Group Board

Agenda

Meeting in Public on Thursday, 01 May 2025, 12:30 – 15:15

Barnes, Sheen and Richmond Rooms, Queen Mary's Hospital, Roehampton, SW15 5PN

12: 30 Feedback from Board visits

Introductory items

Time	Item	Title	Presenter	Purpose	Format
13:00	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	Chairman	Approve	Report
	1.4	Action Log and Matters Arising	Chairman	Review	Report
13:05	1.5	Group Chief Executive Officer's Report	GCEO	Review	Report

Items for Review and Assurance – Quality

Time	Item	Title	Presenter	Purpose	Format
13:25	2.1	Care Quality Commission – Well Led Inspection: Letter in advance of full report	GCCAO	Review	Report
13:35	2.2	Quality Governance Review Part 2	GCNO/GMO	Review	Report
13:45	2.3	Group Maternity Services Quality Report February - March 2025 data	GCNO/GMO	Review	Report
13:55	2.4	Integrated Quality and Performance Report	GDCEO	Review	Report
14:05	2.5	Quality Committees Report	Committee Chair	Assure	Report

Items for Review and Assurance – Finance, Audit and Risk

Time	Item	Title	Presenter	Purpose	Format
14:15	3.1	Group Financial Performance Year End 2024/25	GCFO	Review	Report
14:20	3.2	Finance and Performance Committees Report	Committee Chair	Assure	Report

Items for Review and Assurance – People

Time	Item	Title	Presenter	Purpose	Format
14:30	4.1	People Committees Report	Committee Chair	Assurance	Report

Items for Review and Assurance – Infrastructure					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:40	5.1	Infrastructure Committees Report	Committee Chair	Assurance	Report

Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:50	6.1	GESH Learning from Deaths Quarterly Report: Q2 (Jul-Sep) and Q3 (Oct – Dec) 2024/25	GCMO	Note	Report
	6.2	2024 NHS Staff Survey Results	GCPO	Note	Report
	6.3	Annual Fit and Proper Persons Report 2024/25	GCCAO	Note	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:50	7.1	New Risks and Issues Identified	Chairman	Note	Verbal
	7.2	Questions from members of the public and Governors of St George's*	Chairman	Review	Verbal
	7.3	Any Other Business	All	Note	Verbal
	7.4	Reflections on the Meeting	Chairman	Note	Verbal
14:55	7.5	Patient / Staff Story	GCNO	Review	Verbal
15:15	-	CLOSE	-	-	-

***Questions from Members of the Public and Governors**

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Officer – Facilities, Infrastructure and Estates	GCOFIE
Ann Beasley	Non-Executive Director and Vice Chair ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Pankaj Davé	Non-Executive Director – SGUH	PD
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 – ESTH/SGUH	YJ
Khadir Meer^	Associate Non-Executive Director - SGUH	KM
Peter Kane	Non-Executive Director – ESTH/SGUH	PK
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Michael Pantlin*^	Interim Group Deputy Chief Executive Officer	IGDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Victoria Smith*^	Group Chief People Officer	GCPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Claire Sunderland Hay^	Associate Non-Executive Director - SGUH	CSH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
In Attendance		
Liz Dawson	Group Deputy Director Corporate Affairs	GDDCA
Natilia Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications Officer	GCCO
Ed Nkumrah	Director of Performance and Head of PMO	DoP
Apologies		
Natalie Armstrong	Non-Executive Director – ESTH/SGUH	NA
Ralph Michell*^	Group Chief Transformation Officer	CGTO
Observers		
John Hallmark		

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

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

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

Minutes of Group Board Meeting

Meeting in Public on Thursday, 06 March 2025, 9:45am–1.00pm

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director & Vice Chair – ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Pankaj Davé	Non-Executive Director – SGUH	
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director – ESTH / SGUH	YJ
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Victoria Smith*^	Chief People Officer	CPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Claire Sunderland-Hay	Associate Non-Executive Director – SGUH	CSH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
IN ATTENDANCE		
Lizzie Alabaster	Site CFO-ESTH	Site CFO-ESTH
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
APOLOGIES		
Natalie Armstrong	Non-Executive Director	NS
Andrew Grimshaw	Group Chief Finance Officer	GCFO

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

		Action
	FEEDBACK FROM WARD VISITS	
	The Board provided the following feedback from their respective visits to a number of wards at SGUH: Site Office: YJ, the GCEO and Mark Lowcock had visited the Site Office. They had been struck by the system that displayed on a screen a real time overview of	

activity across the hospital. This had been developed in-house and other trusts were interested in adopting it. A wider variety of information was available including data on the number of patients with No Criteria To Reside, ambulance wait times and the number of patients waiting to be admitted. The GCEO added that the NHS had become risk averse and there had to be a focus on patient flow – both ensuring that they were seen quickly and that they moved through quickly. An illustration was given of how long it could take for social care to review a patient ready to be discharged with it taking at least 15 days from referral to a social worker being allocated.

Gunning Ward (orthopaedics): PK, MD-IC and the GDCEO had visited the ward. They had been greeted by the Lead Nurse and Discharge Nurse. They were fully staffed which helped with workload and there was a real sense of teamwork. Areas the staff had identified for improvement were pressure ulcers and through a team approach their figures for December had been much improved. There could be learning for others from this. Flow was an issue with one patient ready to be discharged for more than 12 weeks but no care at home was available. The space had felt quite cluttered and tricky to navigate. The GDCEO added that they had spoken to an international member of staff who said that they felt nurtured and supported.

Heberden Ward: PD and the GCNO had had an excellent visit to the elderly care ward. The ward had been clean, tidy and well kept. Continuity of staffing was seen as a strength and helped with a consistent and caring approach. Pathways to social care and the impact of delirium and dementia were highlighted as issues by staff but the culture was seen as a positive. The GCNO had given suggestions on how to manage patients with dementia who could often be asleep during the day and awake at night. Staff also reported that they were aware of the Freedom to Speak Up team and how to access this. The MD-SGUH had visited the ward shortly after PD and GCNO and agreed that this was a well-run ward. Staff had commented to her how much they appreciated the earlier visit from the Board.

Surgical Admissions Lounge and Jungle Ward: PW, CSH and the GCPO had visited the area. The matron was on leave and the receptionist off sick, so the ward manager was under real pressure but was well organised. To avoid adding to the pressure, they had instead visited Jungle Ward where the matron showed them round. Jungle Ward was mainly planned day cases although there were some referrals from ED. As might be expected from a children's ward it was quite noisy and busy but uplifting. The facilities could be improved, for example the kitchen space was a cupboard and there were only 2 toilets, one of which was out of order. The sluice area was also tiny. The GCPO remarked that there were 40-60 patients per day but a matron only 2 days per week which seemed a low level. Talent management and developing people could bring greater opportunities and improve retention.

Freddie Hewitt Ward and Blue Sky Unit: The GCMO and the Chairman heard that 19 patients were being seen that day in Blue Sky with referrals from multiple sources, including ED and GPs. The ward had just received their platinum accreditation. They had spoken with a student nurse who gave good feedback. Students were placed from Roehampton, Kingston and Kings. On Freddie Hewitt Ward, there were 17 beds and the ward had just come through its busiest time with the winter flu season and norovirus. There was good team work with doctors which was seen as a strength. The ward was clean and uncluttered. Challenges reported were the level of safeguarding concerns and the level of mental health needs in the patients who needed a different type of care. These two issues created a level of

	anxiety for staff. They had spoken to 2 patients and their parents who said that they were receiving fabulous care with Luci Etheridge, Site CMO, receiving particular praise. GICU: AG and the GCCAO had visited the General Intensive Care Unit which had 18 beds. They had arrived as the huddle was taking place, with the matron – Susan, well organised. Staff were focused and doing a good job with an estate that was not ideal. There was a strong sense of team. They had also spoken about violence and aggression and how this was split between those who had capacity and those who did not. A business case for psychological support had been made as there were high levels of anxiety. Staff had been very complimentary about the support that was provided. Planning for when they relocated to the new ICU building and what happened to the vacated space was also raised. Benjamin Weir Ward: The MD-ESTH, GCCO and AB had visited the ward and talked about communication and how we engaged with staff. They also visited cardiac HDU which had been very calm with a stable staff team who were very positive. They were also clear on patient confidentiality with no patient data on display. Greater access to training was raised as an area that staff would like. They had received silver accreditation ward and knew what to do to achieve gold. Board members had also visited coronary care. The number of newly qualified staff who then moved onto other wards, or had to leave London, was noted. The MD-ESTH remarked on the experience of patient transport and how the eligibility for this may need clearer explanation to patients as it had now become expected as an entitlement when first option should be for them to make their own way to hospital. Some constraints around internal tests had been raised. The GCEO informed the Board that the Ward Accreditation Scheme was under review so that there was greater consistency and included broader themes such as budgets and that it would extend beyond wards. Higher standards may mean that some wards were downgraded, not because their standards had fallen but because the accreditation had become harder to attain. The Chairman concluded by thanking everyone for their reports, and that it was very positive to hear about so much good work.	
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting, particularly Sir Mark Lowcock (Chair Designate) and Hann Latuff (newly elected Governor Merton). Apologies were received from Natalie Armstrong and Andrew Grimshaw.	
1.2	**Declarations of Interests**	
	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley, Yin Jones, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Mark Bagnall, Andrew Grimshaw, Richard Jennings, Stephen Jones, Victoria Smith as Executive Directors.	

	There were no other declarations other than those previously reported. With the agreement of the Board the following roles were confirmed: • Ann Beasley, Vice Chair of the ESTH Board in addition to SGUH • Pankaj Davé, SGUH Health and Wellbeing NED Champion and SGUH NED Security Champion • Yin Jones, NED for Maintaining High Professional Standards, ESTH Board in addition to SGUH.
1.3	**Minutes of the Previous Meeting**
	The Minutes of the Group Board meeting on 9 January 2025 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	The Group Board reviewed and noted the Action Log. • PUBLIC20250901.2: A proposal for the key metrics to be monitored in the IQPR will be presented to the Board at the March meeting. This was proposed for closure as it was contained within the report on the agenda. The remaining actions were not yet due.
1.5	**Group Chief Executive's Officer (GCEO) Report**
	The GCEO took the report as read and highlighted the following issues: • SGUH Anaesthesiology**:** this had received its third reaccreditation, one of only a small number of trusts to have achieved this. • Culture and EDI**:** the group had celebrated International Women's Day as well as LGBTQ+ month. • Electronic Patient Record (EPR): the EPR Programme at ESTH was progressing well with the go live date of 9 May confirmed. The Infrastructure Committee were monitoring this on behalf of the Board and a full report would come in the private session. • Collaboration: The GCEO had been appointed as Chair of the of the NHS Workforce Group looking at a new Employee Records System. The GCPO was also involved with the work of the group. • Tributes: The GCEO paid thanks to the Chairman and the DGCEO who were both attending their last meetings for their support and challenge over their 8 and 3 years respectively. During discussion the following were raised: • CQC Well Led inspection (SGUH): All those who had been involved in the recent CQC Well Led inspection at SGUH were thanked for the contribution, with it felt that the Trust had been open and showed the work being done in the best possible light. The GCEO was asked whether there were any immediate reflections. In response, the GCEO said that a lot of work had gone into the preparation and that we had tried to present a fair view of where

	things were. The inspectors had been supportive and interviews had been conversational and everyone felt that they had been provided with the opportunity to say what they wanted to. Learning from the SGUH inspection would be used to assist with the ESTH CQC Well Led inspection, which was anticipated during 2025/26. This would be a focus once the 2025/26 financial planning was completed. The MD-ESTH added that clarity of governance structures had been a key part of the inspection, this had been aided by the new Group Accountability Framework but there would be a need to demonstrate that there was learning from SGUH and their inspection feedback across the group. • New Hospitals Programme: In response to a question, the GCEO said that mitigating the risks across the estate at ESTH following the delay to the New Hospitals Programme was a priority, as there was concern about a major infrastructure failure – particularly at St Helier. The MD-ESTH and GCOFIE were working the risks, mitigations and options through and a report would come to a later meeting of the Board. • Annual Planning: Progress on work with the Integrated Care Board (ICB) and local partners on social care to reduce length of stay was raised. The GCEO said that the new CEO at the South West London ICB was looking at greater integration with GPs and social care, acknowledging that the system had not always worked as collegiately as it might have done. How greater clinical voice could be incorporated was also being looked at. **The Group Board noted the Group Chief Executive's Report.**	
2.0	**ITEMS FOR ASSURANCE**	
2.1	**Quality Committee-in-Common Report**	
	Andrew Murray, Chair of the Quality Committees-in-Common, presented the key issues considered by the Committees in January and February 2025: • Maternity Services: This was an item later on the agenda, but it was highlighted that assurance remains limited. Following delegation from the Board, AM and the GCNO had reviewed the evidence and signed off the CNST submissions for both Trusts. ESTH was fully compliant in all 10 areas and SGUH in 9/10 due to the late notification of 2 neonatal deaths. The Committees had looked at the data on Post Partum Haemorrhage (PPH) at SGUH which was higher than the national average. A correction was made to the report which referred to 'placenta ecreta' which should read 'placenta acreta'. One explanation for the higher than average PPH could be that SGUH received a more complex cases, but the Committees were not satisfied that this would be the sole reason without further evidence to support the assertion. Staffing levels at SGUH were now where they should be but this needed to be supported by good rostering to ensure all shifts were covered appropriately to ensure patient safety. Leadership in midwifery was not where it needed to be and this was being followed up.	

The Committees had asked for a unified action plan which incorporated all the actions from the reviews that had taken place and the Section 29A warning notice.

- Concerns regarding safety in the Group's Emergency Departments: This remains a concern. Much action continues to take place and risks are being actively mitigated but the Committees needed to see that improvements were sustained and embedded.

- Concerns regarding Never Events: The Committees had received an excellent report on Never Events and the mitigations, actions and learning that were taken from them. On the information and evidence provided to the Committees, assurance had been increased to reasonable but this was considered 'tentative' and would be kept under review. The full report had been provided to the Board as an appendix.

- Patient Transport, ESTH: Issues with patient transport at ESTH were of concern to the Committees and the impact that this had on patient care, particularly in renal. There was confidence that ESTH was doing all that it could to mitigate the problems that were being caused by the provider.

- Fundamentals of Care – Dementia and Delerium: The Committees had had a detailed review of this area, noting that more needed to be done particularly in identifying and supporting patients with dementia.

During discussion the following issues were raised:

- Maternity: The GCEO said that a lot of work had been done to address issues in maternity at SGUH but the focus now needed to be move away from process to culture, noting that this was not the first time intervention had been needed in the unit. The Chairman added that there had been progress in the past but it had then deteriorated again. Board members commented that the response to the CQC Section 29a Warning Notice in ED had been very open but this had been the opposite in maternity, which seemed defensive. The importance of ensuring all members of the Board were familiar with the issues in maternity was noted.

  AM reminded the Board that he had two roles in relation to maternity – Chair of the QCiC and NED Maternity Safety Champion. This gave him additional insight into maternity and meant he spent more time in the unit than other NEDs. He agreed with the assessment that there had been very different responses to the Section 29a from ED and maternity, with the latter being defensive and focused on how good some of their outcomes were rather than those patients giving birth and neonates who could have avoided harm.

  The GCMO explained that with regards to high PPH numbers, this was likely partly due to complex cases but this would not be the only reason. National benchmarking was available and he was confident that future reports to the Committees would show an improvement.

	• Never Events: It was clarified that the report on Never Events related to SGUH only. It was confirmed that learning was shared across the group and a similar paper from ESTH would be provided to the Committees. **The Group Board noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in January and February 2025.**
2.1.1	**Quality Committees-in-Common Annual Report and Effectiveness Review** **The Board:** **a. Reviewed the Quality Committees-in-Common annual report and effectiveness review.** **b. Reviewed the Committee terms of reference and agreed that no changes be made.** c. **Noted the update on the forward workplan for the Committees for 2025/26.**
2.2	**Finance Committees-in-Common Report**
	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in January and February, including: • Finance Report M10: Both trusts were showing an underlying adverse position to plan at M10 (ESTH £4.2m and SGH £6.1m), showing baseline pressures and CIP shortfalls in addition to cyber attack support impact at SGH (£0.9m). The Financial Recovery Board was meeting monthly. It was felt that the actions in place were the right ones but they may need to be reinvigorated. • Planning: The planning guidance had not been issued until January. Indicative numbers looked 'heroic' in scale but every effort was being made to work towards them. The Board noted the lateness of the planning information and how it would benefit providers if 3-5 year plans could be developed. • IQPR: AB commented on the excellent IQPR and how this helped the Committee focus on the right issues. Despite not always meeting national standards there were many places where things were going well. The DGCEO thanked AB for her comment but assured the Board that there was not complacency over areas where improvement was needed. **The Board noted the issues considered by the Finance Committees-in-Common at its meeting in January and February 2025.**
2.2.1	**Finance Committees-in-Common Annual Report and Effectiveness Review** **The Board:** **a. Reviewed the Finance Committees-in-Common annual report and effectiveness review.** **b. Reviewed the Committee terms of reference and agreed the change of name to the Finance and Performance Committees.**

	c. Noted the update on the forward workplan for the Committees for 2025/26.	
2.3	**People Committees-in-Common Report**	
	Yin Jones, Chair of the People Committees-in-Common, set out the key issues discussed and considered by the Committees in February 2025. The Committees had received an update on the integration of the group People function and the new team members that were supporting the GCPO. The staff survey information had also been received, with the Committee pleased to see that there had been an increase in engagement at both Trusts. The Committee had also considered the outcome of the annual effectiveness review and noted the improved reporting that had been identified. However, more consistent and homogenous reporting from both trusts was seen as an area for further work in 2025/26. The response rate had only been 50% and it as hoped that this would improve in 2025/26. **The Board noted the issues considered by the People Committees-in-Common at its meeting in February 2025.**	
2.3.1	**People Committees-in-Common Annual Report and Effectiveness Review** **The Board:** **a. Reviewed the People Committees-in-Common annual report and effectiveness review.** **b. Reviewed the Committee terms of reference and agreed that no changes be made.** **c. Noted the update on the forward workplan for the Committees for 2025/26.**	
2.4	**Audit Committees-in-Common**	
	Pete Kane, Chair of the Audit Committees-in-Common, introduced the report which set out the key issues considered by the Committees at meetings in February 2025. These included: • Audit: Both external and internal audit were on track. Progress on internal audit was improved on the previous year. The timeliness of management responses was also improving. • Group Policy Framework: The Committee had reviewed and approved the group wide policy framework which would consolidate the number of policies with group wide ones to be developed wherever possible. • Group Risk Management Framework: The Committee had considered the framework and the rationale behind the separation of the BAF and the corporate risk register. The new framework would give additional assurance and it was recommended for approval by the Board. **The Group Board:** **a) Noted the report of the Audit Committees-in-Common meeting held on 19 February 2024**	

	b) Approved the Group Risk Management Policy, following review and endorsement by the Audit Committee	
2.4.1	**Audit Committees-in-Common Annual Report and Effectiveness Review** **The Group Board:** **a. Reviewed the Audit Committees-in-Common annual report and effectiveness review.** **b. Noted the update on the Committee terms of reference and supported the change of name to the Audit and Risk Committee.** c. **Noted the update on the forward workplan for the Committee for 2025/26.**	
2.5	**Infrastructure Committees-in-Common**	
	Ann Beasley, Chair of the Infrastructure Committees-in-Common, set out the key issues discussed and considered by the Committees in January and February 2025. These included: • Planning permission that had been granted for the renal building at SGUH; £3.1 million that had been awarded for LED lighting replacements across the group and a fire enforcement notice regarding fire safety deficiencies at St Helier Hospital issued by the London Fire Brigade. • The Committees had expressed concern over the non-compliant rating and requested an update about the costs associated with completing and ongoing annual review of the asbestos management survey. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in January and February 2025.**	
2.5.1	**Infrastructure Committees-in-Common Annual Report and Effectiveness Review** **The Group Board:** **a. Reviewed the Infrastructure Committees-in-Common annual report and effectiveness review.** **b. Reviewed the Committee terms of reference and agreed the minor amendments.** **c. Noted the update on the forward workplan for the Committee for 2025/26.**	
2.6	**Building Your Future Hospitals Programme Board**	
	Phil Wilbraham (PW), Programme Board Chair, referred the meeting to their annual report and effectiveness review. It was noted that the future of the Programme Board and its terms of reference would be reviewed once there was clarity on the level of oversight that would be needed following the delay to the programme.	

	Thanks were recorded to PW for his chairing of the Programme Board and his resilience during the uncertainty of the NHP. MD-ESTH was also commended for his efforts which were not reflected in the outcome. **The Group Board:** **a. Reviewed and agreed the BYFH Programme Board annual report.** b. **Noted that that the forward workplan for the Programme Board for 2025/26 and terms of reference will be reviewed in due course.**	
3.1	**Group Maternity Services Quality Report**	
	The GCMidO joined the meeting. The report provided Perinatal Quality Surveillance Model data for November and December 2024 and an update on the compliance status for both Trusts under Year 6 of the Maternity Incentive Scheme (part of the wider Clinical Negligence Scheme for Trusts (CNST)). In discussion, the Board queried the issue with appraisals and why these were not being completed. The GCNO explained that appraisals were being completed but there was an inconsistency in how they were recorded and reconciled. Over time the systems would be integrated but this was some time away. The GCMidO reported that the Perinatal Quality Surveillance Model (PQSM) data has shown that outcomes at both trusts had either remained stable or improved over the last 15 months, and there was no cause for concern. At ESTH there are two red risks: the lack of a 2nd operating theatre at Epsom and general environmental issues that were highlighted in the 2023 CQC inspection. Work is underway to address both of these. SGUH had one extreme risk on the risk register relating to the laser stack in the fetal medicine unit which is out of its life span and manufacturer maintenance contract. Medical Physics has advised that the stack and the laser both needs replacing. The stack has been requisitioned. However, the laser has not yet been requisitioned, due to difficulty in finding a replacement. The MBRRACE-UK Perinatal Mortality Report 2022 was received with the Board noting that all cases were reviewed. The higher than average PPH (Port Partum Haemorrhage) rates had been discussed earlier in the meeting. The findings of the Section 29A had been discussed in detail by the Quality Committees-in-Common and the warning notice, response and progress against actions were appendices to the report. The GCMidO recognised the challenges in sustaining improvements in the maternity unit but there was improved governance, new leadership and greater oversight. The GCCAO confirmed to the Board that since the last meeting a specific maternity risk had been added to the SGUH corporate risk register. As had been discussed earlier in the meeting, a unified action plan was being produced. It was confirmed that learning from the actions required in maternity at SGUH were being shared across the Group. **The Group Board:** **a. Noted the information provided in the Perinatal Quality Surveillance Model (PQSM) and that trend data for quality outcomes does not indicate any special cause for concern for either trust.** **b. Noted the progress against the action plan for the NHSR thematic review of Early Notification Scheme (ENS) cases for SGUH.**	

	c. Noted the progress against the actions arising from the review of the 2020 MBRRACE findings. d. **Noted that the immediate safety actions from the SGUH CQC inspection (October 2024) have been completed and all longer-term actions from the inspection have been incorporated into a wider improvement plan.**	
3.2	**Integrated Quality and Performance Report**	
	The GDCEO presented the report, which provided an overview of the key operational performance information, and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data. The report highlights successes achieved throughout the month and operational challenges affecting performance. **The Group Board noted the report.**	
3.3	**Finance Report (Month 10, 2024/25)**	
	The CFO-ESTH presented the report, advising that both Trusts were reporting underlying positions adverse to plan at M10 (ESTH £7.0m and SGH £9.8m), driven by baseline pressures and CIP shortfalls and in addition a £0.9m income loss following SGUH supporting other trusts following cyber-attacks. CIP delivery for the year has been risk assessed at 100% for ESTH and 94% for SGUH **The Group Board noted the report.**	
3.4	**Public Sector Equality Duty (PSED) Report**	
	The GCPO referred the meeting to the report, which set out the array of work being undertaken. The Chairman asked about the objectives, with the GCPO confirming that these had been set out before she had joined but they had not been through any governance process and that needed attention. She would also like to see more focus on health inequalities before she was in a position to present objectives that could be fully endorsed. The Chairman said that there was a need to recognise the deadline for submitting but in future years the Board would like to see a simpler and more impactful report that referred to other documents rather than repeating information. **The Group Board noted and approved the PSED 2023–2025 report for publication.**	
3.5	**Gender Pay Gap Report**	
	The GCPO referred the meeting to the report, which was taken as read. In discussion it was agreed that it would be helpful to see trends over time and benchmarking against other trusts in future reports. In response to a question about ethnicity data, the GCPO said that in future years she would like to have a report that included data on all protected characteristics. **The Group Board:** **a. Reviewed the Gender Pay Gap Report**	

	b. **Approved it for publication.**	
4.0	**ITEMS FOR NOTING**	
	The Group Board noted: • The Healthcare Associated Infection Report. • Group Accountability Framework, approved in private session on 6 February. • Equality, Diversity and Inclusion Action Plan, approved in private session on 6 February. • Safeguarding Annual Report 2023-24, received in private session on 6 February.	
5.0	**Any other business**	
	Retirement of Chairman On behalf the Board, the Vice Chair paid tribute to the Chairman as she reached the end of her term of office. Setting out how the Chairman had first become Chair at SGUH and then ESTH, and the challenges and successes that had been faced during her tenure – including leading SGUH out of special measures alongside the CEO. Her wisdom, bravery, careful thought, always putting patients at the heart of decision making ensured that she was leaving the Group in a good place. The positive change in culture had been led from the top with her warmth and friendliness being valued by everyone. The warm wishes of the Board and the Group went with her, and she was wished the very best in all that she did next. **James Marsh** The Chairman paid tribute to James Marsh at his last meeting, wishing to acknowledge his work at ESTH and then for the Group. He had been a friend and counsel to many and would be much missed.	
5.3	**Reflections on meeting**	
	The Chairman asked GDCEO to give his reflections of the meeting. In summary, the following observations and reflections were offered: • The Board visits at the start of the day was a really powerful process ensuring patients were at the forefront of decision making. • That he had learnt over the last 3 years that a group in the NHS was a complex organisation with challenges of governance and leadership that were impacted by an external environment that was becoming more challenging. • That the Group and NHS as a whole were at an inflection point, making it the right time for him to step down as GDCEO. It had been a privilege to be surrounded by colleagues who together were greater than the sum of their parts. He also wished to thank the Chairman for her support, guidance and leadership.	

5.4	Patient Story
	Matt Sunter, Lead Nurse Cardiology, and Paul Curtis, patient, were welcomed to the meeting. MS explained that a clinical trial - STRONG-HF was published in the Lancet in 2023 for heart failure patients introducing a 4 pillar approach to heart failure drug treatment. The trial was actually stopped early as the patients on the trial had overwhelming good outcomes. SGUH was not in the clinical trial however the team adopted the 4 pillar therapy as a QI project last year. Paul Curtis was a patient who underwent this drug regime which is started as an inpatient and generally patients are optimised and stabilised within 2 weeks of discharge. Paul was one of 11 patients at SGUH who joined this programme. Paul spoke about his experience and journey through the heart failure service. Paul was also part of the Heart Failure patient focus group which had provided feedback communication and how valuable seeing the same person during treatment was as this had given real confidence to him and his wife. The Board thanked Paul for sharing his experience and asked about any ways in which the service could have been better. He said that the care couldn't be faulted but sometimes the communication could be better. Multiple messages were received, sometimes changing appointments or saying that tests were needed but no reason given. He appreciated that others may have had their appointment changed when he needed urgent treatment, so he understood this sometimes needed to happen. It would also be helpful if patients were told how long they could expect their appointment to be so they could plan their day and that letters giving results etc could be written in plain English. Paul said that he was fortunate as his wife worked for a GP so she could ask them but without that he would not always be able to understand what was being told. The GCMO said that writing in more accessible ways was something that doctors were working on and the feedback was very helpful. MS added that what the team has learnt through this trial was the benefit of a more aggressive approach to treating heart failure. The results have been really positive with a reduction of hospital admissions in this group of patients. They also now ensured, wherever possible, that patients saw the same team member and had their contact number they could call between appointments if they had any questions. Use of the patient focus group had been really helpful in understanding different perspectives. The Chairman thanked Paul and Matt for speaking to the Board, saying that it was extremely valuable to hear directly from patients and those caring for them.
CLOSE	
The meeting closed at 1.15pm.	

Group Board (Public) - Updated 25 April 2025

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20241107.2	07-Nov-24	3.1.5	Interstitial Lung Disease at ESTH	The Board requested that a report detailing the timescales of when systems and functions to support whistleblowing and FTSU are to be embedded into the organisation, be presented at a future meeting to allow the Board to track the progress of this.	04-Jul-25	GCCAO	This was orginally proposed as an action for the March meeting but isto be brought to the Group Board for review alongside the draft FTSU strategy for the Group, this would be the July meeting.	NOT YET DUE
PUBLIC20250901.1	09-Jan-25	3.6	Group Freedom to Speak Up Report	The Mandatory Training Group to review the current mandatory training requirements package to ensure there is a consistent approach to MAST across the group, particularly in key areas such as Freedom to Speak Up training. (GCPO)	04-Sep-25	GCPO		NOT YET DUE

Group Board

Meeting in Public on Thursday, 01 May 2025

Agenda Item	1.5	
Report Title	**Group Chief Executive Officer's Report**	
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 Group Board on strategic and operational activity across the St George's, Epsom and St Helier University Hospitals and Health Group. Specifically, this includes updates on:

- The national context and impact at Group and Trust level
- Our work as a Group
- Staff news and engagement
- Next steps

Action required by Group Board

The Group Board is asked to note the report.

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 Report

Group Board, 01 May 2025

1.0 Purpose of paper

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

2.0 National Context and Updates

Abolition of NHS England and cuts to Integrated Care Boards

2.1 In my report to the Group Board in March, I provided an update on the leadership changes at NHS England. Since then, the Government has announced that NHS England will be abolished, with some functions absorbed into the Department of Health and Social Care. The Government also announced cuts to Integrated Care Boards of 50%.

2.2 A new NHS Transformation Executive Team – led by Sir James Mackey – has replaced the NHS England Executive Group and will support ongoing business priorities, statutory functions and day to day delivery. The 10-year health plan – due to be published in the summer – will set out the new operating model.

2.3 We are advised that ICBs will have a critical role to play in the future as strategic commissioners. A new model ICB is to be published at the end of April to help systems create a structure to support the delivery of their statutory requirements. In the meantime Sir Jim encourages ICBs to work at pace to reduce their costs by 50 per cent.

2.4 Providers are also being asked to reduce their corporate cost growth by 50% by the end of quarter three. This is the growth in the teams over the last five years. We at gesh had already started reviewing the growth in our corporate areas since the Covid-19 pandemic. We will rapidly finalise this work and move forward with our plans. In addition, the Chief Nursing Officer for England will be looking at reducing the unwarranted variation in corporate nursing roles across different systems. More guidance on this is expected to follow this review.

New Permanent Secretary at the Department of Health and Social Care

2.5 In addition to the changes involving NHS England and ICBs, the Cabinet Secretary has announced the appointment of Samantha Jones as the new Permanent Secretary of the Department of Health and Social Care (DHSC). Samantha Jones is currently a Non-Executive Director at DHSC and previously served as interim Permanent Secretary and Chief Operating Officer at 10 Downing Street. Prior to her career in central government, Samantha Jones led the New Models of Care programme at NHS England and served as Chief Executive of two hospital trusts, including as Chief Executive of Epsom and St Helier University Hospitals between 2007 and 2011.

Supreme Court ruling on women's rights

2.6 The Supreme Court has recently ruled that the legal definition of a woman should be based on biological sex and is binary. We know that many of our staff, patients and visitors will be concerned by this ruling and how it will impact them. We are waiting for guidance from NHS

England and will review our policies in line with their recommendations. In the meantime, we continue to help our teams care for all people with dignity and respect.

New Board member appraisal guidance

2.7 On 1 April 2025, NHS England published new guidance relating to the completion of Board member appraisals. NHS England states that the guidance was developed in service of board effectiveness and to ensure a consistent and standard approach to appraisal. It sets out what should be included in Board member appraisals and how appraisals should be undertaken. Appraisals for all NHS board members are required to: incorporate the six domains of the NHS Leadership Competency Framework (LCF) in assessment, discussion and documentation; include multi-source feedback; be development focused; include objectives that are specific, measurable, achievable, relevant and timebound, and include an equality, diversity and inclusion objective. The guidance includes a new system of overall performance ratings (outstanding, good, satisfactory, improvement needed). In addition, the new guidance makes explicit the need for appraisals to take account of behaviours and values to ensure a holistic evaluation of the appraisee's performance.

2.8 All Non-Executive Director appraisals for 2024/25 have been completed. In line with national requirements, the outcomes of the ESTH NED appraisals have been submitted to NHS England. In line with local arrangements, the outcomes of the SGUH NED appraisals have been reported to the SGUH Council of Governors Nominations and Remuneration Committee. Executive Director appraisals for 2024/25 are currently being undertaken.

3.0 Our Group

CQC 'well led' inspection at St George's – initial feedback

3.1 As the Board is aware, 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. On 11 March 2025, we received a letter from the CQC providing high-level feedback from the visit, which is the subject of a later agenda item. We hope to receive the full inspection report in the coming weeks, and will bring the final report and planned actions in response to the report to a future meeting of the Group Board in public.

Introducing our new, transformative electronic patient record system

3.2 This month we are preparing to launch a new electronic patient record system. iClipPro brings all patient information – from medical history to results of investigations and medications prescribed – together in one place across all our hospitals. While Epsom and St Helier will transfer over to the new platform, the current iClip system at St George's will be updated. It will mean clinicians will have more information at their fingertips and represents a significant, innovative and exciting gesh Group development, both for our patients and our staff. There have been many challenges to get us to this point but my thanks to all the teams involved who are working flat out to make sure we are ready for the cut over on 9 May.

Renal development programme on pause

3.3 Earlier this year, the government announced that our Building Your Future Hospitals (BYFH) programme has been delayed. Our Renal Development Programme was part of the BYFH programme and was expected to receive funding that is currently unavailable. As we have been unable to secure funding to progress with the Renal Development Programme this year, we will

now need to pause the programme. While this takes place, there will be no impact for patients receiving kidney care at St Helier and St George's who will continue to receive excellent treatment from our specialist doctors and nurses.

3.4 We know this will be disappointing news for many of our patients, colleagues and communities, and we are eager for the pause to be as short as possible. However, without funding to restart the programme and as costs rise due to the delay, it will be increasingly difficult to do so.

NHS Staff Survey Results 2024

3.5 I firmly believe that happy staff makes for happy patients, and the annual NHS Staff Survey provides a crucial insight into how our staff feel about working at gesh. The survey results are a substantive item on the Board's agenda, so I will not dwell on the details but I did want to emphasise just how important the survey is and how much I appreciate the honesty of staff, having read every comment. I am delighted that we have seen significant increases in the number of staff at both St George's and Epsom and St Helier completing the survey this year compared with the previous year – in fact, St George's is the 10th most improved acute Trust in the country, with all scores relating to the People promise on the rise, which is real progress. Staff have also been candid about where we need to do better. Action plans developed at a local level will help drive changes that will make gesh a great place to work, while at a Trust and Group level we're focusing on improving leadership, promoting fairer career development, improving retention and fostering inclusion.

Communicating change with our staff

3.6 The NHS is facing unprecedented financial challenges. As set out in the finance papers later in the agenda, the financial position in the South West London system, and across gesh, is very challenging.

3.7 We are determined to support everyone who works at gesh through this period of change and financial challenge. Every month the Group Executive holds a Teams Live event for all staff, regardless of their role, grade or location of work. I am pleased to report that these events have had record attendances in the last two months with 1,300 colleagues joining in March and more than 1,000 in April. Hundreds more staff watch these events on catch up via our intranets. The high attendance is no doubt in part due to concerns our colleagues have about service change. We will always be transparent with staff, share information when we have it and address their questions head on. Our survey responses show that our colleagues value the opportunity to be able to ask anything and get a straight answer. Staff engagement is a high priority for me and I will be leading a series of roadshows, with my executive colleagues, over the coming months to create more opportunities for face to face conversations with colleagues.

Home secretary visit to St George's

3.8 In March, I was pleased to welcome Home Secretary Yvette Cooper to St George's. She came to meet our teams and see our knife amnesty bin - the first of its kind in a UK hospital. Since installing the bin a year ago, around 150 weapons – including zombie knives and machetes - have been handed in which is helping to make our staff, patients and communities safer. During the Home Secretary's visit, which was covered in The Times, she spoke to members of our trauma team about the impact knife crime has on victims, their families and the people who care for them. We are very proud that St George's not only provides excellent physical and psychological support to patients who have experienced knife crime; we are also taking an active role in preventing it happening in the first place. The knife amnesty bins are being rolled out to Epsom and St Helier hospitals in the coming months.

4.0 Appointments, Events and Our Staff

Changes to the Executive team

4.1 Michael Pantlin took up post as Group Deputy Chief Executive Officer on 22 April 2025, succeeding James Marsh who stood down from the Board in March 2025. Michael joins us on a six-month secondment from Surrey Heartlands Integrated Care Board. In his new role, Michael will assist me in managing the Financial Recovery Board and oversee programmes aimed at increasing efficiency and resource use to deliver safe care across the Group. A full, open and transparent process for the recruitment of a substantive Group Deputy Chief Executive Officer will commence over the coming weeks.

4.2 In addition to welcoming Michael to the Executive team, I am also pleased that Ralph Michell has taken up the role of Chief Transformation Officer on an interim basis for six months. Ralph is acting up into this role from his substantive role as Group Director of Strategy and Integration. In his new interim role, Ralph will lead on strategy and transformation, performance and project management and continuous improvement.

Abseil St Helier

4.6 Well over 100 participants took part in an abseil on Friday (25 April) raising more than £35,000 for the Epsom & St Helier Hospital Charity. Having taken part in a charity abseil myself, I know just how brave everyone is for volunteering to do this and raise much needed funds for our staff and patients. My personal thanks to MPs Bobby Dean and Helen Maguire, and all our colleagues who made the descent. Funds raised will be spent on projects across our hospitals, providing enhanced support to patients, their families and our staff.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 01 May 2025

Agenda Item	2.1	
Report Title	**CQC Well Led Inspection (St George's)**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Group Executive Committee	18 March 2025
Purpose	**For Review**	

Executive Summary

The Care Quality Commission (CQC) undertook a Well Led inspection at St George's University Hospitals NHS Foundation Trust (SGUH) between 25 and 27 February 2025. The Trust has not yet received the report of the inspection but has received a letter (dated 11 March 2025) providing high level written feedback which has previously been circulated to members of the Group Board (attached at Appendix 1). The CQC has requested that the findings of the inspection as set out in its letter be discussed at the next public Board meeting.

This report sets out the initial written feedback from the CQC on its Well Led inspection at St George's, maps these against the Trust's internal readiness assessment, and sets out some key actions being taken both in response to the CQC's initial feedback and to improve further the Trust's position in relation to the Well Led framework.

It is important to flag, however, that that the full CQC Well Led inspection report will provide far greater detail than the CQC's initial feedback letter, and the views presented could yet evolve as the CQC prepares its final report. As a result, a full action plan to respond to the CQC's Well Led inspection findings at St George's will be developed following the receipt of the final report. The action plan will be presented to the Group Board for approval. Implementation of actions will be monitored on an ongoing basis by the Group Executive Committee with biannual updates to the Group Board.

The learning from the Well Led inspection at St George's will carry over into preparations for a potential Well Led inspection at Epsom and St Helier University Hospitals NHS Trust.

Action required by Group Board

The Group Board is asked to:

a) Note the feedback received from the CQC dated 11 March 2025 following their inspection, as set out in Appendix 1.

b) Discuss the initial actions and areas of focus to respond to the feedback and improve in areas identified through the inspection and the Trust's self-assessment.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	CQC Well Led feedback letter dated 11 March 2025
Appendix 2	Summary of actions in response to initial CQC feedback

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

Well Led is one of the five domains the CQC uses to inspect NHS provider trusts, as part of its regulatory role. The Well Led framework was most recently updated in April 2024.

Equality, diversity and inclusion implications

EDI is embedded within Quality Statement 4 of the 2024 Well Led framework, and the CQC's written feedback includes feedback on the Trust's position on EDI.

Environmental sustainability implications

Environmental sustainability is embedded within Quality Statement 8 of the 2024 Well Led framework, and the CQC's written feedback includes feedback on the Trust's position on this.

CQC Well Led Inspection (St George's)

Group Board, 01 May 2025

1.0 Purpose of paper

1.1 This report provides the Group Board with the initial feedback received from the Care Quality Commission (CQC) following its Well Led inspection at St George's University Hospitals NHS Foundation Trust in February 2025.

2.0 Background

2.1 The CQC undertook a Well Led inspection at St George's between 25 and 27 February 2025. This was the first Well Led inspection held at the Trust since 2019. The overall CQC rating for the Trust in 2019, as well as its rating for the Well Led domain, was "requires improvement".

2.2 The Well Led inspection was undertaken in line with the CQC's updated Well Led framework published in April 2024. The new framework, which contains eight quality statements against which trusts are measured build on the previous 2017 Well Led framework, but with a greater emphasis on: quality, diversity and inclusion; freedom to speak up; environmental sustainability; population health; and partnership and inter-agency working. A summary of the framework and quality statements is set out below:

Shared direction and culture	• We have a shared vision, strategy and culture. This is based on transparency, equity, equality and human rights, diversity and inclusion, engagement, and understanding challenges and the needs of people and our communities in order to meet these.
Capable, compassionate and inclusive leadership	• We have inclusive leaders at all levels who understand the context in which we deliver care, treatment and support and embody the culture and values of their workforce and organisation. They have the skills, knowledge, experience and credibility to lead effectively and do so with integrity, openness and honesty.
Freedom to Speak Up	• We foster a positive culture where people feel that they can speak up and that their voice will be heard.
Workforce equality, diversity and inclusion	• We value diversity in our workforce. We work towards an inclusive and fair culture by improving equality and equity for people who work for us.
Governance, management and sustainability	• We have clear responsibilities, roles, systems of accountability and good governance to manage and deliver good quality, sustainable care, treatment and support. We act on the best information about risk, performance and outcomes, and we share this securely with others when appropriate.
Partnerships and communities	• We understand our duty to collaborate and work in partnership, so our services work seamlessly for people. We share information and learning with partners and collaborate for improvement.
Learning, improvement and innovation	• We focus on continuous learning, innovation and improvement across our organisation and the local system. We encourage creative ways of delivering equality of experience, outcome and quality of life for people. We actively contribute to safe, effective practice and research.
Environmental sustainability	• We understand any negative impact of our activities on the environment and we strive to make a positive contribution in reducing it and support people to do the same.

2.3 Ahead of the CQC Well Led inspection, the Trust undertook a self-assessment against the new framework and considered this at the Group Board development session in December 2024.This self-assessment informed the Trust's preparations for the inspection as well as longer-term actions to strengthen the Trust's position in relation to the requirements of the new framework.

2.4 The inspection took place between 25 and 27 February 2025 and involved interviews with members of the St George's Trust Board, including Non-Executive and Executive Directors, members of the St George's Site Leadership Team, meetings with each of the three Clinical Divisional Triumvirates, as well as meetings with key leads and staff including the Freedom to Speak Up Guardian, Guardian of Safe Working Hours, Caldicott Guardian, leads for patient safety, complaints, learning from deaths, safeguarding and pharmacy, as well as the chairs of the staff networks, representatives of Staff Side, and patient representatives. A number of follow-up interviews were also held by the CQC in the weeks following the on-site inspection.

2.5 Care service CQC inspections of maternity, the emergency department and surgery had taken place in late 2024 prior to the Well Led inspection.

2.6 The Trust has not yet received the Well Led inspection report from the CQC. Upon receipt, there will be a process of factual accuracy checking ahead of the finalising of the report. The CQC Well inspection report for St George's will be presented to the Group Board in public session upon completion.

3.0 Initial feedback from the CQC

3.1 The Trust received a letter from the CQC on 11 March 2025 providing initial written feedback on the inspection. The letter is attached to this report at Appendix 1. A copy of this letter has been shared previously with all members of the Group Board, as well as with members of the St George's Council of Governors. In its letter, the CQC encourages the Trust to discuss the findings of its inspection at the Trust's next public Board meeting, using this letter to inform the Board's discussions in the event that the full inspection report is not available at that time.

3.2 The CQC's letter makes clear that the initial feedback does not replace the final inspection report and is intended to provide a summary of the high-level findings from the inspection and a basis upon which to start considering any actions needed. While we would expect the final report issued by the CQC to reflect the initial feedback provided, it is important to note that follow-up interviews were continuing at the point at which the feedback letter was issued and that the CQC was also reviewing a large quantity of documents requested in advance of the inspection. As a result, the conclusions issued in the final report may evolve and that the detailed findings are likely to require further actions to be taken. No indication of a rating has yet been provided and this is likely to be provided in the final inspection report.

3.3 In terms of positive areas of feedback, the CQC:

- welcomed the positive and open engagement of the Trust with the inspection;
- recognised the engagement of the Trust with staff, patients and stakeholder in developing its strategy;
- noted that leaders it spoke to were compassionate, capable and caring;
- concluded that processes for managing fit and proper persons requirements were managed to a high standard;
- recognised the work the organisation had taken to foster a positive speaking up culture and in strengthening its freedom to speak up service;
- observed that there were many areas where there are effective structures, processes and systems of accountability to support the delivery of care;
- noted that leaders were focused on continuous learning, innovation and improvement across the organisation and local system and that the Trust's research function was well established;
- observed that the Trust demonstrated a commitment to collaborative working with system partners and had a positive relationship with the university; and
- noted the commitment regarding and progress in relation to environmental sustainability.

3.4 The CQC also highlighted a number of areas for further focus and development, including:

- the need to embed the strategy and strategic objectives across the organisation and to share the vision and strategy;
- the need for progress in develop the Trust's culture and for realising the benefits of the group model;
- the need for some leadership roles to be more clearly defined or with clearer lines of accountability especially in relation to interplay between the Executive and Site Leadership;
- the need to develop more robust succession planning;
- the need to ensure all staff feel safe in raising concerns;
- the importance of greater progress in developing an inclusive culture;
- the importance of clarifying roles are responsibilities at group and site level;
- inconsistencies in documentation regarding duty of candour and complaints; and
- the impact of the Trust's estates challenges. In respect of the capital programme budget of £100m cited in the CQC's letter, the Trust has requested that this be amended to clarify the Trust's actual capital programme budget, which is considerably lower.

4.0 Actions following the inspection

4.1 A full action plan to respond to the CQC's Well Led inspection findings will be developed following receipt of the full CQC inspection report. This will be developed by the Executive team and will be presented to the Group Board for approval.

4.2 In the meantime, the Trust is progressing a number of actions to respond to these initial findings, many of which had been identified through the Trust's internal self-assessment prior to the inspection some of which are longer-term actions. A high level summary of these actions is set out in Appendix 2.

4.3 It is possible that there will be a CQC Well Led inspection at Epsom and St Helier at some point in the next 12 months. Much of the preparatory work an actions taken in relation to the St George's inspection will be of relevance in preparing for the ESTH Well Led inspection. A focused programme of preparation will build on the SGUH experience and a similar process of self-assessment and readiness preparation will be undertaken for ESTH.

5.0 Recommendations

5.1 The Group Board is asked to:

a) Note the feedback received from the CQC dated 11 March 2025 following their inspection, as set out in Appendix 1.

b) Discuss the initial actions and areas of focus to respond to the feedback and improve in areas identified through the inspection and the Trust's self-assessment.

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Sent via email

Our reference: AP8254

Chief Executive Jacqueline Totterdell
Organisation: St Georges University Hospitals NHS Foundation Trust

Address 1: Blackshaw Road
Town: Tooting
County: London
Postcode: SW17 0QT

Date:11 March 2025

CQC Reference Number: AP8254

Dear Jacqueline Totterdell,

Re: CQC inspection of St Georges University Hospitals NHS Foundation Trust

Following our on-site trust level assessment, I thought it would be helpful to give you written feedback as discussed at the inspection.

This letter does not replace the draft report we will send to you, but provides initial high-level findings and provides you with a basis to start considering what action is needed.

We would encourage you to discuss the findings of our inspection at the public session of your next board meeting. If your next board meeting takes place prior to receiving a final or draft inspection report, this correspondence should be used to inform discussions with the board. When scheduling a discussion of this letter, or the draft report, please inform your CQC Regional Communications Manager, who is copied in to this letter.

An overview of our feedback

The feedback to you is:

Firstly, thank you to you and your teams, we felt that people were open and transparent describing challenges and successes.

Shared Direction and Culture

There has been engagement with staff, patients, and stakeholders. There is on-going work to understand the challenges and needs of people and communities. Our initial findings demonstrate that the trust's strategic objectives have not been effectively embedded across the organisation. There is still work to be done to ensure that the vision and strategy is shared, and the culture is based on transparency, equity, equality and human rights, diversity and inclusion. There is an acknowledgement that the benefits from the group model have not yet been realised in line with strategic objectives and there is more work to be done.

Capable, compassionate and inclusive leaders
Generally, leaders we spoke with were compassionate, capable, inclusive and caring. However, we identified that some leadership roles require defining or clearer lines of accountability particularly when considering the interplay with site leadership. Concerns were identified regarding the bandwidth of individual roles and associated accountability, suggesting potential challenges in allocating sufficient time for effective oversight. We identified further work was required to develop robust succession planning. We saw evidence of talent management opportunities but this was not reflective across the whole trust. We found that the fit and proper people files were well organised in line with the trust policy and Regulation 5 and were managed to a high standard.

Freedom to speak up
We found evidence that the organisation worked hard to foster a positive culture. The Freedom to Speak Up framework and approach had been updated and was well-integrated within the service, resulting in a notable increase in individuals raising concerns. While the increased utilisation of Freedom to Speak Up processes suggests a positive cultural trend, we were made aware that some people still do not feel that their voices are being heard or that it is safe to raise concerns.

Workforce equality, diversity and inclusion
Senior leaders acknowledged that whilst they valued diversity in the workforce, there was still more work to be done to ensure an inclusive culture. The board's composition did not adequately reflect the demographics of both staff, and the communities served. The trust had introduced initiatives and leadership programmes to support diversity and inclusion, however, we were not assured that these initiatives and others were being measured or monitored for effectiveness in line with the EDI strategy.

Governance, management and sustainability
We found that there were many areas where there were effective structures, processes and systems of accountability to support the delivery of care. For example, the use of an accountability framework and the divisional incident review groups. However, we found that the governance systems needed to be reviewed to support the delivery of the strategy and consistent delivery of quality care across all services. This includes ensuring that roles and responsibilities are clear at group and site level. Our review of documentation demonstrated that Duty of Candour communications and complaints were not always conducted in line with policy and in some instances, we felt that the trust lacked transparency.

Learning, improvement and innovation

Leaders we spoke with were focused on continuous learning, innovation and improvement across the organisation and the local system. The trust research function was well established and was constantly exploring ways to involve investigators in research opportunities. Leaders told us this was challenging and sometimes there was not enough capacity to support creativity and innovation, however, there was a willingness from people to get involved. We have not yet explored the safety and effectiveness of research activity and will review this further. The organisation's ward accreditation programme is well established and embedded and some staff told us that this could benefit from introducing an external peer review process.

Partnerships and communities
The trust understood their duty to work in partnership with others to deliver services that work seamlessly for people. The trust demonstrated a commitment to collaborative working through system-wide meetings and showcased successful examples of cross-site working in areas such as pathology, renal, and pharmacy services. The trust had a positive relationship with a local university and was working collaboratively to develop new accredited courses and clinical and nursing roles.

Environmental sustainability – sustainable development
Our interviews with senior leaders demonstrated that those responsible for environmental sustainability recognise the negative impact of the trust's activities on the environment. The trust has a 'Green Plan' in place and is identifying actions to make a positive contribution in reducing any negative impacts and supporting people to do the same. This includes eliminating waste and pollution, implementing the principles of a circular economy, regenerating nature and operating within ecosystem boundaries and developing environmental management systems to support this. The trust's operational effectiveness is significantly impacted by the state of its estate, evidenced by a substantial backlog of repair work. While a £100 million capital programme is allocated to address essential hospital needs, including safe water, fire safety, and asbestos remediation. However, during our assessment, we noted a limited clinical input into this programme. This raises concerns about whether the prioritisation of these works fully aligns with the immediate and long-term clinical needs of patients**.**

A draft inspection report will be sent to you once we have completed our due processes, and you will have the opportunity to check the factual accuracy of the report. I am also copying this letter to Karen Bonner at NHS England.

Could I take this opportunity to thank you once again for the arrangements that you made to help organise the inspection, and for the cooperation that we experienced from you and your staff.

If you have any questions about this letter, please contact me through our National Customer Service Centre using the details below:

Telephone: 03000 616161

Write to: CQC

Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

If you do get in touch, please make sure you quote or have the reference number (above) to hand. It may cause delay if you are not able to give it to us.

Yours sincerely

Antoinette Smith

Deputy Director of Operations

c.c. Chair of Trust

Name of NHS England representative

CQC regional communications manager

Appendix 2: High level actions in response to CQC feedback and self assessment

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
Shared Direction and Culture	• There has been engagement with staff, patients and stakeholders in the development of the strategy.	• The Trust's strategic objectives have not been effectively embedded across the organisation. • There is still work to be done to ensure that the vision and strategy is shared, and the culture is based on transparency, equity, equality and human rights, diversity and inclusion. • There is an acknowledgement that the benefits of the Group model have not yet been realised in line with strategic objectives and there is more work to be done.	• Develop and agree through the Group Board outstanding corporate enabling strategies (digital, estates, research and innovation) and develop plans for launch to staff across the Group and clear plans for implementation. • Integrate CARE framework into team objectives at every level of the Group and establish CARE board reviews by teams. • Integrate CARE framework into the PDR framework for individual objectives and appraisals for all staff • Integrate CARE framework into Ward Accreditation Scheme • Undertake Group-wide refresh of values • Progress actions in relation to EDI (see EDI section below)
Capable, Compassionate and Inclusive Leadership	• Generally, leaders we spoke with were compassionate, capable, inclusive and caring. • We found that the fit and proper persons files were well organised in line with the Trust policy and Regulation 5 and were managed to a high standard.	• We identified that some leadership roles require defining or clearer lines of accountability particularly when considering the interplay with site leadership. • Concerns were identified regarding the bandwidth of individual roles and associated accountability, suggesting	• Embedding of the new Group Accountability Framework. • Deliver the Board approved Talent Management Strategy (Feb 2025) to give all our staff opportunities to develop their careers during their tenure with the Trust. • Develop set of shared values across the Group.

Appendix 2: High level actions in response to CQC feedback and self assessment

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
		potential challenges in allocating sufficient time for effective oversight. • We identified further work was required to develop robust succession planning. • We saw evidence of talent management opportunities but this was not reflective across the whole Trust.	• Implement our vision for High Performing Teams. • Fully establish the gesh Culture Forum as a driver of culture change across the Group.
Freedom to Speak Up	• We found evidence the organisation worked hard to foster a positive culture. • The Freedom to Speak Up framework and approach had been updated and was well-integrated within the service, resulting in a notable increase in individuals raising concerns.	• While the increased utilisation of Freedom to Speak Up processes suggests a positive cultural trend, we were made aware that some people still do not feel that their voices are being heard or that it is safe to raise concerns.	• Refresh the SGUH FTSU vision and strategy 2020-2024 and establish this on a Group-wide basis. A new Group-wide FTSU policy was approved by the Group board in January 2025. • Strengthen mechanisms for disseminating learning from speaking up inc. introducing regular communications to staff showcasing how the organisation has responded to concerns. • Develop and launch protocol for risk assessing and investigating allegations of detriment, in line with new NGO guidance. • Develop and publish new guidance for responding to concerns as part of wider manager's toolkit. • Development and use of the Insights Report to target support and interventions to teams that may be struggling and / or require support.

Appendix 2: High level actions in response to CQC feedback and self assessment

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
Workforce Equality, Diversity and Inclusion		• Senior leaders acknowledged that while they valued diversity in the workforce, there was still more to be done to ensure an inclusive culture. • The Board's composition did not adequately reflect the demographics of both staff, and the communities served. • The Trust had introduced initiatives and leadership programmes to support diversity and inclusion, however we were not assured that these initiatives and others were being measured or monitored for effectiveness in line with the EDI strategy.	• Implementation of the EDI Action Plan approved by the Group Board in February 2025. • Implementation of the Diversifying our Leadership plans, including introducing the Shadow Board initiative. • Focus on improving the diversity of the Board through upcoming Executive and Non-Executive appointments processes. • Launching the Talent Strategy to staff.
Governance, Management and Sustainability	• We found that there were many areas where there were effective structures, processes and systems of accountability to support the delivery of care. For example, the use of an accountability framework and the divisional incident review groups.	• However, we found that the governance systems needed to be reviewed to support the delivery of the strategy and consistent delivery of quality of care across all services. • This includes ensuring that roles and responsibilities are clear at group and site level. • Our review of documentation demonstrated that Duty of Candour communications and complaints were not always conducted in	• Embed the Group Accountability Framework approved by the Board in February 2025. • Embed the Group Risk Management Framework as approved by the Group board in March 2025. • Implement actions from the Phase 1 and Phase 2 Quality Governance Reviews. • Review issues identified by the CQC in relation to Duty of Candour and complaints.

Appendix 2: High level actions in response to CQC feedback and self assessment

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
		line with policy and in some instances we felt that the Trust lacked transparency.	
Partnerships and Communities	• The Trust understood their duty to work in partnership with others to deliver services that work seamlessly for people. • The Trust demonstrated a commitment to collaborative working through system-wide meetings and showcased successful examples of cross-site working in areas such as pathology, renal, and pharmacy services. The Trust had a positive relationship with a local university and was working collaboratively to develop new accredited courses and clinical and nursing roles.		• Development, agreement and implementation of Group roadmap • Confirm Alliance governance structures
Learning, Improvement and Innovation	• Leaders we spoke with were focused on continuous learning, innovation and improvement across the organisation and the local system. • The Trust research function was well established and was constantly exploring ways to	• Some staff told us that [the ward accreditation programme] could benefit from introducing an external peer review process.	• Delivery of High Performing Teams strategic initiative. • Embedding of use of CARE boards throughout Group as a tool for Continuous Improvement. • Refresh Ward Accreditation Scheme.

Appendix 2: High level actions in response to CQC feedback and self assessment

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
	involve investigators in research opportunities. Leaders told us this was challenging and sometimes there was not enough capacity to support creativity and innovation, however, there was a willingness from people to get involved. • The organisation's ward accreditation programme is well established and embedded.		
Environmental Sustainability	• Our interviews with senior leaders demonstrated that those responsible for environmental sustainability recognise the negative impact of the Trust's activities on the environment. • The Trust has a Green Plan in place and is identifying actions to make a positive contribution in reducing any negative impacts and supporting people to do the same.	• The Trust's operational effectiveness is significantly impacted by the state of its estate, evidenced by a substantial backlog of repair work. • While a £100 million capital programme [sic] is allocated to address essential hospital needs, including safe water, fire safety, and asbestos remediation. However, during our assessment, we noted a limited clinical input into this programme. This raises concerns about whether the prioritisation of these works fully aligns with the immediate and long-term clinical needs of patients.	• Embed the green plan governance structures and processes and gesh Steering Group meetings. • Develop a KPI scorecard for environmental sustainability. • Start delivering clinical engagement workshops within the next 6 months and conclude within 12 months. • Initiate and deliver identified decarbonisation projects.

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	**2.2**	
Report Title	**Quality Governance Review Part 2 (Divisional Pilot)** Integrated Care and Renal Services at ESTH and Surgery, Neuro, Cancer and Theatres (SNCT) Division at SGUH	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Chief Medical Director	
Report Author(s)	Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance Rebecca Ellis, Group Head of Nursing for Quality and Safety Governance Alison Benincasa, Group Director of Compliance Sarah Hodgson, Business Manager, Group Chief Nursing Officer	
Previously considered by	Group Executive Gesh Quality Group Quality Committee in Common	15 April 2025 13 February 2025 24 April 2025
Purpose	**For Assurance**	

Executive Summary

This paper presents the findings from the Quality Governance Review Part 2 (Divisional Pilot).

This Quality Governance Review Part 2 was undertaken by Sally Herne, an external healthcare improvement specialist, working in collaboration with gesh Group colleagues.

This work followed on from previous work undertaken independently by Sally Herne, focusing on St George's maternity (the Quality Governance Review Part 1), which was commissioned in response to the findings of a CQC inspection, and whose output and resulting actions have previously been discussed at QCiC and by the Group Board.

The aim of this Part 2 "pilot review" was to build on the findings and insights provided by the Part 1 maternity review, and to examine a representative sample of Divisions other than maternity, one from each Site (ESTH, SGUH and Integrated Care).

The intention was, and is, to use the findings from this Part 2 review into these three areas to formulate a time-bound Quality Governance improvement plan that can be rolled out across the gesh Group.

The purpose of this paper is to share with QCiC the findings of the Part 2 pilot review in these three areas, as described in the individual reports that constitute the three Appendices to this paper.

A further paper, informed by the discussion at this QCiC, will come to QCiC in May 2025 describing the time-bound Quality Governance improvement plan for the Group that will arise from this Part 2 pilot review

The participating Sites and Divisions were:

- Integrated Care
- Renal Services at ESTH
- Surgery, Neurosciences, Cancer and Theatres (SNCT) at SGUH

Using a structured quality improvement approach, the pilot review identified both strengths/good practice and weaknesses/challenges, some of which were also highlighted in the Quality Governance Review Part 1 (Maternity Services).

The strengths include collaborative learning cultures, strong audit and incident management practices, and psychological safety.

The challenges/weaknesses include variation in leadership capacity, access to real-time data, administrative support, and inconsistency in risk escalation.

The pilot review also identified strong clinical engagement and an appetite for improvement.

Action required by Group Executive
The Board is asked: 1. Note the findings from the Quality Governance Review Part 2. 2. Note the action plan will be presented to Quality Committees-in-Common in May 2025.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Renal Services Report, ESTH
Appendix 2	Surgery, Neuro, Cancer, and Theatre Review (SNCT) Report, SGUH
Appendix 3	Integrated Care Report, ESTH

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☒ Right care, right place, right time	
☐ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
There is a risk that the Divisions will not have sufficient resources to deliver the required improvement actions. The action plan to be presented to Committee in May 2025 will identify how this risk will be mitigated within current financial resources.				
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:				
To be determined.				
Legal and / or Regulatory implications				
Compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.				
Equality, diversity, and inclusion implications				
The governance improvements emphasise the importance of fostering a culture of collaboration and psychological safety. This focus inherently supports principles of equality, diversity, and inclusion by promoting an environment where all staff members feel valued and empowered to contribute.				
Environmental sustainability implications				
No significant environmental sustainability implications have been identified.				

Quality Governance Review Part 2 (Divisional Pilot)

Integrated Care and Renal Services at ESTH and Surgery, Neuro, Cancer and Theatres (SNCT) Division at SGUH

Group Board, 01 May 2025

1.0 Quality Governance Review Part 2 (Divisional Pilot)

The learning from the Quality Governance Review Part 1 (Maternity Services) indicated that Divisional Quality Governance across the Group would benefit from review. In the first instance this would take the form of a pilot study to assess the maturity and effectiveness of divisional governance arrangements with a view to rolling out across all Divisions within the Group.

The Quality Governance Review Part 2 (Divisional Pilot) commenced in October 2024. The participating Divisions were Integrated Care and Renal Services at ESTH and Surgery, Neuro, Cancer and Theatres (SNCT) Division at SGUH.

Structured quality improvement methodology was used to:

- Identify strengths
- Surface systemic gaps
- Generate insights to inform a standardised, sustainable approach to governance.

2.0 Findings

The findings provide a view of leadership capacity, data usage, risk management, and local governance culture, with implications for both operational delivery and strategic oversight. Some of these findings were also highlighted in the Quality Governance Review Part 1 (Maternity Services).

The following strengths were identified:

- Engagement with audit
- Open learning cultures
- Structured safety processes in specific services (Integrated Care and SNCT)

The following weaknesses were identified:

- Maturity: Insufficient clinical leadership capacity and protected time for governance
- Lack of administrative support for core governance functions
- Effectiveness: Limited access to real-time data to support decision-making

- Inconsistency in risk scoring and escalation processes
- Missed opportunities for cross-divisional learning

The strengths and weaknesses for each division are provided within section 2 of the Divisional reports within appendices 1, 2 and 3.

4.0 Next Steps: Action Plan Development

The Divisional Reports have been shared with the Divisional Triumvirates, the Site Leadership Team and Executive Team.

A detailed SMART action plan will be developed to address the learning points for each Division and the key learning for the Group.

The action plan will be presented to Quality Committee in Common on 29 May 2025.

5.0 Recommendations

1. Note the findings from the Quality Governance Review Part 2.
2. Note the action plan will be presented to Quality Committee in Common in May 2025.

Appendix 1

Group Governance Pilot Review - Part 2

Renal Services ESTH, September-November 2024

Review Team:

Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance

Rebecca Ellis, Group Head of Nursing for Quality and Safety Governance

Dr Sally Herne - Intensive Improvement Director Intensive Support for Challenged Systems, NHS England

1. Background and Context

This report is designed to provide a summary of findings following a quality governance review within the Renal Services, Epsom & St Helier University Hospitals NHS Trust. It is acknowledged that there is on-going collaborative work in progress to join services with St George's University Hospitals Foundation Trust with the outcome of a group approach within the speciality of renal Medicine.

The services supplied spread across a large geographical area which extends to West Surrey and Sussex, with a number of satellite services that are managed by the Trust, GESH, or by commercial companies, which are independently registered with the Care Quality Commission.

This report is designed to provide the Divisional Leadership Team (DLT) with a summation of the findings from the four different parts of the review.

- A collection of information about the 'as is' i.e. how quality governance is overseen and the system of roles and responsibilities within the Renal Division
- Self-assessments against the four themes of a good quality management system (Total Quality Management, TQM) and the eight areas of the Good Governance Institute (GGI) Maturity Matrix undertaken on 16th October via Teams with Division selected staff. The GGI initial findings were discussed at the time of the meeting.
- Observation of a set of quality oversight meetings specifically selected by the Division – Clinical Practice Group (joint with St George's meeting), Matrons Meeting, Divisional Operational Governance, Divisional Clinical Governance Group, Integrated Finance & Performance with the Site Leadership Team and ESTH Patient Safety and Quality Group.
- A daily nursing staffing huddle was observed as requested by the Division on 30th September 2024

- The ESTH Weekly Incident Review Panel Meeting was also observed on 16th October as Renal Services presented their Divisional Incident Review for the month of September
- Discussions with the Divisional Director of Nursing and Governance stakeholders on 6th November.

The Division is asked to consider this summary and set a core of value adding SMART (specific, measurable, achievable, realistic and timely) objectives for improvement between now and December 2025 using **table 1**. Progress on these will then be reported to the site either via PSQG or performance review meetings. We encouraged all teams involved in this governance pilot to choose a few key areas which would make a measurable difference.

Table 1: Divisional self-set priorities for quality and governance – TO BE DEVELOPED

Priority area	SMART Objective for December 2025	Owner	Where progress will be overseen by the Division

2. SWOT Analysis

The overall Strengths, Weaknesses, Opportunities and Threats are set out below in **table 2**. These are based on the self-assessment the Division completed and the observations from the review team.

Table 2: SWOT analysis as identified from observations and information during the review

Strengths	Weaknesses
• Collaborative working across the group with strategic vision • Sharing patient experiences • The Division and teams are very proactive in dealing with unplanned events and shows effort to resolve issues within the service • Psychological safety, learning and sharing following a recent patient event with staff debrief • Active participation in national work streams and data collections • The Division has a dedicated data/IT member in the Division • GGI Maturity Matrix self-assessed patient carer feedback, regulatory compliance, incident management and mortality as strongest elements	• Availability of meaningful, timely, accurate intelligence and data, which reflects the uniqueness of the patients and service • Support for quality and governance leads and clinical governance workload spread • Clarification of responsibility with regard to governance workload spread • Hearing from all staff– what's on their worry list as well as the good things that have happened from individual teams • Poor group IT systems limit joined up working across GESH to support sharing of current and strategic work • Coverage re: aspects of quality and triangulation gaps • CQC preparedness – no discussion of on-going actions from mock inspections to

• Staff attendance to national specialty forums allows sharing of national research and initiatives • SWL ICB has enabled the fixed term employment of a Renal Frailty CNS, to enable greater to improve quality shared decision making • Ward accreditation and CQC internal inspections with feedback in place • Greater benchmarking and collaborative opportunity via the London Kidney Network	promote a culture of 'making it business as usual' and improvement • Timeliness of meeting papers publication, lack of Terms of Reference across a majority meetings • Potential missed opportunities of learning from other divisions • GGI Matrix identified clinical effectiveness, clinical audit and risk management as weaker areas of governance with no consensus between staff on the maturity of clinical audit • 1PA for dedicated Quality lead per week • 0.25PA for dedicated Audit lead per week • Whilst promoting safe space for open conversation amongst divisional colleagues having minutes taken by meeting attendees can also be seen as restricting full participation in meetings. With the use of ToRs and meeting culture such as confidentiality re: sensitive information in JDs, this would encourage openness for greater conversation. • Limited action lead identification with completion dates. This places the emphasis on the meeting chair and detracts from individual ownership and responsibility, thus assurance • MDT approach and inclusion to all aspects of clinical governance • Evidence of written assurance

Opportunities	**Threats**

• Work in progress in preparation for service reconfiguration with a group approach • Roll out of Making Data Count as part of the Total Quality Management Programme (GESH Quality Improvement-QI) • Development of self-service quality reporting • Positive self-assessed early experiences of using PSIRF approach to learning • 14 divisional staff trained in QI and methodology across medical, nursing, allied health professional and operational groups • Greater sharing of learning and information across professional groups shifting the thinking and culture of being involved regardless of role • CQC future reports will give scores as well as ratings to show where you are in the pack and which organisations it may be helpful to learn from • Capture of patient information via M&M meetings i.e. DNARCPR status, treatment escalation plans in place, treatment regimes, patient ethnicity, any reported incidents, concerns, causes of death- are there trends, patterns and good practice which can be shared widely	• Challenges in oversight and assurance in both directly provided services and the network of sub-contracted satellite units run by Diaverum and Davita with separate CQC registration for each and different processes. This also includes trust contract patient transport services • Financial constraints limits risk mitigation • Operational pressures impact the opportunity, time and resource available for governance and quality • Aspects of access to mandatory and statutory training increasing potential risk • Change to CQC framework for assessment so the bar has changed from what people have been used to

3. Recommended areas to consider for improvement

There is an evident sense of ambition and desire to improve within the Division of Renal. Quality of care for patients mattered very much from observations, including relaying patient stories of experience. Teams were trying to create constructive forums for learning with staff who had been involved in cases where something had gone wrong. Successes were being captured, celebrated and shared. Collaboration and learning with the St George's team was being progressed through the Partnership Board and the Kidney Network also offers opportunities for learning and benchmarking. There is therefore much which is good work to build on.

We would encourage the Division consider the following areas for improvement as outlined in **table 3**. Some of these can be owned by the Division alone; others require collaboration with ESTH at Site level or Group.

Table 3: Findings and Recommendations

Help teams be better placed to use information for improvement	**Divisional, Site and Group actions to support improvement**
Findings: 1) A number of different quality reports are produced within the Division that support meetings using a variety of report templates over different time periods (monthly, two monthly, over the current year, yearly comparison) using several designs (bar charts, pie charts and tables). This makes it harder to distinguish between normal variations in data and actual shifts over time that provides more impact to inform decisions and quality improvement. Rolling out "Making Data Count" Statistical Process Control charts and needed training on how to utilise and fully interpret is essential. 2) Revalidation of data was needed when the definition or narrative was not immediately clear i.e. transport issues 'abort' 'not fulfilled', and clinics i.e. 'consultant away, unavailable' 3) Data that supports reports requires manual extraction and validation prior to further sharing which can take extended time to complete in conjunction with different timeframe reviews. There is current work at group level to automate the collection of data, reduce the burden and give staff more access to real time information. 4) Methods of data collection need to consider the needs of the service to comply with national data collection and the Kidney Network. 5) Capturing of all divisional governance information including FFT, Gratuity, PALS enquiries, Complaints/PHSOs, Duty of Candour, NPSA alerts, Audit, GIRFT, accreditation. Gaps in information leading to assumption and not assurance, learning from deaths	**Division:** 1) The Division needs to confirm and ensure staff are trained and can provide narratives that add value and reflect real time intelligence. This could be included in a planned training needs analysis for other connected IT work streams (iCLIP PRO). 2) Division Data and information to be provided monthly from each satellite unit regardless of management structure/contract to enable greater oversight and on-going assurance by the Divisional leadership Team (DLT) using clinical governance indicators. Dependent on contract, support from site will be needed. 3) Feedback is reviewed by the Division not only via the annual PREM survey but reflects patient feedback from other regular local sources such as FFT, Gratuity Reports, PALS enquiries, complaints, which could be funnelled by location, service. Next steps would be to look at population need. 4) The Division critiques data upon receipt from an MDT approach over a longer timeframe where possible, to show position improvement or deterioration and identification of contributory factors of influence, to provide wider learning. **Site/group** 1) Once data is available in a systematic way, training in the interpretation of data and theme identification is available via NHS course (hssib.org.uk) which the Division could access for staff who need to support. 2) The group and site explicitly request accurate data by external agencies (EMED) as part of contractual requirements which

	reflects safety for patients /service users and value for money using non-emergency transport services. 3) The group to provide expertise for roll out of reporting and training into quality ensures standard reports and that the quality component is comprehensive, adds value, reflects standard timeframe review and shows improvement/challenge over time where appropriate. 4) The group supports that methods of data collection are centralised and the Division to ensure that a 'one stop shop' will meet the needs for service, group and national benchmarking and local data collections for patients and services. Hearing the rationale for data requirements specific to the Division will support information which reflects their unique needs, with capture of the narrative, which can be reviewed at any point.
Insight, oversight and assurance **Findings:** 1) Focus on central information with less supply of local soft intelligence available from staff 2) The Division invest a great deal of time into governance, however, improvement in assurance is needed 3) Limited continuous oversight and service feedback into contracted services and therefore greater assurance is needed 4) There is a sense of 'just do it'. Work is undertaken and completed without evidence of the actions taken to provide assurance to the DLT, site or group.	**Divisional, Site and Group actions to support improvement** **Division:** 1) The Division to include opportunity to hear staff worries/concerns by providing discussion time in current meetings and routine department work 2) Whilst the Division openly thanks staff for their continued efforts, there is little opportunity for open discussion of worries or concerns, which could raise the profile of emerging risk as well a detrimental effect on staff motivation. Meeting reconfiguration/scrutiny could enable this to be captured by the Division 3) Divisional meeting chairs to support equity of time for paper presentation and discussion, time for pre meeting checks of matters arising/action log and agenda and meeting, time for escalation of risk

	4) Staff need to have clarity of their responsibility and accountability re: engagement, presentation of papers and timeframes for completion of actions 5) Terms of Reference to prevent unnecessary delay in actions and reports to inform the Division 6) The Division to obtain, information and assurance across all services including contracted services i.e. satellite units and transport 7) Review the governance workload and resource in the Division regarding work spread including staff trained in QI **Site/Group:** 8) To support the Division in opening governance channels of communication and information sharing with contracted services where needed such as EMED and service tenders
<u>Escalation</u> **Findings:** 1) It is very evident that the Division deals with operational and clinical challenges extremely well and teamwork, well demonstrated. 2) There were occasions when the Division has struggled to resolve issues regardless of their extreme efforts and created work arounds rather than addressing the issue. 3) Escalation was demonstrated regarding transport issues; however, this appears to have been a long-term issue and increasing risk. Based on observation, and risk review, risks such as violence and aggression, estate/environmental issues (i.e. lift breakage) had been longstanding risks which the Division recognised and captured but had not been resolved. It is not	**<u>Divisional, Site and Group actions to support improvement</u>** **Division:** 1) With the support from site, triangulate information across the quality and governance domains to provide real time indicators of performance and issue from contracted services 2) To scrutinise risks including those that have a risk scoring below 15 **Site:** 1) Support the regular on-going receipt of information from EMED 2) Validated Business Intelligence information which accurately reflects the service configuration and patient need

known how these had previously been escalated to support the Division in remedy or mitigation	3) Hold contracted services to account to provide agreed quality and governance information as set out by Site and group 4) Challenge historical risks which remain open and offer support for those that the Division has acted upon, but the risk remains despite controls and mitigations

4. Organising and Overseeing Quality

4.1 Service Structure

Renal Services is a complex mix of NHS provided services and sub-contracted services run by either ESTH, GESH or independent providers, which have a mixture of procedural documents relating to quality. The team therefore has a dual role in overseeing governance of its own care and holding other providers to account for their performance through contract management. The governance structures within the service were refreshed in September 2024, in place and are set out in **table 5.** Independent provider oversight for satellite units is via a quarterly meeting and the relationship is managed by members of the leadership team (ADDON, Contracts Manager). We did not look into the contractual assurance arrangements and staff from the independent providers did not provide feedback in the surveys. We therefore cannot comment on their governance maturity.

