Group Board

Agenda

Meeting in Public on Thursday, 04 July 2024, 09:45 – 14:00

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

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
09:45	-	Feedback from visits to various parts of the site	Board members	-	Verbal

1.0 Introductory items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:30	1.1	Welcome and Apologies	Chairman	Note	Verbal
	1.2	Declarations of Interest	All	Note	Verbal
	1.3	Minutes of previous meeting	Chairman	Approve	Report
	1.4	Action Log and Matters Arising	Chairman	Review	Report
	1.5	Board membership: Implications of City St George's merger	Chairman / GCCAO	Approve	Report
10:35	1.6	Group Chief Executive Officer's Report	GCEO	Review	Report

2.0 Items for Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
10:45	2.1	Quality Committees-in-Common Report	Committee Chair	Assure	Report
10:55	2.2	Finance Committees-in-Common Report, including updated Terms of Reference	Committee Chair	Assure	Report
11:05	2.3	People Committees-in-Common Report	Committee Chair	Assure	Report
11:15	2.4	Audit Committees-in-Common Report	Committee Chair	Assure	Report
	2.4.1	Audit Committee Annual Reports 2023/24: • SGUH Audit Committee • ESTH Audit Committee	Committee Chair/GCCAO	Approve	Report

3.0 Items for Review					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
11:25	3.1	Independent Review of Maternity Governance and Management Response	GCNO/GCMO	Review	Report
11:35	3.2	Group Maternity Services Report	GCNO	Review	Report
11:50	3.3	Integrated Quality and Performance Report	GDCEO	Review	Report

12:05	3.4	Group Finance Report (Month 2 2024/25)	GCFO	Review	Report

4.0 Items for Decision

Time	Item	Title	Presenter	Purpose	Format
12:10	4.1	Group Board Assurance Framework	GCCAO	Approve	Report

5.0 Closing items

Time	Item	Title	Presenter	Purpose	Format
12:20	5.1	New Risks and Issues Identified	Chairman	Note	Verbal
	5.2	Any Other Business	All	Note	Verbal
	5.3	Reflections on the Meeting	Chairman	Note	Verbal
12:30	5.4	Patient / Staff Story	GCNO	Review	Verbal
12:50	-	CLOSE	-	-	-

Questions from Members of the Public and Governors

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman – ESTH / SGUH	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director ESTH / SGUH, Vice Chair - SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones^	Non-Executive Director – SGUH	YJ
Peter Kane	Non-Executive Director – SGUH & ESTH	PK
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Derek Macallan	Non-Executive Director - ESTH	DM
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Angela Paradise*^	Group Chief People Officer	GCPO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
Tim Wright	Non-Executive Director – SGUH	TW
In Attendance		
Edwin Addis	Governance Manager (minutes)	GM
Benedicta Agbagwara-Osuji	Director of Midwifery and Gynaecology Nursing – ESTH	DMGN
Anna Macarthur	Group Chief Communications & Engagement Officer	GCCEO
Ralph Michell	Group Director of Strategy	GDOS
Apologies		
Observers		
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, 02 May 2024, 10:00 – 13:00

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

PRESENT		
Gillian Norton	Group Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director – ESTH / SGUH, Vice Chair SGUH	AB
James Blythe^	Managing Director – ESTH	MD-ESTH
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director – SGUH	JH
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Derek Macallan	Non-Executive Director – ESTH	DM
James Marsh*^	Group Deputy Chief Executive Officer	GDCEO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Angela Paradise*^	Group Chief People Officer	GCPO
Kate Slemeck^	Managing Director – St George's	MD-SGUH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director	PW
Tim Wright	Non-Executive Director - SGUH	TW
IN ATTENDANCE		
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications and Engagement Officer	GCCEO
Patricia Morrissey	Interim Deputy Director of Corporate Affairs (Minutes)	IDDCA
APOLOGIES		
Yin Jones^	Non-Executive Director – SGUH	YJ
Martin Kirke	Non-Executive Director and Vice Chair – ESTH	MK
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC

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

		Action
1.0	**INTRODUCTORY ITEMS**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting and noted apologies from Yin Jones and Martin Kirke, Non-Executive Directors. The Chairman noted that as the meeting was taking place off site Board members had not had the opportunity to undertake their regular Board to Ward visits ahead of the meeting. However, ward visits had taken place at Queen Mary's Hospital, Roehampton the previous week ahead of the Board Development Session.	
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 were noted, having previously been notified to the Board: • Gillian Norton as Group Chairman; • Ann Beasley, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Andrew Grimshaw, Richard Jennings, Stephen Jones, James Marsh, Angela Paradise and Arlene Wellman as Executive Directors. Derek Macallan declared a new interest in relation to his role as a Trustee of the Fountain Therapy Trust, which offers low-cost counselling. Arlene Wellman declared a new interest in relation to her role as a Trustee of the General Nursing Council for England and Wales Trust, which funds research to enhance the practice and profession of nursing. The Board Members' Register of Interests would be updated.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the Group Board meeting on 8 March 2024 were approved as a true and accurate record, subject to one minor amendment to include Arlene Wellman on the list of attendees.	
1.4	**Action Log and Matters Arising**	
	The Group Board reviewed and noted the Action Log and agreed to close the action proposed for closure: PUBLIC2024010012.2 and PUBLIC 202401012.3. PUBLIC202401012.4 would be considered at a future Board Development Session. The remaining item was not yet due. The GCCAO set out proposals for the appointment of a new Senior Independent Director (SID) for SGUH which had been discussed initially at the Group Board on 8 March. The proposal was that Ann Beasley be appointed to the role, but the Board needed to consult the Council of Governors on this, which had taken place at the Council of Governors meeting on 20 March 2024. At that meeting there had been a comment regarding AB's length of service on the Board and whether her role at South West London and St George's Mental Health Trust impacted her capacity to be independent. The Governors noted the comments and endorsed	

	the Board's recommendation to appoint Ann Beasley as Senior Independent Director for the SGUH Board. The Chairman informed the Group Board that Alfredo Benedicto had been elected as the new Lead Governor for SGUH.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The GCEO updated the Group Board on the following: • **Staff news:** Victoria Smith had been appointed as the new Group Chief People Officer and would take up her role on 1 July 2024. Mark Bagnall had been appointed as the new Chief Infrastructure, Facilities and Infrastructure Officer and would join the Group on 27 August 2024. Both roles were members of the respective Boards of SGUH and ESTH. Victoria and Mark would have opportunities to meet other Board members as part of their induction programmes. • **Events:** The GESH100 Leadership Forum had taken place on 26 April and had received very positive feedback, in particular with reference to the quality of the speaker who provided thought-provoking insights on leadership and effective teams. The intention was to hold these forums every six months. • **Ensuring a Safe Workplace for Staff:** A Violence and Aggression Task Force had been established with a key aim of producing a revised violence prevention and reduction policy, including information on procedures and processes for sanctions and guidance and providing staff with the skills to de-escalate situations, where possible. • **Operational and financial challenges:** Both Trusts faced an extremely challenging year ahead and would have to deliver on the financial and operational commitments made. Communications with staff had reinforced the severity of the financial challenge and staff were now actively engaged with both the challenge ahead and also the opportunity to do things differently and improve ineffective processes. **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 at its meetings on 28 March and 25 April 2024 and drew particular attention to the following: • **Cardiac Surgery (SGUH)**: The Committee had received regular quarterly reports as part of the enhanced oversight arrangements for quality and safety in Cardiac Surgery and was assured that the service and outcomes were in line with similar units across the country and had been for some time. Considering the sustained improvements made, the Committee recommended to the Board that the Committee's special oversight arrangements for Cardiac Surgery, which had been in place for 5 years, should be stepped down. A new process for overseeing the quality and safety of all specialist services was being developed by the Executive. • **Interstitial Lung Disease (ESTH):** The Committee reviewed a report on the treatment of Interstitial Lung Disease (ILD) at ESTH and the actions	

being taken by the Trust to address quality and safety concerns in the treatment of ILD. An external review by an independent panel of assessors and a separate review of culture and ways of working within the ESTH Respiratory Medicine Department had been commissioned by the Trust. A detailed discussion would take place at the Committee's informal meeting in May and a detailed paper would be provided to its June meeting followed by regular updates thereafter.

- **Independent Review of Maternity Governance:** The Committees received the report which had been commissioned by the Group Board into quality governance within Maternity Services, and this helped to provide insight into the Board's concerns regarding the apparent gap between what was happening on wards and what was being relayed to the Board, which had been demonstrated by the CQC inspection of maternity services at SGUH in March 2023. A second phase of the review would commence shortly, which would look at quality governance more broadly across the Group.
- **Quality and Safety with the Group's Emergency Departments:** There had been two fatal patient falls in the ED at SGUH and concerns with these had triggered an unannounced CQC inspection. At the April meeting, the Committees received an update on the enhanced falls prevention work including greater focus on risk assessments being undertaken within the department. Cross-Trust and cross-Group learning on falls prevention was being shared, and this was an area the Committees would keep under regular review, particularly given the intense operational pressures on EDs across the Group.
- **Patient Safety Incident Review Framework (PSIRF):** The Committees received updates on PSIRF implementation which was still in the transition phase. The Committee was keen to see the outputs from PSIRF in terms of assurance that the appropriate issues and themes were subject to further exploration, and not just that the framework had been implemented.

The Chairman invited comments and questions from the Group Board and the following points were raised and noted in discussion:

- AB noted that it was encouraging to see the summary of the Committee's focus on addressing health inequalities and suggested that it would be helpful to see a summarised version of this included within the Committee's Annual Report to the Group Board.
- In response to a query from AB regarding the treatment of ILD, AM explained that the lung condition required optimal treatment and that he was not confident that this had been provided. The Chairman commented that it was appropriate that the issues had been set out in the Committee's report to the Group Board in public but suggested that, at this stage, a more detailed discussion should take place in the Board's private meeting.
- In response to a query from AB regarding whether the patients that had fallen had died as a result of the falls, AM confirmed that the patients had died as a result of the falls and that this was why the CQC had visited. The GCNO added that the area where the falls had taken place had been reviewed, changes implemented and extra staff deployed.
- AB asked if there was ever a point at which a full ED would not accept more patients. The GCMO answered that fundamentally this could not

	happen although a patient with a specific condition could be diverted to a hospital better able to meet their needs. The MD-ESTH noted that any action taken at a local level would impact those providing services in neighbouring areas and that, as the whole system was on a knife-edge, it was the system that required a re-balance rather than the Group's own capacity and demand. The MD-SGUH commented that the doors to ED could not be shut as there was no alternative. However, there had been learning from the recent industrial action and the work on flow and length of stay had provided a release valve for ED. AM noted that there was a perception that it was safer to come to ED rather than to be at home and that a conversation about how to balance risk within the system was required. The Chairman suggested that consideration should be given outside the meeting as to when would be an appropriate time to have the difficult conversation about how to balance risk within the system. • The GCMO expressed his thanks to colleagues in Cardiac Surgery who had contributed to the sustained improvement in the service and noted that the internal safety governance within the service was seen as an exemplar across the organisation. In response to a query from the GCEO as to whether the learning from Cardiac Surgery was being shared with other teams to address challenges, the GCMO confirmed learning was shared to demonstrate that even the most intractable issues can be resolved. **The Group Board:** • **Noted the issues escalated by the Quality Committees-in-Common and the wider issues on which the Committees received assurance in March and April 2024.** • **Agreed to step-down the Committee's arrangements for quarterly oversight of cardiac surgery (SGUH) on the basis of sustained improvements in the governance and safety of the service.**	
2.1b	**Quality Committees-in-Common Annual Report to the Group Board**	
	The GGCAO introduced the report setting out how the Committees had fulfilled their duties and responsibilities as outlined in the Terms of Reference during 2023/24 and highlighted that: • The section on health inequalities would be added to the Quality Committees-in-Common Annual Report as per the previous discussion at item 2.1a. • The effectiveness review demonstrated that there had been an improvement in the effectiveness of the Committee over the year, that the Committee Chair had helped to focus the Committee meetings on the right topics and that there had been some improvement to the quality and timeliness of papers. • A number of revisions and updates to the Terms of Reference were suggested, including to the frequency of meetings on which the Committee had had a good discussion. **The Group Board:** • **Noted the annual report from the Quality Committees-in-Common.**	**GCCAO**

	• **Endorsed the proposed minor changes to each Committees' terms of reference.** • **Endorsed the proposed forward workplan for the Committees for 2024/25.** • **Noted the outcomes of the 2023/24 Committee effectiveness review.** • **Endorsed the Committees' proposal to move to bi-monthly meetings in 2024/25.**	
2.2a	**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 its meetings on 5 April and 25 April 2024, and highlighted the following: • **Financial Planning 2024/25:** Committee members had spent considerable time discussing planning for 2024/25 and the Committee considered the plans for the budget to be as ambitious as they could be under the circumstances. The plan had been submitted to the South West London (SWL) Integrated Care Board (ICB) but it was likely that further iterations would be required. The focus now would be the delivery of the Cost Improvement Plans (CIPs) already identified. The Committee Chair acknowledged the hard work going on across the organisation and noted in particular the pressures on ED. In light of this, additional investment was being made in ED. TW noted that it would be an extremely challenging year ahead and that difficult decisions would be required about prioritisation of investment in new technology as much of the digital work plan was not achievable given the financial constraints. The GCEO noted that circa £2bn funding was being made available via the NHS Information Technology Fund and that GESH would need to be fleet of foot and ready to take advantage of the funding as soon as it became available. The MD-ESTH noted that ESTH was clear on its digital priorities and had a list of fully costed IT schemes ready to roll-out when funding allowed. PW congratulated the team for the delivery of the 2023/24 year end forecasts and for the timely submission of the first draft accounts. **The Group Board noted the issues escalated by the Finance Committees-in-Common and noted the wider issues on which the Committees received assurance at its meetings in April.**	
2.2b	**Finance Committees-in-Common Annual Report to the Group Board**	
	Ann Beasley, Chair of the Finance Committees-in-Common, introduced the report setting out how the Committees had fulfilled their duties and responsibilities as outlined in the Terms of Reference and highlighted that: • The Committees' Terms of Reference would be reviewed at the May 2024 meeting. • The outcomes of the effectiveness review included feedback from respondents on the need for more concise papers and more focussed presentation of papers at meetings.	

	• In an effort to keep the meeting to 3 hours in duration it was proposed that performance would be considered every other month. Finance would continue to be considered at every meeting. The Chairman noted that respondent feedback about the chairing of Finance Committee meetings had also been very positive. **The Group Board noted the Finance Committees-in-Common annual report.**	
2.3a	**People Committees-in-Common Report**	
	Tim Wright presented the report on behalf of Yin Jones, Joint Chair of the People Committees-in-Common, setting out the key issues considered at the People Committee meetings on 22 March and 18 April 2024 and highlighted the following: • **Draft People Strategy:** The Committees had welcomed the opportunity to engage with the draft strategy and had noted that an Equality, Diversity and Inclusion (EDI) plan was being developed to complement the strategy. • **Equality Delivery System (EDS)**: The Committees agreed that further work was needed before the EDS reports could be approved for publication. The Committees agreed that the reports would come back to its next meeting in June 2023 ahead of consideration by the Board. The delay in sign-off would mean that the Trusts would not meet the deadline for publishing the reports. • **Medical Revalidation Responsible Officer Q3 Report:** The Committees had received the Q3 report from the Responsible Officers at each Trust and agreed that it had received reasonable assurance in relation to medical revalidation. ESTH appraisal compliance was at 93% and exceeded the target of 90%. SGUH was below target at 88%. • **Guardian of Safe Working Q3 Report:** The Committees had received the Q3 GOSW report and had taken reasonable assurance from the report. There were no reported safety concerns at SGUH and only one reported concern at ESTH. • **Group Workforce Key Performance Indicators Report**: The Committees considered the Group Workforce Key Performance Indicators report and noted that while turnover was lower at both Trusts, the monthly sickness rates were above target and unlikely to come down to pre pandemic levels. The HR team were planning to review and align sickness absence processes across both Trusts. • The Committees also received reasonable assurance in relation to the ESTH Bank Service Insourcing and good assurance on job planning for 2024/25. During discussion, the following points were raised: • In response to a query from DM regarding future alignment of systems for both job planning and appraisals across GESH, the GCPO confirmed that there were no plans to align these systems at the present time, but a review of systems would take place as part of the restructure of the HR function as there was a desire to automate processes wherever possible. The GCMO supported bringing the systems together as there would be business planning benefits with a single system.	

	• AB welcomed the update on job planning but queried whether a £2m overpayment had been made. The MD-SGUH confirmed that any under- or over-payments would be paid or recovered as appropriate and that the focus was now on moving forward to increase the number of job plans signed off and to continue to address the drift in doctors claiming for additional Programmed Activities (PAs). • In response to a query from AB regarding whether there was any evidence to support the assumption that sickness levels would not return to pre pandemic rates, the GCPO clarified that further work was required to delve into the average rates presented in order to better understand where the high levels of absence were and what was driving it. The plan was also to work with managers to become more effective in managing staff absence. The MD-ESTH noted that absence management processes were being used far too late and that more proactive interventions should take place at an earlier stage, including referrals to occupational health. The GCEO noted that the pandemic had been a terrible time for colleagues and that a gentle approach had been adopted but that a different approach was now needed to support colleagues back to work, including the use of flexible working arrangements. **The Group Board noted the issues escalated to the Group Board and the wider issues on which the Committees received assurance in March and April 2024.**	
2.3b	**People Committees-in-Common Annual Report to the Group Board**	
	Tim Wright provided a brief introduction to the report which set out how the Committees had fulfilled the duties and responsibilities as outlined in their Terms of Reference during 2023/24 and highlighted the proposal to move to bi-monthly meetings which would also help with the timely production of effective assurance reports. The GCCAO noted that there was a recuring theme in the effectiveness review feedback on ensuring the balance between assurance and matters of operational detail. In light of this suggested amendments to the Terms of Reference made the Committee's assurance role more explicit. **The Group Board:** • **Note the annual report from the People Committees-in-Common.** • **Endorsed the proposed minor changes to each Committee's terms of reference.** • **Noted the outcomes of the 2023/24 Committee effectiveness review.** • **Endorsed the Committees' proposal to move to bi-monthly meetings in 2024/25.**	
3.0	**ITEMS FOR REVIEW**	
3.1	**Group Maternity Services Quality Report February - March 2024 data**	
	Natilla Henry was welcomed to the Group Board meeting in her capacity as Group Chief Midwifery Officer (GCMidO) to present the regular Maternity Services Report at each Group Board meeting. The GCMidO introduced the report noting that the structure had evolved over time and particularly in response to the feedback from the CQC and from the	

Independent Review of Maternity Governance. As well as the usual Maternity Incentive Scheme (MIS) requirements the paper now included data on patient experience and staff survey outcomes to ensure a broader view of all maternity services. The GCMidO highlighted:

- The gap between patient and staff experience. The NHS Staff Survey and SCORE survey indicated a deteriorating position for both Trusts and with high levels of burn out and sickness, and poor work life balance reported at ESTH. This contrasted with the patient experience and results of the NHS Maternity Services 2023 Benchmark Report which was published in early 2024 which showed that maternity teams across the group scored as the top two (ESTH 1st and SGUH 2nd) in London for care given to women and their babies.
- The MBBRACE-UK Perinatal Mortality Report for 2022 provided assurance that neither ESTH nor SGUH were negative outliers for either stillbirth or neonatal death. However, the report noted that not all Perinatal Mortality Review Tool (PMRT) reviews had an external panel member, but this was not a mandatory requirement and the critical factor was the completion of PMRT reviews in a timely manner.
- The external team that conducted the MBRRACE-UK 2020 review of cases across GESH maternity services recommended that the services needed to gain assurance that GPs who provide antenatal care undertake saving babies lives care bundle and foetal monitoring training. The NHS London Team did not consider that this was the Group's responsibility and confirmation in writing of this position had been requested.
- In terms of concerns, at ESTH maternity workforce configuration was underway, which would see a reduction in midwifery continuity of care teams. At SGUH the service had identified an increasing number of Caesarean Sections taking place at full dilatation for which a review was underway to identify any contributory factors, and safety concerns, as well as addressing the training needs of the medical workforce as it should be known sooner if a vaginal delivery was possible.
- Training compliance to March 2024 was on track apart for Maternity Support workers at ESTH which was below target at 88%.
- Midwifery fill rates remained a challenge and SGUH remained below the threshold of >94% across February and March 2024 due to short- and long-term sickness. Following an establishment review, and supported investment, a number of posts were out to advert which would help but managing sickness was also recognised as key.
- In terms of extreme risks, at ESTH there were two risks related to the lack of a second obstetric operating theatre and environmental issues. At SGUH there was one risk related to the shortage of midwifery staffing.

During discussion the following points were raised:

- The MD-ESTH noted that both extreme risks at ESTH were part of the capital budget for 2024/25 and suggested that this demonstrated that capital prioritisation was working effectively. He also noted that the fill rate had been impacted by the alignment of annual leave requirements across the Group, which had resulted in a bulge of annual leave in month 12. It

	was hoped that this was a one-off but would be tracked over the coming months. • In response to a query from DM about the reduction in midwifery continuity of care teams from 10 to 2 teams and whether this reflected a 80% reduction in staff, the GCMidO confirmed that there was no reduction in staff numbers but that some staff were being moved elsewhere within the service and were being consulted as to their personal preferences, which would hopefully increase their job satisfaction levels. • TW queried the opportunities to compare and contrast services and whether there was a formal mechanism to share learning across the Group, in particular in relation to learning from incidents as the figure at SGUH seemed far higher than ESTH. In response the GCMidO confirmed that the format of the report would be considered again but that it would be important to keep the length to a manageable level. • In response to a query from PW as to whether the deterioration in staff experience might make it difficult to sustain patient outcomes in the long-term, the GCMidO noted that while staff were reporting negative feelings this did not translate into the care delivered to women, but the Group could not rely on the fact that staff would continue to perform irrespective of how they felt. • The GCNO noted ESTH would now be under the same maternity support programme as SGUH but the support provided would be different and would reflect the specific requirements at ESTH. Both Trusts had achieved full compliance with the Maternity Incentive Scheme and had received full rebates on their contributions to the Clinical Negligence Scheme for Trusts (CNST) which would be reinvested in staffing. **The Group Board noted:** • **The successful outcome against the CNST MIS Year 5 scheme and the publication of CNST MIS Year 6 scheme.** • **The key areas of success, risks, and mitigations.**	
3.1b	**Maternity and Neonatal Safety Champions**	
	AM introduced the report in his capacity as Non-Executive Maternity Safety Champion and outlined that the report was deliberately separate from the Group Maternity Services report as it provided direct feedback from the 'walk the floor' visits, assurance that action was being taken in response, and ensured maternity and neonatal issues were communicated and championed at Board level. The GCMO noted that the CQC had been critical of SGUH for not recording incidents of moderate harm where the incidents were related to recognised complications and the care had been good. It was acknowledged that this was not appropriate and all incidents considered by mothers to be harmful were now recorded as such. As a consequence, the number of incidents was increasing but this should be seen as a positive and it should not be inferred that this necessarily involved poor care. **The Group Board noted the report.**	
3.2	**Integrated Quality and Performance Report**	

Highlights from the Integrated Quality and Performance Report (IQPR) were provided for the month of March 2024. In relation to quality, SGUH declared 6 Serious Incidents (SIs) in March 2024, including 1 Never Event (a wrong site surgery in Plastics). This brought the total number of Never Events to 10 for the full year which was significantly higher than previous years. ESTH was over trajectory for *Clostridium Difficile* (*C. Diff*) infections with 63 cases over the nationally-set ceiling for the Trust of 38 cases. SGUH remained within trajectory. There were no new MRSA infections in-month, meaning that the year-to-date case numbers were zero for SGUH and two for ESTH. A lot of good quality improvement work had taken place related to VTE assessments and this was showing early signs of improvement at ESTH.

In relation to operational performance, both Trusts continued to face significant internal and external challenges. Improvements in capped theatre utilisation were being maintained at ESTH and SGUH and would help the situation with long waiters and overall efficiency. ESTH had delivered against all three national cancer standards in February 2024 which was excellent and SGUH had stabilised, with reported improved Faster Diagnostics Standard (FDS) performance. There was a good headline figure for 4 hour waits at both Trusts but there were severe pressures on ED, with significant numbers of patients spending longer than 12-hours in ED.

During discussion the following points were raised and noted:

- The GCMO commented on the number of Never Events relating to retention of foreign objects and wrong site surgery. There had been a run of events related to cases involving multiple skin lesions and while it was no excuse the complexity of the cases was leading to the Never Events. A major piece of work was underway to improve the situation, including improving communication between patients and doctors so that a patient could be their own advocate, better photography of sites, as well as seeing the same surgeon throughout, although this would be harder to deliver.
- DM expressed concern that less articulate patients, including those for whom English was a second language, could potentially suffer a health inequality when relying on communication. The GCMO agreed that an inequality could arise and that sensible mitigations would be required. He explained that he could not think of one Never Event related to wrong site surgery that was judged to have been due to a health inequality.
- AM noted that:
  - i) Specific actions related to the recent Never Events in skin surgery were being actively tracked by the Quality Committee to ensure the Board had assurance regarding actions to identify and embed learning. It was nonetheless concerning that such incidents were still being seen and that it was necessary to keep going back to check if the right actions were being taken.
  - ii) In relation to theatre safety, a separate set of broader actions were now being taken to determine if actions were working, including audit, rather than waiting to see if a Never Event occurred.
- The Chairman noted that the Quality Committee was sighted on the issue and would continue to seek assurance on improving patient safety, on which the Board would continue to be briefed.

	The Group Board noted the report.	
3.3	**Group Financial Performance Year End 23/24**	
	The GCFO set out the good news that both Trusts had achieved their Year End forecast positions for 2023/24 although both had reported material deficits. The full draft accounts had been submitted on time and the audit would be completed by the end of June. A technical adjustment had been made to the planned deficit positions in accordance with the NHS England accounting plan to off-set deficits. This resulted in a change to what would be published compared with that monitored by the Board throughout the year. However, this did not impact the underlying financial positions as previously reported. **The Group Board noted the draft year end positions for each organisation.**	
4.1	**Our priorities for 2024/25**	
	The GDCEO provided an overview of the Group priorities for 2024/25 setting out four key 'Board to Ward' priorities under the 'CARE' objectives and suggested SMART objectives which would translate into a revised IQPR. The priorities would create a framework and working tool for priority setting throughout the Group so that it was clear to all colleagues how they could contribute to the organisation's goals. The Chairman invited comments and questions from Group Board members and the following points were raised and noted in discussion: • AM asked whether the full CARE acronym could be incorporated within the plan on a page. • TW asked if it was possible to colour code the SMARTER priorities grid to aid understanding. • The GDCEO agreed to review the document to incorporate these suggestions. **The Group Board:** • **Approved the 'plan on a page' for 2024/25, including 'board to ward' priorities and priorities for our strategic initiatives and corporate departments.** • **Noted the emerging SMART objectives/metrics, which will be translated into a revised IQPR for July Board.**	**GDCEO**
5.0	**ITEMS FOR NOTING**	
5.1	**GESH Gender Pay Gap Report**	
	The Chairman noted that the Gender Pay Gap report had been approved by the People Committee-in-Common under delegated authority from the Boards and had been included on the Board agenda for noting and transparency purposes. It was important that the Group Board reviewed and approved such reports for publication in future. Although the People Committee forward plan had included this item in January 2024, delays in the preparation of the report meant that the Board had had no choice but to delegate authority in order to meet national reporting requirements and deadlines. This needed to be addressed for 2024/25. **The Group Board noted the report.**	

5.2	**GESH Learning from Deaths Quarterly Report: Q2 (July - Sept) and Q3 (Oct – Dec) 2023/24**	
	AM briefly introduced the report and outlined that the Quality Committee had focussed on the mortality data at ESTH which was still high. While this may be due to data issues, no assumptions were being made and the data would continue to be investigated and the appropriate action would be taken. **The Group Board noted the report.**	
6.0	**CLOSING ITEMS**	
6.1	**Any new risks and issues identified**	
	The Chairman queried whether Never Events had been picked up as a risk and the GCCAO confirmed that they had been. The risk related to ED was flagged for recalibration, while this was not a new risk and was one of the central quality problems nationally, there had been a shift with much more corridor care taking place than had been the case previously. The Executive would revisit the calibration of the ED risk. **The Board noted the emerging risk related to Interstitial Lung Disease and the broader implications related to professional practice.**	**GCCAO**
6.2	**Any other business**	
	There was no other business.	
6.3	**Reflections on meeting**	
	The Chairman asked the GCCAO to give his reflections on the Board meeting, who offered the following observations: • It had been one year since the Board had started to meet as a Group Board and it was notable that the Board was working seamlessly as a single Board rather than as two separate Boards meeting together. • In terms of meeting practicalities, the meeting had kept to time overall and most of the papers had been made available in a timely way, apart from some late Committee papers which was due to the timing of Committee meetings. • There were good levels of participation by Board members with discussions building from the points raised as well as interesting challenges. • The Board discussion would resonate with staff, including the discussions on finance, maternity and ED pressures. However, staff might have reasonably expected to see more of a Board focus on cultural aspects in the public session and while this was in part explained by the People Strategy having to be taken in the private session due to purdah requirements, further thought could be given to how to bring a more explicit focus to cultural aspects in the public sessions. • There had been a good discussion on maternity governance and the discussion had highlighted the potential value in having a development session focused on quality safety performance in other key services.	

	• Further consideration was suggested of how best to communicate with staff so that they can see the role the Board plays. The Chairman invited further comments and the following points were raised: • TW noted the distinction between absolute and relative performance measures and while it was right to strive to achieve national targets, it would also be constructive to compare our performance to those around us as there were some system-wide issues that impacted performance that were outside our control and this needed to be understood. • The GCEO noted that the re-design of the HR function meant that it was hard to drive the cultural work without the supporting resource but that she would discuss with the GCPO what might be possible to re-start some of the work that had stalled as the GCEO was keen to ensure that this was progressed. The Chairman asked that further consideration be given on how to better support the staff networks as these were not being fully utilised.	**GCPO**
6.4	**Patient / Staff Story**	
	The Group Board welcomed Mrs Louise Holmes to the meeting. Louise had worked for many years in the Education Department and now hosted the Volunteers Induction Programme at St George's as a volunteer and remained a hugely loyal to supporter of St George's. Louise shared her story with the Board and outlined that in April 2023, she had fallen and landed on both her elbows, fracturing both right and left. Louise was seen in the Emergency Department at SGUH and had a very positive triage experience. She was referred to Trauma and Orthopaedics (T&O) and sent home expecting to receive a call from the T&O team in 2 days. As a carer herself Louise was now dependent on the support of family to assist with her basic needs as her broken elbows left her significantly immobilised. Unfortunately, she did not receive a call and decided to attend ESTH where she again received a good service. On attending the T&O clinic at SGUH the experience was not wholly positive and she was left to feel as though she was a nuisance and told to remove her sling and 'get on with it'. Louise felt that she could have been given more information and support from the team to help her through this difficult period. She was unable to find information on the St George's website but was able to find excellent information online from another Trust that made her feel more informed and in control, as well as paying for her own private physiotherapy assessment. The support of her family aided her recovery and without it she would have been left in a very difficult situation being unable to care not only for herself but also her disabled daughter. Vicky Mummery, Lead Emergency Practitioner, outlined the improvements and learning in place and in progress, as a result of friends and family feedback including: • Improving the availability of clear and consistent information via a designated intranet page for UTC practitioners, with all relevant Standard Operating Procedures (SOPs), guidelines and patient information available in a timely manner. This included direct access to the external facing patient information leaflets that the Trust currently offers for patients or family to access either via QR code or by print out if required.	

	• A UTC-Virtual Fracture Clinic (VFC)-Physio working group: an on-going collaborative project over the past 6-9 months to review and streamline the patient information leaflets for differing MSK conditions that will include across services information. This also includes implementation of the 'Get U Better' app that is able to be provided to patients on discharge from ED/UTC. This app also allows patients to refer themselves to their GP and/or physiotherapy services as required, alongside containing useful information such as exercises, pain/symptom management etc. • UTC-VFC working group: UTC and VFC working collaboratively to improve referral pathways, including a clear outlined inclusion/exclusion SOP for both VFC and F2F appointments within orthopaedics to ensure the right follow-up is provided to the right patients at the right time. The Chairman asked Board members for questions and comments and the following points were raised: • The MD-ESTH noted that he was seeing common themes as part of the complaints process related to the flow of information and consistency of advice from ED and fracture clinic and asked whether there was a community of practice in order to share this good practice, including referencing the good evidence base for 'Get U Better' and to spread this across settings. VM noted that she would be meeting with ESTH colleagues to discuss. • MD-SGUH apologised to Louise for the service she had experienced and asked whether anyone had asked about her caring responsibilities. Louise confirmed that no one had asked about her caring responsibilities and that as she hadn't realised how immobilised she would be she hadn't mentioned it. However, she was confident that this would have eventually been picked up as she frequently attended appointments at SGUH with her daughter and staff were always sensitive to how she was managing. The Chairman noted that it was not good enough to rely on another part of the service to pick up on the impact of her injuries on her caring responsibilities. DM and the GCMO concurred that it was important to ask about caring responsibilities before sending patients' home. • DM noted that he was shocked by the dismissive attitude of staff and asked Louise if we were doing enough about relational aspects. Louise confirmed that contact with a human face would be helpful rather than relying solely on an app and noted that even spending a few extra minutes to communicate about the delays in the T&O clinic when she attended would have made it a more positive experience. **On behalf of the Group Board, the Chairman thanked Louise for presenting her story and for her continued support for SGUH.**	
CLOSE		
The meeting closed at 13.01.		

QUESTIONS FROM MEMBER OF THE PUBLIC AND SGUH GOVERNORS
The following questions had been received from members of the public:

Questions from Councillor Peter McCabe, Merton Council:

Question 1: What is the latest estimate of the cost of the proposed new hospital at Belmont? What enabling works have been completed to date at the Belmont site? What is the total expenditure on these works and how have these works been funded?

Response: We are working with the New Hospital Programme to refresh our design to accommodate national guidance known as Hospital 2.0, and once that has advanced sufficiently we will update our cost estimates. Work to date has been funded almost entirely by the New Hospital Programme (part of NHS England) with some support from SWL ICB.

In May 2023, we relocated our Patient Transport Service to its new home in Merton from the Malvern Centre at Sutton Hospital. We also relocated back care from the Malvern Centre to St Helier. A readiness assessment of further proposed enabling schemes is now underway (this includes land acquisition from the Royal Marsden Hospital, relocation / reprovision of the Malvern Centre, junction improvements, site demolitions and the site power upgrade). The total cost of enabling works to date is £1.6m

Question 2: When will the outline business case for the proposed new hospital at Belmont be completed? Will the Trust consult with local partners before it is submitted?

Response: We plan to complete our OBC by the end of 2024, subject to support and funding from the New Hospital Programme. We will engage with a wide range of partners prior to its submission. However, it should be noted that we have already consulted on the clinical model of care and the location of the new hospital and we will not be revisiting these points.

Question 3: What is the estimated cost of the current maintenance backlog for St Helier Hospital? What is the plan to clear this backlog? Is the Trust planning to demolish any part of St Helier Hospital?

Response: Backlog maintenance costs at St Helier last year were estimated to be at c.£54m. We have recently undertaken a new 6 facet survey for Epsom and St Helier hospitals which will give us a clearer picture of where we are in terms of backlog (as the last conditions survey was done in 2019). We are still validating the data, however early indications are that there is likely to be an increase at both trust sites due to a number of factors including inflation and further deterioration of the estate. The outputs and next steps from this conditions survey will help us to shape our fiveyear Estates Strategy and ensure our assumptions are fully integrated with St George's University Hospitals NHS Foundation Trust. We will publish the outputs and next steps from this conditions survey once validated, but this new survey will help us to re-examine our estates risk profile and opportunities for early delivery of site upgrades. It should be noted that the backlog of costs does not sufficiently illustrate just how challenging it is to look after patients in a non-modern environment. Addressing the backlog will not deliver an environment that is fit for the delivery of modern healthcare, this is particularly true of the St Helier estate.

There are no immediate plans to demolish any part of St Helier hospital. However, once our emergency and acute services move to the new Specialist Emergency Care Hospital, a significant amount of space will be vacated. This will enable us to potentially dispose of the oldest and worst parts of our estate, retaining departments and buildings that are in good condition and investing in those areas.

As part of our plans to retain 85% of services at the district hospital sites, our long-term plans will consider how we can reconfigure and make best use our existing estates to deliver even more joined-up care for local people, built around what matters to them. For example, subject to further discussions with other local providers and stakeholders, we may use vacated space to provide:

- *community beds within the district hospitals*
- *additional primary care accommodation*
- *a new ambulance station for the area*
- *additional children's and adults mental health services*

Question 4: How many visits were made to each of the Emergency Departments of: St George's Hospital Epsom Hospital St Helier Hospital between the financial years 2018/19 and 2023/24

Response:

Site	*2018/2019*	*2019/2020*	*2020/2021*	*2021/2022*	*2022/2023*	*2023/2024*
Epsom - ED	*44842*	*41957*	*32216*	*53689*	*54883*	*54543*
Epsom - UCC	*16053*	*19199*	*15045*	*13847*	*12646*	*12795*
St Helier - ED	*66157*	*64174*	*53842*	*73996*	*70341*	*67105*
St Helier - Eye Unit	*5537*	*5396*	*2554*	*3149*	*3224*	*3656*
St Helier - UCC	*23241*	*26528*	*13576*	*21043*	*20137*	*19381*
St George's	*152202*	*148468*	*107982*	*151299*	*147462*	*148826*

While the St George's attendance numbers appear to have reduced, the main contributory factor to this is the recommissioning in 2022 of the Urgent Care Centre at Queen Mary's Hospital to become a GP led provision meaning this activity is no longer counted in the St Georges activity.

Group Board (Public) - 4 July 2024

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTION	WHEN	WHO	UPDATE	STATUS
PUBLIC20240502.01	02-May-24	2.1b	Quality Committee Annual Report to the Group Board	A paragraph sumarising the recent discussions on health inequalities would be added to the Committee's annual report to the Group Board.	04-Jul-24	GCCAO	Completed. The paragraph on health inequalities from the Committee's report to the May Group Board meeting has been added to the Committee's Annual Report to the Group Board 2023/24.	PROPOSED FOR CLOSURE
PUBLIC20240502.02	02-May-24	4.1	Priorities for 2024/25	The GDCEO agreed to review the plan on a page for the 2024/25 priorities to include the full CARE acronym and to colour code the SMARTER priorities grid.	04-Jul-24	GDCEO	Verbal update to be provided at meeting.	DUE
PUBLIC202401012.4	12-Jan-24	3.7	Group Strategy Implementation Update	The GDCEO plans to bring proposals for resourcing the delivery of the strategy to a future meeting, linked to forward planning for 2024/25.	08-Mar-24	GDCEO	Verbal update to be provided at meeting. **Previous update provided to Group Board on 2 May:** The intention is for this to be discussed at a Group Board development session following a detailed discussion at GEM on 7 May.	DUE
PUBLIC20240502.03	02-May-24	2.3	New risks and issues	The risk related to ED was flagged for recalibration, while this was not a new risk and was one of the central quality problems nationally, there had been a shift with much more corridor care taking place than had been the case previously. The Executive would revisit the calibration of the ED risk.	05-Sep-24	GCCAO	The quality and safety risks on both Trusts' Corporate Risk Registers, including in relation to ED safety, are being reviewed by the GESH Quality Group and the Quality Committees-in-Common in August.	NOT YET DUE
PUBLIC20240502.04	02-May-24	2.3	Reflections on meeting	The Chairman asked that further consideration be given on how to better support staff networks, as she felt these were not being fully utilised.	05-Sep-24	GCPO	In progress.	NOT YET DUE
PUBLIC20240308.1	08-Mar-24	2.3	People Committees in Common report	Publication timetable to be drawn up of statutory people-focused reports.	05-Sep-24	GCPO	In progress. Forward plan for the People Committees-in-Common incoprorating these items is due to be considered by the People Committees-in-Common in August 2024.	NOT YET DUE

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	1.5	
Report Title	**Board Membership: Implications of City St George's Merger**	
Non-Executive Lead	Gillian Norton, Chairman	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

As a university hospital, St George's Trust Board membership includes a Non-Executive Director who is appointed by St George's University of London (SGUL). The St George's Trust Constitution provides that "*a person may be appointed as a non-executive director only if: he/she is a member of a public constituency; or where any of the trust's hospitals includes a medical or dental school provided by a university, he/she exercises functions for the purposes of that university*". The individual appointed by the University to serve on the Trust Board as a Non-Executive Director is the SGUL Vice Chancellor (and prior to the establishment of the Vice Chancellor position, the SGUL Principal). Likewise, Epsom and St Helier as a university hospital also has a university-appointed Non-Executive Director on the Board. The Establishment Order for Epsom and St Helier University Hospital provides that "*one of the non-executive directors of the trust shall be appointed from the University of London*". However, ESTH, in contrast to SGUH, does not have a practice of the Vice Chancellor of SGUL being the university appointee on the Trust Board.

On 1 August 2024, SGUL is scheduled to merge with City University on London to form the new City St George's University. What is currently SGUL will form part of a new, multisite combined institution, which will be one of the largest multi-faculty institutions in London. City St George's will be led by Professor Sir Anthony Finkelstein, the current President of City University.

With this merger, there will no longer be a separate SGUL Vice Chancellor. Within the newly merged institution, there will be an Executive Dean leading a new school of health and medical sciences. While the St George's University Hospitals NHS Foundation Trust Constitution is worded in a way that enables there to be a change in the individual and role of the person appointed by the university, it is nevertheless necessary to provide clarity as to how the NED role appointed by the University will operate in the short- and longer-term. Until the appointment of a substantive Executive Dean, the individual to be appointed to the Trust Board will be Professor Philippa Tostevin, Professor of Practice – Surgical Education and Head of the Centre of Clinical Education. Once a new substantive Executive Dean is in post, it will be the Executive Dean of the (St George's) school of health and medical sciences who will be appointed by City St George's to serve as a Non-Executive Director on the Trust Board. At that point, the Executive Dean would serve as the NED on the Boards of both SGUH and ESTH.

While this change does not require a change to the SGUH Trust Constitution, there is a reference to SGUL within the Constitution in relation to the member of the Trust's Council of Governors appointed

by SGUL. This will require a minor administrative amendment to the Constitution, which the Council of Governors will be asked approve. No changes are required to the ESTH Establishment Order.

As part of the refresh of the SGUH and ESTH Standing Orders, Scheme of Delegation and Standing Financial Institutions, to be completed by the end of Q3 2024/25, we will also be setting out explicitly that the Executive Dean will act as the University appointee as a Non-Executive Director on the Boards of both SGUH and ESTH.

Action required by Group Board

The Board is asked to:

a. Note that Professor Tostevin will serve as NED on the Board of St George's University Hospitals NHS Foundation Trust until a substantive Executive Dean of the University's school of health and medical sciences is in post
b. Note that the individual appointed by the new City St George's to serve on both the SGUH and ESTH Trust Boards will be the Executive Dean of the school of health and medical sciences for City St George's, once appointed.
c. Note that a minor update will be required to the SGUH Constitution to replace the reference to SGUL with City St George's.

Committee Assurance	
Committee	No Applicable
Level of Assurance	Not Applicable

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

Implications

Group Strategic Objectives

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

Risks

There is a risk that the composition of the SGUH Board may not be consistent with its governing documents in the event that clarity is not provided about the NED representation on the Trust Board from the newly merged university.

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 financial implications directly related to this proposal.

Legal and / or Regulatory implications

The Board must be comprised in a way that is consistent with the NHS Act 2006 (as amended).

Equality, diversity and inclusion implications

No direct EDI implications as a result of this proposal.

Environmental sustainability implications

There are no environmental sustainability implications of this report.

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	1.6	
Report Title	**Group Chief Executive Officer's Report to Group Board**	
Non-Executive Lead	Jacqueline Totterdell, Group Chief Executive Officer	
Report Author(s)	Jacqueline Totterdell, Group Chief Executive Officer	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

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

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

Action required by Group Board

The Group Board is asked to note the report.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

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

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

Group Chief Executive Officer's Report

Group Board, 04 July 2024

1.0 Purpose of paper

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

2.0 Overview

2.1 Over the last few months, we have continued to work towards achieving our strategic ambitions of providing outstanding care across our hospital Group, as we mark one year since the publication of our Group Strategy.

2.2 Staff across our Group continue to work hard to deliver high quality care, timely treatment while realising financial efficiencies. We have met and exceeded critical targets, such as the national ambition that no more than 5% of patients wait longer than six weeks for their diagnostic test and achieving the national standards relating to cancer wait times for faster diagnosis. Improvements in theatre utilisation have also been achieved, with both ESTH and SGUH achieving top quartile performance nationally, with 82% and 81.4% respectively against the national target of 85%. Elective activity has also exceeded our plan at both ESTH and SGUH. At the same time, while our performance has been good in many areas, there remain particular pressures on our Emergency Departments across our Group, and we are working hard to ensure our ED staff are well supported. The key drivers for operational pressures at both Trusts are unplaced patients remaining in the EDs and pressures resulting from high numbers of patients with mental health needs presenting at ED. Wider flow through our hospitals represents an ongoing challenge.

2.2 We continue to develop our hospital Group in order to fully realise the benefits of working at scale. Our programme of integrating our corporate services has continued, with the completion of consultations on the restructure of our corporate nursing teams and the first phase of restructuring of our corporate medical teams. This comes on top of the restructures already completed in Corporate Affairs, Communications and the Deputy CEO's office. We have also agreed timescales for the remaining corporate services to come together on a Group-wide basis. In addition, we are exploring options for deepening collaboration between our clinical services across the Group and this will be a key area of focus in the coming months. We have reviewed and adapted our arrangements for overseeing progress in these areas through the establishment of a new Executive Collaboration Group, which will be responsible for overseeing and coordinating both corporate services integration and collaboration between clinical services.

3.0 National Context and Updates

3.1 **Implementation of the first phase of Martha's Law:**

St. George's is one of 143 hospital sites that will test and roll out Martha's Rule in its first year, with the aim of ensuring that patients and families have a clear and consistent way to seek urgent review if they or their loved one's condition deteriorates and are concerned it is not being responded to. The scheme is named after Martha Mills, who died from sepsis in 2021 at

age 13 due to the failure to escalate her intensive care despite concerns raised by her family of her worsening condition.

Martha's Rule is made up of three components to ensure concerns about deterioration are responded to swiftly. First, an escalation process will be available 24/7 through various publicly displayed advertisements, enabling patients and families to contact a critical care outreach team to assess and escalate care if necessary. Second, NHS staff will also have access to this same process if they have concerns about a patient's condition. Third, clinicians at participating hospitals will also formally record daily insights and information about a patient's health directly from their families, which will help to identify and address any concerning changes in behaviour or condition noticed by the people who know the patient best.

We believe that as this policy expands in future years, these principles will greatly improve patient partnership and positively impact patient outcomes and experiences.

3.2 **London Cyber Attack:**
A recent cyber-attack disrupted blood tests and transfusions at several hospitals in South East London (King's College Hospital, Guy's and St Thomas' and some primary care services). St George's and Epsom and St Helier were not directly affected by the cyber attack, but have been active in supporting our colleagues in South East London while they respond to the incident. The Group has worked closely with system partners to make sure we continue to provide services to our patients while supporting others. We have, for example, taken on some specialist patient where care was impacted at other hospitals.

4.0 Our Group

4.1 **Electronic Patient Record Implementation:**
As the Board is aware, we are progressing with the development of a new Electronic Patient Record (EPR) system at Epsom and St Helier, on a shared domain with St George's. The new EPR system will give secure access to health records to support clinical decision-making and give our patients greater control of their care, including not having to repeat their medical histories, and represents a big leap in digital healthcare. Intensive work has been underway at ESTH for some time to prepare for the implementation of EPR. We have recently reviewed and strengthened the governance of programme to ensure we are in a strong position to fully implement the system. Alex Shaw, Site Chief Operating Officer at ESTH, has taken on the role of Senior Responsible Officer for the EPR rollout. This ensures that there is senior operational leadership of the programme. At the same time, I have taken on the role of chairing the EPR Programme Board in order to provide overall oversight of the programme. The Infrastructure Committees-in-Common is providing Board-level oversight of the programme and a 'go live' date will be presented to the Board for consideration at the appropriate stage. In the meantime, we continue to work closely with the London Digital lead to provide assurance on progress.

4.2 **Patient Safety Incident Response Framework:**

As the Group Board is aware, we have been rolling our the new national Patient Safety Incident Response Framework (PSIRF) in a phased way across our hospital Group over the past year. PSIRF implementation is being guided by the Group PSIRF implementation lead and PSIRF Programme Manager, and there has been close working between our central PSIRF team and divisional and ward staff who will implement PSIRF at Site level. A 'go live' check list was developed to support services in transitioning to the new Framework and I am pleased that the Group completed its transition to the new Framework at the end of June

2024. PSIRF will have significant implications for the way in which we treat and investigate incidents, but this new approach will help identify and embed learning from incidents and help promote a culture of patient safety.

4.3 **New Renal Unit:**

We have continued our plans to improve kidney care in South West London, Surrey and beyond, which will be transformed into a specialist renal unit designed to treat the most seriously ill patients. St George's, Epsom and St Helier University Hospitals and Health Group has been permitted to proceed with more detailed plans. The proposed facility, which will be based at St George's, will be used by patients who currently receive care at St George's and St Helier hospitals and will be one of the largest and most modern renal services in the UK. Our plans will help transform the quality of kidney care in the region by having specialist inpatient care in one place. The local delivery of most outpatient care and dialysis will still occur close to people's homes, with 95% of patients continuing to receive care and treatment in local hospitals, clinics and at home.

4.4 **Quality Governance Review:**

In March 2023, the Care Quality Commission (CQC) inspected maternity and midwifery services at St George's. During and after its inspection, the CQC identified areas where significant improvements needed to be made to maintain safe services to patients. Following this, the Group commissioned a review of quality governance arrangements across GESH, with the objective of identifying improvements that can be made to strengthen the governance of maternity services. The first phase of this work – which focused on quality governance in maternity services - is now complete and the report of the independent review, together with the management response, is on the Group Board agenda. Work is underway to implement the recommendations and actions arising from Phase 1. Phase 2 of the review will have a wider focus on quality governance across both SGUH and ESTH, particularly at divisional level, to ensure that there is effective quality governance from service to division to site and upwards to the Board. This second phase will be implemented in a way that enables the Group to adopt a model of reviewing quality governance maturity in a robust and ongoing basis.

4.5 **Visits:**

Richard Meddings, Chairman of NHS England, recently visited SGUH to learn about the efforts being made to reduce health inequalities and to observe innovations within the NHS. During his visit, he engaged with the staff and saw a demonstration of how virtual reality is used in physiotherapy for trauma patients. Additionally, he visited the Liver Bus to gain insight into our work in Hepatitis and HIV testing. We are now offering a Hepatitis C test and a non-invasive liver health check to more communities than ever before in SW London. This is a crucial step in addressing health disparities and working towards the goal of eliminating Hepatitis C for all.

5.0 Appointments, Events and Our Staff

5.1 Our Staff:

- **New Group Chief People Officer:** I am delighted that Victoria Smith started as our new Group Chief People Officer on 1 July, following a recruitment process earlier this year. Vicky has a wide variety of experience, most recently as HR Director for the Ministry of Defence where she is looking after 60,000 people. Vicky will have overall responsibility for HR across the Group, and one of her priorities will be to drive forward our work on integrating the function so that we can work closer together and deliver better patient care. As well as this, Vicky will continue our work to improve staff

experience, making sure staff are empowered and engaged, whatever their role. As well as welcoming Vicky, I would also like to thank Angela Paradise, who has served as Interim Group Chief People Officer since January 2024, for her work in leading the HR function and developing our new People Strategy, and I wish her well for the future.

- **GESH Celebrations:** Over the last few weeks, I have spent time with staff celebrating various important events, including Pride Month, Armed Forces Week, Eid Al Adha, National Health Estates and Facilities Day, Windrush Day, and so much more. I am inspired by how our diverse teams come together to celebrate one another and reinforce our CARE values, and by the energy and enthusiasm brought by our staff networks across our Group.

- **Volunteer Thank You Awards at ESTH:** On 18 June, the Trust hosted a thank you awards which recognised and celebrated the hugely valuable contribution of our volunteers at Epsom and St Helier to the hospital, patients, visitors and staff. I would like to add my own thanks to all of our volunteers.

- **St Georges Catering Services:** Catering services at St George's have been recognised as "exemplary" by NHS England and have been chosen to join the NHS Exemplar Trusts Programme for Catering. This is in recognition for innovation, high food standards, and consistent service in providing food for patients, staff and visitors. St George's is one of only 20 hospitals across the country to have been awarded this accreditation.

- **ESTH Simulation and Human Factors team:** The Elena Power Centre for Simulation and Human Factors (EPC) at Epsom and St Helier has been named a Finalist for not one but two HSJ Patient Safety Awards later this year. The awards take place on 16 September and the EPC team is a finalist for both the Harnessing Human Factors Approach to Patient Safety and the Patient Safety Education and Training Award categories. I wish the team the very best of luck and congratulations on being selected as a finalist.

5.2 Events:

- **St George's Hospital Charity:** St. George's Hospital Charity was awarded 'Highly Commended' in the Best Charity of the Year category at the 2024 Wandsworth Business Awards. This was the charity's first time participating, and it was one of nine local charities shortlisted, ultimately coming in second to Age UK Wandsworth. The annual Wandsworth Business Awards recognize and celebrate both emerging and established businesses in the area for their excellence in various aspects. The charity's award application highlighted St. George's Hospital's integral role in the Wandsworth community, staff and patient initiatives for improving wellbeing and care, as well as the charity's work with the local community and businesses for fundraising and community connection to the hospital.

6.0 Recommendations

6.1 The Group Board is asked to note the report.

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	2.1	
Report Title	**Quality Committees-in-Common Report to Group Board**	
Non-Executive Lead	Derek Macallan, Non-Executive Director and Member of the Quality Committee (Chair of the June 2024 meeting)	
Report Author(s)	Derek Macallan, Non-Executive Director and Member of the Quality Committee (Chair of the June 2024 meeting)	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

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

- **Maternity Governance Management Response:** The Committees reviewed the management response to the independent review of maternity governance, which had been commissioned by the Group Board following the CQC inspection of maternity services at SGUH. The Committees were assured that an effective management action plan had been developed and that the Committees will closely oversee delivery of the actions.

- **Patient Safety Incident Response Framework:** The Committees received an update on PSIRF implementation and heard that all services across the Group had now completed the transition from the SI Framework to PSIRF, which had been achieved within the established national timescales for transition. The Committees were assured that both Trusts were meeting safety standards and learning from patient safety incidents, though further embedding of the new framework was needed. The Committees noted that both trusts continue significant work to embed a safety culture in the operating theatre setting following the increase of Never Events involving wrong site surgery and retained foreign objects over recent months.

- **Group Quality and Safety Strategy:** The Committees reviewed the updated Group-wide Quality and Safety Strategy and confirmed that they were content to support the presentation of the strategy to the Group Board for approval.

Action required by Group Board

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

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

Quality Committees-in-Common Report
Group Board, 04 July 2024

1.0 Purpose of paper

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

2.0 Items considered by the Committees

2.1 At its meetings on 27 June 2024 the Committees considered the following items of business:

June 2024
• Group Update on Health Inequalities • Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF) • Update on quality and safety within the Group's Emergency Departments • Group Maternity Services Report* • Executive Response to the Independent Review of Maternity Governance* • Group Integrated Quality and Performance Report* • Group Annual Patient Experience Report • Board Assurance Framework – Quality and Safety Strategic Risks* • Quality Impact Assessment of the Cost Improvement Programme

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

2.2 The Committees were quorate in June 2024.

3.0 Key issues for escalation to the Group Board

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

a) Independent Review of Maternity Governance / Maternity Services Update

At the meeting in April 2024, the Committees had reviewed the findings of the independent review of maternity governance, which had been commissioned by the Group Board following the outcome of the Care Quality Commission (CQC) inspection of maternity services at SGUH, which had highlighted a number of issues including the robustness of ward-to-Board reporting on maternity. At the meeting in June 2024, the Committees received and welcomed the management response to the review. The independent report and management response in on the Group Board agenda in July 2024, but the Committees wished to convey to the Group Board their assurance that an effective management action plan had been developed and that the Committees would closely oversee delivery of the actions. A second phase of the wider quality governance review would be starting shortly and an updated terms of reference was being finalised. This

second phase would consider quality governance more broadly across the Group, particularly at divisional level, and would look to put in place systems and processes for enhancing quality governance maturity.

b) Group Patient Safety and Incident Report and update on Patient Safety Incident Review Framework (PSIRF)

The Committees had have previously provided updates to the Group Board on their work in seeking assurance on the implementation of the new national Patient Safety Incident Response Framework (PSIRF), which has replaced the Serious Incident (SI) Framework. At their meeting in June, the Committees received an update on PSIRF implementation and heard that all services across the Group had now completed the transition from the SI Framework to PSIRF, which had been achieved within the established national timescales for transition.

