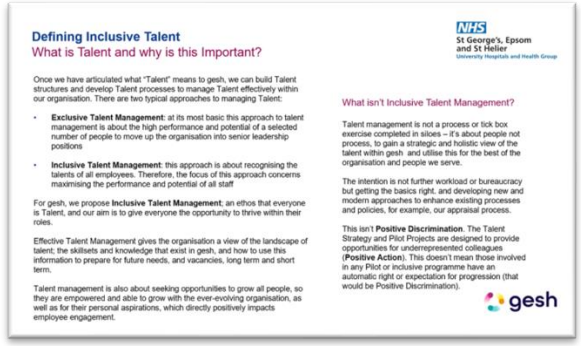
Inclusive Talent Management Strategy: Fostering Growth and Equality at gesh

Inclusive Talent Management Strategy: Fostering Growth and Equality at gesh

gesh Talent Management and Leadership Development Update

Strategic Alignment and Foundations
gesh remains committed to advancing a Talent Management agenda that is strategically, ethically, and financially aligned with the group's goals. Talent Management and Leadership Development were flagged as critical priorities during culture diagnostics at STG (2020) and ESTH (2022). In response, a Head of Leadership and Talent was appointed in August 2022 to lead efforts in addressing these needs.

Progress and Priorities
Significant progress has been made in the past year, focusing on evolving leadership priorities and addressing financial challenges. Recognised as a vital asset, Talent Management enhances long-term value while fostering a supportive, developmental, and ethically responsible culture.



Aligned with gesh's CARE strategy specifically its "Empowered and Engaged Staff" pillar Talent initiatives aim to promote inclusivity, celebrate diversity, and prepare the workforce for future challenges. The strategy prioritises equality, inclusivity, and professional growth for all team members through continuous consultation and collaboration with the Executive Team.

Key Highlights:

- **Talent Strategy Development**
- Currently undergoing governance processes, with expected sign-off by the end of 2024
- **Strategic Goals**
- Foster a **culture of learning and career opportunity**.
- Enhance **business agility and continuity**
- Promote **diversity at all levels**, focusing on ethnic diversity in higher bands and SLT roles.
- Core Work streams

The strategy is structured around five integrated workstreams:

- **gesh Leadership Competency Framework and Learning Programmes**: Establishing leadership capabilities aligned with organisational needs.
- **Career Conversations and Enhanced Appraisal Process**: Empowering career development through improved feedback mechanisms.
- **Inclusive Positive Action Programmes**: Supporting underrepresented groups to achieve equity.
- **Inclusive Recruitment**: Strengthening recruitment practices to ensure fairness and diversity.
- **Succession Planning**: Securing organisational resilience through strategic workforce planning.

By building on the foundations laid so far, gesh is poised to implement a comprehensive Talent Management strategy that aligns with its commitment to development, inclusion, and long-term organisational success.

The Long Term Workforce Plan identifies improved retention as a key element of its workforce expansion aims, establishing a renewed focus on retention through improved culture, staff wellbeing and leadership.

gesh: Driving Strategic Retention Initiatives for Success

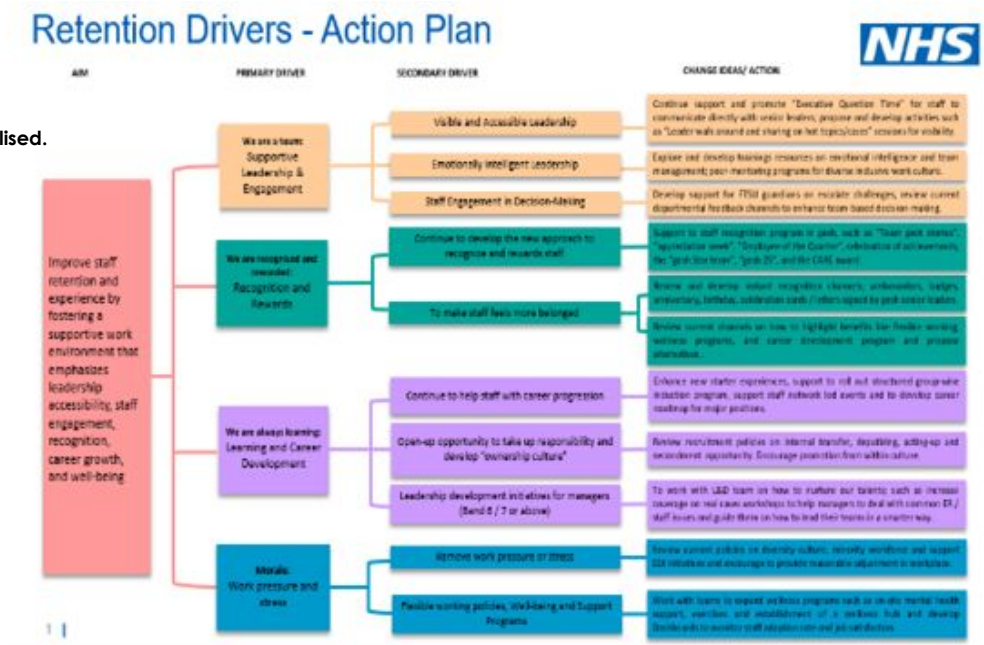
Four Drivers for Retentions

gesh Driving Strategic Retention Initiatives for Success

Overview

gesh joined other 115 organisations for the second phase of The People Promise Exemplar programme, to deliver the high impact interventions set out in the People Promise together in one place, at the same time to achieve improved outcomes and optimum staff satisfaction and retention. Recent analysis of staff survey results across both Trusts has identified key focus areas for improvement:

- **We are recognised and rewarded**
- **We are always Learning**
- **We are a team**
- **Morale, Work Pressure and Stress**



These insights align with the People Strategy Implementation Plan currently being finalised.

Proposed Actions

1. **Focus on High-Turnover and low staff survey score Teams**
   - Identify teams (operational areas, clinical services, wards) with higher-than-average turnover and low staff survey scores.
   - Conduct listening sessions with support from Business Partners (BPs) and local managers to gather insights on challenges and identify improvement areas.
   - Analyse exit survey data to supplement findings and pinpoint retention drivers.
2. **Pilot and Embed Key Initiatives**
   - Collaborate with identified teams to trial and embed initiatives from the People Strategy and the People Promise Exemplar programme, including:
   - Reward and recognition frameworks (e.g., new manager's guide)
   - Career development resources from the talent strategy
   - Explore and develop trainings resources on team management; peer-mentoring programs for diverse inclusive work culture.
3. **Learn from Exemplar Programme Successes**
   - Leverage insights and successful initiatives from other Trusts participating in the People Promise Exemplar programme.

Next Steps and Collaboration Requests:

- Stakeholders are encouraged to highlight new deliverables aligned with the focus areas and explore opportunities for piloting them with targeted teams.
- Collaboration with the People Promise Retention Manager will ensure alignment and maximise the impact of retention efforts.

St George's Overview Key Achievements Activities 2023-2024

***Launch of the 2024-2026 EDI Action Plan**

Successfully introduced the new Equality, Diversity, and Inclusion (EDI) Action Plan across the gesh group. Builds on the strong framework established by the 2020 EDI Action Plans.

Progress and Impact of 2020 EDI Action Plans

- Introduced in late 2020, these plans have significantly improved experiences for individuals from marginalised groups.
- Delivered numerous actions and projects, fostering tangible progress in inclusivity and equity.

Commitment to Cross-Trust Collaboration

Reinforced partnerships and shared initiatives among trusts to ensure unified efforts toward EDI goals.

On-going Efforts and Strategic Alignment

- Remaining open actions and live projects have been mapped to NHSE's EDI Improvement Plan to ensure relevance and coherence.
- Aligned with the People Strategy 2024-2026, reflecting a commitment to continued organisational growth and inclusivity.

Strengthened Group Collaboration

- Focus on closer collaboration between St George's and Epsom and St Helier to share best practices
- Emphasises collective learning and unified approaches across the group to enhance EDI initiatives.
- The new phase builds on previous successes, ensuring alignment with national priorities and an integrated approach to driving equity, diversity, and inclusion.

Armed Forces Staff Network Introduction
Recognition and Achievement

- Building on the prestigious Gold Award from the British Armed Forces, a testament to our commitment to supporting the Armed Forces community.

Launch of the Armed Forces Staff Network

Established a dedicated network to provide tailored support for:

- Veterans
- Reservists
- Cadet Force Adult Volunteers
- Partners and spouses of current and former Armed Forces personnel

Commitment to Inclusivity and Support

- Demonstrates continued efforts to foster an inclusive workplace, honouring the contributions and unique needs of Armed Forces personnel and their families.

This initiative underscores our on-going dedication to recognising and supporting the Armed Forces community within our gesh.

Centralised Process and Budget for Reasonable Adjustments
Streamlined Support for Staff: Introduced a centralised process and budget 2023 to efficiently manage and deliver Reasonable Adjustments.
Enhanced Access and Experience: Improves access, reduces wait times, and ensures timely support for staff with disabilities or long-term health conditions.
Comprehensive Assistance
Covers procurement of necessary items, support, or training to minimise the workplace impact of health challenges. Includes coordination and funding assistance for claims via Access to Work.

Commitment to Inclusivity: Reinforces our dedication to creating an equitable work environment, enabling all staff to thrive.
This initiative represents a significant step toward enhancing workplace accessibility and support for

***Work with the DAL Service to Coordination with Access to Work**: Streamlined funding and coordination of claims through Access to Work, further enhancing support for staff with disabilities.

Review and Update of E-Learning Modules: Conducted a review and update of two bespoke e-learning modules Disability Awareness (for all staff) and Workplace Adjustments (for line managers).

Enhanced Training Content: Updated modules to include information on accessing new support services and implementing reasonable adjustments in the workplace, ensuring staff and managers are better equipped to support colleagues with disabilities.

Renewed STGH's Disability Confident Status
Achievement of Level 2 Disability Confident Employer Status Successfully attained Level 2 (Disability Confident Employer) status, reflecting a commitment to inclusive recruitment and workplace practices.
Path to Level 3 (Disability Confident Leader)
Plans are in place to achieve Level 3 (Disability Confident Leader) status by 2025, further solidifying our dedication to accessibility and inclusivity.
Commitment to Inclusive Recruitment and Talent Management

As a Disability Confident Employer, we are committed to recruiting, retaining, and supporting individuals with disabilities and long-term health conditions through inclusive recruitment and talent management strategies.

Strengthening Inclusive Recruitment
Recruitment Inclusion Specialists, Trained over 250 specialists, supporting 500+ interview panels to promote diversity in hiring. Updated Inclusive Recruitment Module, Refreshed the SWL Inclusive Recruitment Module with the SWL Recruitment Hub.

Enhancing LGBTQ+ Visibility and Inclusivity in the Workplace and Patient Care

Launch of LGBTQ+ Staff Network Art Installation: Introduced an art installation to celebrate the LGBTQIA+ workforce, raise awareness, and reinforce our commitment to being a proud and inclusive employer.

Promoting a Safe and Inclusive Space: The installation serves as a visual reminder to staff, visitors, and patients that our hospitals are a safe space for the LGBTQIA+ community.

Improving Patient Care and Experience: By increasing visibility of the LGBTQIA+ community, we aim to positively impact patient care and address the poorer health outcomes this group often faces when accessing services. LGBTQ+ Network Awareness Campaign: Hosted activities during LGBTQ+ History Month to raise awareness of issues faced by the Intersex community, particularly in healthcare.

***Fireside Discussion with Intersex Activist Yasmin Benoit Fostering Open Dialogue on Key Challenges**

Fireside Discussion with Intersex Activist: Featured talks by Intersex activist Yasmin Benoit in a fireside chat format, fostering open dialogue on key challenges.

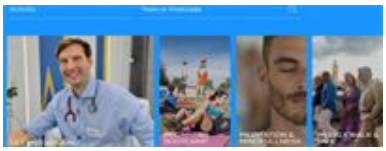
Staff Engagement and Education on Intersex Issues: Promoting Resources and Raising Awareness

Staff Engagement and Resource Promotion: Conducted interviews with staff and promoted valuable resources to further educate and engage the workforce on Intersex issues.

Menopause Awareness and Support Initiatives: E-Learning Module and Inclusive Cafés for Staff
Introduced a Menopause Awareness e-learning module to supplement our menopause policy and menopause cafés to support individuals experiencing menopause, providing a free, safe, and inclusive space to learn about menopause, its impact on staff, and to share experiences.

The E-Learning Specifically Aids
The e-learning specifically aids those with line management responsibilities with guidance and information about practical support. We provide a wide range of physical activity and exercise opportunities for all staff.

Physical Activity and Exercise Opportunities for Staff
The organisation offers a range of physical activity and exercise opportunities for staff, partnering with www.Actio.uk to provide free or discounted options on-site and in the local area.



STGUH's South Asian History Month 2024 saw staff come together in a lively celebration of South Asian heritage, honouring its profound influence and legacy

Wellbeing and Cultural Heritage
No Limit Cycle Challenge for Black History Month: Partnered with the Black Asian and Minority Ethnic-led No Limit Cycling Club to host the No Limit Cycle Challenge, promoting wellbeing and fostering a sense of community among riders of colour in 'non-traditional' spaces. Diwali Celebration with
REACH Network: Celebrated Diwali with the REACH staff network, featuring a performance by the Tooting Bal Sanskar children's group, a local organisation dedicated to teaching Hinduism, Gujarati, and Bollywood dance. Around 12 talented children performed traditional folk dances, adding energy and joy to the celebration.

Additional folk dances, adding energy and joy to the celebration.

Expanding Peer Support through Training Health and Wellbeing Champions and Mental Health First Aiders: Trained additional Health and Wellbeing Champions and Mental Health First Aiders, bringing the total to 120 Champions and 70 Mental Health First Aiders across the Trust. These trained colleagues provide peer support; assist in crises, and signpost staff to available resources.

Strengthening Staff Support and Wellbeing
Cost-of-Living Support Initiatives. To support financial wellbeing, we've introduced a dedicated intranet page, access to Wagestream for early wage access, financial webinars, free energy-saving boxes, and sustainable commuting options like free recycled bicycles for lower-paid staff.

Staff Recognition and Wellbeing Initiatives
To boost staff morale and recognition, the Acts of Kindness campaign celebrated exceptional individuals and teams based on patient feedback, recognising 16 individuals and 4 teams, while the October Wellbeing Challenge engaged 184 staff members in activities promoting physical, mental, and social wellbeing.

Further information on the Health Wellbeing page

St George's Overview Key Achievements Activities 2023-2024

Enhanced Collaboration and Best Practice Sharing Across Southwest London Trusts and ICS
Strengthened Collaboration Across Trust
Improved cooperation and sharing of best practices among Southwest London Trusts and the Integrated Care System (ICS).

Neurodiversity Awareness Training Initiative
St George's EDI Team launched a Train the Trainer program for 'Neurodiversity Awareness' in the Workplace.
This initiative helps other trusts develop their own internal workshops or identify expert personnel to deliver neurodiversity training within their organisations.

Building Capacity for Inclusive Practices
Empowers trusts across the region to enhance their support for neurodiverse staff, fostering a more inclusive workplace environment. This initiative exemplifies our commitment to cross-organisational collaboration and the dissemination of inclusive best practices across Southwest London to enhance equitable recruitment practices.

Empowering Staff Through Career Development and Confidence Building

- Co-Designed Career and Confidence Sessions
- Collaboration between the Learning and Development Team and EDI Team to deliver Career Conversations and Imposter Syndrome bitesise sessions.
- Specifically tailored for the REACH and Women's Staff Networks to address unique career challenges and support professional growth.

Comprehensive Support and Training

- Sessions included expert talks, strategies for overcoming self-image issues, and practical workshops on:
- **Strategic Career Planning**
- **Writing Successful Applications**

Interview Preparation and Networking
Enhanced Access to Resources

- Information stands and guidance from professional leads provided actionable insights for career development within the NHS. These sessions empower staff with the tools and confidence to advance their careers while fostering a supportive and inclusive workplace environment.

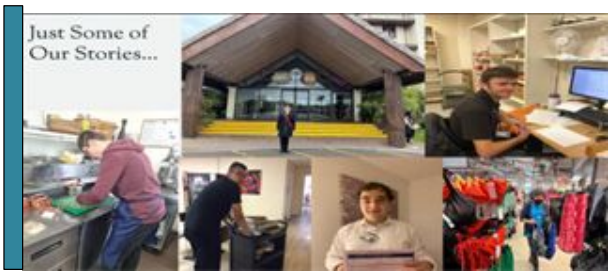
Mandatory e-Learning Modules on Disability Awareness and Workplace Adjustments

Updated e-Learning Modules: The Disability Awareness and Essential Workplace Adjustments modules were updated to include details of the new Central Fund and launched alongside guidance packs developed with key stakeholders, including the Disability Staff Network and Calibre graduates.

Targeted Team Training: In collaboration with the Disability Advice Line, training was provided to departments such as Employee Relations and Occupational Health to support staff with disabilities and long-term health conditions.

Mandatory Training: The Disability Awareness module, mandatory for all staff, promotes inclusivity and understanding of disability, while the Essential Workplace Adjustments module, mandatory for line managers, educates on legal responsibilities and practical support for staff with disabilities.

Project Search Internship Program Supporting Employment and Inclusivity



Longstanding Commitment: Proudly supporting the DFN Project Search Programme for its 12th year at St George's.
Supported Internship Program: Project Search provides internships for young adults with learning disabilities and/or autism, combining classroom teaching with hands-on work experience across Trust departments, mentored by staff volunteers.
Strong Employment Outcomes: Over 70% of Project Search graduates at St George's have secured permanent employment, with many joining departments such as General Porters, Theatre Porters, and Catering.

Outstanding Program Recognition: The program has been rated "outstanding" by external inspectors and has received broad support from multiple departments within the Trust.

Golden Ticket Scheme: Launching in 2025, this scheme will offer Project Search graduates a direct route to paid employment at the Trust, bypassing traditional interviews, and forming part of our inclusive recruitment efforts, which contributed to achieving Disability Confident Employer level 2 status.

SGUH Staff Networks

Active Staff Networks at St George's (Established in 2019):

- Race, Equality, and Cultural Heritage (REACH) Staff Network
- LGBTQ+ Staff Network
- Disability and Wellness (DAWN) Staff Network
- Women Network

Women's Staff Network The established Staff Networks and their Network Leadership Committees (NLCs) have actively engaged staff, consulting on significant policy and process changes, and organising key celebratory and awareness events. Network Chairs also participate in the gesh Culture Forum, chaired by the CEO, providing them with a platform to influence key organisational decisions. Each of the four recognised Staff Networks benefits from a dedicated charity grant and a designated budget for network activities and development.

REACH Network
The REACH Network, with over 300 members, plays a crucial role in supporting St George's organisational culture program and driving change through the gesh Culture Forum. **Key activities include:**
'See ME First' Initiative: Launched in 2022, this initiative promotes Equality, Diversity, and Inclusivity within the organisation. It emphasises that Black, Asian, and Minority Ethnic staff should be treated with dignity and respect. The initiative continues to grow in visibility, with participants wearing the "See ME First" badge to demonstrate their commitment to the values of Excellence, Kindness, Responsibility, and Respect, echoing Dr. Martin Luther King Jr.'s sentiment of being judged by character, not by skin colour.
Cultural Celebrations: The network hosts key cultural celebration events for Windrush Day, Black History Month, Eid, Diwali, and Chinese New Year, fostering inclusivity and awareness.
Future Initiatives: In the coming year, REACH will collaborate with the EDI and ER teams to introduce Employee Relations Inclusion Specialists (ERIS), who will serve as impartial reviewers for Employee Relations cases, aiming to reduce bias in these referrals.

DAWN Network
The Disability and Wellness Network (DAWN) has 108 members and plays a pivotal role in driving change through the gesh Culture Forum and various initiatives. Key activities include:
Deaf Awareness Week 2024: The network organised a pop-up stand to encourage staff to test their hearing and participate in a British Sign Language (BSL) taster course, raising awareness of hearing impairments.
Sensory Pods Initiative: In collaboration with City and St George's University and the St George's Hospital Charity, the network is planning to introduce sensory pods for neurodiverse patients and staff. These pods will provide a low-sensory environment in a busy, acute hospital setting to reduce sensory overload.
Health Conditions/Disability Engagement: The network hosts regular staff engagement events focused on health conditions and disabilities, including UK Disability Month activities such as weekly virtual talks from staff, BSL sessions, mindfulness sessions, and promoting best practices and resources.
Mandatory Training Development: The network contributed to the development and review of the Disability Awareness and Essential Workplace Adjustments mandatory training modules, enhancing disability inclusion across the Trust.
Calibre Leadership Programme: The network continues to support the Calibre Leadership Programme, a talent development initiative for staff who are neurodiverse or have long-term health conditions. The program empowers staff to overcome workplace barriers.
'**My Health Matters Too' Campaign:** In collaboration with the EDI team, the network launched a poster campaign highlighting the importance of visibility and reasonable adjustments for staff with disabilities and long-term health conditions, showcasing staff with both hidden and visible disabilities across various Trust roles.

LGBTQ+ Network

The LGBTQ+ Network, with 175 members, plays an essential role in supporting the organisational culture programme and driving change through the gesh Culture Forum. Key achievements and activities include:

Pride Celebrations: The network successfully hosted Pride events throughout the year, promoting inclusivity and visibility for LGBTQ+ staff and patients.

Intersex Awareness Week: The network held events to raise awareness of Intersex issues, highlighting the unique challenges faced by the Intersex community in healthcare.

Trans Rights & Best Practices: In collaboration with the EDI team, the network.

Women's Network
The Women's Network, with a membership of 200, provides a platform to address the experiences of female colleagues, particularly those underrepresented at senior levels.

Key achievements and activities include:

Breastfeeding/Chest feeding Room: The network led the successful implementation of a dedicated breastfeeding/chest feeding room on site, ensuring a supportive environment for new mothers.

Menopause Café: Continuing to support staff navigating pre-menopausal, menopausal, or related challenges, the network facilitates a safe space for sharing experiences and offering peer support.

Imposter Syndrome Sessions: The network hosted virtual sessions to help address self-doubt and feelings of inadequacy among staff, empowering them to overcome imposter syndrome.

Future Initiatives: Looking ahead, the network plans to host sessions on financial independence and generational wealth, aiming to empower members and challenge the traditional male-dominated financial investment space.
These initiatives continue to drive positive change, support women's advancement, and foster inclusivity within the Trust.

Improving Patient Experience and Ensuring Equality at St George's

St George's is dedicated to enhancing patient experience and meeting the requirements of the Public Sector Equality Duty (PSED). Key initiatives highlight the Trust's commitment to inclusivity and equality for all patients and staff.

- **Transgender Inclusion:** In collaboration with LGBTQ+ Staff Networks and clinical teams, St George's introduced a policy to improve the experience of transgender staff and patients, ensuring dignity, respect, and equality in healthcare and employment.
- **Patient Partnership and Experience Group (PPEG):** The PPEG successfully expanded volunteer involvement, ensuring diverse patient and carer voices are heard and integrated into decision-making processes.
- **Inclusive Equality Impact Assessment for Renal Care Centre:** An inclusive Equality Impact Assessment was conducted for the new Renal Care Centre, ensuring accessibility and equity for patients from underrepresented groups.

- **gesh Delivery of our Culture and Leadership Programme**

In 2023, we introduced a leadership programme to ensure all leaders are capable, confident and empowered to lead with compassion, authenticity, and inclusivity, driven by our core values and vision
in support of our strategic aims.
The programme is an opportunity for leaders from across our organisation to learn together and create positive relationships and understanding while strengthening our organisational culture, staff engagement and morale.
The programme covers four topic areas:
• **Module 1** - Leading self and teams
• **Module 2** - Leading change and innovation
• **Module 3** - Leading for high performance and conflict resolution
• **Module 4** - Leading the Operation
• **Module 5** - Leading in the SGUH/ESTH system

As we continue to evolve and adapt to meet the changing needs of our workforce, one thing remains constant: our dedication to cultivating a workplace where every individual feels valued, supported, and empowered to thrive. Together, we will continue to uphold our commitment to staff engagement, recognising that it is the cornerstone of our success in delivering outstanding patient care now and in the future.

SGUH -Learning and Development Newsletter – Key Highlights

Explore our key initiatives designed to enhance leadership and management skills:

Compassionate and Inclusive Leadership Programme: **A modular course for middle managers focusing on self-management, team management, and inclusivity**. **Additional funding** is required to sustain this impactful programme.
Management Apprenticeships:

Levels 3–7 available, with **126 active apprentices' currently** participating, supporting leadership development at all levels.
Management Fundamentals Toolkit:

A one-stop resource for people managers, **accessible online via LMS and supplemented with face-to-face sessions**. It covers essential management areas such as:

- Inducting new starters
- Managing performance
- Developing teams

Invest in your growth and leadership journey today!

Epsom St Helier Overview Key Achievements Activities 2023-2024

*Embedding Sustainable Culture Change at ESTH
Key Highlights:
Staff Engagement Crucial for Change: Success relies on input and buy-in from all organisational levels to foster sustainable culture change, enhancing both workplace culture and patient care.

NHS Culture & Leadership Program: Launched in 2022, the program by NHS England aimed to assess and improve the Trust's organisational culture and staff experience.

Role of Culture Champions: Seventeen multi-professional Culture Champions, from clinical and non-clinical backgrounds, facilitated focus groups, team visits, and leadership interviews, providing insights into staff experiences.

Extensive Staff Feedback: Over 700 voices were gathered through the discovery phase, with Culture Champions driving engagement and communication efforts.

Legacy of Culture Champions: Although their formal roles have concluded, the Champions are expected to continue as informal advocates for cultural improvement at ESTH.

Our People's Panel
An initiative that aims to ensure future key projects and programmes are co-designed with patients and local people. For further information about the Trust People's Panel can be viewed at our website.

Updating Workforce Priorities to Align with Trust Strategy

Strategic Alignment: The refreshed Trust Strategy presents an opportunity to reassess workforce priorities.

Workforce & Development Review: The Trust People and Organisational Development Strategy (2021-2025) have been reviewed to support the updated strategic goals.

Goal: Ensure workforce priorities enable the effective delivery of the Trust's refreshed aims.

Post-Black History Month Competition Celebrates Black Heritage

On-going Celebration: Although Black History Month ended on October 31, the Library Team continues to honour it with a special competition.

Artwork by Leonie Lindo: The self-taught realist painter was commissioned to create "Honouring Motions to stand," representing this year's theme.

Competition Details: Participants are encouraged to read a book from the Borrow Box Black Heritage Month collection and submit a 250-word summary.
Prises: The top four summaries, judged by an external panel, will win a framed, signed A4 print of Lindo's artwork.

*New People Committee Upholds EDI Focus
Group Model Transition: The Trust's shift to a group model has introduced a new governance structure.

People Committee (PC): A Board sub-committee, dedicated to workforce issues and well-being.

Commitment to Equality, Diversity, and Inclusion (EDI): EDI remains a prioritised, standalone agenda item for the PC, reinforcing its importance in Trust operations.

*Collaborative Celebrating Diversity Calendar (2024-25)
We're excited to announce a joint initiative between **ESTH) SGUH:** the **Celebrating Diversity Calendar (2024-25)**.
This collaboration highlights our shared commitment to equality and inclusion, celebrating the rich diversity of our workforce and communities.

The calendar serves as a powerful tool to inspire impactful initiatives, foster belonging, and break down barriers.
Together, ESTH and SGUH are paving the way for a more inclusive future one that celebrates diversity every day.

gesh 25 Celebration Honours Long-Serving NHS Staff
Epsom Celebration Event: The third gesh 25 event was held at Epsom to honour colleagues from Epsom, St Helier, and community services, recognising over 850 years of combined service to the NHS.
Recognition Ceremony: Chairman Gillian Norton and Deputy Chief Executive James Marsh presented certificates and badges to long-serving staff, expressing gratitude for their dedication.
Celebratory Gathering: The event included afternoon tea with Board members, executives, and site leaders, accompanied by live music.
Memorable Milestone: Michael Rutt, Pensions Advisor, received a standing ovation for his impressive 51 years of service.
Event Highlights: Quick video highlights are available for viewing.

Celebrating National Allied Health Professions (AHP) Day
Recognition of AHP Contributions: National AHP Day on October 14 celebrated the essential work of 14 professional groups, the third-largest clinical workforce in healthcare:
AHP Day Awards Ceremony: Hosted by Jill Thorpe, Associate Director of Nursing and AHPs, with awards presented by leaders from across the Trust.
Award Categories and Winners:
Diversity Champion: Sutton's At Home Team
Innovation of the Year: Children's Speech and Language Therapy, Sutton Health & Care
Living the Trust Values: SDHC Community Neuro Rehab Team
AHP of the Year: Jumana Ahmed, Acute Paediatric Dietitian
Practice Educator of the Year: Anabel Cejudo-Rubio, OT with Acute Therapies
Support Worker Award: Linda Quigg, SHC At Home Team
Team of the Year: Operating Department Practitioners
Unsung Hero: Nicole Murphy, Rehab Assistant at Molesey Hospital
Acknowledgment: Congratulations and gratitude to all AHPs for their daily contributions to patient care.

Opening of Langley Wing Therapy Garden at Epsom
New Outdoor Space: The Langley Wing Therapy Garden at Epsom Hospital has opened to support patient recovery and well-being, particularly for those in Elderly Care, Dementia, and Neuro Rehabilitation wards.
Therapeutic Services: The garden complements therapeutic teams in Cardiac Rehabilitation and Orthotics, aiding recovery for patients with various conditions
Generous Funding: Made possible by The Friends of Epsom and West Park, who have supported the hospital for over 60 years.
Future Staff Benefits: Plans are in place to create designated areas for staff to enjoy during breaks.
Opening Event: The garden was officially opened with contributions from various stakeholders, including The Friends of Epsom, local MP, hospital staff, and project teams.

Epsom St Helier Overview Key Achievements Activities 2023-2024

Debunking Menopause Myths: A Presentation by Carolyn Croucher, ESTH
The "Debunking the Myths" presentation by Carolyn Croucher, a gynaecologist at East Surrey Teaching Hospital (ESTH), offered valuable insights into menopause and its varied impact on individuals.
The session addressed common misconceptions surrounding menopause, highlighting how it affects people differently based on factors such as age, lifestyle, and ethnicity.
This informative event, organised by the Wellbeing Team led by Norma Perry, aimed to empower attendees with accurate knowledge and foster a better understanding of menopause, ultimately promoting a more supportive and informed approach to women's health.

***Our pledge to create a safe and dignified workplace**

Launch of NHS Sexual Safety Charter at gesh
Purpose of the Charter: Ensures a safe and respectful environment across NHS organisations, emphasising dignity and the prevention of sexual harassment, misconduct, or inappropriate behaviour.

Upcoming Launch: The charter will be launched across gesh next week with a virtual event led by Arlene Wellman on Monday 18 November at 11 a.m., featuring special guests. On-going Events, Additional activities will take place throughout the week to reinforce the commitment. Full details are available on the intranet.

***Skin of Colour Training UK's 2025 Conference**
Skin of Colour Training UK, led by Dr. Marisa Taylor, Consultant Dermatologist, is excited to announce its 1st face-to-face conference, taking place on January 23-24, 2025, at the Royal College of Physicians in London.
This event, the first UK Deanery approved dermatology conference of the year, will focus on promoting inclusivity and addressing the needs of skin of colour in dermatology.

The conference aims to enhance cultural competence among healthcare professionals and foster diversity in dermatological education. ESTH and STGH (gesh), along with other institutions, are warmly invited to attend and participate in this ground-breaking event.

Commemorating Armistice Day across the Group
On November 11, colleagues, patients, visitors, and members of our Armed Forces community came together across the Group to mark Armistice Day

. Each location hosted a service and observed the two-minute silence, reflecting on the significance of the day. Readings were shared by chaplains, veterans, Armed Forces community members, and staff, emphasising the shared values of service, dedication, and resilience that unite us all.

Thank you to everyone who helped organise these events, and those who attended. As Veteran Aware organisations, it's important we identify members of the armed forces community that we have contact with. Recording this information and supporting signposting will improve the experience of veterans, acting members of the armed forces, and the families.

Training is available through the Patient Experience team, either virtually (so accessible across all sites) or bespoke sessions as part of

Head of Security, Paul Grsegorsek, Provides Critical Aid in Ukraine
Paul Grsegorsek, the Head of Security, travelled to Ukraine to deliver essential aid to those impacted by the on-going crisis. While in Ukraine, he worked at refugee centres along the border, providing support to displaced individuals. Additionally, Paul assisted in the transportation of orphaned children as part of the official refugee placement efforts. His dedication and selfless contributions have had a significant impact on the lives of many in need during this challenging time.

Epsom St Helier Overview Key Achievements Activities 2023-2024

Women and Allies' Network Past Events: 2023 – 2024

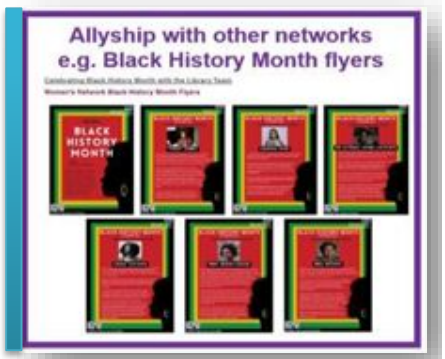
Epsom and St Helier Women's Network Update
The Women's Network, established in 2019 by Rebecca Bennett, Postgraduate Medical Centre Administrator, champions gender equality at Epsom and St Helier University Hospitals NHS Trust. Our mission is to foster professional and personal growth, educate staff on gender equality, and create a workplace and community that values inclusivity.
We host monthly meetings on Teams, open to all staff, and encourage male colleagues to join as allies. Your involvement can be as much or as little as you wish.

Introducing Our Leadership Team:
Co-Chairs: Potenza Atiogbe and Rachel Addy
Secretary: Breana Cronk-Moore
NED Sponsor: Aruna Mehta
Executive Sponsors:
James Blythe (Managing Director) and Lizzie Alabaster (Site Chief Financial Officer)
Celebrating the Contributions of Women in the NHS

gesh International Women's Day virtual celebration 08 March 2024

Key Highlights: Women and Allies' Network Update

- **International Women's Day and Month 2024**: Featuring a virtual event on "Imposter Syndrome" with Douglas Hamandishe.
- **Name Change**: Now proudly called the Women and Allies' Network.
- **Leadership Support**: Welcoming new Executive Sponsors, James Blythe and Lizzie Alabaster.
- **Increased Visibility**: Regular features in *Team Talk* and *The News*.
- **Engaging Events**: Hosted impactful sessions such as "Becoming a Chief Medical Officer" and menopause discussions; recordings are available on the hub.
- **Enhanced Resources**: Access Borrow-Box virtual collections, print materials, and the eLearning hub for support.
- **Merchandise**: Promotional stock being prepared for network visibility.
- **Collaborative Allyship**: Partnering with other networks, including Black History Month initiatives.
- **Inclusive Meetings**: Monthly virtual meetings on the third Thursday, open to all staff.
- **Membership Drive**: Actively recruiting new members during March 2024 celebrations.



Championing Diversity Women Lead the Way at gesh

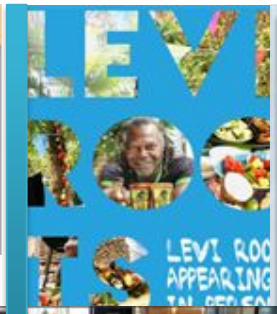
*Women represent the majority of the NHS workforce, and at gesh, nearly three-quarters of the staff are women. As Chairman Gillian Norton proudly states in a video recorded to mark the occasion: "I'm proud that this is an organisation with so many women who do so many things for our patients and communities." Their dedication and contributions are integral to the success and impact of the healthcare services provided.

Race, Equality, and Cultural Heritage (REACH Network
Introducing Our Leadership Team:
Co-Chairs: **Louise Emmett and Dr Benedicta Ogeah**
Executive Sponsors **Professor Arlene Wellman**

REACH and Allies' Network Past Events: 2023 – 2024

- The vibrant and diverse spirit of our community was on full display at the **"Too *Hot to Handle"** event series, which celebrated an array of cultural milestones and histories. Among the highlights:
- The trust embraced the essence of **Ramadan 2024**, marked on [insert exact date], with a shared commitment to reflection and togetherness.
- ***Levi Roots**, renowned for his contributions to Caribbean cuisine, joined us during **Black History Month** at ESTH Restaurant. With his signature flair, he served up a delicious feast of rice, peas, and chicken while celebrating cultural heritage.
- *In a thought-provoking **Black History Month 2023** event, **Shola Mos-Shogbamimu** hosted a dynamic fireside discussion alongside **Professor Arlene Wellman** and other executive leaders, diving into pressing topics and shared experiences.
- **South Asian History Month 2024** was a vibrant celebration of South Asian heritage, with staff coming together to honour the contributions and rich history of the **community.**
- **The EDI in Finance Spotlight initiative shone a light on efforts to champion equity and inclusion within financial sectors**, highlighting the transformative impact of diverse leadership and inclusive practices.
- **Origami Christmas Wreaths**: Festive Creativity in Action Organised by our Women's Network Allies, led by **Rumiko Yonezawa**, the initiative brought staff together to craft beautiful origami wreaths.
- The activity symbolised unity, creativity, and teamwork during the holiday season.
- It was a heartfelt celebration of collaboration and festive spirit, highlighting the talent and dedication within our network.

These events showcased our on-going dedication to celebrating diversity, nurturing dialogue, and creating a sense of unity across cultures and traditions.








Enabling network and Allies' Network Events: 2023 – 2024

Introducing Our Leadership Team:
Chairs: Dionne Daniel
Deputy Chairs: David Fernandes
Executive Sponsors Gillian Norton Chairman (gesh)

Empowering NeurodiversityAutism and ADHD Training Session

The Enabling Network recently hosted a powerful training session led by Stephanie Pool, Advanced Nurse Practitioner, who shared her unique insights into living with Autism. Stephanie's presentation offered a deeper understanding of the challenges and strengths of neurodiverse individuals and provided practical tools for fostering inclusivity. Attendees also gained valuable knowledge of the latest national guidance and best practices for supporting colleagues and patients with Autism and ADHD.

This eye-opening session reinforced the importance of awareness and advocacy, empowering attendees to create a more inclusive environment for neurodiverse individuals

Celebrating Disability History Month: Annual Workforce Disability Conference
The Annual Workforce Disability Conference, hosted by the Enabling Network, celebrated Disability History Month with inspiring sessions and key initiatives.
Key Highlights:

- Baroness Tanni Grey-Thompson delivered an inspiring keynote on empowering opportunities for people with disabilities.
- The launch of the SWL Disability Advice Line, a vital resource for workplace disability support.
- Discussions on fostering inclusivity, overcoming challenges, and celebrating the contributions of people with disabilities.

The conference emphasised the on-going need for advocacy and

***LGBTQ+ and Allies' Network Events: 2023 – 2024**
Chairs: James Pavett-Downer
Deputy Chairs: Vacant
Executive Sponsors: Kate Slemeck, Managing Director (STGUH)

Celebrating Pride 2024: A Joint Venture by ESTH and STGUH
In a spirit of collaboration and inclusivity, Epsom and St Helier University Hospitals joined forces with St George's University Hospitals to mark Pride 2024 and honour LGBTQ+ History Month with a series of impactful events.

Addressing Health Inequalities and Homophobia -Staying Safe and Empowered

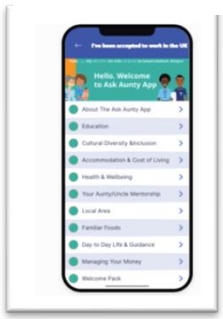
As part of the 2023 LGBTQ+ History Month celebrations, a series of impactful discussions highlighted crucial issues faced by the LGBTQ+ community. NHS England representatives spoke about the persistent health inequalities impacting LGBTQ+ individuals, urging for better access to care and improved support across healthcare systems.
In addition, Surrey Metropolitan Police delivered an insightful session on safety, focusing on homophobia awareness and providing essential strategies for LGBTQ+ individuals to stay safe and supported in their communities.
These sessions were essential to raising a deeper understanding of the challenges faced by the LGBTQ+ community, while empowering individuals to advocate for their rights and well-being. The discussions also emphasised the importance of collaboration, education, and continued efforts to ensure a safer, more inclusive society for all.

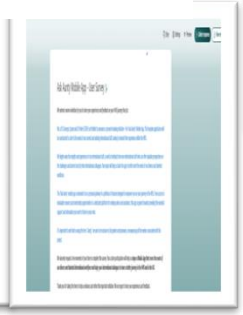
***Sexual Orientation and Gender Identity Monitoring at gesh (ESTH and STGUH)**
At gesh (Epsom and St Helier University Hospitals), we are committed to improving the inclusivity and quality of care for all patients, with a particular focus on sexual orientation and gender identity monitoring. This initiative is key to ensuring that LGBTQ+ individuals receive the tailored care and support they deserve, while also helping us understand and address the unique health challenges faced by this community. By collecting and analysing data on sexual orientation and gender identity, we aim to create more personalised and responsive care pathways, remove barriers to healthcare access, and promote equality. This approach will empower our healthcare professionals to better meet the needs of patients from diverse backgrounds, ensuring that everyone at gesh feels seen, respected, and valued.

*AskAunty Secures over £1/4 Million in NHSE Funding for London Rollout!

"Securing funding for the Pilot Ask Aunty Project is an incredible achievement and highlights South West London (SWL) as a leader in innovation within the Equality, Diversity, and Inclusion (EDI) space. This jointly funded initiative, supported by the ICB and gesh, will make a significant difference in supporting international staff across South West London and beyond". **Melissa Berry: EDI Programme Director SWL ICB.**

App **Resource Material** **Questionnaire**





Ask Aunty" Secures Over £250,000 in NHSE Funding for National Rollout
We are thrilled to announce that *Ask Aunty*, a pioneering programme designed to support international staff at St George's, Epsom, and St Helier Hospitals (gesh), has received over £250,000 in funding from NHS England for its expansion across London. The initiative, led by Professor Arlene Wellman, MBE, aims to ensure that international employees feel welcomed, supported, and empowered in their personal and professional journeys.

What is Ask Aunty?
Ask Aunty is a comprehensive support programme offering tailored assistance to international healthcare workers to help them integrate seamlessly into their new roles and communities.

Two Core Services:

- **Mentoring:** Experienced colleagues, affectionately called "Aunties" or "Uncles," provide personal and professional guidance to new international staff.
- **Dedicated App:** A user-friendly app offers vital resources, including mental health and well-being support, training opportunities, professional development, and accommodation assistance.

A Year of Impact
In the past year, gesh has made a significant difference, welcoming 421 international employees to the gesh team. This influx has enriched cultural understanding within the organisation and contributed to improved patient care.

Programme Goals
The *Ask Aunty* programme is designed to:

- Enhance staff experiences, leading to better patient outcomes.
- Foster greater social and cultural understanding across the organisation.
- Provide targeted support for both personal and professional needs.

Championing Diversity and Support

Professor Arlene Wellman, MBE, shared her passion for the programme:
"As an internationally educated nurse myself, I have first-hand experience of the needs of internationally trained colleagues who continue to join our diverse workforce. I am passionate about the programme and what it delivers for staff like me who has come to the UK to progress our careers and deliver fantastic care." She further emphasised the challenges faced by international healthcare workers, such as language barriers, cultural adjustments, and navigating the complexities of the UK healthcare system.

"Social isolation can worsen these challenges. It's essential we have programmes like Ask Aunty to support our international colleagues, who are vital to the on-going success of gesh. This programme will ensure our staff feels comfortable, happy, and well-supported throughout their journey with us".