External services are used to provide support to patients. One example is the EMED transport service. This independent national company started working with the Trust in April 2024 and provides non-emergency patient transport services being CQC registered with 70 contracts across the UK.

In parallel, ESTH Renal is working on an integration programme with their colleagues at St George's. This is overseen by a Programme Board and is working to co-design a joint service to operate from a new building, including aligning policies, procedures building relationships and pathways. The work has resulted in some joint meetings within the governance structure e.g. the Clinical Practice Group included in **table 4**, with a great deal of time by the DLT being used for this work stream.

4.2 Divisional Governance Meetings

There are a number of meetings within the Division that presents information relating to operational and clinical governance. The time allocated for internal divisional forums averages 15 hours per month (meetings not observed included consultant meeting, M&M, Renal Services Team and Incident Review, as not requested) as seen in **table 4**. Site forums average 4 hours per month (including PSQG, Performance and Finance with Site leadership and Site Incident Review Group (CIRG), attended when reviews need to be presented. There was occasional blurring of the operational and clinical governance strands, with duplication of information.

There is a forward planner which provides dates and time for meetings. As part of the observational part of this review, two meetings were rescheduled, with explanation i) a ward staff debrief following a recent patient event ii) due to sickness and annual leave, the reasons were very reasonable.

Meeting etiquette is outlined with expected attendance to ensure quorate representation. However, there are a number of meetings with no meeting Terms of Reference (Clinical Practice Group ToRS supplied). As a result, items were deferred due to lack of presence of a member of staff and no deputy present. Expectations from members of meetings were not outlined re: actions outputs accountability and responsibilities.

Papers were received at short notice (up to the day before) and not all information was shared i.e. data and mock CQC inspection reports with on-going action plans. There were also IT challenges in opening documents when shared via Teams and across sites.

Papers included minutes of the last meeting, agenda with matters arising, which also contained information relating to actions and papers. There were two meetings observed where the matters arising were focused on, rather than the agenda. This resulted in confusion as matters arising drove the progress of the meeting and not the agenda. There were occasions when items were not discussed equitably re: time i.e. the Clinical Practice Group, Risk. Improvement in meeting structure and chair scrutiny pre-meeting with realistic timeframes for paper presentation/discussion would help in conjunction with meeting terms of reference, where expectations are explicitly described (members, attendance, responsibility, action timeframes) and staff engagement.

One meeting was minuted by a matron (on a rotational basis). This could prevent active discussion for the individual and seems a poor use of time by a senior member of the Team, which led to the question by the observer, could there be more use of administrative support? However, the Division felt this provided a safer space for conversation and discussion of a sensitive nature.

The use of standing agenda items would support that all aspects of clinical governance are highlighted and not lost, even when there is no update, assurance would be demonstrated that there was discussion and noting, including M&M and audit reports.

With the use of better data capture, an overall monthly dashboard would supply overall data over time, without the loss of key quality governance data, i.e. incident profile (including harm, sub-category-to provide more detail, actions-SWARM, AAR, MDT, PSIIs, never events), PALS, complaints /PHSOs, Inquests, NPSA alerts, Duty of Candour, FFT, Gratuity, Tendable (until January 2025)/RATE results, audits in progress/completed, safeguarding referrals learning, patient stories/feedback, M&M key messages, open risks with current scoring, controls and mitigation, procedural document approval, expiration. If nothing is reported for a month, it is noted as N/A, rather than having no narrative, leading to assumption. Inclusion of information could also be used for emerging risks and actions taken.

Rather than creating varying charts according to the specific meeting being held, greater utilisation of automated standard reports which have the same timeframe would allow greater oversight, comparison and visibility of improvement/deterioration with less time needed by the Team to manually extract. This in turn would also permit mirroring of data, analysis and triangulation. There were run/SPC charts used for performance data, but not consistently across the aspects of clinical governance.

All meetings encouraged participation, questioning, which at times was limited and team feedback was not captured, preventing appreciative enquiry. Use of subject matter experts could also provide the fresh eye approach.ie. tissue viability to conduct a deeper look into patient skin damage. If existing skin damage is noted on admission (one reason for incident reporting) how is this being managed for those patients in the community and relayed to groups i.e. GPs and supporting services if used?

Table 4: Renal Meeting Structure-Frequency, Chair with meeting time allocation per month

The table below reflects a baseline from the information supplied by Renal Services and observation. The Division feels that the amount of time per month exceeds the total of 22 hours 15 minutes per month as other meetings are also attended.

Meeting	Frequency	Chair	When	Length of Time per month
Site Patient Safety & Quality Group (observed)	Monthly	Site Chief Nurse or Chief Medical Officer	Divisional representation	2 hours
Divisional Tri Meeting	Weekly	DDO	Required attendees- DMD, DDON, DDO, GM	4 hours
Clinical Governance Group (observed)	Monthly	DDON, DMD	Required attendees- DMD, DDON, DDO, Q&PSM, Quality Lead, Admin support in place	2 hours
Operational Governance Meeting (observed)	Monthly	DDO or DDON	Quoracy DDO (or deputy), DDON (or deputy), DMD, HR Business Partner (or deputy), Finance Manager (or deputy), General Manager (or deputy), one matron	1 ½ hours
Performance & Financial Meeting with SLT (observed)	Monthly	Site Leadership Team	Renal Tri to present	1 ½ hours
Audit- Under review	Monthly	Audit Lead	TBC	TBC
Mortality & Morbidity	Monthly	Quality Lead	Monthly Required attendees – minimum of 25% of consultants, Lead Nurse Minutes supported by the Quality & Patient Safety Manager	1 hour
HD Quarterly KPI	Quarterly	Quality Lead, Audit Lead, ADON	(4 times a year) Required attendees: DMD, DDON, ADDON, DDO, Audit Lead, Quality Lead five consultants Minutes supported by the Business Support Manager	15 minutes
Renal Matrons Forum (observed)	Monthly	DDON or ADDON	Required attendees: DDON, ADDON,8 Renal matrons	1 ½ hours
Consultant Meeting	Monthly	DMD	Required attendees: consultants (minimum 50%) plus additional attendees	1 hour

			invited for topic presentation/discussion	
Renal Services Team Meeting	Monthly	DGM or GM	Renal staff. Required DMD, DDON, DDO, Q&PSM, GM, SM, ASMs, representative from each staff group i.e. outpatients, POD, matrons, consultants, specialist nursing, each ward	1 hour
Contract Provider Assurance Meeting	Quarterly or per contract	Contract Manager/ GM/ ADDON	Varies	Varies
Dialysis Matrons	Monthly	ADDON	Dialysis matrons	1 ½ hours
Renal Clinical Practice Group (observed)	Monthly	DON	Multi-professional across group, includes technicians and Education Team	1 hour
Divisional Incident Review Meeting	Weekly	Quality & Patient Safety Manager/DON	Required: ADDON, Clinical Quality lead, Clinical Director/s Optional: Matrons, others dependent on topic/incidents reviewed	4 hours
Total time per month				22 hours 15 minutes

5. Detailed Findings

5.1 Organising and oversight of Quality in the Renal Divisional Governance Structure

The responsibilities for governance are set out below in **table 5**. The divisional triumvirate is supported by a quality and safety manager and two quality leads – one with a brief for quality overall (1PA/week) and a second with the specific responsibility for audit (0.25PA/week). There is access to the trust mortality reviewer (1PA/week)

Table 5: Outline of accountability and responsibility for quality governance using the Good Governance Institute key domains, as supplied by Renal Services

GGI Matrix domains	Accountable-Renal	Responsible – Renal overall
Best Practice compliance including NICE guidance	Renal Tri	DDON, ADDON, Clinical Quality lead, Audit Lead, Quality & Patient Safety Manager, Consultants, Matrons
Regulatory compliance	Renal Tri	Quality & Patient Safety Manager
Risk Management	Renal Tri	Quality & Patient Safety Manager (supports the Division to complete risk assessments)
Patient Safety and incident management	DDON and Joint Clinical Directors	Clinical Quality Lead Quality & Patient Safety Manager
Patient and carer feedback	Renal Tri	All renal matrons and consultants DDON ADDON
Improvement implementation and lessons learned	Renal Tri	All renal matrons and consultants DDON, ADDON, Quality & Patient Safety Manager
Clinical Audit	Audit Lead	Audit Lead-Consultant Nephrologist
Mortality	Clinical Quality Lead	All consultants responsible for completing level 1 mortality reviews of patients who were under their care. Registrars support reviews.

5.2 Feedback from Divisional Governance

The following provides interview feedback from staff within the division and provides insight into specific aspects of the ‘as is’ position of governance, improvements and suggestions. These staff have designated responsibility, additional to their substantive roles with designated allocated time.

The Quality lead has been in the role for approximately two years (1PA/week). Their work is driven by incidents, mortality & morbidity, complaints. They provide medical opinion and support reviews in care and patient treatment via the various quality domains including adverse events, patient experience, learning and local resolution.

The site Chief Medical Officer (CMO) holds Quality Lead meetings and the Quality Lead liaises regularly with the site Associate Medical Director for Quality. Requests to support wider cross divisional review is via this pathway.

5.2.1 Mortality & Morbidity

Meetings are held regularly with administrative support provided by the Divisional Quality & Patient Safety Manager and are recorded and minuted. The general format of meetings discusses patient mortality and morbidity information via PowerPoint slides with summary information being supported by registrars. This forum is also used for shared learning from divisional and site incidents. The last meeting held was held in September 2024, but no report was submitted to the Divisional Governance Meeting in October (the observer reviewed February and March data). There was no information seen looking at Summary Hospital-level Mortality Indicator (SHIMI) or Hospital Standardised Mortality Ratio data (SHMR).

5.2.2 Other Quality Domains

The Quality Lead co-chairs the Divisional Incident Review Group (DIRG) with the Divisional Director of Nursing. This group meet on a weekly basis and review incidents reported using the Patient Safety Incident Framework (PSIRF). Incidents are reviewed, themes discussed, and direction of incidents confirmed, i.e. SWARM (incident huddle that takes place as close as possible in time and place to the incident), After Action Review (AAR), Multi Disciplinary Team (MDT) Review or presentation to site central incident review group (CIRG). Learning is identified and actions initiated. Due to other clinical commitments, The Quality Lead is unable to regularly attend site CIRG and has not received any formal PSIRF training as yet, but the Group has scheduled more internal training dates.

Complaints is another pathway of work which the Quality Lead supports, including medical review of health records, providing medical information and supporting meetings with patients and families as part of local resolution. On further enquiry, there was limited insight of PHSO and its relevance to complaints.

Information for patient inquests is also provided as well as conducting incident reviews for the site.

5.2.3 Audit

There is an Audit lead with allocated time of 0.25PA/week.

From discussion, the Audit Lead believes there is a genuine interest in audit by staff although there is a challenging resource, time. A refresh of audit within the Division is in progress which includes:

- A new meeting schedule
- Extending invitation to other members of the MDT
- Holding regular audit events similar to a quality half day
- Greater collaboration with educational supervisors at the start of the year would be advantageous in identifying trainees to support audit which is then planned.

From the interviews, common challenges were identified, these included:

- The time allocated to quality governance was challenging when fitting in with other work commitments, including attending site quality related committees
- The work needed to be done was identified i.e. review of Local Safety Standards for Invasive Procedures (LocSSIPs). A divisional tracker was maintained to support awareness of priorities for review, which needed further time to progress
- Geographical location of services
- The planning and implementation of renal integration
- Timely access to data and health records
- Challenges in the process for audit registration and support from the designated central team, which has led to a ‘just do it’ approach with lack of registration, therefore lack of site awareness of audits being undertaken
- Questions related to contracted services and their audit profile
- Lack of training in PSIRF/SEIPS training (access to courses has been a challenge). HSIB training mentioned as a possible way to achieve this.
- Greater opportunity for interact with other quality leads across the group would be welcomed

6. Total Quality Management

A Total Quality Management (TQM) survey tool was devised for the three Divisional reviews to complete so that the review team could capture current opinion and self-assessment of divisional staff in four aspects of quality:

- Quality planning and redesign – understanding the need and population it serves
- Quality assurance – checking that the service is providing good care and meeting requirements
- Quality control: Monitoring service quality and performance
- Quality Improvement: Systematic processes to improve performance and quality

The Division chose to have a facilitated session on 16 October 2024 via Teams which had 15 attendees who had been invited to by the Divisional Management Team. The professional groups and numbers are outlined in **table 6**. Feedback on the TQM was not given at the time of the workshop.

As part of learning from this event, the project lead reduced and rephrased a number of questions for the survey, as such; Renal Services had 34 questions compared to Integrated Care and SNCT who were asked 26 questions.

Table 6: Professional groups and number of attendees who completed the TQM session

Professional group	Number of attendees
Administrative & Clerical	3
Divisional Team	3
Medical	2
Nursing	6
Specialty & Care Group	1
Total	**15**

6.1 Total Quality Management: Quality planning and redesign

The survey results suggest that members of the team felt that the process of understanding need generally and how that might affect different cohorts of patients was relatively strong. However, ensuring there was robust evaluation from other organisations and from the team's own work to redesign services was judged as more embryonic. The weakest area of quality planning was translating the team's understanding of need and opportunities for improvement into a set of quality priorities each year, as seen in **table 7.**

Table 7: Staff responses in areas of quality planning and redesign, grouped by opinion

Question	Positive	Neutral	Negative
Understanding population need and how we are meeting it	80%	20%	0
Understanding of variations in outcomes, experiences and access to care	80%	20%	0
Learning from other organisations	66.7%	26.7%	6.7%
Evaluating changes to care	66.7%	20%	13.3%
Setting quality priorities based on understanding of need and gaps in service	46.7%	40%	13.3%

6.2 Total Quality Management: Quality Assurance, escalation

The team's approach to looking across all the elements of quality was rated highest in the quality assurance domain, despite some significant differences of opinion in the GGI survey on clinical audit, in particular. Sharing the outcomes of independent sources of assurance was also rated highly. The weaker areas were regulatory compliance where 1/3 of respondents felt neutral or negative about the arrangements in place. This was one of the areas where the GGI matrix suggested the team felt its arrangements were strong so this may be worth some exploration as seen in **table 8.** Holding people to account for delivery and providing support where people are struggling was the lowest scoring area. The team may wish to discuss this further.

The profile of 'business as usual' through the lens of CQC needs to be raised. There was very limited evidence of departmental feedback or assurance. It would be advantageous that this aspect of quality forms part of more discussion and meeting agendas, with clear staff

responsibility and accountability to reflect progress, issues, actions and remedy in written reports.

Table 8: Staff responses in areas of quality assurance grouped by opinion

Question	Positive	Neutral	Negative
Quality governance looks at quality in the round	86%	6.7%	6.7%
Robust system for keeping tabs on CQC compliance between inspections	66.7%	13.3%	20%
Sharing outcomes of external reviews and inspections	86.6%	13.3%	0%
Holding people to account for delivery and providing support	46.7%	33.3%	20%

6.3 Escalation

The total quality management survey asked specific questions about escalation, **table 9.** For the people responding there appears to be confidence in the senior management team to respond to escalations. The majority of staff also felt there was an atmosphere of psychological safety which supports raising concerns. However, psychological safety is never experienced equally, and the team are encouraged to consider who might find it harder to speak up or share ideas. Advice on responding to those groups can be found here psychological_safety_whitepaper.pdf

Using the risk register with regular scrutiny of mitigations, controls and definition would support local intelligence, which needs to include commercial services. This is very clearly being done regarding patient transport but needs to explicitly describe risks within other services on a deeper level for the satellite units and information sharing from commercial partners on a regular basis.

Table 9: Staff responses relating to escalation, grouped by opinion

	Positive	Neutral	Negative
Where we cannot fix an issue ourselves, we have an effective system for alerting the senior management team	80%	20%	0%
If we escalate issues upwards we get feedback and action	73.3%	13.3%	13.3%
It feels safe to have honest, transparent discussions about concerns and to offer ideas	73.3%	20%	13.3%

6.4 Total Quality Management: Quality Control

6.4.1 Use of data for making decisions and driving improvement

In the Total Quality Management Survey, the questions on availability, accuracy and timeliness of information tended to score lowest in the quality control section as seen in table 10. This was also a significant area of concern expressed by staff verbally at the session we held, with reliance on time consuming processes to manually extract and clean data. This affected the ability to meet reporting requirements for the National Registry and local clinical networks. The team were also reporting some challenges in bringing people together to reflect on what the data was telling them.

From observation, the Division has been struggling for some time to gain meaningful data with explanations given (from discussion) from Business Intelligence (VTE assessments) and had shown issue with the IT system, which demonstrated lack of pull through of completed VTE assessments, which could impact on other services and divisions.

There were also examples of misinformation. In Mandatory and Statutory Training information, there was a line of '0' compliance, which on discussion had been inappropriately allocated as no staff worked within the identified area. In conjunction with this, one Business Intelligence report had another division in its filter title (Clinical & Cancer Services) but did contain information relating to the Renal Division.

Definition of data - A number of patients using CAPD or RDU for day case assessments and/or interventions do not warrant VTE assessments. As such, the data could be inaccurate to demonstrate need and review, which has been highlighted on a number of occasions to BI. This would impact negatively on the needs of the population and skew data.

Renal Services have been working to develop the CV5, a specific divisional software program will allow direct extract for data requirement for national renal data collection as well as record prescriptions needed for patient treatment. The Division has invested a great deal of time and effort to upgrade equipment to enable this for current and strategic work. This work has been supported by a specific member of IT staff working in Renal Services.

Table 10: Staff responses in areas of quality control, grouped by opinion

Question	Positive	Neutral	Negative
We have a robust set of key performance indicators to monitor quality that include what staff and patients think it is important to measure	53.4%	40%	6.7%
We trust the data that measures how we are doing	20%	60%	20%
We are able to access data in real time i.e. see today's data today	20%	40%	20%
We regularly bring the team together to regularly reflect on our KPIs, staff and patient feedback	66.6%	13.3%	20%

6.5 Total Quality Management: Quality Improvement

The NHSE team which led the replacement of the Serious Incident Framework with PSIRF were clear that some of the most common responses to an incident or death – such as audit or developing a policy were ineffective in driving behavioural change and dealing with the human factors often involved. The evidence for quality improvement approaches embedding improvement is much stronger. Services were actively involved in QI initiatives, including formal research and development, national and regional networks and collaboratives.

One of the areas we would encourage people to reflect on is the *effectiveness* of their learning. The pressure of operational demands and lack of time meant this was often not part of the conversation but knowing whether all the time currently being invested in. Teams can use some of the following to facilitate the discussion

- What is the experience of patients and families involved in safety and complaints investigations? Did the team behave transparently and honestly? Were the questions they wanted included and answered?
- What is the experience of staff taking part in internal investigations and external processes such as Coronial inquiries? Were they able to be honest and open about the circumstances of the incident or complaint? Were they supported by their team and the organisation? Was their key learning reflected in the investigation outcome?
- Does soft intelligence and surveys such as the staff survey suggest our service is a place people can speak up either to raise concerns, challenge the status quo or share ideas?
- Are we getting a clear picture of the themes in our learning and is this reflected in the quality priorities being set?
- Are there changes in the themes over time and any evidence we are making inroads into known areas of concern e.g inequalities in access to care, experience of care or outcomes?
- Are we prioritising and building expertise in quality improvement and safety science overall and the places where we have quality concerns?
- Do teams have the time and support to do the quality improvement work needed to respond to learning?

In the total quality management survey, the team identified strength in sharing learning within the team. Less than half the team agreed that there was a core quality improvement methodology being used to support making improvements following incidents, complaints, claims or deaths; that the full MDT was being utilised to work on QI or that QI capability was being developed in a sufficient range of people and places. Staff attending the session highlighted that there was a core of people within Renal who had QI training but were perhaps not being utilised to best effect. Sharing learning outside the team e.g. through networks, conferences, publications etc. was less well developed than internal sharing mechanisms. This would suggest that there is scope to strengthen the link between investigating and learning and achieving sustained benefits for patients and staff.

Table 11: Staff responses in areas of quality improvement, group by opinion

Question	Positive	Neutral	Negative
We have an agreed quality improvement methodology we use, and we use it to address concerns raised by deaths, incidents or complaints	46.7%	33.3%	20%
We are training a broad range of people in the team in quality improvement skills and building their confidence	20%	60%	20%
There is a match between where in the team we have quality improvement skills and where we need to do quality improvement	33.%	46.7%	20%
People with a diverse range of skills and perspectives are involved in our quality improvement initiatives	46.7%	53.3%	0%
We regularly bring people working on quality improvement together to learn quickly what is and isn't working	46.7%	20%	43.3%
We share the learning from our quality improvement initiatives within the team	80%	20%	0%
We share the learning from our quality improvement initiatives outside the team where it is relevant	53.3%	40%	6.7%

6.5.1 Learning

Learning is clearly apparent, but evidence was limited within clinical governance forums i.e. M&M, as there was no written report. The Renal Division share verbally, but this again is not picked up in wider conversation. Using patient stories is an invaluable measure to gauge good work and learning as well as indicate where improvement is needed for patients. Inclusion of lessons triangulated across governance provides powerful intelligence of achievements, change and issues that need to be acted upon.

7. Good Governance core processes for reviewing and addressing quality concerns

The Good Governance Institute (GGI) matrix (2018) was another tool used to capture staff opinion of their views relating to eight key elements regarding quality governance via RATE survey: implementing best practice e.g. NICE guidelines; CQC regulation; risk management patient safety and managing incidents; patient and carer feedback; improvement, implementation and lessons learned; clinical audit; mortality. Scoring of self-assessment ranges are outlined in **table 12**.

Table 12: GGI Score ranges and definition

Score	Progress level	Broad level of achievement
0	No	-
1	Basic	Principle accepted and commitment to action
2	Early progress	Early progress in development
3	Firm progress	Progress becomes mainstreamed
4	Results	Initial achievements evident
5	Maturity	Results systematically achieved over time
6	Exemplar	Other learning from our consistent achievement

In the Good Governance Institute Maturity Matrix, we found a range of views amongst the respondents and therefore have highlighted where the bulk of staff landed. This seemed to group the eight components in three blocks. Some of the same areas were highlighted as less mature – risk management, implementing best practice and Improvement Implementation and Lessons Learned. Renal scored Patient and Carer feedback as Early to Firm. Patient Safety and Mortality were rated as more mature but Regulatory Compliance was also rated as Firm Progress to Results. This is at odds with some of the feedback in the Quality Assurance part of the Total Quality Management Survey where one third of staff gave a neutral or negative response to the question on whether the services kept robust tabs on compliance between CQC inspections. The Clinical Audit results were unusual, with a high degree of disagreement on the rating. When we examined the raw data, the difference of opinion did not appear to relate to professional group or Band, although Consultants were less likely to suggest a rating of 4 – Results. This may be useful for the team to probe further to understand it.

A current patient inquest had been highlighted that required staff statements at the Clinical Governance Group. The Clinical Director wanted assurance that staff involved were being supported, reflecting safety culture thinking and staff wellbeing.

7.1 Patient Experience

At the time of the review, the Renal Division was taking part in an annual national renal patient experience survey, PREM. This is an annual national spot audit (September-November) which specifically captures experience and feedback from renal patients and service users. There was definite focus on obtaining feedback with staff interviewing patients, with feedback informing that the response rate had increased due to staff efforts with use of paper forms.

There was evidence of use of ongoing monthly trust patient feedback via Friends and Family, noting September 2024 feedback. It is not known how this is evaluated in commercial units. From observer review of the September Trust gratuity report as shared at the start of November, there were two comments regarding Renal. There was no recognition of these positive messages, which could be due to the time lapse between capture and sharing. It is not known how these positive messages are shared with teams, staff or divisions by the Patient Experience Team prior to trust sharing.

There were examples of when patients and their families were engaged with at times when things went wrong i.e. verbal duty of candour, meetings. Less visible was the capture of questions, partnership working and pathways to demonstrate actions taken, timeframes to support resolution in writing and feedback.

7.2 Regulatory Compliance

From the information supplied by the Division slide re: accountability/responsibility (**table 4**), it appeared that there was a lack of understanding. The Trust has a previously established framework to support areas in CQC preparedness and monitoring via internal inspections and feedback. There was evidence of two ward inspections in July 2024, however, there were no updated or evidenced monitoring of action plans, which led to questions that the CQC assessment framework was not being used to support a 'business as usual' culture, evidence improvement or guide areas of further work.

Details of duty of candour completion and compliance was not clear within the information supplied (Q1 Quality Report, presented at PSQG in November). It is not known how this is monitored on an on-going basis. This could be more visible in a summary dashboard over in months over a longer time period. The recording if data to include 'N/A' or '0' would demonstrate consideration and no lead to the need for assumption.

National Patient Safety Alerts, monitored by site and nationally were included in information, again a summary dashboard could provide greater assurance. Documentation did reflect those occasions when alerts were not applicable to the service.

7.3 Clinical Audit & Effectiveness

From feedback from the Audit Lead, there is a genuine interest in improving practice using audit. As part of the current refresh, a renal audit half day will be introduced including invitations to the MDT. As data collection is seen as a challenge, this could be an area where other groups of staff could support i.e. those staff who have completed quality improvement training, with a forward planner of audits to be completed in line with service, trust and group priorities.

Currently at site level, the process of audit registration in conjunction with perceived lack of support including data collection from the Audit Department has led to local audits being completed which have not been registered. Therefore, the audit profile could be seen as weak with lack of SLT knowledge of work being completed. Easier methods to register audits with available data sources would add value with greater collaborative working.

As suggested by the Audit lead, working with educational supervisors alongside appraisal, trainee discussion and use of QI trained staff creates greater opportunity for auditing and benchmarking practice. In conjunction with this, meeting with the Audit Team and the Chair of the Audit Committee would support a clearer audit vision support and greater partnership working.

Table 13: Outline the Good Governance Institute (GGI) self-assessment by divisional staff

Early to Firm Progress (Score of 2-3 on the Matrix scale) *Early = "early progress, in development" ;* *Firm = "progress is being mainstreamed"*	**Firm Progress to Results (Score of 3-4 on the Matrix scale)** *Firm = "progress is being mainstreamed" ;* *Results = "initial achievements evident"*	**No consensus – evenly split between Basic (Score 1), Early Progress, Firm Progress and Results.**

Risk Management – 62% of staff rated maturity in one of these categories **Implementing best practice including NICE** – 57.2% **Improvement Implementation and lessons learned** – 57% **Patient and carer feedback** – 57%	**Patient Safety and managing incidents** – 62% **Mortality** – 72% **Regulatory Compliance –** 64%	**Clinical audit**

Appendices

Appendix 1 – Structure of Services (as confirmed by DDON)

Service location	NHS/ Commercially delivered	Staffing	Consultant/Matron
Ward A6	ESTH	NHS staff	
Ward B6	ESTH	NHS Staff	
Home Haemodialysis	ESTH	NHS Staff	One consultant Band 7 Manager
StH Dialysis Unit	Davita UK for facilities only	NHS staff	Four Consultants ESTH Matron
Coulsdon (Dialysis)	Davita UK		One Consultant
Crawley (Haemodialysis)	Diaverum, shared commercial management with Brighton		Two Consultants
Croydon (Dialysis)	Davita UK for facilities only	NHS staff	Three Consultants ESTH Matron
Epsom (Dialysis)	ESTH/Fresenius	NHS staff	One Consultant ESTH Matron
Farnborough (Dialysis)	Davita Uk		Three Consultants
Kingston (Dialysis) Unit	Led by ESTH and services delivered to St George's		ESTH audits their patients at this unit. Clinical governance is currently managed separately
Sutton (Dialysis)	Davita UK		One Consultant
West Byfleet	Davita UK		Two Consultants

Appendix 2 - List and dates of meetings observed

Event	Date
Matrons meeting (including TQM and GGI matrix sessions)	16th October
Clinical Practice Group	17th October
Clinical Governance meeting	23rd October
Renal Operational Governance meeting	30th October
Renal Finance and Performance meeting with SLT	30th October
ESTH Patient Safety and Quality Group	8th November

Appendix 2

Group Governance Pilot Review –Part 2

Surgery Neurosciences Cancer and Theatres, SGUH
September-November 2024

Review Team:

Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance

Rebecca Ellis, Group Head of Nursing for Quality and Safety Governance

Dr Sally Herne - Intensive Improvement Director Intensive Support for Challenged Systems, NHS England

1.0 Background and Context

This report is designed to provide a summary of findings following a quality governance review within the Surgery Neurosciences Cancer and Theatres (SNCT) Division, St George's Hospital which occurred between September and November 2024, with a summation of the findings from the five parts of the governance review:

- A collection of information about the 'as is' i.e. how quality governance is overseen and the system of roles and responsibilities in SNCT
- A self-assessment of divisional invited staff (21) against the eight areas of the Good Governance Institute (GGI) Divisional Maturity Matrix from a facilitated session via Teams on 3 October 2024
- Observation of a set of quality oversight meetings in Neurosurgery, Neurosciences, Surgery, Divisional and site level
- A self-assessment via a RATE platform (internal on line survey) against the four themes of a good quality management system (Total Quality Management, TQM) undertaken on from 21 -28 November 2024 as shared by the Division. Initially this session was to be a facilitated session in early November 2024, however this was not possible due to staff availability within the Division. This contributed to a lower than expected response rate (6).
- Discussions with a selection of staff in governance roles in four specialties - Neurosurgery, Plastics, ENT and Urology.

In the first instance, the Divisional Management Team is asked to approve this report for factual accuracy. This in turn will be used as part of a group report using the three pilot divisions' information to form recommendations. As this work is undertaken, the Division is also asked to consider this summary and set a core of value adding SMART (specific, measurable, achievable, realistic and timely) objectives for improvement between now and December 2025 using table 1. Progress on these is then reported to the site either via PSQG or performance review meetings. We encouraged all teams to choose a few key areas which would make a measurable difference, whilst the Group Executive consider the total outputs of this Phase 4b Pilot review and the next steps for our hospitals and Care Systems.

Table 1: Divisional self-set priorities for quality and governance – TO BE DEVELOPED

Priority area	SMART Objective for December 2025	Owner	Where progress will be overseen by the Division

2.0 SWOT Analysis

The overall strengths, weaknesses, opportunities and threats are set out in **table 2**. These are based on the self assessment the Division completed and the observations from the Group Wide Governance Pilot Review Team members.

Table 2: SWOT analysis

Strengths	Weaknesses
• High value placed on achieving quality care for patients • Obvious discretionary effort balancing day to day clinical work and other demands • Divisional governance team support • M&Ms and coordinator support • Incident management, risk management and complaints processes self-assessed as stronger elements of GGI Matrix and embedded • Patient safety, clinical effectiveness, patient experience and risk in the self assessed as a strength via the TQM survey	• Lack of clarity on what good looks like to guide people trying to deliver an important function • Support for governance clinical/manager leads and directorate staff to manage quality governance • Availability of meaningful, timely, synthesised intelligence and data that answers the ‘so what’ • Differentiating between and getting the most out of the meetings at care group, directorate and divisional level • Coverage of quality across all the domains of safety, effectiveness, experience, regulatory compliance and risk

• High rates of low no harm reporting in many specialties • Commitment to learning and providing psychological safety • Protected time at governance half days • Some excellent examples of benchmarking, needs analysis, deep dives into quality issues and closing the loop on quality concerns • Active participation in national audit, peer review, research and networks • Well-developed accreditation programmes with expertise from outside the division involved in judging CQC compliance. Reinspection dates set based on results	• Clinical effectiveness (NICE, GIRFT and Audit) self-assessed as weaker aspects of the GGI Matrix with lower profile. Limited coverage in several meetings observed. • CQC preparedness covered at site level, but not featured at care group, directorate or divisional meetings observed. It was also not clear how findings of accreditation visits were being triangulated with other information to form a rounded view of compliance. • Risk – what gets captured, meaningful assurance, how it is used to drive the agenda and escalate clearly • Difficulty freeing up ward-based staff to attend governance half days and bringing people together from a QI perspective to learn quickly – what is and isn't working • Ensuring multidisciplinary engagement in governance, particularly the M&M process • Holding to account and supporting when there is limited progress was self assessed as a weaker area from the TQM survey
Opportunities • Roll out of self-serve reporting for quality which should provide more data in real time which may free up time from the governance team, help embed SPC reporting and benchmarking • Access to help with 'making data count' type reports and training to use this via the GESH QI and BI teams	**Threats** • Operational pressures – impact on attendance, engagement, time to follow through, information being circulated and read before meetings • Financial environment – impact on resolving risks

• SGUH reviewing role descriptions and support for doctors acting as governance leads • Review of the way the Division organises governance (Divisional tri + governance team) • Training in Quality Improvement within the Division • CQC future reports will give *scores* as well as ratings to show where you are in the pack and who it may be beneficial to learn from (DDNG)	• Change to CQC framework for assessment and there may be gaps between the quality statements and focus of the accreditation programme • CQC concerns about safety in surgery (never events)

3.0. Organising and Overseeing Quality

The following provides information relating to the 'as is' divisional position relating to quality and clinical governance.

3.1 Structures

The SNCT Division is a very large unit in its own right with a number of specialty care groups and directorates. The structure chart (Appendix 1) shows a combination of care group, directorate and divisional governance meetings on a monthly cycle, supplemented with topic specific safety, effectiveness and patient experience groups doing more detailed work. The main emphasis of these topic specific groups is safety such as safeguarding and medicines safety. **Table 3** shows the meetings held at the speciality care group and directorate levels and how these differ from the expectations at divisional level.

3.2 Responsibility and Accountability

The accountability framework for the organisation suggests that the site leadership team and Executive hold the Divisions to account, Divisions hold Directorates to account and then Directorates hold their Care Groups to account. This was not always reflected in the structures in place within SNCT as outlined in **table 3**. For example, Care Groups provide a report based on their local data on rotation into the Divisional Governance Meeting. The reports for Surgical and Neurosciences care groups do not go through any Directorate meeting first for assurance, to enable the Directorate to identify themes across specialties which might benefit from a directorate or divisional response or to provide support and constructive challenge. At directorate level, both the teams we observed had very limited administrative support for the Chairs of their main meetings – the Clinical Director (CD) in Surgery and the Head of Nursing (HON) in Neurosciences. If the Division chooses to have governance meetings which replicate the Accountability Framework, this needs to be addressed to make it workable. The number of care groups in the Surgical Directorate makes support for the CD and HON particularly important.

The roles and responsibilities list in Appendix 2 shows accountability for day to day responsibility on aspects of governance at care group, directorate and divisional level working through systems of triumvirates – Medical, Nursing and Management. Medical staff have 0.5PA in their job plan to act as governance leads at specialty level. This is a standard time allocation. Nurses and managers subsume governance work within their overall job. Some of the findings suggest that rather than working as a triumvirate, nursing and medical inputs can feel quite separate and there may be instances where the strands are not being drawn together to provide a rounded picture of progress risks and learning. This was most evident in Neurosurgery and Neurosciences directorate where the Neurosurgery M&M process was very much doctor led and was not linked into the overall governance meeting. We also noted that Falls, Pressure Ulcer and other harm free care issues were dealt with in a nursing forum separate to the Surgical Directorate monthly meeting, but information relating to this information was contained in Quality Reports.

The medical staff in governance leadership roles we spoke to recognise the importance of their role and were committed to quality. They were keen to provide constructive learning environments for members of the team and to have a positive impact on patient care within the time they had available. The medical leads spoken to described themselves as responsible for governance in the

round i.e. there was not usually an audit lead working alongside them to lead on that aspect. The time available to cover safety, experience, effectiveness and risk was felt to be a challenge in the 0.5 PA funded by the Trust, particularly in large specialties with a lot of complex, high risk patients. Awareness and knowledge of risk was also limited as ‘it appears vague with the risk register being a ‘vague document’ with no output. This opinion possibly relates to the accessibility of speciality risks.

A Job Description for the governance lead role exists, but the clinicians we spoke to were mostly not aware of it. Some described doing what they hoped were the right things in the absence of guidance from the trust or, in some cases, any handover from predecessors. This could mean they gravitated towards the aspects of the role they were most familiar with e.g. the learning from deaths and harm. Some leads had not had relevant training (e.g. PSIRF, SEIPs, human factors, making data count or quality improvement methodology) and described difficulties knowing who they could ask for help within the Directorate and within the Group. One lead did not realise there was a Divisional Governance team available for support, although they had been in post for several months. More time and support for governance leads was the most common suggestion for improvement cited in the GGI survey (Appendix 3 point 6).

The site CMO asked for a recommendation on how the governance leads might be configured and supported in the future. We are suggesting a clearer division of labour between the doctors in governance roles, other senior staff who may lead on other aspects of governance e.g. complaints, the divisional governance divisional management team and the site as outlined in table 16.

3.3 Risk

The Trust has a risk framework which sets out expectation about where risks should be managed and escalated based on their scores. From this review, the documented risks were being shared upwards appropriately. However, there is a gap between what staff articulate as on their worry list and what people document in their risk register e.g. Trust process for managing access to critical care beds, risk of staff burn out, pressures on Nye Bevan nursing staff, responsiveness to the Emergency Department from on-call teams. This creates a potential gap between what is a concern and what is visible to people outside the local team raising it. Added to this, we found some issues being formally raised as requiring escalation to the next tier, despite the operational, workforce, clinical and financial challenges facing the Trust. We did find an example of local concerns being raised directly with teams outside SNCT that the Directorate and Division may be unaware of. In Surgery, care groups present their reports in rotation to the monthly Divisional Governance Meeting. As there is currently no directorate forum to discuss quality issues in Surgery, the first airing of these reports is at the Divisional Meeting. This reduces the layers of reporting but also misses the opportunity for the Directorate to discuss it, address issues or share learning before then.

The Division is large and complex and now sits within GESH where the Group layer can lead to some confusion about whether it is the site leadership, group leadership or both who need to be informed. Some staff within SNCT were confident about escalating within their directorate or to the Divisional leadership team but were less clear about the structures outside the Division. Churn in teams means documents circulated in the past may be unknown to newer arrivals e.g. the Group list of escalations to be made direct to Executives.

Table 3: Governance arrangement variation between work as planned and work as done

Team	Expected	Actual
Neurosurgery care group	Monthly multidisciplinary governance meeting, chaired by clinical lead	Monthly M&M meeting chaired by the governance lead. Topics set by the chair who also runs the meeting and holds a lot of the actions. Informal style and structure felt to be psychologically safer. Minutes maintained by M&M coordinator. The meeting discusses cases of good care, all deaths and complications. The priorities are cases not known to be usual complication of the procedure. The cases discussed use the trust template to record the outcome of the conversation and cases will be discussed when the consultant leading on the case can be present so may wait more than a month for review. This meeting also discusses incidents, audit updates, care pathways and research in the specialty. The membership is medical. Other aspects of safety e.g. safeguarding, clinical effectiveness and patient experience are not discussed.
Plastics Care Group	Monthly multidisciplinary governance meeting	3-4 x a year quality whole day for the MDT chaired by the governance lead, with agenda, papers and minutes collated by an administrative lead. Whilst the agenda is decided by the governance lead, other members of the team can submit ideas. The agenda has regular slots on audit, research and a major item on M&M cases. Cases are selected by consultant teams for their potential learning value. Other ad hoc reports include investigations of Local Safety Standards for Invasive Procedures (LocSSIPs) and never events and the care group governance report which is shared from the Division. Other monthly meetings in Plastics are focused on operational issues e.g. staff changes, job plans, trainee issues, the PTL, finances etc
ENT Care Group	Monthly multidisciplinary governance meeting	Care Group governance and M&M meetings led by the Quality Lead, and contributes to other divisional meetings when the speciality has had input as well as other speciality meetings (i.e. Head & Neck, neck malignancy). Limited participation on Divisional governance due to work plan and clinical commitments.
Urology Care Group	Monthly multidisciplinary governance meeting	Hour long M&M meetings are held 2-3x a month to discuss cases prioritised using the Clavien-Dindo classification. These are chaired by the governance lead and supported by the M&M coordinator. Only doctors are invited currently and attendance can be poor. Every quarter the trust-backed quality half days are used to have MDT discussions about other M&M cases, complaints & compliments, audits, QI work, risk and areas such as MAST and Appraisal. The monthly care group meeting is more of a business meeting, where the Care Group lead sets the agenda. Quality may be discussed but there is no discussion of the governance pack or a formal link between the quality meetings and the care group meeting e.g. critical learning, emerging risks etc

Neurosciences Directorate	Monthly multidisciplinary governance meeting	Monthly meeting chaired by the HoN to discuss the quality pack produced by the governance team and the risk register. Occasionally has audit presentations e.g. Stroke Sentinel. There is no identified administrative support for the meeting which means the team don't have a forward plan, minutes, an agenda or the ability to track progress against what was agreed at previous meetings. This lack of an audit trail is clearly a risk. There is a separate doctor led M&M meeting for each care group but the learning from this is not fed into the main governance meeting. The CD and HoN are both conscious of the need to tie these strands together.
Surgical Directorate	Monthly multidisciplinary governance meeting	No governance meeting exists at directorate level. There is a monthly business meeting chaired by the CD to which care group leads and GMs are invited, with one representative from Nursing. This meeting circulates the Directorate governance pack and a new complaints report developed by the DDNG. However, there is limited discussion of the report in the meeting. For example the time spent on 7th October 2024 was • Introduction to the governance report – 2 mins • Never events in Plastics and Max Fax – 2 mins • Complaints report – 1 min Care group updates tended to focus on issues such as job planning. There is a reliance on Performance Review Meetings with the Division and the Divisional Governance meeting to have detailed discussions about care group quality.

The purpose of governance is the same, irrespective of specialty and therefore the outcomes needed are also the same. How teams achieve those objectives is where there is some scope for variation and tailoring e.g. fitting attendance around theatre lists, ward rounds and clinics. The degree of variation in how teams discharge their responsibilities and the outputs they produce seems to be more born of a lack of guidance from Trust or Group about what good looks like. This creates a grey area around the expectations of each layer of management. When we carried out the GGI self-assessment one of the most overt themes in what needed to improve was clearer guidance, expectations and standardisation (See Appendix 2) so this is clearly something teams would welcome.

4.0 Total Quality Management

A Total Quality Management (TQM) survey tool was devised for each area in scope to complete so that the review team could capture current opinion and self-assessment of divisional staff in four aspects of quality:

- Quality planning and redesign – understanding the need and population it serves
- Quality assurance – checking that the service is providing good care and meeting requirements
- Quality control - monitoring service quality and performance
- Quality Improvement - systematic processes to improve performance and quality

The Division initially chose to have a facilitated session on 11 November 2024

via Teams, however this was not possible due to unavailability of a number of staff. Due to the timeframes of the governance review instead, the online RATE survey was supplied to the Divisional Management Team who in turn sent to staff to complete between 21-28 November 2024, which consisted asking 26 questions. Unfortunately, the response rate was low at 6, which was comparable as seen in Integrated Care's response rate (8), however, valuable staff opinion was still captured. Responses supplied by professional group is outlined in table 4 with 50% being medical staff.

Table 4: TQM responses by professional group

Professional group	Number of attendees
Corporate teams (including Estates and Facilities)	1
Divisional Team	1
Medical	3
Nursing	1
Total	**6**

4.1 Total Quality Management: Planning for Quality and redesign

The Division assessed themselves as strong in evaluating changes to care, however their grip was lessened in understanding the needs and outcome and accessibility of services for the population we serve (**table 5**). This could reflect on the lack of ability to access and review data i.e. patient demographics, SHMI, HSMR in care groups and triangulation across patient experience. With the sharing of information using speciality knowledge, there is potential to develop services and support quality priority planning using this information especially in tertiary services.

Table 5: Staff responses in areas of quality planning and redesign, grouped by opinion

Question	**Positive** *(Agree strongly & Somewhat agree)*	**Neutral** *(Neither agree nor disagree)*	**Negative** *(Strongly disagree)*
Understanding population need and how we are meeting it	67%	33.%	0
Understanding which groups in our patient population might have poorer outcomes or struggle to access our services and why this might be	50%	50%	0
Learning from other organisations	50%	33.3%	16.7%
Evaluating changes to care	83.3%	0	16.7%
Understanding what we could do better to set quality priorities each year	50%	16.7%	16.7%

4.2 Quality assurance, escalation

Quality Assurance is the periodic testing of whether systems are maintaining quality. They include inspections (e.g. HEE, CQC, Health and Safety Executive), accreditation (both the internal SGUH scheme and external programmes such as those run by Royal Colleges), peer review, benchmarking and the checks made by the Trust's Internal Audit team. SNCT participates in a broad range of these types of activity and therefore has multiple ways to multiple opportunities to triangulate your own internal view of how services are performing with more independent sources. The governance packs include some of this e.g. outcomes of the SGUH accreditation visits, based on the CQC key lines of enquiry. We would encourage agreeing what other independent feedback could be used as part of the governance reporting.

Table 6 reflects that staff assessed themselves strongly in looking at all aspects of quality however had less grip in the monitoring learning and actions from CQC inspections, with limited sharing of external reviews. The group is developing pathways which capture good work completed at local level and developing work streams that reflects patient need, quality and governance. These include, simulation, the use of ward accreditation, internal inspections and new ways of learning and thematics following PSIRF introduction.

Clarity and work spread of staff with governance remits should be reviewed to ensure staff understand their responsibilities regarding quality and governance including outputs and engagement. With resources such as refreshed job descriptions, shared forums, awareness of systems for support and training, there would be better understanding, knowledge and skill to support existing motivation, career development and importantly level of accountability and pathway to timely escalation. Those responses seen in **table 7** reflected the strong ability within the Division to have honest and transparent discussions and offer ideas for resolution. This shows that the Division strongly values opinion and ideas from the teams, which it should continue.

Effective escalation depends on having several elements in place

- Clarity on what needs to be escalated, where, when and by whom and differentiation of operational escalation (e.g. bed pressures, access to on-call staff, gaps between planned and actual staffing) and quality escalation e.g. never events which need to be notified,

significant staff safety incidents, RIDDOR reportable events. Many staff we asked about 'escalation' automatically thought of the first.

- Documenting the escalation to ensure it is visible and there is a written audit trail of concerns
- Transparency about the nature of the concern, what response is needed, from whom and by when
- Timely feedback to teams escalating on the outcome of their concern being raised
- On going monitoring of the issue to ensure the concerns have been addressed

Table 6: Staff responses in areas of quality assurance grouped by opinion

Question	**Positive** *(Agree strongly & Somewhat agree)*	**Neutral** *(Neither agree nor disagree)*	**Negative** *(Strongly disagree)*
Quality governance looks at quality in the round	100%	0	0
Robust system for keeping tabs on CQC compliance between inspections	50%	33.3%	16.7%
Sharing outcomes of external reviews and inspections	66.7%	16.7%	16.7%
Holding people to account for delivery and providing support	33.3%	50%	16.7%

Table 7: Staff responses relating to escalation, grouped by opinion

Question	**Positive** *(Agree strongly & Somewhat agree*	**Neutral** *(Neither agree nor disagree)*	**Negative** *(Strongly disagree)*
Where we cannot fix an issue ourselves, we have an effective system for alerting the senior management team	67%	16.7%	16.7%
If we escalate issues upwards we get feedback and action	67%	16.7%	16.7%
It feels safe to have honest, transparent discussions about concerns and to offer ideas	83.3%	0	16.7%

4.3 Quality control

4.3.1 Use of Data for Making Decisions and Driving Improvement

Any team providing patient care should consider the following to know whether their data and intelligence is working for them:

- Can we access data in real time to help us identify promptly where there appears to be a change?
- Does our data show we are performing in the key areas of quality and how we compare with other peer services? Can we distinguish reliably whether we are getting better, worse or staying the same?

- Do we have a clear sense of the underlying themes in our incidents, deaths, complaints and claims over time e.g. quarter to quarter, year to year and what that means it is most important to address?
- Do we understand our compliance with national regulatory requirements before someone comes to inspect us?
- Can we easily distil from the information we are getting what our key quality priorities are and why?
- Can we say that our learning has been effective e.g. reduced potential repeat harm or poor patient experience and been supportive of staff involved in incidents, deaths and coroner cases?
- Can we go beyond saying whether we meet staffing ratios and actually say whether staffing is safe i.e. cross check workforce against safety indicators?
- Can we distinguish between service issues and individual professional concerns e.g. consultant mortality or morbidity rates?

The main barriers we identified were the time needed to collate and clean data, access to benchmarking, having a balance between looking at the current period and being able to step back and look at longer term themes and trends including real time information (**table 8**). The self-assessment via TQM of availability of data especially in real time caused limitation in the ability to have intelligence of potential/actual issues emerging or improvements and good practice, therefore restricting discussions and quick action which the Division felt was a strength.

The divisional governance team produce quality packs for consideration at the divisional governance meetings. These include aspects of safety, effectiveness, patient experience and risk. This requires a lot of work on the part of the governance team to extract it, cleanse it and send it on to the relevant team – approximately three days a month. We identified an opportunity for the Division to capitalise on work the Quality and BI teams are doing to automate production of quality data so teams can access their data more in real time. The Governance lead is linking with the lead to ensure SNCT need is understood.

Benchmarking can be powerful not only for charting comparisons with peers but also the potential opportunities for improvement. This was shown very clearly in the use of National Joint Registry data by the T&O team. GIRFT, national audit, model hospital and peer review processes which are all potential sources of benchmarking data. It would be helpful to explore with the BI team how much the automation process can build comparator data into the automated reporting. The new model of CQC assessment should also produce scores within rating categories to show where an organisation is in the pack and identify other organisations which it may be useful to learn from.

The Division also produces a pack for PSQG every quarter. This is vast at 71 slides and there may only be 30 minutes to discuss it all.

The Group Board has an Integrated Performance Report which is based on best practice techniques promoted by the ‘Making Data Count’ (MDC) programme making-data-count-getting-started-2019.pdf (england.nhs.uk). MDC uses Statistical Process Control Run Charts to display, interpret and narrate data. MDC has advantages over tables, RAG ratings and other traditional methods:

- SPC can be used with pretty much any data – activity, performance, quality, workforce and finance. Rare events such as never events or hospital acquired infections can still be turned into SPC charts using ‘days between events’ as the measure rather than the volume

- SPC usually plots at least 12-24 months data in a run chart allowing people to view progress over time and spot regular, seasonal trends and know whether they are improving, deteriorating or staying the same year to year
- Visual charts can convey meaning much more quickly than tables of numbers and avoids reacting to things which are not significant
- SPC run charts tend to prompt more useful insights, questions and discussions to help investigate areas of concern and test possible improvements
- Run charts can be used to predict future likelihood of achieving a target and to set trajectories that are more realistic.

Given far more decisions about patient care are taken by teams at care group level compared to the board, it is important GESH makes the investment in providing Making Data Count based reports and training in its use for teams working below Board level and SNCT encourage staff to be trained in the methodology.

The two other key elements of using data to improve quality are the quality of narrative and triangulation. We saw multiple reports, including the core governance packs, where the narrative emphasised counting over insight i.e. this month the number is bigger/smaller than last period. Making Data Count training is available free of charge to help people craft narrative which is meaningful and succinct – interpreting the messages in the run chart and setting out the team's decisions about what actions they need to take in response Search (england.nhs.uk). Adopting this style of narration would help generate more insightful discussions and better assurance.

The Divisional 71 slide pack provided for PSQG every quarter has some areas of commonality with the one used at the Divisional governance meeting (41 slides, held monthly) but with some additional elements. It may be worth considering whether one pack can suffice for both audiences and what that needs to include.

Table 8: Staff responses relating to Quality Control, grouped by opinion

Question	Positive *(Agree strongly & Somewhat agree)*	Neutral *(Neither agree nor disagree)*	Negative *(Strongly disagree)*
We have a robust set of key performance indicators to monitor quality that include what staff and patients think it is important to measure	66.7%	16.7%	16.7%
We trust the data that measures how we are doing	50%	16.7%	33.3.%
We are able to access data in real time i.e. see today's data today	33.3%	50%	16.7%
We regularly bring the team together to regularly reflect on our KPIs, staff and patient feedback	83.3%	16.7%	0

4.4 Quality Improvement

The NHSE team which led the replacement of the Serious Incident Framework with PSIRF were clear that some of the most common responses to an incident or death – such as audit or developing a policy were ineffective in driving behavioural change and dealing with the human factors often involved. The evidence for quality improvement approaches embedding improvement is much stronger. Services were actively involved in QI initiatives, including formal research and development, national and regional networks and collaboratives.

One of the areas we would encourage people to reflect on is the effectiveness of their learning. The pressure of operational demands and lack of time meant this was often not part of the conversation but knowing whether all the time currently being invested in. Teams can use some of the following to facilitate the discussion.

- What is the experience of patients and families involved in safety and complaints investigations? Did the team behave transparently and honestly? Were the questions they wanted included and answered?
- What is the experience of staff taking part in internal investigations and external processes such as Coronial inquiries? Were they able to be honest and open about the circumstances of the incident or complaint? Were they supported by their team and the organisation? Was their key learning reflected in the investigation outcome?
- Does soft intelligence and surveys such as the staff survey suggest our service is a place people can speak up either to raise concerns, challenge the status quo or share ideas?
- Are we getting a clear picture of the themes in our learning and is this reflected in the quality priorities being set?
- Are there changes in the themes over time and any evidence we are making inroads into known areas of concern e.g. inequalities in access to care, experience of care or outcomes?
- Are we prioritising and building expertise in quality improvement and safety science overall and the places where we have quality concerns?
- Do teams have the time and support to do the quality improvement work needed to respond to learning?

Strength was self-assessed in areas of quality improvement methodology and shared learning, however the later GGI scoring indicated less maturity. This could reflect the number of staff trained in QI which has not been closely reviewed in this division, as well as the ability to bring staff together to support QI work which reflects the quality priorities.

Table 9: Staff responses in areas of quality improvement, group by opinion

Question	**Positive** *(Agree strongly & Somewhat agree)*	**Neutral** *(Neither agree nor disagree)*	**Negative** *(Strongly disagree)*
We have an agreed quality improvement methodology we use, and we use it to address concerns raised by deaths, incidents or complaints	83.3%	16.7%	0
We are training a broad range of people in the team in quality improvement skills and building their confidence	50%	16.7%	33.3%
There is a match between where in the team we have quality improvement skills and where we need to do quality improvement	50%	16.7%	33.3%

People with a diverse range of skills and perspectives are involved in our quality improvement initiatives	50%	50%	0
We regularly bring people working on quality improvement together to learn quickly what is and isn't working	33.3.%	33.3.%	33.3.%
We share the learning from our quality improvement initiatives within the team	83.3%	16.7%	0
We share the learning from our quality improvement initiatives outside the team where it is relevant	83.3%	16.7%	0

5.0 Good Governance Institute Matrix for reviewing and addressing quality concerns

The Good Governance Institute (GGI) matrix (2018) was another tool used to capture staff opinion of their views, relating to eight key elements regarding quality governance via RATE survey: implementing best practice e.g. NICE guidelines; CQC regulation; risk management patient safety and managing incidents; patient and carer feedback; improvement, implementation and lessons learned; clinical audit; mortality. Attendees by professional group of the facilitated session are outlined in table 10. Scoring of self-assessment ranges and definitions are seen in **table 11**. We found a range of views and therefore have highlighted where the majority of staff were landing in their assessment. This seemed to group the components in two areas: either early to firm progress or firm progress to maturity.

Table 10: Attendees of the GGI facilitated session by professional group

Professional Group	Number of attendees
Administrative & Clerical	7
Allied Health Professional	1
Divisional Team	1
Medical	2
Ward/Department	2
Nursing	8
Total	**21**

Table 11: GGI Score ranges and definition

Score	Progress level	Broad level of achievement
0	No	-
1	Basic	Principle accepted and commitment to action
2	Early progress	Early progress in development
3	Firm progress	Progress becomes mainstreamed
4	Results	Initial achievements evident
5	Maturity	Results systematically achieved over time
6	Exemplar	Other learning from our consistent achievement

In the GGI results, 60% of staff responding to the survey suggested the Division was between Early Progress and Firm Progress on demonstrating regulatory compliance. We did not tend to see CQC compliance (either the output of self assessment or taking action on regulatory actions)

on the agenda for governance meetings at care group, directorate or division. This left us unsure if the risks for inspection were fully understood by teams (as opposed to nursing staff). In contrast, this was an explicit part of the agenda at site level and was considered at the PSQG meeting we observed. The priority for CQC inspection is to understand the position on the Safe and Well Led domains, using the new quality statements in the Single Assessment Framework.

The lower profile of clinical effectiveness highlighted by staff in the GGI survey may also mean that some of the critical benchmarking GIRFT, national audits and NICE compliance offer may not be being harnessed as much as it could.

Table 12: GGI self-assessment rating by SNCT

Early to Firm Progress (score of 2-3 on the matrix scale)	**Firm Progress to Results (score of 3-4 on the matrix scale)**
• **Risk** - 71% of staff responding rated risk in one of these 2 categories • **Implementing best practice including NICE** - 67% • **Improvement Implementation and lessons learned** - 57% • **Clinical Audit** - 71% • **Regulatory Compliance** - 62%	• **Patient Safety and managing incidents** - 62% • **Patient and carer feedback** - 57% • **Mortality** - 67%

From the GGI matrix survey, strengths and weaknesses were seen which were linked to the key elements. These have been detailed in table 13 and 14 according to early-firm progress and firm to results level.

Table 13: SNCT strengths and weaknesses of areas rated Early to Firm Progress

Strengths	**Weaknesses**
• Risks are included in the governance packs and in most cases risks were being discussed and reviewed outside the meeting. Some examples of future risks being identified and discussed were also noted e.g. sufficient volumes for surgeons to maintain their skills. • Some meetings were prioritising what was discussed on the basis of risks evident in their quality data e.g. never events in Plastics and never events in Neurosciences. • NICE, GIRFT and national audits due for submission and results included in the governance packs and being monitored centrally. Support is available from the Trust Audit Team. • Lessons learned were being extracted from individual cases reviewed at M&M and in relation to complaints and incidents	• Staff voiced concerns in their reports or verbally but these were not always reflected on as risks and documented as such, reducing their visibility to others and keeping them on the watch list for the service • Risk was not always the determinant of what the burning issues for discussion are at a governance meeting so their potential to help introduce more focus could be better exploited. • Some risks were long standing and seemed stuck. In these instances in particular it is important the team can say what evidence they have that the mitigations are working. If they don't have evidence to that effect they need to escalate the concern.

• Most governance meetings had clinical audit results led by medical staff included and some nurse/AHP/pharmacy audit. • Work is ongoing to test CQC compliance and areas of risk within the Division and accreditation visits provide a fresh eyes view of the outcome.	• PSIRF has encouraged learning from clusters of events with common features as this adds more value. More emphasis on thematic learning as a tool for insight and QI would be beneficial. • Staff in the GGI survey felt clinical effectiveness tended to have a lower profile than other aspects of quality and the opportunities this work has to identify opportunities was being missed. There were also concerns that actions were not always being followed up where compliance was sub-optimal to ensure the loop had been closed. This was also an area of concern picked up by PSQG. The current mechanism for assurance action plans are happening and delivering results appears to be through the Clinical Audit team which is acceptable but the directorates and division need to know where there are gaps. • Regulatory compliance and its risks were not often covered in the governance meetings we observed so it is not clear if the various strands of quality are being drawn together.

Table 14: SNCT strengths and weaknesses of areas rated Firm Progress to Results

Strengths	**Weaknesses**
• Incident prevalence, harm and learning are routinely well covered at governance meetings • Complaints, compliments and FFT feedback well covered at governance meetings • Teams we saw data for were reporting high proportions or low and no harm incidents • Duty of candour compliance tracked and reported • Positive feedback on PSIRF approach to increase thematic approaches to investigation and learning	• Some staff in key positions had not been trained in PSIRF and were unclear how or where to access the next wave of training • Learning from deaths – M&M outputs, structured judgement reviews, coroner and medical examiner feedback not always tied into the overarching governance meetings or reporting • Some M&Ms struggling with attendance and also not involving the MDT in the conversation • Thematic analysis across complaints (including PHSO cases), claims, deaths and

• Examples of deep dives undertaken where data suggested the service is an outlier for mortality/complications • M&Ms in place, prioritising learning from cases where there was both an opportunity to learn from complications or death and also from excellence. Dedicated M&M coordinators in place. • Deaths, harm, feedback from patients regularly covered at quality half days	incidents can help identify some of the deeper drivers of quality concerns e.g. staffing levels, access to senior supervision or culture. This was recognised as important but not yet in place.

6.0 Recommended areas to consider for improvement

There is a very clear vision to improve governance at divisional level. Quality of care for patients mattered very much to the staff we spoke to. Teams were trying to create constructive forums for learning which acted with sensitivity towards staff who had been involved in cases where something had gone wrong. Successes were being captured and celebrated. There is therefore much which is good work to build on.

We would encourage the Division consider the following areas for improvement laid out in **table 15**. Some can be owned by the Division alone, others require collaboration with Group or site.

Table 15: Findings and Recommendations

Priority	Responsible team(s)
Set clear standards and expectations to guide governance at care group, directorate and divisional level **Findings:** 1) The NHS train people to be clinicians, managers and leaders but tends to assume that if you are experienced you inherently know what good governance looks like and how to enact it. When we spoke to staff, they needed and wanted clear guidance so they know rather than hope they are doing the right things. We will recommend principles and outcome measures in our report to the group executive meeting (GEM). 2) The lack of guidance has led to variations in approaches. Variation is not an issue if the necessary outcomes from governance are being achieved. However, this wasn't always the case e.g. some areas of quality were getting less coverage. Guidance on the outcomes governance needs to achieve at division, directorate and care group allows people to use their discretion and choose the optimal way to deliver them for their service(s). 3) For meetings at directorate level to be effective, there needs to be support in place for whoever chairs those meetings. In both Surgery and Neurosciences this was lacking, with no consistent audit trail of what was discussed and decided. The Clinical Director and/or Head	**Divisional, Site and group actions to support improvement** **Division:** 1) Division to ensure that each directorate and care group has the required support to have a meaningful regular forum to discuss quality **Site:** 1) Work with site to agree the model for governance leads and the support from the Directorate team and the Divisional Governance team. We have suggested a division of labour in the report **Group:** 1) This requires Group to set standards and the division to agree with its directorates and care groups how this is translated at the local level to get best value out of the different meetings you have, minimise repetition and re-work and release time where possible.

of Nursing time being used to pull together agendas and papers and information being sent out shortly before a meeting with limited time for attendees to read it.	
<u>Help teams be better placed to use information for improvement</u> **Findings:** 1) Current governance reports at divisional, directorate and care group level tend to be tables, bar charts and line graphs. This makes it harder to distinguish between the normal variations in data and genuine shifts over time that are more powerful ways to inform decisions and direct quality improvement. Rolling out "Making Data Count" Statistical Process Control charts and training on how to utilise them is essential. 2) A lot of the current reports require data to be manually pulled and cleansed before it is distributed. This can take a significant amount of the Divisional governance leads' time each month – time they could re-direct towards teams who need help. There is work going on in parallel to automate collection of data, reduce the burden and give people more access in real time, but this was not widely known about. 3) There were numerous meetings where staff were asking for better thematic analysis to help them see the underlying factors leading to deaths, complaints, incidents rather than just focusing on individual cases or the previous month – this could be where the Governance team invests more time in future to help people step back and see the bigger patterns and underlying drivers of quality. 4) Where CQC compliance was discussed, the emphasis was on the findings of accreditation visits. These fresh eyes visits add value, but can only ever be a census at a specific point in time. It is high risk to rely on them to act as a predictor of compliance on their own. We did not see discussions of regulatory compliance where accreditation	**<u>Divisional, Site and group actions to support improvement</u>** **Division:** 1) The Division to ensure critical mass of staff receive training to enable them to interpret and narrate reports 2) BI teams to ensure the work to establish a self-serve platform for quality data meets SNCT needs and help teams with their thematic analysis. HSIB provide a three hour course on de-mystifying thematic analysis NHS courses (hssib.org.uk) 3) Any refreshed quality reporting should be triangulated against the findings of the accreditation programme of visits to provide a more continuous, live sense of regulatory compliance. **Site/Group:** 1) Site and group to provide expertise for roll out of reporting and training

findings were being considered alongside other internal and independent information to form a more rounded view.	
<u>Help governance leads maximise their effectiveness</u> **Findings:** 1) The most cited theme for improvement was more support for staff with governance roles – time, development, contacts and 'how to'. The Job description for a governance lead is currently being updated by the Site Chief Medical Officer's team. It would be helpful to clarify: - The priorities for the 0.5 PA time - The balance between doing and ensuring other members of the MDT are covering governance activities e.g. what can the governance lead charge others such as nurses, the general or service manager, leads for audit, NICE or GIRFT - What leads should expect from the trust or division by way of support - The competencies required e.g. PSIRF, SEIPS/Human Factors, Risk, Making Data Count and basic QI would all be helpful to consider. 2) In addition, some written induction information which provides them with the standards and expectations, development and network opportunities, the structures they feed into and where they can access help within and outside the division, tools and templates would be helpful. The structures issue has become more important in the move to group, where corporate structures can be harder to understand. Best practice guidance and useful links have been shared with the divisional team.	**<u>Divisional, Site and group actions to support improvement</u>** **Division:** 1) The Division is best placed to produce the induction pack, define priorities and support available resources 2) The Division to review the workload spread and options to involve others i.e. staff who have completed quality improvement related work **Site/Group:** 1) Job description and person specification is the responsibility of the SGUH/group Chief Medical Officer's team 2) To consider governance as a speciality and include as part of career progression

Reframe how people think about Risk	**Divisional, Site and group actions to support improvement**
Findings: 1) Risk was one of the lower scoring areas in the Good Governance Institute Maturity Matrix. We saw examples where people were expressing concerns but not making the connection that what they were describing was likely to be a risk. As a result, there was a gap between what was written down and the worry list for a team. If a risk isn't captured, none of the processes which should follow from it (mitigation and escalation) kick in. Meeting chairs are in a good position to ensure meetings explore whether any new concerns have been identified from papers, discussions or data and what actions need to be taken as a result. 2) Risk is also a tool for prioritisation – out of all the things governance could cover; risk is the guide on what most needs discussion and action. We found a mixture of practice where some teams were focusing their energies on their known risks, however this was not universal. 3) The team is using the trust process for risk management. Risks are captured and scored and mitigations are listed. There is one ingredient missing – assurance. This is particularly important for risks which are long standing and seem stuck e.g. some of the infrastructure risks which require scarce capital funds. Assurance is the **evidence** a team uses to **know** if their risk is being mitigated. This requires the routine data collected about a service to be used to inform risk scoring, closure or escalation. 4) There was limited formal escalation of concerns between meetings, which seems unusual given the mix of staffing, operational and financial challenges.	**Division:** 1) Chairs of meetings and their administrative support to: - Encourage translation of worries expressed verbally or in a report into risks and risk management process e.g. regular section on new risks on the agenda - Use the risk register to determine the priorities for covering issues in their meeting - Set out the assurance evidence for risks, where the priority are areas on the risk register for a year without a change in the score or where risks are significantly overdue e.g. ageing equipment. - Nudge people at the end of the meeting on what needs to be escalated upwards, what the response required is, who needs to respond and how urgently a response is needed **Site:** 1) Greater scrutiny and challenge of long term risks which remain open despite controls and mitigations are in place and reviewed regularly 2) Greater insight of those risks that have a risk scoring of less than 15, which could provide intelligence of emerging risk

Ensure Clinical Effectiveness has sufficient profile **Findings:** 1) The Divisional governance meeting regularly includes items on audit and NICE compliance. However, below Division the profile of effectiveness (NICE, audit and GIRFT) was more variable. Implementing best practice and clinical audit were two of the lower scoring areas in the Good Governance Institute Maturity Matrix. Some staff also fed back their concern that areas like GIRFT were not being given sufficient priority and governance processes were not following up and checking actions had been implemented. The governance team keep a running log of which audits and guidelines are due for review/submission and the outcome. There does need to be a mechanism for directorates and care groups to have assurance that action plans for areas of non-compliance have been developed, are happening and yielding results 2) The same relatively low scrutiny of clinical effectiveness was replicated in the site Patient Safety Quality Group (PSQG) we observed where another division was presenting their quarterly pack so this may not be just an SNCT issue	**Divisional, Site and group actions to support improvement** **Division:** 1) Chairs of meetings to use the guidance in Appendix 4 on creating a forward plan for governance on ensuring there is coverage of clinical effectiveness 2) Care Groups and Directorates to clarify how they assure themselves non-compliance is being addressed provide this assurance/evidence at divisional level
Strengthen areas of multidisciplinary engagement in quality governance **Findings:** 1) It is not unusual for different professions to lead on aspects of quality, but good governance draws the strands together to build a holistic picture of quality. We noted some areas where there seemed to be a professional silo and the outputs were not connected into the main governance meeting. That applied to some aspects of nursing and allied health professional (AHP) work e.g. harm free care but particularly M&Ms. We identified two meetings where non medics did not attend or were not invited. The Trust and professional bodies	**Divisional, Site and group actions to support improvement** **Care Group/Directorate/Division:** 1) Directorates to ensure care group M&Ms invite non-medical staff to attend. Where this is felt to be a risk to psychological safety there may be a need to look at the health of the MDT. GESH OD team may be able to support this or advise. The psychological safety ladder can be used to encourage teams to reflect on this aspect of their MDT The Psychological Safety Ladder Canvas | By Gustavo Razzetti (fearlessculture.design)

such as the Royal College of Surgeons both set the expectation that M&M is a multidisciplinary forum to enable it to capture the insights of different members of the team caring for a patient. We did hear that including non-medics may constrain discussions. If that is the case, this may indicate a cause for concern about the degree of psychological safety in the MDT. 2) The area of learning from deaths – use of data (SHMI, SHMR) M&M outcomes, Structured judgement reviews, coroner cases, feedback from the medical examiner, deep dives e.g. for mortality outliers were not always linked into the overall learning for the care group/directorate, despite its fundamental importance. It is also not often reflected in the packs produced by care group leads presenting to Divisional Governance.	2) All care groups to ensure that work led by specific professions are linked into the overarching governance structures, particularly, linking in learning from deaths. Review the time resource for governance and M&Ms, as suggested by TQM opinion

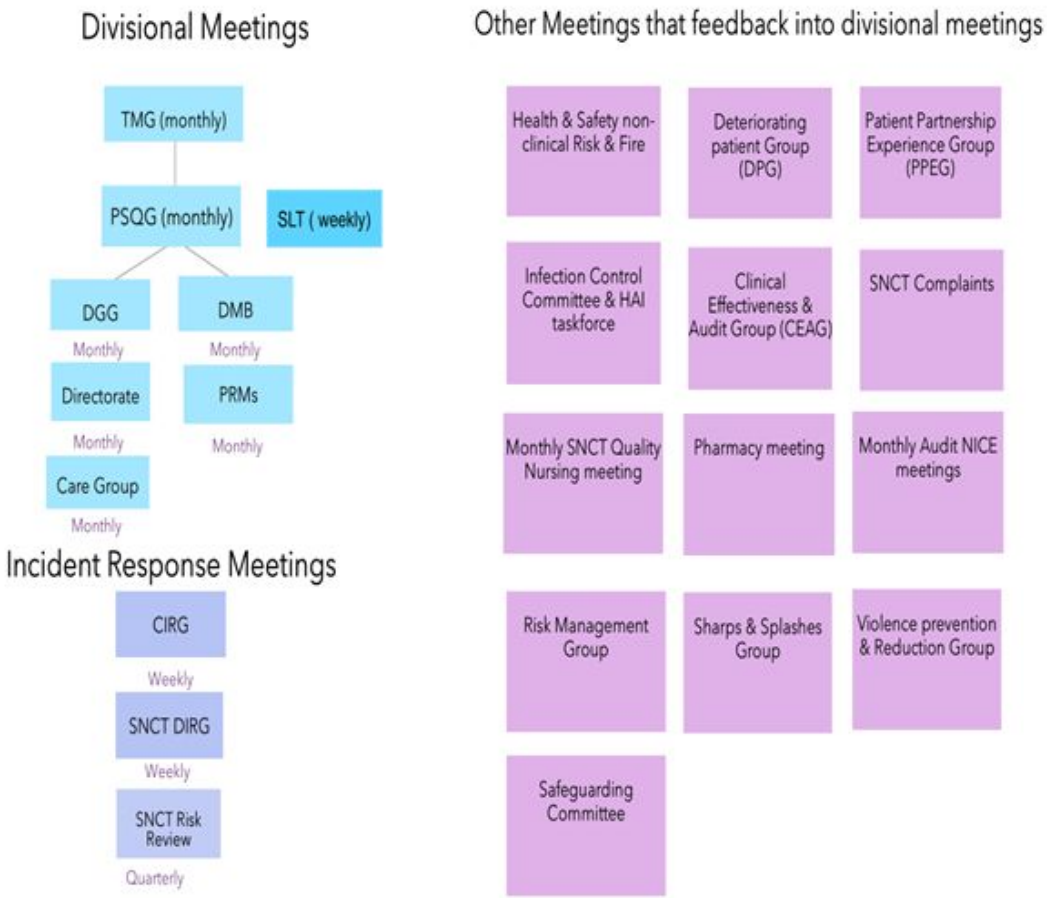
Table 16: Recommendations for governance roles, actions and support from care group, division to site and group level

Doctors in Governance lead roles	Care Group/Directorate leadership	Divisional Governance team	Site /Group
'Conductor of the orchestra' with overview of Safety, Effectiveness, Compliance, Experience and Risk for the area they represent. Leads on one or more component of quality in their job plan. A standard PA allowance may be set but there should be room to recognise the different workloads associated with specialties either with additional PAs or distributing specific lead roles e.g. Audit/GIRFT/NICE	Ensures there is a clear division of responsibilities between Doctors in Governance lead roles, the Lead Nurse/Head of Nursing and the General Manager/Service Manager to ensure there is an identified lead for Safety, Effectiveness, Compliance, Experience and Risk. Provides administrative support to the individual leads for components of quality. Provides administrative support for the governance meetings and half	Acts as specialist support to the Divisional Triumvirate and network of governance leads **Division** Provides synthesised reports of quality trends and themes to inform the sense of quality successes, priorities and risks. Holds the administrative function for divisional governance meetings – developing the forward plan, agendas and reports, maintaining action logs and risk register.	Sets the core job description for governance leads Provides frameworks and standards for leads and teams to work to. Holds divisions to account for quality and maturity of divisional governance Provides training and development for common areas of competency for

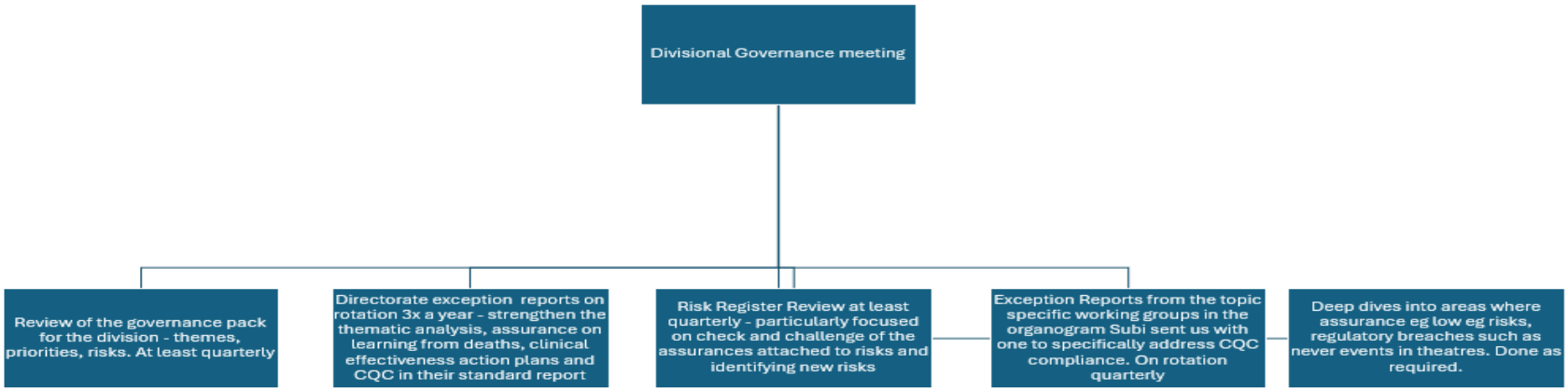
leads to other members of the team with SPA time job planned as is the system in Maternity. Exception reports and escalates quality concerns to Care Group / Directorate meeting	days in the care group/directorate - developing the forward plan, preparing agendas and reports, maintaining action logs and risk register Exception reports and escalates quality concerns to the Division	**Directorates/Care Groups** Acts as expert coaching support for teams at directorate or care group level Develops the induction programme for new governance leads to help them be as effective as possible Ensure there is a training needs analysis for governance leads in their division and access for governance leads to relevant internal and external training Supports networking of governance leads to share learning	governance staff e.g. PSIRF, human factors, SEIPS

Appendices

Appendix 1 – Roles and Responsibilities and Governance Structure provided by the Division



Appendix 2: Divisional responsibility and accountability related to Good Governance Institute (GGI) key elements



	Divisional Level - Accountable	Divisional Level - Responsible	Directorate level - Accountable	Directorate level - Responsible	Care Group level - Accountable
Best practice compliance including NICE guidance	Divisional Chair DDNG DDO	SNCT Gov team SNCT Audit team Identified specialised Leads	Clinical Director HON GM	Identified Leads/team	CGL Matron SM
Regulatory compliance	Divisional Chair DDNG DDO	SNCT Gov team SNCT Audit team Identified specialised Leads	Clinical Director HON GM	Identified Leads/team	CGL Matron SM
Risk Management	Divisional Chair DDNG DDO	SNCT Gov team SNCT Risk Mgmt team Identified specialised Leads	Clinical Director HON GM	CGL Matrons SM	CGL Matron SM

Patient Safety and incident management	Divisional Chair DDNG DDO	SNCT Gov team Governance Leads & HON	Clinical Director HON GM	CGL/Governance Leads Matrons SM	CGL Matron SM
Patient and carer feedback	Divisional Chair DDNG DDO	SNCT Gov team Patient experience team CGL and HON	Clinical Director HON GM	CGL/Governance Leads Matrons SM	CGL Matron SM
Improvement implementation and Lessons learned	Divisional Chair DDNG DDO	Directorate Tri	Clinical Director HON GM	CGL/Governance Leads Matrons SM	CGL Matron SM
Clinical Audit	Divisional Chair DDNG DDO	SNCT Gov team SNCT Audit team Identified specialised Leads	Clinical Director HON GM	Identified Leads	CGL Matron SM

Appendix 3 – Timetable of Interviews and Observations with Records and Reports

Event	Date
Phone call with Neurosurgery Governance lead	10 September 2024
Phone call with Neurosurgery Clinical lead	11 September 2024
Phone call with Clinical Director Surgery	12 September 2024
Phone call with ENT Governance Lead	28 October 2024
Interview with Urology Governance Lead	9 October 2024
Interview with Neurosciences Head of Nursing	1 October 2024
1. Observation Neurosurgery M&M Meeting	12 September 2024
2. Observation Surgical Directorate Business Meeting	7 October 2024
3. Observation Neurosciences Directorate Meeting	14 October 2024
4. Observation SNCT Divisional Governance Meeting	16 October 2024
5. Observation SGUH PSQG	22 October 2024
6. Good Governance Institute Maturity Matrix Survey	3 October 2024
7. Total Quality Management on line Survey Report	21-28 November 2024

Appendix 3

Group Governance Pilot Review – Part 2

Integrated Care, September-November 2024

Review Team:

Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance

Rebecca Ellis, Group Head of Nursing for Quality and Safety Governance

Dr Sally Herne - Intensive Improvement Director Intensive Support for Challenged Systems, NHS England

1.0 Background and context

This report is designed to provide the Integrated Care Leadership Team (ILT) with a summation of the findings from the different parts of the review including:

- A collection of information about the 'as is' i.e. how quality governance is overseen and the system of roles and responsibilities in Integrated Care
- Self-Assessment against the four themes of a good quality management system (Total Quality Management-TQM) and the eight areas of the Good Governance Institute (GGI) Maturity Matrix
- Children's Therapies, Children's Services Management and Governance, Children and Adults Assurance, the PCN/INT Meeting, Surrey Downs Healthcare Board and Integrated Care SLT
- Opportunistic observation of Integrated Care's report to ESTH Incident Review Panel and a Learning event for Sutton Health and Care.
- Testing and checking our understanding with the leads for quality and chairs of specific meetings.

