St George's University Hospitals NHS Foundation Trust
Council of Governors Meeting

12 March 2025 (Public)
Agenda and papers

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on Wednesday, 12 March 2025, 17:30 – 19:15

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

Feedback from Governor visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
17:30	-	Feedback from visits to various parts of the site	Governors	Note	Verbal

1.0 Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
17:45	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	All	Approve	Verbal
	1.4	Action Log and Matters Arising	All	Note	Verbal

2.0 Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
17:55	2.1	Group Chief Executive's Report	GCEO	Update	Report
18:10	2.2	Strategy Update	DS&I	Update	Report

3.0 Quality and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18:20	3.1	SGUH Operational Performance	MD-SGUH	Discuss	Report
18:35	3.2	Never Events	GCMO	Discuss	Report

4.0 Finance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:00	4.1	Finance Update	GCFO	Discuss	Report

5.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:15	5.1	Any Other Business	All	Note	Verbal
	5.2	Council of Governors Forward Plan/Calendar of Events	All	Note	Report
	5.3	Reflections on Meeting			

St George's University Hospitals
NHS Foundation Trust

Council of Governors Purpose	The general duty of the Council of Governors and of each Governor individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhatt	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Sandhya Drew	Public Governor, Rest of England	SD
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Chelliah Lohendran	Public Governor, Merton	CH
Hann Latuff	Public Governor, Merton	HL
Julian Ma	St George's University of London	MA
Atif Mian	Staff Governor, Allied Health Professionals and other Clinical and Technical Staff	AM1
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Georgina Sims	Appointed Governor, Kingston University	GS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
In Attendance		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director, Vice Chair	AB
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director	YJ
Peter Kane	Non-Executive Director	PK
Ralph Michell	Director of Strategy & Integration	DS&I
Andrew Murray	Non-Executive Director	AM
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Apologies		
Natalie Armstrong	Non-Executive Director	
Pankaj Dave	Non-Executive Director	
Marie Grant	Public Governor, Rest of England	
Claire Sunderland Hay	Associate Non-Executive Director	

St George's University Hospitals NHS Foundation Trust

Minutes of the Meeting of the Council of Governors (In Public)
Thursday 12 December 2024
Harry Axton Room, Hunter Wing

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Trust Chairman	Chairman
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
James Bourlet	Public Governor, Rest of England	JB
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
John Hallmark	Public Governor, Wandsworth	JH1
Chelliah Lohendran	Public Governor, Merton	CH
Julian Ma	St George's University of London	JMA
Lucy Mowatt	Public Governor, Wandsworth	LM
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Georgina Sims	Appointed Governor, Kingston University	GS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
In Attendance		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall	Group Chief Officer, Facilities, Infrastructure & Environment (item 2.4)	GCOFIE
Ann Beasley	Non-Executive Director, Vice Chair	AB
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director	YJ
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director	AM
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer (item 2.3)	GCPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Tim Wright	Non-Executive Director	TW
Apologies		
Sandhya Drew	Public Governor, Rest of England	SD
Peter Kane	Non-Executive Director	PK
Atif Mian	Staff Governor, Allied Health Professionals and other Clinical and Technical Staff	AM1
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
Absent		
Stephen Worrall	Appointed Governor, Wandsworth Council	SW

	Feedback from Governor visits	Action
	Feedback from visits to various parts of the site A number of Governor visits had taken place since the last meeting. The visit to theatres had raised on question on staff rotas and whether those working very late then had to be back in theatre early the following morning. MD-SGUH did not think this would be happening but would look into this.	**MD-SGUH**

1.0	OPENING ADMINISTRATION	Action
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting.	
1.2	**Declarations of Interest** There were no new declarations of interest.	
1.3	**Minutes of the Public meeting held on 25 September 2024** The minutes of the meeting held on 25 September 2024 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors reviewed the action log and agreed to close the actions proposed for closure as these were items on the agenda.	
2.0	**STRATEGY**	
2.1	**Group Chief Executive Officer's (GCEO) Report** The GCEO referred the meeting to her report and highlighted the following points: • The Secretary of State for Health and Social Care and the Chancellor had visited St George's ahead of the autumn budget. They had been very interested in the work that was taking place and had taken time to speak with staff. A follow up letter from the Chancellor had commented on the warm welcome she had received. • The Electronic Patient Record programme was moving forward. This had been used at St George's for some time so the focus of the work was at ESTH but some areas at St George's would see differences. It was noted that elective work would reduce in May to support the change over. DF remarked that when the change had been made St George's there had been a number of days when records had to be maintained manually and suggested that this be shared with ESTH as a potential risk. • A response had been submitted to the Government's consultation on the 10 year plan for the NHS, In response to a question, the GCEO said it was too early to be sure but she felt it unlikely that the 10 year plan, once issued, would result in any significant changes to our strategic plan as it contained the same themes. Minor adjustments would be made if needed. • In common with most acute providers, St George's had an operating deficit. Deloitte had been appointed to carry out some analysis of whether any further	

	savings could be made or processes that could be improved. The first report had confirmed that the right controls were in place and that leaders had a grip on these. Work would continue to look at other areas of cost savings – it had been suggested that a recruitment freeze could be implemented but she was reluctant to do this on an indiscriminate basis. The pace of progress with digital improvements would need to increase to support savings. • It had now been confirmed that the CQC Well Led Inspection would take place from 25-27 February 2025. ESTH would be inspected at a later date. • The NHS Sexual Safety Charter had been launched across the group. SF asked what the success criteria were, beyond an increase in reporting. GCEO confirmed that it was anticipated that there would be an initial increase in reporting but also that the staff survey would show improvements in how safe staff felt at work. • The gesh Care Awards had taken place on 10 December, thanks were recorded to the Comms Team for their work in making it such a successful evening. It was confirmed that the awards were to be an annual event. • The annual staff survey had now closed. There had been a significant push to encourage staff to take part, with a final figure of 47%. JMA asked about collaboration and partnerships, and in particular the relationship under the new structure at City St George's. The GCEO said that it was early days, but it was felt that this would be a real opportunity for SGUH to be seen as a place with academic strength. In discussion it was noted that there was a period of change at the university following the merger which was unsettling for people. The Chairman confirmed that there was a relationship with both the Head of School and Head of the University, with the former being a significant post. The Chairman was a member of the University Council and the new Head of School would be joining the Board from the new year. The Chairman noted that the university had enormous capacity that SGUH could not match, so although both parties were clear this was a partnership, it would need to be ensured that the SGUH priorities were not driven by the University. The link with Kingston University for nursing and midwifery courses was also recognised as important. JB asked for information on employment checks within the trust and whether there were external sources who individuals could be referred to. The GCEO explained that all staff had pre-employment checks which included DBS, right to work in the UK and ID checks. Once employed any concerns about capability or conduct could also be raised with relevant professional bodies. During discussion, the GCEO said that she was proud of the diverse workforce at SGUH, and that included diversity of views. Steps should only be taken if the action of a member of staff brought the trust into disrepute and/or breached one of the trust policies.	
2.2	**Strategy Update** GDCEO referred the meeting to his report, explaining that business planning was underway with the Care Framework used for priority setting. Progress was also being made by the GCMO on a gesh approach to research. The new GCOFIE was also working with the strategy team on the timelines to bring the estates function together, with it being noted that the most significant estates issues were at ESTH. The recent Group Board Development Session had considered a gesh surgery strategy which would bring benefits for SGUH patients and for SGUH tertiary services.	