*SWL ICB Disability Advice Line Secures second round of Funding 2025

The Disability Advice Line (DAL) is dedicated to putting disabled staff and those with long-term health conditions at the heart of our work. Our vision is to create a South West London (SWL) where employees and employers alike understand the value of accessibility and fairness, and where everyone can benefit from reasonable adjustments that promote inclusivity, equity, and empowerment in the workplace." **Melissa Berry: EDI Programme Director SWL ICB.**

Epsom St Helier DAL Launch 2023

"The Disability Advice Line has been praised for its clear, compassionate guidance and practical support. Users highlight its expertise and understanding in helping individuals navigate challenges, empowering them to move forward with confidence. **Sandra Ovid (Founder of the DAL) and Enabling Chair Dionne Daniel**

Kingston DAL Launch 2024

Croydon DAL Launch 2024

As a team, I'm confident to say that we are happy with the DAL and would like it to continue.

St George's DAL Launch 2024

Croydon Health Services (CHS) has greatly benefited from the implementation of the Disability Advice Line (DAL) service.
As of October 2024, 35 enquiries have been made, 66% from internal staff and 24% from internal managers.
The most frequent queries involve support with reasonable adjustments, accessing dyslexia software, redeployment support and ordering equipment through Access to Work.
The DAL has not only supported staff practically, but has also provided staff with confidence in the fact that CHS is listening and will support them in the workplace.
When accessing the service, staff receives personal, 121 support and are shown how to practically help themselves, for instance, how to contact Access to Work or complete paperwork as they work through the forms with the DAL Officer. Hence the DAL empowers staff. Managers also feel supported as they have a designated contact to reach out to for advice, guidance and support, ensuring they can help their staff and get it right first time. This is critically important for good working relations and output.
Through use of the DAL, CHS is able to identify key areas for further improvement, for instance, 16.67% of respondents accessing the DAL did not disclose their disability or chose not to declare. This could indicate privacy concerns or reluctance to share personal information. This is something that the Trust are keen to work on and keep an eye on as time progresses
We engaged with more than 100 staff, handing out 100 goodie bags that we put together plus extra DAL pens and sticky pads. **Croydon Health Service**

'St George's Hospital launched the Disability Advice Line (DAL) service in February 2024 following a stakeholder event involving service users and key teams with involvement in the provision of reasonable adjustment support. Our EDI Team host monthly drop in sessions for staff to meet the DAL Advisor and receive face to face advice in a confidential space'. **EDI Team and DAWN network St George's.**

Kingston and Richmond Hospital

"The Disability Advice Line was soft launched at Kingston and Richmond on the 18th November 2024. The Equality Diversity and Inclusion team hopes it will create a culture of inclusivity through its open and welcoming approach to staff, managers, and stakeholders and we look forward to working closely with the DAL team. The Equality Diversity and Inclusion team hosted Disability Advice Line information stands on the 21st and 22nd of November at Thames House and Kingston Hospital. They both attracted a high level of interest from staff. Over the course of the two days, the team interacted with more than 100 staff members, distributing 100 goodie bags, along with additional DAL-branded pens and sticky pads. The feedback from staff was encouraging, with many commenting on the initiative's value and expressing their intention to share the information with their colleagues. The DAL was discussed at the December 12th All Staff Brief to further heighten awareness of the service". **EDI Team and Network chair**

Royal Marsden Hospital

Our Trust is eager to make greater use of the Disability Advice Line (DAL) service, which has already proven helpful to our recruitment colleagues. We are fully committed to supporting its launch and would love to collaborate with DAL Advisor to host a couple of drop-in sessions, January 2025 ensuring our teams can benefit from this valuable resource. **Priti Davey, Inclusion Partner.**

***gesh Hospitals**

Bareness Tanni –Grey-Thompson, Launched of SWL Disability Advice Line 6 December 2023

WDES NHS Team

NHS WDES Team "The SWL Disability Advice Line (DAL) provides a vital resource for staff with disabilities and long-term health conditions across six provider trust sites. The DAL will supplement the tools line managers have to enable them to enhance capacity and foster confidence in supporting disabled staff in the workplace"**.Peter Loughborough**

Lexxic

"Lexxic believe in a world where all minds belong, and we recommend the SWL Disability Advice Line (DAL) for their commitment to helping neurodivergent staff access confidential support and information as well being a resource for management to gain the tools and resources needed to support their staff members. This is a great commitment from South West London Integrated Care Board and we look forward to supporting you with this"

Pooja Sudera is a Consulting Business Psychologist

NHS Calibre Programme

Running the Calibre programme in the NHS for over seven years, it was clear to me that there has been a significant gap in support for disabled staff. So, I really was pleased to see the creation of the Disability Advice Line.

In today's complex and demanding world, especially within the NHS, fostering an inclusive environment where everyone thrives is crucial. For me, it is really pleasing to see how the Disability Advice Line tackles this challenge head-on. It does so by using a very innovative approach. Instead of just helping, it empowers disabled staff, managers, and their colleagues by giving them the confidence to discuss disability openly.

By providing expert advice, support, and resources, the Disability Advice Line bridges the gap in disability awareness and understanding. This collaborative effort not only strengthens businesses and organisations but also creates a more welcoming and supportive environment for all individuals within the community.

Consequently, I cannot overstate the DAL's importance. Its collaborative approach dismantles barriers and ensures everyone in South West London feels valued, respected, and equipped to thrive. I really look forward to it growing and thriving across the NHS. **Dr Ossie Stuart**

Danielle Chandler DAL Advisor:

Danielle is the Disability Advise Line (DAL) Officer for SWL Integrated Care System. She brings a wealth of expertise in disability-related work, with a background that includes the NHS Provider Trusts, ICBs, and most recently, Diabetes UK, where she excelled in engaging patients and enhancing service delivery for better health outcomes.

The Disability Advice Line (DAL), provided by the South West London Integrated Care Board (ICB), stands as a dedicated support service for individuals with disabilities and long-term health conditions. Our objectives for 2025 are:

- **Provide clear, up-to-date guidance:** on reasonable adjustments and support
- **Improve NHS Trust inclusivity:** through targeted initiatives
- **Promote DAL and advocate:** for disability-related improvements
- **Develop a funding strategy:** for long-term service continuity
- **Implement data reporting:** to track progress and enhance services

DAL Activities 2024 Across SWL Provider Trusts

Croydon Healthcare

DAL Launch at Croydon Hospital (2024): 35 total inquiries received.
Physical Impairments: 16.67% of respondents.
Learning Disabilities: 16.07% reported.
Undisclosed: 16.67% chose not to disclose.
No Disability: 22.22% reported no condition.
Long-Standing Illness: 13.89% reported.
Sensory Impairments & Mental Health: Both at 2.78%.

Most inquiries came from internal employees, with managers following, highlighting strong internal engagement and employee-focused issues driving the inquiries.

St Georges Hospital

DAL Launch and Engagement: The DAL service launched at St George's in February 2024 and has since received 35 enquiries.

Audience: 84% of the enquiries came from staff with a disability, while 11% were from line managers seeking advice on supporting staff members with disabilities.

Common Queries: The most frequent inquiries were about learning disabilities, neuro-divergence, reasonable adjustments, and assistance with accessing and ordering equipment through Access to Work.

Kingston Hospital

Launch and Engagement: The **DAL Inquiries at Kingston:** 12 total inquiries (as of October data). The report supersedes this data, as the DAL was officially launched in November, resulting in a significant increase in inquiries.

Breakdown of Enquiry Sources:

Internal Employees (83.33%): The majority of inquiries came from staff seeking support on disability-related issues.

Internal Managers (8.33%): A smaller portion of inquiries came from managers seeking guidance on supporting employees or Trust processes.

HR (8.33%): Inquiries from HR were related to disability adjustments and compliance.

Epsom St Helier Hospital

DAL Launch at Epsom St Helier Hospital (2023):

Total Inquiries:
The Disability Advisory Line (DAL) received a total of **59 inquiries** in 2024.

Internal Employees
The majority of inquiries, **67%**, originated from internal employees, indicating a high level of engagement and a need for attention to internal issues within the Trust.

Internal Managers
Managers accounted for **27%** of the inquiries. This may reflect their roles in addressing employee concerns and navigating Trust processes.

HR/Occupational Health
A small portion, **3%**, of the inquiries came from the HR and Occupational Health department, highlighting health-related matters raised within the Trust.

The data emphasises that internal employees are the primary source of inquiries, followed by managers. This suggests that internal matters and employee engagement are significant drivers of inquiry activity.

Royal Marsden Hospital

We have received one enquiry from **HR** seeking advice on disability matters, which is a positive sign of engagement. It's worth noting that the Disability Advice Line (DAL) has not yet been officially launched at Royal Marsden.

The service is still in the process of being embedded and promoted within the organisation, with plans for the official launch in the early part of **2025** across the sites **Surrey and Chelsea** Increased awareness and outreach will help further enhance its visibility and accessibility for both staff and managers moving forward.

Revitalising Staff Networks and Strengthening Executive Support at gesh

The gesh has a number of active staff networks: the Disability Network, LGBTQ+ Network, Women's Network, LGBTQ+ and the REACH Network. While some of these networks faced challenges in maintaining momentum during the pandemic, they are now focused on revitalising their activities and developing action plans to address key issues such as the Gender Pay Gap, WRES, and WDES initiatives within ESTH. The group leadership team has agreed to allocate executive sponsors to each network, along with potential site sponsors, to enhance support and engagement moving forward.
All staff networks benefit from active executive sponsorship, which includes a named site sponsor and a group, their responsibilities, fostering advocacy and accountability.

The site sponsor plays an active role by attending meetings and events related to their site. In contrast, the group executive sponsor helps maintain a consistent approach and advocates for network aims at group-level meetings, providing a point of escalation when necessary. Current executive sponsors include **Jacqueline Totterdell (CEO),Stephen Jones (CCAO), Victoria Smith (CPO), Kate Slemeck (MD STGUH), and Luci Etheridge (CMO), along with Arlene Wellman (GCNO) James Bylthe (MD ESTH), and Gillian Norton (Chairman).** Additionally, in 2023, STGUH appointed an executive sponsor for the Project Search Programme, a supported internship initiative for young adults with learning disabilities. This sponsor has been instrumental in advocating for the program and addressing barriers to improve the transition from internship to paid permanent employment within the Trust.

Strengthening Staff Networks for Inclusive Development

- **gesh Eight Active Staff Networks**: The Trust hosts the DAWN, Enabling Network (STGUH and ESTH), LGBTQ+ Network, (STGUH and ESTH), Women's Network, (STGUH and ESTH), and the REACH Network (formerly BAME Staff Network (STGUH and ESTH)).
- **Renewed Momentum Post-Pandemic**: Networks are focusing on revitalising engagement, recruiting new members, and creating action plans.
- **Focus Areas**: Initiatives include addressing the Gender Pay Gap, Ethnicity Pay Gap, EDS, Staff Survey, Social disruptions which impact on certain groups and patients outcomes, Health Inequalities Workforce Race Equality Standard (WRES), and Workforce Disability Equality Standard (WDES).
- **Executive Sponsorship**: Each network will be supported by executive sponsors, with potential for additional site-specific sponsors, to enhance impact across the group.

Plans for 2024-2025: Strengthening Network Oversight and Sponsorship Framework

In 2024, we are excited to implement a new **Sponsor and Network Charter** at **gesh STGUH and ESTH**. Under this framework, **executive members** will take on greater responsibility in collaborating with their allocated networks, ensuring a more hands-on strategic approach to support and development. The **CEO** will have an overarching role, providing strategic umbrella oversight and guidance to ensure all networks align with our broader organisational goals. This structure will strengthen accountability, foster deeper connections across networks, and ensure that all initiatives are effectively integrated and supported at every level.

The Role and Importance of Staff Networks at gesh

At St George's and Epsom and St Helier (gesh) hospitals, staff networks play a vital role in fostering an inclusive and supportive culture for all employees. With a combined workforce of 17,756, the staff networks provide protected spaces where individuals can come together around shared experiences, identities, and goals. These networks are integral to nurturing a culture of belonging, trust, and openness within the organisation.

Staff Networks at gesh

The staff networks align with the protected characteristics outlined in the Equality Act 2010 and focus on fostering inclusion and representation. These include:

- **REACH BAME** (Black, Asian, and Minority Ethnic)
- **Disability** (Enabling and DAWN)
- **LGBT+** (Lesbian, Gay, Bisexual, Trans + Queer/Questioning, Intersex, Asexual, and other identities)
- **Women**

These networks serve as energetic support systems for employees, enabling them to share heritage, lived experiences, and insights while collectively improving the staff experience.

Why Staff Networks Matter

Staff networks at gesh are more than support groups; they provide important expertise on matters related to equality, diversity, and inclusion. Their contributions include:

- **Enhancing Workforce Development**: Staff networks provide insights and recommendations that inform senior leaders and boards, ensuring workforce strategies are inclusive and equitable.
- **Improving Employee Experience**: By offering a sense of community, staff networks contribute to better job satisfaction and retention rates.
- **Shaping Internal Policy and Patient Care**: The NHS People Plan recognises the importance of these networks in influencing national-level policy and improving patient care outcomes.

Driving Change and Accountability

At gesh, staff networks are seen as essential partners in the journey toward a more inclusive workplace. Their role in shaping decisions and fostering open dialogue directly contributes to a more equitable and supportive environment for all employees, ultimately enhancing the overall organisational culture and performance.

Meet gesh Network Sponsors

Jacqueline Totterdell, Group Chief Executive

Stephen Jones

Professor Arlene Wellman

Gillian Norton

Dr Luci Etheridge

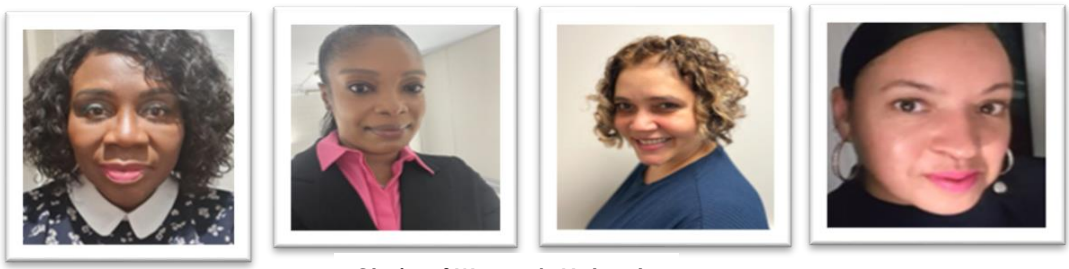
James Blythe

Victoria Smith

Kate Slemeck

Meet gesh Networks Chairs

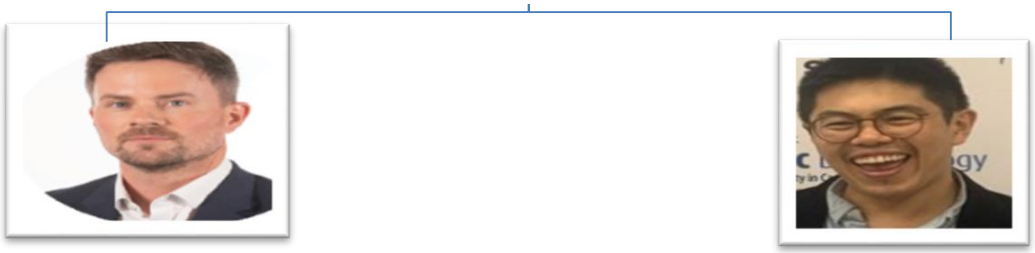
Chairs of REACH Networks



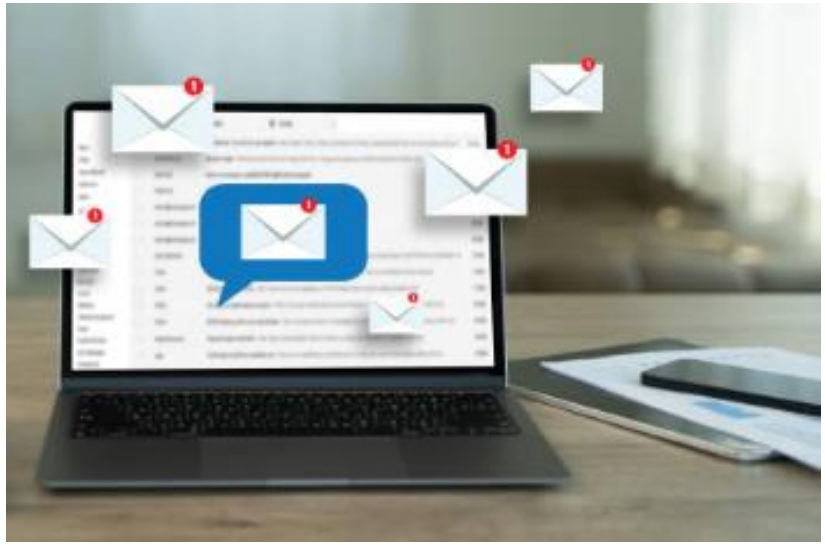
Chairs of Women's Networks

Chairs of Enabling and DAWN Networks

Chairs of LGBTQ+ Network



The Importance of Executive Question Time: Promoting Equality, Inclusion, and Engagement



Executive Question Time**, launched on 17 March 2023**, plays a pivotal role in fostering transparency, trust, and open communication across gesh. This forum provides a valuable opportunity for staff to voice their concerns and ask questions directly to senior leaders, including **Group CEO Jacqueline Totterdell and the Group Executive Team**.

Why Executive Question Time Matters

Leadership Involvement:

- Direct interaction with senior leaders demonstrates their commitment to being accessible and transparent. This visibility helps build trust and shows employees that their voices matter.

Staff Engagement and Communication:

- The forum encourages meaningful dialogue and ensures that pressing issues raised by employees are heard and addressed. It provides a platform for staff to gain clarity, share feedback, and contribute to the decision-making process.

Equality and Inclusion Benefits:

Empowering All Voices:

- By inviting participation from all staff members, the initiative ensures inclusivity and amplifies voices that may otherwise go unheard.

Addressing Disparities:

- Leadership accessibility helps identify and tackle issues affecting diverse groups, fostering a more equitable workplace.

Building Trust Across All Levels:

- Open dialogue reinforces a sense of belonging and shared purpose, which are essential for creating a more inclusive culture.
- Executive Question Time is more than a conversation; it's a commitment to listening, learning, and taking action. It underscores the importance of leadership in shaping a workplace culture that values equality, inclusion, and meaningful engagement.

SGUH Health and Wellbeing 2023-2024

Improving Staff Health and Wellbeing at St George's

At St George's, we are committed to fostering a culture that prioritises the mental, physical, and financial wellbeing of our staff. We understand that the challenges of busy schedules, strikes, financial pressures, and limited breaks can take a toll. That's why we have implemented a range of initiatives to support our teams, ensuring they feel valued, empowered, and equipped to provide the best possible care to our patients.

In this section, we outline the comprehensive measures we've introduced to enhance staff wellbeing, from financial support and mental health resources to recognition programs and physical health initiatives. These efforts reflect our dedication to creating a workplace where every individual can thrive amidst the demands of healthcare.

Finance Wellbeing Support

Key Initiatives:

Financial Wellbeing Support:

- Financial wellbeing intranet page with toolkits, resources, and emergency funding options.
- Launch of Wagestream for early access to wages, out-of-salary savings, and debt advice.
- Financial wellbeing webinars, staff benefits roadshows, and energy savings sessions.
- Free energy-saving boxes distributed to staff at St George's and Queen Mary's Hospitals.
- Free recycled bicycles for staff in lower pay bands, supported by Wandsworth Council's Dr Bike team.
- £2 healthy meal options available at Ingredients restaurant, including a salad bar, jacket potatoes, and soup.

Menopause Support

Mental and Physical Wellbeing:

- Health and wellbeing intranet pages offering resources and free access to wellbeing apps (Headspace, Unmind, The Body Coach).
- 70 Mental Health First Aiders available to support staff locally.
- 120+ Health and Wellbeing Champions leading wellbeing initiatives such as lunchtime walks, book clubs, exercise sessions, and wellbeing talks.
- Menopause support through the Peppy Menopause App, webinars, and dedicated policy.
- Events to mark awareness days, including Mental Health Awareness Day, Time to Talk Day, Menopause Awareness Day,
- Stoptober, Alcohol Awareness, Nutrition and Hydration Week.
- Exercise facilitator-led sessions at the free outdoor gym, with free access to the gym at Queen Mary's Hospital and local gym discounts.
- On-site and online exercise classes, bookable via a single platform.

Outdoor Exercise and Fitness Support

- **Recognition and Morale Boosting:**
  - Acts of Kindness campaign, celebrating 16 individuals and 4 teams based on patient feedback.
  - Wellbeing Challenge with 184 staff participants in October, focusing on boosting physical, mental, and social wellbeing.
- **Counselling and Support:**
  - Staff Counselling Team offering NICE-recommended interventions including one-to-one therapy (CBT, EMDR, Trauma-Focused Therapy) and group support.
  - Schwartz Rounds to promote open discussions about the challenges staff face and help de-stigmatise healthcare experiences.

Additional Staff Benefits:

- **Flexible working policy** to support work-life balance.
- **Free flu and COVID-19 vaccinations** for all staff.
- **Occupational health assessments** and reasonable adjustment recommendations.
- **Fast-tracked physiotherapy** services for staff.
- **Smoking cessation support** to help staff quit.
- **Arts and choir classes** offered by St George's Charity.

These initiatives ensure staff at St George's feel valued and supported, empowering them to navigate challenges and deliver excellent patient care

ESTH Health and Wellbeing 2023-2024

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Staff Support and Wellbeing at ESTH

At ESTH, we strive to ensure that every staff member feels appreciated and supported, particularly as they face increasing pressures. Our on-going focus on mental, physical, and financial wellbeing ensures that our staff are equipped to provide the best possible patient care, even in challenging circumstances.

In this section, we outline the comprehensive measures we've introduced to enhance staff wellbeing, from financial support and mental health resources to recognition programs

and physical health initiatives. These efforts reflect our dedication to creating a workplace where every individual can thrive amidst the demands of healthcare.

Financial Wellbeing Support:

- Initiatives to assist staff through the cost-of-living crisis, offering information on accessing benefits, discounts, and money-saving tips.
- Free financial advice available from an independent financial company.
- Webinars on managing financial pressures and understanding NHS pensions.
- Costco membership promotion for NHS staff.
- Health and wellbeing intranet pages updated with local and national resources, and free access to wellbeing apps (Headspace, Unmind, and The Body Coach).
- Occupational Health teams delivering health MOT checks for staff aged 40+.
- 40 staff attended mental health awareness training, with 17 signing up to become Mental Health Champions.
- Mental Health Champions support staff by signposting resources, de-stigmatising mental illness, and fostering open discussions.
- **Menopause support:** Access to the Menopause Café, webinars, podcasts, and the Peppy Menopause app, with a dedicated policy
- Discounted onsite osteopathy treatments for staff.
- Free or discounted online exercise classes available to staff.
- **Acts of Kindness campaign:** 16 individuals and 4 teams recognised based on patient feedback, with staff encouraged to share acts of kindness on a virtual wall.
- Wellness Action Plans for staff to complete with line managers to identify factors that promote health at work.
- **ESTH Staff Counselling service:** Provides face-to-face or virtual counselling, team wellbeing sessions, debriefs, management support, and mediation.

Additional Staff Benefits:

- Flexible working policy to support work-life balance.
- Free annual flu and COVID-19 vaccinations for staff.
- Occupational Health assessments and recommendations for reasonable adjustments.
- Fast-tracked physiotherapy for staff.
- Schwartz Rounds promoting open discussions and de-stigmatising challenging healthcare experiences.
- On-going wellbeing and mental health training for staff.
- Smoking cessation support to help staff quit.
- These initiatives reflect our commitment to supporting the wellbeing of our staff, ensuring they remain resilient, motivated, and ready to deliver excellent care.

gesh: Promoting Staff Survey and culture Initiatives

2023 The NHS Staff Survey is the largest annual workforce survey in the world and has been conducted every year since 2003. It is one of the primary ways Trusts hear from staff about their experiences of working in the NHS.

Staff Engagement Hits New Highs in gesh 2024 Survey
The 2024 gesh staff survey has reached impressive new milestones, showcasing the organisation's on-going commitment to listening to its workforce. A total of **8,649** staff survey questionnaires were completed this year a remarkable achievement that reflects growing engagement and dedication among employees.

This success would not have been possible without the exceptional efforts of the Staff Survey Group, led by the **dedicated Humaira Ashraf, Interim Director of OD and Culture and Renee Barrett EDI Programme Lead.** Their hard work and focus have been instrumental in driving these outstanding levels of participation and engagement across the organisation.

The record-breaking response highlights the collective commitment to fostering a culture where every voice is heard, contributing to an environment of continuous improvement and shared success.

Key Highlights
SGUH: Workforce grew by **9.43%,** from **9,544** in 2023 to **10,444** in 2024. Survey participation soared by **30.57%,** with **4,758** responses compared to **3,644** last year. Response rates jumped **7.6 points**, from **38.0%** to **45.6%.**
ESTH: Workforce increased by 6.08%, from **6,873** in 2023 to **7,291** in 2024. Survey responses rose by **12.33%,** with **3,891** submissions compared to **3,464** in 2023. Response rate improved by **3.4 points**, from **50.0% to 53.4%.**

These numbers highlight significant progress in staff engagement, highlighting our collective dedication to fostering a thriving workplace. Let's continue this momentum into the year ahead!

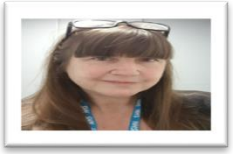
We encourage staff to participate in the annual NHS Staff Survey and the quarterly NHS People Pulse survey for staff which enables us to understand the views and experience of staff working at our Trust. Staff engagement work continues to be monitored at executive level by our People Management Group and Culture, Equity, and Inclusion Programme Board, and at Board level by the People Committee.

As part of gesh's culture workstream, recent insights from the Staff Survey and culture improvement efforts have highlighted the importance of Civility and Psychological Safety across the organisation. Recognising that kindness, respect, and the ability to speak up are foundational to a positive healthcare environment, gesh has prioritised these values as central themes within its Big 5 initiatives. To advance this priority, gesh is hosting a series of virtual events open to all staff.

These sessions will provide opportunities to explore civility and psychological safety, gather feedback, and share ideas. The discussions will focus on how staff interacts with one another celebrating successes, identifying areas for improvement, and emphasising the connection between a respectful workplace culture and patient safety.

Grounded in research and best practices, this initiative underscores gesh's commitment to fostering an inclusive and supportive culture, making these events a cornerstone of the organisation's broader culture work stream.

Weekly Staff Survey Prise Draw Winner: Omahri Bell, Patient Pathway Coordinator at St George's and Angela Loughran, Therapy Technical Instructor at St John's Therapy Centre.



Is one of the first winners in our weekly 10 x £50 prise draw for everyone who completes their Staff Survey. Participants are entered every week, so the earlier the survey is completed, the more chances there are to win. The Importance of Staff Feedback

STGUH: Empowering Staff Voices

Omahri emphasised that the Staff Survey is key to identifying areas for improvement, such as communication, purpose, and inclusivity. It helps tailor support to ensure staff can reach their full potential by understanding their needs and concerns.

He added, "It helps colleagues feel that their opinions matter and are valued. Open feedback channels contribute to a culture of trust, fairness, and accountability."

ESTH: Empowering Staff Voices

Angela shared that participating in the survey is a valuable opportunity to provide feedback on what's working and what could be improved. By sharing their views, staff help the organisation live its values, ensuring it remains a great place to work where voices truly matter.

To participate, look for the survey in your inbox under '*Staff Survey 2024*. It takes less than 15 minutes to complete, is completely confidential, and can be accessed at work on any email-enabled device

gesh: Freedom To Speak-UP

This section covers an overview of the role and importance of Freedom To Speak Up (FTSU) Guardians in the NHS, including the origins of the role, its expansion into various healthcare settings, and the current number of Guardians across organisations. It also highlights how FTSU Guardians contribute to fostering a culture of transparency, patient safety, and staff wellbeing by providing a safe space for raising concerns.

Freedom To Speak up Guardians (FTSU) are employed across the NHS. This role was created as a result of the recommendations published in 2015 by Sir Robert Francis following his review of the Mid Staffordshire Hospital Trust. See the full report here.

FTSU Guardians were originally recruited for secondary healthcare settings, but this is now evolving and the role is widening so we now see Guardians in primary care settings, hospices, and private hospitals and more recently in the private sector as organisations recognise the value of FTSU. There are currently 1200 Freedom to Speak Up Guardians in 738 organisations.

Guardians offer an impartial service offering confidential, independent and sensitive advice and support to all workers raising concerns.

The benefits that organisations see coming from a positive speaking up culture include better patient outcomes, improved staff wellbeing and improved management practices.

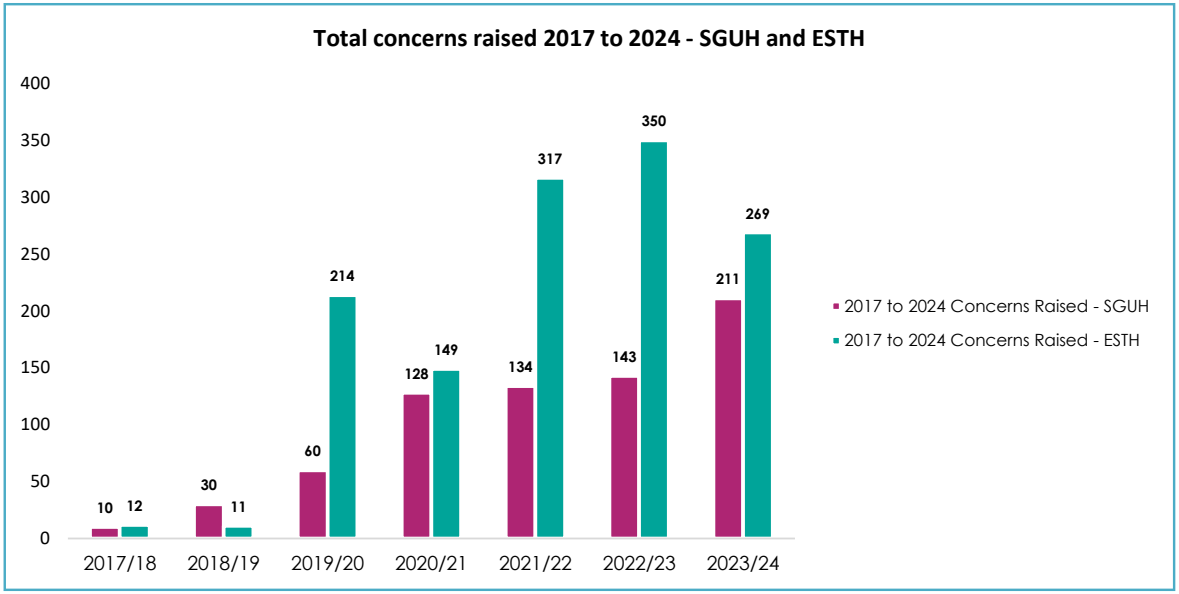
Nationally, year upon year data shared with the NGO from Guardians show that there is an increase in workers raising concerns directly to their Guardian. FTSU Guardians have handled over 133,000 cases since the National Guardian's Office first started collecting data in 2017.

Anonymised data for 2023-24 on staff accessing gesh services by protected characteristics and complaint types is unavailable. This data is not required by the National Guardian's Office, and past attempts to collect it faced reluctance from staff. However, starting next financial year, we plan to begin recording this data, recognising some information may remain incomplete due to privacy concerns.

gesh: FTSU Team Structure and Collaboration Protected Characteristics

Overview of the gesh FTSU Team Structure and Collaboration by Protected Characteristics

- **Team Composition**: The gesh FTSU team includes four women and one man.
- **Diversity**: The team comprises two white women, one white man (executive lead), and two Black British Caribbean women. Two members have disclosed disabilities.
- **Locations**: Team members are based across different sites: one each at SGUH, ESTH. The Group Guardian rotates between all three sites, while the executive lead is based at St George's.



Analysis Summary

This reporting period reflects positive achievements in the FTSU service, including high informal resolution rates, improved staff training completion, and increased trust in FTSU mechanisms at SGUH. The contrasting trends between SGUH and ESTH highlight unique engagement patterns across sites, underscoring the importance of site-specific FTSU strategies to address and adapt to varying staff needs and concerns.

gesh: Freedom To Speak-UP- Achievements

Summary Achievements in Freedom to Speak Up (FTSU)

- **Informal Resolution of Cases**
    - In **2023/24, 70%** of cases raised were successfully resolved through informal channels, demonstrating effective early intervention and issue management.

Increased Staff Knowledge and Training

- Approximately **90%** of staff have completed the mandatory FTSU training module at SGUH, reflecting enhanced staff understanding of how to raise concerns and fostering a culture of openness.

Growth in Staff Engagement with FTSU

- Over the past four years, there has been a marked increase in staff approaching the FTSU Guardian, signalling growing trust and awareness.

Overview of Concerns Raised in 2023/24

- Total Concerns Raised
- **SGUH: 211** concerns raised between April 1, 2023, and March 31, 2024.
- **ESTH: 269** concerns raised in the same period.

SGUH Trends

- **Consistent Year-on-Year Increase**: Since FTSU's establishment in 2017/18, SGUH has seen a steady rise in concerns raised.
- **Significant Growth in 2023/24**: Concerns rose by **68 cases**, marking a substantial **47.5%** increase over 2022/23. Previous increases were smaller **(4.7% in 2021/22 and 6.7% in 2022/23 respectively),** making 2023/24 a standout year for FTSU engagement.

Cumulative Data:

- Since 2017, SGUH staff have raised a total of **722** concerns.

ESTH Trends

- **Fluctuating Profile**: Unlike SGUH, ESTH has experienced varied trends, including a notable spike in concerns in 2019/20**.**
- **Recent Decrease in 2023/24**: A total of **269** concerns were raised, representing a **23.1%** drop (81 fewer concerns) compared to the previous year. This follows a **30%** decrease in 2020/21 and subsequent increases of **112%** in 2021/22 and **10.4%** in 2022/23**.**

Cumulative Data:

- Since 2017, a total of **1,322** concerns have been raised at ESTH.

Since 2017/18, both Trusts have experienced an increase in the number of concerns raised through FTSU. However, there was a 23.1% decline in concerns at ESTH in 2023/24.

This reduction is partly due to changes in how FTSU cases are recorded at ESTH, following the launch of a Group-wide FTSU service in January 2024 and a review of the recording processes at both Trusts, in line with guidance from the National Guardian's Office.

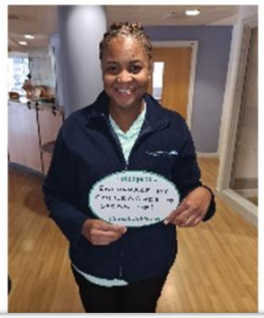
As a result, the decline reflects a move towards more robust data recording systems, which will enhance the ability to compare FTSU data across systems, regions, and nationally.

In conclusion, while there has been a short-term decline at ESTH, the long-term trend demonstrates progress in fostering an open and supportive culture for raising concerns. The introduction of more effective data recording systems will further strengthen the ability to monitor and act on FTSU concerns across the Trusts.

The Group-wide FTSU Strategy, approved by the Board in September 2020, identified year-on-year increases in concerns as a positive indicator of greater staff confidence in speaking up and a safer environment for doing so. This strategy is now due for review and will be updated to reflect evolving needs and best practices.

Meet gesh FTSU Team


MAKE IT SAFE TO SPEAK UP
ENCOURAGE MY COLLEAGUES TO SPEAK UP


ENCOURAGE MY COLLEAGUES TO SPEAK UP


Freedom to Speak Up
"Speak Up. We'll listen"


Freedom to Speak Up


Freedom to Speak Up
Speak up, we'll listen

gesh: Chaplaincy Services: Caring for the Whole Person

Every day, NHS services touch the lives of individuals and families experiencing profound moments of joy, challenge, and sorrow. Whether facing complex treatments, receiving life-changing news, or navigating the final stages of life, patients and their loved ones need more than just physical care they need emotional and spiritual support as well.

This is where NHS Chaplaincy Services play a spirited role. As an fundamental part of personalised healthcare, Chaplaincy provides pastoral, spiritual, and religious care to people of all faiths and none. These services offer a compassionate presence, helping individuals find meaning, purpose, and hope during some of life's most difficult journeys.

Key Highlights for 2024-2025:

- Recruiting and training volunteers to broaden faith-based support.
- Enhancing and refurbishing chapel and multi-faith spaces for inclusivity.
- Strengthening staff support structures within the Chaplaincy team.
- Expanding chaplaincy support to St George's University, London.
- Developing faith, cultural, and civic events across gesh sites.

Service Impact (April 2023 – March 2024):

- **Patients Supported:** 16,566
- **Family Members Supported:** 5,536
- **Staff Supported:** 1,192
- **Students Supported:** 308
- **Funeral Service Attendees:** 719
- **Spiritual Centre Service Attendees:** 12,737
- **Total Engagements:** 37,058

gesh Chaplaincy Services: Supporting Holistic Care:

The gesh Chaplaincy team provides professional pastoral, spiritual, and religious care to patients, their families, and staff, aligning with NHS Chaplaincy guidelines to deliver personalised, holistic care.

The service caters to individuals of diverse beliefs, including various faiths and non-religious perspectives, reflecting the Trust's inclusive approach. Through personalised support, diverse rituals, and community engagement, the Chaplaincy ensures meaningful care for all.

gesh: Chaplaincy Services

Building an Inclusive Chaplaincy: A Whole-Team Approach

At gesh, we are committed to ensuring our Chaplaincy service is accessible to people of all faiths and none. Here's how we're fostering inclusivity and collaboration:

Promoting Accessibility

- A **multi-faith, inclusive Chaplaincy service** is promoted both within and beyond the Group, welcoming everyone regardless of their beliefs.
- **On-going staff training** for clinical and non-clinical teams ensures awareness of our inclusive service and encourages referrals for patients, families, and staff.

Collaborative Initiatives

Community and On-Site Engagement

- Building relationships with **local faith communities** to support belief systems not currently represented within the Chaplaincy Team.
- Continuing **ward visits** by Chaplains and volunteers to provide pastoral and spiritual care for patients, families, and staff.

Through these efforts, we aim to provide compassionate, accessible, and holistic care that meets the diverse needs of all who seek support.

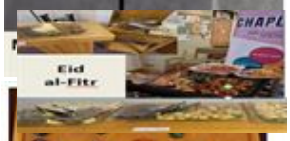
Active Engagement: Addressing Health Inequalities through Patient Involvement

Active engagement with patients is at the heart of all the Group's health inequalities programmes. By closely understanding the needs of local patients, carers, and residents, the Group can effectively identify, design, and deliver targeted projects aimed at reducing health inequalities.

Patient and Public Involvement

The Group's patient and public involvement initiatives are guided by Equality Impact Assessments (EIA). These assessments help pinpoint specific groups that require focused attention, ensuring that our programmes are inclusive and address the unique challenges faced by diverse communities.

Through this collaborative approach, the Group continues to bridge gaps in healthcare access and outcomes, aligning our efforts with the needs of those we serve.



Interfaith Week

Diwali at EGH

Armistice Day Service

Baby and Children Memorial Service

gesh: Chaplaincy Service Has Engaged With Our Diverse Communities

Active engagement with patients is a common thread through all of the Group's health inequalities programmes. By understanding what local patients, carers and residents need, the Group is able to identify, design, and deliver projects that help us to reduce health inequalities. Our patient and public involvement activities are informed by equality impact assessments (EIA), which highlight specific groups we need to focus on.

The table below shows how gesh Chaplaincy Service has engaged with our diverse communities over the last 12 months and the protected characteristics (defined by the Equality Act 2010,we have also included carers and those listed as an inclusion group as defined by social care act and the Health Inequality Duty 2006).

Chaplaincy Service

Inclusion groups defined by Health Inequalities Duty 2006 include people who are: • Looking after children and young people • Carers and Patients: unpaid, family members • Homelessness People, people on the streets, staying temporarily with friends, family in hospital or B&Bs • People involved in criminal justice system; offenders in prison/on probation, ex-offenders • People with addictions and or substance misuse issues • People or families on a low income • People with poor literacy or health literacy (e.g. poor understanding of health services, poor language skills • Poor and living in deprived areas	Age	Disability	Gender Reassignment	Marriage and Civil Partnership	Pregnancy and maternity	Race	Religion or Belief	Sex	Sexual Orientation	Carers	Socioeconomic deprivation
The Chaplaincy Department has provided a 24/7 service through core hours and out of hours service to cater for patients, family , carers and staff members' pastoral, spiritual and religious needs. This includes ward visits and also facilitating video calls between patients and families. The service has been open to all from the protected groups.	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑	☑

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

gesh

Section 2

Equity, Diversity, and Inclusion: Legal and Mandatory Requirements Overview 2024:

- Equality Delivery System 2022 (SGUH, ESTH and gesh Combined)
- Gender Pay Gap 2023 (SGUH, ESTH, and gesh Combined)
- Workforce Race Equality Standard 2024(SGUH, ESTH and gesh Combined)
- Workforce Disability Equality Standard 2024(SGUH ESTH and gesh Combined)
- High-Level EDI Action Plan(gesh)

gesh: Equality Delivery system (EDS 2022)- Reporting period 2022-2023

Equality Delivery System (EDS) Reporting for gesh

The Equality Delivery System 2022 (EDS) is a key component of the NHS Standard Contract, designed to support gesh in engaging with local partners and communities to assess and improve performance. Serving as an accountable improvement tool, the EDS facilitates discussions with patients, the public, staff, staff networks, community groups, and trade unions. Through these engagements, we evaluate and enhance our services, workforce, and leadership.

In February -April 2024, gesh held two virtual and face-to-face EDS workshops, involving both staff and patients. These workshops showcased achievements from 2022-23 and encouraged stakeholder feedback to influence goals and priorities for 2024-25.

During these events, representative stakeholder groups assessed and scored gesh's performance across three key domains, using available evidence and insights. The overall scores for gesh, as follows, reflect performance in each domain *Service and Patients, workforce and Inclusive Leadership*

Scoring methodology:
Once each outcome has a score, they are added together to gain domain ratings. **Using the middle score out of the three services from Domain 1**, domain scores are then added together to provide the overall score, or the EDS organisation rating

gesh Overall Score Calculation:

- **Domain 1 (Service and Patients)**: The middle score from three services (Cancer, Maternity, and Diabetes) is used, resulting in **7.5**.
- **Domain 2 (Workforce)**: An average score of **7.5** from SGUH and ESTH.
- **Domain 3 (Inclusive Leadership)**: The consistent score of **5** from both SGUH and ESTH.
- **Total Score**: The combined domain scores equal **20**, leading to the **EDS rating of Developing**.