Integrated Care leads elected to send the surveys for the Good Governance. Eight staff completed both the TQM and GGI surveys and therefore it was difficult to get any meaningful information from it. The reports are included for information only. We would recommend that if the team want to repeat the exercise, they do it as part of a conversation at an event where there is a reasonable cross section of staff e.g. a quality half day or big tent learning session. The minimum number of responses to get useful data is approximately 20. The RATE platform can be used to collect responses and generate reports for discussion quickly. It also allows people who may not feel comfortable speaking up in a large meeting the opportunity to have their views considered.

Integrated Care was asked to consider this summary and set a core of value adding SMART (specific, measurable, achievable, realistic and timely) objectives for improvement between now and December 2025 using **table 1**. We encouraged all teams to choose a few key areas which

would make a measurable difference , whilst the Group Executive consider the total outputs of this Phase 4b Pilot review and the next steps for our hospitals and Care Systems.

Table 1: Integrated Care self–set priorities for quality and governance – TO BE DEVELOPED

Priority area	SMART Objective for December 2025	Owner	Where progress will be overseen by the Division

2.0 SWOT Analysis

The overall Strengths, Weaknesses, Opportunities and Threats are set out below in **table 2**. These are based on the self-assessment the Service completed and the observations from the review team.

Table 2: SWOT Analysis as identified from observations and information during the review

Strengths	Weaknesses
• High levels of engagement and commitment to quality • Mature, well documented governance structure with standard agendas and forward plans • Clear system of accountability and responsibility • Good tracking of actions at meetings observed e.g. SDHC Board, ILT • Agendas aligned with key areas of risk and provide rounded picture of quality • Deep dives in use to investigate areas of concern e.g. pressure ulcers, podiatry services • CQC self-assessments include external 'fresh eyes', SEND reports • PCNs encouraged to own their data • Multiple learning fora in place • Staff such as therapy leads have dedicated time for management tasks	• Quality data is still in traditional format and would benefit from Making Data Count format, synopsis and training for staff. At one meeting, workforce information was limited to ESTH and not LBS • Surrey Downs Board and SHC internal assurance reviews performance and finance data a month in arrears and quality data which is two months in arrears which may make it difficult to triangulate • Inconsistency in clear owners and deadlines not always set in the meeting to hold people to. However, this was well demonstrated in the ILT meeting • Risk management – translating worry list into documented risks, staff not always aware of risk policy and which risks are visible at different levels e.g. what is and isn't on the corporate risk register • Capturing of emerging risks which caused issue and were not high or extreme was limited

• Well-developed audit programme in Children's Services • Some good examples of the loop being closed between investigation, improvement and re-checking impact • Robust check and challenge of risks by IC quality lead and leadership team • Formal communications cascade from meeting to meeting in place in Children's Services • Summary Dashboard used within Children's Therapy Services provides a quick reference point to key quality measures, which was mirrored with ILT papers • Reflections on the meeting included as standard at Surrey Downs Board and ILT • September DIRG rapidly identified a concern about delays in care and escalation for a set of patients in Podiatry • Supportive multi-agency investigations e.g. into recently investigated LeDeR case. • Scrutiny of risk description, controls and mitigations was clearly evident on open risks which had a 12 and above rating by SLT.	• Some meetings had significant number of documents e.g. multiple policies and Standard Operative Procedures (SOPs) for review with limited time to read them beforehand and difficult to discuss fully in the meeting • Some staff described challenges attending statutory mandatory training provided by ESTH at main bases. Suitability of some statutory mandatory training for community staff also questioned e.g. Manual Handling • Lower profile of Clinical Effectiveness in the coverage of quality

Opportunities	Threats
• Roll out of Making Data Count as part of the Total Quality Management programme (GESH QI) • Development of self-service quality reporting (Tom Magill) • Expansion of Therapy Outcome Measures to assess effectiveness (national Royal Colleges) • CQC future reports will give scores as well as ratings to show where you are in the pack and which organisations it may be helpful to learn from (IC Quality Leads) • The service identified changing needs in the population, which have led to questions and opportunity to delve deeper. Increase in children's incontinence referrals, insulin prescription & management of patients in the community, increase in complex patients being cared for in the community and prevention of acute admission	• Increasing demand and capacity challenges constraining time for non-patient facing activities • Financial environment – impact on resolving risks and ability to be accountable (ILT) • Change to CQC framework for assessment so the bar has changed from what people have been used to • Lack of collaboration seen in one school service which has transferred to IC and resistance of school senior staff.

3.0 Recommended areas to consider for improvement

Table 3: Findings and Recommendations

Help teams be better placed to use information for improvement	**Service, Site and group actions to support improvement**
Findings: 1) Current quality reports at service, partnership and Integrated care management team level tend to be tables, bar charts and line graphs. This makes it harder to distinguish between the normal variations in data and genuine shifts over time that are more powerful ways to inform decisions and direct quality improvement. Rolling out "Making Data Count" Statistical Process Control charts and training on how to utilise them is essential 2) A lot of the current reports require data to be manually pulled and cleansed before it is distributed. This can take a significant amount of staff time. There is work going on at Group to automate collection of data, reduce the burden and give people more access in real time, but this was not widely known about. The project needs to ensure it meets the specific needs of Community services 3) There were a number of meetings where staff were asking for better thematic analysis to help them see the underlying factors leading to deaths, complaints, incidents rather than just focusing on individual cases or the previous month – this could be where analysts and quality leads invest more time in future to help people step back and see the bigger patterns and underlying drivers of quality. The approach to PSIRF demonstrated the power of this type of analysis 4) There were instances where the value of benchmarking was raised during the conversation. Internal and national audits, GIRFT e.g. UEL and virtual ward work streams, model hospital etc. are all potential sources. We also learned there will be a forthcoming expansion of Therapy Outcome Measures.	**Integrated Care:** 1) Integrated care to ensure critical mass of staff receive training to enable them to interpret and narrate reports and provide a stronger 'so what' 2) Integrated care to engage with quality and BI teams to ensure the work to establish a self- serve platform for quality data meets needs of staff working in community services and help teams with their thematic analysis. HSIB provide a 3-hour course on de-mystifying thematic analysis NHS courses (hssib.org.uk) 3) Integrated care to investigate use of benchmarking and outcomes data to support scrutiny of performance, including GIRFT, TOMS 4) Integrated Care to work with Business Intelligence to triangulate the findings of the CQC assessment visits with other routine data to establish whether services are Safe, Effective, Caring, Responsive and Well led

5) The Surrey Downs Health Care (SDHC) Board and Sutton Health & Care (SHC) Adult and Children's internal assurance meetings were reviewing performance and finance data which was one month in arrears but quality data which was two months old. One of the important roles of an integrated performance report is to look at the relationship between activity, workforce, performance and quality. Looking at different periods in the same report may impede this 6) We did not see evidence of how the findings of how the CQC self-assessment visits were being triangulated against other sources of information to form a more continuous picture of regulatory compliance	5) Agree an approach to looking at the same time period across the different parts of the integrated performance report **Site/group:** Group to provide expertise for roll out of reporting and training into quality to ensure the standard report and quality component of the community contract are in a more meaningful format
Reframe how people think about Risk **Findings:** 1) We saw examples where people were expressing concerns but not making the connection that what they were describing was likely to be a risk. As a result, there is a potential gap between what was written down and the worry list for a team. If a risk isn't captured, none of the processes which should follow from it (mitigation and escalation) kick in. Meeting chairs are in a good position to ensure meetings explore whether any new concerns have been identified from papers, discussions or data and what actions need to be taken as a result. 2) The team is using the ESTH risk management framework. Risks are captured and scored and mitigations are listed. There is one ingredient missing – assurance. This is particularly important for risks which are long standing and seem stuck e.g. some of the infrastructure risks which require scarce capital funds. Assurance is the **evidence** a team uses to **know** if their risk is being mitigated. This requires the routine data collected about a service to be used to inform risk scoring, closure or escalation. 3) Types of risk reports varied at more local level to that seen in higher level meetings, where common risks used different ID numbers. This would match the service configuration between SDHC and SHC. ? to join up risks within the group model using a standardised format	**Service, Site and group actions to support improvement** **Integrated Care:** Chairs of meetings and their administrative support to 1) Encourage translation of worries expressed verbally or in a report into risks and risk management process e.g. regular section on new risks on the agenda 2) Set out the assurance evidence for risks, where the priority is areas has been on the risk register for a year without a change in the score or where risks are significantly overdue e.g. ageing equipment 3) Encourage clarity of escalation: what are you escalating, to whom and what is the response you need.

4) There was limited formal escalation of concerns between meetings, which seems unusual given the mix of staffing, operational and financial challenges.	
Encourage reflection not only on the learning from cases but whether the mechanisms for learning are effective in reducing avoidable harm and poor patient experience **Findings:** 1) Integrated Care has a range of fora where staff come together to discuss learning. This may be between specific teams e.g. cross Primary Care Network (PCN) learning, for specific professionals or across the two partnerships such as the Big Tent annual event. We saw specific examples of learning being shared in meetings e.g. in the PCN assurance reports and the deep dive into pressure ulcers. This could be strengthened further by encouraging people to reflect on the *impact* of their learning and whether it is effective.	**Service, Site and group actions to support improvement** **Integrated Care:** 1) Quality leads at local level and organisers of learning events encourage reflection. Teams can use the questions below if this is helpful - What is the experience of patients and families involved in safety and complaints investigations? Did the organisation behave transparently and honestly? Were the questions they wanted included and answered? - What is the experience of staff taking part in internal investigations and external processes such as Coronial inquiries? Were they able to be honest and open about the circumstances of the incident or complaint? Were they supported by their team and the organisation? Was their key learning reflected in the investigation outcome? - Does soft intelligence and surveys such as the staff survey suggest Integrated Care is a place people can speak up either to raise concerns, challenge the status quo or share ideas? - Are we getting a clear picture of the themes in our learning and is this reflected in the quality priorities being set? - Are there changes in the themes over time and any

	evidence we are making inroads into known areas of concern e.g. inequalities in care? Are we sharing our learning with teams we commonly share care with e.g. primary care, diagnostics, ED, ITU, care homes, ambulance services?

4.0 Organising and Overseeing Quality

4.1 Structures

Integrated Care (IC) has a well-documented governance structure to oversee the networks of services, partnerships and the overall organisation. This was refreshed in April 2024. As well as a network of meetings to oversee operational services, there are cross partnership groups looking at medicines, Patient Safety Incident Framework (PSIRF) and Policies.
Clinical Effectiveness is monitored either via the ESTH Audit Committee or via SWL forums.

We observed three meetings for Sutton Health and Care (Children's Therapies, Children's Services Management and Governance and Adult and Children's Assurance Meeting), two for Surrey Downs (PCN/INT assurance meeting, Surrey Downs Board) and the Integrated Leadership Team. The meetings we observed tended to have terms of reference/purpose (constituted), standard agendas or a forward plan, action logs and minutes. The structure as described was the structure we saw happening in practice. Dedicated administrative support was in place and most papers were distributed at least 48-72 hours before the meeting.
Given the complex nature of the organisation and the short length of time it has existed compared to the Acute parts of GESH, the arrangements seem to be mature. We observed respectful, collegiate discussions taking place. The chairing of the SLT meeting also demonstrated welcoming of feedback by asking for reflections of attendees.

4.2 Responsibilities

Integrated Care has a model for leadership of quality which differs from other parts of the Group. The Senior Leadership Team for Integrated Care has two leads for most aspects of quality (Appendix 1) who also holds the quality lead roles for the two Partnership Boards covering Sutton and Surrey Downs. The quality leads are assisted by a dedicated Head of Quality & Governance. Below Partnership level, leadership for quality sits with the clinical and managerial teams responsible for individual PCNs, bedded units, specialist and interface services. Dedicated medical leadership is primarily in the form of funded GP PCN leads. Other staff e.g. the Head of Children's Therapies and individual Children's therapy services complete governance work in their dedicated management time. We did not gain any feedback on whether GP time or management time for nurses and AHPs was sufficient. Individuals we did speak to seemed clear about what good governance looked like in their area of practice. The only exception was the role of the PCNs in non-coronial deaths in the community (see learning).

4.3 Use of Information for Decision Making and Improvement

Integrated Care needs to produce data on quality for a multiplicity of audiences – commissioners to demonstrate progress against the community contract, ESTH as the host organisation, SGUH for Group, two Partnership Boards and individual teams. The data capture is not automated and can mean staff, including the Director of Multiprofessional Leadership, must pull raw data from the Risk system, Datix. A platform which holds all the relevant data

which can generate reports for the relevant meeting would be much more time efficient. There is an opportunity for the team to capitalise on work the Quality and Business Intelligence (BI) teams are doing to automate production of quality data so teams can access their data more in real time. The quality leads have been given a contact within the BI
function to discuss this with and ensure the needs of Community services are understood and factored into the roll out.

We observed discussions where members asked how Surrey Downs or Sutton compared with other organisations as part of trying to make sense of the data they were reviewing.

Benchmarking can be powerful not only for charting comparisons with peers but also the potential opportunities for improvement. It would be helpful to explore with the BI team how much the automation process can build comparator data into the automated reporting and where there are opportunities to strengthen this in future e.g. with the expansion of Therapy Outcome Measures (TOMS). The new model of CQC assessment should also produce scores within rating categories to show where an organisation is in the pack and identify other organisations which it may be useful to learn from.

The Quality Dashboards used at partnership level can be very detailed because they report aggregate data and data for individual services such as the bedded units. There is a summary page to help set out the critical messages. However, this kind of summation was not always available in the meetings we observed. There was an opportunity to strengthen reporting by working with GESH BI and QI teams to expand use of Making Data Count Statistical Process Control charts into quality data. Training for those who produce the main quality reports is critical. MDC has advantages over tables, RAG ratings and other traditional methods

- SPC can be used with pretty much any data – activity, performance, quality, workforce and finance. Rare events such as never events, or hospital acquired infections can still be turned into SPC charts using ‘days between events’ as the measure rather than the volume. This would be appropriate for indicators such as incidents at unit level or pressure ulcers in the quality dashboard.
- SPC usually plots at least 12-24 months data in a run chart allowing people to view progress over time and spot regular, seasonal trends and know whether they are improving, deteriorating or staying the same year to year.
- Visual charts can convey meaning much more quickly than tables of numbers and avoids reacting to things which are not significant.
- SPC run charts tend to prompt more useful insights, questions and discussions to help investigate areas of concern and test possible improvements.
- Run charts can be used to predict future likelihood of achieving a target and to set trajectories that are more realistic.
- Benchmarking can be incorporated

There is some narrative attached to the Quality Dashboard and Divisional Incident Review Group (DIRG) themes reported into the ESTH Incident Review Panel. Making Data Count training on adding narrative is available through NHS England and helps to crystallise the ‘so what’. The MDC approach could also help lift out the critical messages from the finance, workforce and performance packs of information where there is a significant amount of data to digest. We also noted that some meetings were reviewing performance and finance data a month in arrears but quality data which was two months in arrears. This was attributed to the need to cleanse quality data prior to presentation e.g. to establish if a pressure ulcer was developed in the care of the service or not. However, this makes it very difficult to triangulate

the interplay of workforce, finance, performance and quality. We would recommend the Leadership team agrees an approach which allows you to examine data which covers the same period.

5.0 Quality Management

The papers we received and meetings we observed placed most emphasis on aspects of patient safety. This was in line with the risks identified on the risk register e.g. increasing rates of pressure ulcers in the community and gaps between demand and capacity. Dashboards show positive practice e.g. high rates of low/no harm reporting and detailed tracking of duty of candour compliance. Patient Safety alerts are managed centrally through the Medicines Committee/ESTH PSQG, shown in the governance structure. Integrated Care has recently begun to implement PSIRF. We observed an ESTH Incident Review Group where the Integrated Care DIRG reported September 2024 data. This identified several new risks including a theme of delayed referral and escalation of a group of patients in the Podiatry service, EMIS system errors which can result in duplicate visits and administration of double doses of medication. The discussion of the actions was robust and considered both patient and IT risks. A deep dive was commissioned to look into the factors behind the increase in pressure ulcers, which was presented to Surrey Downs Board and showed a thorough analysis of the causes, an action plan to address them, refreshed competency and training programme and a framework for re-checking whether compliance with grading and treatment had improved.

The ILT discussed a review paper focusing on diabetes care. This identified an increase in prescription and service need for insulin administration. This showed an increase for community services workload along with challenges with patient self-management.
Integrated Care is delving deeper to explore reasons and options.

5.1 Patient and Carer Feedback

All the meetings we observed had active discussions of feedback from patients and carers including friends and family test, compliments and complaints. Children's services were exploring ways to capture children and parents' experiences through use of iPad-based surveys and use of therapy outcome measures which capture the impact on parents' wellbeing.

5.2 Risk Management and Escalation

The majority of meetings we observed included a paper relating to the risk register. These tended to focus on movement of risks and changes in the scoring. There were clear examples of where risk was being used to prioritise items on the agendas for the meeting and to commission more detailed work to understand the issues. Early on we noted a disparity between what was on the Integrated Care Risk Register and the Corporate Risk Register. This appeared to be a timing issue related to when the corporate risk team took a cut of the Integrated Care register to report to the Executive. If this preceded the date when the Quality leads had scrutinised the risk and interrogated the scoring. Risks which had previously met the threshold for addition to the Corporate Risk Register may be downgraded by the check and challenge and therefore not require escalation. This was a known issue and was being resolved by the Division and Group Chief Corporate Affairs Officer's team.
Several meetings identified new risks, but it was variable whether these were *formally* recognised and recorded. However, gaps in services identified in relation to specialist palliative care and community mental health at PCN/INT meetings were not subject to a risk assessment. EMIS system concerns and delays dispensing medication in community pharmacy were clearly escalated to the Integrated Care Board (ICB). As with ESTH and St George's teams, we felt

there was an opportunity to strengthen the approach to risk by challenging the *evidence* teams are using to judge whether a risk had been successfully mitigated. Feedback from IC provided during the review confirmed that all risks were being discussed and agreed in either Children's or Adults assurance meetings which was reflected in a Datix dashboard.

From observation of the SHC Children's Assurance meeting, which again showed maturity, could be missing other quality risks as only high-level risks were highlighted.

5.3 Regulatory Compliance

Integrated Care has its own stand-alone approach to assessing compliance with CQC requirements. Teams which include fresh eyes external expertise assess the service against the key lines of enquiry on a specific day every quarter. We could not establish whether the findings of the assessments were being triangulated with routine data to get a more continuous, live picture of compliance. This would be a more reliable predictor of compliance at inspection. A specific forum receives the action plans and monitors actions. We saw progress against those actions being followed through in Children's services, where it is a regular item on the agenda for the overarching management group and individual services. The plan is to move to a biannual review and to refresh the approach to align it to the new quality statements in the single assessment framework. However, as the independent review of Care Quality Commission (CQC) carried out by Dr Penny Dash had raised questions about the SAF, the leadership had decided to pause any change.

5.4 Learning and Mortality

Integrated Care has a number of fora used to share learning between teams and agencies. Every PCN/INT routine report highlights cases of interest e.g. safeguarding concerns to share with the other attendees. As the time available for the discussion is limited, we were told more of the learning that takes place in clinical leads events, operational meetings and DIRG. The 'Big Tent' is an annual event bringing together all staff to discuss pre agreed subjects such as use of quality improvement approaches. We observed a multi-agency learning event convened to discuss the death and LeDeR investigation of a complex patient. Sutton Health and Care staff from the service directly affected by the case (Community Nursing), other teams, the ICB, GP practices and specialists such as the Safeguarding and Learning Disability teams were in attendance. Attendees were engaged and supportive and praised the SHC leadership response to the staff affected by the case. The Division was able to identify changes which had been made due to their learning. For example, the increasing complexity of patients being cared for in the community has resulted in the establishment of patient of concern meetings to coordinate care. We would encourage the two Partnership Boards and their constituent services to go one step further and routinely reflect on the impact of these changes on patient experience, outcomes and staff experience. The system for learning from deaths in community services was changing at the time of the review.

Before September 2024, the only deaths Integrated Care were responsible for investigating were those occurring in bedded units. As we were not observing these services, we were not able to test how this was working. In September, the Medical Examiner system was extended to cover non coronial cases in the community. The systems were too new for us to assess. The PCN/INT meeting we observed did discuss the changes – not all PCNs were clear on their role in the new arrangement. England » Information for primary care on extending medical examiner scrutiny to non-coronial deaths in the community

5.5 Clinical effectiveness

We saw examples of clinical effectiveness work in the meetings we observed. PCN/INT and Children's Therapies meetings routinely reported compliance against hand hygiene

standards. Benchmarking on Falls had been successfully used to support roll out of a Falls Rehabilitation pathway. The Surrey Downs Board receives a dashboard where one page is focused on effectiveness covering any audit results, new NICE guidance and learning from deaths. Sutton Health and Care Children's services had a well-developed annual audit programme reported into the Management and Assurance meeting. Specific services such as Children's Therapies were able to describe how this was supplemented with audits on areas of concern e.g. whether Therapy review recommendations were fully incorporated into Education Health and Care Plans. However, clinical effectiveness tended to have a lower profile than safety incidents and patient experience in the meetings we observed. There was no data on patient reported outcome measures in the papers we received, although the expansion of therapy outcome measures beyond speech and language services represents an opportunity to introduce these. We did not observe discussions of GIRFT, although there are work streams for virtual wards, musculoskeletal services and urgent care Virtual Wards - Getting It Right First Time - GIRFT.

The pathway for clinical audit awareness and oversight was via the ESTH Audit committee, PSQG as well as the SWL emergency care board (covering virtual wards across South-West London and national forums for specialties).

Appendices

Appendix 1 – Roles and Responsibilities and Governance Structure *(shared with the team)*

As is - Roles and Responsibilities

	Accountable – Integrated Care overall	Responsible – Integrated Care overall	Accountable – Partnership level	Responsible – Partnership level	Banstead PCN Accountable (acc) / Responsible (resp)	Children's Therapies Accountable (acc) / Responsible (resp)
Best practice compliance including NICE guidance	Simon Littlefield & Keisha Antonopoulos	Liz for both Beth Wilson for Children services	Simon Littlefield & Keisha Antonopoulos	Ops managers	Acc: Keisha Antonopoulos Resp: Tri which includes ops and clinical leads	Acc: Beth Wilson Resp: Sandra Quilty & Kate Edwards
Regulatory compliance	Thirza Sawtell	Simon Littlefield & Keisha Antonopoulos	Thirza Sawtell	Simon Littlefield & Keisha Antonopoulos	Acc: Binu Cherian Resp: Tri which includes ops and clinical leads	Acc: Lucy Botting Resp: Beth Wilson
Risk Management	Lucy Botting / Binu Cherian	Ops managers	Lucy Botting / Binu Cherian	Ops managers	Acc: Binu Cherian Resp: Tri which includes ops and clinical leads	Acc: Sandra Quilty Resp: Kate Edwards
Patient Safety and incident management	Simon Littlefield & Keisha Antonopoulos	Ops managers	Simon Littlefield & Keisha Antonopoulos	Ops managers	Acc: Keisha Antonopoulos Resp: Tri which includes ops and clinical leads	Acc: Simon Littlefield Resp: Sandra Quilty & Kate Edwards
Patient and carer feedback	Simon Littlefield & Keisha Antonopoulos	Ops managers	Simon Littlefield & Keisha Antonopoulos	Ops managers	Acc: Keisha Antonopoulos Resp: Tri which includes ops and clinical leads	Acc: Beth Wilson Resp: Sandra Quilty & Kate Edwards

Appendix 2 - List of meetings observed and dates of the meetings

Event	Date
Surrey Downs PCN/INT Assurance meeting	10th October
Sutton Health and Care Adults and Children's Internal Assurance Meeting	10th October
Surrey Downs Healthcare Board	17th October
Sutton Health and Care Children's Services Management and Governance Meeting	17th October
ESTH Incident Review Panel	23rd October
Sutton Health and Care Learning event	24th October
Integrated Care SLT	8th November (25th October cancelled)

Note: Outputs from the TQM and Good Governance Institute (GGI) sessions/surveys have been shared with teams, along with the Divisional GGI Matrix and copies of the Good Practice Guide for Governance Leads.

gesh

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

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	2.3
Report Title	**Group Maternity Services Quality Report November and December 2024 data**
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer and Director of Infection Prevention and Control
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Jacqueline Gabriel-King, Interim Director of Midwifery and Gynaecology and Nursing (Outpatients), SGUH Emily Kaliwoh, Lead Midwife for Governance SGUH Annabelle Keegan, Director of Midwifery and Gynaecology Nursing, ESTH Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH Alison Benincasa, Group Director of Compliance
Previously considered by	ESTH Women and Children's Divisional Management Team ESTH Senior Leadership Team SGUH Maternity Governance Meeting SGUH Women and Children's Divisional Management Senior Leadership Team 07.04.25 SGUH SLT 15.04.25 QSCIC 24.04.25
Purpose	**For Assurance**

Executive Summary

Purpose

This report aims to meet the requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM) (December 2020), to facilitate regular review and discussion of maternity key performance indicators (KPIs), by the designated sub-committee of the Group Board. The KPIs include maternity outcome and perinatal mortality data plus data on training compliance and key risks on the risk register, which together provide an overall picture of maternity and neonatal safety.

The report includes, as appendices 1, 1a and 2, 2a **the mandated measures** required as part of the NHS England Perinatal Quality Oversight Model - Perinatal Quality Surveillance Model data for January and February 2025.

The report also includes updates on:

- Feedback from the Maternity Incentive Scheme Year 6 submission as part of the Clinical Negligence for trusts (CNST) scheme for SGUH
- CQC MUST and SHOULD Do actions from the 2023 inspection for SGUH and ESTH
- SGUH response to NHS Resolution regarding their Thematic Review of the MBRRACE Early Notification Scheme (ENS) cases from 2017 – 2024

2.0 Key risks and issues for escalation:

For SGUH:

- There was a maternal death on 03 March 2025 (Datix DW223760) which has been reported to the CQC (as per the required process). This incident has been reviewed internally and the national Maternity & Newborn Safety Investigations (MNSI) service has accepted the case for investigation. A verbal update on immediate learning and safety improvements from our local investigation will be provided by the GCNO and GCMO at the QCiC meeting on 24 April 2025.
- SGUH achieved full compliance with 9/10 safety standards for MIS Year 6. This was noted as low risk prior to the final submission, however MBRRACE-UK have included additional cases into the numbers which has meant that the trust has been declared non-compliant with safety action 1. An appeal has been submitted on the grounds that the additional cases were not part of the cohort of cases that should be included, and the response to the appeal is awaited.
- The National Maternity Perinatal Audit has flagged SGUH maternity services as a potential alarm-level outlier for postpartum haemorrhage in 2023. Some immediate safety improvement actions have already been taken, and work is ongoing to identify any further learning and safety improvements that may be required. More detail is provided in Appendix 3.
- The digital maternity transformation went live on 8 February 2025. Several challenges have arisen post-implementation as the system undergoes optimisation and mitigations are either in place or currently under development to address issues identified.

For ESTH:

- An IT issue has emerged whereby Cardiotocographs (CTGs) from the ST Segment Analysis (STAN) machines are not being downloaded for storage. CTG recordings are often key evidence for determining and/or defending breach of duty in legal cases. This has been reported to the manufacturer (Neoventa) and to the MHRA Yellow Card Scheme. An interim solution (manual download onto an unencrypted USB stick) has been implemented whilst resolution is achieved.

For ESTH and SGUH:

- Medical staffing training compliance has not achieved the 90% compliance target for this reporting period. The issue is with PROMPT training among resident doctors at ESTH, and among consultants at SGUH. There is a plan in place to recover the position

Action required by Quality Committee-in-Common

The Board is asked to:

a) Note the maternity service updates and the key risks and points for escalation.

Appendices

Appendix No.	Maternity
Appendix 1	ESTH Perinatal Quality Surveillance Model data (PQSM)
Appendix 1a	SGUH Perinatal Quality Surveillance Model Data (PQSM)

Appendix 2	ESTH Perinatal Mortality Review/ Board report
Appendix 2a	SGUH Perinatal Mortality Review/Board report
Appendix 3	SGUH 1.5L PPH audit
Appendix 4	MSSP gesh bi-monthly report
Appendix 5	Executive and Non-Executive Board Safety Champions report

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

ESTH: Declared full compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6 via the Board declaration form submitted on 3 March 2025, and would therefore expect to receive 10% rebate of their contribution to CNST.
SGUH: Declared 9/10 compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6 via the Board declaration form submitted to NHS Resolution on 3 March 2025, which would result in none or less than 10% rebate of Trust Contribution.

Legal and /or Regulatory implications

Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations: In January 2025, SGUH maternity received a section 29A Warning Notice. The Trust response includes the immediate safety actions undertaken together with a detailed action plan for further improvements.

Equality, diversity and inclusion implications

The Lead Midwife for Transformation (ESTH) and the Consultant Midwife for public health (SGUH) continue to undertake Focus Groups with women from the Global Majority to understand their experiences, and help to inform and influence service development. At ESTH, this has also included a focus group to explore the experience of students from the Global Majority, which will feed into a larger workstream currently being developed to address cultural issues within the Maternity Service.

Environmental sustainability implications

ESTH: There are several environmental issues which have an impact on service development and business continuity, highlighted in the most recent CQC inspection report (see risk register section, slide 4 of appendix 1).

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

Group Maternity Services Quality Report

Group Board, 01 May 2025

1.0 Purpose of paper

1.1 This report is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (PQSM) (December 2020) to facilitate review and discussion of maternity key performance indicators (KPIs), by the designated sub-committee of the Group Board. The KPIs include maternity outcome and perinatal mortality data plus data on training compliance and key risks on the risk register, which together provide an overall picture of maternity and neonatal safety.

1.2 This report also informs the Quality Committee in Common (designated sub-committee of the Trust Board) of any significant changes, emerging safety concerns, new risks and successes within gesh maternity services, and provides assurance that there are robust plans with monitoring processes in place to make any identified improvements required or address any concerns.

The report includes, as appendices, the mandated data sets that are required to be reviewed by the Committee, as part of the NHS England Perinatal Quality Oversight Model - Perinatal Quality Surveillance Model.

2.0 Content

2.1 The report data covers the position for January and February 2025, and includes

Mandated monthly reporting requirements:

- The perinatal quality surveillance model (PQSM), section 3.1 (appendixes 1 and 1a)
- The maternity quality and safety dashboard trend data in relation to outcomes for birthing people and babies, section 3.1 (appendices 1 and 1a, slide no.3)
- Perinatal mortality by exception (appendices 1 and 1a ESTH and SGUH respectively)
- Details the Perinatal Mortality Review Board Report generated from the Perinatal Mortality Review Tool (PMRT). (Appendices 2 and 2a)
- The Board Safety Champions report (appendices 5)

Key updates include:

- The bi-monthly gesh Maternity Safety Support Programme report (appendix 4)
- Feedback from MIS Year 6 (CNST) for SGUH, section 4.4
- CQC MUST and SHOULD Do actions from the 2023 inspection for ESTH and SGUH, section 4.9
- Risk register and key risks/emerging concerns – by exception, section 3.1.2 and section 4 (appendix 1 and 1a, Slide 4).
- SGUH audit of PPH at or above 1500mL 2023, section 4.8 (appendix 3)

3.0 Context and Overview

3.1 Perinatal Quality Surveillance Model (PQSM) data for January and February 2025

3.1.1 Outcomes

ESTH and SGUH: The outcome dashboard trend data presented in the standard process chart (SPC), shows that outcomes have either remained stable or improved with no significant variation (appendices 1 and 1a, slide 3).

3.1.2 Risk register

ESTH: There are two extreme (red) risks on the risk register:

- the absence of a second operating theatre at Epsom,
- general environmental concerns identified during the 2023 CQC inspection.

While work is ongoing to address both issues, there has been no significant change since the last report, except that the estates team have advised the second theatre at Epsom is expected to be completed end May 2025 (see Appendix 1, Slide 4).

SGUH: There are two extreme (red) risks on the risk register.

- the first concerns the laser stack, which is beyond its intended lifespan and no longer covered by a manufacturer maintenance contract. A replacement stack was ordered and delivered on 10 April; however, data transfer from the old system and commissioning of the new stack are still pending. The replacement laser component remains outstanding due to challenges in sourcing a suitable device and the requirement for clinical trials prior to adoption. In the meantime, a risk assessment has been completed to mitigate potential service disruption in the event of equipment failure.
- the second extreme risk relates to the service not meeting regulatory standards, following a CQC inspection in October 2024, which resulted in the issuing of a Section 29A notice. This risk was formally added to the risk register in February 2025 (see Appendix 1a slide 4)

3.1.3 MBRRACE-UK Perinatal Mortality Report 2023

ESTH: The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 identified ESTH as an outlier for stillbirths during that year. This was primarily due to three cases in which women delivered out of area and had not received any antenatal care at ESTH prior to the confirmed fetal death.

Two of the cases involved concealed pregnancies, and one case involved a woman who was transferred from Birmingham following a confirmed intrauterine death, to deliver closer to her family. Further details of these cases are included in Appendix 1, slides 8–12 of the report.

SGUH: The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 birth has shown that SGUH are average when compared with similar Trusts for stillbirth (up to 5% higher or up to 5% lower) and lower than average for neonatal death (more than 5% and up to 15% lower), see Appendix 1a slides 8-9.

3.1.4 Moderate and above harm cases

ESTH: had a total of 7 moderate harm outcomes across January (3), and February (7). Of the 3 incidents in January 2025, 2 have been presented to the maternity incident review panel and an AAR is underway, while one case is awaiting an initial review (appendix 1 slide 14)

SGUH: A total of 29 incidents were reported at moderate, high, or extreme risk levels in January 2025, and 21 incidents in February 2025. All cases have now been reviewed, and lessons learned will be disseminated accordingly.

The top five incident themes discussed at PSQG remained consistent over the reporting period.; The themes were post-partum haemorrhage (PPH), test results not being reviewed in a timely manner, staffing concerns, and delays in diabetic appointments. Work is ongoing to address these areas.

Notably, 21 of the incidents over the two-month period were related to PPH. A report of the high PPH rate is included in this report at appendix 3.

3.1.5 Training Compliance

ESTH: Training compliance for PROMPT fell below the 90% target in January and February for trainee and staff grade obstetricians, with rates of 80% in January and 79% in February. CTG training compliance for Consultant Obstetricians also declined, falling to 87% in February. All other training requirements across all staff groups remain above the 90% standard (see Appendix 1, Slide 18). To support improvement and maintain compliance for medical staff, the service has introduced a projected attendance list which is monitored on a weekly basis.

SGUH: There has been no significant shift in the training compliance for PROMPT in the midwifery staffing group, which was 87% and 88% for January and February, and Consultant Obstetricians were at 89%. Newborn Life Support Training for Neonatal Nursing staff improved to 89% in February but has not achieved the 90% target since December 2024.

3.1.6 Midwifery fill rate

The fill rate at EGH and STH has remained between 91-92% since December 2024, against a target of >94%. Staffing gaps are mitigated by levelling staff across the units or support from temporary staffing, such as bank or agency.

SGUH overall fill rate for midwifery staffing has improved since the last report in all clinical areas from 84% to above 95% for day and night shifts. The fill rate is challenging for the maternity support workers (MSWs) at below 80% during the day shift across all clinical areas, (see Appendix 1a slide 15). The teams are reviewing how the MSWs are deployed and what is required to improve the fill rates

3.1.6 Executive and Non-Executive Board Safety Champion Engagement

An update of Executive and Non-Executive Board-Level Safety Champions' activity is included in the report at Appendix 5.

4.0 Key issues and risks for consideration not included in the Perinatal Quality Surveillance Model (PQSM)

4.1 SGUH

4.1.1 IClipPRO implementation at SGUH

The digital maternity transformation, involving the transition from Euroking E3 to iClipPRO, went live at SGUH on 8 February 2025. Several challenges have arisen post-implementation as the system undergoes optimisation. These issues have been appropriately escalated by the directorate to the IT project team, as well as to the Divisional and Site Leadership teams. Concerns were also raised and discussed at the Maternity Oversight Group, chaired by the Site Managing Director.

The IT project team has been responsive, working closely with the directorate and senior midwifery team to address and resolve identified issues.

A key clinical risk remains that, following the go-live of iClipPRO at SGUH, maternity records from the previous system (Euroking) were not migrated beforehand (2,673 records). This means that clinicians currently need to access and work across two systems to get a full picture of a woman's pregnancy history, which increases the risk of missing important clinical information.
To address this, an automated tool (BOT) has been developed to transfer the data. However, not all records can be processed automatically and will require some level of manual data entry by midwifery staff. There are three main groups of records affected (as per project team assessment):

1. **Records with data issues** – As of 11 April 2025, 713 out of 2,673 records were excluded due to missing or incomplete data. Of these, around 297 are likely to be fetal medicine unit (FMU) cases that may not require action. Approximately 397 records have already been partially entered manually. Some records may only be missing specific sections, which could allow the BOT to process the remainder.
2. **Family history section** – The system cannot auto-complete the 'Maternal Family History' section for any record, meaning this will need to be manually added for all cases.
3. **Un-processable records** – Some records will inevitably fail automated transfer and will need to be manually reviewed and completed. These are being identified in real-time as the BOT works through the dataset.

This work is taking place alongside efforts to ensure data accuracy for national maternity dataset reporting (MSDS), which is due for submission on 28 April 2025 and supports compliance with CNST Safety Action 2. Completion of the data migration via the BOT is expected by 22 April 2025, however, midwifery validation for accuracy and completeness will extend beyond this period.

Until migration is completed, clinicians are being reminded to check and review patients' records on the legacy system at the point of care.

4.2 ESTH

4.2.1 Appraisal data reporting risk

A risk has been identified with the automatic system used to track appraisal completion via Power BI. In several instances, appraisals are not being recorded correctly. Additionally, when staff transfer between teams or change line managers, the system is not consistently updated in a timely manner, leading to inaccuracies in appraisal status reporting.

As a result, the maternity service at ESTH is currently duplicating effort by maintaining manual records alongside the automated system. Staff are also required to email the Appraisal Team to manually update Power BI. This process is resource-intensive and financially inefficient. It is also likely to represent a wider Trust-level risk.

The issue has been escalated to the Group Chief People Officer who will work with the HR teams to identify an interim solution whilst the BI solution is identified.

4.2.2 Maternity Establishment Review

The maternity establishment is under review to ensure it accurately reflects the current service model and staffing requirements. This follows the recent reconfiguration of community maternity services across both sites. A paper presented in 2024 indicated a reduction in roster fill rates between January and June 2024; however, this data related to the pre-reconfiguration structure. Current roster planning aligns with minimum safer staffing levels for every shift. Significant progress has been made to ensure rosters are consistent with both the revised establishment and budget, enabling improved scrutiny and real-time review.

4.2.3 CTG Data Storage Risk

An IT issue has been identified with STAN machines, which are not downloading and storing CTG traces as expected. The loss of CTG recordings has serious implications, particularly for any future legal proceedings, where such data is often critical for assessing or defending clinical decisions.

The issue has been reported to the manufacturer (Neoventa) and to the MHRA via the Yellow Scheme. While a long-term solution is awaited, IT has proposed a temporary workaround involving manual downloads to a USB stick. It is noted that other local Trusts, including St George's and Kingston, are also affected.

4.3 Birthrate Plus review – SGUH and ESTH

SGUH has submitted the required data to the Birthrate+ team and the senior team has since had a provisional update on the findings. Initial data shows a fall in the birth rate by 990 since the 2021 report, however, the level of complex births remains high, with over 50% in the two highest Birthrate+ categories. The final report is expected by the end of April 2025.

ESTH last Birthrate plus report was in July 2022, and a new review has been commissioned to start September 2025, in line with the three yearly recommended cycle.

4.4 Clinical Negligence Scheme for Trusts, Year 6 and 7 Maternity Incentive Scheme (MIS)

MIS Year 6 closed on 30 November 2024, and the Board Declaration forms for both Trusts were submitted on 3 March 2025, in line with the required timeline.

ESTH declared compliance with all 10 of the 10 safety actions.

SGUH declared compliance with 9 out of 10, as Safety Action 1 (Perinatal Mortality Review Tool - PMRT) was not met due to two neonatal deaths not being reported within the required seven working days.

Following this, SGUH received a letter from NHS Resolution dated 1 April 2025 confirming that:

During the external verification of Safety Action 1, six deaths were found to have been reported to MBRRACE-UK late—one by 67 days. PMRT reviews cannot begin until a death

is notified, which likely contributed to only 35% of reviews (25 in total) being started within the two-month requirement. Additionally, 14 reviews (50%) took longer than six months to publish. While mitigation measures are now in place, the Trust did not meet two verification standards and is therefore deemed non-compliant with Safety Action 1.

As a result, SGUH was informed it would not be eligible to recover its contribution to the CNST maternity incentive fund for Year 6.

The Trust was offered two grounds for appeal and invited to respond if it believed either applied. An appeal has been submitted on the basis that SGUH does not agree with the number of late notifications cited, nor the figures reported for reviews started within two months or completed within six months.

However, SGUH was encouraged to apply for discretionary funds to support improvements to PMRT compliance ahead of MIS Year 7. An application was made for discretionary funding to support strengthening of PMRT processes for Year 7. The outcomes of both the appeal and application for funding are currently awaited.

MIS Year 7 was published on 2 April 2025. Both ESTH and SGUH are actively reviewing and disseminating the updated safety actions to the relevant teams. Further updates will be provided to QCiC throughout the reporting period.

4.5 Maternity Safety Support Programme (MSSP)

MSSP continues to support gesh maternity services and the bi-monthly report from the maternity improvement advisor is included in the report, see Appendix 4.

Since the last report, the MSSP team, along with maternity colleagues, carried out the review of triage at SGUH on 2 April. ESTH triage will be reviewed on 25 April 2025. The outcome of this review would ensure that the Board is fully informed of the challenges in implementing the Birmingham Symptom-Specific Obsteteric Triage System (BSOTS) model and advise of alternative options. It would also allow for the formal documentation of current mitigations, supported by robust policies and audit processes, in response to both service needs and CQC concerns.

4.6 Integrated maternity improvement plan

The November 2024 Quality Committee Focus session was on maternity. The Committee requested that an integrated improvement plan for maternity was developed across GESH. Initial discussions with key stakeholders have taken place, and the main workstreams have been agreed. Support has also been secured from the Transformation Team to assist with the development of the plan template.

Work on the plan was temporarily paused to allow the maternity team to prioritise the response to the Section 29A Warning notice and support the digital transformation programme (iClipPRO), which went live on 8 February 2025. Although the plan was originally scheduled for discussion at the April QCiC meeting, the draft SGUH plan was only finalised and shared on 4 April. This timing did not allow sufficient opportunity for review through the agreed governance process prior to submission to the Quality Committee.

Following a request from the SGUH Site Managing Director, it was agreed with the Committee Chair that the plan would be deferred to the May QCiC meeting to allow the governance process

to be followed appropriately. Oversight and ownership of the plan has been confirmed to ensure clear accountability, traction, and measurable progress once implemented.

The improvement plan for ESTH will be developed separately. While there are shared themes across both sites, differences in specific areas of focus mean a joint plan would skew key metrics and dilute site-specific priorities.

4.7 Review of MBRRACE findings 2021 – ESTH & SGUH

An external review of MBRRACE 2020 and 2021 cases was commissioned by the Quality Committees in Common (QCiC) to assess perinatal data and outcomes at gesh Maternity services and gain an understanding of whether there are any issues that negatively impacted on the incidences of stillbirths or neonatal deaths.

The review followed a previous assessment of MBRRACE cases from 2020, by the same reviewing team. This review focussed on cases reported to MBRRACE during January to December 2021.

The review commenced in July 2024, and the Trust received the report in March 2025. However, the report was returned to the reviewers after factual accuracy check and the Committee will be updated on the review findings once this process is complete.

4.8 National Maternity and Perinatal Audit (NMPA) - SGUH

The NMPA team wrote to SGUH on 19 February 2025, advising that the trust may be a potential alarm-level outlier in the forthcoming National Maternity and Perinatal Audit (NMPA) report for postpartum haemorrhage of greater than or equal to 1500mL, which covers births in 2023.

'We are writing to you because St George's University Hospitals NHS Foundation Trust has been identified as a potential alarm-level outlier for one or more of these three indicators, as detailed in the table below. This means that the indicator lies outside the expected range of values for a trust/board of this size, with a result that is higher than the upper 99.8% control limit (greater than 3 standard deviations (SD) above the mean). This is not necessarily an indication of poor performance, but it does require investigation".

The Trust was required to respond by 25 March 2025; however, the Trust requested a further period of time to ensure a robust response, which was then submitted on 1 April 2025. A deep dive into PPH data for 2024, has been completed and is described at section 4.10 (also see Appendix 3).

4.9 Care Quality Commission (CQC) Inspection 2023

Following the CQC inspections in 2023 SGUH had 15 MUST Do actions and 6 SHOULD Do actions. ESTH has 9 MUST Do actions and 4 SHOULD Do actions. The following actions are outstanding as of 14 April 2025. These actions will be completed by the end of June 2025.

ESTH	
MUST Do 2	The service must ensure that premises and equipment are suitable and fit for purpose (Epsom and St Helier sites)

SGUH	
MUST Do 2	The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night.
MUST Do 5	The service must ensure that all staff groups complete mandatory training in a timely way.
MUST Do 7	The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments.
MUST Do 11	The service must ensure all staff are provided with annual developmental appraisals.
MUST Do 12	The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems
MUST Do 14	The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them.
SHOULD Do 3	The service should ensure it takes account of the Workforce Race equality Standards to provide equity for staff from ethnic minority groups.
SHOULD Do 4	The service should formalise a second consultant ward round on the labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations.
SHOULD Do 5	The service should examine its culture and involve staff in improving it, including staff members with protected characteristics under the Equality Act 2010.
SHOULD Do 6	The service should improve executive knowledge of and involvement in maternity services, including but not limited to, growth of the maternity safety champion role and health inequalities for women and birthing people who use the service.

4.10 Post-Partum Haemorrhages (PPH) review – SGUH

SGUH had a total of 41 moderate harm outcomes in Nov/Dec 2024, of which 22 were for post-partum haemorrhages. Following a detailed discussion about the high rate of PPHs, at February's Quality Committees in Common, the Chair requested further information to better understand what is driving this, outside of being a referral centre for placenta accreta patients. The deep dive for data covering PPHs in 2024, is included in this report at Appendix 3.

A review of the audit data suggests that there is an association between PPH and vaginal delivery following induction of labour and with forceps delivery. The following actions are being taken to reduce PPH rates, raise awareness and improve prevention and management of PPH:

- Introduction of Carbetocin (a vasoconstrictor) for caesarean and instrumental deliveries in theatre.
- Provide PPH staff awareness weeks bi-annually beginning in quarter 1 2025/2026
- Introduction of PPH station within mandatory PROMPT training.
- Instrumental delivery teaching for trainees.
- Aligning our maternity dashboard with Maternity Services data set (MSDS) metrics to ensure consistent reporting.

4.11 Maternal death 3 March 2025 at SGUH (Datix DW223760) – immediate actions

A maternal death occurred at SGUH on 3 March 2025. The mother had booked at 9+1 weeks and had a history of hypertensive disorders (since age 20) and cardiomyopathy for which she was under the care of the SGUH cardiology team. She had a BMI of 41. She received joint antenatal care with maternal medicine and the hypertension clinic. On 28/02/2025 (33+0 weeks) the mother was admitted to the antenatal ward. Her condition deteriorated during her admission, and she sadly died on 3 March 2025 at 03:03hr. Her baby boy was admitted to the neonatal unit, where he has since been discharged home and is doing well. Both verbal and written duty of candour occurred. On 15 April 2025, her husband and her mother were seen by the bereavement midwife and Consultant Obstetrician to advise that the initial investigation has identified gaps in care. This is being further investigated, and immediate actions have also been identified at the internal Central Incident Review Group.

The case was accepted by Maternity and Newborn Safety Investigation (MNSI) Team for a maternal death investigation. MBRRACE, SWL ICB, NHSE Maternity Regional Team and CQC have been informed.

4.12 Diabetes Service at SGUH

As previously reported, the Consultant Obstetric Lead and Consultant Midwife for Maternal Medicine have raised significant concerns regarding the current capacity to provide timely care for women diagnosed with gestational diabetes. There has been a marked increase in the number of women requiring specialist diabetic antenatal care, which now exceeds the available clinic capacity. As a result, women are waiting longer than the locally agreed standard of two weeks for review by the specialist midwife.

This delay presents a clinical risk, particularly given that NICE guidance recommends more frequent and timely contact with healthcare professionals during pregnancy to optimise diabetic control and reduce risks to both mother and baby.

Capacity constraints are being reviewed with support from the Women's Health Operational Team; however, staffing issues within the diabetic midwifery team are compounding the problem.

Employee Relations support has been requested to address the staffing issues with the aim of ensuring a fair and equitable resolution that supports both staff wellbeing and the delivery of a safe and effective diabetes service.

5.0 Successes

5.1 ***MBRRACE-UK:*** The MBBRACE-UK Perinatal Mortality Report for 2023 has confirmed that SGUH is not a negative outlier for either stillbirth or neonatal death.

5.2 It is anticipated that ESTH will receive the 10% rebate from their CNST contribution.

6.0 Actions and what success will look like

6.1 All MUST and SHOULD dos that were issued to ESTH and SGUH by the CQC in the 2023 inspections of maternity services will be completed by end of June 2025 (deferred from the original deadline of 31 March 2025).

6.3 SGUH is awaiting the outcome of their appeal against the decision of being non-compliant for MIS Year 6.

7.0 Next steps

7.1 Finalise the integrated maternity improvement plan for SGUH by May 2025 (deferred from the April agenda to the May meeting).

7.2 Respond to the CQC inspection report in respect of their inspection of SGUH maternity in October 2024 (once received)

7.3 Agree the leadership structure for Maternity Services across gesh and commence recruitment to substantive posts.

8.0 Recommendations

8.1 Quality Committees-in-Common is asked to:

a) Note the maternity service updates and the key risks and issues for escalation.

b) Consider any aspects where further assurance is required.

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Appendix 1

ESTH - Perinatal Quality Surveillance Model Data

January and February 2025

Presented by:
Natilla Henry
Group Chief Midwifery Offer

24th April 2025

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Background and Overview

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) at every meeting.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

Epsom And St Helier University Hospitals NHS Trust

CQC Maternity Ratings	Overall	Safe	Effecti	Caring	Well-Led	Responsive
	Requires Improvement	Requires Improvement	Good	Good	Requires Improvement	Outstanding

Maternity Safety Support Programme	Yes

	2025											
	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Findings of review of all perinatal deaths using the real time data												
Findings of review all cases eligible for referral to MNSI.												
Report on:												
The number of incidents logged graded as moderate or above and what actions are being taken, serious incidents declared, serious incidents closed and progress on action plans												
Training compliance for all staff groups in maternity related to the core competency framework and wider job essential training												
Minimum safe staffing in maternity services to include Obstetric cover on the delivery suite, gaps in rotas and midwife minimum safe staffing planned cover versus actual												
Service User Voice feedback												
Staff feedback from frontline champions and walk-abouts												
HSIB/NHSR/CQC or other organisation with a concern or request for action made directly with												
Coroner Reg 28 made directly to Trust												
Progress in achievement of CNST 10												

Proportion of midwives responding with 'Agree or Strongly Agree' on whether they would recommend their trust as a place to work or receive treatment (Reported annually)	59%
Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually)	70%

RAG Rating	Explanation
Green	All parameters within normal limits, progress being made with action plan within anticipated time period, or action plan created
Amber	Progress with action plans not within anticipated time limit
Red	Issues identified, new reports available

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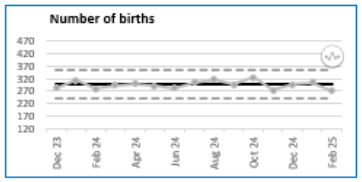
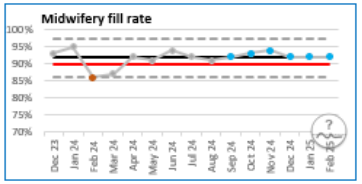
Outcomes Dashboard

Maternity overview ESTH

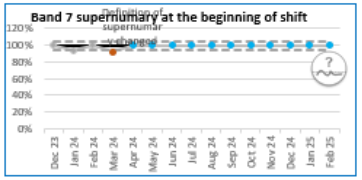
Latest month 01/02/25
Number of births 272
No significant change



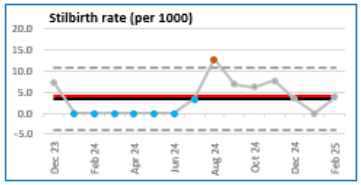
Latest month 01/02/25
Midwifery fill rate 90%
Significant Improvement



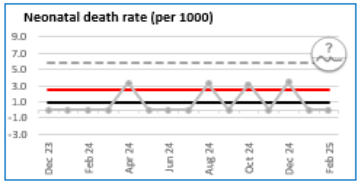
Latest month 01/02/25
Supernumary status 100%
Significant Improvement



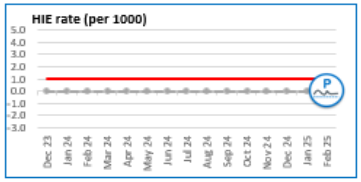
Latest month 01/02/25
Still birth rate/1(3.7
No significant change



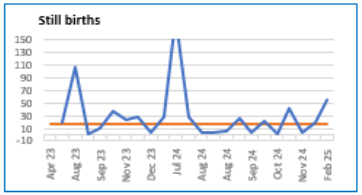
Latest month 01/02/25
Neonatal Death 0.0
No significant change



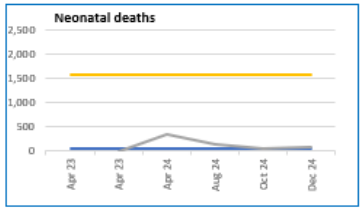
Latest month 01/02/25
HIE rate/1000 0.0
No significant change



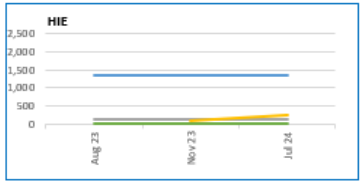
Date of last stillbirth ######
Average days between 17.0
No significant change



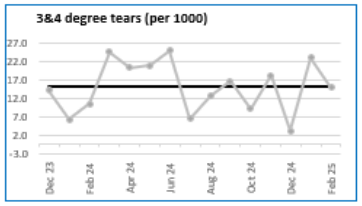
Date of last neonatal death 29/12/24
Average days between 69.2
No significant change



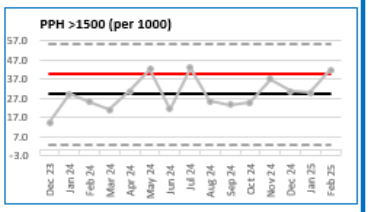
Date of last HIE ######
Average days between HIE 148.7
No significant change



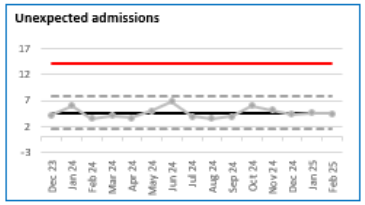
Latest month 01/02/25
3&4 degree tears (per 1000) 15.2
No significant change



Latest month 01/02/25
PPH >1500 (per 1000) 41.7
No significant change



Latest month 01/02/25
Unexpected admissions to NNU ATAIN 4.5
No significant change



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Risks – High and Extreme (10 and above)

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

Description of Risk	Review Date	Update	Current Risk Level	Risk Owner
Lack of 2nd obstetric operating theatre at Epsom	31/05/2025	Work has now started to convert Rose Room into a 2nd theatre	Extreme	Annabelle Keegan
General environmental issues were highlighted during the 2023 CQC inspection	31/07/2025	Work to sound-proof the STH bereavement room has been completed; work to increase the unit footprint to accommodate triage is planned.	Extreme	Kathryn Hughes
Maternity lift breakdowns restricting access to labour and maternity wards and risk of entrapment for staff and patients	31/07/2025	An external lift was installed at STH but this does not give access to the main building (main theatres) as does not go down to basement level. At EGH contingency measures are in place through SWLEOC.	High	Annabelle Keegan
Nitrous Oxide exposure on Labour Ward	31/07/2025	The second round of room testing is currently underway. The HoM has provided details of the rooms in which Entonox is used to Estates for further action.	High	Annabelle Keegan
Our current staffing establishment only allows backfill for 23 hours of mandatory training and this is not sufficient to cover essential and nationally mandated training. SGUL by contrast have 34 hours per year.	31/07/2025	This is currently unresolved due to financial constraints.	High	Natilla Henry
The maternal assessment unit (MAU) at EGH is located in a separate building to Labour Ward	31/07/2025	There is a SOP and process in place to control the risk. Work to increase the unit footprint to accommodate MAU is planned.	High	Annabelle Keegan

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Perinatal Mortality

- **ESTH Data from the PMRT data tool**

	Feb 2024 – Jan 2025	Mar 2024 – Feb 2025
Antepartum stillbirths	11	12
Intrapartum stillbirths	0	0
Stillbirth (unknown timing	1	1
Early neonatal death	4	4
Late neonatal death	1	1
	(17)	(18)
<24 weeks	2	2
24 – 27 weeks	5	5
28 – 31 weeks	2	2
32 – 36 weeks	4	5
37 – 41 weeks	4	4
≥ 42 weeks	0	0

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 birth has shown that ESTH are average when compared with similar Trusts for neonatal death (up to 5% higher or up to 5% lower) and high than average for stillbirth (more than 5% higher). This shows a worsened position from the 2022 report.

- **Cases discussed, themes and open actions (please also see Appendix 1)**

PMRT Panel	Cases reviewed Nov/Dec 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date
ESTH: 4 panel meetings held 10/01/2025, 31/01/2025, 14/02/2025 and 19/02/2025. There was an external panel member at both the February panels)	INC-161101 INC-162556 INC-162505 INC-164940 INC-159711 INC-164880	No new clear emerging themes identified to date that contributed to the deaths, but the panel has noted that there is a trend of not completing partograms/observations in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes).	There is one on-going action due 31/10/2025, for the Fetal Monitoring Midwife to add a case study to mandatory CTG training.

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MBBRACE-UK 2023 Perinatal Report

The MBRRACE-UK perinatal mortality report: 2023 births was published in February 2025. The key messages were:

- ESTH's stabilised and adjusted stillbirth, neonatal death and extended perinatal mortality rates were around average for similar Trusts and Health Boards.

- When deaths due to congenital abnormalities were excluded, ESTH's rates for stillbirth and extended perinatal mortality was 5% higher than other similar Trusts and Health Boards; the neonatal death rates were around average.

The recommendation action from MBRRACE-UK was to review the data to ensure accuracy and ensure that a PMRT review has been carried out for each case to identify actions.

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Background and Overview

In 2023, there included 3 cases of women who did not receive care at our Trust prior to the death of the baby (2 concealed pregnancies and one transfer from the Midlands for social reasons); had these cases not been attributed to the Trust our rates would have been around average for similar Trusts and Health Boards (amber)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	15	4.06	2.98	(2.46 to 3.80)	Up to 5% higher or up to 5% lower
Neonatal	3	0.81	1.02	(0.64 to 1.64)	Up to 5% higher or up to 5% lower
Extended perinatal	18	4.87	4.00	(3.49 to 5.20)	Up to 5% higher or up to 5% lower

Perinatal mortality (excluding deaths due to congenital anomalies)

Type of death	Number	Crude rate	Stabilised & adjusted rate (95% C.I.)		Comparison to the average for similar Trusts & Health Boards
Stillbirth	15	4.06	2.94	(2.26 to 4.66)	More than 5% higher
Neonatal	3	0.81	0.72	(0.44 to 1.09)	Up to 5% higher or up to 5% lower
Extended perinatal	18	4.87	3.65	(2.96 to 5.58)	More than 5% higher

MBRRACE -UK Data	2019	2020	2021	2022	2023
Stillbirth	9	9	13	6	15*
Neonatal Death	5	6	1	2	3
Total	14	15	14	8	18*

Up to 5% higher or up to 5% lower (same as average)
More than 5% higher than average
More than 5% and up to 15% lower than average

Reported cases - 2023

MBRRACE-UK Ref	Date of birth/death	Gestation at birth	Eligible for PMRT/ Grading	Ethnicity	In/out of area	Post-mortem	Additional information
85599	19/01/2023	38+6/40 BMI 25.5 Smoke - N	Yes AA	White	Out of area	No – the death was a result of placental abruption.	This case was investigation by HSIB; they did not make any safety recommendations.
86143	19/02/2023	24+4/40 BMI 23 Smoke N	Yes B A	White	In area	Yes – small placenta with maternal vascular malperfusion and retroplacental haemorrhage.	No further information.
86456	12/03/2023	24+4/40 BMI 35.7 Smoke N	Yes A A	Other Asian	Out of area	Yes – small placenta with findings of diffuse chorionic hemosiderosis and chronic deciduitis.	No further information.
86535	15/03/2023	22/40 BMI 38.4 Smoke N	Yes A A	White	In area	No	This woman was not booked for antenatal care as did not realise she was pregnant; she presented to the ED with weight gain where the IUD was diagnosed.
86743	30/03/2023	27/40 BMI 26.1 Smoke N	Yes A A	Chinese	In area	Yes – acute necrotising chorioamnionitis and acute necrotising funisitis due to possible PPROM	No further information.
87066	19/04/2023	22+4/40 BMI 24.9 Smoke N	Yes A B	White and Black Caribbean	In area	Yes – Cause of death undetermined.	Death attributed to late miscarriage.

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MBRRACE-UK Ref	Date of birth/death	Gestation at birth	Eligible for PMRT	Ethnicity	In/out of area	Post-mortem	Additional information
87098	20/04/2023	26+5/40 BMI 23.7 Smoke N	Yes B A	Pakistani	Out of area	No – death attributed to infection identified from placental histology.	This woman was not book at ESTH. All care was provided in Birmingham where the IUD was diagnosed; she was transferred to ESTH for delivery only to be near family.
87235 (NND)	28/04/2023	37/40 BMI 37.6 Smoke N	Yes B B B	White	In area	Yes – attributed to birth asphyxia, although the blood gases at birth showed no evidence of this.	This death occurred following planned caesarean section (previous CS and 3 episodes of RFM). This case is subject to a Coroner's inquest.
87280 (NND)	20/04/2023 (date of death 28/04/2023)	36+6/40 BMI 26 Smoke N	Yes A B A	White	In area	Yes –Enteroviral infection (Coxsackievirus)	No further information.
87401	09/05/2023	33/40 BMI 27.5 Smoke N	Yes C A	Indian	In area	No	The cause of death was attributed to chorioamnionitis secondary to maternal E coli infection.
87992	16/06/2023	23+4/40 BMI 29 Smoke N	Yes B A	White	In area	No – the death of twin 2 was attributed to late miscarriage secondary to placental abruption/chorioamnionitis.	Twin pregnancy with feticide of Twin 1 for Trisomy 18.
89175	25/08/2023 (twins)	25+2/40 BMI 20.3 Smoke N	Yes B A	Pakistani	Out of area	No	The deaths were attributed to acute twin to twin transfusion syndrome.
89220	03/09/2024	38/40 BMI 31.6 Smoke N	Yes B A	Bangladesh	In area	No	This case was investigated by HSIB who identified inconsistent use of interpreters; however, the report contained no safety recommendations

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MBRRACE-UK Ref	Date of birth/death	Gestation at birth	Eligible for PMRT/ Grading	Ethnicity	In/out of area	Post-mortem	Additional information
89837	11/10/2023	33+5/40 BMI 21.9 Smoke N	Yes B A	White	In area	No	The cause of death was undetermined. This was a twin pregnancy and the death was confirmed at 24+5/40.
90188	03/11/2023	31+4/40 BMI 25.6 Smoke N	Yes B B	White and Black Caribbean	Out of area	Yes – HIE attributed to maternal vascular malperfusion and retroplacental haematoma.	No further information.
90672	02/12/2023	38+1/40 BMI 26.8 Smoke N	Yes B A	Black African	In area	No	The cause of death was not determined. The woman transferred her care to ESTH at 34+1/40 from Leeds.
90702	05/12/2023	36+1/40 BMI 26.1 Smoke N	Yes B B	White	In area	Yes – true knot in the umbilical cord with associated placental problems.	No further information
86003	05/02/2023	Estimated 40/40	N	White and Black Caribbean	Out of area	N/A	This woman delivered at home and the baby died at home. She was not booked for care with ESTH but was brought into ESTH via the ED by ambulance.

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Grading of care

A PMRT review was completed for all eligible cases and 14 of the 17 reviews (82%) included an external panel member.

Of the cases reported in 2023, 1 case had issues identified which the panel concluded may have made a difference to the outcome (C);

- The woman was not given explicit advice of the signs of infection and when to re-attend the unit. The panel felt that had the woman been given clearer information she may have attended sooner, and this could have changed the outcome. This has been shared and strengthened guidance is now in place in line with RCOG.

In all other cases, the grading was A (no issues identified) and B (issues identified that would not have made a difference to the outcome. These issues included the need to review our blood test set following stillbirth with the regional team, ensuring women had written information around reduced fetal movements, the use of a partogram in intrauterine death cases and the frequency of maternal observations.

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Findings

- 3 cases (amber) reported did not receive any maternity care from ESTH up to the point that the baby died; this has adversely affected our stabilised and adjusted mortality rate when congenital abnormalities are excluded.
- Excluding the 3 cases, our rate would have been similar to other Trusts.
- 8 of the 15 cases who received care with ESTH occurred in women from a non-white background; this shows that the perinatal mortality rate is higher for women from a Global Majority background, but analysis of 2024 cases has shown that this has improved to 50% against a split of 64.4% from a white background and 35.6% from a non-white background.
- In the 8 women who consented to a postmortem 5 had placental issues identified (one of which also had infection identified); 2 deaths were attributed to infection and one to birth asphyxia (although the cord gases were normal).
- Of the 9 women who did not have a postmortem, 4 did not have a cause of death determined.
- There were no obvious themes identified.

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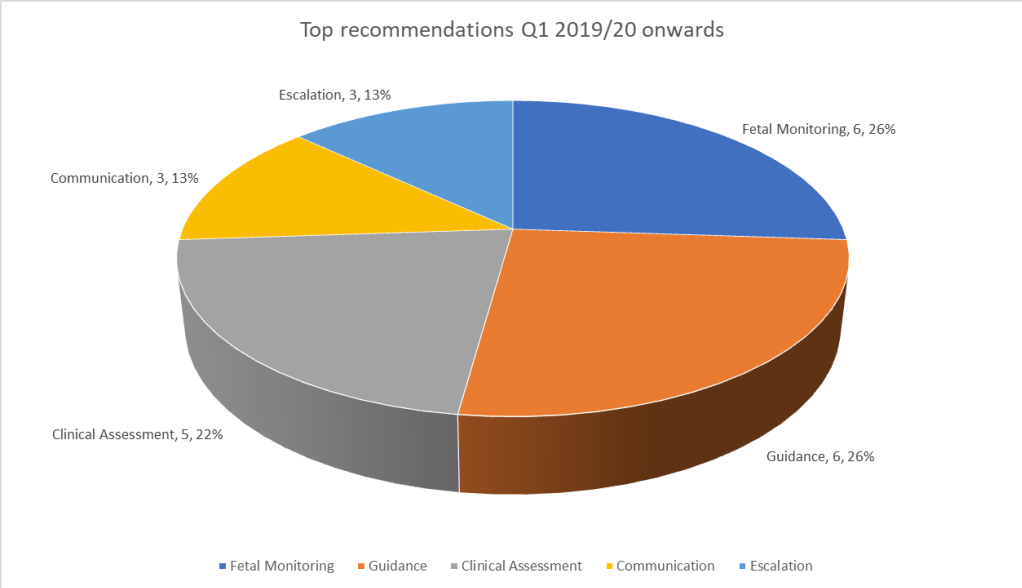
MNSI Cases

- There are currently no cases open with MNSI. There were 2 cases closed with MNSI during Jan/Feb 2025.
- One case was closed with no safety recommendations, and this was presented to Trust PSIR Panel in March 2025. We will be strengthening our antenatal CTG guidance in response to the MNSI report.
- The other case had 4 safety recommendations; an action plan had already been agreed by a Trust MDT learning response in response to concerns identified by the Trust
- The actions planned relate to care on the Birth Centre and included risk assessment, informed consent, management of intermittent auscultation and management of blood-stained liquor.
- There are no other open actions in response to MNSI reports.



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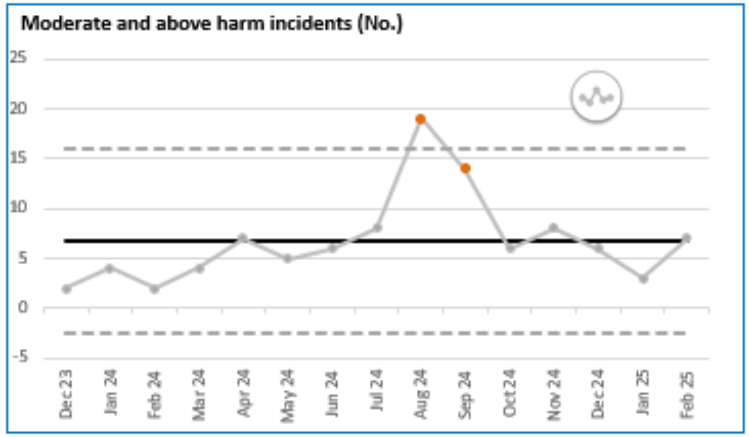
Moderate and above Harm Outcomes

In January 2025 there were 3 moderate harm outcomes identified; these related to:

- Postpartum haemorrhage (1)
- Term baby admitted to the NNU(1)
- Missed high vaginal wall tear (1)

Of the 3 incidents, 2 have been presented to the Maternity Incident Review Panel and an AAR is being completed; the PPH is awaiting an initial review and will be downgraded is care was as expected.



In February 2025, there were 7 moderate harm outcomes identified; these related to:

- Post-partum haemorrhage (4)
- 3rd/4th degree tear (2)
- Stillbirth (1)

The stillbirth case has been reported to MBBRACE-UK and will undergo a PMRT panel review; all other cases are currently under review.

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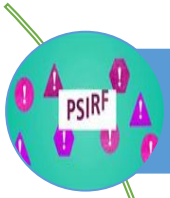
PSIIs/Learning/Themes



There are currently no open actions from PSIIs/legacy SIs. The action from the most recently completed PSII (guidance for uterine inversion) has been completed and the guidance is awaiting upload to VICTOR.

During January and February 2025, 6 investigations were closed; 3 were closed through review by the PMRT panel (see separate PMRT report on the CNST update slides), 2 were MNSI cases and 2 1 was closed following an MDT learning response.

There are currently 5 open investigations/learning responses; 3 cases are being reviewed by the PMRT panel and 2 are undergoing after action review (AAR). Both cases undergoing AAR have had MDT panels.

We have found that the SWARM and rapid AAR approach does not always fit well with the Maternity Specialty as, in order to undertake a meaningful review for learning, we need to look back over the whole of the antenatal care. Whilst this means our AARs may take longer, this is the right thing to do to gain a meaningful outcome and learning.

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Incident themes (PSIRF)

Top 5 Incidents January 2025

The majority of incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in January 2025 were:

- Readmission of baby (10)
- Term baby admitted to the neonatal unit (9)
- 3rd degree perineal tear (9)
- Blood loss >1500mls (11)
- Maternal readmission (6)
- Postnatal delay in procedure (6)
- Antenatal delay in care or procedure (6)

Top 5 Incidents February 2025

- Readmission of baby (23)
- Blood loss >1500mls (10)
- Guidelines not followed (4)
- Term baby admitted to the neonatal unit (4)
- Postnatal delay in care (5)
- Maternal readmission (9)

This indicates a relatively stable position over time and further information is included on the Outcomes Dashboard (slide 3). Detailed information is provided monthly to the Trust PSIR Panel via the specialty's DIRG Report.