The report received by the Committees sought to provide assurance that both Trusts were meeting safety standards and learning from patient safety incidents. The report would continue to cover the legacy Serious Incidents while also reporting on investigations under the new Framework. The Committees noted that both trusts continue significant work to embed a safety culture in the operating theatre setting following the increase of Never Events involving wrong site surgery and retained foreign objects over recent months. Since the last meeting of the Committee, two Never Events had been declared at ESTH – a retained guidewire in a central line and a wrong site surgery in a dermatology patient. One Never Event had been declared in March 2024 at SGUH, involving a wrong site surgery in a dermatology patient. Details of the immediate actions and the ongoing improvement work were shared in the report.

The Committees were pleased to learn that on PSIRF training, good progress was being made, with 89% of relevant staff at ESTH and 91% of staff at SGUH having now completed Level 1 training, however it was noted that the Medical & Dental staff group was still to achieve the target.

The Committees recognised that using PSIRF was relatively new in some areas of the Group. Going forwards, there would be the opportunity to bring together further information and assurance relating to the safety themes which were emerging and the efforts being made to resolve them across the Group.

Following debate, the Committee agreed that they felt there was reasonable assurance relating to the implementation of PSIRF. Further work on embedding PSIF was necessary, though this was inevitable at this stage and there would be opportunities to increase learning and making more positive changes across the Group. As systems developed there should be the opportunity to see wider evidence for embedding learning from incidents which was leading to change.

c) Group Quality and Safety Strategy

The Committees received a progress update on the development of the new Group-wide Quality and Safety Strategy, which will support the ambitions of the wider Group Strategy. The Strategy, which had been discussed by the Group Board previous, would be a key enabler for the Group in delivering its vision for 2024 to 2028 – *Outstanding Care, Together*. The strategy sets out the strategic objectives in terms of quality and safety for 2024-2028 against these three areas: (i) *Strong Governance: We will strengthen*

governance & oversight of quality and safety; (ii) Better Flow / Shorter Waits: We will improve flow through our services, so that patients get the right care, in the right place, more quickly; (iii) A Learning Organisation: We will embed a culture of psychological safety, continuous improvement, learning from mistakes, and learning from others. Against these three areas, a set of five priorities have been defined with corresponding actions. The objectives and actions have been aligned to our in-year quality priorities 2024/25. The Committees confirmed that they were happy to support the Quality Strategy which would be presented to the Group Board for approval in July 2024.

4.0 Key issues on which the Committees received assurance

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

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

The Committees have brought a consistent focus to seeking assurance regarding safety and quality in the Group's Emergency Department in the context of the intense operational pressures across the Group, and it has reported on its previous discussions to the Group Board. Issues in ED ranged from the number and acuity of patients, the environment with the departments and looking after patients with mental health needs where ED was not always the appropriate place to receive the care they needed. The Group's EDs faced significant operational pressures, with overcrowding in ED a key issue, which had been highlighted by staff, and there were challenges with wider patient flow across the Trusts. This was recognised as one of the biggest risks to patient safety across the Group. Following recent falls in ED at SGUH, and in the context of these wider pressures, the Committees sought assurance that the standard operating procedures (SOPs) for triage and streaming in the departments were fully understood and were being consistently applied. The Committees reviewed the SOPs for triage and streaming in the three EDs across the Group, and the SOP for initial assessment and direction/streaming for adult and paediatric patients attending the ED by ambulance, GP/111 referral and walk-in. The Committees also received a verbal update from the Site Chief Nursing Officer for SGUH on how the SOPs worked in practice. The Committees noted that the Sites had been asked to work together to ensure that a standard set of metrics were developed so that audits could be undertaken to assess whether the SOPs were being consistently followed. The Sites had also been asked to work together to develop a Paediatric Initial and Secondary Assessment SOP. The Committees were assured that the appropriate SOPs were in place, and were assured that plans were in place to ensure compliance.

b) Maternity Services Update

The Group Board has an update on maternity services on its agenda for the Group Board meeting on 4 July. As a result the Committee would simply highlight that it received the regular update report from the Group's maternity services. Points to note included:

- In recognition of both Trusts achieving all Safety Actions for Clinical Negligence Scheme for Trusts Year 5, NHS Resolution had issued a rebate payment equal to their 10% contribution into the scheme, plus a share of the surplus funds in respect of trusts that did not achieve full compliance in all ten safety actions. For ESTH the total rebate was £1m and for SGUH £800k. The Maternity and Perinatal Incentive Scheme for Year 6 had recently been published.
- Whilst there had been an increase in compliance by most staff in completing mandatory training there continued to need to be an improvement in this requirement

with the Anaesthetist in both trusts. There also remained concerns relating to training compliance for obstetric medical staff for Safeguarding (adults and children) remained low at 39% and 79% respectively.

- Safe Staffing levels: In April 2024 safe staffing levels were 94% at St Helier, 92% at St George's and 89% at Epsom, against a target of 94%.

c) Interstitial Lung Disease

Further to the report to the May Group Board meeting, in June the Committees received a further update on the work being undertaken in relation to Interstitial Lung Disease at ESTH. The Committees heard that progress was being made in relation to review of case notes, with the commissioning of an external review, and with the review of working practices. While the Committees recognised the significance of the issues, they were assured that appropriate actions were being taken forward to explore the issues identified and improve working practices. The Committees will continue to maintain close oversight of this.

d) Group Annual Patient Experience Report

The Committees received the Group Annual Patient Experience Report covering April 2023 to March 2024. The report covered the work undertaken relating to patient experience and included voluntary services, partnership working, carers, veterans, patient surveys, patient support groups, engagement activities, patient information and communication. Key areas of work within the year included the Carers Discharge Project and the Veteran Aware projects. Other projects included working in compliance with the accessible information standards, patient information, communication, and multiple engagement projects. The Committees recognised and commended the efforts of the increasing number of volunteers working in the two Trusts across the Group. The number of volunteers was once again increasing, following a reduction during the Covid-19 pandemic. Work experience restarted at ESTH in July 2023, with 33 students taking part in placements. A number of priorities for 2024/25 had been developed and would continue to focus on a number of key areas including: supporting carers; supporting veterans; patient experience, including gaining the patients voice in the fundamentals of care programme across the Group. The Committees recognised the importance of the work which had taken place in improving patient experience and supported the positive plans for the year ahead. The Committees agreed they had received substantial assurance relating to the patient experience work taking place across the Group.

5.0 Other issues considered by the Committees

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

a) Quality Assurance process of the Cost Improvement Programme

The Committees received an update on the Quality Impact Assessment (QIA) of Cost Improvement Plans (CIP). The process was well-recognised nationally as an essential component of quality and safety governance in NHS organisations. The QIA process aimed to prevent unacceptable negative impacts on the safety and quality of patient care while recognising that financial control is essential to providing good care to patients. The Committees recognised that for the two Trusts to deliver their financial plans, there may be some quality trade-offs but there could be no compromise on safety. The Committees heard

that it was be common for the QIA process to lead to an amendment or refinement of a CIP proposal rather than outright rejection, but some proposals would inevitably be rejected on quality or safety ground, and this demonstrated the rigour of the process. For Q1 2024/25, the majority of the CIP schemes were still been developed and, at present, and one scheme had been presented to the Group QIA panel from ESTH, with more to follow in the coming weeks and months.

b) Health Inequalities

The Committees received a verbal update on the areas of work being undertaken across the Group to tackle health inequalities. A formal update paper would be brought to the August meeting. One of the major work strands which was being developed related to data quality and ensuring that ethnicity data was being captured effectively and consistently. A deep analysis of this data had been carried out across the Group, which had determined where this was being achieved well and where it needed to be improved. The information and would be used to help to tailor specific services where needed. As a result of this initial analysis a number of clinical services and areas at both trusts were working with the quality improvement team to improve their data quality. Work was also taking place to start to build a community of practise of clinicians who were already very active in the field of health inequalities in their own services. The first meeting of this team would be taking place in early July 2024.

6.0 Recommendations

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

Group Board

Meeting on Thursday, 04 July 2024

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

Executive Summary

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

Action required by Group Board

The Board is asked to:

a) Note the issues considered by the Finance Committees-in-Common at its meeting in May and June 2024

b) Approve the updated Terms of Reference for both the SGUH and ESTH Finance Committtees as reviewed and endorsed by the Finance Committees-in-Common.

Committee Assurance	
Committee	Finance 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	Finance Committees Terms of Reference

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance Committee-in-Common Report
Group Board, 04 July 2024

1.0 Purpose of paper

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

2.0 Background

2.1 At its meetings on 31st May and 28th June 2024, the Committee considered the following items of business:

31 May 2024	28 June 2024
• Planning 24/25 • Finance Report (M1) • CIP Update (M1) • Controls update • Cash update • Costing update • Business Case update • IQPR • Terms of Reference update	• Planning 24/25* • Finance Report (M2)* • CIP Update (M2) • Controls update • Cash update • Finance BAF risk update* • Update from Group Recovery Board • NHS Standard Contract sign off • Business Case update • IQPR* • Operational BAF risk update* • Finance policies update and SGH approvals • SWL Procurement partnership update • SWL Pathology update

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

2.2 The Committee was quorate for both meetings.

3.0 Analysis

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

a) Financial pressures impacting on investment opportunity- In considering the BAF risk, committee members noted the negative impact on staff of constantly having to reject proposals for investments to improve services due to the financially constrained position.

b) London Ambulance Handover changes- The Committee noted the risk of reducing the maximum handover time from 45 mins to 30 mins or 15 mins when corridor care is already being experienced at the Emergency Departments in the group.

c) Cyber attacks- Committee members noted the financial impact was being worked up for the direct and opportunity cost of supporting South East London during the Synnovis attack. They also observed the risk of similar attacks in South West London and how the procurement department can assist this.

d) Virtual Ward- Colleagues discussed the progress being made with partners across the health economy on Virtual ward, with more progress expected in the coming months.

4.0 Sources of Assurance

4.1

a) Planning update

The GCFO noted the revised financial plan submitted by each organisation on 12th June. Committee members discussed the impact of supporting the Cyber attacks and Industrial Action in the coming months.

b) Finance Report M2

The GCFO noted ESTH and SGH were on plan as at M2 24/25, although both organisations had pulled forward benefits from future months in order to deliver the plan.

c) CIP update

The GCFO noted the progress in turning schemes to 'Fully Developed' at the two trusts although too much CIP was sitting in 'Plans in Progress' or 'Opportunity'. Committee members noted medical rates and sickness absence as potential areas to make savings.

d) Controls update

The GCFO noted the self-assessment carried out by each trust for the ICB to review. Committee members noted the update

e) Cash update

The GCFO introduced the cash update noting no significant risk at present although this relied upon a cash backed deficit funding commitment from NHSE that has yet to be formally confirmed.

f) Recovery Board update

The GCFO informed the committee of the work being undertaken by the Recovery Board. Committee members noted the importance of system partners considering more transformational service reforms in order for the ICS to properly address its underlying deficit and move resources to address underlying population health issues.

g) NHS Contracts sign off

The GCFO informed the committee of the requirement to sign off contracts with NHS commissioners by 5th July, and the Chair of the Finance Committee will be updated on any remaining issues prior to final sign off on 5th July.

h) Business Case update

The SGH DFS noted progress made with Renal and Critical Care business cases.

i) IQPR

Urgent and emergency care services at both trusts continue to experience significant pressures. 4-hour wait performance at SGUH in May 2024 was 76.8%, against a trajectory of 78.6%. The key drivers for operational pressures at both sites are unplaced patients remaining in the Emergency Department including mental health patients impacting on ambulance delays and capacity within the department to see and treat patients. Although overall LAS performance at SGUH remains comparable to previous months, patients are waiting longer to be offloaded, seeing an increase in patients breaching between 30-60 minutes.

RTT waiting lists are higher than planned, with an increase at ESTH through April 2024. Gynaecology remains the biggest challenge for both 65 and 52 week waits; however, there has been improvement, with the total Gynaecology PTL reducing by 782 and the total waiting for a first appointment reducing by 1,641. At SGUH, 28 patients are waiting for more than 65 weeks against a plan of 15, although it should be noted that the Trust reported one of the lowest 65-week wait positions nationally at the end of 2023/24.

ESTH delivered against all three **national cancer standards** in April 2024: 28-Day Faster Diagnosis (85%), 31-Day Decision to Treatment (96%), and 62-Day Referral to First Treatment (90.6%). SGUH performed better than trajectory for 62 Day Referral to First Treatment, achieving 78%. SGH Faster Diagnosis performance of 71.8% against plan of 74.9% for April 2024. Challenges within Gynae; Reduced access to scans and delay to starting one stop clinics, Lower GI: CTC capacity and endoscopy process delays are contributing factors.

Integrated Care Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in May 2024. Sutton Health & Care achieved 88.3% and Surrey Downs Health & Care, 87.3%, with a continued focus on encouraging more referrals. Virtual Ward occupancy target of 80% continues to be met at Surrey Downs and continued step change of improvement seen at Sutton.

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

a) Group Policies

The Committee noted progress in combining policies across the group and approved updated Business Expenses and Petty Cash policies

b) Terms of Reference

Committee members approved updated terms of reference for the SGUH and ESTH Finance Committees which are shown as an appendix to this report. As separate legal entities, each Trust's Finance Committee must be constituted separately with its own separate ToR, but these are harmonised to ensure the effective working of the Committees-in-Common arrangements.

c) SWL Procurement Partnership update

The SWL leads for Operational and Commercial procurement noted the work being undertaken to deliver the agreed business plan for 2024/25 and to review cyber security risks with key suppliers following the recent Synnovis attack.

d) SWL Pathology update

The GCFO noted that the partnership was on plan at M2 and noted the work on demand management savings that was progressing. He also noted the work on testing in ED and how better partnership working was resolving issues with delays.

5.0 Implications

5.1 The Committee considered the BAF operational-related risks whilst noting a formal update would go directly to Group Board. MDs at both organisations were content having fed into the process in recent months.

5.2 The Committee considered the BAF finance risk in the June committee and agreed with the assessment of the highest score, '25', for each organisation.

6.0 Recommendations

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

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NHS
St George's University Hospitals
NHS Foundation Trust

Finance Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

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

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

3. Purpose

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

- Approving the annual financial plan and reviewing financial performance to ensure the Trust achieves its annual financial targets and uses public funds wisely.
- Approving the annual operational plans and reviewing performance to ensure each Trust achieves its annual performance targets.
- Ensuring financial, workforce and operational plans triangulate.
- Reviewing and approving the investment in service development opportunities and approving tender proposals.
- Seeking assurance that key risks relating to finance and performance as included on the Group Board Assurance Framework and the Corporate Risk Register for each Trust, are being effectively managed and mitigated.
- Overseeing and providing assurance to the Group Board on progress in the delivery of the Group’ strategic objective of delivering affordable healthcare fit for the future, and the financial aspects of Group strategic initiatives.

4. Duties

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

Finance and Business Planning

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

Financial Strategy and Management

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

Procurement

- Overseeing the implementation of relevant procurement strategies.
- Approving the annual procurement plan and receiving progress reports on its implementation.
- Seeking assurance in respect of the effective operation and financial management of any collaborative activity hosted by the Trust.

Business Cases, Benefits Realisation and Return on Investment

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

Operational Performance

- Reviewing the operational performance of the Trust on a regular basis across the range of performance indicators within the Integrated Performance Report prior to consideration by the Group Board, including NHS Constitutional Standards.

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

General

- Referring any matter to any other Board Committee and responding to items referred to the Committee from other Board Committees and / or the Board.
- Obtaining assurance on the risks to delivery of the Trust's strategic and corporate objectives in relation to finance and performance, with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee. This includes reviewing regularly relevant risks on the Corporate Risk Register and reviewing the entries on the Group Board Assurance Framework which relate to the scope of the Committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seeking assurance that appropriate actions are taken in response, as requested by the Audit Committee.
- Seeking assurance that the Trust has in place appropriate policies that fall within the Committee's scope and approving relevant policies in line with Scheme of Delegation.
- Receiving and reviewing reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, and seeking assurance that appropriate action is being taken to address these.
- As required, reviewing any Trust strategies within the remit of the Committee prior to approval by the Board (if required) and monitor their implementation and progress.

5. Membership and Attendance

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

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

The membership of the Committee comprises:

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

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

- Site Chief Finance Officer
- Site Chief Operating Officer

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

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

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

6. Quorum

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

- At least two non-executive directors
- At least two executive directors

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

7. Accountability and Reporting Arrangements

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

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

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

8. Meeting Format and Frequency

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

9. Declarations of Interest

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

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

The Board has approved the potential conflict relating to those members who hold in-common appointments across the St George's, Epsom and St Helier University Hospitals and Health Group, so this will not need to be declared at each meeting under normal circumstances.

10. Meeting Arrangements and Secretariat

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

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

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

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

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

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

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

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

6

Document Control

Profile	
Document name	Finance Committee Terms of Reference
Version	0.3
Executive Sponsor	Group Chief Finance Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	31 May 2024
Date of Trust Board approval	TBC - 4 July 2024
Date for next review	July 2025

Group Board

Meeting in Public on Thursday, 04 July 2024

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

Executive Summary

Following on from the People Committees-in-Common report in the public meeting, this report provides the confidential issues considered by the Committee on 20 June 2024 and highlighted to the Board. These were:

- NHS Staff Survey: Top 10 and lowest 10 performing departments: The Committees reviewed an analysis of the departments with the highest and lowest levels of engagement with the staff survey and the triangulation of engagement levels with a number of other key workforce indicators. The Committees welcomed the excellent format of the report and detailed analysis of the survey data presented in this form which provided helpful insight into those departments within each Trust that may be encountering challenges and may require support. The Committees also noted that work was being undertaken by the Executive to develop an 'insights report' for the Group that would bring together both hard data and soft intelligence to help identify teams encountering challenges so that the appropriate support could be put in place at an early stage.

- Group Freedom to Speak Up Report 2023/24: The Committees received a report from the newly-appointed Group Freedom to Speak Up (FTSU) Guardian, which set out an analysis of the numbers of concerns raised by staff across the Group in 2023/24 and the trends and themes arising from those concerns. Concerns relating to Trust processes, particularly recruitment and employee relations, management conduct, and bullying and harassment were the most prevalent. Patient safety concerns continued to be relatively low, though the number of patient safety related concerns being raised via FTSU remained higher than in previous years. The timely resolution of concerns remained a key area of concern to the FTSU Guardian, though the new Raising Concerns Oversight and Triangulation Group was helping in this regard.

Action required by Group Board

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

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committees-in-Common Report

Group Board, 04 July 2024

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees-in-Common at its meeting on 20 June 2024 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

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

2.0 Items considered by the Committees

2.1 At its meeting on 20 June 2024, the Committees considered the following items of business:

20 June 2024
• NHS Staff Survey: Top 10 and lowest 10 performing departments* • Guardian of Safe Working Reports Q4 2023/24 • Group Freedom to Speak Up Report 2023/24 • Workforce Performance Report • Sickness Absence Internal Audit Reports (ESTH and SGUH) • Certificates of Sponsorship Update • Group Board Assurance Framework – Strategic People Risks (SR12, SR13, SR14)*

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

2.2 The Committees are now meeting every two months as previously agreed by the Group Board, and the chairing of the meetings rotates between the Joint Chairs. An informal meeting of the Chairs and CPO take place between Committee meetings.

2.3 The meeting in June 2024 was impacted by a number of apologies, and this impacted on the Committees' consideration of some of the above agenda items. While the SGUH People Committee was quorate for the meeting, the ESTH Committee was not. The Acting Group CPO was ill and unable to attend and the Deputy was not available. The Committee welcomed Humaira Ashraf to the meeting, who was supporting the HR directorate in relation to culture, equality, diversity and inclusion.

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>NHS Staff Survey 2023:</u>

The Committees, and the Group Board, have previously considered in detail the results of the 2023 NHS Staff Survey for both SGUH and ESTH, and have reviewed both the overall

engagement levels and key movements in relation to specific questions in the survey. At its meeting in June, the Committees reviewed an analysis of the departments with the highest and lowest levels of engagement with the staff survey and the triangulation of engagement levels with a number of other key workforce indicators, such as turnover rates, sickness absence rates, mandatory training compliance, appraisal rates, number of employee relations (ER) cases, and number of Freedom to Speak Up (FTSU) concerns. This analysis had been broken down by Trust, and the Committee reviewed the analysis for both SGUH and ESTH.

The Committees noted that there was a clear correlation between staff engagement scores and these other key workforce indicators; departments that manage to maintain low turnover and low sickness rates alongside high training compliance typically report higher staff engagement, and conversely high turnover and sickness absence, along with numerous employee relations cases often correspond with lower engagement scores. The Committee noted that, perhaps unexpectedly, the correlation between engagement scores and FTSU cases was less clear.

The Committees welcomed the detailed analysis of the survey data presented in this form, and agreed that triangulating the data with the wider workforce indictors in the form of heat maps was a useful process which provided helpful insight into those departments within each Trust that may be encountering challenges and may require support. The Committees were keen to ensure that lessons were learnt from those departments that recorded high engagement scores and positive results across the wider workforce metrics. This could help those departments with lower scores and more adverse wider metrics to learn and improve. The Committees recognised that wider factors, such as the cost of living and pressures on the NHS more broadly, could mean some departments are likely to have lower results in line with national issues of staff shortages and high levels of demand e.g. ED. At the same time, the Committees agreed on the importance of leaders and managers across the Group reviewing and owning the data, and taking practical steps to tackle local issues identified through the survey.

The Committees also noted that work was being undertaken by the Executive to develop an ‘insights report’ for the Group that would bring together both hard data and soft intelligence to help identify teams and departments encountering challenges so that the appropriate support and interventions could be put in place at an early stage. The Executive was due to review a first cut of this ‘insights report’ in July and the intention was that this would be presented to Group Board in the coming months.

b) <u>Freedom to Speak Up Report:</u>

The Committees received a report from the newly-appointed Group Freedom to Speak Up (FTSU) Guardian, which set out an analysis of the numbers of concerns raised by staff across the Group in 2023/24 and the trends and themes arising from those concerns.

A total of 211 concerns had been raised via FTSU at SGUH in 2023/24, an increase of 47%, and a total of 269 concerns had been raised via FTSU at ESTH, a reduction of 23% over the same period. Across the Group, the staff groups raising the highest number of concerns were Nursing and Midwifery staff and Administrative and Clerical staff. At SGUH, there had been a significant increase in the number of Administrative and Clerical staff raising concerns in 2023/24, which was principally related to the rise in the number of collective concerns, mainly around Trust processes and, in particular, fairness in recruitment processes. The Committees heard that there was a high level of similarity in the nature of the concerns being raised via FTSU across the Group. Concerns relating to Trust processes, particularly recruitment and employee relations, management conduct,

and bullying and harassment were the most prevalent. Patient safety concerns continued to be relatively low, though the number of patient safety related concerns being raised via FTSU remained higher than in previous years, as had been discussed in some detail by the Committees on previous occasions. The timely resolution of concerns remained a key area of concern to the FTSU Guardian. While most concerns were resolved informally, through advice and signposting, where concerns needed some formal investigation these could often take considerable time to reach a resolution. The Guardian also highlighted the link between concerns being raised and staff going on sick leave. In relation to training, the Committees heard that at SGUH, over 9,200 staff (93.4% of all staff) had completed their FTSU training, which was recommended by the National Guardian's Office (NGO). At ESTH, by contrast, just 80 members of staff had completed the training over the past 5 years.

The Committees were updated on the formation of a new Group-wide FTSU function. A new Group FTSU Guardian had recently been appointed, currently supported by three Deputy Guardians. Work was underway to align systems and processes across the Group, such as escalation processes, recording of data, and implementing the new nationally-mandated FTSU policy. A new case management system had also been implemented from 1 April 2024, which would support the Group in tracking FTSU cases and times for resolution. The new Raising Concerns Oversight and Triangulation Group was assisting in resolving and escalating concerns, and providing a mechanism to share themes and trends in concerns. The Group Board had also completed the FTSU Board Reflection Toolkit at its recent development session in June 2024.

The Committees asked about the disparity in staff training on FTSU across the two Trusts (9,200 trained at SGUH and 80 at ESTH) and heard that while the NGO-recommended training had been incorporated into the Mandatory and Statutory Training (MAST) programme at SGUH, it continued to remain optional at ESTH. The Committees heard that a review of MAST training was underway to define a consistent Group-wide set of MAST training courses and the Committees expressed eagerness for FTSU to be included in this. The Committees also discussed the comparatively high numbers of concerns raised by Administrative and Clerical staff, particularly at SGUH and reflected on the impact of budget controls and the holding of vacancies. The Committees will continue to receive regular reports on FTSU over the coming year and will be keen to see the impact of the work being undertaken to triangulate concerns and speed up the timeliness of resolution of concerns.

c) Fragility of the HR function:

The Committees discussed the ongoing fragility of the HR function and agreed that this constituted a significant risk. The Committee noted that a new substantive Group Chief People Officer would be starting on 1 July 2024 and there was substantial work being done on ensuring that the their induction and onboarding goes well.

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) Guardian of Safe Working Hours Report:

The Committees received the reports of the two Trusts' Guardian of Safe Working Hours. At SGUH, the Committees heard that although exception reports had dropped overall in Q4, acute medicine continued to be an area of particular pressure and shortages of senior anaesthetic registrars continued to be an area of concern. Urology registrars had raised concerns about junior rota cover on weekday evenings and at weekends. At the SGUH Junior Doctors' Forum (JDF), junior doctors raised concerns about writing prescriptions on behalf of Physician Associates (PAs) and the lack of guidance on this and the Committees heard that the Site CMO was co-ordinating work on the governance of Physician Associates within the Trust. At ESTH, the Committees heard that there were no immediate safety concerns during Q4 which contrasted with the situation two years ago in which 46 such concerns had been raised. The ESTH JDF meeting in February had been well attended and was an important source of feedback. The Committees sought assurance that work was being undertaken to identify and address any barriers to reporting and heard that focused work had been undertaken on this and that such work was being progressed on a Group-wide basis. However, this would need to be an ongoing area of focus as it was key that junior doctors felt empowered to raised exception reports without fear of detriment. In relation to Physician Associates, the Committees agreed that they would revisit the management of this new staff group at a future meeting. The Committee recognised the excellent work and the quality of the presentation.

b) Group Board Assurance Framework:

The Committees reviewed the three strategic risks on the new Group Board Assurance Framework (BAF) which had been delegated by the Group Board to the People Committees in Common. The Committees heard that there were no proposed changes to the headline risk scores or assurance ratings for any of the three risks, which was not an unexpected position just three months after agreeing the new BAF. However, a number of updates had been made to the controls and actions to address gaps in control. The most significant completed action was the Group Board's approval of a new Group People Strategy, which provided a framework for addressing various aspects of the risks articulated in the BAF. The progress and completion of the HR restructure was also seen as key to mitigate the risks. The Committees also noted the importance of the new substantive GCPO feeding into the actions and timescales for addressing identified gaps in control. The Committees recommended the risk scores and assurance ratings for SR12, SR13 and SR14 to the Group Board.

5.0 Other issues considered by the Committees

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

a) Sickness Absence Internal Audit Reports:

The Committees received reports from the internal auditors relating to sickness absence at both ESTH and SGUH, which had been referred to the People Committees-in-Common by the Audit Committees of the two Trusts. The ESTH report had been reviewed by the ESTH Audit Committee in February 2024 and the SGUH report had been reviewed at the Audit Committees-in-Common in May 2024. Both internal audit reports had received 'partial assurance' ratings from the internal auditors. The auditors had found that some good controls were in place. At SGUH, these included sickness absence templates, procedures and Occupational Health referral mechanisms. At ESTH, these included the fact there is an up-to-date sickness absence policy, the management of staffing levels and monitoring of key performance indicators. However, importantly, the auditors also identified a number of concerns and gaps in control.

At SGUH the auditors were unable to complete testing in a number of areas such to the lack of information provided by management and, as a result, the review had to assume controls in these areas were lacking. The auditors also highlighted wider gaps and weaknesses in control related to sickness absence policies and procedures, the level of reporting to the Board relating to sickness, and mechanisms to reduce the impact of staff sickness at ward and divisional level. For SGUH, the auditors had raised seven medium priority actions and two low priority actions and the partial assurance rating reflected this.

At ESTH, the auditors highlighted concerns regarding compliance with existing policies for managing sickness absence by line managers, and highlighted that a number of processes, such as maintaining regular contact with sick staff, submitting and recording fit notes, monitoring sickness absence patterns, and completion of return to work interviews were not being followed. The auditors had identified two high priority and four medium priority actions, which had been accepted by management and the partial assurance rating reflected this.

The Committees agreed that, in the absence of the GCPO and Deputy GCPO, it was not possible to have a detailed discussion and that it would need to bring the reports back to a future meeting both to consider the findings and to review and seek assurance regarding the management actions to improve the controls. The Committees noted, however, that sickness absence had significant implications both on teams and the wider financial position of the two Trusts. The Committees agreed that tackling these issues should be high on the new GCPO's priorities on her arrival.
The Committee also discussed how far the issues were a lack of policy and controls from HR and how far these existed but were not always being used by line managers. The Committees noted that the Audit Committees-in-Common had requested a detailed update on progress at its December 2024 meeting, with a verbal update at its September 2024 meeting, and they agreed to add the sickness absence audit reports and management actions to its forward plan to ensure appropriate oversight by the People Committees until the control environment was improved significantly.

b) Workforce Performance Report:

The Committees received the Workforce Performance Report for Month 1 (April) 2024/25, which set out key workforce metrics covering vacancy rates, turnover, sickness absence, core skills compliance, appraisal compliance and employee relations activity across the Group. In the absence of the GCPO and Deputy GCPO, the Committee agreed that a detailed discussion was not possible and that it would need to revisit the data at its next meeting. The Committee, however, noted that: the vacancy rate at ESTH was 11.45% for month 1, which was above the 10% vacancy rate that had been established. By contrast, the SGUH vacancy rate stood at 6.36% for the same period. Vacancy rates in the 'estates and ancillary' staff group were particularly high (25.19% at ESTH and 19.92% at SGUH) and the Committees references their previous discussions about these areas and agreed that it would be important to seek assurance on the impact of this and how the gaps were being managed once the new Group Chief Infrastructure, Facilities and Environment Officer was in post. Turnover rates across the Group are 0.99% (0.93% at ESTH and 1.05% at SGUH). Both Trusts reported monthly sickness absence rates above their respective targets: at ESTH the sickness absence rate was 5.15% against a target of 3.8%; at SGUH, sickness absence stood at 4.67% against a target of 3.2%. Core skills compliance was 84% at ESTH and 91% at SGUH against a KPI of 85%. With the exception of medical and dental staff, appraisal rates continued to be below the 90% target.

6.0 Recommendations

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

Group Board

Meeting in Public on Thursday, 04 July 2024

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

Executive Summary

The report sets out the key issues discussed and agreed by the Audit Committees-in-Common at its inaugural meeting on 17 May 2024:

- Annual Report and Accounts 2023/24: The Committee was assured by the progress on completing the annual report, annual accounts, and quality report ahead of the national deadline for submission on 28 June 2028. The Committees also received updates on the external audit work at both Trusts. The Audit Committees have separately met since the Committees-in-Common meeting on 17 May to recommend these to the Board.

- Internal Audit: The Committee reviewed six internal audit final reports, four for SGUH and two for ESTH. The Committees discussed, in particular, those which had receive 'partial' assurance conclusions; sickness absence and cyber assessment framework at SGUH; and and VTE at ESTH. The Committees reviewed the draft Head of Internal Audit Opinions for both Trusts for 2023/24 and encouraged management to engage earl with the 2024.25 internal audit plan to avoid a large number of final audit reviews being completed towards the end of the year. Good progress continued to be made in relation to following up on previous internal audit actions at both Trusts.

- Counter Fraud: In terms of the Counter Fraud Annual Reports, both SGUH and ESTH returns proposed 'green' ratings for the two Trusts, with the Trusts assessed as fully compliant with the requirements, with supporting evidence of the counter fraud work undertaken.

Action required by the Board

The Board is asked to note the report of the inaugural Audit Committees-in-Common meeting held on 17 May 2024.

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

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

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in substantive reports presented to the Board.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

Report of the Audit Committees-in-Common

Group Board, 04 July 2024

1.0 Purpose of paper

1.1 The Audit Committees-in-Common met on 17 May 2024 for its first meeting in an 'in common' format. This was a positive first meeting in this format, which ensured appropriate Trust-level oversight of the year-end processes given that the two Trusts remain separate statutory entities while supporting Group-wide learning across a range of compliance and control issues. The Committees agreed to bring the following matters to the attention of the Group Board.

1.2 The Committees each held further meetings on 12 June 2024 to review the Annual Reports and Accounts 2023/24 prior to Board approval. Thes were held on a Trust-specific basis, rather than an 'in-common' format and a report on these separate meetings has been provided to the separate Trust Boards.

2.0 Audit Committee Report

2.1 Annual Report, Accounts and Quality Accounts – Update

The Committee was updated on the preparation of the two Trusts' Annual Reports. The deadline for submission to NHS England was 28 June 2023 and advanced drafts of the reports had been shared with the Group Executive and the Audit Committee Chair. Further drafts incorporating feedback would be shared with the Group Chairman and all Audit Committee members ahead of the final review by each Trust's Audit Committees on 12 June 2024. In relation to the Quality Reports, the Committee heard that the drafts were well advanced in their preparation. As the Quality Committees-in-Common were now meeting on a bi-monthly basis, the intention was to share the reports with Quality Committee members for comment on email circulation ahead of Audit Committee and Trust Board review. The Audit Committees-in-Common welcomed the progress made with both the Annual Reports and Quality Reports and, in particular, endorsed the work undertaken to align, as far as possible within the regulatory framework, the content of the reports to present a consistent Group-wide narrative.

2.2 External Audit 2023-24 Update

The Committees received updates on the external audits underway at both SGUH and ESTH, which were being led by separate audit teams. The Committees heard that good progress was being made on the audits at both Trusts, the auditors were working well with the finance teams, and that there were no issues to report to the Committee though significant work remained to be completed prior to the Audit Committee meetings scheduled for 12 June. The Committees recognised the pressures on the finance team caused by managing two separate audits of accounts, and noted that the planned restructure of the finance teams at the two Trusts as part of the Group Corporate Services Integration programme would help ease these pressures next year. For both Trusts, there had been slight delays in the submission of the first draft of accounts and a second submission was required, but NHS England had been made aware in advance.

2.3 Internal Audit Progress Report

The Committees received a report setting out progress against the agreed 2023/24 internal audit plan for each Trust. For SGUH, four final internal audit reports had been completed since the SGUH Audit Committee last met in February: Risk Management (reasonable assurance); Medical Devices (reasonable assurance); Productivity – Sickness Absence (partial assurance); Cyber Assessment Framework (partial assurance). Three draft reports had also been issued (Venous Thromoembolism; Key Financial Controls; and Data Quality), the completion of which

had been material to the auditors being able to issue a Draft Head of Internal Audit Opinion (HOIA), but these had recently been completed and the auditors were still working with management on the findings and actions. For ESTH, two final audit reports had been issued since the ESTH Audit Committee last met in February 2024: Risk Management (reasonable assurance); and Venous Thromboembolism (partial assurance). Three draft reports had also been issued but, as with the SGUH draft reports, these had recently been completed and were yet to be agreed with management (Data Quality, Theatre Utilisation, and Key Financial Controls). The Committees agreed that in the interests of completing the 2023/24 internal audit plan in a timely way, and avoiding a knock-on impact on the 2024/25 plan, the separate Trust Audit Committee meetings in June 2024 would consider these outstanding audit reports.

In terms of follow-up to previous internal audit actions, the Committees heard that work was progressing well and, in the case of SGUH, had contributed materially to the auditors being able to issue a Draft HOIA. At SGUH, of 24 open internal audit actions, 18 had been evidenced as implemented and were closed, five actions were in progress with new revised dates, and evidence was awaited to close one further action. A total of 11 actions are not yet due and would be followed up in due course. At ESTH, of 36 open actions, 25 actions had been implemented and were closed, 7 actions were in progress with revised dates, and evidence was awaited in relation to 4 further actions. A total of 11 actions were not yet due and would be followed up at the appropriate time.

2.4 Final Internal Audit Reports

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

- Risk Management (reasonable assurance – ESTH and SGUH): This audit had been undertaken separately at both Trusts and the Committee considered these together so that appropriate Group-wide learning could be considered. The audits had focused on the new Group Board Assurance Framework and the outcome of reasonable assurance was welcomed. The Committee noted that the risk appetite statement, which had been agreed by the Group Board in approving the BAF, would be integrated into a new Group Risk Management Policy, which would be presented to the Committee for review in the autumn. The Committees also heard that a document library was being introduced to ensure that all assurances on the BAF could be evidenced and retrieved as required. The Committees received the reports for ESTH and SGUH and welcomed the helpful recommendations to further strengthen controls.

- Medical Devices (reasonable assurance - SGUH): The Committees welcomed the reasonable assurance rating and that the review had identified a number of good controls in relation to medical devices at SGUH. There was a robust policy framework in place for the management and maintenance of medical equipment and all were up-to-date. There was effective reporting on performance. The Trust had struggled to maintain some targets, such as having zero open jobs beyond eight weeks. Management had agreed the three actions identified by the auditors.

- Cyber Assessment Framework (partial assurance - SGUH): The report had reached a conclusion of partial assurance and had identified three high priority and four medium priority actions. The Committee was informed the review's findings reflected wider IT issues and needed to be considered in the context of the wider Group IDT programme. The review had identified known gaps in Trust processes and polices which would be addressed and planned into programmes of work. The actions related to data security and data loss prevention, data encryption, and business resilience. The Committees heard that the current digital plan was not extensive and that it was easy for pressures to build. As the Group Digital Plan was developed the question of what level of resource

was allocated to different priority areas. The IDT team would also need to utilise existing tools and consider how they could be leveraged to try and contain costs.

- Productivity – Sickness Absence (partial assurance - SGUH): The SGUH review followed an earlier sickness absence audit at ESTH, which had also received 'partial assurance', and been reported to the ESTH Audit Committee in February 2024. The SGUH report had identified one high priority action, six medium and two low priority actions, which had been agreed with management. While the audit highlighted some good controls which were in place (e.g. sickness absence templates, procedures and Occupational Health referral mechanisms), the auditors were unable to complete testing in a number of areas due to lack of information provided by management. As a result, for the sake of the audit, the auditors had needed to assume controls in these areas were lacking. The areas where actions had been raised related to: the sickness absence policy, which needed updating, the review of other sickness related procedures, the level of detail reported to the People Committee and Board on sickness absence, action taken to reduce sickness absence triggers, and mechanisms to reduce the impact of sickness absence at ward and divisional levels. The Committees heard that the sickness absence policy had been updated but was currently with the unions for feedback. The disciplinary ad grievance policies were also being updated. The Committees also heard that HR would be working closely with the Communications team on messaging around the importance of managing sickness. The Committees considered the audit report to be helpful, particularly when triangulated against the similar ESTH audit. The recommendations in relation to when periods of sickness were taken – i.e. coinciding with typical holiday periods – needed review and follow up, with actions taken where appropriate where staff were abusing the system. The Committee considered that this needed to be a key focus for the Executive team. The Committees felt there was an overreliance on HR to improve performance on sickness absence, and considered that more needed to be done to ensure line managers at all levels saw the management of sickness as a key part of their roles. The Committees also reflected that previous action plans appeared to have had little material impact in addressing the issue and encouraged management to implement evidence-based actions drawing on best practice from other organisations. The Committees also agreed that sickness absence needed greater visibility at Board level due to its significant cost implications. The Audit Committees-in-Common referred this report, along with the ESTH equivalent, to the People Committees-in-Common for ongoing oversight of actions to address the issues identified as the Board Committee responsible for people issues, but also asked that a full written update on progress be provided to the Audit Committee in December 2024 with an interim update in September 2024.

- Venous Thromboembolism (partial assurance - ESTH): There were two high priority and eight medium priority management actions. The particular areas for improvement were in relation to the Trust's VTE assessment and management, despite increased focus on performance, with the Trust continuing to perform below the national target. However, good practice was also identified particularly in AMU at St Helier and Maternity at both Epsom and St Helier Hospitals. The Committees recognized that the audit had been requested as VTE had been an area of challenge at ESTH, and management had looked for the review to help identify areas of focus to implement actions to address issues. The Committee welcomed the report, noting the challenge of implementing the management actions without implementation of the shared EPR. It also noted that the work underway to integrate teams and processes across SGUH and ESTH would also assist in sharing best practice and learning across the Group.

The Committees welcomed the progress in completing these reviews. It heard that the internal auditors were seeking early management approval of the scopes for Q1 and Q2 2024/25 reviews in order to ensure the 24/25 internal audit programme was more evenly spread through the year, with less pressure at the end of the year. This would require Executive engagement with signing of the scopes. The Committees also requested that the auditors update their reporting templates to ensure that a management response was contained within the audit reports, even if this was simply to state agreement with the findings and recommendation. This would be implemented for the 2024/25 internal audit programme.

2.5 Head of Internal Audit Opinion (HOIA) 2023/24

The Committees received the draft HOIA reports for both SGUH and ESTH. For each Trust, the auditors had issued draft HOIAs with 'reasonable assurance', concluding that each organisation had adequate and effective frameworks for risk management, governance and internal control but with further enhancements having been identified through the internal audit programme in 2023/24. The reports were issued in draft and were updated for the separate Audit Committees held in June, which received the remaining audit reviews that had been issued as draft reports to management at the time of the May meeting of the Audit Committees-in-Common. At ESTH, a total of 9 internal audit reviews had been issued, 7 of which had been issued as final including 5 reasonable assurance reviews and two partial assurance reviews (the June ESTH Audit Committee meeting received two further reasonable assurance reviews). At SGUH, a total of 7 audits had been completed, 5 of which had been issued as final including 3 reasonable assurance and two partial assurance reviews (the June SGUH Audit Committee received (one reasonable assurance and one partial assurance). For SGUH, the number of completed internal audit reviews was significantly less than scheduled and the issuing of a 'reasonable assurance' HOIA for the year had been marginal, and owed much to the progress achieved in completing follow-ups to previous audits. For 2024/25, the Committees looked to management to engage more proactively with the audit programme and welcomed the plans to ensure monthly attendance of the internal auditors at the Group Executive meetings to promote engagement and drive forward progress.

2.6 Group Counter Fraud Quarterly Report, Annual Report and Self Assessment

The Committees considered a regular report on progress with current and new counter fraud cases under investigation across the Group. There had been 9 new referrals since the February meetings of the two Audit Committees, with 5 referrals at SGUH and 4 at ESTH. Counter Fraud had closed 12 cases since February 2024 and there were 14 open investigations currently in progress. The Committees also noted that the Home Office had reinstated SGUH to an 'A'-rated licence for issuing certificates of sponsorship to staff from overseas following previous concerns reported to the Board. In terms of the Counter Fraud Annual Reports, both SGUH and ESTH returns proposed 'green' ratings for the two Trusts, with the Trusts assessed as fully compliant with the requirements, with supporting evidence of the counter fraud work undertaken. The Committees noted the actions to address two amber rated components around fraud and bribery risks. The Committees also noted the year-on-year improvements in declarations of interest compliance by staff, on which there was a separate report on the agenda.

2.7 Group Breaches and Waivers Report

The Committees considered the regular breaches and waivers report for Q4 2023/24, which was presented on a Group-wide basis. The Committee was told there had been the expected increase in the usage of waivers over the final quarter of the year. At SGUH, the number of waivers increased to 23 up from 13 in Q3. The overall value also increased to £8,867,515 (£527,791 in Q3). At ESTH, number of waivers increased to 10 (4 in Q3). There was an increase in overall value to £803,546 (£608,933 in Q3). The increase in use was being driven by the number of significant capital programmes at ESTH. However, the Committee noted the increase in usage at both Trusts had not been as significant as in previous years. The incidences of breaches at both Trusts remained static and saw an overall decrease in value. The Committees

noted that the Group was still committed to introducing 'No PO No Pay' acknowledging implementation had been challenging. The procurement team continued to work with suppliers to minimise risk of disruption during its introduction.

2.8 Group Information Governance and Cyber Security Update

The Committees received an update reporting on the preparations for the submission of the final full Data Security Protection Toolkit (DSPT) by end of June 2024. The baseline assessment had been submitted at the end of February 2024. The IDT team had completed 44 of the toolkit's 108 mandatory requirements at time of the meeting with most of the remaining requirements related to technical controls and measures which would be completed after the penetration testing which is expected to be completed 15 days ahead of submission. Compliance for DSPT staff Data Security Awareness training is currently 91.8% for SGUH and 82.5% for ESTH. The two Trusts are no longer required to achieve the national 95% compliance target and the Group Training Needs Analysis (TNA) target has set 90% compliance to be achieved. This was expected to be met by both Trusts by time of the final submission of the DSPT. The Committees welcomed the assurances for the submission of the DSPT. The GCFO gave further assurances of senior management oversight of the DSPT submission at both Trusts in his capacity as the Senior Information Risk Owner (SIRO). The Committees noted the challenge of capital and resources across the Group but were assured that there are processes already in place to ensure critical work is prioritised. The Committees noted the latest iterations of the cyber dashboard which require further development noting they had not incorporated the trends data and maturity index previously requested by the Committee, which looked forward to receiving a more developed iteration of the dashboard in September.

2.9 Review of Shadow IT systems (SGUH)

The Committees received an update on management actions in response to an internal audit review undertaken by the previous auditors which considered SGUH's approach to the issue of shadow IT systems across SGUH. The original management responses to the review had been acknowledged as being insufficient. The paper presented to Committee outlined the revised IDT management approach to managing shadow IT at SGUH, though the work has been done in collaboration with ESTH IDT colleagues, aligning approaches as part of the work to develop Group digital standards. The Committee noted that work was ongoing to: implement a framework for managing and controlling risks associated with shadow IT systems; prioritise those systems which would have the greatest impact in the event of failure; bring more systems under centralised control of IDT; and introduce a Group-wide policy for shadow IT. The Committee will receive an update on progress at its meeting in September 2024.

2.10 Annual Review of Conflicts of Interests Compliance

The Committees received a report setting out compliance at both Trusts with the national requirements for managing conflicts of interests in 2023/24. SGUH had achieved 74% compliance for 'decision-making' staff (those at Band 8b and above, all consultants, and all staff in certain teams) making declarations of interests in 2023/24. This represented an increase of 8% on the previous year. ESTH had achieved 81% compliance which was also an 8% increase from 2022/23. The Committees noted the actions being taken forward to drive up compliance to 85% and above in 2024/25. There will also be auditing of a limited sample of declarations by decision-making staff during 2024/25, particularly those staff members working in high-risk areas. In addition, there will be an increased focus on the declaration of gifts and hospitality by all members of staff, accompanied by a communications campaign during the year to raise awareness of the rules relating to gifts and hospitality. The Committees welcomed the progress in improving compliance over 2023/24 and endorsed the proposed approach for improving compliance further in 2024/25 and prioritise high risk areas.

2.10 Review of Audit Committee Effectiveness and Committee Annual Reports 2023/24

The Committees received the outcomes of the Committee effectiveness reviews for the SGUH and ESTH Audit Committees for 2023/24, which had been undertaken separately. Albeit based

on a limited number of returns, the results from the effectiveness reviews had shown the overwhelming view that the Committees were operating effectively. The majority of comments about improvement were focused on how the Committees could work effectively as Committees-in-Common in 2024/25. The Committees noted the two Committees' Annual Reports which draw out the key areas of work over 2023/24. The Committees also reviewed and endorsed minor adjustments to the Terms of Reference to each Committee, which had been updated to strengthen areas of shared learning for the Committees. The 2024/25 forward workplan for the Audit Committees-in-Common drew on guidance from the National Audit Office, the NHS Audit Committee handbook, the terms of reference as well as previous committee experience, and this was also endorsed by the Committees.

3.0 Recommendation

3.1 The Board is asked to note the report of the Committee's meeting held on 1 February 2024

Peter Kane
Audit Committee Chair, NED
July 2024

Group Board

Meeting on Thursday, 04 July 2024

Agenda Item	2.4.1	
Report Title	**SGUH and ESTH Audit Committee Annual Reports and Annual Committee effectiveness reviews 2023/24**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

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

This report sets out the outcomes of the Committee effectiveness reviews undertaken for the SGUH and ESTH Audit Committees for the financial year 2023/24, and presents an annual report of the work of each Trust's Audit Committee over the same period.

In February 2024, the Group Board agreed that the Audit Committees of the two Trusts would meet in 2024/25 as Committees-in-Common. The terms of reference for each Trust's Audit Committee has been reviewed in light of both the Committee effectiveness reviews and in the context of the move to meeting as Committees-in-Common. Some minor amendments to each Committee's terms of reference are proposed, which have been reviewed and endorsed by the Audit Committees-in-Common. The report also sets out some practical steps for further strengthening the two Committees' effectiveness over the year ahead. Finally, the report presents a draft forward work plan for the Audit Committees-in-Common for 2024/25.

The Audit Committees reviewed and approved the Committee annual reports 2023/24, terms of reference, forward plan, and Committee effectiveness reviews at the first meeting held as an Audit Committees-in-Common on 17 May 2024.

Action required by Group Board

The Board is asked to:

a. Receive and note the annual reports from the SGUH and ESTH Audit Committees which sets out how the Committees fulfilled their respective terms of reference in 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Review and endorse the proposed forward workplan for the Committees for 2024/25;
d. Receive and note the outcomes of the 2023/24 Committee effectiveness review for each Trust's Audit Committee.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	SGUH Audit Committee Annual Report 2023/24: • Committee Annual Report • Terms of Reference Review • Committee Effectiveness Review
Appendix 2	ESTH Audit Committee Annual Report 2023/24: • Committee Annual Report • Terms of Reference Review • Committee Effectiveness Review
Appendix 3	Audit Committees-in-Common forward plan 2024/25

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications relating to this report. The Committee's terms of reference and forward workplan set out how the Committee will oversee and provide assurance to the Board that effective plans are in place to provide assurance on governance, risk, internal control and financial management.

Legal and / or Regulatory implications

There is a statutory requirement for all Trusts to have Audit Committees in place.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

SGUH and ESTH Audit Committee Annual Reports to the Group Board

Group Board, 04 July 2024

1.0 Purpose of paper

1.1 This paper provides the Group Board with the annual reports of the work of the SGUH and ESTH Audit Committees in 2023/24, which includes a review of each Committee's terms of reference, a draft forward plan of business for the 2024/25 for the Committees meeting in an 'in common' format, and a summary of the outcomes of the two Trusts' Committee effectiveness reviews for 2023/24.

2.0 Background

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

2.2 In 2023/24, the Audit Committees of the two Trusts met separately. The effectiveness reviews were therefore undertaken separately for each Committee, and an annual report for 2023/24 has been prepared for each Committee. With the two Trusts' Audit Committees meeting as Audit Committees-in-Common in 2024/25, next year's Committee effectiveness review will be undertaken on a Group-wide basis, as has been the case for the other Board Committees in 2023/24.

3.0 Audit Committee Annual Reports for SGUH and ESTH

3.1 The Annual Reports for the SGUH and ESTH Audit Committee for 2023/24 are set out at Appendices 1 and 2 respectively. The draft reports sets out:

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

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

4.0 Terms of Reference Review

4.1 In line with good governance practice, the terms of reference for the two Committees have been reviewed. Given that the terms of reference were redrafted at the start of 2022/23 the approach adopted to the review has been to revise and update the terms of reference where needed rather than to start again and define an entirely new terms of reference.

4.2 With this in mind, the principal changes to each Committee's terms of reference:

- Updates references to reflect the development of a Group Board Assurance Framework
- Makes clear the practice already agreed by the two Audit Committees for ensuring learning is identified from the internal audit programmes across the Group
- Clarifying how the Audit Committees-in-Common will submit reports to the Group Board

4.3 The changes to each Trust's Audit Committee terms of reference are set out at Appendices 1 and 2 respectively.

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

5.0 Committee Forward Workplan 2024/25

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

5.2 The forward workplan for the Audit Committees-in-Common for 2024/25 is set out at Appendix 3. This has been developed drawing on the previous forward plans of the two Committees, the terms of reference, and the NHS Audit Committee Handbook. The plan will, however, be a living document and will flex as appropriate during the year to accommodate unforeseen issues.

6.0 Committee Effectiveness Review 2023/24

6.1 The SGUH and ESTH Audit Committees undertook Committee effectiveness reviews in the Spring of 2024. The results of this are set out in Appendices 1 and 2 respectively. The summary report draws out the key themes from the review.

6.2 The key messages emerging from the effectiveness review are that, overall, the Committee is working effectively, that respondents fed back that the Committees are operating extremely or very effectively. Relatively few suggestions were put forward for how the Committees can improve their effectiveness for the year ahead, but the main feedback centred around ensuring the benefits of working as Committees-in-Common while maintaining effective safeguards in light of the two Trusts being separate statutory organisations.

7.0 Recommendations

7.1 The Board is asked to:

a. Receive and note the annual reports from the SGUH and ESTH Audit Committees which sets out how the Committees fulfilled their respective terms of reference in 2023/24;
b. Review and endorse the proposed minor changes to each Committee's terms of reference;
c. Review and endorse the proposed forward workplan for the Committees for 2024/25;
d. Receive and note the outcomes of the 2023/24 Committee effectiveness review for each Trust's Audit Committee.

SGUH Audit Committee Annual Report 2023/24

1 April 2023 – 31 March 2024

Contents

Audit Committee Annual Report 2023/24

1. Introduction

This report sets out the work of the Audit Committee of St George's University Hospitals NHS Foundation Trust during the reporting period 1 April 2023 to 31 March 2024. It provides a high level overview of the Committee's work over the past year and sets out how the Committee has discharged its responsibilities as set out in its terms of reference over the past year, in line with good corporate governance practice.

2. Committee purpose and duties

The Audit Committee has been established to ensure that that the Trust has in place effective mechanisms and systems of internal control and to provide the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee's purpose and duties are set out in its terms of reference as approved by the Trust Board on 7 July 2023. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Provide appropriate challenge and support whilst living the Trust's values.
- Seek assurance that the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2023 to March 2024), the following were members or regular attendees of the Audit Committee:

St George's Audit Committee			
Name	Role	Designation	Period
Peter Kane	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 March 2024
Ann Beasley	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Tim Wright	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Yin Jones	Member	Associate Non-Executive Director	1 April 2023 – 31 March 2024
Andrew Grimshaw	Attendee	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
George Harford	Attendee	Site Chief Financial Officer	1 April 2023 – 31 March 2024

Other executive directors and senior leaders including the Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Director of Procurement, and the local counter fraud specialist also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews. In addition, internal auditors and external auditors attended each of the meetings.

3.2 Committee meeting attendance

In 2023/24 the quorum for each meeting of the Committee was two members. For avoidance of doubt only non-executive directors are members of the Committee.

The Committee held a total of 5 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committee were quorate.

Name	Role	Attendance
Peter Kane	Committee Chair	5/5
Ann Beasley	Member	4/5
Tim Wright	Member	5/5
Yin Jones	Member	3/5

In line with the requirements that the Committee should only comprise non-executive directors as members, the following individuals were not members of the Committee and did not form part of the quorum but regularly attended the Committee during 2023/24:

Name	Role	Attendance
Andrew Grimshaw	Group Chief Finance Officer	5/5
Stephen Jones	Group Chief Corporate Affairs Officer	5/5
George Harford	Site Chief Financial Officer	4/5

4. Committee activity and focus

4.1 External Audit and Year End

During the period the Committee received regular progress updates at each meeting from the external auditors, Grant Thornton LLP, on the preparations for and completion of the external audit of the Trust year-end financial statements, the annual report and the quality accounts during the period. The Committee supported the completion of a successful audit process of the 2022/23 financial year. The Committee reviewed the plans for conducting the 2023/24 audit and agreed to recommend to the Board the audit fee for the 2023/24 audit.

The Committee continued to hold private meetings with the external auditors before the start meetings during 2023/24. There were no issues of material concern raised during these meetings. This is a practice the Committee will continue in 2024/25.

4.2 Internal Audit

Following the appointment of RSM UK from April 2023 as the new internal auditors for both St George's University Hospitals and Epsom and St Helier University Hospitals, the Committee approved the 2023/24 audit workplan at its June 2023 meeting.

A delayed start to the audit programme, due to the point in the year a decision on the appointment of a new auditor was made, has meant that the internal audit programme has been back-loaded, and the Committee is reviewing a number of the final internal audit reports for the Trust at its May 2024 meeting, which will feed into the preparation of the 2023/24 Head of Internal Audit Opinion. At the time of writing this report, the internal auditors are working to deliver their workplan and have issued the following final reports:

- Risk management – Reasonable Assurance
- Medical Devices - Reasonable Assurance
- Sickness Absence – Partial Assurance
- Cybersecurity - Partial Assurance

The following reports have been issued in draft to management which are scheduled to be agreed at the next meeting:

- Data Quality
- Key Financial Controls
- Rostering

During 2023/24 Committee also received two late assurance reports from 2022/23 which had been give limited assurance opinions by the Trust's previous auditors. There were for:

- IT Systems not supported by Central IT
- Cybersecurity

For the review of IT Systems not supported by Central IT, management had acknowledged that engagement with and responses to the audit had been inadequate at the time. This had been partially due to the audit coinciding with a significant infrastructure incident which necessitated prioritisation of resource. The Committee considered recommendations to strengthen the controls and improve governance in relation to ICT which should result in improved assurance in future. The Committee received further assurance that future audits will see leads engage fully with internal reviews and provide timely responses to recommendations as well as strengthened processes for signing-off on final reports.