St George's University Hospital

Domain 1: Cancer	
1A: Patients (service users) have required levels of access to the service	2
1B: Individual patients (service users) health needs are met	2
1C: When patients (service users) use the service, they are free from harm	2
1D: Patients (service users) report positive experiences of the service	2
Overall Rating	8
Domain 1: Maternity	
1A: Patients (service users) have required levels of access to the service	2
1B: Individual patients (service users) health needs are met	2
1C: When patients (service users) use the service, they are free from harm	2
1D: Patients (service users) report positive experiences of the service	2
Overall Rating	8
Domain 2: Health and Wellbeing	
2A: Staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	2
2B: Staff are free from abuse, harassment, bullying and violence from any source	1
2C: Staff have access to independent support and advice when suffering from stress, abuse, bullying harassment and physical violence from any source	2
2D: Staff recommend the organisation as a place to work and receive treatment	2
Overall Rating	7

Epsom and St Helier Hospital

Domain 1: Cancer	
1A: Patients (service users) have required levels of access to the service	1
1B: Individual patients (service users) health needs are met	1
1C: When patients (service users) use the service, they are free from harm	2
1D: Patients (service users) report positive experiences of the service	3
Overall Rating	7
Domain 1: Diabetes	
1A: Patients (service users) have required levels of access to the service	1
1B: Individual patients (service users) health needs are met	2
1C: When patients (service users) use the service, they are free from harm	1
1D: Patients (service users) report positive experiences of the service	2
Overall Rating	6
Domain 1: Maternity	
1A: Patients (service users) have required levels of access to the service	1
1B: Individual patients (service users) health needs are met	2
1C: When patients (service users) use the service, they are free from harm	3
1D: Patients (service users) report positive experiences of the service	2
Overall Rating	8
Domain 2: Health and Wellbeing	
2A: Staff are provided with support to manage obesity, diabetes, asthma, COPD and mental health conditions	2
2B: Staff are free from abuse, harassment, bullying & violence from any source	2
2C: Staff have access to independent support/ advice when suffering from stress, abuse, bullying harassment and physical violence from any source	2
2D: Staff recommend the organisation as a place to work and receive treatment	2
Overall Rating	8

Leadership	
3A: Board members, system leaders (Band 9 and VSM) and those with line management responsibilities routinely demonstrate their understanding of, and commitment to, equality and health inequalities	**2**
3B: Board/Committee papers (including minutes) identify equality and health inequalities related impacts and risks and how they will be mitigated and managed	**1**
3C: Board members and system leaders (Band 9 and VSM) ensure levers are in place to manage performance and monitor progress with staff and patients	**2**
Overall rating	**5**

Overall score is calculated by adding all domains - Overall score for gesh

Trust	Domain 1: Services	Score	Domain 2: Workforce	Score	Domain 3: Inclusive Leadership	Score	Total Score	Rating
SGUH	Cancer and Maternity	8	Workforce	7	Inclusive Leadership	5	20	**Developing**
ESTH	Cancer, Maternity, and Diabetes	7	Workforce	8	Inclusive Leadership	5	20	**Developing**
gesh Combined	Service scores combined (7–8)*	7.5	Workforce	7.5	Inclusive Leadership	5	20	**Developing**

Gender Pay Gap 2023 SGUH and ESTH and gesh Combined

It became mandatory from 31 March 2017 for public sector organisations with over 250 employees to report annually on their gender pay gap. The results must be published on a government website, as well as the employer's own website (and remain there for 3 years).

Gender pay reporting presents data on the difference between men and women's average pay within an organisation. It is important to highlight the distinction between this and equal pay reporting, which is instead concerned with men and women earning equal pay for the same (or equivalent) work.

Across the country, average pay of women is lower than that of men and this tends to be because there are fewer women in senior high earning positions in organisations than men. Whilst a workforce may be predominantly female, if the most senior positions are taken up by men, the average pay of women in that organisation could well be lower. The Regulations have been brought in to highlight this imbalance, the aim being to enable employers to consider the reasons for any inequality within their organisation and to take steps to address it. (NHS Employers. Briefing Note: Gender Pay Gap Reporting

This section analyses the Gender Pay Gap (GPG) data from two prominent healthcare organisations St. George's University Hospital (SGUH) and Epsom and St. Helier Hospital (ESTH). By examining their workforce compositions and GPG metrics, this report highlights key insights and trends regarding gender representation and pay disparities.

It's important to note when comparing the GPG data for SGUH and ESTH, it is important to note that combining the data into a single analysis may oversimplify the findings and risk overlooking important nuances. These differences arise due to variations in the sise of the hospitals, workforce composition, and pay structures, all of which can significantly impact the results.

Ethnicity Pay Gap Reporting
While ethnicity pay gap reporting remains voluntary, it is strongly encouraged by the government and is gaining traction in the private sector. The number of employers publishing ethnicity pay gap data has grown from 11% in 2018 to 19% in 2021.

Both Trusts have proactively conducted internal Ethnicity Pay Gap reports, providing a valuable positional check to understand where we currently stand and to identify areas for improvement. This initiative demonstrates a commitment to transparency and progress in addressing pay inequalities.

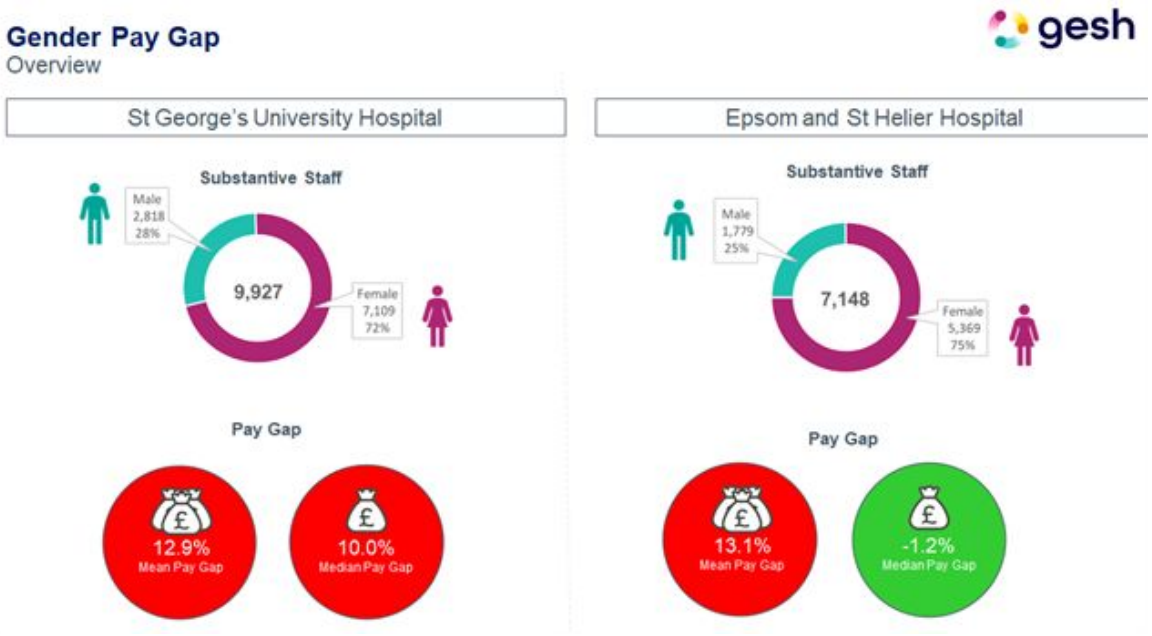
For the purpose of this report, we will only be reporting on the Gender Pay Gap (GPG).To gain a more detailed understanding of each Trust's Gender Pay Gap (GPG) position, please refer to the 2023 published reports for:

St George's University Hospitals (SGUH): link here

Epsom and St Helier University Hospitals (ESTH): link here

These reports provide in-depth insights into the Trusts' performance, actions taken, and future commitments to address pay disparities.

gesh Combined Gender Pay Gap 2023 SGUH and ESTH Substantive Staff



Substantive Staff Composition Overview

The workforce composition across St. George's University Hospital and Epsom and St. Helier Hospital reveals important insights into the gender distribution of substantive staff. Substantive staff refers to employees holding permanent or long-term positions, forming the core workforce in these institutions.

SGUH: employs 9,927 staff, with 72% female and 28% male.

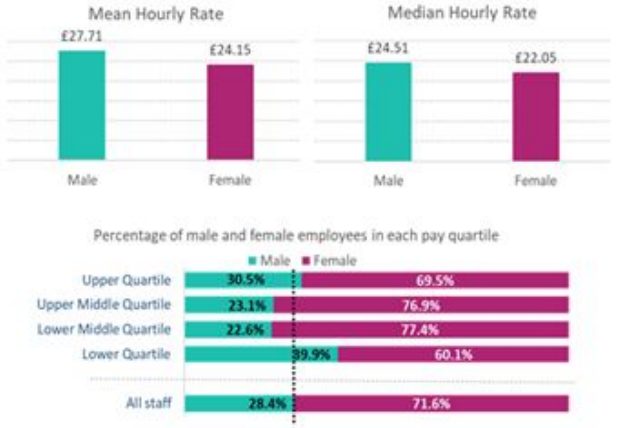
ESTH: has a smaller workforce of 7,148 staff, comprising 75% female and 25% male.

gesh Combined: When combined, the two trusts employ a total of 17,075 substantive staff, with 73% female and 27% male, reflecting a predominantly female workforce consistent with broader trends in the healthcare sector.

This composition plays a key role in understanding the Gender Pay Gap analysis presented later in the report.

gesh Combined Gender Pay Gap 2023 SGUH and ESTH– Mean vs Median Gap

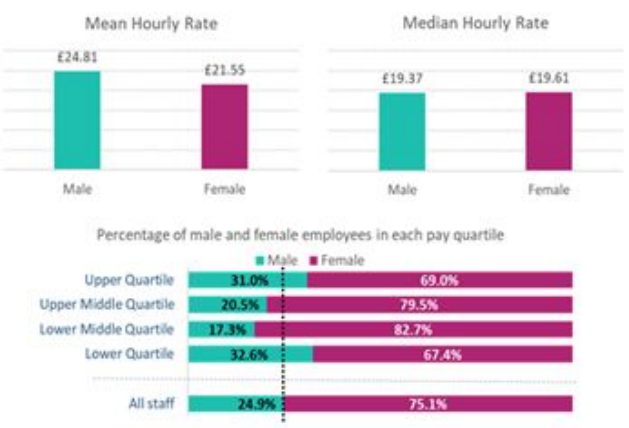
St George's University Hospital



On 31st March 2023 St George's employed 9,927 staff – 7,109 were female and 2,818 were male. The mean hourly pay for males is £2.56 higher than that of females, which is a gap of **12.9%.** Male median pay is £2.46 higher than females, which is a gap of **10%.**

If Medical Staff were removed from STG's overall total, the gender pay gap would be 1.92% in favour of females.

Epsom and St Helier Hospital



On 31st March 2023 Epsom and St Helier employed 7.148 staff – of those, 75% were female.

The mean hourly pay for males is £3.26 higher than that of females, which means on average male staff receive **13.1%** more than female staff. Male median pay is 24p lower than females, which is a gap of **-1.2%. This means that there are more male staff who are receiving significantly higher pay than the others (outliers).**

Key Observations: Combined GPG Analysis (gesh Average)
The combined Gender Pay Gap (GPG) data for SGUH and ESTH offers key insights into pay disparities and workforce representation. By averaging the metrics across both trusts, this analysis highlights overarching trends while acknowledging some nuances may be obscured. The observations focus on mean and median pay gaps, gender representation in senior roles, and the distribution of male roles, offering a snapshot of systemic patterns influencing the GPG.

gesh Combined Key Insights
Mean vs. Median Pay Gaps•

By removing medical staff would reverse the gender pay gap, favouring female staff by (**1.92%) at SGUH and (0.9%) at ESTH.**

This suggests male dominance in high-paying medical roles skews the figures.

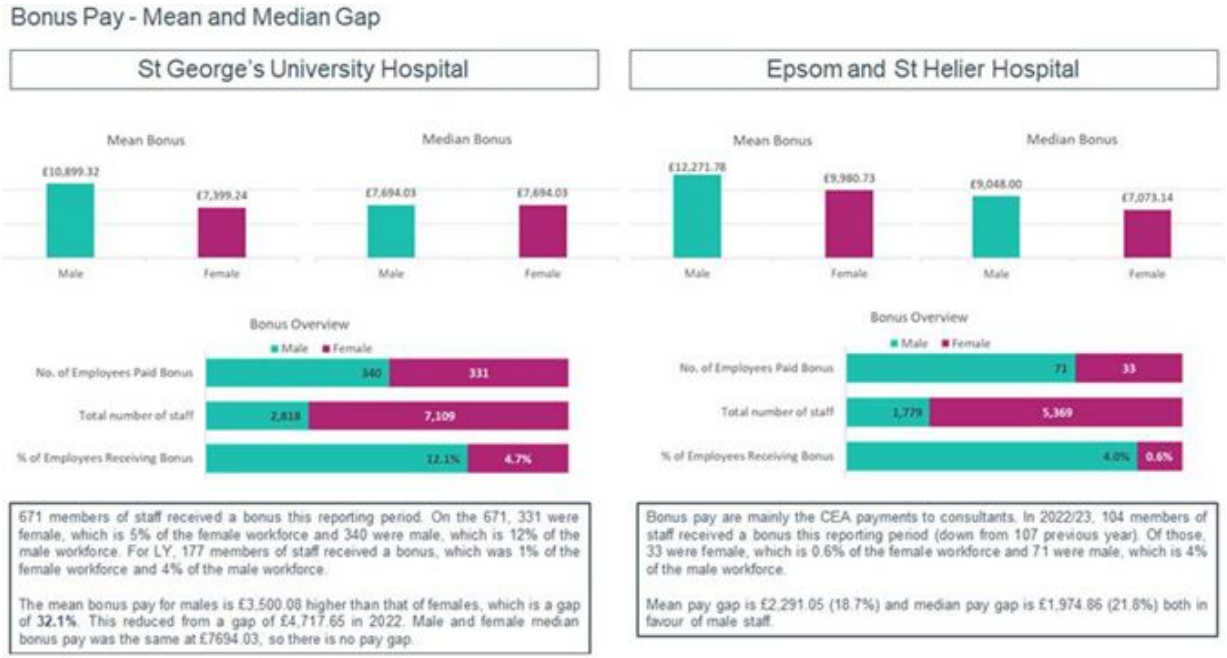
However **ESTH**, despite achieving median pay near parity, the mean pay gap **(13.1%)** highlights the influence of male-dominated high-earning roles, similar to **SGUH**

- The **mean pay gap (13%)** across both hospitals underscores systemic disparities, likely driven by high-earning male outliers in senior or specialised roles.
- The **median pay gap (4.4%)** reflects better pay parity for females in mid-range roles, suggesting more equitable distribution in these bands.

Representation in Senior Roles
- Males are disproportionately overrepresented in **upper quartile roles**, while females dominate the **lower middle quartile roles**, pointing to persistent barriers for women in career progression and leadership roles.

Division in Male Roles
- Male employees are clustered in both **high-paying medical positions** and **low-paying support roles**, while females predominantly occupy roles within the middle pay bands. This polarisation highlights gendered patterns in role allocation and pay.

gesh Combined Gender Pay Gap 2023 -SGUH and ESTH Bonus Pay – Mean vs Median Gap



At St George's University Hospital (SGUH): The mean bonus gap is **32.1%** in favour of male staff, driven by disproportionately high bonuses awarded to senior male medical staffing receiving Clinical Excellence Awards (CEA). Despite this, the **median bonus gap is 0%,** showing parity for mid-range bonus recipients. However, the proportion of males receiving bonuses (**12.1%**) is significantly higher than female staff (**4.7%**), suggesting barriers to bonus eligibility for female medical staffing.

At Epsom and St Helier Hospital (ETSH): The mean bonus gap is (**18.7%)** in favour of male staff, while the median bonus gap is **21.8%,** indicating inequities in both senior and mid-range bonus distributions. Additionally, only **(4%) of males and (0.6%) of females** received bonuses, reflecting more restrictive bonus policies compared to SGUH. This highlights male dominance in high-bonus roles, like SGUH, but with fewer bonuses distributed overall.

Key Observations as gesh (Combined and Averaged):

Mean vs. Median Bonus Gaps

Mean Bonus Gap: (25.4%) in favour of male staff

- This highlights systemic disparities driven by **outliers in high-paying male-dominated medical roles** with CEA pay.

Median Bonus Gap: (10.9%) in favour of male staff.

- The smaller median gap reflects **better parity for mid-range roles**, but some disparities persist, even for staff at the median level.

, **Proportion Receiving Bonuses:**

- Males: **(8.9%)** across gesh **(411 out of 4,597).**
- Females :**(2.9%) across** gesh **(364 out of 12,478).**

Male medical staff are disproportionately more likely to receive bonuses compared to female staff. SGUH has a higher overall percentage of staff receiving bonuses, while ESTH has stricter bonus distribution.

Representation in Senior Medical Roles

Male medical staff dominates in **senior roles eligible for CEAs,** contributing significantly to the mean bonus gap.

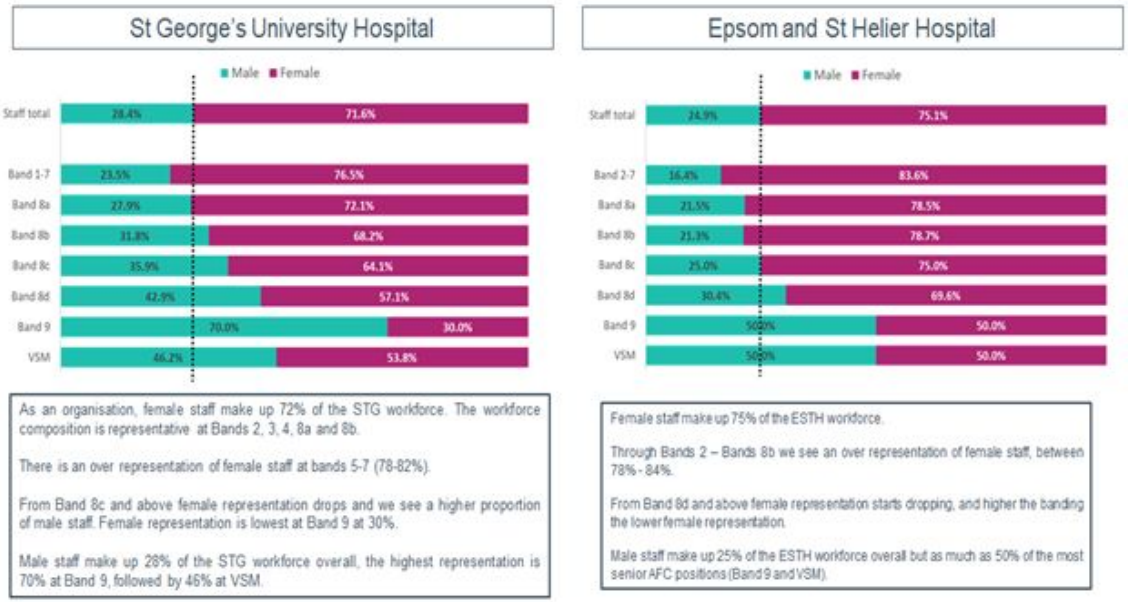
This reflects barriers for females in accessing high-bonus senior positions.

- Bonus policies and allocation criteria appear to favour male-dominated roles, particularly at SGUH, which awards bonuses more broadly.

- No non-medical staffing across gesh received bonus payments.

gesh Combined Gender Pay Gap 2023 - SGUH and ESTH Senior AFC Staff

Spotlight on Senior AFC Staff



Combined Representation Patterns across gesh

Mid-Level Roles:
Females dominate Bands 5–8b, reflecting strong mid-level participation. Across gesh, female representation averages **(72–83%)** in these bands.

Senior Roles:

- Male representation sharply increases at Bands 8c–9, particularly at SGUH, where male staff holds **(70%)** of Band 9 roles.
- ETSH's gender parity at Band 9 and VSM contrasts with SGUH's male-dominated leadership, pulling the overall gesh figures toward imbalance at the most senior level.

Comparison of Senior AFC Staff Gender Representation:

SGUH: Female staff makes **up (72%)** of the overall workforce, with male staff representing **(28%)**. Female representation is high at Bands 5–7 **(78%–82%),** which are mid-level roles. However, from Band 8c onwards, female representation drops significantly:

- Band 8d: (**57.1%)** female,**(42.9%)** male.
- Band 9: **(30%)** female, **70%** male.

VSM (Very Senior Management: (**53.8%)** female, (**46.2%)** male. This highlights significant barriers for female staff in progressing to senior roles, where male staff dominates. Male representation is highest at Band 9 **(70%)**.

ESTH: Female staff makes up **(75%)** of the workforce, with male staff representing **(25%).** Female representation is consistently high across Bands 2–8b (**83.6%–78.7%**), indicating strong mid-level participation. However, from Band 8c onwards, female representation begins to decline:

- Band 8d: **(69.6%)** female,(**30.4%)** male. The gender pay gap is **(3%)** in favour of females.
- Band 9 and VSM: **(50%)** male, **(50%)** female. ESTH achieves gender parity at the most senior levels (Band 9 and VSM), contrasting with SGUH, where male staff dominate these roles. The gender pay gap is **(6%)** in favour of females.

ESTH also employs **610 facilities** staff on local contracts that are typically lower-level roles. This group of staff is split **(45%)** Female and **(55%)** Male. The gender pay gap is even, at **(0.2%)** in favour of males.

Key Observations as gesh (Combined and Averaged):
Gender Composition Across Bands
Mid-Level Roles (Bands 5–8b):

- Female representation is strong across gesh, consistently above (**70%).**
- Male staff remains underrepresented at mid-level roles, especially at **ESTH,** where female representation peaks at **(84%)** in some bands.

Senior Roles (Bands 8c–VSM):

- Female representation declines sharply from Band 8c onwards across both hospitals.
- Male staff dominates Band 9 roles at SGUH **(70%),** while ESTH achieves equal representation **(50%)** at Band 9 and VSM levels.
- Combined data reflects a disparity in senior roles, where SGUH skews male-dominated leadership.

Barriers to Female Progression
SGUH:

- Male staff have significantly greater representation in Bands 9 **(70%)** and VSM **(46.2%),** indicating structural barriers for female advancement to top leadership roles.

- While female representation remains relatively high in Band 8c **(64.1%),** it drops steeply in the higher bands.

ETSH:

- Female representation is stronger at senior levels compared to SGUH, with (**50%)** female representation at Bands 9 and VSM.

However, female representation begins to decline from Band 8c **(75%),** suggesting similar but less severe progression barriers than SGUH. The gender pay gap is (**1.4%)** in favour of females in 8c and above roles.

gesh Combined Gender Pay Gap 2023 SGUH and ESTH Medical Staff

Spotlight on Medical Staff

A Comparison of Medical Staff Gender Representation and Pay Gender Representation:

SGUH:

- Medical staff are **almost** evenly split, with **(49.8%)** male and **(50.2%)** female representation.

Female representation is higher in the earlier career stages:

- Foundation 1**: (70.8%)** female, **(29.2%)** male.
- Foundation 2: **(61%)** female, **(39%)** male.
- Junior Doctor: **(52%)** female, **(48%)** male.

Male representation increases significantly in more senior roles:

- Specialty Doctor: **(55.6%)** male, **(44.4%)** female.
- Consultant: **(53.6%)** male, **(46.4%)** female.

Pay Gaps:

- The overall pay gap for medical staff is **(8%),** with males earning **£3.45**/hour more than females. This has decreased from **(9.83%)** in the previous year.
- Among consultants, males earn **£2.21**/hour more than females, which is a reduction **from £2.36**/hour last year.
- The Doctor in Training pay gap (Foundation and Junior Doctors) decreased from **(11.29% to 7.21%),** reflecting some progress in early career pay equity.

ESTH:

Gender Representation:

- Medical staff are slightly male dominated, with **(51.6%)** male and **(48.4%)** female representation.
- Female representation is higher in early-career roles:
- Foundation 1: **(57.4%)** female, **(42.6%)** male.
- Foundation 2: **(52.3%)** female**, (47.7%)** male.
- Junior Doctor: **(57.6%)** female, **(42.4%)** male.
- **Male representation significantly increases in senior roles:**
- Specialty Doctor: **(59.2%)** male, **(40.8%)** female.
- Consultant: **(60.6%)** male, **(39.4%)** female.
- GP: **(53.8%)** male, **(46.2%)** female.

Pay Gaps:

- The overall pay gap for medical staff is **(10.88%),** with males earning **£4.48**/hour more than females. This has increased slightly from **(10.64%)** last year.
- Among consultants, males earn **£1.99**/hour more than females, an increase from **£0.42**/hour last year.
- The Doctor in Training pay gap (Foundation and Junior Doctors) decreased from **(1.45%** to **0.62%),** indicating significant parity at the earlier career stages.

gesh Combined: Workface Race Equality Standard -Advancing Race Equality Key Highlights

The analysis of gesh(a combined assessment from SGUH and ESTH) provides an overview of key Workforce Race Equality Standard (WRES) indicators across both organisations. While this combined analysis offers valuable insights into broader trends, it is important to note that each trust SGUH and ESTH has its own respective report. These individual reports allow for more granular comparisons and nuanced discussions of specific challenges and progress at each organisation.

Indicator 1:% of BAME Staff in Organisation:

- Approximately **49.66%** of the staff in the organisation identify as BAME (Black, Asian, and Minority Ethnic).

Indicator 2: Relative Likelihood of White Applicants Being Appointed from Shortlisting Compared to BAME Applicants:

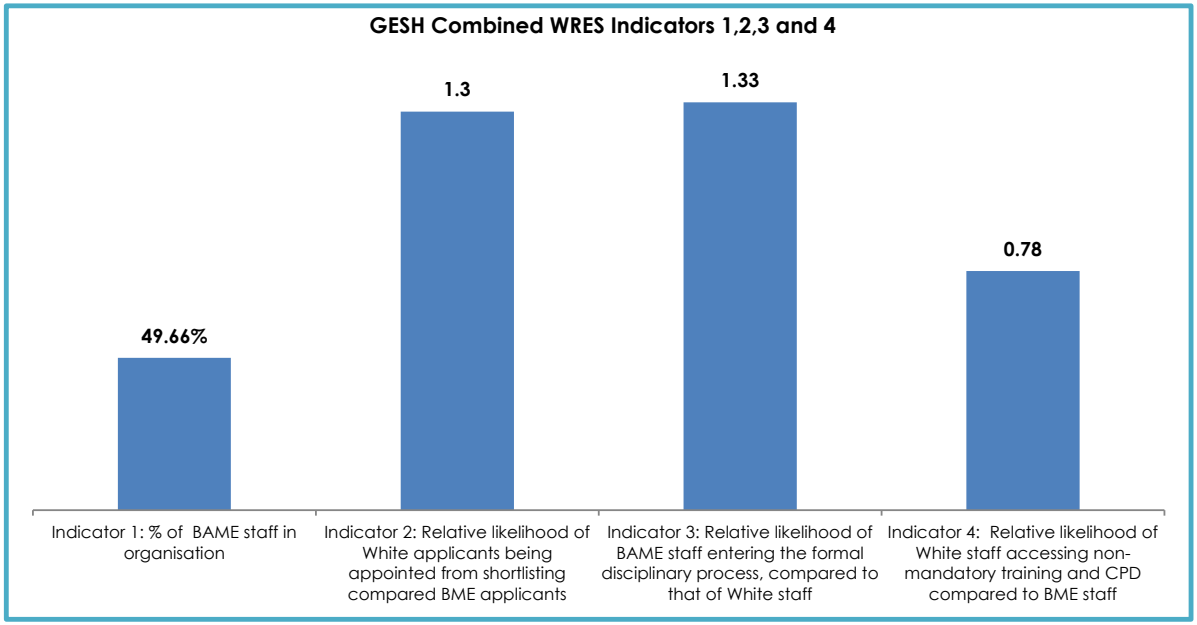
- White applicants are **1.3 times** more likely to be appointed from shortlisting compared to BAME applicants, suggesting potential disparities in hiring outcomes.

Indicator 3:Relative Likelihood of BAME Staff Entering the Formal Disciplinary Process Compared to White Staff:

- BAME staff are **1.33** times more likely to face formal disciplinary action compared to White staff, indicating a potential bias in workplace disciplinary processes.

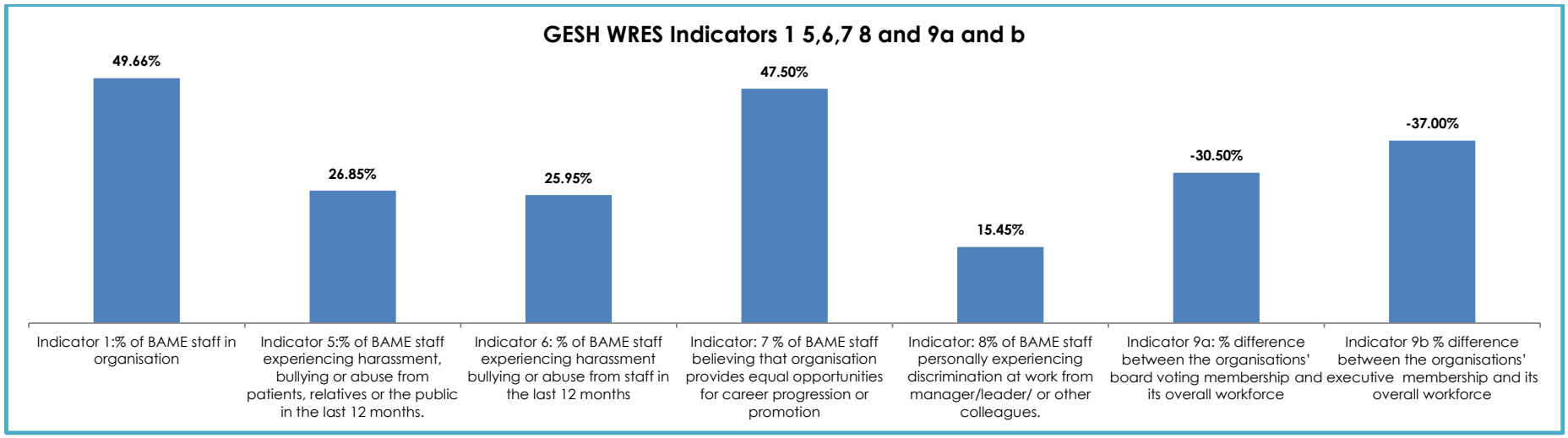
Indicator 4: Relative Likelihood of White Staff Accessing Non-Mandatory Training and CPD Compared to BAME Staff:

- White staff are **0.78** times more likely to access non-mandatory training and Continuing Professional Development (CPD) opportunities compared to BAME staff, suggesting reduced access for White staff relative to BAME staff in this area.



Key Takeaways:

- There are disparities in hiring, disciplinary actions, and training opportunities that may suggest systemic challenges for BAME staff compared to their White colleagues.
- While nearly half of the organisation's staff are BAME, the data points toward areas where equity and inclusion could be improved.



gesh Combined: Proportion of BAME Staff in the Organisation:

- BAME staff makes up **49.66%** of the organisation's workforce, indicating a significant level of diversity. However, the proportion may vary between SGUH and ESTH, reflecting potential differences in recruitment or retention practices.

Harassment, Bullying, or Abuse from Patients, Relatives, or the Public:

- **26.85%** of BAME staff reported experiencing harassment, bullying, or abuse from external sources (e.g., patients, relatives, or the public) within the last 12 months. This is a area that highlights the need for enhanced organisational efforts to ensure the safety and well-being of BAME staff in their interactions with external parties.

Harassment, Bullying, or Abuse from Staff:

- **25.95%** of BAME staff reported experiencing harassment, bullying, or abuse from colleagues or other staff members. Although slightly lower than the figure for external sources, it points to internal cultural and behavioural challenges that require active intervention, such as anti-bullying initiatives and fostering a more inclusive workplace culture.

Perception of Equal Opportunities for Career Progression or Promotion:

- Only **47.50%** of BAME staff believes the organisation provides equal opportunities for career progression or promotion. This indicates a significant perception gap, suggesting potential systemic barriers to career advancement. Variations between SGUH and ESTH may offer deeper insights into how each trust addresses this concern and areas where improvement is needed.
- The data highlights significant disparities in the representation of BAME staff between the organisation's leadership structures and its overall workforce.

Key observations include:

Voting Membership vs. Overall Workforce:

There is a -**30.5%** difference between the representation of BAME staff in the Board's voting membership and the overall workforce.
This suggests a lack of diversity at the decision-making level, with BAME staff being underrepresented in key positions of influence.

Executive Membership vs. Overall Workforce:

- The disparity is even greater at the executive membership level, with a -**37%** difference between BAME representation in leadership and the overall workforce.
- This indicates systemic barriers or challenges that hinder the progression of BAME staff into senior leadership roles.

Overall Workforce Diversity:

- The gesh's workforce is **49.66%** BAME, demonstrating a high level of diversity within the general staff population.
- However, this diversity is not reflected in the organisation's upper tiers, highlighting a potential gap in career progression opportunities or inclusive leadership practices.

gesh: Workface Disability Equality Standard -Advancing Disability Equality Key Highlights

This section provides an analysis of the gesh Workforce Disability Equality Standard (WDES) metrics, focusing on key areas such as the representation of disabled staff, experiences of harassment, bullying, or abuse, and the effectiveness of reporting mechanisms. The data highlights potential areas of concern, including the safety and well-being of staff and workplace inclusivity, while also identifying opportunities to improve organisational practices.

Metric 1: Representation of Disabled Staff:

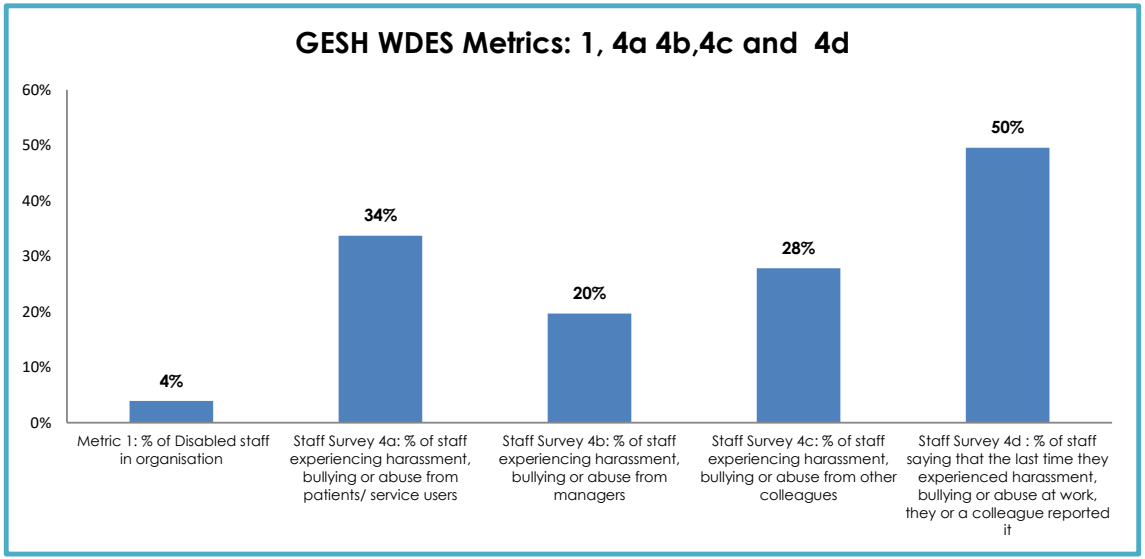
Only **4%** of the workforce identifies as disabled. This reflects a potential underrepresentation and an opportunity to assess recruitment and retention strategies for disabled individuals to ensure inclusivity.

Metric 4a: Harassment, Bullying, or Abuse from Patients/Service Users:

A significant **34%** of staff reported experiencing harassment, bullying, or abuse from patients or service users. This highlights an important need for strengthened measures to ensure the safety and well-being of staff, such as training for patients on respectful interactions and support mechanisms for affected employees.

Metric 4b: Harassment, Bullying, or Abuse from Managers:

20% of staff reported experiencing harassment, bullying, or abuse from managers. This underlines the importance of leadership training and accountability measures to address workplace culture at a managerial level.

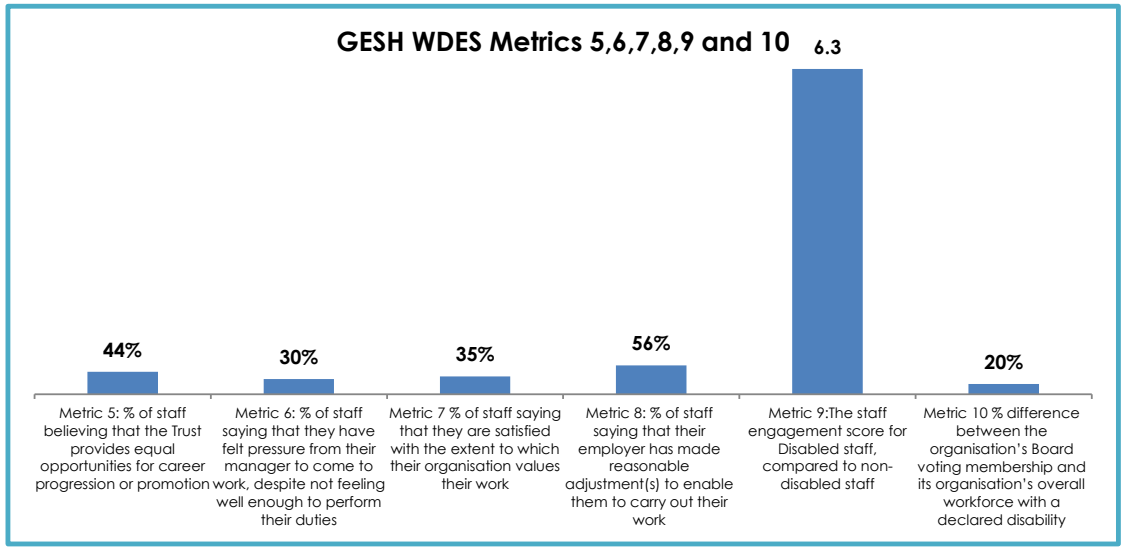


Metric 4c: Harassment, Bullying, or Abuse from Colleagues:

28% of staff experienced harassment, bullying, or abuse from colleagues. This demonstrates a need for organisational initiatives focused on fostering mutual respect, inclusivity, and effective conflict resolution among peers.

Metric 4d:Reporting of Harassment, Bullying, or Abuse:

Key Highlight: Encouragingly, **50%** of staff who experienced or witnessed harassment, bullying, or abuse reported the incidents. While this indicates a reasonable level of confidence in reporting systems. The metrics highlight significant challenges related to workplace harassment, bullying, and abuse from various sources, as well as underrepresentation of disabled staff. However, the **50%** reporting rate is a positive indication of gesh in reporting systems. Targeted actions such as enhancing workplace culture, providing support for staff well-being, and focusing on inclusivity can help address these issues effectively; efforts should be made to further improve this figure by ensuring robust, accessible, and non-retaliatory reporting processes.



Metric 5: Percentage of staff believing the Trust provides equal opportunities for career progression or promotion (44%)

Less than half of the staff believe the organisation provides equal opportunities for career progression or promotion. This suggests a need to examine recruitment and promotion policies to address potential barriers and improve perceptions of fairness and inclusivity.

Metric 6: Percentage of staff feeling pressure from their manager to come to work despite not feeling well enough to perform their duties (30%)

Almost one-third of staff have experienced pressure to work while unwell. This highlights a potential concern regarding workplace culture and support for staff well-being, emphasising the need for better communication about health-related policies and manager training.

Metric 7: Percentage of staff satisfied with how their organisation values their work (35%)

A low percentage of staff feels valued by the organisation, suggesting that more efforts are needed to recognise and appreciate staff contributions. This could include improving feedback mechanisms, employee recognition programs, and engagement initiatives.

Metric 8: Percentage of staff saying the organisation has made reasonable adjustments to enable them to carry out their work (56%)

More than half of staff feels the organisation has taken appropriate steps to make reasonable adjustments, which is a positive outcome. It demonstrates a commitment to supporting disabled staff and adhering to equality obligations, though further improvements can increase satisfaction.

Metric 9: Staff engagement score for disabled staff compared to non-disabled staff (6.3)

The engagement score of 6.3 highlights the level of involvement and motivation among disabled staff. While the score provides a baseline, it will be important to compare this to non-disabled staff scores and track progress over time to ensure equity.(See individual Trust WDES report)

Metric 10: Percentage difference between the Board's voting membership and the workforce with a declared disability (20%)

There is a 20% difference in representation, indicating underrepresentation of disabled individuals at the Board level. This point to a need for strategies to increase representation and ensure leadership reflects the diversity of the broader workforce.

Key Highlights: gesh demonstrates progress in supporting disabled staff, particularly through reasonable adjustments. However, there are clear opportunities for improvement in workplace culture, staff recognition, and leadership representation. Addressing these challenges will contribute to a more inclusive and equitable environment.

SGUH and ESTH Workface Race Equality Standard -Advancing Race Equality Key Highlights

As part of the NHS Standard Contract, gesh is committed to publishing and analysing nine key metrics annually to drive race equality. Over the past year, SGUH and ESTH (combined as gesh) have demonstrated meaningful progress in these metrics, with notable improvements in key areas, reflecting our strategic focus on creating a more inclusive and equitable environment.

St George's Hospital (SGUH)

Significant Improvement across Indicators: SGUH has shown improvement in 8 of 10 key indicators, reflecting steady progress in workforce equality and inclusion.

Progress in Recruitment Equity: The relative likelihood of White applicants being appointed from shortlisting compared to BME applicants has held steady at 1.5, providing a consistent benchmark for measuring progress.

Growing Diversity: The BME staff population has continued to increase year-on-year, now reaching an impressive 53.6%.

Reduced Disciplinary Disparities: The likelihood of BME staff entering formal disciplinary processes has decreased from 1.45 to 1.04, reflecting positive progress toward parity between groups.

Lower Rates of Harassment and Bullying: Experiences of harassment, bullying, and abuse have reduced from both patient-staff and staff-staff interactions, fostering a healthier work environment.

Greater Opportunities for Career Progression: There is a continued rise in the percentage of BME staff who feels the organisation provides equal career advancement opportunities. This has increased each year since 2018, with a notable improvement of +6.1 percentage points**.** For the full comprehensive WRES report, please refer to**:** STGUH WRES 2024

Epsom & St Helier Hospital (ESTH)

Significant Improvement across Indicators ESTH achieved progress in 7 out of 9 indicators, highlighting substantial strides in creating an inclusive work environment.

Progress in Recruitment Equity: The relative likelihood of White applicants being appointed from shortlisting compared to BME applicants has significantly improved, decreasing from 1.30 in 2023 to 0.74 in 2024, highlighting meaningful progress towards equitable hiring practices.

Growing Diversity: The BME staff population continues to grow year-on-year, now comprising 44.2% of the workforce.

Reduced Disciplinary Disparities: The gap in disciplinary actions between White and BME staff has narrowed, with the likelihood ratio dropping from 1.45 to 1.04 a positive step toward equity in accountability.

Lower Rates of Harassment and Bullying: Harassment from patients and staff has slightly decreased and stabilised at contributing to a more supportive environment for BME staff.

Greater Opportunities for Career Progression: The percentage of BME staff who feel the organisation provides equal career opportunities has risen from 46% to 51%, reflecting progress driven by increased access to non-mandatory training and growth-oriented initiatives. For the full comprehensive WRES report, please refer to: ESTH WRES 2024

SGUH and ESTH Workface Disability Equality Standard -Advancing Disability Equality Key Highlights

The annual Workforce Disability Equality Standard (WDES) report is required from all NHS providers, based on data from 31st March each year. It highlights progress on key workforce equality indicators, with data for WDES metrics 1-3 sourced from the ESR and 4 to 9a from the latest NHS staff survey.

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St George's Hospital (SGUH)

- **Workforce disclosure:** 3.7% of the workforce have shared they have a disability on ESR, the Staff Survey indicates figure is closer to 6% of the workforce.
- There is a 0.2 percentage point increase in the proportion of staff who have declared a disability. Overall, this group constitutes 3.7% of the workforce, with 4.8% in non-clinical staff groups and 3.7% in clinical staff groups.

- **Recruitment:** The likelihood of appointment from shortlisting is 0.16 for applicants with a disability, compared to 0.21 for those who did not disclose a disability, demonstrating a narrowing gap in the likelihood of appointment for disabled applicants.
- **Harassment, bullying, and abuse**: There has been a reduction in the percentage of staff experiencing harassment, bullying, and abuse (HBA) from patients/service users and colleagues, although harassment from managers remains a concern, with 21.1% of staff with a disability reporting HBA from managers, 5.8% above the national average.
- **Capability:** While staff with a disability are more likely to enter the capability process, the percentage has decreased from 0.57% to 0.26%, showing improvement.
- **Equal Opportunity:** While the percentage of staff with disabilities believing in equal career progression opportunities has slightly decreased from 44.7% to 41.5%, efforts to address this gap are on-going, with a focus on improving perceptions and opportunities for all staff.
- **Reasonable Adjustment:** 68.9% of staff with disabilities felt that reasonable adjustments had been made to support them in performing their work, showing a positive improvement of 72% compared to the previous year. For the full comprehensive WDES report, please refer to SGUH WDES Report

Epsom & St Helier Hospital (ESTH

- **Workforce disclosure:** The percentage of staff declaring a disability slightly rose from 4.0% to 4.3%. Among non-clinical staff, the proportion reporting a disability increased from 4.89% in 2022-23 to 5.1% in 2023-24.
- However, the percentage of clinical staff reporting a disability declined from 4.17% in 2023 to 3.95% in 2024.