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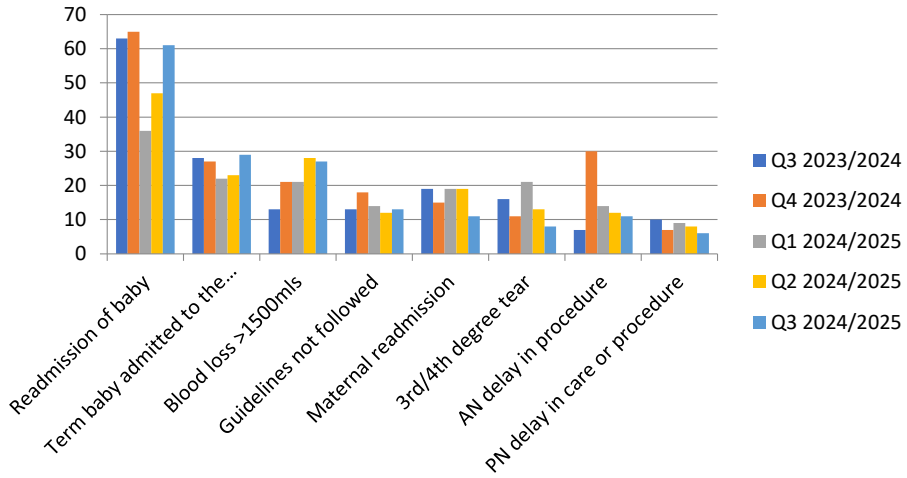
Incident themes Quarterly analysis/QI (PSIRF)



As readmission of babies has consistently been our most frequently reported incident and has a significant impact on both families and the service, we have commenced a deep dive audit and will present the findings and recommendations when the audit has been completed.

Our current PSIRP (areas for local focus below) now needs to be updated in response to our on-going analysis of incident themes:

1. PPH >1500mls has shown consistency over the last 15 months; we have only showed as above the national average on 2 of the last 15 months (National Maternity Dashboard).
2. CTG – we have well-embedded processes associated with audit, training and review with a specialist midwife and consultant in post.
3. There have been low numbers of maternal admissions to HDU with no themes or trends identified.

We are currently progressing a maternity-specific PSIRP; an-depth analysis of incidents is currently being undertaken to inform this, but this will include readmission of babies as one of the areas for local focus.

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Training Compliance

Type of Training and % compliance	Staff Group	ESTH Dec 24	ESTH Jan 25	ESTH Feb 25
PROMPT 90%	Midwifery Staff	94%	97%	93%
	Maternity Support Workers	93%	93%	92%
	Consultant Obstetricians	97%	97%	97%
	Trainee and Staff Grade Obstetricians	100%	80%	79%
	Anaesthetics	100%	98%	98%
CTG Training 90%	Midwifery Staff	95%	97%	93%
	Obstetricians	97% Cons/95% MG	93% Cons/94% MG	87% Cons/100% MG
NLS (Newborn Life Support) 90%	Midwifery Staff	95%	97%	93%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	100%	100%	100%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

Training compliance as at 30/11/2024 (01/12/2023 – 30/11/2024) was greater than 90% and therefore we are compliant with the CNST Maternity Incentive Scheme Year 6. Figures are still not being routinely provided by the neonatal service and this has been escalated so that a robust process for reporting compliance monthly can be established. Compliance dropped in February 2025 due to A/L within the team. There has been an increase in non-attendance from obstetric medical staff from the beginning of 2025 – compliance is expected to increase through the projected attendance list.

All new starters (obstetric medical staff) attend CTG and PROMPT training within 3 months of their start date. Neonatal medical staff attend NLS/BLS as part of their induction when they start.

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Safe Staffing

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Staff Group	Measure	Dec 2024		Jan 2025		Feb 2025	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		92%	92%	91%	92%	92%	92%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	
Neonatal Nursing		94%	95%	95%	97%	91%	96%
Neonatal Medical		92%	100%	92%	96%	92%	96%

The 6 monthly staffing report was submitted to QCiC in October 2024.

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Service User Feedback (complaints, FFT, PALS, MNVP and actions)

COMPLAINTS
We received 4 complaints in January and 4 complaints in February 2025; 4 complaints related to early pregnancy and included care in the ED as part of the complaint; 2 complaints related to postnatal care, 1 complaint related to safeguarding and 1 complaint related to the management of jaundice (which was appropriate on review).

PALS
During January and February 2025 there were 26 contacts; 9 contacts were regarding confirmation of appointments/self-referral and requesting birth debrief appointments. Other recurring themes included positive comments about care (6), community midwife concerns (2), other clinical concerns (3). There was one request for notes and one contact from a family member which was referred to the Safeguarding Team due to concerns around coercive control. 4 concerns were referred as complaints (included above).

FFT (112 responses in October 2024 - latest) - positive feedback:

- ✓ Personalised care
- ✓ Maternity vaccination service
- ✓ Being seen in a timely manner
- ✓ Infant feeding
- ✓ General comments about the excellence of the service and staff

FFT - YOU SAID/WE DID

There were comments around visiting hours, community midwifery care, waiting times in MAU.

We are reviewing MAU to ensure there is medical cover in place to reduce waiting times. Staff have been reminded to ensure woman are give the ***'Welcome to the Maternity Unit'*** leaflet which explains the visiting policy.

ACTIONS – There have been a number of general reminders issued to staff in response to complaints.

To ensure women reinforce to women the need to bring their own formula milk if they wish to artificial feed. Also, actions to remind staff to use professional language at all times and sign-post women to information leaflets.

MNVP – Positive feedback for antenatal care/support and women could not speak highly enough of care in labour. There were lots of positive comments around care on the Birth Centre. There were mixed comments around breastfeeding support on the postnatal ward. More information is required around induction of labour, specifically around timescales, and there were some instances where women felt decision making was taken out of their hands.

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Concerns (MNSI/NHSR/CQC/Regulation 28)

There are no current MNSI letters of concern

There are no current NSHR concerns

The CQC rating for the Maternity Service is 'Requires Improvement' and an action plan is being progress, and reviewed through the Evidence Assurance Panel – ESTH alongside SGUL have entered onto the Maternity Support Programme

There are no current Regulation 28 Reports (reports to prevent future deaths issued by a Coroner)

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Safety Champions (staff engagement/feedback/walk-arounds etc.)

- A staff engagement event took place on 18th February 2025 and the dashboard of current on-going concerns was shared with staff beforehand.
- Quarterly staff engagement events are embedded and have been in place throughout the CNST period.
- A separate Safety Champions Report is submitted to QCiC which includes details of all engagement events, visits and walk-arounds and actions taken in respect of any concerns raised.
- Current issues include triage space and staffing, staffing for the vaccination clinic, on call concerns (lack of Trust Policy and lack of permanents audit midwife. Concerns on-going from previous events include IT issues, issues with prolonged secondments and estates issues.

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Include cultural improvement plans/survey/SCORE survey

Proportion of specialty trainees in Obstetrics & Gynaecology responding with 'excellent or good' on how would they would rate the quality of clinical supervision out of hours (Reported annually) – ***70% (2023)***

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Thank you.

For any other information, please see:

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Appendix 2

SGUH – Perinatal Quality Surveillance Model Data

January and February 2025

Presented by:
Natilla Henry
Group Chief Midwifery Officer

April 2025

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Background

In 2020, NHSE implemented the revised Perinatal Quality Oversight Model. As part of this, in partnership with their LMNS and Regional Maternity Team, local Maternity Units are required to report on a defined set of agreed measures, including as a minimum those defined by NHSE and the LMNS.

As a requirement of the Maternity and Neonatal Incentive Scheme (Safety Action 9), these defined measures should be shared with the Trust Board (or delegated sub-committee) at every meeting.

These slides include the agreed Perinatal Quality Surveillance Model measures in line with the requirements of the LMNS and NHSE.

Outcomes dashboard

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Maternity overview | St Georges Maternity Unit

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Risks – Moderate and above

SGH-Title of Risk	Update	Current Risk Level
FMU laser stack	Stack arrived 10 April 2025, but data transfer not yet done. Laser not yet requisitioned.	Extreme
Meeting patients, mother and/or baby safety in line with regulatory standards	Newly approved risk (February 2025) following CQC Section 29a	Extreme
Infrastructure damage/sewerage flooding on the maternity unit	Action plan in place with Estates. Escalation for any issues logged with estates	High risk
Multiple Information Systems Migrating to a single digital platform. Project underway. To launch Feb 2025	New IT single documentation system went live on 8th February 2025. Risk score for review	High risk
Provision of Home Birth service	Risk for de-escalation at next Divisional Governance	High risk
Closure of Birth Centre	Risk for de-escalation at next Divisional Governance	High risk
Euro king back copying and forward copying IT risk	National risk identified. Cerner being launched Feb 2025	High risk
Viewpoint 5 servers and application out-of-support IDT is working with Med Physics and clinical services to transition to V6 Viewpoint and integrate this with iCLIP. Risk description updated to add risk and impact; controls added.	Awaiting transition to V6 Viewpoint	High Risk
Diabetes team seeing 500+/year women with GDM in the same clinic for women with pre-existing diabetes. Provision of pregnancy care for women with pre-existing diabetes in an MDT clinic although this patient group forms a minority within the clinic which includes gestational diabetics and other endocrine patients	This service being reviewed with the MDT as currently no facility to expand the clinic. Weekly MDT meeting prior to clinic to support focused care	High Risk

Risks – Moderate and above

SGH-Title of Risk	Update	Current Risk Level
High level of short-term sickness	Monitoring process set up. Reports received and discussed at monthly service meeting with senior leaders sharing the impact deficit due to staff sickness shared with Quality Committee in Common, Division and site.	Moderate
Onboarding time laps for recruited midwives	Recruitment and retention midwives to have 2 touch base meetings with new recruits whilst they are waiting for the pre-employment checks to be completed	Moderate
Maternity Unit Security System	Not approved during this year's establishment review, will reassess in the establishment review in 2025. Establishment review to include 7/7 security and 7/7 reception cover on the PNW.	Moderate
Midwifery Manager on call rota	Ongoing optimisation of the Midwifery Manager on call roster. Work with division and HR to understand role of MMoC and expand team through HR processes	Moderate

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Perinatal Mortality

- **SGH Data from the PMRT data tool**

	Feb 24- Jan 25	Mar 24- Feb 25
Antepartum stillbirths	20	17
Intrapartum stillbirths	1	1
Stillbirth (unknown timing	3	3
Early neonatal death	7	7
Late neonatal death	8	4
	(39)	(32)
<24 weeks	8	7
24 – 27 weeks	8	5
28 – 31 weeks	4	5
32 – 36 weeks	8	6
37 – 41 weeks	11	9
≥ 42 weeks	0	0

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Perinatal Mortality

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- **Cases discussed, themes and open actions**

PMRT Panel	Cases reviewed November and December 2024	Emerging Themes/Learning	Open Actions from previous reviews, year to date	
During the period of January /February 2025, SGH held 3 meetings in which 6 cases were discussed. Out of the 6 cases, an external panel member was present for 2 cases.	• ID:95656-IUD • ID:96002- NND • ID:96424-IUD • ID:97027-IUD • ID:96052-IUD • ID:95651- NND	No new clear emerging themes were identified to date that contributed to the deaths of the cases reviewed. Case ID: 95651 was reported to the coroners as it was very complex case. This case was discussed end of January; however, we are waiting for the actions to be completed from the relevant teams and for the recommendations to finalize the report.	The actions from the cases discussed for the period of August 2023 to present	Actions: • ID:90977/1 - The guideline for use of the video laryngoscope is currently in development. There may be further recommendations and actions as part of the SI review. All remaining actions are closed.

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Perinatal Mortality (MBRRACE-UK Perinatal Mortality Report 2023)

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2023 birth has shown that SGUL are average when compared with similar Trusts for stillbirth (up to 5% higher or up to 5% lower) and lower than average for neonatal death (more than 5% and up to 15% lower). These are the same findings that were published in the 2022 report.

1. SGUH has a stabilised & adjusted stillbirth rate of 3.50 per 1,000 total births. This is around the average for similar Trusts & Health Boards.
2. SGUH has a stabilised & adjusted neonatal mortality rate of 2.31 per 1,000 live births. This is lower than the average for similar Trusts & Health Boards.
3. SGUH has a stabilised & adjusted extended perinatal mortality rate of 5.74 per 1,000 total births. This is around the average for similar Trusts & Health Boards.

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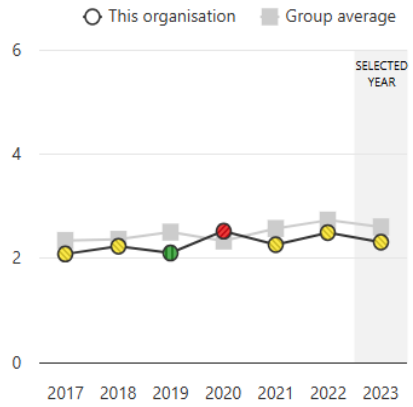
Perinatal Mortality (MBRRACE-UK Perinatal Mortality Report 2023)

St George's University Hospitals NHS Foundation Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: London

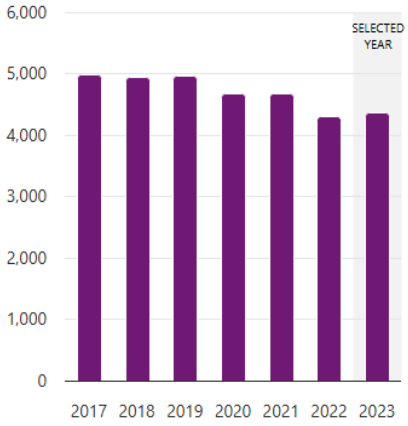
Mortality rates, by year

Stabilised & adjusted neonatal mortality rate per 1,000 live births



Births, by year

Total number of births

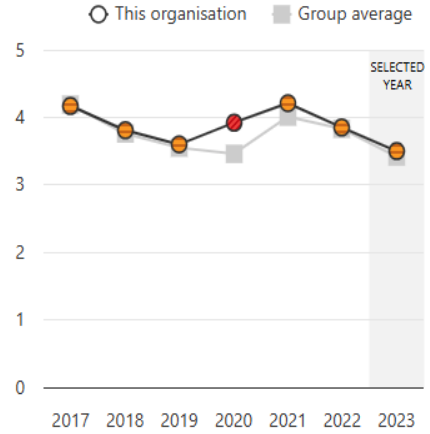


St George's University Hospitals NHS Foundation Trust

Comparator group: Level 3 NICU & neonatal surgery | Country: England | Neonatal network: London

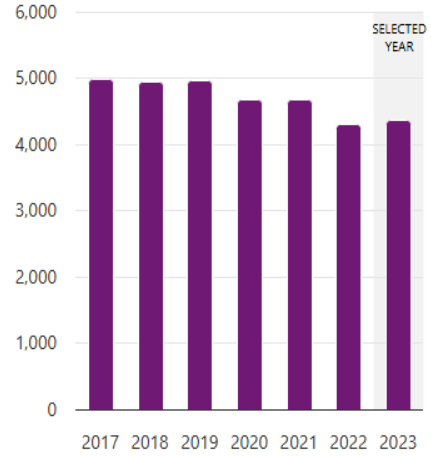
Mortality rates, by year

Stabilised & adjusted stillbirth rate per 1,000 total births



Births, by year

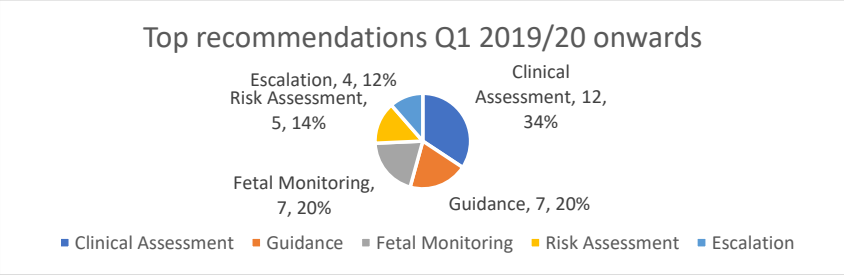
Total number of births



MNSI Cases

There are currently 7 cases open with MNSI

- One case awaiting action plan
- IUD term Draft report with family
- Cooled NNU Draft report with family
- Maternal Death AAR completed expecting draft report end of March/beginning April
- Maternal death 32 weeks MNSI, AAR completed and circulated
- HIE/NNU admission cooled AAR completed draft report in progress
- HIE/NNU admission abnormal MRI, case accepted



From: Georgia Seiti <Georgia.Seiti@mnsi.org.uk>
Sent: 19 February 2025 17:50
To: Jessica Moore ,Manjit Roseghini
Subject: RE: catch up on 03/01/2025
Dear Jess, Manjit, and Fiona,

Thank you for taking the time to meet with me today.

It was great to meet with Emily, the risk lead, and I found our discussion both positive and productive. Emily is well-informed about MNSI's work and cases and is currently organising a face-to-face QRM meeting for March.

I also provided an update on the current cases referred to MNSI that have proceeded to investigation. I will coordinate with Angela, PA for maternity services, to arrange a meeting with Fiona, Jacque (the new interim DoM), and Hugh (the new CD) at the end of March. Additionally, we will reset our monthly catch-up meetings to a time that works best for the new team.

Thank you all for your openness, engagement, and commitment to maintaining a positive working relationship with MNSI.

Best wishes,
Georgia

Case Number	Referral Date	Target Close Date	Trust	Criteria	Current Status	Plan/Notes
MI-037813	30/07/2024	30/01/2025	StG	SB	QA	SH - With the family for FA. Comments due by 25/2/25.
MI-038558	25/09/2024	25/03/2025	StG	MD	Active	Midway review this week. Interviews ongoing.
MI-038731	22/10/2024	22/04/2025	StG	MD	Active	x1 interview to complete- report writing
MI-038752	22/10/2024	22/04/2025	StG	NND	Active	Interviews completed smart 2 prep
MI-039186	02/01/2025	02/07/2025	StG	HIE/CT	Active	Preparing for SMART1 - Full family consent obtained on 23rd
MI-039196	06/01/2025	06/07/2025	StG	HIE/CT	Active	Medical records uploaded. Family contacted. SMART 1 27/2

Moderate and above Harm Cases

In January 2025 there were 29 moderate harm outcomes identified; these related to:

- Postpartum Haemorrhage (17)
- 3rd degree tear (4)
- IUD at 23+4 (1)
- Stillbirth 21+1 (1)
- Late miscarriage 18 weeks (1)
- Cord prolapse (1)
- Triage swab results (1)
- IUD 37+5 (1)
- IUT following hysterectomy ITU admission (1)

1 maternal death admitted via ED. 12 weeks pregnant unbooked. SJR completed. Referred to MNSI but declined, did not fit their criteria.

The above incidents are being reviewed through our moderate cases review meetings and actions will be made as appropriate . The baby that required cooling was referred to MNSI and the case has been accepted.

In February 2025 there were 20 moderate harm outcomes identified; these related to:

- Post-partum haemorrhage (14)
- 3rd degree tear (4)
- Baby fall (1)
- Ureteric injury (1)

The above incidents have been reviewed at moderate cases review meetings.

PSIIs/Learning/Themes

There is 1 open action from an SI. An extension was requested.
There is currently 3 open investigations, 3 PSII and 1 MDT

During January and February 2 AAR were completed

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Incident themes (PSIRF)

Top 5 Incidents January 2025

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in January 2025 were:

- Postpartum haemorrhage
- Test results
- Staffing issues
- Delays in clinics and diabetes appointments

Top 5 Incidents February 2025

Most incidents reported in Maternity Services fall under the maternity and neonatal category. The top 5 reported within this category in February 2025 were:

- Postpartum haemorrhage
- Test results
- Staffing issues
- Delays in clinics and diabetes appointments

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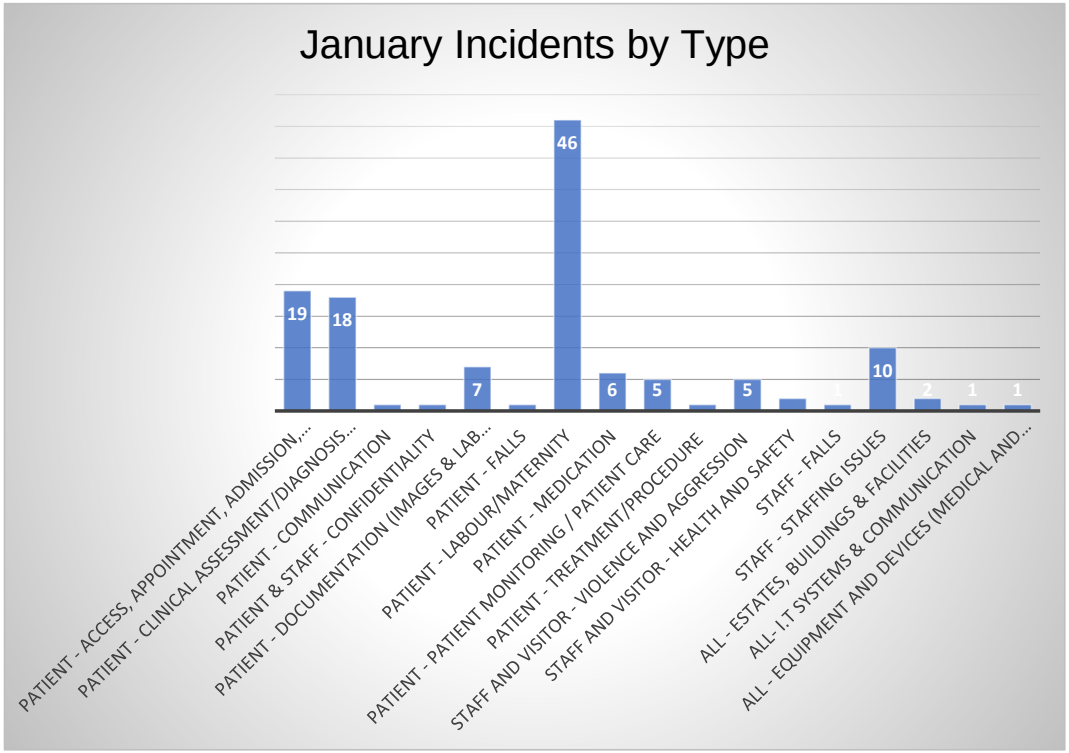
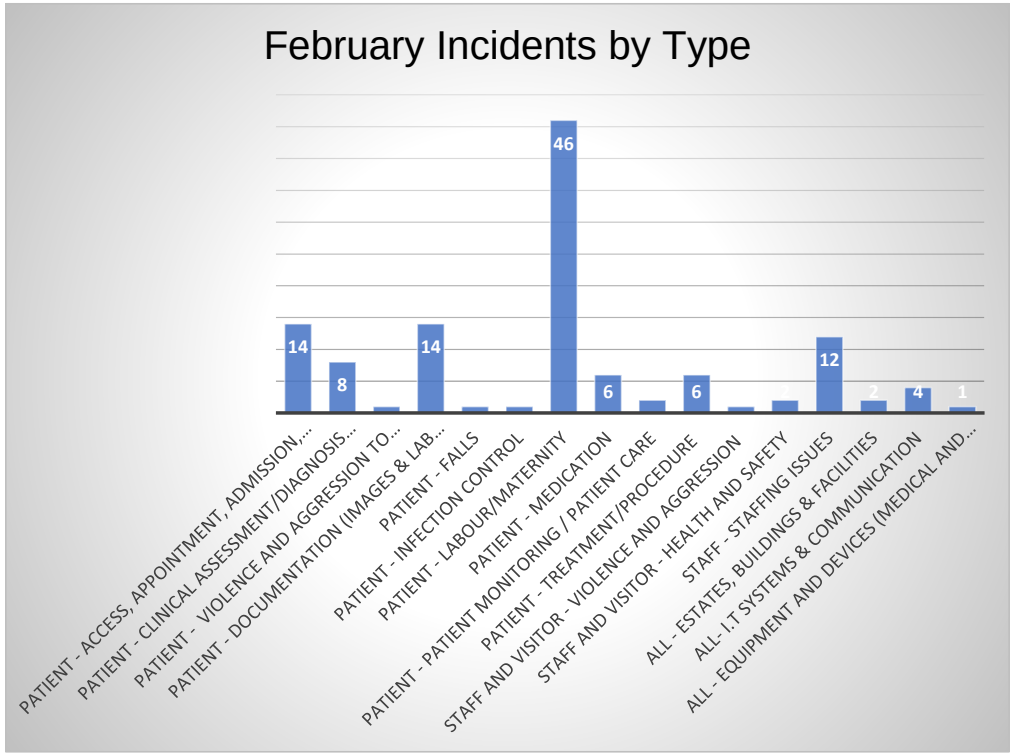
Incident types- January and February 2025





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Training Compliance

Type of Training and % compliance	Staff Group	SGH Dec24	SGH Jan 25	SGH Feb 25
PROMPT 90%	Midwifery Staff	87%	87%	88%
	Maternity Support Workers	92%	91%	93%
	Consultant Obstetricians	95%	91%	89%
	Trainee and Staff Grade Obstetricians	87%	80%	92%
	Anaesthetics	94%	100%	94%
CTG Training 90%	Midwifery Staff	92%	92%	93%
	Obstetricians	94%	91%	90%
NLS (Newborn Life Support) 90%	Midwifery Staff	88%	94%	92%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff	88%	85%	89.04%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff	100%	100%	100%

For PROMPT we are overall at 90%, which is the target.
Midwifery stats are lower due to a combination of factors:

- New starters from Jan and Feb that have not yet attended, but all are booked on to upcoming dates.
- Some staff being pulled for clinical need, meaning they are out of date before they can next attend.
- Some senior staff who consistently DNA / move their study days due to other duties/commitments.

The SBL data is accounted for by all the new starters over the last few months, it is an online module, and they are given scheduled time to complete, but due to other training and clinical pressures, this is sometimes scheduled months after they arrive.

Safe Staffing

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Safer staffing Jan 2025

St George's University Hospitals NHS Foundation Trust
Safer Staffing-Jan- 2025

Ward name	Day: Registered Nurses/ Midwives		Day: Average fill rate - registered staff (%)	Day: Care Staff		Day: Average fill rate - care staff (%)	Night: Registered Nurses/ Midwives		Night: Average fill rate - registered nurses/midwi	Night: Care Staff		Night: Average fill rate - care staff (%)
Carmen Suite	730	662	91%	366	288	79%	690	576	84%	357	333	93%
Delivery Suite	5,142	4,530	88%	1,104	851	77%	4911	4398	90%	1,058	986	93%
Gwillim Ward	2,261	2,069	92%	817	521	64%	1403	1282	91%	713	701	98%
Trust Total	124,230	120,057	97%	53,467	49,236	92%	100,814	98,418	98%	43,816	44,002	100%
			Day Qual			Day HCA			Night Qual			Night HCA
			96.64%			92.09%			97.62%			100.43%

Safer staffing Feb 2025

St George's University Hos
Safer Staffing-Feb- 2025

Ward name	Day: Registered Nurses		Day: Care Staff		Night: Registered Nurses		Night: Care Staff		Overall %
Carmen Suite	683	615	333	295	644	465	322	322	86%
Delivery Suite	4639	4120	1008	741	4,393	4030	966	942	89%
Gwillim Ward	2137	1755	674.5	618	1288	1,200	644	633	89%
Trust Total	112,386	108,954	48,598	45,797	90,677	90,145	40,079	40,814	98%
									Overall
									97.93%

	Jan 2025		Feb 2025	
Band 7 supernumerary MW allocated at start of shift	100%		100%	
Triage Staff Day 2 RM & 1 MSW	100% 1 MW & 1MSW	77% 2 MW & 1 MSW	100% 1 MW & 1 MSW	89% 2 MW & 1 MSW
Triage Staff Night 1 RM & 1 MSW	100%		100%	

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Service User Feedback (complaints, FFT, PALS,MNVP and actions)

COMPLAINTS
There were 10 complaints received in January & February 2025 for Maternity.
5 of the 10 complaints relate to poor communication from midwives.
2 relating to care during delivery
2 relating to postnatal care
1 relating to an infant fall

PALS
There were 20 PALS queries received in January & February for Maternity.
12 related to concerns with care.
5 related to birth debrief discussions
3 related to general information enquiries

FFT positive feedback

- ✓ Caring and compassionate staff
- ✓ Being seen by the same team of midwives
- ✓ Staff described as amazing
- ✓ Care in labour

FFT - YOU SAID/WE DID

The value of face-to-face classes –

Every team in the community now provides their own antenatal classes.

ANC and the Birth Centre are now launching their own face to face classes to create and equitable opportunity.

ACTIONS

A new MNVP Lead appointed – Mrs Amena Ahmed starting in Dec '24 /Jan '25.

Working with SLW core connector to prioritise communities to direct targeted classes – language/deprivation/greatest risk

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MNVP – Maternity Lead – 2025 Action Log

Maternity and Neonatal Voices Partnership (MNVP)

Action No.	Date of Meeting	Action	Lead Officer	Timescale	Comment from Lead Officer	Progress
MNVP 1	17/12/2024	Meeting to be arranged for CLW, M Montagna, G Green and L Tufari to discuss and schedule an education day for midwives and doulas	CLW		Education day arranged for in February at the Tooting Health Clinic – attended by 18 doulas – see Doula/MW joint Action Plan	Completed
MNVP 2	17/12/2024	K Ramdass to arrange for a meeting with L Tufari to discuss if doulas can not be seen as a plus one but support staff	KR			in progress
MNVP 3	12/02/2025	Amena to arrange for a potential face-to-face meeting for June's MNVP	AA	07/03/2025		behind schedule
MNVP 4	12/02/2025	Encourage staff to recruit people into the MNVP	CLW	Ongoing	Community midwives meeting presentation	in progress

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MNVP – Maternity Lead – 2025 Action Log

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MNVP – 15 steps on Gwillim ward facilitated by Consultant Midwife 21.02.2025

Welcoming and Informative:

- With regards to the space feeling welcoming – all staff are very busy (as they should be), but despite this, the ward didn't feel unwelcoming. I was able to roam freely without any questioning (with a name badge)
- I found the tube lighting and the colour of the lighting to be slightly depressing.
- The ward quality indicators could be better presented – CQC require these to be available for all to see.
- The format of some of the information (small text) was unreadable.
- Lots of helpful information is available in and around the ward on information boards, but, the problem is that it may not be placed in the best area. Considering placing information near beds/on the toilet door?
- In the parent room, there were large chairs and screens obstructing view of the information board

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MNVP – 15 steps on Gwillim ward facilitated by Consultant Midwife 21.02.2025

Safe and Clean:

There are lots of cleaners in the ward and cleaning equipment around and also the ward was fairly clean.

The toilet flush was ongoing and not coming off when observing one of the toilets.

The toilets themselves are a little old and not that inviting – I remember post-partum I just wanted to be in and out and not look around too much so I didn't feel queasy.

Hand washing posters could be better promoted – for example information about how to wash hands effectively and properly should be placed near the sink.

It is clear what job role staff member have. Yellow badges, lanyards plus the poster displayed of what each coat colour represents is very useful.

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MNVP – 15 steps on Gwillim ward

Friendly and Personal:

- Staff were friendly in my brief interaction with them.
- The reception indicated to me that was the place to go to should you want to speak to a senior staff member.
- Lots of information is available, some not relevant but lots of it is helpful but could be distributed more effectively.
- Most staff seem hurried – but this is expected as a busy ward.

Organised and calm:

- Food station had opened milk left at room temperature with no lid on.
- I couldn't find any wall decorations that promoted a sense of calm.
- Lots of equipment, mainly BP machines, were left in areas of the corridor and didn't seem to have a designated area that was signed.
- The ward is quite loud mainly because of the cleaning staff moving stuff to clean. This was the noisiest and most persistent noise I experienced.
- The "board of love" – during one of my stays at the ward which was very negative, I found the board of love to be quite pressurising. I felt a pressure that I appreciate my stay and the staff treatment regardless. This time around when I saw it, I felt as though it was there to stop some from complaining.

Concerns (MNSI/NHSR/CQC/Regulation 28)

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Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Safe staffing, Must Do 1, S29A The service must ensure staffing levels are safe and there are effective processes in place to escalate and mitigate safe staffing concerns. (Regulation 12)		100% actions completed	• Signed off at EAP September 2024	
Triage, Must Do 2, S29A The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night. (Regulation 12 (2) (a) (b))		100% actions completed	• Partial approval at EAP on 2nd Dec 2024 • 26th March 2025 for review	Lack of sufficient medical cover. Review and support medical workforce
Policies and Guidelines, Must do 3 The service must ensure adequate and up-to-date policies, pathways and guidance are in place, including implementation of a standard operating procedure in maternity triage and clear, effective escalation pathways to mitigate for risks of short staffing on women, birthing people, babies and staff. (Regulation 12)		100% actions completed	• Signed off at EAP on 2nd December 2024	
Fetal Monitoring, Must do 4 The service must ensure safe care of women in labour especially in relation to fetal monitoring. (Regulation 12 (2) (a) (b)		100% actions completed	• Signed off at EAP on 4 November 2024	
Statutory Mandatory Training **Must do 5** The service must ensure that all staff groups complete mandatory training in a timely way. (Regulation 12)		100% actions completed	• To be presented at EAP in deferred Feb meeting, 26th March	For sign off – slide deck submitted
Audit **Must do 6** The service must ensure non-compliant audits are acted upon and improvement plans put in place. (Regulation 17 (2) (a))		100% actions completed	• Signed off at EAP in Dec 2nd 2024	Audit data requirements embedded into new IT systems and Digital transformation programme (go live Feb 2025) to support full compliance. Ensure further backlog does not occur and monitor this via local governance.
Medicines Safety **Must do 7** The service must ensure medicines are stored safely and there are effective systems and processes in place to		100% actions compliant	To be presented at EAP in 2025	

Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Incident Management, Must do 8, S29A The service must ensure incidents are managed well, including but not limited to effective sharing of learning, using learning to effect change and improvement in practice, ensuring incidents are categorised, harm rated, investigated, referred for external review and reported accurately and appropriately. (Regulation 17 (2) (a) (b))		100% compliant	• Signed off at EAP in 4th February 2025	
Environment, Must do 9, S29A The service must ensure clinical areas are clean, fit for purpose and equipment is properly serviced and maintained in a timely way, including but not limited to emergency trolleys, resuscitaires and appropriate, timely portable appliance testing. (Regulation 15 (1) (a) (c) (d))		85% compliant	• To be presented at EAP in Feb 2025	Action plan with 3-month audit data for Environment audit (MITIE) to be complete Band 7 compliance for daily equipment 100% compliance for monthly audits on RATE
Governance and Communications, Must do action 10 The service must ensure governance processes are effective including but not limited to communication between staff, service leaders and trust executives, clear and up-to-date guidelines in place, acting on audit results, and appropriate incident management. (Regulation 17 (1))		100 % compliant	• To be presented at EAP in Jan 2025 deferred to 4th Feb 202	
Appraisal, Must do 11 The service must ensure all staff are provided with annual developmental appraisals. (Regulation 12)		Currently 75% compliant in Feb, an improvement from 69% .	• Presented at EAP in Feb 2025 • For review at April 2025 meeting	Sustainability of reaching and maintaining >90% appraisal rates remains challenging. DoM working on a forward plan to ensure all staff have dates booked in
Standards of documentation, Must do 12 The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems. (Regulation 17 (2))		85% actions completed	• Presented at EAP in in Feb 2025 • For review 28 April 2025	Maternity Digital Transformation programme launching Feb 2025 Maintaining documentation audit programme, with oversight at Div Gov Meeting
Safeguarding, Must do 13 The service must ensure maternity safeguarding processes are strengthened, including timely staff training, consideration of a maternity safeguarding policy, adequate availability of staff trained in safeguarding concerns, and timely actions to implement safe measures to reduce the potential for baby abduction. (Regulation 13)		100% compliant	• Signed off at EAP 27 September 2024	
Induction of Labour, Must do 14 The service must ensure that women and birthing people experiencing delays in induction of labour are managed and monitored safely, there are effective pathways in place, and that staff follow them. (Regulation 12)		100% compliant	• Signed off at EAP in September 2024 with additional	

Must Do	St Georges Hospital	Action assurance	COMPLIANT	NOT YET COMPLIANT
Bereavement, Must do 15 The service must ensure that documentation in the bereavement suite is completed contemporaneously and in full. (Regulation 17 (2) (c))		100% compliant	• Signed off at EAP - 27 September 2024	
SHOULD DO's				
Should do 1 – Fetal growth The service should ensure continued monitoring and risk assessment of the effectiveness of the fetal growth pathway to ensure the safety of unborn babies		100% compliant	• SBLCB vs3 assessed as compliant by SWL LMNS • Review again at 26 March2025	
Should do 2 – The service should ensure that national screening targets are met, in particular carbon monoxide monitoring and antenatal screening tests are performed in a timely way		100% compliant	• SBLBC vs3 assessed as compliant by SWL LMNS • SQAS review met compliance • Review again at 26 March2025	
Should do 3 – The service should take account of the Workforce Race Equality Standards to provide equity for staff from ethnic minority groups			• Capital Midwife anti-racism framework being rolled out • Development and job opportunities open to all staff • Review 26th March 2025	Gap analysis against WRES standards to be completed in conjunction with Trust EDI lead
Should do 4 – Second Ward Round on Delivery Suite The service should formalise a second consultant ward round on labour ward to ensure adequate medical oversight of patient safety, in line with national recommendations		100% complaint	• Safety Action 4 CNST meets compliance	
Should do 5 – Staff Culture The service should examine its culture and involve staff in improving it, including staff members with protected characteristics		100% Compliant	• Perinatal Culture and leadership Programme completion SCORE survey and Qi /maternity transformation programme underway	
Should do 6 – Executive oversight The service should improve executive knowledge of and involvement in maternity services, including but not limited to the safety champion role and health inequalities for women and birthing people who use the service		100% compliant	• EDS compliance • Planned programme of engagement with Executive and NED safety champions, (gesh and site specific)	

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Staff Engagement session – 18 February 2025

Issues/Concern	Actions	Lead
Tobacco Dependency The funding from the ICB for tobacco dependency comes to an end in March – this forms part of CNST requirements and 'Saving Babies' Lives' Care Bundle.	1. Speak to the ICB about the funding to see if there is anything else that can be done. 2. AW to bring to the Board's attention to consider alternatives.	**1. TBC** **2. GCNO**
Secondments Ongoing lack of security and guidance around secondment roles.	AW to raise this again with the Group People Officer to see what can be done to address these issues.	**GCNO**

Safety Champion Visits: 20 February 2025 – St George's

The Non-Executive Board Level Safety Champion visited the St George's Maternity Unit on 20 February 2025. Following the NED and Executive Safety Champions' walkaround in February, several issues and concerns were identified and have been incorporated an action plan, which is included in the Group Maternity Quality Report.

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FTSU

The SGH FTSU team confirmed that there have not been any FTSU concerns raised in Jan and Feb 2025

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Thank you.

For any other information, please see:

Appendix 2

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

Epsom and St Helier University Hospitals NHS Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/11/2023 to 28/2/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *22*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
23	6	3	13	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
7	3	0	4	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Laura Rowe
Date report generated: 31/03/2025 09:23

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 17)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	4	3	4	2	13
Antepartum stillbirths	*0*	*0*	*4*	*3*	*4*	*1*	*12*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*1*	*1*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	1	0	0	1	1	3
Late neonatal deaths (8-28 days)*	0	0	0	0	0	1	1
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	1	4	3	5	4	17
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	1	2	0	3
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	1	0	0	1
Not Applicable	0	1	4	1	3	4	13
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	1	4	3	5	3	16
No	0	0	0	0	0	1	1
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	1	4	3	5	4	17
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	1	0	0	1	2	4
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	1	0	0	1	1	3

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Report Generated by: Laura Rowe
Date report generated: 31/03/2025 09:23

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 17)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	4	3	4	2	13
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	4	3	4	2	13
Hospital post-mortem declined	0	0	0	1	2	1	4
Hospital post-mortem carried out:							
Full post-mortem	0	0	3	2	2	1	8
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	1	0	0	1	1	3
No	0	0	0	0	0	1	1
Death discussed with the coroner/procurator fiscal	0	0	0	0	1	2	3
Coroner/procurator fiscal PM performed	0	0	0	0	0	2	2
Hospital post-mortem offered	0	1	0	0	1	0	2
Hospital post-mortem declined	0	1	0	0	0	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	1	0	1
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	1	0	0	0	1
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	4	2	2	1	9
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	4	2	2	1	9
No	0	0	0	1	2	1	4

*Includes coronial/procurator fiscal post-mortems

Report Generated by: Laura Rowe
Date report generated: 31/03/2025 09:23

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 13)

Role	Total Review sessions	Reviews with at least one
Chair	19	84% (11)
Vice Chair	18	84% (11)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	18	100% (13)
Community Midwife	0	0%
External	6	46% (6)
Management Team	5	30% (4)
Midwife	123	100% (13)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	5	38% (5)
Obstetrician	40	100% (13)
Other	1	7% (1)
Risk Manager or Governance Team	39	100% (13)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 4)

Role	Total Review sessions	Reviews with at least one
Chair	4	100% (4)
Vice Chair	4	100% (4)
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	4	50% (2)
Community Midwife	0	0%
External	5	100% (4)
Management Team	4	75% (3)
Midwife	31	100% (4)
MNVP Lead	0	0%
Neonatal Nurse	1	25% (1)
Neonatologist	3	50% (2)
Obstetrician	10	100% (4)
Other	3	50% (2)
Risk Manager or Governance Team	16	100% (4)
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Report Generated by: Laura Rowe
Date report generated: 31/03/2025 09:23

Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 17)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	3	0	2	1	6
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	1	2	2	1	6
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	1	0	0	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	2	2	2	2	8
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	2	1	2	0	5
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	1	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	1	0	0	1	0	2
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	1	1
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	1	0	0	1	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	1	0	0	1	2	4
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 17)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**13 causes of death out of 13 reviews**
	Intrauterine death of an appropriately grown and developed third trimester male fetus. Findings of hypoxia ischaemic injury on examination of the brain. Placental findings of maternal vascular malperfusion and a retroplacental haematoma.
	The cause of death was undetermined
	Placental Abruption
	Intra-uterine death of an appropriately grown and developed late trimester male fetus, the cause of which is attributed to the placental findings of acute chorioamnionitis (infection) with fetal inflammatory response (necrotising funisitis) and high grade fetal vascular malperfusion.
	Placental abruption
	Intra-uterine death of an appropriately grown and developed third trimester male fetus, the cause of which is attributed to the placental findings of a tight true umbilical cord knot with associated delayed villous maturation and high-grade chronic villitis with avascular villi.
	The cause of death was undetermined
	Intra-uterine death of an early third trimester female baby at up to one week prior to delivery attributed to confirmed trisomy 21, associated congenital abnormalities and placental pathology
	The cause of death was undetermined
	The cause of death was undetermined
	The cause of death was undetermined
	The PM report found features of an acute hypoxic mode of death, the cause of which is attributed to cord entanglement, which corresponds to the clinical findings at delivery where the cord was around Raed's neck twice.
	Placental abruption and possible FNAIT as documented in the postmortem result: Intra-uterine death of a late second trimester male baby a few days prior to delivery with acute hypoxic changes and evidence of a large subarachnoid haemorrhage; screening for fetal and neonatal alloimmune thrombocytopaenia is advised. Placental examination showed a long umbilical cord with high-grade fetal vascular malperfusion and a large retroplacental clot, the latter raising the possibility of acute abruption
Neonatal deaths	**4 causes of death out of 4 reviews**
	1a. Acute perinatal asphyxia. 1b. Maternal ascending genital tract infection. The placenta was of normal weight. Histology showed acute chorioamnionitis with fetal inflammatory response, in keeping with a maternal ascending genital tract infection.
	Respiratory failure secondary to multiple dysmorphic facial features and undiagnosed congenital abnormalities as described by the post mortem examination.
	Late miscarriage and extreme prematurity (22+0).
	Sudden Unexpected Death in Infancy
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
During resuscitation the baby required intubation but this was not achieved	1	No action entered
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	1	Ongoing intermittent auscultation audit, to now include maternal observations also. A message of the week was circulated on 09.09.24 regarding appropriate intermittent auscultation in labour and maternal pulse.
The type of fetal monitoring used in established labour was not appropriate	1	Ongoing intermittent auscultation audit, to now include maternal observations also. A message of the week was circulated on 09.09.24 regarding appropriate intermittent auscultation in labour and maternal pulse.
This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately	1	A special edition of the Maternity Risk Newsletter focusing on the management and escalation of pink/ blood stained liquor was published on the 19.09.24.
This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis	1	The learning regarding the management of pregnant women with abdominal pain is to be shared at the monthly Clinical Risk Meeting, at daily labour ward safety huddles and an item to be placed in the risk newsletter. In addition, the learning will be shared with the Midwives at the Call a Midwife triage line.
This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines	1	The learning regarding the management of pregnant women with abdominal pain is to be shared at the monthly Clinical Risk Meeting, at daily labour ward safety huddles and an item to be placed in the risk newsletter. In addition, the learning will be shared with the Midwives at the Call a Midwife triage line.
This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate	1	Working party to be established to review and update the guidance. This should include the Labour Ward Lead Consultants, the Matrons and the Birth Centre Leads. The updated guidance should include the process for developing OOG plans, the process for reviewing birth plans and the process for reviewing birth plans when women attend triage.

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Table 8: Top 10 issues** raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The baby had to be transferred elsewhere for the post-mortem	10	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
		No action entered
Placental histology was performed but was not carried out by a perinatal/paediatric pathologist	5	No action entered
		No action entered
		No action entered
		No action entered
		No action entered
During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out	4	To add to mandatory risk training that when the labour assessment proforma on BadgerNet is completed, the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. This will also be fed back at the labour ward huddle and an item placed in the risk newsletter.
		Article in risk newsletter to outline PCA observations. Huddle and handover reminder of observations in labour.
		Observations should be 4 hourly for every woman who is admitted with an IUD/ threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted in a message of the week circulated to all staff, via the handovers and huddles and in the band 7 meetings.
		Clinicians to be reminded that observations should be 4 hourly for every woman who is admitted with an intrauterine death/threatened miscarriage. These women are high risk for sepsis. Once women are in labour our guideline is for hourly pulse in addition to four hourly observations. This will be highlighted at daily labour ward huddle, message of the week, at Band 7 meetings.

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This mother's progress in labour was not monitored on a partogram	4	To add to mandatory risk training that when the labour assessment pro-forma on BadgerNet is completed the partogram is automatically plotted. This must be undertaken in all cases when a mother is in labour including when she has an IUD. In addition this will be fed back at labour ward huddle and in the risk newsletter.
		No action entered
		Clinicians to be reminded that the partogram gives an overview of progress in labour and maternal wellbeing. When caring for a mother with an intrauterine death who is in labour, maternal observations must be documented in the labour assessment on BadgerNet, (this should include an hourly pulse) so the partogram is populated. If the mother has commenced analgesia and/or is contracting this information must also be documented on the partogram. All antenatal inpatient women must have 4 hourly observations. On daily ward round the frequency of observations must be reviewed. This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.
		This will be highlighted at daily labour ward huddle, Band 7 meetings and be circulated as message of the week.
During the early bereavement period the baby was not cared for in a cold cot because the cold cot was not offered	2	The Bereavement Midwife to highlight at yearly mandatory training, the importance of using a cold cot.
		No action entered
This mother smoked during pregnancy but was not offered referral to smoking cessation services	2	No action entered
		The smoking in pregnancy guideline requires review to include referral of women who live with smokers or who exclusively vape to be referred to smoking cessation service for advice.
A completed bereavement checklist was not in the notes	1	The process for uploading the bereavement documentation to BadgerNet requires review and strengthening.
Estimated fetal weights from scans had not been plotted on a chart	1	Inpatient matron to address with the clinician, and will feed back to Clinical Director and Director of Midwifery and Gynaecology Nursing.
In retrospect this mother's care should have been transferred at the start of her care in labour but her risk status was not formally assessed at the start care in labour	1	No action entered
In retrospect this mother's care should have been transferred to obstetric-led care during labour but this need was not identified	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

** There are further issues which can be downloaded directly as a spreadsheet using the Extract Issues/Factors button

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Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Task Factors - Guidelines, Policies and Procedures	1	This mother's risk status was not formally assessed at the start of her care in labour to ensure that her intended place of care in labour was appropriate
		During this mothers's labour maternal observations, commensurate with her level of risk and national guidelines, were not carried out
		The type of fetal monitoring used in established labour was not appropriate
Education and Training - Competence	1	This mother had a placental abruption during her pregnancy and there was a delay in the diagnosis
		This mother had a placental abruption during her pregnancy which was not managed according to national or local guidelines
Task Factors - Procedural or Task Design	1	During resuscitation the baby required intubation but this was not achieved
Task Factors - Decision making aids	1	This mother and/or her baby had an intrapartum complication(s) which was not managed appropriately

Report Generated by: Laura Rowe
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Appendix 2a

PMRT - Perinatal Mortality Reviews Summary Report

This report has been generated following mortality reviews which were carried out using the national Perinatal Mortality Review Tool

St George's University Hospitals NHS Foundation Trust

Report of perinatal mortality reviews completed for deaths which occurred in the period:

1/12/2024 to 31/3/2025

Summary of perinatal deaths*

Total perinatal* deaths reported to the MBRRACE-UK perinatal mortality surveillance in this period: *16*

Summary of reviews**

Stillbirths and late fetal losses

Number of stillbirths and late fetal losses reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of stillbirths and late fetal losses with issues with care likely to have made a difference to the outcome for the baby
12	1	10	1	0

Neonatal and post-neonatal deaths

Number of neonatal and post-neonatal deaths reported	Not supported for Review	Reviews in progress	Reviews completed and published ***	Grading of care: number of neonatal and post-neonatal deaths with issues with care likely to have made a difference to the outcome for the baby
9	3	4	0	0

*Late fetal losses, stillbirths and neonatal deaths (does not include post-neonatal deaths which are not eligible for MBRRACE-UK surveillance) – these are the total deaths reported and may not be all deaths which occurred in the reporting period if notification to MBRRACE-UK is delayed. Termination of pregnancy are excluded. All other perinatal deaths reported to MBRRACE-UK are included here regardless of whether a review has been started or is published.

** Post-neonatal deaths can also be reviewed using the PMRT

*** If a review has been started, but has not been completed and published then the information from that review does not appear in the rest of this summary report

Report Generated by: Melissa Claridge
Date report generated: 15/04/2025 09:47

Table 1: Summary information for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late Fetal Losses (<24 weeks)	0	0	--	--	--	--	0
Stillbirths total (24+ weeks)	0	0	0	0	1	0	1
Antepartum stillbirths	*0*	*0*	*0*	*0*	*1*	*0*	*1*
Intrapartum stillbirths	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Timing of stillbirth unknown	*0*	*0*	*0*	*0*	*0*	*0*	*0*
Early neonatal deaths (1-7 days)*	0	0	0	0	0	0	0
Late neonatal deaths (8-28 days)*	0	0	0	0	0	0	0
Post-neonatal deaths (29 days +)*	0	0	0	0	0	0	0
Total deaths reviewed	0	0	0	0	1	0	1
Small for gestational age at birth:							
IUGR identified prenatally and management was appropriate	0	0	0	0	0	0	0
IUGR identified prenatally but not managed appropriately	0	0	0	0	0	0	0
IUGR not identified prenatally	0	0	0	0	0	0	0
Not Applicable	0	0	0	0	1	0	1
Mother gave birth in a setting appropriate to her and/or her baby's clinical needs:							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Parental perspective of care sought and considered in the review process:							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Missing	0	0	0	0	0	0	0
Booked for care in-house	0	0	0	0	0	0	0
Mother transferred before birth	0	0	0	0	0	0	0
Baby transferred after birth	0	0	0	0	0	0	0
Neonatal palliative care planned prenatally	0	0	0	0	0	0	0
Neonatal care re-orientated	0	0	0	0	0	0	0

*Neonatal deaths are defined as the death within the first 28 days of birth of a baby born alive at any gestational age; early neonatal deaths are those where death occurs when the baby is 1-7 days old and late neonatal death are those where the baby dies on days 8-28 after birth. Post-neonatal deaths are those deaths occurring from 28 days up to one year after birth

Report Generated by: Melissa Claridge
Date report generated: 15/04/2025 09:47

Table 2: Placental histology and post-mortems conducted for the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
Late fetal losses and stillbirths							
Placental histology carried out							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	1	0	1
Hospital post-mortem declined	0	0	0	0	1	0	1
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive post-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
Neonatal and post-neonatal deaths:							
Placental histology carried out							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Death discussed with the coroner/procurator fiscal	0	0	0	0	0	0	0
Coroner/procurator fiscal PM performed	0	0	0	0	0	0	0
Hospital post-mortem offered	0	0	0	0	0	0	0
Hospital post-mortem declined	0	0	0	0	0	0	0
Hospital post-mortem carried out:							
Full post-mortem	0	0	0	0	0	0	0
Limited and targeted post-mortem	0	0	0	0	0	0	0
Minimally invasive PMpost-mortem	0	0	0	0	0	0	0
External review	0	0	0	0	0	0	0
Virtual post-mortem using CT/MR	0	0	0	0	0	0	0
All deaths:							
Post-mortem performed by paediatric/perinatal pathologist*							
Yes	0	0	0	0	0	0	0
No	0	0	0	0	0	0	0
Placental histology carried out by paediatric/perinatal pathologist*:							
Yes	0	0	0	0	1	0	1
No	0	0	0	0	0	0	0

*Includes coronial/procurator fiscal post-mortems

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Date report generated: 15/04/2025 09:47

Table 3: Number of participants involved in the reviews of late fetal losses and stillbirths without resuscitation (N = 1)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	2	100% (1)
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	2	100% (1)
Obstetrician	3	100% (1)
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

Table 4: Number of participants involved in the reviews of stillbirths with resuscitation and neonatal deaths (N = 0)

Role	Total Review sessions	Reviews with at least one
Chair	0	0%
Vice Chair	0	0%
Admin/Clerical	0	0%
Ambulance Team	0	0%
Bereavement Team	0	0%
Community Midwife	0	0%
External	0	0%
Management Team	0	0%
Midwife	0	0%
MNVP Lead	0	0%
Neonatal Nurse	0	0%
Neonatologist	0	0%
Obstetrician	0	0%
Other	0	0%
Risk Manager or Governance Team	0	0%
Safety Champion	0	0%
Sonographer or Radiographer	0	0%

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Table 5: Grading of care relating to the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Perinatal deaths reviewed	Gestational age at birth						
	Ukn	22-23	24-27	28-31	32-36	37+	Total
STILLBIRTHS & LATE FETAL LOSSES							
Grading of care of the mother and baby up to the point that the baby was confirmed as having died:							
A - The review group concluded that there were no issues with care identified up the point that the baby was confirmed as having died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	1	0	1
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following confirmation of the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following confirmation of the death of her baby	0	0	0	0	1	0	1
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
NEONATAL AND POST-NEONATAL DEATHS							
Grading of care of the mother and baby up to the point of birth of the baby:							
A - The review group concluded that there were no issues with care identified up the point that the baby was born	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the baby from birth up to the death of the baby:							
A - The review group concluded that there were no issues with care identified from birth up the point that the baby died	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the baby	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the baby	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the baby	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0
Grading of care of the mother following the death of her baby:							
A - The review group concluded that there were no issues with care identified for the mother following the death of her baby	0	0	0	0	0	0	0
B - The review group identified care issues which they considered would have made no difference to the outcome for the mother	0	0	0	0	0	0	0
C - The review group identified care issues which they considered may have made a difference to the outcome for the mother	0	0	0	0	0	0	0
D - The review group identified care issues which they considered were likely to have made a difference to the outcome for the mother	0	0	0	0	0	0	0
Not graded	0	0	0	0	0	0	0

Report Generated by: Melissa Claridge
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Table 6: Cause of death of the babies who died in this period and for whom a review of care has been completed – number of babies (N = 1)

Timing of death	Cause of death
Late fetal losses	**0 causes of death out of 0 reviews**
Stillbirths	**1 causes of death out of 1 reviews**
	Placenta abruption. maternal vascular malperfusion.
Neonatal deaths	**0 causes of death out of 0 reviews**
Post-neonatal deaths	**0 causes of death out of 0 reviews**

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Table 7: Issues raised by the reviews identified as relevant to the deaths reviewed, by the number of deaths affected by each issue* and the actions planned

Issues raised which were identified as relevant to the deaths	Number of deaths	Actions planned
This mother booked late. Are there any organisations to consider in relation to her booking late?	1	No action entered
This mother booked late. Did this affect her care?	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

Report Generated by: Melissa Claridge
Date report generated: 15/04/2025 09:47

Table 8: Issues raised by the reviews which are of concern but not directly relevant to the deaths reviewed, by the number of deaths in which this issue was identified* and the actions planned

Issues raised which were identified as not relevant to the deaths	Number of deaths	Actions planned
The risk allocation of this mother based on her history at booking was incorrect	1	No action entered
This mother booked early enough but her mid-trimester anomaly scan was carried out after 20+6 weeks	1	No action entered
This mother's progress in labour was not monitored on a partogram	1	No action entered

*Note - depending upon the circumstances in individual cases the same issue can be raised as relevant to the deaths reviewed and also not relevant to the deaths reviewed.

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Date report generated: 15/04/2025 09:47

Table 9: Top 5 contributory factors related to issues identified as relevant to the deaths reviewed, by the frequency of the contributory factor and the issues to which the contributory factors related

Issue Factor	Number of deaths	Issues raised for which these were the contributory factors
Communication - Communication Management	1	This mother booked late. Did this affect her care?
		This mother booked late. Are there any organisations to consider in relation to her booking late?

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Date report generated: 15/04/2025 09:47

Appendix 3

Quality Committee

Meeting on Thursday, 24 April 2025

Agenda Item	3.2	
Report Title	**Postpartum Haemorrhage at SGUH site**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Melissa Claridge, Governance Midwife Christina Coroyannakis, Consultant Obstetrician & Gynaecologist and Lead for Labour Ward, Lead for Audit & Guidelines	
Previously considered by	gesh Quality Group	10 April 2025
Purpose	**For Review**	

Executive Summary

Background

At the February 2025 Quality Committees in Common (QCiC) meeting, the Perinatal Quality Surveillance Model outcomes data was reviewed, highlighting ongoing concerns about high postpartum haemorrhage (PPH) rates at St George's University Hospitals (SGUH). While previous discussions attributed this to St George's role as a Placenta Accreta Spectrum (PAS) referral centre, QCiC requested a more detailed analysis to identify additional contributing factors.

Further underpinning this request, SGUH received notification on 19 February 2025 of being flagged as a potential alarm-level outlier in the 2023 National Maternity and Perinatal Audit (NMPA) for PPH ≥1500ml. Recognising the need for a deeper understanding beyond PAS-related cases, an audit of 2024 PPH data was conducted by the Lead Obstetrician for Labour Ward, Lead for Audit and Guidelines. The key findings and proposed improvement actions forms part of this report

SGUH maternity services provide care to a complex and high-risk population in addition to acting as a regional and national referral centre for several high-risk specialities. SGUH serves a diverse population across southwest London, with services extending to about 3.5 million people in the surrounding regions. The patient demographic mirrors the ethnic diversity of the local population, encompassing a broad spectrum of cultural backgrounds and healthcare needs. Women from black and other ethnic groups are more likely to experience postpartum haemorrhage at the time of birth, regardless of the volume of blood loss used to define PPH. Placenta Praevia and Placenta Accreta: Diagnosis and Management (Green-top Guideline No. 27a) | RCOG

The data for this report has been collected from a retrospective review of all deliveries at SGUH in 2024 using the data metrics as defined in the NHSE Maternity Services Data Set (MSDS). MSDS includes singleton and pregnancies delivered after 34 weeks gestation only and defines PPH as 1.5 litres and above.

SGUH is one of 5 Placenta Accreta Spectrum (PAS) centres across London which takes more PAS referrals than any other centre in London. The MDT caring for PAS patients at this Trust has developed and grown over time benefitting from improved regional support structures and learning

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from governance incidents both locally and regionally. This has resulted in a robust and experienced team who have seen reduced blood loss volume and intensive care admissions despite increasing case numbers.

In addition to PAS the Trust also takes referrals for other complex and high-risk patients including BMI over 50 and EXIT procedures. There are very few other Trusts across the country who carry out these procedures. When PPH rates are adjusted for these, the rate drops from 4.9% to 4.1%. SPC charts demonstrate these PPH rates both with and without adjustment within the body of the report. There is no significant variation in the rate seen in either case.

Induction of labour (IOL) rates are increasing in the UK, and in 2019 a third of women were induced, with the rate for nulliparous women as high as 36%. Induction is undertaken for a variety of reasons, frequently due to prolonged pregnancy and pre-labour rupture of the membranes at term. Induction of labour is a common and important intervention to safely manage risk for women and babies in maternity care. The data for SGUH in 2024 shows an IOL rate of 38% which is in keeping with other UK maternity units. Induction of labour care in the UK: A cross-sectional survey of maternity units - PMC

This data review shows the majority of PPH associated with spontaneous vaginal delivery (SVD) were following IOL. Additionally, PPH is more likely following forceps delivery due to perineal trauma, the figures for SGUH show 32% of PPH was seen in forceps deliveries.

At SGUH there has not been as much of an increase in the caesarean section (CS) rate (around 33%) as other Trusts (50%). This may be because, since 2007, maternity unit staff have been trained in physiological interpretation (ST analysis) of cardiotocography (CTG) resulting in a lower than comparable unit's rates of both hypoxic-ischemic encephalopathy (HIE) and CS. Vaginal births incur lower morbidity overall, but PPH is one of the possible adverse outcomes of this method of delivery. It maybe that this higher rate of vaginal delivery has contributed to an increased PPH rate.

This report contains benchmarking data from the NHSE Maternity Dashboard for the other hospitals who make up the London PAS network. However, there are accepted issues with the quality of the data that several Trusts submit to MSDS. It is possible that this makes SGUH's accurate PPH rates appear artificially inflated. These data quality issues make meaningful comparison very difficult. The data shows that the majority of the other London PAS network centres have PPH rates lower than the SGUH rate. Chelsea and Westminster Trust appear to have a PPH rate of 4.2% despite carrying out very few accreta cases this year. There are only two single site PAS centres within the London network. Centres with multiple hospitals accepting PAS cases dilute the increase in PPH rates between them which again may make the PPH rate at SGUH appear higher than that of its peers.

However, 4.1% remains above the national average of 3.5%, and above the Trust target of <4%, and measures to improve outcome are being actively implemented. The PPH audit data presented in this report is being used to drive local learning and improvement. There appears to be an association between PPH and vaginal delivery following induction of labour and with forceps delivery. This review of indications for, and management of, induction of labour is designed in part to identify further issues requiring intervention to improve PPH outcomes. There is also a focus on the management of PPH following delivery by forceps, where the likely cause of bleeding is trauma, to identify if any change in clinical approach is needed.

In consultation with other tertiary referral trusts in London the maternity unit has introduced a multi-disciplinary governance process to review PPH incidents to ensure themes and learning are rapidly identified. All Datixes are reviewed daily by the Divisional incident review group (DIRG) and appropriate initial review responses determined. PPH cases are reviewed by the governance team and a standardised review tool is completed to ensure consistency and accuracy of approach. Cases are then presented at a bi-monthly MDT meeting which is open to all maternity unit staff. Care is

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graded by the MDT and actions and learning responses are identified. Actions are monitored in the monthly governance meeting and on the Learning from patients' safety events LFPSE reporting system. A monthly report of all case reviews is presented at the Divisional review group. PPH themes are identified and presented at monthly governance meetings and shared with staff via Governance boards, monthly newsletters, and communications email.

The following actions have been taken to try and reduce PPH rates, raise awareness and improve management:

- Introduction of carbetocin for caesarean and instrumental deliveries in theatre.
- Bi-annual PPH staff awareness weeks.
- Introduction of PPH station within our mandatory PROMPT training.
- Hands on instrumental delivery teaching for trainees.
- Aligning our maternity dashboard with Maternity Services data set (MSDS) metrics to ensure consistent reporting.

Action required by Quality Committees-in-Common

The Committee is asked to:

a. Note the steps being taken to reduce PPH rates on the SGUH site and the initial impact of this work.
b. Consider the sources of assurance provided and whether further assurance is required.
c. Note the Trust has responded to the NMPA letter advising that the Trust is a potential alarm-level outlier for PPH of 1.5mL or above.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	[…]

Implications

Group Strategic Objectives

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

Risks

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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☒ 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 implications for the Trust

Legal and / or Regulatory implications

None

Equality, diversity and inclusion implications

Women from Black and ethnic minority groups are more prone to experiencing a PPH, care should be tailored accordingly to reduce this known risk

Environmental sustainability implications

None

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Postpartum Haemorrhage at SGUH site
Quality Committees-in-Common, 24 April 2025

1.0 Purpose of paper

1.1 This paper investigates in detail the above national average Postpartum haemorrhage (PPH) rate at the SGUH site and provides the Committee with more detailed sources of assurance to evidence the governance around PPH, improvements made and highlight any areas of ongoing focus or concern.

2.0 Background

2.1 Postpartum haemorrhage (PPH) is one of the leading causes of maternal mortality and morbidity with 140,000 annual deaths estimated worldwide. PPH is defined as an estimated blood loss of ≥500 mL after a vaginal delivery or ≥1000 mL after a caesarean delivery, or by a postpartum haematocrit reduction of more than 10%. Common causes of PPH include uterine atony, genital tract trauma, retained products of conception, coagulation disorders, uterine inversion, and implantation of placenta into the lower uterine segment. Its incidence is likely underestimated since the clinician must rely on visual estimation of blood loss to make the diagnosis. Furthermore, PPH could occur either immediately or up to 6–12 weeks postpartum, which makes public reporting difficult. Postpartum Hemorrhage - StatPearls - NCBI Bookshelf

2.2 Placenta accreta is a rare complication of pregnancy affecting between one in 300 and one in 2000 pregnancies. A placenta accreta is when the placenta grows into the muscle of the uterus, making delivery of the placenta at the time of birth very difficult. Placenta accreta is more common where a placenta praevia has been found, and when previous caesarean birth has happened, but it can also occur with previous uterine surgery, or with uterine abnormality such as fibroids or a bicornuate uterus. It is more common in older (over 35 years old) women or with fertility treatment, especially in vitro fertilisation (IVF). The presence of placenta accreta/increta/percreta is associated with major pregnancy complications, including life-threatening maternal haemorrhage, uterine rupture, peripartum hysterectomy and maternal death, as well as complications associated with surgical removal including damage to bladder, ureters and other organs. Placenta accreta is thought to be becoming more common, due to a number of factors, including rising maternal age at delivery and an increasing proportion of deliveries by caesarean section. Placenta Praevia and Placenta Accreta: Diagnosis and Management (Green-top Guideline No. 27a) | RCOG

2.3 In March 2023 a CQC inspection of the SGUH site maternity services noted that when reviewing incidents reported by staff, they found incidents were harm-rated inappropriately according to national guidelines (NHS England National Reporting and Learning System, 2019), with incidents often harm-rated at a lower grade than appropriate. An emergency hysterectomy was rated as low harm which did not meet the definition of low harm. Cases of obstetric haemorrhage were inappropriately routinely downgraded from moderate harm rating to no or low harm. In addition, the CQC report found that the trust was in the upper 25% of all trusts reporting for major (more than 1500mls) postpartum haemorrhage (PPH). In November 2022, the rate of major PPH was 49 per 1000 births, compared with the national average of 30 per 1000 births.

2.4 In Feb 2025 SGUH was informed that the maternity unit has been identified as a potential alarm-level outlier for postpartum haemorrhage (PPH) in the 2023 National Maternity and

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Perinatal Audit (NMPA). The report has yet to be finalised and confirmed and so the results have been shared in strict confidence and remain under embargo until 00:01 on 8 May 2025.

3.0 Analysis

3.1 SGUH maternity services provide care to a complex and high-risk population in addition to acting as a regional and national referral centre for the following groups:

- Tertiary fetal medicine unit performing high risk in-utero surgical procedures.
- Level 3 neonatal unit
- Highest performing site within the London Placenta Accreta Spectrum (PAS) network
- Bariatric centre
- Maternal medicine hub
- Late Termination of pregnancy procedures for high-risk patients
- Co-located paediatric surgical centre and adult cardiac and neurosurgical units.

3.2 The data for this report has been collected from a retrospective review of all deliveries at SGUH in 2024 using the data metrics as defined in the NHSE Maternity Services Data Set (MSDS). MSDS includes singleton and pregnancies delivered after 34 weeks gestation only and defines PPH as 1.5 litres and above. It is worth noting that the current maternity dashboard includes all deliveries and only records PPH above 1.5 litres. Recent advice from NHS England is that Trusts align themselves with the MSDS to allow more meaningful and useful benchmarking with other local, regional and national maternity units.

3.3 The method of data collection for this report involved the following processes collated into a spreadsheet:

- Data collected through our database (Euroking)
- Blood loss recorded for each delivery
- Other parameters included:
    - Onset of labour
    - Mode of delivery
    - Reason for delivery
    - Place of booking
    - Gestation

3.4 Also worthy of note is the fact that on 8th Feb 2025 the maternity unit implemented the ICLIP Pro system of electronic documentation. It is possible therefore that there will be some variation in PPH rates reporting as maternity unit staff transition through the initial implementation phase.

3.5 Ethnicity SGUH serves a diverse population across southwest London, with services extending to about 3.5 million people in the surrounding regions. The patient demographic mirrors the ethnic diversity of the local population, encompassing a broad spectrum of cultural backgrounds and healthcare needs (see below for more detailed breakdown of ethnicity data of women giving birth at the Trust). Women from black and other ethnic groups are more likely to experience postpartum haemorrhage at the time of birth, regardless of the volume of blood loss used to define PPH. Following adjustment for maternal and fetal characteristics, particularly birthweight, women from all ethnic minority groups have an increased risk of PPH.

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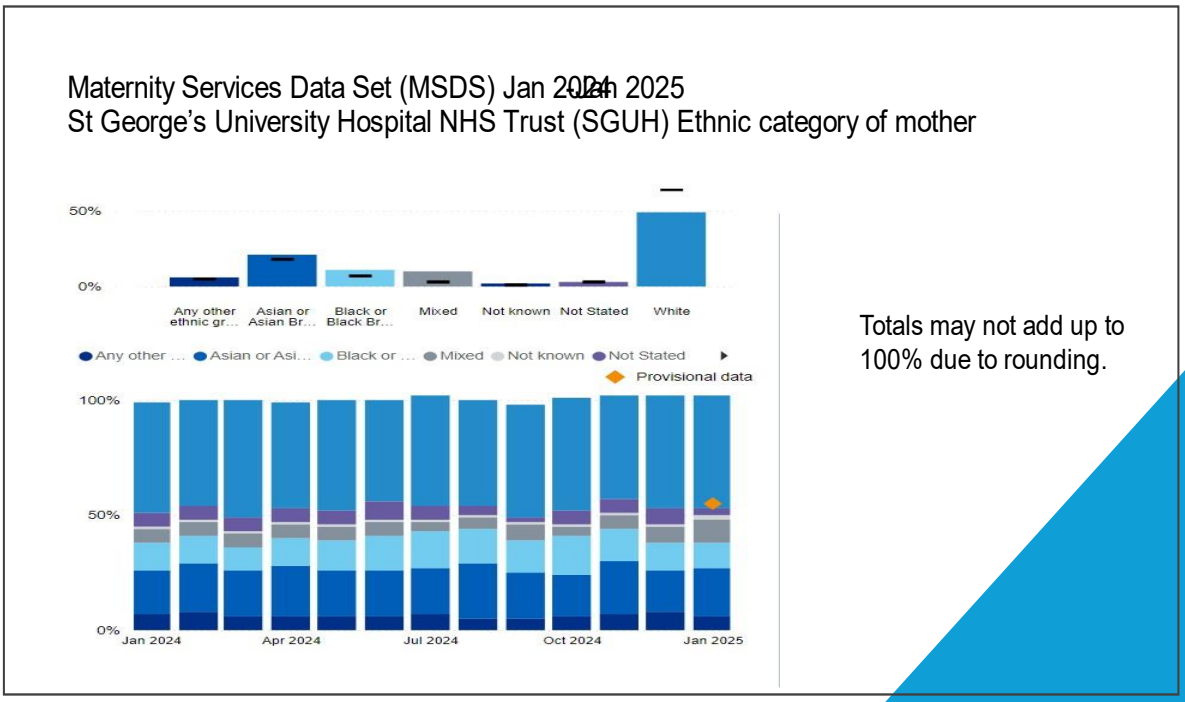

3.6 History and Development of Placenta Accreta Spectrum (PAS) service. SGUH started accepting referrals for patients with PAS in 2015. The service was in its infancy at this stage with both awareness and cases at relatively low levels. In 2019 two significant events occurred: first the team underwent a significant change of clinical personnel and secondly a national programme was commenced for the development of specialist accreta centres. The latter has resulted in RCOG guidance (with SGUH input) for diagnosis and management of placenta accreta and placenta praevia and a specific abnormally invasive placenta (AIP) NHS funding package and regional PAS networks. At a local level these changes have resulted in greater oversight and monitoring of clinical practice and ensured that the MDT are equipped with the specific skills necessary to care for patients with this extremely high-risk complication of pregnancy.

3.7 In 2019 a less experienced team began carrying out these procedures which meant that development and change in the PAS service has been necessary over time. There have been several governance investigations into PAS cases with massive obstetric haemorrhage each of which the PAS clinicians have fully engaged with to ensure the reports provided valuable and essential learning shared with the midwifery, obstetric and anaesthetic team (see table below). The London PAS network has also been pivotal in allowing learning to be disseminated between all PAS centres.

Incident Number	Date	Incident
V214459/V214460/V214461	29/09/2020	Accreta PPH 20 litres
DW181999/X255137	26/12/2022	Accreta PPH 21 litres
DW201286	19/12/2023	Accreta PPH 3.8 litres

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DW200129/DW200119/DW200120	28/11/2023	Accreta PPH 7 litres

3.8 In 2022 PAS was removed from the general haemorrhage maternity unit guidelines and a stand-alone guideline and pathway developed. In Jan 2024 SGUH introduced the thromboelastography (TEG) guided use of fibrinogen concentrate which has resulted in a reduction in the total amount of blood products used for transfusion, reduction in the mean total blood loss, and reduction in the number of admissions to intensive care. The decision was also made to deliver PAS cases at a later gestation to avoid unnecessary admissions to the neonatal unit.

3.9 Last year the PAS team began carrying out biannual case reviews to identify any useful trends or issues and action necessary learning. These reviews are presented to the maternity unit at regular Governance meetings and included in Governance newsletters. This has ensured that these changes have impacted on the management of PPH within the maternity unit generally and not just PAS cases. Now in 2025 there is an experienced MDT team caring for these patients with a robust and considered pathway for patient care in place.

3.10 In May 2024 SGUH began taking PAS referrals from Oxford, in June a cyber-attack at King's College Hospital resulted in SGUH accepting more PAS cases and in addition to this 2024 saw a general increase in PAS cases. SGUH delivered 31 accreta cases in 2024, a 43% increase since 2023. It is predicted that this increase in PAS cases will continue in line with the increased caesarean section rates being seen across the country.

3.11 As mentioned above SGUH is also the bariatric referral centre and a fetal medicine surgical centre. In 2024 SGUH cared for 13 patients with a BMI over 50. Of these, 3 patients had a PPH. BMI over 40 is a known risk factor for PPH the risk increases with the BMI. Additionally, two EXIT procedures were performed this year. This procedure involves delivering the baby's head by caesarean section and stabilising the airway prior to the delivery of the rest of the baby. An EXIT procedure is performed in cases such as lingual cyst where there is likely significant airway compromise following delivery. This procedure involves a large MDT team and can take a considerable amount of time. During this time the patient's abdomen is open which considerably increases the risk of significant blood loss. Both EXIT procedures were performed successfully with good outcome for the babies but with the complication of PPH.

3.12 The PAS, EXIT and BMI over 50 patients are largely referred to SGUH from other Trusts and make up just a proportion of patients referred to us with complex needs. Many of these are additionally high risk for PPH.

3.13 In 2023 the haemorrhage guideline was updated in line with Obs Cymru recommendations, these place greater emphasis on the importance of accurate measuring of blood loss and have ensured that clinicians are meticulous about measuring rather than estimating blood loss. It is possible that this has also contributed to SGUH data recording a higher-than-average PPH rate.

3.14 This SPC chart illustrating PPH rates monthly from Jan 2024 shows the impact of these cases but also shows hopeful signs of a decreasing trend in PPH cases since Jan 2025. The overall PPH rate for 2024 is 179/3664 (4.9%).