	Governors noted that finance remained the biggest challenge to the trust with a balance needing to be made between long term strategic improvements which may need investment against the current financial position. An example of this was the work on High Performing Teams which would make faster progress, and impact more rapidly, if there was the opportunity to direct more funding to it. In response to a question, the GDECO said that the trust was very good at identifying and mapping the work of high performing individuals to support continuous improvement and develop a bank of evidence, but more could be done at a team level. The GDCEO confirmed that the patient portal was proving successful although there were a few challenges to be worked through such as duplicate information showing. The patient portal was being worked on across South West London so that there was single pathway but although networks were supportive, this was not moving as fast as he would have hoped. The Council noted the Group Strategy Update report.	
2.3	**People Strategy Update** The GCPO referred the meeting to her report, explaining that although this was a strategy she had inherited she fully supported its aims. Questions were invited. Governors queried why appraisals were not compulsory? The GCPO said that there was a 73% completion rate on appraisals compared to a target of 80% so there would be a focus on those who had not had an appraisal uploaded in the last 18 months. Feedback from staff was that the process needed to be simplified with the GCPO also believing that the benefits of appraisal as part of reward and recognition needed to be promoted. Line managers also needed to be supported to ensure the conversations were not just retrospective but also looked forward. The GCPO did not believe that making them compulsory was appropriate as they should be a collaborative, supportive and developmental process not linked to disciplinary. It was noted that completion rates would fluctuate during the year as there was no set time period unlike, for example the civil service, where all appraisals were carried out at the same time. Although this has had some benefits it did have a negative impact on service delivery. A query was raised on the leadership of the culture aspects of the strategy as it was felt that it was not clear that this came from the top. During discussion it was noted that the strategy, which was agreed by the Board, was owned by everyone. Although the leadership could be clear on what the strategy was, and how it should be implemented, in a large organisation where they could not be in all departments at all times, it was the responsibility of everyone to ensure a healthy culture. Governors asked about the use of apprenticeships as part of the strategy. The GCPO reminded governors that there was a 0.5% levy which went into an apprenticeship fund which employers could then draw down from for one day of training/study for each apprentice per week. However, this did not cover the cost of backfilling whilst people were on their course which was a significant issue, particularly for clinical staff. The GCPO was asked how the success of the People Strategy would be measured. It was explained that the most effective way of doing this would be through the longitudinal surveys as this would ensure consistency of questions and approach. In the future, the GCPO suggested that some pulse surveys might be considered. Governors thanked the GCPO and noted the report.	

2.4	**Estates Update** The GCOFIE referred the meeting to his report. Before inviting questions, he highlighted the support of the St George's Hospital Charity which had helped fund some of the improvement works set out in the report. The progress on the new ITU was also noted. A query was raised on the delay to the renal unit and whether this was related to funding. GCOFIE reminded Governors that the original business case had been submitted in 2019. Since then, prices had doubled which would have an impact. However, he was optimistic that if the funding was released by the New Hospitals Programme the build could be completed by 2029. The Chairman noted that the renal unit was linked to the BYFH programme at ESTH and the complexities of this should not be underestimated. It had been expected that the planning application would be reviewed by the Local Authority Planning Committee in December but this had been postponed until January. The Chairman confirmed that any delay to the renal unit would not have an adverse effect on patients. Governors asked about the backlog of maintenance. The GCOFIE said that an updated survey was needed but strategies were being implemented to address the backlog, with those that impacted patient and staff safety always prioritised. However, like all trusts, there had been insufficient funding over a long period of time which added to the challenge, which would a take a number of years to resolve. It was queried whether the preferred method was to replace or repair broken equipment. The GCOFIE said that this was dependent on the item as some were not suitable for repair, or repair was more expensive than replacement. The GCOFIE said that the prioritisation of projects could be looked at again but the success measures were always: on time, on budget and the objectives met. The Council thanked him for his report and noted the Estates update.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**Performance (Operational, People, Quality - alternating cycle)** The MD-SGUH referred the meeting to the report, highlighting the work that was being done to improve patient flow. At present there were only 10 patients who had been waiting longer than 65 weeks and the focus was now on those waiting more than 52 weeks. Cancer services had seen a slight dip in September but there was a really good and focused programme to drive down waiting times for breast care. Governors asked whether theatres were being fully utilised. The MD-SGUH said that there were a wide range of issues that impacted on theatre utilisation but SGUH did well with inpatients. QMH was however, not performing well and 1 theatre had been temporarily closed. Governors were assured that there was robust planning and a very engaged team supporting the work. The MD-SGUH was asked about the impact of mental health patients on the ED which had been raised at the last meeting. It was explained that there was collaborative working across the system to address the issue with South West London St George's opening additional beds. From the new year there would also be an additional member of staff in the ED, with experience and knowledge of signposting for patients with mental health conditions that would be more appropriately supported by another provider. In response to a question, the MD-SGUH said that ambulance handover times had not performed as well in October. The London Ambulance Service had a 45 minute wait time but it should be remembered that not all patients who came in by ambulance	

	needed to be admitted. It was acknowledged that at times patients were waiting in corridors.	
3.2	**Learning from Complaints** The GCNO referred the meeting to the report and, in response to questions, explained that the increase in the outstanding complaints was partly due to staff shortages but also here had been more complaints received. It should be noted that not all complaints were upheld. It was confirmed that complaints were triangulated with PSIRF. When asked about different pathways for dealing with complaints, the GCNO said that PALS was an excellent resource, dealing with thousands of issues every year. Patients and relatives could make contact in person, by phone or email. The GCEO added that it was also hoped that any concerns or complaints could be addressed in the moment rather than needing a formal process. Both patients and staff were encouraged to do this, but on occasion a full response was needed. It was raised that there could be inequalities in the complaint handling process with those that knew there was a GCEO or Chairman that could be contacted, taking the route to get a faster response. The GCEO recognised that this did happen on occasion. The GCNO concluded by saying that she would like to reduce the number of complaints, and the time taken to resolve them, drastically. Work would also be done with non-nursing colleagues to support this.	
4.0	**Finance**	
4.1	**Finance Update** On behalf of the GCFO, AB referred governors to the report. The Finance Committee and Board were not confident that the deficit could be recovered in year as, as had been explained, work by Deloitte's confirmed that there was a strong grip on the controls. It was felt that at this point in the year there were limited material savings that could be made. It was queried whether the costs incurred in supporting other trusts impacted by a cyber incident could be recovered. AB responded that it was more likely that this sum would be discounted by NHSE than a payment be made. It was confirmed to governors that the cost of the work by Deloitte's had not been funded by the trust.	
5.0	**Governor Elections**	
5.1	The GCCAO gave a verbal update on the governor elections following the closing of nominations earlier in the week. • 4 nominations had been received for the 2 Rest of England vacancies • 3 nominations had been received for the 2 Merton vacancies • No nominations had been received for the South West Lambeth vacancy Candidates would be given until 16th December to withdraw and the ballot would open on 6th January, closing on the 30th with results available on 31st. New governors would then be in post from 1 February. The GCCAO reminded governors that this was the second time that there had not been any nominations for South West Lambeth. This was despite advertising on the trust website and local forums. Another process would be run next year to try and recruit to this role.	

	AB1 reported that governors had been discussing the support for new governors as some of those recently elected had not felt this had been lacking. The GDDCA was working on an induction programme and a number of governors had offered to be buddies to new governors.	
6.0	**Membership Engagement**	
6.1	The GDDCA referred the meeting to her report highlighting that progress was being made on the membership engagement strategy. There had been a good open rate of emails promoting the Annual Members Meeting and the first newsletter had been issued. It was hoped that the second newsletter would be issued before Christmas. As part of the election mailings, members were being asked to provide their email address as of the 12,000 members, only 4500 email addresses were held. The members and governor pages on the website had also been refreshed. Dates for 'Meet Your Governor' Events had been suggested and calendar invites would be shared. In response to a question, the GCCAO said that there was a 'crib sheet' for governors to use at these events which could be recirculated.	GDDCA
7.0	**Closing Items**	
7.1	**Any Other Business** There were no matters arising.	
7.2	**Council of Governors Forward Plan** The forward plan was noted.	
7.3	**Reflections on the meeting** The Chairman thanked everyone for their contributions but reflected that the agenda had been too long meaning that discussions had had to be shut down. AB1 said responded that there had been a number of items that governors had asked to be on the agenda and agreed with the Chairmans's suggestion that consideration be given to whether there should be fewer items considered in greater depth with more items only for noting. In his absence, the Chairman wished to record her thanks to the GDCEO who would be leaving the trust at the end of March. His hard work, kind approach and dedication had brought much to the trust and the Council.	

Date of next Meeting

12 March 2025 5.30pm-8.30pm Hyde Park Room

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St George's University Hospitals NHS Foundation Trust

Council of Governors

Meeting in Public on Wednesday, 12 March 2025

Agenda Item	2.1	
Report Title	**Chief Executive Officer's Update**	
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 three months to update the Council of Governors on strategic and operational activity across the St George's University Hospitals NHS Foundation Trust. 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 Council of Governors

The Council of Governors is asked to note the update.

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				
N/A				
Environmental sustainability implications				
N/A				

Group Chief Executive Officer's Update

Council of Governors, 12 March 2025

1.0 Purpose of paper

1.1 This report provides the Council of Governors with an update from the Chief Executive Officer on strategic and operational activity across St George's University Hospitals NHS Foundation Trust 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 From a Group-wide perspective, the key part of the announcement was the delay in the construction of the Specialist Emergency Care Hospital (SECH) at Sutton, and the upgrade for Epsom and St Helier Hospitals, which has been allocated to the second wave, with construction scheduled to start between 2033 and 2035 and completion anticipated between 2037 and 2039.