The limited assurance for Cybersecurity was not accepted by management, which queried the accuracy of review's findings and with some of the conclusions reached. The Committee received reassurance that programmes have been put in place to ensure readiness and preparedness for responding to incidents, as well as raising staff awareness of cybersecurity. In response to concerns from the Committee, it was agreed to bring forward the scheduled audit for Cybersecurity so Members could be assured on existing controls.

The Committee's scrutiny of the internal audit recommendation tracker, with the support of Executive leads, resulted in the outstanding recommendations being proactively progressed and a total of 18 management actions have been confirmed as being implemented during

2023/24. The Committee will continue to monitor the implementation of the remaining outstanding recommendations over the coming year.

In addition, given the appointment of a common internal auditor across the St George's, Epsom and St Helier University Hospitals and Health Group, the Committee approved a framework to ensure internal audit reviews undertaken at one Trust within the Group are shared with the 'other' Trust, and that appropriate learning is taken from these reports across the Group. All internal audit reports are shared with members of both Trust's Audit Committees. The Committee also seeks assurance from management that reviews have been shared and have been reviewed by the 'other' Trust – with a short summary of actions taken or assurance as to why existing controls are considered effective and how areas of good practice have been disseminated

The Committee also approved the draft internal audit workplan for 2024/25, developed in accordance with the five-year internal audit strategy with input from the Group Executive. The workplan reflects the greater integration and alignment at Group level with the programme including audits which test Trust-specific controls; audits to be taken at both SGUH and ESTH as well as mandatory audits which would be undertaken at both Trusts. Preliminary work on the 2024/25 plan commenced in the final quarter of 2023/24 to ensure a consistent release of final audit reviews over the next year.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditors, a core element of the Committee's focus in 2023/24 was monitoring the Trust's corporate governance, compliance and systems for internal control.

The Committee received updates on the management of conflicts of interest across the Trust and welcomed an improvement in compliance of decision-making staff in making declarations of interest in 2023/24. By 31 March 2024, 77% of decision-makers at St George's had filed a declaration of interest. This represented an 8% increase in compliance at year end, up from 69% of staff in 2022/23. The Committee heard that the clinical divisions, where the highest proportion of decision-makers are employed, mostly achieved over the 80% compliance target. However, the Committee noted that while the number of Trust locum and Bank staff making declarations had increased in 2023/24, the compliance rate was only 24%. The Committee considered recommendations to increase compliance further in 2024/25, including specific actions to target divisions where compliance was low, as well as awareness raising campaigns and utilising the support of the Group Chief Medical Officer in stressing the importance of clinical colleagues submitting their declarations of interest.

At its meeting in February 2024, the Committee endorsed a proposal that it should meet as a Committee-in-Common with the Epsom and St Helier Audit Committee from April 2024, recognising that it was an appropriate point of time in the Group's formation as well increasing alignment in meeting agendas. The Committee was assured by safeguards which would maintain the appropriate accountability of each Audit Committee of each Trust as separate statutory bodies. These would include holding separate meetings to review the Annual Report and Accounts and receive external auditor reports, as well making the appropriate arrangements for ensuring Trust specific decisions are taken by the appointed Members of each committee.

The proposal was agreed by the Group Board at its meeting in February 2024. The establishment of a committee-in-common realises the benefits of the gesh Group model to

facilitate more efficient meetings management as well enabling greater sharing of learning between the two committees.

The Committee received quarterly reports on use of waivers, as well as provided oversight of the management of losses and special payments. The Committee also received updates on the recovery plan to improve the Trust's performance against the Better Payment Practice Code. The Committee welcomed the reported improvements in performance due to improved operational processes, governance and enhanced training and compliance.

In addition, the Committee reviewed counter fraud arrangements and considered issues and themes raised by the Local Counter Fraud Specialist.

4.4 Trust Annual Report and Accounts

In June 2023, the Committee endorsed the final draft annual report, annual accounts and quality accounts for 2022/23 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2022/23. The report was prepared in line with NHS Foundation Trust Annual Reporting Manual. The Annual Report and Accounts were received by the Trust Board on 27 June and were subsequently submitted to NHS England.

The Value for Money (VfM) Report for 2022/23 highlighted the challenges facing the Trust on financial sustainability. The report identified the criticality of achieving sufficient Cost Improvement (CIP) Plan savings to meet challenging CIP targets to meet achieve its forecast deficit plan. The Committee was informed the CIP challenges and wider concerns around financial sustainability are replicated regionally and nationally. Over 2023/24 the Trust has engaged with its system partners in developing a financial recovery plan to return the system to a balanced position in 2024/25.

In February 2024, the Committee reviewed and agreed plans for the production of the 2023/24 annual report and accounts and also agreed both the accounting policies and the external audit plan and fees for 2023/24.

4.5 Cybersecurity

The Committee received regular reports on the Trust's cybersecurity resilience and how well the Trust is prepared to respond to potential cybersecurity threats. The Committee continued to receive regular updates on the development of a cybersecurity dashboard, as well as updates on how digital and information teams are increasingly aligned and taking a Group-wide approach to matters of shared interest and concerns. The Committee also received updates on the work underlying the annual submission of its Data Security and Protection Toolkit.

5. Committee Effectiveness

The Audit Committee conducted a review of its effectiveness in 2023/24, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. Overall, albeit on a low response rate, respondents to the survey scored the performance and effectiveness of the Committee as either extremely effective or very effective. The main area to focus on in the year ahead is embedding the new arrangements for the Committee operating as a Committees-in-Common with the ESTH Audit Committee and realising the benefits of this while ensuring that each Committee maintains appropriate oversight of the separate systems of governance, risk, internal control and the separate accounts and audit

programmes. Other, more minor, areas to focus on are improving the cover sheets for reports and the timeliness of papers.

6. Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2024/25 is attached (see Appendix 3). The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2024/25 reflects the principles set out in the NHS Audit Committee Handbook and reflects the required matters for the Committee's review. The key point to flag in relation to the 2024/25 forward plan is that it has been developed in the context of the decisions of the SGUH and ESTH Boards that the Audit Committees of the two Trusts will meet as Audit Committees-in-Common in 2024/25.

The proposed Committee workplan for 2024/25 draws out elements of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year.

The Committee's terms of reference have been reviewed. The only proposed changes to the terms of reference, are to insert reference to the Group Board Assurance Framework in section 4(a) iv and to refer to the Committee operating as a Committees-in-Common in its reporting to the Group Board.

7. Conclusion

During 2023/24, the Committee worked hard to deliver its duties as set out in its terms of reference. Its overall effectiveness is reflected in the Committee effectiveness review for 2023/24. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give a reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

SGUH Audit Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

The Audit Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. Purpose

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust’s activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust’s arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust’s Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

(a) Governance, Internal Control and Risk Management: The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Group Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality and Safety Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.
vii. Oversee and provide assurance to the Board on the robustness of the Trust's governance, internal control and risk management arrangements in relation to the Trust's participation in the St George's, Epsom and St Helier University Hospitals and Health Group.

(b) Internal audit: The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.
v. Consider any areas of learning from internal audit reviews conducted across the St George's, Epsom and St Helier University Hospitals and Health Group

(c) External audit: The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also work with the Council of Governors on the appointment or retention of the external auditors.

(d) Financial reporting and accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

(f) Raising concerns: The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

(g) General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.
v. Review the Trust's governance, internal control and risk management arrangements in the context of the St George's, Epsom and St Helier University Hospitals and Health Group.

(h) Management: The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

(i) Annual work plan and Committee effectiveness: Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Membership and Attendance

A Non-Executive Director will chair the Audit Committee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Corporate Affairs Officer and Chief Financial Officer are the Executive Leads for the Audit Committee.

The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair, and one Associate Non-Executive Director.

Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

The following are regular attendees at the Committee:

- Group Chief Financial Officer
- Group Chief Corporate Affairs Officer
- Managing Director – SGUH
- Site Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that director's portfolio. At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Counter Fraud Lead
- Head of Technical Accounting – for the Annual Accounts
- Group Chief Nursing Officer and/or the Group Director of Compliance – for the Quality Account
- Group Chief Communications and Engagement Officer – for the Annual Report

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

6. Quorum

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

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

7. Declarations of Interest

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion.

8. Meeting Frequency

Meetings of the Committee shall be held quarterly.

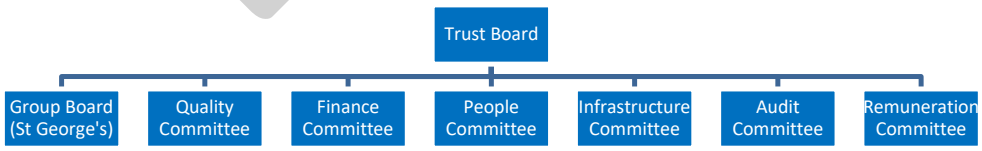
An additional extraordinary meeting will be held to review the external auditor's report and recommend the adoption of the annual report and accounts to the Trust Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

9. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year.
ii. The Group Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than five working days ahead of the meeting.

10. Relationship with other groups and committees

The Committee will report to the Trust Board as shown below.



11. Report to Board

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

Under the Group Board arrangements, the Committee Chair, acting as chair of a Group-wide Audit Committees-in-Common, will report to the Group Board on the meetings that have taken place since the last Group Board meeting. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance and matters for escalation to the Group Board

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

12. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

13. Annual cycle of business

An annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

14. Review of Committee Effectiveness and Terms of Reference review

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

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Trust Board.

Document Control

Profile	
Document name	Audit Committee Terms of Reference
Version	2.1
Executive Sponsor	Group Chief Corporate Affairs Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	17 May 2024
Date of Trust Board approval	TBC – 4 July 2024
Date for next review	July 2025

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St George's Audit Committee

Committee Effectiveness Review 2023/24

Stephen Jones
Group Chief Corporate Affairs Officer

May 2024

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University Hospitals and Health Group

1. Introduction

Purpose, context and recommendations

Purpose

This paper presents the outcomes of the Committee effectiveness survey for the Audit Committee for 2023/24. The report highlights the key themes that emerge and summarises the feedback received and proposes areas for the Committee to consider in how it can further improve its effectiveness in 2024/25, particularly as the Committee begins holding meetings as a Committees-in-Common with the ESTH Audit Committee.

Background and context

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

Summary

Overall, albeit on a low response rate, respondents to the survey scored the Committee as either extremely effective or very effective. The main area to focus on in the year ahead is embedding the new arrangements for the Committee operating as a Committees-in-Common with the ESTH Audit Committee and realising the benefits of this while ensuring that each Committee maintains ap[propriate oversight f the separate systems of governance, risk, internal control and the separate accounts and audit programmes. Other, more minor, areas to focus on are improving the cover sheets for reports and the timeliness of papers.

Recommendation

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

Next steps

Based on the Committee's discussion, actions to improve the Committee's effectiveness will be considered alongside discussion of the 2024/25 workplan and terms of reference at the May meeting.

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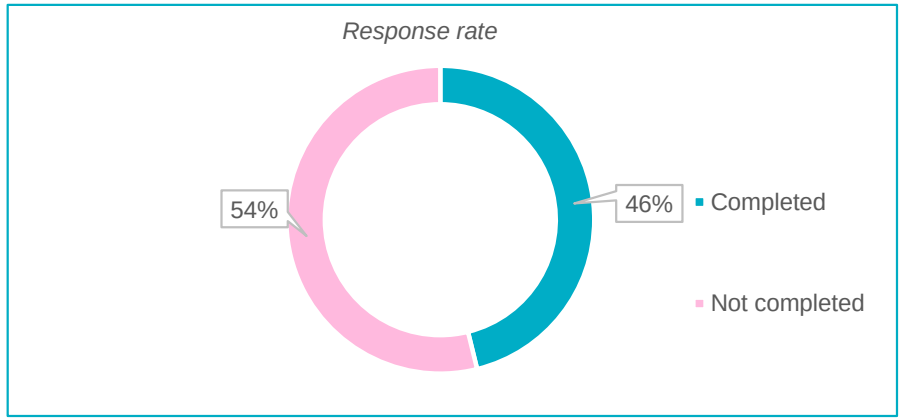
2. Engagement

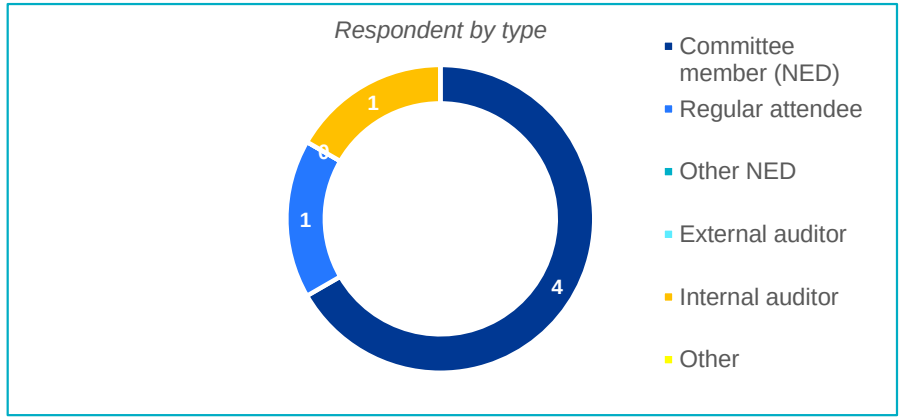
Response rate and respondent types

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

- Members of the Committee (non-executive)
- Regular attendees as set out in the Committee's terms of reference (Group CFO, Group CCAO, MD-SGUH, Group CDO, Site CIO)
- Other executives who had areas subject to internal audit in the course of the year
- Internal auditors
- External auditors

In total, 13 people were invited to participate in the survey. Of these a total of 6 engaged with and provided responses to the survey, a response rate of 46%.





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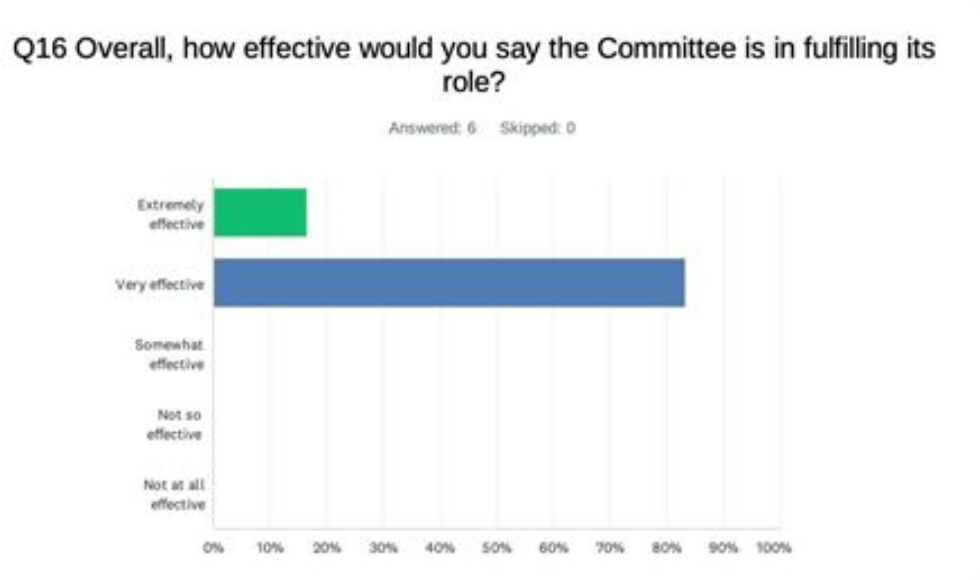
3. Key findings

Overall effectiveness

Question 16 of the survey asked respondents to rate the overall effectiveness of the Committee:

- Extremely effective
- Very effective
- Somewhat effective
- Not so effective
- Not at all effective

No respondents rated the Committee as “somewhat effective”, “not so effective” or “not at all effective”. 1 respondent stated the Committee is “extremely effective” and 5 rated the Committee as “very effective”.



3. Key findings

Overall effectiveness

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

- **Audit Committee membership and skils:** All respondents agreed or strongly agreed that there was good attendance by Committee members, regular attendees, auditors, and others as required, and that members of the Committee understood their role and the expectations of them. Respondents also agreed or strongly agreed that the Committee collectively has the range of skills needed to ensure the Board receives the assurance that it needs on audit, finance, cyber security, governance, risk and internal control.

- **Scope:** All respondents agreed or strongly agreed that the Committee's terms of reference are fit for purpose and appropriate for its remit. In relation to the Committee's forward plan, all respondents either agreed or strongly agreed that the forward plan is fit for purpose and covers the right issues with appropriate frequency.

- **Agendas, papers and meetings:** All respondents agreed that papers for the Committee were circulated in a timely way. One free text comment stated that papers can sometimes be late, but noted that steps are being introduced to address this. All respondents felt there was time on the agenda to explore issues in appropriate depth. One comment did raise that timing issues do occur on occasion when internal audit reports are received by the Committee which do not have fully developed management responses. Another comment highlighted the usefulness of the Non-Executives' meetings with the auditors prior to meetings as this allowed Members to agree specific areas of the agenda to focus on. All respondents agreed that papers for the Committee are clear, concise and provide enough information for the Committee to take informed decisions. All respondents agreed or strongly agreed that meetings of the Committee are chaired effectively, with one comment praising the Chair for their effectiveness and inclusivity.

3. Key findings

Overall effectiveness

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

- **Roles and responsibilities:** Across the subject specific issues for which the Committee holds responsibility, all responses provided indicated the Committee discharges its responsibilities effectively, for example in providing effective assurance to the Board, understanding the Trust's operating environment, key risks to the Trust's business, reviewing financial statements, monitoring internal control, reviewing accounts, reviewing risks of fraud, reviewing outputs of internal audit work, reviewing work of external auditors.

- **Reporting and escalation:** Reporting to the Board was seen to be effective or extremely effective, with no issues raised in relation to the Committee's reports and all agreeing on strongly agreeing that the reports sufficiently describe the matters considered by the Committee and that they provide the Board with an understanding of the level of assurance gained.

- **Scope to improve effectiveness:** The comments provided by respondents all touched on how to realise the benefits of operating as a committees-in-common with the Epsom and St Helier Audit Committee in 2024/25. One respondent commented that acting as committees-in-common could help derive synergies to improve committee effectiveness over the coming year. Another commented that acting as committee-in-common should allow Members greater understanding of performance of similar functions at each Trust as well using recommendations from audits to ensure lessons are learned across the Group. A third comment again highlighted that variances across the Group would realise opportunities for shared learning.

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4. Next steps

"So what" and "what now"?

The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25.

- **Realise the benefits of working as a Committees-in-Common:** The Committee has previously discussed how the Committees-in-Common approach can yield benefits in terms of identifying and embedding cross-Group learning, particularly in relation to internal audit and corporate compliance. The mechanism to achieve this has previously been discussed with the Committee, and going forward reports will draw out the areas of learning more explicitly in reporting. Likewise, the Committee has discussed how to ensure there are appropriate safeguards in place given that the two Trusts remain separate statutory entities with their own separate systems of internal control, and separate accounts and audit programmes. It is suggested that we have a stocktake session in December to reflect on what is working well, and what can be further improved in terms of working as a Committees-in-Common.

- **Continue to make use of pre-meetings for Committee members and auditors:** Committee members reported these were useful, and these will be planned in on a rolling basis through 2024/25.

- **Improve timeliness of papers:** Although generally less of an issue for the Audit Committee than some committees, there is a need to ensure the full pack of papers goes out to the Committee a week ahead of the meeting to enable Committee members to review and digest the reports.

- **Cover sheets:** As with other Committees, report authors and responsible Executives to ensure that cover sheets to reports to the Committee provide an effective overview and draw out the salient issues for discussion and review, as well as identifying learning.

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ESTH Audit Committee Annual Report 2023/24

1 April 2023 – 31 March 2024

Contents

Audit Committee Annual Report 2023/24

1. Introduction

This report sets out the work of the Audit Committee of Epsom and St Helier University Hospitals NHS Foundation Trust during the reporting period 1 April 2023 to 31 March 2024. It provides a high level overview of the Committee's work over the past year and sets out how the Committee has discharged its responsibilities as set out in its terms of reference over the past year, in line with good corporate governance practice.

2. Committee purpose and duties

The Audit Committee has been established to ensure that that the Trust has in place effective mechanisms and systems of internal control and to provide the Board of Directors with an independent review of the Trust's financial, corporate governance, assurance and risk management processes. It utilises, oversees and draws on the work of independent internal and external auditors to provide assurance that these systems are sound and being adhered to across all areas of the Trust.

The Committee's purpose and duties are set out in its terms of reference as approved by the Trust Board on 7 July 2023. These set out that the Committee should:

- Provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement.
- Oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance.
- Review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.
- Provide appropriate challenge and support whilst living the Trust's values.
- Play a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives.

3. Membership and attendance

3.1 Members and attendees

During the reporting period (April 2023 to March 2024), the following were members or regular attendees of the Audit Committee:

St George's Audit Committee			
Name	Role	Designation	Period
Peter Kane	Member	Committee Chair, Non-Executive Director	1 April 2023 – 31 March 2024
Ann Beasley	Member	Non-Executive Director	1 April 2023 – 31 March 2024
Aruna Mehta	Member	Non-Executive Director	1 April 2023 – 31 January 2024
Martin Kirke	Member	Non-Executive Director	1 February 2024 – 31 March 2024
Andrew Grimshaw	Attendee	Group Chief Finance Officer	1 April 2023 – 31 March 2024
Stephen Jones	Attendee	Group Chief Corporate Affairs Officer	1 April 2023 – 31 March 2024
Lizzie Alabaster	Attendee	Site Chief Financial Officer	1 April 2023 – 31 March 2024

Other executive directors and senior leaders including the Epsom and St Helier Site Managing Director, Group Chief People Officer, Group Chief Nursing Officer, Group Chief Medical Officer, Director of Procurement, and the local counter fraud specialist also attended meetings of the Committee during the year to present specific reports or provide updates on internal audit reviews. In addition, internal auditors and external auditors attended each of the meetings.

3.2 Committee meeting attendance

In 2023/24 the quorum for each meeting of the Committee was two members. For avoidance of doubt only non-executive directors are members of the Committee.

The Committee held a total of 7 meetings during the reporting period and the attendance of members and regular attendees as defined in the Terms of Reference are set out below. All meetings of the Committee were quorate.

Name	Role	Attendance
Peter Kane	Non-Executive Director, Committee Chair	7/7
Ann Beasley	Non-Executive Director	5/7
Aruna Mehta*	Non-Executive Director	4/7
Martin Kirke**	Non-Executive Director	1/1

*Term as Non-Executive Director ended 31 January 2024.
** Appointed as member of Committee from 1 February 2024.

In line with the requirements that the Committee should only comprise non-executive directors as members, these individuals were not members of the Committee and did not form part of the quorum.

Name	Role	Attendance
Andrew Grimshaw	Group Chief Finance Officer	7/7
Stephen Jones	Group Chief Corporate Affairs Officer	6/7
Lizzie Alabaster	Site Chief Financial Officer	7/7

4. Committee activity and focus

4.1 External Audit and Year End

The completion of the 2022/23 Annual Accounts audit proved to be challenging with the final accounts being submitted in September 2023 rather than June as required by NHS England guidance. At its meeting in February 2024, The Committee considered a report detailing the

lessons learned from the audit and the accompanying actions to address the issues raised following the review of the audit conducted by the Finance Team as well as the respective review held by the external auditors. The responses to the review should ensure potential issues in future audits are addressed earlier.

The auditors issued an unqualified opinion for the year-end accounts, remuneration report and Staff report 2022/23. Two high level significant risks relating to revenue recognition and the valuation of Trust's land and building assets were identified and the Trust have implemented actions plan to respond to these risks.

The External Audit Value for Money Report highlighted financial sustainability as a significant weakness. This reflects the challenging cost improvement programmes the Trust needed to achieve, as well as the systemwide financial environment.

The Committee continued to hold private meetings with the external auditors before the start of meetings during 2023/24. There were no issues of material concern raised during these meetings. This is a practice the Committee will continue in 2024/25.

The Committee also received initial briefings from the GCFO outlining the expected process for going out to tender for a shared external auditor with SGUH in 2024/25.

4.2 Internal Audit

Following the appointment of RSM UK from April 2023 as the new internal auditors for both Epsom and St Helier University Hospitals and St George's University Hospitals, the Committee approved the 2023/24 workplan at the June 2023 meeting, with the audit programme mapped to the Trust's strategic risks and objectives.

A delayed start to the audit programme, due to the point in the year a decision on the appointment of a new auditor was made, has meant that the internal audit programme has been back-loaded. Over 2023/24 the internal auditors have carried out 12 reviews. At the time of writing, the auditors have issued four final internal audit review reports for:

- Surrey Downs and Sutton Health Care Alliance – Reasonable Assurance
- Cost Improvement Plans – Reasonable Assurance
- Job Planning – Reasonable Assurance
- Risk Management – Reasonable Assurance
- Sickness Absence – Partial Assurance
- Venous Thromboembolism (VTW) – Partial Assurance

The following reports have been issued in draft to management which are scheduled to be agreed at the next meeting:

- Data Quality
- Productivity - Theatre Utilisation
- Rostering
- Key Financial Controls

Work on the review of cybersecurity is ongoing and will be presented to the Committee in 2024/25.

The Committee was pleased to receive reasonable assurance for the reports for Surrey Downs and Sutton Health Care Alliance, Cost Improvement Plans and Job Planning. The Trust was found to have good management and governance structures in place, areas of good practice, and controls and processes and related policies and procedures were found to be well designed.

The partial assurance for sickness absence highlighted areas of concerns and three high level recommendations have been raised.

The Committee also received a final internal audit report from the previous auditors for Medical Staffing – Guardian of Safe Working, which received moderate assurance for the strength of controls embedded at the Trust.

The auditors have also followed up on 26 open internal audit recommendations, including management actions handed over from the previous auditors. 15 recommendations have been implemented. Two actions were waiting on management responses, with the remaining nine recommendations in progress and with new revised completion dates. The Committee will continue to monitor the implementation of these over the coming year.

In addition, given the appointment of a common internal auditor across the St George's, Epsom and St Helier University Hospitals and Health Group, the Committee approved a framework to ensure internal audit reviews undertaken at one Trust within the Group are shared with the 'other' Trust, and that appropriate learning is taken from these reports across the Group. All internal audit reports are shared with members of both Trust's Audit Committees. The Committee also seeks assurance from management that reviews have been shared and have been reviewed by the 'other' Trust – with a short summary of actions taken or assurance as to why existing controls are considered effective and how areas of good practice have been disseminated.

At its meeting in February 2024, the Committee approved the 2024/25 internal audit workplan which was designed to reflect the greater integration and alignment at Group level with the programme including audits which would test Trust-specific controls; audits to be taken at both Epsom and St Helier and St George's as well as mandatory audits which would be undertaken at both Trusts. Preliminary work on the 2024/25 plan commenced in the final quarter of 2023/24 to ensure a consistent release of final audit reviews over the next year.

4.3 Governance, Internal Control and Risk Management and Governance Manual

In addition to reviewing the outputs of external and internal auditors, a core element of the Committee's focus in 2023/24 was monitoring the Trust's corporate governance, compliance and systems for internal control.

The Committee received updates on the management of conflicts of interest across the Trust and welcomed an improvement in compliance of decision-making staff in making declarations of interest in 2023/24. By 31 March 2024, 81% of decision-makers at Epsom and St Helier had filed a declaration of interest up from 73% in 2022/23, an 8% increase at year end. The Committee heard that the clinical divisions, where the highest proportion of decision-makers are employed, mostly achieved over the 80% compliance target. However, Estates and Facilities decision makers had only a 58% compliance rate. The Committee considered recommendations to increase compliance further in 2024/25, including specific actions to target divisions where compliance was low, as well as awareness raising

campaigns and utilising the support of the Group Chief Medical Officer in stressing the importance of clinical colleagues submitting their declarations of interest.

At its meeting in February 2024, the Committee endorsed a proposal that it should meet as a Committee-in-Common with the St George's Audit Committee from April 2024, recognising that it was an appropriate point of time in the Group's formation as well increasing alignment in meeting agendas. The Committee was assured by safeguards which would maintain the appropriate accountability of each Audit Committee of each Trust as separate statutory bodies. These would include holding separate meetings to review the Annual Report and Accounts and receive external auditor reports, as well making the appropriate arrangements for ensuring Trust specific decisions are taken by the appointed Members of each committee. The proposal was agreed by the Group Board at its meeting in February 2024. The establishment of a committee-in-common realises the benefits of the gesh Group model to facilitate more efficient meetings management as well enabling greater sharing of learning between the two committees.

As well as regularly reviewing the use of waivers, write-offs and special payments, the Committee also reviewed counter fraud arrangements and considered issues and themes raised by the Local Counter Fraud Specialist.

4.4 Trust Annual Report and Accounts

In September 2023, the Committee endorsed the final draft annual report, annual accounts and quality accounts for 2022/23 along with the external auditor's opinions and assurance of the production and the true and accurate nature of the financial reports for 2022/23. The Annual Report and Accounts were received by the Trust Board on 25 September ahead of being submitted to NHS England.

The Value for Money found that the most significant risks for the Trust were financial sustainability and financial governance. The report also noted the significant challenge in delivering a deficit budget with demanding cost improvement programmes.

In February 2024, the Committee received an update from the External Audit lead partner on the plans and preliminary work already underway for the production of the 2023/24 annual report and accounts.

4.5 Cybersecurity

The Committee received regular reports on the Trust's cybersecurity resilience and how well the Trust is prepared to respond to potential cybersecurity threats. Members also received regular iterations for development of cybersecurity dashboard. There were also updates on the continued alignment of planning and work at Group-wide level. The Committee also received updates on the work underlying its annual submission of the Data Security and Protection Toolkit.

5. Committee Effectiveness

The Audit Committee conducted a review of its effectiveness in 2022/23, which sought the views of both members and regular attendees. The full report is attached in Appendix 4. Overall, albeit on a low response rate, respondents to the survey scored the performance and effectiveness of the Committee as either extremely effective or very effective.

The main area to focus on in the year ahead is embedding the new arrangements for the Committee operating as a Committees-in-Common with the ESTH Audit Committee and realising the benefits of this while ensuring that each Committee maintains appropriate oversight of the separate systems of governance, risk, internal control and the separate accounts and audit programmes. Other, more minor, areas to focus on are improving the cover sheets for reports and the timeliness of papers.

6. Committee Forward Plan and Terms of Reference

The Committee's proposed forward work plan for 2024/25 is attached (see Appendix XX). The nature of Committee means that key aspects of its work are driven by the work of the internal auditors, external auditors and counter fraud teams. The workplan for 2024/25 reflects the principles set out in the NHS Audit Committee Handbook and reflects the required matters for the Committee's review. The key point to flag in relation to the 2024/25 forward plan is that it has been developed in the context of the decisions of the SGUH and ESTH Boards that the Audit Committees of the two Trusts will meet as Audit Committees-in-Common in 2024/25.

The proposed Committee workplan for 2024/25 draws out elements of the Committees terms of reference for focus over the coming year, including review of the Group Board Assurance Framework, review of the new Group-wide Risk Management Policy and Process, review of the new Group-wide approach to the management of Group- and Trust-wide policies, and internal controls in relation to raising concerns. It is proposed that this focus, rather than changes to the scope of the Committee, will help it further enhance its effectiveness for the coming year.

The Committee's terms of reference have been reviewed. The only proposed changes to the terms of reference, are to insert reference to the Group Board Assurance Framework in section 4(a) iv and to refer to the Committee operating as a Committees-in-Common in its reporting to the Group Board.

7. Conclusion

During 2023/24, the Committee worked hard to deliver its duties as set out in its terms of reference. Its overall effectiveness is reflected in the Committee effectiveness review for 2023/24. Through the work of the Committee the external auditors found no new areas unknown to the Trust that gave cause for concern and reflecting on the Head of Internal Audit Opinion the Committee can give a reasonable assurance rating on the Trust's internal controls, mechanisms and systems of corporate governance.

ESTH Audit Committee

Terms of Reference

1. Name

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

2. Establishment and Authority

The Audit Committee has been established as a Committee of the Trust Board. It is a statutory Committee as set out in the NHS Act 2006 (as amended) and is accountable to the Trust Board. Its constitution and terms of reference are as set out below, subject to amendment by the Board as necessary.

The Audit Committee is authorised by the Board of Directors to:

i. Investigate any activity within its terms of reference
ii. Seek any information it requires and all staff are required to cooperate with any request made by the Committee
iii. Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary

This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. Purpose

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust’s activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust’s arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust’s Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. Duties

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

(a) Governance, Internal Control and Risk Management: The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.
vii. Oversee and provide assurance to the Board on the robustness of the Trust's governance, internal control and risk management arrangements in relation to the Trust's participation in the St George's, Epsom and St Helier University Hospitals and Health Group.

(b) Internal audit: The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.
v. Consider any areas of learning from internal audit reviews conducted across the St George's, Epsom and St Helier University Hospitals and Health Group

(c) External audit: The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also make recommendations to the Board on the appointment or retention of the external auditors.

(d) Annual Report and Accounts review: The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation, the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

(e) Counter Fraud, Bribery and Corruption Arrangements: The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

(f) Raising concerns: The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

(g) Cybersecurity and information governance: The Committee shall review the adequacy and effectiveness of:

i. Structures, systems, processes and controls in place in relation to information governance in the Trust and approve the submission of the annual Information Governance Toolkit submission on behalf of the Board of Directors.

ii. Structures, systems, processes and controls in relation to cybersecurity.

(h) General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.
v. Review the Trust's governance, internal control and risk management arrangements in the context of the St George's, Epsom and St Helier University Hospitals and Health Group.

(i) Management: The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

(j) Annual work plan and Committee effectiveness: Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. Membership and Attendance

A Non-Executive Director will chair the Audit Committee and his/her absence, an individual to be nominated by the remaining members of the Committee will take the chair.

The Chief Corporate Affairs Officer and Chief Financial Officer are the Executive Leads for the Audit Committee.

The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair.

Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

The following are regular attendees at the Committee:

- Group Chief Financial Officer
- Group Chief Corporate Affairs Officer
- Managing Director – ESTH
- Site Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that director's portfolio. At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Counter Fraud Lead
- Head of Technical Accounting – for the Annual Accounts
- Group Chief Nursing Officer and/or the Group Director of Compliance – for the Quality Account
- Group Chief Communications and Engagement Officer – for the Annual Report

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

6. Quorum

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

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

7. Declarations of Interest

All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes.

Anyone with a relevant or material interest in a matter under consideration may be excluded from the discussion.

8. Meeting Frequency

Meetings of the Committee shall be held quarterly.

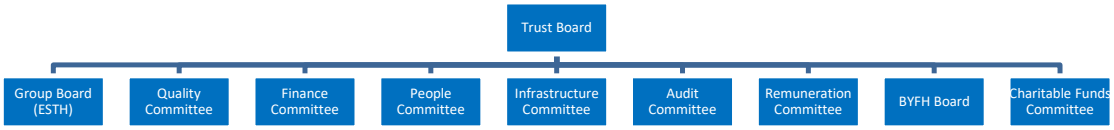
An additional extraordinary meeting will be held to review the external auditor's report and recommend the adoption of the annual report and accounts to the Trust Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

9. Meeting arrangements and Secretarial support

i. An annual schedule of meetings of the Audit Committee shall be established prior to the start of each financial year;
ii. The Group Chief Corporate Affairs Officer will oversee the provision of secretariat support for the Audit Committee. This will include taking accurate minutes, producing an action log and issuing follow up actions, ensuring that the planning for and outcomes of Committee meetings are shared appropriately.
iii. The agenda for the meeting will be agreed and compiled through discussion between the Committee Chair and Executive Leads.
iv. All papers and reports to be presented at the Audit Committee must be submitted as final executive approved reports on the Tuesday one week before the meeting.
v. The agenda and supporting papers for the meeting will be circulated not less than five working days ahead of the meeting.

10. Relationship with other groups and committees

The Committee will report to the Trust Board as shown below:



11. Report to Board

Under the Group Board arrangements, The Committee Chair, acting as Chair a Group-wide Audit Committees-in-Common will prepare a report for the Group Board after each meeting of the Committee. This will set out the key issues considered at each meeting and the degree to which the Committee was assured on these, specifically highlighting any areas in which there is a lack of assurance and matters for escalation to the Group Board

The Committee will, in addition, prepare an annual report to the Board setting out the key areas of focus in the previous financial year.

12. Agenda

Agendas for Committee meetings will be drawn from the Committee's annual cycle of business (forward plan) and will be agreed with the Committee Chair.

13. Annual cycle of business

An annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

14. Review of Committee Effectiveness and Terms of Reference review

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

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Audit Committee including the delivery of its purpose, compliance with the terms of reference and progress against its planned forward cycle of business. Any changes to the Terms of Reference require the approval of the Trust Board.

Document Control

Profile	
Document name	Audit Committee Terms of Reference
Version	2.1
Executive Sponsor	Group Chief Corporate Affairs Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	17 May 2024
Date of Trust Board approval	TBC – 4 July 2024
Date for next review	July 2025

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ESTH Audit Committee

Committee Effectiveness Review 2023/24

Stephen Jones
Group Chief Corporate Affairs Officer

May 2024

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

1. Introduction

Purpose, context and recommendations

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

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

Summary
Overall, albeit on a low response rate, respondents to the survey scored the Committee as either extremely effective or very effective.

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

Next steps
Based on the Committee's discussion, actions to improve the Committee's effectiveness will be considered alongside discussion of the 2024/25 workplan and terms of reference at the May meeting.

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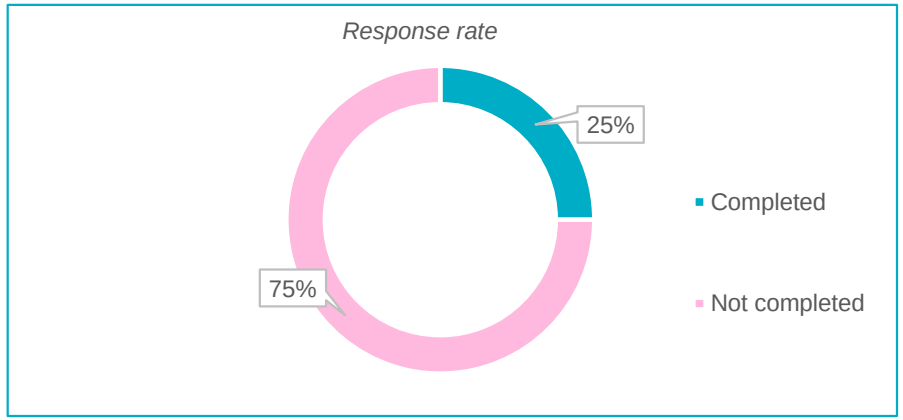
2. Engagement

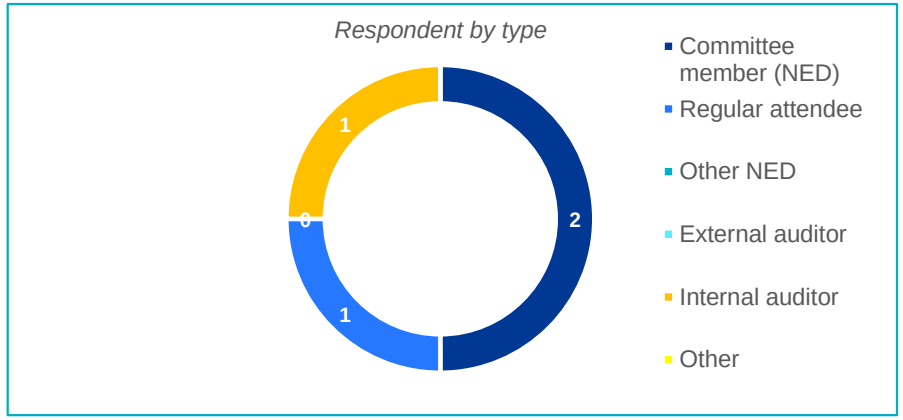
Response rate and respondent types

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

- Members of the Committee (non-executive)
- Regular attendees as set out in the Committee's terms of reference (Group CFO, Group CCAO, MD-ESTH, Group CDO)
- Other executives who had areas subject to internal audit in the course of the year
- Internal auditors
- External auditors

In total, 12 people were invited to participate in the survey. Of these a total of 4 engaged with and provided responses to the survey, a response rate of 25%.





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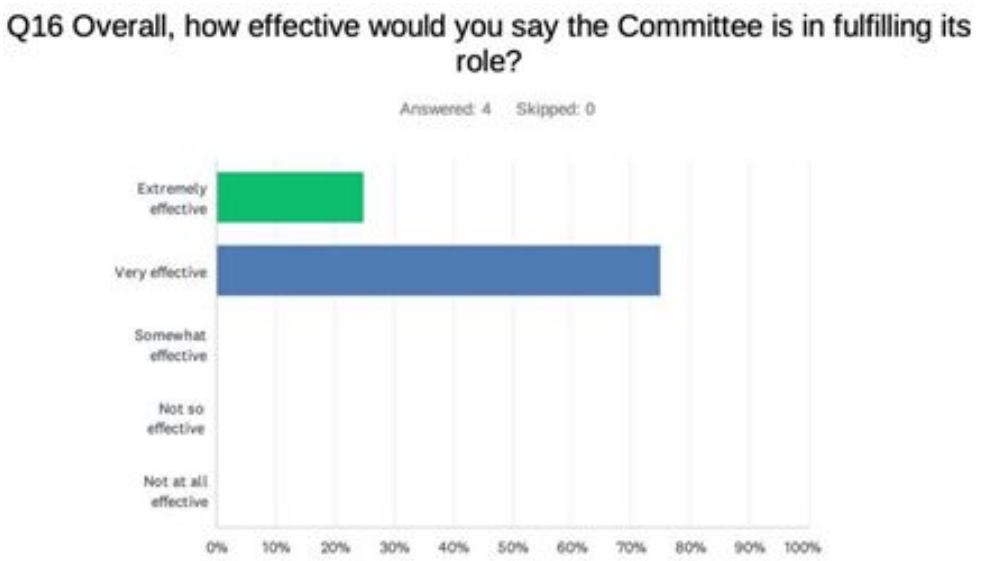
3. Key findings

Overall effectiveness

Question 16 of the survey asked respondents to rate the overall effectiveness of the Committee:

- Extremely effective
- Very effective
- Somewhat effective
- Not so effective
- Not at all effective

No respondents rated the Committee as either “not so effective” or “not at all effective”. 1 respondent stated the Committee is “extremely effective”, and 3 rated the Committee as “very effective”.



3. Key findings

Overall effectiveness

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

- **Audit Committee membership and skils:** All respondents agreed or strongly agreed that there was good attendance by Committee members, regular attendees, auditors, and others as required, and that members of the Committee understood their role and the expectations of them. Respondents also agreed or strongly agreed that the Committee collectively has the range of skills needed to ensure the Board receives the assurance that it needs on audit, finance, cyber security, governance, risk and internal control.

- **Scope:** All respondents strongly agreed that the Committee's terms of reference are fit for purpose and appropriate for its remit. In relation to the Committee's forward plan, all respondents either agreed or strongly agreed that the forward plan is fit for purpose and covers the right issues with appropriate frequency.

- **Agendas, papers and meetings:** All respondents agreed that papers for the Committee were circulated in a timely. One free text comment stated that papers can sometimes be late and said steps are being introduced to address this. All respondents felt there was time on the agenda to explore issues in appropriate depth, with one comment highlighting that meetings do not feel rushed. All respondents agreed that papers for the Committee are clear, concise and provide enough information for the Committee to take informed decisions. All respondents fed back that meetings of the Committee are chaired effectively, with the Committee providing insight and constructive challenge on matters within its remit.

3. Key findings

Overall effectiveness

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

- **Roles and responsibilities:** Across the subject specific issues for which the Committee holds responsibility, all responses provided indicated the Committee discharges its responsibilities effectively, for example in providing effective assurance to the Board, understanding the Trust's operating environment, key risks to the Trust's business, reviewing financial statements, monitoring internal control, reviewing accounts, reviewing risks of fraud, reviewing outputs of internal audit work, reviewing work of external auditors. There was one comment asking whether the approach to counter fraud could be more systematic and with greater focus on prevention.

- **Reporting and escalation:** Reporting to the Board was seen to be effective, with no issues raised in relation to the Committee's reports and all agreeing on strongly agreeing that the reports sufficiently describe the matters considered by the Committee and that they provide the Board with an understanding of the level of assurance gained.

- **Scope to improve effectiveness:** The two comments from respondents focused on the benefits to be derived from the move to the Committee acting as a committees-in-common with the St George's Audit Committee in 2024/25. One comment highlighted the opportunity to develop a Group-wide perspective, using reporting to bring to attention the variance between the two and the opportunities for sharing best practice and learning. The second comment was in relation to the Committee being able to maximise the potential benefits of operating as a committees-in-common, while stressing the importance of ensuring statutory duties continue to be met.

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4. Next steps

"So what" and "what now"?

The Committee is asked to review the following actions to aid the effectiveness of the Committee in 2024/25.

- **Realise the benefits of working as a Committees-in-Common:** The Committee has previously discussed how the Committees-in-Common approach can yield benefits in terms of identifying and embedding cross-Group learning, particularly in relation to internal audit and corporate compliance. The mechanism to achieve this has previously been discussed with the Committee, and going forward reports will draw out the areas of learning more explicitly in reporting. Likewise, the Committee has discussed how to ensure there are appropriate safeguards in place given that the two Trusts remain separate statutory entities with their own separate systems of internal control, and separate accounts and audit programmes. It is suggested that we have a stocktake session in December to reflect on what is working well, and what can be further improved in terms of working as a Committees-in-Common.

- **Continue to make use of pre-meetings for Committee members and auditors:** Committee members reported these were useful, and these will be planned in on a rolling basis through 2024/25.

- **Improve timeliness of papers:** Although generally less of an issue for the Audit Committee than some committees, there is a need to ensure the full pack of papers goes out to the Committee a week ahead of the meeting to enable Committee members to review and digest the reports.

- **Cover sheets:** As with other Committees, report authors and responsible Executives to ensure that cover sheets to reports to the Committee provide an effective overview and draw out the salient issues for discussion and review, as well as identifying learning.

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Audit Committees-in-Common - Committee Forward Work Plan 2024/25

ITEM TITLE	LEAD	ACTION	FORMAT	FREQUENCY	May-24	12/06/2024 - SGUH	12/06/2024 - ESTH	Sep-24	Dec-24	Feb-25
Welcome and Apologies	Chairman	Review	Verbal	Every meeting	✓	✓	✓	✓	✓	✓
Declarations of Interest	All	Review	Verbal	Every meeting	✓	✓	✓	✓	✓	✓
Minutes of previous meetings	Chairman	Assure	Report	Every meeting	✓	✓	✓	✓	✓	✓
Action Log and matters arising	Chairman	Assure	Report	Every meeting	✓	✓	✓	✓	✓	✓
Annual Report, Accounts & Quality Accounts: Plan, Timetable & High level Themes (ESTH and SGUH)	Committee Chair	Review	Report	Annual						✓
Full Draft Annual Reports & Quality Reports (ESTH and SGUH)	Committee Chair	Review	Report	Annual	✓					
Annual Accounts, Financial Statements, Going Concern Statement including NHS Debt Write-off and Value for Money Report (Fi	Committee Chair	Review	Report	Annual		✓	✓			
Final Draft Annual Report including Remuneration, Workforce Report, Annual Governance Statement etc. (SGUH & ESTH)	Committee Chair	Approve	Report	Annual		✓	✓			
Annual Quality Accounts (Final) (SGUH & ESTH)	Committee Chair	Approve	Report	Annual		✓	✓			
Accounting Policies	Committee Chair	Approve	Report	Annual						✓
External Audit Progress Reports (SGUH and ESTH)	External Auditor	Assure	Report	Every meeting	✓			✓	✓	✓
Annual Audit Plan & Fees (SGUH and ESTH)	External Auditor	Approve	Report	Annual						✓
External Audit Findings (Final) (SGUH and ESTH)	External Auditor	Approve	Report	Annual		✓	✓			
Letter of Representation (Financial Audit) (Final) (SGUH and ESTH)	External Auditor	Approve	Report	Annual		✓	✓			
Reports to Council of Governors - Quality (Account) Report and Limited Assurance Opinion (Final) (SGUH only)	External Auditor	Approve	Report	Annual		✓				
External Audit Annual Audit Letters (SGUH and ESTH)	External Auditor	Approve	Report	Annual		✓	✓			
Internal Audit Progress Report (SGUH and ESTH)	Internal Auditor	Review	Report	Every meeting	✓			✓	✓	✓
Internal Audit Recommendation Tracker (SGUH and ESTH)	Internal Auditor	Review	Report	Every meeting	✓			✓	✓	✓
Final Internal Audit Review Reports (SGUH and ESTH)	Internal Auditor	Review	Report	Every meeting	✓			✓	✓	✓
Draft Internal Audit Plan (Draft) (SGUH and ESTH)	Internal Auditor	Review	Report	Annual					✓	
Draft Internal Audit Plan (Final) (SGUH and ESTH)	Internal Auditor	Review	Report	Annual						✓
Draft Annual Report & Head of Internal Audit Opinion (Draft) (SGUH and ESTH)	Internal Auditor	Review	Report	Annual	✓					
Draft Annual Report & Head of Internal Audit Opinion (Final) (SGUH and ESTH)	Internal Auditor	Review	Report	Annual		✓	✓			
Counter Fraud Quarterly Update Reports (SGUH and ESTH)	Local Counter Fraud Service	Review	Report	Every meeting	✓			✓	✓	✓
Counter Fraud Annual Report & Self-Assessment (SGUH and ESTH)	Local Counter Fraud Service	Review	Report	Annual	✓					
Counter Fraud Work Plan and Risk Assessment Annual (SGUH and ESTH)	Local Counter Fraud Service	Review	Report	Annual						✓
Review of Anti-Fraud/Anti-Bribery Policy (every three years)	Local Counter Fraud Service	Note	Report	Every three years						
Losses & Special Payments (SGUH and ESTH)	GCNO	Note	Report	Biannual				✓		✓
Breaches & Waivers (SGUH and ESTH)	GCNO	Note	Report	Every meeting	✓			✓	✓	✓
Aged Debt (SGUH and ESTH)	GCPO	Note	Report	Biannual				✓		✓
Information Governance / Cybersecurity update (SGUH and ESTH)	GCFO	Note	Report	Every meeting	✓			✓	✓	✓
Information Governance Compliance Update and Annual Report (SGUH and ESTH)	GCFO	Note	Report	Annual				✓		
DSP Toolkit: Update (Data Quality/Security) (SGUH and ESTH)	GCFO	Note	Report	Biannual				✓		✓
Group Risk Management Strategy and Policy	GCCAO	Approve	Report	Annual				✓		
Review of Group Board Assurance Framework Internal Controls and Governance Mechanisms	GCCAO	Review	Report	Annual					✓	
Review of Corporate Risk Registers (SGUH and ESTH)	GCCAO	Review	Report	Biannual				✓		✓
Annual Review of Conflicts of Interest Compliance (SGUH and ESTH)	GCCAO	Note	Report	Annual	✓					
Managing Conflicts of Interest: Update on Compliance (SGUH and ESTH)	GCCAO	Note	Report	Annual					✓	
Annual Self-Assessment of Compliance with Foundation Trust Licence (SGUH only)	GCCAO	Note	Report	Annual						✓
Compliance with Trust Constitution and Code of Governance for NHS Provider Trusts (SGUH and ESTH)	GCCAO	Note	Report	Annual						✓
Clinical Audit Programme (SGUH and ESTH)	GCMO	Note	Report	Annual				✓		
Standing Orders, Scheme of Delegation and Standing Financial Instructions (SGUH and ESTH)	GCCAO	Note	Report	Annual				✓		
Use of Trust Seal (SGUH and ESTH)	GCCAO	Note	Report	Annual						✓
Freedom to Speak Up: Internal Controls and Governance (SGUH and ESTH)	GCCAO	Note	Report	Annual					✓	
Group-wide policies: Policy on the development of Group and Trust Policies	GCCAO	Approve	Report	Ad Hoc				✓		
Annual Committee Report to Board including Terms of Reference Update and Committee Forward Workplan (SGUH and ESTH)	GCCAO	Note	Report	Annual	✓	✓				
Review of Committee Effectiveness 2023/24 (SGUH and ESTH)	GCCAO	Note	Report	Biannual	✓					
New Risks and Issues Identified	All	Note	Verbal	Every meeting	✓	✓	✓	✓	✓	✓
Any Other Business	All	Note	Verbal	Every meeting	✓	✓	✓	✓	✓	✓
Reflections on Meeting	All	Discuss	Verbal	Every meeting	✓	✓	✓	✓	✓	✓

Group Board

Meeting on Thursday, 04 July 2024

Agenda Item	3.1.1	
Report Title	**Independent Review of Maternity Governance**	
Executive Lead(s)	Richard Jennings, Group Chief Medical Officer Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Dr Sally Herne, NHSE Improvement Director	
Previously considered by	Group Board Development Session Quality Committees-in-Common Group Executive SGUH CWDT Divisional Triumvirate ESTH Women's & Childrens Divisional Tri SGUH & ESTH Maternity Leadership	06 June 2024 25 April 2024 16 April 2024 March 2024 March 2024 March 2024
Purpose	**For Review**	

Executive Summary

Following the CQC inspection of Maternity at St George's, GESH tendered for an external consultancy to review quality governance arrangements within the Group. Those terms of reference were approved by the Group Executive in May 2023 and are included as Appendix 1.
The Group Chair and Chief Executive also requested verbally that the review addressed two specific questions

- Why did it take CQC to unearth issues in SGUH maternity when Group believed it understood all the issues?
- Have we made our quality governance systems too complicated in the move to a Group structure?

The triple lock in SW London meant that procuring a consultancy firm was ultimately not a viable option, and an Improvement Director from NHS England was seconded for a year to cover the two pieces of work. Given the reduced capacity available to do the work Phase 1 has taken slightly longer than requested in the terms of reference.

This report is designed to brief Group Board on the findings of Part 1 and to give a view on the two questions. It brings together findings from a number of external reviews in 2022 and 2023 and my own analysis to describe what is and is not working in maternity quality governance, plotted against a model which considers quality governance in 3 parts – Anatomy (structural building blocks of governance), Physiology (behavioural aspects of governance) and Vital Signs (ability to step back and reflect on whether governance is fulfilling its' core purpose). Whilst the greatest number of issues are within the anatomy category, there are powerful drivers more associated with the physiological aspects. Strengthening quality governance therefore needs a mix of practical and cultural changes.

In terms of the two questions from the Chair and Chief Executive, it is difficult to replicate an external inspection and completely rule out any surprises. That said, there appear to be six issues which could have contributed. These may also have relevance for quality oversight beyond maternity and are therefore important areas for the Board, Sites and Divisions to reflect on.

Reporting

The way reports were sent up through the governance systems made gaining a rounded view of the issues difficult for leaders at different levels. The format of the regular Maternity report has changed several times, but CNST Maternity Incentive Scheme (MIS) compliance was at the fore in the run up to the 2023 CQC inspection. Given the importance of CNST clinically, financially and reputationally, this was an understandable starting point. The MIS technical guidance sets out a list of what should be regularly communicated to Board for Safety Action 9 on ward to Board reporting MIS-Year-6-guidance.pdf (resolution.nhs.uk) (p.50) . Not everyone receiving the report was aware of this guidance. It was unclear if there had been a conversation to discuss whether this was enough on its own to give division, site, Executive and Board assurance.

There is a significant difference between what CNST measures and the CQC assessment framework. For example, MIS has very little on the maternity specific or trust wide audit compliance looked at by CQC or medicines safety and the known health inequalities gap in Maternity. It suggests including a digest of that month's incidents, HSIB referred cases and complaints but not the themes emerging through those processes. A regular report which focuses on the former therefore can create a visibility gap on CQC key lines of enquiry, unless this is bridged through other means.

In the reports coming to Board the degree to which harm is *avoidable* was often more implicit than explicit. The report self-assessed whether each site was achieving the CNST safety standard on the Saving Babies Lives Care Bundle (SBLCBv3). However, committees did not get to see the actual data underpinning this such as the relative success of Carbon Monoxide Monitoring screening, effectiveness of Fetal Growth Restriction, CTG monitoring compliance or compliance with Management of diabetes and hypertension in pregnancy. There are outcome measures suggested in SBLCBv3 which could be included in a future iteration of the report. CQC inspectors saw some data that concerned them that leaders at GESH had not had the benefit of reviewing first - unplanned readmission to hospital or babies born before the women/birthing person reaches hospital.

The way the reports were presented at Board compounded this further. It could be difficult to weigh the information being presented, particularly in the case of the specialist service at St George's. Benchmarking, narrative, granularity, triangulation and external peer review are all essential to know how to interpret sufficiency of staffing, outcomes and harm. The benchmarking and external assessment of perinatal mortality by MBRRACE commissioned by the Board has demonstrated the value of this kind of independent information for assurance.

Finally, the experts were not in the room for the discussions of the Maternity reports. GESH chose to invite Group Executives to present the report on behalf of the teams. Committees were therefore not hearing or benefitting from the expertise of Midwives, Obstetricians or Neonatologists. Equally the Maternity leadership teams were not privy to the discussion with Group leaders which would help them understand what a Non-Executive chaired committee needs. This could have helped both bridge the gap between what was being reported and what was needed for assurance and also provide support for discussions of specialist and technical issues. The midwives now have a voice through the Chief Midwifery Officer, but the doctor voice is still missing.