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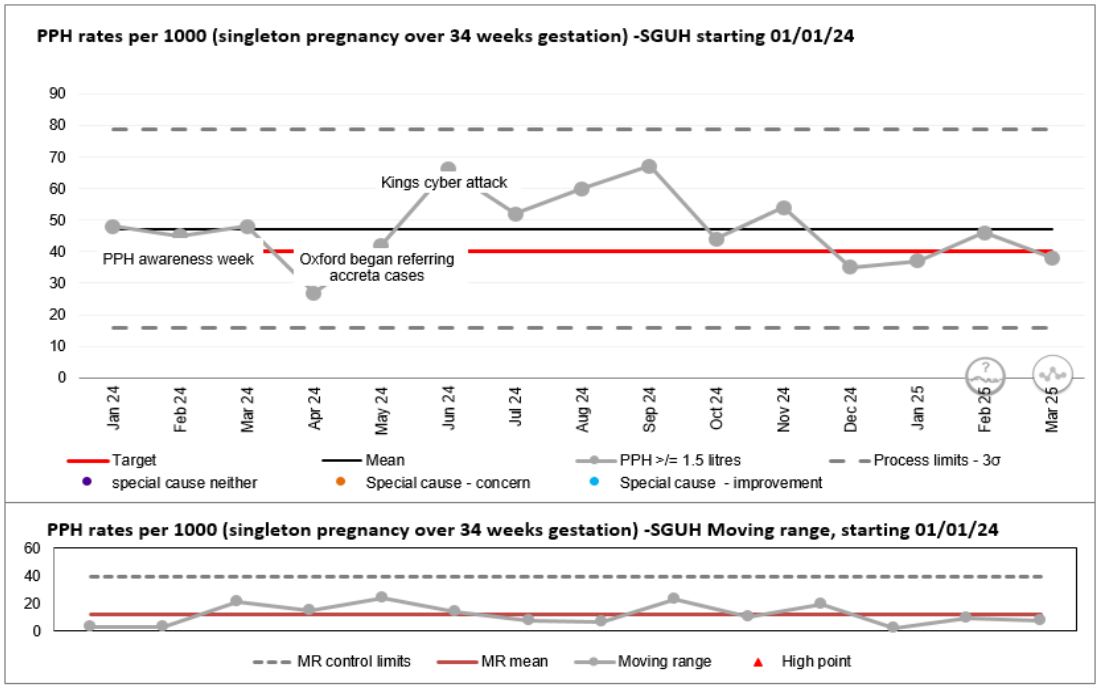
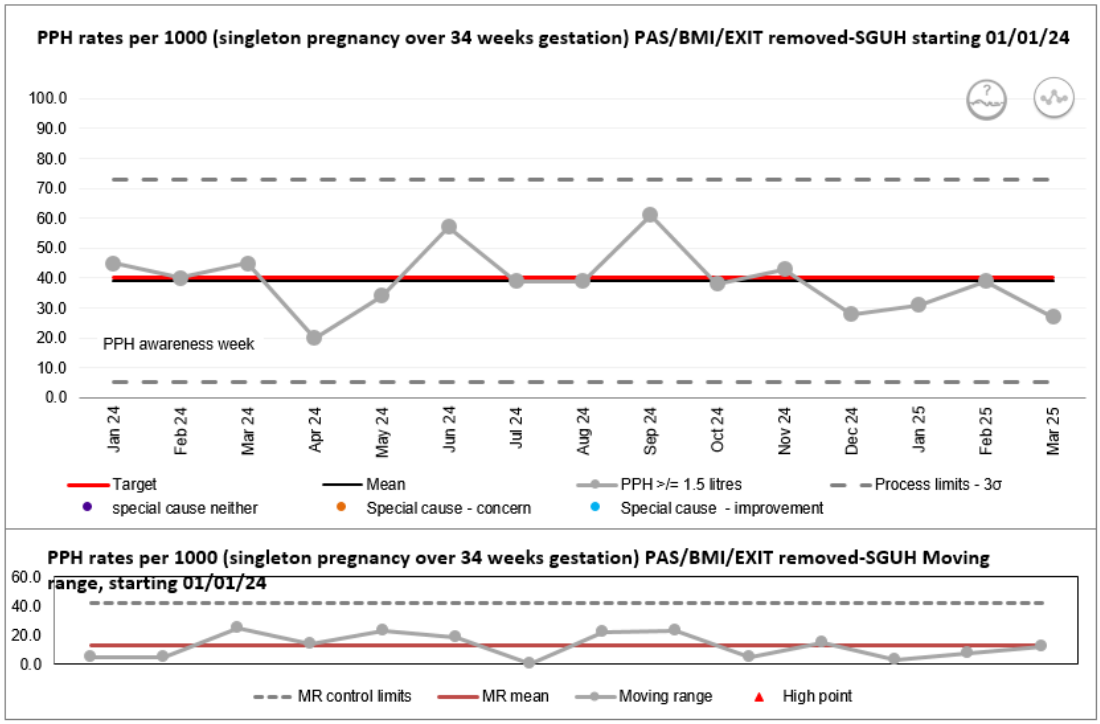


3.15 This SPC chart shows the PPH rate with PAS, BMI and EXIT procedure cases removed. The impact of this is to move the overall PPH rate from 4.8% to 152/3664 (4.1%). Neither of these SPC charts demonstrates significance variation in the PPH rate.



3.16 <u>Onset of labour</u>

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Induction of labour	62	35%
No labour	51	28%
Spontaneous	65	36%

3.17 Typically, no labour caesarean section relates to high-risk cases with an increased risk of PPH such as PAS/EXIT/BMI over 50. The PPH rate for no labour cases is 28%.

3.18 Induction of labour. Induction of labour (IOL) rates are increasing in the UK, and in 2019 a third of women were induced, with the rate for nulliparous women as high as 36%. Rates are increasing world-wide, for example a quarter of births are induced in the United States. Induction is undertaken for a variety of reasons, frequently due to prolonged pregnancy and pre-labour rupture of the membranes at term. The evidence of the safety and effectiveness of IOL in improving outcomes has grown. Evidence suggests that inducing women in additional risk groups would improve outcomes and has driven a further increase in the induction rate, for example for women with hypertension, diabetes in pregnancy, and advanced maternal age. Induction of labour care in the UK: A cross-sectional survey of maternity units - PMC

3.19 Induction of labour is a common and important intervention to safely manage risk for women and babies in maternity care. There is evidence of substantial variation in IOL rates across the UK and recent studies suggest there is a need for the development and implementation of standardised guidance and pathways across maternity systems, including rigorous evaluation (see table below). Evidence has widened the indications for IOL, and rates will continue to increase. The data for SGUH in 2024 shows an IOL rate of 38%, The graph below illustrates IOL rates across the UK and demonstrates that this rate is in line with many other maternity units.

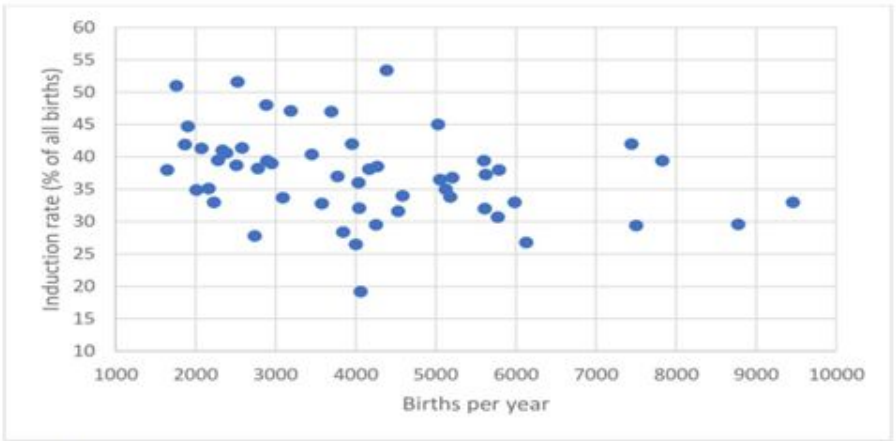

Fig 1. Induction rates according to maternity unit size (number of births per year).

3.20 Induction of labour constitutes a risk factor for PPH increasing the likelihood of PPH from both trauma and lack or uterine tone. The table below showing PPH by mode of delivery and onset of labour demonstrates that the majority of PPH associated with spontaneous vaginal delivery (SVD) were following IOL.

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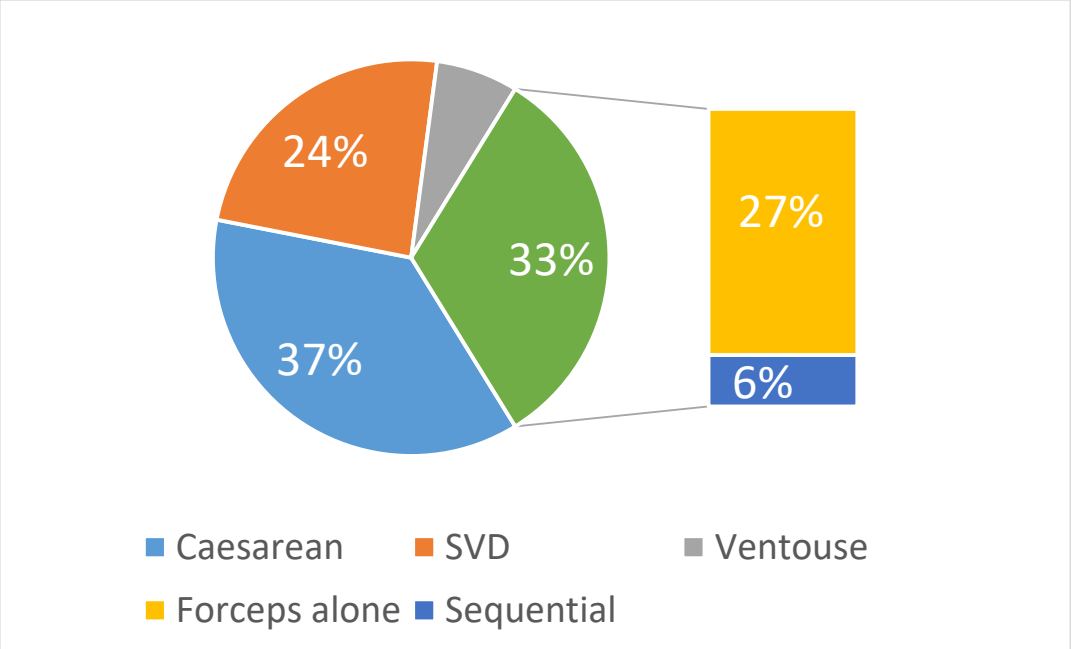
3.21 SGUH 2024: PPH =/< 1.5 litres in singleton pregnancy after 34 weeks.

	IOL	No labour	Spontaneous	Total	% of PPH
EMCS	7	13	9	29	16%
ELCS	0	37	0	37	21%
Forceps	23	0	25	48	27%
Ventouse	7	0	5	12	7%
SVD	24	1	18	43	24%

3.22 Mode of delivery and PPH. Forceps deliveries accounted for 33% of PPH, in 2024 there were 48 forceps and 10 deliveries where sequential instruments including forceps were used during which a PPH occurred. In some of these cases blood loss was at least in part related to vaginal trauma rather than uterine tone.



Maternity Services Data Set (MSDS) Jan 2024-Jan 2025
St George's University Hospital NHS Trust (SGUH) Ethnic category of mother

4.0 Sources of assurance

4.1 Benchmarking data There are 5 commissioned PAS centres across London:

- Barts Health Trust and Barking, Havering and Redbridge Trust

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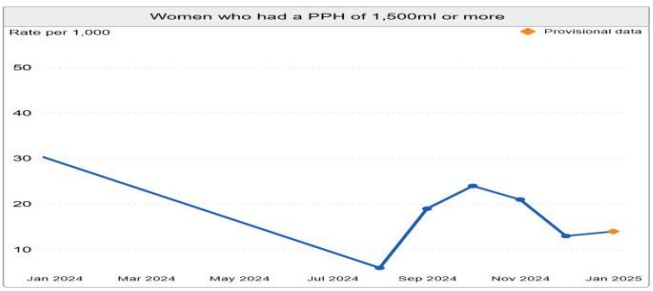
- Kings College London and Guy's and St Thomas's NHS Trust
- University College London
- Imperial College and Chelsea and Westminster NHS Trusts
- St Georges Hospital

4.2 Despite being one of only two single site PAS centres in 2024 SGUH performed more PAS procedures than any other centre in the London PAS network, accepting nearly twice as many PAS referrals as anywhere else in the London network. For the London PAS centres including more than one hospital the increased PPH rate between different sites.

4.3 The data for PPH rates these Trusts submitted to NHS England for 2024 can be seen below. There are accepted issues with the quality of the data that several Trusts submit to MSDS, which is mainly linked to the introduction of new maternity IT systems, which are still being optimised, the graphs are annotated accordingly. It is possible that this makes our more accurate PPH rates appear artificially inflated. These data quality issues make meaningful comparison very difficult.

Maternity Services Data Set (MSDS) Jan-2024 2025
King's College Hospital NHS Foundation (KCL) (PPH rate 1.7%)



*KCL transitioned to EPIC in Sept 2023. They did not report any PPH data from Sept 2023 to July 2024. It is not clear that their data issues are resolved to date.

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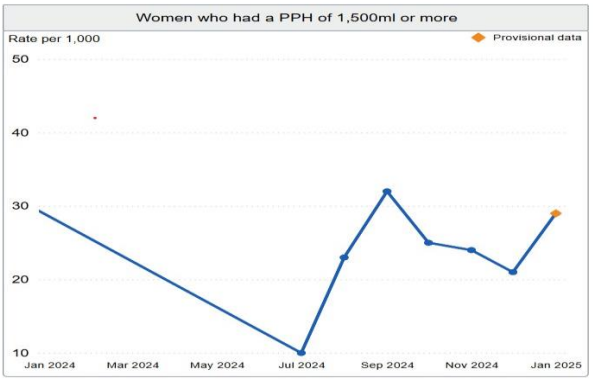
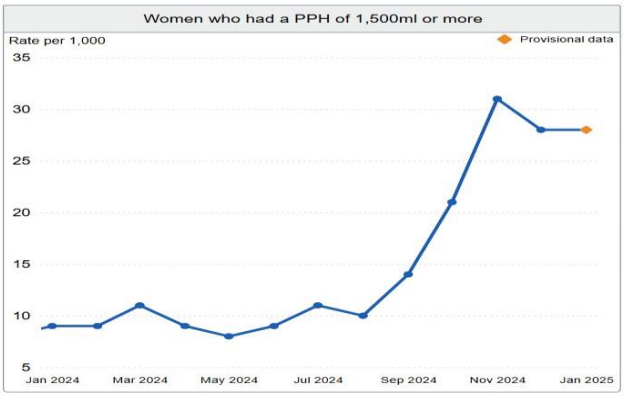
Maternity Services Data Set (MSDS) Jan-2022 to Jan-2025 Guy's and St Thomas' NHS Foundation Trust (GSST) (PPH rate 2.3%)



*GSST transitioned to EPIC in Sept 2023. They did not report any PPH data from Sept 2023 to July 2024. It is not clear that their data issues are resolved to date.

Maternity Services Data Set (MSDS) Jan-2022 to Jan-2025 Barts Health NHS Trust (PPH rate 1.4%)



Barts seem to have been under reporting from 2022. The quality of their data appears to have improved since July 2024 but it is not clear their data issues are resolved to date.

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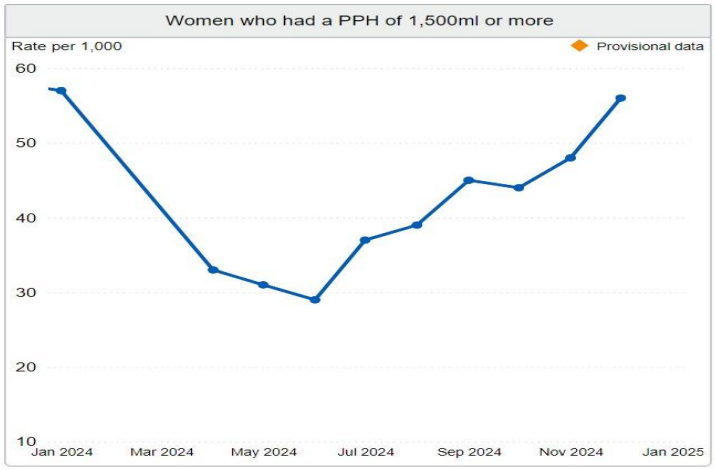
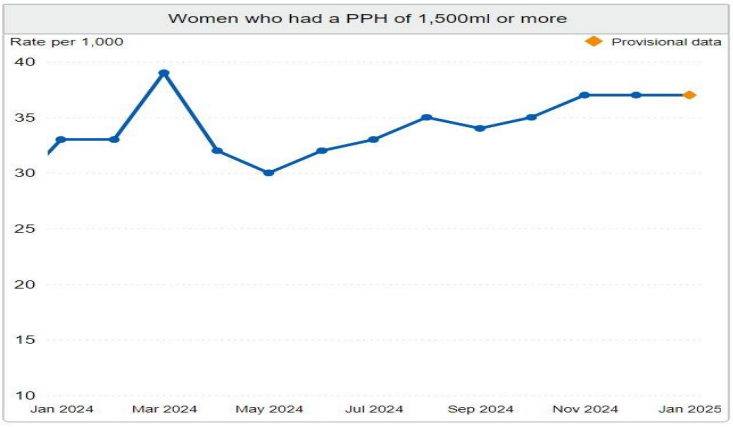
Maternity Services Data Set (MSDS) Jan 2024 – Jan 2025
Chelsea and Westminster NHS Trust (CW) (PPH rate 4.2%)



No data submitted between Jan and April 2024.

Maternity Services Data Set (MSDS) Jan 2024 – Jan 2025
Imperial College Healthcare (ICH) (PPH rate 3.4%)



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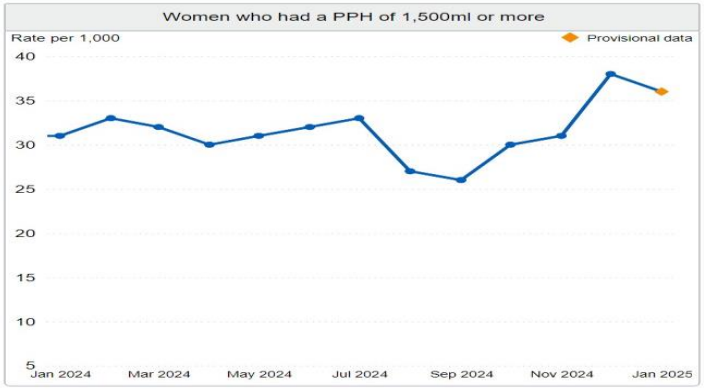
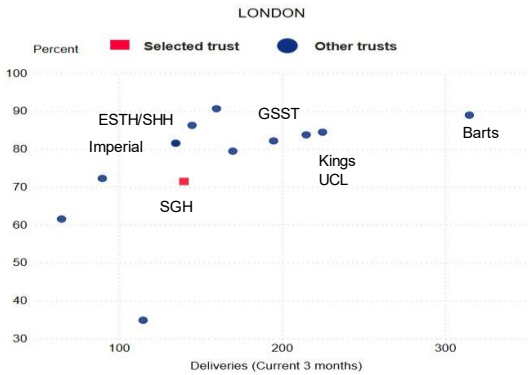
Maternity Services Data Set (MSDS) Jan 2024 – Jan 2025
University College London Hospitals NHS Trust (UCLH) (PPH rate 3.1%)



4.4 However, 4.1% remains above the national average of 3.5%, and above the Trust target of <4%, and measures to improve outcome are being actively implemented. As discussed, the nationally recommended list of indications for induction of labour is ever increasing and we have seen a corresponding increase in our rate of PPH. At SGUH there has not been as much of an increase in the caesarean section (CS) rate (around 33%) as other Trusts (50%). See MSDS data for Robson classification group two which show SGUH has a lower rate of CS for this group than comparative Trusts.

Maternity Services Data Set (MSDS) Jan 2024 – Jan 2025
St George's University Hospitals NHS Foundation Trust



Comparison chart for London Trusts shows CS rate for Robson classification Group two: Nulliparous/single ton/term / IOL

4.5 This may be because, since 2007, SGUH maternity unit staff have been trained in physiological interpretation (ST analysis) of cardiotocography (CTG) resulting in a lower than comparable unit's rates of both hypoxic-ischemic encephalopathy (HIE) and CS. Vaginal births

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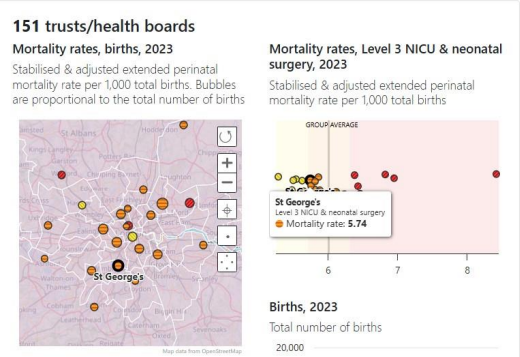
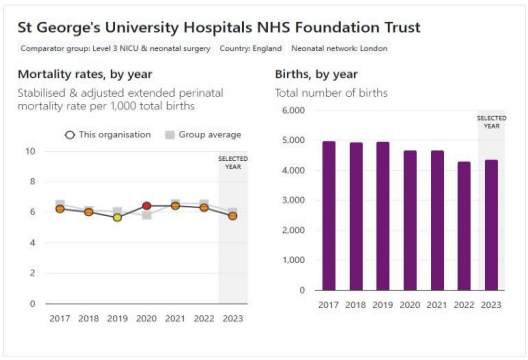
incur lower morbidity overall, but PPH is one of the possible adverse outcomes of this method of delivery. Reassuringly perinatal mortality rates remain below the national average for similar level 3 Trusts with surgical provision.

St George's Hospital 2023 MBRRACE-UK data shows below average stillbirth/neonatal death for comparative Trusts.





4.6 The PPH audit data presented in this report is being used to drive local learning and improvement. There appears to be an association between PPH and vaginal delivery following induction of labour and with forceps delivery. This review of indications for, and management of, induction of labour is designed in part to identify further issues requiring intervention to improve PPH outcomes. There is also a focus on the management of PPH following delivery by forceps, where the likely cause of bleeding is trauma, to identify if any change in clinical approach is needed.

4.7 Governance Process around PPH. In consultation with other tertiary referral trusts in London the maternity unit has introduced a multi-disciplinary governance process to review PPH incidents to ensure themes and learning are rapidly identified. All Datixes are reviewed daily by the Divisional Incident Review Group (DIRG) and appropriate initial review responses determined. PPH cases are reviewed by the governance team and a standardised review tool is completed to ensure consistency and accuracy of approach. Cases are then presented at a bi-monthly MDT meeting which is open to all maternity unit staff. Care is graded by the MDT and actions and learning responses are identified. Actions are monitored in the monthly governance meeting and on the LFPSE reporting system. A monthly report of all case reviews is presented at the Divisional review group. PPH themes are identified and presented at monthly governance meetings and shared with staff via Governance boards, monthly newsletters, and communications email.

4.8 Action taken to try and reduce PPH rates, raise awareness and improve management:

- Introduction of carbetocin for caesarean and instrumental deliveries in theatre.
- Bi-annual PPH staff awareness weeks.
- Introduction of PPH station within our mandatory PROMPT training.
- Hands on instrumental delivery teaching for trainees.
- Aligning our maternity dashboard with Maternity Services data set (MSDS) metrics to ensure consistent reporting.

Appendix 3

5.0 Recommendations

5.1 The Committee is asked to:

a. Note the steps being taken to reduce PPH rates on the SGUH site and the initial impact of this work.
b. Consider the sources of assurance provided and whether further assurance is required.
c. Note the Trust has responded to the NMPA letter advising that the Trust is a potential alarm-level outlier for PPH of 1.5mL or above.

NHS England

Maternity Improvement Advisor Bimonthly Progress Report

Name of Trust: St Georges, Epsom & St Helier
Date report Covers: January / February 2025
Phase: Improvement

Maternity Improvement Advisors:
Amanda Pearson – National Maternity Improvement Advisor
Susie Al Samarrai – Obstetric National Maternity Improvement Advisor

Dates of Site Visits/Meetings/Forums/1:1s

1:1 Meetings
DoM /HoM
Matrons
Site Medical Director (St George's)
Regional Lead Obstetrician

Meetings and Forums
Evidence Assurance Panel
Senior Leadership meeting
Consultant meeting E&SH

Summary of Findings

Obstetric Workforce
Work is ongoing to assess the impact of a lack of junior obstetric staff at St George's, particularly on the overnight section of the rota. The current rota is staffed by 2 registrars on site, covering both obstetrics and gynaecology with the support of on call consultants who are off site. This has the potential to impact on the safe provision of Triage services, without access to timely review if the onsite medical staff are busy with providing care on the labour ward or for gynaecology patients. It has been highlighted that this work needs to progress at pace, but no further update has been provided.

Obstetric Leadership - SGUH
There is a transition period underway as the Clinical Director in Obstetrics post has been appointed to with the new CD commencing in role at the beginning of March following a recruitment process with the outgoing CD handing over throughout March. There will also be a change in the Lead for Governance with the process of identifying a suitable candidate underway.

Fetal Medicine - SGUH
The external review of the Fetal Medicine service is due to commence with agreement of Terms of Reference with the external assessor as well as an anticipated timescale for conclusion.

Equipment checks
St Georges compliance needs to improve, and production board methodology discussed to increase compliance and templates shared

ESTH – compliance (is this saying ESTH are compliant with Equipment check?)

Fresh eyes
SGH have moved to hourly fresh eyes an ongoing audit would be beneficial to demonstrate compliance and areas of focus

Leadership and workforce
The interim DoM for Georges commences post in March which will bring some stability and steer the improvement work alongside the senior midwifery team.

Birth rate Plus is outstanding at SGH and awaiting report following February's submission of data.
ESTH interim and seconded posts have been reviewed, the community review needs to be completed to ensure the on-call service for homebirths is supportive of the staff and women.

Triage
Neither site is currently following the BSOTS methodology, due to challenged estates. MIAs to support an MDT review of all 3 sites to ensure board oversite of mitigations, requirements for compliance and ensure a long-term plan is developed. SGH scheduled for the 2nd of April and ESTH 25 April .

Culture
There is ongoing work at the ESTH sites in relation to the appreciative inquiry work that was undertaken. There has been a significant development in the recruitment process to ensure equity for appointing staff.

Single Perinatal Improvement Plan
Is in the process of being developed with support from the BI team, meeting structure should be reviewed to ensure where the oversight of actions will happen to gain and provide ongoing assurance.

Progress against exit criteria

This will be underpinned by a Trust developed overarching quality improvement plan (Maternity & Neonatal Improvement Plan (MNIP), with realistic milestones developed as part of the improvement phase.

Exit criteria to be signed off and agreed

Newly emerging findings or additional recommendations not included in the MNIP or exit criteria and as observed/identified
[These should be included in the Trust MNIP if not an action that can be quickly resolved]

Recommendation	Trust Lead	Completion date	Progress	RAG Rating
Leadership roles JD to be reviewed and advertised	GCMidO	31/12	Structure and line management not decided	
Governance team meetings to be forwarded	gesh Governance leads Emily K and Laura R	31/12	Not all meetings received	
Guidelines to be forwarded	GCMidO	31/12	All requested guidelines have been received	
Quad meeting invites to be forwarded	Directors of Midwifery	31/1	Meetings not received	
Baby abduction drill and policy to be implemented and updated -SGUH	Lead Midwife Safeguarding	31/3	Abduction drill completed 29 January 2025, and baby abduction policy written awaiting ratification.	
Audit of compliance for sonography KPI's SGUH	Lead Sonographer	31/3		
Review implementation of BSOTS	GCMidO Directors of Midwifery Clinical Directors	31/3	SGUH reviewed on 2 April 2025 ESTH scheduled for 25 April	
SGUH Diabetic service capacity and demand exercise	Consultant Midwife – maternal medicine	31/3	Work is underway to address staffing and clinic capacity to enable the service to return to a fully functioning service	
Review concerns raised about cleanliness and the requirement to add to the risk register	Directors of Midwifery	31/3		
Workforce review of staff with OH restrictions	Directors of Midwifery	31/3		

Next Planned Visits
March ESTH 6th March SGH 113th March Further visits TBA

MIA Support/Focus
Triage Guidelines / SOPS Governance systems and processes

Leadership
Perinatal Improvement Plan

Report distribution:

- Trust executive and maternity clinical leadership team
- Regional Chief Midwife/Regional Chief Obstetrician
- Intensive Support Director
- ICB Chief Nurse
- LMNS SRO
- LMNS Senior Midwife
- System and/or regional service user voice lead

Quality Committee

Meeting on Thursday, 24 April 2025

Agenda Item	3.2	
Report Title	Safety Champions Walkaround of gesh Maternity Services (February and March 2025) - Feedback	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

Maternity and Neonatal Safety Champions play a crucial role in ensuring the safety and quality of maternity and neonatal care within our trusts, facilitating effective relationships, providing strong leadership and ensuring robust governance processes are in place.

The Executive and Non-Executive Board Level Maternity Safety Champions have distinct roles and responsibilities in NHS trusts, particularly in the context of maternity safety and governance, including oversight of the Clinical Negligence Scheme for Trusts (CNST) and Maternity Incentive Scheme (MIS).

Their role is to promote unfettered communication from 'ward-to-board', by working with maternity and neonatal safety champions to ensure that maternity and neonatal issues are communicated and championed at board level. The Executive Board Level Maternity Safety Champion (the Group Chief Nursing Officer and Director of Infection Prevention and Control) and the Non-Executive Board Level Maternity Safety Champions (the Chair of the Quality Committees-in-Common) undertake both formal and informal visits across all three maternity units and chair a regular series of assurance and engagement meetings, offering every staff member an opportunity to voice concerns, share celebrations and hear updates from Senior Leaders.

An executive summary and action log for every gesh Maternity Triangulation and Maternity and Neonatal Senior Leadership Team meeting is approved by the Executive Board Level Maternity Safety Champion and shared with meeting attendees for dissemination wider within their units, as appropriate.

This paper provides a summary of feedback from the Non-Executive Board Level Safety Champions' visit to the St George's maternity unit on 20 February and St Helier on 12 March 2025.

Areas visited at St George's were, Delivery Suite, Triage and Obstetric Theatre. Discussions were held with the governance team, digital midwife and other midwifery, obstetric and support staff within the unit. At St Helier areas visited included Labour ward, Triage and the Maternity Ward, and discussions were held with staff.

Action required by Group Executive

The Group is asked to:

a. Note the contents of the report for assurance of Safety Champion activity, engagement and action.
b. Make any recommendation for further action.

Committee Assurance	
Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

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

Implications

Group Strategic Objectives

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

Risks

SGUH have declared compliance with 9/10 MIS Safety Actions, therefore there is a risk that the Trust will not receive the ten percent (10%) rebate of their CNST contribution, which creates a financial risk.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

No issues to consider

Legal and / or Regulatory implications

Enforcement undertakings applicable to SGUH and ESTH.
Compliance with the Health & Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.

Equality, diversity and inclusion implications

No issues to consider

Environmental sustainability implications

The challenging estates at St Helier and the impact on staff and service delivery

Safety Champion Walkaround feedback

Quality Committees in Common, 24 April 2025

1.0 Purpose of paper

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

2.0 Themes, issues, and concerns

St George's - visited 20 February 2025, accompanied by the Interim Director of Midwifery

iCLIP

- Staff reported that overall, the roll out seems to have progressed well, but many staff are still learning to adapt to using a new system.
- There is a very specific issue that the discharge coordinator no longer has access to medical records so can't do her job – this is significantly affecting flow and patient care. Staff reported that it has been escalated to Cerner, however, the site team have apparently been told that owing to IG restrictions because they are not a qualified midwife or doctor, they cannot have access to the medical record.
- There is another issue in that phone numbers are not pulling through to the postnatal discharge summary so community teams and receiving hospitals don't have a contact number for the patient – this has also been escalated.

  Action: the safety champion requested for these issues to be escalated further, and a workaround developed (for the discharge co-ordinator) in the meantime, and a swift resolution found to ensure discharges include the persons phone number.

Governance

- PSII – the timeframe for completing PSIIs is apparently about 6 months – the Safety Champion feel this seems too long when patients and families will be waiting to hear the outcome. However, he was reassured that urgent learning and actions are taken immediately. **Action:** the safety champion requested to see some data on this.

- Datix's are reviewed daily, and the level of harm is upgraded where needed. He heard that it could take a long time for matrons to review incidents raised through Datix and close the loop. The safety champion felt it was unclear whether matrons have time to review and respond to issues raised through Datix included in their job plans, but also wondered if there was a cultural issue beneath this.

  Action: the safety champion requested to see data on how many Datix are resolved within the right timeframe.

Delivery suite

- The recently introduced Band 7 coordinator daily check log was reviewed – including items such as equipment and controlled drug checks for each shift – this was largely completed but there were still gaps such as on 19/2/25 there was no check on controlled drugs on the day shift. The safety champion expressed concern given this is an issue flagged up in the recent Section 29A notice issued by the CQC.

- Fresh eyes – some senior staff, including from the foetal monitoring and obstetric team gave feedback that they do not believe that 1-hour fresh eyes CTG review is best practice or appropriate for St Georges. Their view is that introducing this will make safety worse. They felt that the department did not have a problem and that recommendations made by CQC were wrong. They emphasised that compliance with local guidelines was over 80% in the last 9 months and that audit showed that assessment of CTGs was consistently correct. The midwife felt that the NICE guidelines on this were not based on evidence, and we should not be following them and gave examples of Wales and another London Trust where they were not being followed. They did accept that they needed to implement 1-hour fresh eyes because they had been told to by CQC and senior executives. They further reported that the next audit may show standards of compliance fall because of moving to 1-hour fresh eyes review. The safety champion raised deep concern about effective implementation if senior leaders do not believe the change is evidence driven and are therefore not bought in.

  The midwife also raised a lack of clarity about how to record compliance with fresh eyes. She stated that 80% compliance could either be viewed as compliance 80% of the time in an individual case or compliance in 80% of women.

  The safety champion was surprised by the lack of clear reporting guidelines and wondered whether SGUH may be reporting better compliance than they really have, particularly if they were reporting on whether they achieved 80% compliance for an individual case in 80% of cases and feels this is a major worry that needs further exploration.

  Action: clarify the reporting and auditing guidelines for fresh eyes at both SGUH and ESTH and that this is clear to staff undertaking audits, such that there is confidence in audit outputs.

- Staff told the safety champion that obstetric registrars do not respond to escalation of concerns by midwives in a timely way and that if, and when they do respond they often just review a CTG on a screen rather than reviewing the clinical scenario in a room. The safety champion asked whether this had been escalated to clinical leaders and was told it had been and that there was training on CTGs being delivered to doctors and that the importance of review was being stressed.

  Action: Clinical Director to provide further assurance on this including on rota, content of training and compliance with medical attendance at training sessions to help rule out cultural issues that may be at play.

- The midwife in charge of delivery suite said she did not have time to speak to the safety champion since she was in charge and was having to look after those in labour.

Triage

- The triage midwives were not able to speak to the NED safety champion when he visited and said they were too busy since there was no receptionist and no helpline person since they were off sick.

- The Executive Safety Champion visited the SGUH triage on several occasions. Staff noted progress with setting up the system to enable contemporaneous recording for calls to the helpline and triage. However, staff are now concerned that with calls rerouted from the helpline to the new location (in triage) when there is sickness during the day or during lunch breaks, the volume of calls increases.
- Similarly, staff highlighted that the midwifery staffing at night (1MW) in triage means that calls could be missed if the MW was reviewing a walk-in patient.
- Staff report that they have been told to do a business case for an additional MW for triage at night.

Obstetric theatre

- The safety champion walked into the SGUH obstetric theatre, and the scrub nurse was on speakerphone on a personal call in another room, there was no-one else in theatre – the drug fridge and controlled drugs cupboard were unlocked, and anyone could easily have walked out with handfuls of drugs without anyone noticing. This is very concerning, particularly given the recent Section 29A notice which flagged up controlled drugs.

Digital midwife

- The safety champion had a very positive conversation with the digital midwife who was very proud and dedicated to her work – she talked through the rollout of iCLIP and 2 other digitisation projects.
- She works in the same room as the person manning the help desk who sits next to her and is constantly talking to patients on the phone, which is a problem since it is very distracting and one side of the conversations can also be picked up when she is on a Teams call, which impacts confidentiality. She has raised this, but it has not yet been resolved.

  Action: review office space and find a solution to ensure conversations with women and birthing people are not overheard thus ensuring confidentiality

Gwillim Ward

- The Executive Safety Champion visited Gwillim ward on several occasions and in response to concerns raised by a concerned member of staff. Staff reported that there were concerns with a number of staff on the ward but that there was a reluctance to raise these issues with managers as there have been times when managers have requested that concerns are sent via email, only for the email to be forwarded to the member of staff named in the issue. Staff reported that they found this compromising to them and therefore have stopped raising any concerns
- A senior midwife also reported that there had been feedback from a relative who was clear that they did not want to make a complaint but instead made some suggestions for how things could be improved generally but that this feedback had been received negatively with some staff wanting to know who the feedback was from so they could review the notes to push back.

Action: The Executive Safety Champion has organised a series of learning sessions for all midwifery staff to explore the importance of professional behaviours and individual accountability. The sessions are being delivered by the Nursing and Midwifery Council and the first hybrid session (virtual and F2F) held on 17 January 2025 was well attended.

St Helier – visited 12 March 2025 accompanied by the Director of Midwifery

The NED safety champion carried out a walkaround of St Helier maternity service and found there is good evidence of action being taken in response to learning opportunities such as installation of a security camera in the assessment unit following safety issues raised 2 months previously in a baby abduction drill.

He observed that the controlled drugs cupboard was locked, with the lead midwife having the key for this. The cupboard was in good order and the logbook shows the drugs are consistently checked on every shift, and responsibilities in relation to this were clear.

The priority issues that would benefit from being addressed are:

- Conversion of a small bathroom in the triage area into a private assessment room to comply with the recommendations from the CQC visit, and to allow privacy when intimate examination or difficult conversations are needed as part of triage. The NED safety champion iterated this is a priority from a quality and patient experience perspective.
- Maternity ward bathroom refits, this is required since the standard is unacceptable with one being out of use and another having a shower that is unusable and a window that does not close. Again, the NED safety champion viewed this to be a key requirement to ensure an acceptable patient experience.
- The NED safety champion was told that there can be a problem with obstetric support for triage at the weekends, with the obstetric team having to cover gynae as well and sometimes not managing to review women within the correct timeframe. The results of triage audits were shared with the NED safety champion, which showed good achievement of time to triage targets by midwives. The audit could be improved to more clearly show how frequently obstetric review is delivered within the target timeframe and whether there is a significant reduction in performance at weekends.

3.0 General reflections from walkaround

The overall reflection from the NED Safety Champion visit to SGUH on 20 February 2025 is as below.

"I remain concerned about the maternity unit at St George's, particularly regarding resistance to change and the lack of progress on previously raised critical issues. The incoming interim Director of Midwifery will face significant challenges and will need to be both robust and willing to address these issues directly, despite potential resistance. It would be helpful to receive information about the incoming interim DOM's level of experience to understand their capacity to navigate these challenges effectively. I also understand there will soon be a change in the Obstetric Clinical Director role—again, it would be reassuring to have confidence in their ability to influence culture and drive forward the necessary changes."

The overall reflection from the NED Safety Champion visit to St Helier on 12 March 2025 is as below.

''The general impression was of happy team members who know what they are meant to be doing and work well together. A good example of this is the team who look after the Birth Centre who readily deploy across to labour ward when not needed in the Birth Centre, with labour ward midwives covering back across if needed. This seems to work seamlessly, and the staff are happy with the arrangement. Unsurprisingly, the estate is seen as a key challenge. The general infrastructure is poor in keeping with the rest of the St Helier estate''.

Action: provide the safety champion with information on the incoming Director of Midwifery and Clinical Director for SGUH

4.0 Actions

Issue / concern	Action required	Lead	Due
Discharge co-ordinator no longer has access to medical notes to do her job	Re-instate appropriate access for the discharge co-ordinator	SGUH Director of Midwifery with CERNER change Team	31 March 2025 Complete
Telephone numbers are not pulling through from iClip to the postnatal discharge paperwork	Escalate to ICT Governance Director (John Taylor) and CERNER Change Team	SGUH Director of Midwifery with CERNER change Team	31 March 2025 Issue fixed / complete
PSII can take up to 6months to complete, therefore learning is not timely	Provide evidence of early learning and dissemination of learning	Emily Kaliwoh – SGUH Governance Midwife	21 March 2025 Complete
Matrons – delay in reviewing and closing Datix incidents	Discussion with matrons to explore challenges and agree solutions to ensure timely reviews	Fiona Walkinshaw SGUH Deputy Director of Midwifery	21 March 2025 Complete
Lack of clear guidelines on how to perform fresh eyes audit	Establish requirement from SBLCBv3 team and National Team	Austin Ugwumadu SGUH Consultant and Obstetric Lead for Fetal Monitoring Virginia Whelehan SGUH Lead Midwife Fetal Monitoring Katie Russell ESTH Fetal Monitoring Midiwfe	30 April 2025 In progress with SGUH and ESTH fetal monitoring team
Obstetric registrars do not respond to midwife escalations in a timely manner and when they do, they only review CTGs via the central monitoring rather than a holistic review in the room	Assurance required on training, including content, attendance at training and rota	Jesica Moore Clinical Director until 31 March 2025 Hugh Byrne Clinical Director from 1 April 2025	11 April 2025
Help desk staff and digital midwife share an office, which impacts confidentiality of conversations with women and birthing people	Review office space and find a solution to the issue	Marie Monahan SGUH Deputy General Manager – Women's Health	30 April 2025
Professional behaviours not always displayed	Arrange on going learning sessions with the NMC for the rest of the year	GCNO	April 2025
Lack of a private space in ESTH triage	Convert the small bathroom in the triage area into a private space to allow for private discussions and examination	Anu Sharma, ESTH General Manager	July 2025
ESTH: challenges with availability of obstetric	Review triage processes, including improving	Radhika Viswanatha, Clinical Director	May 2025

staff for triage at weekends	medical oversight of triage and auditing medical attendance within the target timeframe	Suzanne Powroznyk, Inpatient matron	
ESTH: lack of usable bathrooms of acceptable standards on the Maternity ward	Refit bathrooms to an acceptable standard, to ensure good level of patient experience	Anu Sharma General Manager	July 2025

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	2.4	
Report Title	**Group IQPR**	
Executive Lead(s)	Michael Pantlin - Group Deputy Chief Executive Officer	
Report Author(s)	Group Director of Performance & PMO, ESTH & SGUH Site COOs, Group Chief Nursing Officer, Group Chief Medical Officer	
Previously considered by	Finance Committees-in-Common Quality Committees-in-Common	-
Purpose	**For Review**	

Executive Summary

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

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

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

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

This report format and content will continue to evolve in 2025/26, to reflect the annual plans of the Trusts and as new guidance emerges – such as the Performance Assessment Framework.

Action required by Group Board

The Board is asked to:

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

Committee Assurance

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

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

gesh

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

Group Integrated Quality & Performance Report

March 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 17 April 2025 | Contact: gesh.performance@stgeorges.nhs.uk

gesh CARE Board
Board to Ward Improvement Priorities for 2025/26

C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
Reduce average Non-Elective LOS: SGUH – 10.3 days – normal variation ESTH - 12 days – increasing trend	**Deliver Financial Plan:** Both organisations delivered their financial plan for 24/25	**Achieve Mortality Ratios (SMHI) of 1 or less:** SGUH – 0.86 (below expected) upcoming SDEC reporting likely to adversely impact reported performance ESTH - 1.16 (above expected) (*partly attributable to coding changes)*	**Reduce Staff Turnover Rates <13%** SGUH – 10.6% Achieving Target ESTH - 10.31% Achieving Target
Reduce demand at front door (A&E Attenders): SGUH – 430 per day (2024/25 average 417) ESTH - 442 per day (2024/25 average 434)	**Realise Productivity Opportunities:** - SGUH target 105.0% forecast outturn 111.9% - ESTH target of 107.4%, forecast outturn 111.9%	**Improve VTE Risk Assessment Rates**: SGUH – 63.9%, which is higher than the rate in the previous month but still below target ESTH - 83.8% below target	**Reduce staff sickness absence rates** SGUH - 4.1% vs. target of 3.2% ESTH – 4.8% vs. target of 3.8% Sutton – 4.6% vs. target of 3.8% Surrey Downs – 3.9% vs target of 3.8%
	Deliver CIP Target - SGUH £66.7m and fully delivered - ESTH £40.1m and fully delivered	**Maintain ED 12-hour waits at or below the previous year's level:** SGUH – 8.7% vs. baseline (23/24) of 8.8% ESTH - 14.1% vs. baseline (23/24) of 9.6%	
		Improve in RTT 18 –Weeks Performance by 5%: SGUH –61.6% (March 26 Target of 67.6%) ESTH - 65.3% (March 26 Target 70.4%)	
		Deliver 78% 4-hr A&E Performance by March 26: SGUH –83.6% Exceeding Target ESTH - 74.1% Below Target	

Executive Summary
Safe, High-Quality Care

St George's Hospital

Successes

- **Mortality:** Mortality rates, as indicated by the Summary Hospital-level Mortality Indicator (SHMI), are currently below expected levels at 0.86. The inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set at SGUH may negatively impact SHMI and this will be monitored when the change to reporting is implemented. Impact analysis is included in this month's report.
- **Complaints:** SGUH consistently meets the targets for acknowledging complaints within 3 working days and responding to them within 35 days.
- **Pressure Ulcers:** No category 4 pressure ulcers were reported in February or March 2025.
- **Falls prevention and Management:** Moderate and above harm falls per 1,000 bed days were 0.08 in March 2025, below the quality priority target

Challenges

- **Patient Safety Incident Investigations (PSII):** Two Patient Safety Incident Investigations (PSIIs) were declared at SGUH in March 2025, both in Obstetrics.
- **Pressure Ulcers** In March 2025, one category 3 medical device-related pressure ulcer was reported in CTICU, linked to a cast left on longer than expected due to limited theatre availability.
- **Falls Prevention and Management:** In March 2025, there were 2 moderate harm falls. One fall occurred on Keate Ward resulting in a fractured Neck of Femur. The other fall which occurred in Delivery Suite remains classified as moderate harm due to the Maternity Improvement Plan, despite no actual harm to the baby. The overall number of moderate and above harm falls for SGUH is very similar for 24/25 (31) compared with 23/24 (30) and exceeds the quality priority target of 17. Falls action plan is in place.
- **VTE:** In March 2025, VTE risk assessment compliance within 14 hours of admission slightly increased to 65.9%, up from 62.1% in February 2025, but remains below the 95% target set by NICE guidelines. Actions include a trust-wide review of VTE risk assessment forms and the VTE prevention strategy.
- **Readmission**: Readmission rates remain elevated, mainly due to increased returns to Same Day Emergency Care (SDEC) following expansion of surgical SDEC. Readmissions to non-SDEC areas remain steady at 7%.
- **Infection Control:** C diff YTD 2024/25 60 against the annual threshold of 43. 1 MRSA bactereamia for 2024/25, national threshold is zero avoidable cases. Unavoidable case with a complex medical history.

Epsom & St Helier

Successes

- **Pressure Ulcers**: In March 2025 there were 6 category 2 acquired pressure ulcers this is similar to previous months. There were zero acquired category 3 or 4 pressure ulcers. The total number of category 3 pressure ulcers for 24/25 (3) is below the quality priority target of 7 and there were zero category 4 pressure ulcers in 24/25 meeting the quality priority target of zero.
- **Falls:** In March 2025 there were a total of 84 falls reported in the Acute Services (3.9 /1000 OBDs), marginally less than the previous month. The percentage of unwitnessed falls has seen a 5% reduction from the previous month.

Challenges

- **Complaints:** ESTH has shown a continued decline in performance against the target for acknowledging complaints within three working days. Plans are in place to rectify this.
- **Pressure Ulcers**: In March 2025 there were 3 acquired medical device related deep tissue injuries reported. These were all associated with non-invasive ventilation; the tissues viability team is working with the areas effected, Critical Care Outreach Team and the respiratory Consultant Nurse Specialist to investigate the incidents and agree actions going forward.
- **Falls Prevention and Management:** There was 1 fall reported with severe harm in March 2025 (0.05/1000 OBDs) occurring on the Epsom site at ED SDEC whereby an acutely confused patient fell and sustained a hip fracture. To support the department, the Falls CNS completed an environmental review of the area. The overall number of moderate and above harm falls for ESTH is very similar for 24/25 (19) compared with 23/24 (18) and exceeds the quality priority target of 12. A Trust falls action plan is in place.
- **VTE:** The Trust's VTE performance for March 2025 was 83.8%. The Trust has not met the quality priority target of an increase of 10%. Work is underway to further improve data quality with a focus on low-risk cohorts.
- **Mortality:** SHMI remains high and stable, largely due to the inclusion of SDEC data in the Emergency Care Data Set over the past few months.
- **Infection Control:** C diff: YTD 2024/25 - 75 against the annual threshold of 43. 1 MRSA bactareamia for 2024/25, national threshold is zero avoidable cases. Water Safety issues with positive legionella and pseudomonas from water sampling. Factors to mitigate the risks have been put into place. Actions being monitored via group IPC and ESTH Infrastructure meeting.

Executive Summary
Operational Performance & Productivity

St George's Hospital

Successes

- St George's cancer performance trajectories continued to be met in February 2025: 28-Day Faster Diagnosis Standard (86.5%), 31 Day Standard (96.1%) and 62-Day Treatment Standard (81%).
- Value weighted activity as a percentage of total OP activity continues to exceed target, achieving 50.3% (above the national ask of 49%).
- Diagnostic Performance improved driven by an increase in imaging activity, returning to compliance against the 5% target with 95.3% of patients waiting less than 6 weeks for their diagnostic performance at the end of February.
- Performance against the 4-hour standard continues to exceed the national requirement, with a performance of 83.6% through March 2025.

Challenges

- Patient Initiated Follow Ups (PIFU) rates are below the target of 5%, although continuing to see month-on-month increase. General Cardiology, ICC and Neurology to go live through April 2025, then full roll-out planned to all other specialities.
- Further increase in the number of long waiting patients on a referral to treatment pathway, with 75 patients waiting more than 65 weeks and 1,084 patients above 52 weeks, driven mainly by Neurosurgery and Bariatric Surgery. As of 31st March 2025, 48 patients had appointments scheduled beyond March 2025. The Trust is participating in the national Sprint programme to support full validation of the wait list and is working with the ICB to ensure we are commissioned appropriately to provide services.BADs performance has improved however an outlier against peers. Extensive work has been completed within Breast to identify what the challenges are and a number of are now in place which will be shared with all specialties and we expect performance to improve over the coming months.
- A high proportion of beds continue to be occupied by patients who do not meet the criteria to reside with delays impacted by interface process with social and Residential / nursing home care arrangements and subsequently we have seen the average number of inpatients with a length of stay of over 21 days increase.

Epsom & St Helier

Successes

- Theatre utilisation (capped) remains high at 81.92% in March 2025 and is in the top quartile nationally.
- Cancer performance standards were achieved in February 2025: 28-day Faster Diagnosis standard (82.3%), 31-day standard (100%), and 62-day standard (85.6%).
- Did not attend (DNA) rate reduced to 6.4% in March 2025, ranked 3rd in London.
- 4.7% Patient Initiated Follow Ups (PIFU) rate achieved in March 2025.
- The Trust achieved the ambition to be below 715 in February 2025 for RTT 52-week waits, with 659 patients waiting >52 weeks, the 4th consecutive month that the ambition has been achieved in 2024/25.
- EGH's LOS dropped by 1.43 days (12.42 to 10.99) in March 2025, mainly due to complex patient discharges in February. In contrast, STH's LOS rose by 1.84 days (9.18 to 11.02), influenced by the March discharge of several complex cases, including one with a 489-day stay.
- Whilst above the ambition, March 2025 reports a 16% reduction in 30–60-minute ambulance handovers and a 19% reduction in +60-minute ambulance handovers compared to February 2025.
- Diagnostic waits (DM01) of >6 weeks reduced from 975 in January 2025 to 705 in February 2025.

Challenges

- Emergency department waiting times remained a challenge in March 2025 due to a combination of a 17% month on month increase in Type 1 attendances combined with 22% of overall attendances arriving by ambulance.
- Mental health patients continue to experience prolonged delays in the emergency department prior to transfer to an inpatient mental health bed.
- The Trust's average length of stay (LOS) increased by 0.3 days in March 2025 and is driven by an increase in LOS on the STH site.
- Increasing delays in cancer pathways due to extended waiting times for external diagnostics, including a 3-4 week wait for Endoscopic Ultrasound Staging (EUS). Delays in lung cancer diagnoses are rising due to higher referrals for Navigational Bronchoscopy, at the Royal Brompton. Additionally, PET scans at The Royal Marsden (RMH are delayed due to F-18 FDG (Fludeoxyglucose) supply issues and further delays due to a broken scanner.
- Ongoing capacity issues are impacting the ability to book outpatient appointments within the 7-day ESTH local target, particularly in urology, dermatology, gynaecology, and lower GI. The Cancer Team is collaborating with service teams on demand and capacity modelling to identify areas for improvement.
- Reducing 65-week waits to 0 remains challenging, however plans are in place across the specialities to regularly review and monitor progress.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

- 2-Hour UCR Service performance continues to exceed target (KPI 70%) achieving 78.6% in March 2025 with referral numbers above 2024/25 average.
- Virtual Ward admissions increased through the month with increased occupancy rates at 79% (below KPI Target of 85%)
- DNA Rates reduced to below 3% across March 2025. MSK follow-up continues to see a higher proportion of patients not attending their appointment.
- Reduction in long term sickness (3.8%) due to improvements in Human Resources (HR) performance management.

Challenges

- The Childrens therapy waiting list has seen an increase through March 2025 to 938 from 842 at the end of February, with 73 children waiting over 52 weeks for Children's SALT Services. This has been raised with the ICB. Robust mitigations are in place.
- Virtual Ward admissions have increased 79% , although remained below KPI target of 85%. This was in part due to changes in consultant time for the ward. Mitigations and resolution in place. Changes to the target metric from 85%-90% have been agreed by SWL ICB from April 2025.

Surrey Downs Health & Care(SDHC)

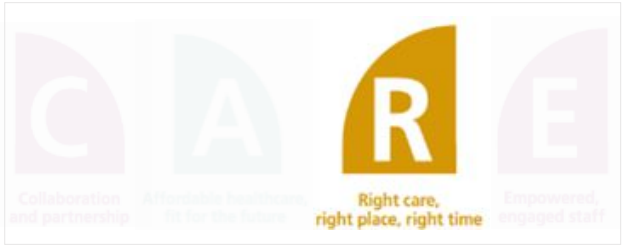
Successes

- Reduction in pressure ulcer cat 3&4 incidents in the reporting month
- Mary Seacole Unit (ESTH) received Silver Ward Accreditation
- Service consistently achieves the 2 –hour Urgent Community Response (UCR) target while managing high levels of referrals – 83.4% in March 2025 against a national target of 70%.
- Above target levels of Virtual ward occupancy rate at 86.2%
- Number of accepted referrals across the service is above the mean with the number of attended appointments showing normal variation. DNA Rate of 2.7% showing sustained improvement.
- Occupancy rate in bedded care was maintained meeting target of 80%.
- Reduction in number of patients waiting 18+ and no waits over 52 weeks.
- MAST compliance remained high in March at 93.5%, showing a slight improvement from 92.3% in February."
- Improvements in agency usage rate to 5.4% (including additionally funded winter projects) seen in February.

Challenges

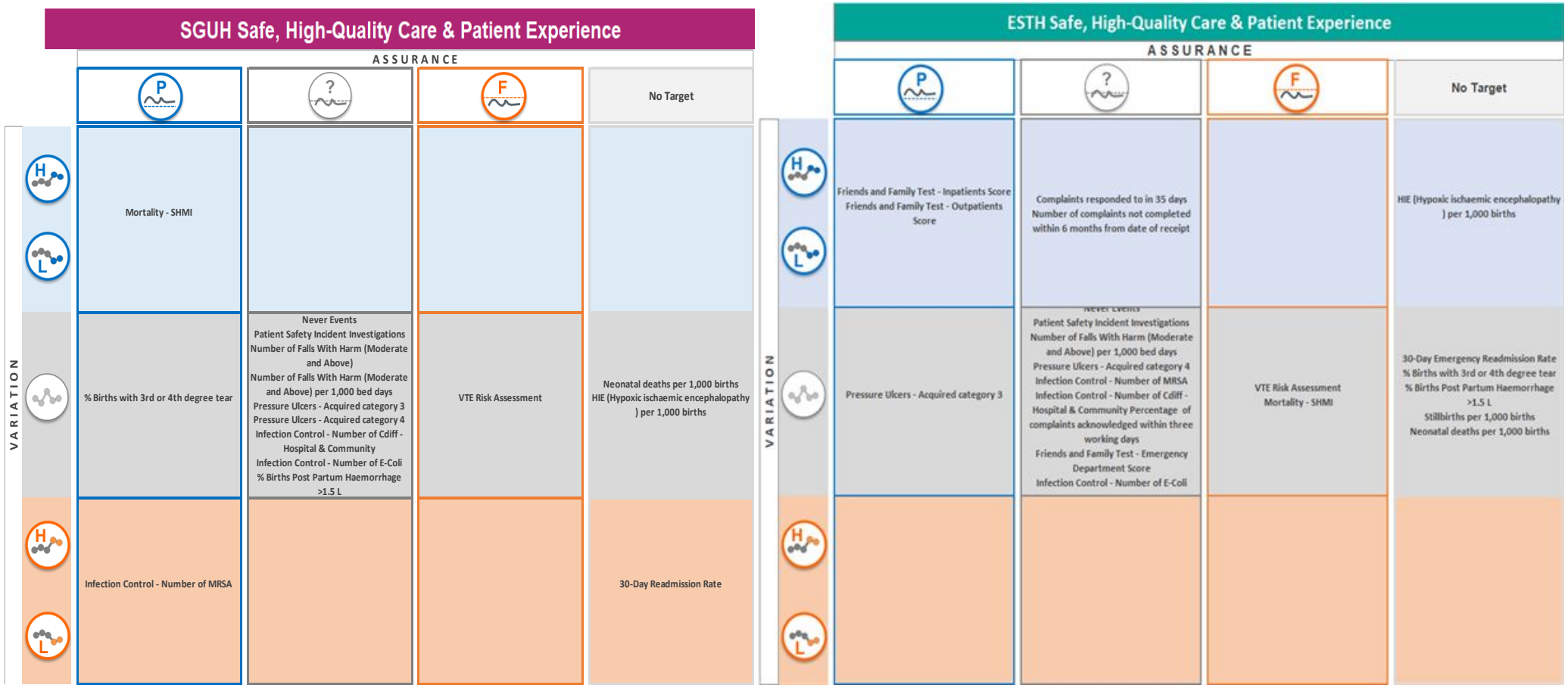
- Although improved sickness rate seen (3.91%) it remains marginally above the target of 3.8%.
- Improvements in Non-Medical Appraisal rate to 82.4% but still below that target of 90%-- staff support offered to improve this
- Number of Falls increased within Community Hospital (highest reported this year.

Quality & Safety



Safe, High-Quality Care & Patient Experience

Matrix Summary



Safe, High-Quality Care

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	Mar 25	0	0	0				Mar 25	0	2	0			
Patient Safety Incident Investigations	Mar 25	1	3	0				Mar 25	0	1	0			
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	Mar 25	0.18	0.08	0.12				Mar 25	0.15	0.05	0.03			
Pressure Ulcers - Acquired category 3	Mar 25	9	6	8				Mar 25	0	0	7			
Pressure Ulcers - Acquired category 4	Mar 25	0	0	0				Mar 25	0	0	0			
30-Day Readmission Rate	Feb 25	12.6%	12.5%	-				Feb 25	6.2%	6.0%	-			
Infection Control - Number of MRSA	Mar 25	0	1	0				Mar 25	0	0	0			
Infection Control - Number of Cdiff - Hospital & Community	Mar 25	3	5	4				Mar 25	2	1	5			
Infection Control - Number of E-Coli	Mar 25	10	9	10				Mar 25	3	3	5			
VTE Risk Assessment	Mar 25	62.2%	65.9%	95.0%				Mar 25	86.0%	83.8%	95.0%			
Mortality - SHMI	Nov 24	0.86	0.86	1.00				Nov 24	1.16	1.16	1.00			
% Births with 3rd or 4th degree tear	Mar 25	3.0%	3.0%	5.0%			3.1%	Mar 25	2.6%	2.7%	-			3.2%
% Births Post Partum Haemorrhage >1.5 L	Mar 25	4.3%	3.6%	4.0%			2.9%	Mar 25	4.2%	4.1%	-			3.2%
Stillbirths per 1,000 births	Mar 25	0.0	8.7	2.0			3.5	Mar 25	3.8	7.3	-			
Neonatal deaths per 1,000 births	Mar 25	3.2	5.8	-			1.6	Mar 25	0.0	0.0	-			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	Mar 25	0.0	2.9	-			1.0	Mar 25	0.0	0.0	-			

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

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

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

*Never Events are a subset of PSIIs

Safe, High-Quality Care
Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Complaints responded to in 35 days	Mar 25	100.0%	92.6%	85.0%			
Percentage of complaints acknowledged within three working days	Mar 25	100.0%	100.0%	100.0%			
Number of complaints not completed within 6 months from date of receipt	Mar 25	2	1	0			
Friends and Family Test - Inpatients Score	Mar 25	98.6%	98.6%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	Mar 25	80.2%	77.9%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	Mar 25	94.3%	94.7%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	Mar 25	79.3%	100.0%	90.0%			3rd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 25	91.0%	83.0%	85.0%			
Mar 25	100.0%	100.0%	100.0%			
Mar 25	7	7	0			
Mar 25	99.0%	100.0%	90.0%			3rd Quartile
Mar 25	0.0%	79.0%	90.0%			3rd Quartile
Mar 25	98.0%	98.7%	90.0%			2nd Quartile
Mar 25	N/A	100.0%	90.0%			N/A

To Note: Complaints and PHSO Metrics have been moved to Watch List Metrics Slide 40

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	Mar 25	0	0	-		
Number of Falls	Mar 25	7	4	-		
Pressure Ulcers Category 3	Mar 25	4	0	0		
Pressure Ulcers Category 4	Mar 25	0	0	0		
Infection Control - Number of Cdiff	Mar 25	0	0	-		
Complaints	Mar 25	0	0	-		
Community FFT	Oct 24	96%	95%	90%		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Mar 25	0	0	-		
Mar 25	12	20	-		
Mar 25	4	3	0		
Mar 25	1	0	0		
Mar 25	0	0	-		
Mar 25	1	0	-		
Oct 24	98%	96%	90%		

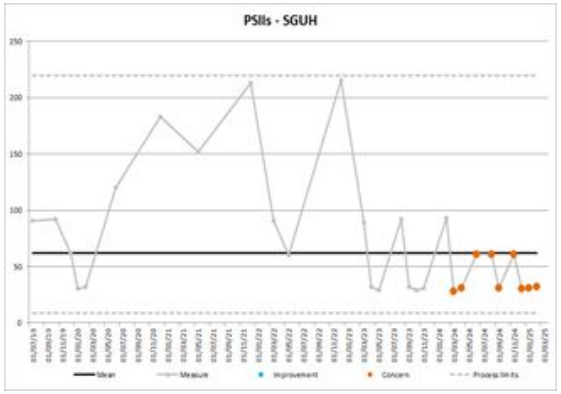
9

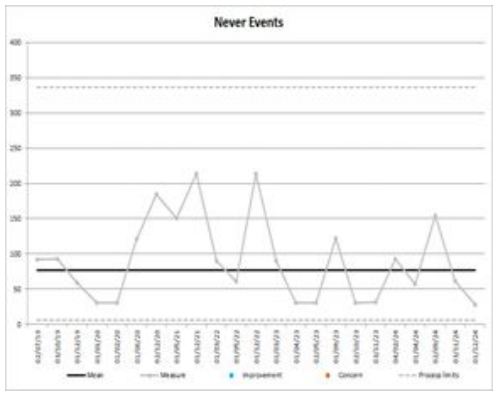
*Community FFT is a subset of Epsom and St Heliers FFT data. The migration to a new system for FFT, has meant a split for Community is difficult. Under Review.

Safe, High-Quality Care

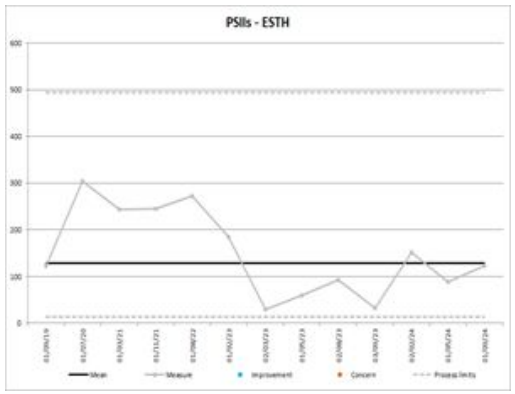
Incident Reporting- Charts now measure Time between incidents

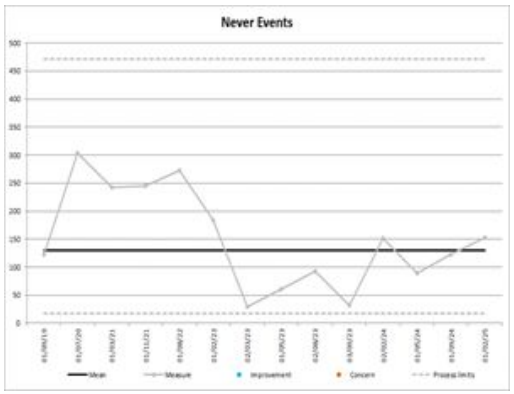
St George's





Epsom & St Helier



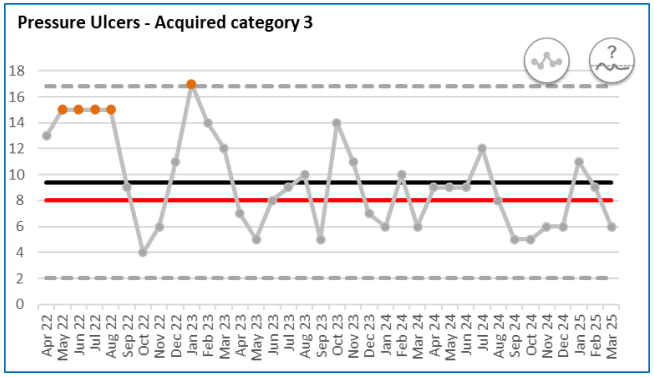


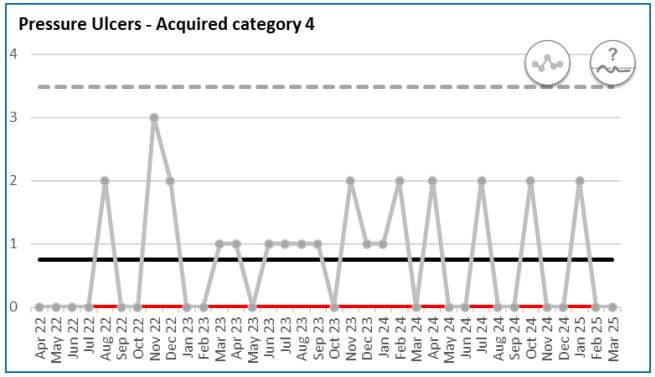
Summary & Actions	Summary & Actions	Summary & Actions	Summary & Actions
Two Patient Safety Incident Investigations (PSIIs) were declared at SGUH in March 2025, both in Obstetrics. These included one maternal death and one unexpected admission to NNU, both of which are being externally investigated by the Maternity and Newborn Safety Investigation (MNSI) programme.	No Never Events were reported at SGUH in March 2025.	Two Patient Safety Incident Investigations (PSIIs) were declared at ESTH in March 2025, both in Planned Care Division. Please see details on NE section. Both incidents will be grouped together and investigated under the same theme	Two Never Events were reported at ESTH in March 2025, both in Planned Care Division. These include a wrong implant used as part of an Endoscopy procedure and a wrong implant used as part of an Orthopaedic surgery in Theatres. Both incidents are being investigated as PSIIs .

The T Charts above measures the number of days between incidents. A good result is when the days between incidents are long

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers - Category 3 & 4



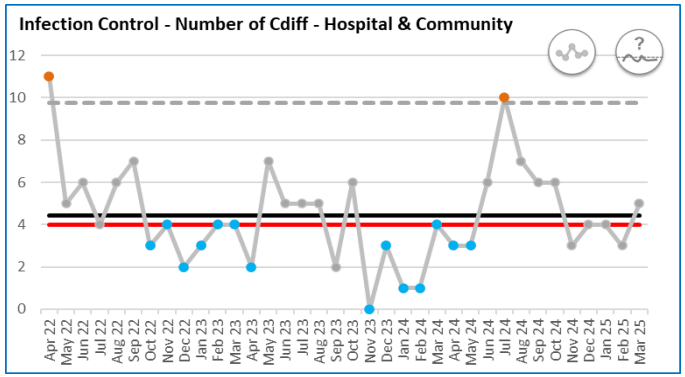


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Category 3 Quality Priority - 95 YTD against Ambition of 89 currently achieving YTD Pressure Ulcers Category 4 Quality Priority 8 YTD against Ambition of 0	• SGUH did not meet the 24/25 quality priority targets for Category 3 and 4 pressure ulcers. However, there was a reduction in the number of pressure ulcers compared to the numbers seen in 2023/2024. • There were zero category 4 pressure ulcers reported in February and March 2025, there were however 6 category 3 pressure ulcers acquired in March 2025, down from January (11) February (9) 2025. • There were 1 Category 3 medical device-related pressure ulcer reported in March 2025, this was acquired in CTICU and as a result of a cast and delays in surgery due to theatre space. SGUH did not meet the 24/25 quality priority targets for Category 3 and 4 pressure ulcers • All patients who developed a Category 3 pressure ulcers in March 2025 were very frail, acutely unwell, and had nutritional deficiencies. . • Inaccuracy in skin assessment documentation and completion of wound assessment and treatment charts continues to be an ongoing theme and may be contributing to the delayed identification and escalation of pressure ulcers at an earlier category (Category 1 or 2).	• The Dynamic Healthcare and Medical Physics teams will continue the gradual mattress replacement program, with completion expected by August 2025. • Trialling After Actions Reviews (AAR) - (new governance process in line with PSIRF). Working in conjunction with quality team across GESH on new PSIRF process. • A working group has been established by the SGUH Deputy Chief Nurses, with support from procurement and the ESTH continence lead, to review continence products at SGH, including catheter fixation devices. • HCA refresher training sessions commenced in February and continued in March and into April, feedback has been extremely positive • CTICU pressure ulcer quality summit occurred in the first week of April 2025, multiple pressure ulcer prevention projects underway across all adult critical care areas. Site CNO and tissue viability team continue to monitor. • The new nationally recommended pressure ulcer risk assessment Purpose –T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool)	Targets under review for 2025/26	Sufficient for assurance

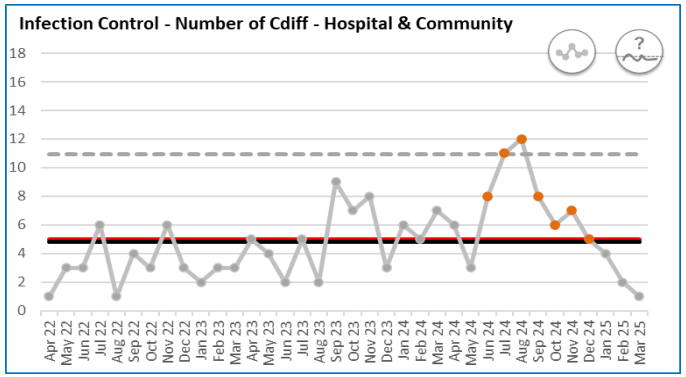
Safe, High-Quality Care

Exception Report | SGUH & ESTH - Infection Prevention and Control

St George's



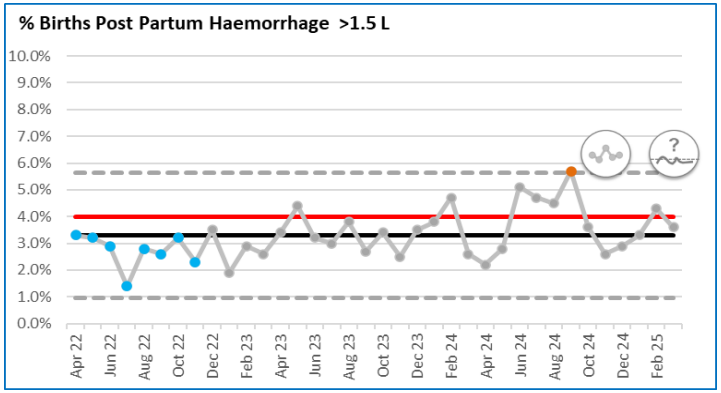
Epsom & St Helier



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH and ESTH : C.difficile Infections (CDI), and MRSA	**Healthcare Associated CDIs:** Both sites have exceeded the annual threshold for 2024/25 • **SGUH: YTD** 2024/25 60 against the annual threshold of 43. • **ESTH**: YTD 2024/25 75 against the annual threshold of 43. **Healthcare Associated MRSA Bacteraemia:** • Both sites had 1 MRSA bactareamia, national threshold is zero avoidable cases	• Both sites: Continue with reviews and identify areas of focused training. Awaiting new national recommendations to reduce increase in incidence from UKHSA • Both cases were unavoidable, lessons learned from review shared widely.	October 2025 achieve aim of a downward trend. Zero avoidable cases for 2025/2026	Sufficient for assurance
ESTH: Water Safety - positive legionella and pseudomonas.	• ongoing issues in E block, STH with legionella and pseudomonas.	• Immediate mitigations- point of use filters (POUs) installed. Agreed to use biocide treatment as a medium solution whilst a permanent solution is being costed ie change complete change of pipework as part of the bigger E block project • Action plan presented at group Estates Infrastructure meeting and progress to be monitored via group IPC strategy meeting	July 2025 remedial works completed/ exit plan for POUs agreed	Sufficient for assurance

Safe, High-Quality Care

Exception Report | SGUH | % of Births with Post Partum Haemorrhage >1.5L

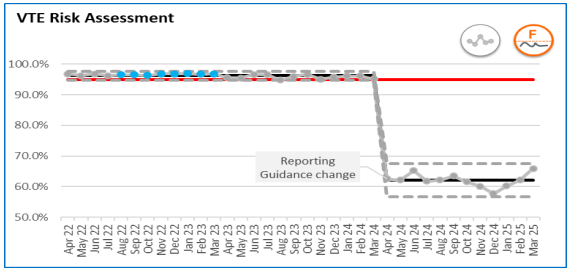


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH The percentage of births with Post Partum Haemorrhage >1.5L and now shows common cause variation.	In February 2025, National Maternity and Perinatal audit notified SGUH that they were flagging as a potential alarm-level outlier for postpartum haemorrhage >1.5L. (PPH) . In March 2025 percentage of Births Post Partum Haemorrhage >1.5L was 3.6% below local target at 4%, and against peer average of 3.1%.	The Trust has carefully analysed potential contributory clinical factors by undertaking a deep dive into PPH data for 2024, which has shown that in addition to factors such as being a placenta accreta spectrum referral centre, undertaking caesarean section for raised BMI (BMI 50), which are known causes for PPH, the data review shows the majority of PPH were associated with spontaneous vaginal delivery following induction of labour, and additionally following forceps delivery due to perineal trauma.	TBC	Not sufficient for assurance

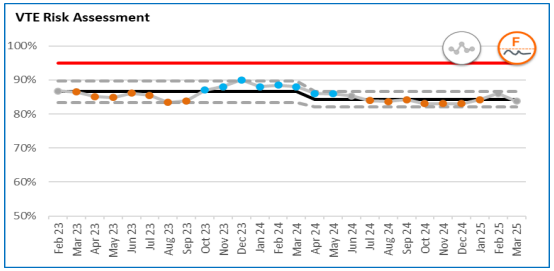
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



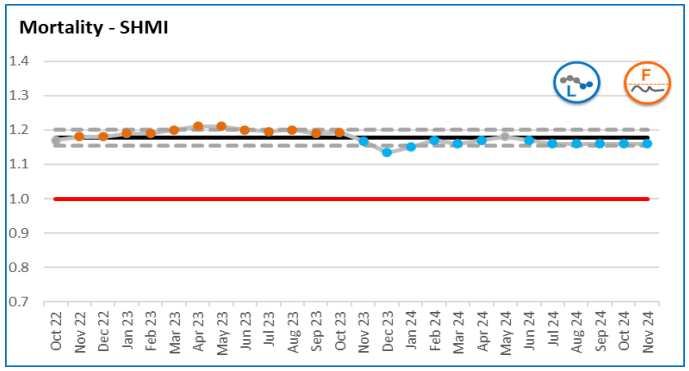
Epsom & St Helier

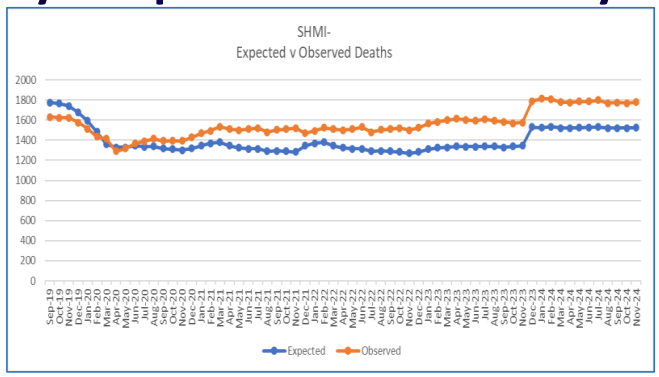


Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE 63.9%. Not meeting target of 95%	• Change in national guidance Apr 2024, now reporting VTE assessment as complete only when done within 14 hours of admission, previous reporting did not consider when the risk assessment was completed leading to a significant decrease in performance. • System pop-up can be overridden within the first 6 hours of admission. • Assessments are not currently triggered for patients with an iClip location of Emergency Department (ED) (low compliance) or on the newly opened Major Trauma ward • Requirement for only doctors and dentists to complete online MAST training and compliance currently sits at 78.1% overall. Training isn't mandatory for the rest of the multidisciplinary team	• VTE Annual Deep Dive presented at Quality Committee in March 2025 • Variation between sites in the way data is collected and performance is audited. The forthcoming transition to Cerner Electronic patient records at ESTH will facilitate this. • Agree and standardise data collection and quality assurance methodologies for both sites, in line with the national standards • The role of the Hospital Thrombosis Group will be reviewed, with a clear gesh steering group structure for oversight and monitoring and accountability through site Divisions and governance structures. • Revise the format, rules and controls for the iclip digital VTE risk assessment form as part of the shared EPR • Review risk assessment performance data at a Divisional level with each Division as part of their fundamentals of care programme • Agree trajectories for improvement on both sites • Agree Divisional Improvement Plans with each Division • Agree a gesh policy on prevention of VTE • Establish gesh VTE champions in key areas across both sites • Improve MAST compliance and targeted training and support for underperforming areas • Agreement that ESTH will change current reporting logic to - Number of patients with risk assessments completed within 14 hours of a Decision to Admit (DTA), if admitted via the Emergency Department	Trajectories under review for 2025/26	Not sufficient for assurance.
ESTH: VTE 84%. Not meeting target of 95%	• Previously reporting on VTE assessments done within 24 hours of admission and only included patients 18 years and over. ICM was updated in April 2024 to include screening of 16–18-year-olds and the 14-hour target • Data quality issues include missing or incomplete coding on the low-risk procedures • Lack of robust process to determine whether risk assessments took place at off-site locations such as Roehampton. • The results of recent review provided insight into 37 (new) procedures that are not currently in the low-risk cohort group. • In Chuter Ede AMU, completion of VTE risk assessment is not embedded into practice and doctors require prompting to do this. • ESTH meets its overall MAST VTE compliance target, although doctors are not compliant		Trajectories under review for 2025/26	Not sufficient for assurance.