- **Recruitment:** The relative likelihood of non-disabled applicants being appointed from shortlisting decreased from 1.21 to 1.15 indicating a reduced advantage for candidates without disabilities in the hiring process.
- **Harassment, bullying, and abuse**: Staff with disabilities has seen a slight decrease in harassment from patients/service users, dropping from 34.5% in 2022-23 to 32.3% in 2023-24, and from managers, decreasing from 19.5% to 18.2%. However, harassment from colleagues remained stable, with a slight increase from 26.1% to 26.4%, and reporting of the latest occurrence of harassment slightly decreased from 48.9% to 48.4%.
- **Capability:** The relative likelihood of staff with disabilities entering the capability process has improved significantly, dropping from 4.78 in 2023 to 4.26 in 2024, reflecting progress in equitable treatment.
- **Equal Opportunity:** The percentage of staff with disabilities believing in equal career opportunities remains stable at 46%, while the percentage of staff without disabilities who share this belief has increased from 52% to 54%, reflecting progress in fostering an inclusive environment.
- **Reasonable Adjustment:** A majority of staff with disabilities previously felt insufficient adjustments were made, but this belief has decreased from 66.2% to 43% in 2024, concerns. For the full comprehensive WDES report, please refer to: ESTH WDES Report

gesh EDI Action Plan 2025

This section outlines the gesh's commitment to fostering an inclusive and culturally intelligent workforce that reflects the diverse communities it serves. Since 2019, efforts have been made to create a workplace where all employees, particularly those from marginalised groups, feel a true sense of belonging. By promoting inclusion, the gesh aims to enhance employee well-being, improve patient care, and strengthen team performance.

The section also introduces the NHSE High Impact Actions, a targeted improvement plan designed to tackle discrimination within the NHS workforce. This initiative aligns with the NHS Long-Term Workforce Plan and seeks to improve staff experiences, boost retention, and ensure equitable opportunities for career progression.

Furthermore, gesh is aligning its existing Diversity & Inclusion Action Plans with the NHSE EDI Improvement Plan to continue driving progress. On-going initiatives will be integrated into a broader strategy, supporting collaboration and best practices across St George's and Epsom and St Helier hospitals.

Our Commitment to Inclusion

Developing a Culturally Intelligent Workforce to Deliver Outstanding Care:

To provide high-quality healthcare to diverse communities, it is essential to have a workforce that reflects and understands those communities. Since 2019, efforts have been made to build an inclusive workplace where all employees feel valued and have a strong sense of belonging. Special focus is given to marginalized groups, including people with disabilities, ensuring authentic inclusion across the organization.

Key Benefits of an Inclusive Workforce:

- Enhanced staff well-being, resilience, and compassionate care delivery.
- Reduction in bullying, discrimination, and exclusion through mutual respect.
- Improved staff retention and reduced sickness, ensuring better continuity of care.
- Greater empathy and patient support through diverse lived experiences.
- Strengthened team performance by leveraging a broad range of skills and expertise.

A Refreshed Focus for EDI

Introduction to NHSE High Impact Actions

The NHSE High Impact Actions provide a structured plan to tackle prejudice and discrimination in the NHS workforce. This aligns with the NHS Long-Term Workforce Plan to enhance employee experience, increase retention, and attract diverse talent. The strategic objectives include:

- Reducing discrimination.
- Increasing leadership accountability for inclusion.
- Supporting workforce equity and positioning the NHS as a model employer.

- Ensuring equitable career progression and social mobility.
- **Aligning with NHSE EDI Improvement Plan**

Since 2020, Culture and Diversity & Inclusion (D&I) Action Plans have focused on improving experiences for marginalized groups, particularly Black, Asian, and Minority Ethnic staff. While many initiatives have been completed, on-going projects are now integrated with the NHSE EDI Improvement Plan and aligned with the People Strategy 2024-2026, identifying six key EDI workstreams to drive progress.

Below are the six gesh EDI workstream:

gesh EDI Action Plan 2025

Introduction

gesh is dedicated to fostering a workforce that is diverse, valued, and representative of the communities it serves, ensuring the delivery of exceptional healthcare services. We are committed to treating all individuals fairly, irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief, sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation, or trade union membership. These are considered protected characteristics. In line with the NHS's six high impact actions, gesh strives to provide an inclusive environment where every individual can achieve their full potential, with a focus on dignity, respect, and equality for all.

gesh: Six high-impact actions on a page

Workstream1: Leadership Commitment (including Board development and Executive:

Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable

Workstream 2: Inclusive Recruitment and Talent Management:

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

Workstream 3: Eliminating pay gaps:

Develop and implement an improvement plan to eliminate pay gaps

Workstream 4: Improving Health and Wellbeing

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

Workstream 5: Supporting internationally recruited staff

Implement a comprehensive induction, on-boarding and development programme for internationally recruited staff:

Workstream 6: Safeguarding our Workforce

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

Equality Impact Assessment and Health Equality Impact Asseement Tootkit

Equality and Health Inequality Impact Assessments (EHIAs) are essential tools for evaluating our plans and decisions in line with the Equality Act 2010 and the Health and Social Care Act 2012. At gesh, we combine public sector equality duty assessments for protected characteristic groups with those for social inclusion groups (e.g., carers, homeless individuals) and people living in deprived or rural areas.

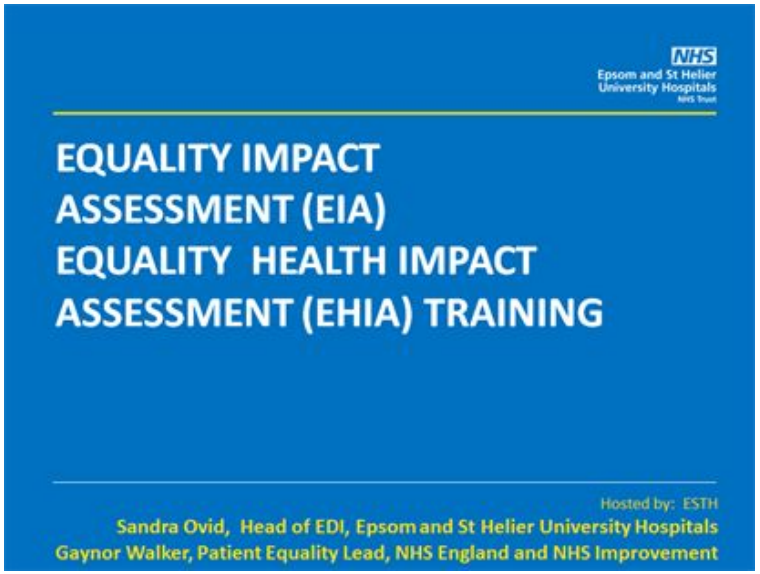
EHIAs are important when introducing or developing policies , processes and changing care services, ensuring that we consider all relevant factors before making decisions. These assessments help us understand how our actions may affect different communities, including staff, and guide us in promoting equality, diversity, and inclusion while addressing health inequalities.

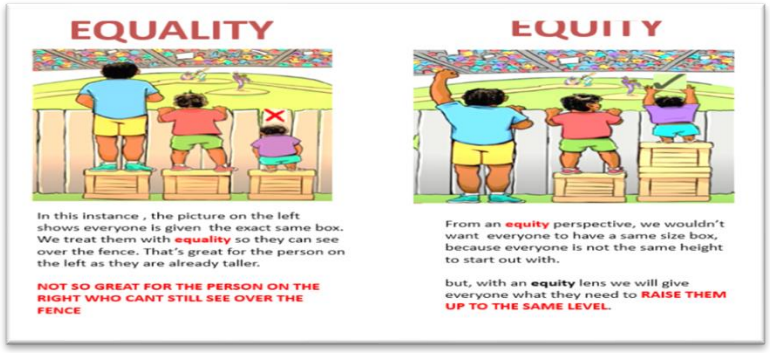
The EHIA process is continuous: it starts at the beginning of a project and is regularly updated throughout its life. EHIAs are reviewed for equality relevance and quality by the Equality Team, ensuring that the assessment meets high standards before approval by the Senior Responsible Officer.

Every paper submitted to decision-making committees includes an EHIA section for active consideration, reinforcing the committee's responsibility for final decisions.

In 2023-2024, we conducted over **100** EHIAs and introduced enhanced training to support authors, Senior Responsible Officers (SROs), and decision-making bodies.

As part of Inclusive Leadership Domain (3) objectives set by our external verifier, we will provide quarterly progress reports to the decision-making committee as part of our on-going EHIA Improvement Plan.





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

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Section 3: Workforce Data Analysis by Protected Characteristics:

- gesh Workforce by PC (ESTH, SGUH and GESH Combined)
- gesh Grade by PC
- Recruitment by PC (ESTH and SGUH)
- gesh Starters and Leavers by PC (ESTH, SGUH and gesh Combined)
- gesh employment Relations by PC (ESTH, SGUH and gesh Combined)
- gesh Promotion by PC ((ESTH, SGUH and gesh Combined)
- gesh Training GESH Combined

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Section 4: Patients & Performance Key Highlights

- Health Inequalities Overview and Vision from Group Chief Medical Officer and Group Chief Nurse
- Patient Demography Overview and Key Performance Indicators
- Accessibility

GESH Advances Equity, Diversity, and Inclusion While Addressing Health Inequalities

This section outlines gesh's efforts to address health inequalities, emphasising its commitment to Equity, Diversity, and Inclusion (EDI). As a key healthcare provider in the South West London (SWL) Integrated Care Board (ICB) system, GESH is dedicated to ensuring equitable access to healthcare for all through targeted initiatives and partnerships at Place, that reduce disparities and promote inclusion.

Dr. Richard Jennings, Group Chief Medical Officer, and Professor Arlene Wellman MBE, Group Chief Nursing Officer. Stated:

"This is an area where we cannot afford to be complacent. We recognise the need to address health inequality collectively as a system, ensuring equitable access to our services for all. Tackling health inequalities has been identified as a priority, embedded within our new group strategy.

This commitment involves working with our partners at Place to actively pursue a more strategic and systematic approach, making reasonable adjustments to care delivery to ensure we do not further embed health inequalities. To support this, we commissioned research to understand how best we can contribute as an acute provider to broader efforts across our local health system to address health disparities.

From this research, we have developed plans to enhance how we use data to understand health inequalities and specific steps to take an active role in making every contact count. This dynamic work is being overseen by our Executive and Quality Committee."

Key Initiatives and Strategic Framework

- **Health Inequalities as a Core Initiative**: gesh has integrated the reduction of health inequalities into its nine strategic initiatives, committing to work with partners for a more systematic approach. This includes making reasonable adjustments to care delivery to prevent exacerbating disparities.
- **Data-Driven Solutions**: gesh is leveraging data analytics to better understand and address health inequalities, ensuring each patient interaction contribute meaningfully to reducing disparities.
- **Oversight and Governance**: This work is monitored by gesh's Executive and Quality Committee under the leadership of Dr. Richard Jennings, Group Chief Medical Officer, and Professor Arlene Wellman MBE, Group Chief Nursing Officer.

Richard Jennings chairs the gesh Steering Group for addressing health inequalities. As part of this activity, the need for additional resource has been identified. Currently, we are recruiting a Health Equity Lead at St George's, and we aim to recruit an additional Health Equity Lead at Epsom and St Helier. This commitment of resource signals our focus on this work. From early 2025, these two new recruits will drive forward a Group-wide programme to address health inequalities, working with our partners at Place. The five workstreams that have been created by the gesh Steering Group include:

1. **Community of Practice:** The gesh Community of Practice Forum meets so that those involved in disparate initiatives to address health inequalities can come together to share learning, good practice and resources. This initiative recognises that there is already much work underway to tackle health inequalities throughout our organisation.
2. **Data:** We have conducted preliminary research into dataset quality, with a particular focus on improving our data collection on ethnicity to support our ability to identify areas where health inequalities exist and so prioritise our work to address inequalities.
3. **Proactive Outreach:** High Intensity Service Users will be identified and proactive outreach will help us to support them appropriately and address needs, particularly in unplanned care pathways.
4. **Reasonable Adjustments:** Through analysis of waiting lists for planned care, either manually or through the use of new technology, we will identify patients that may be facing health inequalities and seek to make reasonable adjustments for their care. This approach will be rolled out Group-wide in time, and overlaps

with the work of the Transforming Outpatients Strategic Initiative and in particular with adopting new technology solutions.

5. **Anchor Institution:** Through our role within the communities we are present in, we will seek to bring value to those who may experience health inequalities, especially through employment opportunities and education.

Collaborative Efforts

A South West London EDI and Health Inequalities Committee have been established to oversee key workstreams aimed at embedding community-centric approaches to health and wellbeing. Collaboration with partners, including Croydon Health Services NHS Trust and Kingston Hospital NHS Foundation Trust, strengthens gesh's initiatives.

Broader Objectives and Plans

Outlined in the **Joint Forward Plan**, NHS partners across SWL are focused on:

1. Reducing health inequalities.
2. Preventing ill health and supporting self-care.
3. Keeping people well and out of hospital.
4. Providing the best care across all services.
5. Leveraging technology to improve care delivery.
6. Ensuring financial sustainability.
7. Meeting Integrated Care Partnership Strategy goals.

Through these measures, gesh underscores its commitment to building a more inclusive and equitable healthcare system that addresses the needs of its diverse population. For further information on Our five-year plan for the NHS in South West London A joint forward plan 2023 – 2028

gesh People Strategy 2024-2026 Patients Key Highlights

In May 2023 we launched our new five-year strategy for St George's, Epsom and St Helier University Hospitals and Health Group. It is designed to give everyone connected to the group clarity about our ambitions for the future, and what we want to achieve.

Our vision for 2028 is to provide outstanding care, together. We have identified four overall aims for 2028, our CARE objectives. These are the things we care about the most and will be central to achieving our vision. Collaboration and partnership Affordable services, fit for the future Right care, right place, right time Empowered, engaged staff In all this, everything we do will be driven by our patients.

This section highlights the key performance metrics and positive outcomes achieved by each Trust ESTH and SGUH during the period from April 2023 to March 2024. By examining the scale of healthcare delivery, workforce capacity, patient satisfaction, and community engagement, we gain valuable insights into the each organisation's operations and areas of excellence.

Patients & Performance Overview and Key Highlights

ESTH
A year in numbers

From 1 April to 31 March 2024, we saw:

The key areas section identifies the significant components of the each organisation's service delivery, including the volume of care provided, workforce management, and patient feedback mechanisms. These areas emphasise the importance of maintaining efficiency, quality, and responsiveness to the needs of the population. With over **667.000** outpatient attendances and over **157.000** patient's visits to the Emergency Department, ESTH continues to demonstrate its ability to meet high patient demand.

Positive Findings

The positive findings section focuses on the successes achieved, such as high patient satisfaction rates, robust maternity services, effective community engagement, and the recognition received through patient compliments. These accomplishments reflect the organisation's dedication to providing high-quality care and fostering trust within the community it serves.

Together, these sections provide a comprehensive view of GESH combined strengths and opportunities for further development, ensuring continuous improvement in healthcare delivery.

1. **High Patient Satisfaction: 93.1% of patients reported a positive experience**, indicating a strong level of trust and satisfaction with the care provided.
2. **Large Volume of Care Delivered:** Over **157,000 Emergency Department attendances**, **85,000 inpatient admissions**, and **667,000 outpatient visits** demonstrate ESTH capacity to handle high patient volumes effectively.
3. **Strong Maternity Services: 3,700 babies delivered** highlights ESTH's role in providing excellent maternity care.
4. **Community Engagement:** A **People's Panel of over 300 members**, with 61 new additions, shows active involvement in improving healthcare services and fostering collaboration with the community.
5. **Recognition through Compliments: 423 compliments** received from patients reflect the appreciation for quality care and positive outcomes.
6. **Well-Supported Workforce:** Approximately **7,000 staff members** underline ESTH's commitment to maintaining a robust and skilled healthcare team.
7. **Extensive Coverage:** Serving a population of over **490,000 people** across south-west London, north-east Surrey, and beyond shows ESTH large-scale impact and commitment to regional healthcare.

Opportunities for Improvement:

Complaints Handling: Understanding and resolving the **516 complaints** to enhance patient trust and satisfaction.

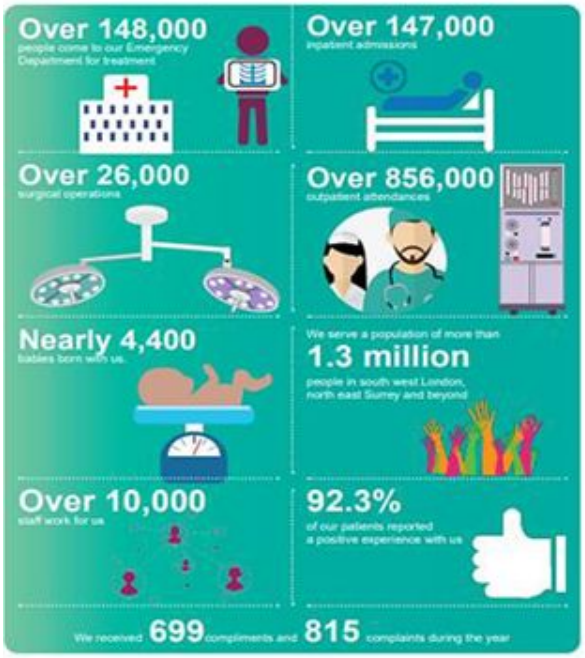
Community Outreach: Strengthening initiatives to further engage the **490,000** population served.

Staff Support: Ensuring adequate resources and support for the **7,000** staff members to sustain quality care delivery.

Patients & Performance Key Highlights

SGUH
A year in numbers

From 1 April to 31 March 2024, we saw:



This section provides a comprehensive overview of SGUH's performance, highlighting significant achievements and identifying opportunities for further growth and enhancement. The data reflects the SGUH critical role in the healthcare landscape, offering essential services to a broad population while maintaining a focus on patient care, satisfaction, and staff strength. With over **856,000** outpatient attendances and more than **148,000** visits to the Emergency Department, SGUH continues to demonstrate its ability to meet high patient demand.

At the same time, there are several key areas where improvements can be made, including complaints management, emergency department capacity, and surgical operations. Additionally, there are exciting opportunities for SGUH to expand its digital capabilities, invest in staff development, and strengthen its community engagement efforts. This balanced view helps provide direction for future development and sustained excellence in healthcare delivery.

Positive Highlights:

1. **High Patient Engagement:** Over **856,000** outpatient attendances demonstrate robust service delivery and accessibility for patients.
2. Over **148,000** visits to the Emergency Department reflect the trust's role as a critical healthcare provider.
3. **Significant Impact on the Community:** Serving a population of **over 1.3 million** indicates the trust's wide-reaching impact across South West London and North East Surrey.
4. **Maternity Services:** Nearly 4,**400 babies delivered** reflect strong maternity and neonatal care services.
5. **Staff Strength:** Employing over **10,000 staff** showcases the trust's position as a significant employer and its capacity to handle high patient volumes.
6. **Patient Satisfaction: A 92.3%** positive experience rate highlights effective care delivery and patient-centered approaches.
7. **Recognitions:** The receipt **of 699 compliments** during the year reflects positive feedback from patients and families.

Opportunities for Improvement:

- **Complaints Management: 815 complaints**, while not disproportionately high given the scale of services, indicate opportunities to further refine patient experience and grievance resolution processes.
- **Emergency Department Capacity: Over 148,000 emergency** visits may suggest pressure on the Emergency Department, indicating a need to explore strategies for demand management and enhanced efficiency.
- **Surgical Operations: Over 26,000 surgical procedures** reflect active performance, but analysis of waiting times and outcomes could identify areas for streamlining services.

AccessAble Key Highlights

AccessAble has been commissioned by both Trusts (Epsom and St Helier NHS Trust and St George's University Hospitals NHS Foundation Trust) since 2017 to provide comprehensive accessibility information for their hospital sites. This initiative aims to ensure that patients, visitors, and staff with disabilities or additional needs can easily navigate and plan their visits to the hospitals.

Key points about the service:

Service Purpose: AccessAble provides detailed accessibility guides for various hospital sites. This service is designed to help people with disabilities, as well as those with other additional needs, navigate the hospital environment with confidence and ease.

Usage and Engagement: For both Trust 2023, the following statistics demonstrate the level of engagement with the AccessAble guides:

Epsom and St Helier NHS Trust (ESTH):

Users: 27,063

Views: 42,017

St George's University Hospitals NHS Foundation Trust (SGUH):

Users: 29,184

Views: 42,190

Accessibility Information Availability:

Detailed accessibility guides for both Epsom and St Helier and St George's sites are available on the AccessAble website. These guides provide users with information such as wheelchair access, available facilities, parking arrangements, entrances, and any other specific needs that could assist patients and their families during their visit.

By offering these resources, AccessAble ensures that individuals can plan ahead and make informed decisions about their hospital visit. The Trusts are committed to making their sites more accessible and user-friendly for everyone, particularly those with mobility challenges or other specific need.

ESTH Language and interpreting Service Key Highlights

This section focuses solely on ESTH data, as SGUH data is currently unavailable. Both trusts use Language Line, though their processes for accessing the service differ slightly.

For more information on communication and information support services at ESTH and SGUH, click the links provided.

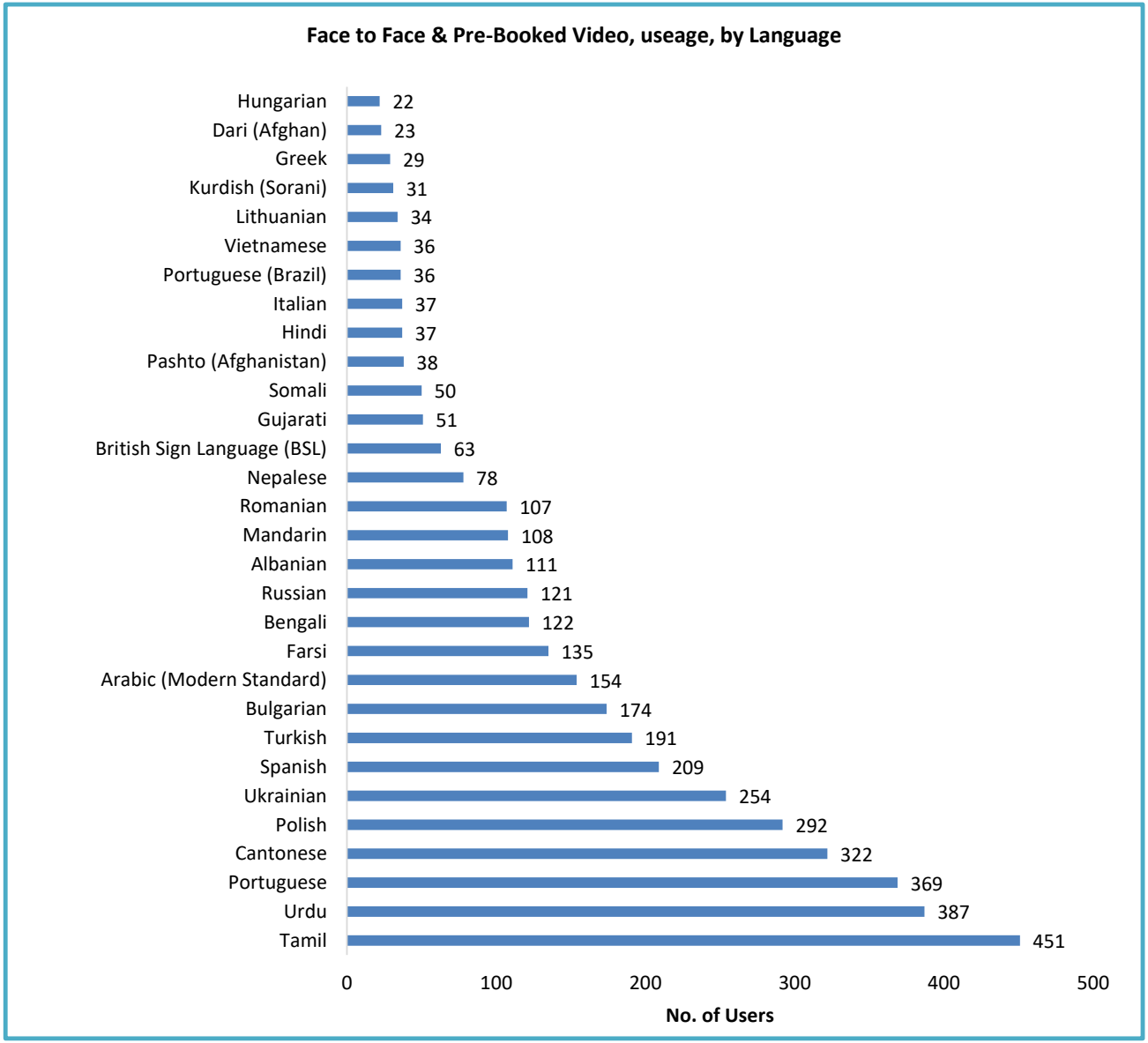
This section analyses "Face-to-Face & Pre-Booked Video Usage by Language," presenting the number of users categorised by language. Below is a high-level analysis:

Top Languages with Highest Usage:

- Tamil has the **highest** number of users, at 451.
- Urdu (387 users) and Portuguese (369 users) follow as the second and third most use d languages.
- Cantonese (322 users) and Polish (292 users) round out the top five.

Moderately Popular Languages:

- Ukrainian (254 users), Spanish (209 users), and Turkish (191 users) form a significant mid-tier category of usage.
- Arabic (154 users) and Farsi (135 users) also represent relatively high usage within this group.



anguages with Lower Usage:

- Hungarian (22 users), Dari (23 users), and Greek (29 users) have the lowest user counts.
- Other low-usage languages include Kurdish (Sorani) (31 users), Lithuanian (34 users), and Vietnamese/Portuguese (Brazil) (36 users each).

Languages with Moderate Usage:

- British Sign Language (63 users), Gujarati (51 users), and Somali (50 users) exhibit moderate levels of engagement.
- Romanian (107 users), Mandarin (108 users), and Albanian (111 users) also fall into this category.

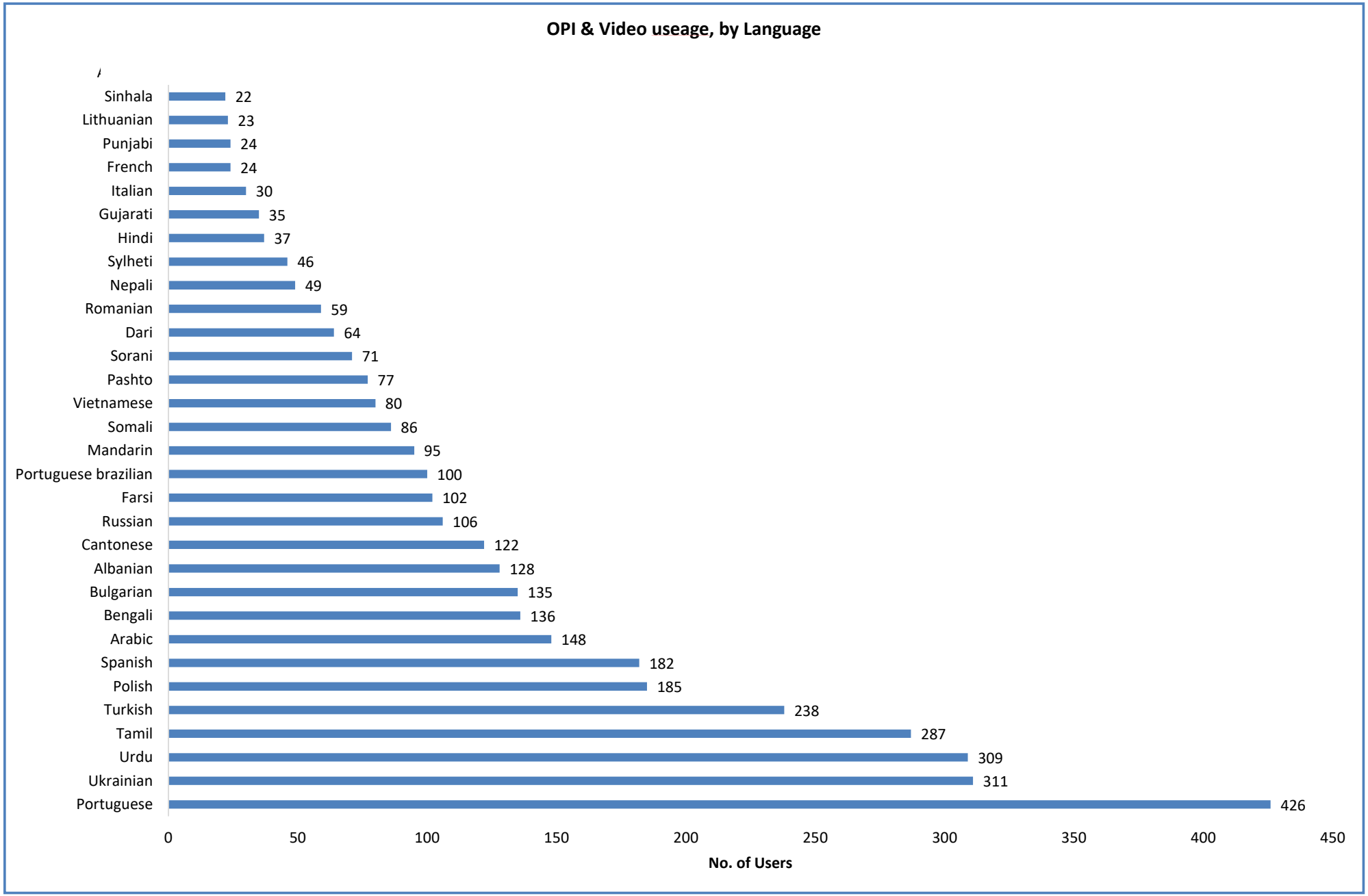
Key Insights:

- There is a significant usage disparity between the top and bottom languages, with Tamil usage far surpassing others.
- Languages like Urdu and Portuguese (both European and Brazilian variants) appear prominently in both high and moderate usage tiers, possibly reflecting a global or regional demand.
- Some niche languages with fewer users, such as British Sign Language or Somali, may represent specialised or localised services.

Potential Implications:

- The high demand for Tamil, Urdu, and Portuguese may necessitate additional resources for these languages to meet user needs
- .The lower-usage languages could be areas for growth or improved outreach depending on organisational priorities and target demographics.
- This analysis emphasises significant variations in user distribution and highlights the opportunity to allocate resources strategically based on language popularity.

ESTH OPI & Video Usage Key Highlights



Most Popular Languages:

- Portuguese is the leading language, with 426 users.
- Ukrainian (311 users) and Urdu (309 users) are the next most widely used languages.

Moderately Popular Languages:

- Turkish (238 users), Polish (185 users), and Spanish (182 users) form a significant mid-tier category of usage.
- Arabic and Bengali have relatively high usage, with 148 and 136 users, respectively.

Least Popular Languages:

- Languages like Amharic (20 users), Sinhala (22 users), and Lithuanian (23 users) have the lowest number of users.
- Other languages with lower usage include Gujarati (35 users) and Hindi (37 users).

Languages with Average Usage:

- Romanian (59 users), Pashto (77 users), Vietnamese (80 users), and Somali (86 users) represent moderate usage levels.
- Cantonese (122 users) and Russian (106 users) are also notable in this category.

Key Observations:

- The usage distribution suggests a significant disparity between the most-used and least-used languages.
- The top five languages (Portuguese, Ukrainian, Urdu, Turkish, and Polish) dominate the usage, accounting for a large portion of the total users.

Potential Implications:

- Higher usage of certain languages may correlate with the user demographics or the availability of services in those languages.
- The lesser-used languages might represent niche audiences that could benefit from increased resources or outreach.
- This analysis highlights the diversity in language usage and identifies areas where user engagement might vary significantly.

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Section 5: Key Conclusions and Insights from the Heads of EDI

1. Key Insights and Final Thoughts

EDI Leads Insights and recommendations: ESTH and SGUH

Sandra Ovid, Head of EDI –Epsom St Helier Hospital

Joseph Pavett-Downer, Head of EDI –St Georges Hospital

Sandra Ovid: "After reviewing the PSED report, it's clear that gesh has made significant progress in diversity, equity, and inclusion, particularly since coming together as a group model."

Joseph Pavett-Downer: "Absolutely, recruitment and early-career initiatives have brought in a more diverse workforce. But the challenge now is making sure that progress continues up the career ladder. Senior leadership is still lacking representation, particularly for women, Black Asian Minority Ethnic staff, and older employees."

Sandra Ovid: "Right, and that's something the report really emphasises. If we want to see lasting change, career progression support has to be a focus. Another issue is the high rate of non-disclosure in key demographic data it's hard to tackle inequalities when we don't have the full picture."

Joseph Pavett-Downer: "Exactly, better data transparency will help make sure strategies are based on real evidence. That's why the report pushes for stronger monitoring and tracking of diversity trends. Plus, there's a real need to support staff networks like Disability, LGBTQ+, Women's, and Black Asian Minority Ethnic networks they're key to fostering inclusion."

Sandra Ovid: "It's great to see that gesh is aligning these efforts with its People Strategy for 2024–2026. With shared governance alongside St George's and Epsom and St Helier Trusts, they have the structure to make real change."

Joseph Pavett-Downer: "And with executive sponsorship backing staff networks, plus a focus on leadership development, gesh is well-placed to keep moving forward. The report makes it clear there's more to do, but the commitment is there, and the right steps are being taken to build an inclusive and equitable workplace.

In concluding

The leadership of gesh is committed to addressing racial equality and supporting colleagues with disabilities and long-term health conditions. They recognise the unique perspectives and talents these employees bring, which enrich teams and enhance patient care. Creating an inclusive workplace remains a key priority, with sustained efforts to reduce inequalities and ensure equitable opportunities.

Over the past year, gesh has made significant strides in strengthening policies, practices, and initiatives. Leaders have engaged with employees, stakeholders, and communities to understand their experiences, shaping future actions to promote equity and inclusion. While progress continues, gesh's leadership is dedicated to building a truly inclusive and equitable organisation.

To measure this progress, NHS uses the annual Staff Survey, redesigned in 2021 to align with the Our People Promise. This tool allows teams and departments to assess their progress and take action for continuous improvement. Only by fully embracing the Our People Promise can gesh become the best place to work for all, where everyone is part of a team that brings out the best in each other.

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	3.5	
Report Title	**Gender Pay Gap – Snapshot 31/03/24**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Joseph Pavett-Downer (EDI) and Phil Longley (WI)	
Previously considered by	People Committees-in-Common	20 February 2025
Purpose	**For Approval / Decision**	

Executive Summary

People Committee in Common recommended this report to the Board for approval

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This report captures data as at 31st March 2024.

For the purpose of the Board, we have included a 'gesh overview' which provides a group picture of our GPG performance. The next section, Site Level Overview, provides the information required to meet our reporting obligations and will be published.

Gesh: On 31st March 2024 St George's, gesh employed 17,739 staff – 12,935 (73%) were female and 4,804 (27%) were male. The mean hourly pay for males is £3.55 higher than that of females, which is a gap of 12.8%. Male median pay is £0.92 higher than females, which is a gap of 4%. For medical and dental staff, the hourly rate for males is £4.20 higher than that of females, which is a pay gap of 9.4%. Male median is £5.62 higher than females, which is a gap of 13%

St George's: Employed 10,336 staff – 7,373 (71%) were female and 2,963 (29%) were male. The mean hourly pay for males is £3.33 higher than that of females, which is a gap of 11.6%. Male median pay is £2.18 p/h higher than females, which is a gap of 8.6%.

ESTH: Employed 7,403 staff – 5,562 (75%) were female and 1,841 (25%) were male. The mean hourly pay for males is £3.57 higher than that of females, which is a gap of 13.6%. Female median pay is £0.39 higher than males, which is a gap of -1.9%.

Definitions of Pay Gap

The **mean pay gap** is the difference between the average pay of all male employees and the average pay of all female employees. The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid

Action required by Group Board

The Committee is asked to:

a. Review the Gender Pay Gap Report
b. Approve for publication

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	GESH Gender Pay Gap Report 31.3.24 draft. V0.5

Implications

Group Strategic Objectives

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

Risks

[Failing to publish our Gender Pay Gap information each year can lead to governance risks such as non-compliance, reputational damage, and legal exposure, while attracting increased scrutiny from regulatory bodies

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

[none identified]

Legal and / or Regulatory implications

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website.

Equality, diversity and inclusion implications

Completion and publication of our Gender Pay Gap report and other equality reports demonstrates our on-going commitment to transparency and accountability. It evidences the boards commitment and shows a willingness to review and learn from equality information.

Environmental sustainability implications

[none identified]

Gender Pay Gap
Group Board, 06 March 2025

1.0 Purpose of paper

1.1 The paper provides the board with an overview of the group and sites gender pay gap information. It is intended to show our performance against the previous years and highlight areas of improvement or deterioration. The paper requires approval to move forward for publication.

2.0 Background

2.1 The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. This report captures data as at 31st March 2024. The NHS has issued guidance on how to calculate the gender pay gap which we follow closely to produce the attached report. .

The statutory requirements of the Gender Pay Gap legislation require that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payments.

Who is included? All staff who were employed across the GESH Group on full pay on 31st March 2024, with the exception of Non-Executive Directors, are included. Bank staff who worked a shift on the snapshot date are also included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded. Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff are not included.

What pay is covered? Both Basic pay and Bonus pay is covered. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards. Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, but not if they are continuous. Workplace vouchers that are paid in addition to basic salary are included, unless they take the form of a salary sacrifice arrangement.

3.0 Key Findings

3.1 This report contains a number of info graphics and charts to provide a clearer picture of the data. Below provide an overview in relation to Mean, Median and Bonus'.

Please see attached report for further information

Gesh Overview: On 31st March 2024 St George's, gesh employed 17,739 staff – 12,935 (73%) were female and 4,804 (27%) were male. The mean hourly pay for males is £3.55 higher than that of females, which is a gap of 12.8%. Male median pay is £0.92 higher than females, which is a gap of 4%.

For medical and dental staff, the hourly rate for males is £4.20 higher than that of females, which is a pay gap of 9.4%. Male median is £5.62 higher than females, which is a gap of 13%

Gesh Bonus: Across the group 917 members of staff received a bonus this reporting period, an increase from 671 in 2022/23. Of the 917 bonuses received, 399 were female, which is 3.1% of the female workforce and 518 were male, which is 10.1% of the male workforce. All bonuses were paid to Consultants in the form of Clinical Excellence Awards (CEA).

The mean bonus pay for males is £1,766.97 higher than that of females, which is a gap of 21.1%. This reduced from a gap of £3,500.08 in 2023.

Male and female median bonus pay was the same at £5,287.26, so there is no pay gap. In terms of a percentage split across the group, 84% of St George's consultants received a bonus payment, compared to 79% of ESTH's consultants.

St George's: Employed 10,336 staff – 7,373 (71%) were female and 2,963 (29%) were male. The mean hourly pay for males is £3.33 higher than that of females, which is a gap of 11.6%. Male median pay is £2.18 p/h higher than females, which is a gap of 8.6%.

618 members of staff received a bonus this reporting period. Of the 618, 283 were female, which is 3.8% of the female workforce and 335 were male, which is 11.3% of the male workforce. All bonus payments were made to Consultants. The mean bonus pay for males is £2,073.08 higher than that of females, which is a gap of 23.6%. This reduced from a gap of £3,500.08 in 2023. Male and female median bonus pay was the same at £5,287.26, so there is no pay gap.

ESTH: Employed 7,403 staff – 5,562 (75%) were female and 1,841 (25%) were male. The mean hourly pay for males is £3.57 higher than that of females, which is a gap of 13.6%. Female median pay is £0.39 higher than males, which is a gap of -1.9%.

299 members of staff received a bonus this reporting period. Of the 299, 116 were female, which is 2.1% of the female workforce and 183 were male, which is 9.9% of the male workforce. All bonus payments were made to Consultants. The mean bonus pay for males is £1,273.42 higher than that of females, which is a gap of 16.7%. This reduced from a gap of £2,111.47 in 2023. Male and female median bonus pay was the same at £3,904.0, so there is no pay gap.

4.0 Sources of Assurance

4.1 The requirement to produce a Gender Pay Gap report was introduced in March 2016, with the first report not due until the following year, March 2017. This was to allow time for organisations to implement systems to collect the required data on the GPG. Therefore, organisations published a report in March 2017 based on data for the period April 2015 through to March 2016.

This one-year lag has continued nationally and resulted in published reports looking at data that is a year old, and any findings and decisions about next steps may be outdated at the time of publishing.

This year, the GESH group will produce and publish our 2025 report - covering the period April 2024 – March 2025, in real time, shortly after the snapshot date of 31st March 2025.

This will bring our Gender Pay reporting in line with the current financial year and ensure any actions are current and in response to live' findings.

Our 2025 report will include Gender, Disability and Ethnicity.

5.0 Recommendations

5.1 The Board is asked to:

a. Review the paper
b. Approve for publication (PCIC recommended the report to the Board for approval).

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Gender Pay Gap Report

Snapshot Date: 31/03/2024

Gender Pay Gap

Introduction

The Equality Act 2010 (Gender Pay Gap Information) Regulations 2017 require all organisations with over 250 employees to report on and publish their gender pay gap on a yearly basis. This is based on a snapshot from 31st March of each year, and each organisation is duty bound to publish information on their website. **This report captures data as at 31st March 2024.**

The NHS has issued guidance on how to calculate the gender pay gap, and that guidance is followed here (see Appendix 1). At the time of writing, St George's, Epsom and St Helier University Hospitals and Health Group (GESH) employs 17,739 employees. By Trust, this is broken down as 10,336 employees at St George's University Hospitals (SGUH) and 7,403 employees at Epsom and St Helier Hospitals (ESTH).

All staff at St George's University Hospitals except for medical and Very Senior Management (VSM) are on Agenda for Change (AfC) payscales, which provide a clear structure for paying employees equally, irrespective of gender. In addition to Medical, Very Senior Management (VSM) and Agenda for Change (AfC), Epsom and St Helier Hospitals also employs 623 Estates & Facilities staff on locally agreed payscales. Non-Executive Directors have been excluded due to the nature of their employment terms and the impact this is having on pay gap disparities.

What is the gender pay gap?
The Gender Pay Gap (GPG) is a mathematical calculation based on the difference between the average (or 'mean') hourly earnings of women compared to the average hourly earnings of men. The Gender Pay Gap highlights any imbalance of average pay across an organisation.

For example, if an organisation's workforce is predominantly female yet the majority of higher paid roles are held by men, the average female salary would be lower than the average male salary. The Gender Pay Gap is not the same as equal pay which is focused on men and women earning equal pay for the same / similar jobs or for work of equal value. It is unlawful to pay people unequally because of their gender.

What do we have to report on?
The statutory requirements of the Gender Pay Gap legislation require that each organisation must calculate the following:

- The mean basic pay gender pay gap
- The median basic pay gender pay gap
- The proportion of males and females in each quartile pay band
- The mean bonus gender pay gap
- The median bonus gender pay gap
- The proportion of both males and females receiving a bonus payments.

Who is included?
All staff who were employed across the GESH Group on full pay on 31st March 2024, with the exception of Non-Executive Directors, are included. Bank staff who worked a shift on the snapshot date are also included. Consultant Additional Programmed Activities (APA's) are included, but general overtime pay and expenses are excluded. Employees who are on half or nil absence or maternity leave, hosted staff (e.g. GP Trainees) and agency staff are not included.

What pay is covered?
Both Basic pay and Bonus pay is covered. Bonus pay is defined as any remuneration that is in the form of money, vouchers, securities or options and relates to profit sharing, productivity, performance, incentive or commission. This includes Clinical Excellence Awards and Distinction Awards.

Recruitment & retention payments (RRP's) are only included if they are a one-off payment at the start of recruitment, but not if they are continuous. Workplace vouchers that are paid in addition to basic salary are included, unless they take the form of a salary sacrifice arrangement.

For detailed information on how the pay gap is calculated please see Appendix A.

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

gesh

Group Overview

Snapshot Date: 31/03/2024

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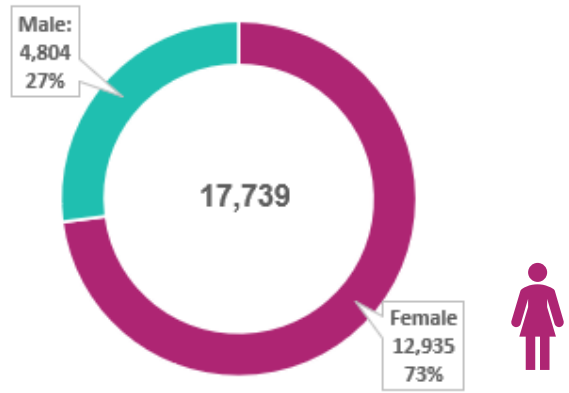
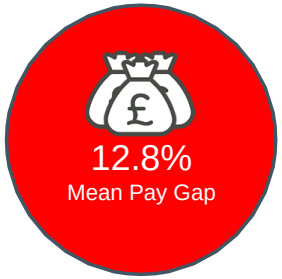
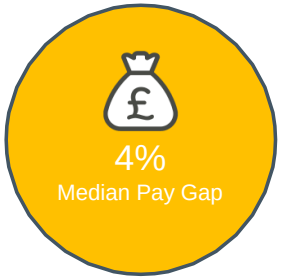
Group Overview

Group Substantive Staff



Pay Gap





Key:
- Green +/- 0-3%
- Amber +/-3-5%
- Red +/- 5% and above

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St George's University Hospital (SGUH)

Pay Gap

Epsom and St Helier Hospital (ESTH)

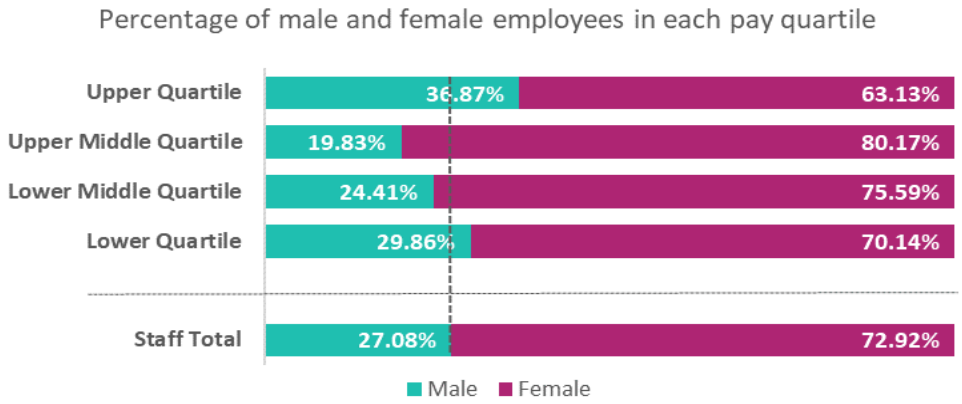
Pay Gap

Gender Pay Gap

Group Basic Pay - Mean and Median Gap

Definitions of Pay Gap
The **mean pay gap** is the difference between the average pay of all male employees and the average pay of all female employees.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid



On 31st March 2024 St George's, Epsom and St Helier University Hospitals and Health Group employed 17,739 staff – 12,935 (73%) were female and 4,804 (27%) were male.

The mean hourly pay for males is £3.55 higher than that of females, which is a gap of **12.8%**. Male median pay is £0.92 higher than females, which is a gap of **4%**.

For AfC (including VSM) only, the hourly rate for females is £0.03 higher than that of males, which is a pay gap of **-0.1%**. Female median is £1.47 higher than males, which is a gap of **-7.4%**.

For medical and dental staff, the hourly rate for males is £4.20 higher than that of females, which is a pay gap of **9.4%**. Male median is £5.62 higher than females, which is a gap of **13%**

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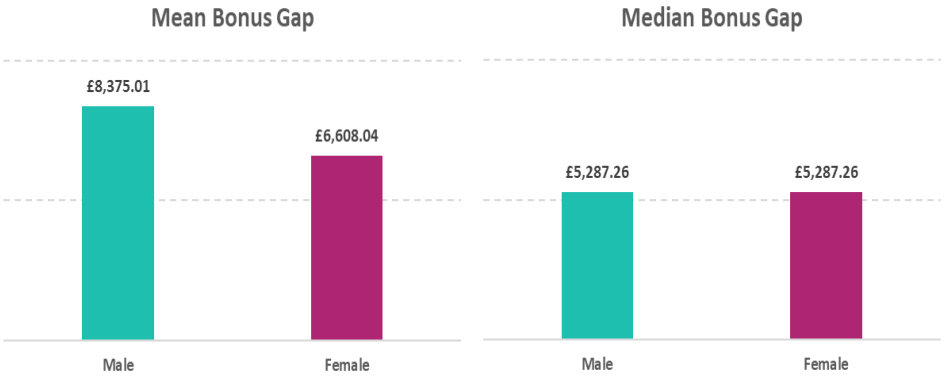
Gender Pay Gap

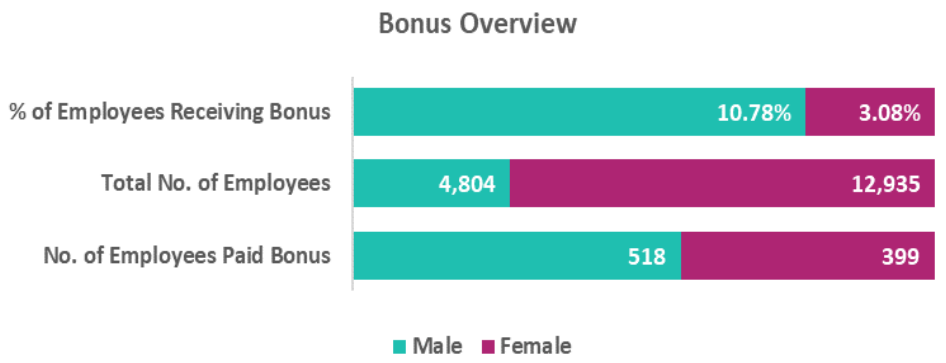
Group Bonus Pay - Mean and Median Gap

Definitions of Pay Gap

The **mean bonus gap** is the difference between the average bonus of all male employees and the average bonus of all female employees.

The **median bonus gap** is the difference between the bonus of the middle male and middle female, when all (eligible) male employees and then all female employees are listed from the highest to the lowest paid





Across the group 917 members of staff received a bonus this reporting period, an increase from 671 in 2022/23. Of the 917 bonuses received, 399 were female, which is 3.1% of the female workforce and 518 were male, which is 10.1% of the male workforce. All bonuses were paid to Consultants in the form of Clinical Excellence Awards (CEA).

The mean bonus pay for males is £1,766.97 higher than that of females, which is a gap of **21.1%**. This reduced from a gap of £3,500.08 in 2023.

Male and female median bonus pay was the same at £5,287.26, so there is no pay gap.

In terms of a percentage split across the group, 84% of St George's consultants received a bonus payment, compared to 79% of ESTH's consultants.

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Gender Pay Gap

Group Spotlight on AfC (and local contracts)

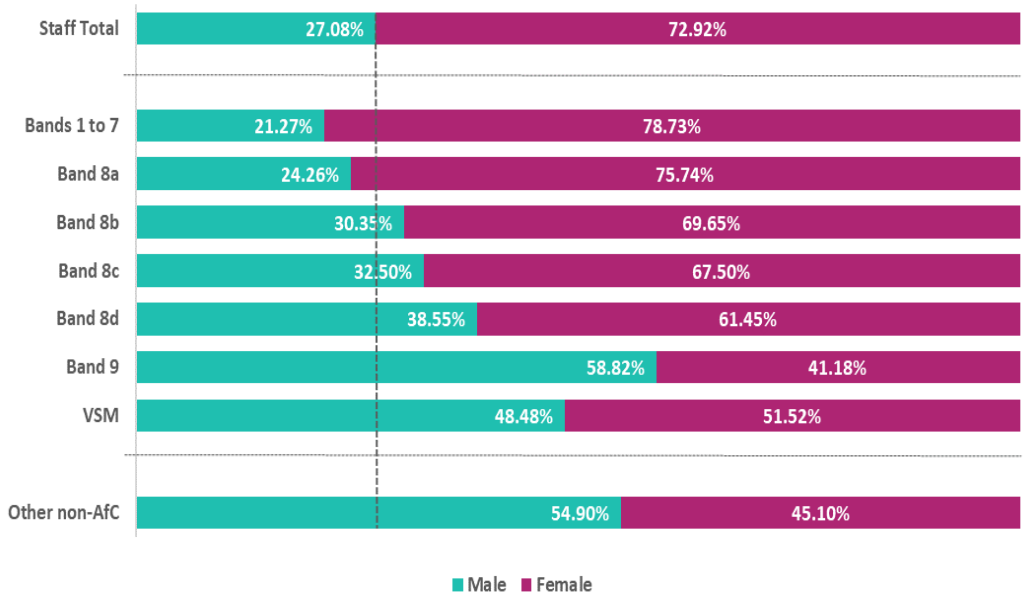
Across the group female staff make up 73% of our workforce.

In terms of representation by band;

- Workforce composition is closest to representative at bands 8a and 8b.
- There is an over representation of female staff at bands 3 to 7 (77% - 82% representation)
- At band 2, and 8c and above, female representation reduces, and we see a higher proportion of male staff.
- Female representation is lowest at Band 9 at 41% (an increase from 30% in 2023). Whilst GESH employs more male band 9s, the mean hourly pay for males is £2.65 less than that of females, which is a gap of **-4.6%**. This is likely due to the spine points within each band.
- Male staff make up 27% of the GESH workforce. The highest representation is 59% at Band 9, followed by Facilities staff on local contracts at 55%.

In terms of representation by Staff group;

- Admin and clerical staff have the highest pay gap, with males earning £3.03 p/h more than that of females, which is a pay gap of **13.4%**.
- Add. prof scientific and technic have a pay gap of **-4.82%** due to females earning £1.17 p/h more than male staff.
- Allied health professionals also have a pay gap of **-3.1%** due to females earning £0.77 p/h more than male staff.
- Nursing support staff have the closest gender pay, with females earning £0.05 p/h more than male staff, which is a pay gap of **-0.33%**. Followed by Qualified Nursing staff, with male staff earning £0.50 p/h more than female staff, which is a gap of **1.9%**.



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Gender Pay Gap

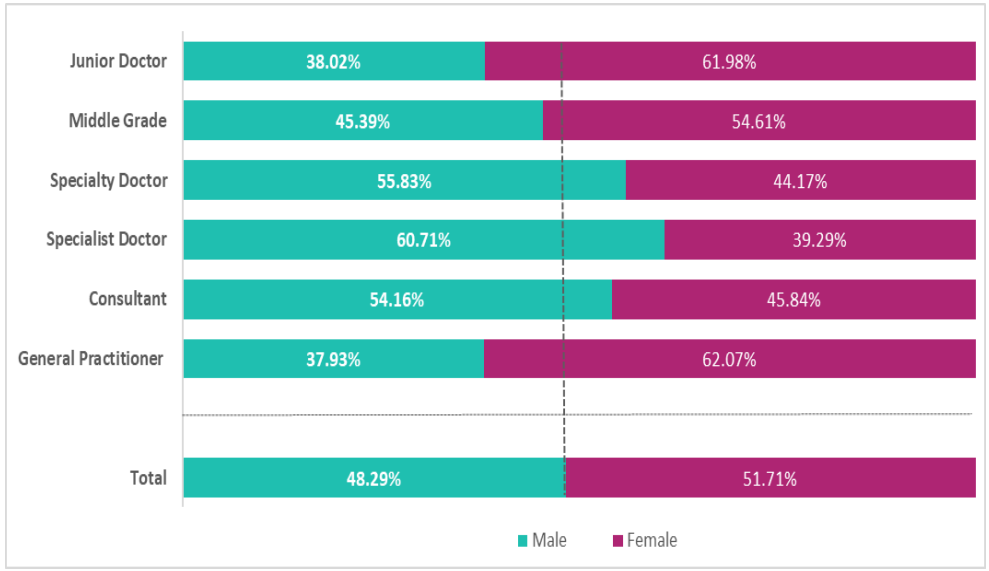
Group Spotlight on Medical Staff

The Medical Staff group includes all ‘Doctor in Training’ through to ‘Consultant’ roles and features the largest gap in hourly pay, and as with previous years it is this pay gap that is the most significant.

The proportion of male to female staff is 48.3% to 51.7%.

The mean hourly pay for males is £4.20 higher than that of females, which is a gap of **9.4%**. Male median pay is £5.62 higher than females, which is a gap of **13%**.

Male consultants were paid on average £2.16 p/h more than their female counterparts, this has decreased slightly from £2.21 in the previous year. This is a pay gap of **3.71%** for 2024. Male median pay is £1.62 higher than females, which is a gap of **2.9%**.



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

gesh

Site Level Overview

Snapshot Date: 31/03/2024

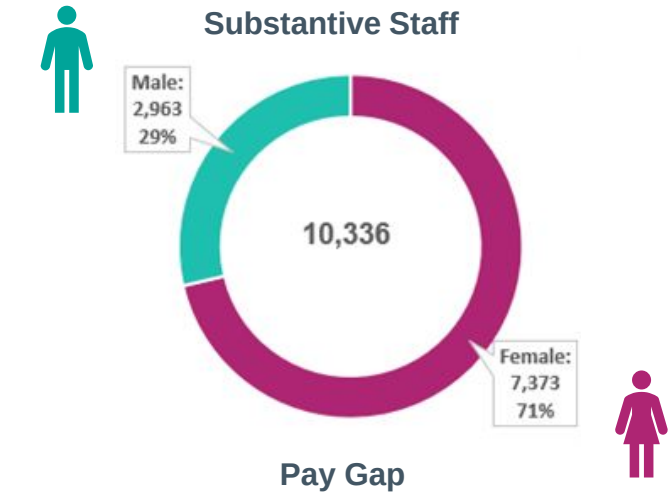
For publication

9

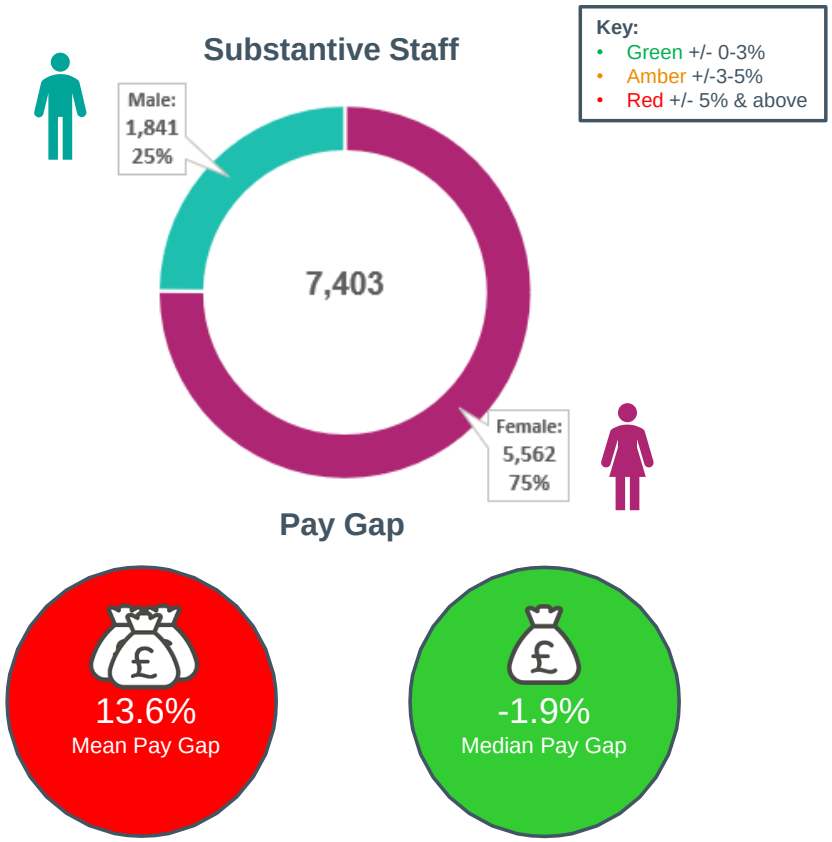
Gender Pay Gap

Site Overview

St George's University Hospital (SGUH)



Epsom and St Helier Hospital (ESTH)



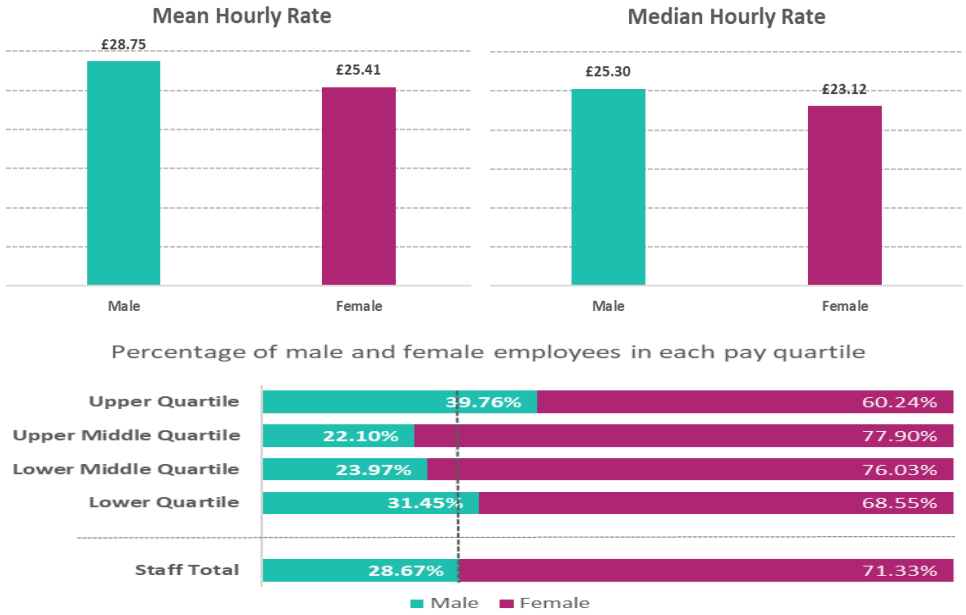
Gender Pay Gap

Basic Pay - Mean and Median Gap

Definitions of Pay Gap
The **mean pay gap** is the difference between the average pay of all male employees and the average pay of all female employees.

The **median pay gap** is the difference between the pay of the middle male and middle female, when all male employees and then all female employees are listed from the highest to the lowest paid

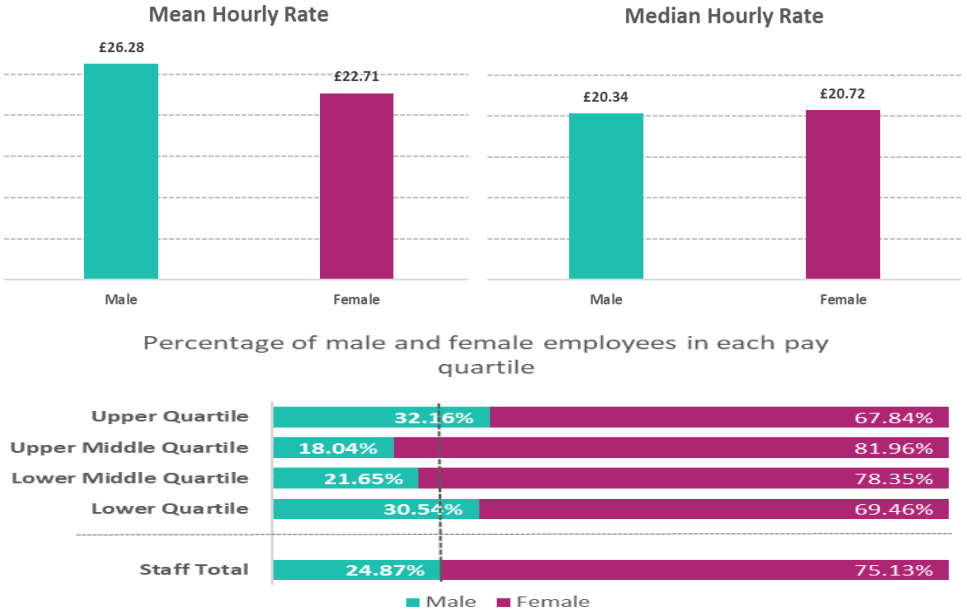
St George's University Hospital (SGUH)



On 31st March 2024 St George's employed 10,336 staff – 7,373 (71%) were female and 2,963 (29%) were male. The mean hourly pay for males is £3.33 higher than that of females, which is a gap of **11.6%.** Male median pay is £2.18 p/h higher than females, which is a gap of **8.6%.**

For AfC (including VSM) only, the hourly rate for females is £0.27 higher than that of males, which is a pay gap of **-1.2%**. Female median is £1.6 higher than males, which is a gap of **-7.9%**.

Epsom and St Helier Hospital (ESTH)



On 31st March 2024 Epsom and St Helier employed 7,403 staff – 5,562 (75%) were female and 1,841 (25%) were male. The mean hourly pay for males is £3.57 higher than that of females, which is a gap of **13.6%.** Female median pay is £0.39 higher than males, which is a gap of **-1.9%.**

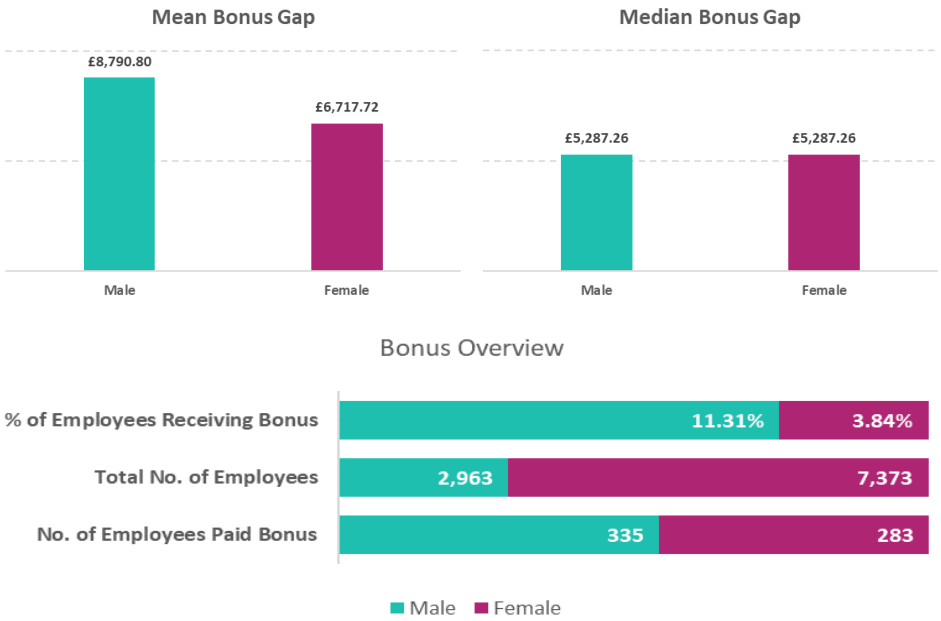
For AfC (including VSM) only, the hourly rate for males is £0.04 higher than that of females, which is a pay gap of **0.2%**. Female median is £1.12 higher than males, which is a gap of **-5.8%**.

Gender Pay Gap

Bonus Pay - Mean and Median Gap

Definitions of Pay Gap
The **mean bonus gap** is the difference between the average bonus of all male employees and the average bonus of all female employees.
The **median bonus gap** is the difference between the bonus of the middle male and middle female, when all (eligible) male employees and then all female employees are listed from the highest to the lowest paid

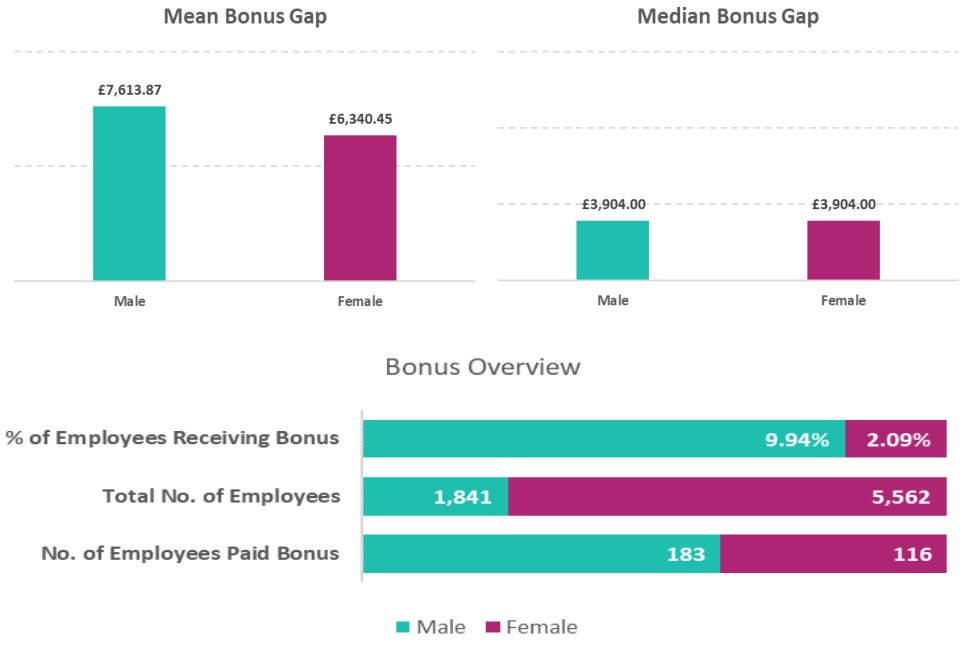
St George's University Hospital (SGUH)



618 members of staff received a bonus this reporting period. Of the 618, 283 were female, which is 3.8% of the female workforce and 335 were male, which is 11.3% of the male workforce. All bonus payments were made to Consultants.

The mean bonus pay for males is £2,073.08 higher than that of females, which is a gap of **23.6%**. This reduced from a gap of £3,500.08 in 2023. Male and female median bonus pay was the same at £5,287.26, so there is no pay gap.

Epsom and St Helier Hospital (ESTH)



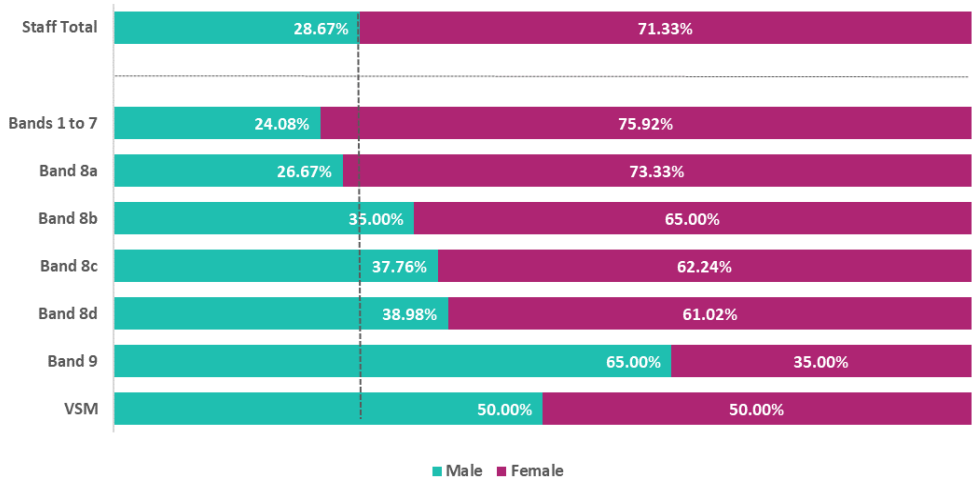
299 members of staff received a bonus this reporting period. Of the 299, 116 were female, which is 2.1% of the female workforce and 183 were male, which is 9.9% of the male workforce. All bonus payments were made to Consultants.

The mean bonus pay for males is £1,273.42 higher than that of females, which is a gap of **16.7%**. This reduced from a gap of £2,111.47 in 2023. Male and female median bonus pay was the same at £3,904.0, so there is no pay gap.

Gender Pay Gap

Spotlight on AfC (and local contracts)

St George's University Hospital (GESH)

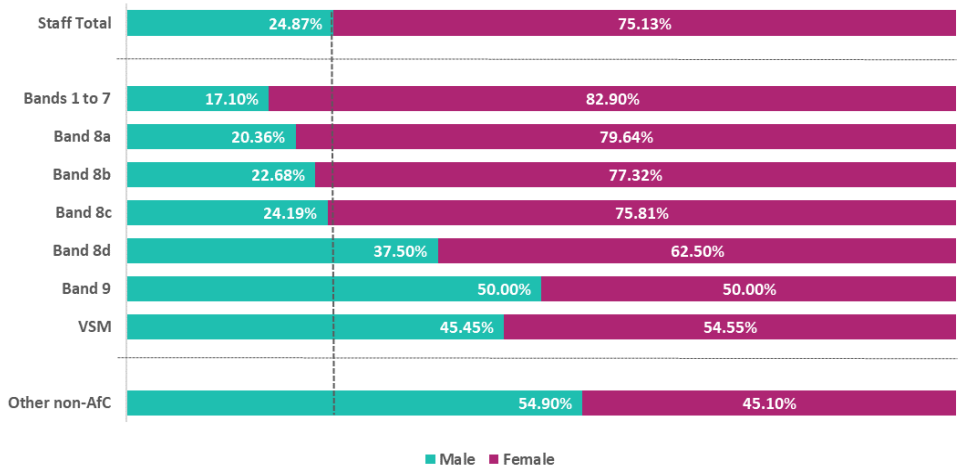


As an organisation, female staff make up 71% of the SGUH workforce. The workforce composition is within range of representative at bands 3, 4 and 8a (68% to 74%). There is an over representation of female staff at bands 5 to 7 (75% and above).

From band 8b and above female representation reduces, and we see a higher proportion of male staff. Female representation is lowest at band 9 at 35% (a 5% increase to 2023).

Male staff make up 29% of the SGUH workforce overall, the highest representation is 65% at Band 9, followed by 50% at VSM.

Epsom and St Helier Hospital (ESTH)



As an organisation, female staff make up 75% of the ESTH workforce. The workforce composition is within range of representative at bands 2, 8b and 8c (72% to 78%). There is an over representation of female staff at bands 3-8a (79% and above).

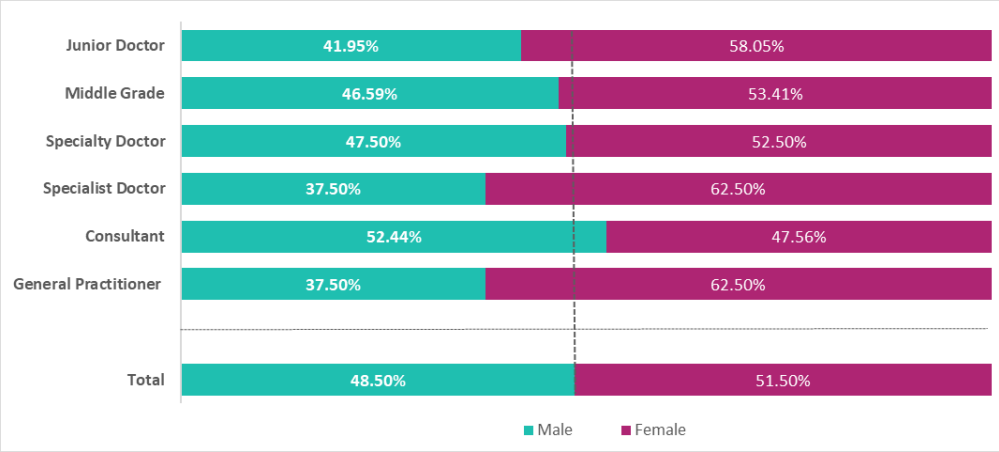
From band 8d and above female representation reduces, and we see a higher proportion of male staff. Female representation is lowest within Facilities (local contracts) at 45%, followed by band 9 at 50%.

Male staff make up 25% of the ESTH workforce overall, the highest representation is 55% within the Facilities staff on local contracts.

Gender Pay Gap

Spotlight on Medical Staff

St George's University Hospital (SGUH)



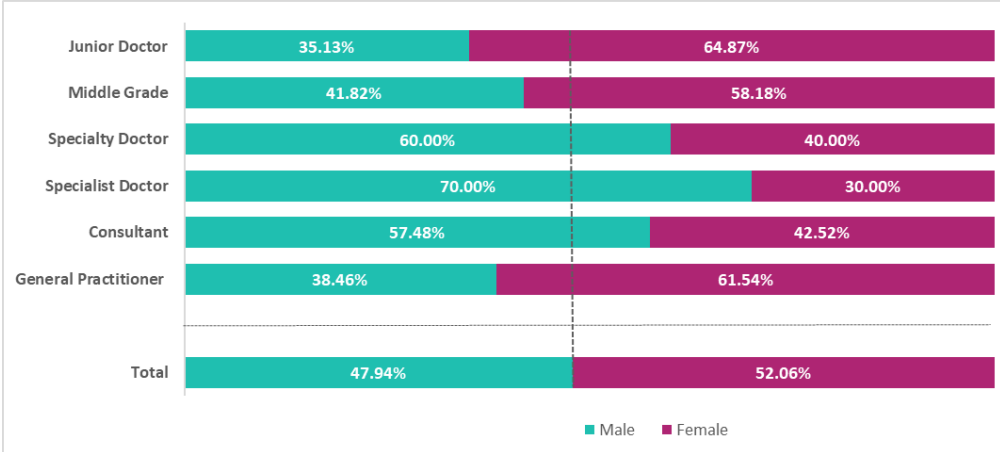
The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles and features the biggest gap in hourly pay, and as with previous years it is this pay gap that is the most significant.

The proportion of male to female staff is 48.5% to 51.5%.

The mean hourly pay for males is £2.94 higher than that of females, which is a gap of **6.6%**. Male median pay is £3.34 higher than females, which is a gap of **7.8**%.

Male consultants were paid, on average, £2.11 p/h more than their female counterparts, this has decreased slightly from £2.16 in the previous year. For 2024, this is a pay gap of **3.6%**.

Epsom and St Helier Hospital (ESTH)



The Medical Staff group includes all 'Doctor in Training' through to 'Consultant' roles and features the biggest gap in hourly pay, and as with previous years it is this pay gap that is the most significant.

The proportion of male to female staff is 47.9% to 52.1%.

The mean hourly pay for males is £6.24 higher than that of females, which is a gap of 14%. Male median pay is £12.48 higher than females, which is a gap of 27%.

Male consultants were paid on average £2.25 p/h more than their female counterparts, this has increased from £1.99 p/h in the previous reporting year. For 2024, this is a pay gap of **3.9%**.

Gender Pay Gap

Site Trend 2020 - 2024

St George's University Hospital (SGUH)

	2020	2021	2022	2023	2024	Line Trend
Mean Pay Gap	13.71%	14.83%	14.59%	12.86%	11.60%	
Median Pay Gap	9.49%	7.94%	9.51%	10.02%	8.62%	
Mean Bonus Pay Gap	29.23%	35.10%	34.17%	32.10%	23.58%	
Median Bonus Pay Gap	33.33%	33.33%	33.33%	0.00%	0.00%	
%males getting bonus	5.03%	4.57%	4.00%	12.07%	11.31%	
%females getting bonus	1.33%	1.07%	0.94%	4.66%	3.84%	

- The mean pay gap reduced year on year, from 14.81% in 2021 to 11.6% in 2024.
- The median pay gap has decreased since last year from 10.02% to 8.62%.
- The mean bonus gap has reduced year on year, from 35.1% in 2021 to 23.58% in 2024
- The median bonus gap remained static for the second year at 0%.
- The % of males receiving a bonus decreased slightly to 11.31%.
- The % of females receiving bonus decreased slightly to 3.84%.

Epsom and St Helier Hospital (ESTH)

	2020	2021	2022	2023	2024	Line trend
Mean Pay Gap	19.52%	18.46%	14.28%	13.16%	13.58%	
Median Pay Gap	12.25%	10.38%	1.88%	-1.23%	-1.89%	
Mean Bonus Pay Gap	15.17%	16.06%	21.55%	24.90%	16.73%	
Median Bonus Pay Gap	0.00%	0.00%	1.25%	0.00%	0.00%	
%males getting bonus	5.88%	5.31%	4.22%	8.99%	9.94%	
%females getting bonus	0.90%	0.74%	0.64%	1.96%	2.09%	

- The mean pay gap has increased slightly from 13.16% to 13.58%.
- The median pay gap dropped in 2022 when a large group of locally paid facilities staff were transferred into the Trust. This has further deceased each year.
- The mean bonus gap dropped in 2024 to 16.73%.
- The median bonus gap remained static for the second year at 0%.
- The % of males receiving a bonus has increased to 9.94%.
- The % of females receiving bonus increased to 2.09%.

Gender Pay Gap

Next Steps

The requirement to produce a Gender Pay Gap report was introduced in March 2016, with the first report not due until the following year, March 2017. This was to allow time for organisations to implement systems to collect the required data on the GPG. Therefore, organisations published a report in March 2017 based on data for the period April 2015 through to March 2016.

This one-year lag has continued nationally and resulted in published reports looking at data that is a year old, and any findings and decisions about next steps may be outdated at the time of publishing.

This year, the GESH group will produce and publish our 2025 report - covering the period April 2024 – March 2025, in real time, shortly after the snapshot date of 31st March 2025.

This will bring our Gender Pay reporting in line with the current financial year and ensure any actions are current and in response to live' findings.

Our 2025 report will include Gender, Disability and Ethnicity.

Appendix: A
Calculating the Gender Pay Gap

To calculate the GPG we first determine the average hourly pay for all valid employees within the month of March 2020. For each employee the total pay - including basic salary, high cost allowance, any extra duties etc. – are totalled, and then divided by the number of hours worked that month. This gives an average hourly rate. Note: The figures in this appendix are an **example data** set to show the calculations, they are not the figures for a specific reporting period.

Calculating the '**mean**' (i.e. average) hourly pay for all male employees and all female employees:

- Total the average hourly pay for each gender and then divided this figure by the number of employees in each group.
- A sample of 14 employees is shown below to assist with understanding these calculations:

For each employee their total monthly pay for March is calculated and then divided by the hours worked to determine an average hourly pay.

To get the mean hourly pay for the two genders all the average hourly rates are added together and then divided by the number of employees (in this case, 7):

- Female: (11.87 + 12.14 + 13.85 + 16.73 + 22.52 + 23.97 + 25.7) / 7 = £18.11
- Male: (13.35 + 18.48 + 19.68 + 24.09 + 33.31 + 52.73 + 52.99) / 7 = £30.66

To calculate the Agenda for Change (AFC) staff only, medical staff must be removed before the calculation. In this example there are only male medical staff (indicated by an asterisk * in the table), and so for just agenda for change male staff the calculation is (13.35 + 18.48 + 19.68) / 3 = £17.17.

To get the mean pay gap the calculation is the difference between the male and female hourly rates divided by the male hourly rate:

- 30.66 – 18.11 = 12.55
- 12.55 / 30.66 = 0.4093, which is 40.93%

For AFC only the calculation would be:

- 17.17 – 18.11 = -0.94
- -0.94 / 17.17 = -0.055, which is -5.48%. A minus value indicates that the pay gap favours female.

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
	Receptionist	£3,341.00	£564.75		£3,905.75	162.95	£23.97
	Senior Staff Nurse - Critical Care	£3,105.58	£564.75	£518.03	£4,188.36	162.95	£25.70
Male	Theatre HCA	£1,585.00	£366.67	£224.34	£2,176.01	162.95	£13.35
	Staff Nurse - Acute Medicine	£2,509.33	£501.87	£55.27	£3,066.47	165.95	£18.48
	Anaesthetic Nurse	£2,509.33	£501.87	£235.53	£3,246.73	164.95	£19.68
	Specialty Registrar – Dermatology*	£4,006.25		£180.17	£4,186.42	173.81	£24.09
	Specialty Registrar - A&E*	£4,006.83		£1,782.90	£5,789.73	173.81	£33.31
	Consultant – Radiology*	£8,477.92		£685.84	£9,163.76	173.8	£52.73
	Consultant – Anaesthetics*	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Outstanding care every time

Appendix: A
Calculating the Gender Pay Gap

To calculate the GPG we first determine the average hourly pay for all valid employees within the month of March 2020. For each employee the total pay - including basic salary, high cost allowance, any extra duties etc. – are totalled, and then divided by the number of hours worked that month. This gives an average hourly rate. Note: The figures in this appendix are an **example data** set to show the calculations, they are not the figures for a specific reporting period.

Calculating the '**median**' (i.e. middle point) hourly pay for all male employees and all female employees:

- Rank the hourly pay rate of each employee, from smallest to largest, again separated by gender, and take the middle point hourly pay in the ranking. This is your 'median' value.
- In the given example the median hourly rate for both female and male staff is highlighted below:

The calculation for the pay gap remains the same:

- 24.09 – 16.73 = 7.36
- 7.36 / 24.09 = 0.3055, which is 30.55%

Excluding medical staff there is again no change in the female median value, but the median hourly rate for male staff is £18.48:

- 18.48 – 16.73 = 1.75
- 1.75 / 18.48 = 0.094, which is 9.47%

Gender	Employee	Basic Pay	High Cost Allowance	Additional	Total	Hours worked	Average Hourly Pay
Female	Training Nurse Associate	£1,567.75	£366.67		£1,934.42	162.95	£11.87
	Administrator	£1,288.80	£293.33		£1,582.13	130.36	£12.14
	HCA - Acute Medicine	£676.66	£168.67	£193.11	£1,038.44	74.96	£13.85
	Staff Nurse - Critical Care	£2,271.67	£454.33		£2,726.00	162.95	£16.73
	Research Nurse	£3,105.58	£564.75		£3,670.33	162.95	£22.52
	Receptionist	£3,341.00	£564.75		£3,905.75	162.95	£23.97
	Senior Staff Nurse - Critical Care	£3,105.58	£564.75	£518.03	£4,188.36	162.95	£25.70
Male	Theatre HCA	£1,585.00	£366.67	£224.34	£2,176.01	162.95	£13.35
	Staff Nurse - Acute Medicine	£2,509.33	£501.87	£55.27	£3,066.47	165.95	£18.48
	Anaesthetic Nurse	£2,509.33	£501.87	£235.53	£3,246.73	164.95	£19.68
	Specialty Registrar - Dermatology	£4,006.25		£180.17	£4,186.42	173.81	£24.09
	Specialty Registrar - A&E	£4,006.83		£1,782.90	£5,789.73	173.81	£33.31
	Consultant - Radiology	£8,477.92		£685.84	£9,163.76	173.8	£52.73
	Consultant - Anaesthetics	£8,477.92		£731.40	£9,209.32	173.8	£52.99

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	4.1	
Report Title	**Group Healthcare Associated Infection Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer and Director of infection Prevention and Control	
Report Author(s)	**Prodine Kubalalika, Group Clinical Director, Infection Prevention and Control**	
Previously considered by	Quality Committees-in-Common	27 February 2025
Purpose	**For Assurance**	

Executive Summary

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

In Quarter 3, the key issues to highlight are summarised below.