Meeting Cycles

There was a focus on frequency of reporting, not least because CNST technical guidance sets an expectation of a monthly Board report. A monthly Quality Committee in Common mitigated against the

reports going through the complex network of division, site and exec first to allow those layers of management to offer support, check and challenge or take action prior to a Group level Board. It also compressed the time available for thinking, planning and doing for the Maternity teams themselves. This was compounded by the web of reporting internally and externally we have exposed through the review. Despite all the reporting and concern about issues such as staffing and the physical environment, very little maternity risk made its way onto corporate risk register and therefore the radar of the wider leadership.

Standards of Assurance

The bar for assurance left the leadership vulnerable to surprises. Board received and took assurance from reports which tended to emphasise whether an action had been completed. It is critical that assurance also demonstrates whether the impact of those actions has been felt and whether the team(s) can sustain their progress. It is high risk to accept less, especially in a speciality subject to so much national concern.

Organisational Culture

Culture may have played a part in two different ways. 'A guide to good governance in the NHS' includes an important quote from Bill Moyes *"There is no such thing as a perfect organisation. The best we can ever hope for is that an organisation is self-aware, recognises its issues, and deals with them effectively".* The report stresses that one of the most important enablers for this is 'problem sensing' leaders who assume that there are issues out there to be found, seek out information that might challenge the perception things are okay, don't take undue comfort in getting most things right, who use a range of means, including soft intelligence, to form a view and who embrace people who highlight concerns. The report describes the very real challenges of making problem sensing a reality in the NHS.

- Providers are increasingly complex, as are the systems they operate within.
- The NHS has a poor track record on bullying behaviours and senior leaders are not immune from being on the receiving end of it, challenging their own sense of psychological safety.
- Problem sensing requires high levels of professional curiosity, but deep curiosity is only possible if leaders themselves have the psychological safety to enable them ask questions about issues which may beyond their portfolio and expertise.
- It also requires leaders to have the resilience to hear, accept and respond to difficult news.
- These challenges are likely to exist in every NHS organisation, but teams and organisations which have had challenging times can find it particularly difficult to operate problem sensing. The prospect of more difficult news and acquiring more to do on top of a long current to do list can be draining and demoralising. Maternity has had a difficult history nationally and locally in recent years. St George's as a site has had to content with quality and financial special measures, Covid, Cardiac Surgery external review and now an increasingly difficult financial environment to work in.

Secondly, evidence shows there is no such things as equality of psychological safety in *any* organisation. Difficulty speaking up is particularly an issue for staff who are women, from a BAME background or who are more junior in the hierarchy. Maternity has many staff who meet all three of those criteria. It is not uncommon to have a gap between leaders' perceptions of how easy it is to raise concerns, challenge how things are done or contribute ideas and the reality of staff experience. Saying my door is always open is not enough. Walkabouts create visibility, but not necessarily approachability. SGUH maternity team felt they escalated concerns vigorously. Leaders outside the service did not feel those messages were clear. Research on just culture and speaking up suggests it is perfectly possible for those two perceptions to co-exist and both positions be honestly held. There is good advice available on the tactics for building psychological safety for the people who really need it in the white paper *"Most of the Advice About Psychological Safety at Work Isn't Helpful".*

Purpose of Governance

The fundamental aim of quality governance can get lost amongst process. Organisations put significant time and effort into risk management, audit, patient experience and safety investigations to learn, embed and improve. Every team and every organisation needs to assess if it is actually achieving that aim, including whether learning is actually effective and to make that part of an iterative, continuous improvement process.

Complexity of Group

The experience of staff involved in Phase 1 suggests navigating Group is highly complex practically and politically. The understanding of the role of Group was low and the relative roles and responsibilities of site leadership versus group in need of greater clarity. This may be inevitable in a large group where the group layer is still relatively new.

Action required by Group Board

The Board is asked to:

a. Note the detailed observations of governance and culture at each Trust and Group level
b. Note the risks identified for delivery of the improvements and mitigations required
c. Consider the relevance of findings for the broader approach to quality governance

Committee Assurance	
Committee	Quality Committees-in-Common
Level of Assurance	Substantial Assurance: The report and discussions assured the Committee that there are robust systems of internal control operating effectively to assure that risks are managed effectively

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Original consultancy terms of reference for Part 1 Review
Appendix 2	Structure and capacity of midwifery and medical leadership and governance roles SGUH and ESTH Governance workload indicators
Appendix 3	Meetings analysis
Appendix 4	Key Points from Hult Ashridge Report 'Speaking Truth to Power at Work'
Appendix 5	Summary of 2023 SCORE and Staff Survey Results in Maternity relevant for governance

Implications

Group Strategic Objectives

☐ Collaboration & Partnerships

☒ Right care, right place, right time

☐ Affordable Services, fit for the future

☒ Empowered, engaged staff

Risks

Risk	Mitigation	Owner	Assurance Mechanism
Culture and volume of meetings compresses the time available for planning, reflection and improvement	Review and recalibrate meetings at unit and site level, using a methodology such as Good Governance Institute initiative at Morecambe Bay or the NHS Institute for Innovation and Improvement Productive Leader Effective Meetings module. Set expectation with Local Maternity and Neonatal System (LMNS) that one report is produced for internal and external audiences	Group Chief Midwifery Officer	Hours released from meetings compared to 2023 baseline Pace of improvement Staff wellbeing & Leadership visibility metrics in staff survey compared to 2023 baseline

The organisation addresses the structural but not the cultural aspects required to support change and build trust	The organisational development approach at GESH embodies 'problem sensing' and just culture behaviours Issues of leadership values not matching local team values are investigated and acted on	Group Chief People Officer	Overall staff survey metrics on reporting culture compared to 2023 baseline Progress against 2023 SCORE metrics in leadership, teamwork and safety climate in Maternity Freedom to Speak up reporting
Strengthening governance arrangements is constrained by the financial position of the Group and SW London	Requests for investment are prioritised, supported by benchmarking and have clear cost benefits Time is released in the form of efficiency gains where possible The organisation uses the review to support requests for investment from commissioners and NHS England (NHSE)	Group Chief Nursing Officer	Successful clawback of Clinical Negligence Scheme for Trusts (CNST) premiums Compliance against Ockenden actions Performance against quality governance outcome measures (see recommendations)

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

Investment may be needed in the governance infrastructure in Maternity, particularly to ensure robust medical input at a time where there are numerous regulatory requirements to fulfil, high national NHS, public and political concern. The extent of the investment needs to be clarified by medical leadership at site and group.

The approach to meetings in the organisation consumes significant amounts of staff time without the benefit of added assurance. There is a potential efficiency opportunity in streamlining the approach to meetings.
Legal and / or Regulatory implications
Recommendations are designed to support effective monitoring of compliance with regard to - Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations - Ockenden Immediate and Essential Actions - CNST Safety standards - Antenatal and Newborn Screening standards - NHSE Maternity Three Year Plan, 2023
Equality, diversity and inclusion implications
Poor maternity outcomes are known to disproportionately affect women from excluded communities and specific ethnic backgrounds. Quality governance mechanisms in maternity need to establish ward to board assurance that the organisation's mechanisms for understanding this and targeting services appropriately is closing the outcomes and experience gap.
Environmental sustainability implications
None identified.

Independent Review of Maternity Governance
Group Board, 04 July 2024

1.0 Purpose of paper

1.1 The purpose of this paper is fivefold :-

- To share a model for considering three dimensions of quality governance
- To summarise in one place the feedback from CQC, NHS England's Maternity Services Safety Programme (MSSP), Ockenden assurance visit and NHS England Antenatal and Newborn Screening Quality Assurance reports as they relate to quality governance and the 2023 Perinatal Culture and Leadership Programme SCORE (Safety, Culture, Operational Risk, Resilience/Burnout and Engagement) Survey and 2023 National Staff Survey results relating to culture, particularly psychological safety, involvement in decision making and improvement readiness.
- To add observations and evidence from this quality governance review which commenced in November 2023 and outputs of two joint governance workshops between SGUH and ESTH.
- To set out the scope, leadership and governance arrangements for a Group-wide Maternity Quality Governance Improvement Programme for approval
- To flag issues which may have broader relevance for the approach to quality governance at GESH for consideration by the Executive and Board.

2.0 Background

2.1 Over the course of 2022 and 2023, insights into quality governance arrangements in Maternity services at SGUH and ESTH have been gleaned through a number of assessment processes

Reporting Body	SGUH	ESTH
NHSE Insight Visit Teams	Ockenden Assurance Visit, May 2022	Ockenden Assurance Visit, May 2022
CQC	Maternity specific inspection Safe and Well Led domains March 2023	Maternity specific inspection Safe and Well Led domains August 2023
NHS England (Screening)	Antenatal and Newborn Screening QA programme May 2023	-
NHS England externally commissioned	Perinatal Culture and Leadership Programme SCORE Survey, May 2023	Perinatal Culture and Leadership Programme SCORE Survey, December 2023
NHS England (Nursing and Midwifery)	Maternity Services Safety Partnership (MSSP) November 2023	Due to take place in Q1 2024/5
Picker Institute	National NHS Staff Survey Autumn 2023	National NHS Staff Survey Autumn 2023

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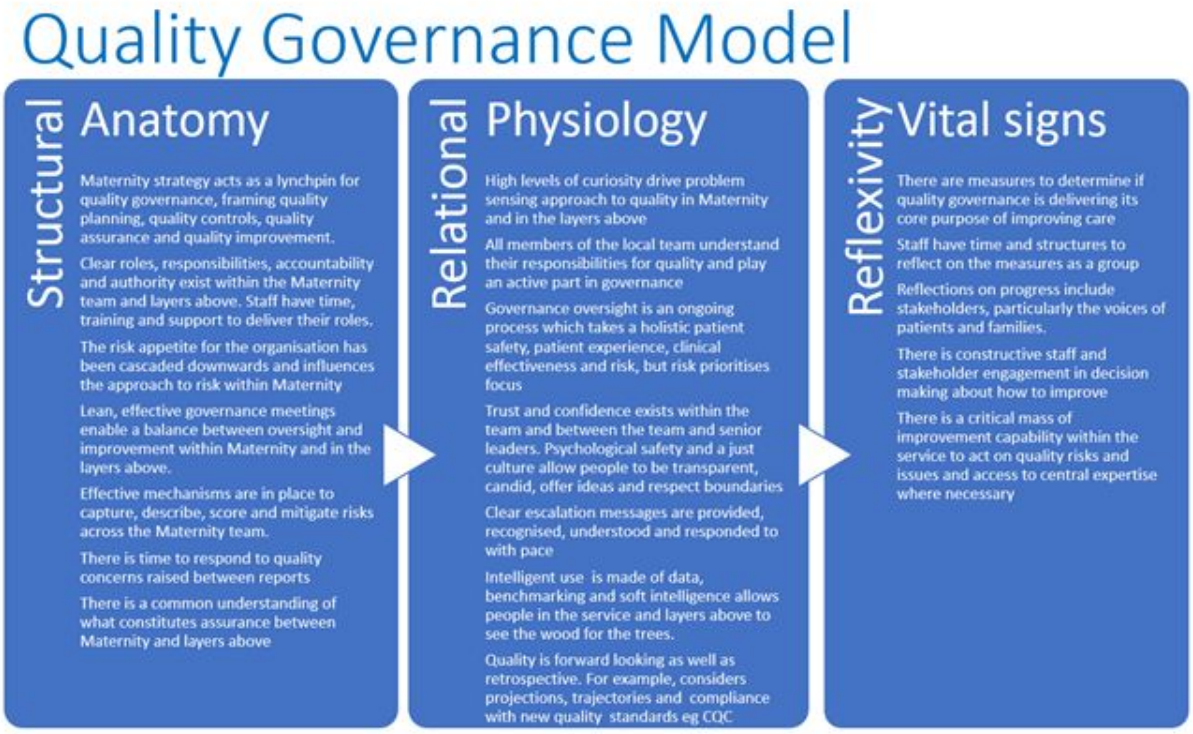
The SCORE survey is a nationally recognised tool for measuring culture and engagement. It has been widely promoted for use in Maternity services. It measures 9 dimensions of Culture and 5 dimensions of engagement. Trusts receive their own scores, the percentage change since the last survey (2019 for SGUH and ESTH) and their benchmark percentile ie what proportion of organisations perform worse than them. This means the higher the percentile noted, the better. Most dimensions set a standard of at least 60% positive responses. Below this should be regarded as a cause for concern. Some SCORE survey dimensions are more relevant to good governance than others. For the purposes of this review, results for burnout climate & personal burnout, local leadership, safety climate, team work, improvement readiness and decision making have been incorporated. Multiple measures within the NHS staff survey cover similar themes and have been used for triangulation.

2.2 In addition, between mid-November 2023 and January 2024, discussions were held with the two Maternity teams, divisions, sites, Group and the 2 LMNS, culminating in two workshops on 26th January and 26th February. Observations of several meetings were also undertaken to gain a sense of how things work in practice. More emphasis was placed on the SGUH site given the CQC rating and concerns shared by MSSP. The lines of enquiry aimed to assess current arrangements using the model of quality governance set out on page 8. This considers governance across three dimensions



3.0 Analysis

Reviewing the approach using the model highlights a number of potential contributory factors to the gap between what senior leaders knew and what they needed to know. The greatest volume is in the Anatomy / Structural category. Given these have been designed in, they can equally be designed out. Although less numerous, there are powerful influences which are in the Physiology / Relational aspects where beliefs and behaviours are very much at the heart. These may take longer to change but the benefits are likely to go beyond the Maternity services if successful. The table below highlights the themes and impacts from the analysis.

3.1 Anatomy

Theme	Current concerns and implications	Recommendations
Strategy	Strategy. A clinical strategy normally acts as a golden thread linking the aspirations and direction for the service with routine quality planning, quality control, quality improvement and quality assurance. That does not appear to be the case for either Trust – strategy and quality governance seem to exist in parallel rather than fusing to create a coherent quality system. Assurance reporting does not report on progress on the strategies or risks to achieving them creating a gap in oversight. External reviews. MSSP and CQC have noted annual plans which should be helping to set priorities for teams and individuals are out of date. This suggests the process of operationalising strategy as part of business planning needs to be more robust. Future direction. Staff contributing to the workshops recommended developing a single strategy for maternity services to set a clear direction for people working in both organisations and maximise the benefits of Group.	Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. Ensure it has SMART (Specific, Measureable, Achievable, Realistic, Timebound) objectives embedded. Build in the recommendation from MSSP to include the **7** features of safety into the new document 1. Commitment to safety and improvement at all levels, with everyone involved 2. Technical competence, supported by formal training and informal learning 3. Teamwork, cooperation, and positive working relationships 4. Constant reinforcing of safe, ethical, and respectful behaviours 5. Multiple problem-sensing systems, used as basis of action 6. Systems and processes designed for safety, and regularly reviewed and optimised 7. Effective coordination and ability to mobilise quickly Ensure that there is total quality management system in place to embed the aims of the strategy. An example from East London Foundation Trust is given here

		ELFT's Quality Management System - Quality Improvement - East London NHS Foundation Trust : Quality Improvement – East London NHS Foundation Trust. Embedding this approach in Maternity may provide a useful model for other services.
Roles and Responsibilities for leadership and governance	Group Complexity. Maternity services now exist in a highly complex multi-site group where the boundaries and responsibilities between local teams, division, site and group are complex and difficult to navigate practically and politically. Staff reported finding it difficult to understand who they should escalate to and in what order. This was exacerbated by their limited understanding of what Group roles do in practice. Introducing a Group Chief Midwifery Officer has added to the confusion. The lengthy job description and lack of an organogram makes it difficult to understand lines of accountability, the level of authority the role carries and how the interface with site leadership should work. This has the potential to create unhelpful tensions for the postholder and staff within the services navigating the new arrangement. Once the issue of future management arrangements for Women and Children's Services has been resolved (see next section), it would be helpful to revisit the Group Chief Midwifery Officer role and describe clearly it's fit with site leadership teams and the reporting line for the two Directors of Midwifery. The experience of the current postholder should be used to shape the end state. In the meantime, the most productive change would be to be clear how this new Group role works constructively with the leadership teams of the two sites so that the division of responsibilities is clear and all involved feel they know what they need to know, when they need to know it. Stability and cohesion. Each trust has had stable medical leadership but periods of churn in the Director of Midwifery (ESTH) and the General Manager (GM) for Women's Health	Develop a clear Responsible, Accountable, Consulted and Informed analysis and organogram to set out the accountability and authority of the Group Chief Midwifery Officer, the site teams, divisions and Maternity teams, whilst discussions are progressing on future management arrangements for Women and Children's Services. (see next section) Prioritise developing the relationships between the Group Chief Midwifery Officer and the two site Managing Directors, Chief Medical Officers and Chief Nursing Officers. Agree touchpoints between the Group Chief Midwifery Officer and site leadership teams to ensure the approach to Maternity quality is coherent and joined up. Refresh the existing Executive protocol for escalation of issues to Group, test it with Maternity staff and recirculate. Recruit substantive GM for SGUH service and explore team coaching support, particularly for the SGUH team. Pursue the MSSP suggestion to recalibrate maternity roles and responsibilities at SGUH, including ensuring there is clarity on the DoM role within the divisional leadership arrangements.

	(SGUH). Both teams need a period of stability, time and support to gel as a collective. Clarity of Responsibilities. The staff survey suggests staff working in maternity in both trusts have a clearer sense of their own responsibilities than those of members of the wider team, but the specialty performed better than both Trust averages. This echoes MSSP concerns at SGUH that roles and responsibilities between bands of midwifery are particularly in need of recalibration to address historic behaviours. Director of Midwifery (DoM) roles in the Structure. Whilst the DoM at ESTH is explicitly included in the divisional Quad for Women's and Children's services, the position remains unclear for the equivalent role at SGUH and therefore her ability to be aware of and influence areas of interdependency may be impeded.	
Capacity for leadership and governance	There appears to be no direct relationship between workload and the capacity allocated to governance work. Detailed data is included in Appendix 2. This issue affects a number of levels. Divisional oversight of Maternity varies significantly between SGUH and ESTH. The CWDT division has oversight of Women's Heath quality, risks and compliance alongside Intensive Care, Paediatrics, Pharmacy, Therapies, Diagnostics and Outpatients. The SGUH Clinical Chair only has 1 Programmed Activity (PA) more than his ESTH equivalent, despite having 5 additional directorates to oversee. Women's Health Leadership. Although the triumvirate structure is the same across the two trusts, there is less allocated PA time for the Clinical Director for Women's Health at SGUH than her ESTH equivalent, despite SGUH being a specialist service handling high risk, complex cases. This role was also noted to be perceived as	Develop an options appraisal for future management arrangements for Women and Children's services and implement the agreed preferred option. This might include leveraging the benefits of Group by progressing integration or a stand-alone Women and Children's Division at the St George's site to allow greater leadership and management bandwidth. Once this is completed, revisit how the Group Chief Midwifery Officer role fits with divisional and site leadership and the line management arrangement for the Directors of Midwifery. Review medical leadership and governance roles using the governance workload data collated by the two Clinical Directors included in Appendix 2. Leverage MSSP support to benchmark medical resourcing for a tertiary unit.

	‘a poison chalice’ by MSSP, with limited appetite from clinicians to act into the role. Governance leadership. The two midwifery led governance teams are structured and resourced differently. They also have different approaches to their work. The benefits of working more across group have not been fully realised but there is an appetite to address this and move towards a more integrated infrastructure. The two teams have suggested a model which has a shared senior layer responsible for both Trusts Maternity quality governance work, with some site-specific resource eg for safety investigations. The organisation can either elect to do this over time, remodelling specific posts as they become vacant, or move more quickly via a formal consultation. The Group Chief Midwifery Officer has requested the teams start to describe a new end state. Many of the conversations about the Maternity service have focused on midwifery, because of staffing and cultural concerns. The role of medical leadership and expertise in Obstetrics, Anaesthetics and Neonatology has been underplayed. Given the need for quality governance to be multidisciplinary, it is critical that infrastructure is considered in the round and the workload associated with the two Obstetric services is taken into account. A comparator of governance workload based on 2023 data is included in Appendix 2 and tends to show greater safety investigation workload per 1,000 births at St George’s. MSSP is likely to be better placed to obtain comparator data for other tertiary units to inform the wider conversation about team job planning and consultant capacity. At present it is unknown whether NHS England will repeat the Maternity staffing Census conducted in 2023. If this is requested, there may be an opportunity to flag the need for additional medical resource.	Ensure that action is being taken to address involvement of Neonatology in joint safety work at the Epsom site. Co-design and work towards an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology across the 2 Trusts. On receipt of a proposal, agree the pace at which the organisation wishes to move in that direction. Include more measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work-life balance to continue to monitor health and safety eg staff absence due to stress, health and safety incidents affecting staff such as verbal and physical assaults, experiences of discrimination and burn out risk. Implement the existing recommendation to develop Band 7 & 8 midwives, new and existing consultants and create a talent pipeline.

	The lead for Obstetrics at ESTH wears numerous other leadership hats and would therefore create a significant gap if she were to step down. Recruitment of new consultants aims to reduce the focus on a single individual. Engagement in governance from Neonatology at Epsom has also been highlighted as a gap, which requires medical support from the lead and the Divisional Medical Director to address. Resilience. Both services have experienced a deterioration in burn out climate (ie the perception that the service is burning out colleagues) and risk of personal burnout. The risk of personal burnout was felt most acutely by midwifery staff. Burnout may compromise willingness to take on additional responsibilities including governance and leadership roles. Bucking the trend, an improvement in work-life balance was noted in the ESTH SCORE survey. Talent Management and Succession Planning. Both CQC and MSSP highlighted the need for a more structured approach to developing the next cohort of medical and midwifery leaders, particularly Band 7 and 8 midwives, new and existing doctors.	
Robust risk architecture	The Board Risk Appetite Statement should be sending a clear message about what the Board wants escalated upwards. Neither team appeared to be aware of the risk appetite statement, so it is not surprising neither Trust's Maternity Risk and Governance Framework makes no reference to it. This suggests a potential disconnect between the intent of the Board and the practical application of risk appetite in other tiers of the organisation. Both trusts were noted as having a gap between concerns identified as part of external reviews and what is actually recorded on the risk register and therefore formally as part of the risk management process. Observing meetings has shown this continues to	Establish a group workstream which includes - Co-creating a single group wide risk and governance framework which embeds PSIRF principles and dovetails with the refreshed group risk framework and risk appetite. MSSP will be able to provide good examples. - Sharing best practice in risk management and escalation - Offering training and coaching to staff identifying risks to complete the Trust documentation and ensure the risk register reflects the whole team's concerns.

	be a gap – for example, staff raise concerns in meetings but are not translating those concerns into risks which need to be documented. The analysis of 2023 risks on the 2 Trusts risk registers shows that ESTH had nearly twice the number of risks scoring 12 or over on their risks register (See Appendix 2). Given the degree of regulatory and operational concerns about Maternity at St George's this disparity is worth looking into. If risks are missed locally, they are likely to be off radar for others in the hierarchy. MSSP also noted limited Maternity risks on the corporate risk register, suggesting the gap is not just at the local level. Identification and mitigation of risks is not yet a team wide activity. Although any member of the Maternity teams can *theoretically* identify a risk and influence the risk register, both Maternity teams identified lack of team confidence using Trust processes to describe, score and capture mitigations for concerns identified. At SGUH, this results in the governance team being asked to complete the risk assessment rather than the staff who have noted the risk and are best placed to determine the potential impact and necessary mitigating steps. MSSP also noted that members of the team such as specialist midwives and those with professional development opportunities did not seem to be shaping the view of risks. At ESTH, staff struggle more with understanding the scoring matrix. This needs coaching and training to address. Different mechanisms are in place in each Trust to oversee risks locally. ESTH has dedicated weekly meetings on a cycle, discussing specific types of risk eg Safeguarding. SGUH relies on a slot at the governance meeting to discuss risk. In practice this means only the very top scoring risks are aired. This focus on a small proportion of risks is then replicated at the Divisional level. There is no dedicated time for the	- Ensuring the practical implications of risk appetite are understood and influencing practice - Refresh local and corporate risk registers to take on board observations made by CQC and MSSP

	leaders within SGUH maternity service to review the *whole* register. There is an opportunity to level up good practice and ensure systems ensure risk identification, scoring and mitigations match the 'worry list' of staff working in the service and compliance gaps.	
Lean Effective Meetings	Meeting burden. Analysis of information supplied by the two trusts suggests there are 220 hours of meetings where maternity is discussed at SGUH every month and 163 hours at ESTH. This volume of meetings is not providing sufficient assurance but does consume significant time. Both trusts have monthly maternity governance meetings but the scope of what is discussed is different and would benefit from some consistency to ensure there is adequate coverage of all pertinent aspects of quality. Without this, it will be difficult for the team to have a holistic view of quality and relay that view upwards. Proportionality. Meetings tend to be focused on safety, with far less time spent on clinical effectiveness, patient experience and risk. This misses the need to have a broad view of what is and isn't working, before using exception reporting to focus on areas of concern. There is not always a direct relationship between risk and the prioritisation of items for discussion. Opportunities to hone the focus onto areas which are greatest quality risks or barriers to progress may be being missed. Complexity of external reporting. Currently the two trusts have to report to two LMNS, two Maternity Voices Partnerships and multiple local authorities. Staff report having to produce different reports for different audiences or similar information but in different formats. This results in governance staff having to transpose information into different templates.	A leaner approach to meetings is adopted to release time for planning and implementing improvement. The methodology Good Governance Institute used with University Hospitals Morecambe Bay focuses on assessing meeting value Lean governance – focusing on what you want to achieve | Good Governance (good-governance.org.uk). Units should be supported to re-think their local meetings to distill what is needed to support assurance and engagement, frequency, members and quoracy. At unit level, the *NHS Institute Productive Leader series 'Meetings Management'* guide might be a more helpful approach. The Improvement Director has an electronic copy which can be shared. Sites may wish to consider where there may be economies to make in frequency, membership or quoracy or where there are opportunities to have a joint cross-trust meeting. A single report on Maternity which serves the purposes of LMNS and Maternity Voices Partnership (MVP) would also help to reduce the time needed to prepare for external meetings. A common understanding of what ought to form standard items and the forward plan for the main governance meeting would be particularly beneficial. This may be a helpful area for MSSP to support. Agree one report for internal and external audiences to reduce the amount of time spent preparing for

		senior internal and external meetings. Executive support may be required in the discussions with external organisations.
Common understanding of what counts as Assurance	Different thresholds for assurance. The process of gathering evidence of progress against CQC must and should dos has highlighted different staff views of what good assurance looks like. If there is variability, there is room for risk. This variability is particularly problematic in a system where staff have to present assurance evidence to multiple audiences, where the standard for assurance can be different. For example, Surrey Heartlands LMNS were intending to set up a separate meeting to receive evidence of compliance against the latest set of CQC must and should dos. One, joined up process working to one standard would reduce risk and save duplicate meetings. Many assurance reports rest on an action being completed eg SGUH Board report on CQC actions July 2023. The standard for full assurance should include evidence the impact of the change has been felt and the change has a reasonable chance of being sustained. The GESH threshold should include all 3 components. Gaps in assurance have been identified. There is no ward to board assurance on progress towards the maternity strategy and no reports currently provide assurance on compliance against national screening standards, including Antenatal and Newborn Screening. Instances of lack of ongoing assurance were also noted eg the Board has not had assurance on Ockenden compliance since August 2022. Whilst a number of the recommendations have been subsumed into other oversight mechanisms, it is worth ensuring that nothing critical is missing. In addition, although the Board signed off the decision to diverge from the approach to fetal growth monitoring used in most trusts at the SGUH site, it is not clear how the organisation is assured this is	The Board sets and communicates clear standards for assurance. The Group establishes a Compliance Evidence Assurance Panel, Chaired by the Group Chief Midwifery Officer. This involves site and external stakeholders in a single discussion on whether a regulatory requirement has been met. This would review evidence of action, impact and sustainability and make recommendations for closure to GESH Quality Group. Support will need to be provided by quality governance staff in divisions and corporate teams to aid teams progressing through the process. A detailed paper to describe this is due at Executive on 16th April. Routine Maternity reports need to ensure ongoing reporting of compliance against historic recommendations which remain relevant eg Ockenden requirements which have not been subsumed into other oversight processes and assurance the SGUH fetal growth monitoring protocol is at least as effective as the systems used in most other trusts. This could be included in the clinical effectiveness section of the new report template. The Group CMO has suggested Quality Committee in Common receives an Annual Report covering compliance against **all** Screening Programmes delivered by GESH. Maternity would include an update on Antenatal and Newborn Screening within this report. Produce a map of the assurance evidence held in Maternity against the CQC Single Assessment Framework quality statements, share findings and action plans to close gaps at site level and

	as effective/more effective on an ongoing basis. In 2023, the CQC moved to a new assessment framework with a number of changes to the evidence requirements. To reduce the risk of surprises at future inspections, it would be beneficial to proactively ask teams to identify the evidence they have available to evidence the quality statements in the five domains. A starter for ten has been shared with both Maternity teams. Our new single assessment framework - Care Quality Commission (cqc.org.uk).	Executive Quality Group. Cascade the request to other teams likely to be the subject of an inspection in the next 12 months or where line of sight of compliance may be limited eg those with current concern flags or not inspected for over 4 years.

3.2 Physiology

Theme	Current concerns and implications	Recommendations
Assurance Reporting	Maternity has a complex set of compliance requirements to monitor, with some nuance in what they measure. Current reporting tends to report 'slices' of how the service is performing eg compliance with CNST standards or CQC must dos. Quality Committee members reported finding it difficult to get a sense of the whole, progress since the last report and impact on risks. Some NEDs were unaware the CNST technical guidance sets out a core information set required for Board in order to meet the governance safety standard. Filtering. MSSP and CQC inspections have raised concerns about the Maternity report not being presented by the Maternity teams themselves. As well as missing the opportunity to offer their expertise, staff reported that their absence from the discussion meant it was hard to get feedback from QCIC and Board. Some of the filtering may also be the result of gaps in psychological safety (see later).	The current is amended to provided a more holistic view and close a number of gaps - Quarterly thematic analysis of complaints, claims and incidents as well as individual cases since last report - Clinical effectiveness compliance (audit, policies, guidelines) - Progress meeting all outstanding regulatory actions not just CQC - More patient experience feedback and quality improvement activity including progress meeting Maternity Voices Partnership requested actions, Baby Friendly accreditation - Progress on the strategy is reported biannually once the current separate strategies have been refreshed. - More consistent and timely staff feedback eg results of the SCORE and NHS staff surveys - Metrics need to include more visibility of avoidable

		harm eg progress on smoking cessation, fetal growth monitoring, and maternal medicine - Glossary of terms A first iteration of this new report has been developed but it is likely to require further iterations to take account of staff suggestions, Board feedback and changing requirements eg latest CNST guidance. Staff involved in producing the report are able to attend QCIC to understand the needs of Non Executive chaired committees and to contribute to the discussion where appropriate.
Use of Data	Making sense of the data can be challenging for non-specialists. The QCIC report is moving to incorporate SPC reporting to allow readers to distinguish normal from special cause variation. ESTH has struggled to provide this due to IT issues involving the version of Excel which can be supported. Triangulation also needs to be developed – particularly analysis of the interplay between staffing levels (midwifery and medical) and safety indicators. The slides developed for SGUH CQC assurance were a helpful step in this direction. Narrative and benchmarking are essential to make sense of the data, particularly to judge the effect of SGUH providing specialist services. MBRRACE external reviews have provided useful benchmarking but this could be extended to a wider data set. Data currently highlights nationally recommended indicators such as stillbirths, incidents of Hypoxic brain injury and postpartum haemorrhage. There is less visibility of indicators which evidence suggests have an impact on avoidable harm eg interventions highlighted in the Saving Babies' Lives care bundle.	Staff responsible for producing the reports are given time to attend Making Data Count training, particularly the modules on narrative, benchmarking and triangulation. Making this a core competency for leaders would be a positive step. A refresh of the metrics reported routinely is undertaken to ensure senior leaders have visibility of factors key to reducing avoidable harm and health inequalities.

	QCIC currently gets information on individual cases investigated by the Trust or HSIB. However, thematic reviews which help to see the bigger picture and inform quality priorities have been missing. There are well known national inequalities issues in Maternity, Both Trusts serve pockets of deprivation and diverse populations. At SGUH SIDM a number of incidents have been discussed where black women who reported concerns felt they were not listened to. It is difficult to glean from current reports whether the organisation is making in-roads to close the outcomes and experience gap, for example, whether services are being effectively targeted.	
Agility	The pattern of having a monthly QCIC meeting has disrupted the normal flow of reporting through Division, Site, Executive to Board as the timeframes for reporting struggle to incorporate the different meeting cycles. This means levels of management were missing the opportunity to scrutinise, challenge or support issues being raised. This has been addressed with the move to bimonthly QCIC from April 2024.	Create a forward plan to indicate when reports are due at Maternity governance, Divisional Governance, Site and Executive Management Team prior to submission to QCIC.
Psychological Safety	Research suggests that, in **all** types of organisation, there is likely to be a gap between perceptions of how easy it is to raise concerns or contribute ideas and the reality. The key findings of the Hult Ashridge report 'Speaking Truth to Power at Work' are included in Appendix 4. Whilst GESH senior leaders may perceive themselves to be open, approachable and keen to hear from staff, it would be wise to assume this will not be everyone's experience. The state of psychological safety will determine what is included in reports, how it is weighed and framed. At St George's, CQC and MSSP both noted 'Management' having a blaming style which suppresses the ability to speak openly. Specific examples were cited around feedback on the CQC report and handling the change in bank pay rates.	The cultural change programme for GESH incorporates learning from the Hult Ashridge report and works toward a problem sensing approach culture-and-problem-sensing.pdf (nhsproviders.org). This would be a helpful area to explore at Board development and with GESH Top 100 leaders. The Board session held to learn lessons from Cardiac Surgery at St George's may also be helpful to revisit. Further work is also required to embed Just Culture. The PSIRF implementation plan is a critical driver for re-setting how learning is extracted and used. The current Patient Safety Incident Response Plans for the two Trusts set out the framework for the new system –

	One of the inhibitors of psychological safety is formal meetings, with long agendas and limited time per item as this gives participants limited time to gather their thoughts and determine how to contribute. Given the information provided in Appendix 3, this is likely to be a contributory factor. There are indicators in recent inspections, the 2 NHS staff surveys and SCORE surveys that suggest the pattern in the Hult Ashridge report is an issue at GESH. (See Appendix 5 for full details) Staff at both organisations felt there was encouragement to report errors, near misses and incidents, feedback on changes made in response and confidence raising concerns about unsafe practice. However, there was much less confidence that staff involved in an error were treated fairly and that it was safe to concerns other than about unsafe practice. This suggests there is still a perceived gap between Just Culture and staff reality. The staff survey includes questions about trust and autonomy. Perceptions of the freedom in how the team does their job was an issue for both services. The concerns were more apparent for SGUH. A good relationship between staff and their local managers, healthy team working and constructive resolution of differences all promote psychological safety. Local leadership, team working and safety climate domains had all declined from the 2019 SCORE survey baseline. Only one area of the local leadership domain in was above standard (predictable leadership visibility) in the SCORE surveys for both trusts. Many of the themes, echoed in the NHS staff survey, suggested staff would welcome more individual feedback about their performance. Similarly, scores for constructive resolution of disagreements in the best interests of patients was well below standard. There was also a concerning gap between the	investigatory priorities, changes in structures and oversight. There is mention of learning and sharing but limited detail on the approach to just culture which is crucial to make this work. Mersey Care has a well developed programme described here. Restorative Just and Learning Culture :: Mersey Care NHS Foundation Trust The Human Resources functions at ESTH and SGUH do a deep dive on a subset of staff survey indicators to identify outlier clinical teams across the wider organisation. Questions on reporting culture (Q19 and 20), Q7 (team working) and local leadership (Q9) are particularly key. This may identify other teams where there may be a gap between what is being surfaced, managed and quality risks senior leaders need to be aware of. The local SCORE and staff survey findings for Maternity are explored with the two teams, particularly the issues of providing feedback, conflict resolution, involvement in decision making, perceptions of inequitable treatment and leadership values. The Perinatal Culture and Leadership Programme includes coaching and facilitation which could support this work. The findings should be used as part of a leadership ‘re-set’.

	value service staff ascribe to and those of 'facility leadership'. There was low confidence suggestions about quality would be acted on was act both trusts. National evidence suggests BAME staff are disadvantaged in being able to speak up either to raise concerns or contribute ideas. Previous staff surveys, Freedom to speak up cases and CQC have highlighted staff experiences of discrimination, bullying and harassment at both Trusts. In the 2023 staff survey at ESTH 83.7% maternity respondents agreed with 'Not experienced discrimination from manager/team leader/other staff' against a Trust average of 88.9%. On the question 'Not experienced harassment, bullying or abuse from other colleagues' the team scored 72%, well below the Trust average of 80.2%. The issue was more significant at SGUH, where the team performs below Trust average for multiple questions - 'Not experienced harassment, bullying or abuse from patients/service users, their relatives or members of the public', ''Not experienced harassment, bullying or abuse from other colleagues', 'Organisation acts fairly on career progression', 'Not experienced discrimination from patients/service users, their relatives or members of the public', 'Not experienced discrimination from manager/team leader or other colleagues'.	

1.3 Reflexivity

Theme	Current concerns and implications	Recommendations
Assurance quality governance is effective	Quality governance processes are a means to an end not an end in themselves. The core purpose is to promote continuous learning and improvement in order to improve outcomes and experience and reduce avoidable harm. For Boards to get assurance their quality governance is achieving that core aim requires getting to the nub of whether learning ad improvement are effective. In the past,	Use the NHSE guidance and suggested questions to agree what a new assurance framework might look like and how the sources of evidence would be gathered.B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk).

	assurance often came in the form of indicators such as whether investigations have been completed in a specific time frame. That tells an organisation whether the learning is timely, not whether it is making a difference. The move to PSIRF provides an opportunity to re-examine the way organisations get assurance that governance is meeting its core purpose. NHS England has published guidance on oversight of PSIRF including the role of the Board. This focuses on principles for oversight and encourages leaders to think about themes such as the quality of learning and whether quality improvement skills and capacity are aligned to bridge learning and practice. NHSE Patient Safety team has confirmed that no organisation currently has a well developed approach to PSIRF assurance. However, there are questions the Board can use to shape their response, some of which have come from discussions with the original author of the PSIRF document. - What is the experience of patients and families involved in safety and complaints investigations ? Did the trust 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 the key learning reflected in the investigation outcome ? - Does soft intelligence and surveys such as the staff survey suggest GESH is a place people can speak up either to raise concerns, challenge the status quo or share ideas ? - Are we, as leaders, 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 eg inequalities in maternity ? - Are we prioritising and building expertise in quality improvement and safety	Report your outcomes in the AGS for 24/25 financial year and keep refining the process. Local teams are encouraged to develop their own equivalent view of the effectiveness of learning and reflect on this at governance half days. The two maternity teams have some of the data needed to inform their own version from the staff survey and SCORE surveys.

	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 ? If GESH builds this new approach to ensuring quality governance is working as it should and reports the outcomes in the Annual Governance Statement (AGS) year on year , the organisation will be ahead of the curve.	
Improvement Readiness	The Improvement Readiness dimension of the SCORE survey tests staff perceptions of the team's ability to find and fix quality defects. Both trusts scores have declined since 2019. Findings were below standard on the question of whether systems effectively fix problems and improve quality, whether learning systems enable insights into successes and having protected time for reflection and learning. The NHS staff survey notes that ESTH and SGUH Maternity services were below the Trust average for '*Members of the team often meet to discuss the team's effectiveness*'	The recommendation to adopt a leaner approach to meetings, develop outcome measures for governance and improve the availability and narration of quality information would all support improving these issues.
Learning mechanisms	Gaps in being able to apply learning effectively have been identified in both CQC and MSSP reviews. • Failure to close the loop between identifying poor compliance, acting on the results and embedding learning. The reports noted poor compliance with areas such as antenatal risk assessment, sepsis screening for babies, MEOWS, born before hospital rates, haemoglobinopathy screening, medicines audit, and lack of benchmarking still birth rates against peer at SGUH. The Antenatal and Newborn Screening Quality Assurance report similarly noted weaknesses in processes to notify the NHSE team of relevant incidents on Datix, deaths of babies or to communicate screening results to women who miscarried or chose a termination.	The workstream to integrate governance teams and approaches includes sharing best practice in disseminating learning and developing stronger mechanisms to ensure the loop is closed between concerns about quality, action plans and evidence of embedding. Agree whether Quality Improvement competence is a requirement for clinical and managerial leadership and conduct analysis of how many staff in the Maternity services have had QI training.

	• Both CQC and MSSP noted weak processes for disseminating patient safety outcomes and learning at St George's. Historically the service has tended to rely on email to disseminate learning, but has taken steps to consult staff on how they want to be communicated with if they are unable to attend meetings to hear discussions first hand. Given ESTH have been commended for their systems by CQC this may be an area where leveraging the benefits of being in a Group would be helpful. • Opportunities to broaden engagement of the wider team and stakeholders in improvement efforts to remedy quality problems were picked up both by CQC and MSSP. • SCORE and the national staff survey both explore how far staff feel able to contribute to decision making and improvement – 32% of ESTH and 22% of SGUH participating in the SCORE survey gave a positive response. There is a marked gradient between the degree to which staff felt able to influence at local level versus feeling they had a voice in the wider organisation.	

4.0 Implications

This review was commissioned to gain and full and honest assessment of why the extent of issues at SGUH were not fully understood by the Board. The information

collected suggests there are a multiplicity of factors involved and to address these effectively really requires root and branch improvement. Iterative changes at the

margins may not go far enough to build confidence in Maternity or other areas of quality governance. Not all the contributory factors are equal and therefore there is

scope to prioritise. The top priorities are highlighted in bold below.

Theme	Recommended actions

Strategy	Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. Ensure it has SMART objectives embedded. Build in the recommendation from MSSP to include the **7** features of safety into the new document. Use the strategy as the basis for a Total Quality Management approach to quality. (p8-9)
Roles and Responsibilities	Produce a Responsible, Accountable, Consulted, Informed analysis to clarify the relative roles of the Group Chief Midwifery Officer, Site Leadership Teams, Divisional Leadership teams and Maternity triumvirates, whilst discussions take place on future management arrangements for Women and Children's Services. (p9) **Clarify the touchpoints between the Group Chief Midwifery Officer and the site leadership teams to ensure all involved are fully informed and involved and the division of labour is clear. (p.10)** Refresh the protocol for escalation of issues to Group and test it with Maternity staff. Reshare with all Divisions. (p10) **Pursue the MSSP suggestion to recalibrate maternity roles and responsibilities at SGUH, including ensuring there is clarity on the DoM role within the divisional leadership arrangements at SGUH (p10)**
Leadership & Governance Capacity & Capability	**Conduct options appraisal for future management arrangements for Women and Children's services and implement preferred option. This might include leveraging the benefits of Group by progressing integration or replicating the ESTH structure of a stand alone Women and Children's Division at the St George's site to allow greater leadership and management bandwidth. Reassess how the Group Chief Midwifery officer role fits into the future arrangement and the implications for line management of the two Directors of Midwifery (p11)** Recruit substantive General Manager for SGUH service and explore team coaching support (p9) **Review medical leadership and governance roles using the data collated by the two Clinical Directors contained in Appendix 2 and workload comparator. Enlist MSSP support to gather benchmarking data from other tertiary centres to support the wider discussion about team job planning in Obstetrics and Gynaecology. Ensure support is in place to improve Neonatology involvement in joint safety work at Epsom. (p.11)** Co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology to support levelling up practice, promote learning across sites and reduce duplication of effort. On receipt of a proposal, agree the pace at which the organisation wishes to move to the new end state(p.12-13) Expand the measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work-life balance. (p12-13)

	Implement the MSSP recommendation to develop Band 7 & 8 midwives, new and existing consultants and create a talent pipeline. (p12-13)
Risk Architecture & Management	Establish a group workstream which includes - Co-creating a single group wide risk and governance framework which embeds PSIRF principles and dovetails with the group risk framework and risk appetite - Sharing best practice in risk management and escalation - Ensuring the practical implications of risk appetite are understood and influencing practice - Refresh local and corporate risk registers to take on board observations made by CQC and MSSP (p14-15))
Lean, Effective Meetings	**Utilise a methodology such as the Good Governance Institute - Morecambe Bay or NHS Institute for Innovation and Improvement Meeting Management approach to identify where meeting structures could be streamlined to reduce duplication and release time (p16, p26)** **Develop a more consistent approach to the information which should flow through a Maternity Governance Meeting to promote a helicopter view of quality and inform exception reporting upwards (p16)**
Strengthening Assurance – Organisational	Agree Board standards for assurance and communicate clearly to teams submitting reports (p 17) Ensure that there is an annual assurance report on compliance with Screening standards, including Antenatal and Newborn Screening. (p17)
Strengthening Assurance – Maternity	**Maintain focus on sustaining delivery against existing regulatory compliance actions and continue the work commenced to map sources of assurance against the CQC Single Assessment Framework. Report gaps and plans to address them to Divisions, site and Group. Utilise the experience in maternity to identify other teams where this type of assessment may reduce the risk of surprises at reinspection. (p17-18)** **Pilot an Evidence Assurance Panel in Maternity to encourage teams to set a robust bar for compliance requirements. If this proves beneficial, expand the approach**. (p17)
Improving Reporting	**Ensure there is 1 holistic maternity report which serves multiple audiences, including the 2 LMNS ESTH reports into. Encourage staff producing the reports to take up Making Data Count introductory, narrative, benchmarking and trajectory setting modules. (p18-19)** **Review the indicators in the Maternity dashboard to ensure senior leaders have greater visibility of *avoidable* harm (eg Saving Babies Lives indicators such as smoking cessation, fetal monitoring, management of diabetes etc) and the impact on health inequalities (p19)**

	Enable maternity staff involved in producing the reports to attend Quality Committee in Common to understand the needs of a NED chaired committee, support iterative improvements to the report and enable them to participate in the discussion as appropriate (p.21) **Produce a forward plan with clear reporting deadlines for division, site, Executive and Group meetings to allow teams to plan their work and share their intelligence with the tiers of management in the right order (p21)**
Organisational Culture	**Commit to embedding Psychological Safety and encouraging 'problem sensing' mindset as a core leadership requirement at organisational level as part of the next phase of organisational development (p21))** **Strengthen the Patient Safety Incident Response Plans to embed good practice in establishing a just culture, using learning from organisations such as Merseycare. (p21)** **Carry out deep dive on the sub-set of national staff survey indicators highlighted in Appendix 4 to identify other teams where there may be gaps between what is being surfaced and the issues in the service to inform Phase 2 of the external review (p.21-22)** **Carry out further analysis and engagement to explore the issues of authority and autonomy raised by the national staff survey 2023, (SGUH being the priority) to inform the approach to organisational development and the accountability framework. (p 22)**
Local Maternity Culture	Continue work to build local Maternity psychological safety particularly through feedback, involvement in decision making, fair and equitable staff management, resolution of differences and improved communications (p20-22) Explore the issues raised in SCORE about facility leaders approach to living the same values through the support provided by the Perinatal Culture and Leadership Programme and use findings to reset behaviours and expectations (p22) Encourage sharing of effective mechanisms for disseminating learning from ESTH to SGUH and evaluate the QI capability within Maternity and Neonatology (p22-23). Agree whether QI capability should be a core management competency. Explore learning from each other on wellbeing (p13)
Effectiveness of Quality Governance	**Use the NHSE guidance and suggested questions to agree what a new assurance framework for quality governance effectiveness might look like and how the sources of evidence would be gathered.B1465-4.-Oversight-roles-and-responsibilities-specification-v1-FINAL.pdf (england.nhs.uk).**

	Report your outcomes in the AGS for 24/25 financial year and keep refining the process. (p.24) Local teams are encouraged to develop their own equivalent view of the effectiveness of learning and reflect on this at governance half days. The two maternity teams have some of the data needed to inform their own version from the staff survey and SCORE surveys (p24)

The scale of what is required may look overwhelming and therefore it is important to acknowledge the assets the Group has in its favour to tackle these issues.

- Period of stability of leadership in each of the Maternity Triumvirates
- Significant experience and expertise within the two teams
- An appetite to work across the two teams to harness the benefits of Group for staff and for patients and reduce duplication of effort
- In-house expertise in Making Data Count, OD and Quality Improvement
- Willingness from external partners including the LMNS and NHSE to provide support for making changes
- Additional investment into staffing on each site
- Additional capacity and professional leadership in the form of the Group Chief Midwifery role
- Maturing Group infrastructure, with corporate teams gradually slotting into place
- Opportunity with implementation of PSIRF to focus on where investigation and learning can add most value

5.0 Recommendations

5.1 Senior Leadership is asked to:

- Note the detailed observations of governance and culture at each Trust and Group level
- Consider the Executive response ahead of the report being reviewed at April QCIC and May Board.
- Note the risks identified for delivery of the improvements and mitigations required
- Consider the relevance of findings for the broader approach to quality governance.
- Identify any areas where the Improvement Director is required to support implementation
- Note the plan for priorities signed off by GEM to be worked up and submitted for discussion and approval at a future meeting
- Provide feedback to Divisions and Maternity teams on next steps

Glossary

AGS – Annual Governance Statement. A core component of the Trust Annual Accounts

CNST – Clinical Negligence Scheme for Trusts, annual risk management self assessment process

GGI – Good Governance Institute

LMNS – Local Maternity and Neonatal System

MSSP – NHS England's Maternity Services Safety Programme, part of the Chief Nurse's directorate

MVP – Local Maternity Voices Partnership

NHS Institute – the NHS Institute for Innovation and Improvement which produced the 'Productives' series of guides to improve team efficiency and effectiveness

QI – Quality Improvement

PSIRF - Patient Safety Incident Response Framework, which has replaced the serious incident framework

PSIRP - Patient Safety Incident Response Plan – the local response to the new national framework

RACI – Responsible, Accountable, Consulted, Informed analysis

SCORE - Safety, Culture, Operational Risk, Resilience/Burnout and Engagement scale used as a core component of the national Perinatal Culture and Leadership Programme

SMART – Specific, Measureable, Achievable, Realistic, Timebound

Group Board

Meeting on Thursday, 04 July 2024

Agenda Item	3.1.2	
Report Title	**Executive Response to the Independent Review of Maternity Governance**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Chief Medical Officer Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Arlene Wellman, Group Chief Nursing Officer. Richard Jennings, Group Chief Medical Officer. Stephen Jones, Group Chief Corporate Affairs Officer. Sarah Hodgson, Business Manager, GCNO & DIPC	
Previously considered by	Quality Committees-in-Common Group Board (development session) Group Executive Meeting	27 June 2024 6 June 2024 28 May 2024
Purpose	**For Review**	

Executive Summary

Following the CQC inspection of St George's maternity unit from 22 March 2023 to 23 March 2023 and the receipt of the CQC report on 17 August 2023, Dr Sally Herne, NHSE Improvement Director, was commissioned by the Group CEO and Chairman to undertake an Independent Review of Maternity Governance.

The Independent Review paper was considered and discussed at the Group Executive Team Meeting on 16 April 2024 and discussed at the Quality Committees-in-Common on 25 April 2024.

The Executive Team was in broad agreement with the direction of travel indicated by the many recommendations, and the CEO asked the GCNO, the GCMO and the GCCAO to prepare a formal Management Response to these recommendations.

This Management Response paper summarises the recommendations, grouping them thematically, and describes the agreed actions being undertaken in response to them and specifically identifies the four immediate priority actions:

- **Culture** – evaluate the Work in Confidence tool. *Sarah Hodgson is setting up a demo for the GCNO, GCMO & GCCAO in June 2024.*
- **Governance & Risk –** Co-create a single, group-wide risk and governance framework. *The introduction of a new risk framework is underway, led by the GCCAO.*
- **Strategy –** Co-create a single 3-to-5 year maternity strategy for gesh with staff, stakeholders and service users. *This will be led by the GCMidO with support from the gesh Strategy Team.*
- **Structure –** Conduct an options appraisal for future management arrangements for Women & Children's services and co-create an integrated multidisciplinary governance

infrastructure for Maternity, Gynaecology and Neonatology. *This will be site-led but under guidance from the Group.*

Accountability will lie with the identified action owners. The Executive will have clear and regular oversight of progress through the gesh Quality Group which meets monthly and at which, a Maternity Services update will be a standing agenda item.

Action required by Group Board

The Board is asked to:

a) Note the management response to the recommendations made in the report (under 'comments'), in particular those where work is already underway and the allocation of accountable individuals.
b) Note and agree to the Management's recommendation of prioritising four key actions.

Committee Assurance	
Committee	Quality Committees-in-Common
Level of Assurance	Choose an item.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	**Independent Review of Maternity Governance – priority actions_June 2024_vs2**

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 original report				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
As set out in the original report				
Legal and / or Regulatory implications				
As set out in the original report				
Equality, diversity and inclusion implications				
As set out in the original report				
Environmental sustainability implications				
None identified				

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Independent Review of Maternity Governance – Executive Response

Arlene Wellman, CNO
Richard Jennings, CMO
Stephen Jones, GCCAO

June 2024

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Action 1 – Evaluate the Work in Confidence Tool.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Include more measures of staff wellbeing in the routine Maternity report and share learning across the two teams on work/life balance.	An updated template has been drafted and will be adapted as we learn more. The first version has been shared with Quality Committee ("QCiC") and Board.	GCMidO	30-Aug-24	NOT YET DUE
	Commit to embedding psychological safety and encouraging a 'problem sensing' mindset as a core leadership requirement.	Regular contact will be maintained with the Maternity teams through touchpoint meetings. We have already introduced a strengthened process for case management of Freedom To Speak Up concerns and we are exploring other possible platforms offering staff routes of escalation (e.g. Work In Confidence - an external employee engagement tool). A new gesh leadership course is launching in September 2024. A core component of this will be psychological safety.	Group Executive	30-Sep-24	NOT YET DUE - THE COURSE LAUNCHES IN SEPTEMBER 2024

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Action 1 – Evaluate the Work in Confidence Tool (ctnd.)

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Strengthen the Patient Safety Incident Response Plans to embed good practice in establishing a 'just culture'.	**Implementation of PSIRF is progressing.**	**GCNO & GCMO**	**Ongoing review**	**THIS IS NOW A STANDING AGENDA ITEM AT THE MONTHLY gesh QUALITY GROUP MEETING**
	HR function should carry out a deep dive on a subset of national staff survey indicators to identify outlier clinical teams and undertake further analysis/engagement to explore the issues of authority and autonomy raised by the national staff survey 2023 (SGUH the priority).	**The HR team has undertaken an analysis of the top 10 and bottom 10 indicators for staff culture.**	**GCPO**	**Ongoing review**	**PRESENTED AT PEOPLE COMMITTEE ON 20.06.24**
	Continue to build local maternity psychological safety through feedback, involvement in decision-making, fair and equitable staff management, resolution of differences and improved communications.	**Implementation of PSIRF and the 'just culture' has been rolled out across the gesh Maternity teams.** **We have already introduced a strengthened process for case management of Freedom To Speak Up concerns and we are exploring other possible platforms offering staff routes of escalation (e.g. Work In Confidence - an external employee engagement tool).**	**GCPO, GCNO & GCCAO**	**19-Jul-24**	**DEMO OF THE 'WORK IN CONFIDENCE' TOOL WAS HELD ON 19.06.24. AWAITING FEEDBACK AND AGREED NEXT STEPS**

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Action 1 – Evaluate the Work in Confidence Tool (ctnd.)

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Culture	Explore the issues raised in the SCORE survey (a maternity and neonatal-specific survey) about facility leaders' approach to living the same values (low confidence that suggestions about quality would be acted on across both trusts) through accessing the support provided by the Perinatal Culture and Leadership Programme.	**Improvement work will continue through the Maternity Improvement Programme.**	**Site Maternity Teams**	**Ongoing**	**THIS IS ACTIVELY MONITORED AT THE SITE LEADERSHIP TEAM MEETINGS**
	* Encourage sharing of effective mechanisms for disseminating learning, e.g. from patient safety outcomes and sharing best practice between ESTH (commended for their systems by CQC) and SGUH. * Identify how many staff within Maternity and Neonatology have had QI training. Should QI capability be a core management competency?	**A number of projects are now underway between the Quality Improvement and maternity teams.**	**GCMidO**	**30-Aug-24**	**NOT YET DUE**

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Action 2 – Co-create a single, group-wide risk and governance framework.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Governance & Risk	Co-create a single, group-wide risk and governance framework, which: - embeds PSIRF principles and dovetails with the group risk framework; - ensures the sharing of best practice in risk management and escalation, and - reduces disparities between concerns raised by external reviews and concerns raised and recorded on local and corporate risk registers by staff, e.g. through offering training and coaching to staff on raising and recording risks.	A new group-wide risk management framework and policy is already in development and will be in place, following Audit Committee review, in Q2 2024/25. Until this group-wide new risk framework is in place, each trust has in place established trust-specific risk management policies, which were reviewed by internal audit in early 2024 with a reasonable assurance rating. The timescales for the development of the new framework were reported to the Audit Committee in May 2024 as part of the internal audit report. A training and development plan to inform staff about the new framework and effective risk management is also being developed as part of the roll out of the new framework.	GCCAO	01-Dec-24	NOT YET DUE

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Action 3 – Co-create a single 3-to-5-year maternity strategy for gesh with staff, stakeholders and service users.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Strategy	* Co-create a single 3 to 5 year maternity strategy for GESH with staff, stakeholders and service users. * Ensure it has SMART objectives embedded. Build in the recommendation from MSSP to include the seven features of safety. Use the strategy as a basis for a Total Quality Management approach to quality.	Work is already underway with the Strategy team. A scoping meeting is scheduled for the w/c 10 June 2024, to explore options and develop a proposal for consideration by the Group Executive.	GCMidO with support from the Strategy Team	Meeting rescheduled to 01-Jul-24	NOT YET DUE

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Action 4 – Conduct an options appraisal for future management arrangements for Women & Children's services and co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology.

THEME	RECOMMENDATIONS	COMMENTS	ACTION OWNER	DEADLINE	STATUS
Structure	* Conduct an options appraisal for future management arrangements for Women & Children's services (and where Maternity Services best sits) and implement the preferred option. Reassess how the GCMidO role fits into the future arrangement. * Co-create an integrated multidisciplinary governance infrastructure for Maternity, Gynaecology and Neonatology to support levelling up practice, promote learning across sites and reduce duplication (e.g. a model which has a shared senior layer responsible for both trusts' maternity quality governance work, with some site-specific resource, e.g. for safety investigations).	**An Options Appraisal paper has been drafted. Group and Site Leadership Teams will meet on 14 June 2024 to progress this.**	**Group Exec leads and Site Leadership Team**	**Meeting rescheduled to 01-Jul-24**	**NOT YET DUE**

Group Board

Meeting on Thursday, 04 July 2024

Agenda Item	3.2	
Report Title	**Joint Maternity Quality Report** **April 2024 data**	
Executive Lead(s)	Professor Arlene Wellman MBE, Group Chief Nursing Officer	
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer Laura Rowe, Lead Midwife for Clinical Governance and Assurance ESTH Dr Benedicta Agbagwara-Osuji, Director of Midwifery and Gynaecology Nursing ESTH Janet Bradley, Director of Midwifery and Gynaecology Nursing SGUH Jessica Moore, Clinical Director Women's Health SGUH	
Previously considered by	ESTH Women's Health Perinatal Meeting ESTH Senior Leadership Team SGUH Divisional Management Team SGUH Senior Leadership Team gesh Quality Group Quality Committees in Common	7 June 2024 12-06-2024 18-06-2024 18-06-2024 13-06-2024 27-06-2024
Purpose	**For Assurance**	

Executive Summary

1.0 Purpose

It is a requirement of the Maternity and Perinatal Incentive Scheme and the Perinatal Quality Surveillance Model (December 2020) that a specified lists of maternity and neonatal monthly indicators are discussed by the Trust Board (or a designated sub-committee of the Trust Board) at every meeting.

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

The report data covers the position in April 2024.

2.0 Significant changes since the last report

ESTH and SGUH: in recognition of both Trusts achieving ten out of ten Safety Actions for CNST year 5, NHS Resolution has issued a rebate payment equal to their 10% contribution into the scheme, plus a share of the surplus funds in respect of trusts that did not achieve full compliance in all ten safety actions. For ESTH the total rebate is £1062661.25, and for SGUH it is £833789.07.

The Maternity and Perinatal Incentive Scheme for Year 6 was published on 2nd April 2024 and both maternity services are working towards meeting compliance.

ESTH: the Director of Midwifery has informed us that she has accepted a job at another Trust and will be leaving her post at ESTH.

3.0 Successes

SGUH
Equality Delivery System (EDS) presentation on 3rd April to an MDT audience including external representatives and SWL ICB colleagues
Visit of Birth Trauma, All Party Parliamentary Group (APPG) on 25 April 2024
'Whose Shoes' event, including staff, service users and LMNS.
Symposium on 26th April to learn about the "Robson Ten Group Classification System", a new perinatal audit system recommended by the World Health Organisation (WHO) & adopted by NHS England for monitoring, assessing, and comparing Caesarean section rates and other perinatal outcomes.

ESTH
'Whose Shoes' event, including staff, service users and LMNS, which focussed on accessibility and communication. The service is currently collating all the feedback to share with staff and generate actions.

4.0 Concerns and new risks

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

The Group Chief Midwifery Officer (GCMidO) contacted NHS Resolution for clarification and advice on the above and was informed in an email dated 22 May 2024 that *'' I can confirm that there is no requirement for general practitioners to undertake SBLCB training or fetal monitoring training within MIS''* and on 23 May 2024, *''that there is no requirement within MIS for GPs who provide antenatal care to undertake SBL training''.* The further reply on the 24th May was in response to a follow up email from the GCMidO seeking clarity that the advice is also applicable to GPs who provide antenatal care.

ESTH
Medical staff attendance at Safeguarding training was highlighted as a significant area of concern by the CQC following their inspection in August 2023. As of April 2024, training compliance for obstetric medical staff for Safeguarding (adults and children) remains low at 39% and 79% respectively.

At the Epsom site, 12 members of staff (9 midwives and 3 MSWs) are currently on maternity leave. Permission to over-recruit to cover maternity leave has been sought, but a decision has not yet been made. This is likely to result in significant staffing pressures and an increased need to use agency staff.

The Director of Midwifery has informed us that she has accepted a job at another Trust and will be leaving her post at ESTH.

SGUH

CNST Safety Action 1 requires Trust to report all perinatal deaths to MBRRACE-UK within 7 working days. The maternity service undertakes a monthly review of outcomes to ensure these are reflected accurately on the internal clinical dashboard and the SWL LMNS collated dashboard. During this process it was identified that two cases of neonatal deaths within the neonatal unit in April 2024 had not been reported to MBRRACE-UK within the 7 working day time frame.

As an outcome of this breach, mitigation to prevent further incidences include.

- All neonatal consultants have been reminded how to undertake rapid MBRRACE reporting.
- Maternity governance team will also undertake twice weekly data runs from the neonatal system Badgernet to identify any neonatal deaths and prompt upload by the neonatal team within the 7-day timeframe.
- Director Of Midwifery liaised with the Clinical Lead for CNST to seek exemption in these two cases.

FMU: Summary of St George's Fetal Medicine Unit concerns as summarised by GCMO on 13 June 2024. Since late 2023 there have been concerns about the safety and outcomes of some complex procedures. Concerns have been around:

- The role of the MDT in agreeing/planning complex procedures, and whether some procedures may have occurred contrary to the view of the MDT, or without waiting for the view of the MDT, when waiting was an option.
- Whether procedures that take a long time might be safer with dual consultant operating
- Whether the timing of some procedures may have been inappropriately based on individual consultant availability, rather than being planned sufficiently ahead.
- Whether those wishing to raise concerns could be confident that those concerns would be received in the right spirit by all in the Unit
- Whether outcomes that might properly be seen as incidents are being recorded on Datix
- Whether in cases of late termination the two doctor signatories to the form are the most appropriate people

The SGH Site CMO has overseen a formal tightening of safety governance arrangements whereby such complex procedures must now always involve two consultants. In addition, signatories to late termination forms must both be consultants.

Consultants are being asked as appropriate to give undertakings to the Site CMO about the ways in which they will work in relation to the above issues. The clinical director and the clinical lead are working with the Site CMO to commission a peer review of FMU.

Digital: the digital transformation project is underway, however, a current challenge with the project is the delay in recruiting the fixed term, B7 digital midwife post to support business as usual in maternity while the incumbent Digital midwife is the clinical lead for the project. The delay in recruitment has been escalated to the Head of IT, Head of the project and to the Project IT SRO, however, the situation has not resolved.

Baby falls: during a Maternity Safety Champion walkabout in February 2024, midwifery staff highlighted incidents of babies being accidentally dropped by parents in the postnatal ward during 2023. The Executive Safety Champion gave this feedback to the maternity leadership team and asked for a review

to take place, as well as to take immediate actions to prevent/minimise this happening. The service has since formed a task and finish group to review the cases and implement measures to minimise the risk of occurrence.

5.0 Training compliance related to the Core Competency Framework (Feb - April 2024)

Type of Training and % compliance	Staff Group	ESTH February 24	ESTH March 24	ESTH April 24
PROMPT 90%	Midwifery Staff	96%	96%	98%
	Maternity Support Workers	91%	88%	90%
	Consultant Obstetricians	93%	93%	92%
	Trainee and Staff Grade Obstetricians	100%	100%	97%
	Anaesthetics	91%	90%	86%
CTG Training 90%	Midwifery Staff	91%	92%	92%
	Obstetricians	92%	92%	94%
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	96%	98%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff			94%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff (requested)			

Type of Training and % compliance	Staff Group	February 24	March 24	April 24
		SGUH	SGUH	SGUH
PROMPT 90%	Midwifery Staff	87%	91%	91%
	Maternity Support Workers	83%	96%	91%
	Consultant Obstetricians	90%	95%	90%
	Trainee and Staff Grade Obstetricians	100%	100%	97%
	Anaesthetics	83%	92%	100%
CTG Training 90%	Midwifery Staff	84%	92%	90%
	Obstetricians	78% (75% Consultant and 80% middle grades)	96% (100% Consultant and 94% middle grades)	93% (100% Consultant and 86% middle grades)
NLS (Newborn Life Support) 90%	Midwifery Staff	89%	91%	92%

Safe staffing

Staff Group	Measure	February 2024		March 2024		April 2024	
Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		94%	77%	93%	80%	94%	89%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

Staff Group	Measure	February 2024	March 2024	April 2024

Midwifery	Fill rate (target >94%)	SGUH 92.6%	SGUH 92.1%	SGUH 92.1% (80% night)
Obstetric	Expected v Fill	100%	100%	100%
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	98.3%	92%	100%
Triage Staff SGUH, 2.0 wte per shift	Shift allocation 100%	100%	100%	100%

ESTH: There has been an increase in long term sickness at the Epsom site during April 2024; this has been due to unavoidable issues including mental health problems and ongoing muscular skeletal problems. These sicknesses are being managed in line with Trust policy and the expectation is that the sickness episodes will be closed within the next 6-8 weeks.

STH had fully recruited but have had 3 resignations in April 2024. This is due to work life balance and for personal reasons unrelated to work. These posts will be advertised in due course. EGH are currently at the interview stage of their recruitment process to appoint 5.4 WTE Band 5 scrub/recovery nurses and a cross site Band 7 theatre coordinator. The same Band 5 nurse recruitment will then be rolled out at STH.

The ongoing maternity staff reconfiguration is ongoing with a proposed implementation on 1st July 2024. The re configuration aim is to provide resilience within the midwifery staffing structure. The addition of 24/7 scrub/recovery nurse cover will also ensure CQC requirements are met.

Delays to inductions are still an ongoing issue, with over 30 incidents raised in relation to this issue since 01/01/2024. Work has begun to ensure that inductions are only offered in accordance with guidelines, following discussions with the obstetric consultant.

SGUH: The overall fill rate in April 2024 for SGH was 92.1% in the day and 80% at night. Closure of the birth centre has still been required to redirect staff to the delivery suite to mitigate gaps. On average the birth centre was open 64% in April, however the team recorded the highest birth rate for the last 3 months. There are new starters joining the Birth Centre core team in May, which is expected to reduce the closure rate.
No training was cancelled or rescheduled in April and specialist midwives can work on the delivery suite when required to maintain safe staffing levels – no unplanned additional support has been required.
Recruitment is underway in response to investment supported by the maternity establishment review with interviews for 14.8WTE midwives on 28th and 30th May (60 candidates shortlisted).

6.0 Current or upcoming plans/reviews/Quality Improvement

ESTH and SGUH
There is a requirement under CNST for the maternity and neonatal team to jointly register and undertake a QI project relating to transitional care and minimising the separation of mothers and babies. At ESTH, this is being led by the Associated Director of Nursing for Paediatric and Neonatal Services, and by the Neonatal Consultant Clinical Lead at SGUH.

There is need to review the arrangements for midwifery manager on call. This will be taken through an options appraisal in collaboration with ESTH, SGUH, ER and HR. This is currently subject to a formal grievance at ESTH, which had been outstanding for >2years.
The outcome of the options appraisal will be shared at a future Quality Committee.

ESTH

The service was reviewed by the Maternity Safety Support Programme between 7th and 10th May 2024. The high-level immediate feedback was provided (Appendix 1 in Reading Room). The full report and recommendations are awaited and an update will be provided to the Quality Committee once received.

SGUH

The maternity service received notification from medical physics in October 2023 that the cardiotocograph (CTG) machines to monitor fetal heart rate in the Day Assessment Unit would go out of licence and support at the end of the year (2023). This was identified as a risk, was escalated through division, site and group and placed on the risk register. The service has since received notification from medical physics that the original date given was an error and that the CTG machines will remain in license up to early 2026. The risk has been reviewed and risk score amended accordingly.

Outcomes of the moderate harm case reviews in maternity suggested that incidents of caesarean section at full dilatation was higher than expected. This led to a review by an MDT working group. The review explored cases between Jan 2022 to April 2024 and determined that this trend was normal variance without cause for concern.

New information (SGUH): The Committee is asked to note emerging information received from the Early Notification Scheme (ENS) arm of NHS Resolution, via email on 17 June 2024. ENS advised the Trust that they will be undertaking a thematic review of all cases the maternity service has referred to MNSI between 1 April 2017 – 31 May 2024.

What has triggered the review?

- The review was primarily triggered by the CQC rating of "Inadequate" and SGH's inclusion in the MSSP programme.
- Historically, the Trust had a low number of cases referred to MNSI, with performance in the Early Notification Scheme (ENS) initially rated green and below the national average.
- After a period in amber (over the national average but less than twice the national average), the Trust returned to green. However, five cases reported in a short timeframe have pushed the Trust back into amber and possibly red. The final status is pending as the national average for this period has not been calculated yet.

The five cases are listed below and includes the date and reason for referral to MNSI, they are not referenced elsewhere in this report as they do not fall in the data period of the report.

SGUH – Cases referred to MNSI between Dec 2023 – April 2024

Cases	MI and DW number	Incident declared	Reason for referral	MRI result	MNSI report status	Referral date
1	MI-036564/DW200437	SI	Therapeutic cooling	Abnormal MRI suggestive of neonatal stroke not HIE	Report with parents for final sign off. Has been discussed at MGM cases for presentation at SIDM when report final.	04/12/2023
2	MI-036652/DW201370	SI	Therapeutic cooling	Abnormal MRI suggestive of neonatal stroke not HIE. Genetic testing found variant with associated with clotting referred to Evelina	Draft report returned to MNSI awaiting final.	22/12/2023
3	MI-036846 DW204518 /DW204520	SI	Therapeutic cooling	Normal MRI Referred for trust and parental concerns	At interview stage	19/02/2024
4	MI-036962/MI-037416 DW204129	SI	Therapeutic cooling stopped after 12 hours. Decision for cooling made on basis of abnormal gases and tone at delivery. Normal CFM and neurology assessment at 12 hrs of age. Senior neonatal consultant decision to stop cooling	No MRI, initially rejected then accepted by MNSI so re-referred.	At interview stage	1st referral 27/03/2024 rejected by MNSI and then re-referred 07/05/2024
5	MI-037041 DW206701	SI	Therapeutic cooling stopped after 10 hours	MRI showed subdural haematoma and skull fracture not HIE	At interview stage	08/04/2024

Action required by Quality Committee-in-Common

The Committee is asked to:

a) Note the key areas of success, risks, and mitigations.
b) Note the CNST rebate awarded to both Trusts for meeting 10/10 Safety Actions in year 5.
c) Note the newly published CNST (MIS) year 6, the change to some safety actions, and submission dates.
d) Note that 2 neonatal cases at SGUH were not reported to MBRRACE-UK within the seven working day period and the actions the service have taken to address and mitigate occurrence of further incidents.
e) Make recommendations for any further action.

Appendices

Appendix No.	Maternity
Appendix 1	**READING ROOM** ESTH MSSP High level feedback
Appendix 2	**READING ROOM** SGUH Review of baby falls on Gwillim, postnatal ward
Appendix 3 A & B	**READING ROOM** A - SGUH Postpartum Haemorrhage (PPH) review B - SPC PPH week by week
Appendix 4 A & B	**READING ROOM** A - SGUH Maternity CQC Action Plan B – SGUH Maternity CQC MUST and SHOULD Do RAG
Appendix 5 A & B	**READING ROOM** A - ESTH Maternity Services CQC Action Plan B – ESTH CQC Action Plan update RAG
Appendix 6	**READING ROOM** CNST Year 6 – overview of significant changes

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications
N/A
Legal and /or Regulatory implications
There is an ongoing requirement to achieve compliance in the MUST and SHOULD Do actions issued by the CQC in line with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations.
Equality, diversity and inclusion implications
As set out in the paper.
Environmental sustainability implications
No issues to consider.

Group Maternity Services Quality Report

Quality Committee-in-Common, 27 June 2024

1.0 Purpose of paper

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

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

2.0 Background

2.1 The report data covers the position in April 2024.

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

Currently the report includes:

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

3.0 Analysis

3.1 Maternity and Perinatal Incentive Scheme (CNST) – Year 6

The Maternity Services at ESTH and SGUH were assessed as compliant with all 10 safety actions in the Year 5 Maternity Incentive Scheme. On 6 June 2024, both Trusts received notification of their 10% contribution award as well as their share of the surplus funds in respect of Trusts that did not achieve ten out of ten Safety Actions. ESTH was awarded a total of £1,281,467.09 and SGUH £833,789.07.

The Technical Guidance for Year 6 of the Maternity and Perinatal Incentive Scheme (MIS) was published on 2nd April 2024. Changes have been made to some Safety Actions and these can be found in (Appendix 6 Reading Room). There are 86 separate requirements that must be evidenced and signed-off by the Trust Board and the ICB after the end of the MIS period (30th November 2024). The deadline date for the Board Declaration Form to be sent to NHS Resolution will be 12:00 midday on 3rd March 2025.

ESTH has convened a working party within the Women and Children's Health Division to monitor compliance with the requirements of the scheme, gather evidence, and complete the Excel audit and monitoring tool (new) which has been provided for Trusts to use for assurance purposes.

Work is on-going but the current position is:

Overview of progress on safety action requirements

Safety Action Requirements:

Safety Action	Red	Amber	Green	Blue	Total Requirements
1	1	5	0	0	6
2	0	2	0	0	2
3	2	0	2	0	4
4	17	3	0	0	20
5	1	4	1	0	6
6	4	2	0	0	6
7	6	1	0	0	7
8	4	14	0	0	18
9	0	8	1	0	9
10	0	8	0	0	8
Total	35	47	4	0	86

Key:

Red	Not compliant
Amber	Partial compliance - work underway
Green	Full compliance - evidence not yet reviewed
Blue	Full compliance - final evidence reviewed

SGUH maternity has also convened a working group to monitor compliance with the requirements of the scheme including use of the Excel audit tool provided by NHS Resolution to track progress. Leads have been allocated for each safety action.

All safety actions are on track, however, in SA1 – PMRT reporting - there was a delay in reporting two neonatal deaths to PMRT/MBRRACE-UK within 7 working days. The review of care (as per PMRT pathways) was however already underway by the time the omission was identified two weeks later. This reporting lapse was due to staffing gaps within the neonatal governance team and no agreed safety netting while recruitment to the post (which was delayed since September 2023) took place. This was flagged to CNST immediately upon detection and an exemption has been requested, which if granted, the service will remain on track for compliance against this safety action.

3.1.1 Safety Action 1: *Are you using the National Perinatal Mortality Review Tool (PMRT) to review perinatal deaths from 8 December 2023 to 30 November 2024 to the required standard?*

Maternity is required to submit a quarterly report to the Trust Board demonstrating compliance with the standards as stipulated in the CNST Year 6 Technical Guidance. Compliance will be reported bi-monthly at every QCiC meeting.

All eligible perinatal deaths should be notified to MBRRACE-UK within seven working days:

For at least 95% of all the deaths of babies in your Trust eligible for PMRT review, Trusts should ensure parents are given the opportunity to provide feedback, share their perspectives of care and raise any questions and comments they may have from 8 December 2023 onwards.

For deaths of babies who were born and died in your Trust multi-disciplinary reviews using the PMRT should be carried out from 8 December 2023; 95% of reviews should be started within two months of the death, and a minimum of 60% of multi-disciplinary reviews should be completed and published within six months.

ESTH

Since the last report in March 2024 there has been 1 eligible case for PMRT review, which has been reported to MBRRACE-UK in accordance with the above requirement. The table also shows reporting of eligible cases (termination of pregnancy and early IUD of a multiple) since 8th December 2023 which are not included within the standard.

Case ID:	Date of Death	Date Reported	Supported for PMRT Review Y/N
90870	14/12/2023	14/12/2023	N (TOP)
91174	03/01/2024	04/01/2024	N (IUD of twin delivered at term)
91830	08/02/2024	09/02/2024	N (TOP)
92409	17/03/2024	18/03/2024	N (TOP)
92613	01/04/2024	02/04/2021	Y

Case ID	Date of Death	Review Started	Review Completed	Parents Informed	Notes
89220	03/09/2023 (Stillbirth at 38/40)	Y	N	Y	***MBRRACE-UK has confirmed that this will not count towards CNST compliance. This is a MNSI case, and the report is still pending.***
90188	03/11/2023 (Stillbirth at 31+4/40)	Y	Y	Y	***Standard met***
90672	04/12/2023 (Stillbirth at 38+1/40)	Y	N	Y	***Standard on track***
90702	05/12/2023 (Stillbirth at 36+1/40)	Y	N	Y	***Standard on track***
92613	02/04/2023 (Neonatal death at 34+4/40)	Y	N	Y	***Standard on track***

ESTH - Perinatal Mortality Reviews

The Perinatal Mortality cases reported and reviewed during the period 1st April 2023 to 30th April 2024 can be found in Appendix 1. In summary:

	March 2023 – February 2024	April 2023 – March 2024	May 2023 – April 2024
Antepartum stillbirths	**13**	**10**	**9**

Intrapartum stillbirths	**2**	**2**	**1**
Stillbirth (unknown timing	**0**	**0**	**0**
Early neonatal death	**1**	**1**	**1**
Late neonatal death	**1**	**1**	**0**
	(17)	**(14)**	**(11)**
<24 weeks	**2**	**2**	**1**
24 – 27 weeks	**4**	**2**	**2**
28 – 31 weeks	**1**	**1**	**1**
32 – 36 weeks	**4**	**4**	**4**
37 – 41 weeks	**6**	**5**	**3**
≥ 42 weeks	**0**	**0**	**0**

The table below shows a summary of cases discussed, themes and open actions in relation to Perinatal Mortality Reviews (PMRT) undertaken in April 2024 and should be read in conjunction with the summary Board report.

PMRT Panel	Cases reviewed April 2024	Emerging Themes	Open Actions from previous reviews, year to date	
ESTH: 1 panel meeting held (26/04/2024 with an external panel member)	INC-143962 (SI also completed and signed-off) ***Grading: B,A***	No new clear emerging themes identified to date that contributed to the deaths but the panel has noted that there is a trend of not completing partograms in labour for cases of intrauterine death and 2 incidents highlighted issues with following up result (unrelated to the outcomes). The case reviewed in April 2024 related to a term intrauterine death; the panel concluded that there were no care or service delivery issues that would have contributed to the stillbirth but other learning has been identified. This woman transferred her care from another Trust and an issue will be raised regionally about how we access care records now that women no longer carry hand-held notes.	INC-130317 and others INC-132938 INC-141041 INC-142169	1. Review to be undertaken by the obstetric team, in conjunction with the regional team, of the blood tests required following a stillbirth. ***This action has been extended as regional review is recommended.*** 2. Roll out the use of the SBAR facility in BadgerNet (29/02/2024). 3. RCOG Pre-labour rupture of membranes leaflet to be included on BadgerNet for women to access and guidance to be updated (31/01/2024). 4. Diabetes guideline to include the management of women on Metformin post steroid administration (31/01/2024). 5. Process for following up results for women discharged before the results are available (31/03/2024). 6. To add issues around the completion of a partogram for IUD cases to mandatory BadgerNet update training 01/05/2024)

Evidence that reports are discussed with the maternity safety champions is a requirement of CNST.

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

There have been no clear themes emerging from the review of stillbirths and neonatal deaths that contributed to the outcome. The panel held in April 2024 included an external member.

The latest ***MBRRACE-UK*** Perinatal Mortality Report for 2022 birth has shown that ESTH are average when compared with similar Trusts for stillbirth (up to 5% higher or up to 5% lower) and lower than

average for neonatal death (more than 5% and up to 15% lower). These are the same findings that were published in the 2021 report.

SGUH

There were 2 neonatal deaths in April 2024 to report. **acknowledged earlier in report as late reporting

The table below reflects antepartum stillbirths, intrapartum stillbirths and neonatal deaths.

		SGUH			
		January 2023 –April 2024		April 2024	
		Total number of Births	Total Number of Deaths	Total number of Births	Total number of Deaths
		5802	63	325	0
Type of Mortality	Antepartum Stillbirths		27		0
	Intrapartum Stillbirths		2		0
	Stillbirth of unknown timing		4		0
	Neonatal Deaths		30		2
Gestational Age	<24 weeks		12		0
	24 - 27 weeks		23		0
	28 - 31 weeks		8		0
	32 - 36 weeks		11		0
	37- 41 weeks		9		0
	≥ 42 weeks		0		0

Perinatal Mortality Reviews

During April 2024, two panel meetings were held, both had external panel members and 4 cases were discussed.

PMRT Panel	4 Cases reviewed in April 2024	External panel member present Y/N	PMRT grading of cases (A-D)	Emerging Themes	Open Actions from previous reviews, year to date	
SGH: 2 panel meetings	ID 90985 (IUD - SGH)	Y	Antenatal care - B Bereavement - A	There were 2 cases reviewed at the meetings in April 2024 where the panel considered there were care issues that ***would have made no difference*** to the outcome, including a missed opportunity to monitor fetal heart in DAU as per cardiologist plan.	ID 89718	1. Frimley will be revising their guidelines around further investigations when a baby has an increasing FI02 - further education to team.
	ID 91359 (NND – born elsewhere and died at SGH)		Antenatal C (St Helier) Intrapartum C (LAS/SH), Postnatal A	There was 1 case reviewed in April 2024 where the panel considered there were care issues that ***may have made a difference*** to the outcome. An opportunity for early recognition of established labour was missed not allowing appropriate management. In another hand, on arrival to SGH via LAS, baby was found to be hypothermic.	ID 90962	2. Midwifery and team leader at Croydon aware of delay in appointments due to capacity. Discussed with POD and plan made for appropriate escalation.
	ID 91254 (IUD – SGH)		Antenatal A, Bereavement A			
	ID 91942 In-utero transfer to SGH (NND)		Antenatal D (CUH), Intrapartum A, Postnatal B (SGH)	There was 1 case reviewed in April 2024 where the panel identified care issues which they considered ***were likely to have made a difference*** to outcome, including the failure in the recognition of risks factors and appropriate management of the pregnancy during the antenatal period.		

3.1.2 **Safety Action 2:** *Are you submitting data to the Maternity Services Data Set (MSDS) to the required standard?*

ESTH and SGUH are compliant with this safety action, however the final outcome will depend upon compliance for the July 2024 data, which will be published in October 2024.

3.1.3 **Safety Action 3:** *Can you demonstrate that you have transitional care (TC) services in place and are undertaking quality improvement to minimise separation of parents and their babies?*

ESTH and SGUH: A pathway into transitional care is in place for both Trusts. ESTH is currently reviewing the configuration of the service. The SGUH neonatal team have commenced recruitment for the neonatal nursing workforce to support a 24/7 transitional care service, following financial investment as part of the establishment review. There is a requirement to register a QI project in relation to TC by 01/10/2024 and to submit a report on progress to the Board by the end of the CNST period and the neonatal team are leading on this safety action.

3.1.4 **Safety Action 4:** *Can you demonstrate an effective system of clinical workforce planning to the required standard?*

There are several requirements around obstetric medical workforce, anaesthetic workforce, neonatal medical workforce and neonatal nursing workforce and a requirement to meet RCOG, ACSA and BAPM standards. These requirements are being tracked via the CNST working groups at both Trusts. The Trust Board or its designated sub-committee must formally note compliance status in the minutes; where the service is non-compliant an action plan must be agreed by the Board, LMNS and the ICB. The due date for any such actions is 30/11/2024.

Consultant attendance at emergencies

Trusts are required to monitor their compliance of consultant attendance for the clinical situations listed in the RCOG workforce document: 'Roles and responsibilities of the consultant providing acute care in obstetrics and gynaecology'. In April 2024 both Trusts were 100% compliant with consultant attendance.

3.1.5 **Safety Action 5:** *Can you demonstrate an effective system of midwifery workforce planning to the required standard?*

There is a requirement to demonstrate that the staffing establishment meets the recommendation of the latest 3 yearly Birthrate+ report or a local workforce plan alternative. The Trust Board agreed to staff the service at both ESTH and SGUH in line with recommendations in January 2024.

Year 6 of the MIS was updated to reflect the new requirement for labour ward coordinators, which now state they must have supernumerary status at the beginning of their shift and that an escalation process is in place which describes action to be taken if the Labour Ward Co-ordinator loses their supernumerary status.

Safe staffing

Staff Group	Measure	February 2024	March 2024	April 2024

Midwifery	Fill rate (target >94%)	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH	ESTH STH	ESTH EGH
		94%	77%	93%	80%	94%	89%
Obstetric	Expected v Fill	100%		100%		100%	
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	100%		100%		100%	
Triage Staff 1 wte per shift	Shift allocation 100%	100%		100%		100%	

Staff Group	Measure	February 2024	March 2024	April 2024
Midwifery	Fill rate (target >94%)	SGUH 92.6%	SGUH 92.1%	SGUH 92.1% (80% night)
Obstetric	Expected v Fill	100%	100%	100%
Band 7 supernumerary MW allocated at start of shift	Shift allocation 100%	98.3%	92%	100%
Triage Staff SGUH, 2.0 wte per shift	Shift allocation 100%	100%	100%	100%

Red Flag Category - April 2024	ESTH St Helier	ESTH Epsom
Coordinator not supernumerary	0	1
Delay in critical activity	0	0
Delayed induction of labour	4	6
Delayed pain relief	0	1
Delayed or cancelled care	1	0
Number of clinical incidents related to red flags	0	0

ESTH

There has been an increase in long term sickness at the STH site during April 2024; this has been due to unavoidable issues including mental health problems and ongoing muscular skeletal issues. These sicknesses are being managed in line with Trust policy and the expectation is that the sickness episodes will be closed within the next 6-8 weeks.

STH had fully recruited but have had 3 resignations in April 2024. This is due to work life balance and for personal reasons unrelated to work. These posts will be advertised in due course. EGH are currently at the interview stage of their recruitment process to appoint 5.4 WTE Band 5 scrub/recovery nurses and a cross site Band 7 theatre coordinator. The same Band 5 nurse recruitment will then be rolled out at STH.

The ongoing maternity staff reconfiguration is due to be implemented later in the year and should go some way to provide resilience within the midwifery staffing structure. The addition of 24/7 scrub/recovery nurse cover will also ensure CQC requirements are met.

Delays to inductions are still an ongoing issue, and work has begun to ensure that inductions are only offered in accordance with guidelines, following discussions with the obstetric consultant.

SGUH

No red flags were reported on Datix for April 2024

The overall fill rate in April 2024 for SGH was 92.1% in the day and 80% at night. Closure of the birth centre has still been required to redirect staff to the delivery suite to mitigate gaps. On average the birth centre was open 64% in April, however, the team recorded the highest birth rate for the last 3 months. There are new starters joining the BC core team in May, which is expected to improve the availability of the birth centre to women and birthing people who wish to use it.

No training was cancelled or rescheduled in April. Specialist midwives can work on the delivery suite when required to maintain safe staffing levels – no unplanned additional support has been required.

Recruitment is underway in response to investment supported by the maternity establishment review with interviews for 14.8WTE midwives on 28th and 30th May (60 candidates shortlisted).

3.1.6 **Safety Action 6:** *Can you demonstrate that you are on-track to achieve compliance with all elements of the Saving Babies Lives Care Bundle Version Three?*

ESTH: the first quarterly review meeting by the LMNS/ICB took place in April 2024 and ESTH were assessed as 93% compliant. The next quarterly review meeting has been scheduled for 15th July 2024.

SGUH: the last quarterly assessment of compliance undertaken by the ICB took place on 17 April 2024 and the service was assessed as being 79% compliant against the 70 interventions, which is an improvement from 71% that was achieved in January 2024. The next quarterly review has been scheduled for 21 July 2024.

3.1.7 **Safety Action 7:** *Listen to women, parents and families using maternity and neonatal services and coproduce services with users.*

Both Trusts have well-established MNVPs; however, this CNST year 6, several additional requirements have been added to their role, which are currently being discussed at a regional level due to concerns about resource, unknown capability of service users and potential training requirements within the MNVP group to take on these extra responsibilities.

SGUH: the longstanding MNVP Chair of ten years, notified the service and SWL LMNS of her intention to step down as Chair. The service acknowledges the support and dedication she gave during her tenure and wish her well for the future. The service is working with the LMNS to recruit a new MNVP chair.

3.1.8 **Safety Action 8:** *Can you evidence 90% attendance for the relevant staff groups at fetal monitoring training, multi-professional 1 day emergencies training and Neonatal Life Support training?*

There is a requirement that 90% of paediatric/neonatal medical staff who attend neonatal resuscitations should have a valid Resuscitation Council NLS certification and in common with most providers in the region, this is likely to be challenging. This has been escalated through the regional teams and the requirement has been discussed at the CNST meeting to ensure the neonatal team are aware they need to report on their compliance with this.

Training compliance:

Type of Training and % compliance	Staff Group	ESTH February 24	ESTH March 24	ESTH April 24

PROMPT 90%	Midwifery Staff	96%	96%	98%
	Maternity Support Workers	91%	88%	90%
	Consultant Obstetricians	93%	93%	92%
	Trainee and Staff Grade Obstetricians	100%	100%	97%
	Anaesthetics	91%	90%	86%
CTG Training 90%	Midwifery Staff	91%	92%	92%
	Obstetricians	92%	92%	94%
NLS (Newborn Life Support) 90%	Midwifery Staff	96%	96%	98%
NLS (Newborn Life Support) 90%	Neonatal Nursing Staff			94%
NLS (Newborn Life Support) 90%	Neonatal Medical Staff (requested)	Data requested	Data requested	Data requested

Type of Training and % compliance	**Staff Group**	**February 24**	**March 24**	**April 24**
		SGUH	**SGUH**	**SGUH**
PROMPT 90%	Midwifery Staff	**87%**	**91%**	**91%**
	Maternity Support Workers	**83%**	**96%**	**91%**
	Consultant Obstetricians	**90%**	**95%**	**90%**
	Trainee and Staff Grade Obstetricians	**100%**	**100%**	**97%**
	Anaesthetics	**83%**	**92%**	**100%**
CTG Training 90%	Midwifery Staff	**84%**	**92%**	**90%**
	Obstetricians	**78% (75% Consultant and 80% middle grades)**	**96% (100% Consultant and 94% middle grades)**	**93% (100% Consultant and 86% middle grades)**
NLS (Newborn Life Support) 90%	Midwifery Staff	**89%**	**91%**	**92%**

3.1.9 **Safety Action 9:** *Can you demonstrate that there is clear oversight in place to provide assurance to the Board on maternity and neonatal safety and quality issues?*

Perinatal Quality Surveillance

This joint maternity report includes all the elements required to be reported in accordance with the Perinatal Quality Surveillance data.

Information regarding the following has been included elsewhere in the report:

- CQC
- Perinatal Deaths (CNST Safety Action 1)
- Training Compliance (CNST Safety Action 8)
- Safe Staffing (CNST Safety Action 5)
- MNSI Cases (CNST Safety Action 10)

There have been no issues of Coroner Regulation 28 and no other new requests or concerns raised directly with the Trusts from other regulatory bodies in April.

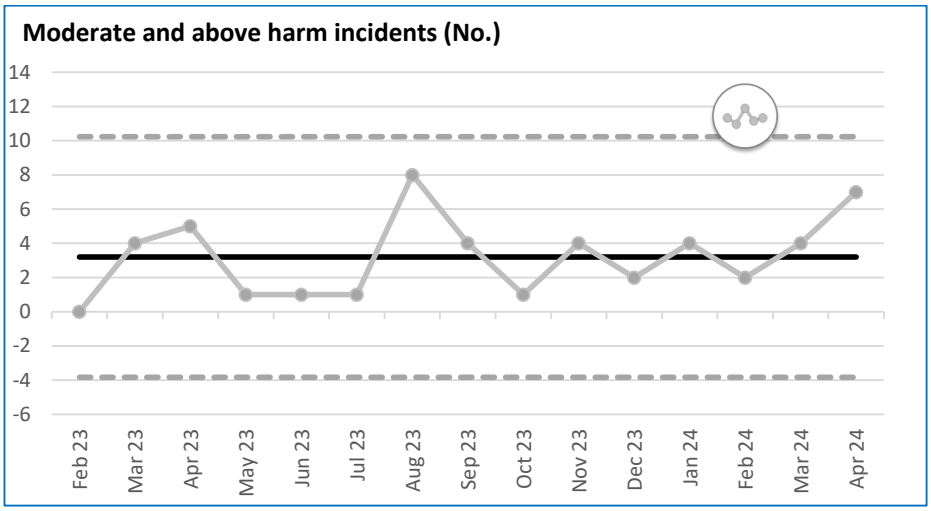
Moderate harm and above incidents

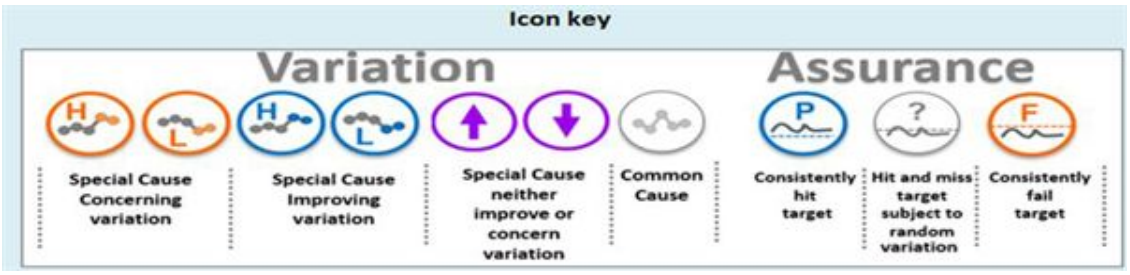
'Harm' relates to the degree of harm caused as a result of a patient safety incident and NHS England Guidance (maternity example) states that a harm grading should only be applied to maternity incidents if it is considered that a patient safety incident, such as an omission or error in care has led to, or contributed to the harm (NHS England, 2019). There is conflicting practice across both Surrey Heartlands and SWL LMNS regarding grading harm for outcomes where no patient safety incidents have occurred to contribute to the outcome, and this has been escalated through the region. The Maternity Safety Support Programme (MSSP) Team confirmed during their diagnostic review at ESTH, that there is yet no updated NHSE guidance but acknowledged there is a need for this.

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

ESTH: In April 2024, there were 7 incidents which were reported as resulting in moderate harm and above; 4 related to 3rd degree tears and 2 related to obstetric haemorrhage >1500mls; these cases are currently being reviewed by the obstetric team to determine if there were any patient safety incidents which contributed to the outcome. There was a case of an inverted uterus following delivery and this case is progressing as a Patient Safety Investigation following presentation to the Trust Incident Review Panel.

The table below shows the trend of moderate harm grading over the last 15 months, with the caveat that the April 2024 incidents may be downgraded following review. This shows a stable position over time.





SGUH: In April 2024, 34 incidents were graded at moderate harm (broken down as seen in table below). Investigations and case reviews are in progress for all incidents.

There is one open internal Serious Incident Investigation, related to a pre-term delivery with twin cord occlusion. This SI is at the stage of a final draft report.

No SI cases were closed in April and there are no overdue SI related actions.

SGUH	Moderate / Severe Harm	Incident detail and immediate safety actions
Moderate (23)		There were 12 incidents relating to post-partum haemorrhages of 1.5 litres and above. These cases have all been discussed in an MDT meeting and quarterly themes will be reported at MGM Business. Feedback has been given to medical and midwifery staff about the importance of completing clear postnatal plans and the PPH proforma.
Moderate		DW206840 ITU admission post MROP, septic, hypotensive requiring vasopressors DW207716 Unexpected admission to NNU
Moderate (9)		9 incidents of 3rd degree tears. These will all be reviewed at an MDT moderate cases meeting.

Patient Safety Incident Investigations (PSII)/Themes

ESTH: there are currently 8 open Patient Safety Investigations in progress, 2 of which are being investigated by MNSI and 1 which is awaiting sign-off by the division. There are no clear themes emerging however, this will continue to be reviewed during and post transition to PSIRF. The maternity service transitioned to the PSIRF model on the 2nd April 2024.

There was one Serious Incident Report completed in April 2024 and this was presented to the Trust Serious Incident Panel in May 2024. Completion of actions from MNSI/PMRT/SI/PSII is monitored centrally via a tracker by the Maternity Risk Team. There is currently one overdue action in progress:

- BadgerNet refresher training to be updated to include a critical alert when results are not checked.

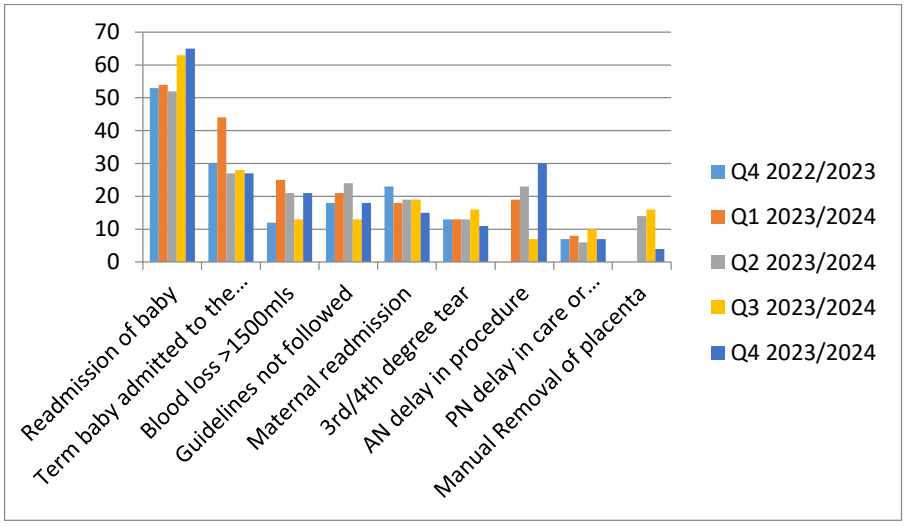
Top 5 Incidents

In April 2024, the top 5 reported incidents were:

- Readmission of baby
- 3rd/4th degree tear
- Maternal readmission
- Term baby admitted to the neonatal unit

- Blood loss >1500mls 5
- Born before arrival

Except for 'born before arrival' this is reflective of the thematic analysis over the last 5 quarters:



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.

SGUH: In April the top five reported incidents were:

- Blood loss over 1.0 litre
- 3rd /4th degree tear
- Maternal transfer to HDU
- Transfer to NNU – planned and unplanned
- Referral for home blood glucose monitoring and unable to offer appointment

The Diabetic MDT are re-evaluating referrals into the Diabetic Service and to support this the teams have been requested to log episodes of referrals as part of this review.

Patient and staff experience and engagement

ESTH: Friends and Family (FFT) feedback

At the time of writing this report, the most recent available FFT feedback is from March 2024. There were 93 responses in total of which 93% were positive, with compliments on the care provided by staff, the décor and the food. Negative comments were around the attitude of one midwife.

SGUH: Friends and Family (FFT) feedback

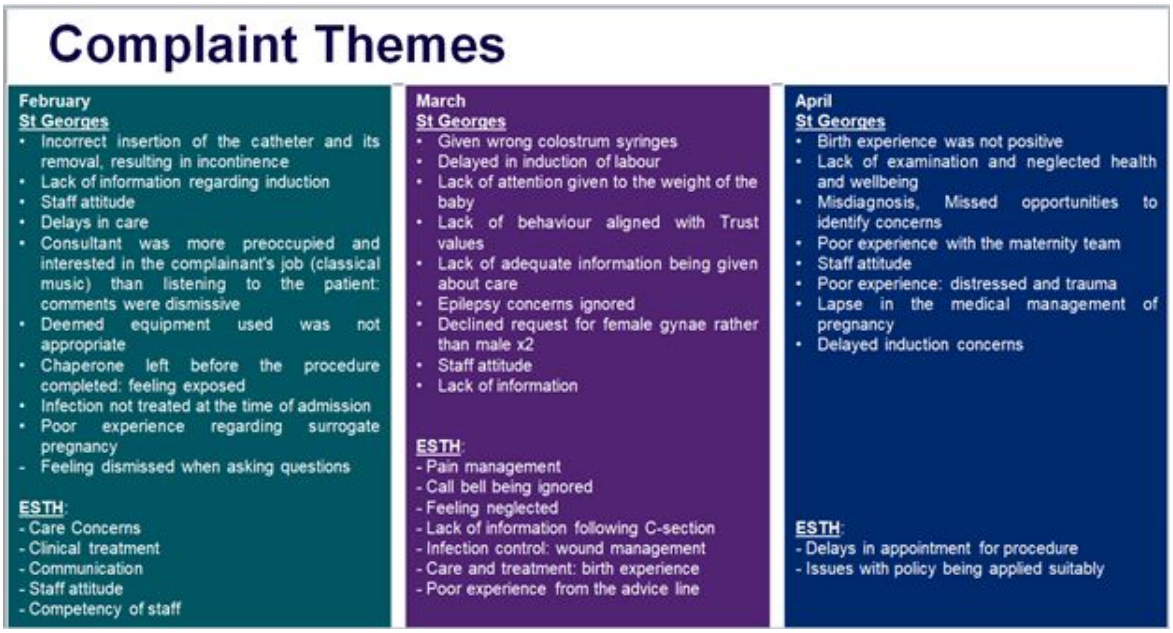
There were 170 responses across the maternity unit with an average of 92% satisfaction rate. The highest performing areas were Carmen Antenatal Ward and Carmen Birth Centre scoring 100%

satisfaction rate. The areas providing opportunities for improvement were ANC describing waiting times and environment as influencing factors in scores. A demand and capacity workstream is underway in ANC to determine which pathways of care can be supported by midwives in the community settings to free up space and capacity in the hospital ANC setting reducing pressure accordingly.

ESTH: Complaints feedback

The maternity service received two complaints in April 2024; both related to retained placental tissue which is a known risk factor associated with pregnancy and does not necessarily indicate negligence. Where women are asymptomatic, conservative management is usually recommended, but occasionally if heavy bleeding persists or there are signs of infection, surgical management is required. The diagnosis of retained placental tissue can only be made from histological examination following removal.

The maternity service received two complaints in March 2024, two complaints in February 2024 and none in January 2024. One complaint related to an alleged GDPR breach, and the other complaints were of a more general nature around care in labour and postnatal care.



SGUH: Complaints

The maternity service received five complaints in April. Two of these relate to patients experience of clinical care and referral routes in FMU, the remaining three include concerns regarding care in the intrapartum and postnatal settings and staff attitude.

Complaints for SGUH Maternity Q4 23/24 are described below:

Patient Experience - Complaints	Midwifery Services Q4 2023—2024
	Q4
Complaints – Number of complaints	11
Complaints – Quarterly performance	81.8% 2 breached in Q4 – 2 amber cases
Complaints – Re-opened	2
Complaints – Oldest Re-opened in Days	243 days – 034AA reopened in 09/23 > 8 months ago. Awaiting meeting
Complaints – Out-of-time	0
Complaints post-investigation Action Monitoring - Number of overdue complaint actions	49

Staff engagement

The Year 6 Technical Guidance for the Maternity and Perinatal Incentive Scheme includes the requirement for engagement events to be held with maternity and neonatal staff within each service every two months, which is an increase from the Year 5 guidance, which was quarterly. Both Trusts have met the requirement for it being in place by 1st July 2024. Issues raised and the progress made against them should be shared with all maternity and neonatal staff. A staff engagement event took place on 15th May 2024 and the dashboard of current on-going concerns was shared with staff beforehand.

ESTH: issues currently on the Dashboard include,

- Maternity Manager on-call arrangements
- Issues with the BadgerNet app and appointments
- Parking
- Staffing issues
- Interpreting services
- Fetal Growth Surveillance
- Lack of de-brief appointments (demand outstripping capacity)
- Lack of office space for specialists
- Variation form and payroll concerns
- Lack of sonography staff
- Bank rates of pay
- Décor issues within STH
- Maternity website
- Lack of clinic venues in the community
- Transitional care staffing (now highlighted by the CQC)
- Complexity of the agency approval process

SGUH: issues currently on Dashboard include,

- Lack of working Birth Pools
- Baby Falls
- CTG machines in DAU potentially out of licence
- Challenge around lack of autonomy regarding financial control
- Recognition of the value and morale boost to staff in investment in TC services
- Limited space in DAU to hold confidential conversations with women.

ESTH: Claims scorecard review

The most recent claims scorecard was published in the summer of 2023; the analysis of this alongside incidents and complaints has been included in the table below.

The Trust had no claims in the yellow or green zones.
Red claims (High Value (over 1 million) and High Volume (3 or over)): There are 7 red claims with a value of £88,475,453, 5 which are on-going (not settled), one of which has been settled with periodical payments and one of which has been closed with no damages.

Blue claims (Low Value (<1 million) and High Volume (3 or over)): There were 58 blue claims with a value of £4,979,975

- 28 claims were settled with damages paid
- 18 claims were closed with nil damages paid
- 12 blue claims are currently open

There are no themes emerging from red claims which relate(d) to:

- Failure to diagnose Cornelia De Lange syndrome in the antenatal period (joint with SGUL)
- Inappropriate management of Syntocinon leading to HIE (settled out of court as causation denied)
- Abnormal CTG leading to HIE (this case has been closed with no damages as MRI confirmed that the insult occurred 2 week prior to birth (antenatal)
- Failure to monitor bilirubin levels leading to Bilirubin-induced neurological dysfunction (open)
- Traumatic delivery resulting in psychological injury for both parents (open)
- Failure to offer growth scan; this would have identified that the baby was in the breech position as an incidental finding (open claim for HIE II following a vaginal breech delivery)
- HIE III following maternal sepsis (open)

Blue claims continued……

- 3rd degree tear – woman claims that she should have been offered a caesarean section due to the estimated fetal weight
- Infection
- Shoulder dystocia – woman claims that she should have been offered a caesarean section due to the estimated fetal weight
- Management of placenta accreta
- Urinary incontinence following delivery
- Care in HDU
- PPH leading to HDU admission
- Trauma to the baby following forceps delivery
- Suturing leading to nerve damage
- Pressure damage
- Inappropriate discharge in early labour.

Correlation with complaints and incidents

Incidents
There are no clear themes emerging from the review of incidents that correlated with a trend in claims (there were no common themes identified in claims). CTG interpretation is a factor in a number of investigations and the fetal monitoring midwife continues to audit and make recommendations and cases where learning has been identified are used in mandatory training. There are regular informal CTG review sessions and a regular fetal surveillance newsletter is produced. CTG concerns have been identified as an area for local improvement on our PSIRF plan.

Blue claim themes: There are no clear themes emerging from review of these claims, 3 of which related to gynaecological management in early pregnancy. Issues identified included: • Failure of antenatal screening to detect abnormalities/maternal conditions • Failure to respect women's choice/birth plans • Retained products of conception • CTG/monitoring in labour • Failure to act appropriate on test results • Diathermy injury • Inadequate pain relief • Feto-maternal haemorrhage	A theme had been identified previously by MNSI in relation to monitoring of fetal growth and training and audit has been strengthened in response to this. This has not emerged as a complaints theme over the last 5 quarters and best practice and performance is monitored via SBLCBv3 by both the Trust and the ICB. **Complaints** All complaints are triaged against the incident reporting system and are linked if there is an investigation on-going. Following receipt of the 2023 scorecard the themes from complaints were analysed over the last year but there was not clear correlation with claims due to no trend being evident. Emerging themes (3 or more mentions) for complaints included: • Staff attitude (no correlation with claims) • PPH cause and management (included as an area for local improvement on our PSIRF plan) • Women feeling coerced into unwanted treatment following explanation of risks • Management of gestation diabetes • Lack of/delay in debrief appointments

April 2024 Claims report

In April 2024 the legal service received 4 new potential claims relating to maternity services. There were no claims closed during April 2024.

Ref	Claim Date	Incident Date	Claim Type	Synopsis
EGH/2024/DYER	12/04/2024	28/06/2021	CNST	Potential claim - Query regarding EPAU and telephone call for maternity care. Query - pre-action only.
EGH/2024/CL/2022	12/04/2024	01/08/2023	CNST	Disclosure request - August 2023, Client went into labour and had to have emergency c-section. Client was then transferred to another hospital. Allegations may pertain to failure to provide appropriate care during the relevant period.
STH/2024/PANA	17/04/2024	30/01/2024	CNST	New claim - This patient came to the Trust on 30/01/24 for c-section, no complications but prolonged bleeding for 8 weeks , saw Consultant privately and investigations found retained products of conception 3x3cm possible retained placenta. Pt had night sweats, cramps and anxiety as a result of the error.
STH/2024/VAN	09/04/2024	12/01/2012	CNST	New claim - The claimant is alleging that the Trust failed to arrange outpatient paediatric follow up appointments within a few weeks of birth which included ultrasound scans. It is alleged that the midwives failed to measure the baby's head circumference which led to the delay in diagnosing arachnoid cysts and hydrocephalus.

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University Hospitals and Health Group

SGUH SCORE CARD 2023

The Trust had no claims in the **Yellow** or **Green** zones.

Red zone claims (High Value (over 1 million) and High Volume (3 or over)):
There are **8** red claims with a value of £88,543,593, all of which are on-going (not settled).
Themes emerging from Red zone claims:

- Two of the eight claims concerned a failure to review CTG pathological reviews

The remaining claims did not have clear themes but related to:

- Failure to appropriately manage labour, resulting in hypoxia and needing long term care
- Failing to consent in order for the claimant to make an informed decision
- Delay in diagnosing Jaundice resulting in Kernicterus and brain damage
- Failure to monitor CL breastfeeding resulting in the development of hypoglycaemia and permanent brain damage
- Delay in providing oral antibiotics which would have prevented premature birth
- ENS 39+2 - induction of labour gestational diabetes. Emergency LSCS under general anaesthetic, uterine rapture confirmed at LSCS, The foetal heart was being intermittently monitored by CTG. An MRI performed showed appearances of hypoxic ischaemic injury associated with a profound, near total hypoxic ischaemic event at term

Blue zone claims (Low Value (<1 million) and High Volume (3 or over)):
There were **33** blue claims with a value of £4,500,322

- 13 claims were settled with damages paid
- 9 claims were closed with nil damages paid
- 11 blue claims are currently open

Blue claim themes:
The most common allegations relate to failing to assess the progress of labour and failing to seek timely reviews and in one case a baby was still-born as a result (open). Other issues identified included:

- Failure to under take c-section at earliest opportunity (open)
- Use of forceps against patients wishes, resulting in trauma to the baby (open)

Blue claims continued….

- Misdiagnosis of vaginal tear 3, resulting in surgery being carried out 12 months later (open)
- Improper administration of epidural leading to severe back pain (settled)
- Failure to interpret and report placenta praevia during ultra sound (open)
- Inappropriate discharge in early labour (settled)
- Failure to act upon a report of reduced movements and to commence CTG monitoring following the administration of pethidine, resulting in intrauterine asphyxia and psychiatric injury (open).

Correlation with complaints and incidents

Incidents
There were no clear themes emerging from the review of incidents that correlated with claims (there were no common themes identified in claims). Obstetric review and foetal monitoring were factors in a number of investigations. Where learning has been identified, review of guidelines have been carried out, breastfeeding pathways has been implemented and retraining has been recommended in some incidents which correlate with claims and complaints.

Complaints
All claims are linked to Complaints and Incidents as soon at they are notified to the Trust. It is noted that the issues identified in the Complaints review which correlated to claims included:

- Poor care received during labour
- Misdiagnosis of vaginal tear
- Failing to act upon a report of reduced movements and commence CTG

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University Hospitals and Health Group

SGUH April 2024 Claims report
Two claims were closed during April 2024

Ref	Incident Date	Claim Date	Claim Type	Synopsis	Settled/ Closed Date	Outcome & Damages	Learning from Incidents/ Complaints/ Inquests/ Claims
227527015/094/1391	26.5.12	29.7.15	CNST	The Claimant's mother suffered pre-term rupture of membranes on 21.5.12. It was alleged that Erythromycin should have been administered in accordance with RCOG guidelines. The Claimant's mother subsequently developed chorioamnionitis and labour was induced. The Claimant was born with brain damage. Expert reports identified that the claimant suffers from spastic diplegic cerebral palsy. Identified risks concerned a lack of clear guidance to administer appropriate antibiotics or adhere to RCOG guidelines following the diagnosis of P-PROM.	15.4.24	Settled: £4,156,000 On the basis of litigation risk	None identified
292964519/052	21.10.16	4.9.19	CNST	Claimant gave birth to her first child on 21.10.16 and underwent an episiotomy with forceps. A grade 3 tear led to post-op complications. Allegations related to inadequate surgical skill in performing the suturing procedure which resulted in long term damage and infection. The claimant underwent 3 debridement procedures and colostomy formation and required colostomy bags for 2.5 years post-surgery. Any future deliveries will have to be by c-section.	11.4.24	Settled: £310,621	Complaint: 801PP Incident: P148260

In April 2024 the SGUH legal service received 3 new potential claims relating to maternity services.

Ref	Claim Date	Incident Date	Claim Type	Synopsis	Care Group	Incidents/ Complaints/ Inquests
24/002	4.4.24	3.12.22	CNST	Potential claim relating to the management of pregnancy. Trust records show that mum had an emergency C-Sect and attended ED multiple times post birth. Allegations relate to delay in treatment.	OBS	Incident Only - no complaints: DW180875:
24/003	15.4.24	30.10.22	CNST	Potential claim re 23yo mother who suffered an intrauterine death at 38wk gestation while awaiting c-section for raised umbilical, uterine artery dopplers and oligohydramnios. Scans were reviewed and a decision was made to defer to 38wks. Unfortunately, the baby died while awaiting elective c-section. Allegations relate to a delay in treatment.	OBS	Incident: DW178955 & complaint: 603YY
24/005	22.4.24	15.3.24	CNST	Potential claim alleging a failure to deliver treatment with appropriate skill and care in March '24 resulting in unnecessary facial scarring. Trust records show that the baby suffered a 6cm round facial abrasion to the left cheek, due to forceps delivery.	OBS	Incident (low harm): DW206081

ESTH SCORE survey

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

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

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

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

SGUH Score survey was undertaken in March 2023. The facilitated sessions and cultural conversations underpinning the formal programme has now completed and the outputs contribute to the development of the improvement workstreams led by the Deputy Director of Midwifery and supported by the QI team.

3.1.10 **Safety Action 10:** *Have you reported 100% of qualifying cases to MNSI and NHSR Early Notification Scheme?*

ESTH: there are currently 2 cases open with MNSI (therapeutic cooling and intrapartum stillbirth) and no cases were closed during April 2024. There have been no cases that required reporting to MNSI/ENS so far during MIS Year 6. There are currently no open actions for the Maternity Service in relation to completed MNSI reports.

SGUH: there are currently 9 cases open with MNSI, five of these relate to babies who required cooling and four cases were intrauterine deaths (IUDs). One case was closed in April 2024 and there are no open actions related to MNSI reports.

3.2 ESTH: Maternity Continuity of Carer (MCoC)

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

ESTH were criticised in the CQC report published in February 2024 for continuing with MCoC since safe staffing could not always be maintained in the in-patient area. At the time of the inspection, work

was already underway to reduce the number of MCoC teams. The consultation with staff ended on the 15 April 2024 and managers are currently working on the allocation of staff to the appropriate area, based on their preferences where possible, and ensuring that we have the required numbers of staff in each area to maintain safety. This is expected to conclude in June 2024.

All staff have been reminded to complete their training needs analysis forms and those that feel they need clinical support have been advised to discuss the requirement with their line manager.

3.3 ESTH NHS Staff Survey 2023

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

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

SGUH: NHS Staff survey 2023 results have not been disseminated down to the service yet, and is recognised by the service as an area that requires urgent and focussed attention to ensure that staff feedback is acted on to drive improvement, staff satisfaction and retention.

3.4 ESTH Maternity Improvement Plan (including CQC action plan)

An interim maternity program manager is currently overseeing the coordination of actions outlined in the CQC action plan, working closely with colleagues to ensure prompt progress. Out of the 26 actions, 11 are on track, with evidence of advancement available. One action has been successfully completed, receiving executive approval. The remaining actions are in various stages of progress, with none having surpassed the agreed deadline at this time.

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University Hospitals and Health Group

Theme	Progress Update	Further Actions
Estates Regulation 15 (1)(b)(c)(e)	• 15 steps peer review carried out in March 2024 supported by senior nursing team • March equipment spot check audit passed and remains green. Matrons will continue to carry out bi weekly spot checks.	On Track
Safe and Effective Care Regulation 12 (1)(2)(a)(b) Regulation 17 (1)(2)(c)	• A record keeping audit has been commenced with a compliance of 96% in April, to ensure records are accurate, complete and contemporaneous. Findings will be fed back to the risk team to be included in the regular risk report. Awareness of risk assessments has also been escalated. • Triage and MAU guidelines have been updated in line with RCOG guidance. • An MAU SOP has been developed and audits are underway to review if the guideline and SOP are being followed. • A MEOWS audit template is being developed to ensure staff are compliant to accurately complete, and document modified early obstetric warning scores in order to identify and escalate women and birthing people at risk of deterioration. • March CTG audit compliance sat at 80% and continues to be monitored in line with saving babies lives care bundle. • SBAR observational audits are to be commenced to ensure staff are handing over using the tool both verbally and on the maternity information system BadgerNet.	On Track
Training Regulation 12 (1)(2)(c)	• PROMPT training for March and April 2024 were compliant in all staffing category's. • Safeguarding training sits at 93% for midwives but only 44% for consultant obstetricians. Additional safeguarding study lessons have been scheduled for doctors to help with compliance.	On Track
Well Led Regulation 18 (1)(2)(a) Regulation 17 (1)(2)(a)(b)	• Phased recruitment for additional staffing in TC has been actioned. • Band 5 theatre scrub nurse job adverts went live end of April 2024. Once in post this will ensure the role of the recovery practitioner is carried out with the right level of qualification. • Bi weekly senior midwives meetings continue to ensure effective oversight of maternity services. • Staff annual appraisals have improved from 77% in March to 91% in April 2024.	On Track

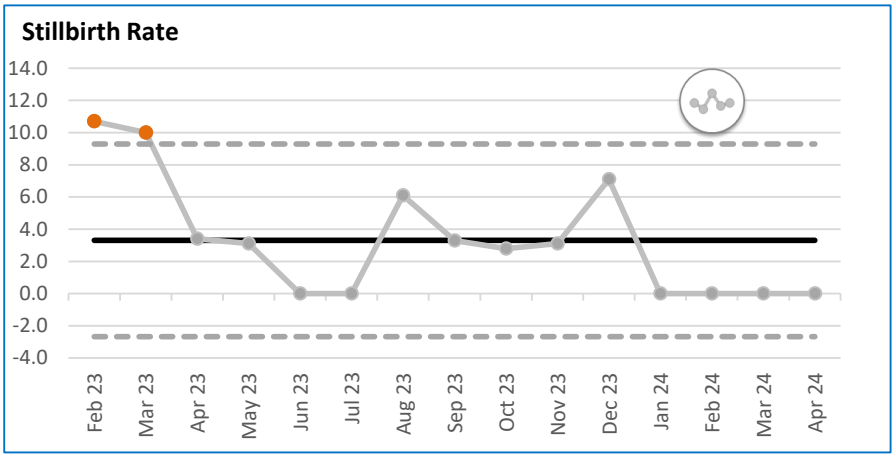
3.5 Outcomes/Trends

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

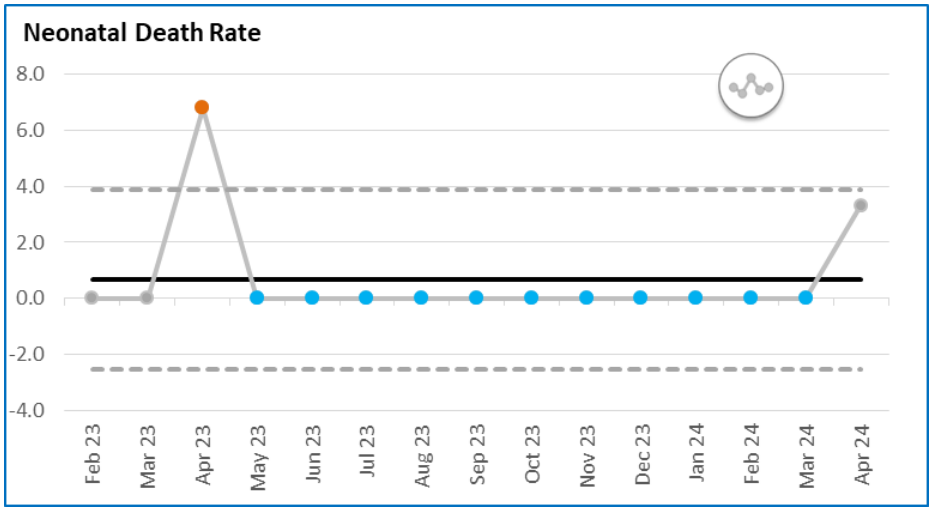
ESTH SPC Governance Dashboard

KPI	Latest month	Measure	Target	Variation	Assurance
HIE cases (No.)	Apr 24	0	-		
Term admission to NNU (No.)	Apr 24	10	-		
Moderate and above harm incidents (No.)	Apr 24	7	-		
Stillbirth Rate	Apr 24	0.0	-		
Neonatal Death Rate	Apr 24	0.3	-		
3rd and 4th Degree Tear (No.)	Apr 24	6	-		
PPH >1500mls	Apr 24	9	-		

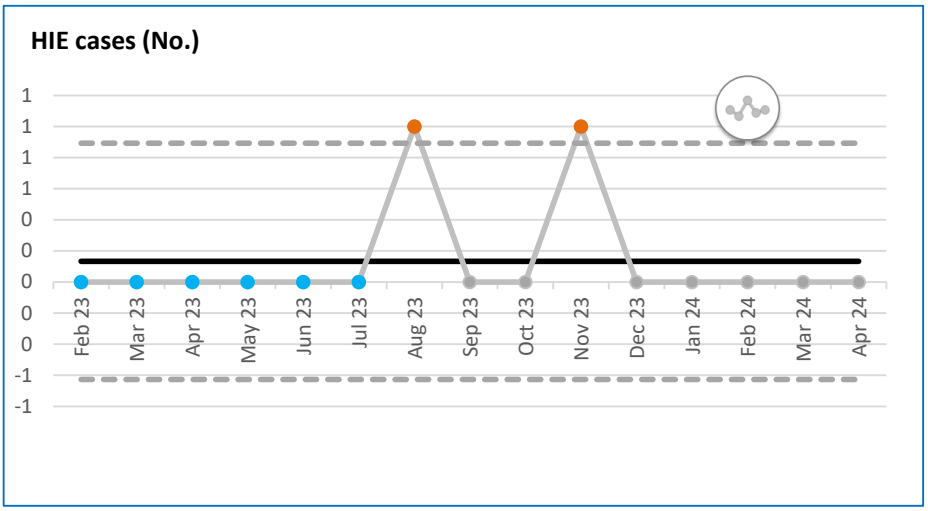
Stillbirth Rate: This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



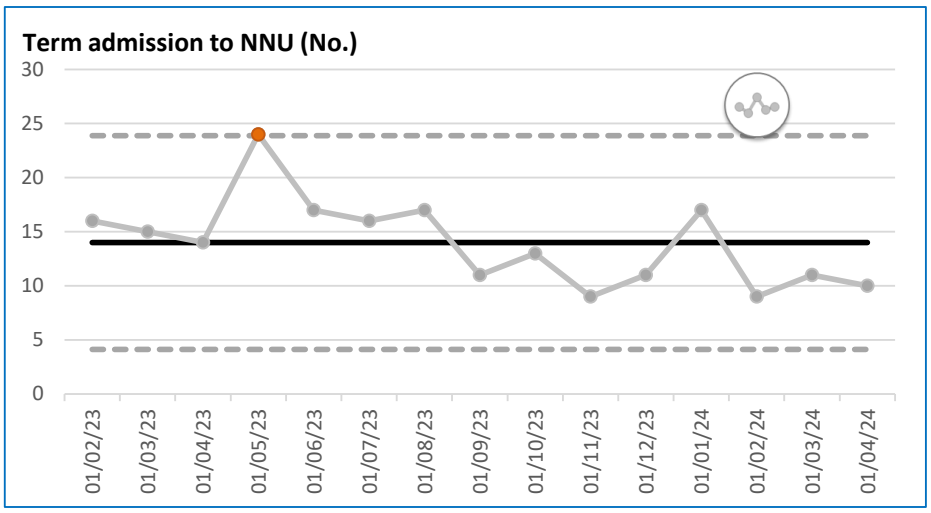
Neonatal Death Rate: This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



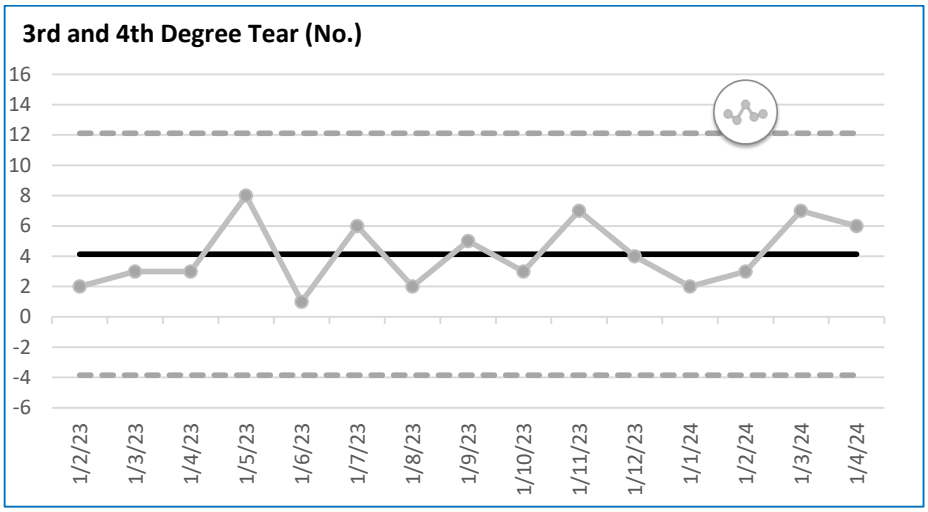
HIE Numbers: This system or process is **currently not changing significantly**. It shows the level of natural variation you can expect from the process or system itself.



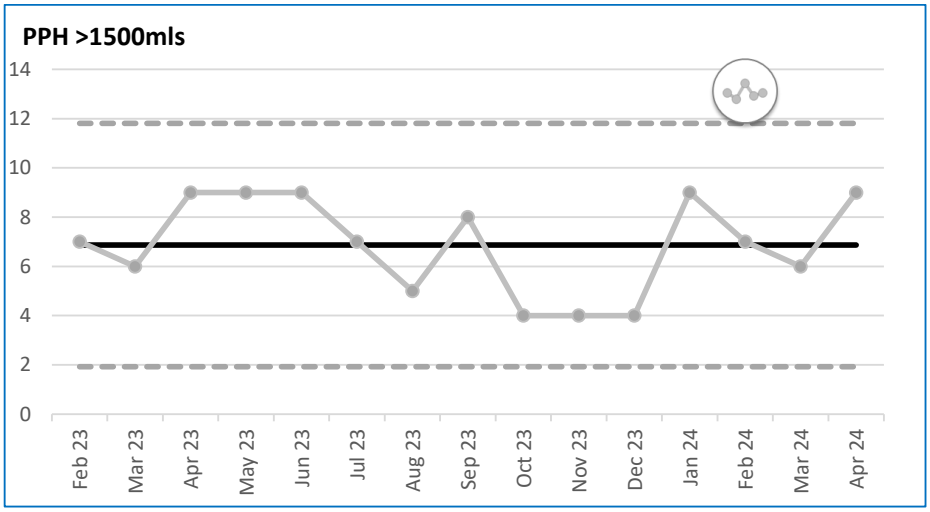
Number of term admissions to NNU: This system or process is currently not changing significantly. It shows the level of natural variation you can expect from the process or system itself.



Third and fourth degree tears: 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.



Post-Partum haemorrhage (PPH) ≥1500mls: 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.



3.7 Risk Register

The risks are reviewed and presented at the maternity governance meetings and updated as required.

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University Hospitals and Health Group

ESTH - Title of Risk	Review Date	Current Risk Level
Lack of 2nd Obstetric Operating theatre at EGH – ***work is currently underway to convert Rose Room into a second theatre at EGH (in line with national standards) and this risk will be closed once the work has been completed.***	31/10/2024	Extreme Risk
Multiple environmental/building and estate-related issues (triage, recovery, bereavement room soundproofing (the latter is part of our capital bids) – ***these issues were all raised in the CQC report and early discussions are underway to assess some storage rooms on SWLEOC adjacent to the maternity unit at EGH to see if these can be used for Triage/Maternal Assessment Unit. Some if the building issues raised will not be resolved until we have the new SECH.***	31/03/2025	Extreme Risk
Maternity Block Lifts (breakdown) – ***this is an on-going issue despite the new external life at St Helier. Week commencing 10/06/2024 we had two entrapments at STH (one requiring the fire brigade to resolve). We are currently looking at de-commissioning the back lift.***	31/12/2024	High Risk
Documentation of blood results in BadgerNet (currently a manual transcribe for some results with no mitigations possible) – ***this has resulted in incorrect blood groups being manually recorded on BadgerNet and the system does not effectively interface with iCM. This should be resolved with the move to Cerner.***	30/09/2024	High Risk
Nitrous oxide exposure on Labour Ward – ***the assessment work is still on-going.***	31/08/2024	High Risk
Staffing establishment and mandatory training uplift – ***the current uplift for mandatory training is not sufficient to cover all the subjects required under the Core Competency Framework and is not line with current requirements.***	31/03/2024	High Risk
Location of the Maternity Assessment Unit at Epsom (in a separate building to Labour Ward) – ***as for the environmental risk above.***	31/10/2024	High Risk
CAM line closures (regional working party considering the scope of the line as demand has outstripped capacity) – ***this has recently been resolved and communications are awaited. The line will only be accepting calls from women booked at the participating trusts, and we only accept calls from 16 weeks of pregnancy.***	31/12/2024	High Risk
Homebirth Service (lack of resource to cover on-calls) – ***work is underway to reconfigure services to provide a 2nd on-call midwife from the community services.***	30/11/2024	High Risk
Transitional care services – ***work is currently underway to reconfigure the service to provide neonatal staff support.***	30/09/2024	High Risk
Lone working in the community for midwifery staff	30/06/2024	Moderate Risk
Flooding in ANC EGH	31/03/2025	Moderate Risk
Ligature risk (hooks and cord pulls)	30/06/2024	Moderate Risk

SGUH: The risks are reviewed and presented at the maternity and divisional governance meetings. They are reviewed and updated by the MDT, supported by the divisional governance team.

Current Risks

Opened	Title	Risk level (current)	Rating (current)	Manager	Last updated	movement
12/10/2020	Shortage of Midwifery Staffing	Extreme	16	Bradley, Janet	05/06/2024	Proposal for risk closure approved at Directorate and Divisional level. Risk to be presented at QCiC as part of the Corporate Risk Register for discussion and approval to close risk as recruitment process completed. The service has raised 2 more risks pertaining to staffing to address the residual issues
17/04/2023	Closure of Birth Centre	High	12	Bradley, Janet	05/06/2024	
01/08/2023	Euroking backcopying and forward copying IT risk	High	12	Bradley, Janet	06/02/2024	
31/01/2013	Infrastructure damage/sewerage flooding on the maternity unit	High	12	Bradley, Janet	22/04/2024	
13/10/2020	Multiple Information Systems	High	12	Bradley, Janet	06/02/2024	
17/04/2023	Provision of Home Birth service	High	12	Bradley, Janet	05/06/2024	
17/04/2023	Redeployment of non-facing staff to patient-facing duties	High	12	Bradley, Janet	05/06/2024	5/6/2024 team to confirm downgrading of risk score at maternity governance meeting from 12(4x3) to 8(4x2). Risk to be kept open and be monitored before considering closing the risk and BAU
29/04/2024	Viewpoint 5 servers and application out-of-support	High	12	Bradley, Janet	04/06/2024	4/6/24: 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.

01/02/2022	Inability to provide Transitional Care services 24/7	Moderate	9	Ramdass, Karen	12/06/2024	
19/01/2024	Midwifery Manager on call rota	Moderate	9	Bradley, Janet	05/06/2024	
15/04/2024	One working birthing pool (out of two) on Carmen Birth Centre	Moderate	9	Bradley, Janet	24/04/2024	
17/04/2023	Poor compliance with training requirement	Moderate	9	Bradley, Janet	12/06/2024	12/6/2024 Risk score to be re-assessed in October 2024 following review of monthly compliance with training
15/01/2020	Maternity Unit Security Risk	Moderate	8	Bradley, Janet	06/02/2024	
09/02/2023	Maternity Helpline 24 hr cover	Low	4	Bradley, Janet	12/06/2024	12/06/2024 risk score downgraded from 8(c2 x L4) to 4(c2 x L2)

Recently Closed risks

Opened	Title	Risk level (current)	Rating (current)	Manager	Date Risk closed	Update on closure
21/04/2023	Interrupted provision of Continuity of Care	None	3	Bradley, Janet	12/06/2024	12/06/2024 Risk mitigated by protecting integrity of service. Maternity team agreed to close risk
19/03/2024	Carmen Birth Centre emergency call bells	Moderate	9	Bradley, Janet	24/04/2024	

Drafted risks waiting for review/approval (in the holding bay for discussion at DGB)

Opened	Title	Risk level (current)	Rating (current)	Manager	Last updated
10/04/2024	Lack of specialised support outside of standard working hours- maternity diabetes service	Moderate	9	Bradley, Janet	10/04/2024
29/04/2024	Home blood glucose monitoring for women with suspected gestational diabetes late in pregnancy	Low	6	Bradley, Janet	29/04/2024

13/06/2024	High level of short-term sickness	High	12	Bradley, Janet	12/06/24 (proposal)
13/06/2024	Onboarding time lags for new recruits	High	12	Bradley, Janet	12/06/24 (proposal)

The risk register demonstrates the current position.

3.8 Audit

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

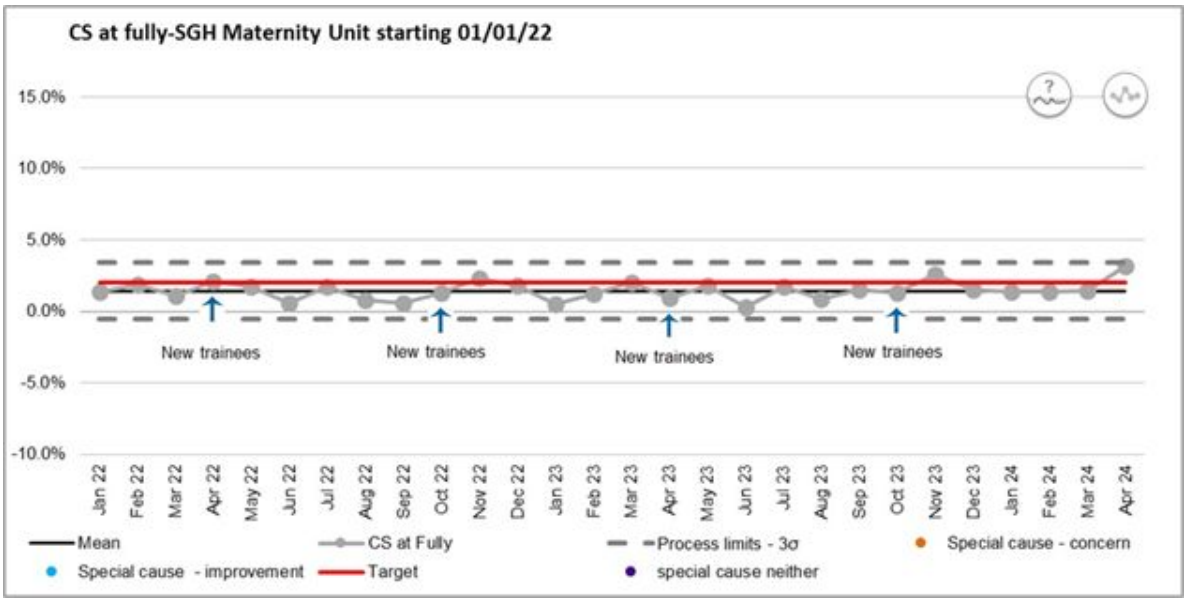
- Smoking cessation
- Fetal Monitoring
- Fetal Growth restriction
- Reduced fetal movements
- Pre-term birth
- Management of pre-existing diabetes.

In April 2024, the ICB's quarterly assessment showed ESTH were 93% compliant with the 70 interventions, a 12% improvement since January 2024. The next assessments will be in August 2024. Quarterly assessments and re-audits will continue every six months until 100% compliance is achieved.

A formal audit program is being established, detailing named leads, frequency, and presentation, in response to the CQC inspection and associated information requests. Monthly compliance monitoring is in progress, with quarterly assurance reporting being implemented. Audit outcomes are generally positive, though a key compliance issue remains the low uptake of Adult Safeguarding training among Consultant Obstetricians, which has been escalated to the Board by the safeguarding lead.

3.9 SGUH review of Caesarean Section at full dilatation

Outcomes of the moderate harm case reviews in maternity led the MDT working group to explore the incidents of Caesarean Section at full dilatation. This review explored cases between Jan 2022 to April 2024 and determined that this trend was normal variance without cause for concern.



3.10 SGUH Maternity Triage Audit

In April 2024, excluding the encounters where data was not recorded, 95% of women attending maternity triage were seen within the local target of 30 minutes (down from 98% in March). 79% of women attending maternity triage were seen within the 15-minute target set by the RCOG (down from 84% in March) (Maternity Triage, Good Practice Paper No. 17, 2023). 5% (up from2.4% in March) of women were not seen within 30 min (21 in total, with 1 being seen after more than 1hr).

17 breaches occurred during the day, 4 during the night. As in previous months, events of non-compliance with the guidance occurred more often during the day shift. However, in 5 instances of breaches during the day shift all triage couches were occupied and no bed available for use in DS (this was documented by the midwife). The >1hr breach was a PN lady with a perineal complaint; the midwife had prioritised the pregnant ladies with pain/RFM.

	Compliance with St George's framework (initial assessment by midwife within 30 minutes), where 'time seen' was documented	**Compliance with national RCOG guidance (initial assessment by midwife within 15 minutes) where 'time seen' was documented**
April 2024	95% (432/453 encounters)	79% (359/453 encounters)
Day shifts	94%	74%
Night shifts	97%	89%

	St Georges/NICE framework (30 minutes)	**RCOG framework (15 minutes)**
Day shift (07:30-20:00)	6% (17/295-day encounters)	26% (76/295 encounters)
Night shift (19:30 – 08:00)	3% (4/158-night encounters)	18 % (18/158 encounters)

The data shows that women attending in the daytime were more likely not be assessed within either the 15 or 30-minute time frame than those attending during the night. Just as in March audit, more than twice as many women were seen during the day compared to the night.

The gold standard for St George's maternity triage staffing is 2 midwives (Band 7 or Senior band 6) and a healthcare assistant/maternity support worker during the day. The minimum standard to ensure safety is 1 midwife and 1 healthcare assistant/maternity support worker. This staffing recommendation has been supported in the Maternity Establishment review and investment awarded to recruit to these levels. The recruitment to support this has commenced.

3.11 SGUH baby falls on the postnatal ward

During a Maternity Safety Champion walkabout in February 2024, midwifery staff highlighted incidents of babies being accidentally dropped by parents in the postnatal ward during 2023. The Executive Safety Champion gave this feedback to the maternity leadership team and asked for a review to take place, as well as to take immediate actions to prevent/minimise this happening. The service has since formed a task and finish group to review the cases and implement measures to minimise the risk of occurrence.

The incidence of falls in SGH over the past five years were collated and findings are noted below.

Year	Number of Baby falls in Postnatal ward Gwillim
2019	2
2020	3
2021	2
2022	1
2023	**5 - (1 x Jan, 1 x May, 1 x Nov, 2 x Dec)**
2024	1

BAPM (2020) The Prevention, Assessment and Management of in-Hospital Newborn Falls and Drops states that there is an estimated rate of falls 16-41/100,000 nationally. There were 250 reported falls in England between Sept 2017- August 2018.

The identified risk factors described in this study include:

- Co-bedding/ co-sleeping while breastfeeding
- Impaired awareness of mother (e.g., fatigue/sedation/mobile phones/dim lighting)
- Impaired Mobility of mother (e.g., epidural, post-surgery, disability)
- Primiparous mother
- Underlying maternal medical conditions (epilepsy, diabetes, disability, anaemia, high BMI)
- Social issues (young mother, single mother, drug misuse, language barriers)
- Time of day (e.g., night-time, limited family support outside of visiting hours)

A thematic review of each case in SGUH in 2023 took place on 3 June 2024 and the broad findings and actions to address can be seen in (Appendix 2 in Reading Room - the full review)

3.12 SGUH Postpartum Haemorrhage (PPH) review

The Clinical Director and Lead for Governance has provided evidence of the revised process in the way moderate harm is managed in maternity governance and has used the current process for PPH surveillance to demonstrate this. The review and change to process resulted from feedback and recommendation from the CQC Inspection in March 2023, where they highlighted that the correct level of harm was not being appropriately applied to incidents such as PPH, 3rd and 4th degree tear, where the practice was to record these incidents as low or no harm, which subsequently resulted in missed opportunities for learning and service improvement. The review and process can be found in (Appendix 3 Reading Room).

4.0 Sources of assurance

4.1 ***MBRRACE-UK:*** The MBBRACE-UK Perinatal Mortality Report for 2022 has confirmed that neither ESTH nor SGUH are negative outliers for either stillbirth or neonatal death. Currently, GESH have commissioned an external review of stillbirth cases in 2020 and 2021; the 2020 review has been completed and has not raised any significant concerns. The report noted that a percentage of PMRT reviews did not have an external panel member. It should be noted that 2020 was during the height of the COVID-19 pandemic and the standards around PMRT (CNST) had been suspended.

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

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

5.0 Implications

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

- The publication of new Technical Guidance for the Maternity and Perinatal Incentive Scheme Year 6.
- There are no clear themes emerging in respect of the ESTH Maternity Service.
- ESTH - the impact of the aging estate on ability of the service to provide a modern Maternity Service in line with national guidance.
- ESTH trends of outcomes have remained stable over the last 15 months.
- Consideration needs to be given to completion dates for actions, particularly around PMRT, to ensure that they are achievable.
- A programme of safety champions engagement sessions has been re-established.
- ESTH - the CQC inspection report was published 14 February 2024 and there is a deterioration in the overall rating – changing from GOOD to Requires Improvement
- ESTH - MSSP have provided high-level feedback from their recent visit.
- SGUH has noted an increase in caesarean sections at full dilatation and undertook a review, which showed a trend of normal variance without cause for concern.
- SGUH PPH review – change in grading of harm, which provides better opportunity for learning and service improvement.
- SGUH x2 neonatal cases that were reported to MBRRACE-UK outside the 7 working day window, and potential risk meeting compliance in CNST Safety Action 1
- SGUH review of baby falls on the postnatal ward and the ongoing work via a task and finish group to implement measures to minimise further incidents of this type.
- SGUH received notice from the Early Notification Scheme arm of NHS Resolution on 17 June 2024 that they will be carrying out a thematic review of all cases referred to MNSI between 1 April 2017 – 31 May 2024

6.0 Recommendations

6.1 Quality Committees in Common is asked to.

a) Note the successful outcome against the CNST year 5 and the rebate payment awarded to both Trusts as a result.
b) Note the publication of CNST year 6 and the changes to some safety actions.
c) Note the key areas of success, risks, and mitigations.
d) Note the improvement work to ensure the appropriate level of harm is assigned to incidents such as PPHs, to ensure opportunities for learning and service improvement are not missed.
e) Make recommendations for any further actions.
f) Note that on the 17 June 2024, SGUH received notice from the Early Notification Scheme arm of NHS Resolution that they will be carrying out a thematic review of all cases referred to MNSI between 1 April 2017 – 31 May 2024. An update will be provided to the Committee as these progresses to its conclusion.

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	3.3
Report Title	**Integrated Quality and Performance Report**
Executive Lead(s)	James Marsh, Group Deputy Chief Executive Officer
Report Author(s)	Group Director of Performance & PMO, ESTH & SGH Site COOs
Previously considered by	Quality Committees-in-Common Finance Committees-in-Common
Purpose	**For Assurance**

Executive Summary

This report provides an overview of the key operational performance and quality measure information, and improvement actions across St George's Hospitals (SGH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

Action required by Group Board

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

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

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

Implications

Group Strategic Objectives

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

Risks

As set out in the report.

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

- Enforcement undertakings applicable to St George's and Epsom and St Helier Hospitals
- Compliance with the Health and Social Care Act 2008 (Regulations 2014) and CQC Registration Regulations

Equality, diversity, and inclusion implications

No EDI issues to consider.

Environmental sustainability implications

No environmental sustainability issues to consider.

Group Integrated Quality and Performance Report

Group Board, 04 July 2024

1.0 Purpose of paper

This report provides an overview of the key operational performance, quality, safety, and outcomes information, as well as improvement actions across St George's Hospitals (SGH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

2.0 Quality & Safety

ESTH, SGH and IC reported a number of quality-related improvements and successes in May 2024 including.

- Nil MRSA infections in-month, bringing year-to-date cases to zero for SGH, and ESTH.
- No Never Events were reported in May 2024 for SGUH and IC.
- VTE Risk Assessment continues to be within target for SGH, and performance levels have been consistent in recent months at ESTH.
- Observed mortality rates as measured by the (Summary Hospital-level Mortality Indicator (SHMI) continue to track below expected levels at SGUH.
- Mental Capacity Act Training (Level 2) is compliant at both SGUH and ESTH.
- Integrated Care now have Organisational Membership to The Queen's Nursing Institute- providing access to learning, education, shared forums and coaching opportunities from dedicated Community Nursing focused organisation and peers.

Key **challenged** areas are as follows.

- **Serious Incidents**: SGUH declared two Patient Safety Incidents (PSIIs) in May 2024. One incident occurred in Obstetrics, and the other in the Breast Clinic. Duty of candour has taken place, and investigations are ongoing. At ESTH, seven Serious Incidents were reported, two of which were Never Events. These Never Events involved a retained guidewire in a central line and a wrong-site surgery on a dermatology patient. Investigations are ongoing.
- **Pressure Ulcers:** A decrease was observed in the number of Category 3, 4, and unstageable pressure ulcers in May 2024 at SGUH. Of the nine reported cases, three were medical device-related pressure ulcers (MDRPUs), two of which were caused by ventilation fixation devices for patients with problematic airways. The Corporate Nursing Directorate is collaborating with the Medical Physics team to develop and implement a comprehensive Trust-wide pressure ulcer-relieving mattress replacement programme. Other actions include e-learning targeted at Healthcare Assistants and

updating the Trust-wide pressure ulcer prevention action plan. At ESTH, there were zero Category 3, 4, and unstageable pressure ulcers.

- **Patient Experience (Friends and Family Test) –** The proportion of patients responding positively to the Friends and Family Test in the Emergency Department continues to track below target at both SGH and ESTH. Improvement actions aim to reduce waiting times by increasing the capacity of treatment pods to facilitate the discharge of non-admitted patients, increasing the capacity of in-and-out spaces so clinicians have more room to work, amending the Consultant Referral and Triage (RAT) rota to provide patients with a more senior review sooner, and using Same Day Emergency Care (SDEC) to redirect patients to medical services if appropriate.

- **Venous Thromboembolism (VTE) Assessment rates:** ESTH is still off target for assessments. The Site Senior Leadership Team is leading on improvement initiatives with VTE screening being discussed at Integrated Performance Review meetings. The VTE policy is also being reviewed.
- **Complaints –** Meeting the target has been challenging due to suboptimal reporting and monitoring systems and processes, staff absences, and operational pressures. Actions in place to aid recovery include weekly divisional complaints meetings, revision of investigation completion times, and the development of weekly complaints flash reports.

- **Mortality**: The Summary Hospital-level Mortality Indicator (SHMI) is reported as higher than expected for ESTH, with rates steadily improving. This is being closely monitored with proactive measures in place to prevent deaths.
- **Key challenges in Integrated Care** relate to Hand Hygiene, C. Difficile and Covid cases on bedded units and Pressure Ulcer Management.

3.0 Operational Performance

All three sites - ESTH, SGUH and IC – reported a number of operational performance improvements and successes in May 2024. The key highlights are as follows.

- RTT waits over 52 weeks reduced at SGUH in April 2024 and exceeded trajectory.

- Improved waiting list performance for adults at Sutton and Surrey Downs continues to be maintained.

- ESTH delivered against all three national cancer standards in April 2024: 28-Day Faster Diagnosis (85%), 31-Day Decision to Treatment (96%), and 62-Day Referral to First Treatment (90.6%). SGUH performed better than trajectory for 62 Day Referral to First Treatment, achieving 78%.

- Patient-Initiated Follow-Up (PIFU) rates at ESTH remain relatively high, while activity continues to increase at SGUH. The new PIFU process launched at SGUH in April 2024 will improve performance further over the coming months.

- Advice & Guidance utilisation rates have seen a significant improvement with both ESTH and SGUH now meeting target of 16 per 100 outpatient appointments following agreement with SWL to include other referrals for assessment. Performance was 55.5% at ESTH and 17.8% at SGUH in April 2024.

- Improvements in capped theatre utilisation were reported at both sites in May 2024. Both ESTH and SGUH achieved top quartile performance nationally, with 82% and 81.4% respectively, against the national target of 85%. Elective activity exceeded the plan at both ESTH and SGUH.

- ESTH ranks first in SWL for the proportion of elective admissions that were day cases (BADS Procedures) with a performance of 84%.

- ESTH delivered 77.5% performance against the 4-hour ED standard in May 2024 exceeding trajectory and an improvement compared to April 2024.

- Sutton and Surrey Downs continue to exceed the 70% 2-Hour Urgent Community Response targets in May 2024. Sutton Health & Care achieved 88.3% and Surrey Downs Health & Care, 87.3%, with a continued focus on encouraging more referrals. Virtual Ward occupancy target of 80% continues to be met at Surrey Downs and continued step change of improvement seen at Sutton.

A summary of the **key challenges** and **mitigating actions** are as follows.

- RTT waiting lists are higher than planned, with an increase at ESTH through April 2024. Gynaecology remains the biggest challenge for both 65- and 52-week waits; however, there has been improvement, with the total Gynaecology waiting list reducing by 782 and the total waiting for a first appointment reducing by 1,641. At SGUH, 28 patients are waiting for more than 65 weeks against a plan of 15, although it should be noted that the Trust reported one of the lowest 65-week wait positions nationally at the end of 2023/24.

- At Sutton Health & Care, the waiting list for children's services is challenged; this is a national issue recognised at SWL/Place. At the end of May 2024, 79 patients were waiting for more than 52 weeks, with children's OT services holding the highest proportion (51 patients).

- DNA rates are not meeting current targets at both SGUH and ESTH although both sites are seeing improvements with a reduction in the number of patients that missed their appointments. A number of actions are in place as part of the Outpatient Transformation programme including 2-way messaging functionality, reviewing letter templates and specialty audits that will seek to reduce rates further.

- Urgent and emergency care services at both trusts continue to experience significant pressures. 4-hour wait performance at SGUH in May 2024 was 76.8%, against a trajectory of 78.6%. The key drivers for operational pressures at both sites are unplaced patients remaining in the Emergency Department including mental health patients impacting on ambulance delays and capacity within the department to see and treat patients. Although overall LAS performance at SGUH remains comparable to previous months, patients are waiting longer to be offloaded, seeing an increase in patients breaching between 30-60 minutes.

- The numbers of medically optimised patients on both hospital sites remain high, with many patients requiring complex discharge planning. The Urgent and Emergency Care (UEC) pathway continues to be a priority for improvement for the Group. The Sutton Health and Care Reablement Unit has been operating at full occupancy with a robust system in place to ensure the early identification of suitable patients to transfer to the unit. A Length of Stay workstream has been set up at SGUH to identify where LOS reductions can be made. At ESTH, the 2024/25 work programme covers a range of actions including electronically streaming/redirecting patients to UTC/SDEC and community pathways. This initiative aims to support capacity alleviation and avoid unnecessary admissions for patients attending the Emergency Department who do not require acute care.

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4.0 Sources of Assurance

4.1 Quality Committees-in-Common

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

4.2 Finance Committees-in-Common

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

6.0 Recommendations

6.1 The Board is asked to note the report and make suggestions for any further action.

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

Group Integrated Quality & Performance Report

May 2024

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

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 21 June 2024

Executive Summary

Safe, High-Quality Care

St George's Hospital

Successes

- **Never Events**: There were no Never Events in May 2024.
- **Falls:** The overall number of falls was down to 83 in May 2024, from 123 and 122 in February and March 2024, respectively.
- **Infection control**: The Trust continues to report zero MRSA bacteraemia for the year. There were 3 C. difficile infections reported during May 2024, statistical process analysis continues to show improvement.
- **Mental Capacity Act Training:** MCA Level 2 compliance has reached the target of 85% since Q3 2023/24.

Challenges

- **Serious Incidents and PSII:** St George's declared 2 Patients Safety Incidents (PSII) in May 2024, 1 incident occurred in Obstetrics, the other in Breast Clinic.
- **Falls:** Three moderate harm falls were reported in May 2024, 1 each on a medical, surgical and neurology ward. All incidents are being investigated and the patients are recovering.
- **Pressure Ulcers:** There were nine Acquired Category 3 & 4 and unstageable pressure ulcers in May 2024, similar to April 2024 (11). None were category 4.
- **Infection Control:** There were eight cases of E. coli bacteraemia during May 2024. Of the eight cases, seven have been classified as hospital-onset healthcare associated. Statistical process analysis beginning April 2021 shows the Trust is currently in a period of common cause variation.
- **Friends and Family ED** – The number of patients that would recommend the department to friends and family was 71% for May 2024, the most consistent theme for negative responses was waiting times.

Epsom & St Helier

Successes

- **Falls Prevention and Management:** There were a total of 91 falls reported within the Acute Services in May 2024 - 4.4 falls per 1,000 OBDs. Unwitnessed falls for the Acute Services in May 2024 was 70% - however, this remains lower than June 2023 which is in keeping with the longest period of decline. The second cohort of the Falls Champion Programme has been completed, with eight new Champions successfully completing the programme. The service will support champions to complete their Quality Improvement Projects. Bed/trolley rails risk assessments to be trialled in the Emergency Department.
- **Pressure Ulcers:** The number of pressure ulcers remain low. Four Hospital acquired pressure ulcers; two category 2, and two deep tissue injury. No grade 3 or 4 pressure ulcers . Reduction in outstanding ward level investigations (only 5 outstanding). Task and finish group with areas of concern have started and will report to the Fundamental of Care meeting as well as training on the use of purpose-T as pressure ulcer assessment tools as per new national guidelines.
- **VTE:** The Trust marked National Thrombosis Week (6th to 12th May) VTE stalls were set up across sites . It was an opportunity to promote the @Let's talk clots' app for smart phone users Divisions are now asked to lead on the reporting of incidents and validation of data .

Challenges

- **Serious Incidents and Never events:** In May, there were 7 SI's , of which, 2 were Never Events. The Never Events were: a retained guidewire in a central line and a wrong site surgery in a dermatology patient.
- **Falls Prevention and Management** There were three falls with moderate or above harm reported in May. Reports of unwitnessed falls increasing while patients are described as receiving Enhanced Care (level 3/4). Fundamentals of Care study days are available on a monthly basis; however, attendance at the Healthcare Support Workers (HCSW) days is low. Staff Bank members attendance at the Fundamentals of Care (FoC) study days continues to be low.
- **VTE**: There were nine Hospital Acquired Thrombosis (HATs) cases reported in May 2024: 4 inpatients, and 5 within 90 days of discharge. There was a dip in VTE Risk Assessment Performance in May 2024 (86%), from its peak of 90% in January 2024. This is an ongoing challenge to get the trust to the national target threshold of 95%. The VTE policy is undergoing peer review for feedback before being submitted for approval.

Executive Summary
Operational Performance

St George's Hospital

Successes

- The Elective Recovery Fund (ERF) activity shows good progress against our plan of delivering 110% of value weighted activity. The 2024/25 internal production plan has now been updated to show numerical and value weighted trajectories for divisions to monitor performance against both values.
- Advice and Guidance utilisation rates at SGUH have improved significantly after agreement with South West London (SWL) to include Referral Assessment Services (RAS) appointments and is now meeting target of 16 per 100 outpatient appointments.
- The new PIFU process was launched on April 24th this will considerably improve our performance and improve our Outpatient value weighted activity as a result over the coming months.
- Number of 52-week waiters on a referral to treatment pathway is ahead of trajectory with the total waiting list size seeing a reduction through April 2024. However, capacity will continue to be impacted by industrial action.
- Cancer 62 Day combined performance achieved 78% ahead of planned trajectory of 75%.
- Theatre capped utilisation rates further improved to 81.4% with continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists.
- Number of patients with a length of stay greater than 21 days has reduced through May 2024 and ahead of planned trajectory.

Challenges

- Faster Diagnosis performance of 71.8% against plan of 74.9% for April 2024. Challenges within Gynae; Reduced access to scans and delay to starting one stop clinics, Lower GI: CTC capacity and endoscopy process delays are contributing factors.
- Whilst theatre utilisation improved, performance was limited due to increased estates issues in May 2024 which caused some delays to the start of lists which lead to over runs, negatively affecting capped theatre utilisation. Clinical and operational teams continue to focus on early discharges and further embedding of the day-of-surgery admission pathways.
- High proportion of beds continue to be occupied by patients not meeting the criteria to reside, and Pathway 2A (Merton + Wandsworth) and Pathway 3 awaiting discharge, adversely impacting on flow from the emergency department to wards and Decisions To Admit (DTAs) in the emergency department.
- 4 Hour Performance did not meet plan in May 2024 driven by high numbers of complex mental health patients in the department, ambulance conveyances waited longer to off load and limited in-and-out spaces to see and treat patients impacted by DTA's.

Epsom & St Helier

Successes

- ESTH ranks first in SWL for the proportion of all admissions that were day cases (BADS Procedures) with a performance of 84%.
- A&G utilisation for April is 55%, above the 16% target.
- Theatre utilisation (capped) still remains high in May 2024 (82%), although slightly lower than the previous month. Theatre utilisation for w/e 26th May was over the target of 85%.
- All cancer performance standards were achieved in April 2024: 28 day Faster Diagnosis (85%), 31 day first treatment (97.3%) and GP 62 day first treatment (90.6%).
- The trust delivered 77.5% performance against the 4-hour ED standard in May 2024 exceeding trajectory and an improvement compared to April 2024 where we delivered 76.4% performance.
- LAS 60-minute performance improved at 61 in May 2024 a reduction from 68 reported in April 2024.
- Non-elective re-admission rates remain stable at 5.06% in May 2024.
- Although Gynaecology long waits remain high, the total PTL and patients waiting for first appointment within this service has reduced significantly since January 2024. The total Gynaecology PTL has reduced by 782 and total waiting for first appointment by 1641.

Challenges

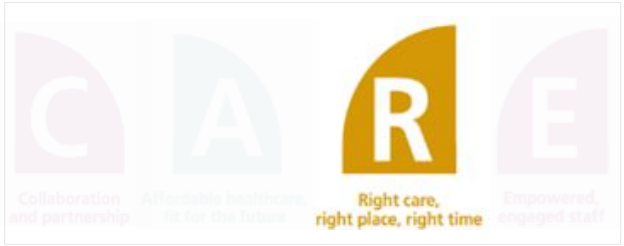
- 52 and 65 week waits increased from March 2024 to April 2024. The specialties with the highest cohort of 65 week waits at the end of April 2024 were Gynaecology (74), Community Paediatrics (17) and General Surgery (9). Gynaecology also remains the biggest challenge for 52 week waits.
- EUS capacity is challenging as current waiting times are 3-4 weeks, however this has reduced from 5-6 weeks due to the opening of the RMH Oak Centre and the provision of a weekly additional list.
- EBUS reporting TAT is at 10 working days (target 7 working days).
- Gynae capacity for TWW appointments and GA hysteroscopy continues to be challenging. If these challenges continue over the summer, it is anticipated that there is a potential risk to cancer performance.
- UEC pathway and flow remain key challenges with a high proportion of patients waiting more than 12 hrs in the emergency department (11.9%). High numbers of unplaced patients including mental health patients remaining in ED for prolonged periods.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)	Surrey Downs Health & Care(SDHC)
Successes 2-hour Urgent Community Response (UCR) target continues to exceed target achieving 88.3% in May 2024. Reablement unit occupancy 97.7% with length of stay at eight days. Work is in progress to decrease length of stay to five days to support flow. High level of mandatory and statutory training (MAST) maintained at 90.5% Further reduction in sickness rates to 4.2%. Virtual ward occupancy has increased from 61.2%- 67.1%. Improvement work ongoing. **Challenges** Pathway 3 delays have increased to 16 days (mean) due to an increase in complex discharges. Improvement work ongoing. Waiting times for children over 52 weeks have increased to 83. Children's OT services holding the highest proportion (51 patients).	**Successes** Consistently achieving the 2-hour UCR target with 87.3% in May 2024 while managing high levels of referral numbers. Maintained the Improvement in waiting lists across all services. Improvement Length of Stay in community hospitals to 20 days. High levels of Mandatory and Statutory Training (MAST) being maintained at 93.1%. Non-Medical – appraisal rate is 87.8% , with plans in place with line managers to ensure this rate continues to improve. Increased virtual ward occupancy rate to 97% meeting target of above 80% with 254 patients seen in May **Challenges** Sickness rate remains above target, mainly due to long term sickness. Improvement from last month to 4.3% (Target-3.8%) . Robust absence management process in place . High vacancy rate (19.3%), Golden Hello scheme is in place and more recruitment events planned.

Quality & Safety



Safe, High-Quality Care

Overview Dashboard

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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	May 24	0	0	0				May 24	0	2	0			
Serious Incidents	May 24	2	0	0				May 24	4	5	0			
Patient Safety Incidents Investigated	May 24	0	2	0							0			
Number of Falls With Harm (Moderate and Above)	May 24	4	3	0				May 24	2	3	0			
Pressure Ulcers - Acquired category 3&4	May 24	11	9	0				May 24	0	0	0			
Mental Capacity Act & Deprivation of Liberties - Level 2	May 24	85.7%	86.2%	85.0%				May 24	88.8%	90.3%	85.0%			
Infection Control - Number of Cdiff - Hospital & Community	May 24	3	3	4				May 24	6	3	4			
Infection Control - Number of MRSA	May 24	0	0	0				May 24	0	0	0			
Infection Control - Number of E-Coli	May 24	11	8	7				May 24	4	4	7			
VTE Risk Assessment	May 24	95.4%	96.0%	95.0%				May 24	86.0%	86.4%	95.0%			
Mortality - SHMI	Jan 24	0.95	0.94	1.00				Jan 24	1.13	1.15	1.00			
% Births with 3rd or 4th degree tear	May 24	2.5%	3.1%	-				May 24	3.7%	3.7%	-			
% Births Post Partum Haemorrhage >1.5 L	May 24	2.2%	2.8%	4.0%				May 24	3.1%	4.2%	4.0%			
Stillbirths per 1,000 births	May 24	0.0	3.4	2.0				May 24	0.0%	0.0	-			
Neonatal deaths per 1,000 births	May 24	0.0	6.9	2.0				May 24	3.3%	0.0	-			
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	May 24	0.0	0.0	2.2				May 24	0.0%	0.0	-			

Patient Safety Incident Investigations being implement at ESTH hence no data

Safe, High-Quality Care

Overview Dashboard | Patient Experience & Integrated Care

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Number of Complaints Received	May 24	76	71	-			
Complaints responded to in 25 days	May 24	83%	97%	85%			
Percentage of complaints acknowledged within three days	May 24	100%	100%	-			
Friends and Family Test - Inpatients Score	May 24	98%	98%	90%			
Friends and Family Test - Emergency Department Score	May 24	76%	71%	90%			
Friends and Family Test - Outpatients Score	May 24	94%	94%	90%			
Friends and Family Test - Maternity Score	May 24	86%	89%	90%			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 24	22	38	-			
May 24	48%	79.1%	85.0%			
May 24		100.0%	100.0%			
May 24	81%	83%	90%			
May 24	81%	83%	90%			
May 24	98%	98%	90%			
May 24	95%	92%	90%			

Sutton Healthcare

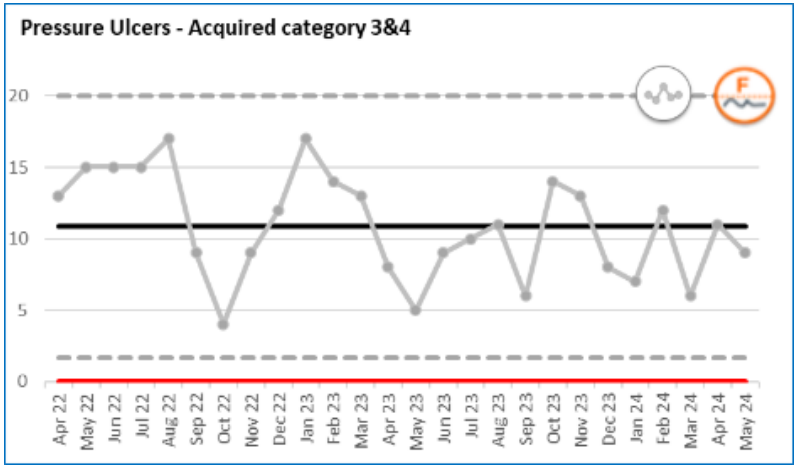
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Serious Incidents				-		
Pressure Ulcers Category 3	May 24	4	5	-		
Pressure Ulcers Category 4	May 24	1	0	0		
Infection Control - Number of Cdiff	Mar 24	0	0	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
			-		
May 24	7	6	-		
May 24	0	0	0		
May 24	0	0	-		

Safe, High-Quality Care

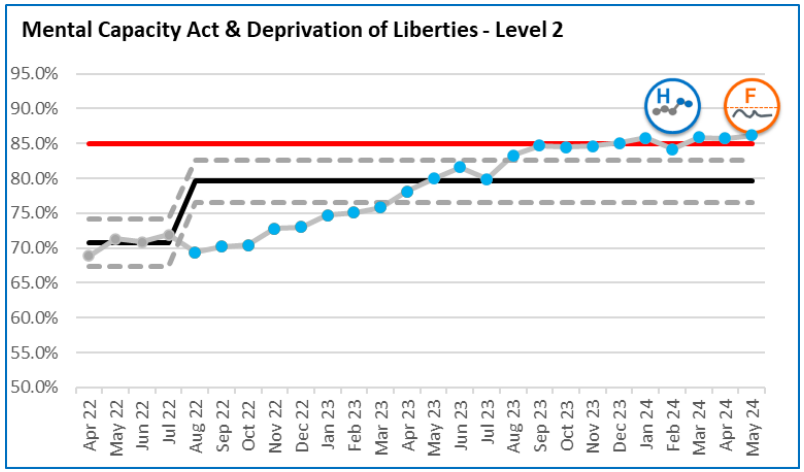
Exception Report | SGUH Pressure Ulcers Category 3 and Above



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Grade 3 and above Common cause variation and consistently not meeting target	There were 9 Acquired Category 3 & 4 and unstageable pressure ulcers in May 2024, similar to April 2024 (11), with no category 4 cases. Of these 9, 3 occurred in critical care areas, 4 in the Medicine/Cardiovascular Division and 2 in surgical and neurology areas. 3 of the 9 pressure ulcers were medical device related (MDRPUs), 2 of MDRPUs were caused by ventilation fixation devices for patients with problematic airways. Medical physics have expressed some concerns regarding the need for replacement of pressure relieving mattresses.	Services where harm has occurred continue to complete investigations and produce local action plans that are managed within the division Healthcare Assistant targeted e-learning developed and awaiting sign-off. RSM, the Trust's internal audit provider conducted an onsite visit on the 15th and 16th May 2024. Initial feedback has been given and the final report expected by the end of May 2024. Trust wide pressure ulcer prevention action plan to be updated once RSM report published.	TBC	sufficient for assurance

Safe, High-Quality Care

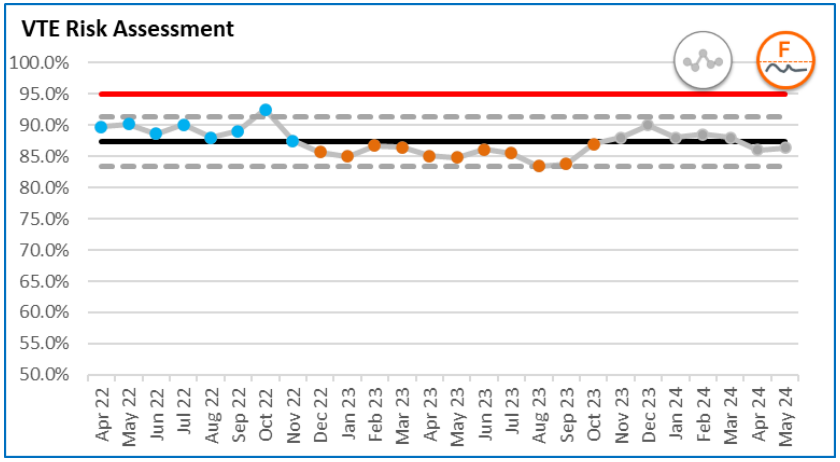
Exception Report | SGUH Mental Capacity Act & Deprivation of Liberties Level 2



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality Rating
SGUH Mental Capacity Act (MCA) & Deprivation of Liberties Level 2 Special cause variation of an IMPROVING nature. Target not consistently met	MCA Level 2 compliance has reached the target of 85% since Q3 2023/24. There are large numbers of rotating staff and new starters which impact on compliance rates across the Trust. Recruitment to vacant Specialist Practitioner post within MCA team underway, with start date in May.	Dedicated Induction sessions for newly qualified staff, rotating Junior Doctors and speciality specific trainings are offered by the Practitioners within the team. The Safeguarding and MCA team offer Level 2 face to face training for clinical care groups across the Trust. This training is delivered to areas identified as in need by the team and as requested by specific clinical areas. The St George's Adult Safeguarding CNS/Practitioners provide specialist education and support for safeguarding and MCA queries, providing a more comprehensive service to the Trust. This assists with compliance and knowledge across the Trust. A training strategy for St George's is currently in development taking into account current training provision of MCA.	August 2024	sufficient for assurance

Safe, High-Quality Care

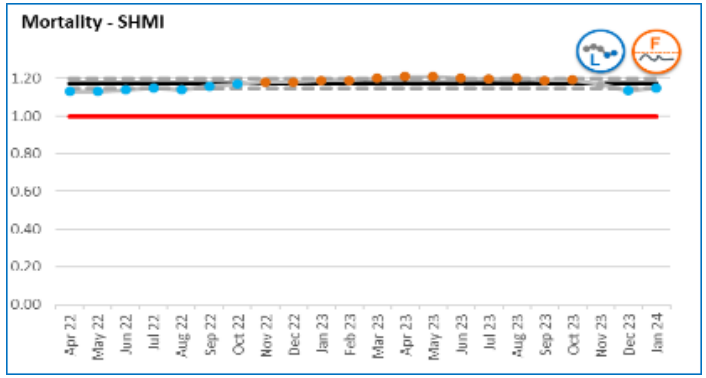
Exception Report | ESTH VTE Risk Assessment

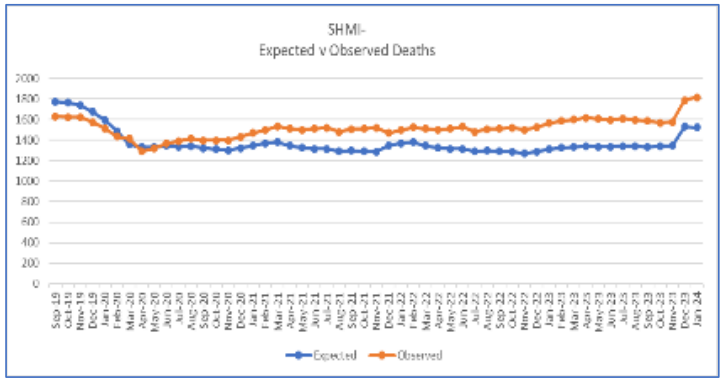


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH VTE Performance Common cause concerning variation and consistently failing target	Risk Assessment Screening remains a challenge. Lack of ownership by the appropriate health professionals and divisions Variation in data collection which is being addressed	• Action plan updated and discussed at audit committee; changes required. • From 1st June , divisions are asked to lead on reporting incidents and investigations • Performance of VTE screening is now being discussed at IPR meetings • Policy rewritten and is going to PRG for approval at the next meeting • Going work on data validation with the Information Management team • Trial of SPC charts for all areas to monitor their performance. This is joint work with the Continuous Improvement team	Under review	sufficient for assurance Data definitions under review.