Safe, High-Quality Care

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





SHMI Source NHS Digital data based on rolling 12 months-October 2023 to November 2024 reported in April 2025

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently above expected rate	ESTH's mortality index is classified as 'higher than expected', but it shows a consistent trend. In 2020, ESTH reclassified Same Day Emergency Care (SDEC) activity as non-inpatient activity. This change reduced the total spell count used in the Summary Hospital-level Mortality Indicator (SHMI) model, leading to a decrease in the expected number of deaths, a trend that has been evident since then. Other Trusts were initially expected to adopt a similar reporting approach by July 2024. However, national data shows that by the end of September 2024, only 48 Trusts had submitted data, up from just 18 at the end of the previous year. As a result, NHSE has extended the deadline for Trusts to implement this reporting change to July 2025.	Comprehensive deep dives and thematic analyses of outlying areas have been conducted, covering electrolyte imbalances, UTIs, COPD, and pneumonia. The findings did not indicate any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has highlighted areas for improvement. Any identified care concerns are reported and thoroughly investigated Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. Collaboration between clinicians and coders will be highly beneficial in improving record accuracy. While coding has improved and continues to be reviewed, further enhancements are needed in areas such as UTI and Acute Bronchitis Several enhanced monitoring workstreams are in place, including mortality reviews and medical examiner scrutiny	Under review	sufficient for assurance

Safe, High-Quality Care

Exception Report | SGUH - SDEC Reporting change impact on SHMI

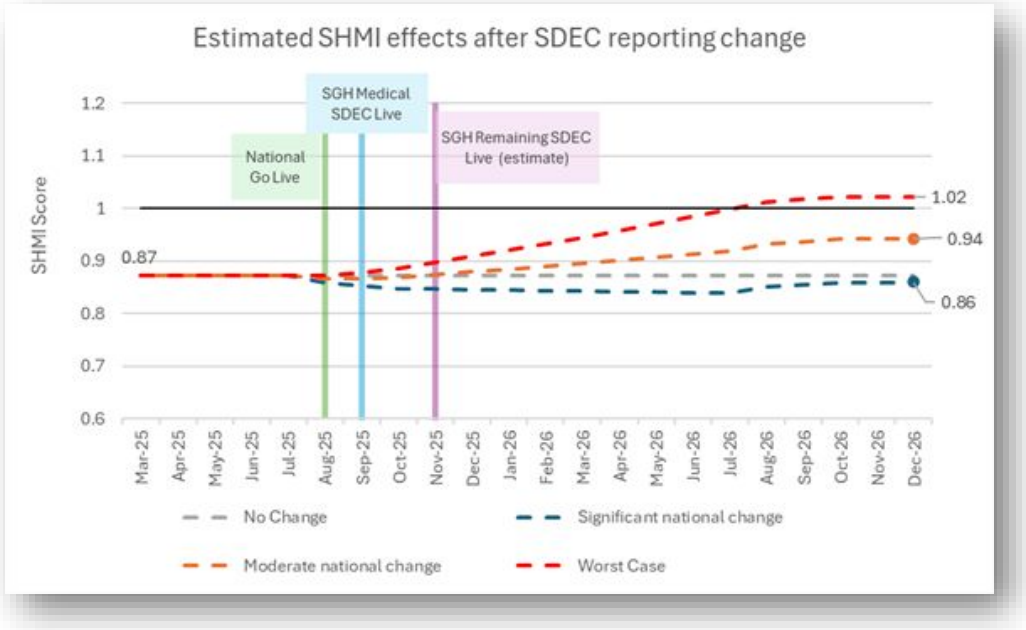
SGUH's SHMI score is expected to increase (worsen) when the Trust transitions SDEC reporting from Admitted Patient Care episodes to Emergency Care Data Set (ECDS) Type 5 activity, in line with the national directive requiring all Trusts to implement this change by July 2025. The extent of the impact will depend on how many other Trusts have also complied at the time of SGUH's transition.

Since SHMI is a comparative measure, if SGUH adopts the change ahead of others, its score may appear artificially higher due to the removal of lower-risk admissions, while other Trusts continue to benefit from their current reporting structure. However, if compliance is widespread by the time SGUH transitions, the effect on its relative SHMI position will be less significant.

Based on SGUH's current strong performance (0.87 in the 12 months to October 2024) and its plan to phase in the reporting change from August 2025, our modelling indicates a worst-case scenario score of 1.02 (marginally above the standardised 'middle' value of 1) and a likely (moderate scenario) score of 0.96, as shown in the chart overleaf.
Experience from ESTH suggests the following metrics could also be impacted by the transition

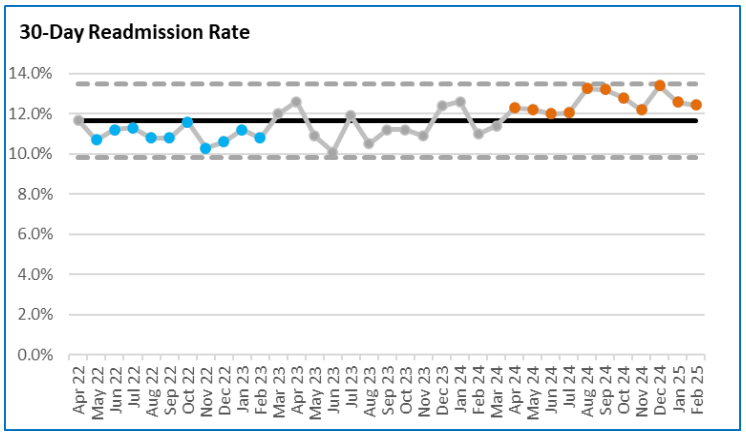
1. **Productivity** –deterioration due to reduction in admissions without a corresponding reduction in reported cost.
2. **Readmissions** –improvement due to exclusion of activity with a higher probability of readmission
3. **A&E conversion rates to admission** –improvement from a reduction in reported admission
4. **NEL LOS (1+) benchmarking** – depending on the scale of SDEC pathways nationally that include overnight stays.

This is closely monitored by operational and business intelligence teams.



Safe, High-Quality Care

Exception Report | SGUH Emergency Readmission Rates



	2023/24 Q1	2023/24 Q2	2023/24 Q3	2023/24 Q4	2024/25 Q1	2024/25 Q2
Readmissions	1,292	1,358	1,352	1,417	1,493	1,607
Denominator	11,582	12,080	11,758	12,120	12,181	12,336
Overall Readm Rate	11.2%	11.2%	11.5%	11.7%	12.3%	13.0%
Overall Readm to SDEC Rate	4.0%	3.8%	4.0%	4.5%	5.1%	6.0%
Overall Readmission to Non-SDEC Rate	7.1%	7.5%	7.5%	7.2%	7.2%	7.0%
Readmissions to SDEC	464	454	466	542	618	746

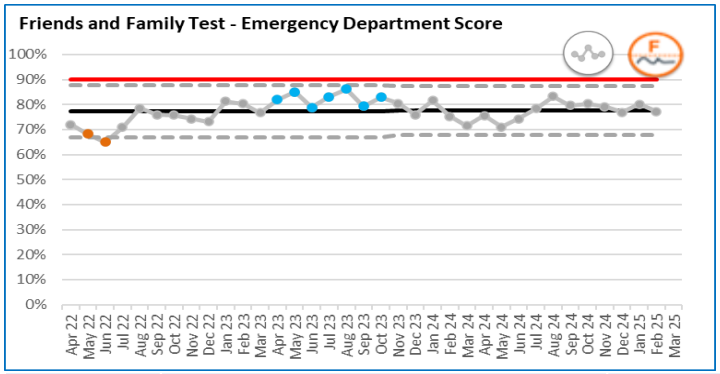
Expansion of Surgical SDEC Impact

Readmissions to SDEC: Nye Bevan	*144*	*156*	*144*	*139*	*191*	*306*
Readm to SDEC Nye Bevan Rate	*1.2%*	*1.3%*	*1.2%*	*1.1%*	*1.6%*	*2.5%*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: Upward trend in Emergency readmissions within 30 days of a prior inpatient spell.	The overall rate saw a slight increase between 2022/23 and 2023/24; however, the quarterly rate for 2024/25 has risen significantly. Analysis indicates that the increase is driven by activity into Same Day Emergency Care (SDEC) areas, particularly following the expansion of surgical SDEC at the end of Q1 2024/25 (Nye Bevan). SDEC activity is mainly coded as an inpatient admission method and patients can have multiple attendances with the aim to avoid hospital admission with overnight stay – this has seen an impact on readmission rates. Readmission rates to non-SDEC areas are very steady around 7%. This has currently not been identified as an emerging theme within patient safety but will be monitored.	• Reviewing Same Day Emergency Care (SDEC) pathways to assess and optimize patient flow and service efficiency. • Migrated SDEC activity reporting from the Admitted Patient Care (APC) data set to the Emergency Care Data Set (ECDS), in line with national directive to all providers, is due to be implemented at SGUH in July 2025. The deadline for Trusts to implement the change has been extended each year, the latest extension is to July 2025. • **Process limits will be recalculated to reflect the change outlined. This will eliminate the need for exception reporting from next month.**	N/A	sufficient for assurance

Safe, High-Quality Care

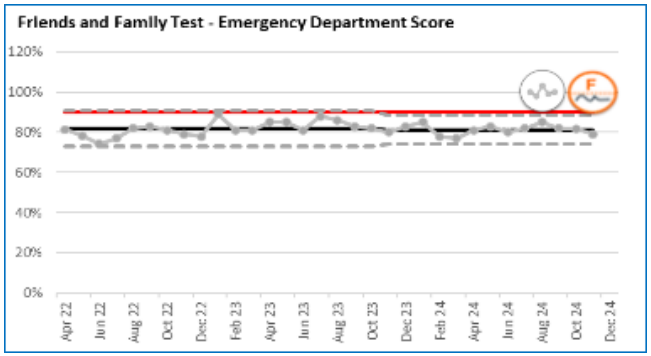
Exception Report | SGUH Emergency Department Patient Experience

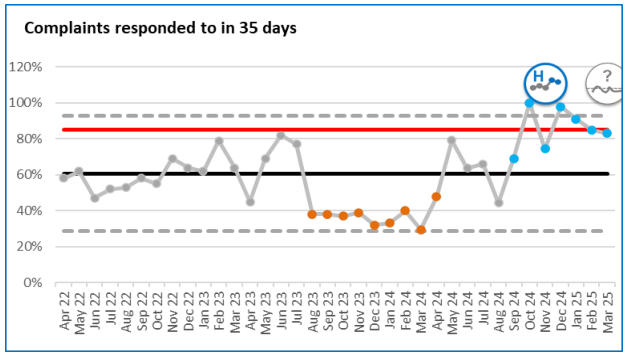


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score Special case concerning variation Consistently failing target	The ED FFT survey response rate continues to be well above the national average with 1,378 patients responding to the survey in March 2025. The number of patients that would recommend the department to friends and family was 78% for March 2025 - a slight increase compared on the previous month. During March 2025 , the number of ED attendances and patients waiting for a bed in the department remained high with the most consistent theme for negative responses being waiting times.	**Ac**tions for improving patient experience whilst waiting in ED include: 1. Review of patient feedback by each area with the relevant leads to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 3. Standardised documentation template for use by RNs when looking after patients in the corridor – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments. We are also offering all patients a comfort pack, consisting of eye masks and ear plugs - ongoing 4. Nurse In Charge (NIC) checklist on RATE – quality checklist to be completed by NIC at the start of each shift to identify safety checks completed within the department - ongoing 5. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles - ongoing 6. Consultant Referral and Triage (RAT) rota ongoing. Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary - ongoing 7. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 8. Same Day Emergency Care (SDEC) ongoing - 10 new clinical pathways for medical SDEC launched to redirect patients to medical service if more appropriate. Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic - ongoing	TBC	sufficient for assurance

Safe, High-Quality Care

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



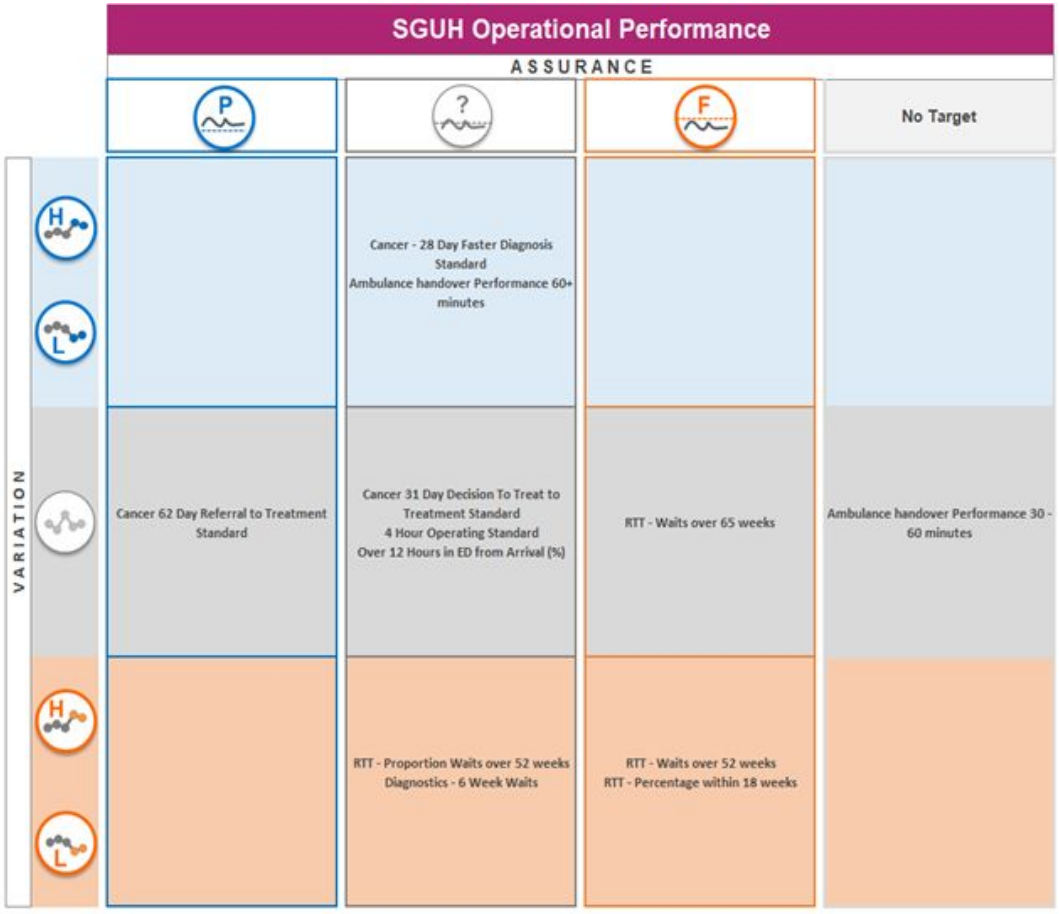


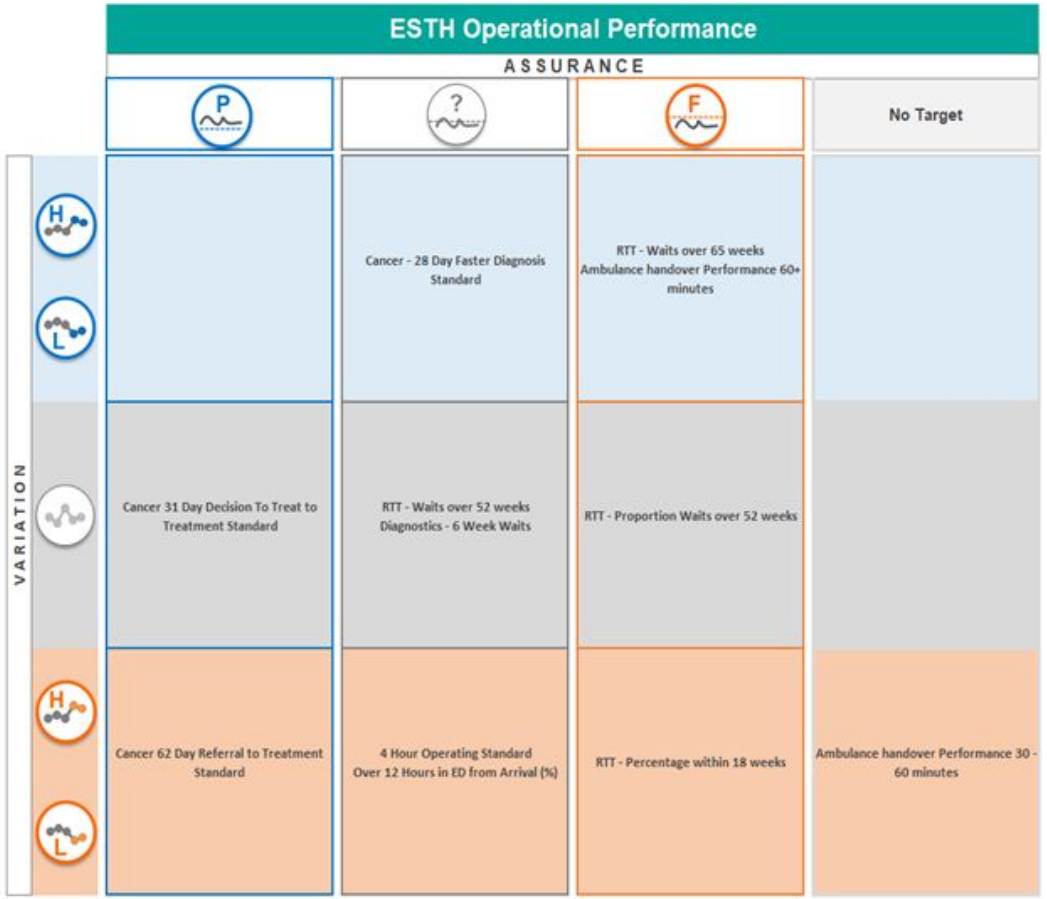
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Normal variation Consistently failing target	The FFT contract at ESTH has ended, and steps have been taken to move this onto Gather, the system currently used at St George's. The technical solutions are ready, and IG approval has been cleared for poster access to the survey (March). IG approval is still pending for text messaging the survey to patients, alongside access to a text messaging service through procurement. External data reporting continues, although not directly comparable to previous months and shows some variations, especially in services where surveys are conducted via text. The reported numbers remain lower for certain services (e.g., ED), pending IG approval for the proposed text messaging service.	• Improve Response rates across both hospital sites • Analyse the themes and trends of patients who provide negative feedback. • Suggestions have been made to involve volunteers in the ED at ESTH to help gather feedback, including FFT, but recruitment efforts have not been successful so far. • The Medical Division is focused on improving patient experience during peak periods of emergency care demand by increasing staffing levels and optimizing patient flow to create more inpatient capacity.	July 2025	Not sufficient for assurance
ESTH Complaints responded to in 35 Days Target met and achieved since Dec 2024	The target was not met in March (83%) and there remains a strong commitment to improve and return performance to within and above target level moving forward. Ownership of responsibilities has varied between the complaints and divisional teams, with the majority of the responsibility resting with the complaints team. This is due to the structure of the complaint process that was previously in place. .	• Several actions as part of the complaints improvement work stream are underway to support improving this metric and are ongoing and previously reported. • A review and re-allocation of current cases has taken place within the complaints team to support completion of complaints.	June 2025	Not sufficient for assurance

Section 2.1:
Operational Performance

Section 2.1 Operational Performance

Matrix Summary





Operational Performance

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
RTT - Waits over 65 weeks	Feb 25	60	75	0		F	3rd Quartile	Feb 25	44	46	0	L	F	2nd Quartile
RTT - Waits over 52 weeks	Feb 25	1055	1084	129	H	F	3rd Quartile	Feb 25	623	659	715		?	2nd Quartile
RTT - Proportion Waits over 52 weeks	Feb 25	1.53%	1.55%	1.00%	H	?	2nd Quartile	Feb 25	1.3%	1.3%	1.0%		F	3rd Quartile
RTT - Percentage within 18 weeks	Feb 25	61.8%	61.6%	67.6%	L	F	2nd Quartile	Feb 25	64.8%	65.3%	70.4%	L	F	2nd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Feb 25	80.2%	86.5%	77.0%	H	?	2nd Quartile	Feb 25	83.0%	82.3%	77.0%	H	?	2nd Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Feb 25	93.9%	96.1%	96.0%		?	2nd Quartile	Feb 25	96.9%	100.0%	96.0%		P	Top Quartile
Cancer 62 Day Referral to Treatment Standard	Feb 25	80.4%	81.0%	70.0%		P	2nd Quartile	Feb 25	85.7%	85.6%	70.0%	L	P	2nd Quartile
Diagnostics - 6 Week Waits	Feb 25	5.4%	4.7%	5.0%	H	?	2nd Quartile	Feb 25	5.5%	5.5%	5.0%		?	2nd Quartile
4 Hour Operating Standard	Mar 25	80.9%	83.6%	78.0%		?	Top Quartile	Mar 25	73.4%	74.1%	78.0%	L	?	2nd Quartile
Over 12 Hours in ED from Arrival (%)	Mar 25	9.1%	8.7%	8.8%		?	2nd Quartile	Mar 25	14.6%	14.0%	9.6%	H	?	3rd Quartile
Ambulance handover Performance 30 - 60 minutes	Mar 25	157	63	-				Mar 25	588	495	-	H		
Ambulance handover Performance 60+ minutes	Mar 25	2	4	0	L	?		Mar 25	59	48	0	L	F	

Watch metrics have been moved to Appendix Slide 42

Operational Performance

Overview Dashboard

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Two hour UCR performance	Mar 25	77.8%	78.6%	70.0%			
Virtual ward - Bed Occupancy	Mar 25	58.7%	79.3%	85.0%			
Total Waiting List Size Adult	Mar 25	1869	2150	-			
Total Waiting List Size Adult 18-52wks	Mar 25	0	20	-			
Total Waiting List Size Adult >52wks	Mar 25	0	0	-			
Total Waiting List Size Children	Mar 25	842	938	-			
Total Waiting List Size Children 18-52wks	Mar 25	358	362	-			
Total Waiting List Size Children >52wks	Mar 25	15	73	-			

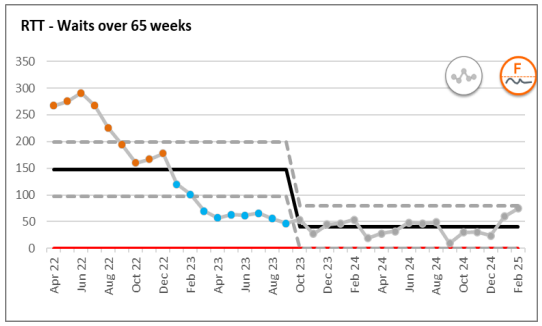
Surrey Downs

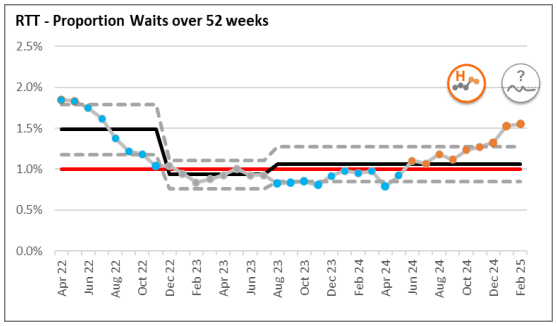
Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Mar 25	84.9%	83.4%	70.0%			
Mar 25	80.2%	86.2%	80.0%			
Mar 25	5908	5708	-			
Mar 25	80	60	-			
Mar 25	0	0	-			

Watch metrics have been moved to Appendix Slide 42

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)

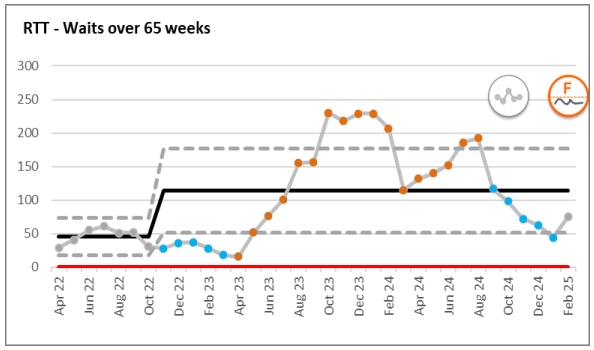


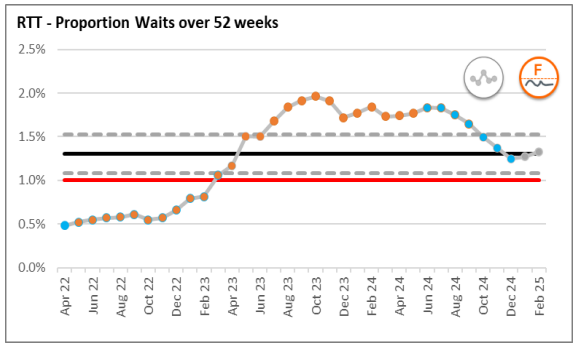


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan 52 week waits behind plan	At the end of February 2025; • 65 week waits – Further increase with 75 open pathways over 65 weeks. Increase since December 2024 predominantly driven by within General Surgery, Vascular Surgery and Gynae. • 52 week waits –1,084 open pathways, impacted largely by on the non-admitted PTL and General Surgery on the admitted PTL. 52 weeks waits have increase by 43% over the past 12 months and currently is 1.55% of total PTL size. • Continued growth in overall PTL size. Over the past 12 months non-admitted PTL growth of 10.8% and admitted PTL 12.4%. • A high volume of out of area referrals have contributed to the long wait position. This is currently being addressed with ICBs	**Validation Sprint –** The Trust Is participating in the national *Sprint* programme to support full validation of the wait list and encourage an increase in timely clock stops. Reducing the overall PTL and removing duplicate pathways. **Demand Management:** Working with the ICB to ensure we are commissioned appropriately to provide services. **Revision of all Directories of Service DoS:** The Trust is focusing on ensuring that there is defined criteria for primary care to access services. Work has already begun in a number of specialties. **Theatre Productivity:** Focusing on late starts and early finishes as well as intercase down time and overall capped theatre utilisation	**June 2025** **Phased approach Completion June 2025** **Phased approach – completion June 2025** **March 2026**	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



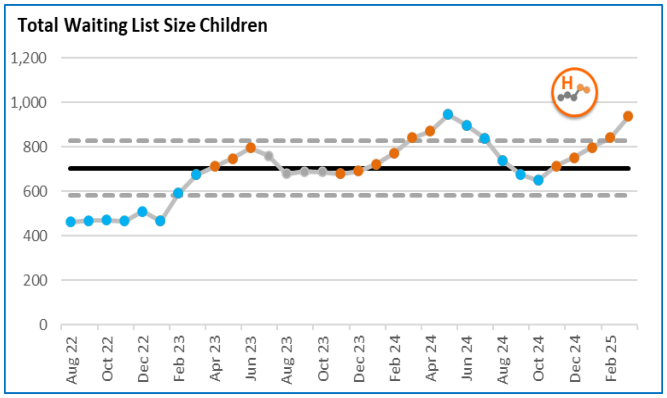


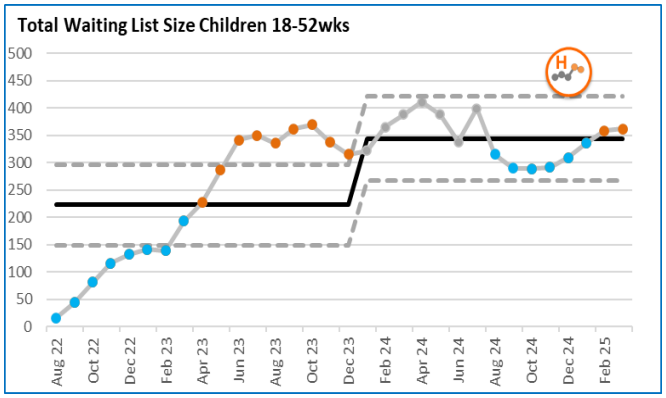
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 65Wk waits not meeting plan special cause variation	• 52-week waits achieved the ambition to be below 715 in February 2025, with a total of 659 patients waiting more than 52 weeks, the fourth consecutive month that the ambition has been achieved in 2024/25. The specialties with the highest volumes were Dermatology (143), Gynaecology (101), and General Surgery (68). • However, 65-week waits continue to be above the ambition of zero in February 2025, with a total of 46 patients waiting more than 65 weeks. The specialties with the highest volumes were Gynaecology (14), Dermatology (4), Gastroenterology (4), and General Surgery (4). • Gynaecology and Dermatology are the most challenged specialties at ESTH, with several actions being taken to mitigate.	• Weekly long waiter updates continue to be provided to SWL ICS for assurance. • Recovery plans are in place and ongoing for the most challenged specialties. • **Gynaecology:** Patients waiting more than 52 weeks for treatment continue to decrease, with additional capacity being funded. • **Medicine:** Mitigations are in place, including additional consultant support approved in dermatology, cardiology, and gastroenterology and is in place currently to M03 FY25/26. Mutual aid from Croydon for lung function tests stalled in March with the service seeking confirmation of when patients are to be booked (likely to be April); notification also received that this mutual aid may not be continued, which presents a risk to the service and performance. Insourcing is in place for Dermatology, Respiratory, and Neurology for M01 FY25/26 only. The Virtual Lucy digital healthcare platform, supporting the demand in Dermatology, project ceased on 31st March 2025. Overall, it had a positive impact on performance discharging 620 patients (43% of patients sent) from the Dermatology PTL. • **Planned Care:** All 65 week waits are monitored robustly within the division, but reduced tracking for General Surgery poses a risk to the 52 week wait backlog. Endoscopy faces challenges in securing deep sedation lists, while over 600 colorectal patients remain overdue, with half unbooked. The cessation of WLIs has worsened waiting times in Colorectal. With regards to ENT, there was a period of reduced outpatient provision due to Specialty Doctor vacancies, though core capacity resumed in February.	ESTH are aiming to have 0 patients waiting more than 65 weeks by the end of March 2025.	Sufficient for assurance

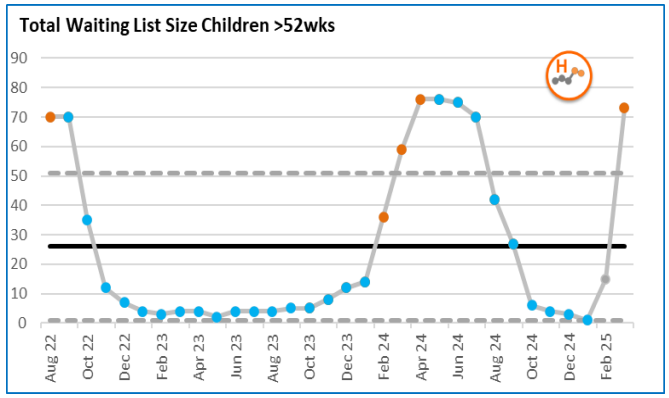
Operational Performance

Exception Report | Community Services Waiting Times (Children)

Sutton Healthcare



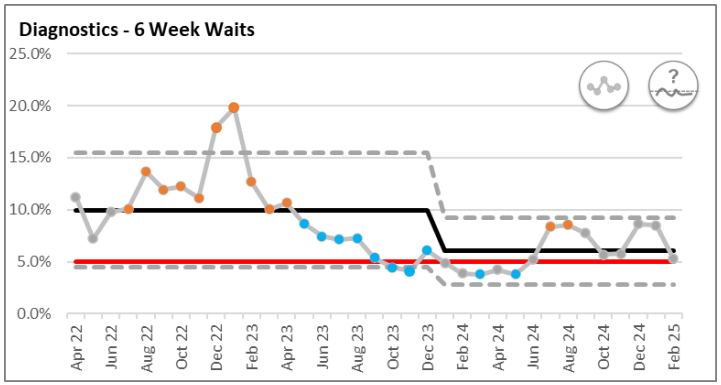




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	There has been significant progress at Sutton in reducing waiting lists overall (children and adults) and median waiting times. However, the waiting list size and waits over 52 weeks for Children's SALT Service has grown due to increased demand. The growth in children requiring NHS therapy services is a national issue recognised at SWL/PLACE. EMIS recording issues affecting clock stops in Children's OT have been investigated, and system changes are being implemented to improve waiting time accuracy. This has contributed to an increase in >52-week waits.	• PLACE/SWL Programme of work under way. • SHC Review of harms with Integrated Care CNO. • SHC additional triage/support for parents, and SHC additional clinic sessions run. Improvements also made in triage, priority clinics (productivity /efficiency). • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Sufficient for assurance

Operational Performance

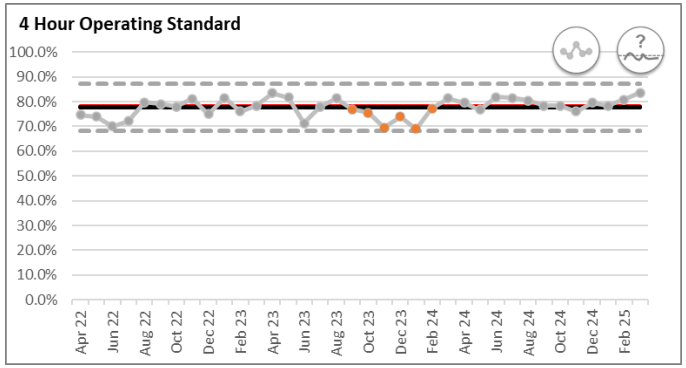
Exception Report| ESTH Diagnostic Performance

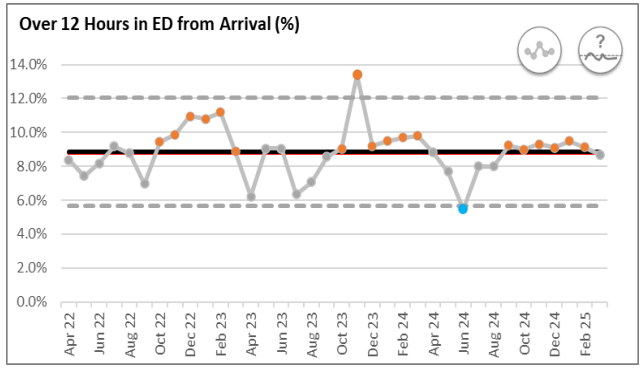


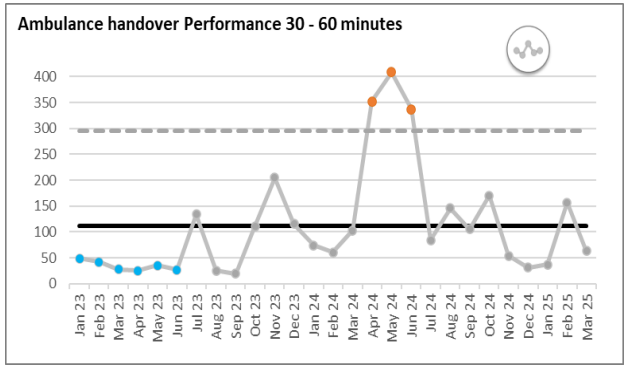
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 5.53% not meeting target of 5%	At the end of February 2025 there are 705 patients waiting more than 6 weeks for their diagnostic (DM01). This is a reduction on the previous month (January 2025) where there were 975. As a result, the performance for February 2025 increased to 94.47%, from 91.46% in January 2025, which is still slightly below the target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of February 2025 were Endoscopy (231), ECHO (129) & Urodynamics (102).	• **Endoscopy:** There are challenges around capacity for patients requiring deep sedation due to limited anaesthetic resources and workforce challenges. Saturday WLI additional sessions are on hold at present due to ongoing discussions around pay rates for nursing and medical staff. Significant challenges within the admin team have also contributed to the deteriorating position. Options paper being drafted to help support with activity loss during I clip pro. • **ECHOs:** The number of breaches end of February were 129, which is a significant improvement from January (320). Recruitment is still ongoing for the permanent band 7 and a maternity cover 12 months fixed-term post was approved in VCP recently. The substantive member of staff will go on maternity leave in mid-May. Efforts are still ongoing to increase echo capacity with multiple W/L initiatives, like mutual aid. The access policy was reviewed recently and 'no shows' are being removed from the waiting list, after lack of contact with the department within 2 weeks from their appointment. • **Urodynamics:** The service is undertaking an audit to understand if all patients on the waiting list require a diagnostic test. The urology service has offered capacity to support backlog clearance if this is required. One of the urogynaecology nurses has resigned so there is a risk that gynaecology capacity will be affected while recruitment is undertaken.	TBC	sufficient for assurance

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



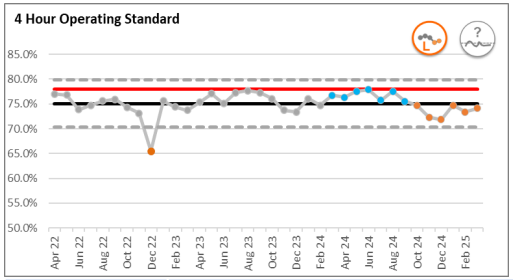


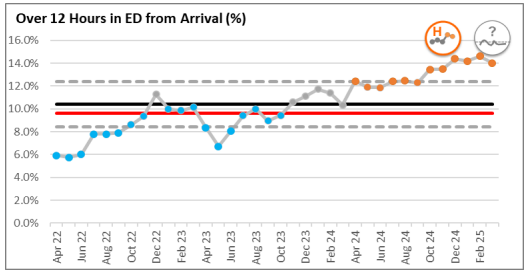


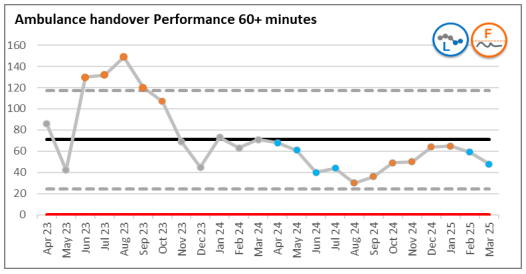
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in March 2025 12 Hour waits Special cause variation of a CONCERNING nature	Four Hour Performance in March 2025 further improved with 83.6% of patients either admitted or discharged within four hours of their arrival. Performance remains in the top quartile nationally. Admitted performance improved through March 2025 however remains challenged. ED Capacity main driver for longer waits, with a high number of DTAs in the department which impacts waits over 12 hours The key drivers of operational pressures and delays are: • Volume of DTA's in department • Number of complex mental health patients spending >24hrs in department	• During March we had additional GP support out of hours, this included keeping UTC (funded b the ICB) open 24 hours on 11 occasions during the month, and direct booking into GP slots run by seldoc OOH. • Dedicated Treatment pod for faster delivery of IVs and dedicated investigation cubicle. • 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, increase in surgical SDC capacity delivered with more planned. • Direct access to Paediatric clinics for UTC plastic patients. • Weekly meetings with London Ambulance Service (LAS) to resolve issues between both Trust and LAS. • Frailty Same Day Emergency Care (SDEC) pilot in progress. • Additional Emergency Practitioner on duty in peak hours to manage patients in the streaming queue. • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Long waiting patients in ED are continually monitored through their stay. Tests / diagnostics required for their onward treatment are requested while a ward-based bed is sought	TBC	sufficient for assurance From April 2025 only type 1 attendances will be counted to measure 12 hours waits

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers



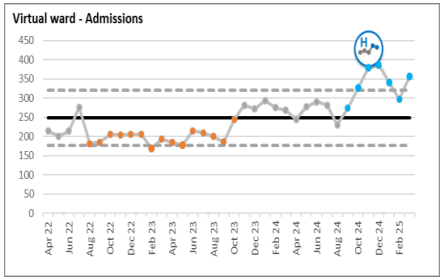
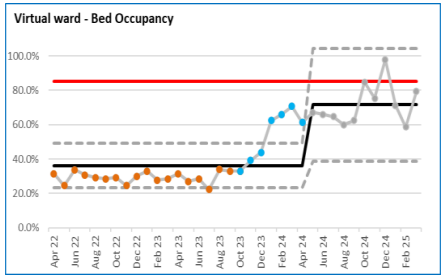
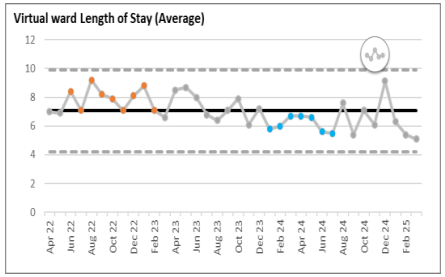
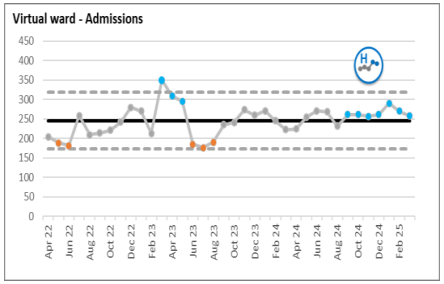
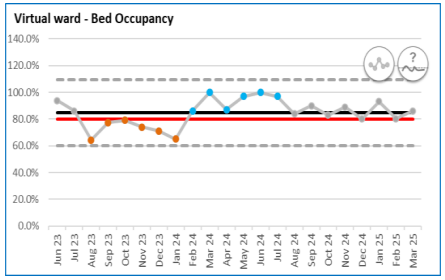
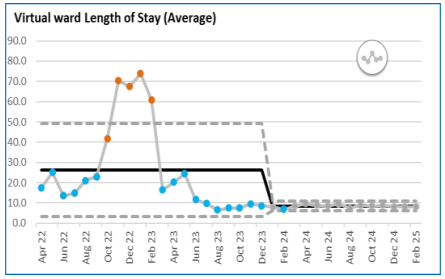




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 75% ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 60+ Min Consistently not meeting target	Emergency department wait times remained a challenge in March 2025 due to a combination of a 17% month on month increase in Type 1 attendances combined with 22% of overall attendances arriving by ambulance. Patients spending >12-hours in ED remains challenging with 14.2% of patients spending > 12 hours in ED in February. Whilst below the ambition there was an improvement in 4-hour performance in the month of March 2025, reporting 74.1% versus 73.4% in February 2025. 60-minute ambulance handover delays remain high in March 2025 (48) but is an improvement compared to February 2025 (59). Time to first assessment and decision to admit remain above the ambition of 60 minutes and 180 minutes respectively, however, time to triage remains at 15 minutes in March 2025 in line with the 15-minute ambition. High numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• The ESTH Urgent Care Transformation programme hosts an agreed set of priorities for 2024/25 which includes PLACE deliverables. Key outputs and KPIs include but are not limited to, the electronic streaming/redirection and direct booking of patients to UTC/SDEC/GP for patients who attend ED but do not require treatment in the major's area and a reduction of Trust LOS by 1.5 days. • Work continues to support LAS direct conveyances to UTC, GP, SDEC, SACU, and timely internal surgical transfers from Epsom to St Helier. • SWL winter funding in collaboration with Sutton PCN GP colleagues continued to support additional GP resource in ED for appropriate patients in March. The initiative included the treatment of all patients within SWL to alleviate pressure within the ED footprint at St Helier. Available funding supported the extension to 7-day cover into March 2025 for adult activity. Throughout March 2025 additional clinics were implemented to support paediatric activity located within paediatric STH ED footprint to support appropriate patients. • The Same Day Acute Frailty response service launched in April 2024, supported by a dedicated space and frailty MDT for early assessment, treatment, and clear exit pathways. This enhances ED flow, admission avoidance, and reduces LOS. Winter funding provides additional weekend clinical support, including senior in-reach and review in the frailty hub. • Focussed work with Surrey & Borders Mental Health Trust continues to progress the development of a proposal/business case for a mental health CDU on the Epsom site. We are also working with SWL & St Georges Mental Health Trust to explore rapid access clinics for appropriate patients.	TBC	sufficient for assurance

Operational Performance

Exception Report| **Integrated Care | Virtual Wards**

Sutton Healthcare			
Surrey Downs			

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Admissions to virtual ward continue above the mean (357 admissions through March 2025). Occupancy rates show normal variation increasing through March to 79.3%.	• SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. • LoS reduction programme with ESTH and Sutton Alliance is in progress. • Engagement work with appropriate wards and with clinicians continues. • Work to explore additional pathways into virtual ward in development.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Admissions to virtual ward remain above the mean with bed occupancy rate continuing to exceed target of 80%.	• On-going development of enhanced care and new pathways in Virtual Wards.	N/A	Sufficient for assurance

Section 2.2:
Operational Productivity

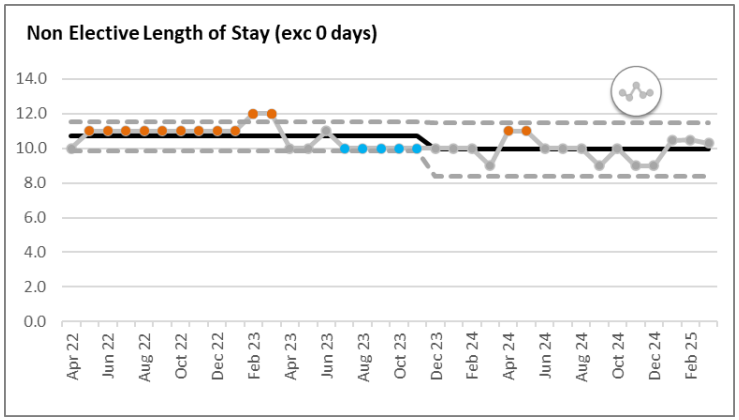
Operational Productivity

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
Non Elective Length of Stay (exc 0 days)	Mar 25	10.5	10.3	-			N/A	Mar 25	11.7	12.0	-			N/A
Theatre Utilisation (Capped)	Mar 25	81.6%	81.6%	85.0%		F	2nd Quartile	Mar 25	80.3%	81.9%	85.0%		F	Top Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Dec 24	80.8%	80.1%	83.6%		F	Lowest Quartile	Dec 24	77.7%	78.0%	83.6%		F	Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Mar 25	1.8%	1.9%	5.0%	H	F	Lowest Quartile	Mar 25	5.1%	4.7%	5.0%		?	Top Quartile
Outpatients Missed Appointments (DNA Rate)	Mar 25	9.2%	9.1%	8.0%	L	F	Lowest Quartile	Mar 25	6.6%	6.4%	6.0%		F	2nd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Mar 25	52.7%	52.0%	49.0%		P	2nd Quartile	Mar 25	46.8%	48.4%	49.0%	H	F	3rd Quartile

Operational Productivity

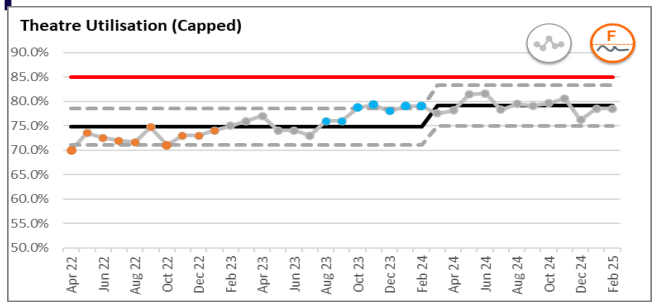
SGUH – Non-Elective Length of Stay (NEL LOS)

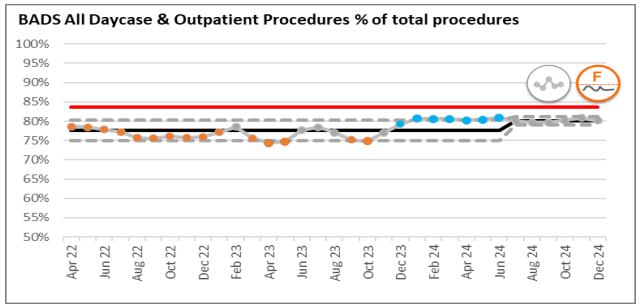


Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Mar-25	116 Beds (approx.) to reduce by 1.5 days

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 remains stable although slightly above the mean – on average in-patients staying for 10.3 days through March 2025 • Super Stranded patients >21 days has seen an upward trend however seeing normal variation approx. 173 patients per day • Number of patients not meeting criteria to reside- largest proportion of delays driven by 1. Hospital process – Awaiting therapy review of need for supported discharge – average 12 beds per day 2. Interface process – based social care service arrangements still underway (pathway 1 – average 9 beds per day 3. Interface process – Residential / nursing home care arrangements still underway (Pathway 3) – average 9 beds per day • 10% of discharges before 11am	• The Emergency floor and the Integrated Care Transfer Hub continue to review if Social Workers & CLCH partners can attend on site. • 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, current performance 87% of patient have a CTR form completed • >21 day LoS meetings embedding lead by MedCard Deputy DDO. • LoS Triumvirate working on further actions to continue to drive down NEL LoS. • Improved usage of discharge lounge through March 2025 • Need to communicate with patients and visitors the importance of hand hygiene to help prevent the spread of IPC issues.	TBC	Sufficient for assurance

Operational Productivity
SGUH - Theatre Utilisation & Daycase Procedure Rates





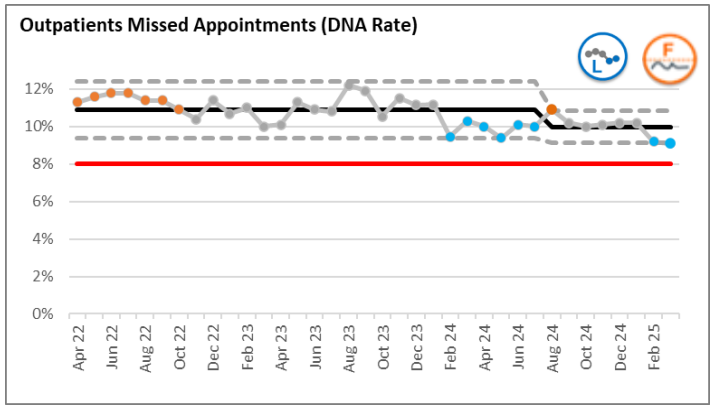
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Mar-25	342 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Dec-24	717 cases opportunity to move to IP to DC (3 month period) compared to peer

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation 83%- IP 81%-DSU 69%- QMH	• Capped Theatre Utilisation: 81.6% across the month of March 2025. Most specialties have theatre utilisation above 80%. The surgical specialties with the lowest theatre utilisation were Dentistry (75%), Gynae (79%), Plastics (75%) and Neurosurgery (76%). [Week ending 23rd March utilisation improved to 85.0%]. • Total cases performed increased with average cases per session was 1.54 compared to 1.58 in February 2025. • 3% of total cases cancelled on the day including patient DNA.	• Adherence to 6-4-2 escalation processes being implemented to improve theatre capped utilisation and improve scheduling standards • Ongoing work with Business Intelligence colleagues to review theatre performance dashboards, aimed at improving reporting of cancellations and monitoring of DQ issues • Working to improve POA and comms process with patients to reduce DNAs and hospital initiated cancellations.		sufficient for assurance
SGUH: Improving trend, below top quartile peer	• December performance (80.1%) below peer upper quartile (86.8%) • Outpatient % of total procedures (inpatient, daycase and outpatient) above peer average positively at 41.4% (peer 32.3%) • Daycase % of total procedures (inpatient, daycase and outpatient) below peer average at 66.1% (peer 75.7%). Breast, ENT, Max Fax driving this in Model Hospital data • Discrepancy between the expected and actual overnight stays for elective cases due to coding and documentation errors. This discrepancy alters the true picture of BADS compliance. If this is due to data issue, we could improve compliance just by correcting data. • Due to the complexity of patients referred to SGUH Procedures normally coded as daycase can often be booked as an intended management of elective overnight which can under count actual DC).	• BADS compliance being discussed with all surgical specialities within theatre transformation to explore opportunity. “Right Procedure, Right Place” • Investigating whether intended management code is being used correctly (particular outlier). Test for change instigated in Breast where 50-68% believed to be incorrect were confirmed; Primary reason is the incorrect recording when adding patient to the wait list **Actions taken** include auditing data, identifying patterns, updating data retrospectively, w/c 10-Mar, no impact to revenue but will improve data accuracy, training, reports in place to monitor. **Next steps include** -Finalising the Trust-wide training -Update Job Aids for administrative and clinical staff -Engage and roll out to other services -Iclip technical update to ‘Intended Management’ to fix issue at source. Approved by CICG -retrospective audit and data correction across all services for Q4	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Mar-25	1,375 appointments

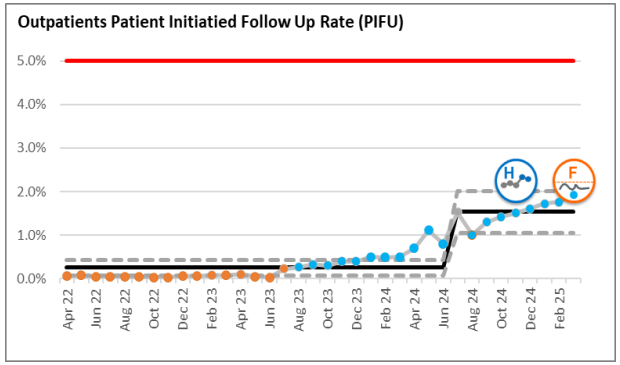
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

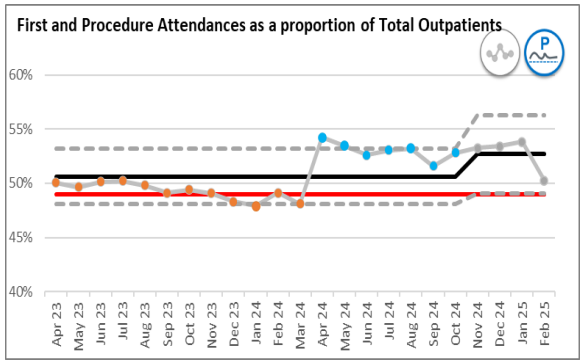
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	Current DNA rates of 9.1% showing a further reduction compared against Peer average performance 8.6% . Highest proportion of DNA's within Physiotherapy, Dermatology, Rheumatology.	- Speciality-level data reviewed weekly with all operational leads in Elective Access Meetings and also monitored via CARE board by SLT weekly. - Reviewing Model Hospital data to view performance against peers and review opportunity to reduce DNAs - Working Group established to focus on Top 10 – First Meeting 12th March 2025 agreeing to trail some different strategies to reduce the DNA rate's; ○ **Cardiology** – A trial will be conducted to call patients with an upcoming appointment within the next six weeks who previously DNA'd to confirm their attendance. The impact of this approach will then be audited. ○ **Therapies** – A historic DNA audit will be conducted using Zesty for the past three weeks, as there were changes in the Call Centre's flow during this period. This will allow us to compare responses and assess whether the new flow has improved accessibility for callers. ○ **Respiratory** – A preventative DNA audit will be conducted using Zesty's two-way texting system over a one-month period. Patients will receive a text a week before their appointment, allowing them to respond cancel or reschedule if needed. The impact of this intervention on DNA rates will then be assessed.	TBC	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups

St George's



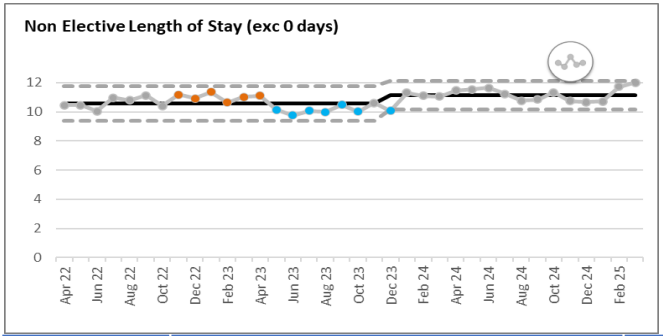


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Mar-25	*0 (exceeding target)*
PIFU Rates	Mar -25	*to be confirmed*

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 March 2025 continues to see a positive upward trend at 1.9%.	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure 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 PIFU Pathways. Conversations are ongoing with General Managers in Spec Med for the remaining Spec Med specialities (Diab & Endo, Resp Med, Rheum, Lymphedema) with clinical pathways being discussed and finalised. Cardiology are aiming to go live with two pathways (General Cardiology and ICC) in April 2025 pushed back from March due to admin pressures. Neurology will be officially live with PIFU end of April 2025, staff training has taken place, patient leaflets being finalised and processes have been agreed, we should see a further increase in overall volume in the next couple of months. • We have contacted specialities who have begun to use PIFU but have not had discussions with us about patient leaflets and local processes. Also informing specialties around incorrect processes i.e. PIFU has been indicated on eCDOF but no order has been placed.	5% target for end of 25/26	sufficient for assurance

Operational Productivity

ESTH – Non Elective Length of Stay



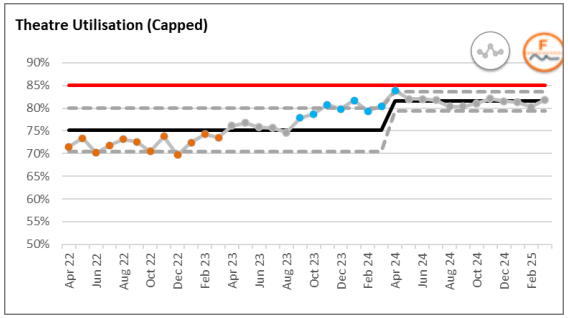
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Mar-25	20 WTE for corridor care reduction

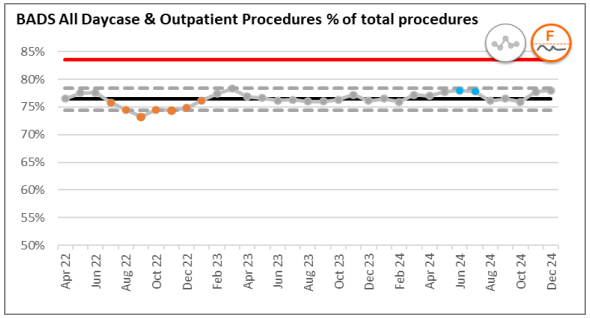
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation not meeting plan Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Number of medically optimised patients on both hospital sites remain above the ambition with many patients requiring complex discharge planning to support discharge with the number of >7 and >14 LOS patients remaining static in March 2025 and the number of >21 LOS patients reducing slightly. A high number of patients have awaited a complex pathway 3 placement or onward inpatient neuro-therapy provider. Timely discharge continued to be impacted by IPC constraints across both sites. A significant cohort of our medically fit patients are requiring on-going acute therapy prior to discharge.	• Daily reports in place identifying those patients who are medically fit for discharge shared with internal and external stakeholders, including our therapy team. Reports now updated to include notification of the presentation of patients with a historic significant LOS. • Revised boarding process was implemented on Monday 2nd September successfully incorporating additional areas. • Highest utilisation of our discharge lounge to support flow on both sites. • The complex paediatric discharge panel meeting for patients who require additional support/escalation to progress discharge arrangements. • Weekly DMT led 14 day + LOS reviews continue, this has been complemented this month by a review of all patients with a LOS of 1-14 days in collaboration with the virtual wards and supporting pathways. • The Trust complex discharge panel has now progressed to reviewing all patients with an expected complex discharge including those patients identified as homeless on admission. The meeting includes key internal stakeholders, including CNO/deputy representation and relevant system partners as appropriate. • LOS metrics at ward/department level continue to receive ongoing scrutiny enabling us to monitor areas reporting an increased LOS or patients holding no CTR. • Revised KPI's have been drafted and agreed with partners to support escalation for business as usual in addition to separate KPI's and timelines in the event of acute surge and/or to support the compliance of LAS 45 implementation. • The review of individual patient flow/LOS work streams and attributed improvement trajectories continue to be monitored closely to ensure progression and impact on wider 1.5 days LOS reduction. • A focused piece of work for those patients requiring progression on pathway 2 is underway with a pilot commenced across acute and community therapy teams to support therapy in-reach for an agreed number of patients	TBC	sufficient for assurance

Length of stay activity for Epsom and St Helier includes activity for two community wards located in the acute hospital setting.

Operational Productivity

ESTH - Theatre Utilisation & Daycase Procedure Rates



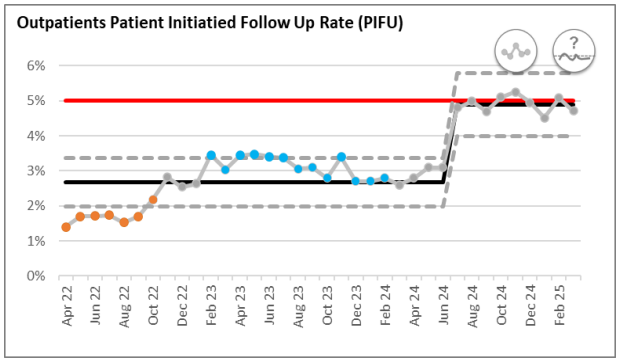


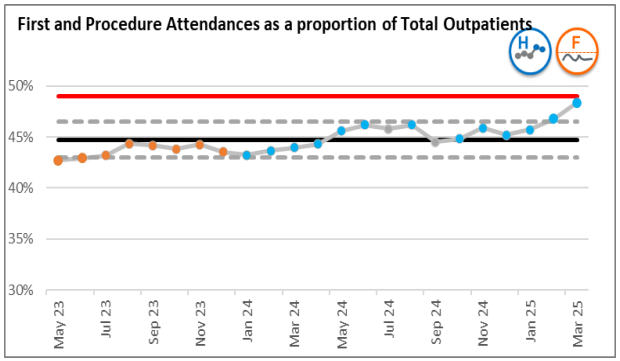
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Mar-25	3% productivity gives an opportunity of £554k in additional income
Day cases and outpatient procedures (BADS)	Dec24	N/A

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%) BADS performanc e Not meeting target, Improving trend	**Utilisation** continues to consistently perform over 80%. ESTH ACPL for March was 3.90. **Late Starts** remain under the 30 minute target at 17mins, and our **underruns** at 29 minutes. **On The Day Cancellations (OTDC)** remain higher than we would like at 7.52%. We continue to review top OTDC reasons - 'Patient unfit' (cough/cold) continues to be the top cancellation reason for both *'Patient' & 'Clinical'* Cancellations	**Perioperative Care pathway and processes:** • Following the success of the initial pilot, the Group are working through plans to roll out the initiative to ENT and T&O at Epsom, in April. This will support a growing pool of 'green' patients, who can be declared *'fit'* on the same day they are listed for surgery. • **Day Case Rates (BADs):** Model Hospital data for BADs quarter ending Dec 24 is **77.9%** overall for ESTH**.** ESTH **excluding EOC** is **89.1%**. Improvements have been ongoing with the commenced EOC process changes for recording hips/knee procedures. • We have met with EOC colleagues and agreed that they will validate their day case activity daily to ensure that when ESTH data is submitted to model hospital the correct day case position for EOC is included going forward. • The estimated position for March is **84.2%** overall for ESTH and **93.8% excluding EOC**. • We are reviewing High Volume Low Complexity procedures against GIRFT with a view to increasing day case rate for certain procedures (Lap Chole and Hernias). **On The Day Cancellations:** • 'Patient unfit' (cough/cold) continues to be the top cancellation reason for both *'Patient' & 'Clinical'* Cancellations . • We are setting up a Theatre List Planning Task and Finish Group to ensure robust processes are in place to support efficient scheduling of lists. • **Specialty Deep Dives:** • We are working with specialties who are consistently underperforming against 85% utilisation to understand the challenges and implement changes to support improved utilisation. • **Staring on Time:** • A Task and Finish Group has been set up to support lists starting on time in line with the opening of the new consenting space at Epsom.	TBC	sufficient for assurance

Operational Productivity

ESTH – Reduction in Outpatient Follow-Ups



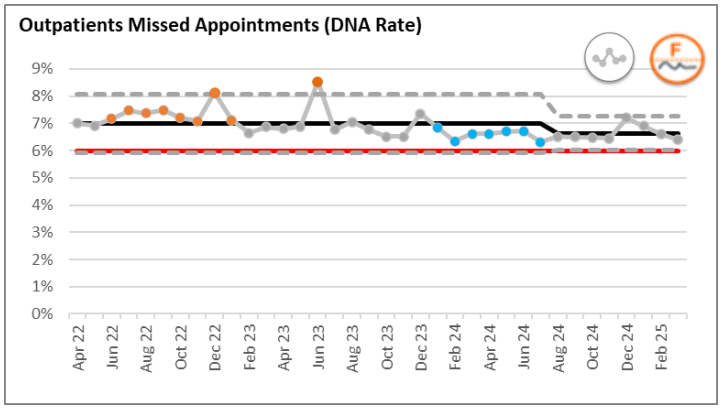


Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
Outpatients: [1st + Proc] as a % of Total OP	Mar-25	£600k
Outpatients: PIFU Rates	Mar -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
PIFU – normal variation First & Procedure attendances – improving trend	Need to: Reduce follow-up activity Reduce DNA Rates Increase PIFU Rates	A critical focus area will be reducing our high-cost evening and weekend outpatient clinic spend—**while continuing to maintain our 65% RTT performance and ensuring outpatient waiting lists do not grow**. To deliver this, the 2025/26 Outpatient Transformation programme will focus on **Reducing follow-up activity by 50% via the following workstreams:** ▪ Maximising the use of **Patient-Initiated Follow-Up (PIFU) – National benchmarking exercise complete to identify areas of opportunity.** ▪ Reducing **DNA rates** and ensuring the Access Policy is well understood and followed ▪ Overbooking in high DNA clinics, where appropriate ▪ **Tightly gatekeeping referrals** into our services ▪ **Creating more efficient outpatient pathways**, both clinically and administratively ▪ Ensuring **One-Stop clinics** are operating effectively Data packs to identify specific areas of focus and opportunity have been developed and will be shared with divisional tri's during April, to agree detailed implementation plans.	TBC	sufficient for assurance

Operational Productivity
ESTH Missed Appointments (DNA Rate)

Epsom & St Helier



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Mar-25	689 Attendances

The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Normal variation, no significant change Failing target of 6%	DNA rate has further reduced to 6.4% in March, ranking 3rd in London. DNA reduction work continues to be a focus in 2025/26 as per slide 17.	Completed detailed analysis to identify specialties with a DNA rate above 6% and will further deep dive into variation at clinic and clinician level, applying DNA checklist guiding principles as mitigation. In addition, we are scoping opportunity to overbook clinics with higher DNAs by 10% to maximise clinic utilisation.	TBC	sufficient for assurance

gesh

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

Appendices

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Watch List Metrics

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mixed Sex Accommodation Breaches	Mar 25	116	155	0			
Number of Complaints Received	Mar 25	69	71	-			
Number of re-opened complaints in month	Mar 25	1	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Mar 25	0	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Mar 25	0	1	-			
RTT - Total Size Incomplete Waiting List	Feb 25	69079	69734	64968			
On the Day Cancellations not re-booked within 28 days	Mar 25	5	4	-			
Outpatient Advice & Guidance Rate per 100 First OPA	Feb 25	19.6	20.4	16.0			
Emergency Department Attendances per day	Mar 25	409	430	-			
Mental health delays 4 Hour Breaches	Mar 25	125	108	-			
Length of stay > 21 days (super stranded)	Mar 25	161	173	117			
Overnight G&A beds occupancy - Adults	Mar 25	94.6%	94.0%	90.8%			
Number of patients not meeting criteria to reside (Daily Avg)	Mar 25	128	118	86			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 25	46	47	0			
Mar 25	26	61	-			
Mar 25	0	2	-			
Mar 25	0	1	-			
Mar 25	0	1	-			
Feb 25	48932	49557	44688			
Mar 25	1	1	-			
Feb 25	54.6	49.5	16.0			
Mar 25	421	442	-			
Mar 25	196	233	-			
Mar 25	175	172	120			
Mar 25	89.5%	88.0%	84.4%			
Mar 25	215	221	117			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Reablement Unit Bed Occupancy	Aug 24	100.0%	100.0%	100.0%			
Reablement Unit Length of Stay (Average)	Aug 24	8.8	10.0	5.0			
Two hour UCR referrals received	Mar 25	483	476	-			
Virtual ward - Admissions	Mar 25	297	357	-			
Virtual ward Length of Stay (Average)	Mar 25	5.4	5.1	-			
Discharge to Assess- Pathway 0-3 Delays (Median Days)	Mar 25	6	4	-			

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Mar 25	470	513	-			
Mar 25	270	258	-			
Mar 25	8	9	-			
Mar 25	2	3	-			

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Mar 25	4.7%	4.1%	3.2%		F	
Agency rates	Feb 25	0.1%	1.1%	-	L		
MAST	Mar 25	92.2%	92.1%	85.0%	H	P	
Vacancy Rate	Mar 25	5.6%	4.6%	10.0%	L	P	
Appraisal Rate Medical	Mar 25	81.6%	83.2%	90.0%		F	
Appraisal Rate Non Medical	Mar 25	74.5%	78.6%	90.0%	H	F	
Turnover	Mar 25	10.8%	10.6%	13.0%	L	P	
Percentage BAME staff band 6 and above	Mar 25	46.7%	47.0%	-	H		

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 25	5.4%	4.8%	3.8%		F	
Feb 25	3.3%	2.4%	-	L		
Mar 25	87.6%	86.7%	85.0%	H	?	
Mar 25	12.4%	12.5%	10.0%	H	F	
Mar 25	94.5%	94.7%	90.0%	L	P	
Mar 25	80.4%	79.0%	90.0%		F	
Mar 25	10.6%	10.3%	12.0%	L	?	
Mar 25	40.6%	40.7%	-	H		

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	Mar 25	5.5%	4.6%	3.8%		?	
Agency rates	Feb 25	3.8%	3.8%	-			
MAST	Mar 25	91.2%	89.6%	85.0%	H	P	
Vacancy Rate	Mar 25	17.3%	15.2%	10.0%	L	F	
Appraisal Rate Medical	Mar 25	100.0%	100.0%	90.0%	H	P	
Appraisal Rate Non Medical	Mar 25	80.1%	77.9%	90.0%	H	F	
Turnover (12-Month)	Mar 25	13.9%	12.5%	12.0%		?	
Percentage BAME staff band 6 and above	Mar 25	38.2%	38.0%	-	H		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mar 25	5.0%	3.9%	3.8%		?	
Feb 25	6.4%	5.4%	-	L		
Mar 25	92.3%	92.1%	85.0%	L	P	
Mar 25	16.7%	16.2%	10.0%	L	F	
Mar 25	100.0%	100.0%	90.0%	H	P	
Mar 25	82.4%	82.5%	90.0%	L	?	
Mar 25	16.4%	15.9%	12.0%		F	
Mar 25	22.1%	22.0%	-	H		

Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

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
Non Elective Length of Stay	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).		
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	Gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	Gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital

Glossary of Terms

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

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

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

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

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

Group Board

Meeting in Public on Thursday, 01 May 2025

Agenda Item	2.5	
Report Title	**Quality Committees Report to Group Board**	
Non-Executive Lead	Andrew Murray, Quality Committees Chair, ESTH and SGUH	
Report Author(s)	Andrew Murray, Quality Committees Chair, ESTH and SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees-in-Common (QCIC) at their meetings in March and April 2025 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. **Group Patient Safety Incident Report:** The Committees received an update on the Group Patient Safety Incident Response Framework for the period of January and February 2025. The Committees were advised that although no Never Events occurred during this reporting period, there had been two subsequent Never Events at ESTH in March, involving wrong implants/prostheses. The Committees requested that full details of these incidents be presented at the May meeting. The Committees also received the PSIRF Policy and explored the implications that embedding this policy will have on gesh. The Committees endorsed the proposed approach for integrating Patient Safety Partners and maintaining oversight of patient safety improvement plans.
2. **Quality Priorities 2025-26:** The Committees reviewed the proposed quality priorities for 2025-26, agreeing that they would:
   - Carry over key priorities from 2024/2025 that have yet to be met (including the three most challenging Fundamentals of Care priorities)
   - Address emerging risks identified by the recent CQC inspections.
   - Promote further opportunities for improvement.
   - Ensure alignment with the overarching Quality and Safety Strategy.

   The Committees also received assurance that the draft Quality Accounts would be presented to the May Committees, prior to Board sign off in June 2025.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees and the wider issues on which the Committees received assurance in March and April 2025.

Committee Assurance

Committee	Quality Committees
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Forward Planner

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

Quality Committee Report
Group Board, 06 March 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees-in-Common at its meetings in March and April 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 27 March 2025 and the 24 April 2025 the Committees considered the following items of business:

27 March (Focus Session)	24 April 2025
• Maternity Action Plans in response to CQC • Deep Dive into VTE • Key Issues Update	• Key Issues Report • Group Patient Safety Incident Report • Group Monthly Maternity Services Report • Learning from Deaths Report Q2&Q3 • VTE Improvement Action Plan • Quality Governance Review Part 2 • Quality Priorities • Quality Governance Architecture • Quality Committee Forward Planner 2025-26 • Group Chaplaincy Report • Caldicott Guardian Annual Report

2.2 The Committee was quorate at the meetings in March and April 2025.

3.0 Key issues for escalation to the Group Board

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

The Committees received an update on the Group Patient Safety Incident Response Framework for the period of January and February 2025. The Committees were advised that although no Never Events occurred during this reporting period, there had been two subsequent Never Events at ESTH in March, involving wrong implants/prostheses.

The GCMO assured the Committees that work is underway to mitigate and minimise the risk around the two never events which occurred in March. The Committees requested that full detail of these incidents and actions being taken in response be presented at the May meeting.

The Committees welcomed the news that all serious incident investigations have now been closed at ESTH, thanking the GCNO and her team for the work undertaken to achieve this.

Assurance level: reasonable, since the PSIRF processes appear to be working well.

3.2 Group Monthly Maternity Services Report

The Committees received the Maternity Services Report; the following risks were escalated:

For SGUH:

- There was a maternal death on 03 March 2025 which has been reported to the CQC (as per the required process). This incident has been reviewed internally and the national Maternity & Newborn Safety Investigations (MNSI) service has accepted the case for investigation.
- SGUH achieved full compliance with 9/10 safety standards for MIS Year 6. This was noted as low risk prior to the final submission, however MNSI have included additional cases into the numbers which has meant that the trust has been declared non-compliant with safety action 1. An appeal has been submitted on the grounds that the additional cases were not part of the cohort of cases that should be included, and the response to the appeal is awaited.
- The National Maternity Perinatal Audit has flagged SGUH maternity services as a potential alarm-level outlier for postpartum haemorrhage in 2023. Some immediate safety improvement actions have already been taken, and work is ongoing to identify any further learning and safety improvements that may be required.
- The digital maternity transformation went live on 8 February 2025. Several challenges have arisen post-implementation as the system undergoes optimisation and mitigations are either in place or currently under development to address issues identified.
- An IT issue has emerged whereby Cardiotocographs (CTGs) from the ST Segment Analysis (STAN) machines are not being downloaded for storage. CTG recordings are often key evidence for determining and/or defending breach of duty in legal cases. This has been reported to the manufacturer (Neoventa) and to the MHRA Yellow Card Scheme. An interim solution (manual download onto an unencrypted USB stick) has been implemented whilst resolution is achieved.