2.3 From a St George's perspective, the direct implications of the announcement were in relation to the consolidation of Renal services on our Tooting Site. Our Renal Development Programme is a big priority for gesh and will transform care across South West London and Surrey, bringing specialist kidney care into one place while strengthening outpatient services in local hospitals, clinics and at home. A key part of our plan is the development of a new state-of-the-art renal facility adjacent to the Atkinson Morley Wing. We are currently advancing through the next stage of its design to ensure it meets the highest standards of care for patients and in January 2025 Wandsworth Council approved the plans for the build. Following the recent review of the New Hospitals Programme, we have been asked to temporarily pause progress on the new unit. We are ready to move forward as soon as a clear path is agreed with all of our partners.

Government plans for reducing waiting lists

2.4 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 the South West London Elective Orthopaedic Centre (SWLEOC) on 6 January 2025. SWLEOC, which is a partnership between the four acute trusts in South West London, provides orthopaedic services to patients from St George's, Epsom and St Helier, Croydon and Kingston. As part of the announcement, the Prime Minister, the Secretary of State for Health, and the Chief Executive of NHS England toured SWLEOC, hearing from staff about the service's success in reducing length of stay for patients needing procedures such as hip and knee replacements.

2.5 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).

2.6 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.

2.7 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 SWLEOC, shone a spotlight on the vital work of the Centre in reduce waiting lists and tackling the elective care backlog to the benefit of patients across South West London.

Leadership changes at NHS England

2.8 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.

2.9 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

2.10 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.

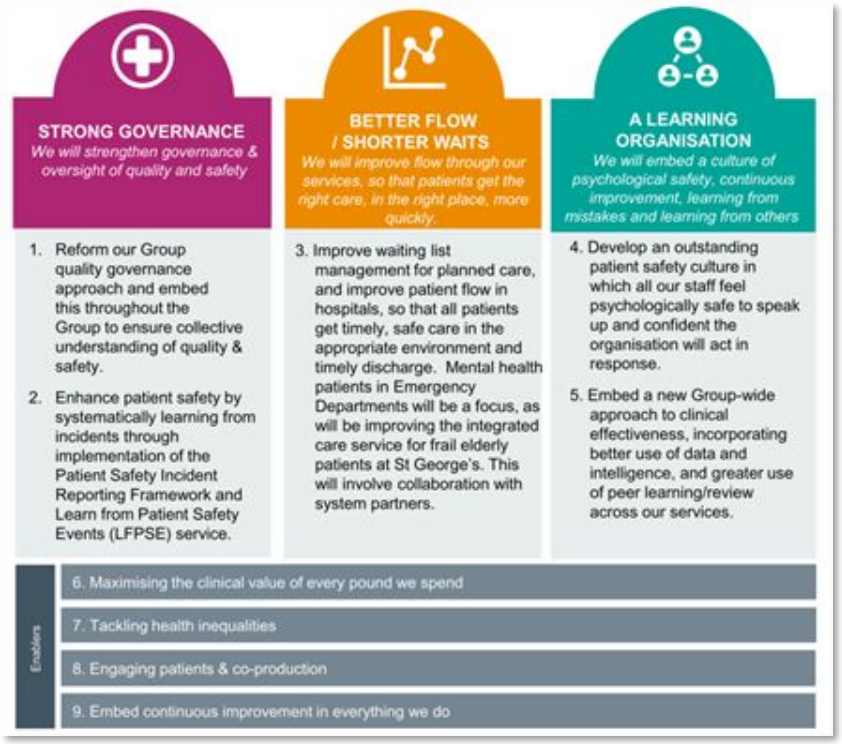
3.0 Our Group

Launch of our new gesh Quality Strategy

3.1 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. Despite these challenges, the overarching Group Strategy, launched in May 2023, set ambitious goals, including the aspiration that by 2028:

- Waiting times among the best in the NHS
- Lower than expected mortality rates and a reduction in avoidable harm
- Improved patient outcomes and patient experience
- A reduction in health inequalities

3.2 To help us achieve these overarching ambitions, we have developed a Group-wide Quality and Safety Strategy, which the Group Board approved in September 2024 and was launched to staff in December 2024. The new Quality and Safety Strategy outlines our plans for the next four years to strengthen our quality governance and oversight of quality and safety, reduce waiting lists and improve flow through our hospitals, and support us in becoming a learning organisation, with a strong culture of psychological safety and continuous improvement. The core elements of our new Quality and Safety Strategy are set out below:



Launch of our new gesh People Strategy

3.3 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.

3.4 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 for 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":

3.5 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.

3.6 The People Strategy Implementation Plan has been developed which sets out clear timescales for the delivery of the Strategy. This has been reviewed by the People Committee, which will continue to monitor implementation closely.

Launch of our new gesh Equality, Diversity and Inclusion Plan

3.7 In addition to our new People Strategy, the Group Board has also approved a new Group-wide Equality, Diversity and Inclusion Plan. The Plan was developed to align with and implement locally the "high impact actions" set out in the national EDI action plan published by NHS England in June 2023. The Plan is structured into six overarching workstreams:

i. Leadership commitment (including Board development and Executive sponsorship

ii. Inclusive recruitment and talent management
iii. Eliminating pay gaps
iv. Improving health and wellbeing
v. Supporting internationally recruited staff
vi. Safeguarding our workforce

3.8 In terms of our leadership commitment, all Board members (Non-Executive and Executive Directors and Executive Directors) have a specific EDI objective as part of their annual objectives. We have strengthened our sponsorship of the Staff Networks and the corporate support available to the networks. We are reviewing all senior management role descriptions through an EDI lens to ensure we appoint leaders that demonstrate a deep commitment to driving race equality, inclusion and positive culture. We are also ensuring that the Board receives relevant EDI data and relevant reporting, including pay gap reporting, reporting on the Workforce Race Quality Standard and Workforce Disability Equality Standard, and preparing an annual Public Sector Equality Duty Report.

CQC 'well led' inspection at St George's

3.9 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

Gesh CARE Awards

4.1 In December 2024, we hosted our first ever gesh CARE Awards. This event is linked to our CARE Strategy, which aims to sustain an organisation of "engaged and empowered staff". Nearly 400 guests attended the event to celebrate the dedication and achievements of our teams, while nearly 300 people watched the event online.

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

4.3 This is one of several initiatives we have launched to reflect our CARE strategy and respond to the feedback received in our 2023 NHS Staff Survey.

Farewell and thank you to Gillian Norton

4.4 I wanted 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.

Welcome to Sir Mark Lowcock

4.5 I also very much look forward to working with our incoming Chair, Sir Mark Lowcock KCB, who succeeds Gillian on 1 April 2025. 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 James Marsh

4.6 As well as saying goodbye to Gillian, we also say goodbye to James Marsh, who stood 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.

4.7 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

4.8 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

4.9 Over the past week, we have celebrated International Women's Day, with our Women's staff networks hosting a series of events throughout the month. This year's #AccelerateAction theme is all about taking bold steps towards gender equality. We held a gesh International Women's Day celebration event at St George's on 5 March have further events planned later in the month.

4.10 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.

4.11 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 Council of Governors is asked to note the update.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Wednesday, 12 March 2025

Agenda Item	2.2	
Report Title	**Group Strategy Update**	
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer	
Report Author(s)	Zahra Abbas, Group Strategy and Planning Manager Annastacia Emeka-Ugwuadu, Head of Group PMO	
Previously considered by	n/a	
Purpose	**For Noting**	

Executive Summary

On 15 May 2023 we launched our new five-year strategy for St George's, Epsom and St Helier University Hospitals and Health Group. **Our vision for 2028 is – we will offer outstanding care, together.**

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

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

This report describes progress in these three areas since the last COG update.

Action required by Council of Governors

The Council of Governors is asked to:

1. Note the update

St George's University Hospitals
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Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group Strategy Update

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
Regulated activities				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
As per report				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations				
Equality, diversity and inclusion implications				
As per report				
Environmental sustainability implications				
As per report				

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Group Strategy update

Council Of Governors

Ralph Michell
Director of Strategy

Report Authors:

Zahra Abbas, Strategy and Planning Manager
Annastacia Emeka-Ugwuadu, Head of Group PMO

13 March 2025

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Introduction

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This is the latest update to Council of Governors on progress delivering our Group strategy.

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

In response to this analysis, the Board has agreed some actions as part of planning for 25/26, which are also summarised here.

Council of Governors is asked to note the update

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Changing environment for gesh (1)

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

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

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Changing environment for gesh (2)

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

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Our approach to delivering our strategy

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Local improvement

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

Corporate enablers

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

Strategic initiatives

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

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University Hospitals and Health Group

Local improvement

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

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

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

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Corporate enablers

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

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

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

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Strategic Initiatives Update

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Initiative / Programme	Update
Building Your Future Hospitals (BYFH)	• The recent government decision to place BYFH in Wave 2 has resulted in a further 5 years delay for the programme, pushing SECH development further back to 2033-2035. Several Group level discussions have taken place since this development and key external stakeholders have been informed of the delay & remain supportive, acknowledging that time is needed to establish a forward plan.
Collaboration across GESH	• Structural integration of corporate services is now complete for corporate affairs, communications, Deputy CEO office, corporate nursing. It is nearing completion for corporate medicine. The senior leadership of the HR department has now been integrated, with integration of the rest of the department underway. Integration of the estates & facilities department has begun. Integration of the finance department is expected to conclude in 25/26, with a timeline for digital service integration being developed. • There has been progress in collaboration across clinical services, including in surgery, anaesthetics, renal, paediatrics, and pharmacy. • Corporate teams are taking action to enable integration/collaboration across the Group, including aligning policies
Collaboration across Southwest London hospitals (Acute Provider Collaborative)	• Work to strengthen APC partnerships hosted by gesh (e.g. SWLEOC), and to deliver agreed transformation programmes continues. • Intensive work underway to identify new collaborative opportunities as part of planning for 25/26. • Scoping exercise on potential new digital technology in elective care is being progressed by task and finish group.
Collaboration with Local Partners (Place)	• The programme of work continues to progress across the three established workstreams: provider partnership, integrated frailty services, and length of stay. • Communities of Practice established with group frailty consultants enabling alignment to national best practice while being responsive to local needs leveraging Place partnerships as vehicles for delivery. • Merton and Wandsworth Provider Alliance Working Groups successfully established with mandate endorsed by gesh Board for stimulating delivery of collaboration and development of alliance care models. • A group review of site project plans for managing length of stay has been successfully convened, with robust performance metrics developed to track delivery and provide assurance.

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Strategic Initiatives Update

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Initiative / Programme	Update

Strengthening our Specialist Services	• The ICB has formally approved the commencement of system-level commissioning of specialised services starting from 1 April 2025.
	• Work underway to strengthen the financial position of our specialised services including:
	  ○ The paediatric teams have collaboratively developed a networked model for paediatric oncology shared care units across gesh, meeting NHS England's service specification at a lower cost while enhancing staff expertise and delivering holistic, locally accessible care.
	  ○ The paeds team have developed a proposal for a networked model
	  ○ Work to strengthen our Major Trauma Centre 'Model of Care' is underway, bringing together multidisciplinary teams to deliver more joined up care.
	  ○ Strengthening Cardiac Surgery Services: Successfully recruited a substantive cardiac surgeon starting April 2025 who specialises in minimal access mitral surgery and will be part of the dissection rota. 2 Cardiac Anaesthetists have been recruited substantively.

High Performing Teams & Leaders	• Design and delivery groups enabling further development and alignment of planned work for this strategic initiative progressing well. The initial outlines and structure for most workstreams complete. • Initial scoping of financial benefit enabled through embedding high-performing teams/a quality management system now complete. • Team making progress to upskill staff and leaders through robust CI training and platform to converge and share best practice. • Group exec away day to discuss the progression of HPT and relationship with operational excellence. • Gesh leadership programme launched with strong alignment to HPT. • Engaging with site leads to enable discussion or priority first focus areas / services – agreement has been made in principle.
Culture, diversity and inclusion	• gesh Culture Forum and gesh People group successfully established to provide better assurance and more robust governance/steer. • Planning continues in the development of a shared set of values across gesh alongside a behaviours framework • Mapping of existing leadership development programmes progressing. • Sexual Safety Steering Group established (chaired by Group CNO) - meetings in progress to oversee activity • Policy and toolkit currently in development due to be launched April 25
Shared electronic patient records across gesh	• Programme still on track to achieve May 25 Go- Live. Development and sign off cut over plan underway. • Formal organisational readiness oversight structure stood up. • Action plan has been developed following the completion of programme reviews. • Upcoming priorities include reviewing Critical Friend assurance feedback and progressing with identified action areas
Transforming Outpatients	• The programme structure is in place and operational, including Steering Group and Design & Delivery groups for the four key workstreams • New, group-wide, Outpatients Transformation projects have been identified to support operational and financial imperatives, whilst aligning site based schemes • A strong focus on a 'Digital First Approach', through pioneering AI and Automation tools.

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Our ambitions for 2028

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

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

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Board response

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At its January meeting, the Board reviewed the changing environment/progress in delivering the strategy and agreed that:

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

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

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

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Recommendation

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St George's Council of Governors is asked to:

- Note the update

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St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Wednesday, 12 March 2025

Agenda Item	3.1	
Report Title	**SGUH Operational Performance**	
Executive Lead(s)	Group Deputy CEO	
Report Author(s)	Group Director of Performance & PMO	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

This report provides an overview of the key operational performance information across St George's Hospitals (SGUH) based on the available data (January 2025), highlighting several improvements and achievements, along with an overview of significant challenges and the actions implemented to address them.

Action required by Council of Governors

The Council of Governors is asked to:

1. Note the report.

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

Regulated activities

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

St George's University Hospitals
NHS Foundation Trust

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

Financial implications

Legal and / or Regulatory implications

Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity and inclusion implications

Environmental sustainability implications

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SGUH Operational Performance Report

January 2025

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 07 Mar 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.

Operational Performance

Overview Dashboard | Elective Care

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St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	National Benchmark
Elective Ordinary Activity % of plan	Jan 25	88.5%	86.2%	-			
Elective Daycase Activity % of plan	Jan 25	106.0%	92.2%	-			
Outpatient first attendances without a procedure - ERF scope % of plan	Jan 25	145.8%	144.0%	-			
Outpatient procedures - ERF scope % of plan	Jan 25	94.6%	72.6%	-			
Diagnostic Activity	Dec 24	98.8%	106.0%	-			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Oct 24	79.7%	80.2%	83.6%			Lowest Quartile
Theatre Utilisation (Capped)	Jan 25	76.2%	78.5%	85.0%			2nd Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Jan 25	1.6%	1.7%	5.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Jan 25	53.4%	51.8%	49.0%			2nd Quartile
Outpatients Missed Appointments (DNA Rate)	Jan 25	10.2%	10.2%	8.0%			Lowest Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Dec 24	17.9	16.1	16.0			3rd Quartile
RTT - Waits over 65 weeks	Dec 24	31	24	0			2nd Quartile
RTT - Waits over 52 weeks	Dec 24	858	906	410			2nd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Dec 24	84.5%	86.1%	77.0%			Top Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Dec 24	96.1%	94.6%	96.0%			2nd Quartile
Cancer 62 Day Referral to Treatment Standard	Dec 24	76.9%	77.4%	70.0%			2nd Quartile
Diagnostics - 6 Week Waits	Jan 25	11.8%	5.4%	5.0%			2nd Quartile
Watch List KPIs							
RTT - Total Size Incomplete Waiting List	Dec 24	67362	68291	63826			Highest 25%
RTT - Percentage within 18 weeks	Dec 24	62.6%	62.1%	92.0%			2nd Quartile
RTT - Median Waiting Time	Dec 24	12.7	13.5	-			2nd Quartile
On the Day Cancellations not re-booked within 28 days	Jan 25	3	8	0			2nd Quartile

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

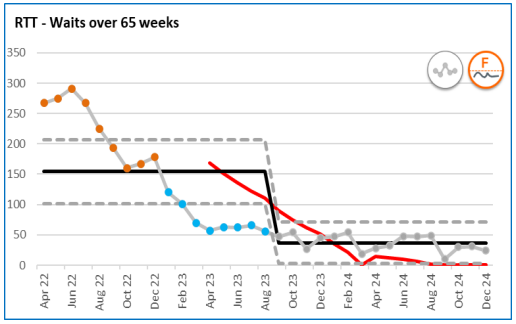
Operational Performance

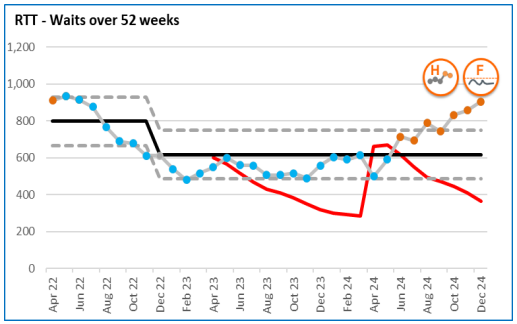
Overview Dashboard | Urgent and Emergency Care

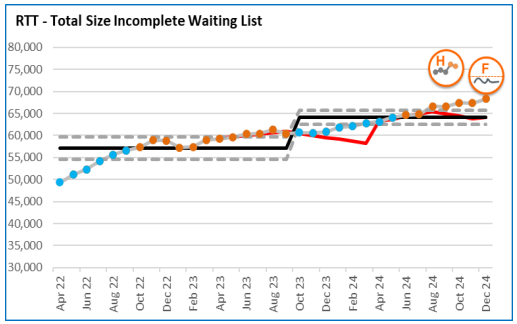
	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
4 Hour Operating Standard	Jan 25	79.7%	78.3%	78.0%			Top Quartile
Over 12 Hours in ED from Arrival (%)	Jan 25	9.1%	9.5%	8.8%			Top Quartile
Ambulance handover Performance 30 - 60 minutes	Jan 25	31	37	-			
Ambulance handover Performance 60+ minutes	Jan 25	1	2	0			
Non Elective Length of Stay	Jan 25	9.4	10.4	-			
Length of stay > 21 days (super stranded)	Jan 25	151	161	117			3rd Quartile
Overnight G&A beds occupancy - Adults	Jan 25	94.7%	94.6%	90.8%			2nd Quartile
Number of patients not meeting criteria to reside (Daily Avg)	Jan 25	128	137	86			2nd Quartile
Watch List KPIs							
Mental health delays 4 Hour Breaches	Jan 25	124	125	-			

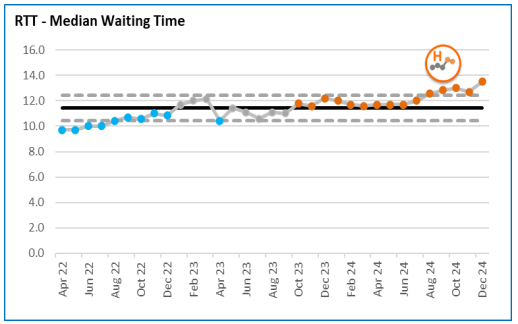
Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)





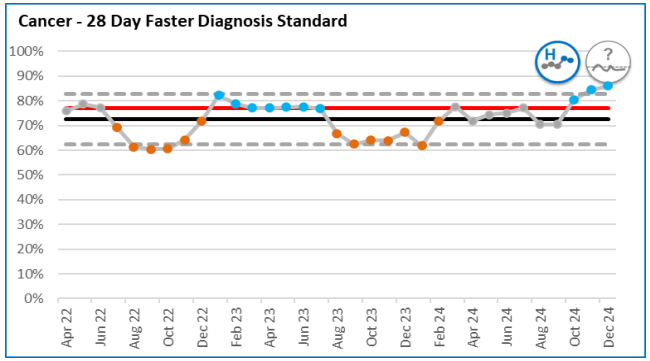


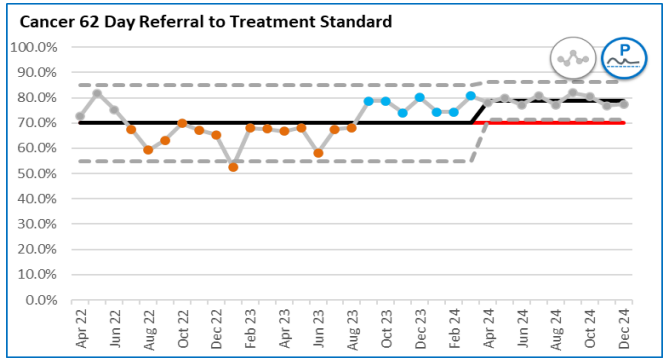


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 0 52 week waits behind plan of 364 Waiting list size behind plan by 9%	At the end of December 2024; • 65 week waits – Further reduction 24 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 | SGUH Cancer Faster Diagnosis Waiting Times

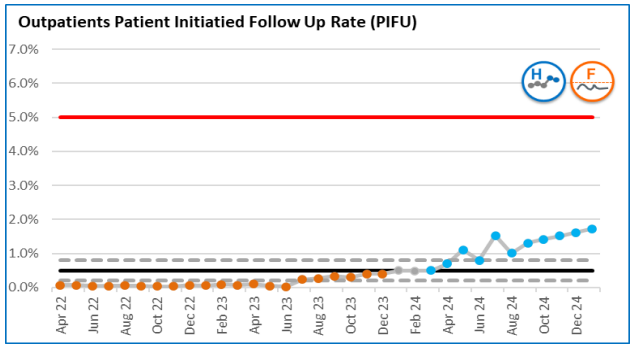




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS Target being met 62 Day Standard Meeting System Wide Target	The Trust recorded a further improved Faster Diagnosis performance in December 2024 achieving 86.1%, surpassing 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

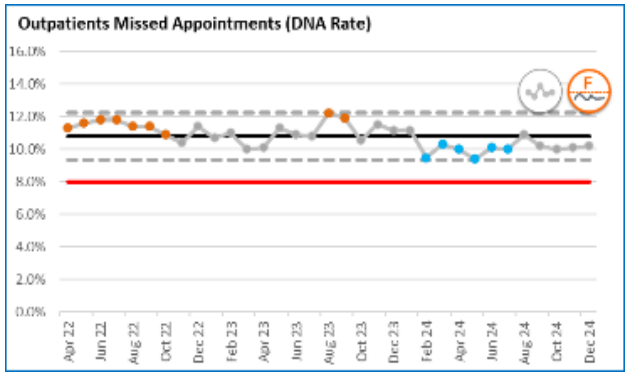
Exception Report | SGUH Patient-Initiative Follow Up (PIFU)



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

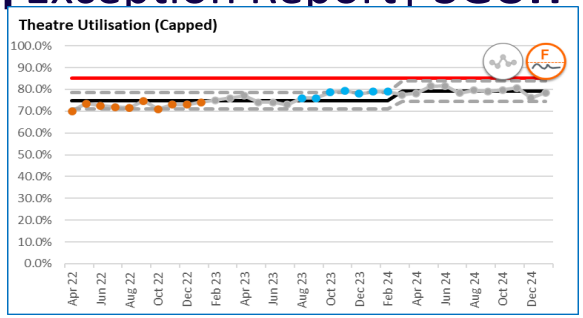
Exception Report| SGUH Missed Appointments (DNA Rate)

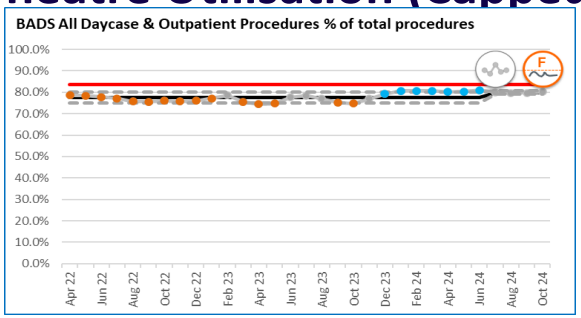


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	• Current DNA rates of 10.2% compared against Peer average performance 8.6% • First appointment DNA Rate 11% highest 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

Operational Performance

Exception Report | SGUH Theatre Utilisation (Capped) & Daycase Rate





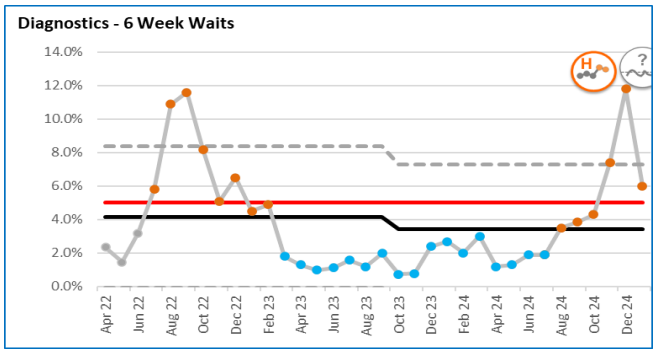
Model hospital recently updated capped utilisation methodology introducing additional exclusions which improves performance for both Trusts. Internal reporting to be updated to align.

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

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

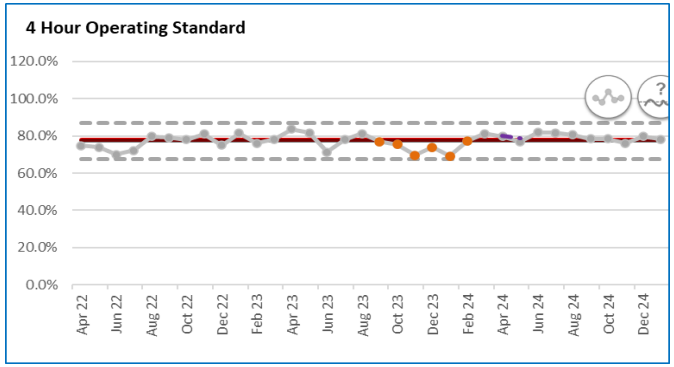
Exception Report | SGUH Diagnostic Performance

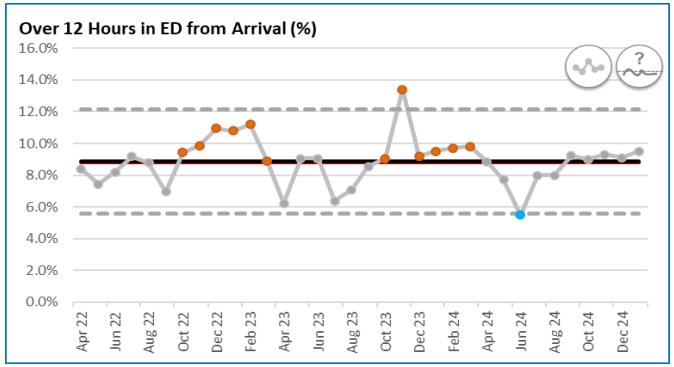


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Target not met	At the end of January 2025, 94.6% of patients waited less than six weeks for a diagnostic test compared to 88.2% at the end of December 2024, showing an 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| SGUH A&E Waits

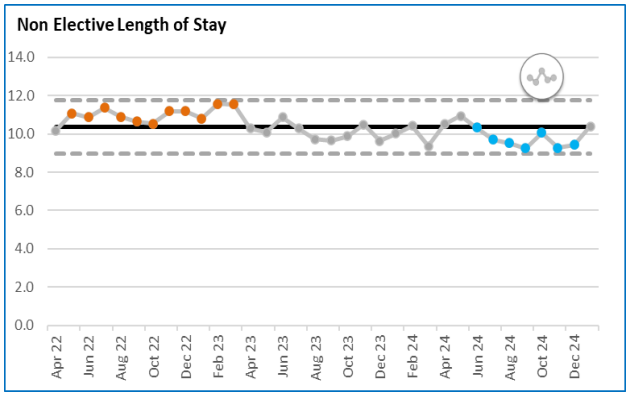


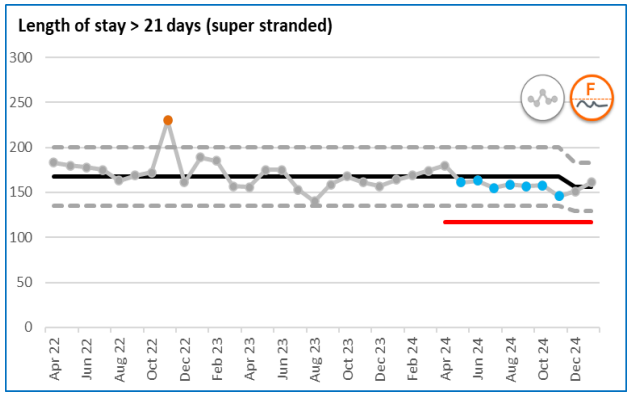


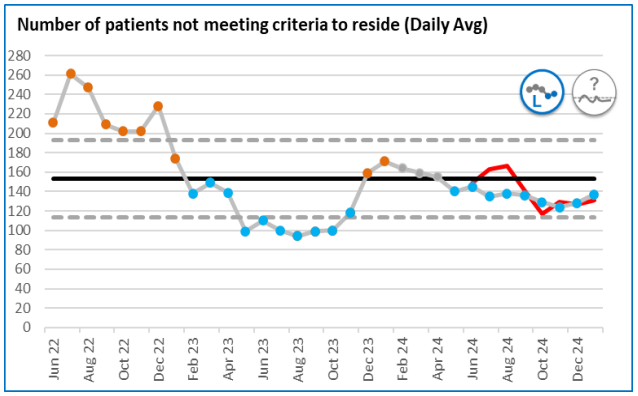
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in January 2025 – variances in performance	Four Hour Performance in January 2025 was 78.3% Admitted performance continues to be challenged with average 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 | SGUH No Criteria to Reside (NCTR) and LOS







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

gesh

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

Appendices

13

Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Appendix 2

Metric Technical Definitions and Data Sources

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

Glossary of Terms

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

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

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

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

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

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NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting on Wednesday, 12 March 2025

Agenda Item	3.2	
Report Title	**Never Events at St George's: 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	Group Board Quality Committee	06 March 2025 27 February 2025
Purpose	**For Assurance**	

Executive Summary

The Council of Governors has previously been briefed on Never Events at St George's and the Council has sought assurance from Non-Executive Directors regarding the oversight of the Board the Quality Committee in relation to actions being taken by management to address the causes of recent Never Events.

This paper reports on the progress made to reduce the number of Never Events at St George's and provides detailed sources of assurance to evidence improvements made and highlight any areas of ongoing focus or concern. The paper was discussed at the Quality Committee of the Board on 27 February and was presented to the Group Board on 6 March 2025.

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.

In reviewing this report at its February 2025 meeting, Board Quality Committee was keen to understand the actions being taken to learn from Never Events and prevent a recurrence. The Committee felt that the report was of high quality and demonstrated increased grip and appropriate action being taken. As such, the Quality Committee reported to the Board in March that it felt it was able to raise its level of assurance on Never Events from “limited” to “reasonable”. Never Events, however, remain an area of focus for the Board and the Quality Committee.

Action required by Council of Governors

The Council of Governors is asked to:

a. Note the steps being taken to reduce Never Events at St George’s and the initial impact of this work
b. Note the ongoing active oversight of learning from Never Events from the Board and Quality Committee.

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☒ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

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 St George's: Update on progress
March 2025

1.0 Purpose of paper

1.1 The Council of Governors has previously been briefed on Never Events at St George's and the Council has sought assurance from Non-Executive Directors regarding the oversight of the Board the Quality Committee in relation to actions being taken by management to address the causes of recent Never Events.

1.2 This paper reports on the progress made to reduce the number of Never Events at St George's and provides detailed sources of assurance to evidence improvements made and highlight any areas of ongoing focus or concern. The paper was discussed at the Quality Committee of the Board on 27 February and was presented to the Group Board on 6 March 2025.

2.0 Background

2.1 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 NHs England (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 St George's Central Incident Review Group (CIRG) provides a regular update to the Board's Quality 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. An improvement action plan was presented to the Quality Committee in 2023, following a cluster of 8 Never Events at St George's.

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 St George's (SGUH) by type Jan 2023 to Jan 2025

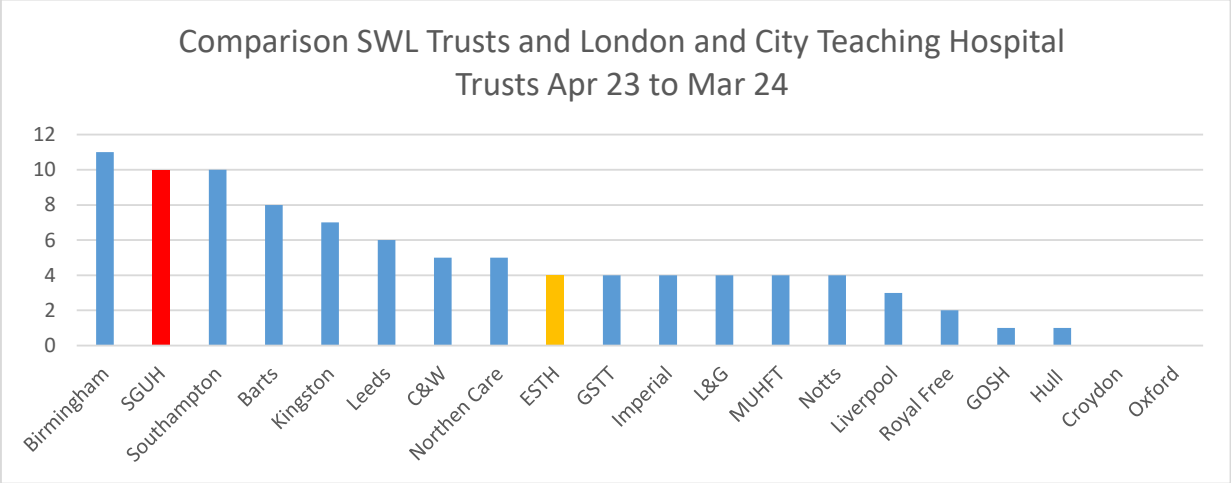
SGUH NEVER EVENTS JAN 23 TO JAN 25						
RETAINED FOREIGN OBJECT (n =7)			**WRONG SITE SURGERY (n =9)**			**WRONG PATIENT SURGERY (n =1)**
Guidewire (1)	**Part of surgical instrument (3)**	**Swab (3)**	**Wrong site block (2)**	**Wrong skin lesion (6)**	**Other (botox) (1)**	
Apr 23 NITU DW187382	Nov 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		

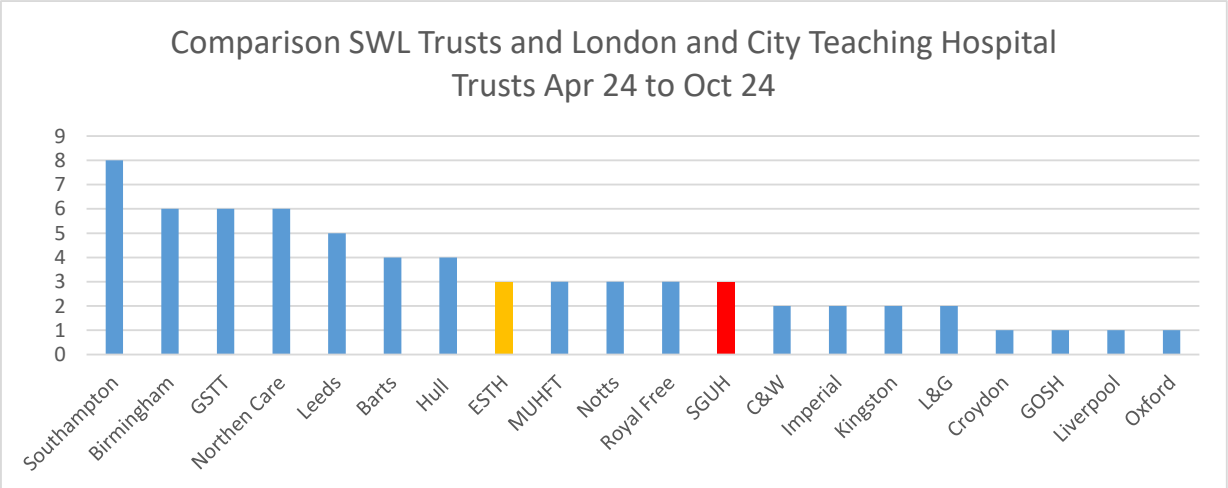
3.2 Comparison of this data with the NHSE dataset is outlined in Table 2 and Graphs 1 and 2.

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 (Local Safety Standards for Invasive Procedures).

- Wrong skin lesion surgery – although this is the commonest type of Never Event reported nationally, SGUH was an 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. 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.

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%

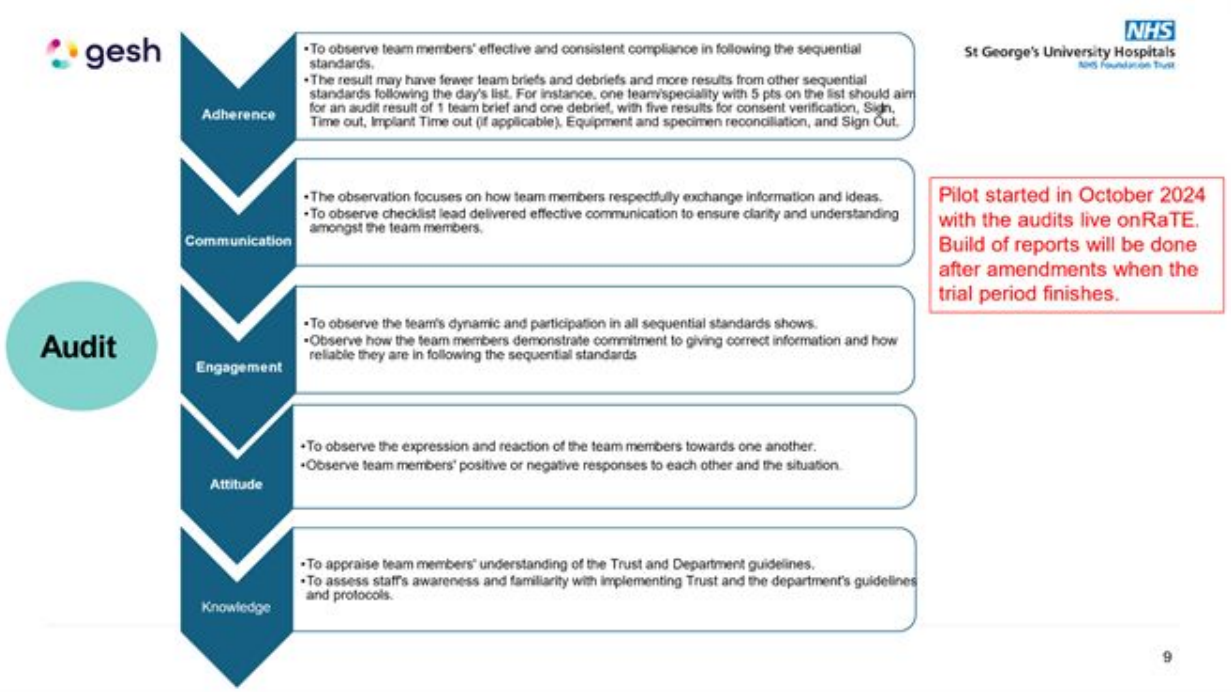
The Divisions have been asked to focus on improving compliance with training for medical and dental staff by April 2025, and to use the PTTT sessions to highlight the importance of ensuring all staff demonstrate competence in the basic elements of patient safety.

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:

- 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. 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 Council of Governors is asked to:

a. Note the steps being taken to reduce Never Events at St George's and the initial impact of this work
b. Note the ongoing active oversight of learning from Never Events from the Board and Quality Committee.

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

Council of Governors: March 2025
Finance report

GCFO, SGH Site CFO, ESTH Site CFO

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

Group M10 position

SGH

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	Overview	What actions/mitigations are required?
Summary I&E	• **The YTD adverse position for SGH reporting adverse to plan £9.8m for. 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). • **Delivered mitigations** this is SGH £13m	• 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. • 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.	• 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.
CIP delivery	• SGH £6.6m adverse to plan (although this includes b/f £0.8m benefit) with £9.1m less recurrent than plan. • When the mitigations the trust have delivered the full value of the original CIP programme in year.	• 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.
Capital	• SGH M10 YTD position is behind plan mainly due to slippage in ITU	• Careful monitoring and forecasting of capital will be required in both trusts across the year. • 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.	• Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management. • Review requirements into 25/26.
Forecast to year end	• The trust is forecasting it will be £13m adverse to plan at year end after the impact of mitigations. • SWL has been informed that we expect to miss our financial plan.	• Every effort will be made to improve on this position. • A further £10m of funding in respect of depreciation could become available via NHSE. Confirmation is being sought.

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SGH - Summary M10 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.

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SGH revenue metrics Scorecard

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SGH Finance Scorecard

NHS South West London

Finance

	Category	YTD Plan	YTD Actual	YTD Variance	YTD RAG	% Variance	FY Plan	FOT	Variance	RAG	% FY Variance
OPEX	Substantive Pay	569.1	587.1	-18.0	A	-3.2%	680.3	681.6	-1.2	G	-0.2%
	Bank Pay	51.7	49.3	2.4	G	4.7%	61.9	62.3	-0.3	G	-0.6%
	Agency Pay	14.7	9.4	5.3	G	36.2%	17.6	17.9	-0.3	A	-1.5%
	Pay Costs	635.5	644.0	-8.5	A	-1.3%	759.9	759.9	0.0	G	0.0%
	NonPay Costs	385.1	400.9	-15.8	A	-4.1%	456.4	458.7	-2.3	A	-0.5%
	OPEX	1,020.6	1,044.9	-24.3	A	-2.4%	1,216.3	1,218.6	-2.3	G	-0.2%
Income	Operating income from patie...	898.6	904.1	5.4	G	0.6%	1,072.2	1,072.2	0.0	G	0.0%
	Other operating income	136.5	142.2	5.7	G	4.2%	164.0	164.4	0.4	G	0.3%
	Total Operating Income	**1,035.2**	**1,046.3**	**11.1**	**G**	**1.1%**	**1,236.2**	**1,236.6**	**0.4**	**G**	**0.0%**
I&E	Reported I&E	-5.8	-16.5	-10.8	R	-185.9%	-4.3	-4.3	0.0	G	0%
	Recurrent I&E	-73.3	-93.2	-19.9	R	-27.2%	-86.1	-101.6	-15.5	R	-18.0%
Cash	Cash & cash equivalents	15.2	42.1	26.9	G	177.0%	15.0	15.0	0.0	G	0.0%

Operational pressures have lead to an increase in ED cohorting and additional HCAs for boarding, also increases usage in UTC for GPs and additional cover for Consultants unable to work nights. Acute Medicine and Senior health ward nursing is also nursing increased due to Boarding nurse in Richmond, enhanced care. Jr Docs pressure include Less than full time trainees as well as significant gaps in rotas leads to high levels of bank and agency spend. Key areas are Neonatal, Plastics and T&O. Increased spend on clinical consumables, this is being reviewing versus improved additional ERF activity. Non pay inflationary pressures above the 2% funded. Contracts that are causing inflationary pressure compared to planning assumptions. E.g. NHSBT (20%), Wandsworth Council rates (20%), Mitie contract (4.3%).
The income variance is broadly driven £6.5m related to Commercial pharmacy/Pathology income with offsetting costs. £2.5m from SWL ICB in M5, is above planned levels of income. £1.3m IA income from NHSE offsetting IA costs.
Total pay costs at SGH are rated amber, with an overspend of 1.3% or £8.5m. IA/Cyber impacts account for £1.5m adverse, with CIP a further £2.8m and challenges in ED and acute wards accounting for the majority of the balance. Non-pay has an adverse variance of £15.8m (4.1%) and this variance is partially driven by a mismatch in income and non pay which is in review. The remaining challenge is from CIP and inflationary pressure. Pay inflation pressure is not being seen YTD, although the bank pay award is expected to give an additional pressure into 2526

Workforce

		Plan (in month)	Actual (in month)	Variance (in month)	RAG (in month)	% Variance (in month)
WTEs	Substantive WTE	9,358	9,736	-379	A	-4.0%
	Bank	601	895	-294	R	-48.9%
	Agency	249	111	138	G	55.4%
	Total WTEs	10,208	10,743	-535	R	-5.2%
Cost per WTE	Substantive	6.1	6.0	0.0	G	0.3%
	Bank	8.5	6.0	2.5	G	29.1%
	Agency	5.9	2.8	3.1	G	52.2%
	Total Cost per WTE	6.2	6.0	0.2	G	3.1%

SGH are behind plan in M10 with increases in winter pressures and an additional CIP assumption of 510 WTE only partially delivered.
SGH have significantly lower agency WTEs than plan which is driving a favourable variance against total WTE plan. Agency costs per head, however, were higher than plan so the underspend in cost for agency is not of the same scale and the reduction in WTEs.

Efficiency

	YTD Plan	YTD Actual	YTD Variance	YTD RAG	% YTD Variance	FY Plan	FOT	Variance	RAG	% Variance
Recurrent Efficiency	36.8	27.7	-9.1	R	-24.9%	46.0	36.2	-9.8	R	-21.3%
Non-Recurrent Efficiency	18.1	20.7	2.5	G	14.0%	22.5	32.3	9.8	G	43.5%
Total Efficiency	**54.9**	**48.3**	**-6.6**	**R**	**-12.0%**	**68.5**	**68.5**	**0.0**	**G**	**0.0%**

SGH are £6.6m adverse to CIP targets, CIP risk has been identified as an FOT gap which mitigations are being worked though by the Exec. The Trust will need to ensure that recurrent efficiency continues to be delivered in year so as not to increase the financial challenge in 2025/26. ERF also has challenges related to industrial action and cyber attack that will impact on delivery.

Performance

Metric	M07	M08	M09	YTD	Target	Variance
ERF	111%	113%	109%	111%	105%	6%
LoS*	9.6	8.9	9.1	9.7	9.4	-0.4
Outpatient attendances as a First or Procedure**	48%	48%	48%	48%	49%	-1%
A&E Target	78%	76%	80%	80%	78%	2%

Good progress on LOS although significant challenge expected to maintain and improve this position over the winter period.

*Based on 23/24 average of 11.30 days and ambition to reduce by 1.5 days
**Based on system target of 49%

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2025/26 Financial Plan: Key deliverables

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- The very clear message from NHSE is that all systems are expected to deliver their control totals. For SGH this is a deficit of £40m. Inclusive of the full delivery of a 5% CIP SGH would report a deficit of circa £96m.
- The Finance Committee and Group Board discussed the challenge of reconciling the need to try and meet the control total compared to deliverability of the scale of CIP in year.
- Delivery of this kind of challenge will be dependent on robust action both within the trust, group and system.
- The Executive team is working proactively with system partners to look at opportunities to improve the position.
- An update following the Trust Board will be provided to the Governors.

	Gross deficit (unmitigated)	NHSE target deficit	Deficit seen as deliverable by SWL	CIP opportunity identified to date
SGH	**£156m**	**£40m**	**£96m**	**£41m**
	• 24/25 exit underlying deficit of £156m when all FYE and NR items adjusted plus new cost pressures and impact of 25/26 planning guidance of £12m. • Gap before any mitigating actions (CIPs).	• SGH proportion of SWL deficit target set by NHSE.	• Deficit seen as deliverable by SWL/gesh management team. • Based on delivering CIPs total £60m (5%). • Key driver is insufficient time to deliver scale of action needed	• Value of CIPs identified to date against the 5% target of £60m seen as deliverable by SWL/gesh. • £7.1m is fully developed/plans in progress. • £33.9m is opportunity (an opportunity is seen but there is not a detailed plan yet) • £18.9m is unidentified - requires further schemes to get to 5% CIP

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SGH Movement from 24/25 outturn

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- This table summarises the planning gap for 25/26 compared to 24/25.
- Key challenges remain within the financial position including the run rate from the current financial year, Non-recurrent benefits and income which are not able to be repeated in the current year and new pressures our expectations in line with the latest financial planning guidance.
- We continue to work to refined and improve the position and what is presented is to show the scale of the challenge represents a work in progress position.

Heading	This month £m	Comment
Plan 24/25	-4.3	The deficit as per the reported plan.
Non-recurrent deficit support	-45.8	Support funding from NHSE to bridge the cash gap caused by
Original 24/25 planning gap	**-50.1**	This is the proportion of the SWL £120m deficit that is referenced. This funding was provided by NHSE to a). Provide cash to the trust in order to maintain payments , and b). To balance the wider NHS financial position. While some version of this can be expected in 25/26 its scale will be dependent on the overall deficit NHSE task SWL to deliver.
Forecast variance from plan	-13.2	The forecast variance to the plan
Non-recurrent benefits in plan	-42.9	One-off actions in 24/25 that reduce the deficit in year but are not expected to repeat
Non-recurrent income in plan	-15.8	Non-recurrent income in the plan that is not expected to be received again in 25/26, or confirmation has not been received that it will
24/25 underlying year end deficit	**-122.0**	**This is the underlying level of deficit being incurrent by the trust. This represents 13.9% of total forecast expenditure**
25/26 unfunded new cost growth and pressures	-33.6	These are new costs that are anticipated or possible in 25/26. These are high and some should be resolved or reduced through management action.
25/26 gross deficit before mitigations	**-155.6**	**Based on current estimates, this represents the high range of the potential deficit for 25/25**

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Drivers of the deficit

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- Summary bridge highlighting the underlying deficit as the trust exist from 24/25, together with the new cost pressures that could impact on 25/26.