Safe, High-Quality Care

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



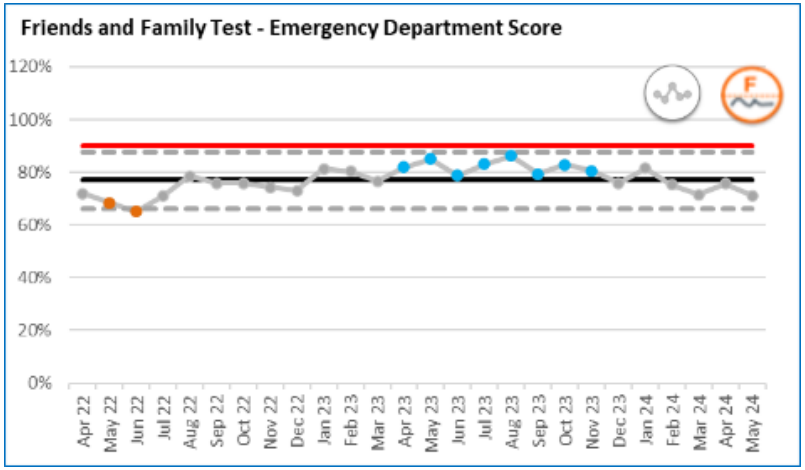


SHMI Source NHS Digital data based on rolling 12 months- February 2023 to January 2024 reported in May 2024

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently exceeding expected rate	• Remains classified as 'higher than expected.' • During 2020, Epsom and St Helier University Hospitals NHS Trust (ESTH) stopped reporting Same Day Emergency Care (SDEC) as inpatient activity. This change has subsequently reduced the total spell count in the Summary Hospital-level Mortality Indicator (SHMI) model. • The SHMI Score has increased over time, influenced by the reduction in expected deaths caused by fewer spells (particularly post-covid) • Higher deaths reports in the recent months, areas include electrolyte imbalances that seem to show high ratio, and UTI that remains high • Previous deep dives did not show issues in care, but coding is not always accurate • The 12-month rolling data continues to show an improving trend.	• Deep dives and thematic analyses are ongoing, with a focus on ensuring safe patient care. Analysis to include electrolyte imbalances, ITI, COPD and pneumonia • An in-depth review of themes from Structured Judgement Reviews (SJRs) has identified a list of actions being implemented • Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites • Coder-clinician collaboration - To reinforce the message how Clinician-Coder collaboration will be extremely beneficial to improve the recording.	Under review	sufficient for assurance

Safe, High-Quality Care

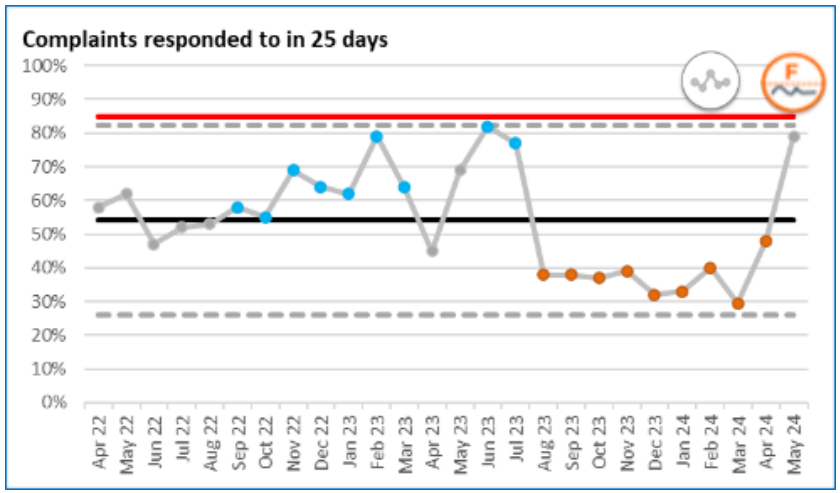
Exception Report | SGUH Patient Experience



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score Special case concerning variation Consistently failing target	The ED survey response rate continues to be good with 1539 patients surveyed in May 2024. The number of patients that would recommend the department to friends and family was 71% for May 2024. During May the number of ED attendances and patients awaiting a bed in the department continued to be high with the most consistent theme for negative responses being waiting times.	Actions for improving waiting times include: 1. New majors B flow model going live 18th June a)ECCU always open regardless of DTAs b)Increased capacity of treatment pod so non-admitted patients will receive treatments quicker c)Increased capacity of in-and-out spaces so clinicians have more space to review patients and are not waiting for a cubicle 2. Consultant Referral and Triage (RAT) rota a)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 3. Same Day Emergency Care (SDEC) a)10 new clinical pathways for medical SDEC launched 15th May to redirect patients to medical service if more appropriate b)Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic	TBC	sufficient for assurance

Safe, High-Quality Care

Exception Report | ESTH Complaints responded to in 25 days



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Complaints responded to in 25 Days Consistently not meeting target, Special cause variation of a CONCERNING nature.	•The current complaints process is not robust and does not enable a consistent monitoring approach to investigation completion timescales. •Due to how Datix is currently configured, the complaints team cannot consistently capture performance against this metric. •Many factors have played a role in this, including but not limited to high levels of sickness absence within the complaints team and operational pressures within the division.	Several actions as part of the complaint's improvement workstream are underway to support improving this metric: •Introduction of weekly divisional complaints team meetings between the division and the complaints team. This enables discussion of each complaint. •The investigation completion timescale has been revised to ensure adequate time for applying the principle 'investigate once, investigate well'. • The Datix system, which provides complaints management and monitoring tools, is undergoing a reconfiguration. This will enable and support robust monitoring of all stages of the complaint process. • A weekly complaints flash report has been introduced. This provides data on the complaints due for closure the following week and those that have been breached.	August 2024	Not sufficient for assurance

Operational Performance

Operational Performance

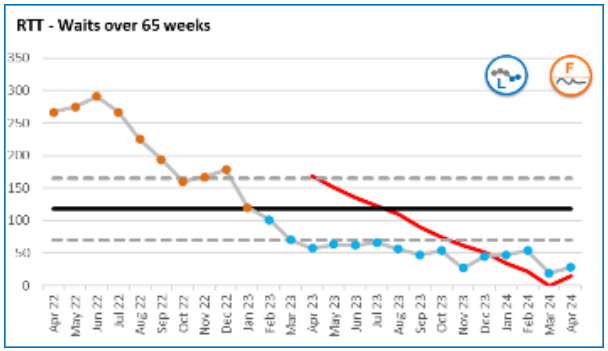
Overview Dashboard | Elective Care

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Elective Ordinary Activity	May 24	1012	1128	1167				May 24	625	659	626			
Elective Daycase Activity	May 24	4743	4580	4517				May 24	3174	3189	3189			
Outpatient first attendances without a procedure - ERF scope	May 24	30477	32289	21399				May 24	10984	11690	11890			
Outpatient procedures - ERF scope	May 24	24952	22116	15993				May 24	11533	11725	12011			
Diagnostic Activity	May 24	19108	21113	19903				Apr 24	16118	17035	16691			
Day Case Rates (BADS Procedures)	Feb 24	70.7%	70.2%	85.0%			Lowest Quartile	Feb 24	83.7%	84.0%	85.0%			2nd Quartile
Theatre Utilisation (Capped)	May 24	78.2%	81.4%	85.0%			Top Quartile	May 24	83.9%	82.0%	85.0%			Top Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Apr 24	0.5%	0.7%	5.0%			Lowest Quartile	Apr 24	2.6%	2.8%	5.0%			2nd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	May 24	58.9%	58.0%	49.0%				May 24	43.5%	45.3%	44.9%			
Outpatients Missed Appointments (DNA Rate)	May 24	10.0%	9.4%	8.0%			Lowest Quartile	May 24	6.6%	6.7%	6.0%			2nd Quartile
Outpatient Advice & Guidance Rate per 100 First OPA	Apr 24	21.2%	17.8%	16.0%			3rd Quartile	Apr 24	58.7%	55.5%	16.0%			2nd Quartile
RTT - Waits over 65 weeks	Apr 24	19	28	15			Top Quartile	Apr 24	115	132	120			2nd Quartile
RTT - Waits over 52 weeks	Apr 24	613	499	546			2nd Quartile	Apr 24	853	871	850			2nd Quartile
RTT - Total Size Incomplete Waiting List	Apr 24	62847	63170	63265				Apr 24	49193	50067	47284			
RTT - Percentage within 18 weeks	Apr 24	65.3%	66.8%	92.0%			2nd Quartile	Apr 24	65.9%	67.7%	92.0%			2nd Quartile
RTT - Median Waiting Time	Apr 24	11.6	11.7	-			Top Quartile	Apr 24	11.2	11.4	-			
Cancer - 28 Day Faster Diagnosis Standard	Apr 24	77.6%	71.8%	77.0%			3rd Quartile	Apr 24	83.7%	85.0%	77.5%			2nd Quartile
Cancer 31 Day Decision To Treat to Treatmnent Standard	Apr 24	96.0%	92.7%	96.0%			2nd Quartile	Apr 24	100.0%	96.0%	96.0%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Apr 24	80.8%	78.0%	70.0%			2nd Quartile	Apr 24	90.2%	90.6%	85.0%			Top Quartile
Diagnostics - 6 Week Waits	May 24	1.2%	1.3%	5.0%			Top Quartile	Apr 24	3.8%	4.2%	5.0%			Top Quartile
On the Day Cancellations not re-booked within 28 days	May 24	1	1	0				May 24	1	1	0			

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

Operational Performance

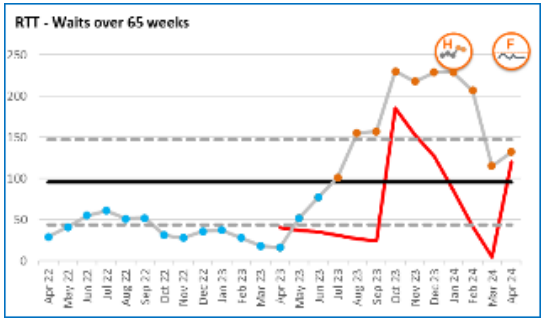
Exception Report | SGUH Referral to Treatment (RTT) 65+ Weeks

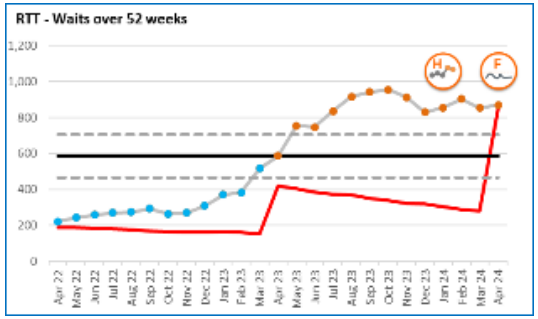


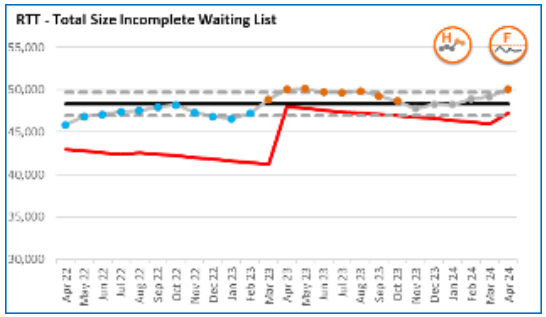
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan of 15 patients	• Reporting 28 pathways against plan of 15. Although it should be noted that the Trust are performing in the top quartile nationally with one of the lowest 65 week wait cases nationally at the end of 2023/24 • We have seen waiting list growth in Gynae, Dermatology, General Surgery and Neurosciences. • Workforce challenges are being addressed • The impact of lost capacity due to industrial action has limited our ability to drive down wait times. Prioritising cancer, urgent and long waits meant the wait list profile changed.	**Production Plan:** The 2024/25 internal production plan has now been updated to show numerical and value weighted trajectories. Providing a one truth forum for divisions to monitor performance and identify areas of challenge requiring solution. **GIRFT Programmes:** The Trust is looking to work with GIRFT on the 'Faster Further' and 'Theatre Productivity' programmes to support an increase in productivity **Waiting List Validation:** We are moving our 'technical' wait list validation process over to the patient portal. This will allow us to run technical validations more frequently with less administrative burden. **Improvement and action plan:** Elective Access meeting has agreed a set of action plans with divisions. Setting measurable benefits, timeframes and action owners.	September 2024	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)



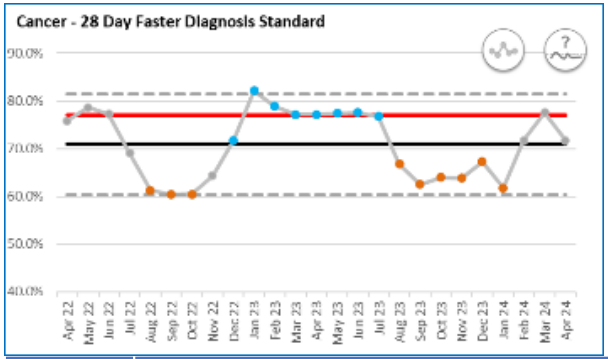




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Waiting list size not meeting plan Median waiting times – special cause variation 52Wk & 65Wk waits not meeting plan special cause variation	• 52 week waits remained above the ambition of 850 in April 2024 with a total of **871** patients waiting more than 52 weeks. The specialties with the highest cohort were Gynaecology (366), Community Paediatrics (174) and Cardiology (66). • 65 week waits also remained above the ambition of 120 in April 2024 with a total of **132** patients waiting more than 65 weeks. The specialties with the highest cohort were Gynaecology (74), Community Paediatrics (17) and General Surgery (17).	• Recovery plans in place and ongoing for Community Paediatrics, Gynaecology, Cardiology and Gastroenterology. • Insourcing for Gynaecology continues and although long waits remain high, the total PTL and patients waiting for first appointment within this service has reduced significantly since insourcing began in January 2024. The total Gynaecology PTL has reduced by 782 and total waiting for first appointment by 1641. However, there has been an increase in the Gynaecology IP/DC waiting list for which a demand and capacity analysis is being undertaken. • Insourcing for Community Paediatrics continues, as well as the locum in post. This has supported the reduction in 65 week waits from 65 in January 2024 to 17 in April 2024. However, 52 week waits for this service remains pressured. • Divisions and performance team continue to work in collaboration to manage 52 week waits daily and expedite next steps. Updates being provided to South West London on a weekly basis for patients 60weeks+. 65wk+ and 78+ clearance lists also being circulated to divisions to increase visibility of pathways needing additional focus. • All patients over 12 weeks who have not been seen or contacted in the past 12 weeks continue to be contacted to confirm if they still wish to be seen.	No date planned for clearance of 52 week waits. 65 week waits due to be cleared by September 2024 in line with the national target	Sufficient for assurance

Operational Performance

Exception Report | SGUH Cancer Faster Diagnosis Waiting Times

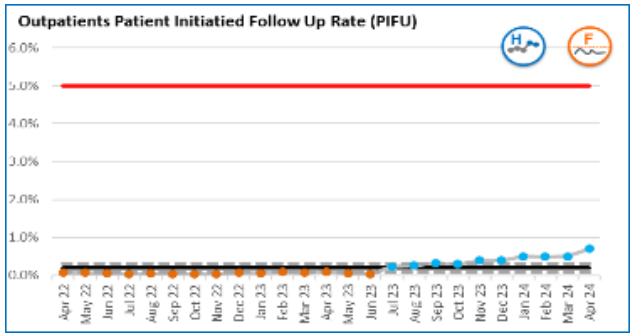


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FDS – Plan of 74.98% not met	**Faster Diagnosis performance of 71.8% against plan of 74.9% for April 2024.** • Gynaecology reduced access to scans and delay to starting one stop clinics has resulted in a decline in FDS performance. • Lower GI: CTC capacity and endoscopy process delays are contributing factors. • Radiology diagnostic modalities are not consistently achieving the NHSE recommended turnaround time of 7 days for reporting of OP FDS diagnostics. • Pathology: At any given point in the month, 35% of cancer specimens are waiting over 10 days to be reported. • Breast performance has dropped due to access to one stop. • Skin saw a return to baseline performance at 92.7% **62-day Performance was at 78% against a plan of 75% for April 24.** • Theatre capacity constraints continue in Urology and Thoracic Surgery.	• **Summer Resilience funding (70K**) has been awarded for Q1 to support performance delivery. Tumour sites awarded include Haem, H&N, LGI, Derm, Breast and Urology. • **Skin:** The Trust is working on implementation of Teledermatology. • **Gynaecology** plan to run an all-day one-stop clinic at QMH from June 2024. RMP funding has been agreed and will support this service to improve the position. • **Lower GI.** Discharge at scope being worked up and expected to be operational in next three months. Stratified Follow-up will release up to 60 Follow up slots. • **Pathology:** Informatics project to identify all cancer specimens as they enter the lab, to support fast streaming. Currently this is a manual process, which cross references specimens to the cancer PTL after the event. This is not contemporaneous leading to delays in streaming. • **Radiology:** Dashboard under development to support real time tracking of radiology scans and reports against national KPIs. • **Lung thoracic:** The delays are to increased referrals relating to Targeted Lung Health Checks programme. Business case has been developed for additional resources to improve RTT times.	Recovery time scales are dependent on resources	sufficient for assurance

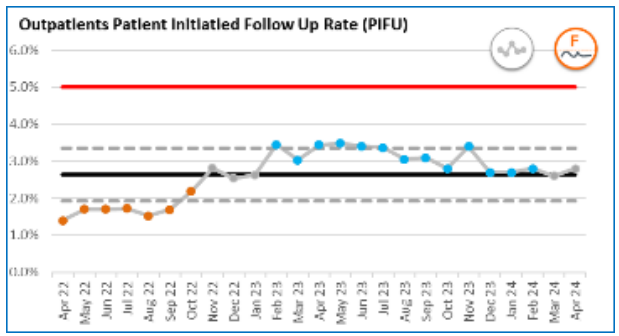
Operational Performance

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

St George's



Epsom & St Helier



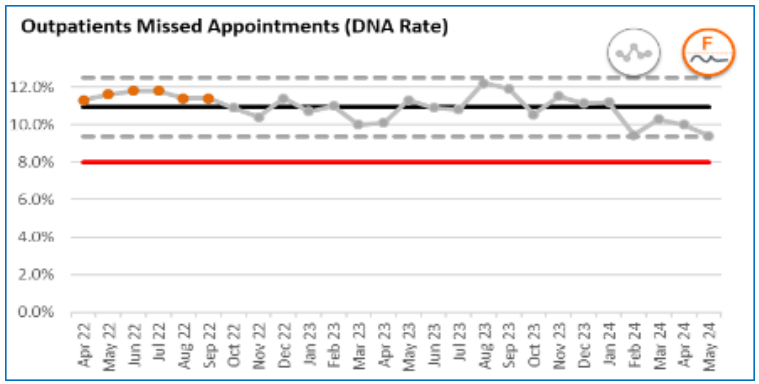
Rate reported one month in arrears in line with Model Hospital reporting

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target	In month performance for May was 1.23%(data not yet uploaded to Model Hospital). Activity continues to increase with the technical solution to PIFU now designed and rolled out in 6 services (T&O, Urology, Plastics, Gynae, Dermatology and Therapies). We have now gone live with PIFU functionality in the patient portal as of 14th May 2024 and being used well in a live services.	• Second version of PIFU launched in six services, data showing minimum levels of 1.23% as of May 2024, increase of 0.6% within in March *(completed)* • Third version, due to be ready in September (IT Transformation led project) following consultation with clinical teams. • Remaining GIRFT specialities(Gastro and ENT) are in the process of going live. • Transformation Programme work to identify other recommend pathways *(ongoing)* • Tableau report has now been developed but in draft phase *(new)*	2% planned for July 2024	sufficient for assurance
ESTH PIFU Rate: Consistently not meeting target	Engagement with PIFU amongst clinicians varies, but we continue to look for more opportunities for PIFU to Discharge and PIFU to Assess.	• March showed a slight reduction in PIFU. A renewed focus on PIFU has since been undertaken across the OP Transformation programme specialties including the OP Transformation workshop that ran on 6 June and the first OP Transformation Newsletter shared in May had a spotlight on PIFU success stories. • Whilst overall PIFU was down slightly again, Paeds ENT grew in March and hit 5% for the first time. • Our internal Outpatient Dashboard indicates an increase from April onwards.	3.5% planned for March 2025 (National Target 5%) 5% target not yet planned to achieve.	sufficient for assurance

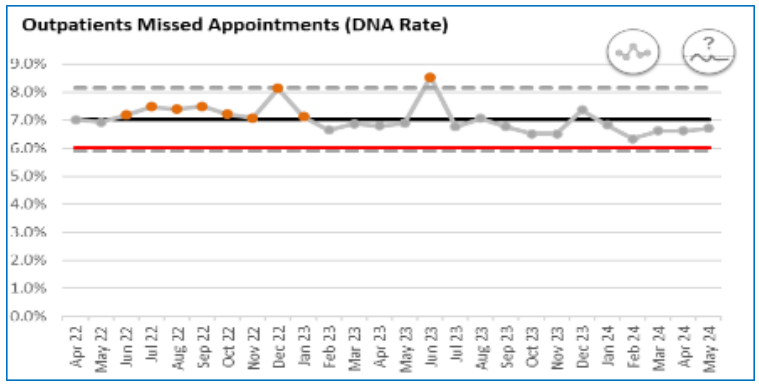
Operational Performance

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

St George's



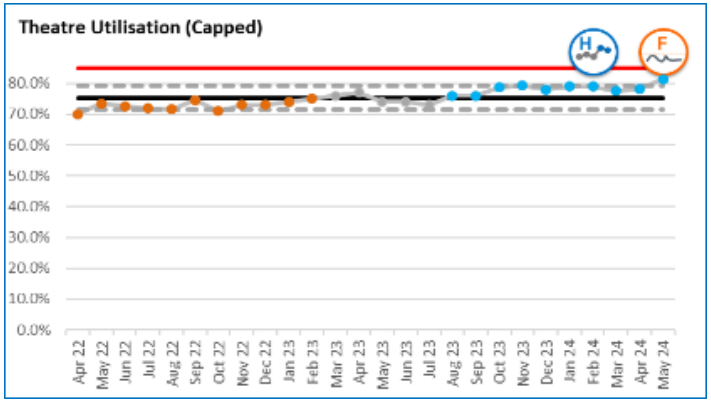
Epsom & St Helier



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Special cause variation of an improving nature however has consistently failed target	Continued improvement of position and has decreased from 12% to 9%. Submitted data via SUS/SLAM incorrectly included clinic slots "no longer in use / closed", this has artificially inflated our DNA position. This is being reviewed by the BI team to rectify the denominator.	• All services review their appointments that have one way reminder texts monthly for Day 7 and Day 2 before every appointment (one way message to patient but they cannot text back). • Cardiology have had a significant improvement over past three months, reducing their rates from 10.3% in January 2024 to 7.9% in April 2024. In order to further improve they have turned on their 2-way messaging functionality (patient can respond) since 6th May as they have staffing levels currently to support managing their responses • Diagnostics have focus on reviewing letter and text reminders – taking their DNA rates from 6.3% in January 2024 to 1.4% in April 2024 • Being supported by BI to resolve external reporting issues – Recovery data not yet known	TBC	Work in progress to resolve und er-reporting
ESTH Common cause variation, no significant change Failing target of 6%	With the new calculation, performance is above the target of 6%. However, the data still shows a trend of the DNA rate reducing over the past 2 years and work to reduce this further will continue.	• DNA rates continue to be below 7% for the 5th month in a row. • Work continues with the teams using the following process: 1) Use the OP dashboard to identify clinics with a high DNA 2) Check if they are on the text reminder service and add if not and appropriate to 3) If they are, a telephone patient audit is carried out to identify barriers for patients and identify mitigations to implement to support more patients to attend. • An example of where this is effective is in Gynaecology where using this approach, DNA rates have dropped from 10.1% in Mar to 7.42% in May.	TBC	sufficient for assurance

Operational Performance

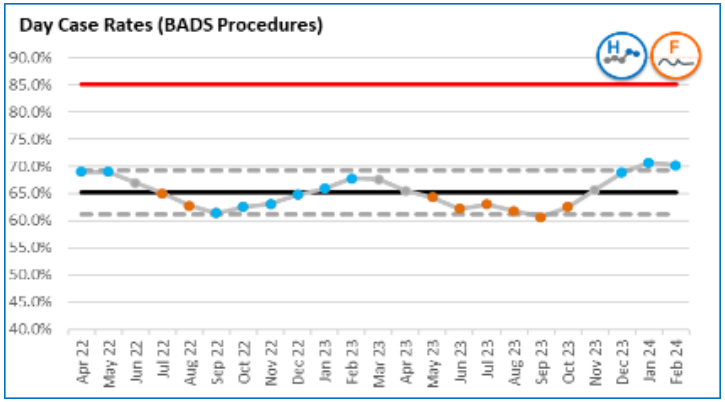
Exception Report | SGUH Theatre Utilisation (Capped)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Theatre Utilisation (capped): Consistently not meeting target (85%) and special cause improving trend.	Adherence to 6-4-2 booking principles. Increased estates issues in May 2024 caused some delays to the start of lists which led to over runs, negatively affecting capped theatre utilisation. Theatre utilisation has improved by 3% from April to May to above 80%.	Continued focus on scheduling, particularly 6-4-2 escalation processes, to ensure fully booked theatre lists. New 6-4-2 meeting structure being rolled out w/c 1st July with oversight by the Chief Operating Officer. Theatre performance meeting has been established to ensure lists are fully optimised and booking rules are adhered to. 6-4-2 and scheduling guidelines are being formalised in a document for specialities to work towards. Lists not booked to >75% utilisation with 2 weeks' notice are being reviewed and stood down. Unless there is a clinical exception to this standard. Further work is being planned to understand the scope for improvement of average cases per session across different specialities. Theatre Transformation support started in May 2024, theatre user group meetings are now taking place regularly with each speciality to critically analyse theatre performance, in addition to demand and capacity. The output from these meetings has been positive and has clinical involvement. The groups will also review equipment requirements, ensuring teams have the right kit at the right time, in the right place.	TBC	sufficient for assurance

Operational Performance

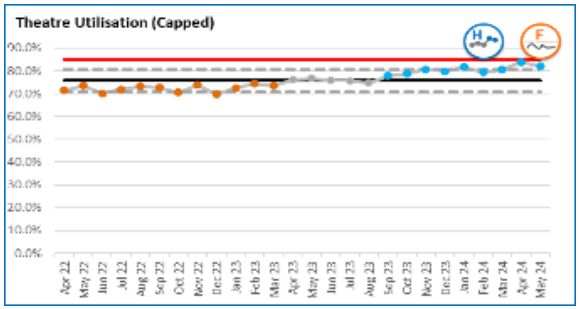
Exception Report| SGUH Daycase Rate (BADS Procedures)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Day Case Rates (BADS Procedures) not meeting 85% target with improving trend	Data quality issues such as where patients on day case wards (particularly DSU wait) had LoS of 1 or more days. Effects of data correction and improved recording is showing an improving trend.	BADS compliance is being discussed with all surgical specialities within theatre transformation deep dives to explore opportunity. Further work is required to ensure cases are being coded appropriately from DTT. We are also undertaking a significant piece of work on QMH which includes expanding the inclusion criteria at QMH which will increase throughput.	TBC	sufficient for assurance

Operational Performance

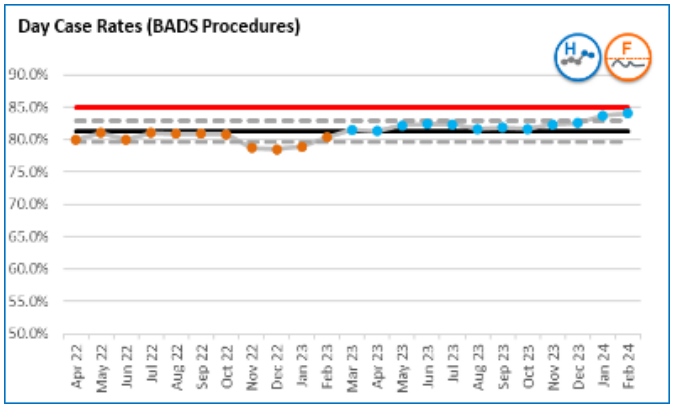
Exception Report | ESTH Theatre Utilisation (Capped)



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%)	On the 26th May – ESTH achieved **85% utilisation**, this is the third time ESTH has done this in the Trust 's recorded history (previous dates = April 21st 2024 & April 28th 2024). The main driver to achieving over 85% has been by decreasing the OTDC (on the day cancellation) rate. Staff continue to help achieve high levels of **patient satisfaction.** Epsom Day Case & POA received a 5 star rating for May's Friends & Family test . ESTH are very proud of the teams!	▪ 70% of **Template Biopsy** lists will be relocated to the Urology Outpatient Centre, and the first lists have moved. This has started with x1 list per week from June, and will increase to x2 per week from July, with an aim to increase further across August/September. ▪ The first ***'Get home SWIFTLY'*** Task & Finish Group launched in June. This has been established to explore creating dedicated day case bays on SWIFT Ward which in turn would increase flow, prevent delays, and improve turnaround. A pilot starts on Monday 17th June. ▪ The first ***'On the day cancellation'*** (OTDC) Task & Finish Group launched in June. This has been established to reduce avoidable cancellations. One key action was to ensure all non-clinical cancellations are escalated for support before the cancellation occurs. ▪ Planned Care now have approval for additional rooms and collocated clinics for the **Pre-Operative Assessment staff** – this is a big success as it will bring a number of efficiencies to the service and the team are just working through equipment requirements. ▪ The team are launching a **Theatre Utilisation & Management Procedure/Manual**. ▪ In order to be more productive, ESTH are focusing on using the theatre lists that run robustly, but also focusing on its 'theatre estate' and **aiming to ensure 85% of templated theatre sessions are utilised**. This means ensuring less theatre sessions are closed/run fallow. A piece of work is underway to calculate what % of templated sessions were utilised across 23/24 to be clear on what improvement is required across 24/25. ▪ A **Health & Wellbeing T&F Group** will be launched in June/July.	TBC	sufficient for assurance

Operational Performance

Exception Report | ESTH Daycase Rate (BADS Procedures)



Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Not meeting target of 85%. Improving trend	ESTH is close to the 85% target is nearly being met, but there is a definite opportunity for improvement. Important to note that Endo, ENT and Eyes are all at 100% which will mask scores that are lower than peers in Urology, Gynae and General Surgery.	• ESTH scores highest against SWL peers for the proportion of all admissions that were day cases (BADS Directory of Procedures 6th Edition). ESTH's day case rate is 84%, against a target of 85%. Peer median is 80.7 (Model Hospital). • However there are further opportunities for improvement. High volume specialties such as Eyes, ENT and Endoscopy are achieving 100%. Other specialties such as General Surgery (74%), Gynaecology (60%), and Urology (60%) are lower than ESTH peers. ESTH aims to support an improvement in Day Case rates amongst these specialties within the 'Get Home SWIFTLY' task and finish group. • Urology have already done lots of work with the coding/quality team, theatres, consultants and junior doctors to drive day case and get patients discharged by midnight specifically for HoLEP, TURP, TURBT & URS procedures. Once they are able to do some of these procedures in day case it should further improve their % rates and save overnight admissions.	TBC	sufficient for assurance

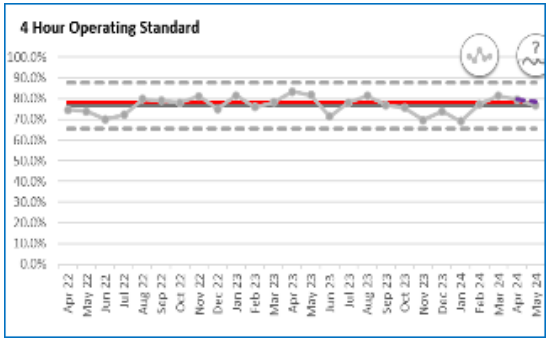
Operational Performance

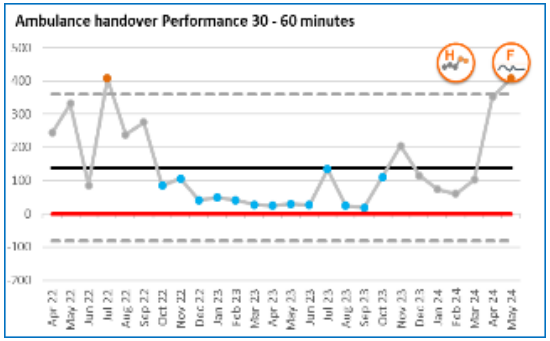
Overview Dashboard | Urgent and Emergency Care

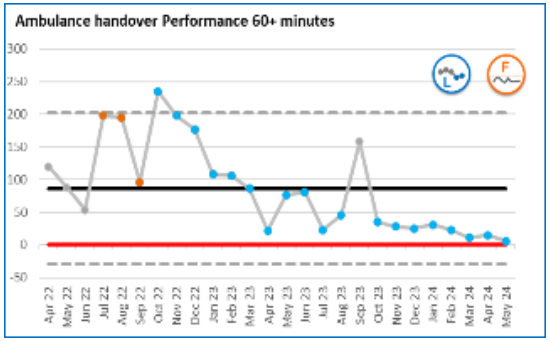
KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
4 Hour Operating Standard	May 24	79.7%	76.8%	78.0%			2nd Quartile	May 24	76.4%	77.5%	78.0%			2nd Quartile
Emergency Department LOS >12 Hours (% of attendance)	May 24	8.8%	7.7%	-				May 24	12.4%	12.0%	-			
Ambulance handover Performance 30 - 60 minutes	May 24	352	409	0				May 24	479	489	0			
Ambulance handover Performance 60+ minutes	May 24	15	6	0				May 24	68	61	0			
Mental health delays 4 Hour Breaches	May 24	123	130	-							-			
Readmission Rate - Non Elective	Apr 24	13%	11%	-				May 24	4.9%	5.1%	-			
Length of stay > 21 days (super stranded)	May 24	180	161	163				May 24	175	174	122			
Overnight G&A beds occupancy - Adults	May 24	95.4%	94.6%	96.9%				May 24	90.7%	90.2%	88.3%			
Number of patients not meeting criteria to reside	May 24	155	140	91				May 24	211	212	120			

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers



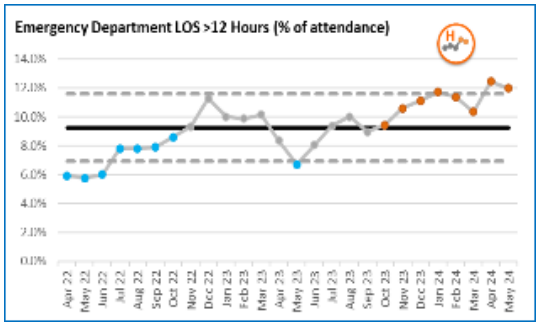


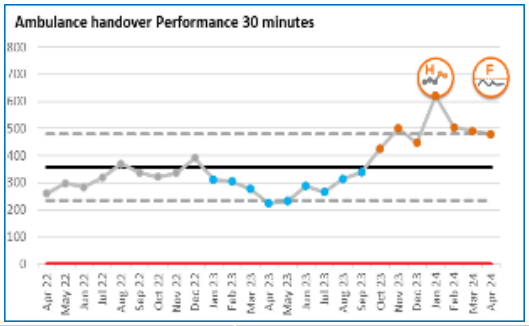


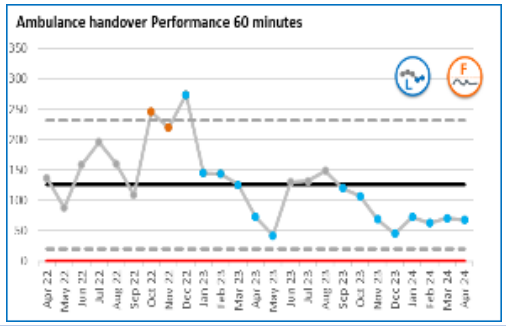
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Operating Standard not meeting plan of 78.6% LAS Target consistently not met	Performance in May was 76.8% not meeting plan of 78.6%. The key drivers of operational pressures are: DTA's in department High number of complex mental health patients spending >24hrs in department Limited in-and-out spaces to see and treat patients 78% of 2,696 LAS arrivals were off-loaded <15 minutes. due to an increase in DTA's and pressures within the department, ambulance conveyances waited longer to offload seeing an increase in 30-60 minute breaches. 6 days of >95% non-admitted pathway performance.	Maintaining Extended Emergency Care Unit (EECU) to facilitate waiting of results Maintaining in and out spaces to improve performance and capacity within the department ED to ensure front door RATTING and use of hot clinics is robustly managed Continue to work with 111 to optimise UTC utilisation Community in reach to aid admission avoidance to be pushed for Development of SDEC – medical pathways live 15th May Develop UTC 24/7 Proposal in line with ask from NHSE. Additional EP to front of house for UTC to improve wait times for investigations Navigator at front of house to redirect patients to more suitable healthcare settings in place Monday to Wednesday. Enhanced boarding and cohorting continue to be business as usual across site. Weekly meetings with LAS are underway to resolve issues both Trust and LAS have faced Majors B workstream to streamline clinical effectiveness and treatment areas for patients. SDEC workstream to build SDEC services portfolio LOS workstream to identify where LOS reductions can be made Trusted Assessor Pathway for LAS straight to SDEC	June 2024	ED Performance: sufficient for assurance LAS: Under review

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers



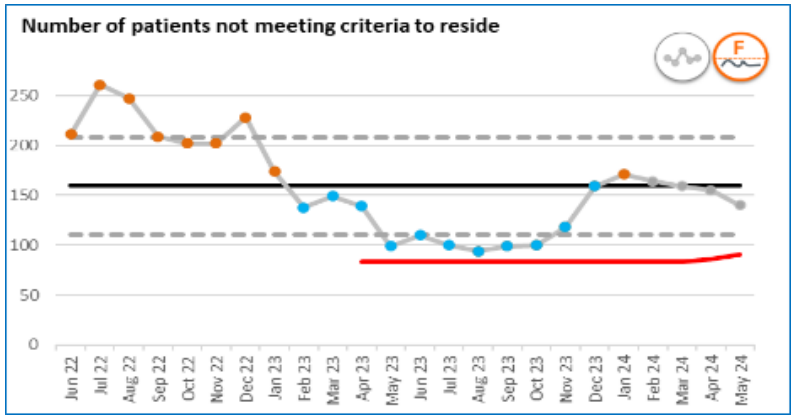




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH ED LOS>12 Hours - Special cause variation of a CONCERNING nature. LAS 30-60 Min Consistently not meeting target, Special cause variation of a CONCERNING nature.	We saw an improvement in ED performance in May 2024, reporting 77.5% performance versus 76.4% in April 2024. Patients spending longer than 12-hours in ED also remains challenging with 11.9% of patients spending longer than 12-hours in the department in May 2024, although an improvement compared to April 2024 where we reported 12.4%. ➢ 60-minute ambulance handover delays remain high with 61 reported delays in May 2024, however a reduction on the 68 reported in April 2024.. Time to first assessment and time to decision to admit remain above the ambition of 60 minutes and 180 minutes respectively We continue to see high numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• The launch of our 2024/25 work programme hosts an agreed set of priorities for 2024/25 which now includes PLACE deliverables. This includes key outputs, including but not limited to, the electronic streaming/redirection to UTC/SDEC and community pathways for those patients who attend ED but do not require acute care to support alleviation of ED capacity and admission avoidance. • The launch of our Same Day Acute Frailty response service took place w/c 22nd April. The provision is supported by a dedicated space and frailty MDT to ensure early and specialty assessment, treatment with clear exit pathways supporting direct/early flow from ED for appropriate patients supporting admission avoidance and reduced length of stay. • We are focusing on increasing direct to SDEC, SACU, and AGU referrals, surgical transfers from Epsom to St Helier, frailty front door, and direct bookings to UTC. LAS direct to SDEC conveyances continue to be a priority with increasing numbers of patients being conveyed directly to SDEC month on month. • Focussed work with colleagues from Surrey and Borders Mental Health Trust continues to progress the development of a proposal/business case for a mental health CDU on the Epsom Hospital site. We are also working with SWL & St Georges Mental Health Trust to explore mental health rapid access clinics for appropriate patients presenting to ED.	TBC	sufficient for assurance

Operational Performance

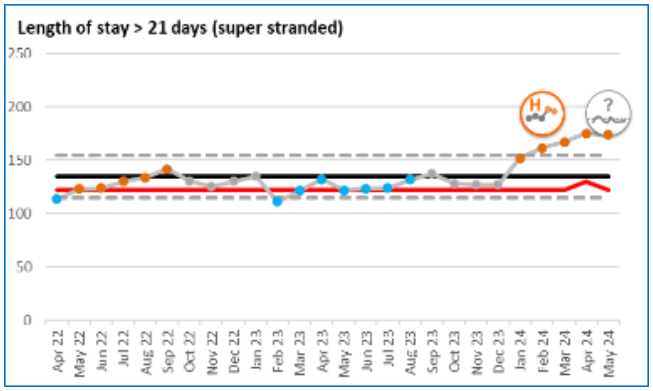
Exception Report | SGUH No Criteria to Reside (NCTR)

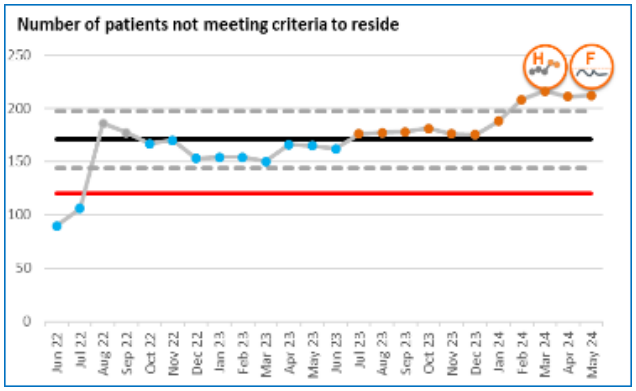


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR: Consistently not meeting target	High number of patients not meeting the criteria to reside not meeting plan however showing an improving trend. • Largest cohort of patients awaiting; Speciality/ Medical/ Psychology Review or Plan, Care Package (Social) and Residential home - Including interim (Social) • Attributable to on large Wandsworth and Merton Authorities • Specialties with high volumes are Elderly Medicine Service and Trauma and Orthopaedics • There has been significant improvement in the number of NCTR forms completed prior to 9.30am daily, which in turn is now reflecting a more accurate number of patients NCTR	• The Emergency floor and the Integrated Care Transfer Hub have seen benefits in Social Workers & CLCH partners being on site, particularly when working closely with Therapies • Since April there has been united efforts to prevent bedding in SDEC / AAA overnight as ways to reduce admissions and increase flow earlier in the day • Good improvement in earlier discharges however it would be helpful to see this split by ward • Divisional Bronze and consultant of the day review of P0 lists • MADE “style” Events has resumed given increased operational pressure • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • The Trust has replaced Red2Green with the National Criteria to Reside tool for daily electronic tracking patients' readiness for safe and timely discharge to improve patient flow and reduce length of stay. • Focussed sessions with ward teams to improve NCTR data capture and accuracy, supported by Transfer Of Care Team.		sufficient for assurance

Operational Performance

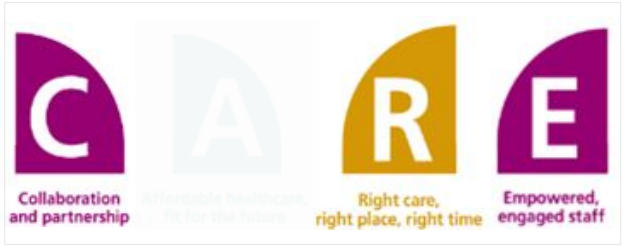
Exception Report | ESTH Super Stranded & No Criteria to Reside (NCTR)





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Super Stranded NCTR: Not meeting plan, Special cause variation of a CONCERNING nature.	Numbers of medically optimised patients on both hospital sites remain high, with many patients requiring complex discharge planning to support discharge. A particular challenge relates to those patients on pathway 3 who require discharge to a nursing/residential home. A significant cohort of our medically fit patients are those requiring on-going therapy prior to discharge. This is also reflected in our non-CTR patient cohort, with a high number of patients waiting for a hospital-based action prior to discharge being progressed. We have recently implemented revised reporting for patients who do not meet the criteria to reside, incorporating an increased number of reasons why patients remain in hospital, ensuring an increased focus on actions required to facilitate discharge	• Daily reports in place identifying those patients who are medically fit for discharge by specific discharge pathway, shared with internal and external stakeholders, including our therapy team to enable progression of key actions. • The undertaking of weekly DMT led 14 day + LOS reviews continue progressing to a newly formed complex discharge panel to include acute and relevant system partner(s) as appropriate. • We are in the process of implementing a complex discharge panel to review all patients with a LOS of > 45 days. The meeting will include external and internal stakeholders, including CNO/deputy representation • Our LOS KPI dashboard has been reviewed and now includes LOS metrics at ward/ department level, enabling us to identify and focus on areas reporting an increased LOS. • We have undertaken a review of individual patient flow/LOS work streams and the identification of individual improvement trajectories and how these will contribute to a wider LOS reduction • The Sutton Health and Care Reablement Unit has been operating at full occupancy with a robust system in place to ensure the early identification of suitable patients to transfer to the unit.	TBC	sufficient for assurance

Integrated Care



Integrated Care Performance

Overview Dashboard | Integrated Care

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	May 24	3	5	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	May 24	3	4	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	May 24	0	0	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	May 24	4	16	-			
Reablement Unit Bed Occupancy	May 24	97.0%	97.7%	-			
Reablement Unit Length of Stay	May 24	9	8	-			
Two hour UCR performance	May 24	86.4%	88.3%	70.0%			
Two hour UCR referrals received	May 24	452	446	-			
Virtual ward - Admissions	May 24	245	277	-			
Virtual ward - Bed Occupancy	May 24	61.2%	67.1%	80.0%			
Virtual ward Length of Stay	May 24	2	2	-			
Total Waiting List Size Adult	May 24	1631	1222	-			
Total Waiting List Size Adult 18+	May 24	7	3	-			
Total Waiting List Size Adult 52+	May 24	1	0	-			
Total Waiting List Size Children	May 24	871	932	-			
Total Waiting List Size Children 18+	May 24	411	416	-			
Total Waiting List Size Children 52+	May 24	76	77	-			

Surrey Downs

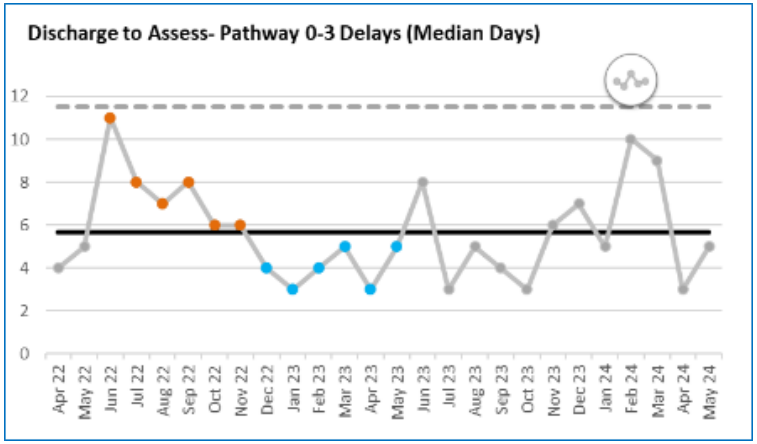
KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Discharge to Assess- Pathway 0-3 Delays (Median Days)	May 24	3	2	-			
Discharge to Assess- Pathway 1 Delays (Median Days)	May 24	3	2	-			
Discharge to Assess- Pathway 2 Delays (Median Days)	May 24	1	1	-			
Discharge to Assess- Pathway 3 Delays (Median Days)	May 24	21	14	-			
Community Hospitals Bed Occupancy	May 24	85.3%	88.0%	80.0%			
Community Hospitals Length of Stay	May 24	29	20	-			
Two hour UCR performance	May 24	84.1%	87.3%	70.0%			
Two hour UCR referrals received	May 24	552	567	-			
Virtual ward - Admissions	May 24	225	254	-			
Virtual ward - Bed Occupancy	May 24	87.0%	97.0%	80.0%			
Virtual ward Length of Stay	May 24	5	5	-			
Total Waiting List Size Adult	May 24	4438	4764	-			
Total Waiting List Size Adult 18+	May 24	58	107	-			
Total Waiting List Size Adult 52+	May 24	0	0	-			

Pathway 0 – Home with self-funded POC / Self funded placement / No support / family support / restart
Pathway 1 – Support to recover at home; able to return home with support
Pathway 2 – Rehabilitation or short term care in 24 hour bed based setting, community hospital
Pathway 3 Requires on-going 24-hour nursing care, often in bedded settings. Long term care likely to be required
EOL – Expected discharge and end of life in Community / Expected death on ward

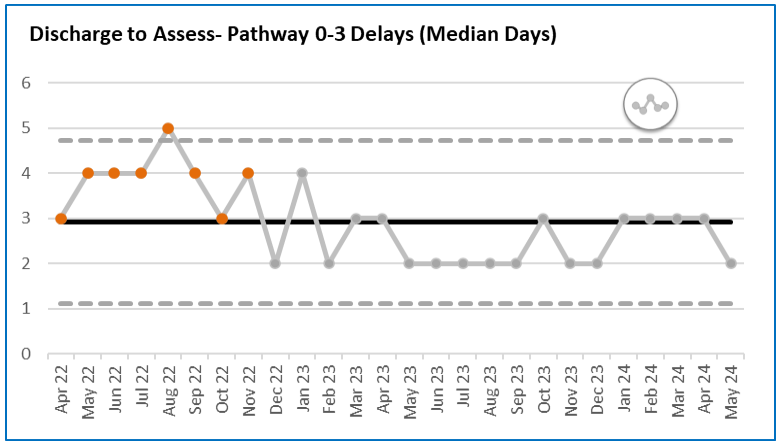
Integrated Care

Exception Report| Median days Discharge to Assess

Sutton Healthcare



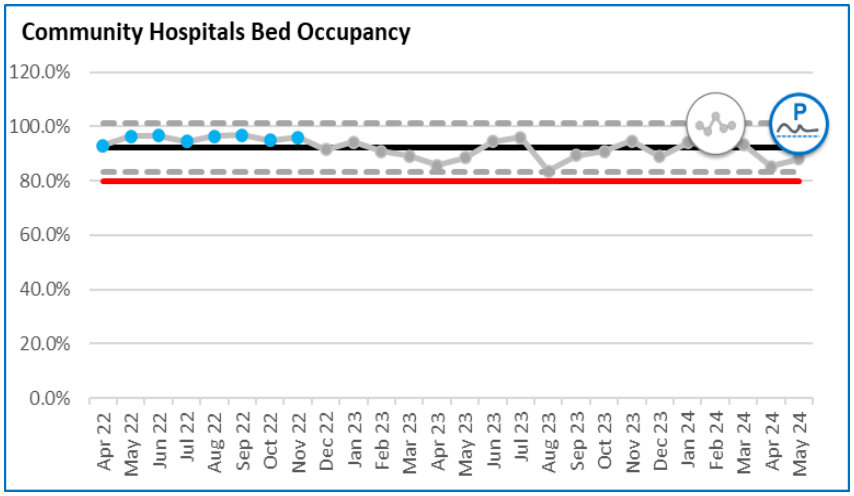
Surrey Downs

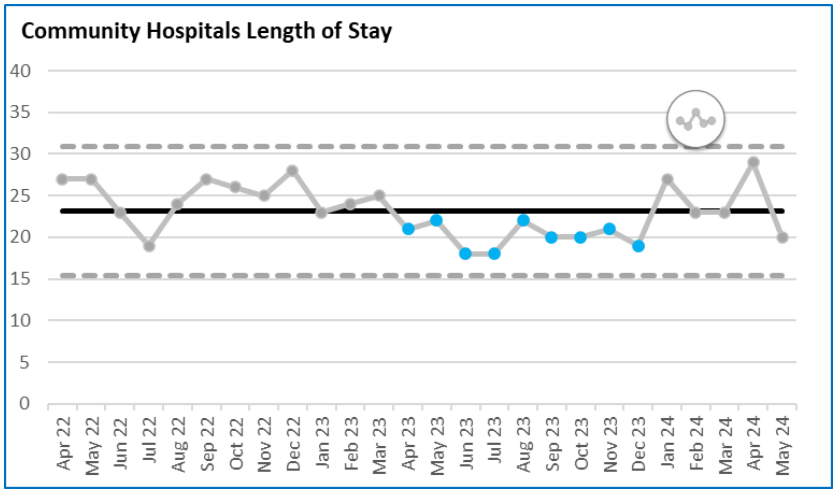


Site & Metric	Cause of variance/ non-compliance / challenges	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Common cause variation only with median days increasing through May, driven by an increase in pathway 3 delays.	• Work is ongoing with partners to mitigate recent increase in length of stay which has been largely due to an increase in admissions to ESTH and complex discharges	N/A	Sufficient for assurance
Surrey Downs Health & Care	Common cause variation only with median days at 2 across May.	• Continued focus on improving referral to discharge time. • Home First IT software (pathways to care) will further streamline the administrative processes. • LOS reduction program in development	N/A	Sufficient for assurance

Integrated Care

Exception Report| Surrey Downs Bed Occupancy & Length of Stay



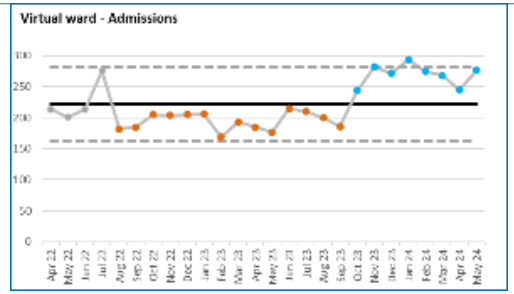


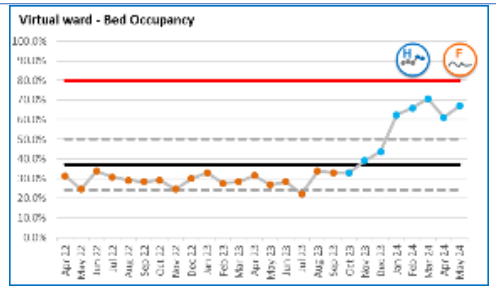
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Surrey Downs Health & Care	Common cause variation with occupancy and length of stay as expected. Improvement in LOS from previous month	• Process for escalations of delays is in place • Working on Choice policy implementation	TBC	Sufficient for assurance

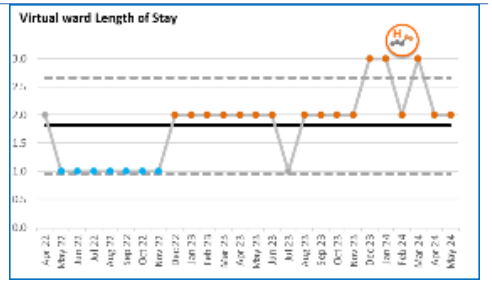
Integrated Care

Exception Report | **Virtual Wards**

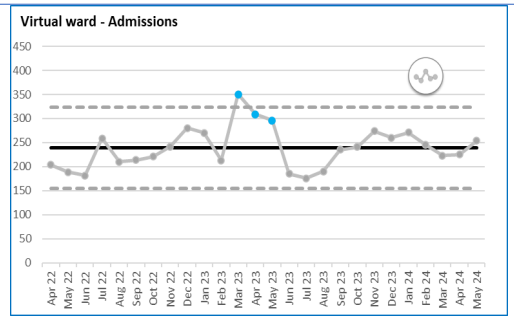
Sutton Healthcare

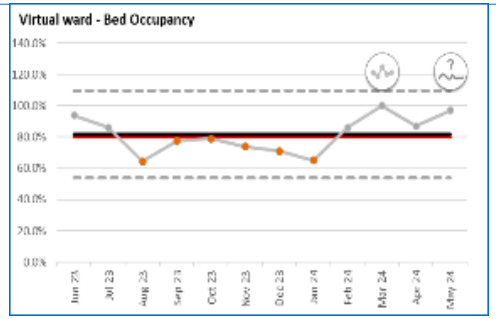


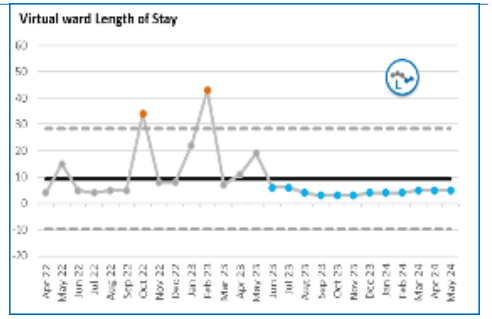




Surrey Downs





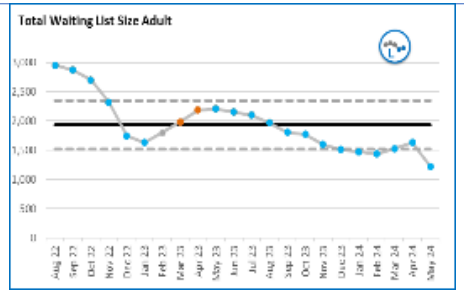


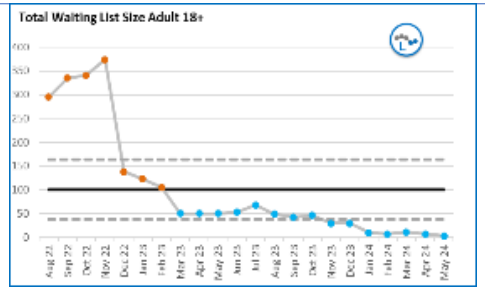
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Service target occupancy rates amended from December 2023. Positive increase in admissions and bed occupancy in recent months.	• SHC Virtual Ward continues to in-reach into St Georges Hospital and St Helier Hospital. • Engagement work with appropriate wards and with clinicians continues.	TBC	Sufficient for assurance
Surrey Downs Health & Care	Performance as expected and showing common cause variation. Bed occupancy has increased for a consecutive month above the mean.	• On-going development of enhanced care in Virtual Wards.	N/A	Sufficient for assurance

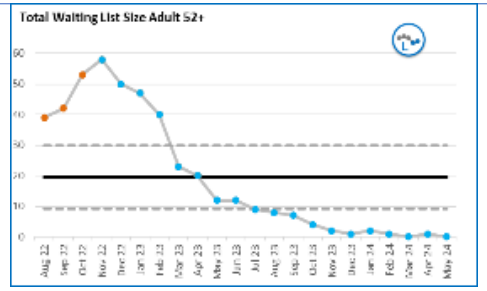
Integrated Care

Exception Report| **Adult Waiting List Performance**

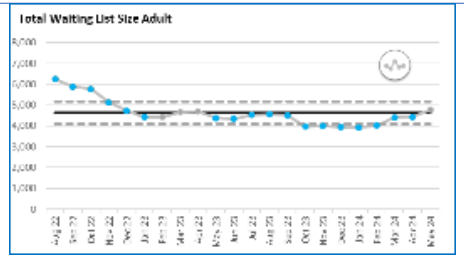
Sutton Healthcare

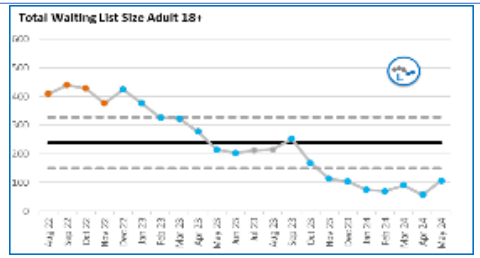


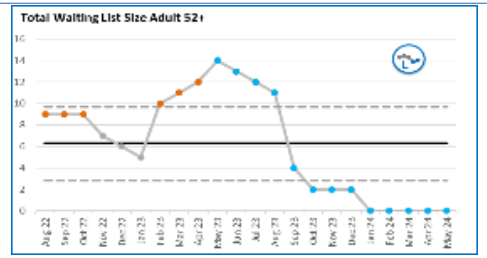




Surrey Downs





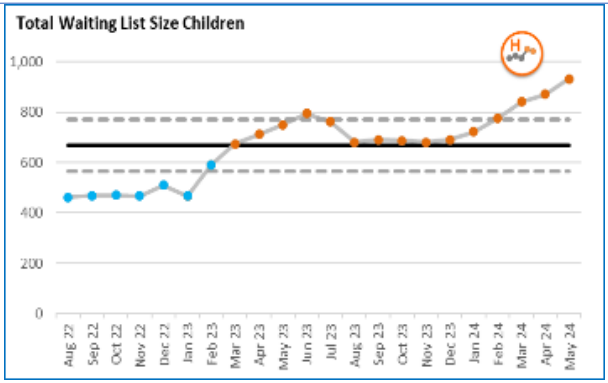


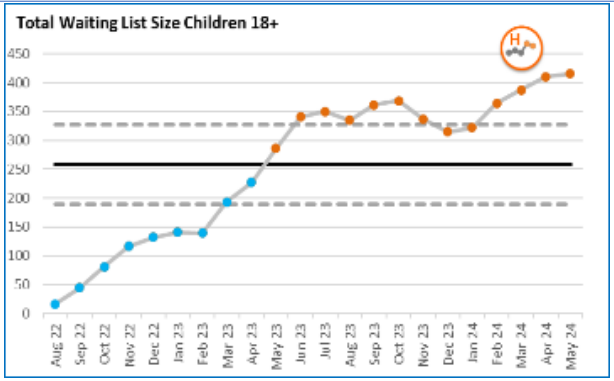
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Maintained improvement in waiting list size remaining below the mean.	• Service improvement plans in place to manage the waiting list.	N/A	Sufficient for assurance
Surrey Downs Health & Care	Improving trend across waiting lists.	• Service level plans to manage the Waiting List is in place	N/A	Sufficient for assurance

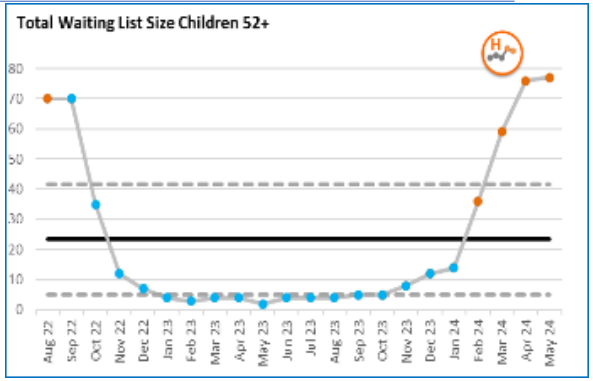
Integrated Care

Exception Report | Children's Waiting List Performance

Sutton Healthcare







Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	National issue recognised at SWL/PLACE. Children's OT and SALT services have the highest proportion of open referrals for therapy services. 79 patients waiting for more than 52 weeks with children's OT services holding the highest proportion (51 patients)	• PLACE/SWL aware with work being taken forward across SWL. • Mitigations in place within SHC to reduce waiting list. • Improvements made in triage, priority clinics (productivity /efficiency). • Additional clinics in place.	TBC	Sufficient for assurance

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Appendices

37

Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	May 24	4.1%	4.2%	3.2%		F	
Agency rates	May 24	2.7%	2.1%	-			
MAST	May 24	91.3%	91.3%	85.0%	H	P	
Vacancy Rate	May 24	6.4%	7.2%	10.0%	L	P	
Appraisal Rate Medical	May 24	86.4%	87.3%	90.0%	H	F	
Appraisal Rate Non Medical	May 24	76.5%	75.1%	90.0%	H	F	
Turnover	May 24	13.6%	13.5%	13.0%	L	F	
Percentage BAME staff band 6 and above	May 24	44.8%	44.8%	-	H		

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 24	4.5%	4.5%	3.2%		F	
May 24	2.8%	3.3%	-			
May 24	84.0%	84.8%	85.0%	H	F	
May 24	11.5%	12.0%	10.0%	L	P	
May 24	96.0%	95.3%	90.0%	H	?	
May 24	73.9%	75.3%	90.0%	H	F	
May 24	12.4%	12.5%	13.0%	L	F	
May 24	39.0%	38.7%	-	H		

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Sickness Rate	May 24	4.4%	4.0%	3.2%	L	F	
Agency rates	May 24	5.8%	5.5%	-			
MAST	May 24	87.3%	90.5%	85.0%		P	
Vacancy Rate	May 24	14.4%	15.4%	10.0%		F	
Appraisal Rate Medical	May 24	100.0%	100.0%	90.0%		?	
Appraisal Rate Non Medical	May 24	74.5%	73.2%	90.0%	H	F	
Turnover	May 24	2.9%	2.0%	13.0%		P	
Percentage BAME staff band 6 and above	May 24	37.1%	36.7%	-	H		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 24	5.6%	4.3%	3.8%		?	
May 24	8.2%	7.7%	-	L		
May 24	89.8%	93.1%	85.0%	H	P	
May 24	19.6%	19.3%	10.0%	L	F	
May 24	100.0%	100.0%	90.0%	H	?	
May 24	87.8%	87.8%	90.0%	H	F	
May 24	1.6%	1.5%	12.0%		P	
May 24	19.8%	19.4%	-	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
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	National Framework for Reporting and Learning from Serious Incidents	Local Data
Serious Incidents	An incident that occurred in relation to NHS-funded services and care resulting in one of the following: Acts or omissions in care that result in; unexpected or avoidable death. injury required treatment to prevent death or serious harm, abuse.	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	Gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	Gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
Mental Capacity Act and Deprivation of Liberty (MCADoL)	The Deprivation of Liberty Safeguards are a part of the Mental Capacity Act and are used to protect patients over the age of 18 who lack capacity to consent to their care arrangements if these arrangements deprive them of their liberty or freedom. Percentage of staff receiving MCA Dols Level 2 Training	Gesh Priority	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital

Glossary of Terms

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

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

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

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

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

Group Board

Meeting on Thursday, 04 July 2024

Agenda Item	3.4	
Report Title	**Finance report Month 02 (May)**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	CGFO plus site CFOs	
Previously considered by	Finance Committees-in-Common	28 June 2024
Purpose	**For Noting**	

Executive Summary

Both trusts are on plan at month 02. The plan position for both trusts at this point in the year is a deficit.

There are pressures in both plans that are being managed with non-recurrent resources and delivery of the plan by year end is at risk.

The paper outlines key actions being taken to help support delivery of the plan by year end. The Group Executive Team are focused on seeking to deliver this.

Action required by Group Board

The Committee is asked to note this paper.

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

Appendices	
Appendix No.	**Appendix Name**
	None

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
BAF SR4.				
CQC Theme				
☒ Safe	☒ Effective	☐ Caring	☐ Responsive	☒ Well Led
NHS system oversight framework				
☐ Quality of care, access and outcomes			☒ People	
☐ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☐ Local strategic priorities	
Financial implications				
IN support of delivering the Group financial plans.				
Legal and / or Regulatory implications				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

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Group Board (Public) 4th July 2024
24/25 M2 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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University Hospitals and Health Group

Group M2 position

GESH

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The summary slides used for the system recovery Board compare actuals to the 12th June plan.
Given timing of the final plan position during M2 reporting, general ledgers had not been updated for the revised plan position to facilitate full reporting against the 12 June submission.

	Issue	Action
Summary I&E	• Both organisations are on plan after bringing forward NR benefits from later in the year (SGH £2.0m, ESTH £1.3m). • For both trusts, delivery of the plan in full by year end should be seen as being at material risk.	• Continued focus on cost control and the development and delivery of CIPs through site management meetings.
Expenditure and WTEs	• Pay expenditure is overspent against budget in both trusts. • WTEs for both trusts are largely in line with plan	• Increased focus on control actions in key areas notably agency controls all staff groups, medical temporary staff costs, nursing rota management and continued challenge through vacancy control. • Opportunities for system wide work on medical staffing and agency costs. • Management of activity pressures, especially in the UEC pathway in support of both CIP plans and mitigating current pressures above plan.
CIP delivery	• ESTH delivery is £0.4m adverse YTD with £2.2m remain unidentified and £15.0m in opportunity • SGH on plan (although the latter includes b/f £1.2m benefit) with £24.0m in opportunity and zero in unidentified.	• Continued focus on CIPs identification and delivery within the Trust. • Work actively with SWL groups to identify other opportunities and system wide actions, including estates, medical staffing and agency. • See CIP update paper
Capital	• No reported position at M2. • ESTH: Material risks remain on funding the EPR project, this is outside of the agreed capital plan. • SGH: Minor delays in ITU could attract NHSE attention.	• Careful monitoring and forecasting of capital will be required in both trusts across the year. • Continued engagement with National and SWL ICB on funding mechanism for EPR. • Continue focus on key projects.
Cash	• Material pressure on cash could be experienced at both trusts given potential risk against CIPs and other expenditure pressures.	• Cash update outlines ESTH and SGH current and expected drawdown position. • Maintain focus on cashflow forecasting and management ensuring effective processes in place for working capital management. • See cash update paper

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ESTH Trust Summary reported position

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Table 1 - Trust Total

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	601.0	49.5	50.0	0.5	99.7	99.7	0.0
	Other Op. Income	45.8	3.9	4.1	0.2	7.5	7.6	0.0
Income Total		**646.8**	**53.4**	**54.1**	**0.7**	**107.2**	**107.3**	**0.0**
Expenditure	Pay	(463.1)	(39.0)	(40.2)	(1.2)	(78.6)	(80.4)	(1.8)
	Non Pay	(207.3)	(18.0)	(18.0)	(0.0)	(35.7)	(34.6)	1.1
Expenditure Total		**(670.4)**	**(57.0)**	**(58.2)**	**(1.2)**	**(114.3)**	**(115.0)**	**(0.7)**
Post Ebitda		(31.1)	(2.6)	(2.1)	0.5	(5.2)	(4.5)	0.7
Grand Total		**(54.7)**	**(6.1)**	**(6.2)**	**(0.0)**	**(12.3)**	**(12.3)**	**(0.0)**

- The Trust is reporting being on plan in month and YTD but only after bringing forward £1.2m non-recurrent benefits (£1.0m in April and £0.2m May).
- Patient Care Income is £0.5m favourable in month (£0.1m new funding for the Consultant pay award in M2 actual but not in plan, £0.1m high cost devices and £0.2m correction of phasing of income recognition that should have been recognised in M1). M1 was under plan by £0.4m due to not delivering the 5% productivity assumption in efficiency. This was partially delivered at M2.
- Other Operating Income is £0.2m favourable in month and on plan YTD. In month R&D income was £0.1m above plan and staff recharge income was £0.1m above plan, both of these are offset with matching costs.
- Pay is £1.2m adverse in month and £1.8m adverse YTD. In month Medicine overspent £0.5m between Alex Ward (24 beds bed capacity funding plan assumed closed from M2 until M10), A&E, enhanced care and medical staffing; Planned Care was £0.2m adverse as pay; consultant pay award added £0.1m of unbudgeted cost at M2 offset by accrued income as per guidance, £0.1m staff recharges offset by income.
- Non pay is on plan in month and £1.1m favourable YTD as £1.3m of non-recurrent benefits were put in the position YTD.

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SGH - Summary Reported Position

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Table 1 - Trust Total

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	Patient Care Income	975.6	83.2	83.8	0.6	165.7	166.8	1.0
	Other Operating Income	152.8	12.8	12.6	(0.2)	25.5	26.9	1.4
Income Total		**1,128.4**	**96.0**	**96.4**	**0.4**	**191.2**	**193.7**	**2.5**
Expenditure	Pay	(719.8)	(61.7)	(61.8)	(0.1)	(123.4)	(123.9)	(0.5)
	Non Pay	(443.4)	(39.0)	(39.3)	(0.3)	(79.7)	(81.6)	(1.9)
Expenditure Total		**(1,163.2)**	**(100.7)**	**(101.1)**	**(0.4)**	**(203.1)**	**(205.6)**	**(2.5)**
Post Ebitda		(25.1)	(3.2)	(3.2)	0.0	(4.0)	(4.0)	0.0
Grand Total		**(59.9)**	**(7.9)**	**(7.9)**	**0.0**	**(15.9)**	**(15.9)**	**0.0**

The Trust is reporting a £15.9m deficit YTD in M2, which is on plan.

Income

- Income is £2.5m above plan, with ERF overperformance of £0.7m and additional income across SWLP and R&D offset by additional costs. The Consultant Pay Award is adjusted. in the planned income and expenditure

Pay

- Pay is £0.5m overspent mainly due to premium temporary nursing costs (agency and bank) across wards driven by high operational demand impacting on ED and wards, mainly Acute Medicine. Pressure in M2 has reduced versus exit run rate from Q4 reducing the pressure on the baseline budgets. The Consultant Pay Award is adjusted in the planned income and expenditure.

Non-Pay

- Non-Pay is £1.9m overspent, due to CIP under-delivery of £0.7m (offset by ERF Income) and additional costs across managed services being offset by additional income. £0.8m of non-recurrent benefits are included in the position.

Group Board

Meeting in Public on Thursday, 04 July 2024

Agenda Item	4.1	
Report Title	**Group Board Assurance Framework**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Finance Committees-in-Common Quality Committees-in-Common Group Executive	28 June 2024 27 June 2024 25 June 2024
Purpose	**For Approval / Decision**	

Executive Summary

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

The first full iteration of the Group BAF was agreed by the Group Board in March 2024. For each strategic risk, the BAF sets out:

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

This is the first regular review of the BAF since it was agreed by the Group Board in March 2024. As we are only 3 months on from having agreed the starting position on the BAF, there are no proposed changes to the headline risk scores or assurance ratings at this stage. Detailed work has been undertaken with relevant leads to refine the actions to address gaps in control and assurance and present timelines for delivery of mitigating actions. There has also been some progress in progressing, and in some instances, completing these actions over the past three months, but as would be expected for the principal risks to the delivery of a five-year strategy, these are not sufficient at this stage to shift the risk scores.

The quality, people and finance risks were reviewed at the Quality, People and Finance Committees-in-Common in June 2024. The digital and estates risks were reviewed by the Infrastructure Committee earlier this year and are scheduled to be reviewed further at the next meeting. Risks relating to collaboration and partnerships (strategic risks 1-3) are reserved to the Group Board.

This remains an initial iteration of the Group BAF, the entries will continue to be iterated and refined. In particular:

- Controls and actions will be refined to ensure those most material to the risk are captured
- Timelines for a number of identified actions to control risks need to be defined. This will enable effective plotting of risk reduction schedules
- Supporting risks on the two Trusts' corporate risk registers will require review

Action required by Group Board

The Group Board is asked to:

a) Review the current risk scores and assurance ratings for each strategic risk on the Group BAF at the end of Q1 2024/25.
b) Note the risks that have been reviewed by the relevant Committees.
c) For the risks reserved to the Group Board, review and agree the risk scores and assurance ratings at Q1 2024/25.

Committee Assurance

Committee	All Board Committees
Level of Assurance	N/A

Appendices

Appendix No.	Appendix Name
Appendix 1	Group Board Assurance Framework

Implications

Group Strategic Objectives

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

Risks

As set out in report.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

N/A

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Group Board Assurance Framework

July 2024

Stephen Jones
Group Chief Corporate Affairs Officer

4 July 2024

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Overview

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

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

Review of the Group BAF at Q1 2024/25
Three months on from the Group Board's approval of the new BAF, the Group Board is asked to consider the latest position, including any changes. The Strategic Risks related to finance (SR4), operations (SR8), quality (SR7, 9, 10, 11), People (SR12, 13, 14) have been reviewed by the Finance Committees-in-Common, Quality Committees in Common, and People Committees-in-Common in June 2024. The risks related to estates (SR5) and digital (SR6) are scheduled for review at the next meeting of the Infrastructure Committees-in-Common. The risks related to Collaboration and Partnership (SR1, 2 and 3) are reserved to the Group Board.

Risk scores

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

Assurance ratings

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

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Group BAF: Overview at 4 July 2024

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

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Group BAF: Overview at 4 July 2024

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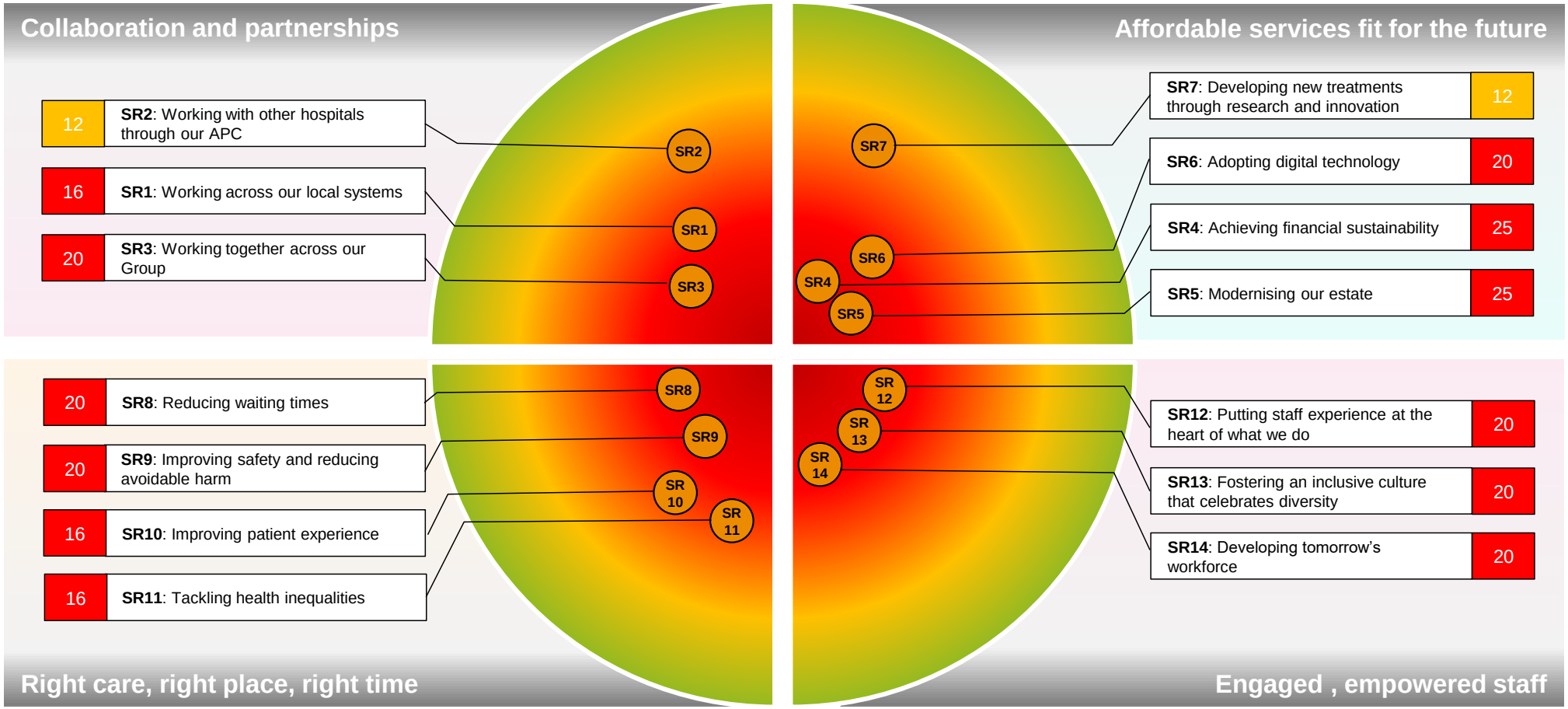

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
Collaboration and Partnerships								
SR1: Working across our local system *If we do not act as an effective, collaborative partner across the whole patient pathway and wider health and care system, then we will not build effective integrated models of care across primary, community, mental health, acute and specialist care, resulting in unsustainable demand for acute services, patients not receiving care in the most appropriate setting, and lower health outcomes.*	16 (4x4)	16 (4x4)	12 (4x3)	Reasonable	Good	No changes to risk score at Q1 2024/25. Work required to flesh out actions to address identified gaps in controls and timelines for completion.	No changes to controls.	No changes to assurance ratings.
SR2: Working with other hospitals through our APC *If we do not foster strong, collaborative relationships with other providers through the Acute Provider Collaborative and focus on where we can add the most value in terms of the quality and sustainability of services, then we will not deliver effective, efficient and sustainable services for the benefit of patients across South West London and Surrey, resulting in longer waiting lists, unwarranted variation in and less responsive care, and less efficient use of resources across our system.*	12	12	8	Reasonable	Good	No changes to risk score at Q1 2024/25. Work required to flesh out actions to address identified gaps in controls and timelines for completion.	No changes to controls.	No changes to assurance ratings.

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
Collaboration and Partnerships								
SR3: Working across our local system *If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.*	16 (4x4)	16 (4x4)	12 (4x3)	Reasonable	Good	No changes to risk score at Q1 2024/25. Work has progressed with Group Corporate Services Integration, albeit with agreed critical paths yet to be agreed for HR, Finance, Estates, and IT. Work underway to develop proposals for collaboration of clinical services, discussed at June 2024 Group Board development session.	Completion of supporting strategies on: People; Quality and Safety; Green Plan. Definition of governance framework for the oversight of delivery of Strategic Initiatives Establishment of new Executive Collaboration Group Definition of new timelines for the completion of Group Corporate Services Integration. Completion of restructures in following areas: Corporate Affairs; Communications; DCEO; Corporate Nursing; Phase 1 Corporate Medical.	No changes to overall assurance ratings.
Affordable Services, Fit for the Future								
SR4: Achieving financial sustainability *If we do not manage costs effectively, optimise productivity, and ensure our activities are effective, then we will not return to financial balance, resulting in the poor use of public funds and unsustainable services for patients.*	25 (5x5)	25 (5x5)	20 (5x4)	Limited	Reasonable	No overall change to risk score at Q1, but both Trusts are now risk-scored at the maximum 25 (previously ESTH was 20). Both Trusts on plan at M2 2024/25. Detailed plans for the full value of the CIP to be established. Operational pressures continue to present pressures above / outside agreed financial plans.	Financial control environment continues to be strong. Work on developing CIPs continuing. Staff are being engaged on the scale of the financial challenge.	No changes to overall assurance ratings.

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
SR5: Modernising our estate *If we do not secure capital funds necessary to address areas of material risk across our estates and deliver our green plans, then we will be unable to maintain a safe estate, reduce our carbon footprint, and transform services for patients, resulting in increased risk to patient and staff safety and to the safe and sustainable delivery of clinical services*	25 (5x5)	25 (5x5)	20 (5x4)	Limited	Reasonable	No changes to risk score at Q1 2024/25. To be reviewed at next meeting of the Infrastructure Committees-in-Common.	No changes to controls.	No changes to overall assurance ratings.
SR6: Adopting digital technologies *If we do not build a robust digital infrastructure and adopt transformational digital solutions, then we will not deliver new and innovative models of care or support staff to work more flexibly and efficiently, resulting in poorer patient outcomes, less efficient services and staff disengagement.*	20 (5x4)	20 (5x4)	15 (5x4)	Limited	Reasonable	No changes to risk score at Q1 2024/25. To be reviewed at next meeting of the Infrastructure Committees-in-Common.	No changes to controls.	No changes to overall assurance ratings.
SR7: Developing new treatments through research and innovation *If we do not create the right culture, infrastructure and partnerships, then we will not become a thriving centre for research and innovation and not attract sufficient research funding, resulting in poorer health outcomes for patients, and challenges in attracting and retaining high calibre staff*	12 (4x3)	12 (4x3)	8 (4x2)	Reasonable	Good	No changes to risk score at Q1 2024/25. Impending merger between St George's University of London and City University represents significant opportunity in relation to research. Need for alignment of research priorities across Group.	No changes to controls. Work undertaken with GCMO to define timescales for completion of actions to address identified gaps in control. Appointment of new lead for non-medical research.	No changes to overall assurance ratings.

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
Right Care, Right Place, Right Time								
SR8: Reducing Waiting Times *If we do not foster and support continuous improvement to improve the efficiency and effectiveness of our services, then we will not improve flow through our hospitals, resulting in patients waiting too long for treatment, poorer clinical outcomes and risk of harm, and staff disengagement.*	20 (5x4)	20 (5x4)	15 (5x3)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Significant operational pressures continue in relation to ED and wider flow. Additional pressures created through presentation of patients at ED with mental health needs. Capacity of social care is limited, impacting on discharge. Work required to set out actions being taken to address identified gaps in controls and timelines for completion.	No changes to controls.	No changes to assurance ratings.
SR9: Improving safety and reducing avoidable harm *If we do not develop robust quality governance systems and processes, use our data intelligently, and develop a strong safety culture that supports learning, then we will not deliver safe, effective and responsive care to our patients, resulting in increases in avoidable and harm and mortality and poorer clinical outcomes.*	20 (5x4)	20 (5x4)	15 (5x3)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Emergency Department overcrowding remains one of the highest safety risks across the Group. Evidencing the embedding of learning from Never Events is a key gap in light of number of Never Events across the Group.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July. Full implementation of and transition to new PSIRF Framework Progress in establishing Group-wide Corporate Nursing and Corporate Medical teams (phase 1). Completion of Phase 1 Quality Governance Review with agreed management response. Phase 2 Quality Governance review commencing.	No changes to assurance ratings.

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
Right Care, Right Place, Right Time								
SR10: Improving Patient Experience *If we do not equip our staff to make improvements in their services and build effective relationships with patient groups, then we will not deliver improvements in the quality, effectiveness and efficiency of our services, resulting in lower quality of care, increased risk of harm, and less efficient services.*	16 (4x4)	16 (4x4)	12 (4x3)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Work required to refine material actions to mitigate identified gaps in control. Some gaps relate to wider programmes of work: EPR implementation, outpatient transformation.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July. Complaints and PALS teams established on a Group-wide basis through the Group Corporate Services Integration programme.	No changes to assurance ratings.
SR11: Tackling Health Inequalities *If we do not pursue a more strategic and systematic approach to tackling health inequalities in collaboration with our local partners and act as an anchor institution, then we will fail to play our part in improving the health of our local population, resulting in less equitable access to care and poorer outcomes.*	16 (4x4)	16 (4x4)	12 (4x3)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Work on this area is underway. A key area of focus is improving data in relation to ethnicity and other protected characteristics.	Development of Group Quality and Safety Strategy for Group Board approval on 4 July. Health Inequalities Steering Group and wider governance established, but need to review membership to include patients and EDI team. Work programme defined with planned reporting through the Quality Committees-in-Common.	No changes to assurance ratings.

Group Board Assurance Framework Summary – July 2024

Strategic risk	Risk Score			Assurance		Rationale for change / commentary	Changes to controls since last review (March 2024)	Changes to assurance since last review (March 2024)
	Original Mar-24	Current Jul-24	Target Mar-25	Current Jul-24	Target Mar-25			
Engaged, Empowered Staff								
SR12: Putting staff experience at the heart of what we do *If we do not give our staff the tools and support they need or develop high performing teams and outstanding leaders and managers at every level, then our staff will be unable to perform to their best and may not feel fairly treated, resulting in services that are less efficient, poorer quality of care for patients, and difficulties in recruiting and retaining high calibre staff.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Key priorities in relation to leadership development, strengthening Employee Relations, and developing Strategic Initiative in relation to High Performing Teams	Group Board approval of Group People Strategy Development of initial proposals in relation to talent management (presented to Group Executive in June 2024) Progress in developing plans for Group-wide HR restructure	No changes to assurance ratings.
SR13: Fostering an inclusive culture that celebrates diversity *If we do not develop our organisational culture to make the Group a more inclusive place to work that celebrates our diversity and tackle discrimination, then our staff will not feel valued, empowered or psychologically secure, resulting in lower staff engagement, poorer staff wellbeing, challenges with recruitment and retention, and lower quality of care to patients.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Key priorities in relation to developing strategic initiative relating to Culture, refreshing approach and maximising impact of work to improve Equality, Diversity and Inclusion, and promoting psychological safety and staff confidence in speaking up.	Group Board approval of Group People Strategy Establishment of new Raising Concerns Oversight and Triangulation Group	No changes to assurance ratings.
SR14: Developing tomorrow's workforce *If we do not retain, train and transform our workforce for the future, then we will not be able to support the delivery of new models of care, encounter shortages in our workforce, and increase our reliance on agency staff, resulting in lower quality and less efficient services for patients, and higher staffing costs.*	20 (4x5)	20 (4x5)	16 (4x4)	Limited	Reasonable	No changes to risk score at Q1 2024/25. Work required to flesh out actions to address identified gaps in controls and timelines for completion.	Group Board approval of Group People Strategy Progress in developing new Group-wide HR policies.	No changes to assurance ratings.

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Group Board Assurance Framework

Group Board
4 July 2024

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Collaboration and Partnerships

Strategic Risks 1 – 3

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

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Strategic Risk	SR1	Working across our local systems

Current Risk Score: 16

Assurance: Reasonable

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

Strategic objective	Collaboration and Partnerships
Last review date	07 March 2024
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Cautious (Moderate)

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

Change since last review

⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Mar-25	Jun-25	Sept-25	Dec-25	Mar-26	Jun-26	Sept-26	Dec-26
	16	20										

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

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

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Put in place clear processes to ensure structured feedback from ICBs into Group Executive and Board	GCEO	TBC	TBC
2	Working across the ICB to prepare for devolution of specialised commissioning	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

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

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Collaboration and Partnerships
Last review date	07 March 2024
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	South West London Acute Provider Collaborative Memorandum of Understanding in place setting our principles of collaboration	1	Updates from APC presented to Executive team	Reasonable	Second - Management
2	SWL APC has established an APC Board comprising the Chairs and CEOs of the SWL providers, which meets bimonthly	2	Updates from APC presented to Executive team	Reasonable	Second - Management
3	Governance structure for the APC established	3	Updates from APC presented to Executive team	Reasonable	Second - Management
4	Group CEO is lead CEO of the South West London Acute Provider Collaborative	4	Updates from APC presented to Executive team	Reasonable	Second - Management
5	Formal SWL APC partnerships in place for recruitment, orthopaedics, procurement, pathology	5	Review of key performance metrics of APC partnerships through the Site, Executive and relevant Board Committees	Reasonable	Second - Management
6	Agreed set of SWL APC priorities in place for 2023/24	6	Delivery overseen by APC Board	Reasonable	Second - Management
7	A range of elective programmes and clinical networks are in place across the SWL APC covering elective recovery, outpatients and diagnostics	7	Delivery overseen by APC Board	Reasonable	Second - Management
8	APC Programme Director in place	8	Regular meetings with GCEO and updates provided to Executive	Reasonable	Second - Management

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

Strategic Risk	SR3	Working together across our Group

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Collaboration and Partnerships
Last review date	07 March 2024
Monitoring Committee	Group Board
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*	
1	Group-wide strategy in place and approved by Boards
2	9 strategic initiatives agreed with Executive leads for each identified
3	MoU and Information Sharing Agreement in place to support the development of the Group
4	Group governance arrangements established at Board, Committee and Executive level
5	Group Corporate Services programme established, with legal agreements in place to support the operation of Group-wide services
6	Executive Collaboration Group now established to oversee the development of clinical and corporate collaboration and integration across the Group
7	Performance data reviewed on Group-wide basis

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Strategy progress updates reviewed by Group Board bi-annually, and by the Executive on a monthly basis	Reasonable	Second - Management
2	Programmes of work for each established, with executive review of Strategic Initiatives on a monthly basis	Reasonable	Second - Management
3	In place and approved by the Boards	Reasonable	Second - Management
4	Group Board and Committees-in-Common established and review effectiveness annually	Reasonable	Second - Management
5	Timescales established for integration of corporate functions across the Group. Corporate Affairs, Communications, DCEO, Corporate Nursing and Phase 1 Corporate Medical completed.	Weak	Second - Management
6	Recently reconstituted and will be providing regular reporting of progress to the Group Executive	Reasonable	Second - Management
7	Group-wide Integrated Quality and Performance Report presented to Committees and Group Board	Reasonable	Second - Management

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

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

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

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

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

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

Affordable Healthcare, Fit for the Future

Strategic Risks 4 – 7

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

Group Board Assurance Framework 2024/25

Strategic Risk	SR4	Achieving financial sustainability – Group Assessment

Current Risk Score: 25

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	28 June 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Cautious (Moderate)

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

Change since last review: ⟺

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

Key controls *What are we already doing to manage the risk?*	
1	Managing income and expenditure in line with budget.
2	Ensuring there is an effective financial control environment.
3	CIPs. Identifying and delivering actions to improve the financial position.
4	Robust understanding of cost structures and productivity.
5	Maintaining a five year forward view.
6	Maintaining the capacity and capability of the finance team.
7	Capital: clear view of future capital needs and how to meet them
8	Robust processes to forecast and manage cash.
9	Maintaining an effective procurement environment
9	External engagement with SWL, London and national finance teams.

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Financial performance is in line with budget/plan	Weak	First - Operational
2	Evidenced through finance reports, audit reports and against KPIs	Reasonable	Second - Management
3	Project Management and meeting structure in place to identify, plan and deliver CIPs in line with target.	Reasonable	First - Operational
4	Costing systems and known areas for improvement in place.	Reasonable	Second - Management
5	A five year “long term financial plan” is in place	Weak	Second - Management
6	Clearly defined statement of how demands on dept are meet by available resources.	Weak	Second - Management
	Detail available of prioritised capital need together with available funding.	Weak	Second - Management
7	Daily cashflows for 13 week and rolling 12 months in place.	Reasonable	Second - Management
8	Procurement has effective policies and processes, sufficient capacity and capability and are actively engaged with users.	Weak	Second - Management
9	Good engagement with SWL and London. ICS CFO attends Group FinCom.	Reasonable	Third - External

Group Board Assurance Framework 2024/25

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Uncertain planning environment for 24/25. • Scale of financial challenge and time allowed to recover. • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding	• Working across the Group. • Working across the SWL system.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Continued weekly budget review with SLT leads and divisions underway	MDs	Jul-24	On Track
2	CIPs, work ongoing to identify new opportunities.	MDs	Apr-24	Off Track
3	Detailed review performance against key benchmark data, explain or address variance	GCFO	Jun-24	TBC
4	Detailed review performance against key productivity data, explain or address variance	MDs	Jun-24	TBC
5	Work with SWL and London CFOs to agree trajectory to return to financial balance	GCFO	Mar-26	TBC
6	Develop a 5-year financial model; two stages rapid high-level view and then detailed LTFM. Aligns to refresh for BYFH	GCFO	Sep-24	TBC
7	Explore alternate sources for funds. Where not possible identify non-capital mitigations to known risks	MDs/GCFO	Apr-24	TBC
8	Revised departmental structure	GCFO	Mar-24	TBC
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management	GCFO	Mar-25	On Track
10	Increase communication on finance maintaining open communication while maintaining engagement	GCFO	Mar-25	TBC

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-1961	25	Inability to achieve long term financial sustainability due to inefficiencies of providing range of services across two 'subscale' acute sites, contributing to an increasing underlying structural deficit
ESTH	CRR-1960	25	Inability to undertake the required capital investment programme with the SWL capital programme CDEL limits

Group Board Assurance Framework 2024/25

Strategic Risk	SR5	Modernising our estates

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

Current Risk Score: 25

Assurance: Limited

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Infrastructure Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

Key controls *What are we already doing to manage the risk?*	
1	Ensure we have a comprehensive understanding of our infrastructure risks across all sites
2	Having clear, risk based, preventative maintenance schemes that can be flexed based on affordability
3	A clear, transparent, risk based approach to capital prioritisation
4	Sourcing alternative sources of capital
5	Aligned estate strategy & green plan
6	Infrastructure Committee / Governance & Communication
7	Use major capital projects to address wider infrastructure risks wherever possible

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	External condition surveys, risk assessments, reporting to Infrastructure Committee	Good	Second - Management
2	Internal audits on maintenance undertaken / due. Regular estates reporting to plan to Infrastructure Committee	Reasonable	First - Operational
3	Both Trusts have processes for agreeing collectively the annual capital plans, with clinical, operational and E&F input	Reasonable	Second - Management
4	Limited work done to date, examples include external SALIX funding for green projects and phasing BYFH funds	Weak	First - Operational
5	A group estate and green plan are currently being produced although these will be difficult to deliver with limited capital, particularly the 80% carbon reduction target by 2032 and Net Zero by 2040, which are NHSE requirements	Reasonable	First - Operational
6	The Infrastructure Committee is proving effective at understanding and reviewing E&F risks	Good	Second - Management
7	Whilst projects are always looking to improve wider infrastructure wherever affordable and appropriate,	Weak	First - Operational

Group Board Assurance Framework 2024/25

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Develop longer term capital plans (5 yrs+) that are better aligned with our strategies and affordability envelope
2	Communicate estate risks to clinical teams more widely
3	Ensure our business continuity plans are up to date and better reflect our infrastructure risks
4	Be clear on those risks that we are not mitigating and the potential impacts
5	Communicate infrastructure benefits from projects better
6	
7	

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2036	20	Risk of fire in Lanesborough and St James'
SGUH	CRR-762	20	Infrastructure backlog
SGUH	CRR-2061	15	Lack of UPD/IPS power supplies site-wide

Related risks on BAF and Corporate Risk Register – ESTH

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

Group Board Assurance Framework 2024/25

Strategic Risk	SR6	Adopting digital technology

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	23 January 2024
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Finance Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

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

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

Group Board Assurance Framework 2024/25

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Group Board Assurance Framework 2024/25

Strategic Risk	SR7	Developing new treatments through innovation and research

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

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Affordable Services Fit for the Future
Last review date	27 June 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Seek (Significant)

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

Change since last review: ⟺

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

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

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Approved by Board but to be succeeded by Group-wide research and development strategy in 2024/25	Reasonable	Second - Management
2	Regular meetings of SGUH/SGUL Joint Strategic Board	Reasonable	Second - Management
3	Leadership positions in the Clinical Research Network. Group CEO chairs the CRN Partnership Board	Reasonable	First - Operational
4	TACRI Steering Group reporting to SGUH PSQG	Reasonable	Second - Management
5	5-year designation from NIHR	Reasonable	Third - External
6	Reporting on research through to the JRES and Quality Cttee	Reasonable	Second - Management
7	Required wider Group-wide integration of non-medical research support team	Weak	Second - Management
8	Reporting on research through to the Quality Committee	Reasonable	Second - Management

Group Board Assurance Framework 2024/25

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

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and secure Group board approval for Group-wide research and development strategy	GCMO	Nov-24	On Track
2	Bring together the delivery arms of research for ESTH and SGUH on a Group-wide basis through the integration of corporate services	GCMO	Sep-24	On Track
3	Explore opportunities for building a wider relationship with City University through its merger with St George's University of London	GCMO	Apr-25	On Track
4	Create more research capacity through job planning	GCMO	Jun-25	On Track
5	Establish research data warehouse	GCMO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description

NHS
St George's, Epsom and St Helier
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Right care, Right place, Right time

Strategic Risks 8 – 11

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

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

Strategic Risk	SR8	Reducing waiting times

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	28 June 2024
Monitoring Committee	Finance Committees-in-Common
Lead Executive	Site Managing Directors
Risk appetite	Cautious (Moderate)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	OPEL escalation triggers and actions in place	1	OPEL triggers regularly used and activated	Good	Second - Management
2	Daily surge call in place with system partners to help manage capacity and to escalate delayed patients / discharges	2	Used regularly to escalate concerns. Integrated TOC at SGUH means constant updates and escalation. SGUH boarding SOP in place and "live"	Reasonable	Second - Management
3	Boarding arrangements to depressurise ED with SOPs in place	3	ED performance reported to Site, Exec, Committees and Board	Reasonable	Second - Management
4	Transfer of care functions in place to facilitate discharge	4	In place. Integrated TOC team established on site at SGUH.	Good	Second - Management
5	Winter plan in place	5	Reviewed and approved by Finance and Quality Committees	Good	Second - Management
6	Validation of PTLs	6	Decrease in number of patients waiting longer than 52 weeks	Good	Second - Management
8	Long length of stay MDT meetings in place (SGUH) Divisional check and challenge of LLoS (ESTH)	8	Oversight of LoS by Site Leadership teams. Meetings in place and increased when needed.	Reasonable	Second - Management
9	Regular bed management meetings to help manage flow	9	Oversight of flow by Site Leadership teams	Reasonable	Second - Management
11	QMH Surgical Treatment Centre in place to help reduce waiting times ERF plan at ESTH and use of QMH capacity	11	Activity reviewed by SGUH Site team (improved utilisation and theatre to ESTH). ESTH@QMH plan being mobilised	Good	Second - Management
12	Mutual aid across SWL	12	Reviewed by Site and Executive teams. Managed via ICB.	Reasonable	Second - Management
13	Virtual wards established	13	Hospital@Home capacity used 100%, remote monitoring capacity underutilised due to lack of demand	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Volume of patients attending EDs and large numbers of DTAs
2	Numbers of patient outliers across the hospitals
3	Staff concerns regarding pressures in EDs
4	Strengthening of arrangements for addressing pressures due to patients with mental health issues attending EDs
5	Increase 'criteria-led discharges' and other advanced discharge tools to support early discharges
6	Delays in local authorities supporting discharge and availability of social care support
7	Availability of alternatives to ED
8	Strengthening mutual aid across Group and across SWL
9	Theatre productivity

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Staff burnout, illness and disengagement • Moral injury to staff • Increasing violence and aggression directed at staff • ability to physically accommodate further excess demand in site footprint (ESTH) • Inability to compete on pay with other providers for key staff	• TBC

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Work with system partners to pursue mental health trust provision of a dedicated emergency mental health facility outside EDs.	Site MDs	TBC	TBC
2	Collaboration with South West London & St George's Mental Health Trust and Surrey and Borders Partnership NHS FT in relation to patients with mental health issues attending EDs.	Site MDs	TBC	TBC
3	Implementation of actions to respond to staff concerns in EDs	Site MDs	TBC	TBC
4	Optimise discharge planning across the entire week including through 'criteria-led' discharges	Site MDs	TBC	TBC
5	Implementation of electronic patient record system across the Group on a shared domain with SGUH	GCEO and EPR SRO	TBC	TBC
6	Implementation of actions to improve theatre productivity	Site MDs	TBC	TBC
7	Recruitment to cardiac anaesthetist vacancies	MD-SGUH	TBC	TBC
8	Strengthening of mutual aid across Group and SWL	MDs	TBC	TBC
9	Work programme to understand health inequalities impact of long waits	GCMO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

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

Strategic Risk	SR9	Improving patient safety and reducing avoidable harm

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	27 June 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	GCMO / GCNO
Risk appetite	Cautious (Moderate)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*	
1	Quality governance structures and processes
2	Established governance on management of patient serious incidents under outgoing SI framework and new PSIRF framework
3	Safety data established as core part of Integrated Quality and Performance Report
4	Established governance on quality impact assessments of cost improvement plans
5	Governance and reporting on learning from deaths established
6	Established clinical audit plan
7	Established ward accreditation programme
8	Group-wide infection prevention and control governance in place
9	Influenza and Covid vaccination programme
10	Commissioned external quality reviewed by Royal Colleges and other national bodies

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Internal reporting to Site, Executive, Committees, and Group Board; CQC reports	Weak	Third - External
2	Oversight of PSIs and SIs by Mortality Monitoring groups and regular reporting to Quality Committee	Reasonable	Second - Management
3	Safety data reviewed regularly by Site, Executive Quality Committee and Group Board	Good	Second - Management
4	QIAs process agreed and individual QIAs reviewed by Site and Executive, with Quality Committee oversight	Reasonable	Second - Management
5	Regular reporting to Quality Committee and Group Board	Good	Second - Management
6	Reporting on clinical audit plans to Site quality groups and to Quality Committee	Good	Second - Management
7	Reporting on ward accreditation through IQPR	Reasonable	Second - Management
8	Regular reporting on IPC to Executive, Quality Committee and	Good	Second - Management
9	External NHS England data on vaccination rates – compliance rates low but among the best compliance rates in London	Weak	Third - External
10	Tracking action plans developed in response to external reviews	Reasonable	Third - External

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Increasing financial pressures • Magnitude of ED risks, and pressures of overcrowding	• Closer collaboration with system partners to develop integrated care approaches across primary, secondary, community and mental health settings.

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2393	20	Regularising Flow
SGUH	CRR-2240	20	Long wait for elective cardiology procedures
SGUH	CRR-2681	16	Industrial action
SGUH	CRR-2606	16	Consent
SGUH	CRR-2174	16	Midwifery staffing
SGUH	CRR-1626	15	Wrong blood in tube

Related risks on BAF and Corporate Risk Register – ESTH

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

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

Strategic Risk	SR10	Improving patient experience

Current Risk Score: 16

Assurance: Limited

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	27 June 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Nursing Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

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

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

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

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

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

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**

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

Strategic Risk	SR11	Tackling health inequalities

Current Risk Score: 16

Assurance: Partial

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

Strategic objective	Right Care, Right Place, Right Time
Last review date	27 June 2024
Monitoring Committee	Quality Committees-in-Common
Lead Executive	Group Chief Medical Officer
Risk appetite	Open (High)

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

Change since last review: ⟺

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

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

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

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Improve quality of data collection in relation to ethnicity and other important demographic or protected characteristic information
3	Developing reporting on health inequalities (evidenced-based reporting on impact)
4	Review of patient involvement from health inequalities perspective
5	Patient representation on HI Steering Group
6	EDI team representation on HI Steering Group

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

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description

NHS
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University Hospitals and Health Group

Engaged, Empowered Staff
Strategic Risks 12 – 14

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

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

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

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	20 June 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*	
1	Well developed staff support programmes in place across Group
2	Board level Wellbeing Guardian in place at both Trusts
3	Established ESTH and SGUH leadership development programmes
4	GESH 100 leadership forum in place
5	Staff induction in place at both Trusts
6	Employee Relations Service Improvement Plan in place
7	Culture programme in place (including leadership culture, psychological safety, and openness to change)
8	Group-wide Continuous Improvement team established and in place
9	Established ESTH and SGUH Quality Improvement programmes

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Delivery of staff support is reviewed by People Committee which has taken good assurance on this.	Good	Second - Management
2	Approved by the two Boards; Wellbeing Guardian is a member of People Committee.	Good	Second - Management
3	Outputs reviewed locally and by HR. Leadership particularly at middle management remains an area of challenge.	Weak	First - Operational
4	Positive feedback from staff involved in first two GESH100 events.	Reasonable	Second - Management
5	Programme of induction events monitored by HR	Reasonable	First - Operational
6	Ongoing operational challenges for ER functions at both Trusts particularly at SGUH e.g. timeliness of investigations	Weak	Second - Management
7	Overseen by Group CEI Programme Board, Executive and People Committee. Impacted by capacity issues.	Weak	Second - Management
8	CI team established.	Reasonable	First - Operational
9	Outputs from QI reviewed at Site, Executive and Committee.	Weak	Second - Management

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

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Fragility of HR	• Results of 2023 NHS Staff Survey • Group-wide communications approach • Launch of the Disability Advice Line • Appointment of new temporary Director of Culture & OD

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

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

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

Strategic Risk	SR13	Fostering an inclusive culture that celebrates diversity

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	20 June 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Cautious (Moderate)

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

Change since last review

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

Key controls *What are we already doing to manage the risk?*	
1	Group and Site-based CEI Programme Boards in place
2	Big 5 priorities with clear programmes established and matured
3	Civility and Psychological Safety programme well established
4	Workforce Race Equality Standard Action Plan developed
5	Workforce Disability Equality Standard Action Plan developed
6	Framework for raising concerns in place with FTSU Guardians in place across the Group and Raising Concerns Group established
7	Staff networks in place at both Trusts
8	NHS Staff Survey Results reviewed systematically with action plans developed
9	Established values in place at each Trust

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Culture work has been paused for some months, but new temporary Director of Culture and OD now appointed	Weak	Second - Management
2	Regular reporting of progress against Big 5 to People Committee, and analysis of impact against Staff Survey results	Reasonable	Second - Management
3	Regular reporting of progress against CAPS to People Committee. Impact on staff survey results unclear.	Reasonable	Second - Management
4	Action Plan in place. Single Group-wide WRES plan in development.	Weak	Second - Management
5	Action Plan in place. Single Group-wide WRES plan in development.	Reasonable	Second - Management
6	Regular reporting of concerns raised through FTSU considered at People Committee and Group Board	Reasonable	Second - Management
7	Networks meet regularly and programme of Board engagement with network chairs	Reasonable	Second - Management
8	Review of NHS Staff Survey results through Executive, People Committee and Group Board	Reasonable	Second - Management
9	Monitored by Site, Executive and People Committee	Reasonable	Second - Management

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

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

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

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

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

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

Strategic Risk	SR14	Developing tomorrow's workforce

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	20 June 2024
Monitoring Committee	People Committees-in-Common
Lead Executive	Group Chief People Officer
Risk appetite	Open (High)

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

Change since last review

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

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

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

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Leadership capability and capacity
2	Talent management programme
3	Quality of appraisals
4	Strengthening rostering particularly for medical staff
5	Maximising the Apprenticeship Levy
6	Supporting the development of new roles
7	Strengthening Employee Relations

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop new two-year People Strategy as a sub-strategy of the Group strategy	GCPO	May-24	Completed
2	Develop and implement Group-wide talent management programme	GCPO	Jun-24	On Track
3	Review and revise HR policies on a Group-wide basis to ensure these are up-to-date and easily accessible for staff	GCPO	Dec-24	On Track
4	Implement fully the Employee Relations Service Improvement Plan to ensure efficient running of ER service	GCPO	Mar-25	Off Track
5	Develop and implement a Group-wide leadership development programme at every level & across professions	GCPO	Mar-25	TBC
6	Increase completion rate for and quality of appraisals	GCPO	Mar-25	TBC
7	Maximise opportunities to the Group through use of the Apprenticeship Levy	GCPO	Mar-25	TBC
8	GCEO leadership of London-wide programme of work on future workforce	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2533	16	Workforce recruitment
SGUH	CRR-2534	16	Workforce retention
SGUH	CRR-1684	16	Junior doctor vacancies
SGUH	CRR-2344	16	Shortage of anaesthetic consultants
SGUH	CRR-2174	16	Midwifery staffing
SGUH	CRR-2530	16	Appraisal rates
SGUH	CRR-1036	16	Apprenticeship levy
SGUH	CRR-2681	16	Industrial action

Related risks on BAF and Corporate Risk Register – ESTH

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

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University Hospitals and Health Group

Scoring the Group Board Assurance Framework

(i) Risk scores

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

Risk grading (scoring)

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

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

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

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

Strength of controls

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

Strength of controls

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

(iii) Calculating the overall level of assurance

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

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

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

Further development

Although the BAF presented to the Board is the first full iteration, it is important to note that the BAF will necessarily iterate and develop over the coming months. It is a live document that will be continually updated through reviews at Committee and the Group Board. It is worth, in particular, flagging three areas of focus in this further work:

- Refining and honing the controls, assurances, gaps and actions so that the BAF captures the most material of these. This is important to ensure the BAF is a useful tool for the Group Board and to ensure it is focused on the right areas.

- For the actions to address gaps in control, fully populating these over the coming weeks and months to ensure that the Committees and Group Board can track progress in managing BAF risks. Once these are populated, reporting on the BAF will set out risk reduction schedules that will project how the risk score and assurance ratings are forecast to evolve with the implementation of the material actions identified. This will enable the Committees and Board to see how the material actions will impact the risk and help reduce the risk score over time.

- Relevant risks on the Corporate Risk Registers of both Trusts have been provisionally mapped against the strategic risks on the BAF. This highlights that, in some areas, the Corporate Risk Registers need to be further developed and updated, and this will be a key area of focus in the coming weeks and months in order to ensure that the BAF and CRRs are used in concert in an appropriate way.

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

Scoring the BAF

Risk scores and assurance ratings

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NHS
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