For ESTH and SGUH:

- Medical staffing training compliance has not achieved the 90% compliance target for this reporting period. The issue is with PROMPT training among resident doctors at ESTH, and among consultants at SGUH. There is a plan in place to recover the position.

The Committee noted the update, agreeing that the Committee will continue to monitor how risks within the maternity services are mitigated. The Committee also requested to be advised of any learning which is identified as a result of the maternal death.

Assurance level:

SGUH limited – since the Committees are still waiting for the Integrated Maternity Improvement Plan and the gesh Maternity Leadership plan. In addition the initial response to increased levels of Post-Partum Haemorrhage and the issues raised around the maternal death continue to indicate a comfort-seeking rather than a problem-sensing culture.

Furthermore safe staffing and training compliance remains below target and has done so for a long time.

ESTH reasonable – since there are fewer areas for improvement outstanding and there is clearer evidence of good leadership. Although training and safe staffing levels also do not consistently meet targets there has not been evidence of the same cultural issues in relation to responding to concerns.

4.0 Key issues on which the Committees received assurance

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

4.2 Quality Priorities

4.2.1 The Committees reviewed the proposed quality priorities for 2025-26, agreeing that they would:

- Carry over key priorities from 2024/2025 that have yet to be met (including the three most challenging Fundamentals of Care priorities).
- Address emerging risks identified by the recent CQC inspections.
- Promote further opportunities for improvement.
- Ensure alignment with the overarching Quality and Safety Strategy.

4.2.2 The Committees also received assurance that the Quality Accounts will be presented to the Committees in May 2025 prior to Board sign off in June 2025. The Quality Accounts will be published on the Trust websites by 30 June 2025.

4.2.3 Group Integrated Quality and Performance Report
The Committees received the IQPR report, which detailed the following successes and challenges for SGUH and ESTH:

4.3.1 **Successes**
SGUH

Mortality: Mortality rates, as indicated by the Summary Hospital-level Mortality Indicator (SHMI), are currently below expected levels at 0.86. The inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set at SGUH may negatively impact SHMI and this will be monitored when the change to reporting is implemented. Impact analysis is included in this month's report.

Complaints: SGUH consistently meets the targets for acknowledging complaints within 3 working days and responding to them within 35 days.

ESTH
Pressure Ulcers: In March 2025 there were 6 category 2 acquired pressure ulcers and this is similar to previous months. There were zero acquired category 3 or 4 pressure ulcers. The total number of category 3 pressure ulcers for 24/25 (3) is below the quality priority limit of 7 and there were zero category 4 pressure ulcers in 24/25 meeting the quality priority target of zero.

Falls: In March 2025 there were a total of 84 falls reported in the Acute Services (3.9 /1000 OBDs), marginally less than the previous month. The percentage of unwitnessed falls has seen a 5% reduction from the previous month.

4.3.2 **Challenges**

SGUH

VTE: In March 2025, VTE risk assessment compliance within 14 hours of admission slightly increased to 65.9%, up from 62.1% in February 2025, but remains below the 95% target set by NICE guidelines. Actions include a trust-wide review of VTE risk assessment forms and the VTE prevention strategy.

Readmission: Readmission rates remain elevated, mainly due to increased returns to Same Day Emergency Care (SDEC) following expansion of surgical SDEC. Readmissions to non-SDEC areas remain steady at 7%.

ESTH

Complaints: ESTH has shown a continued decline in performance against the target for acknowledging complaints within three working days. Plans are in place to rectify this.

VTE: The Trust's VTE performance for March 2025 was 83.8%. The Trust has not met the quality priority target of an increase of 10%. Work is underway to further improve data quality with a focus on low-risk cohorts.

4.4 VTE Improvement Action Plan

4.4.1 At the Quality Committees-in-Common Focus Session on 27 March 2025, the Committees reviewed and discussed a deep dive paper on the topics of venous thromboembolism (VTE) and the Group's performance against the national VTE Risk Assessment requirements (>95% within 14 hours of admission) and performance in appropriate pharmacological and mechanical treatments.

4.2.2 The paper clearly articulated the areas in which the Group was failing to meet the required standards for VTE risk assessment, prescription of pharmacological prophylaxis, and application of mechanical prophylaxis. The paper also explored the underlying reasons why our performance may be challenged in these areas. To address these patient safety challenges, and to secure a trajectory towards compliance, a high-level Action Plan accompanied the paper. The Committees requested more detail in the Action Plan, which was presented to the Committees at its subsequent meeting on 24th April 2025.

4.4.3 The Action Plan has been developed to address the following aspects:

- Urgency: Actions have been split into immediate, medium- and long-term sections to enable us to move ahead with immediate actions to address our performance straight away where possible, and therefore limit the risks identified in this area as quickly as we can.
- Targeted: Actions have been targeted to the key stakeholders across the Group, with tailored messaging that will ensure that all parties know their individual responsibility for tackling the issues (e.g. Consultants, Junior Doctors), and key Services know to prioritise this issue within their local management groups, local ward rounds, and local governance meetings.
- Systemic: We have leveraged our Patient Safety Incident Response Framework by embedding this issue within the PSIRP (Patient Safety Incident Response Plan) to ensure it flows into all Divisional Governance improvement plans for action, and reports up to the Site PSQG for assurance.

- Digital: We have acknowledged the challenges we face with our digital prompts on i-Clip. There are certain IT improvements that must wait until the EPR implementation at ESTH. We are ready to put this improvement in place as soon as we can, once the IT freeze is lifted.

4.4.4 The Committee welcomed the action plan, agreeing it provided good assurance that the plan would mitigate the issues which had been previously identified.

Assurance level: Reasonable – since although targets are not met, particularly at SGUH, the report gives confidence that issues are understood and the action plan is good.

5.0 Reports for discussion

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

5.2 Learning from Deaths

The Committee received the report, which covered both Q2 (July -September) 2024/25 and Q3 (October - December) 2024/25. The key summary of the report is as follows:

- Overall mortality at ESTH appears to be improving. However, both measures remain “higher than expected”
- Overall mortality at SGUH is “lower than expected”

The Committee reviewed both SGUH and ESTH mortality rates in detail, noting the following:

ESTH:

- A high percentage of deaths (38.8% Apr-Dec 2024) continue to be scrutinised through Structured Judgment Reviews.
- Structured Judgement Reviews have highlighted that sepsis care is improving and a newly appointed Clinical Lead for Sepsis further is taking forward work to align approaches across the group. There is a specific focus on identifying and treating sepsis at presentation in the Emergency Areas.
- There remains a large number of cardiac arrests occurring in the ED.

SGUH:

- The investigation of mortality in cardiology, particularly AMI and following PCI, has been reported to MMG. The investigation considered data and clinical pathways, with an independent review of mortality. Mortality was not related to procedural complications and areas of clinical concern were not identified. Improvements in coding processes through collaborative working have been achieved and are being monitored. Improvements in scheduling have resulted in more timely access to treatment. An action plan has been agreed and will be reported to MMG.
- NHS Blood and Transplant (NHSBT) will visit St George’s renal transplant unit on the 10th April. This follows an alert reported in the previous version of this report related to 2 patient deaths and 2 kidney losses with 30 days of implantation

The Committee welcomed the report, noting that it was an effective and informative document. Committee members agreed that it was able to take substantive assurance that there is a robust process in place to enable learning from deaths in the organisation.

5.3 Quality Governance Review Part 2

The Quality Governance Review Part 2 was undertaken by Sally Herne, an external healthcare improvement specialist, working in collaboration with gesh Group colleagues. This work followed on from previous work undertaken independently by Sally Herne, focusing on St George's maternity (the Quality Governance Review Part 1), which was commissioned in response to the findings of a CQC inspection, and whose output and resulting actions have previously been discussed at QCiC and by the Group Board.

The aim of this Part 2 "pilot review" was to build on the findings and insights provided by the Part 1 maternity review, and to examine a representative sample of Divisions other than maternity, one from each Site (ESTH, SGUH and Integrated Care).

The Committee welcomed the paper, noting that there were multiple recommendations and that these needed to be distilled into key SMART actions by the time the implementation plan is presented to the Committee in May 2025.

5.4 Quality Governance Architecture

The Committee received the report, which detailed the gesh Quality Governance architecture, and illustrated a series of Site- and Group-based organograms, building on what was seen in the January committees with an accompanying narrative. It represents a Group-wide piece of Governance work that resulted from a number of collaborative meetings across Sites and with the Senior Leadership teams.

The Committees noted the report, agreeing the organogram was very helpful and provided a clear line of accountability through the quality governance structure. The Committees agreed it would be helpful to include examples of how information is passed from one level of governance to another e.g. what reporting mechanism is used to pass information from divisional level to site level. This report should be kept updates and used as a point of reference for the future since it describes the Quality Governance Architecture

5.5 QCIC Forward Plan (2025/26)

The Committee agreed the proposed forward plan for 2025/26, noting that this is subject to change in-year depending on emerging concerns. The forward planner is attached as an appendix to this report.

5.6 Group Chaplaincy Report

The Committee received the report, noting that the priorities for 2025/26 were as follows:

- Enhancing spiritual care spaces across sites.
- Expanding volunteer recruitment to ensure full faith representation.
- Strengthening community engagement to promote inclusivity.
- Raising awareness of chaplaincy services for all, regardless of religious or non-religious beliefs.
- Improving online and ward-based publicity to increase accessibility.

5.7 Caldicott Guardian Annual Report

The report was presented to the Committee for noting. The Committee also noted that the activity of the Caldicott Guardians will most probably continue to increase through 2025-26 due to changes in healthcare delivery and national policy that is driving greater digitalisation and data sharing to realise the potential of NHS data for the public good.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to by the Quality Committees to the Group Board and the wider issues on which the Committees received assurance in March and April 2025.

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	3.1	
Report Title	**2024/25 key financial metrics**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Site CFOs	
Previously considered by	Finance Committees-in-Common	25 April 2025
Purpose	**For Noting**	

Executive Summary

This paper summarises the key financial metrics that will be reported as part of the draft accounts submissions.

The key elements of the financial position are seen to be in line with planning and forecasting expectations.

The GCFO expects there will be no material changes or issues in the finalisation of the draft accounts due on the 25th April. If there are any material changes then these will be reported to and discussed with the Chair of the Audit Committee.

Action required by Group Board

The Board is asked to note the positions that is expected to be reported.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
Attachment 1	M12 Financial Position – Full Report

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
Poor planning could lead to failure to complete the statutory audits on time				
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				
Materially higher cost for the 2024/25 audits				
Legal and / or Regulatory implications				
Completion of the external audit could be impeded.				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

gesh

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

Group Board (Public) 01st May 2025

Month 12 (Year End) 2024/25 Financial position

GCFO, SGH Site CFO, ESTH Site CFO

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

Executive summary

gesh

- This update on the financial year end is brief and based on draft information as the Trusts complete year end processes ahead of submission and external audit.
- The key financial targets for both trusts are achieve the revenue control total and achieve the capital delegated expenditure Limit (CDEL). Both trusts have reported they expect to meet these targets in the "Key Headline Metrics" and expect to confirm this in the "Draft Accounts" to be submitted on 25th April 2025.
- The positions reported here are consistent with in-year reporting methodologies and are subject to audit before the submission of the Final Accounts in June.
- The key dates for the accounts are outlined below. Both trusts expect to submit the draft accounts on time.
- Work on the External Audit has commenced.

- This position has been discussed at the Finance & Performance Committee on 25th April and reported to the Audit Committee on 22nd April.

Provider Timetable	Date	Status
Key headline metrics submitted		Achieved both trusts
First submission unaudited accounts	25 April 2025	On track both trusts
Final Agreement of balances and full accounts	30 June 2025	On track both trusts

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

SGH Draft Year End 24/25

gesh

The numbers included within this slide are best estimates of the Trust's financial position ahead of the final accounts' submission. These remain draft until final account submission 25th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Plan £m	Actual £m	Variance £m
Income	**1,247.8**	**1,282.8**	**35.0**
Expenditure	**(1,152.1)**	**(1,287.1)**	**(35.0)**
Surplus / (Deficit)	**(4.3)**	**(4.3)**	**-**

Income and Expenditure

- The Trust is reporting a deficit of £4.3m at year end, which is on plan.
- The plan includes £45.8m deficit funding from SW London ICB.

Capital	CDEL £m	Actual £m	Variance £m
Capital Spend	**(47.2)**	**(47.2)**	**0.0**

Capital Spend

- The Trust is reporting capital spend of £47.2m, in line with plan.

Cash	23/24 Closing Cash £m	24/25 Closing Cash £m	Movement £m
Cash Balance	**48.5**	**80.4**	**31.9**

Cash

- The Trust ended the year with a cash balance of £80.4m which is £31.9m higher than the opening balance for the year. The trust received PDC for capital in March that will be paid out in 25/26. In addition, large revenue receipts were received in later months to support the I&E forecast without cash outflows to offset.

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

ESTH Draft Year End 24/25

gesh

The numbers included within this slide are best estimates of the Trust's financial position ahead of the final accounts' submission. These remain draft until final account submission 25th April. This shows performance against control totals, excluding items such as donated capital and impairments.

I/E	Updated Budget £m	Actual £m	Variance £m
Income	**718.7**	**761.1**	**42.6**
Expenditure	**(723.8)**	**(766.4)**	**(42.6)**
Surplus / (Deficit)	**(5.1)**	**(5.1)**	**0.0**

Capital	CDEL £m	Actual £m	Variance £m
Capital Spend	**(41.2)**	**(40.0)**	**1.2**

Cash	23/24 Closing Cash £m	24/25 Closing Cash £m	Movement £m
Cash Balance	**50.6**	**52.2**	**1.6**

Income and Expenditure

- The Trust is reporting a deficit of £5.1m at year end, which is on plan.
- The plan includes £41.6m deficit funding from SW London ICB.

Capital Spend

- The Trust is reporting capital spend of £40.0m, £1.2m less than plan. Key drivers are £3.6m additional national funding , £0.5m additional SWL offset by £5.2m underspend on planning assumption on national funding not confirmed on BYFH and UKPN.
- The Trust delivered all its BAU schemes to the agreed increased M11 outturn which was £0.8m less than the original plan.
- Underspends of £0.3m NHP funding not required and £0.1m PDC schemes not fulfilled by 31st March

Cash

- The Trust ended the year with a cash balance of £52.2m which is £1.6m more than the opening balance for the year. Large revenue receipts were received in later months to support the I&E forecast without cash outflows to offset.

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	3.2	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance and Performance Committee at its meetings in March and April 2025 and sets out the matters the Committee wishes to bring to the attention of the Board.

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

Action required by Group Board

The Board is asked to:

a) Note the paper

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	[Add name or delete if not required]
Appendix 2	[Add name or delete if not required]
Appendix 3	[Add name or delete if not required]

Implications

Group Strategic Objectives

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

Risks

[Set out summary of risk and state link to Board Assurance Framework]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance and Performance Committee Report
Group Board, 01 May 2025

1.0 Purpose of paper

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

2.0 Background

2.1 At its meetings on 28th March and 25th April 2025, the Committee considered the following items of business:

28th March 2025	25th April 2025
PUBLIC MEETING • Finance Performance M11 • Forecast and mitigations M11 • Business Planning 2025/26 • Business Cases • Impairments • Productivity update	**PUBLIC MEETING** • Financial Performance 2024/25* • Business Planning 2025/26* • CIP Update 2025/26 • Financial Recovery Board update • Cash reporting • Productivity update • IQPR • SWL Procurement Partnership update

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

2.2 The Committee was quorate for both meetings.

4.0 Sources of Assurance

4.1

a) Financial Performance 2024/25

Both trusts have reflected delivery of the 2024/25 financial plan in their draft accounts submissions. Committee members welcomed this achievement.

b) Business Planning / Financial Recovery Board update / CIP 25/26

Committee members focussed on CIP progress for 25/26 where progress was slower than was needed to fully deliver the plan. The Committee noted the strategy to improve the level of fully developed schemes.

c) Business Cases / Impairments

Committee members noted the confirmed impairment values included in year end accounts of each organisation following the pause on projects in relation to the new hospitals programme.

d) Productivity update

The SGH DFS updated on the latest productivity information including some of the data quality challenges that may show the two Trusts as outliers. Committee members asked for more productivity metric progress reports and noted that more productivity measures would be included in the IQPR with the April data.

e) Cash 25/26

The GCFO noted some of the emerging guidance on Cash management in 2025/26 which was noted by committee members. Given the challenges within the likely final settlement, rigorous monitoring of cash will be required in the year ahead.

f) IQPR

Operational colleagues updated on some of the key challenges in delivering elective and non-elective targets as we begin the new financial year. Whilst there was strong performance against benchmarks in many areas, the Committee recognised the need to improve performance in A&E and with length of stay.

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

a) SWL Procurement partnership report

The SWLPP Director of Commercial Procurement highlighted performance against breaches and waivers, CIP progress and benchmarking analysis with similar organisations. The GCFO noted how many lower quartile organisations are community or mental health providers who procure significantly lower values of spend with less complexity.

5.0 Implications

5.1 The Committee noted no reason to change the current BAF operational-related risk SR 8 – Reducing Waiting Times and recommended no changes to the score of ‘20’ and limited assurance.

5.2 The Committee noted no reason to change the current BAF finance risk SR4 - Achieving financial sustainability and recommended no changes to the score of ‘25’ and limited assurance.

6.0 Recommendations

6.1 The Group Board is asked make decisions as requested above and to note the issues escalated to the Board and the wider issues on which the Committee received assurance in March and April 2025.

Group Board Meeting (Public)

Meeting on Thursday, 01 May 2025

Agenda Item	4.1	
Report Title	**People Committee Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committee Chair, SGUH & ESTH NED	
Report Author(s)	Yin Jones, People Committee Chair, SGUH & ESTH NED	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees-in-Common at its meeting in April 2025 and the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- Group Chief People Officer (GCPO) Report: The Committee received a verbal update from the GCPO that focused on financial challenges and the need to foster a culture of high-performing teams, continuous improvement, and staff empowerment to meet the challenges. The Committee noted the verbal update and highlighted the importance of clear communication, involving staff in finding solutions, and managing the change process in a caring and professional manner during this challenging financial year.
- The 2024 NHS Staff Survey showed an improvement in staff engagement, but there was still work to be done to reach the top five London acute trusts. The Committee discussed the need for measurable outcomes, ensuring actions have a personal impact, and potentially using a "pledge" system for accountability. A future paper will provide updates on action plans and KPIs.
- Workforce KPI Performance Report
  The Committee welcomed the new format and noted the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. The Committee discussed the data, including concerns related to over establishment of 868 WTE – i.e. discrepancy between the funded establishment (18,164 WTE) and the current deployment (19,032 WTE).
- Committee Governance (Forward Planner 2025/26) The Annual Forward Planner 2025/26 was reviewed and approved, subject to amendments. Amendments included adding a regular update on key strategic projects, incorporating a deep dive on flexible working, removing the Maternity Establishment item, and adjusting the length of some agendas that had too many items.

Action required by Choose an item.

The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the Committees received assurance in April 2025.

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

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

Implications

Group Strategic Objectives

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

Risks

The Committee did not review People risks (SR12,13 and 14) at this meeting.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committee Report
Group Board, 01 May 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meeting in April 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

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

2.0 Items considered by the Committees

2.1 At its meeting in April 2025, the Committees considered the following items of business:

17 April 2025
• Group Chief People Officer Report • NHS Staff Survey 2024 Response • Shadow Board Update • Staff Health and Wellbeing Update • Workforce KPI Performance Report • Workforce Controls • Committee Governance (Forward Planner 2025/26)

2.2 As in 2024/25, the Committee is meeting every two months as agreed by the Group Board, and the chairing of the meetings is done by Yin Jones who became the joint Non-Executive Director for both ESTH and SGUH and the joint Chair of the People Committees-in-Common in January 2025. An informal meeting between the Chair and GCPO takes place between Committee meetings.

3.0 Key issues for escalation to the Group Board

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

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

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

Financial Challenges: The Committee discussed the significant financial pressures facing the NHS in the current year. Specific targets for reducing agency spend (30% at SGUH, 40% at ESTH) and bank spend (10% at both trusts) were noted. A target to reduce corporate service cost growth by £10m was also highlighted. The GCPO explained that, while redundancies were not ruled out, they would be a last resort, with a focus on redeployment, natural attrition, and managing temporary staff costs. A multi-disciplinary group is considering the cultural implications of these challenges. Change management capability building is underway.

Culture and Behaviours: The need to foster a culture of high-performing teams, continuous improvement, and staff empowerment to meet challenges was discussed. Raising standards of behaviour, addressing concerns locally, and improving inclusion and belonging (Equality, Diversity and Inclusion - EDI) remain priorities. Key elements of the Talent Management Strategy, such as career conversations and fair recruitment processes, were highlighted as means to address EDI concerns raised in the staff survey.

Recent Media Coverage: The GCPO acknowledged recent media stories concerning both Trusts and invited the Committee to ask any questions they had regarding the issues or the organisation's handling of them, either during the meeting or privately afterwards.

The Committee noted the verbal update and highlighted the importance of clear communication, involving staff in finding solutions, and managing the change process in a caring and professional manner during this challenging financial year.

b) NHS Staff Survey 2024 Response

Following the lifting of the national embargo, the Committee discussed the full results and benchmarking. Results showed improvement, with SGUH ranking 10th and ESTH 15th nationally for score improvement. Staff engagement was a key strength for both Trusts, scoring above the national average. SGUH received a certificate recognising improvements across all seven People Promise themes and engagement.

ESTH performed well on 'Compassion and Inclusivity' and 'Safe and Healthy' but needed to focus on flexible working and appraisal/learning satisfaction. SGUH showed strength in engagement but lagged behind the national average on 'Safe and Healthy' (linked to staffing level concerns), access to learning, flexible working, and pay satisfaction. All divisions were developing local action plans based on detailed results, supported by HR Business Partners and new data tools.

The Committee discussed the need for measurable outcomes, ensuring actions have a personal impact, and potentially using a "pledge" system for accountability. A future paper will provide updates on action plans and KPIs.

4.0 Key Issues on which the Committees received assurance

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

a) Workforce KPI Performance Report

The Committee welcomed the new format and noted the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. The Committee discussed the data, including concerns over the discrepancy between the funded establishment (18,164 WTE) and the current deployment (19,032 WTE). The deployment in March 2025 represented a 1.5% increase (about 280 WTE) compared to February 2025. Admin staff turnover/starters and leavers under one year was also highlighted as a concern. An action was taken to review the effectiveness of vacancy controls for admin roles. The need for robust workforce planning and better data triangulation with finance was highlighted. The Committee received Reasonable Assurance on the Workforce KPI Performance.

b) Workforce Controls

The Committee reviewed the proposed programme to enhance oversight over workforce deployment and expenditure, comprising seven key workstreams: Temporary Staffing, Control Environment, Rostering Optimisation, Payroll Optimisation, Digital Transformation, Workforce Planning, and Data/Insights. The Committee welcomed the programme and noted that it required significant change management, resource alignment (supported by the Heads of Service restructure) and leveraging expertise across both Trusts.

5.0 Other issues considered by the Committees

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

a) Shadow Board Update

The Committee was presented with a plan to establish a Shadow Board to improve ethnic diversity at senior levels and offer developmental opportunities. £30k funding had been secured and a Request for Quotes issued to potential providers, with selection planned for mid-May 2025. The programme aims to launch in September 2025, running for at least six months (duration flexible based on supplier proposals), targeting Band 8b+ staff (level to be finalised) with at least 50% representation from Global Majority and disabled colleagues.

The Committee highlighted the importance of mentorship/sponsorship, ensuring participants have time release, and board engagement for the programme's success. Several NEDs volunteered to support the initiative.

b) Staff Health and Wellbeing Update

An overview of activity over the last six months was presented to the Committee. SGUH now has 111 trained Mental Health First Aiders. Work is needed to expand this accredited training to ESTH too. Specialist women's health appointments and men's health checks have been popular. Support for night-shift workers is being enhanced. The Committee discussed the financial wellbeing tool, Wagestream, which is used at SGUH but not ESTH. An action was taken for ESTH to review its adoption and report back. The Committee welcomed the plans for embedding well-being conversations into line management, appraisals (using Wellness Action Plans), and team meetings.

c) Committee Governance (Forward Planner 2025/26)

The Annual Forward Planner 2025/26 was reviewed and approved, subject to amendments. Amendments included adding a regular update on key strategic projects, incorporating a deep dive on flexible working, removing the Maternity Establishment item, and adjusting the length of some agendas that had too many items. The Certificate of Sponsorship item will remain pending an audit outcome.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated to the Group Board and the wider issues on which the People Committee received assurance. The People Committee agreed to escalate to the Board the importance of strengthening the connection and data alignment between the People Committee and Finance Committee agendas, particularly concerning workforce size against funded establishment.

Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	6.1	
Report Title	**gesh Learning from Deaths Quarterly Report: Q2 (July - September) 2024/25 and Q3 (October - December) 2024/25**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer	
Report Author(s)	Martine Meyer AMD for Quality, ESTH Rumiko Yonezawa Associate Director of BI and Analytics, ESTH Jay Wijayarathne, Principal Clinical Analyst, ESTH Laura Rowe Lead Midwife for Clinical Governance and Risk ESTH Rebecca Suckling, Site CMO, ESTH Luci Etheridge, Site CMO, SGH Ashar Wadoodi, Learning from Deaths Lead, SGUH Kate Hutt, Group Head of Mortality & Effectiveness Amy Christensen, Group Senior Manager Learning from Mortality	
Previously considered by	Quality Committees-in-Common	24 April 2025
Purpose	**For Assurance**	

Executive Summary

Trusts are required to collect, scrutinise and publish specified information on deaths on a quarterly basis. This paper summarises the two sites' approaches to learning from deaths, and the key data and learning points.

Some key points to note from this report are:

- Overall mortality at ESTH appears to be improving. However, both measures (SHMI and HSMR) remain "higher than expected"
- Overall mortality at SGUH is "lower than expected" as measured by both SHMI, and HSMR (overall mortality is discussed in Section 2).

At ESTH:

- A high percentage of deaths (38.8% Apr-Dec 2024) continue to be scrutinised through Structured Judgment Reviews.

- Structured Judgement Reviews have highlighted that sepsis care is improving and a newly appointed Clinical Lead for Sepsis further is taking forward work to align approaches across the group. There is a specific focus on identifying and treating sepsis at presentation in the Emergency Areas. (Section 3.1).

- There remains a large number of cardiac arrests occurring in the ED. This is discussed in Section 3.1.

At SGUH:

- The investigation of mortality in cardiology, particularly AMI and following PCI, has been reported to MMG (Section 3.2). The investigation considered data and clinical pathways, with an independent review of mortality. Mortality was not related to procedural complications and areas of clinical concern were not identified. Improvements in coding processes through collaborative working have been achieved and are being monitored. Improvements in scheduling have resulted in more timely access to treatment. An action plan has been agreed and will be reported to MMG.

- NHS Blood and Transplant (NHSBT) will visit St George's renal transplant unit on the 10th April. This follows an alert reported in the previous version of this report related to 2 patient deaths and 2 kidney losses with 30 days of implantation (see section 3.2)

Group-wide and national issues:

- Mortality and Morbidity provision at ESTH is being reviewed with a gap analysis, focussing on understanding current provision, gaps in support and provision and establishing standardised best practice.

- A significant step towards standardisation has been achieved through implementation of Healthcare Evaluation Data (HED) benchmarking platform at SGH for mortality data analysis, bringing SGH in line with ESTH.

- Our Medical Examiner services have maintained compliance with all national requirements following a successful transition to a statutory system from 9th September 2024 (Section 5).

Action required by Group Board	
That the Group Board note the continued work in accordance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these.	
Committee Assurance	
Committee	Quality Committees
Level of Assurance	Reasonable Assurance: The report and discussions assured the Committee that the system of internal control is generally adequate and operating effectively but some improvements are required, and the Committee identified and understood the gaps in assurance

Appendices
Appendix 1: SGH Cardiology AMI signal – action points
Appendix 2: SGH Cardiology summary
Appendix 3: SGH Cardiology Action plan results following MI signal review
Appendix 4: ESTH Mortality Overview
Appendix 5: To address QCiC Action Log 1.4 Oct 2023, Row 8 ESTH & SGH
Appendix 6: SGUH LFD NQB Dashboard

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships		☒ Right care, right place, right time		
☐ Affordable Services, fit for the future		☐ Empowered, engaged staff		
Risks				
Failure to achieve high standards in mortality governance presents a risk to the delivery of safe patient care.				
CQC Theme				
☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes		☐ People		
☐ Preventing ill health and reducing inequalities		☐ Leadership and capability		
☐ Finance and use of resources		☐ Local strategic priorities		
Financial implications				
Legal and / or Regulatory implications				
Learning from Deaths' framework is regulated by CQC and NHS Improvement and demands trust actions including publication and discussion of data at Board level.				
Equality, diversity and inclusion implications				
Analysis of the HSMR by age, sex and ethnicity is possible using HED (Appendix 5). For ESTH, mortality rates exceed 95% upper confidence interval across both sexes, older age groups, and certain deprivation quintiles. For SGH higher than expected mortality is observed in the 1-4 age group. The new MCCD includes mandatory reporting on ethnicity which may support improved data collection.				
Environmental sustainability implications				
None Identified.				

gesh Joint Learning from Deaths Quarterly Report
Q2 2024/25 (July – September 2024) and Q3 2024/25 (October – December 2024)

1.0 PURPOSE

1.1 The purpose of this joint paper is to provide the Quality Committee in Common with an update on progress against the Learning from Deaths agenda, as outlined in the national guidance on learning from deaths. The paper also summarises the activity of the respective Medical Examiner's offices.

1.2 The report describes sources of assurance that the Group is scrutinising mortality and identifying areas where further examination is required. In line with the Learning from Deaths framework, we are working to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements.

2.0 NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

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2.1 There have been 317 in-patient deaths in Q2 24/25 (July – September 2024) and 417 in Q3 24/25 (October – December 2024).

2.2 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS England]
As described previously ESTH participated in a pilot project to transition Same Day Emergency Care (SDEC) data from the Admitted Patient Care (APC) dataset to the Emergency Care Data Set (ECDS), a change known to impact SHMI calculations. It is expected that from July 2025, all NHS trusts in England will adopt this new methodology.

The latest SHMI, covering discharges from November 2023 to October 2024, was higher than expected at 1.16, based on 40,975 patient spells with 1,770 observed deaths compared to an expected 1,520. Mortality at St Helier Hospital is within the expected range at 1.10, while Epsom Hospital remains higher than expected at 1.27. Mortality was 'as expected' across all diagnosis groups.

SHMI for 10 diagnostic groups (November 2023 to October 2024)

Diagnosis group	SHMI value	Banding
Septicaemia (except in labour), Shock	1.13	As expected
Cancer of bronchus; lung	1.44	As expected
Secondary malignancies	1.26	As expected
Fluid and electrolyte disorders	0.97	As expected
Acute myocardial infarction	0.74	As expected
Pneumonia (excluding TB/STD)	1.07	As expected
Acute bronchitis	1.42	As expected
Gastrointestinal haemorrhage	1.05	As expected
Urinary tract infections	1.39	As expected
Fracture of neck of femur (hip)	0.76	As expected

2.3 **Hospital Standardised Mortality Ratio (HSMR)** [source: Healthcare Evaluation Data (HED)]
The HSMR for December 2023 to November 2024 stands at 107.37, higher-than-expected (23,063 super spells, 1,011 observed deaths, 942 expected deaths). The trend in the monthly HSMR has been improving and the gap between expected and observed deaths has narrowed, aligning with lower monthly values. HSMR calculations include adjustments for patients documented as receiving palliative care.

HSMR for December 2023 to November 2024 data

	Value	Banding
All admission methods	107.37	Higher than expected
Elective admissions	82.12	Lower than expected
Non-elective admissions	107.87	Higher than expected

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2.4 There have been 285 in-patient deaths in Q2 24/25 (July – September 2024) and 381 in Q3 24/25 (October – December 2024).

2.5 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]
Latest SHMI data covers discharges from November 2023 to October 2024, and is lower than expected at 0.87. (67,320 spells, 1,670 deaths observed, 1,915 expected).

SHMI for 10 diagnostic groups (November 2023 to October 2024)

Diagnosis group	SHMI value	Banding
Septicaemia (except in labour), Shock	0.86	As expected
Cancer of bronchus; lung	0.67	Lower than expected
Secondary malignancies	0.98	As expected
Fluid and electrolyte disorders	0.69	As expected
Acute myocardial infarction	0.98	As expected
Pneumonia (excluding TB/STD)	0.76	Lower than expected
Acute bronchitis	*	*
Gastrointestinal haemorrhage	0.75	As expected
Urinary tract infections	1.30	As expected
Fracture of neck of femur (hip)	0.97	As expected

* value not given due to small numbers

2.6 **Hospital Standardised Mortality Ratio (HSMR)** [source: Healthcare Evaluation Data]
The most recent HSMR covers discharges between January and December 2024 and is lower than expected at 86.3.

HSMR for January 2024 – December 2024 data

	Value	Banding
HSMR	86.3	Lower than expected
HSMR weekday non-elective admission	82.1	Lower than expected

HSMR weekend non-elective admission	95.8	As expected

The Trust contract with Telstra, providers of the Dr Foster Benchmarking platform, has ended and benchmarking is now carried out using Healthcare Evaluation Data (HED). This is a significant financial saving and brings SGH in line with ESTH. Telstra have developed a new version of HSMR, called HSMR+ which is not available to non-subscribers to their tools. HED will continue to focus on SHMI analysis, whilst also providing access to the established HSMR.

3.0 LEARNING FROM DEATHS OBJECTIVES

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3.1 **Mortality Reviews**

The elevated national mortality statistics form part of mortality vigilance. Engagement with the Medical Examiner's office supports the identification of improvement from bereaved families and medical examiners. A high percentage of deaths are reviewed with SJRs to provide enhanced oversight. Areas of focus for enquiry and quality improvement are agreed at the Reducing Avoidable Death and Harm (RADAH) meeting.

Priority Work Streams and Signals (ESTH)

Workstream and Priority area	Key updates
Mortality Data: Raised HSMR/SHMI	
Clinician-Coder collaboration	Concern: Excess of deaths reported with a UTI code. Previous analyses found that coding accuracy is sub-optimal, with only about one third of patients having confirmed UTI. Action: The Clinical Coding team is liaising with SGH to develop a robust process for reviewing cases where there are excess deaths to ensure accuracy.
Mortality and Morbidity Activity	
1. Sepsis	There has been an improvement in the utilisation of specific assessments of suspected sepsis using observations to quantify the risk of severity of sepsis including death. Improvement is required to reduce the variations in performance against quality standards [QS161] including the critical need for rapid diagnosis and treatment in the context of the intense pressures faced by clinical staff. **Actions:** To increase early identification, the Sepsis Lead met with Sutton GPs to support actions to reduce delay in assessment where sepsis is suspected in primary care settings.

<table>
<tr><td>2. Community mortality reviews</td><td>The similarity between SHMI and HSMR does not suggest that the excess of mortality sits outside of the hospital post discharge. However, it is recognised that there is no formal review of deaths after discharge and Sutton Heath and Care and the ICB quality team are establishing a project to review mortality post discharge from hospital.</td></tr>
<tr><td>3. Working with the Medical Examiner team to identify quality concerns</td><td>A Working Group is developing guidance for hypernatraemia. MEs notify the lead of any cases of hypo/hypernatraemia to support the improvement programme.</td></tr>
<tr><td>4. CCOT</td><td>The Critical Care Outreach Team (CCOT) expect to have 7-day cover at both STH and EGH by end January 2025.</td></tr>
<tr><td colspan="2">Additional workstreams</td></tr>
<tr><td>Resuscitation Team: Cardiac Arrest Outlier</td><td>The total number of hospital cardiac arrests has reduced, as presented in October 2024, from 128 in 2022/2023 to 101 in 2023/2024. However, there is an increase in Q3 2024/2025 with a reduction in survival to discharge.

During the resident and Consultant industrial action a reduced rate of in-hospital cardiac arrest rates was observed due to the number of senior decision makers present making earlier appropriate escalation plans. The higher number of elderly (>75) individuals being resuscitated supports that escalation decisions are not being made in a timely manner. This has reduced year on year but is still above the national average and for similar hospitals. Clinical audit has established that the cardiac arrests are predominantly in patients with a decision to admit.

NCAA cumulative data for ESTH: Q3 2023/24 vs. Q3 2024/25
Q3 analysis includes data from 01/04/2024-31/12/2024
<table>
<tr><td></td><td>Q3 2023/24</td><td>Q3 2024/25</td></tr>
<tr><td>Total admissions</td><td>61,664</td><td>61,459</td></tr>
<tr><td>Total CA</td><td>67</td><td>82</td></tr>
<tr><td>CA/1,000 admissions</td><td>1.09</td><td>1.33</td></tr>
<tr><td>Ward CA</td><td>24</td><td>33</td></tr>
<tr><td>Ward CA/1,000 admissions</td><td>0.37</td><td>0.54</td></tr>
<tr><td>ROSC >20 minutes</td><td>53.6%</td><td>51.9%</td></tr>
<tr><td>Survival to discharge</td><td>32.3%</td><td>23.4%</td></tr>
</table>

Q3: Cardiac Arrests in Patients >75
<table>
<tr><td></td><td>Q3 2023/24</td><td>Q3 2024/25</td></tr>
</table>
</td></tr>
</table>

	ESTH	50.7%	48.7%
	Similar Hospitals	43.1%	46.9%
	All Hospitals	44.0%	41.6%

There has been a slight reduction in the proportion of cardiac arrests occurring within the ED footprint (included SDEC areas), however, this remains significantly higher than similar trusts. From March 2025, all in hospital cardiac arrests in the ED footprint will undergo an SJR.

Q3: Cardiac Arrests within ED Footprint

	Q3 2023/24	Q2 2024/25
ESTH	47.8%	43.9%
Similar Hospitals	26.5%	25.1%
All Hospitals	19.7%	19.0%

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3.2 **Mortality Monitoring Group (MMG)**

MMG aims to create an environment where sharing learning and triangulating information becomes second nature. Processes are monitored and ratified through MMG, which is chaired by the Site Chief Medical Officer (CMO).

Table 2: Priority Work Streams and Signals (SGUH)

Workstream	Key updates
Mortality investigations: Cardiology diagnosis and procedure groups	Over the last year, we have investigated mortality within cardiology, specifically related to acute myocardial infarction (AMI) and patients that have undergone a procedure. This was triggered by SHMI and HSMR data suggesting higher than expected mortality. A deep dive commissioned from Dr Foster suggested procedure related mortality was divergent from other Heart Attack Centres, therefore this was the primary focus. The investigation by the clinical team considered data quality and the clinical pathway (see Appendix 1), specifically: • Audit of the accuracy of AMI coding • Detailed audit of timeliness to catheter lab access • Detailed review of procedure related mortality Review of patients coded as non-ST elevation myocardial infarction (NSTEMI) showed a large number (approximately 15%) with other diagnoses had been miscoded because of a small Troponin rise. Clinical validation has been introduced to support improved accuracy of coding, and in-turn, benchmarked data. Analysis suggests this action is having a positive impact.

	At present the British Cardiovascular Intervention Society (BCIS) suggest that 60% of NSTEMI patients should go to the catheter lab within 72 hours of presentation. Over the period examined, this target was achieved in only 50%. Work has been undertaken with Acute Medicine and the Emergency Department (ED) to reorganise the schedule, prioritising non-elective patients at the start of the morning list. Cohorting patients and considering discharging low risk cases to be treated as early outpatients has also been introduced. Local data suggests we are now achieving the BCIS standard for 70%. (See Appendix 2). Analysis of percutaneous coronary intervention (PCI) related deaths was carried out by a consultant specialising in high risk interventions who had not been directly involved in any of the cases. The reviewer concluded that none of the deaths were directly related to the procedure. The reviewer found that the mortality was related to the volume of high risk cases. (See Appendix 3). Independent, prospective review of all deaths following a cardiology procedure was conducted by the Learning from Deaths team. Over the 9 month audit 53 deaths were reviewed using the SJR methodology. Overall care was deemed as good or excellent in 50 cases, with 3 identified as adequate. Problems in care were noted for 19 patients. These problems were not felt to have definitely led to harm, but where there were questions or potential concerns these were raised with the clinical team to inform M&M discussion. Problems ranged from missed blood tests to device problems during procedures. The most common problem was delayed procedures which was found in 3 of the 19 cases. Overall, the learning from deaths team did not identify any concerning trends. MMG felt assured that the mortality data was understood and was not caused by poor care or treatment. Monitoring actions have been agreed to ensure the outcome of improvement actions is tracked and oversight maintained. • The service will share their findings with the regional network to inform the understanding of why outcomes in London centres appear to be worse than other areas and to support ongoing benchmarking and evidence-based actions. • The service will define a process for monitoring outcomes which will include national BCIS data to provide assurance of improvement. The Learning from Deaths team will provide benchmarking data to facilitate triangulation with local data. • The review of procedural mortality is to be presented to the cardiology interventional group for their input. The service will be asked to provide an update to MMG in Q2 25/26.

Mortality and Morbidity (M&M) activity	The M&M team continue to provide support to speciality groups across the Trust and to promote adherence to agreed standards. In this period improvement has been observed in ED. Clear patient selection criteria has been implemented and there is now a dedicated M&M meeting with better attendance. Monitoring of this improvement is incorporated in the broader ED governance plan. The team continue to develop the triangulation to identify and promote learning. Collaboration with the Patient Safety Team is well established and detailed information forms a key element of divisional quarterly reports to Patient Safety and Quality Group.
Perinatal mortality review tool	MMG continues to receive Perinatal Mortality Review Tool (PMRT) summary reports. This is part of NHS Resolution's Maternity Incentive Scheme to support safer maternity and perinatal care. The latest report covered the period April 2024 to June 2024. From the 4 standards within reporting, we were compliant with three: • 100% of parents asked to contribute their perspectives of care and to raise any questions or comments (target 95%) • 95% of reviews started within 2 months of the death and 80% of multidisciplinary reviews completed and published within 6 months (targets 95% and 60% respectively) • Quarterly reports submitted to the Executive Board We did not meet the requirement to report all eligible perinatal deaths to MBRRACE UK within 7 working days. This standard was met for 60% of cases. Actions have been agreed to ensure compliance in future periods. In this period there were 7 perinatal deaths. Two have been referred for Maternity and Safety investigation (MNSI), which have not yet concluded. There were five cases reviewed: two neonatal deaths and three stillbirths. One case was reviewed where no care issues were identified and in three other cases care issues were identified which would have made no difference to the outcome. There was one case where the review group identified care issues which they considered may have made a difference to the outcome of the baby. Issues that were identified include using appropriate translation services for non-English speaking patients. Resuscitation notes should be completed in full, so that any reviews can be appropriately completed and late referrals for booking appointments should be given priority. Actions to address these points are being delivered by NNU consultants and the maternity risk team.

	In November 2024 MMG received the external perinatal mortality report commissioned to gain an understanding of any issues negatively contributing to stillbirths and neonatal deaths which occurred during 2020 to determine if there are areas of improvement. Recommendations made by the report are being assessed and taken forward as part of a wider governance improvement programme and will be managed by the Maternity Oversight group. It was noted that comparison with issues arising from PMRT is beneficial and therefore MMG should have oversight of such reports to support triangulation and ensure all actions are taken forward. The CMO (MMG Chair) is working with senior leaders on the Maternity Oversight group and within directorate and divisional governance teams to ensure appropriate maternity representation at MMG to prevent duplication, whilst ensuring there is an effective link and that work is carried out in a coordinated way.
External alert: Renal Transplant	Following the NHS Blood and Transplant (NHSBT) alert reported in the previous version of this report, NHSBT plan to visit the renal transplant unit on the 10th April. The alert related to 2 patient deaths and 2 kidney losses with 30 days of implantation. These cases have undergone internal review, with detail provided in the previous version of this report. The site visit will have a number of aims. The panel will review the unit's response to all deaths and graft losses which triggered the alert, plus any new cases since the initial alert. Comparison data for peer centres will also be considered and relevant unit protocols and process documentation will be reviewed. Going forward MMG have asked the service to provide annual data pertaining to patient deaths and 30 day graft losses as a means of providing internal oversight of data submitted externally.

4.0 OUTPUTS OF MORTALITY GOVERNANCE PROCESSES

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4.1 Mortality Review Team

The Mortality Review team plays a key role in improving patient care by conducting Structured Judgement Reviews (SJRs) and incident investigations, closely collaborating with Medical Examiners. Insights from reviews are discussed at the Reducing Avoidable Death and Harm (RADAH) meeting, where areas to improve are identified to enhance patient safety and care across the Trust.

Reviews are performed for all deaths that meet the National Quality Board criteria and several locally defined categories:

- Deaths of patients with COVID judged to be likely nosocomial.
- Deaths which are requested by the complaints team.
- Deaths where an inquest is being opened.
- Deaths where there is an unexpected cardiac arrest.
- Deaths where there is a cardiac arrest within the ED footprint

When there is capacity routine SJRs are completed to benchmark general quality of care. Below is a summary of the overall assessment care ratings of the SJRs, conducted by the Mortality Review Team for Q2 (2024/25) and Q3 (2024/25).

Table: Overall Assessment of Care Ratings

Overall care judgement	Q2 24/25		Q3 24/25	
	Number	**Percentage**	**Number**	**Percentage**
Excellent care	6	6%	6	4%
Good care	57	58%	84	56%
Adequate care	31	31%	55	36%
Poor care	5	5%	5	3%
Very poor care	0	0	1	1%
Total	**99**		**151**	

Concerns identified through the SJR process are rated as minor, moderate, or high. High concerns are automatically reported through the clinical reporting system (DATIX), and where appropriate, an incident review is recommended. Reviewers also liaise directly with the responsible consultant to suggest learning for improvement be discussed in M&M morbidity meetings. They also provide positive feedback when excellent care is observed. All SJRs assessed as overall ‘poor’, or ‘very poor’ care have a second SJR by another reviewer.

The DATIX reference numbers for the 'poor' or 'very poor' ratings for Q2 & Q3 24/25 are 4261, 4314, 4326, 4348, 4455, 4638, 4509, 4737, 4748, 4792 and 4897.

SJRs, have been completed for 99 deaths in Q2 (2024/25) and 151 in Q3 (2024/25), which represent 35% and 40% of deaths respectively. The percentage of overall ‘poor/very poor’ assessments was 5% in Q2 and 4% in Q3 which is on par with the previous quarters. The percentage of overall ‘good/excellent’ assessments was 64% in Q2 and 60% in Q3.

Reviewers are required to identify concerns in care, their level and the type. In Q2, 46 care concerns were reported across 33 out of 99 SJRs (33%). In Q3, 69 care concerns were reported across 46 out of 151 SJRs (30%).

Table: Type of concerns in care provided

Type of concern	Q2 (2024/25)		Q3 (2024/25)	
	Number	Percentage of total concerns	Number	Percentage of total concerns
Assessment/ Investigation/Diagnosis	5	11%	18	26%
Medication/IV fluids/electrolytes/Oxygen	4	9%	6	9%

Treatment and Management Plan	13	28%	23	33%
Infection management	5	11%	2	3%
Operation/invasive procedure	0	0%	2	3%
Clinical monitoring	1	2%	1	1%
Resuscitation following a cardiac/respiratory arrest	4	9%	3	4%
Communication	5	11%	5	7%
Other including organisational issues	9	20%	9	13%
Total	46		69	

Concern in Care/Level of Concern	High		Moderate		Minor		Total Q2 24/25	Total Q3 24/25
	Q2 24/25	Q3 24/25	Q2 24/25	Q3 24/25	Q2 24/25	Q3 24/25		
Assessment/ Investigation/Diagnosis	2	2	2	10	1	6	5	18
Medication/IV fluids/electrolytes/Oxygen	1	1	3	2	0	3	4	6
Treatment and Management Plan	1	5	11	12	1	6	13	23
Infection management	0	1	4	1	1	0	5	2
Operation/invasive procedure	0	0	0	2	0	0	0	2
Clinical monitoring	1	0	0	1	0	0	1	1
Resuscitation following a cardiac/respiratory arrest	1	2	3	1	0	0	4	3
Communication	2	0	2	4	1	1	5	5
Other including organisational issues	1	1	6	6	2	2	9	9
Total	9	12	31	39	6	18	46	69

4.2 **Learning from excellence**

In the reporting period the following areas were identified by the Mortality Review Team and fed back to individual teams and Divisions:

- Sepsis care is improving
- Palliative Care Team and AOS (Acute Oncology Service) continue to provide very good care, with excellent response times
- ReSPECT forms being completed in a timely manager at EGH
- Difficult/sensitive conversations with patients and families are very well documented, and positive feedback sent to Haematology, Stroke, Learning Disability Team
- Areas of improvement in DNACPR/PTEP completion

4.3 **Learning from mortality in Mortality and Morbidity meetings**

To date M&M processes have been held at divisional level. As part of the integration of corporate services, mortality services, including Learning from Deaths and

Bereavement services were integrated in Q3 2024/25. This will allow us to identify opportunities to learn from what works well in each trust and implement best practice across the gesh group.

A key element of this will be the introduction of governance support for M&M meetings, with the aim of identifying learning arising from the review of deaths and serious complications. An action plan has been developed to support this work at ESTH. This will involve completion of a baseline assessment and evaluation of existing M&M structures, allowing prioritisation of areas for support.

The intention is for M&M meetings to follow key agreed principles, supporting clinical teams to conduct well-structured and efficient meetings, which generate learning.

4.4 **Perinatal Mortality**

The Trust has continued to demonstrate full compliance with the Clinical Negligence Scheme for Trusts (CNST) Safety Action One, as evidenced by the bi-monthly Perinatal Mortality Review Tool reports. In addition to summarising compliance, each report also detailed potential areas for learning and improvement. Over the year there were no clear themes identified which contributed to the outcomes in these cases.

During Q2 and Q3 2024/2025 there were 12 stillbirths reported to MBRRACE-UK, 3 early neonatal deaths and 1 late neonatal death. Of the neonatal deaths, 2 were at <24 weeks' gestation (i.e. late miscarriage). In all cases, the panel did not identify any care issues which they felt either may or would have caused a difference in the outcome. All the issues identified would not have made a difference to the outcome and included:

- Monitoring of labour and observations (use of the Partogram and PCA observations)
- The importance of using a cold cot following delivery
- Follow up of pathology results
- Access to information leaflets on the electronic notes

All child deaths are reviewed locally by clinical teams and presented at the monthly paediatric Divisional Management Team meeting.

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4.5 **Mortality Reviews Summary Data**

The need for SJRs has been identified for 43 patients in Q2 and 43 patients during Q3 which equates to approximately 13% of inpatient deaths. The reasons for requesting a review are summarised below.

All child deaths are reviewed locally by clinical teams and Child Death Overview Panel.

Triggers for review	Q2 24/25	Q3 24/25
Confirmed learning disability +/- clinical diagnosis of autism	5	5
Significant mental health diagnosis	10	11
ME or clinical team detected possible learning or potential issue with care	2	11
Deaths following elective admission	7	5

Areas subject to enhanced oversight *	18	11
Family raised significant concerns	1	0
Total SJR during period	**43**	**43**

*Patients that underwent cardiology procedures.

The SJR methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 43 deaths reviewed in Q2 24/25 a problem that resulted in harm was identified in relation to 1 patient. This death is included in section 4.7 Learning from Mortality. In Q3 there were no problems in healthcare that were felt to have led to harm.

Problems in healthcare identified.

Problem in healthcare	No harm		Possible harm		Harm		**Total**	
	Q2 24/25	Q3 24/25	Q2 24/25	Q3 24/25	Q2 24/25	Q3 24/25	Q2 24/25	Q3 24/25
Assessment	2	0	1	2	0	0	3	2
Medication	5	1	1	0	1	0	7	1
Treatment	2	4	5	7	0	0	7	11
Infection control	1	1	0	0	0	0	1	1
Procedure	2	0	0	0	0	0	2	0
Monitoring	2	0	0	2	0	0	2	2
Resuscitation	1	0	1	0	0	0	2	0
Communication	2	2	0	1	0	0	2	3
Other	0	1	1	3	0	0	1	4
Total	17	9	9	15	1	0	27	24

The SJR methodology considers phases of care and requires an assessment of overall care. Care is found to be good in the majority of cases; however, in Q3 there was one patient who was felt to have received poor care. This is detailed in section 4.8.

Overall care rating

	Q2 24/25		Q3 24/25	
Overall care judgement	Number	Percent	Number	Percent
Excellent care	3	7.0	1	2.3
Good care	35	81.4	39	90.7
Adequate care	5	11.6	2	4.7
Poor care	0	0	1	2.3
Very poor care	0	0	0	0
Total	**43**		**43**	

SJR reviewers make an initial assessment, based solely on case note review, whether there is any indication that the death may have been avoidable. In Q3 there was one death which the reviewer felt was probably avoidable. This is explained in section 4.8.

Judgement on avoidability of death is made for all reviews

Avoidability of death judgement	Number Q2 24/25	Percentage Q2 24/25	Number Q3 24/25	Percentage Q3 24/25
Definitely not avoidable	39	90.7	36	83.7

Slight evidence of avoidability	3	7.0	4	9.3
Possibly avoidable but not very likely (less than 50:50)	1	2.3	2	4.7
Probably avoidable (more than 50:50)	0	0	1	2.3
Strong evidence of avoidability	0	0	0	0
Definitely avoidable	0	0	0	0
Total	**43**		**43**	

4.6 **Learning from mortality**

Any patient who is deemed by a reviewer to have suffered poor care, or where death may have been avoidable, is discussed in a monthly mortality review meeting. The group take a decision regarding the need for notification to the Patient Safety Team, and/or referral to the clinical team to discuss in their M&M. This process helps to triangulate medical examiner scrutiny, the M&M process, structured judgement reviews and patient safety processes to achieve learning from deaths.

Individual SJRs are shared with clinical teams regardless of outcome, including examples of good practice. A quarterly summary report is also provided for each division, encouraging transparency and triangulation.

4.7 **Cases from Quarter 2 24/25**

In Q2 there was one death which was judged to have been possibly avoidable, although not very likely, and one death where a medication problem was felt to have led to harm.

Ref	Reasons for review	Clinical concern	Outcome
#8031 (DW213427)	Death possibly avoidable but not very likely (less than 50:50)	(1) Excess warfarin dosing (2) In hospital fall	The clinical team completed an incident review which was then discussed by the divisional governance team. A CT scan did not reveal any bleeding, and it was concluded that the incidents did not contribute to death.
#8008 (DW211397, DW211352, DW211353).	Problem in healthcare led to harm (medication)	(1) Limited preop assessment (2) Interventional radiology stopped insulin during procedure	Several specialties were involved, and a number of incidents reported. Actions have been agreed around diabetic ketoacidosis management and insulin prescribing, with education being led by practice educators. This death was discussed in each relevant specialty M&M and satisfied the reviewer that all concerns had been addressed.

4.8 **Cases from Quarter 3 24/25**

In Q3 there was one death which was judged to been more than likely avoidable, and two deaths that were felt to be possibly, but not very likely, avoidable. In one case (ref #8067) overall care was also judged to be poor.

Ref	Reasons for review	Clinical concern	Outcome
#8077 (DW225855)	Death probably avoidable (more than 50:50)	Lost to follow up following liver biopsy	This case has been discussed in M&M meetings and the clinical team identified the need to look at their processes for ensuring appropriate follow up. This is being taken forward by the Hepatology Speciality Group. The incident has been reported on Datix to ensure appropriate consideration and action at the MedCard Divisional Incident Review Group (DIRG).
#8067	Death possibly avoidable but not very likely (less than 50:50) and poor overall care	Patient over-anticoagulated and died following a GI bleed	Reviewed at senior health M&M. noted that several years anticoagulation and only one extra dose given so unlikely to have caused this patients death. No additional action required as questions were answered through liaison between Learning from Deaths Lead and clinical team with M&M discussion
#8048 (DW217657)	Death possibly avoidable but not very likely (less than 50:50)	Possible bleed related death following trans-jugular liver biopsy. Periods of hypotension during recovery	MedCard discussed this case at DIRG on 3rd April 2025 and concluded this was not for escalation. This is a rare but possible complication of a necessary test in a biopsy. The brief deterioration post procedure was judged to have been managed appropriately.

5.0 MEDICAL EXAMINER SERVICE

All ME services report directly to their Regional Medical Examiner and are accountable to the National Medical Examiner. Each ME service is independent of the host trust. All

ME services are required to make a quarterly returns to the office of the National ME. During Q3 2024/25 the Medical Examiner service moved to a statutory footing.

EPSOM & ST HELIER

5.1 Sutton & Epsom (S&E) Medical Examiner (ME) service is hosted by Epsom & St Helier Hospitals (ESTH). The service has met all the key requirements and agreed milestones reviewing 100% (317 Q2 24/25 & 417 Q3 24/25) of adult and paediatric deaths in the Trust.

5.2 Prior to commencement of the statutory status the service was in an extremely strong position with all designated community providers in Sutton & Surrey, including Hospices and Private Hospitals referring deaths for review. The service continues to promote and encourage community engagement with the second edition of the Medical Examiner Newsletter issued in January. Presentations have been confirmed for 2025 to support further training and development opportunities.

5.4 The ME service works closely with the mortality reviewers to identify cases where mortality review is indicated. The Lead ME & MEO attend the Mortality Review Meetings. The number of deaths referred for an SJR by the ME service was 47 in Q2 24/25 and 78 in Q3 24/25. Of these, 20 (13 Q2 24/25, 7 Q3 24/25) were for review of on-ward cardiac arrests and 11 (4 Q2 23/24, 7 Q3 24/25) were for COVID-related deaths. This number has steadily reduced following the significant reduction in COVID cases, the changes in working practices following action provided from previous SJR reviews plus the proportionate reviews undertaken by the MEs where the understanding and accuracy of review is now greater. A further 8 SJRs were completed following coronial confirmation that these deaths were now subject to inquest.

5.5 Positive feedback continues to be shared with the Patient Experience team, Ward teams and individuals on a regular basis. There were 604 pieces of positive feedback in Q2 and Q3 (EGH 84%, SGH 80%, Trust 82%), which includes specific comments relating to the care provided and where there are “no care concerns”.

Of note, wards caring for patients with respiratory issues and those treated in the ED department have again been the recipients of positive feedback despite the pressures that both areas have experienced over the past weeks and months.

5.6 The ME service scrutinises deaths in the community setting covering the PCNs of Sutton and Epsom. Since inception the service has had Primary Care Doctors as MEs and this has supported provision to the wider community. The number of Community deaths scrutinised was 198 in Q2 24/25 and 241 in Q3 24/25.

The service is recognised as an exemplar at regional and national level for collaborative, forward-thinking practice. The data and supporting narratives submitted each quarter to the National ME is used as an example of “Good Practice” to support other services.

5.7 A limited out of hours service, approved by the National ME, was introduced in Q2 with its primary objective to support requests for rapid release of the deceased, usually to meet faith requirements with the operational hours to coincide with those of the registry offices

5.8 The service continues to evolve. The weekly ME service bulletin has enabled the entire team to keep abreast of all cases occurring at both sites which is vital given the two very different coronial jurisdictions in which they operate. This provides opportunity to share updates from within the ME service itself and with the wider community such as coronial and registration services. The ME Development afternoon in November included a presentation from Public Health, providing the team with insight into local mortality statistics and an opportunity to establish a network of contacts. Meetings with the ICB also proved fruitful with the sharing of bereavement pathways with plans to develop a single route for the bereaved for both Hospital and Community deaths. The Surrey Senior coroner attended a meeting with the hospital relating to a new PM service being introduced at ESTH and praised the excellent working relationship with the ME service.

5.9 Feedback on the Bereavement and ME services is gathered as part of an end-of-life care and bereavement survey. Data is only available covering the period from October 2024 to January 2025 with a total of 15 postal replies received. A summary of the information gathered reads as follows.

- Bereavement service: Excellent (10), Very good (4), No comment (1). Comments made: supportive, empathetic, timely and appropriate
- ME service: Excellent (9), Very good (3), No comment (1), Didn't know (2). Comments made: good explanations, professional, clear information
- MCCD: No delay (10), No comment (3), Delay (2)

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN REVIEWED BY THE ME Q2 (2024/25) & Q3 (2024/25)		
	Q2	**Q3**
Number of in-hospital deaths reviewed (in-patient **and** ED)	317	417
Adult deaths		
Cases not notified to the Coroner and MCCD issued directly	259	365
Cases notified to the Coroner and MCCD issued following agreement by Coroner	33	28
Cases referred to the Coroner and taken for investigation	18	21
Child deaths		
Cases not notified to the Coroner and MCCD issued directly	4	2
Cases notified to the Coroner and MCCD issued following agreement by Coroner	1	0
Cases referred to the Coroner and taken for investigation (including ED)	2	1
Timeliness and rejections by registration service		
Number of MCCDs not completed within 3 calendar days (NB: no account is taken of B/H or weekend, and requirement is 5 days)	84	116
Number of MCCDs rejected by registrar after ME scrutiny	0	0
Number of cases where urgent release of body is requested and achieved within requested time	14	18
Number of cases where urgent release of body is requested and NOT achieved within requested time	0	0

Achieving communication with the bereaved		
Number of deaths in which communication did not take place		
Reasons for no communication: Declined	0	1
No response	1	1
No NOK	1	1
Not documented	0	0
Detection of issues and actions		
ME referred for structured judgement review (including COVID related deaths and on-ward cardiac arrests)	47	78
ME referred to other clinical governance processes (including safeguarding, nursing issues)	0	0
ME referred to external organisation for review (including GP practices, LAS)	0	0
Families referred to PALS	1	2

Triggers for SJR by ME service

Triggers for review:	**Q2**	**Q3**
Confirmed learning disability +/- clinical diagnosis of autism	6	15
Bereaved raised concerns	8	8
ME or clinical team detected possible learning or potential issue with care	10	28
Unexpected death e.g. following elective admission	0	0
Maternal or neonatal death	2	1
Areas subject to enhanced oversight (learning will inform quality improvement work)	2	7
Provider learning/improvement where there is an unexpected cardiac arrest (OWCA)	13	7
Provider learning/improvement with COVID judged to be likely nosocomial (Covid Infections)	4	7
Death linked to a service specialty/specific diagnosis	0	0

ST GEORGE'S

MERTON & WANDSWORTH MEDICAL EXAMINER SERVICE

5.10 Merton & Wandsworth Medical Examiner (ME) service is hosted by St George's. Over the last two quarters the M&W ME service met all the required KPIs and milestones.

5.11 In Q2 24/25 the ME service scrutinised all 285 deaths that occurred at St George's and 169 deaths that were referred by community providers. In Q3 24/25 activity was higher, with all 381 inpatient deaths and 212 deaths outside of hospital scrutinised.

5.12 The ME service became statutory on 9th September and therefore Q3 represents the first quarter where all deaths in Merton & Wandsworth that were not investigated by the coroner were scrutinised. Having developed positive relationships with the majority of community providers during the non-statutory phase the service was well placed to receive all referrals. The Lead ME attended a Merton & Wandsworth engagement event with SGH teams and excellent feedback was shared.

5.13 The service implemented a comprehensive implementation plan and communication strategy with community providers and clinical teams within the acute Trust. This resulted in a seamless transition and positive feedback. This support is ongoing to ensure all are familiar with the new statutory processes. During this period Medical Examiner Officers (MEOs) visited some GP teams and in the acute trust training has been provided to new foundation doctors, international doctors and several departments including intensive care, ED and paediatrics.

5.14 A limited out of hours service, approved by the National ME, had been piloted since the end of 2023/24, which informed the development of a formalised process in September 2024. Since then an out of hours service has been delivered between 8am and 11am every Saturday, Sunday and required Bank Holiday. All MEs have been involved in covering these 33 sessions and there has been no gaps in service. The service is supported by both Merton and Wandsworth's Registration services and the Clinical Site Team. The principal driver of this extended service is to support requests for rapid release of the deceased, usually to meet faith requirements. During this period the out of hours ME Service has successfully supported the urgent certification of 9 deceased out-of-hours with no delays caused by the ME service.

5.15 The Lead Medical Examiner is a regular faculty member for national Medical Examiner training. He presented at the British Association of Perinatal Medicine (BAPM) national conference on the role of the ME in neonatal death reviews and the potential to improve experiences for families and health professionals.

5.16 The ME service remains positively engaged with Trust Learning from Deaths processes and is the primary route through with deaths requiring structured judgement review are identified. In Q2 24/25 the ME service flagged 42 deaths for SJR, and 38 in Q3 24/25.

5.17 Feedback on the ME service is gathered as part of an end of life care and bereavement survey. In Q2 24/25 100% of the bereaved felt they were spoken to sensitively and given opportunity to ask questions and 100% reported that their experience of the service was excellent, very good or good. In Q3 24/25 these figures were 100% and 86% respectively.

6.0 RECOMMENDATION

That the Committee note the continued work in accordance with the Learning from Deaths framework and the key areas of learning and development identified, along with the actions taken to address these issues at both sites.

APPENDIX 1

STG Cardiology AMI signal – action points
Meeting date: *25 April 2024 (online via MS Teams)*

Attended by: *Dr Raj Sharma, Dr Manav Sohal, Dr Simon Wilson, Dr Sree Kondapally*

Key action points

1. **Improving data quality:**
   HSMR (used by Dr Foster) is a ratio of the observed vs. expected deaths, and therefore heavily predicated on data quality, accuracy and diagnostic labelling. For instance, it is common knowledge that the expected mortality for 'NSTEMI' is higher (6.1%), as compared to either 'ACS' (1.7%) or 'unstable angina' (0.3%). Hence, calculations based on incorrect labelling of NSTEMI as ACS/unstable angina would result in an artefactually lower expected death (i.e., the denominator) thereby artefactually inflating the HSMR. Similarly, deaths attributable to other causes, when wrongly labelled as AMI, can artefactually increase the numerator (and thereby HSMR).

   Through a joint exercise we undertook with the Clinical Coding team, we observed that ~18% of all deaths previously attributed to AMI (between October 2023 and March 2024) were in fact due to other causes. We will therefore undertake more in-depth work in improving: (a) diagnostic labelling of AMI (thereby reclassifying patients with vs. without NSTEMI more accurately, potentially decreasing the numerator) and (b) comorbidity coding (thereby potentially increasing the denominator) (Table1). The latter is especially important in attributing the correct level of risk (of expected deaths), based on the burden of comorbidities.

Table 1 - Diagnosis	
Improving diagnostic labelling	**Improving comorbidity coding**
Labelling NSTEMIs as NSTEMIs (not loosely as ACS)	Recording a comprehensive list of comorbidities for all patients, and amending as needed during hospital stay to refine both granularity and depth
Educating SHOs, SpRs and ACS nurses to use correct diagnostic labels for cases	Continuing to work with Clinical Coding to map out full set of comorbidities for patients
Continuing to work with Clinical Coding to rectify coding errors	Embedding novel solutions in future (such as AI) for comprehensive data capture

2. **Meeting current benchmarking standards for invasive angiography for NSTEMI patients:**
   NICOR data show that ~50% of NSTEMI patients at STG currently undergo invasive angiography within 72 hrs, as compared to the expected standard of ≥60% (Figure 1). We will continue to improve access to cath labs through a set of bespoke measures (Table 2).

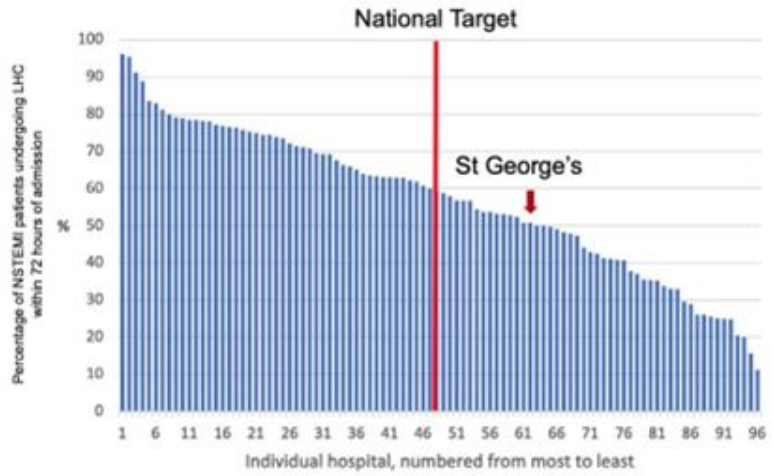


Table 2 - Intervention
Cohorting high risk ACS patients for expedited access to cath lab lists
Conducting mini MDTs in cath labs to expedite decision-making in multi-vessel CAD
Where feasible, completing PCI to critical, non-culprit lesion during index procedure instead of waiting for an in-patient staged procedure
Embedding novel solutions (such as Ortus software) to facilitate safe, early discharge and remote monitoring of low-risk patients before they can return for an urgent elective procedure

3. **<u>Deep dive (internal review) into procedural mortality:</u>**
   Data submitted from St George's Hospital to the NICOR suggest a 30-day mortality of around 5% for the year 2022-23. However, given the lack of granularity regarding PCI-related mortality, we will undertake a further in-depth review of both case-/indication-specific and operator-specific mortality related to PCI procedures. Based on these findings, we will formulate an action plan to mitigate such risk in future.

APPENDIX 2

Summary

From March 8, 2023, to April 30, 2024, a total of 1,177 cases were analysed. The mean age of the deceased patients was 70 years, while the overall mean age of all patients was 66 years.

- **Total Cases:** 39 cases (all had indications for procedure)
- **Mortality:** 37 patients died within 30 days; 2 patients died after 120 days.
- **Place of death:** Cath lab 5- none as consequence of procedural complications, 34 on ITU/Wards

Causes of death, apart from MI

Hypoxic brain injury	8
Catastrophic GI bleed	1
New diagnosis of lung ca – DNACPR, VF on ward but no CPR	1
Lung Ca, bronchoscopy, died on ITU	1
Thrombocytopenia – IC bleed	1

Clinical Presentation:

- STEMI (ST-Elevation Myocardial Infarction): 30 cases
- NSTEMI/ACS (Non-ST-Elevation Myocardial Infarction/Acute Coronary Syndrome): 8 cases
- Elective cases: 1 case

- Out-of-Hospital Cardiac Arrest (OOHCA): 43% (17 cases).
- Cardiogenic Shock (CS): 64% (25 cases).
- Additional Details:
    - Intubated and ventilated prior to PCI: 20 cases
    - Intubated and ventilated at the time of procedure: 3 cases

Intensive Care Unit (ITU) Escalation: 76% of patients (30 cases) required ITU care.

Mechanical Support: 35% utilized mechanical support devices:

- IABP (Intra-Aortic Balloon Pump): 12 cases
- Impella: 3 cases
- IABP + impella 1 case

Complications Recorded: Included coronary dissection, perforation, stent thrombosis, and others. 8 complications were recorded, but only 5 were confirmed in the catheter lab report

IN SUMMARY:
I felt all procedures were indicated. Five patients who died in cath lab were in cardiogenic shock and died at the time of procedure despite best standard care. A significant number of patients

died on ITU or post ITU care. None of the recorded complications at the time of the procedure led to patient death.

Questionable is that some patients who died due to poor neurological outcome (hypoxic brain injury), GI bleed, cardiac arrhythmias but DNAR due to underlying malignancy still impact performance of interventional group but I suspect same rule applies to other heart attack centres.

Dr Marciej Marciniak
March 2025

APPENDIX 3

14/1/25

ACTION PLAN RESULTS FOLLOWING MI MORTALITY SIGNAL REVIEW: Dr Rajan Sharma

CODING

- Since October 2023, cardiology clinical coders and cardiology physicians meet once a month to ensure deaths appropriately coded.
- From the period October 2023 to mid-September 2024 10 MI deaths (out of 67 MI deaths in total) have been reclassified to other non-cardiac causes. This represents 15% all deaths for that period

NSTEMI Access to Cath Lab

- Recent internal review of MINAP show that for last quarter 2024, 70% of NSTEMI patients now have an invasive angiogram within 72 hours based on agreed action plan. This benchmarks SGH very favourably nationally and with other London centres and exceeds the advised national standard of 60%.

AUDIT PCI Procedures

- See attached file
- From March 2023 to April 2024 1177 cases analysed by Dr Maciej Marciniak and Dr Simon Wilson (both interventional cardiologists)
- 39 cases died following cath lab procedure
- In 12 cases cause not cardiac
- 17 cases OOHCA and 25 cases cardiogenic shock
- 16 cases had mechanical support with Intra aortic balloon pump or Impella
- All cases felt appropriate for coronary intervention
- No procedural related issues

Dr Rajan Sharma
Consultant Cardiologist and Clinical Director Cardiology and Cardiac Surgery

APPENDIX 4 (EPSOM & ST HELIER DATA)
ESTH Mortality Overview (Crude Mortality Rate vs. SHMI and HSMR[1])
Data extracted from HED (Healthcare Evaluation Data platform)

[1] Please note that the data in Appendix A consists of monthly values for SHMI/HSMR, intending to illustrate trends, and differs from the 12-month rolling values mentioned in the report

APPENDIX 5: To address QCiC Action Log 1.4 Oct 2023, Row 8

Analysis of protected characteristics
The Equality Act 2010 protects individuals from discrimination because of:

- age
- disability
- gender reassignment
- marriage and civil partnership
- pregnancy and maternity
- race
- religion or belief
- sex
- sexual orientation

These are called protected characteristics.

In September 2022, the Quality Committee in Common requested that future Learning from Deaths reports should include analysis of themes by protected characteristics. In order to provide this analysis, it would be necessary to routinely and reliably collect this data for all patients. Currently, as part of routine data, NHS organisations collect data on age, sex, and race (if taken to be ethnicity). Data is not collected routinely and consistently across all patient populations for the other characteristics, and these are not compulsory fields in the patient management system.

EPSOM & ST HELIER DATA

The SHMI can be analysed by age, sex, and deprivation quintile using the HED platform. For the latest reporting period (September 2023 – August 2024), most results are within expected levels, with some exceptions. Metrics above the 95% confidence interval are shown in blue on the graphs.

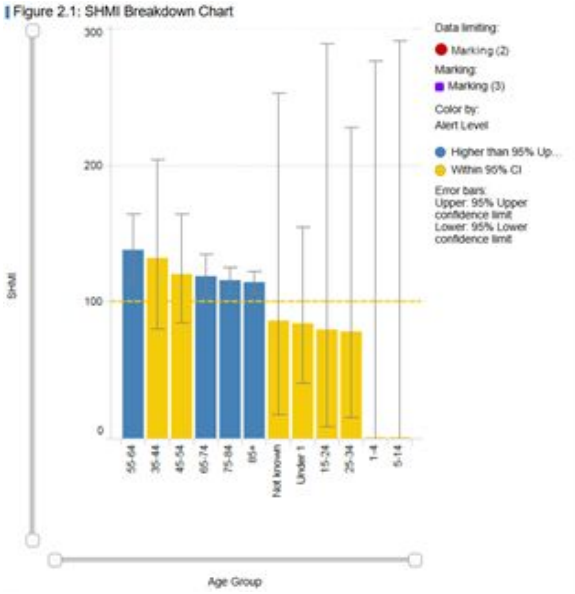
Both male and female categories are notable, with mortality rates exceeding the 95% upper confidence interval (CI). The age groups 55-64, 65-74, 75-84, and 85+ also show mortality rates above the 95% threshold. Also, Deprivation Quintiles Q2 (less deprived), Q4 (less affluent), and Q5 (most affluent) report mortality rates above the 95% upper CI.