C.difficile Infections (CDI): We continue to see a substantial increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low-level fluctuations in CDI cases observed prior to the COVID-19 pandemic. Review of cases has not revealed any themes, however some of the reasons for the increase are likely multifactorial and may be associated with post-pandemic changes in population immunity and potential changes in diagnostic testing capabilities.

This shift to an upward trend for CDI, which was initially observed during the pandemic, suggests a need for additional efforts to return and maintain previously low prevalence levels.
A briefing note was issued by UKHSA in December 2024 reporting the increase in CDI infections in England and a UKHSA *C. difficile* Technical Group has been formed with further surveillance and recommendations to be published in 2025.

Seasonal Influenza: Consistent with national reports, in December there was a big increase in Influenza A positive admissions across the group which resulted in several bay/ward closures and significant impact on bed capacity.
SGUH: a decision to open a Flu ward was made late in December and Rodney Smith was designated as the dedicated Flu ward with enhanced IPC measures in place. The ward reverted to a normal ward in January 2025.
ESTH: At the peak of the increased prevalence, both A&Es,' identified designated cohorting areas to manage patients presenting with respiratory and flu infections to inform safe placement of patients on admission to the wards.

SGUH Hydrogen Peroxide Vapour (HPV) Decontamination: There are issues with delays in accessing the use of higher level of disinfection such as hydrogen peroxide vapour (HPV) at SGUH despite this being included in the Mitie contract. Several meetings have been held between IPC and

Estates leads to ensure that Mitie are delivering as per contractual arrangements and held to account if unable to. The IPC and Estates teams are also currently looking at sourcing HPV or Ultraviolet machines for both ESTH and SGUH. A business case is being written up for executive approval and funding.

SGUH: Continues to be an outlier nationally for the reduction of long bone fracture surveillance as quarterly infection rates (2.5%) are higher than the national benchmark of 0.9%.A Task and Finish Group is being established to review surgical policies and practices including skin preparation, antibiotic prophylaxis, and patient warming prior to procedure and to review individual cases.

Groupwide: Ventilation non-compliance cross the group, including theatres at SGUH, not meeting HTM standards due to aging buildings and lack of funding. A plan for high-risk areas is needed, with prioritisation and additional funding essential and this is being developed in conjunction with Estates.. No immediate clinical risks have been reported and ongoing collaborative work/risk assessments and identification of mitigations continue to be undertaken between IPC and Estates.

Action required by Group Board

The Board is asked to:

- Receive the Healthcare Associated Infection (Infection Control) Report from Sites and Group for assurance
- Make any necessary recommendations

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Appendix 1	Quarterly Group Infection Prevention and Control Report: October-December 2024
Appendix 2	READING ROOM: ESTH Quarter 3 IPC Report October-December 2024
Appendix 3	READING ROOM: SGUH Quarter 3 IPC Report July – October-December 2024

Implications

Group Strategic Objectives

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

Risks

As set out in the paper

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

The Health and Social Care Act (2008): The Hygiene Code - code of practice on the prevention and control of infections. (Updated 2023) https://www.gov.uk/government/publications/the-health-and-social-care-act-2008-code-of-practice-on-the-prevention-and-control-of-infections-and-related-guidance

Health and Social Care Act (2008) Regulated Activities Regulations 2014: Regulation 12 Safe Care and Treatment

Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises (2021) NHS England » Health Technical Memorandum 03-01: Specialised ventilation for healthcare premises

Equality, diversity and inclusion implications

No issues to consider

Environmental sustainability implications

No issues to consider

Group Healthcare Associated Infection Report
Group Board, 06 March 2025

1.0 Purpose of paper

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

2.0 Summary of key performance measures

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

3.0 Key Issues:

3.1 *C. difficile Infections* (CDI): There has been a substantial increase in the number of healthcare acquired CDI infections across the group. This is in contrast with the consistent decline and low-level fluctuations in CDI cases observed prior to the COVID-19 pandemic.
A briefing note was issued by UKHSA in December 2024 reporting the increase in CDI infections in England and a UKHSA *C. difficile* Technical Group has been formed with further surveillance and recommendations planned to be published in 2025.

ESTH: During Q3 there were 18 Trust attributed CDI cases, (11 Healthcare Onset Healthcare Associated and 7 Community Onset Healthcare Associated). At the time of drafting this paper, the YTD is now 73 which has exceeded the Trust trajectory of 63 for 2024/25.

All cases were reviewed using the PSIRF model to assess if there were any lapses in care. There was only 1 lapse in care identified in Q3 due to noncompliance with Trust antimicrobial policy. YTD number of lapses of care is five, some were due to non-compliance with Trust antimicrobial policy, delay is sampling and or isolation at onset of symptoms.

All samples are routinely sent to the reference laboratory for ribotyping and none of the cases are similar suggesting there is no same strain that is circulating in our hospitals or evidence of cross infection.

The IPC Lead doctor is undertaking an audit on risk factors, diagnosis and management of CDI cases isolated in Q2 of 2024/25. The findings will be shared in the next report.

SGUH: During Q3, there were 13 CDI cases (8 HOHA; 5 COHA). At the time of drafting this paper, the YTD is now fifty-five which has exceeded the Trust trajectory of 43 for 2024/25.

Ribotyping has been received for thirteen cases, all unique therefore ruling our possible cross transmission. Of the thirty-nine cases reviewed to date, 5 cases have been identified as having a lapse in care, due to the inappropriate use of antibiotics.

Despite SGUH breaching monthly CDI targets, a comparison between all NHS Trusts shows that SGUH was within the first quartile range with regard to CDI rates (per 100,000 bed days), meaning

the Trust's performance is within the top 25% of the 135 Trusts who have submitted their figures during Q3 with a rate of 16.47 per 100,000 bed days.

The issues with delays in getting higher level of disinfection such hydrogen peroxide vapour (HPV) use at SGUH not only has an impact on capacity but can impact the ability to reduce the risk of spread of infection in the clinical environment. Currently at SGUH, manual chlorine decontamination is undertaken following discharge of infected patients, however it is essential that due to increased incidences of CDI and other multi resistant organisms, a higher level of decontamination is introduced (similar to the current practice at ESTH) to ensure the risk of onward transmission and environmental colonisation is reduced.

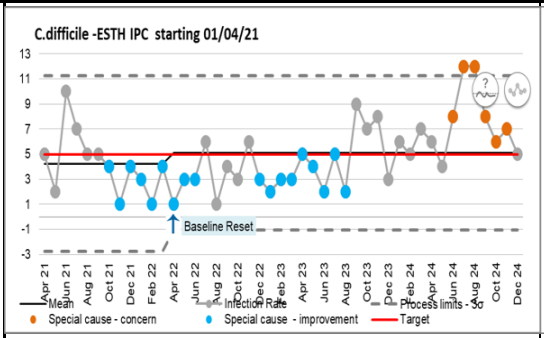
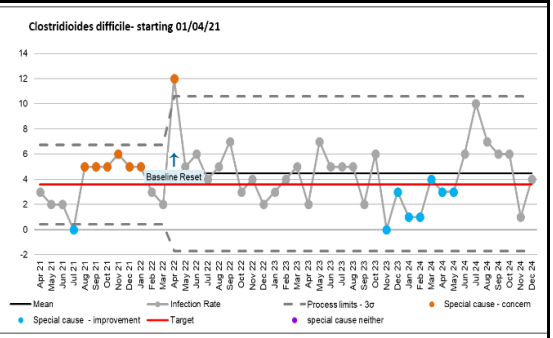
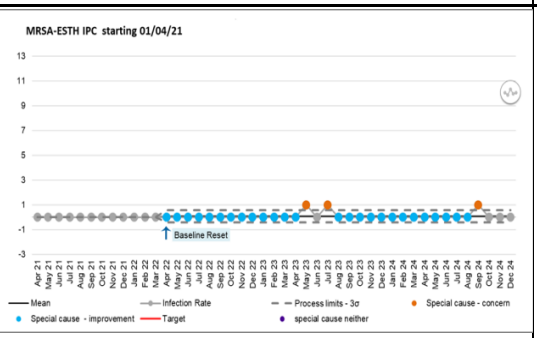
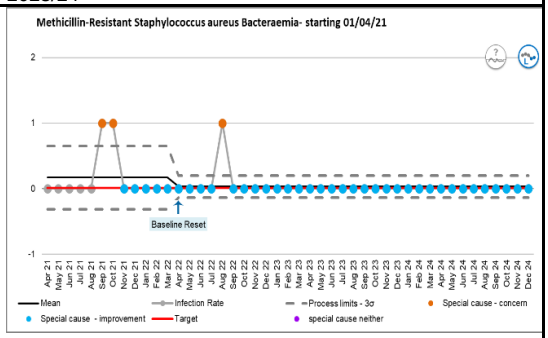
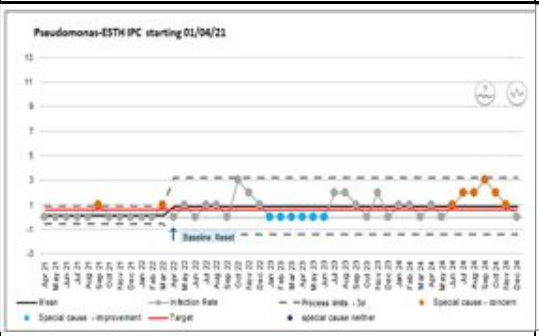
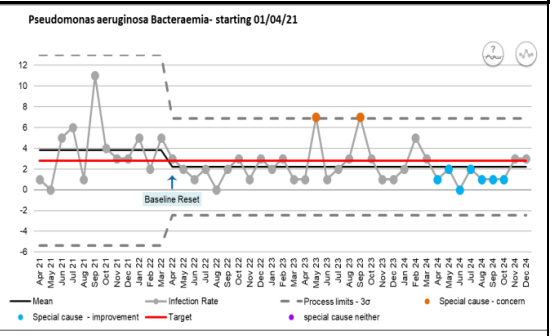
3.2 Influenza A: Consistent with national reports, there was a steep increase in influenza cases across both sites resulting in significant bed pressures.

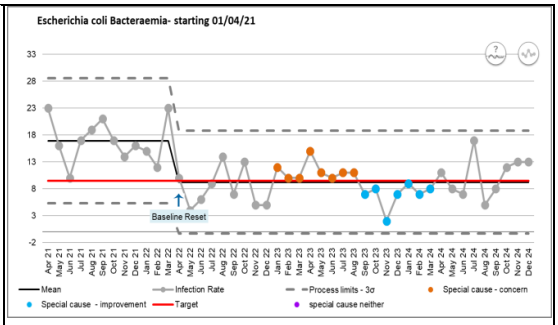
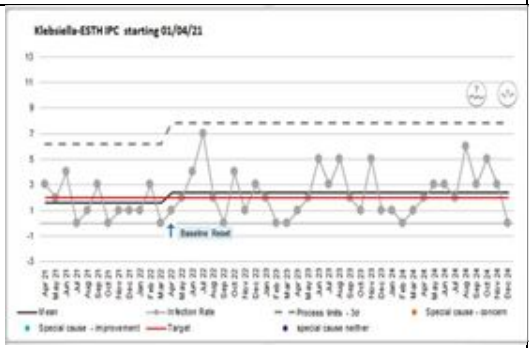
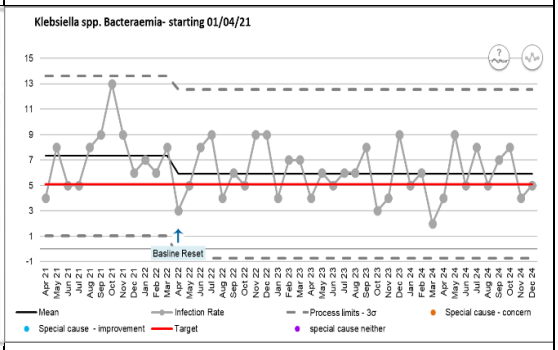
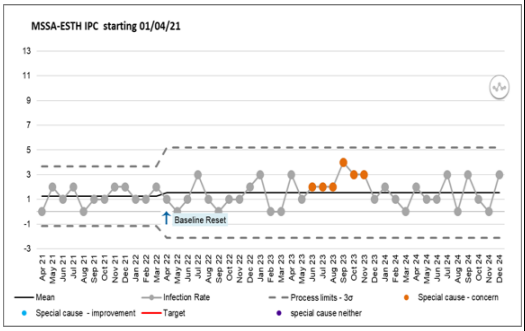
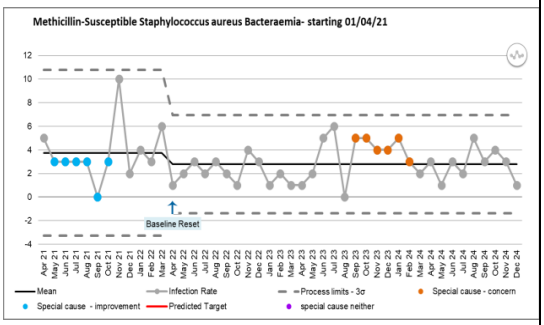
ESTH: In Quarter 3 there were 3 influenza outbreaks resulting in full ward closures and 20 clusters.

SGUH: In Quarter 3 there were 241 cases of influenza resulting in 6 outbreaks with full ward closures.

4.0 Healthcare Associated Infections

The table below summaries the quarterly HCAI position at site level. Efforts continue to aim to reduce the number of gram-negative infections. The IPC team continues to consistently monitor trends and new local/national initiatives to prevent and manage these infections.

HCAI	ESTH	SGUH
C. *difficile* infection		
	During Q3 there were 18 Trust attributed C. difficile cases, (11 Healthcare Onset Healthcare Associated and 7 Community Onset Healthcare Associated).	There were 13 cases of Trust attributed C. difficile infection in Q3 of 2024/25, YTD 48. This is a slight deterioration in performance when compared with 11 cases in Q3 of 2023/24
MRSA bloodstream infection		
	No MRSA bloodstream infections were reported in Q3. YTD is 1, against a threshold of 0.	No MRSA bloodstream infections were reported in Q3. YTD is 0, against a threshold of 0.
Pseudomonas aeruginosa		
	There were 3 *Pseudomonas aeruginosa* bloodstream infections attributed to the Trust during Q3 (1 HOHA, 2 COHA) YTD is 12 which is over the set national threshold 8 cases.	There were 7 *Pseudomonas aeruginosa* bloodstream infections in Q3. YTD 14 against a national threshold of 34. This is a slight deterioration in performance when compared to five cases throughout Q3 of 2023/24

E-coli	 There were 15 cases of *E. coli* bloodstream infections during Q3 (7 HOHA and 8 COHA). YTD is 43 against a national objective of 61 cases.	 There were 40 *Escherichia Coli* bloodstream infections in Q3, YTD 98 against a national threshold of 114. This is deterioration in performance when compared to twenty-five cases during Q3 of 2023/24.
Klebsiella spp.	 There were 9 Klebsiella s*p*. infections reported during this period (6 HOHA, 3 COHA) YTD is 28 cases. The set national objective for 2024/25 is 25 cases.	 There were 18 *Klebsiella spp.* bloodstream infections in Q3, YTD 56 against a national threshold of 62. This is comparable in performance when compared with eighteen cases throughout Q3 of 2023/24.
MSSA	 There is no national trajectory for MSSA BSI. During this period, 4 MSSA infections were reported, bringing YTD total to 14. There is no national threshold	 There were 9 MSSA bloodstream infections in Q3, YTD 26. There is no national threshold. This is an improvement in performance when compared to thirteen cases in Q3 of 2023/24.
Covid-19 Update	Covid-19 positive cases:186 Covid-19 deaths: 14 Nosocomial infections: 60 Nosocomial deaths: 2 **YTD positive cases: 710** **YTD nosocomial deaths: 6**	Covid-19 cases: 159 Covid-19 deaths: 12 Nosocomial infections: 54 Nosocomial deaths: 5 **YTD positive cases: 802** **YTD nosocomial deaths: 27**

5.0 Site Specific Updates

Epsom & St Helier Hospital

5.1 COVID-19: Consistent with national reports, there has been a downward trend for COVID-19 positive admissions across the group. The health group continues to follow national testing and management guidance for COIVD-19.

ESTH: In Quarter 3 there were 201 COVID-19 cases across the Trust.

There were 51 COVID-19 deaths in Quarter 3 compared to thirty-eight deaths in Quarter 2. Four nosocomial deaths met the criteria for a review using the PSIRF model.

Outbreaks: There were 2 outbreaks reported in Quarter 3 on Alexandra and A3 wards.

5.2 Surgical Site Infections Surveillance: The IPC team is undertaking the #Neck of Femur (NOF) SSI module and an optional module for large bowel.

Large Bowel: A total of 18 cases were followed in Q3 and no SSIs were reported. Data collection and reconciliation is in progress and the report will be shared once it has been published by the UKHSA surveillance team.
Fractured Neck of Femur: A total of 84 cases and 1 SSI organ/space have so far been reported for this quarter. The patient with the SSI, underwent a left dynamic hip screw (DHS) surgery on 25/11/24 and the infection was identified on 26/12/24 whilst the patient was still an inpatient. The patient had a wound washout and revision of DHS on 28/12/24. The patient was treated with antibiotics and discharged home on 29/01/25 on 12 weeks of antibiotics.
SWLEOC continues to undertake continuous orthopaedic surveillance for hips, knees, shoulder and spinal surgeries. Data reconciliation for October to December is in progress and the data will be shared when available.

5.3 Water Safety: Ongoing concerns with water safety across both sites. NNU issues with reduced flow rate, mitigations in place. Estates will be undertaking an in-depth survey to rule cause of the slow rate of water on NNU. Extensive water sampling to test for legionella and pseudomonas (400 samples) has been conducted across the maternity/NNU wing (E block) to test the integrity of our water system and inform actions that need to be undertaken. Results/outcomes will be discussed at the Water Safety Group with the Trust external Authorising Engineers (W) and action plans will be shared with relevant stakeholders

5.4: IPC Awareness Week: The IPC team participated in the international IPC awareness week held between 28th October to 1st November. The theme of the week was 'Moving the needle and reset the clock' on Healthcare Associated Infection (HAI). The aim of the week was to raise awareness of the importance of following basic standard infection prevention and control precautions such as hand hygiene, use of PPE, decontamination of patient equipment and the environment, management of laundry, waste and sharps and how these basic tasks can prevent HAIs.

St George's Hospital

5.6 COVID-19. There were 202 COVID-19 cases reported during Q3, and of these 48 were nosocomial infections. During Q3, there were 16 deaths where the patient tested positive for COVID-19 during their admission, however there were no deaths listed on Part 1A of the death certificate.

5.7 Outbreaks: During Q3, there were 13 COVID-19 outbreaks (mostly where two cases in the same bay were diagnosed with COVID-19).

5.8 Candida auris: There are a few hospitals in and around London with increased rates of Candida auris; an emerging fungal pathogen which can affect both adult and paediatric populations largely within healthcare settings, especially in high-dependency and intensive care units.

Two cases were identified in Q3, and staff followed the local protocol for Candida auris management. There was some learning identified following the management of the two cases in relation to screening.
The IPC team are proposing extending screening to include Candida auris to other areas as highlighted in the group-wide update section. This will align with the new proposed screening guidance that is due to be published by UKHSA in March 2025.

5.9 Surgical Site Infections Surveillance: The IPC team undertakes continuous reduction of long bone fracture SSI surveillance. The current surveillance period of October-December 2024, the results are still pending as the data is being reconciled and due to be submitted to the national portal by 31 March 2025.
In the previous Quarter, 119 procedures were followed up and 3 infections were identified: 1 organ space detected at re-admission; 2 deep incisional detected at re-admission and during admission. It should be noted that this is an improvement compared to the previous surveillance period (April-June 2024) where 5 infections were identified.

However, SGUH continues to be an outlier nationally as quarterly infection rates for long bone surgery of 2.5% is higher than the national benchmark of 0.9%. A Task and Finish Group is being established to review surgical policies and practices including skin preparation, antibiotic prophylaxis, and patient warming prior to procedure and to discuss reported infections. In addition to this, the IPC team is reviewing the surgical site surveillance procedure and is working collaboratively with the Limb Reconstruction specialist nurse to aid in real-time surveillance.

5.10 Hydrogen Peroxide Vapour (HPV) Disinfection: To align practices and in response to the increasing C diff cases, the site has been requested to start using HPV disinfection following discharge of patients with C diff or multi resistant organisms.

It was highlighted as a concern that the HPV machines Mitie had on site, were very old and taking a long time to complete the task, thus impacting on patient flow. Following discussions between Mitie and Facilities and to meet their contractual arrangements, Mitie have agreed to hire newer models and more efficient machines.

Integrated Care: Surrey Downs Health & Care and Sutton Health & Care

5.11 Sutton Health & Care Reablement Unit: Several COVID-19 clusters/outbreaks were reported in Q3. IPC action plan implemented due to recurrent themes and non-compliance with basic IPC practices and the ward remains on enhanced surveillance.

5.12 Surrey Downs Health and Care, Mary Seacole Unit: Influenza A outbreak in December which resulted in bay closure and a Norovirus outbreak in December resulting in full ward closure and affecting fifteen patients. Incident meeting was held, and relevant IPC precautions were implemented.

6.0 Group IPC Update

6.1 Group wide activity in Quarter 3 is summarised below:

- **Group policies:** the IPC leads across the group are in the process of updating policies and merging suitable ones to group policies. Seven polices have been updated as group policies and 3 are awaiting ratification.
- **High Consequence Infectious Diseases (HCID):** both site IPC lead nurses have been tasked with leading the implementation of the HCID e.g. Ebola, Mpox etc. pathway and ensuring both sites have an agreed pathway with ED/Infectious Disease teams in the event of admitting a suspected/confirmed case. Infection Control nurses have attended the NHS England HCID training and efforts are currently in place to cascade the training to ED/infectious disease teams. There are issues with acquiring some of the recommended PPE nationally, however both sites have managed to acquire relevant /equivalent PPE required to manage cases on the HCID pathway.
- **Ventilation Compliance:** Ventilation non-compliance across the group is of great concern. This includes some of the theatres on both sites not meeting HTM standards due to aging buildings and lack of funding for remedial actions. An action plan has been requested from Estates team with prioritisation for high-risk areas and consideration for additional funding to remedy the works being of high priority. It should be noted that no immediate clinical risks to patients have been reported and IPC continues to risk assess and work collaboratively with estates colleagues to ensure maximum safety for patients.
- **Winter Respiratory Activity:** Group wide communication was sent out to all staff reminding both staff and visitors of increased respiratory activity and to wear masks as appropriate. A decision was made not to mandate wearing of masks and instead the key messaging focused on emphasising the importance of other controls including vaccination
- **Admission Screening in High-Risk Areas:** IPC is reviewing the criteria for admission screening in high-risk areas (ITU, PICU, coronary care units and NICU) to include other multi resistant organisms such as VRE and Candida auris. Currently on both sites, all admissions into the above areas are screened for MRSA and (CPE if they meet the criteria). Introduction of Candida auris is in response to the reported increased incidences of cases in some of the London hospitals and recommendations from the pending updated national guidance from UKHSA. A briefing paper will be written for executive approval as there is a cost implication and impact on our current contractual arrangements with SWL Pathology services.
- **Nurse-led Vascular Access Service:** Following the integration of vascular access into corporate nursing, SGUH has appointed a substantive Vascular Access Service lead. Work has begun with the two site leads to review standardising practices, products and policies across the group.
- **Fit Testing Service:** both hospitals now have established fit testing service with substantive staff.
- **HPV machines:** Business case is being written to source funding for HPV and or UV light machines for higher level of decontamination for both sites.

7.0 Recommendations

7.1 The Group Board is asked to:

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

Group Board

Meeting in Public on Thursday, 06 March 2025

Agenda Item	4.2	
Report Title	**Group Accountability Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Group Board (Private)	6 February 2025
	Group Executive Committee	21 January 2025
	Group Executive *(workshop)*	14 January 2025
	Group Executive *(workshop)*	10 December 2024
Purpose	**For Assurance**	

Executive Summary

This paper sets out the Group Accountability Framework as approved by the Group Board in private session on the 6 February 2025. The Framework builds on the Group Operating Model, developed in 2022, and has been developed through two Executive workshops in December 2024 and January 2025, and through the Group Executive Committee.

Over the course of its first three years of operation, the Group has evolved its ways of working and processes and mechanisms of accountability. The purpose of the Group Accountability Framework is to codify how the St George's, Epsom and St Helier University Hospitals and Health Group currently operates and how its constituent Trusts, Sites, Divisions and Group-wide corporate services function and interact to support the delivery of the gesh Group strategy, *Outstanding Care, Together.* Rooted in the Group's strategy, the Framework provides a structured approach that defined roles, responsibilities, reporting mechanisms and expectations to ensure effective governance, performance and continuous improvement across the Group. The objectives of the Framework are to:

- Align the Group's strategic objectives with the day-to-day operation to the Group and the delivery of safe, high quality and sustainable patient-centred care
- Establish robust performance monitoring to track, evaluate and report key performance indicators for quality, operational performance, financial sustainability and people.
- Support effective financial stewardship, value for money and operational delivery across the Group by clarifying responsibilities for developing, delivering and reporting on the constituent Trusts' financial and operational plans
- Support staff empowerment and engagement by clarifying the responsibilities delegated and defining accountability as a shared commitment to outstanding care
- Help to embed a culture of continuous improvement and learning
- Facilitate openness, transparency and public accountability in the delivery of services to patients, staff and local communities

A number of supporting principles are set out which underpin the Framework, and the accountability relationships are defined, with worked examples across quality performance, operational performance and financial performance.

The Framework seeks to define the current operation of the Group and seeks to be a statement of the present rather than act as a vision or strategy for how relationships should evolve in the future. The

Framework will need to be reviewed and updated as the Group develops, and in particular as Group-wide clinical services begin to be established and the Group introduces Group-wide clinical networks. As a result, it is proposed that the Group Board review the Group Accountability Framework on an annual basis (and earlier if there are material changes in the operation of the Group) to ensure that the Framework is, at all times, an accurate reflection of the operation of our Group, with the Audit Committee seeking assurance on its effective operation in line with its responsibilities in relation to governance, risk and internal control.

Action required by Group Board

The Group Board is asked to note the decisions made at the Group Board (Private) on 6 February 2025:

a. Approval of the Group Accountability Framework;
b. Noted that the Framework will need to evolve in line with the development of the Group, in particular as Group-wide clinical services and clinical networks are established;
c. Agreed that the Group Accountability Framework is reviewed by the Group Board on an annual basis (or earlier as required)

Committee Assurance	
Committee	N/A – Group Board
Level of Assurance	N/A

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Accountability Framework

Implications

Group Strategic Objectives

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

Risks

If the Group does not have clearly defined accountability structures and mechanisms, there is a risk that the Group – and its constituent Trusts – will not be robustly governed and that this impacts on the ability of the Group to delivery is strategic objectives across the CARE framework.

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

The Group Accountability Framework defines the accountability and governance mechanisms across the Group as a whole, as well as within the two constituent Trusts as separate legal entities. The regulation of the two Trusts by NHS England and the CQC is undertaken on a Trust-basis.

Equality, diversity and inclusion implications

There are no EDI implications related to the proposed accountability mechanisms set out in this report.

Environmental sustainability implications

There are no environmental sustainability implications of this report.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NHS
St George's, Epsom
and St Helier
University Hospitals and Health Group
Group Accountability Framework
Supporting the delivery of outstanding care, together
Approved by Group Board: 6 February 2025
Version 1.0

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

Purpose of the Group Accountability Framework

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The gesh Group Accountability Framework sets out how the St George's, Epsom and St Helier University Hospitals and Health Group operates, and how its constituent Trusts, Sites, Divisions and Corporate Services function and interact to support the delivery of the gesh Group Strategy, *Outstanding Care, Together*.

Rooted in our Group Strategy, the Framework provides a structured approach that defines roles, responsibilities, reporting mechanisms and performance expectations to ensure effective governance, performance, efficiency and continuous improvement. It underpins patient safety, the quality, performance and sustainability of services, and ensures transparency in our operations and decision-making to our patients, staff and the communities we serve.

Purpose of the Accountability Framework

- Defines roles and responsibilities with clear delineation of duties, responsibilities and accountabilities across the Group from the Board to the front line, helping to ensure staff across the Group understand their role in the delivery of the Group Strategy
- Promotes effective governance, risk management and escalation, robust assurance, sound, agile decision-making, and compliance of the constituent Trusts of the Group with their statutory and regulatory responsibilities
- Supports continuous improvement across the Group at all levels
- Facilitates transparency, trust and confidence in the operation of the Group among patients, staff, local communities, partners and regulators

Objectives of the Accountability Framework

1. Align the Group's strategic objectives with the day-to-day operation to the Group and the delivery of safe, high quality and sustainable patient-centred care
2. Establish robust performance monitoring to track, evaluate and report key performance indicators for quality, operational performance, financial sustainability and people.
3. Support effective financial stewardship, value for money and operational delivery across the Group by clarifying responsibilities for developing, delivering and reporting on the constituent Trusts' financial and operational plans
4. Support staff empowerment and engagement by clarifying the responsibilities delegated and defining accountability as a shared commitment to outstanding care
5. Help to embed a culture of continuous improvement and learning
6. Facilitate openness, transparency and public accountability in the delivery of services to patients, staff and local communities

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University Hospitals and Health Group

Principles underlying the Framework

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An Accountability Framework is only as strong as the culture of accountability we create. How we work, our behaviours and actions, will determine whether the Accountability Framework works effectively in practice. To support that culture of accountability, this Framework sets out a clear set of principles for how we operate as a Group leadership community:

- **Alignment with strategic objectives:** The Framework should support the delivery of the Group Strategy and the strategic objectives set out in the CARE framework (Collaboration and Partnership; Affordable Healthcare, Fit for the Future; Right Care, Right Place, Right Time; Empowered Engaged Staff)
- **Clear delivery expectations:** There should be clear, agreed objectives and measures of success for each part of the Group, which support delivery of the Group's vision, goals and strategic priorities
- **Consistency in setting standards:** there should be consistent standards developed and applied to all services regardless of which Site provides them
- **Common rules-based approach:** there should be clarity over the triggers for intervention, at hospital and divisional level. These should be proportionate to risk.
- **Localise where possible but centralise where necessary:** authority and accountability should be as close as possible to patient services, while recognising that the role of Group Leadership needs to be 'tighter' in certain circumstances.
- **Accountability at all levels:** Accountability must be embedded throughout the Group at every level, from the Board to the ward
- **Encouraging openness, honesty and integrity:** Processes should promote openness and honesty over issues and risks, and the support needed, and promote ethical behaviour, fairness and integrity in decision-making and practice
- **Recognise inter-dependencies within the Group and with other partners:** there are clear inter-dependencies within the Group between the hospitals and between all components of the Group model. There are also clear inter-dependencies with the wider system.
- **Equity and Inclusion:** there is a compassionate and inclusive leadership culture across all parts of the organisation and at every level
- **Responsiveness and Adaptability:** The Framework must be flexible enough to respond to changing circumstances, such as the evolving needs of patients, staff and communities, and the changing policy and regulatory landscape within which the Group operates

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University Hospitals and Health Group

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Overview and purpose of the Group Model

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

Our gesh Group Model

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The context

The St George's, Epsom and St Helier University Hospitals and Health Group comprises two statutory entities, St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust.

After years of collaboration and creating closer working ties, the two Trusts agreed to form a Group in June 2021. Working as a Group allows for more joined-up decision making for the benefit of our patients, staff and the communities we serve – strengthening our clinical services and improving outcomes, greater access to a wider range of services, reduced variation in levels of care, a more resilient clinical and corporate workforce.

Our Group strategy, *Outstanding Care, Together* sets out the Group's vision and strategic objectives through to 2028 – for greater collaboration, delivering affordable healthcare fit for the future, delivering the right care at the right place at the right time, and fostering an engaged empowered staff. Our Group is led by a Group Board and a single Group Executive team. Our our Board Committees meet as Committees-in-Common and a number of our key governance groups are now Group-wide forums.

The separate corporate services of the two Trusts are in the process of coming together as Group-wide support services, with Corporate Nursing, Communications, Corporate Affairs and the Deputy Chief Executive's Office having already formed Group-wide teams, with Corporate Medical, Human Resources, Finance, Digital and Estates and Facilities moving along the same path. Plans are also in development for the formation of Group-wide clinical services, with a Group Pharmacy Strategy approved by the Board in September 2024, a Group Surgery Strategy in development, and move towards the consolidation of renal services on the St George's site. Group-wide clinical networks are also in the process of being established to provide leadership and set consistent standards.

The Group, however, is not a legal form in itself, and the collaborative arrangements established through the Group model and set out in this Accountability Framework are ultimately discharged through the governance of each sovereign Trust within the Group.

NHS
St George's University Hospitals
NHS Foundation Trust

NHS
Epsom and St Helier
University Hospitals
NHS Trust

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

Our gesh Group Model

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The benefits of Group working

We formed the gesh Group to deliver outstanding care, together for our patients staff and the communities we serve. We believe that working as a Group enables us to deliver better care than we can as two separate organisations working independently. We see the following benefits and further potential in working as a Group:

- **Driving improvements in quality of care:** Ensuring improved use of specialist input through scale and driving greater specialisation, sharing leadership and talent, sharing learning and best practice across a larger footprint, and using our scale to working differently with our partners to provide care closer to home.
- **Providing improved service resilience:** Increasing service size and pooling specialist services across the group, improving recruitment and retention through increased development opportunities and improved training and development
- **Improving timely access to services:** Through increasing throughput through creation of specialist centres and single points of access, improving patient choice and shared approach to waiting lists, and providing mutual aid
- **Delivering improvements in equity:** Reducing unwarranted variation across our sites and using our scale as an anchor institution to work with our partners to tackle health inequalities in our communities
- **Delivering financial benefit:** By streamlining management structures, reducing duplication, increasing throughput through economies of scale and better matching demand to capacity across the Group.

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

Our gesh Group Model

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The principles underpinning collaboration across the Group

- Focus on the delivery of benefits to our patients and staff of working together as a Group
- Deliver on our aspiration to be clinically-led organisations: empowering clinical teams to develop solutions to their problems, supporting clinical leaders to see and lead all aspects of their service, and ensuring clinicians shape every aspect of how the organisations run
- Take decisions that affect the Group with a single mind, and foster a collective / shared purpose across the wider leadership teams
- Empower the site teams to deliver, and delegate decision-making to lowest appropriate level, supported by a common accountability framework
- Ensure clarity of roles and responsibilities at all levels across the Group to avoid duplication, supported by a standardised governance framework across the sites
- Support Clinical Collaboration and reduce unwarranted clinical variation whilst supporting sites to respond to the different needs of their local communities and to actively embrace the local cultures of the different sites
- Recognise the continuing legal and regulatory requirements of the sites as sovereign statutory organisations – and internal accountabilities of Group Executives as Board members of each Trust

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

Our gesh Group Model

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Our Group structure

Our Group structure consists of:

- **Group Leadership:** Establishes the vision and values for the Group, sets the strategic direction and corporate priorities, shapes the culture, and holds the other parts of the Group to account for delivery. The Group Leadership consists of both the Group Board and the Group Executive. The Site Managing Directors are part of the Group Leadership through their membership of the Group Executive and Group Board.
- **Site Leadership Teams:** Provide operational leadership to our hospitals and community services, and at 'place'. They operate with significant delegated authority for the provision of safe, high quality services, strong operational performance, and robust financial management within the scope of the services for which they are responsible.
- **Group Corporate Services:** Support the hospitals, Site leadership and Group leadership with high quality and responsive corporate support services.

The Group Model seeks to support the right balance between Sites having local freedoms to deliver objectives in a flexible way that meets local needs, while realising the benefits from standardisation overseen by the Group leadership to ensure consistently high standards and equity of care.

Our Group structure continues to evolve:

- **Clinical service collaboration:** The Group is currently developing plans for greater clinical collaboration, with some services sharing leadership and governance arrangements and an aligned clinical model with shared pathways and policies, and others moving towards a single Group-wide service with a single management and governance structure. These are being developed during 2025/26 and their operation will be set out in a future iteration of this Accountability Framework.
- **Clinical networks:** The Group is also developing a number of clinical networks to support the development of common standards and to help reduce unwarranted variation. As these networks are established, the Group Accountability Framework will be updated to reflect the operation of these.
- **System-wide collaboration:** In addition, the Group hosts a number of services as part of the South West London Acute Provider Collaborative, including South West London Elective Orthopaedic Centre, South West London Pathology, and South West London Procurement, while recruitment is delivered through the Group's partnership with South West London Recruitment, hosted by Kingston Hospital.

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University Hospitals and Health Group

Our gesh Group Model

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

Group clinical services
Shared clinical services across the Group – from 2025/26

Our hospital and community sites

- Epsom & St Helier acute site
- St George's acute site
- Integrated Care site

Partnership services
Delivered through the SWL APC

- South West London Elective Orthopaedic Centre
- South West London Pathology
- South West London Procurement
- South West London Recruitment

Group corporate services

- Estates & Facilities
- Information Technology
- Finance
- Human Resources
- Corporate Nursing
- Corporate Medical
- Deputy CEO Office
- Corporate Affairs
- Comms

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University Hospitals and Health Group

A 'well led' Group

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Our Group model supports both of our Trusts in being 'well led' organisations, as defined in the new CQC Well Led KLOEs:

Shared Direction and Culture	**Capable, Compassionate and Inclusive Leadership**	**Freedom to Speak Up**
The **Group Board** sets the strategic direction for the Group and defines the annual corporate objectives linked to the Group strategy. The Group Board shapes culture across the Group, seeking to create an inclusive, engaged and empowering culture within which our clinical and corporate teams can flourish.	The **Group Board, Group Executive, Sites and Group Corporate Services** seek to foster capable, compassionate and inclusive leadership at every level of the Group. The **Group Executive** sets the leadership standards, learning offer and framework for talent management, which is delivered locally.	The **Group Board, Group Executive, Sites and Group Corporate Services** work to promote a culture of psychological safety in which all staff feel safe and supported to raise concerns, without fear of detriment.
Environmental Sustainability	**St George's, Epsom and St Helier University Hospitals and Health Group**	**Workforce Equality, Diversity and Inclusion**
The **Group Board** sets the strategic priorities for delivering our commitments to environmental sustainability through the Group Green Plan. The **Group Executive, Sites and Group Corporate Services** work to deliver the objectives established by the Group Board.		The **Group Board, Group Executive, Sites and Group Corporate Services** work to foster an inclusive culture that promotes equality and values diversity. The **Group Board** sets the standards and EDI initiatives are delivered by the **Sites and Group Corporate Services**.
Learning, Improvement and Innovation	**Partnerships and Communities**	**Governance, Management and Sustainability**
The Group Board, Group Executive, Sites and Group Corporate Services ensure the necessary processes and capabilities are in place to support learning, improvement and innovation. The Group Executive is developing a single continuous improvement methodology in partnership with the Sites.	The **Group Board and Group Executive** lead on engagement with the two systems within which the Group operates. **Sites** lead on engagement at 'place'. **Group Corporate Services** provide support to engagement with partners and the local community.	The **Group Board and Group Executive** holds the group to account and leads a governance framework that connects to the wider system and supports regulatory compliance. Sites and Group Corporate Services work within the governance structures and accountability framework to deliver services.

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University Hospitals and Health Group

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Our Vision and Strategy

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

Our vision and strategy

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Vision

Our vision for 2028 is simple but powerful – we will offer outstanding care, together

Strategic Objectives

C – Collaboration and partnership

To deliver improvements in quality of care while taking difficult decisions to make our services sustainable for the long term, we will play a leading role in integrating services around the needs of our patients. Our vision is that by 2028 gesh will be a driving force behind the most integrated health and care system in the NHS, and will be recognised as a national exemplar for integrated working – working with GPs, local government and community partners to keep people well in the community and avoid unnecessary trips to hospital, integrating services across the gesh Group, collaborating with other hospitals in south west London on shared services, elective recovery and financial sustainability, and working through regional networks to integrate our tertiary services with primary and secondary care.

A – Affordable healthcare, fit for the future

We will make our services sustainable for future generations. By 2028, we will have taken the difficult action required to break even each year financially. We will have reduced our carbon footprint, and be on our way to net zero by 2040. We will have modernised key parts of our estate, and made major strides in adopting digital technology. Additionally, we will be a thriving centre for research and innovation, playing our part in the development of tomorrow's healthcare.

R – Right care, right place, right time

We will offer high-quality care to our patients. In 2028, waiting times for our services will be among the best in the NHS, and we will have an outstanding safety culture, delivering lower than expected mortality rates and a reduction in avoidable harm. We will also be improving outcomes and patient experience, and working with our partners to tackle health inequalities in our communities.

E – Empowered, engaged staff

To square the circle of delivering improvements in quality of care while taking difficult decisions to make our services sustainable for the long term, we will need to make best use of our greatest asset – our highly skilled, committed workforce. Our vision is that by 2028 gesh will be among the top five acute trusts in London for staff engagement. This will involve getting the basics right for our employees, putting staff experience and wellbeing at the heart of all we do, fostering an inclusive culture that celebrates diversity and embeds our values, developing tomorrow's workforce, and supporting our staff to work differently.

Our approach to delivering our strategy

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

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University Hospitals and Health Group

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Accountability through our Group Governance Structures

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

Overview of Group Governance Structures

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Establishment of Group governance structures

The gesh Group comprises St George's University Hospitals NHS Foundation Trust and Epsom and St Helier University Hospitals NHS Trust, as two legally separate entities working together collaboratively the through the Group. Group governance structures have been put in place to facilitate and govern the collaboration of the two Trusts through the Group model: a Group Executive was formed in February 2022, Committees-in-Common started operating from April 2022, a Group Board was formed in April 2023, and the Group Executive Committee and a series of Group-wide sub-groups have been established over the course of the past 18 months.

The continued sovereignty of the separate Trust Boards and the two Trusts as separate legal entities

The Group governance structures that have been established since February 2022 help the Group operate with a common strategy and take decisions with a Group-wide perspective. At all times, however, the Group structures derive their authority from the two Trusts as sovereign legal entities and the separate Boards of Directors that are legally accountable for leading the two Trusts. Both Trusts hold separate CQC registrations, are required to submit separate annual plans to NHS England, and are required to prepare separate annual reports and accounts. The external regulatory environment regulates the Group at the level of the Trust, and the two Trusts are therefore held to account externally on the basis of Trust-level quality, financial and operational performance.

The practical operation of Group governance structures

In establishing the governance of the Group, the two Trust Boards therefore retain ultimate accountability for the governance of each Trust as separate legal entities.

- **The Group Board:** The two separate Trust Boards have established the Group Board as a Committees-in-Common arrangement. There is a Group Board Committee (St George's) and a separate Group-Board Committee (Epsom and St Helier). They meet concurrently, with a shared agenda and with substantial delegated authority from each Trust Board. Each Group Board Committee remains, at all times, accountable its respective Trust Board, has its own distinct membership and must be quorate in its own right.
- **Committees-in-Common:** Committees-in-Common have been established for the Quality, Finance, People, Infrastructure, Audit and Remuneration Committees of the two Trusts. When a Committee meets in-common, it is a meeting of the relevant SGUH Committee and a meeting of the equivalent ESTH Committee, meeting at the same time and with a shared agenda. Each Committee has its own distinct membership and must be constituted and quorate at all times. The Committees remain accountable to the separate Trust Boards, but submit reports to the Group Board to facilitate Group working.
- **Group Executive:** The Group Executive team are the Executive Directors of St George's and of Epsom and St Helier. It is accountable to the two separate Trust Boards for the delivery of the strategy and for the quality, financial and operational performance of each Trust but, in practice, this accountability to the Trust Boards operates through the Group Board structure.
- **Executive sub-groups:** These are Group-wide decision-making forums with distinct subject-specific remits, intended to support the Group Executive Committee in discharging its responsibilities and seeking assurance from Sites and Group Corporate Services for quality, financial and operational performance.
- **Site Leadership teams:** The three Site leads lead the delivery of acute care at St George's and Epsom and St Helier and community services through the Integrated Care Site. The clinical services delivered by both Trusts are delivered in practice by the Sites and the Divisions which report into them.

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University Hospitals and Health Group

High-level Group Governance Structure

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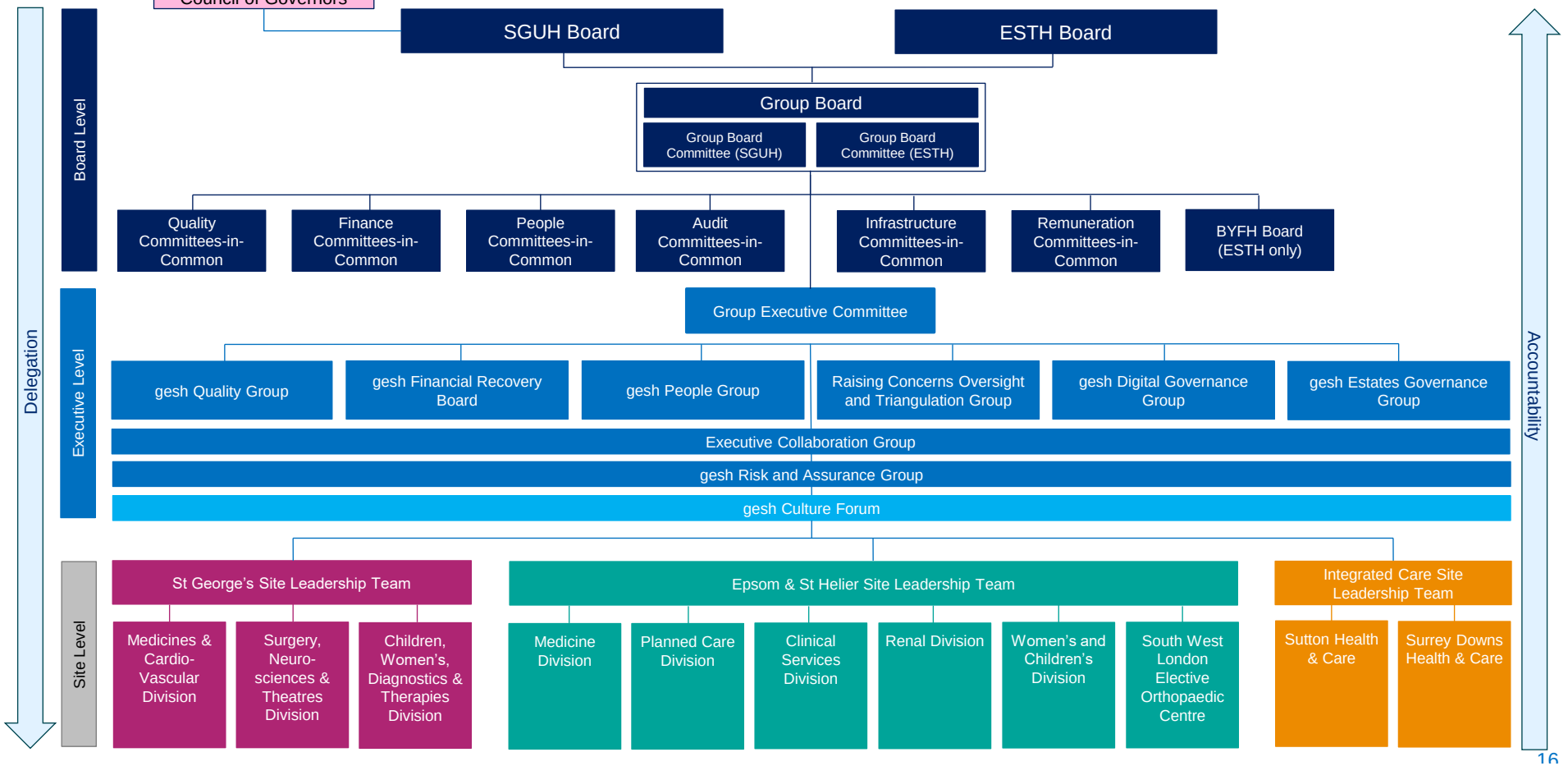

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St George's, Epsom and St Helier
University Hospitals and Health Group

Board Governance Structure

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Group Board

***Chair:* Group Chairman**

Sets strategy for the Group and for the two constituent Trusts

Holds Executive team accountable for the performance of the Group and its two constituent Trusts

Shapes culture of the two Trusts and Group-wide

Quality Committees-in-Common

Chair: Andrew Murray

Oversight and assurance on the delivery of the Group Quality and Safety Strategy

Oversight and assurance of the development and delivery of the research and innovation strategy

Oversight of strategic risks relating to quality on the Group BAF

Provides assurance to the Boards on the safety and quality of care to patients

Seeking assurance that the Trusts has in place effective quality governance

Oversight and assurance on key quality metrics

Finance Committees-in-Common

Chair: Ann Beasley

Oversight and assurance on the delivery of the financial and operational performance objectives set out in the Group Strategy

Oversight of strategic risks relating to finance and operational performance on the Group BAF

Oversight and assurance of the development and delivery of the two Trusts' financial and operational plans

Oversight and assurance on the delivery of Cost Improvement Plans

Oversight of the two Trusts' performance through the Integrated Quality and Performance Report

Review / approval of business cases within delegated authority

People Committees-in-Common

Chair: Yin Jones

Oversight and assurance on the delivery of the Group People Strategy

Oversight of strategic risks relating to people on the Group BAF

Providing assurance to the Boards on the development of a sustainable, engaged and empowered workforce that supports the delivery of safety, high quality care

Monitoring key performance indicators relating to people

Oversight and assurance on culture, equality, diversity and inclusion, and staff wellbeing

Oversight of education and training

Infrastructure Committees-in-Common

Chair: Ann Beasley

Oversight and assurance in relation to the delivery of the estates and digital commitments in the Group strategy and Group Green Plan (and oversight of the development of a Group Estates strategy and Group Digital strategy)

Oversight of strategic risks relating to estates and digital on the Group BAF

Providing assurance to the Boards on the operation of the Trusts' estates, facilities, and digital and information technology infrastructure

Seeking assurance in relation to health and safety and measures to tackle violence and aggression against staff

Audit Committees-in-Common

Chair: Peter Kane

Provides a objective review of each Trust's financial accounts

Review the findings of external auditors and the annual external audit plan

Approval of annual internal audit plan and review of individual internal audit reports and themes

Review of Annual Report and Account for each Trust

Provides assurance to the Boards on governance, risk management and internal control

Oversight of cybersecurity and information governance

Oversight of counter fraud

Remuneration Committees-in-Common

Chair: Group Chairman

Setting of remuneration of Executive Directors and VSM staff

Oversight of Executive and VSM appointments

Oversight of Executive and VSM performance

Oversight of severance and exit packages for Executives and VSM in line with national policies

Oversight of Employment Tribunal settlements above a defined threshold

BYFH Board *(ESTH only)*

Chair: Phil Wilbraham

Set the direction and framework for the Building Your Future Hospital (BYFH) programme

Oversee and seek assurance on the delivery of the BYFH programme and programme plan

Review and approve (within delegated limits) financial expenditure on the delivery of the programme

Seek assurance in relation to the risks to the BYFH programme

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University Hospitals and Health Group

Executive Governance Structure

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Group Executive Committee

Chair: **Group GCEO**

Oversight of the delivery of the Group Strategy, delivery of Group benefits, and quality, operational, financial and workforce performance across the Group

gesh Quality Group

Chair: GCNO / GCMO

- Oversight of delivery of the Quality and Safety Strategy
- Development and monitoring delivery of Quality Priorities
- Oversight of consistent and effective Quality Governance
- Sets common Group-wide policies and standards
- Focus on areas of unwarranted variation, Group-wide learning
- Oversight Group QIA process
- Oversight of significant external quality reviews
- Reporting, insights and assurance prior to Quality Committee

gesh Financial Recovery Group

Chair: GCFO

- Oversight of financial delivery across the Group – against plan for both Trusts and in relation to CIP programmes
- Sets common Group-wide policies and standards for finance and financial reporting
- Finance reporting, insights and assurance prior to Finance Committee

gesh People Group

Chair: GCPO

- Oversight of delivery of the Group People Strategy
- Leads on the High Performing Teams & Culture, Diversity and Inclusion Strategic Initiatives
- Sets common Group-wide policies and standards
- Sets framework for workforce planning
- Oversight of agreed workforce KPIs and focus on areas of unwarranted variation
- Workforce reporting, insights and assurance prior to People Committee

Raising Concerns Oversight & Triangulation Group

Chair: GCCAO

- Oversight of management of concerns in an effective and timely way
- Triangulation of concerns with wider metrics to identify challenged services and hotspot areas requiring support / intervention
- Oversight of learning from concerns
- Sets common Group-wide policies and standards for raising concerns
- Reporting, insights and assurance prior to review by Committee and Board

gesh Digital Governance Group

Chair: GCFO

- Oversight of the development of the Group Digital Strategy and of delivery once agreed by the Group Board
- Sets common Group-wide policies and standards for digital, IT and IG
- Oversight of Informatics projects and KPIs across the Group
- Digital, IT, IG and Cyber reporting, insights and assurance prior to Infrastructure Committee and Audit Committee (Cyber, IG)

gesh Estates Governance Group

Chair: GCIFEO

- Oversight of the development of the Group Estates Strategy and of delivery once agreed by the Group Board
- Oversight of delivery of the Group Green Plan
- Oversight of significant statutory and regulatory compliance
- Estates, Facilities and Health & Safety reporting, insights and assurance prior to Infrastructure Committee

Executive Collaboration Group *Chair: Deputy CEO*

Leads on the oversight, coordination and delivery of the collaboration across the Group, including both corporate and clinical services collaboration, and the development of the Group model.

gesh Risk and Assurance Group *Chair: GCCAO*

Oversees the key risks across the gesh Group, ensuring these are appropriately managed and mitigated. Ensured common standards and a consistent approach to the management of risk across the Group.

Group Culture Forum *Chair: GCEO*

Engagement forum to understand the lived experience of staff, develop the culture of the Group and develop initiatives to promote staff engagement and equality, diversity and inclusion.

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

Group Executive Team

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GROUP CHIEF EXECUTIVE

Jacqueline Totterdell

EXECUTIVE DIRECTORS

James Marsh Deputy Chief Executive	**Richard Jennings** Group Chief Medical Officer	**Arlene Wellman** Group Chief Nursing Officer & DIPC	**Andrew Grimshaw** Group Chief Finance Officer	**Victoria Smith** Group Chief People Officer	**Mark Bagnall** Group Chief Infrastructure, Facilities and Environment Officer	**Stephen Jones** Group Chief Corporate Affairs Officer	**Anna Macarthur** Group Chief Communications and Engagement Officer	**James Blythe** Managing Director Epsom & St Helier	**Kate Slemeck** Managing Director St George's	**Thirza Sawtell** Managing Director Integrated Care
Strategy	Quality Governance	Quality Governance (Lead)	Finance	Recruitment	Estates	Corporate Governance	Internal Comms	Epsom & St Helier Acute Services	St George's Acute Services	Sutton Health and Care
Integration	Patient Safety	Patient Safety (Lead)	Procurement	Employee Relations	Soft Facilities Management	Risk Management	Media, Content and Campaigns	Business Continuity and EPRR	Business Continuity and EPRR	Surrey Downs Health and Care
Performance and PMO	Mortality	Infection Prevention & Control	Counter Fraud	Workforce Transformation	Health and Safety	Legal Services	Public Affairs inc. BYFH	Place Lead – Sutton	Place Lead – Wandsworth & Merton	
Continuous Improvement	Clinical Audit	Patient Experience	Digital and IT	Culture and OD	Violence & Aggression	FTSU Executive Lead				
	Bereavement	Complaints and PALS	Information Governance	Equality, Diversity and Inclusion	Green Plan	Executive and Site Support				
	Health Inequalities	Safeguarding	Cybersecurity	Staff Health and Wellbeing	Patient Transport					
	Research & Development	Chaplaincy	Senior Information Responsible Officer	Occupational Health						
	Medical Education	Non-Medical Education								
	Professional Medical Leadership	Professional Nursing Leadership								
		Professional AHP Leadership								

The gesh Group Operating Model is underpinned by a clear Group Leadership structure to enable:

- Optimisation of collective resources to enable more effective and collaborative working
- Clear lines of formal accountability underpinned by matrix working
- Realisation of the benefits of the Group model

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Accountability Relationships

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Accountability Relationships

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We have defined the specific roles, responsibilities and contributions of the Group Executive, Sites leadership teams, and Group-wide Corporate Services in relation to the delivery of our Group Strategy and

Values

Our values are fundamental to providing outstanding care together and inform and shape everything we do. They define how we will work to deliver outstanding care, the behaviours we expect and through which we hold ourselves and each other mutually to account.

Strategy

The Group Strategy provides the unifying vision and strategic objectives for the Group as a whole at Board, Executive, Site, Divisional and Service Level. The CARE framework is being cascaded throughout the Group to provide a common framework for delivery.

Board & Committees	Group Executive	Sites	Divisions
The Boards of the two Trusts, via the Group Board arrangement, set strategy, shape culture and hold the Executive team to account for the performance of the two Trusts within the Group. Board Committees seek and provide assurance to the Group Board about performance of the Trusts, the delivery of relevant corporate enabling strategies, and the management of strategic risks.	The Group Executive is accountable to the Group Board for the delivery and implementation of the strategy, overseeing the overall performance of the Trusts, and fostering a culture and common framework for continuous improvement. It is responsible for the operation of the Group model and the realisation of Group benefits, taking decisions on mutual aid and resolving trade-offs between quality, performance and finance with significant regulatory implications. It oversees strategic and significant operational risk.	Sites are accountable to the Group Executive for the delivery of safe, high quality and sustainable services, and for the deployment of the strategy and the promotion of a culture of continuous improvement across the Site. They are responsible for building the Site financial and operational plans bottom up, the development of clinical services, and delivery of performance standards, making trade-offs between quality, performance and finance and escalating trade-offs with significant regulatory implications.	Divisions (and Partnerships for Integrated Care Site) are accountable to the Sites for the design and development of services, the provision of safe, high quality and sustainable services within their remit. They promote a culture of CI across their services. They help build the Site finance and operational plan bottom up and are accountable for delivering agreed performance standards. Divisions balance quality, performance and finance, and escalate significant trade-offs to the Site leadership team.

Delegation & Empowerment, Support & Challenge

Assurance, Accountability & Escalation

Corporate Services

Group Corporate Services provide specialist corporate support across the Group – to Divisions, Sites, the Group Executive and the Group Board. These services include Communications, Corporate Affairs, Corporate Nursing and Medical, Digital, Estates, Finance and Human Resources. Group Corporate Services accountable to the Group Executive for the delivery of agreed performance standards, and are responsible for providing professional, high quality corporate services to the Sites.

Accountability Framework

The Group Accountability Framework outlines the accountabilities and relationships between the different components of the Group and sets out how accountability operates in practice.

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The role of the Trust Board and Group Board

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Role of the Group Board and Board Committees

Under our Group Model, the two sovereign Trust Boards have delegated extensive authority to the Group Board (operating as Committees-in-Common) to discharge many of their functions. On behalf of the two Trust Boards, the Group Board:

- **Sets the strategic direction** of the Group, and its constituent Trusts
- **Oversees the delivery of high quality and effective care** for all patients and service users, drawing on timely information and data
- **Shapes the culture of the organisation**, seeking to ensure the Group has an open, curious and transparent culture which supports the sharing of information, provides psychological safety and fosters learning and improvement, and promotes the values of the Trusts
- **Ensures effective governance** arrangements are in place across the Group to lead the organisation effectively and meet all statutory and regulatory requirements

Board Committees support the Group Board and Trust Boards in the discharge of their responsibilities by seeking assurance on behalf of the Board and providing detailed scrutiny in specific areas of governance and activity, and by proving oversight to support effective decision-making.

Accountability of the Group Board

- The Group Board is accountable to its respective Trust Board.
- At St George's, the Non-Executive Directors are accountable to the Council of Governors for the performance of the Board, and through the Council to the members of the Trust. In practice, the Board also has accountabilities through the SWL Integrated Care System and to NHS England.
- At Epsom and St Helier, the Trust Board is accountable to the through the SWL and Surrey Heartlands Integrated Care Systems and has a line of accountability to NHS England and ultimately to the Secretary of State for Health and Social Care.

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The role of the Group Executive

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The Group Executive team comprises the chief officers of the Group, and its constituent Trusts. The members of the Executive team are the accountable Executive Directors on the Boards of the two Trusts.

The Group Executive team is responsible for the overall operational leadership and management of the Group, and of the two Trusts.

The Executive team works closely with the Group Board and the Site Leadership Teams to ensure that both Trusts deliver safe, high quality and sustainable services for patients, staff and local communities, implement the Group Strategy, and meet their respective statutory and regulatory obligations.

A key responsibility of the Group Executive, working with the Board, is to identify and respond rapidly to risks, issues and opportunities arising within and outside the Group. The Group Executive will devolve authority where:

- There are lower levels of statutory and / or regulatory accountability
- There are lower levels of risk associated with service delivery with confidence in capability / capacity to sustain delivery
- There are less significant economies of scale in organisation once at Group level
- It is more important to be agile and to respond rapidly to the local environment
- It is a priority to retain talent on a long-term basis

The Group Executive will support the local Site leadership teams to enact the changes necessary to respond to issues and risks in the best interests of the Site and the wider Group. Within this framework of devolved decision-making, there may, however, be occasions on which it is necessary for the Group Executive to intervene directly.

Role of the Group Executive

- Accountable to the Group Board for the overall performance of the Group (quality, operational and financial), and its two constituent trusts, compliance with statutory and regulatory requirements, delivery of the financial and operational plans of the two Trusts, and the provision of safe, high quality and sustainable services
- Accountable to the Group Board for the effective deployment and implementation of the Group Strategy, and corporate enabling strategies, and Strategic Initiatives
- Responsible for leading the Group model, promoting the values and culture necessary for effective Group working, and setting the common frameworks, standards, structures and processes to realise the benefits of Group working
- Establish a Group-wide framework, approach and culture to support effective continuous improvement at every level
- Responsible for balancing quality, performance and finance across the two Trusts as legal entities, and agreeing or resolving trade-offs, particularly where these cannot be resolved at Site level or have significant regulatory implications, and for ensuring upward communication of significant trade-offs to the Board
- Responsible for taking decisions in relation to mutual aid across the Group in order to address challenges or to address unwarranted variation e.g. in access
- Responsible for seeking assurance from the Sites on quality, operational and financial performance, and for providing support to operational delivery by the Sites
- Responsible for overseeing the effective governance of the Sites
- Responsible for leading engagement with the ICS and wider system, including where challenges and opportunities facing the Group require system-wide action

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The role of the Sites

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The Sites deliver operational and clinical services on behalf of the Group. Acute services are delivered through the St George's and Epsom and St Helier acute Sites and community services through the Integrated Care Site, working through the Sutton Health and Care and Surrey Downs Health and Care partnerships. Through their local leadership, the Sites enable the delivery of regulatory and statutory requirements by the two Trusts within the Group.

The Sites provide the main interface with our patients and respond to the needs of our diverse communities across South West London and Surrey by ensuring equitable access and safe, high quality and sustainable services. Each Site maintains its own distinct identify within the Group reflecting the services they provide and differences in the local populations they serve. In doing so, the Sites operate within a Group-wide framework designed to address unwarranted variation in access, quality of care and outcomes and to tackle health inequalities in our communities.

As with all parts of the Group, Sites work in a matrix model. Site Directors also have system leadership roles, and each Site has a key role with their respective boroughs and is central to place-based partnerships.

Role of the Sites

- Accountable to the Group Executive for the overall performance of the Site (quality, operational and financial), for the delivery of Site financial and operational plans, and for the provision of safe, high quality and sustainable services across the Site
- Responsible for the effective cascade and implementation of the Group Strategy across the Site.
- Responsible for nurturing local service transformation and service development, and for fostering an empowering culture of continuous improvement across the Sites
- Responsible for developing the Site financial and operational plans within the framework established by the Group Executive, working closely with the clinical divisions to build the plans bottom-up
- Responsible for the oversight of the performance of the Clinical Divisions, of the delivery of Divisional-level financial and operational plans, and for ensuring that there is a robust divisional structure in place to support the delivery of safe, high quality and sustainable care
- Responsible for Site level quality impact assessments, and for taking decisions in relation to trade-offs between quality, performance and finance, and for escalating these (with options and / recommendations) to the Group Executive where such trade-offs involve significant regulatory implications
- Responsible for Site-based workforce planning
- Responsible for managing risks at Site level within the framework established by the Group
- Responsible for leading engagement at place

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The role of the Divisions

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The Clinical Divisions play a critical role in delivering safe, high quality and sustainable services for patients, staff and local communities, and directly oversee the delivery of care by individual services and specialties. Clinical Divisions are responsible for ensuring there is robust quality and financial governance across the Division and for the services within their remit.

Role of the Divisions

- Accountable to the Site Leadership Team for the overall performance of the Division (quality, operational and financial), for the delivery of Divisional financial and operational plans, and for the provision of safe, high quality and sustainable services across the Division
- Responsible for contributing to the development of the Site financial and operational plan bottom-up, working with clinical services across the Division, and for the delivery of those plans at Divisional level
- Responsible for Divisional level quality impact assessments, and for taking decisions in relation to trade-offs between quality, performance and finance, and for escalating these (with options and / recommendations) to the Site Leadership Team where there are such trade-offs involve significant regulatory implications
- Responsible for enabling and supporting continuous improvement across the Division
- Responsible for nurturing local service transformation and service development within the Division
- Responsible for Divisional workforce planning
- Responsible for the oversight of the performance of the services / directorates / care groups within the Division, and for ensuring that there are robust quality and financial governance structures in place to support the delivery of safe, high quality and sustainable care across the Division
- Responsible for managing risks at Divisional level within the framework established by the Group
- Responsible for escalating significant risks and issues to the Site Leadership Team

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University Hospitals and Health Group

The role of the Group Corporate Services

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Group Corporate Services provide specialist corporate support to teams across the Group, at Board, Executive, Site and Divisional levels. They include: Communications; Corporate Affairs; Digital and Information Technology; Estates and Facilities; Finance; Human Resources; Corporate Nursing; Corporate Medical; and the Deputy Chief Executive's Office (responsible for strategy and integration, performance and project management office, and continuous improvement).

Group Corporate Services are led by the members of the Group Executive team. Some of the smaller corporate services (Communications, Corporate Affairs, Deputy Chief Executive's Office; Corporate Nursing, Corporate Medical) have been structured to provide fully integrated Group-wide teams. Other, larger corporate services (Digital and IT, Estates and Facilities, Finance, Human Resources) are currently going through or planning change programmes to develop Group-wide services, but are likely to retain strong footprints at Site level.

Role of Group Corporate Services

- Accountable to the Group Executive for the overall performance of the services provided
- Accountable to the Group Executive for the delivery of financial plans of the corporate service, identifying and delivering against cost improvement plans, and for managing finances in line with budgets
- Responsible for the delivery of professional, high quality corporate services to the Executive, Sites and Divisions
- Responsible for service development
- Responsible for enabling and supporting continuous improvement across the corporate services
- Responsible for the oversight of the performance of the corporate service
- Responsible for managing risks across the corporate service within the framework established by the Group
- Responsible for escalating significant risks and issues to the Group Executive

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Accountability in practice: Quality performance

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Group Executive

- Accountable to the Group Board, and collectively responsible, for the delivery of the delivery of safe, high quality services and for implementation of the Group Quality and Safety Strategy
- Responsible for ensuring robust quality governance across the Group
- Responsible for setting required quality, safety and professional standards
- Responsible for approving deviations from established standards where these have significant regulatory implications for the Trusts
- Responsible for fostering a strong safety culture across the Group, including a culture of psychological safety and continuous improvement
- Responsible for setting and implementing a robust Quality Impact Assessment framework and process across the Group
- Responsible for reviewing and agreeing significant trade-offs between quality, operational performance, and finance, particularly where there are significant regulatory implications, and for being clear with the Board about these
- Responsible for oversight of the most challenged clinical services across the Group
- Responsible for leaning in to support the Sites in delivering safe, high quality services
- Responsible for working with the system to develop system responses to quality challenges

Site

- Accountable to the Group Executive for the delivery of safe, high quality services, including any Group-wide clinical services managed by the Site, and for implementing the Group Quality and Safety Strategy at Site level
- Responsible for ensuring robust quality governance at Site level and within the Divisions
- Responsible for understanding challenged services within the Site and working with Divisions to take action to improve
- Responsible for working with Clinical Divisions in the design and development of services, and promoting a culture of continuous improvement across the Site to develop innovative solutions to improve quality
- Responsible for leading Site-level Quality Impact Assessments and for making trade-offs between quality, performance and finance, and for escalating and making proposals to the Group Executive for trade-offs with significant regulatory implications
- Responsible for developing action plans in response to external reviews and inspections, working collaboratively with services and with Executive quality leads, and for ensuring the delivery of identified improvement actions

Division

- Accountable to the Site Leadership Team for the delivery of safe, high quality services across the Division
- Responsible for ensuring effective quality governance across the Division
- Responsible for working with directorates, specialties and services to take action to address areas of under-performance on quality and in response to external reviews and inspections, with the support of the Site and Executive leads for quality
- Responsible for taking actions to address challenged services, and for escalating to the Site team where further support is needed
- Responsible for undertaking Divisional-level Quality Impact Assessments and for making trade-offs between quality, performance and finance and for escalating (with proposals) to the Site for significant trade-offs
- Responsible for the design and development of services, and for supporting directorates, specialties and services in local service transformation, and for promoting a culture of continuous improvement

Corporate Services

- Accountable to the Group Executive for managing each service in line with agreed Key Performance Indicators
- Responsible for managing corporate services in a way that delivers the agreed KPIs and for taking action to address areas of under-performance
- Responsible for undertaking Quality Impact Assessments on efficiency proposals within the corporate service and for escalating to the Group Executive the consequences of delivering against CIPs

Delegation & Empowerment, Support and Challenge

Assurance, Oversight and Accountability

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University Hospitals and Health Group

Accountability in practice: Operational performance

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Group Executive

- Accountable to the Group Board, and collectively responsible, for the delivery of the operational plan and of national mandated and locally agreed performance standards (e.g. NHS Constitutional standards)
- Responsible for setting the framework for operational planning
- Responsible for ensuring robust operational performance governance across the Group
- Responsible for leading the organisations in developing a culture of collaboration on performance for 'thinking Group'
- Responsible for reviewing and taking decisions on mutual aid across the Group e.g. to address challenges at one Trust or to address unwarranted variation in access
- Responsible for setting and implementing a robust Quality Impact Assessment framework and process across the Group
- Responsible for reviewing and agreeing significant trade-offs between quality, operational performance, and finance, particularly where there are significant regulatory implications, and for being clear with the Board about these
- Responsible for leaning in to support the Sites in delivering against the agreed operational plans

Site

- Accountable to the Group Executive for the development and delivery of the Site operational plan and for the delivery of nationally mandated and locally agreed operation standards
- Responsible for managing the Site in line with the agreed operational plan and taking actions to address deviation from plan
- Responsible for understanding areas of under-performance and working with Divisions to take action to improve performance
- Responsible for working with the Clinical Divisions in the design and development of services, and for promoting a culture of continuous improvement across the Site to develop innovative solutions to improve performance
- Responsible for leading Site-level Quality Impact Assessments and for making trade-offs between quality, performance and finance, and for escalating and making proposals to the Group Executive for trade-offs with significant regulatory implications
- Responsible for leaning in to support the Clinical Divisions in delivering against agreed Divisional financial plans
- Responsible for supporting Divisions in local service transformation to support long-term sustainability

Division

- Accountable to the Site Leadership Team for the delivery of relevant nationally mandated and locally agreed operating standards
- Responsible for managing the Division in line with the operating plan
- Responsible for contributing to the development of the annual operating plan bottom up
- Responsible for working with directorates, specialties and services to taking action to address areas of under-performance
- Responsible for undertaking Divisional-level Quality Impact Assessments and for making trade-offs between quality, performance and finance and for escalating (with proposals) to the Site for significant trade-offs
- Responsible for leaning in to support directorates, specialties and services in delivering in line with the financial plan
- Responsible for the design and development of services, and for supporting directorates, specialties and services in local service transformation to support long-term sustainability

Corporate Services

- Accountable to the Group Executive for managing each service in line with agreed Key Performance Indicators
- Responsible for managing corporate services in a way that delivers the agreed KPIs and for taking action to address areas of under-performance
- Responsible for undertaking Quality Impact Assessments on efficiency proposals within the corporate service and for escalating to the Group Executive the consequences of delivering against CIPs

Delegation & Empowerment, Support and Challenge

Assurance, Oversight and Accountability

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Accountability in practice: Financial performance

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Group Executive

- Accountable to the Group Board, and collectively responsible, for the development and delivery of the financial plan at the two Trusts
- Responsible for setting the framework for financial planning and scoping the requirement for each Trust's financial plan
- Responsible for collating at Group level the financial plans from the Sites and Group Corporate Services
- Responsible for ensuring robust financial governance across the Group
- Responsible for leading and managing the Group in line with the financial plans agreed by the Group Board
- Responsible for setting and implementing a robust Quality Impact Assessment framework and process across the Group
- Responsible for reviewing and agreeing significant trade-offs between quality, operational performance, and finance, particularly where there are significant regulatory implications, and for being clear with the Board about these
- Responsible for leaning in to support the Sites in delivering against the agreed financial plans

Site

- Accountable to the Group Executive for the development and delivery of the Site financial plan
- Responsible for managing the Site in line with the agreed financial plan and taking actions to address deviation from the financial plan
- Responsible for working with the Clinical Divisions to develop the annual Site financial plan (including CIP plans) bottom up, which will form the basis of the Trust financial plan
- Responsible for leading Site-level Quality Impact Assessments and for making trade-offs between quality, performance and finance, and for escalating and making proposals to the Group Executive for trade-offs with significant regulatory implications
- Responsible for escalating the consequences of delivering against CIP requirements to the Group Executive
- Responsible for leaning in to support the Clinical Divisions in delivering against agreed Divisional financial plans
- Responsible for supporting Divisions in local service transformation to support long-term sustainability

Division

- Accountable to the Site Leadership Team for the delivery of the Divisional financial plan
- Responsible for managing the Division in line with the plan and taking actions within the Division to address deviation from the financial plan
- Responsible for working with directorates, specialties and services to develop the Trust financial plan bottom up and identify the required CIPs to meet the target
- Responsible for undertaking Divisional-level Quality Impact Assessments and for making trade-offs between quality, performance and finance and for escalating (with proposals) to the Site for significant trade-offs
- Responsible for escalating the consequences of delivering against CIPs to the Site
- Responsible for leaning in to support directorates, specialties and services in delivering in line with the financial plan
- Responsible for supporting directorates, specialties and services in local service transformation to support long-term sustainability

Corporate Services

- Accountable to the Group Executive for managing each service in line with its financial plan and for the delivery of CIPs necessary to meet the agreed target for corporate services
- Responsible for contributing to the development of the Trust financial plans
- Responsible for undertaking Quality Impact Assessments on efficiency proposals within the corporate service and for escalating to the Group Executive the consequences of delivering against CIPs

Delegation & Empowerment, Support and Challenge

Assurance, Oversight and Accountability

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Accountability in practice

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Accountability in practice

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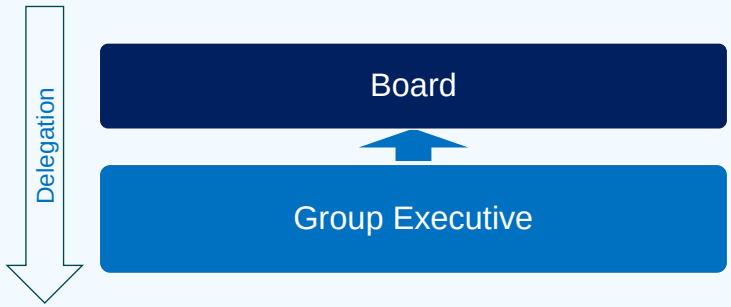
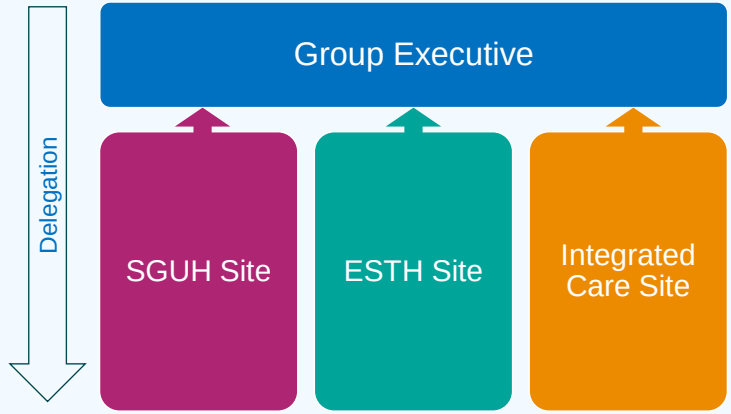
Group Executive to Board



Accountability through…	• Strategy implementation reports and Group Board Assurance Framework • Monthly finance and financial planning reports • Integrated Quality and Performance Report • Subject-specific assurance reports (e.g. Staff Survey, WRES, WDES, Maternity Services) • CEO report to Board
Accountability via…	• Group Board meetings • Board Committee meetings

Sites to Group Executive



Accountability	
Accountability through…	• Site reports to Group Executive Committee • Site-based IQPR • Site-based finance reports • Subject-specific assurance reports through GEC sub-groups
Accountability via…	• Group Executive Committee and sub-groups of GEC

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Accountability in practice

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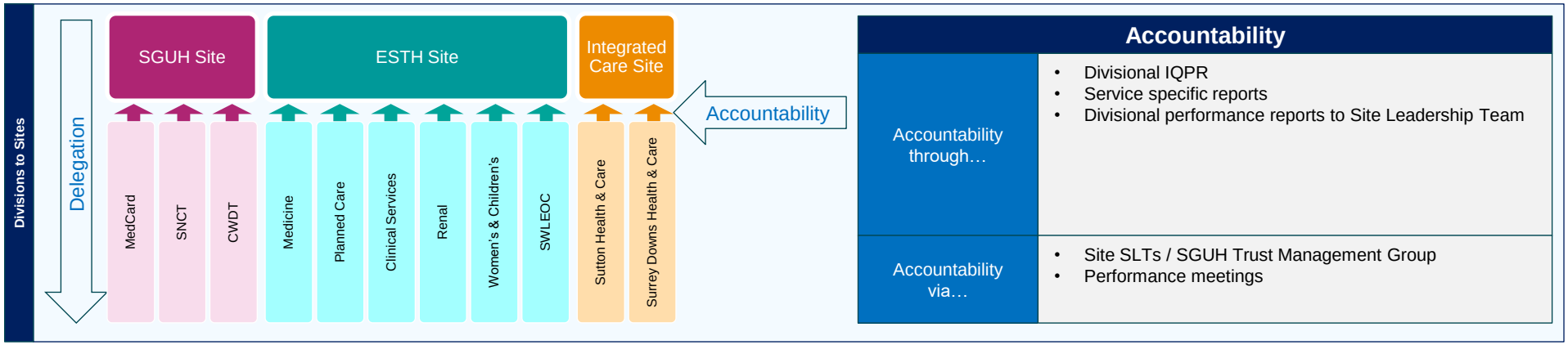

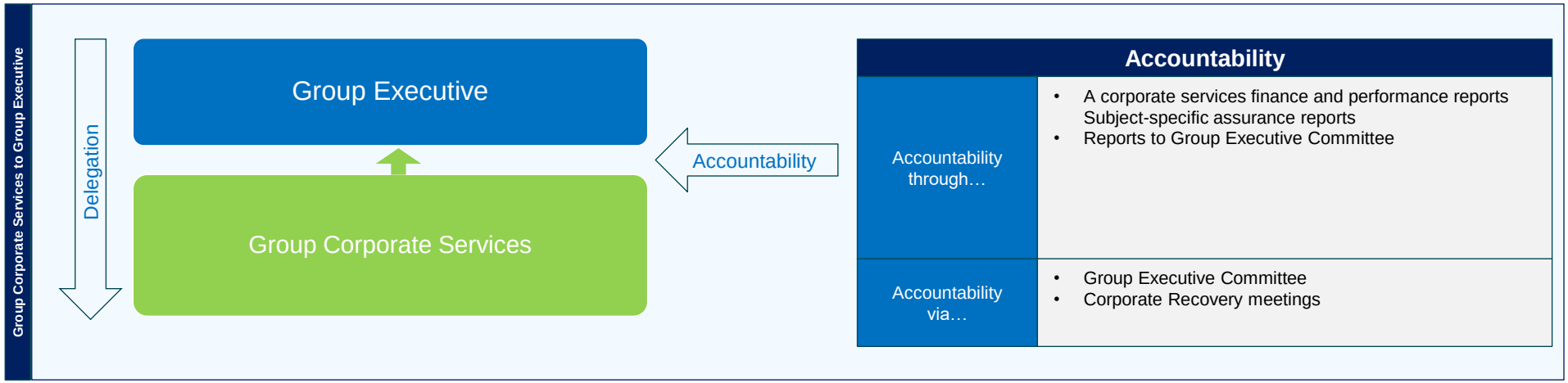

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Performance Oversight and Assurance Ladder

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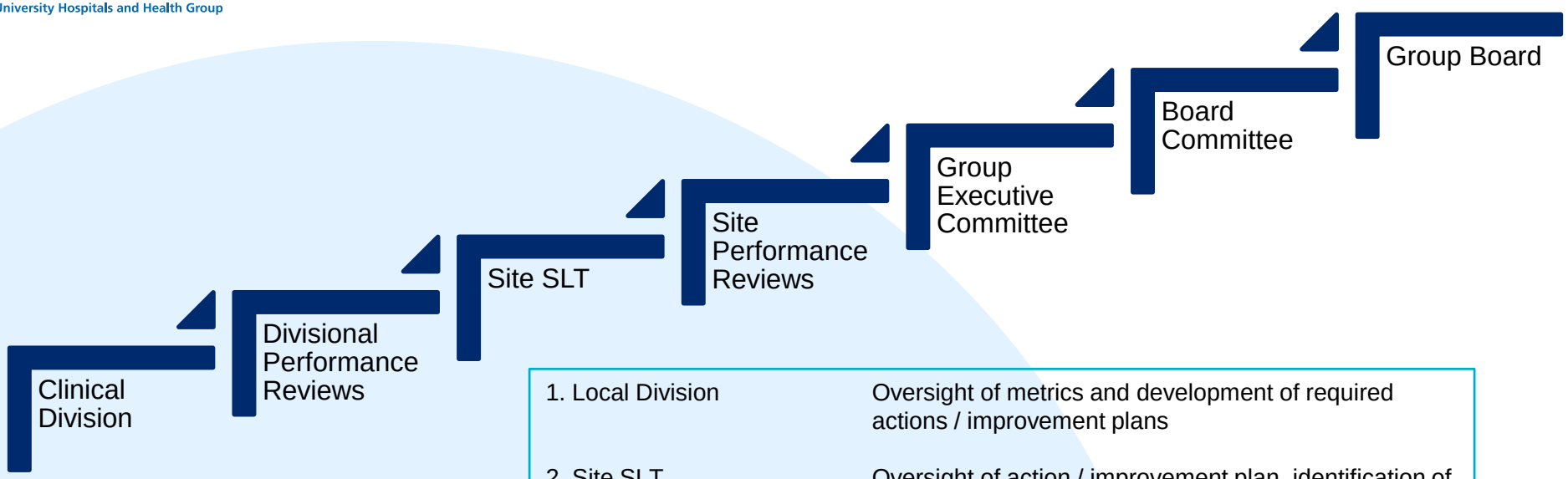

1. Local Division	Oversight of metrics and development of required actions / improvement plans
2. Site SLT	Oversight of action / improvement plan, identification of additional support as required
3. Performance Review	Outputs from SLT discussion to be flagged for further discussion and next steps for support agreed
4. Group Executive Cttee	Oversight of issues and risks associated with recovery of performance
5. Board Committee	Oversight of issues and risks and assurance of delivery of recovery / improvement plan

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Group Executive Director Appraisals

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The formal governance mechanisms and processes of the Group and clear lines of accountability and assurance are underpinned by regular staff appraisals. Annual appraisals and regular 1:1s are used to set and review clear, measurable objectives for Group Executive Directors which are then cascaded through the organisation, ensuring that staff have clarity of purpose and accountability.

The connection between Group Executive Director and Executive Team objectives is illustrated in the diagram below:

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	4.3
Report Title	**Diversity & Inclusion Action Plan 2025-2028**
Executive Lead(s)	Victoria Smith (G.CPO)
Report Author(s)	Joseph Pavett-Downer, Head of EDI
Previously considered by	Board Development Days 2024, GEM, PCIC
Purpose	**For Noting**

Executive Summary

In 2024, we shared our proposal '*A refreshed focus for EDI; Aligning with NHSE High Impact Action Plan',* which outlined our recommendation to review all open EDI related actions (across gesh) and align activities with NHSE's High Impact Action Plan. This mandatory NHSE EDI Improvement Plan sets out many clear recommendations for organisation to implement to successfully deliver on the NHS People Plan. Our proposal was endorsed by the relevant governance committees, and we began phase two – a review and mapping of all EDI related actions. This included incorporating any priority areas which were identified with Staff Network leads and Board Members as part of Board Development days in 2024.

Following approval at the Board Development Day (6/2/25) we are pleased to share our ratified Diversity & Inclusion Action Plan 2025-2028. Following Board endorsement this plan will now undergo final proof / refinements ahead of publication.

The action plan is structured into six overarching workstreams, each guided by NHSE's EDI Improvement Plan priorities and our gesh People Strategy. These six gesh EDI workstreams are: Leadership Commitment (including Board development and Executive Sponsorship), Inclusive Recruitment and Talent Management, Eliminating Pay Gaps, Improving Health and Wellbeing, Supporting internationally recruited staff and Safeguarding our Workforce.

Whilst these six workstreams may feel broad it is necessary to be able to structure and programme manage our commitments within these areas. Many of the actions within these six workstreams are already underway, with some actions already close to completion. There are also several specific commitments which will be prioritized for delivery based on factors such as staff experience/feedback, business impact, resource availability and risk. **An example of three of these priority areas are included, for Board purposes only, as the final 3 pages of the EDI Action Plan.**

We recognise the scale of this plan and so a key component to the success of it will be our team's ability to 'make it make sense' with clear communication, marketing and messaging to stakeholders and decision makers across the business.

Next step – Following endorsement the EDI Team will proceed with final proofing before publication. This will include development of a communications plan to further share and socialize the action plan across our workforce.

Action required by Group Board
The Board is asked to: a. Note the previously approved final action plan for publication and implementation.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Diversity & Inclusion Action Plan 2025-2028

Implications

Group Strategic Objectives

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

Risks

There is a risk that the programme of work set out here doesn't progress quickly enough due to: lack of engagement of teams through which some of the change is planned; that the actions don't have the intended impact on the 6 high impact objectives; or if there isn't sufficient capacity in the organisation to enact change. To avoid these the programme of work is realistic in ambition but still focused on the most significant points. Executive leadership buy-in and ownership is essential, so the actions are prioritised and accounted for their strategic planning.

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

No significant implications, the plan sets out approaches to ensure much of what is already available is more fairly distributed and processes already planned and in place are implemented more effectively, without further expense. It's anticipated that expenses incurred will be offset by the reduced attrition and need to launch costly recruitment campaigns, and reduced costs associated with ER cases.

Legal and / or Regulatory implications

None, though failure to deliver on the 6 high impact actions will be reviewed negatively by external audit for example CQC.

Equality, diversity and inclusion implications

We anticipate improved outcomes for aspects of staff experience measured and reported in the WRES and WDES.

Environmental sustainability implications
None

Diversity & Inclusion Action Plan 2025-2027
Group Board, 06 March 2025

1.0	**Purpose of paper**
1.1	*To share our Diversity & Inclusion Action Plan 2025-2027 and outline of EDI relation actions and priorities.*
2.0	**Background**
2.1	NHSE's high impact action plan (HIAP) is a mandatory improvement plan which sets out targeted actions to address the inequality and discrimination within the NHS. Following the launch of the HIAP we did an initial review of our internal action plans and identified many which align well with the HIAP. The ask from our Board has been to focus energy and streamline EDI actions across the group in order to ensure we are able to deliver any commitments we make. With this in mind, we proposed a '*Refreshed Focus for EDI'*. This original proposal (to align actions) has been discussed at length as part of the Board Development Days in March and April 2024, and more recently by the Group Executive at the July Group Executive meetings. Based on the feedback received from the July GEM, we have made several thoughtful amendments to enhance the proposal and finalised our draft EDI Action Plan. All feedback from these board sessions has been incorporated and the final proposal attached.
3.0	**Sources of Assurance**
3.1	Aligns with gesh People Strategy, NHSE People Promise, Long Term Plan and EDI Improvement Plan.
4.0	**Recommendations**
4.1	The Committee is asked to: Review the final plan and approve for wider engagement and implementation from early 2025.

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

gesh

Diversity & Inclusion Action Plan 2025-2028

Aligning with the NHSE High Impact Action Plan

Last modified: 30/01/2025

Introduction

gesh is committed to building a workforce which is valued and whose diversity reflects the communities it serves, enabling it to deliver the best possible healthcare service to those communities.

Everyone who works across the group, or applies to work with us, must be treated fairly and valued equally irrespective of age, disability, race, nationality, ethnic or national origin, gender, religion or belief, sexual orientation, marital status, pregnancy and maternity status, domestic circumstances, social and employment status, HIV status, gender reassignment, political affiliation or trade union membership. Many of these are known as *protected characteristics* (see opposite).

gesh is committed to enabling everyone in the Trust to achieve their full potential in an environment characterised by dignity and mutual respect.

Figure 1: The 9 Protected characteristics enshrined in the Equality Act 2010

Development of the D&I Action Plan

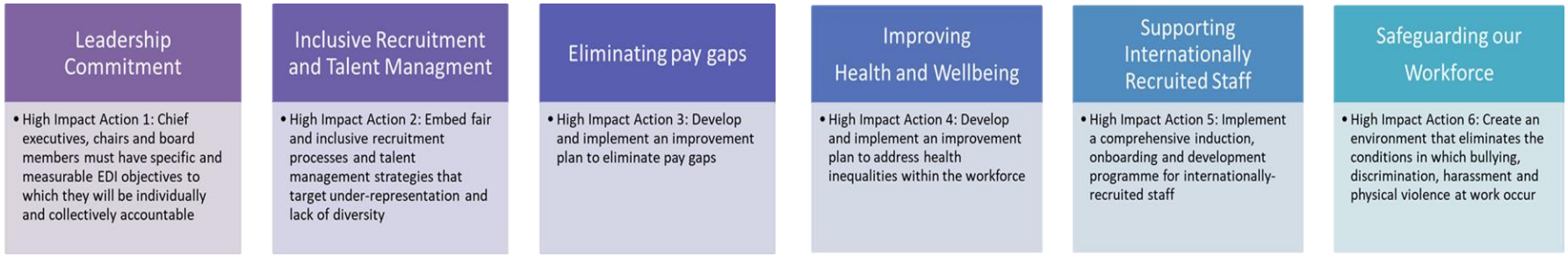
Our 2025 action plan has been developed following discussions with our Board, Executive and Non-Executive Directors and Site Management Teams. We have also consulted with stakeholders from a range of services, our Staff Networks and Staff Side Representatives.

The action plan includes actions that we are currently in the process of implementing and also actions that we are planning to undertake within the next 12-18 months.

Aligning with NHSE EDI Improvement Plan

Our existing Culture and D&I Action Plans, which were introduced in late 2020, have driven a continued focus and commitment to improving the experience of those from marginalised groups, particularly those from Black, Asian and Minority Ethnic communities. Whilst many of the actions and projects set out in these action plans have now been successfully delivered, there are still a number to be implemented, particularly as we move to closer group working and sharing best practice across both St George's and Epsom and St Helier.

These open actions or live projects have been mapped across to NHSE's EDI Improvement Plan (appendix a) and aligned to our People Strategy 2024-2026. This mapping exercise has identified six gesh EDI workstreams:



WORKSTREAM ONE: Leadership Commitment (including Board development and Executive Sponsorship)

NHSE HIA 1 Objective: *Chief executives, chairs and board members must have specific and measurable EDI objectives to which they will be individually and collectively accountable*

Key Success Measures: **-** Increased % of BME leaders in bands 8A and above;
- Year on year improvement in Equality Reporting metrics i.e. WRES, WDES, EDS.
- Improved staff survey score: 'Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion'
- Reduction in staff survey scores for: 'Percentage of staff experienced discrimination at work from manager / team leader or other colleagues in last 12 months'

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
1.1	Every board and executive team member must have EDI objectives that are specific, measurable, achievable, relevant, and timebound (SMART) and be assessed against these as part of their annual appraisal process (By Mar 24).	1.1.1 Ensure every Board member has a SMART EDI objective agreed as part of their annual objectives. 1.1.2 Individual Board members to explore and agree a personal action which will form part of their annual appraisal. 1.1.3 Review progress bi-annually to ensure continued momentum and accountability.	Head of EDI Chair (NEDs) GCEO (Executives)	July 25
1.2	Board members should demonstrate how organisational data and lived experience have been used to improve culture. (By Mar 25)	1.2.1 Ensure EDI reports and progress updates use organisational data and feedback to track the impact of our EDI action plan and ensure EDI reports are reflected in our Board and People Committee forward planners so that the Board can actively monitor progress against the plan. 1.2.2 Routinely present updates on EDI compliance and projects to Site Leadership Team (SLT) and Group Executive (GEM). 1.2.3 Network Executive Sponsors to ensure delivery of their role against our Exec Sponsor role profile, which includes a commitment to proactively engage with their respective network leadership teams and members. 1.2.4 Continue quarterly meetings between Chairman, CEO and Network Chairs	Head of EDI GCPO	April 25
1.3	NHS boards must review relevant data to establish EDI areas of concern and prioritise actions. Progress will be tracked and monitored via the Board Assurance Framework (by Mar 24)	In addition to the above our Board will continue to review and approval all mandatory EDI related reporting, including WRES, WDES, PSED, and Pay Gap Reports.	As above	Ongoing

1.4	Boards should be able to demonstrate their understanding of and progress towards race equality, an essential criterion in job descriptions for board members and all very senior manager (VSM) grades.	1.4.1 Review all VSM and Board level job descriptions through an EDI lens to ensure we attract and appoint leaders that demonstrate a deep understanding and commitment to driving race equality, inclusion and positive culture. 1.4.2 Introduce a set of recommended questions or a question brief to ensure that all VSM and Board interviews include a basic set of Culture and Inclusion related questions.	Head of EDI GCPO (Executive) GCCAO (NED)	July 25
1.5	To tackle race discrimination effectively, Boards must give due consideration to national policies and recommendations from other Arms Lengths Bodies.	Ensure we continue to report routinely and stay up to date with current and upcoming legislation, national requirements and best practice.	Head of EDI GCPO	On-going
1.6	Executive teams within the organisations should actively talk about the benefits of allyship as well as champion and sponsor LGBT+ staff networks. They should also build the concept of allyship into existing and new development programmes	See action 1.2.3 *Network Executive Sponsors to ensure delivery of their role against our Exec Sponsor role profile, which includes a commitment to proactively engage with their respective network leadership teams and members*	Head of EDI GCPO	On-going
1.7	Board will use the EDI dashboard to establish internal data driven accountability and scrutinise progress at an organisational, divisional, departmental, occupation, and site level to address under-representation and pay gaps	In addition to the above our Board will continue to review and approval all mandatory EDI related reporting, including WRES, WDES, PSED, and Pay Gap Reports. 1.7.1 Ensure Recruitment and Selection data, across including gender, race, lgbq+ and disability, are regularly reviewed at SLT and GEM???	Head of EDI GCPO	On-going

WORKSTREAM TWO: Inclusive Recruitment and Talent Management

NHSE HIA 2 Objective: *Embed fair and inclusive recruitment processes and talent management strategies that target under-representation and lack of diversity.*

Key Success Measures: **-** Increased % of BME leaders in bands 8A and above;
- Increased likelihood of appointment for BME shortlisted applicants;
- Improved staff survey score: '*Percentage of staff believing that the organisation provides equal opportunities for career progression or promotion'*

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
2.1	Create and implement a talent management plan to improve the diversity of executive and senior leadership teams (by June 2024) and evidence progress of implementation	2.1.1 Complete final refinements of our gesh Talent Management Plan and submit for board approval. 2.1.2 Begin implementation and pilot from early 2025 2.1.3 Complete options appraisal of *Diversifying our Leadership*	A. Dir of L&OD Head of Talent	Dec 25
2.2	Implement a plan to widen recruitment opportunities within local communities, aligned to the NHS Long Term Workforce Plan. This should include the creation of career pathways into the NHS such as apprenticeship programmes and graduate management training schemes (by October 2024).	2.2.1 Work with SWL Recruitment Hub to explore opportunities across SWL 2.2.2 Continue to implement existing Inclusive Recruitment Initiatives which includes group wide embedding of; ➢ Recruitment Inclusion Specialist Scheme ➢ Active Career Conversations ➢ Standardised Job Profiles ➢ Golden Ticket Scheme (Project Search) ➢ Level 3 Disability Confident Employer Status	G. Dir of ES Head of EDI (SGUH)	Dec 25
2.3	Line managers should have meaningful conversations with their teams, to align personal aspirations with job roles and requirements. This should include the option of phasing retirement and exploring alternative work patterns	2.3.1 Integrate CARE objectives in the PDR Process. 2.3.2 Embed Coaching Culture across the group. *2.3.3* Introduce effective Communications Training. *Also see action 2.2.2 Standardised Job Descriptions*	Head of L&D	July 25
2.4	Commissioners and providers of talent management and career development programmes must ensure that these are fully accessible and inclusive. Progress can be measured by tracking the number of Disabled people in leadership roles.	2.4.1 Ensure completion ERAF/EQIA for new processes and initiatives, including our Talent Management and Career Development Programmes 2.4.2 Ensure thorough stakeholder engagement and socialisation of Talent Management and Career Development Programmes 2.4.3 Embed Neurodiversity in the Workplace E-learning and F2F Workshop across the group	Head of Talent Head of L&D	April 25

2.5	Review recruitment practices to ensure they are fully inclusive of all ages, removing bias and improving accessibility for people wishing to join the NHS.	See action 2.2.1 and 2.2.2	n/a	n/a
2.6	Organisations should encourage flexible working as part of local attraction, recruitment and retention. The plan should embed the NHS Pension Scheme and highlight its value across the career journey, with special focus on flexible retirement for staff in late-stage careers.	2.6.1 Launch group wide Flexible Working Policy 2.6.2 Ensure policy / additional guidance includes advice and recommendations in relation to flexible retirement	Head of HR Projects and Strategy	Mar 25
2.7	NHS organisations should ensure that their flexible working policy is easily accessible and suitable for all their staff; supporting work–life balance, health and wellbeing, and enabling CPD	2.6.1 Ensure Flexible Working Policy is accessible via trust intranet and promoted upon launch across the group. *2.6.2 How do we ensure it is used/supported?*	Head of HR Projects and Strategy	Mar 25
2.8	NHS organisations should work in partnership with local educational institutions and voluntary sector partners to support social mobility by improving recruitment from local communities.	We will continue to engage and participate in initiatives and recruitment activities which aim to engage local communities, such as SWL ICB Apprenticeship working group, recruitment fairs and partner with local colleges.	G. Dir of ES	On going
2.9	Promote the visibility of leaders with a disability through effective campaigns alongside providing leadership and career development opportunities tailored to disabled staff. Progress can be measured by tracking the number of disabled staff in leadership roles.	2.9.1 Launch My Health Matters Too Campaign across the group 2.9.2 Explore Propel Train the Trainer offer *Also see action 2.4.3 Neurodiversity in the Workplace E-learning*	Head of EDI	April 25
2.10	Implement recommendations from the inclusive recruitment and promotion practices programme, and ensure each stage of the recruitment pathway is accessible, does not discriminate and encourages people with disabilities to apply for roles in the NHS. This can be tracked via the WDES, using Trac data.	2.10.1 Explore recommendations from the Inclusive Recruitment Programme to ensure alignment with current trust activities focused on Inclusive Recruitment. *Also see action 2.2.1. and 2.2.2*	G. Dir of ES	Dec 25

WORKSTREAM THREE: Eliminating pay gaps

NHSE HIA 3 Objective: *Develop and implement an improvement plan to eliminate pay gaps*

Key Success Measures: **-** Year-on-year reductions in the gender, race and disability pay gaps

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
3.1	Implement the Mend the Gap review recommendations for medical staff and develop a plan to apply those recommendations to senior non-medical workforce	3.1.1 To be explored by Group Executive, Senior Leadership Team and relevant service leads.	G.CMO	July 25
3.2	Analyse data to understand pay gaps by protected characteristic and put in place an improvement plan. This will be tracked and monitored by NHS boards. Reflecting the maturity of current data sets, plans should be in place for sex and race by 2024, disability by 2025 and other protected characteristics by 2026.	3.2.1 Introduce annual group wide Pay Gap Report which covers; Gender, Ethnicity and Disability.	Dir. Of Workforce Transformation	July 25
3.3	Implement an effective flexible working policy including advertising flexible working options on organisations' recruitment campaigns.	*See action 2.6.1*	n/a	n/a
3.4	Board will use the EDI dashboard to establish internal data driven accountability and scrutinise progress at an organisational, divisional, departmental, occupation, and site level to address under-representation and pay gaps	*See action 1.7 and 3.2.1*	n/a	n/a
3.5	NHS organisations to focus on closing the gender pay gap and improving the experiences of the lowest paid people, extending the Mend the gap review recommendations for medical workforce to the wider workforce.	*Delivery of workstream actions 3.1 – 3.4 aims to reduce the gender pay gap and ensure closer monitoring which will deliver against this recommendation.* *To discuss / considered by Exec/Board.*	n/a	n/a

WORKSTREAM FOUR: Improving Health and Wellbeing

NHSE HIA 4 Objective: *Develop and implement an improvement plan to address health inequalities within the workforce*

Key Success Measures: **-** Improved staff survey metrics on Health and Wellbeing
- Improved staff survey score % of staff saying that their employer has made reasonable adjustment(s) to enable them to carry out their work
- Improved staff survey score % of staff saying that they have felt pressure from their manager to come to work, despite not feeling well enough to perform their duties

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
4.1	Line managers and supervisors should have regular effective wellbeing conversations with their teams, using resources such as the national NHS health and wellbeing framework.	4.1.1. Embed Wellness Action Plan into onboarding process and improve monitoring. 4.1.2. Develop and implement Health Passport for Staff. 4.1.3. Launch Menopause training and guidance for managers. 4.1.4. Develop a series of Wellbeing Toolkits to guide managers in supporting staff wellbeing *Also see action 2.4.3 Embedding Neurodiversity in the Workplace e-learning*	H&WB Lead	July 25
4.2	Work in partnership with community organisations, facilitated by ICBs working with NHS organisations and arm's length bodies.	Continue delivery of existing workstreams, including those with SWL IBC for improving Health and Wellbeing, and EDI. These include initiatives such as DAL, Ask Aunty, Womens Health Consultants, and Cost of Living Support.	n/a	n/a
4.3	Organisations to ensure that diversity training on gender reassignment and sexual orientation is included within mandatory training	4.3.1 Following outcome of the national MAST review gesh will explore whether the relevant training offer can become part of its mandatory training framework. The national review is likely to conclude in early 2025. 4.3.2 Launch our LGBTQ+ awareness module at ESTH.	Head of L&D	July 25
4.4	NHS organisations should ensure that their reasonable adjustments policy is effectively and efficiently implemented.	4.4.1 Launch Disability in the Workplace Policy across the group. 4.4.2 Ensure Reasonable Adjustment advice and resources are promoted and readily accessible across the group intranet. *Also see action 2.4.3 Embedding Neurodiversity in the Workplace e-learning across the group*	Head of EDI	April 25

WORKSTREAM FIVE: Supporting internationally recruited staff

NHSE HIA 5 Objective: *Implement a comprehensive induction, onboarding and development programme for internationally recruited staff*

Key Success Measures: - Improved staff survey score: 'Sense of belonging for internationally recruited staff'
- Reduction in instances of bullying and harassment from team/line manager experienced by (Internationally recruited staff)

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
5.1	Before they join, ensure international recruits receive clear communication and support around their conditions of employment; including guidance on latest immigration policy, conditions for accompanying family, financial commitment and future career options.	The Group Workforce and Professional Standards Team provide an established and comprehensive onboarding programme for all international nursing and midwifery recruits including a bespoke induction programme, welcome pack and financial support.	n/a	n/a
5.2	Create comprehensive onboarding programmes for international recruits.	A bespoke onboarding programme is in place for all international recruited nursing and midwifery staff.	n/a	n/a
5.3	Line managers and teams who welcome international recruits must maintain their own cultural awareness to create inclusive team cultures that embed psychological safety	5.3.1 Ensure continued D&I presence at all inductions, including Corporate, Medical and International. 5.3.2 Continue to embed Ask Aunty initiative across the group, including App launch. 5.3.3 Introduce robust Cultural Intelligence Training offer.	Head of EDI	Dec 25
5.4	Give international recruits access to the same development opportunities as the wider workforce. Line managers must proactively support their teams, particularly international staff, to access training and development opportunities.	International recruits will have equitable access to training and CPD available across the group. In addition, programmes such as access to apprenticeships and foundation skills training will be available.	n/a	n/a

WORKSTREAM SIX: Safeguarding our Workforce

NHSE HIA 6 Objective: Create an environment that eliminates the conditions in which bullying, discrimination, harassment and violence at work occur

Key Success Measures: **-** Decreased likelihood of BME staff entering the formal disciplinary process.
- Reduction in BME staff survey score: '*Percentage of staff experiencing harassment, bullying or abuse from staff in last 12 months'*
- Reduction in BME staff survey score: '*Percentage of staff experienced discrimination at work from manager/team leader/colleague'*

No.	NHSE HIA Recommendation	GESH Action	Responsible Officer	Deliver By
6.1	Review data by protected characteristic on bullying, harassment, discrimination and violence. Reduction targets must be set (by March 2024) and plans implemented to improve staff experience year-on-year.	6.1.1 Reduction Targets to be considered by Group Executive, Senior Leadership Team and relevant service leads.	GCPO	July 25
6.2	Review disciplinary and ER processes. There should be assurances that all staff who enter formal processes are treated with compassion, equity and fairness. Where the data shows inconsistency in approach, immediate steps must be taken to improve this.	6.2.1 Launch 'Just Culture' to ensure a restorative approach to ER processes. 6.2.2 Explore introduction of ER Inclusion Specialist (ERIS) to support ER cases for employees from BME communities or those with a Disability. 6.2.3 Review roles and responsibilities of those involved in supporting or offering guidance and advice in relation to ER cases. Ensuring clear expectations in relation to understanding of discrimination and equalities and close partnership working between EDI, ER, and OH. 6.2.3 As part of our Policy Review, review and launch a group wide disciplinary policy.	Head of ER	Dec 2025
6.3	Ensure safe and effective policies and processes are in place to support staff affected by domestic abuse and sexual violence (DASV). Support should be available, and staff should know how to access it.	6.3.1 Continue to plan for the gesh DASV launch week beginning 18 November 2024. 6.3.2 gesh Sexual Misconduct Policy to be launched April 2025. 6.3.3 To confirm assurance reporting structure Dec 2024.	CNO Office	April 25
6.4	Create an environment where staff feel able to speak up and raise concerns, with steady year-on-year improvements. Boards should review this by protected characteristic and take steps to ensure parity for all staff	Training on speaking up, listening up and following up is mandatory within the organisation. FTSU data shows year in year increases on staff speaking up to FTSU Guardians within the organisation.	n/a	n/a

		The Group Guardian works closely with the board to ensure oversight of themes, and particular attention is paid to detriment concerns ensuring that staff do not come to detriment by raising concerns.		
6.5	Provide comprehensive psychological support for all individuals who report that they have been a victim of bullying, harassment, discrimination or violence	Our Staff Support, Counselling and Mediation Services offer comprehensive support for individuals who report being victims of bullying, harassment, discrimination, and violence. The teams seek to address the emotional, psychological, and relational aspects that may be evoked by these incidents, ensuring staff receive the care and support they need. Available support includes, individual counselling and support, Mediation & Conflict resolution and preventative and restorative interventions: Our FTSU team are also trained mental health first aiders and work closely with staff support teams to ensure that staff who speak up are adequately supported and protected.	n/a	n/a
6.6	Have mechanisms to ensure staff who raise concerns are protected by their organisation.	FTSU Guardian works closely with board, executive and non - executive lead for FTSU to ensure that staff who raise concerns of detriment are listened to and the issues raised investigated as necessary in line with the Freedom to Speak Up Policy. The executive lead oversees all such cases to ensure senior level involvement.	n/a	n/a

Appendix A: NHSE High Impact Actions

High-impact actions

This plan prioritises the following six high impact actions to address the widely-known intersectional impacts of discrimination and bias.

Measurable objectives on EDI for Chairs Chief Executives and Board members.

Success metric

1a. Annual Chair/CEO appraisals on EDI objectives via Board Assurance Framework (BAF).

Overhaul recruitment processes and embed talent management processes.

Success metric

2a. Relative likelihood of staff being appointed from shortlisting across all posts

2b. NSS Q on access to career progression and training and development opportunities

2c. Improvement in race and disability representation leading to parity

2d. Improvement in representation senior leadership (Band 8C upwards) leading to parity

2e. Diversity in shortlisted candidates

2f. NETS Combined Indicator Score metric on quality of training

Eliminate total pay gaps with respect to race, disability and gender.

Success metric

3a. Improvement in gender, race, and disability pay gap

Address Health Inequalities within their workforce.

Success metric

4a. NSS Q on organisation action on health and wellbeing concerns

4b. National Education & Training Survey (NETS) Combined Indicator Score metric on quality of training

4c. To be developed in Year 2

Comprehensive Induction and onboarding programme for International recruited staff.

Success metric

5a. NSS Q on belonging for IR staff

5b. NSS Q on bullying, harassment from team/line manager for IR staff

5c. NETS Combined Indicator Score metric on quality of training IR staff

Eliminate conditions and environment in which bullying, harassment and physical harassment occurs.

Success metric

6a. Improvement in staff survey results on bullying / harassment from line managers/teams (ALL Staff)

6b. Improvement in staff survey results on discrimination from line managers/teams (ALL Staff)

6c. NETS Bullying & Harassment score metric (NHS professional groups)

The following information is supplementary for the purpose of the Board meeting only and intended to provide a more detailed look at two examples of priority actions within the EDI action plan

Refreshed Executive Sponsorship

(Workstream One, item 1.2.3)

7 Principles of Staff Network Sponsorship

1. Site Leadership and Executive **Sponsors should dedicate time to understanding their networks**, ensuring they are equipped to offer advice, support, and advocacy for the network's agenda. This engagement is key to fostering trust and collaboration.

2. We are committed to maintaining site staff networks and **encouraging joint group working**, allowing network chairs and members to realise the value of collaboration and stronger inter-group partnerships.

3. It is essential that **every member of the Group Executive** has a network sponsorship role, with clear objectives around being an **authentic ally**. This includes active participation in network objectives, events, and meetings, as well as visible endorsement.

4. **Our CEO's active support** is crucial in advocating for all staff networks. They will focus on increasing representation of underrepresented groups in leadership roles, with a strategic focus on organisation-wide inclusion.

5. **Site SLT members are encouraged to join and support staff networks**, taking on a sponsorship role that provides local advocacy and strengthens organisational buy-in. This ensures networks are seen as integral to our overall success.

6. Non-Executive Directors (NEDs) will regularly engage with staff network chairs, **offering external expertise and insights**. While they do not hold formal sponsorship roles, their involvement adds valuable external perspectives to network initiatives.

7. The **SLT and Executive Sponsors are accountable for ensuring networks have a strong voice** within our governance and decision-making processes. They will work closely with network chairs to align network aims with our People Strategy and EDI action plan, ensuring that networks are properly resourced and supported.

The following information is supplementary for the purpose of the Board meeting only and intended to provide a more detailed look at two examples of priority actions within the EDI action plan

Shadow Board Initiative

(Workstream Two, item 2.1.3)

Purpose

To create new and authentic voices feeding into our board and at the forefront of decision-making to modernise and more accurately meet the needs our of diverse colleagues and communities we serve.

Programme Format

A six-month programme for leaders aspiring to Senior, Executive and Board roles. Compromises of 4, 1-day learning modules, 4 shadow board meetings (facilitated by a NED) and 4 Action Learning Sets.
12-15 spaces available with an inclusive application and decision process.
Designed, run and facilitated by external organisation, allowing objectivity and psychological safety
The cohort will include at least 50% global majority staff and seek to be highly representative of our diverse workforce.

Outcomes expected:

- Facilitates a 'whole systems' approach.
- Facilitates the CQC Well – Led approach.
- Draws upon a wider and more diverse pool of talent and skills to challenge, govern, manage risk and finances and innovate.
- Promotes a more inclusive culture at every level
- Identifies an executive talent pool and future potential leaders.
- Enables growth for the future through expanding and developing the workforce

The following information is supplementary for the purpose of the Board meeting only and intended to provide a more detailed look at two examples of priority actions within the EDI action plan

Improved Leadership Support and Awareness

(Supports Multiple Workstream Deliverables)

Group Board

Meeting on Thursday, 06 March 2025

Agenda Item	4.4	
Report Title	**GESH Summary of Annual Safeguarding Report 2023-2024**	
Executive Lead(s)	**Arlene Wellman, Group Chief Nursing Officer**	
Report Author(s)	**Daisy Tate, Associate Director of Safeguarding** **Sam Page, Director of Safeguarding**	
Previously considered by	Patient Safety & Quality Group (EStH) Patient Safety and Quality Group (SGUH) Quality Committees in Common Group Board (Private)	13/09/2024 27/08/2024 31/10/2024 06/02/2025
Purpose	**For Noting**	

Executive Summary

The Safeguarding Children and Adults Annual Reports for both Trusts demonstrate that each Trust is meeting their responsibilities under statutory Section 11 duties of the Children's Act 2004 and The Care Act 2014. There are risks with the delivery of training and safeguarding supervision, both of which underpin compliance with statutory safeguarding compliance.
The Annual Reports detail how each Trust is assessed on their performance both internally and externally regarding safeguarding adults, children, and young people.

The key points for 2022-23 from the Trust Annual Reports are:

- Service achievements
- Risks and challenges
- Priorities for 2024-25

The safeguarding activity for both Trusts is shown in the table below, which includes a comparison with the previous year.

	Adults		Children		DoLs Urgent application	
	2022/23	**2023/24**	**2022/23**	**2023/24**	**2022/23**	**2023/24**
EStH	2292	2179	3004	2751	860	691
SGH	1803		697 (in-pt) 3368 (ED)			
SDH&C & SH&C	625	953				

Action required by Group Board
Having reviewed the report in private session, the Board is asked to: a. Note the report in public session.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	READING ROOM – ESTH Safeguarding Adults & Children Annual Report
Appendix 2	READING ROOM – SGUH Safeguarding Adult & Children Annual Report

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships		☒ Right care, right place, right time		
☒ Affordable Services, fit for the future		☒ Empowered, engaged staff		
Risks				
As set out in the papers in the Reading Room				
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				
No issues to consider				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations Compliance with the Care Act 2014, the Children's Act 2004 and Working Together 2018.				
Equality, diversity and inclusion implications				
As set out in the papers in the Reading Room				
Environmental sustainability implications				
No issues to consider				

Safeguarding Annual Reports for Adults, Children and Young People

Group Board, 06 March 2025

1.0 Purpose of paper

1.1 The purpose of this report is to demonstrate compliance with Statutory Requirements by providing an overview of the work undertaken by the safeguarding teams at ESTH and SGUH in 2023/24.

1.2 The report demonstrates compliance with the statutory and mandatory reporting requirements relating to safeguarding and promoting the welfare of adults, children, and young people.

1.3 The full annual reports for both sites are available in the Reading Room

2.0 Statutory and Mandatory Responsibilities

2.1 The following processes and structures are in place to achieve the Statutory and Mandatory responsibilities for each Trust.

2.2 Lead adult and child safeguarding professionals and an MCA Lead were in place, meeting the statutory requirements as identified in Section 11 of the Children Act 2004, Working Together to Safeguard Children (2018), the Care Act (2014), NHS England Accountability and Assurance Framework (2019) and the Mental Capacity Act (2005).

2.3 The Group Chief Nurse is the Group Board Executive Lead for Safeguarding. Alongside the Site Chief Nurses, ESH Associate Director of Nursing for Safeguarding and SGH, Head of Safeguarding, they provide strategic leadership and oversight of Safeguarding. During 2023/24, the dedicated Site Safeguarding Leadership was combined into one Interim Group Director post to support Corporate Integration.

2.4 Safeguarding governance arrangements have been established and embedded, with oversight from the Joint Safeguarding Committees (JSC), chaired by the Deputy Chief Nurse (SGH) and Site Chief Nurse (ESTH). The ICB is in attendance and provides support and challenge to governance processes.

2.5 There is active involvement with the Local Safeguarding Adult and Children Partnership Boards across the relevant Boroughs, with ESTH and SGUH membership of a range of Board sub-groups.

2.6 ESTH and SGUH are active members of the London Mental Capacity Act Forum lead by NHS England.

2.7 ESTH and SGUH attend Clinical Reference Groups and Learning from Lives and Deaths Quality Assurance and Governance meetings for our Learning Disability population.

2.8 SGUH provides research and attends Multi Agency High Risk Domestic Abuse Panels (MARAC) for the local Boroughs. ESTH provides research. Both Trusts have a hospital located Independent

Domestic Violence Advocate funded by the Mayor's Office on Policing and Crime. Epsom General Hospital no longer has a site IDVA due to a funding decision within Surrey.

2.9 ESTH and SGUH have contributed to several learning reviews across the local Boroughs, incorporating Safeguarding Adults Reviews (SAR), Child Safeguarding Practice Reviews (CSPR), Rapid Reviews (RR) and Domestic Homicide Reviews (DHR).

2.10 There is a safeguarding training programme in place to ensure ESTH and SGUH staff have received the requisite 'essential-to-role' safeguarding training, including Safeguarding Adults, Safeguarding Children, Mental Capacity Act (MCA) including Deprivation of Liberty Safeguards (DoLS) and Prevent training.

2.11 Policies, protocols, and processes are in place to support the assessment of need and vulnerability of children, young people and adults accessing ESTH and SGUH services.

2.12 Safeguarding supervision, (mandatory and ad hoc) is delivered by the safeguarding team to support staff in decision making and prioritising the needs and wishes of children, young people, and adults, where there is a high level of complexity, risk, and vulnerability.

2.13 The Named Professionals provide clinical supervision to their teams as part of line management duties, with additional supervision for the children's team by the Named Doctor.

2.14 The Child Looked After nurse specialists and maternity safeguarding team are given safeguarding supervision by the children's safeguarding team.

2.15 The Named Professionals access safeguarding supervision via the ICB Safeguarding Designates in group restorative clinical supervision; this includes the Named Midwife, Named Nurse Looked After Children (LAC) and the Practice Educator for MCA & Safeguarding.

2.16 The Named Nurse for Children's Safeguarding also has supervision from the Designate Nurse for Children's Safeguarding.

2.17 Robust recruitment processes are in place, with pre-employment clearance for all new staff. ESTH and SGUH comply with guidance in relation to modern day slavery and human trafficking and undertakes enhanced Disclosure and Barring (DBS) checks for staff working with children and adults.

Safeguarding Activity 2023/24

Number of referrals

	Adults		Children		DoLS Urgent application	
	2022/23	**2023/24**	**2022/23**	**2023/24**	**2022/23**	**2023/24**
EStH	2292	2179	3004	2751	860	691
SGH	1803*	1718*	697 (in-pt) 3368 (ED)	127 (in-pt) 3622 (ED)	437	396
SDH&C & SH&C	625	953				

***** *includes referrals to the Domestic Abuse CNS (recorded separately at SGUH)*

The significant drop in numbers of referrals relating to children who were in-patients has been attributed to an increased presence of the safeguarding team on the paediatric wards. This allows for ad hoc supervision and case discussion resulting in more appropriate referrals to the safeguarding team.

3.0 Key Achievements 2023/24

3.1 **ESTH:** During this reporting period the ESTH safeguarding team has:

- Ensured that the safeguarding service ran across the Trust despite operational business continuity being in place due to vacancy and unplanned absence within the team.
- Participated in multi-agency audits across Borough Place's and identified valuable learning opportunities.
- Delivered high quality, specialist training in Mental Capacity Act (MCA), Safeguarding Adults and Safeguarding Children across the organisation.
- Retained a visible presence throughout the Trust to provide safeguarding leadership and support to clinical areas.
- Developed and improved data collection within children's safeguarding to meet the emerging needs of populations.
- Supported with the Trust launch of Oliver McGowan Training Level 1; this is now with the Learning and Development teams and the ICB.
- Managed the team through a period of uncertainty and change with the launch of corporate services integration.
- Team reconfiguration with the loss of a dedicated site Associate Director of Nursing, Safeguarding Adults, Children and Community; sharing instead a joint AD post with SGUH safeguarding team.
- Completed Section 11 Children's Act audits for Merton and Sutton; clear learning and action plans developed relating to supervision.
- Inspected as part of a Joint Targeted Area Inspection for Sutton, looking at Early Help.
- Actively recruited to posts, remaining resilient and confident during the onboarding processes.
- Worked proactively and assertively with colleagues to embed safeguarding within every clinical intervention.

3.2 **SGUH:** During this reporting period the SGUH safeguarding team has:

- Managed vacancies within the team, with several longstanding staff members moving to new roles in other Trusts.
- Reviewed data collection and internal reporting to enable better evidence of 'what' and 'how' work undertaken to safeguard children, young people and adults at risk.
- Review adult safeguarding practitioner and MCA practitioner roles to combine specialisms. This will improve the breadth of practice, reduce duplication of work and improve quality of practice.
- Ratified multiple policies, including Safeguarding Children, Safeguarding Adults, Mental Capacity Act and Domestic Abuse.
- Continued recognition pan-London for innovative working relationship with Wandsworth DoLS team, enabling our BIA staff to undertake assessments to support competency.
- Sponsored an additional staff member to undertake specialist training in the Mental Capacity Act as Best Interest Assessor (this is now included in the Training Needs Analysis)
- Continued to create highly specialist training for staff cohorts in MCA, including paediatric inpatient staff with differentiation between staff banding and decisions to be made.

- Launched Safeguarding Champions training; developed MCA Level 2 Train the Trainer roll out with ongoing supervised practice opportunities.
- Whole team (including Maternity and Looked After Children) monthly specialist safeguarding training to ensure ongoing development and disseminate new learning across the safeguarding services.
- Reviewed and relaunched Safeguarding Children's Level 3 training to include case studies and contextual harms.
- Retained a visible presence throughout the Trust to provide safeguarding leadership and support to clinical areas, including Queen Mary's, and all Tooting site clinical areas.
- Intranet site for children's safeguarding has been redesigned to improve functionality, recognition of the team and provide clarity of how to refer, when to refer and who to escalate concerns to.
- Adult Safeguarding, DA, MCA and LD intranet sites have been updated with new contact details and policy.
- Standard Operating Procedures have been created within Adult Safeguarding to provide templates for roles and responsibilities of the specialist team, clinical teams and wider Trust staff.
- Developed and improved data collection within Children's Safeguarding to meet emerging needs of populations (i.e. types of incidents and more depth of reason for presentation to ED)
- Continued to work with Tableau for 'Was Not Brought' monitoring for children.
- Trained an additional 8 paediatric staff to deliver Safeguarding Supervision (awaiting supervised sessions to enable competency sign off post training).
- Supported Learning & Development teams to launch Oliver McGowan Training Level 1.
- Relaunched the Trust FGM Steering Group with Maternity colleagues.

3.3 **Additional Achievements of note in 2023/24**

- Created Business Continuity Plans across Safeguarding to support clinical areas to respond and manage safeguarding referrals during IT downtime.
- Managed the team through a period of uncertainty and change with the launch of corporate services integration.
- Team reconfiguration with the loss of a dedicated site Head of Safeguarding and shared this post with Epsom & St Helier Safeguarding team.
- Completed Section 11 Children's Act audits for Merton and Wandsworth (SGUH), and Merton, Surrey and Sutton (ESTH).
- Been inspected as part of a Joint Targeted Area Inspection for Merton, looking at Serious Youth Violence; recognised as a strong member of the Children's Partnership with excellence in recognition of 'Child' status for 16/17-year-olds (SGH).
- Participated in Wandsworth and Merton Partnership Boards as active members providing a unique acute Trust input (SGH); participated in Merton, Surrey and Sutton Boards (ESTH).

4.0 Key Risks and Challenges 2023/24

4.1 There have been key risks and challenges which have featured in 2023/24 which are provided in more detail in Annual Reports which can be found in the Reading Room together with the appropriate development or improvement actions and which are summarised as follows:

ESTH:

Training: Training compliance with Safeguarding Adults Level 3 has remained well below target. Delivery of training has been impacted by ongoing vacancies within the team. Other training

remains slightly below target compliance, however with clear and achievable plans achieve this. Mental Capacity Act training remains challenging, with further work in 2024/25 to align the offer across Group. This was highlighted in a recent Prevention of Future Deaths order.

Supervision: Adult and Children Safeguarding Supervision and Training compliance remains a risk and there are plans in place to increase compliancy. This has also been placed on the risk register. Further work on trends, compliance and training records is required and teams will ensure this is available going forward and will be added to the next annual reports. The Section 11 audits for Sutton, Merton and Surrey identified Childrens Safeguarding Supervision as an area of particular concern, impacted further by there being 1 trained supervisor within the Trust. Extensive work in planning this delivery is in place for 2024/25, included with funding via NHSE to support 'train the trainer' via the Head of Children's safeguarding to develop greater breadth of practice.

Mental Health presentations in ED: There have been increasing number of complex mental health presentations within unplanned care, with a cohort of children and young people with no medical need for admission remaining in hospital for extended periods.

Staffing: Capacity within the safeguarding team is currently an ongoing concern, due to current vacancies within both adult and children's teams. Recruiting and retaining staff has been exceptionally challenging, and there has been a high rate of sickness within the team. The two acute Trust leads are having to backfill practitioner work, leading to non-attendance at local Partnership Board meetings, or completing of audits and other quality assurance. As consequence of this, the safeguarding team capacity has been added to the risk register. Within community adult services, referral rates have nearly doubled within 2023/24 with no increase in support for the relevant lead; a Champions Programme has been developed and further work is underway to develop this.

Clinical Systems Change: delays to Cerner implementation have impacted workflow and improvements within the existing system. It has been noted that functionality within iCM will not be replicated in Cerner, with no equivalent 0 – 19 health service electronic notification being able to be completed by the assessing clinician in Cerner. Within iCM these are done at point of concern to Merton, Surrey and Sutton. This has been noted to the Cerner build and design team.

Quality Assurance: due to the level of staffing and need to provide a frontline safeguarding response, there has been no internal audit or quality assurance programme in place. This includes the ability to identify themes within care groups and offer dedicated support.

SGUH:

Children's Safeguarding Supervision; Statutory requirement under Children's Act. Delivery of Supervision in an acute environment continues to be challenging with staffing and acuity impacting staff being released to attend. There has been a working group, and the policy has been reviewed to allow for the non-case holding nature of inpatient/acute staff to be recognised. Safeguarding supervision is underway in multiple formats suitable to busy acute site and staff input to make this meaningful is being included in the policy. Recording supervision remains very labour intensive, with no simple central electronic record system currently available. Attempts to link Supervision compliance with appraisals or line manager 1:1 are ongoing.

Safeguarding Adults Level 3: Staffing challenges in 2023/24 have delayed the implementation of the Level 3 Adult Safeguarding training for staff. Work has been underway rapidly to review the Training Needs Analysis, develop and deliver training, however, has been impacted by both acuity within the Trust and also the ongoing work to find a sustainable way to record training or supervision received. Currently there is no way for individual staff members to record their own

training, reflection or supervision relating to safeguarding (which can be accessed from many sources) meaning that the levels are not reflective of the expertise within the Trust.

Clinical Systems Change: Delays in changes being made to clinical systems impact workflow and efficiency across all teams, particularly relating to ED Liaison however also for referrals to all of the Adult teams. The change is particularly significant in Children's Safeguarding with the ongoing increase in attendances post Covid and the liaison system being manual/not automated to school nurses and health visitors. This is an area of increasing risk as will be replicated for ESTH in 2025/26 with significant risk to patients and the organisation without an effective electronic solution. The Adult Safeguarding team, including Learning Disability and Mental Capacity Act continue to have no Cerner referral system live, requiring extensive manual data entry and collection.

Discharge: concerns relating to discharge increased from 2022/23, however most cases were closed following a preliminary investigation. The number of substantiated allegations reduced from the previous year. Extensive work with Transfer of Care team and clinical colleagues has been underway.

Paediatric Mental Health: Managed within Head of Nursing for Mental Health by Paediatric CNS, however rates continue to increase with more children and young people presenting in crisis or dysregulated. Work with the Safeguarding Children's Partnership, SGH Executive team and CAMHS is underway. There has also been an increase in placements being delayed and/or breaking down due to dysregulation. Workstreams are underway internally and via the ICB with the LD Commissioner and Named Designates supporting partnership working to improve the patient journey.

5.0 Priorities for 2024/25

5.1 The following areas are a priority for 2024/25, forming the basis for the Group workplan. This has been created with safeguarding leads across the Group to underpin safeguarding team integration with a Group model.

- Standardise safeguarding policies and processes where appropriate across the Group.
- Develop Trust safeguarding pages on the Intranet sites to allow for ease of access and operability.
- Ensure the voice and views of individuals at risk of abuse or neglect and those who support them is heard and responded to in order to improve the outcomes for individuals.
- Further improve quality of data collection to reflect the variety and scope of work undertaken; align with new data sets from NHS England.
- Monitor quality relating to the Standard Operating Procedures to ensure proportionate, effective and high-quality response to colleagues.
- Review the annual audit plan, completing internal and external reviews of compliance in line with strategic plans for gesh, our Partnerships & local needs.
- Support development of 'one team' for safeguarding across gesh, while delivering a high-quality site-specific safeguarding service. This will be enabled by Cerner roll out allowing cross site support and document review to enable quality assurance.
- Work with clinical areas to embed learning following clinical concerns/alerts & incidents.

- Implement the planned Level 3 Adult Safeguarding training; reviewing the existing plan, aligning training requirements and delivering a high-quality offer across sites to improve the current training compliance to achieve target.
- Inaugural gesh Safeguarding Conference in 2024, with plan to review annually.
- Continue to provide flexibility in delivery of MCA training to support specific clinical area need focusing on improving legal literacy in the application of the law.
- Develop Best Interests Assessor training for Safeguarding team members at Band 7+ to improve legal literacy, working with the Local Authority and building capacity, cross agency working an MCA excellence within the team.
- Embed Team Training Needs Analysis to ensure continued team development.
- Attain, and maintain, training compliance at 85% across the Group.
- Support team with bespoke Training Needs Analysis to identify learning and development opportunities.
- Develop standardised reporting so that the same information is being captured and reported across Group.
- Develop Safeguarding Champions to increase knowledge and capacity across community services. Using feedback from this, to utilise the programme within the Acute Trusts.

6.0 Recommendations

6.1 The Board is asked to:

a. Receive the report for assurance
b. Make recommendations for any further action