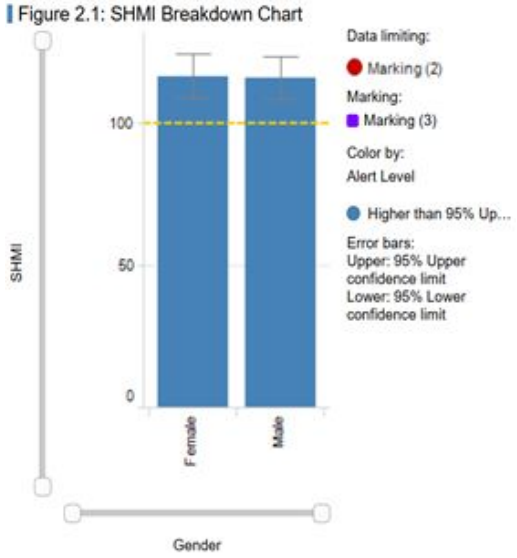
SHMI by Age groups

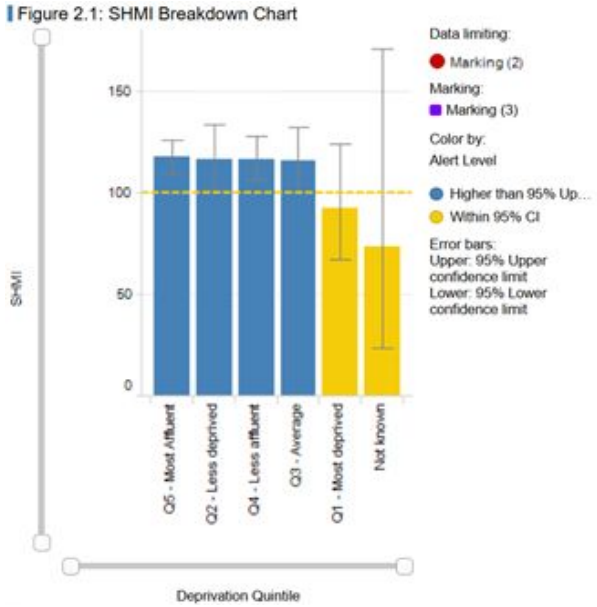
SHMI by Sex

SHMI by Deprivation Quintile

Data extracted from HED – Healthcare Evaluation Data platform on 26.02.2025

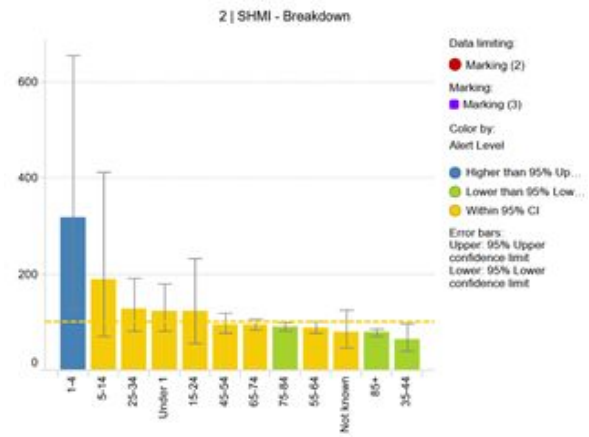




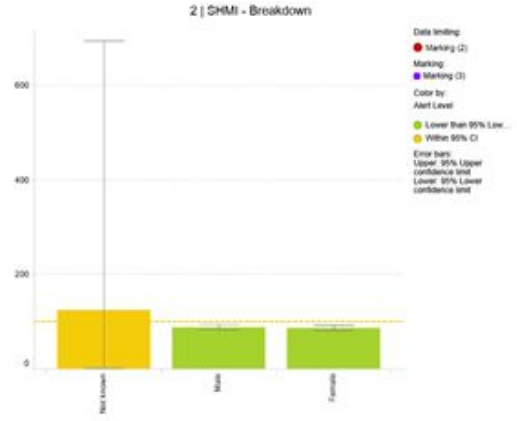


ST GEORGE'S DATA source: HED [Healthcare Evaluation Data]

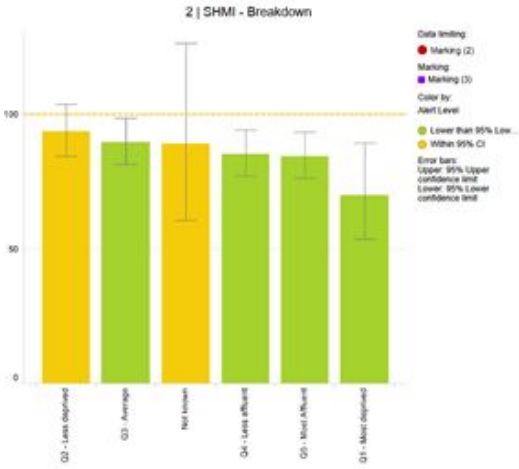
SHMI by age



SHMI by sex



SHMI by deprivation



Analysis by sex and deprivation shows that mortality is either as expected, or lower than expected. Analysis by age shows higher than expected mortality in the 1-4 age group.

APPENDIX 6: (ST GEORGE'S DATA)

Learning from Deaths Dashboard

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2024-25

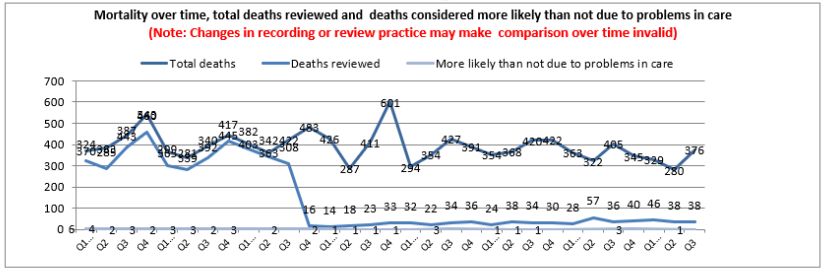
Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
161	103	15	13	0	1
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
376	280	38	38	1	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
985	1435	122	161	1	3

Time Series: Start date 2017-18 Q1 — End date 2024-25 Q3



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	6.7%	This Month	1	6.7%	This Month	13	86.7%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	1	2.6%	This Quarter (QTD)	1	2.6%	This Quarter (QTD)	4	10.5%	This Quarter (QTD	32	84.2%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	1	0.8%	This Year (YTD)	4	3.3%	This Year (YTD)	16	13.1%	This Year (YTD)	101	82.8%

gesh

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

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - December 2024-25

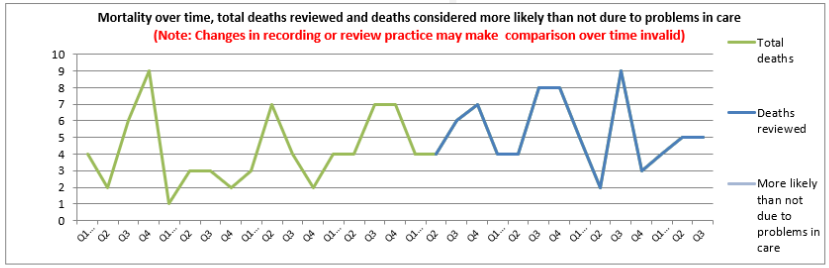
Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	1			0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
5	5			0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
14	19			0	0

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
2	2	2	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	3	4	3	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
4	19	4	19	0	0

Time Series:	Start date	2017-18	Q1	End date	2024-25	Q3



Group Board

Meeting on Thursday, 01 May 2025

Agenda Item	6.2	
Report Title	**2024 Staff Survey and Corporate response**	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Tairu Drameh, Head of Culture and Staff Engagement	
Previously considered by	People Committee-in-Common	17 April 2025
Purpose	**For Noting**	

Executive Summary

This report provides an analysis of the 2024 NHS Staff Survey results for Epsom and St Helier Hospital (ESTH) and St George's Hospital (SGUH), comparing their performance against national averages. It summarises the survey findings, highlighting strengths and areas for improvement, and outlines corporate actions taken to address key issues.

Summary of Results:
Both trusts demonstrate strengths in areas such as compassionate leadership, diversity, and staff engagement. ESTH shows strength in promoting a safe and healthy work environment, while SGUH has made progress in reducing burnout and enhancing staff morale. However, challenges persist in areas like flexible working practices, appraisal satisfaction, and workplace inclusivity. Workforce equality standards reveal disparities, particularly for BAME staff and staff with disabilities, requiring targeted actions to address harassment and improve access to reasonable adjustments.

Corporate Actions:

1. Improve line management and leadership: Leadership development programs and competency frameworks are being implemented to enhance management capabilities, with significant engagement in existing training initiatives.
2. Keeping staff healthy and safe: Well-being initiatives across mental, physical, social, and financial health pillars include training programs, support resources, and workshops to address staff needs.
3. Deliver culture and diversity & inclusion programme: Bespoke training and frameworks aim to enhance inclusivity and strengthen recruitment practices, supported by staff engagement initiatives.
4. Improve training and career development: A Talent Strategy is in place, focusing on fair recruitment, career progression, and leadership competency development, with additional initiatives like shadow boards being introduced.
5. Deliver NHS exemplar intervention on retention: Targeted efforts in priority departments focus on embedding flexible working practices, engaging staff through consultations, and improving retention rates.

This report concludes that while notable progress has been made, sustained efforts are required to address ongoing challenges. The implementation of the CARE Strategy and People Strategy will play a critical role in driving improvements and fostering alignment with staff expectations and gesh's values.

Action required by Group Board
The Board is asked to: a. Note and endorse this report's key findings. b. Note the progress and next steps outlined for the five corporate actions: line management and leadership, staff health and safety, culture and diversity, training and career development, and retention. c. Note engagement initiatives, such as divisional working groups, staff engagement events, and site-level forums.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	2024 Staff Survey and Corporate response

Implications

Group Strategic Objectives

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

Risks

[…]

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

[…]

Legal and / or Regulatory implications

[…]

Equality, diversity and inclusion implications

[…]

Environmental sustainability implications

[…]

2024 Staff Survey and Corporate response

Group Board, 01 May 2025

1.0 Purpose of paper

1.1 This paper provides a comprehensive analysis of the 2024 NHS Staff Survey results, comparing ESTH and SGUH against national averages, and identifying key strengths and challenges.

1.2 Share thematic insights from staff feedback, highlighting factors impacting staff satisfaction, and workplace culture.

1.3 Updates on the progress of corporate actions aimed at addressing survey findings, including leadership development, well-being support, diversity, and retention initiatives.

2.0 Background

2.1 The NHS Staff Survey was conducted between 7 October and 29 November 2024, managed by Picker, an independent healthcare research organisation. A total of 8,660 staff members participated in the survey, marking a 22% increase in responses compared to 2023. This enhanced participation reflects a growing engagement among staff across the Trusts.

The survey results provide valuable insights into staff experiences and perceptions, covering key themes such as engagement, morale, leadership, equality, and workplace well-being. The findings also benchmark the performance of ESTH and SGUH against national NHS averages, offering a comprehensive comparison of strengths and challenges. This analysis informs our ongoing efforts to improve staff satisfaction, organisational culture, and alignment with the CARE Strategy, the People Strategy and the NHS People Promise values.

3.0 [Key issues for consideration]

3.1 ESTH results show positive results in compassionate care, leadership, and staff engagement, surpassing national averages in several areas such as health initiatives and advocacy metrics. However, challenges remain in flexible working options and appraisals satisfaction.

3.2 SGUH demonstrates strong staff engagement and progress in reducing burnout. Its focus areas for improvement include boosting morale, retention, and addressing disparities faced by BAME staff and those with disabilities.

3.3 Both Trusts face challenges with workplace equality, particularly for BAME staff and individuals with disabilities. Areas requiring action include harassment reduction and increasing access to reasonable adjustments.

3.4 Recurring concerns across both Trusts include management practices, organisational changes, pay dissatisfaction, workload pressures, and workplace culture.

4.0 Sources of assurance

4.1 Aligns with the CARE Strategy, People Strategy, NHSE People Promise, Long Term Plan and EDI Improvement Plan.

4.2 Board and Board Committees oversight
4.3 Executives oversight.

5.0 Recommendations

5.1 The People Committee is asked to:

a. Review and endorse this report's key findings
b. Endorse progress outlined for the five corporate actions

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Staff survey board update

Tairu Drameh
January 2025

Introduction

The 2024 staff survey results for both Epsom and St Helier Hospital (ESTH) and St George's Hospital (SGUH) provide insights into employee perceptions and experiences across various domains. This report offers an analysis of key areas of improvement from 2023 to 2024 and includes recommendations based on the Picker Average scores. The themes of the report include Response Rates, Vision and Values, Goals and Performance, Learning and Innovation, Support and Compassion, Equity and Inclusion, and Teamwork. Additionally, the impact on NHS People Promise themes, staff engagement, and morale will be discussed.

The staff survey took place between 7 October to 29 November 2024. The survey was carried out by Picker, who was also commissioned by 58 other acute and acute community organisations.

Both organisations saw enhanced engagement, underscoring the effectiveness of initiatives like survey days, visible leadership support, and managers releasing staff to complete the survey.

The overall rise in participation shows gesh's commitment to fostering an environment where staff feedback is valued and drives organisational change. By implementing strategies such as a managers' toolkit, weekly response rate updates, and outreach to areas with lower historical response rates, the trust strengthened connections with its workforce. These efforts elevated survey participation and demonstrated a shared dedication to improving staff experience and well-being across both Trusts.

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Content

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Key findings

The 2024 group survey results show overall positive trends, with most areas showing either improvement or stability compared to the previous year. Compared with the Picker average both trusts were lower in some areas, but greater improvements were seen in gesh than in other Trusts overall.

The improvement seen in 2024 has resulted in a 0.1 point increase in our people promise indicators.
The 2024 survey highlights several strengths for the group, such as open communication, role clarity, and positive relationships.

Results indicate that areas for improvement include resource availability, staff recognition, support for health and well-being, and addressing discrimination and harassment. By focusing on these areas, gesh can create a more inclusive, supportive, and high-performing workplace.

In 2024, a total of 8,660 staff members across gesh participated in the annual staff survey, reflecting a 22% increase from the 7,108 participants in 2023 (figure 1.0 and 1.1).

The overall positive score improved compared with the 2023 survey and ranks number 10 and 15 most improved across Acute and Acute Community Trusts which ran the NHS Staff Survey 2024 with Picker (figure 1.2).

Figure 1.0: Overview of organisation comparisons and changes over 12 months

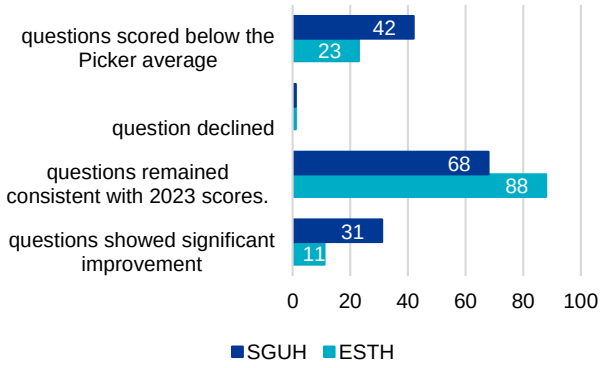


Figure 1.1: Higher response rates in St George's and Epsom and St Helier Hospitals in 2024 compared with 2023

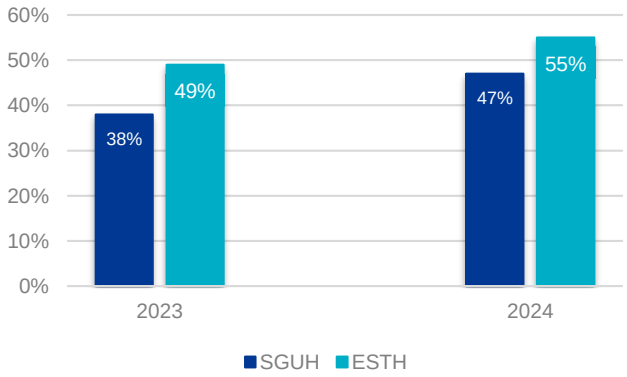
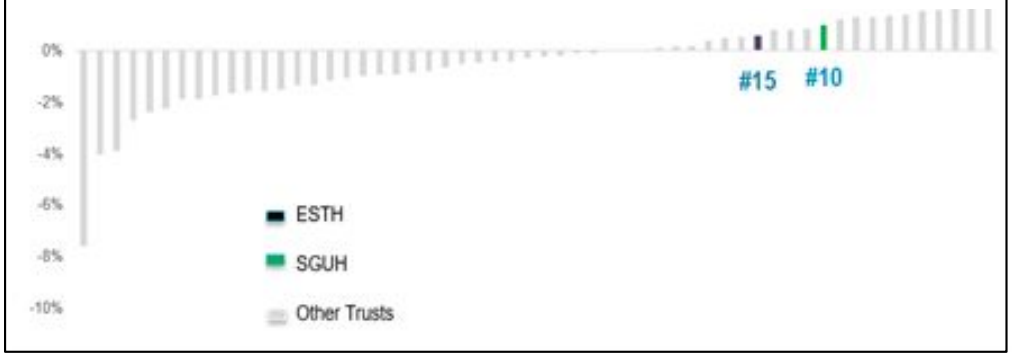


Figure 1.2: Overall positive score in 2024 compared with 2023 ranking for gesh compared with other acute and acute community Trusts



Vision and Values: Commitment to high quality, compassionate care

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Staff feeling secure in raising concerns about unsafe clinical practices increased in both Trusts. At SGUH, this improved significantly, however as both Trusts still fall slightly below the Picker Average ongoing efforts are needed to reinforce a culture of safety and responsiveness (figure 2.0).

A high percentage of staff believe that the care of patients/service users is the group's top priority, reflecting gesh's focus on patient care and alignment with the CARE strategy. Positive responses surpassed the Picker Average of 72.5% (figure 2.1). The positive perception of patient care being a priority could be due to the alignment of the organisation's strategy with staff values, although the minor increase in the ESTH score could suggest the potential benefits of enhancing transparency in how patient care priorities are communicated.

Although gesh scores for the organisation acting on concerns raised by patients/service users are above the Picker average, there is room for improvement as the ESTH score only rose by 1% while SGUH remained stable (figure 2.2). The stability or slight rise across both Trusts may point to issues with follow-through and system-level changes that are needed to boost staff trust in the feedback loop, addressing this could enhance trust and responsiveness.

Figure 2.0: Our staff feel relatively secure raising concerns about unsafe clinical practice, with scores close to the Picker Average

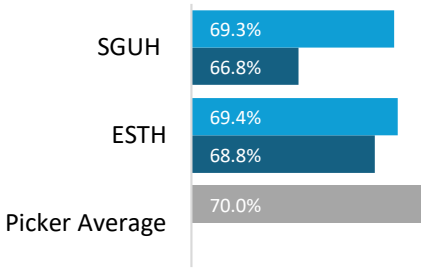


Figure 2.1: Our staff believe that the care of patients/service users is the group's top priority.

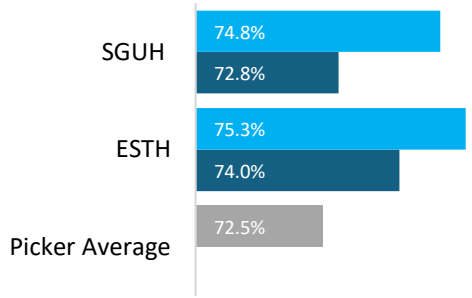
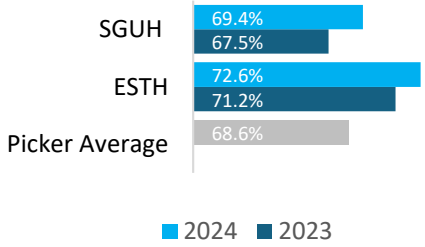


Figure 2.2: gesh scores for the organisation acting on concerns raised by patients/service users are above the Picker Average



Goals and Performance: Ensuring effective performance

Staff in gesh generally know their work responsibilities and feel trusted to do their jobs, reflecting a strong foundation of role clarity and trust within the organisation. Staff feeling trust in doing their jobs remains high for both Trusts, with ESTH slightly above the Picker average and SGUH below, although both scores have not significantly changed from 2023 (figure 3.0).

Our group results show there are significant challenges in meeting conflicting demands, having adequate materials and supplies, and ensuring enough staff to do the job properly, potentially indicate the need for attention to improve operational efficiency (figure 3.1). External pressures, such as increasing patient volumes or staffing shortages, which are issues all Trusts are experiencing may explain the results. Addressing these challenges requires focusing on resource management and operational efficiency.

Results indicate that recognition for good work and clear feedback from immediate managers are areas that need improvement, through manager development, to enhance staff motivation and performance (figure 3.2).

Figure 3.2: Results indicate that recognition for good work and clear feedback from immediate managers are areas that need improvement to enhance staff motivation and performance.

Figure 3.0: Staff in gesh generally know their work responsibilities and feel trusted to do their jobs

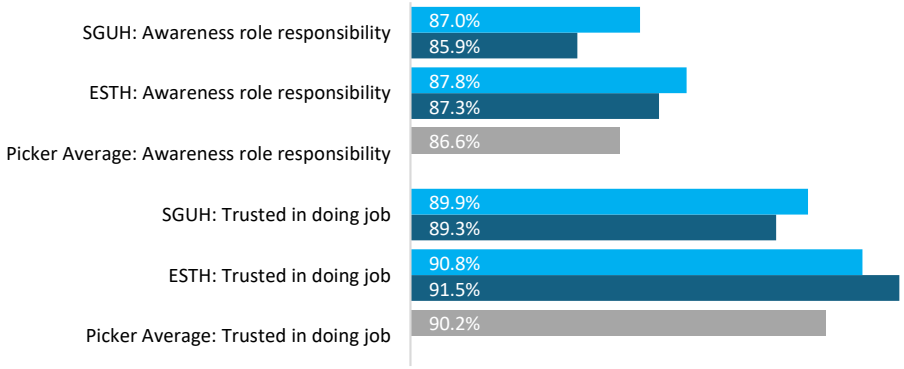
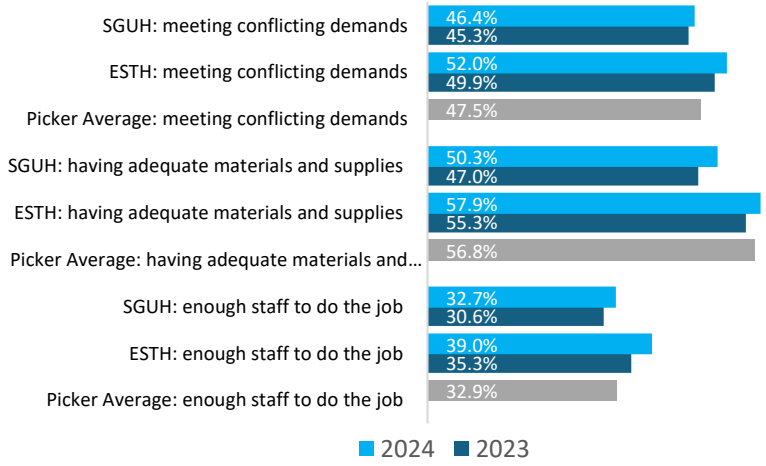


Figure 3.1: Our group results show there are significant challenges in meeting conflicting demands, having adequate materials and supplies, and ensuring enough staff to do the job properly



Learning and Innovation: Fostering learning, and development

The moderate staff satisfaction with learning and development opportunities suggests that as a group we have a culture that values continuous improvement but may lack sufficient investment or structure in formal learning opportunities (figure 4.0). More needs to be done in supporting staff growth and managers releasing staff to undertake courses.

Staff in the group feel they can make improvements in their area of work and are involved in deciding changes that affect their work. In both Trusts these rose compared to last year but were below the Picker average (figure 4.1).

Staff perception of career development opportunities in ESTH decreased and were below the Picker Average, whiles SGUH saw a minor increase and is to slightly above the Picker Average (figure 4.2). The slight decline in career development opportunities across the group reinforces the need for career progression frameworks to manage and attract Talent. The need for stronger career development strategies points to potential gaps in engagement, which could impact staff retention.

Figure 4.2: Staff feeling there is opportunity to develop their career in gesh

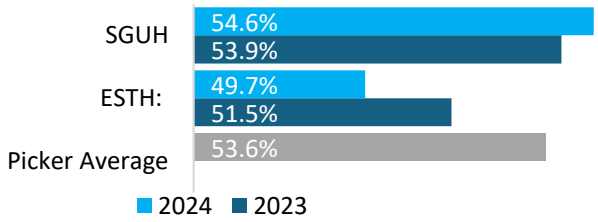


Figure 4.0: Our staff are moderately satisfied with learning and development opportunities

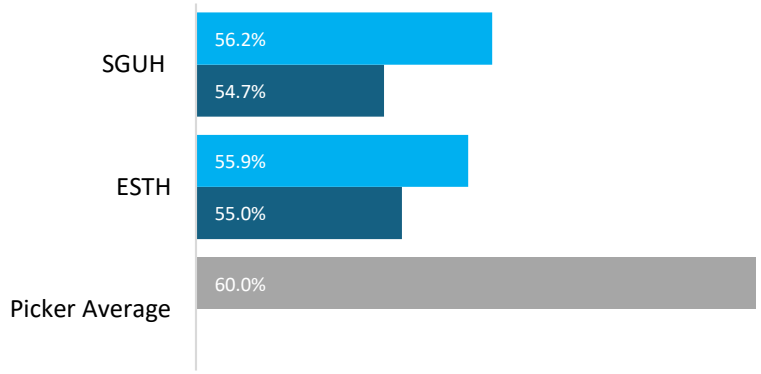
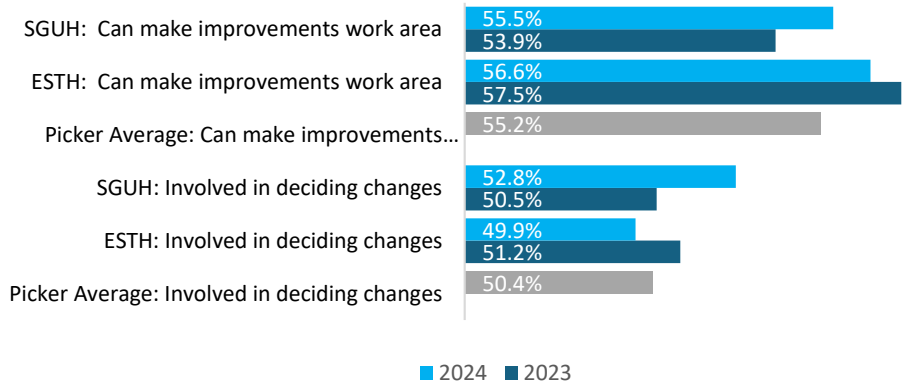


Figure 4.1: Staff in the group feel they can make improvements in their area of work and are involved in deciding changes that affect their work



Support and Compassion: Promoting psychological safety and supportive environments

The group takes action on health and well-being, but work-related stress and burnout are concerns. At ESTH there was an improvement in numbers of staff who believed the organisation took positive action on health and well-being in 2024, though below the Picker Average. Not feeling unwell due to work-related stress slightly improved compared with 2023 and was above the Picker Average. In contrast, SGUH saw a slight decrease in positive responses on health and well-being and fell below the Picker Average. Not feeling unwell due to work-related stress, was stable, but below the Picker Average (figure 5.0).

The mixed results regarding health and well-being initiatives suggest that while some actions have been taken, they may not be comprehensive or fully effective. For instance, while work-related stress has shown some improvement, the fact that many staff still feel unwell due to work-related stress indicates a need for more robust mental health support, stress reduction strategies, and a more responsive management approach to employee well-being.

The survey results also suggest there is a need for better support from immediate managers and more opportunities for flexible working patterns (figure 5.1). The lower scores for support from immediate managers and flexible working options indicate a significant area for improvement, as these factors can directly influence staff morale and productivity. Prioritising support to staff and work-life balance is crucial to enhancing staff well-being and engagement.

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Figure 5.0: The group takes action on health and well-being, but work-related stress and burnout are concerns

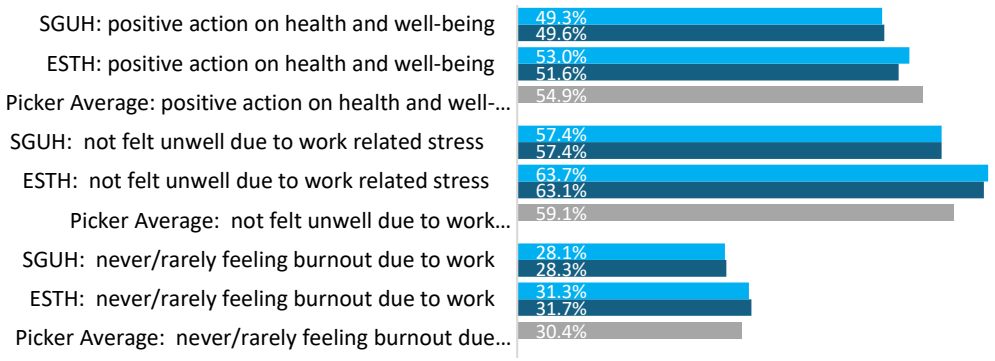
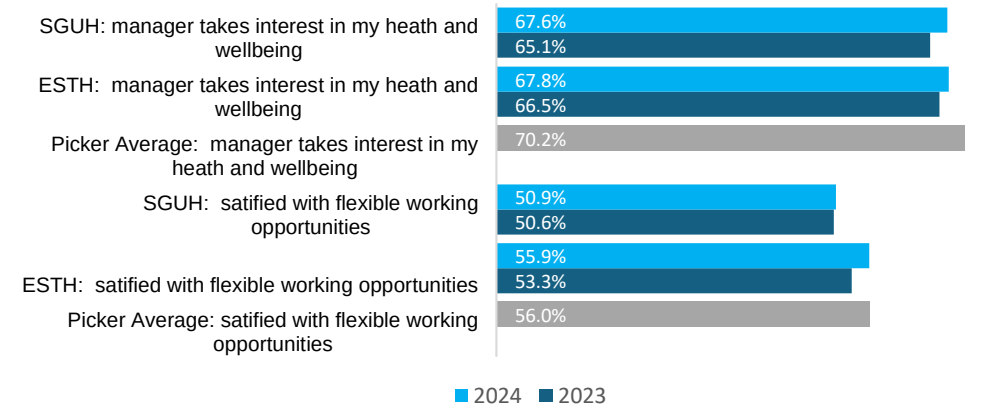


Figure 5.1: The low scores for support from immediate managers and flexible working options indicate a significant area for improvement



Equity and Inclusion: Advancing equity diversity, and inclusion

Discrimination from patients/service users, managers, and colleagues is a concern. ESTH reported more positive results in staff experiencing discrimination from managers or colleagues in 2024 compared with 2023, but still above the Picker Average of 9.9% (figure 6.0).

Staff with disabilities at both Trusts report a lower likelihood of gesh taking positive action on health and well-being compared with other trusts represented by the Picker's average. 45.1% of staff with disabilities at ESTH and 42.9% at SGHU agreed that gesh took positive action on health and well-being. Both percentages were below the Picker Average of 54.9%.

Staff feeling there is not fairness in promotion remains a challenge for gesh, although there were modest improvements in the scores for our Trusts from last year. There were also modest improvements in fairness in career progression results suggesting current initiatives could be having an effect (figure 6.1).

Improving consistency, and tailoring wellbeing initiatives to meet the needs of diverse staff groups will contribute to a more equitable workplace; a priority within the implementation of the High Impact Action EDI Plan framework. The Trust has work in place to strengthen talent management with equity as the driver for fairness in progression and promotion. These focus on introducing frameworks for positive action, career conversations and manager training.

Figure 6.0: Discrimination from patients/service users, managers, and colleagues is a concern for the group

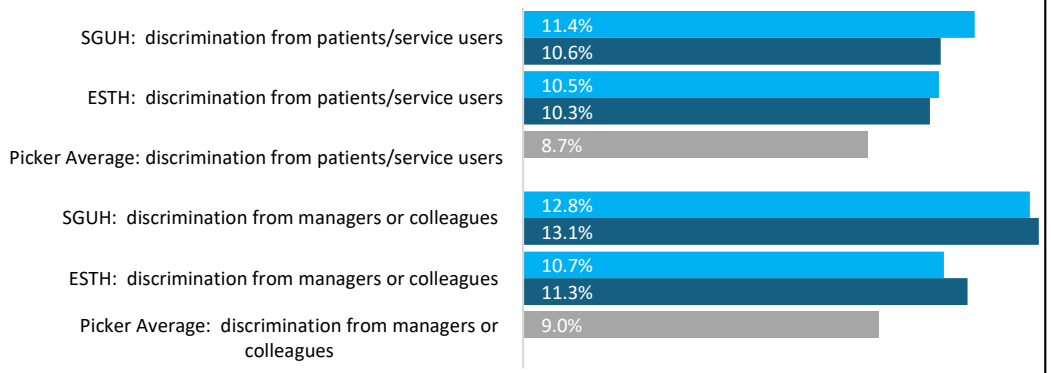
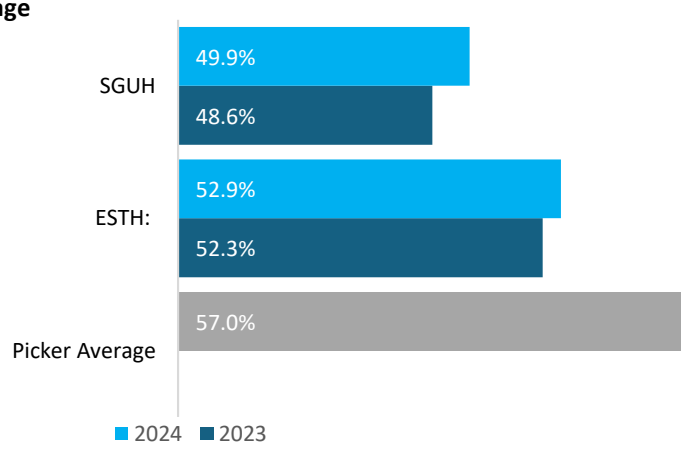


Figure 6.1: Staff feel there is not fairness in promotion, although there were modest improvements in the scores for the group from last year. We still lag behind the Picker Average



Teamwork: Building high performing, cohesive and collaborative teams

Relationships at work are generally positive and compare favourably with the Picker average, with team members having shared objectives and meeting to discuss the team's effectiveness (figure 7.0).

Feedback indicated that there is a need for better understanding of each other's roles and more constructive handling of disagreements to enhance teamwork (figure 7.1). These may relate to challenges in communication and conflict management, which commonly undermine team cohesion. These areas may be impacted by work stress, time pressures, or unclear role boundaries. This is an area review of results and discussion at team level is recommended to understand local needs.

The strategic emphasis on high performing teams has led to workstreams with objectives for developing leaders for high performing teams. Reinforcing these with respect to the CARE strategy in appraisals and performance reporting at individual and team level supports collaborative drive towards results and every individual understanding their role in achieving these.

Figure 7.0: Relationships at work are generally positive, with team members having shared objectives

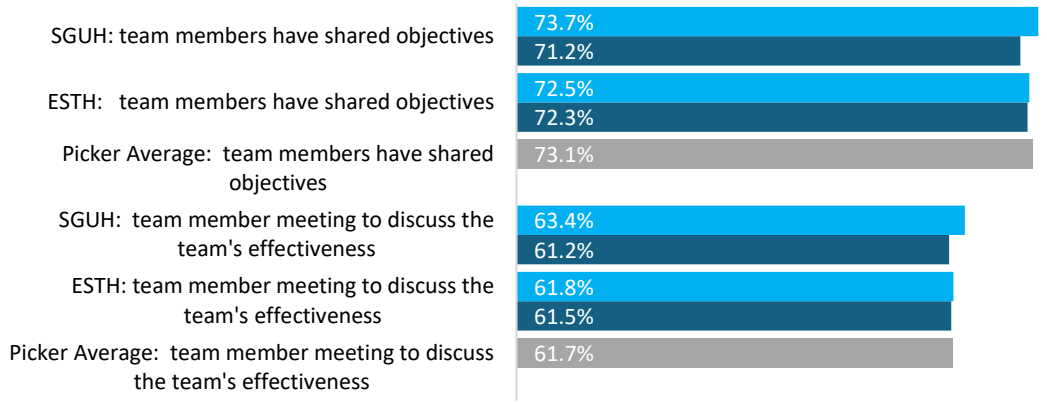
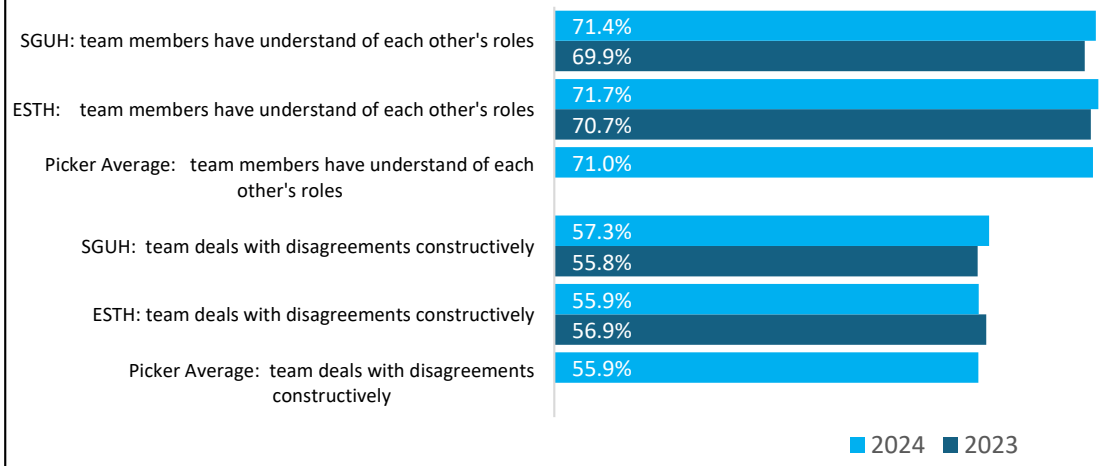


Figure 7.1: There is a need for better team members to have understanding of each other's roles and more constructive handling of disagreements to enhance teamwork.



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Next Steps and Corporate Actions

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Supporting teams with next steps

In our continuous effort to enhance the effectiveness and impact of our staff survey reporting and action planning, we are excited to introduce a new approach that focuses on efficiency, engagement, and actionable insights. In previous years, we produced detailed PowerPoint reports at both the division and care group levels. While comprehensive, this method was resource-intensive and limited our ability to provide enhanced support to HR Business Partners (HRBPs) divisions and teams. To address these challenges and better support our teams, we are proposing the following changes:

- **Hypothesis-driven analysis**

HRBPs will conduct hypothesis-driven analysis at the division level, with support from the Organizational Development (OD) team. This approach will allow for more targeted and meaningful insights.

- **Action plan development**

Divisions will create or amend their action plans based on the analysis and share them with their respective teams. This ensures that action plans are relevant and tailored to the specific needs of each division.

- **Manager support workshops**

We will schedule workshops to help managers interpret their results. These sessions will provide managers with the tools and knowledge they need to effectively address the survey findings.

- **Working Groups**

Site-level and divisional working groups will be established to support the delivery of the divisional action plans. These groups will foster collaboration and ensure that action plans are implemented effectively.

- **Engaging Infographics**

To communicate the survey results in an engaging and accessible way, we will create simple infographics. These infographics will highlight strengths and areas for improvement, aligned with our People Promise. They are designed to support local huddles and facilitate engagement with all team members.

By adopting this new approach, we aim to streamline our processes, enhance support for HRBPs and divisions, The shared ownership of this approach will ultimately drive more effective and impactful action planning. We believe this will lead to better outcomes for our teams and the group as a whole.

Corporate Actions

Our proposed corporate action plan is designed to address the key improvements and challenges identified in our staff survey, aligning with our overarching people strategy and exemplar people promise programme. By focusing on the following areas, we aim to create a more supportive, inclusive, and development-focused environment for all staff at gesh.

- **Improve line management and leadership**

Implementing comprehensive leadership development programmes will foster compassionate and inclusive management practices. This aligns with our people strategy to enhance line management and leadership. By establishing a multiprofessional group-wide leadership development framework, including the senior leadership programme, compassionate and inclusive leadership programme, and management fundamentals, we aim to build strong, empathetic leaders who can effectively support their teams.

- **Keeping our staff healthy and safe**

Launching initiatives to promote health and wellbeing across the organisation is crucial. By implementing Health and Wellbeing standards, promoting Health and Wellbeing Champions training, and tackling violence and aggression against staff, we ensure a safe and supportive workplace. This will lead to improved staff morale, reduced absenteeism, and a healthier work environment.

- **Deliver our culture and diversity & inclusion programme**

Implementing the High Impact Action EDI Plan framework will ensure a fair and inclusive workplace with consistency across gesh. By focusing on training availability, improving awareness and understanding of LGBTQ+ issues, enhancing ER processes for minority groups, and promoting inclusive practices for career development, we aim to create a diverse and equitable environment. This will enhance staff engagement, satisfaction, and retention.

- **Improve training and career development**

Implementing talent management initiatives, including positive action programmes, career conversations, and enhanced recruitment processes, will support staff development and retention. By investing in our employees' growth, we aim to build a skilled and motivated workforce, ready to meet future challenges and opportunities.

- **Deliver the NHS exemplar Intervention on retention**

In 2024, GESH signed up to the NHS People Promise and became an exemplar organisation, joining a mix of acute, community, and mental health providers. NHS England is working with us through a dedicated resource to deliver interventions that will improve staff retention. This commitment underscores our dedication to creating a supportive and engaging work environment, ultimately leading to higher retention rates and a more stable workforce

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Appendix

Staff Survey 2024:Positive highlights and areas for improvement

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Staff Survey 2024: Positive highlights and areas for improvement

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University Hospitals and Health Group

SGUH	ESTH
31 Questions Improved **Top 5 Positive Highlights:** • Would trust us for family/friends' care – 69% (up from 67%) • Last incident of physical violence reported– 75% (up from 72%) • Would recommend us as an employer – 63% (up from 59%) • Appraisal improving job performance – 29% (up from 26%) • Fewer staff working extra hours – 67% (up from 66%)	**11 Questions Improved** **Top 5 Positive Highlights:** • More staff to do the job well – 39% (up from 35%) • Appraisal helping to improve performance – 32% (no change) • Less work frustration – 27% (up from 26%) • Reduced work-related stress – 64% (up from 63%) • Better at handling conflicting demands – 52% (up from 50%)
1 questions declined **Top 5 Areas to Improve:** • Not experienced physical violence incidents – 86% (down from 88%) • Disability adjustments need improvement – 67% (down from 69%) • Reducing work fatigue – 48% (down from 49%) • Staff coming to work unwell – 43% (down from 44%) • More autonomy in work decisions – 50% (down from 51%)	1 questions declined **Top 5 Areas to Improve:** • Fewer staff not working extra hours – 61% (down from 63%) • Disability adjustments need improvement – 69% (down from 71%) • More career development opportunities needed – 50% (down from 52%) • Energy for family/friends – 35% (down from 37%) • Greater involvement in change decisions – 50% (down from 51%)

gesh

Report Title: 2024 Staff Survey and Corporate response

Date: 11 April 2025

Author: Tairu Drameh. Head of Culture and Staff Engagement

Introduction

This report follows the 2024 staff survey results update report presented to the Board in January 2025, alongside the publication of the National Staff Survey results by the NHS Staff Survey Coordination Centre on 13th March 2025, which benchmarks all NHS organisations. It provides a comprehensive comparison of the 2024 NHS Staff Survey results for Epsom and St Helier Hospital and St George's Hospital against national averages. The analysis delves into performance across key areas, including the NHS People Promise elements, engagement and morale themes, and workforce equality standards.

The report outlines valuable insights into key metrics, trends, and areas for improvement, aiming to inform our engagement and culture improvement efforts. It incorporates a thematic analysis of staff free text feedback, offering critical perspectives on factors affecting staff satisfaction, organisational effectiveness, and patient care. Additionally, the report highlights engagement activities at the divisional level designed to enhance staff engagement and promote continuous improvement. Finally, it provides a detailed update on the progress made against the five corporate actions to drive improvement based on the 2024 staff survey results.

1. Benchmark of Epsom and St Helier and St George's survey scores against the National Average

A comparison of the two trusts across the seven People Promise elements and staff engagement and morale themes shows different levels of alignment with national benchmarks. The key observations below highlight both strengths and challenges (see table 1).

Table 1. Benchmark of the group's survey scores against the National Average

People Promise Theme	Epsom and St Helier Score	St George's Score	National Average	Insights
We are compassionate and inclusive	**7.21**	**7.11**	**7.21**	ESTH matches the average; St George's is slightly below.
We are recognised and rewarded	**5.94**	**5.81**	**5.92**	ESTH exceeds the average; St George's is slightly below, indicating dissatisfaction with pay and recognition.
We each have a voice that counts	**6.66**	**6.62**	**6.67**	Both Trusts are slightly below the average, which highlight a need for empowering staff voices further.
We are safe and healthy	**6.23**	**5.98**	**6.09**	ESTH exceeds the average, showcasing positive work environment efforts. While St George's lags the average, highlighting further focus needed in this area.

We are always learning	**5.52**	**5.55**	**5.64**	Both Trusts lag behind the average, highlighting development as a focus area.
We work flexibly	**6.15**	**5.92**	**6.24**	Both Trust results are below the average, which indicate there is a need to enhance flexible working practices.
We are a team	**6.71**	**6.67**	**6.74**	Scores are close to the average, reflecting moderate teamwork and leadership compared to the national avg.
Staff Engagement	**6.93**	**6.91**	**6.84**	Both trusts perform above average, with strong advocacy trends.
Morale	**5.92**	**5.75**	**5.93**	Epsom aligns with average morale levels, while St George's is slightly lower, with indicators showing challenges around work pressure and retention.

1.1 Key findings

Our results for Epsom and St Helier's show that the Trust's strengths lie in compassionate care, supported by high scores in leadership and diversity, alongside above-average results in burnout reduction and health initiatives. The challenges and areas for improvement include bringing flexible working options up to the national average and improving satisfaction with appraisals to enhance learning opportunities.

St George's strengths on the other hand are evident in strong staff engagement (advocacy and motivation) and incremental gains in reducing burnout. Key challenges involve boosting morale by addressing retention and work pressure, and tackling disparities highlighted by workforce equality standards scores for black and minority ethnic (BAME) staff and those with disabilities.

1.2 Workforce Equality Standards (WRES/WDES)

Table 3. WRES and WDES benchmarks

WRES Key Metrics				
Indicator	**ESH Performance**	**SGH Performance**	**National Benchmark**	**Insights**
Harassment/ Bullying (colleagues) (BAME: WRES)	**27.03%**	**28.05%**	**24.78%**	Staff from ethnic minorities report challenges with both Trusts scores above avg.
Career Progression (BAME: WRES)	**51.01%**	**45.16%**	**49.70%**	Opportunities remain underrepresented particularly at SGUH
Staff with disability reporting	**29.26%**	**31.21%**	**25.24%**	Staff with disabilities report challenges with harassment, notably

harassment (WDES)				higher than the avg. scores at both Trusts
Reasonable Adjustments for staff with disability (WDES)	**67.19%**	**67.19%**	**73.92%**	Challenges in accessing reasonable adjustments.

1.3 Key summary from the comparative analysis

The comparative analysis reveals that while both Trusts demonstrate strong staff engagement and alignment with compassionate care values, challenges persist in flexible working, workplace safety, and workforce equality. These challenges are especially pronounced in the varied experiences of our BAME and disabled colleagues. Addressing these areas with targeted interventions will enhance staff satisfaction, morale, and overall organisational performance. The results of the comparative analysis are consistent with the feedback provided by staff in the free text section of the staff survey.

2. Free Text feedback analysis

The thematic analysis conducted for staff feedback reveals significant challenges in both St George's and Epsom and St Helier Trusts, with recurring themes highlighting issues in management, organisational change, employee well-being, and workplace culture (see table 4.).

2.1 Thematic analysis findings

Table 4. Themes from St George's free text feedback

St George's NHS Trust Findings		
Theme	**Mentions**	**Key Observations**
Management	246	Concerns about communication, decision-making, and staff engagement.
Change	149	Mixed views regarding organisational changes and their impact on staff morale.
Health	149	Staff mental and physical health concerns, including stress and burnout.
Pay	102	Discontent with compensation amidst increasing responsibilities and workloads.
Stress	93	Persistent stress linked to resource constraints and excessive demands.
Training	78	Limited access to career development opportunities affects staff motivation.
Environment	72	Challenges in workplace conditions, including infrastructure and resources.
Staffing	64	Concerns over insufficient staffing levels and their impact on patient care.
Workload	58	Growing workloads contribute to exhaustion and decreased morale.
Bullying	57	Instances of bullying and harassment require urgent intervention.

Table 5. Themes from Epsom and St Helier free text feedback

Epsom and St Helier NHS Trust Findings

Theme	Mentions	Key Observations
Staffing Levels and Workload	337	Resource shortages impacting patient safety and staff well-being.
Other	257	Diverse concerns indicating the need for deeper analysis and tailored solutions. E.g. providing better support during organisational changes, happy to work in this organisation, concerns about parking, wrong banding.
Management and Leadership	132	Lack of leadership visibility and engagement affecting workplace culture.
Pay and Benefits	92	Staff dissatisfaction with pay structures and benefits.
Workplace Culture	63	Issues around inclusivity, collaboration, and communication persist.
Facilities and Equipment	Fewer mentions	Insufficient resources hindering operational efficiency and staff performance.
Training and Development	Fewer mentions	Limited career progression opportunities reduce staff motivation.

These results for both Trusts suggest that staff are experiencing significant challenges related to management practices, organisational changes, and their overall well-being. Issues with pay, stress, and workload are also prominent, indicating potential dissatisfaction with compensation and working conditions. Additionally, the presence of themes like bullying and concerns about staffing levels point to potential problems with workplace culture and resource allocation. The findings overall demonstrate the necessity of enhancing engagement at both divisional and team levels. Management teams and staff should collaboratively address areas of challenge and celebrate areas of strength, driving continuous improvements. Our new group and sites culture forums discussions will support in reinforcing this approach.

3. Engagement activities at divisional level

This section of the report provides a comprehensive overview of the engagement activities undertaken at the divisional level, designed to enhance staff engagement and drive continuous improvement. These initiatives align with our gesh's CARE Strategy and People Strategy as well as our commitment to delivering on the People Promise and fostering a culture of leadership and collaboration. By leveraging data-driven insights and implementing targeted strategies, these activities aim to create an environment where staff feel valued, motivated, and empowered to contribute to our organisational success.

3.1 Staff survey results and thematic reports

In-depth thematic reports based on the People Promise and Culture & Leadership frameworks have been created at divisional and service levels. These reports provide actionable insights into staff perceptions and experiences, allowing divisions to identify key areas for improvement. The reports have been shared with divisional teams, managers, and staff to ensure transparency and collaboration. They are also published on the intranet for accessibility and ease of use by all stakeholders. Link: SGUH-staff-survey-2024-results and ESTH-staff-survey-2024-results).

3.2 Corporate staff survey engagement plan

A structured strategic engagement plan has been developed, outlining timelines and strategies for achieving continuous improvement in staff engagement. This plan serves as a roadmap for divisional and service teams, providing clear guidance on how to own, drive and implement effective engagement activities.

3.3 Top and bottom 10 department analysis

A comprehensive analysis of the departments with the highest and lowest staff engagement scores is being finalised, triangulated with workforce metrics such as turnover, absence rates, mandatory training, employee relations cases and freedom to up speak cases. This data-driven approach allows targeted support to be directed to areas requiring the most attention, ensuring resources are utilised effectively and efficiently. The top and bottom 10 analysis will be finalized by 17th April and shared with the group executive management, site leadership teams, and divisional management teams.

3.4 Support materials

A range of support tools has been developed, by the head of culture and staff engagement including staff survey action planning guides and thematic analysis guides to help managers produce meaningful insights from survey results. These resources have been shared widely across divisions and services and are available on the intranet to ensure accessibility (SGUH-staff-survey-2024-support materials and ESTH- staff survey support materials) Managers can use these tools to lead engagement initiatives confidently and collaboratively.

3.5 Business intelligence (BI) portal development

A BI portal for accessing detailed staff survey results has been successfully developed for Epsom and St Helier, providing managers and leaders with intuitive tools to analyse survey data. A similar BI toolkit is in development for St George's, with the aim of further enhancing data accessibility and insights generation across divisions.

3.6 Management conversations and planning

Regular conversations have taken place between Divisional Management Boards, leaders, and managers by the Human Resources Business Partners (HRBPs) in both Trusts to discuss survey results, review previous engagement plans, and develop new action plans. These dialogues promote collaboration, accountability, and alignment, ensuring divisions finalise their engagement plans by the end of May 2024. By mid-June 2025, divisions should begin implementing the delivery of their plans. By August and September 2025, they should be engaging with teams to share the message, "You said, together we did," while also celebrating their achievements.

3.7 HRBP support and staff survey working groups

HRBPs are actively working with divisions to establish staff survey working groups. These groups are dedicated to driving continuous improvement planning and delivering engagement initiatives, fostering ownership and staff engagement improvements at the divisional and service levels.

3.8 Staff engagement events, webinars and workshops

A series of engagement events, webinars and workshops are scheduled to commence in May 2024. These interactive sessions aim to foster staff voice and involvement and inspire creativity, engagement and reinforce gesh's commitment to its staff, creating opportunities for staff feedback and collaboration.

3.9 Site level working groups

Site leaders across both Trusts continue to offer support and oversight for staff survey action plans, engagement, and implementation through site-level working groups.

3.10 Benefits of this new approach

The above initiatives deliver substantial benefits to staff engagement and organisational improvement, including:

- Enhanced engagement levels: By analysing survey data and sharing thematic insights, divisions can address staff concerns more effectively, improving overall morale and satisfaction.
- Increased accessibility and transparency: Publishing reports, support materials, and BI tools on the intranet ensures staff and managers have equal access to resources, fostering trust and collaboration.
- Strategic targeting of support: Focused attention on departments with the lowest engagement scores enables the group to allocate resources effectively and support areas most in need. This will be supported by the site level working groups and local divisional working groups.

The new approach ensures that the actions undertaken by divisions and teams are aligned with the corporate actions, which are consistent with our CARE strategy and People Strategy.

4. Corporate actions updates

This section of the report provides a detailed update on the significant progress achieved against the five corporate actions identified in direct response to the findings of the 2024 Staff Survey. These strategic initiatives, formally signed off by both Group Executive Management and the Group Board, represent a committed effort across the group to address key areas highlighted by our staff survey feedback.

The following updates detail activities undertaken within each of the five corporate actions:

1. Improve line management and leadership
2. Keeping our staff healthy and safe
3. Deliver our culture and diversity & inclusion programme
4. Improve training and career development
5. Deliver the NHS exemplar Intervention on retention

4.1 Improve training and career development

- Talent Strategy: Finalised in March 2025, the GESH Talent Strategy is being implemented with five key focus areas over the next 18 months: developing a career conversations framework, establishing group-wide succession planning, enhancing recruitment fairness, introducing positive action programs, and creating leadership competency frameworks.
- Shadow Board: Following board approval, procurement commenced in April 2025 for this inclusive development programme.

- Progress: Addressing staff feedback on career progression (cited by 42% of STG leavers as a reason for departure) remains a key focus.
- Challenges: Resource constraints and varied appraisal systems across sites present challenges to timelines and unified rollouts.
- Next Steps: Focus includes designing a values-driven appraisal system, piloting succession planning, and standardising recruitment.

4.2 Improve line management and leadership

- Talent Strategy: The March 2025 Talent Strategy prioritises strengthening management and leadership capabilities.
- Leadership Development: Three internal Senior Leadership Programmes have engaged 52 Band 8B-9 participants, achieving satisfaction rates exceeding 90%. A competency gap analysis has been completed.
- Three cohorts of the Compassionate and Inclusive Leadership Multidisciplinary Programme have been successfully completed. The programme, designed for middle managers in Agenda for Change bands 6, 7, and 8a, has seen the participation of approximately 75 managers.
- Challenges: Internal team turnover has postponed Cohort 4 of the leadership programme, and budget pressures impact cohesive offerings. Embedding new behaviours requires supportive cultures. An additional 250 middle managers are on the waiting list, eager to participate in the Compassionate and Inclusive Leadership Programme.
- Next Steps: Development of a GESH-wide leadership competency framework, delivering behavioural support programmes, and pooling resources for integrated initiatives under the new People Strategy. Build internal capacity and capability to enable the continued delivery of the Compassionate and Inclusive Leadership Programme.

4.3 Keeping our staff healthy and safe

- Wellbeing Pillars: Significant activity across Mental, Physical, Social, and Financial wellbeing pillars.
- Key Achievements:
    - Mental Health: Trained 23 new Mental Health First Aiders at St George's (total 111) and 45 Mental Health Champions at ESTH. Engaged 132 staff in Grief Awareness Week and 104 in Stress Awareness sessions.
    - Physical Health: Expanded Menopause support (30 new participants SGH) and successfully rolled out Men’s MOT at St George's (28 participants), with ESTH rollout planned for April 2025. Sleep initiatives launched.
    - Financial Health: Enrolled 407 staff (98 in this period) at St George's onto the Wage stream programme.
    - Social Health: Trained 19 new Health and Wellbeing Champions (total 181). Over £362,570 in charity funding allocated to staff welfare. Over 880 staff participated in Arts Club workshops.

- Next Steps: Standardising Health and Wellbeing Champion roles, enhancing manager toolkits, expanding Men's MOT to ESTH, and continuous monitoring.

4.4 Deliver our culture and diversity & inclusion programme

- GESH Culture Forum: Refreshed forum launched to drive the People Strategy, including ED&I strategy, Talent Plan, and our values and behaviours. St George's forum continues bi-monthly; ESTH paused temporarily for GESH alignment.
- EDI Framework: Implementation of the High Impact Action EDI Plan framework has commenced.
- Inclusion Programmes:
    - Training: Bespoke Disability Awareness e-learning achieved 70% compliance; LGBTQIA Awareness module developed; over 300 staff attended Active Bystander training.
    - Recruitment: Over 150 Recruitment Inclusion Specialists trained, supporting nearly 500 interview panels via the SWL Inclusive Recruitment Module.
    - Support: DFN Project Search achieved 70% graduate employment (14 roles at SGH); Menopause policy and cafés launched.
    - Collaboration: Enhanced shared practice via SW London EDI Leaders Network.
- Engagement: Monthly Executive Question Time forums and Ally Movie Nights continue.

4.5 Deliver the NHS exemplar intervention on retention

- Programme Status: Joined the national programme in February 2024. Completed self-assessment and identified four target departments (Acute Medicine SGUH, Engineering SGUH, Patient Transport ESTH, Pharmacy ESTH) based on key metrics.
- Engagement: A multi-disciplinary People Promise Retention Consultation Group is established. Listening sessions conducted in Pharmacy and Patient Transport. Hosted NHS England site visit in January 2025.
- Focus Area: Embedding People Promise values and increasing adoption of flexible working.
- Challenges: Mitigated early delays; managing clinical team capacity for engagement; improving flexible working data capture; ensuring sustainability.
- Next Steps: Trust-wide rollout of the "We Work Flexibly" initiative (April-July 2025), developing a flexible working dashboard, continued staff engagement in target areas, and integrating the programme into GESH culture and communications.

5. Risks and issues

5.1 Capacity constraints (operational & engagement)

Limited time and resources at various levels hinder the implementation and embedding of engagement efforts. Divisions and teams report lacking the necessary capacity to adequately prioritise and focus on implementing staff engagement activities alongside pressing operational demands. We will need to ensure that divisions and teams prioritise staff engagement alongside operational demands, linking it to core performance goals, at the same time highlight its benefits for

their teams and patient outcomes. Furthermore, we need to enhance the offer of self-service tools (BI tools and OD resources) for divisions and emphasise the risks of neglecting engagement.

5.2 Sustainability and embedding change

Ensuring improvements are long-lasting remains a challenge, especially with embedding new leadership behaviours without supportive workplace cultures which may potentially limiting the long-term impact of training. To address this challenge leaders and divisions will need to provide continuous feedback to reinforce behaviours post-training by establishment of accountability frameworks that track progress in adopting new leadership practices, ensuring long-term impact beyond initial training sessions. This will enable senior leadership and divisional management teams to take shared responsibility for embedding changes, rather than leaving it solely to the training facilitators.

5.3 Operational fragmentation/alignment

There are issues with the alignment of some initiatives as there are differences between sites systems which creates hurdles.

5.4 Resource constraints and budget challenges

The People function faces resource limitations that create bottlenecks in delivering group-wide engagement activities, staff surveys, and support. Budgetary constraints further delay critical initiatives such as leadership development programs, hindering the function's ability to drive wide-scale culture change across a large and geographically dispersed group. Building resilience will require fostering shared ownership across functions and securing additional support to better align priorities within current financial constraints.

6. Conclusion

In conclusion, the 2024 Staff Survey results are generally a good news story, highlighting some positive progress in the right direction for both our Trusts. The overall positive score improved compared with the 2023 survey and ranks us number 10 (SGUH) and 15 (ESTH) as most improved across Acute and Acute Community Trusts. Our results demonstrate our commitment to creating an inclusive and supportive workplace, while also identifying areas that require focus for improvement. The findings demonstrate strengths in compassionate leadership, staff engagement, and advocacy, aligning with the values of the NHS People Promise.

Achievements such as advancements in leadership development, enhanced well-being support, and efforts to strengthen diversity showcase our progress toward fostering a culture of collaboration and continuous improvement. However, challenges in areas such as flexible working, retention, and workplace inclusivity must remain a priority to further enhance staff satisfaction and morale.

Building on existing strengths while addressing these challenges will be necessary for maintaining staff satisfaction and motivation. The effective implementation of our CARE Strategy and People Strategy is crucial for driving these improvements. By integrating these strategies into ongoing initiatives, we demonstrate our commitment to aligning our organisational values with staff expectations. This approach will help address the highlighted challenges and ensure sustained progress in staff satisfaction, morale, overall performance and staff response rates and scores.

Moving forward, focusing on the principles of these strategies across all operations will play a significant role in delivering meaningful change and supporting our motivated workforce with the financial and delivery challenges faced by the group and NHS organisational bodies alike.

Appendix A: **Detailed breakdown of performance**

Table 2. detailed breakdown of the group's performance benchmark against the national average

People Promise Themes	ESTH	SGUH
We are Compassionate and Inclusive	Performs in line with the national avg. (7.21). Strengths are evident in diversity and compassionate leadership scores, with staff reporting feeling respected and valued.	Shows strength in compassionate culture (7.17, above the 7.05 national avg.). However, challenges exist with the inclusion score (6.72 vs 6.81 national avg.) and diversity equality/respect metrics (7.72 vs 8.08 national avg.), both falling below national avg.
We are Recognised and Rewarded	Scores slightly above the national average (5.94 vs 5.92), with manager recognition aligning with best practices. However, pay satisfaction remains an area of concern.	Performance is below the national average by a margin of -0.11. Staff satisfaction with pay is significantly low at 28.74% compared with the avg. at 31.14%.
We Each Have a Voice That Counts	Overall scores are consistent with the national average of 6.66. There are some improvements in the sub-score for staff feeling able to raise concerns, which is now at 6.38.	We perform well in staff autonomy, with a score (6.95) matching the national avg. (6.96).
We are Safe and Healthy	Outperforms both SGH (by +0.25) and national avg. (by +0.14). This is partly attributed to improvements in burnout reduction efforts.	Faces challenges, particularly regarding perceptions of "adequate staffing" (33.68%), which is reported as being among the lowest scores and below the national avg. performance level.
We Are Always Learning	Appraisals satisfaction remains low, scoring 5.52, lagging behind the national avg.	While scores for "supported development" show an upward trend (54.36% vs 56.17% avg.), they still lag behind the best-performing trusts nationally. Appraisals satisfaction (4.52) lags behind the national avg.
We Work Flexibly	Shows notable performance regarding staff perception of work/home life balance (6.15), scoring just slightly below the national avg.	Flexible working options are below the national average (5.92 vs 6.24), showing a notable difference of -0.32.
We Are a Team	The trust performs close to the national avg. in this area (ESH: 6.71 vs 6.74 avg.). Strong team collaboration and mutual respect	The trust scored close to the national averages in this area. (SGUH: 6.67 vs 6.74 avg.).

	are indicated, reflecting a positive internal culture.	
Staff Engagement	Outpaces the national benchmark (+0.09), with staff advocating for the Trust as a place to work (63.12%, exceeding the average of 60.90%).	The Trust showcases robust advocacy metrics, with 63.12% of staff recommending the Trust as a workplace, surpassing the national benchmark (60.90%).

Group Board

Meeting in Public on Thursday, 01 May 2025

Agenda Item	6.3	
Report Title	**Fit and Proper Persons Test Annual Compliance Report 2024/25**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	-	-
Purpose	**For Assurance**	

Executive Summary

This paper provides assurance to the Group Board that all Board Directors at both Trusts within the Group remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework (FPPT) for England published in August 2023.

All Directors on the Boards of both Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH) have successfully undergone all of the required checks under the Fit and Proper Persons Test Framework in 2024/25 and the two Trusts will make the required submissions to NHS England following the Group Board's consideration of this report, ahead of the 30 June 2025 deadline.

Two Non-Executive Directors, and one Interim Non-Executive Director at SGUH, two Non-Executive Directors at ESTH, and three Executive Directors with appointments at both Trusts have left the organisations in 2024/25. The required Board Member References have been completed for these departing Board members in line with the requirements of the Framework.

Two new Non-Executive Directors and one Associate Non-Executive Director joined SGUH, and one new Non-Executive Director joined ESTH. Chiew Yin Jones became a Non-Executive Director at ESTH having completed the necessary checks as a member of the SGUH Board. Two Executive Directors joined at both Trusts in 2024-2025. The relevant FPPT checks were completed for both.

Action required by Group Board

The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2024/25 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	FPPT Checks Annual Compliance 2024/25

Implications

Group Strategic Objectives

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

Risks

If we do not implement fully the FPPT Framework and apply it consistently, there is a risk that directors could be appointed to the boards who do not meet the required standards for appointment. This could potentially impact on patient safety and / or organisational performance and would likely trigger external regulatory intervention.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications.

Legal and / or Regulatory implications

Full implementation of the Fit and Proper Persons Test is a requirement under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the 2023 Fit and Proper Persons Test Framework for board members.

Equality, diversity and inclusion implications

There are no specific EDI implications associated with the fulfilment of the FPPT requirements.

Environmental sustainability implications

There are no specific environmental or sustainability implications associated with the FPPT requirements.

Fit and Proper Persons Test Annual Compliance Report 2024/25
Group Board, 01 May 2025

1.0 Purpose of paper

1.1 The purpose of this paper is to provide assurance to the Group Board that all Board Directors at both Trusts within the Group remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework for England published in August 2023.

2.0 Background

2.1 In 2014, the Government introduced a 'fit and proper person' requirement which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the Care Quality Commission (CQC), which includes all provider licence holders and other NHS organisations to which licence conditions apply. These 'fit and proper person' requirements were introduced via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The Regulation 5 requirements are that:

a) The individual is of good character (whether the individual has been convicted of an offence; whether the individual has been erased, removed or struck off a register maintained by a regulator of health and social care professionals).
b) The individual has the qualifications, competence, skills and experiences that are necessary for the relevant office or position or the work for which they are employed.
c) The individual is able by reason of their health of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
d) The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
e) None of the grounds of unfitness specified in the Regulation apply to the individual (undischarged bankrupt, subject of a bankruptcy restriction, insolvent, included in the children's or adults' barred lists for safeguarding, or prohibited from holding relevant office).

2.2 In 2018, Tom Kark KC was asked by the Government to lead a review of the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the 2014 Regulations. The Kark Review was tasked with determining whether the fit and proper person test was working in its existing form and how it might be adapted to ensure better leadership and management and prevent the employment of directors who are incompetent, misbehave or mismanage. It included looking at how effective the FPPT was "*in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors*". Published in 2019, the Review highlighted areas it considered needing improvement to strengthen the existing regime, including seven recommendations to Government. These included proposing that: all directors meet specific standards of competence to sit on the board of any health-providing

organisation; a central database of directors be established to hold relevant information about qualifications and history; a mandatory reference be required for each director; the test be applied to commissioners and arms length bodies.

2.3 In August 2023, NHS England published a new *Fit and Proper Persons Test Framework for board members* in response to the Kark Review, and grounded in the requirements of the 2014 Regulations. In publishing the new Framework, NHS England explained that it would "*support the implementation of the recommendations of the Kark Review*", "*promote the effectiveness of the underlying legal requirements*", and "*introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set a standard competences for all board directors, a new way of completing references with additional content whenever a director leave an NHS board, and extension of the application to some other organisations, including NHS England and the CQC*". The new Framework became effective on 30 September 2023, with certain provisions (such as the introduction of mandatory new Board member references and using a new Leadership Competency Framework in all new board member recruitment) being introduced immediately and other elements (such as requirements around the storing of information on the Electronic Staff Record) being introduced in a phased way ahead of full implementation of the Framework by 31 March 2024.

2.4 Under the new Framework, full Fit and Proper Person Test assessments must be undertaken:

- For all new appointments to board member roles, whether permanent or temporary, where greater than six weeks (including promotions, temporary appointments and secondments, acting-up arrangements.
- Where an individual board member changes role within their current organisation (e.g. if an existing board member moves into a new board role that requires a different skill set).
- Annually, for all existing board members, that is, within a 12-month period of the date of the previous FPPT assessment to review any changes over the previous 12 months.

2.5 As part of the Framework, there is a requirement for NHS organisations to formally capture FPPT information, and wider information to support recruitment referencing and ongoing development of board members, and entering this onto board members' ESR record.

2.6 For departing board members, the employing organisation is required to complete a Board Member Reference in all circumstances, including retirement, which is retained in that individual's FPPT files in the event that it is requested for new board appointments at another NHS organisation.

2.7 In terms of assurance and oversight, the Framework sets out that:

- As part of Well-Led Reviews, the CQC will consider the quality of processes and controls supporting FPPT, the quality of individual FPPT assessments, board member references, and the retention of relevant data.
- NHS England has oversight through receipt of an annual FPPT submission by NHS organisations.
- Every three years, NHS organisations are expected to undertake an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.
- Annually, an update should be taken to a meeting in of the Board in public to confirm that the requirements for the FPPT have been satisfied.

2.8 The Group Board agreed a new Group-wide policy on the Fit and Proper Persons Test at its meeting in January 2025, and this incorporates the requirements of the national FPPT framework published in August 2023.

3.0 Fit and Proper Persons Test: Summary of Checks Undertaken

3.1 The following checks are undertaken as part of the FPPT assessment for all Board members of Epsom and St Helier University Hospitals NHS Trust (ESTH) and St George's University Hospitals NHS Foundation Trust (SGUH):

FPPT Checks for new starters	Annual FPPT Checks
Identity Check inc. Right to Work in the UK	FPPT Self Declaration
Disclosure and Barring Service Check	Check of Professional Registration (if applicable)
Check of educational qualifications	Check of Insolvency Register
References covering the past 6 years	Check of Disqualified Directors Register
Check of Professional Registration (if applicable)	Check of Charity Commission Register for Removed Trustees
Check of Insolvency Register	Check of Employment Tribunals Register
Check of Disqualified Directors Register	Media Check
Check of Charity Commission Register for Removed Trustees	Social Media Check
Check of Employment Tribunals Register	
Media Check	
Social Media Check	
FPPT Self Declaration	
Occupational Health Check	

3.2 In addition to the Disclosure and Barring Service (DBS) checks for new starters, DBS checks were also undertaken for any director that had a DBS more than three years old. In line with our new Fit and Proper Persons policy, agreed by the Board in January 2025, all Board members will have a DBS check at least every three years.

3.3 Board Member References were also completed for all board members who left the Boards during 2024/25.

4.0 Fit and Proper Persons Test: Outcome and Compliance 2024/25

4.1 During February and March 2024/25, under the supervision of the Group Chairman, who is accountable for FPPT under the Framework, all existing Board members of both ESTH and SGUH underwent the annual FPPT assessment as outlined above for 2024/25:

- All Board members completed Annual FPPT Self Assessment Forms. These forms have been reviewed and are all satisfactory.

- The further annual check set out above were undertaken by an independent background checks company contracted by South West London Recruitment Hub. These have been completed for all Board members and no issues have been identified that affect the fit and proper status of any member of either Trust Board.

- In addition, the SGUH Senior Independent Director and ESTH Vice Chair reviewed the FPPT compliance of the Group Chairman for 2024/25.

4.2 Appendix 1 sets out the completion of the tests for members of the ESTH and SGUH Boards for 2024/25.

4.3 Following the completion of the FPPT checks and review of this report by the Group Board, both ESTH and SGUH will make annual compliance submissions to NHS England in line with the requirements of the Framework, ahead of the deadline of 30 June 2025.

Departing Board members, 2024/25

4.4 Under the FPPT Framework, the employing NHS organisation is required to complete a Board Member Reference for any departing Board member using the prescribed reference template. Board Member References are completed by the Chairman for all Non-Executive Directors departing the organisation, and by the Chief Executive for all Executive Directors. Board Member References have been completed for all departing Board members of both ESTH and SGUH in 204/25.

Board member	Role	Trust	Date left	Board Member Reference Completed
Jenny Higham	Non-Executive Director	SGUH	31 August 2024	Y
Philippa Tostevin	Interim Non-Executive Director	SGUH	31 December 2024	Y
Martin Kirke	Non-Executive Director	ESTH	31 December 2024	Y
Derek Macallan	Non-Executive Director	ESTH	31 December 2024	Y
Tim Wright	Non-Executive Director	SGUH	31 January 2025	Y
James Marsh	Group Deputy Chief Executive Officer	SGUH and ESTH	7 March 2025	Y
Angela Paradise	Interim Group Chief People Officer	SGUH and ESTH	31 June 2024	Y

New Board members, 2024/25

4.5 During 2024/25, the following Board members joined the Boards of ESTH and SGUH:

Board member	Role	Trust	Date joined	FPPT completed
Victoria Smith	Group Chief People Officer	ESTH and SGUH	1 July 2024	Y
Mark Bagnall	Group Chief Officer Facilities, Infrastructure and Estates	ESTH and SGUH	27 August 2024	Y
Philippa Tostevin	Interim Non-Executive Director	SGUH	4 September 2024 (Left 31 December 2024)	Y

Claire Sunderland Hay	Associate Non-Executive Director	SGUH	18 October 2024	Y
Natalie Armstrong	Non-Executive Director	ESTH and SGUH	1 January 2025	Y
Pankaj Davé	Non-Executive Director	SGUH	1 February 2025	Y
Chiew Yin Jones	Non-Executive Director	ESTH*	1 January 2025	Y

** Chiew Yin Jones holds a pre-existing appointment as a Non-Executive Director at SGUH*

Conclusion

4.7 All Directors on the Boards of both Epsom and St Helier University Hospitals NHS Trust and St George's University Hospitals NHS Trust satisfy the requirements of the Fit and Proper Persons Test required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and meet the requirements of NHS England's Fit and Proper Persons Test Framework for board members 2023.

5.0 Recommendations

5.1 The Group Board is asked to note that the Fit and Proper Persons Test has been conducted for the period 2024/25 and that all Board members of both ESTH and SGUH satisfy the requirements of the Test.

St George's University Hospitals NHS Foundation Trust - Fit and Proper Persons Test Annual Compliance 2024/25

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Norton	Gillian	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Armstrong	Natalie	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Beasley	Ann	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Davé	Pankaj	Non-Executive Director (from 1 February 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Jones	Chiew Yin	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Sunderland Hay	Claire	Associate Non-Executive Director (from 18 October 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Tostevin	Phillipa	Interim Non-Executive Director (until 31 December 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Wright	Timothy	Non-Executive Director (until 31 January 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Bagnall	Mark	Group Chief Officer Facilities, Infrastructure and Estates (from 27 August 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Grimshaw	Andrew	Group Chief Finance Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Marsh	James	Group Deputy Chief Executive Officer (until 7 March 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Paradise	Angela	Interim Group Chief People Officer (until 26 July 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Slemeck	Catriona	Managing Director - St George's	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Smith	Victoria	Group Chief People Officer (from 1 July 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Completed	Confirmed	Completed
Wellman	Arlene	Group Chief Nursing Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

Epsom and St Helier University Hospitals NHS Trust - Fit and Proper Persons Test Annual Compliance 2024/25

Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements Found	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Norton	Gillian	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Armstrong	Natalie	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Beasley	Ann	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Jones	Chiew Yin	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kirke	Martin	Non-Executive Director (until 31 December 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Completed	N/A	Completed
Macallan	Derek	Non-Executive Director (until 31 December 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Completed	N/A	Completed
Murray	Andrew	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Wilbraham	Phil	Associate Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Totterdell	Jacqueline	Group Chief Executive	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Bagnall	Mark	Group Chief Officer Facilities, Infrastructure and Estates (from 27 August 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Confirmed	Completed	Confirmed	Completed
Blythe	James	Managing Director - Epsom & St Helier	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Grimshaw	Andrew	Group Chief Finance Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Jennings	Richard	Group Chief Medical Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed

Jones	Stephen	Group Chief Corporate Affairs Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Marsh	James	Group Deputy Chief Executive Officer (until 7 March 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Paradise	Angela	Interim Group Chief People Officer (until 26 July 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Sawtell	Thirza	Managing Director - Integrated Care	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Smith	Victoria	Group Chief People Officer (from 1 July 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Confirmed	Completed	Confirmed	Completed
Wellman	Arlene	Group Chief Nursing Officer	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed