Group Board

Agenda

Meeting in Public on Thursday, 03 July 2025, 12:30 – 16:00

Conference Room 1, Wells Wing, Epsom Hospital, Dorking Road, Epsom KT18 7EG

Feedback from Board visits					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
12:30	-	Feedback from visits to various parts of the site	Board members	-	Verbal

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

Strategy, Risk and Governance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:15	2.1	Strategy Stocktake including Group Operational Plan	GDCEO/GCTO	Review	Report
13:45	2.3	Group Board Assurance Framework: Q1 2025/26 Review	GCCAO	Approve	Report

Quality – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
13:55	3.1	Quality Committees Report	Committee Chair	Assure	Report
14:05	3.2	Group Maternity Services Report	GCNO / GCMO	Assure	Report

Finance, Performance, Audit and Risk – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:15	4.1	Finance and Performance Committees Report	Committee Chair	Assure	Report
14:25	4.2	Finance Report – Month 2	Committee Chair	Review	Report
14:30	4.3	Integrated Quality and Performance Report	GDCEO	Review	Report
14:45	4.4	Audit and Risk Committees Report	Committee Chair	Assure	Report

People – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
14:55	5.1	People Committees Report	Committee Chair	Assure	Report
15:05	5.2	Group Freedom to Speak Up Report	GCCAO & GFTSUG	Review	Report

Infrastructure – Items for Review and Assurance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:15	6.1	Infrastructure Committees Report	Committee Chair	Assure	Report
15:25	6.2	Group Green Plan Refresh	GCFIEO	Approve	Report

Closing items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
15:35	7.1	New Risks and Issues Identified	Chair	Note	Verbal
	7.2	Questions from members of the public and Governors of St George's*	Chair	Review	Verbal
	7.3	Any Other Business	All	Note	Verbal
	7.4	Reflections on the Meeting	Chair	Note	Verbal
15:40	7.5	Patient / Staff Story	GCNO	Review	Verbal
16:00	-	CLOSE	-	-	-

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

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Chair	Chair
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Officer – Facilities, Infrastructure and Estates	GCOFIE
Ann Beasley	Non-Executive Director and Vice Chair ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	JB
Pankaj Davé	Non-Executive Director – SGUH	PD
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH/SGUH	PK
Ralph Michell*^	Group Chief Transformation Officer	CGTO
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Michael Pantlin*^	Interim Group Deputy Chief Executive Officer	IGDCEO
Victoria Smith*^	Group Chief People Officer	GCPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
In Attendance		
Liz Dawson	Group Deputy Director Corporate Affairs	GDDCA
Natilla Henry	Group Chief Midwifery Officer	GCMidO
Anna Macarthur	Group Chief Communications Officer	GCCO
Apologies		
Natalie Armstrong	Non-Executive Director – ESTH/SGUH	NA
Yin Jones	Non-Executive Director – ESTH/SGUH	YJ
Khadir Meer^	Associate Non-Executive Director - SGUH	KM
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Claire Sunderland Hay^	Associate Non-Executive Director - SGUH	CSH
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, 01 May 2025, 12:45-15:20

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

PRESENT		
Mark Lowcock	Group Chair	Chair
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Mark Bagnall*^	Group Chief Facilities, Infrastructure and Environment Officer	GCFIEO
Ann Beasley	Non-Executive Director, Vice Chair – ESTH / SGUH	AB
James Blythe*	Managing Director – ESTH	MD-ESTH
Pankaj Davé	Non-Executive Director – SGUH	PD
Andrew Grimshaw	Group Chief Financial Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*^	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director – ESTH / SGUH	PK
Khadir Meer^	Associate Non-Executive Director – SGUH	KM
Andrew Murray	Non-Executive Director – ESTH / SGUH	AM
Michael Pantlin*^	Interim Deputy Group Chief Executive Officer	IGDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD-IC
Victoria Smith*^	Group Chief People Officer	CPO
Kate Slemeck^	Managing Director – SGUH	MD-SGUH
Claire Sunderland-Hay^	Associate Non-Executive Director – SGUH	CSH
Arlene Wellman	Group Chief Nursing Officer	GCNO
Phil Wilbraham*	Associate Non-Executive Director – ESTH	PW
IN ATTENDANCE		
Natilla Henry	Group Chief Midwifery Officer (item 2.3)	GCMidO
Elizabeth Dawson	Group Deputy Director of Corporate Affairs	GDCCA
APOLOGIES		
Natalie Armstrong	Non-Executive Director	NA
Yin Jones	Non-Executive Director – ESTH / SGUH	YJ
Ralph Michell	Group Chief Transformation Officer	RM
OBSERVERS		
Alfredo Benedicto	Appointed Governor – Merton Healthwatch	
John Hallmark	Public Governor - Wandsworth	
Jackie Parker	Public Governor - Wandsworth	

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

		Action
	FEEDBACK FROM WARD VISITS	
	Ann Beasley (AB) took the Chair for this item and Board member provided the following feedback from their respective visits to a number of wards: Douglas Bader Unit, Brysson White Unit and Gait Lab: The Chair, PD, AM, KM GCMO, MD-ESTH and GCPO had visited the Gait Lab where they had heard about the long waiting lists as the team was only able to see 6 patients per day. Some issues with equipment were reported. For example, the specialist walking pad needed recalibrating. Board members had also met the bone health team whose overall aim was to reduce falls and improve bone health. They had talked to the physiotherapist and occupational therapists who said they enjoyed their jobs and there was a positive culture and a sense of commitment. It was noticed that not all of the space was utilised and that some of the equipment had been loaned to other area, and it was possible that not all of this was needed. There was a lack of clarity over the GP and self-referral route which could usefully be reviewed and also frustration from the team that the service ended at the border of Wandsworth as staff felt they could do more. Wolfson and Outpatients: PW, PK, MD-ESTH, GCFO, GCNO and GCOFIE visited this area and noted that the team had been well prepared for their visit, welcoming them to a lovely space with a garden. The ward had 36 beds and saw a broad spectrum of both in and outpatients. The area was undergoing a refurbishment, which was a requirement of a Private Finance Initiative (PFI) contract, but which Board members reported did not feel necessary especially when compared with other non-PFI parts of the Trust. There had been a good team atmosphere with nurses commenting on how helpful consultants were. One of the issues highlighted by the team was the slow pace of recruitment processes. It had been shared that the average length of stay was 3 months and there was good engagement with families to help support patients. Catering was reported as being of good quality and the humanity shown to patients was impressive. For outpatients there was a 5-6 month wait for a urology appointment which staff felt could be addressed with additional funding. ENT patients were also seen in the department with staff believing there could be better triaging by GPs to avoid hospital appointments for minor issues. Prosthetics and Orthotics: AB, YJ, GCEO, GGCAO and IDGCEO had visited this area. Board members were impressed with the facilities to make orthotics and had seen the process from scanning patients through to the manufacturing and fitting of prosthetics and orthotics. They noted some concerns about equipment raised by staff, including a handheld scanner which was held together with tape and an aged laptop that frequently crashed. The GCEO had encouraged the team to reach out to her and she would help ensure that these equipment issues were addressed. Board members also spoke to an apprentice prosthetist and orthotist who was training at the department and who spoke very highly of the opportunity and support from the team. The IGDCEO commented that QMH was a great space for patients, but which highlighted the challenges that were faced by the other sites. They had talked with staff about the need for improved technology and how the kit was not always fit for purpose and was sometimes difficult to procure some basic kit.	

1.0	**INTRODUCTORY ITEMS**
1.1	**Welcome, introductions and apologies**
	The Chair welcomed everyone to the meeting, particularly Khadir Meer, new Associate NED for SGUH, and Michael Pantlin, Interim Group Deputy Chief Executive Officer, both of whom had completed their Fit and Proper Persons checks. The SGUH Governors who were observing were also welcomed. Apologies were received from Natalie Armstrong, Yin Jones and Ralph Michell.
1.2	**Declarations of Interests**
	The standing interests in relation to shared roles across the St George's, Epsom and St Helier University Hospitals and Health Group of the following directors was noted, which have previously been notified to the Board: • Mark Lowcock as Group Chair; • Ann Beasley, Peter Kane and Andrew Murray as Non-Executive Directors; • Jacqueline Totterdell, Mark Bagnall, Andrew Grimshaw, Richard Jennings, Stephen Jones, Michael Pantlin, Victoria Smith and Arlene Wellman as Executive Directors. There were no other declarations other than those previously reported.
1.3	**Minutes of the Previous Meeting**
	The minutes of the Group Board meeting on 6 March 2025 were approved as a true and accurate record.
1.4	**Action Log and Matters Arising**
	The Group Board reviewed the action long noting that none were due for this meeting.
1.5	**Group Chief Executive's Officer (GCEO) Report**
	The GCEO took the report as read and invited questions. The following issues were raised and noted in discussion: • AB asked how the recent Supreme Court judgment on the definition of sex within the Equality Act 2010 would impact on the Group. The GCPO responded that the first step was to make sure that trans staff felt supported. This was a complex issue and it was not yet clear what actions would be needed, and sector guidance from NHS England was awaited. The GCPO added that whatever the judgement or guidance issued, gesh would remain a caring, compassionate and respectful organisation for all its staff. • PD said that as part of his induction he had observed the Executive Question Time that was open to all staff across the Group to attend. He commended the Executive team on how some difficult issues had been handled with openness and transparency, providing great engagement with staff. He noted that bullying and harassment had come up as question with the 32 others 'liking the question'. The GCPO had made clear in the session that bullying was not acceptable but the number of people 'liking' could indicate this was an area to be looked into

	further. It was noted that the issue of bullying and plans to address this had been examined by the People Committee. The Board recorded thanks to the staff from ESTH, and the ESTH Charity, for the success of the recent fundraising abseil at St Helier which had far exceeded its target. **The Group Board noted the Group Chief Executive's Report.**
2.0	**ITEMS FOR REVIEW AND ASSURANCE – QUALITY**
2.1	**Care Quality Commission – Well Led Inspection: Letter in advance of full report**
	The GCCAO reminded the Board that that the CQC Well Led inspection at SGUH had taken place 25-27 February, and while the full inspection report had not yet been shared, the CQC had provided a letter setting out high-level feedback on the inspection which it had asked was discussed at the next public meeting of the Board. Also included in the papers was a draft action plan to respond to the feedback, which drew on the Trust's self-assessment against the Well Led framework. The GCCAO commented that the CQC letter appeared fair and balanced and chimed with the Trust's self-assessment. The GCCAO explained that many of the actions were already being taken forward but the plan would need to be reviewed and finalised in the context of the full inspection report which would provide much greater detail on the CQC's findings. Until the full report was received, the GCCAO emphasised the need for caution both in terms of finalising an action plan and in terms of the overall outcome of the inspection. The CQC had requested a large range of documentation from the Trust as part of the inspection, and it would need to triangulate the conclusions of its on-site inspection with this wider body of information, so the conclusions in the final report could yet be different from those set out in the letter. Once the final report was received it would be shared with the Board, and a full action plan would be brought back to the Board. The GCCAO added that the lessons from the SGUH CQC Well Led inspection would be applied to the preparations for the expected CQC Well Led inspection at ESTH, the timing of which was not yet known. He added that, as part of strengthening both Trusts' position in relation to the new Well Led framework, an annual process of Well Led self-assessment would be introduced. The Board agreed that the letter seemed well balanced and thanked all those that had been involved in the inspection. A query was raised on when the report could be expected. The GCCAO responded that the CQC's official target for turning around inspection reports was 8 weeks but the CQC had flagged at engagement meetings in January 2025 that there was a considerable backlog of reports to work through and that the Trust could expect it to take longer than this. It was hoped that the report would received by the end of the month and the Trust would seek clarity from the CQC on this. **The Board noted the letter and the action plan.**
2.2	**Quality Governance Review Part 2**
	The GCMO reminded the Board that the Quality Governance Review Part 2 built on the work commissioned by the Board in response to the findings of the CQC's inspection of SGUH maternity services in March 2023. Whereas the first part had

	focused on maternity services, the second part was a broader review of the strength of quality governance across the Group. The review had piloted an approach of using the Good Governance Institute maturity matrix to look at the strength of quality governance in one division (or equivalent) from each Site with the aim of developing timebound action plans to improve quality governance over the next year. The three areas reviewed were Integrated Care, the Renal Services Division at ESTH, and the Surgery, Neurosciences, Cancer and Theatres (SNCT) Division at SGUH, and the details reports on these areas where included in the papers. The GCNO added that there were clear areas for learning, particularly in relation to variation in leadership capacity, access to data, administrative support and consistency in risk escalation, but also some really good practice, particularly in Integrated Care which would be shared across the Group. Andrew Murray (AM) commented that the Quality Committee had reviewed the full reports at its meeting in April 2025 and had concluded that a lot of information had been gathered through the review that provided a helpful insight into the current maturity of quality governance in the three areas assessed. An action plan that drew together the key areas for improvement and which could be tracked had been requested by the Committee, and it was expected that this would be reviewed by the Committee at its meeting later in the month. The Site Managing Directors remarked that the relative size of the divisions should be noted so any actions would need to be proportionate in regard to the time and resource required. Each Site Senior Leadership Team would need to own the action plans and ensure there was consistency across divisions. **The Board noted:** • **the findings from the Quality Governance Review Part 2** • **that an action plan will be presented to the Quality Committees in May 2025 following which the action plan would be submitted to the Board.**	
2.3	**Group Maternity Services Quality Report**	
	The Chair invited AM, as Chair of the Quality Committee, to comment on the report. AM explained that a lot of time had been spent at Quality Committee on seeking assurance in relation to the quality, safety, governance and culture of maternity services. Post Partum Haemorrhage (PPH) data showed that SGUH was an outlier. The Committee had requested more detail to understand the reasons for this. The original reporting had suggested that the higher PPH rates were due to the unit dealing with more complex cases. However, the Committee had not been provided with the evidence to support this assumption, and it was the case that when complex cases were adjusted for, SGUH remained an outlier for PPH. It was suggested that the service could be defensive as a default and needed to be more inquisitive of the data. The training data presented to the Committee showed that training compliance was still not meeting the targets set and this had been the case for some time. This had been escalated and the Committee understood that this was a focus for the team. AM added that the Committee had been notified of a maternal death at SGUH in March 2025 from which there would be a lot of learning, particularly with regard to	

escalation to obstetrics. As Maternity Champion, AM concurred with the view of the Committee that action needs to be more robust on how maternity teams can get support from obstetrics colleagues.

AM noted that the Quality Committee had asked for an integrated maternity action plan which brought the various improvement actions into a single plan. This had also been requested at the Group Board meeting on 6 March 2025. The Committee had not yet received the integrated plan and was keen to review it given the importance of ensuring that all actions, including those required by the CQC Section 29A Warning Notice, were managed and tracked, with clear Committee oversight.

The Chair thanked AM for his opening comments and invited the Group Chief Midwifery Officer (GCMidO) to comment. He added that, as incoming Chair, maternity was a key priority and ensuring the Group Board, and the Quality Committee, had the information necessary to be assured about the safety, quality, performance and culture of the service.

The GCMidO endorsed the comments made by AM regarding PPH rates at SGUH. On the issue of being more inquisitive about the data, she added that she had fed back to the team on the tone of their reporting and, whilst they felt that they had been reflecting benchmarking data rather than being defensive, they had acknowledged that they could be more curious about what lay behind the data.

On the Section 29A Warning Notice at SGUH, MD-SGUH added that the actions required were being delivered but they now needed to ensure they were being embedded. She and the GCNO chaired an oversight group which met every two weeks and there was a lot of work going on around culture that was being supported by the HR team. Support for the new leadership was also important. The MD-SGUH explained that the draft integrated maternity action plan required further work to consolidate some of the duplication across the various reports, and this was being addressed prior to submitting the report to the Quality Committee.

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

- PD asked whether it was possible to be more specific about the issues being referred to when talking about culture. The GCNO responded that at SGUH this related to defensiveness, a lack of curiosity and the raising of concerns. At ESTH this was a much closer knit team but this could have the downside of cliques developing.

- In response to a query from CSH, the GCMO explained that the new leadership in SGUH maternity were highly engaged and there were promising foundations for a change in the culture of the team. He added that it should not be forgotten that there were some highly innovative practices within SGUH maternity. However, this did sometimes mean that the basics were being missed, and this related to the issue of psychological safety in raising concerns.

The Chair thanked everyone for the helpful discussion. He asked authors to reflect on the length of papers submitted to the Board as the report presented contained a

	total of 111 pages, noting that effective assurance was not necessarily best achieved through a high page count. He commented that it was important that the integrated maternity action plan be submitted to the Quality Committee in May 2025, given the Board had requested this at its meeting in early March. In light of the importance of the issue, and the role of the Board in overseeing the improvements to maternity, the Chair asked that a paper be brought to the Group Board in July bringing together the key elements of the integrated maternity improvement plan and the actions being taken in relation to leadership of the service. **The Board noted the report and the actions being taken.**	**MD-SGUH / GCNO**
2.4	**Integrated Quality and Performance Report**	
	The IGDCEO presented the report, which provided an overview of the key operational performance information and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) Sites, based on the latest available data. The report had been reviewed in detail by both the Finance and Performance Committees and the Quality Committees. The IGDCEO commented that 2025/26 would see additional challenges largely brought about the financial situation. He asked the Board to note that the IQPR would be refreshed during the year. The Chair invited the Site Managing Directors to highlight the key performance data related to their Sites: • The MD-IC explained that she was reviewing the metrics in the IQPR and considering how these could best used to for Integrated Care and the way it operated – including the acuity and complexity of the patients it served. The MD-IC added that the satisfaction of carers should be considered, while for many having a relative at home was a positive it could also be a burden. The national focus on moving hospital to patients being treated in the community was to be welcomed, and would require careful working through for the Group. • The MD-ESTH said that there continued to be challenges in the Emergency Departments. He asked that it be noted that the roll out of the new Electronic Patient Record system would have a short-term impact on the ESTH performance as the new system went live and bedded in. • The MD-SGUH highlighted that the 65- and 52-week data for SGUH was going in wrong direction and this was being reviewed. In response to a question, the MD-IC said that the keys to an effective integrated care system were strong relationships and partners being honest about problems so that there could be joint working to resolve them. The MD-ESTH responded to a question from PW and said that there was a low level of trust and high risk aversion to virtual wards from some medical teams. Clinical leadership would have to support with addressing this but noted that 100% of the virtual ward beds had been filled that week. **The Group Board noted the report.**	

2.5	**Quality Committees Report**	
	There being no additional matters for consideration that had not been discussed in the previous items the **Group Board noted the report.**	
3.0	**Items for Review and Assurance – Finance, Audit and Risk**	
3.1	**Group Financial Performance Year End 2024/25**	
	The GCFO referred the meeting to the report, adding that data was consistent with previous reporting. The key elements of the financial position were in line with planning and forecasting expectations. The draft accounts had been submitted on time and the audit was underway. **The Group Board noted the report.**	
3.2	**Finance and Performance Committees Report**	
	Ann Beasley (AB), Chair of the Finance and Performance Committees, referred the meeting to the report and said that the Committees had reviewed 2024/25 and month 1 of 2025/26 information, noting the huge amount of work for the finance team. The 2025/26 budget was still a work in progress but the financial situation would mean it would be incredibly difficult to deliver all services to the same level as now. Although both Trusts were performing well, the improvements that services and teams wanted to make would be impacted by the need to reduce costs, while also noting that there were safeguards in place to ensure savings did not adversely impact safety. AB noted that there would be impairments in the ESTH accounts due to the Building Your Future Hospital (BYFH) programme being postponed. **The Group Board noted the report.**	
4.0	**Items for Review and Assurance – People**	
4.1	**People Committees Report**	
	On behalf of Yin Jones, Chair of the People Committees, Phil Wilbraham (PW) reported that the Committees had received a very helpful update from the GCPO which had reflected on how the financial situation was impacting on staff and culture. The engagement scores for the 2024 NHS Staff Survey had improved at both Trusts which was positive. The Committee had also considered the workforce planning data and had noticed that reports contained different data on the numbers of staff, and the reasons for this needed to be better understood. AB commented that inconsistency in the workforce numbers had been raised previously and this felt like something that should be grasped. The GCFO responded that, historically, quite a lot of work had been done on this and it was reasonably well understood why the numbers would not reconcile perfectly but there was always more to be done. The GCPO added that the new Group lead for workforce transformation would support with addressing the challenges in these	

	areas. This was still a work in progress and would be reported on regularly to the People Committees. The Board commended the improved metrics in the staff survey. The GCPO noted that it was positive to see so many staff engaged but there was caution around survey fatigue and how much further the number of responses could be increased. Additionally, the GCPO did not want to just chase improvements on the numbers but to see a meaningful impact from the feedback staff were giving. **The Group Board noted the report.**	
5.0	**Items for Review and Assurance – Infrastructure**	
5.1	**Infrastructure Committees Report**	
	AB, as Committee Chair, took the report as read and reminded the Board that the Committee alternated the focus of its meetings between digital and estates. All meetings looked at the EPR which was scheduled to go live on 9 May. The digital focus meeting, held in April, had looked at the current status of digital, with Non-Executive Directors disappointed with the lack of progress on developing a Group-wide digital strategy and with the delay with receiving the report from the external review of digital services, which had been commissioned several months earlier. Whilst understanding the reasons for this, AB added that the impact on the organisation of the current digital and IT position should not be underestimated and the Committee urged greater focus on improving the IT position. In the estates focused meeting held in March fire safety concerns at St Helier had been noted, with a report await from the London Fire Brigade (LFB) inspection. The Committee were closely monitoring this as there was limited assurance in this area. The GCFIEO commented that, following his recent meeting with the LFB, a fire safety enforcement notice for St Helier was expected. AB added that water safety issues at St Helier were also a concern and the Committee had reviewed a report that had explored a particular set of water safety issues at St Helier. It was noted that most public buildings would have some level of water safety issues to be addressed. The Committee had been satisfied that all appropriate mitigations were currently in place but this would need to be kept under close review and long-term mitigations to address the underlying issues would be required. The GCEO acknowledged, and shared, the frustrations of the Committee with regards to the external report into digital which had now been delayed by two months. Both the GCEO and the GCFO were making frequent attempts to obtain the report. The GCEO agreed to follow-up with the external reviewer to ascertain a firm date by which the Executive would receive the report. **The Group Board noted the report.**	**GCEO**
6.0	**ITEMS FOR NOTING**	
	The Group Board noted: • GESH Learning from Deaths Quarterly Report: Q2 (Jul-Sep) and Q3 (Oct – Dec) 2024/25	

	• 2024 NHS Staff Survey Results, which had been discussed by the Group Board in detail at its private meeting in March 2025 given the embargo on the publication of the results. • Annual Fit and Proper Persons Report 2024/25.	
7.0	**CLOSING ITEMS**	
7.1	**New Risks and Issues Identified**	
	No new risks or issues had been raised.	
7.2	**Questions from members of the public and Governors of St George's**	
	There were no questions received in advance from the public or from Governors of St George's present at the meeting.	
7.3	**Reflections on meeting**	
	The Chair asked AB to lead the Board in reflecting on the meeting. AB considered that it had been a good meeting but suggested that, had she been an observer she may have queried whether there had been enough challenge. A lot of work, including robust challenge, took place in Committees so to repeat it at the Board meetings risked being performative but it was important that the public saw the challenge provided by the Board. There had been some good challenge in the maternity item and the question from PD on whether we were clear on what we meant by culture had also been helpful. AB had noticed that whilst most people were engaged, there had been times when people had been working on emails rather than fully focused on the meeting. Reflecting on the new format, AB felt that the having the ward visits later in the day had been positive and the feedback had been more succinct. Less positive in her view had been the placement of the Committee reports at the end of each section of the agenda, and she suggested that having these at the beginning would allow Chairs to set the scene for the items being discussed. AB added that having the private session first and a shorter overall meeting allowed Board members to be fresher for the more complex matters. Other Board members gave their reflections which supported those given by AB. The GCEO added that making sure the CARE strategy was woven into reporting and discussions was important and suggested that the use of a CARE board where the meeting started with a stand-up discussion of key metrics, as was done at Group Executive meetings, could potentially be considered by the Board. The Chair thanked everyone for the feedback, adding that he had been keen to trial a different format given the discussions at the April Board development session and in the context of the cost to the organisation of all-day meetings that involved the Executive. He invited Board members to send to him directly any further thoughts on the meeting and he would reflect further on the structure of future meetings.	

5.4	**Patient Story**	
	Jill Ambrose (Patient) and Paula O'Shea (General Intensive Treatment Unit Team Leader / lead Nurse for Critical Care Follow Up) were welcomed to the meeting. Jill shared her experience of being a patient for 60 days in ITU having contracted sepsis which had resulted in long term health issues. She had been discharged from hospital just at the start of the Covid lockdown in 2020 which had impacted on the support and rehabilitation she had been able to receive. Working with Paula and the team, Jill had championed the first adult critical care support group for survivors of critical illness at St George's. Guidance had been developed that would help to address some of the challenges faced by patients further to ITU admission and she also explained how the support group had been launched and was continuing to evolve. In follow up questions Jill explained how the psychological impact that a stay in ITU could manifest unexpectedly and often some time after patients had been discharged. The peer-to-peer support provided by the group was invaluable in helping with this as people did not feel so alone as others understood what they were going through from personal experience. The Board thanked Jill and Paula for their presentation and particularly to Jill for sharing her experience.	
CLOSE		
The meeting closed at 3.20pm.		

Group Board (Public) - Updated 25 April 2025

Action Log

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

Group Board

Meeting in Public on Thursday, 03 July 2025

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

Executive Summary

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

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

Action required by Group Board

The Group Board is asked to note the report.

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

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

Group Chief Executive Officer's Report

Group Board, 03 July 2025

1.0 Purpose of paper

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

2.0 National Context and Updates

NHS 10 Year Plan

2.1 The Government is expected to publish imminently its NHS 10 Year Plan. The development of the plan was announced shortly after the general election last year, and is informed in part by the Independent Investigation of the National Health Service in England by Lord Darzi, published in September 2024, which was intended to set out the scale of the challenges facing the NHS, and by a 'national conversation' entitled 'Change NHS: help build a health service for the future'.

2.2 While the details of the Plan have not yet been released, the Government has set out the 'three shifts' that are expected to underpin the Plan and shape the NHS over the coming decade:

- Moving more care from hospitals to communities, by providing more tests, scans, treatments and therapies nearer where people live and providing more health services at places such as GP clinics, pharmacies, local health centres and in people's homes.
- Making better use of technology in health and care, by moving from analogue to digital and utilising artificial intelligence and advanced robotics.
- Focusing on preventing sickness not just treating it, but spotting illness earlier and tackling the causes of ill health to help people stay healthy and independent for longer and take pressure off health and care services.

2.3 Expected to be published in the coming weeks, the Plan will have significant implications for how we organise and deliver health services across our local system, involve a greater focus on neighbourhood health, and will involve close working with our partners in the NHS, local government and across our communities to help realise the three shifts. We have already spent time as an Executive team and as a Board in considering the potential implications of these changes and we will need to continue this over the coming months.

Spending Review 2025

2.4 The Government announced its Spending Review 2025 on 11 June, which included further investment in the NHS. Under the Spending Review plans, the budget for the NHS nationally will grow by 3% in real terms each year over the course of the Spending review period to £232bn by 2028/29, amounting to a £29bn increase in annual resource budgets at a national level.

2.5 As part of the Review, the Department of Health and Social Care has committed to delivering at least 5% savings and efficiencies over the Review period, including £17bn in savings over three years by improving productivity by 2%. The NHS will also be required to reduce the need for

temporary staffing by capping agency spending and eliminating agency use for entry level positions.

2.6 Capital budgets will be held flat in real terms over the course of the Spending Review period, peaking at £14.8bn nationally in 2028/29, and includes £30bn over the next five years for the maintenance and repair of NHS facilities, with over £5bn for the most critical repairs.

2.7 The Government also announced a number of separate funding settlements, designed to support the delivery of the Government's three shifts, including £10bn of investment in NHS technology and digital transformation projects by 2028/29, with specific investment for the NHS App and a single patient record system; further funding to support the training of more GPs and employing 8,5000 additional mental health staff; £80m for tobacco cessation programmes; and £600m to launch the launch of a new Health Data Research Service to accelerate the discovery of life-saving drugs.

2.8 The Spending Review also allocated over £4bn in additional funding for adult social care for 2028/29 compared with 2025/26.

Model Integrated Care Board Blueprint

2.9 As part of the changes to the architecture of the NHS which I set out in my report to the Group Board in May 2025, the Department of Health and Social Care has announced major changes to Integrated Care Boards (ICBs). As well as announcing that ICBs will need to make reductions of 50% in their costs by December 2025, NHS England has published a new Model ICB Blueprint, which sets out plans for how the role of ICBs will change in the coming months. NHS England has affirmed that ICBs will remain essential to the future success of the NHS but has set out how their role will be consolidated as 'strategic commissioners', focusing on providing system leadership for population health, setting evidence-based long-term population health strategy, and delivering the strategy through payer functions and resource allocations, as well as evaluating impact and outcomes. The bluepint sets out that ICBs will

- grow those capabilities and functions necessary for them to undertake their role as strategic commissioners successfully
- selectively retain and adapt the governance and management functions that enable delivery of strategic commissioning e.g. quality management, board and corporate governance, clinical governance and core operations
- review for transfer to other parties, those functions that are not core to strategic commissioning and may be better undertaken by others in future.

2.10 Under the blueprint, a range of functions are proposed to move from ICBs to provider trusts, including responsibilities around estates and digital, and local workforce development and training, with strategic workforce planning, development and training, emergency preparedness, resilience and response and oversight of provider performance moving to NHS regional teams. We will be engaging closely with our partners across the system as the ICBs transition into their new role.

National maternity investigation

2.11 The Department of Health and Social Care (DHSC) has announced a new 'rapid national investigation' into NHS maternity and neonatal services. The investigator, announced on 23 Junee 2025, will examine the worst-performing maternity services across England and also review the whole of the maternity system. The stated intention is to bring together the findings of past reviews into maternity into a single set of actions to ensure that every woman and baby received, safe, high quality and compassionate maternity care. The review will commence this

summer and is expected to report back to the Secretary of State for Health and Social Care in December 2025. Although there has been some reporting as to which maternity units will be reviewed, the list of the 10 worst performing has not been published at this stage.

2.12 The Chief Executive of NHS England and Chief Nursing Officer for England have written to all NHS trust Chairs and Chief Executives about the review and has emphasised that:

"We ask every local NHS Board with responsibility for maternity and neonatal care to:

- *Be rigorous in tackling poor behaviour where it exists. Where there are examples of poor team cultures and behaviours these need addressing without delay.*
- *Listen directly to families that have experienced harm at the point when concerns are raised or identified. It is important we all create the conditions for staff to speak up, learn from mistakes, and at the same time staff who repeatedly demonstrate a lack of compassion or openness when things go wrong need to be robustly managed.*
- *Ensure you are setting the right culture: supporting, listening and working, through coproduction, with your Maternity and Neonatal Voice Partnership, and local women, and families.*
- *Review your approach to reviewing data on the quality of your maternity and neonatal services, closely monitoring outcomes and experience and delivering improvements to both.*
- *Retain a laser focus on tackling inequalities, discrimination and racism within your services, including tracking and addressing variation and putting in place key interventions. A new anti-discrimination programme from August will support our leadership teams to improve culture and practice. This also means accelerating our collective plans to provide enhanced continuity of care in the most deprived neighbourhoods, providing additional support for the women that most need it."*

NHS pay awards 2025/26

2.13 On 22 May 2025, the Department of Health and Social Care announced an above inflation pay increase of 3.6% for all Agenda for Change (AfC) staff for 2025/26. This follows the 5.5% increase in 2024/25. The Department has also accepted recommendations from the national pay review body to fund further changes to the AfC pay structure, which are likely to come into effect in 2026/27. On the same day, the Department separately announced a 4% increase in pay for consultants, specialty doctors, specialists and GPs.

New very senior managers pay framework

2.14 NHS England published a new framework for very senior managers (VSM) pay on 15 May 2025, which applies to all integrated care board (ICB) and NHS provider trust VSMs from 1 April 2025. The stated purpose of the new framework is '*to create consistency, increase transparency and offer sufficient flexibility to attract talented candidates to the most challenging roles and challenged providers..[by] reard[ing] successful, high performing senior leadership and, in turn driv[ing] performance improvements so that all patients have local access to the best standards of care*'. The framework aligns with recommendations from the Messenger and Pollard review of NHS leadership capabilities and the Kark and Russel reviews on accountability, governance and transparency in remuneration practices.

2.15 The new framework sets out new pay banding, with minimum and maximum ranges, to help determine remuneration rates. Remuneration is also linked under the framework with organisational performance, and specifically with the organisation's 'segment' rating against the NHS oversight framework. VSMs not meeting their objectives and targets will not be eligible for pay awards. There is local discretion over the award of a non-consolidated, non-pensionable performance payment of up to 10% of basic salary for exceptional contribution, which are expected to apply in relation to the delivery by the organisation of improvements significantly above trajectory, for example significantly reducing an organisation's deficit or moving the organisation out of its challenged status within a defined timescale. The Government has characterised the new framework as a 'carrot and stick' approach to drive performance improvement.

3.0 Our Group

Financial Recovery

3.1 The Executive team and the organisations as a whole have continued to focus on financial recovery and identifying and delivery the Cost Improvement Plans necessary to fulfil our financial plans for 2025/26. As the finance papers presented to the Group Board demonstrate, the level of challenge in meeting our financial targets is unprecedented and will require very difficult decisions over the coming year. Those decisions will take place with robust internal governance mechanisms to ensure that all efficiency savings and cost improvement plans are scrutinised carefully for their impact on safety, quality, performance, and equality impact. As an Executive team, and as a Board, we have been clear that we will not approve scheme that impact negatively on safety. However, the financial pressures we face inevitably mean we cannot to all we may wish to develop our services.

3.2 Taking our staff with us in delivering our financial plans is absolutely critical. Over the past few weeks, the Executive team has been engaging with staff across the Group, and particularly with budget holders at all levels, through a series of financial recovery roadshows to discuss the scale of the challenge and the opportunities we have to become more efficient as organisations and to drive out cost, while maintaining safe services for our patients and staff. These roadshows have been helpful in facing our financial challenges together, discussing how we can support our frontline teams, and consider suggestions for cost savings. I have been impressed with the engagement of our staff with these roadshows and will make these part of how we engage with the organisations on an ongoing basis, alongside forums such as our Executive Question Time.

Launch of our new Shared Electronic Patient Record system

3.3 Our new Electronic Patient Record system, iClip Pro, was launched across the gesh Group on 9 May 2025. The new system brings together multiple IT systems across our sites into one, giving staff a complete overview of a person's care ion real time. The launch of iClip Pro across the Group marks a significant and exciting moment for gesh. The system will make a real difference for our staff and patients – keeping data secure, reducing delays and supporting clinicians by providing comprehensive access to the information they need. New kit and software will also help speed up observations, monitoring, and prescribing – freeing up more time for patient care and meaning fewer delays. All staff across the gesh Group will now be using a single system, which will help streamline administrative tasks and minimise duplication.

CQC 'well led' inspection at St George's

3.6 As the Board is aware, the Care Quality Commission (CQC) undertook a planned "well led" inspection at St George's between 25 and 27 February 2025. The inspection followed previous

CQC service inspections of maternity, Emergency Department and Theatres at St George's and Queen Mary's Hospitals in recent months. We understand that the CQC inspection report will be shared with the Trust for factual accuracy checking in the coming weeks. A publication date for the report has not yet been confirmed.

4.0 Appointments, Events and Our Staff

Veteran Aware Re-Accreditation

4.1 Both Epsom and St Helier University Hospitals and St George's University Hospitals have successfully achieved re-accreditation in recognition of their outstanding support for the Armed Forces community. This important milestone reflects the dedication, teamwork and shared values of both organisations, who continue to set a high standard in delivering care and support to veterans and their families. The re-accreditation highlights each trust's commitment to the Armed Forces Covenant, reaffirming their pledge to ensure that those who serve or have served in the Armed Forces, and their families, are treated with fairness and respect. It also celebrates the successful integration of the two trusts, paving the way for a stronger, more unified approach to supporting the Armed Forces community. I would like to express my thanks to all of those involved, especially the Armed Forces working groups, whose leadership and hard work have been key in driving this achievement forward.

Celebrating Pride Month

4.2 At the start of June, we were proud to celebrate Pride Month, in which we celebrated the diversity, strength and voices of our LGBTQ+ communities, and reaffirmed our commitment to inclusion and equality. WE proudly raised the Pride flag at Epsom, St George's and Queen Marys, alongside our incredible LGBTQ+ Staff Network, marking the start of a month filled with celebration, learning and visibility. I would like to pay tribute to the work of our LGBTQ+ Staff Network for their ongoing work and for making Pride month such a success across our Group.

St George's featured in new Netflix documentary

4.3 A new six-part series will be launched on Netflix in July which will showcase the work of the London Major Trauma System, including St George's. The series, *Critical: Between Life and Death*, will be launched on 23 July. The now-established London Major Trauma System was the first of its kind and is a unique network of hospitals made up of four major trauma centres and a number of trauma units, ambulance services and air ambulance services. The series provides behind the scenes insights into the ground-breaking care provided by our trauma teams. A trailer for the services has been launched which provides an early glimpse of the series.

5.0 Recommendations

5.1 The Group Board is asked to note the report.

Group Board

Meeting on Thursday, 03 July 2025

Agenda Item	2.1	
Report Title	Strategy stock-take and priorities for 25/26	
Executive Lead	Ralph Michell, Group Chief Transformation Officer	
Report Author(s)	Group Strategy, Transformation, PMO and Performance teams	
Previously considered by	Group Executive Board	13/05/24
Purpose	**For Approval / Decision**	

Executive Summary

The Board agreed a five-year strategy for the Group in 2023. Given the significant changes in the external environment since then, and the fact that we are approximately half-way through the life of the strategy, the Board agreed in January 2025 to do a stock-take on the strategy.

At its April development session, the Board received a horizon-scanning report and considered the implications for the Group. At its June development session, the Board welcomed the Chief Executive of the South-West London Integrated Care Board to hear about the plans to develop a long-term vision for services in our region, received proposals for a refresh of the strategy (attached as an annex), and considered how the Group's strategic positioning, partnerships and plan might need to change. Informed by the horizon-scan and internal gesh strategy stock-take, the Board focused this discussion on:

- The future configuration of services across SWL/Surrey
- The Government's aspiration for a 'neighbourhood health service', with care shifting from hospital to community
- Strategically important capabilities for the organisation (digital, our culture/management system, our organisational shape)

This paper builds on those discussions to set out a way forward.

Action required by Group Board

The Board is asked to:

- Agree the proposals

Committee Assurance

Committee	NA

Level of Assurance	NA

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Strategy stock-take and priorities for 25/26

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

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Strategy stock-take and priorities for 25/26

Board Meeting - 3 July 2025

Lead Executive: Ralph Michell, Group Chief Transformation Officer

Group Strategy, Transformation, PMO and Performance teams

Introduction

The Board agreed a five-year strategy for the Group in 2023. Given the significant changes in the external environment since then, and the fact that we are approximately half-way through the life of the strategy, the Board agreed in January 2025 to do a stock-take on the strategy.

At its April development session, the Board received a horizon-scanning report and considered the implications for the Group. At its June development session, the Board welcomed the Chief Executive of the South-West London Integrated Care Board to hear about the plans to develop a long-term vision for services in our region, received proposals for a refresh of the strategy (attached as an annex), and considered how the Group's strategic positioning, partnerships and plan might need to change. Informed by the horizon-scan and internal gesh strategy stock-take, the Board focused this discussion on:

- The future configuration of services across SWL/Surrey
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- Strategically important capabilities for the organisation (digital, our culture/management system, our organisational shape)

This paper builds on those discussions to set out a way forward. The Board is asked to agree the proposals.

Proposed positioning & next steps

	Proposed positioning / approach	Next steps
The long-term configuration of services in South West London & Surrey	• Engage open-mindedly, collaboratively and flexibly with the development of the South West London long-term plan – whilst maintaining support for agreed schemes such as the consolidation of the Group's renal services at St George's, and the consolidation of Epsom St Helier's major acute services • To be in the best position to engage with SWL-wide discussions, proactively consider the right future for services across our Group – including paediatric and maternity services	1. Strengthen collaborative working relationships to support development of SWL strategy. 2. Ongoing internal thinking on long-term change in key services such as paediatrics, maternity and surgery, via our newly-mobilised gesh-wide Clinical Strategy & Standards Groups 3. Further board development time as the SWL plan develops
Neighborhood health / hospital to community shift	• Seek to make our contribution to building a 'neighbourhood health service', shifting care into the community • Work in collaboration with partners in this space, acting with humility and being clear that both models of care and operating models/system architecture will need to be co-designed with partners, and cannot be only be in the gift of the Group • Seek to better understand the proposed 'integrator role' put forward in the London target operating model for neighbourhood health; noting that further clarity on this role will likely emerge over the coming weeks with the publication of the national ten year plan.	1. Continue working with partners in our local places and ICBs to improve the model of care available in our local neighbourhoods, and to build the collective operating model to deliver it. 2. Receive and digest the NHS ten year plan, expected to be published by DHSC/NHSE shortly
Priority capabilities	• Build our digital capacity/capability Continue to work on building the right culture for high performance across gesh • Executive to focus on organisational shape/development, maximising the benefits of Group without pursuing changes to legal form in the near term.	1. Restructure / change operating model for our Group's digital services 2. Develop digital strategy in this financial year 3. Refresh of 'high performing teams' programme & governance, and Executive development session

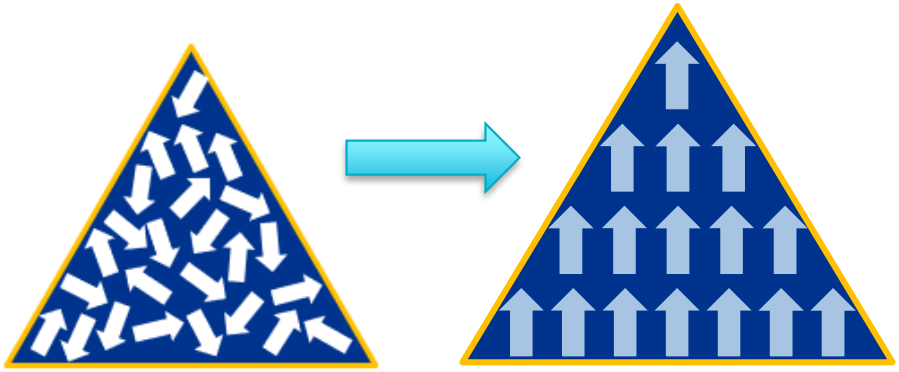
2025/26 – a year of transition

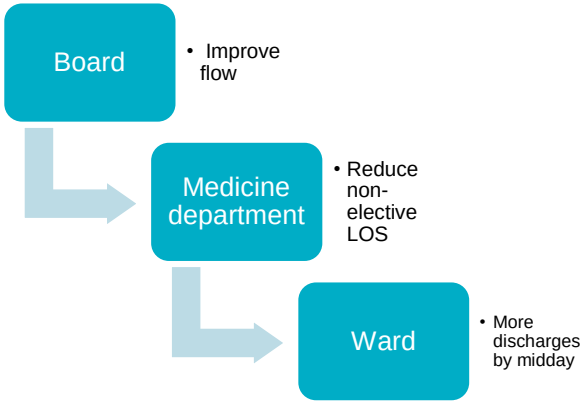
Given that the external environment continues to change rapidly (with the NHS ten year plan and South West London plan being developed), and the Board's desire to develop its strategic approach with partners rather than unilaterally, it is proposed that we treat 2025/26 as a year of transition:

- Working with our partners to develop the clinical strategy for SWL
- Reflecting the positioning / shifts in emphasis described above in our plans for 25/26
- But not agreeing / publishing any revision to our Group strategy until we have agreed collective aspirations with our system partners, likely later this financial year.

Our proposed plan for 2025/26 is set out overleaf on this basis.

Board-to-ward priorities





- Like many NHS organisations seeking to adopt a continuous improvement approach, we are seeking to better prioritise and align the work of our departments/teams.
- Setting ‘board to ward priorities’ (objectives which every team in the organisation can contribute to in some way) is an important part of this process.
- In January, the Board agreed to roll over the 24/25 board to ward priorities to 25/26 – but now that we have an agreed financial plan we need to agree performance indicators.

Proposed performance indicators

	C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Board to ward priority for 25/26 (agreed January)	Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
Performance indicators (proposed for review)	**Reduce average Non-Elective LOS**	**Deliver Financial Plan**	**Improve VTE Risk Assessment Rates towards the 95% national ambition**	**Reduce staff sickness absence rates**
	Reduce delays between planned and actual discharge (and patients in beds Not Meeting Criteria to Reside)	**Deliver positive Implied Productivity rates (*headline NHSE measure*)**	**Maintain ED (Type 1) 12-hour waits at or below the previous year's level**	**Increase the percentage of staff who would recommend gesh as a place to work**
How will we know if we are succeeding?	**Increase the number of patients seen by Urgent Community Response teams**	**Deliver CIP Target**	**Deliver RTT 52 –week waits performance targets**	
		Cash : Current balance (M12) Cash stress expected (based on current cashflows)		

Our transformation portfolio

When we agreed our 2023-2028 Group strategy, we said that we would deliver our ambitions through a mixture of local improvement (enabling teams across the organisation to make everyday improvements against our shared ‘board to ward’ priorities) and large-scale, multi-year, complex change programmes (our nine strategic initiatives).

As our strategy stock-take shows, the world looks significantly different for some of those programmes now compared to 2023. For instance, one of the 9 was to deliver a shared EPR across our Group – we have now delivered it. Now – as the external operating environment continues to change – we need to turn our focus to ensuring we realise the benefits.

Given the scale of financial challenge facing the NHS, we have also mobilised a highly ambitious financial recovery programme, which will require far-reaching transformation, appropriately governed and resourced.

We are therefore reshaping our transformation portfolio – with the proposed outline set out overleaf.

Proposed Group Transformation Portfolio

	Neighbourhood & Place-Based Service Models (including Hospital to community shift)	Productivity improvements through a programmatic approach	Service reconfiguration	Our ways of working and making improvements as gesh
Tier 1 (Strategic – done together as Group)	Integrated, place-based models of care / neighbourhood teams	Nursing & AHP Staffing Productivity; Medical Staffing Productivity; Diagnostic Demand Optimisation	Group Integration programme (clinical & corporate services)	High performing teams; Culture, values and ED&I
Tier 2 (Group enabled, site delivered)	Ward/ bed closures; Outpatient transformation	Admin & clerical review; Sickness Reduction & prevention		
Tier 3 (Locally led & delivered)	*Wide range of local schemes, e.g. relating to theatre productivity, community services improvements*			

Please note that the list of programmes will be updated as the Group Financial Recovery Programme and CIP evolve.

Key enablers: Estates, Digital, Workforce Controls, Procurement

Group Transformation Portfolio Development - Next Steps

Work is already underway to design and develop the proposed programmes of work through the tiering approach introduced for financial recovery programmes which is incorporated in the proposed Group Transformation Portfolio.

Subject to Board approval, further work will be to undertaken to put in place the foundational best practices for programme management which focuses on;

- Leadership roles and responsibilities, including confirmation of SROs and senior programme resource
- Governance arrangements including stakeholder mapping, and identification and management of interdependencies
- Planning – detailed programme plans, goals setting, measures of success, and benefits realisation

Recommendation

The Board is asked to agree the proposals for:

- How the Group should position itself in the months ahead
- Seeing 25/26 as a year of transition, working with partners to develop the strategy for South West London ahead of any gesh-specific revised strategy
- Performance indicators for our board to ward priorities
- The high-level shape of our transformation portfolio

Annex 1: Group Strategy Stocktake 2025

May 2025

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Why take stock of our strategy?

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We have taken stock of our strategy in light of progress made to date, changes in the external environment, and our financial position.

We are roughly half-way through the life of our 2023-2028 strategy. Whilst we have made **progress against some of our strategic ambitions**, we have further to go on others.

Since the 2024 general election, **major structural and policy changes** have reshaped the NHS, including plans to abolish NHS England and reduce ICB roles and budgets.

A **10-year health plan** is expected in June 2025, likely centred on three major shifts: strengthening prevention and early intervention, rebalancing care towards community and primary services, and harnessing digital innovation to improve outcomes and efficiency. The London region has published a **case for change and target operating model for a 'neighbourhood health service'**. This is likely to impact our priorities, and we need to proactively consider how we will deliver these shifts.

At the same time, **ICBs have been asked to reduce their budgets** by at least 50%, and to play a radically different (and reduced) role, with some functions transferred to providers and increasing talk of 'accountable care organisations' .

Our **financial position is incredibly challenging**, and the requirement to deliver significant savings is urgent, likely to be a feature every year for the rest of our 2023-28 strategy, and likely to require strategic/transformational change. Our strategy needs to reflect and help answer this challenge.

The **delay of the New Hospital Programme,** and the reconfiguration of services across Epsom St Helier it entailed, has major ramifications for our strategy.

Over the next several months, SWL will embark on a system-wide **process to draw up a 10-year plan for the NHS in SWL**, to deliver national priorities and financial sustainability. We expect this process to re-look at the configuration of acute services in our region, as well as how we move to a 'neighbourhood health service'.

While there is much focus on our finances, we also have **continued scrutiny on quality of care** and outcomes. We are responding to a number of CQC reviews and are likely to see more. We expect national **pressure to meet performance targets to ramp up in the next few years as the election approaches**.

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Are we on track to meet our ambitions for 2028?

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	Collaboration & partnership	Affordable healthcare, fit for the future	Right care, right place, right time	Empowered, engaged staff
Ambition for 2028	"By 2028 gesh will be a driving force behind the most integrated health and care system in the NHS"	"By 2028, we will have taken the difficult action required to break even each year financially"	"In 2028, waiting times for our services will be among the best in the NHS (top quartile), and we will have an outstanding safety culture, delivering lower than expected mortality rates and a reduction in avoidable harm."	"By 2028 gesh will be among the top five acute trusts in London for staff engagement"
Where are we now	**Mixed progress**. Growing number of trusts across the NHS pursuing Group model – we have made progress but much further to go. At place level, recognised good practice in Surrey Downs/Sutton but further to go in Merton/Wandsworth. A relatively mature APC by national standards but the test will be delivering radical change needed for sustainable provision in SWL.	**Extremely challenging**. Despite delivering very significant cost improvement YTD, we are forecasting a deficit for 24/25, and future years likely to be extremely challenging across the NHS.	**Mixed progress.** Waiting times generally compare well to the rest of the NHS (top or 2nd quartile), but are not where we would want them to be – incl. high concern re pressures on A&E. Mortality rates lower than expected at SGUH but higher at ESTH (partly due to coding issues), & mixed progress on reducing avoidable harm - see IQPR report for detail.	**Mixed progress.** Based on the 2024 National Staff Survey, ESTH is ranked 10th with a score of 6.93 (up from 11th with a score of 6.80 in 2022) and SGUH 12th with a score of 6.91 (from 12th with a score of 6.79 in 2022) out of 22 acute Trusts in London for engagement. We would need to be at 7.4 to score among the top five.

More detail set out overleaf

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Our approach to delivering our strategy

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Local improvement

Local improvement pursued by teams across the Group, against our CARE framework. The Board agrees annual 'board to ward priorities' to support this, and receives updates against these priorities through the Integrated Quality & Performance Report (IQPR).

Corporate enablers

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

Strategic initiatives

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

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Local improvement update

Local action taken by all our staff, Board to Ward, to deliver continuous improvement against our CARE objectives.

Over the past two years, we have made progress in embedding the CARE framework across the Group, and using this to drive local improvements. We recognise there is still more to do to ensure the whole Group is strategically aligned.

- The CARE strategy is now visible and accessible across digital and physical spaces, featured in staff induction, the Leadership Programme, and on the intranet, with consistent branding and communications across gesh,
- The Board agreed Board-to-Ward priorities in 2024/25 to ensure strategic alignment. These have been rolled forward into 2025/26, recognising the need for every level of the Group to deliver these.
- The monthly Group Integrated Quality & Performance Report (IQPR) tracks was aligned to the CARE framework and monitors progress against the Board-to-Ward priorities
- CARE objectives have been reflected in executive and some directorate-level annual goals, aligning leadership around shared priorities.
- Our approach to staff recognition is aligned to the strategy. The CARE Awards, held in December, recognised contributions across 12 CARE-linked categories and were attended by over 400 staff, supported by strong internal communications.
- We have designed a revised Ward Accreditation Programme, launching in Q1 2024/25, which will be explicitly tied to the CARE framework.
- Teams across the Group are increasingly using the CARE framework to articulate their purpose and priorities, supported by facilitation from corporate teams.

What more could we do?

- Ensure that the Group's strategic objectives are more fully and effectively embedded across the organisation.
- Ensure that all senior leaders are familiar with the CARE strategy. For example, there is work to be done to ensure all teams have CARE boards, and to embed CARE into PDRs.
- Our HPT programme is a key enabler to ensure we embed the strategy across the Group, but has not progressed at the pace we hoped for (see later slide for further details).

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Corporate Enablers

Action led by corporate teams against corporate strategies

While progress on our corporate strategies has varied due to competing priorities, where strategies have been developed, they are supported by implementation plans and clear governance to drive delivery and achieve our objectives.

Strategy	Progress update
People	Approved by Board in May 2024, and now being translated into an implementation plan. Progress is being reported to the People Committee in Common three times a year.
Digital	Work has commenced bur progress has been slow due to capacity constraints and the focus on EPR. Aiming for board approval in Autumn 2025.
Environmental sustainability	Approved by Board in July 2024, and translated into an implementation plan. Progress is being reported to the Infrastructure Committee in Common four times a year.
Quality & Safety	Approved by Board in July 2024, and translated into an implementation plan. Progress is being reported to the Quality Committee in Common three times a year.
Research & Innovation	Competing priorities have delayed the development of the strategy. We are aiming for publication in winter 2025.
Estates & Facilities	Work has commenced on the Group Estates Strategy but progress has been slow due to resource constraints.

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Strategic initiatives

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Large-scale, Board-led, complex programmes of work running over many years, which will help us deliver our vision for 2028.

Initiative	Key accomplishments	Looking forward
Building Your Future Hospitals (BYFH) **Objectives:** **Objective 1**: Submit Outline Business Case **Objective 2**: Submit Planning application **Objective 3**: Progress SECH site enabling works	All major risks have materialised and as of 1 April 2025, the programme team and external advisors were stood down. **OBC Refresh (Sprints 1 & 2):** Completed, covering options appraisal, workforce model, benefits, and clinical engagement. Strategic Case draft finalized. **RMH Land & Services:** SFBC draft complete; RMH confirmed Haematology at SECH; draft Heads of Terms agreed. **Demand & Capacity:** Initial NHP-led modelling and validation completed. **Funding & Planning:** MoU agreed; programme plan revised (May 2024). **Design & Governance:** SECH design option agreed by RMH, BHFH, and Group Board. RIBA Stage 2b concluded; positive NHP feedback received. **Stakeholder Engagement:** Ongoing input from Trust, ICB, and planning authorities (e.g., Sutton, TfL). Group-wide clinical/non-clinical engagement; 360+ responses to BYFH roadshows. **Strategic Agreements:** Progress made with securing agreement in principle with RMH on the strategic elements of the land required for the SECH, RMH capital contribution, RMH Haematology floor at SECH, Link Bridge & the Sutton Multistorey car park. **Post-Pause Activity:** 25/26 proposal (Renal, RMH land, Sutton planning, site reconfiguration) submitted to NHP (Feb 25). BYFH cost impairment confirmed via FIC and auditors.	• No SECH until mid 2030s at the earliest present major risk / strategic challenge • Ongoing efforts to progress SECH enablers (e.g. Epsom multi-storey car park) • Work underway to assess/mitigate estate risk at ESTH • Engagement in SWL's development of a new ten year plan will be critical
Collaboration across GESH **Objectives:** **Objective 1**: Integrate most corporate services **Objective 2**: Submit full business case for renal build **Objective 3**: Agree three Group-wide clinical strategies, and begin implementation	**Structural integration of corporate services** complete for corporate affairs, comms, Deputy CEO office and corporate nursing. Structural integration of HR is underway. Phase 2 TUPE & phase 3- Research & Dev. consultation successfully completed for corporate medicine. Integration of estates & facilities has begun. Finance integration timeline revised and designs underway. IT integration timeline to be reviewed. **Renal integration programme has paused**: BC drafted and shared informally with NHSE however, the pausing of NHP, part funder of the renal build has impacted this and the inflationary pressure on building costs continues to be a significant risk. **Group wide clinical collaboration**: There has been progress in collaboration across clinical services, including in surgery, anaesthetics, renal, paediatrics, and pharmacy. Business case for Clinical Strategy & Standards Groups (CSSGs) approved at GEC.	• The CQC well-led inspection noted that the benefits of the group model have not yet been fully realised. • The Board previously agreed that ultimately we should pursue a merger, partly to enable faster/deeper realisation of the benefits of Group – but this is unlikely to be supported in the short/medium term • 'Group Roadmap' under development to more clearly articulate our vision for how the Group will change over coming years • Potential to radically rethink how some services work across gesh (e.g. paediatrics, maternity, surgery), and to play this into SWL's ten year plan being developed over the coming months

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Initiative	Key accomplishments	Looking forward
Collaboration across Southwest London hospitals (Acute Provider Collaborative) **Objective 1:** Deliver agreed transformation programmes (e.g. PACS) **Objective 2:** Strengthen hosted APC partnerships (SWLEOC; SWL Procurement; SWL Pathology) **Objective 3:** Develop partnership programmes to support long-term financial sustainability (e.g. hubs)	PACS programme has been challenging, but an independent review of the Optum PACS product has been undertaken along with an options appraisal for the way forward, and preparations for the relaunch of the programme are underway. Work to strengthen hosted APC partnerships continues, including recent work to improve productivity at SWLEOC as part of planning for 25/26. A range of newer partnership programmes have been developed/progressed in 24/25, particularly in elective care (single point of access for ENT now live, ophthalmology single point of access progressing, joint image store for teledermatology procured by Croydon with gesh joining soon, agreement to adopt ambient AI in outpatient services jointly across APC).	Opportunity to think more radically about configuration of services across SWL's 4 acutes as part of the development of a 10 year plan There may also be opportunities for the APC to take on some functions currently delivered by the ICB, given nationally-mandated changes to ICB role.
Collaboration with Local Partners (Place) **Objective 1:** Develop gesh-wide approach to frailty **Objective 2:** Work with local partners to reduce length of stay **Objective 3:** Work with partners on redesign of community services in Merton & Wandsworth	**Alliance Development**: Provider Alliances established in Merton and Wandsworth to support collaborative service delivery and integrated care transformation (reactive and proactive models). **Wandsworth**: All providers signed a Memorandum of Understanding. Delivery programmes include Urgent Community Response (UCR), intermediate care with a home-first approach, and Integrated Neighbourhood Teams. **Merton**: Piloted Frailty Front Door MDT; evaluation shared to inform future frailty pathway. Organisational Development with PPL Consultancy to formalise alliance model. Completed scoping for Integrated Acute Frailty Service with consultant input, aligned to SWL and national best practice. **Group wide collaboration & approach**: Scoping for Integrated Acute Frailty Service completed, identifying key development areas with frailty consultant input, aligned to SWL and national best practice. Established Communities of Practice with frailty consultants and operational teams across all sites. Joint workshops identified 2025/26 priorities: KPIs, workforce training, proactive care MDTs, community response, and Front Door Same Day Emergency Care (SDEC) model. **Performance & LOS Improvement**: Developed a unified LOS dashboard with standardised metrics and methodology. Group-level project plans for LOS in place and shared benchmarking support length of stay reduction. Aligned performance reporting approach with SWL to ensure consistency and transparency.	The upcoming NHS 10-Year Plan prioritises "neighbourhood health" and a shift of care from hospitals to the community. Potential for us to reframe this initiative and accord it higher priority. Re-procurement of Merton and Wandsworth community services also likely in coming years. Changing role of ICBs may mean we want to reposition ourselves in this space. There will be capacity implications. Work to date has been highly dependent on an interim PD and this resource/contract continuity are at risk.

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Initiative	Key accomplishments	Looking forward
Strengthening pecialised Services **Objectives:** **Objective 1:**Get gesh ready for devolution of specialised service budgets **Objective 2:** Strengthen the services we want to be renowned for. **Objective 3:** Improve oversight of our specialised service portfolio	**Devolution of specialised services**: System-level influence through active participation in SLOSS and collaboration with NHSE and ICBs in preparation for delegation of specialised commissioning; no financial risks identified. Risk and oversight framework developed to support proactive management of delegated services. **Strengthening of services**: Programme re-scoped following a light-touch review — now focused on strengthening Neurosciences, Major Trauma, Renal, Cardiac Surgery, and Children's services. Major Trauma: Future model of care defined; Cardiac Surgery: Theatre/care capacity expanded; recruitment and retention actions underway. Renal: Integration across the gesh progressing. Children's Services: Continued engagement with stakeholders in response to the paediatric cancer centralisation to Evelina. "Time for a Change" charity campaign launched—£2.5m raised; paediatric ward refurbishment starts June 2025. **Improved oversight**: Detailed SLAM, PLICS, and activity analysis completed to identify opportunities for service consolidation or networked models. Governance and delivery structures under review to ensure programme effectiveness and benefits realisation.	A South London review of specialised services is ongoing, and there may be opportunities to reconfigure services across South London, enabling us to focus on services where we are strongest – with patient and financial benefits. This could be brought into the development of SWL's ten year plan. However, our work to date to explore these opportunities has not identified large-scale opportunities whose benefits obviously outweigh the potential challenges of delivery. An exception may be paediatrics, where review of services across South London could align with the development of our wider gesh paediatric strategy.
High Performing Teams & Leaders **Objectives:** **Objective 1**: Support our teams to develop shared goals, linked to our strategy **Objective 2**: Support teams to use continuous improvement habits and tools against these goals **Objective 3**: Align our approach to performance	**HPT Framework Principles:** defined and delivery plans explored. **Engagement with stakeholders:** Engaged site leads and SGUH Deputy Chief Nurse to define priority focus areas and support ward transformation; HPT progress and operational excellence alignment discussed at Group exec away day. Implementation Plan developed and pilot engagement in wards underway **Ongoing Collaboration with NHS Elect** to refine engagement narrative and co-design a collaborative quality management system across GESH. **New Ways of Working Piloted** with positive early feedback, incorporating evidence-based practices and iterative learning. **Building capability and developing leaders**: CI and Improvement Practitioner courses delivered to multiple cohorts, with tailored sessions integrated into GESH leadership. Hundreds trained; CI Converge meetings in place to support peer learning and knowledge-sharing. CI team co-developed and integrated a CI module into the GESH Leadership Programme, now launched and aligned with HPT. Partnership confirmed with Royal Free to support the local "What Matters to You" initiative.	There are differences of view on the emphasis we should give to this programme in the current climate. We could see it as central to our financial recovery – empowering teams throughout the organisation to identify & reduce waste. Or we could take the view that we are in a world of asking staff to accept difficult decisions and that we need to focus our energy/investment/management bandwidth elsewhere.

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Initiative	Key accomplishments	Looking forward
Culture, diversity and inclusion **Objectives:** **Objective 1**: Implement sexual safety charter **Objective 2**: Develop and implement plan to tackle violence & aggression against staff **Objective 3**: Deliver our diversity & inclusion plan	**Sexual Safety Charter-** Sexual Safety Charter launched with eLearning available. Policy and toolkit in development for April 2025 launch. Anonymous reporting platform also in progress. **Tackling violence & aggression**: Draft policy developed and awaiting ratification. Psychological Safety audit tool launched. Operation Cavell: ongoing collaboration with Metropolitan Police to improve conviction rates for staff-targeted assaults and hate crimes. Civility and psychological safety embedded in all manager training. Working towards compliance with the Violence Prevention and Reduction (VPR) standard. Psychological safety featured as a core theme at the ESTH WRES conference **Delivery of EDI plan**: People Strategy now launched and robust governance groups in place to oversee delivery. Key policies are being refreshed, with the Gender Pay Gap report approved and new policies on Disability at Work and Menopause introduced. The EDI High Impact Action Plan has also been approved, supporting ongoing inclusion efforts.	Again there may be differences of views. How do we enable culture via a revised and shared set of values as a critical enabler to delivering our vision for 2028 (including financial recovery) – with the investment of change capacity / Executive bandwidth required? Or how do we continue our work on culture / D&I in a different way?
Shared electronic patient records across gesh **Objective:** Implement an EPR domain share for ESTH by May 2025.	New EPR went live on 9 May – with intensive work now underway to ensure stabilisation, management of emergent issues, etc.	A second phase of this programme offers a strategic opportunity to consolidate gains, embed the EPR into business-as-usual, optimise, and accelerate digital transformation across the Group. The national ten year plan will set out an agenda to shift the NHS 'from analogue to digital' In discussions to date at Board/with individual execs, there is an appetite for us to be more ambitious in this space – but also a recognition that we have significant resource constraints (capital, revenue, internal capacity). Integrating our IT services into a single Group-wide digital function (including to offer BAU support for the shared EPR) will be a key enabler

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Initiative	Key accomplishments	Looking forward
Transforming Outpatients **Objectives:** **Objective 1:** Redesign pathways with primary care, e.g. more advice & guidance for GPs. **Objective 2:** Offer more Virtual & telephone Clinics **Objective 3:** Expand use of Patient Initiated Follow-Up pathways	Collaborating with Site teams to oversee initiatives to 'Get the Basics Right' and align with Group-wide strategy. Regular engagement with primary care has improved **A&G utilisation**, with both sites consistently meeting NHSE targets. ESTH now enhancing referral tools and triage to support FU-to-new conversions. SGUH deployed A&G via Cerner for GPs and is piloting digital pathways in key areas to reduce follow-ups. Decision was made to shift from prioritising virtual telephone appointment to **DNA reduction**, however work done on increasing use of Attend Anywhere to reduce F2F appointment and use digital video platforms**.** SGUH's DNA rate is 9.1%, trending down toward the 8.6% peer average. Weekly specialty-level reviews are in place, with targeted strategies focused initially on the Top 10 specialties. ESTH has successfully lowered its DNA rate to 6.4%, ranking 3rd in London. Detailed analysis is underway to identify variations and plan to allow for 10% overbooking to improve utilisation is underway. **PIFU** to Discharge and PIFU to Longer Term Condition functionality now available to all specialities. All GIRFT specialties are now live with PIFU at SGUH and roll out to other specialities underway. PIFU automated onboarding and off boarding letters are now in place. Of 22 services, 14 PIFU Pathways now gone live. ESTH PIFU National target of 5% surpassed for the 3rd time in Nov 24 and currently at 4.7% as of March 25. **Group embracing Digital First approach;** prioritisation exercise has identified key deliverables that enables the positioning of gesh a leader in outpatient transformation across SWL. Key initiatives—including automation, digital patient communications, and addressing digital exclusion—are progressing from pilot to broader implementation and will drive delivery of quality and financial goals . Automation of outpatient coding now live in 2 specialties and business cases to enable the pilot of CLai for Ambient Voice Technology (AVT) and further robotic process automation (RPA) are in progress. **Clinical Engagement** to increase the use of the Patient Portal at SGUH has commenced and this will be extended to ESTH post Cerner implementation.	Potential to transform outpatient pathways using AI and digital tools, enabled by a shared EPR and underpinned by a coherent digital strategy. These, as well as the standardisation of pathways and consolidation of processes between sites could unlock efficiencies, enhance outcomes and deliver longer term benefits and financial savings (reflected in our financial recovery plan). The stocktake presents a potential opportunity to review how we set ourselves up to deliver these opportunities (e.g. to be clearer on group vs site responsibilities).

Group Board

Meeting in Public on Thursday, 03 July 2025

Agenda Item	2.2	
Report Title	**Group Board Assurance Framework: Q1 2025/26 Review**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Finance & Performance Committees	27 June 2025
	Quality Committees	26 June 2025
	People Committees	19 June 2025
	Infrastructure Committees	13 June 2025
	Group Executive Committee	24 June 2025
	gesh Risk and Assurance Group	28 May 2025
Purpose	**For Review**	

Executive Summary

This paper sets out the strategic risks on the Group Board Assurance Framework (BAF) as at Q1 2025/26 for consideration by the Group Board. It asks the Group Board to review the BAF as a whole, consider the proposed risk scores and assurance ratings at Q1 2025/26 and agree stretching but realistic target risk scores and assurance ratings for year end 2025/26.

The Group Board Assurance Framework (BAF) brings together the key risks identified by the Board in the delivery of the Group Strategy. In March 2024, the Group Board agreed 14 strategic risks on the BAF, each aligned to one of the four themes set out in the Group Strategy, *Outstanding Care, Together 2023-28*. Oversight of 11 of the 14 strategic risks are delegated to the relevant Committees of the Boards, with 3 strategic risks are reserved to the Group Board, all of which relate to Collaboration and Partnerships.

The Q1 2025/26 review of the BAF comes 16 months after the Group Board agreed the new Group BAF in March 2024, and just over two years following the publication of the Group Strategy. The Q1 review comes in the context of the Board undertaking a stocktake of the strategy, which presents an opportunity to review the strategic risks on the BAF as a whole. It also takes place in the context of significant changes in the Group's external environment – the imminent publication of the Government's NHS 10 Year Plan, changes to the architecture of the NHS at national level (with the abolition of NHS England) and system level (with the major changes to the structure and role of Integrated Care Boards). It also takes place against the backdrop of unprecedented financial challenges for the Group and the NHS as a whole, despite increases in NHS funding through the 2025 Spending Review, and the postponement by the Government of the Building Your Future Hospitals Programme. Internally, the Q1 review takes place in the context of ongoing work to improve quality governance, the external review of digital services, ongoing risks related to the estates across our sites, particularly at St Helier, and the Board's agreement to review the culture and high performing teams strategic initiatives and redefine these workstreams as 'critical enablers' of the Group strategy.

At Q1 2025/26, it is proposed that the risks on the BAF are maintained at their current positions – there are no proposed changes to any of the risk scores at this point. In some cases, even where we have made progress in implementing some of the mitigating actions we have identified which might otherwise warrant an improvement in the risk score, the changes external environment in some cases increase the underlying risk. So while the scores are static at Q1, this reflects a more nuanced position of progress in mitigating risks (in most cases) against a backdrop of an increasingly risky external environment.

In relation to the assurance ratings, there is one proposed change – increasing the assurance rating for SR11 (tackling health inequalities) from “limited” to “reasonable”.

In relation to target risk scores and target assurance ratings for year-end 2025/26, the proposal is to roll forward the targets from 2024/25, which were not achieved, as the targets for the current year. The exceptions to this are SR5 (estates), SR6 (digital), SR9 (improving patient safety) where the relevant Committees of the Board did not feel that it was realistic to propose a reduction in the risk score by the end of the year. The Committees did, however, propose stretching targets for all assurance ratings by year end.

In relation to the risks reserved to the Board, there are no proposed changes to risk scores or assurance ratings to SR1 (Working across the local system), SR2 (Working with our APC) or SR3 (Working across the gesh Group). The reasons for this are set out in the paper.

Action required by Group Board

The Group Board is asked to:

a) Note the recommendations relating to the risk scores and assurance ratings from the Committees of the Board for Strategic Risks 4-14
b) Review and agree the risk scores and assurance ratings for Strategic Risks 1-3 which are reserved to the Group Board
c) Agree the risk scores and assurance ratings for the Group BAF as a whole as at Q1 2025/26
d) Review and agree the proposed target risk scores and target assurance ratings for year-end 2025/26

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Group BAF: Overview (as at 30 June 2025)
Appendix 2	Group BAF: Full Strategic Risks

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				
Compliance with the Health and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006 (as amended), NHS System Oversight Framework, Code of Governance for NHS Providers.				
Equality, diversity and inclusion implications				
SR13 sets out the risks relating to EDI.				
Environmental sustainability implications				
N/A				

Group Board Assurance Framework: Q1 2025/26 Review
Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This paper sets out the strategic risks on the Group Board Assurance Framework (BAF) as at Q1 2025/26 for consideration by the Group Board.

1.2 The strategic risks on the BAF for which the Group Board has delegated oversight have been reviewed by the relevant Board Committees, as well as by the Group Executive Committee. The Group Board has reserved to itself oversight of the strategic risks related to collaboration and partnerships.

1.3 The paper asks the Group Board to review the BAF as a whole, consider the proposed risk scores and assurance ratings at Q1 2025/26 and agree stretching but realistic target risk scores and assurance ratings for year end 2025/26.

2.0 Background

2.1 The Code of Governance for NHS provider trusts (2023) requires boards to "establish procedures to manage risk, oversee the internal control framework, and determine the nature and extent of the principal risks the trust is willing to take to achieve its long-term strategic objectives" and to identify the principal risks to the delivery of the board's strategic objectives. To assist with this, all NHS provider organisations are required to have a Board Assurance Framework (BAF). The BAF is owner by the Board and is intended to be a key tool in supporting it to understand the strategic risks facing the organisation and the sources of assurance relating to the management and mitigation of these strategic risks.

2.2 A BAF brings together in one place principal risks the Board has identified to the delivery of its strategy. The BAF provides a structured approach to identifying and mapping the main sources of assurance and coordinating them to best effect. The BAF is distinct from operational risks arising from day-to-day activities which are typically identified 'bottom-up' by managers at various levels of the organisation, the highest rated of which are captured on each organisation's Corporate Risk Register. Decisions regarding the scoring of risks on the BAF, and to the escalation / de-escalation of risks, are for the Board, following review by the relevant Committee.

2.3 At gesh, the Group Board developed a Group-wide Board Assurance Framework through a series of Board development sessions in June 2023. This culminated in the agreement by the Group Board of 14 strategic risks to the delivery of the Group Strategy, *Outstanding Care, Together 2023-28*, . The strategic risks were agreed by the Group Board in November 2023, together with an agreed risk appetite for each strategic risk. The first full iteration of the new Group BAF was reviewed by the Group Board in March 2024. Of the 14 strategic risks on the Group Board Assurance Framework, 11 strategic risks are allocated to the relevant Committee of the Board as set out below, with the three strategic risks relating to collaboration and partnership reserved to the Group Board itself:

Committee	Strategic Risk
Finance & Performance	SR4: Achieving Financial sustainability SR8: Reducing Waiting Times
Infrastructure	SR5: Modernising our Estates SR6: Adopting Digital Technology
Quality	SR7: Developing New Treatments through Research and Innovation SR9: Improving Safety and Reducing Avoidable Harm SR10: Improving Patient Experience SR11: Tackling Health Inequalities
People	SR12: Putting Staff Experience and Wellbeing at the Heart of What We Do SR13: Fostering an Inclusive Culture that Celebrates Diversity SR14: Developing Tomorrow's Workforce

2.4 The strategic risks reserved to the Group Board are:

- SR1: Working across our local system
- SR2: Working with other hospitals through our Acute Provider Collaborative
- SR3: Working across the Group

2.4 Alongside agreeing the strategic risks on the Group Board Assurance Framework, in November 2023 the Group Board also agreed its risk appetite for each strategic risk on the BAF. The risk appetite helps the Board to understand which risks are currently at a level beyond its agreed appetite, the actions required to mitigate each risk to a level the Board is prepared to tolerate, and facilitate effective decision-making based on an understanding of where the Board is prepared to tolerate risks at a higher level and where it wishes to be more cautious.

3.0 Group Board Assurance Framework: Overview (as at 30 June 2025)

3.1 The Group Board will review the Group Board Assurance Framework on a quarterly basis throughout 2025/26. This report presents the position across all 14 of the Strategic Risks on the BAF as at Q1 2025/26, following review by the relevant Board Committees. The summary of the BAF risk scores and assurance ratings, together with the proposed 2025/26 target risk scores and assurance ratings and the agreed risk appetite is set out at Appendix 1. The full entries for each strategic risk on the BAF are set out at Appendix 2.

3.2 The Q1 2025/26 review of the BAF comes 16 months after the Group Board agreed the new Group BAF in March 2024, and just over two years following the publication of the Group Strategy. The Q1 review comes in the context of the Board undertaking a stocktake of the strategy, which presents an opportunity to review the strategic risks on the BAF as a whole (see section 7 below). The review also takes place in the context of significant changes in the Group's external environment – the imminent publication of the Government's NHS 10 Year Plan, changes to the architecture of the NHS at national level (with the abolition of NHS England) and system level (with the major changes to the structure and role of Integrated Care Boards). It also takes place against the backdrop of unprecedented financial challenges for the Group and the NHS as a whole, despite increases in NHS funding through the 2025 Spending Review, and the postponement by the Government of the Building Your Future Hospitals Programme. Internally, the Q1 review takes place in the context of ongoing work to improve quality governance, the external review of digital services, ongoing risks related to the estates across our sites, particularly at St Helier, and the Board's agreement to review the culture and high

performing teams strategic initiatives and redefine these workstreams as 'critical enablers' of the Group strategy.

3.2 For all strategic risks on the BAF, the controls, assurances, gaps in control, and mitigating actions have been reviewed at Q1 2025/26. At Q1 2025/26, it is proposed that the risks on the BAF are maintained at their current positions – there are no proposed changes to any of the risk scores at this point. In some cases, even where we have made progress in implementing some of the mitigating actions we have identified which might otherwise warrant an improvement in the risk score, the changes external environment in some cases increase the underlying risk. So while the scores are static at Q1, this reflects a more nuanced position of progress in mitigating risks (in most cases) against a backdrop of an increasingly risky external environment.

3.3 In relation to the assurance ratings, there is one proposed change – increasing the assurance rating for SR11 (tackling health inequalities) from "limited" to "reasonable".

3.4 The Group Board has previously agreed to set annual target risk scores which are intended to be stretching but realistic, with the purpose of focusing attention in-year on bringing the risks down to within the risk appetite agreed by the Group Board. The Committees have each agreed proposals on target risk scores and target assurance ratings for year-end 2025/26. Overall, these carry forward the target risk scores and assurance ratings from 2024/25, as these were not attained. However, there are some exceptions:

- The Infrastructure Committees agreed that it was unrealistic to set a target risk score for SR5 (estates) and SR6 digital lower than their current levels (25 for SR5 and 20 for SR6), as they did not consider a reduction in risk score in-year realistic given the scale of the risks and challenges.

- The Finance Committees agreed that it was unrealistic to set a target risk score for SR8 (reducing waiting times) lower than its current level (20) on account of the operational pressures and considered it unrealistic to set a target lower than the current level.

- The Quality Committees agreed that it was unrealistic to set a target risk score for SR9 (improving patient safety) lower than its current level (20) on account of the scale of the financial efficiencies facing the organisation, not withstanding the robust mechanisms to ensure CIPs did not adversely affect safety.

4.0 Strategic Risks Reserved to the Group Board: Collaboration and Partnerships

4.1 Our Group strategy sets out our overall strategic objectives in relation to collaboration and partnerships:

> *"To deliver improvements in quality of care while taking difficult decisions to make our services sustainable for the long term, we will play a leading role in integrating services around the needs of our patients. Our vision is that by 2028 gesh will be a driving force behind the most integrated health and care system in the NHS, and will be recognised as a national exemplar for integrated working – working with GPs, local government and community partners to keep people well in the community and avoid unnecessary trips to hospital, integrating services across the gesh Group, collaborating with other hospitals in south west London on shared services, elective recovery and financial sustainability, and working through regional networks to integrate our tertiary services with primary and secondary care."*

Strategic Risk 1: Working across our local systems

4.2 With these overall strategic ambitions for promoting working collaboratively with our partners, our strategy sets out our vision for how we will work with our local communities and local systems:

> *"As a Group we want to develop our role as an active collaborative partner in our local communities (Surrey Downs, Sutton, Merton and Wandsworth), contributing to improving the health of our local population and delivering more integrated care…Our vision for 2028 is that working together with partners, we will support people in our local communities through each phase of life – 'start well, live well and age well'…Our organisations will be an integral partner in the delivery of integrated models of care across primary, community, mental health and acute care, and these models of care will have a direct impact on improving the health of our local population, addressing health inequalities and making services sustainable for the long term. Beyond provision of services, we will also act as an 'anchor institution' playing our full role as part of the wider south west London anchor programme."*

4.3 Strategic Risk 1 (SR1) on the Group Board Assurance relates to this strategic objective of collaborating with our local systems. The risk description and current risk and assurance position on SR1 is set out below, and the full BAF entry for SR1 is set out in Appendix 3:

SR1: Working across our local systems	
Full Risk Description	*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.*

Current risk score	Target risk score 2024/25	Risk appetite	Current assurance rating	Target assurance rating 2024/25
16 (4c x 4l)	**12** (4c x 3l)	**Cautious (Moderate) 8-9**	**Reasonable**	**Good**

4.4 Update on SR1 controls, assurances, gaps and actions:

- Since the last review of SR1 by the Group Board, a review of the controls currently in place has been undertaken to ensure these accurately reflect the control environment relating to the strategic risk as defined by the Board.

- There are a number of emerging risks and opportunities. Opportunities include: the leftward shift announced by the Government, moving care from hospitals to communities given the strengths of the gesh Group in relation to Sutton Health and Care and Surrey Downs Health and Care; the focus on neighbourhood health; the changes to the structure and roles of ICBs set out in the model ICB blueprint; and the opportunities afforded by the SWL clinical review. At the same time, some of these opportunities are also risks, particularly the changes to ICBs.

- 7 gaps in control are identified, the most significant of which relate to: working through how the Group works most effectively at Place, especially in Merton and Wandsworth; strengthening collaborative working relationships with local authorities; developing a model

for engagement with integrated neighbourhood working; developing a gesh frailty service drawing on the strengths of ESTH; and developing a SWL primary care strategy.

- In terms of mitigating actions, a memorandum of understanding for the Wandsworth Provider Alliance has been concluded. A further 8 actions to address gaps in control have been identified, with some of these requiring target completion dates.

4.5 Risk score: The current risk score for SR1 is 16, measured as a score of 4 for impact, and 4 for likelihood. Despite progress, the recommendation is to hold the risk score at the current rating at Q1 2025/26. This is on the basis that significant actions to mitigate the risk are currently in progress but not yet scheduled for completion. The risk score of 12 remains above the risk appetite agreed by the Board, set as "cautious" (10-12).

4.6 Assurance rating: The current assurance rating for SR1 is "reasonable" and there is no proposed change to this for Q1 2025/26, though the changes in the Group's external operating environment present opportunities and risks which could have implications for the assurance rating over the coming months.

4.7 Target risk scores and assurance ratings: The target risk score for SR1 for 31 March 2025 was to reduce the risk score from 16 to 12 and increase the assurance rating from "reasonable" to "good". This was not attained by the end of 2024/25.

Strategic Risk 2: Working with other hospitals through our Acute Provider Collaborative

4.8 In relation to working with the South West London Acute Provider Collaborative, the strategy sets out our vision for 2028:

> *"We see significant further opportunity to collaborate with other hospitals in south west London, and our aspiration is that the gesh Group, constituting two of the 4 trusts in south west London, can help accelerate the delivery of these opportunities. Our vision is that: through the leadership of our clinical networks, we deliver a shared best-practice model of care, to the same high standard, across south west London; through a shared understanding of hospital capacity and patient demand, we ensure patients across south west London are seen and treated in the right place, at the right time, and by the right clinicians – equalising and driving down waiting times across our region, and maximising the number of patients that we are able to treat within south west London…; we build on our success to date in delivering elective care from dedicated elective centres and facilities (such as those we currently have at Epsom Hospital and Queen Mary's Roehampton), where elective procedures are not at risk of being cancelled to make way for emergency cases; our patients increasingly have access to diagnostics in the community, through a range of Community Diagnostic Centres and Hubs developed across south west London; we deliver a growing range of joint clinical support services and joint corporate functions, building on successes to date such as South West London Pathology, the South West London Procurement Partnership and the South West London Recruitment Hub."*

4.9 Strategic Risk 2 (SR2) on the Group Board Assurance relates to this strategic objective of working with other hospitals across the SWL Acute Provider Collaborative. The risk description and current risk and assurance position on SR2 is set out below, and the full BAF entry for SR2 is set out in Appendix 3:

SR2: Working with other hospitals through our Acute Provider Collaborative	
Full Risk Description	*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	Target risk score 2024/25	Risk appetite	Current assurance rating	Target assurance rating 2024/25
12 (4c x 3l)	**8 (4c x 2l)**	**Open (High) 10-12**	**Good**	**Good**

4.10 Update on SR2 controls, assurances, gaps and actions:

- Since the last review of SR2 by the Group Board, a review of the controls currently in place has been undertaken to ensure these accurately reflect the control environment relating to the strategic risk as defined by the Board.

- 6 gaps in control are identified, the most significant of which relate to: development of a medium-to-long term APC strategy, clarifying arrangements for ICB oversight, agreeing clear outputs from established networks across the APC, and clarifying APC working in the context of the gesh Group.

- 7 actions are identified to mitigate the risk. 3 actions are overdue which relate to the medium-to-long term APC strategy, the outputs from networks across the APC, and delivery of the PACS programme. Work on developing the specification and business case for ambient AI across SWL is on track. Timelines for the following actions which have been added to the BAF from the work on the corresponding strategic initiative are being reviewed: reviewing opportunities for collaboration to reduce 52-week waits in dermatology, gastroenterology and gynaecology; and strengthening the APC partnerships hosted by gesh.

4.11 Risk score: The current risk score for SR2 is 12, measured as a score of 4 for impact, and 3 for likelihood. No changes are proposed for Q1 2025/26. This is on the basis that mitigating actions require further development and clarification on timelines. The risk score of 12 is within the risk appetite agreed by the Board for risks relating to working with the APC.

4.12 Assurance rating: The current assurance rating for SR2 is “good” in the context of the controls already in place, and there is no proposed change to this for Q1 2025/26.

4.13 Target risk scores and assurance ratings: The target risk score for SR2 for 31 March 2025 was to reduce the risk score from 12 to 8 and maintain the assurance rating as “good”. The reduction in risk score was not attained by the end of 2024/25. The proposal is to roll forward the targets to year end 2025/26.

Strategic Risk 3: Working across the gesh Group

4.14 In relation to collaboration across our gesh Group, the strategy sets out our vision for 2028:

> *“Having come together as a Group, a key part of our strategy for the coming five years will be to seize the opportunities that Group working brings. Our vision is that: we will build on the strengths of both trusts, so that patients experience the same high standard of care, no matter which hospital they attend or where in our catchment area they come*

from; our trusts will play complementary roles in the local NHS's offer to patients, rather than seeking to compete with one another – with our acute hospital services and the community services we host offering a joined up service to patients; our patients will be able to move seamlessly from one hospital to another in order to access specialist care or faster treatment; we will increasingly act as 'one workforce', with more joint roles, joint training, staff able to rotate across sites, and the development of new roles across the Group – enabling us to offer improved outcomes for our patients, and a richer set of career opportunities for our staff; our IT systems will underpin this collaboration, with our staff able to seamlessly access and share electronic patient information to improve the care we offer; we will make best use of our collective infrastructure, delivering maximum value for patients from the assets available to us; by sharing corporate functions, we will deliver economies of scale, enabling us to invest more into patient care."

4.15 Strategic Risk 3 (SR3) on the Group Board Assurance relates to this strategic objective of collaborating across the gesh Group. The risk description and current risk and assurance position on SR3 is set out below, and the full BAF entry for SR3 is set out in Appendix 3:

SR3: Working across the gesh Group	
Full Risk Description	*If we do not harness the full benefits of collaboration and integration across our Group and capitalise on our strengths, then we will be less than the sum of our parts, fail to keep pace with improving standards and face challenges in retaining the breadth of services for the benefit of our local communities, resulting in unwarranted variation in care and poorer outcomes for patients.*

Current risk score	Target risk score 2024/25	Risk appetite	Current assurance rating	Target assurance rating 2024/25
20 (5c x 4l)	**15** (5c x 3l)	**Open (High) 10-12**	**Limited**	**Reasonable**

4.16 Updates since the last review of SR3: Since the Group Board last reviewed SR3 in January 2025, there have been a number of developments which are relevant to the Board's consideration of this risk:

- A new Group Accountability Framework has been developed and was agreed by the Group Board in February 2025.
- A Group Roadmap has been developed, which provides a framework for approaching the integration of clinical services across the Group – with services adopting different models of integration depending on their nature.
- A new framework for the development and management of Group-wide policies has been agreed by the Group Executive Committee and Audit Committee, and there have been a number of Group-wide policies agreed over recent months, replacing previous trust-based policies and providing a single policy approach across the Group.
- In relation to the integration of corporate services, the following services across the two trusts have now been brought together into single Group-wide functions, releasing savings to frontline clinical teams and ensuring that corporate functions are designed to support the Group effectively: Corporate Affairs, Communications, Deputy Chief Executive's Office (strategy, project management office, continuous improvement); Corporate Nursing; and Corporate Medical. The integration of corporate functions in HR and Estates and Facilities have commenced. Finance and Digital are yet to begin the process of integration.

- The Group Executive has now received the report of the external review of digital services, which provides recommendations on how the Group-wide digital function should be structured so as to support our ambitions to come together as a Group.

- The Board has agreed to review the strategic initiatives relating to culture and high performing teams and to reframe them as 'critical enablers' of the delivery of the strategy, with the Executive scheduled to hold a workshop to work through this in September.

- A Group-wide surgery strategy and a Group-wide paediatrics strategy are currently in development, following the agreement of a Group-wide pharmacy strategy by the Board in 2024.

4.17 Update on SR3 controls, assurances, gaps and actions:

- Since the last review of SR3 by the Group Board, a review of the controls currently in place has been undertaken to ensure these accurately reflect the control environment relating to the strategic risk as defined by the Board. These changes focus on ensuring that the controls are specific and tailored to the risk, as defined by the Group Board.

- The following new controls have been put in place:

  i. Group Accountability Framework agreed
  ii. Framework for Group-wide policies agreed
  iii. New Group-wide Risk Management Framework agreed

- 6 gaps in control are identified, the most significant of which relate to: the development of new strategies on digital, estates, and research and innovation; concluding the integration of corporate services; and developing digital services to support Group-wide integration.

- A further 3 actions to address gaps in control have been completed since the last review of the BAF: (i) Group Accountability Framework; (iii) Framework for Group-wide policies; (iii) Group Roadmap. Four actions are overdue: (i) Corporate Services Integration; (ii) Developing the remaining supporting strategies in digital, estates, and research; (iii) approval of the Group surgery strategy; and (iv)approval of the Group paediatrics strategy. The timescales for the action related to the alignment of digital services remains to be defined and receipt of the external review of digital will enable a due date to be set. The action relating to reviewing the two trusts' standing orders, scheme of reservation and delegation of powers, and standing financial instructions remains on course for bringing to the Group Board in November 2025.

4.18 Risk score: The current risk score for SR3 is 20, measured as a score of 5 for impact, and 4 for likelihood, reflecting the impact of effective collaboration across the Group in being able to deliver on our Group strategy. Despite progress in a number of areas, the recommendation is to hold the risk score at the current rating at Q1 2025/26. This is on the basis that significant actions to mitigate the risk are currently in progress but not yet scheduled for completion, the most notable of which include: the conclusion of corporate services integration, progress in integrating clinical services, and being able to evidence how the benefits of the Group have been realised. The risk remains above the risk appetite agreed by the Board, set as "open" (10-12).

4.19 Assurance rating: The current assurance rating for SR3 is "limited" and there is no proposed change to this for Q1 2025/26. This reflects the position in relation to corporate services integration progress by the People Committee.

4.20 Target risk scores and assurance ratings: The target risk score for SR3 for 31 March 2025 was to reduce the risk score from 20 to 15 and increase the assurance rating from "limited" to "reasonable". This was not attained by the end of 2024/25. It is proposed to roll these targets forward to year end 2025/26, which is considered stretching but realised on the basis that a number of the mitigating actions are due for completion during the course of 2025/26.

5.0 Strategic Risks Overseen by Board Committees

5.1 The Group board agreed to delegate to the relevant Board Committees oversight of Strategic Risks 4 to 14. All of these risks have been reviewed by the relevant Committee during the course of June 2025.

5.2 A summary of the outcome of each Committee's review of the strategic risks within its remit is set out below

Finance and Performance Committee:

- The Committee reviewed the two strategic risks within its remit at its meeting on 27 June 2025, SR4 (financial sustainability) and SR8 (reducing waiting times).

Risk	Q1 25/26 risk score	Proposed target risk score 25/26	Board-agreed Risk appetite	Q1 2025/26 assurance rating	Proposed Target assurance 25/26
SR4	25 (5c x 5l)	25 (5c x 5l)	Cautious (Moderate) 8-9	Limited	Reasonable
SR8	20 (5c x 4l)	20 (5c x 4l)	Open (High) 10-12	Limited	Reasonable

- In relation to SR4, the Committee considered that in light of the unprecedented financial challenges facing the Group and the wider NHS, the degree of risk in the delivery of the two trusts' financial plans, and the need for system-wide action to address the structural issues driving the financial position of South West London, the risk score should be maintained at the maximum risk score of 25, with an assurance rating of limited. The risk score remained significantly above the Board's agreed risk appetite for financial risk, which was set as "cautious" (8-9). The Committee agreed to recommend to the Group Board that the target risk score (20) and assurance rating (reasonable) from 2024/25 be rolled forward to year end 2025/26.

- In relation to SR8, the Committee considered that the current risk score of 20 should be retained, alongside the current assurance rating of limited, on the basis of the continuing operational pressures, particularly in terms of emergency department, flow and discharge. The risk score remained significantly above the Board's agreed risk appetite for operational risks, which was set as "cautious" (8-9). The Committee agreed to recommend to the Group Board that the target risk score (20) and assurance rating (reasonable) from 2024/25 be rolled forward to year end 2025/26.

Infrastructure Committee:

- The Committee reviewed the two strategic risks within its remit at its meeting on 13 June 2025, SR5 (modernising our estates) and SR6 (adopting digital technology).

Risk	Q1 25/26 risk score	Proposed target risk score 25/26	Board-agreed Risk appetite	Q1 2025/26 assurance rating	Proposed Target assurance 25/26
SR5	25 (5c x 5l)	25 (5c x 5l)	Open (High) 10-12	Limited	Reasonable
SR6	20 (4c x 4l)	20 (5c x 3l)	Open (High) 10-12	Limited	Reasonable

- SR5 – Modernising our Estate: The Committee agreed to propose that the current maximum risk score of 25 be retained at Q1 2025/26, alongside an assurance rating of partial, in the context of the postponement of the Building Your Future Hospitals Programme, the consequent need to manage extreme estates risks on the St Helier site over a considerably longer period, and the knock-on effect of the BYFH delay on the consolidation of renal services at St George's. The risk score remained significantly above the Board's agreed risk appetite for estates risks, which was set as "open" (10-12). The Committee agreed to recommend to the Group Board that the target risk score (20) from 2024/25 was not realistic to set for year end 2025/26, given the scale of the estates challenges and the Committee agreed that the current risk score (25) be set as the only realistic target for March 2026. However, it did agree to that the 2024/25 target assurance rating (reasonable) be rolled forward to year end 2025/26.

- SR6 - Adopting Digital Technology: The Committee considered that the current risk score of 20 and current assurance rating of "limited" remained appropriate at Q1 2025/26. The implementation of the shared Electronic Patient Record system was a very significant step forward. However, in the context of the external review of digital services, which was received by the Group Executive in late June 2025, and the work needed to implement the changes recommended, it would not be appropriate to lower the risk score or increase the assurance rating at the present time. The risk score remained significantly above the Board's agreed risk appetite for digital risks, which was set as "open" (10-12). The Committee agreed to recommend to the Group Board that the 2024/25 target risk score (15) was unrealistic to proposed for year end 2025/26, and agreed that the current score of 20 be set as the only realistic score for March 2026 given the scale of the challenges in IT. However, it agreed to recommend that the 2024/25 target assurance rating (reasonable) be rolled forward to year end 2025/26.

Quality Committee:

- The Committee reviewed the four strategic risks within its remit at its meeting on 26 June 2025, SR7 (research and innovation), SR9 (improving patient safety and reducing avoidable harm), SR10 (improving patient experience), and SR11 (tackling health inequalities).

Risk	Q1 25/26 risk score	Proposed target risk score 25/26	Board-agreed Risk appetite	Q1 2025/26 assurance rating	Proposed Target assurance 25/26
SR7	16 (4c x 4l)	12 (4c x 3l)	Seek 15-25	Limited	Reasonable
SR9	16 (4c x 4l)	12 (4c x 3l)	Minimal (Low) 4-6	Limited	Reasonable
SR10	16 (4c x 4l)	12 (4c x 3l)	Minimal (Low) 4-6	Limited	Reasonable

Risk	Q1 25/26 risk score	Proposed target risk score 25/26	Board-agreed Risk appetite	Q1 2025/26 assurance rating	Proposed Target assurance 25/26
SR11	16 (4c x 4l)	12 (4c x 3l)	Open (High) 10-12	Reasonable	Reasonable

- SR7 - Developing treatments through research and innovation: The Committee agreed to propose that the current risk score of 12 be retained at Q1 2025/26, alongside the current assurance rating of "reasonable". This was on the basis that while progress has been made on the integration of research functions across the Group, further mitigating actions are required to reduce the risk score. We would expect to see the risk score reduce following: (i) the completion of alignment of research activities across the Group; (ii) tangible progress in developing the strategic partnership between gesh and City St George's; and (iii) the agreement of a Group-wide research and innovation strategy to provide a framework for driving forward the research agenda for gesh. These would reduce the likelihood score, and potentially the impact score as well. The current risk score remained within the Board's agreed risk appetite for risks related to research and innovation set as "seek" (15-25). The Committee agreed to propose that the 2024/25 target risk score (8) and assurance rating (good) be rolled forward to year end 2025/26.

- SR9 - Improving patient safety and reducing avoidable harm: The Committee agreed to propose that the current risk score of 20 be retained at Q1 2025/26, alongside an assurance rating of "limited". This was on the basis that significant actions to mitigate the risk are currently in progress but not yet scheduled for completion, the most notable of which include: (i) implementation of the new quality governance improvement plan (which is scheduled for full implementation by the end of Q1 2026/27); (ii) full implementation of the maternity improvement plan (the final actions are scheduled for completion in November 2025). The score also reflects the scale of the financial pressures on the two Trusts within the Group; while the QIA process ensures that safety is maintained and is not compromised through CIP delivery, delivering financial savings does have an impact on the ability of the organisation to deliver improvements in quality, and indeed can involve difficult decisions that might impact quality in some cases, albeit with careful risk assessment in place. The risk score remained above the Board's agreed risk appetite for risk related to patient safety, which was set as "minimal" (4-6). The Committee considered that in the context of the current financial challenges, it was not realistic to roll forward the 2024/25 target risk score (15) for year end 2025/26, however, it did agree to roll forward the target assurance rating of "reasonable".

- SR10 - Improving patient experience: The Committee agreed to propose that the current risk score of 16 and assurance rating of "limited" be retained at Q1 2025/26. The risk remains above the risk appetite agreed by the Board (Minimal – Low: 4-6)

- In relation to SR11 (tackling health inequalities), the Committee considered whether a reduction in the risk score could be considered in the context of the progress that has been achieved since this risk was first agreed by the Group Board in March 2024 in developing a programme of work to focus on and address health inequalities. However, on balance it regarded a reduction in the risk score as premature at this stage and agreed to propose that the current risk score of 16 be retained at Q1

2025/26. However, it agreed that the progress made since the BAF was agreed in March 2024 meant that it would be appropriate to increase the assurance rating from "limited" to "reasonable". The risk currently remains above the Board's risk appetite for risks relating to health inequalities, set as open" (10-12). The Committee agreed to recommend that the 2024/25 target risk score (12) be rolled forward for year end 2025/26 with the realistic target assurance rating of "reasonable".

People Committee:

- The Committee reviewed the three strategic risks within its remit at its meeting on 19 June 2025, SR12 (staff wellbeing), SR13 (culture and diversity) and SR14 (developing tomorrow's workforce).

Risk	Q1 25/26 risk score	Proposed target risk score 25/26	Board-agreed Risk appetite	Q1 2025/26 assurance rating	Proposed Target assurance 25/26
SR12	**16** (4c x 4l)	**12** (4c x 3l)	**Cautious (Moderate) 8-9**	**Limited**	**Reasonable**
SR13	**16** (4c x 4l)	**12** (4c x 3l)	**Cautious (Moderate) 8-9**	**Limited**	**Reasonable**
SR14	**16** (4c x 4l)	**12** (4c x 3l)	**Cautious (Moderate) 8-9**	**Limited**	**Reasonable**

- SR12 - Putting staff experience and wellbeing at the heart of what we do: The Committee agreed to propose that the current risk score of 20 and assurance score of "limited" be retained at Q1 2025/26. This was on the basis that while a number of good controls are in place, there remain a number of gaps in control for which mitigating actions are not yet in place, most notably in relation to leadership development and capacity, core processes, and lack of an agreed Group approach to continuous improvement. This was also on the basis of the Group Board agreeing that the high performing teams and culture strategic initiatives needed to be rethought, in part due to a lack of progress in delivery. The risk score remains above the risk appetite agreed by the Board, set as "cautious" (8-9). The Committee agreed to propose that the 2024/25 target risk score (16) and target assurance rating (reasonable) be rolled forward to year end 2025/26.

- SR13 - Fostering an inclusive culture that celebrates diversity: The Committee agreed to propose to the Board that the current risk score (20) and assurance rating (limited) be retained at Q1 2025/26. This is on the basis that while there had been important progress in relation to the development of an EDI plan, the agreement of a new talent strategy, the agreement of a new Group-wide Freedom to Speak Up policy, and in the context of significantly improved engagement scores through the 2024 NHS Staff Survey, the scale of the work required to strengthen the culture of the organisations and diversify senior leadership, alongside the work required to redefine the culture strategic initiative, meant that it would be premature to reduce the risk score or increase the assurance rating at this stage. The risk remains significantly above the Board's agreed risk appetite for people related risks, set as "cautious" (8-9). The Committee agreed to propose that the target risks score (16) and target assurance rating (reasonable) from 2024/25 be rolled forward to year end 2025/26.

- SR14 - Developing tomorrow's workforce: The Committee agreed to propose that the current risk score of 20 and assurance rating of "limited" be retained at Q1 2025/26. The risk remains significantly above the Board's agreed risk appetite for people related risks, set as "cautious" (8-9). The Committee agreed to propose that the target risks score (16) and target assurance rating (reasonable) from 2024/25 be rolled forward to year end 2025/26.

6.0 Board and Committee oversight of the BAF and Corporate Risk Registers

6.1 In March 2025, the Group Board approved a new Group-wide risk management policy and risk escalation framework, following review by the Audit Committees-in-Common. The new policy establishes a robust and consistent framework for identifying, scoring, assessing, managing, escalating and monitoring both clinical and non-clinical risks across the Group. It replaces the previous Trust-based risk management policies.

6.2 As part of the new risk management framework, the Executive has established a new gesh Risk and Assurance Group, as a sub-group of the Group Executive Committee. The gesh Risk and Assurance Group is the main Executive governance forum for overseeing the management of risk across the Group and is responsible for: overseeing the integrity and effectiveness of the Group's risk management arrangements; overseeing the implementation of the risk management policy and risk appetite as agreed by the Group Board; ensuring that appropriate processes are in place to identify, treat and escalate risk and ensure risks are defined and managed in a consistent way across the Group; ensuring risk management is integrated effectively into the governance of the Group at every level, including at Group, Site, Divisional and Directorate level; providing assuring to the Executive that risks at the corporate, site and divisional levels have undergone effective and rigorous check and challenge; promoting an open, anticipatory and proactive risk-aware culture; horizon scanning for new and emerging risks; and providing a forum for effective risk management across the Group. The gesh Risk and Assurance Group reviews the Group Board Assurance Framework, the Corporate Risk Registers of the two Trusts within the Group, and high and extreme risks across the sites and corporate services. It also considers recommendations for escalation of risks to, or de-escalation of risks from the Corporate Risk Registers by the Sites and Corporate Services. The gesh Risk and Assurance Group met for the first time on 28 May and will meet monthly.

6.2 Alongside strengthening the Executive oversight of risk management, the role of Board Committees is also being strengthened in relation to risk. The Audit and Risk Committee has also been strengthened in relation to its oversight of risk. While the Committee already reviews the annual internal audits of risk management at both Trusts and reviews the risk management policies, from September 2025 the Audit and Risk Committees will receive reports from the gesh Risk and Assurance Group, alongside the Corporate Risk Registers of both Trusts and the Group BAF. It will also undertake a rolling programme of deep dives on risk to review significant risks across the Group. Other Board Committees already review the strategic risks on the BAF, but from September 2025 will receive risk reports on the Corporate Risk Register risks and other significant risks within each Committee's remit. Starting this from September will help to ensure that the risks have been appropriately scrutinised at Site and Executive level prior to presenting to Board Committees.

6.3 In line with NHS England's guidance on the Insightful Board, published in December 2024, the Group Board will receive the Group Board Assurance Framework on a quarterly basis at the following meetings during 2025/26:

Quarter	Board meeting	Committee review
Q1 2025/26	July 2025	June 2025
Q2 2025/26	November 2025	October 2025
Q3 2025/26	January 2026	December 2025
Q4 2025/26	May 2026	April 2025

7.0 Refreshing the Group Board Assurance Framework

7.1 The Group Board Assurance Framework was developed by the Board through a series of Board development sessions in 2023, following the approval of the Group Strategy in April 2023. The new BAF was agreed by the Group Board at its meeting in March 2024.

7.2 As set out in the strategy stocktake paper at agenda item 2.1, there have been very significant changes in the Group's external operating environment since the strategy was agreed in April 2023. The Group Board, at its development session in June 2025 which took stock of the strategy, provided a steer that, overall, the strategy itself remained an appropriate vision for the Group, and that a redrafted strategy was not required. However, there was a recognition that a number of factors would likely make 2025/26 a year of transition, most notably the imminent publication of the Government's NHS 10 Year Plan, South West London Integrated Care Board's decision to develop a system-wide clinical strategy, as well as the changes to the functions and form of ICBs and the evolving financial context. Although the Board indicated a new or redrafted strategy was not required until all partners across the SWL system had agreed their collective aspirations, it is clear that as the external environment has evolved, so too have the risks to the delivery of the strategy.

7.3 As a result, and in keeping with good risk management practice, it is proposed that a refresh of the strategic risks on the Group Board Assurance Framework is undertaken over the coming months to ensure that the risks defined by the Board to the achievement of its strategic objectives remain appropriate. This will involved relooking at the risks themselves, not only the risk scores and assurance ratings. As part of this, there is an opportunity to reflect on the overall number and shape of the risks on the Group BAF. The intention would be to develop any changes to the BAF ahead of a discussion about reframed strategic risks at the October Board development session.

7.4 Also in line with good risk management practice, it is proposed that, alongside the review of the strategic risks on the BAF, the Board reviews and refreshes its risk appetite statement. This is important to undertake on an annual basis, and even more so in the context of the significant changes in the external environment since the Board last agreed its risk appetite in November 2023.

8.0 Recommendations

8.1 The Group Board is asked to:

a) Note the recommendations relating to the risk scores and assurance ratings from the Committees of the Board for Strategic Risks 4-14
b) Review and agree the risk scores and assurance ratings for Strategic Risks 1-3 which are reserved to the Group Board
c) Agree the risk scores and assurance ratings for the Group BAF as a whole as at Q1 2025/26
d) Review and agree the proposed target risk scores and target assurance ratings for year-end 2025/26

Appendix 1: Group Board Assurance Framework – Overview (as at 30 June 2025)

Strategic Objective	Strategic Risk	Summary risk description	Board level oversight (Committee)	Executive lead	Current Risk Score (May 25)	Proposed target Risk Score (Mar 26)	Agreed Risk Appetite	Current assurance rating	Proposed target Assurance rating (Mar 26)
Collaboration & Partnerships	SR1	Working across our local system	Group Board	GCEO	16	12	Cautious 8-9	Reasonable	Good
	SR2	Working with other hospitals through our Acute Provider Collaborative	Group Board	GCEO	12	8	Open 10-12	Good	Good
	SR3	Working across the Group	Group Board	GCEO	20	15	Open 10-12	Limited	Reasonable
Affordable services fit for the future	SR4	Achieving financial sustainability	Finance & Performance	GCFO	25	20	Cautious 8-9	Limited	Reasonable
	SR5	Modernising our estate	Infrastructure	GCFIEO	25	25	Open 10-12	Limited	Reasonable
	SR6	Adopting digital technology	Infrastructure	GCTO	20	20	Open 10-12	Limited	Reasonable
	SR7	Developing new treatments through research and innovation	Quality	GCMO	12	8	Seek 15-25	Reasonable	Good
Right Care, Right Place, Right Time	SR8	Reducing waiting times	Finance & Performance	Site MDs	20	20	Cautious 8-9	Limited	Reasonable
	SR9	Improving safety and reducing available harm	Quality	GCMO & GCNO	20	20	Minimal 4-6	Limited	Reasonable
	SR10	Improving patient experience	Quality	GCMO & GCNO	16	12	Minimal 4-6	Limited	Reasonable
	SR11	Tackling health inequalities	Quality	GCMO	16	12	Open 10-12	Reasonable	Reasonable
Empowered, Engaged Staf	SR12	Putting staff experience and wellbeing at the heart of what we do	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable
	SR13	Fostering an inclusive culture that celebrates diversity	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable
	SR14	Developing tomorrow's workforce	People	GCPO	20	16	Cautious 8-9	Limited	Reasonable

Strategic Risk	SR1	Working across our local systems

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.*

Current Risk Score: 16

Assurance: Reasonable

Strategic objective	Collaboration and Partnerships
Last review date	03 July 2025
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Cautious (Moderate)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jul-25	4	4	16	Reasonable
Target	Mar-26	4	3	12	Good

Change since last review: ⟺

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	16	16	16	16								

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

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

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Working though how the Group works most effectively at Place, building on how effectively it operates at system level
2	Strengthening collaborative working relationships with local authorities
3	Strengthening partner relationships
4	Need to develop a model for engagement with integrated neighbourhood working
5	Need to develop a gesh frailty service
6	Development of SWL primary care strategy
7	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**
• Changes to the structure and capacity of ICBs in the Model ICB Blueprint •	• Leftward Shift priority announced by Govt and expected in NHS 10 Year Plan • Focus on neighbourhood health • Changes to the structure and capacity of ICBs in the Model ICB Blueprint • Opportunity to place more of a role at Place in Wandsworth and Merton • SWL ICB clinical review

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 Wandsworth Provider Alliance Memorandum of Understanding signed by all providers	MD-IC	Mar-25	Completed
2	Put in place clear processes to ensure structured feedback from ICBs into Group Executive and Board	GCEO	Mar-25	On Track
3	Develop gesh model of engagement for integrated neighbourhood working including proactive care MDT in Merton and Wandsworth	MD-IC / MD-SGUH	Dec-25	On Track
4	Strengthen Partner relationships and Alliance model across Merton through Alliance organisational development	MD-IC / MD-SGUH	Dec-25	On Track
5	Develop gesh integrated frailty services that align to national best practice	MD-IC	TBC	TBC
6	Agree delivery strategy against 2025/26 Frailty Community of Practice priorities	MD-IC	TBC	TBC
7	Agree 2025/26 Length of Stay Community of Practice	MD-IC	TBC	TBC
8	Develop benefits realisation framework for Integrated Care programme	MD-IC	TBC	TBC

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

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

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

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

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

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

Current Risk Score: 12

Assurance: Reasonable

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

Strategic objective	Collaboration and Partnerships
Last review date	03 July 2025
Monitoring Committee	Group Board
Lead Executive	Group Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	4	4	16	Limited
Current	Jul-25	4	3	12	Reasonable
Target	Mar-26	4	2	8	Good

Change since last review

⟺

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-27	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	12	12	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	Governance structure for the APC established	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	Group CEO is lead CEO of the South West London Acute Provider Collaborative	3	Updates from APC presented to Executive team	Reasonable	Second - Management
4	Formal SWL APC partnerships in place for recruitment, orthopaedics, procurement, pathology	4	Review of key performance metrics of APC partnerships through the Site, Executive and relevant Board Committees	Reasonable	Second - Management
5	Agreed set of SWL APC priorities in place for 2023/24	5	Delivery overseen by APC Board	Reasonable	Second - Management
6	A range of elective programmes and clinical networks in place across the SWL APC covering elective recovery, outpatients and diagnostics	6	Delivery overseen by APC Board	Reasonable	Second - Management
7	APC Programme Director in place (new appointment from March 2025)	7	Regular meetings with GCEO and updates provided to Executive	Reasonable	Second - Management
8	Established collaborative partnerships: SWL Recruitment, SWL Procurement, SWLEOC, SWL Pathology	8	Reporting integrated into performance reports to Committees and Group Board	Reasonable	Second - Management
9	System-wide clinical networks: cardiology, neurology, radiology in place	9	Reporting through relevant reports to Committees and Group Board	Reasonable	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Need to develop a medium-to-long term APC strategy
2	Need to clarify arrangements for ICB oversight
3	Need for clear outputs from established networks across the APC
4	Need to clarify APC working in the context of the gesh Group
5	Opportunity to explore 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**
• Impact of changes to ICBs	• Priorities set out in the NHS 10 Year Plan

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	Overdue
2	Define clear outputs from the networks established across the APC	GCEO	Dec-24	Overdue
3	Deliver the SWL-wide PACS programme and agreed forward programme for PACS with provider	GCTO	Sep-24	Overdue
4	Finalise specification and business case for Ambient AI	GCTO	Sep-25	On Track
5	Review opportunities for collaboration to reduce 52 week waits in dermatology, gastroenterology and gynaecology	GCTO	TBC	TBC
6	Strengthen APC partnerships hosted by gesh	GCTO	TBC	TBC
7	Developing SWL model of surgical hubs with APC support	GCEO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
No specific related risks relating to the APC on the CRR			

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

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

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

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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	03 July 2025
Monitoring Committee	Group Board
Lead Executive	Group Deputy Chief Executive Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Jan-24	5	5	25	Limited
Current	Jul-25	5	4	20	Limited
Target	Mar-26	5	3	15	Reasonable

Change since last review

Risk Score	Mar-24	Jun-25	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	Group-wide strategy in place and approved by Boards, with People strategy, Quality strategy, Green Plan approved by Group Board
2	9 strategic initiatives agreed with Executive leads for each identified, and governance of the initiatives agreed by the Group Board
3	MoU and Information Sharing Agreement in place to support the development of the Group
4	Group Accountability Framework developed and approved by the Group Board
5	Group governance arrangements established at Board, Committee and Executive level
6	Group Corporate Services programme established, with legal agreements in place to support the operation of Group-wide services
7	Executive Collaboration Group now established to oversee the development of clinical and corporate collaboration and integration across the Group
8	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	Good	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	Good	Second - Management
4	Framework used to inform where and how decisions are taken and on escalation of issues	Reasonable	Second - Management
5	Group Board and Committees-in-Common established and review effectiveness annually	Good	Second - Management
6	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
7	Recently reconstituted and will be providing regular reporting of progress to the Group Executive	Reasonable	Second - Management
8	Group-wide Integrated Quality and Performance Report presented to Committees and Group Board	Good	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Need to define supporting strategies on digital, estates, research and innovation
2	Need to develop clinical supporting strategies in priority areas
3	Need to complete Group Corporate Services integration programme – finance, digital, and remaining stages of HR and Estates & Facilities restructures
4	Need to develop common systems, processes and policies across the Group
5	Revised governance documentation to reflect the Accountability Framework
6	Need to align digital and IT systems across the Group

Emerging risks and opportunities *What else is relevant to how we managing the risk?*	
Emerging risks	**Emerging opportunities**
• Financial support to help integrate the Group	• Focus on digital as part of NHS 10 Year Plan as an enabler of Group-wide working and integration

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 agree Group-wide Accountability Framework, drawing on Group Operating Model	GCCAO	Feb-25	Completed
2	Develop a framework for policies across the Group	GCCAO	Feb-25	Completed
3	Develop Group Roadmap to provide a framework for the integration of clinical services across the Group	GDCEO	Apr-25	Completed
4	Finalise and approve designs for remaining corporate areas for integration, and complete integration of Group Corporate Services to agreed timeline	GDCEO	Jul-24	Overdue
5	Remaining supporting strategies to be developed, reviewed and approved by the Group Board: Digital, Estates, Research	Exec Leads	Nov-24	Overdue
6	Group-wide Surgery Strategy to be presented to the Group Board in January 2025	GDCEO	Jan-25	Overdue
7	Group-wide Paediatrics Strategy to be presented to the Group Board in June 2025	GDCEO	Jun-25	Overdue
8	Delivery of the 9 Strategic Initiatives to support the implementation of the Group strategy	GDCEO	Mar-28	Off Track
9	Develop plans for restructuring the High Performing Teams and Culture Strategic Initiatives into 'critical enablers'	GDCEO	Oct-25	On Track
10	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-25	On Track
11	Align digital and IT systems across the Group through the actions arising from the External Review of Digital	GCTO	TBC	TBC

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
SGUH	CRR-2963	20	Group Corporate Services

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
ESTH	CRR-652	20	Group Corporate Services

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
No specific related risks on the gesh Group on ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
No specific related risks on the gesh Group on ICB BAF	

Group Board Assurance Framework 2025/26

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	03 July 2025
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	Jul-25	5	4	25	Limited
Target	Mar-26	5	4	20	Reasonable

Change since last review

Risk Score	Mar 24	Jul 24	Jan 25	Jul 25	Nov 25	Jan 26	May 26	Jul 26	Nov 26	Jan 27	May 27	Jul 27
	25	25	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 2025/26

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 SWL planning
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**
• Clear message from NHSE 25/26 plans need to be delivered. • Scale of financial challenge • Organisational engagement given activity pressures and tired workforce. • Scale of identified investments remain above available funding • Cashflow management	• Working across the Group. • Working across the SWL system.

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Continued weekly budget review with SLT leads and divisions underway	MDs	Mar-26	On Track
2	CIPs, work ongoing to identify new opportunities.	MDs	Mar-26	Off Track
3	Detailed review performance against key benchmark data, explain or address variance	GCFO	Mar-26	On Track
4	Detailed review performance against key productivity data, explain or address variance	MDs	Mar-26	On Track
5	Work with SWL and London CFOs to agree trajectory to return to financial balance	GCFO	Mar-26	On Track
6	Develop a 5-year financial model; two stages rapid high-level view and then detailed LTFM. Aligns to refresh for BYFH	GCFO	Mar-26	On Track
7	Explore alternate sources for funds. Where not possible identify non-capital mitigations to known risks	GCFO	Mar 26	On Track
8	Revised departmental structure	GCFO	Mar-25	Overdue
9	Continued focus on cash management, notably cashflow forecasting, debt recovery and creditor process management	GCFO	Mar-25	On Track
10	Increase communication on finance maintaining open communication while maintaining engagement	GCFO	Mar-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
20	Financial sustainability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
16	Failure to deliver the ICB financial plan

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

Strategic Risk	SR5	Modernising our estates

Current Risk Score: 25

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	03 July 2025
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	Mar-24	5	5	25	Limited
Current	Jul-25	5	5	25	Limited
Target	Mar-26	5	5	25	Reasonable

Change since last review

Risk Score	Mar 24	Jul 24	Jan 25	Jul 25	Nov 25	Jan 26	May 26	Jul 26	Nov 26	Jan 27	May 27	Jul 27
	25	25	25	25								

	Key controls *What are we already doing to manage the risk?*
1	Board level governance of the estates infrastructure established through Infrastructure Committees
2	Executive level governance of estates infrastructure established via Group Executive Committee
3	Premises Assurance Model in place for both Trusts as central register of assurances on estates safety, effectiveness and governance
4	Programme of annual Authorised Engineer reporting is in place to provide independent assurance of condition of estates
5	6-Facet full condition surveys undertaken for both Trusts
6	Ongoing programme of Authorised Engineer inspections
7	Estates and Engineering Reactive Maintenance is in place
8	Risk-based programme of Planned Preventative Maintenance in place that can be flexed based on affordability
9	Risk-based approach to capital prioritisation is in place

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	The Infrastructure Committees focus on estates, facilities and health and safety issues on a bimonthly basis.	Good	Second - Management
2	An Executive Estates Governance Group is in development to provide more structured Executive oversight of estates issues.	Weak	Second - Management
3	The PAM is presented regularly to the Infrastructure Committees for oversight and assurance.	Reasonable	Second - Management
4	AE reports are regularly presented to the Infrastructure Committee for oversight and assurance.	Reasonable	Third - External
5	A new 6-facet survey is planned for SGUH in 2025/26 as previous survey was undertaken more than 5 years ago.	Reasonable	Third - External
6	AE reports and outcomes reported to the Infrastructure Committee	Reasonable	Third - External
7	Performance for completion rates of emergency and high priority jobs in a positive place at SGUH	Reasonable	Second - Management
8	Internal audits on maintenance undertaken	Reasonable	Third - External
9	Both Trusts have processes for agreeing collectively the annual capital plans, with clinical, operational and E&F input	Weak	Second - Management

10	Group Green Plan in place and approved by Group Board	10	Group Green Plan approved by Group Board in July 2024. Governance arrangements and KPIs agreed.	Good	Second - Management

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Develop a Group-wide Estates strategy
2	Integrate Estates and Facilities teams at SGUH and ESTH into a single Group-wide function to provide aligned and integrated leadership of estates across the Group
3	Develop and implement actions to respond to issues identified in Authorised Engineer reports
4	Six-facet surveys: Completion of actions to respond to ESTH 6-facet survey and commissioning of new SGUH 6-facet survey
5	Wider mitigation plan to address ongoing poor condition of the St Helier Hospital estate in the context of the delays to BYFH
6	Develop longer term capital plans (5 yrs+) that are better aligned with our strategies and affordability
7	Communicate estate risks to clinical teams more widely
8	Develop plans to address water safety issues at St Helier Hospital
9	Develop Plans to address fire safety issues at ESTH identified by the LFB

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
-	Ensure Infrastructure Committee is fully informed on all matters of infrastructure risk	GCIFEO	Mar-25	Completed
-	Complete six-facet survey at ESTH	GCIFEO	Apr-24	Completed
1	Develop a Group-wide estates strategy and secure sign off through Group Board: This is now more likely to be in a position to agree at Board in March 2026.	GCIFEO	Dec-25	Off Track
2	Implement plans for integrating the E&F directorates on a Group-wide basis: First phase of E&F corporate integration plan has been implemented; phase 2 has been planned and approved by Group Executive Committee.	GCIFEO	Sep-25	On Track
3	Develop and implement plans to respond to Authorised Engineer reports	GCIFEO	Mar-26	On Track
4	Commission new six-facet survey for SGUH: Plans being developed with procurement for tender in 2025/26	GCIFEO	Mar-25	Off Track
5	Develop longer-term mitigation plans to address ongoing poor condition of the St Helier Hospital estate in the context of the delays to BYFH	GCIFEO	TBC	TBC
6	Develop longer term capital plans in line with revised estate strategies and conditions surveys	GCIFEO	Dec-25	On Track
7	Ensure clinical engagement on all infrastructure issues; capital planning, risk management etc on an ongoing basis	GCIFEO	TBC	TBC
8	Develop plans to address water safety issues at St Helier Hospital, both in the short and long term: Current mitigations are in place to ensure the safety of patients and staff. An initial review of the options was discussed at the Group Executive Committee in May 2025, with a more detailed assessment due in late June 2025.	GCIFEO	Jun-25	On Track
9	Undertake Fire Safety Audit at ESTH, conducted by Authorised Engineer: This is to be commissioned in June 2025	GCIFEO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2036	15	Fire Safety
SGUH	CRR-762	20	Infrastructure backlog
SGUH	CRR-2061	15	Lack of UPD/IPS power supplies site-wide

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

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
12	Failure to modernise and fully utilise our estates

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

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

Strategic Risk	SR6	Adopting digital technology

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Affordable Services Fit for the Future
Last review date	03 July 2025
Monitoring Committee	Infrastructure Committees-in-Common
Lead Executive	Group Chief Transformation Officer
Risk appetite	Open (High)

Risk Score		Impact	Likelihood	Overall Risk Score	Assurance rating
Inherent	Mar-24	5	5	25	Limited
Current	Jul-25	5	4	20	Limited
Target	Mar-26	5	4	20	Reasonable

Change since last review

Risk Score	Mar 24	Jul 24	Jan 25	Jul 25	Nov 25	Jan 26	May 26	Jul 26	Nov 26	Jan 27	May 27	Jul 27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	Board level governance of the digital agenda established through Infrastructure Committees
2	Executive level governance of the digital agenda across the Group gesh established through Digital Governance Group
3	Board-level Executive leadership of the digital agenda established (through the Group Chief Transformation Officer)
4	Senior professional leadership of digital services across the gesh Group established through Group Chief Digital Information Officer
5	Expertise and capacity of the gesh Digital and ICT teams
6	Agreed resourcing plan in place for digital services
7	Shared Electronic Patient Record system launched in May 2025
8	ICT disaster recovery plans in place
9	Cybersecurity and malware strategies/responses in place and tested
10	Management of IT assets

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	The Infrastructure Committee focuses on digital on a bimonthly basis and the Audit & Risk Committee receives quarterly reports on cyber.	Good	Second - Management
2	The Digital Governance Group is established and meets monthly. Its terms of reference and attendance is currently being reviewed.	Reasonable	Second - Management
3	Transition of Executive portfolio for digital services from GCFO to GCTO effective from 1 June 2025.	Good	Second - Management
4	A new GCDIO has been appointed on an interim basis from the SWL ICB while recruitment to the substantive post is undertaken.	Reasonable	Second - Management
5	Current team capabilities strong but demands on both sites large and growing. More consideration of transformative action.	Weak	First - Operational
6	Resourcing under material pressure due to wider pressures on capital availability across the gesh Group.	Weak	Second - Management
7	EPR rollout has been smooth and has been overseen by the EPR Programme Board and Infrastructure Committee.	Reasonable	Second - Management
8	Disaster recovery plans require further work and testing.	Reasonable	First - Operational
9	Partial assurance internal audit on cybersecurity (ESTH and SGUH)	Weak	Third - External
10	Partial assurance internal audit review of IT assets identified strengths but also weaknesses in the management of IT assets.	Weak	Third - External

Gaps in controls *What do we need to do to control the risk that we are not yet doing?*	
1	Strategy: Develop a Group-wide digital strategy, ensuring linked to known demands and resources.
2	Structures: Undertake external review of digital services across the gesh Group
3	Integration: Integrate separate ICT teams on a Group-wide basis
4	Governance: Strengthening Executive oversight of digital agenda
5	Prioritisation (1): Develop plans to support Board agreement to prioritise digital as a key enabler
6	Prioritisation (2): Develop agreed set of digital priorities for 25/26 (with necessary trade-offs)
7	Resilience: Continue to refresh systems as required. Review learning from previous projects.
8	Disaster recovery: Continue to refine and test plans
9	Cybersecurity: Maintain focus and ensure plans, systems and processes kept up to date
10	Artificial Intelligence: Agreed Group-wide approach and framework for AI development / deployment

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. • Delivery against key projects taking longer than planned • Growing cybersecurity threats • Financial uncertainties, making it challenging to plan digital projects	• Expected emphasis on digital within the NHS 10 Year Plan • Transfer of responsibilities for digital from ICBs to providers in new Model ICB Blueprint • Closer Group working • SWL-wide solutions being explored for the medium/longer term

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
-	Rollout of Electronic Patient Record: Roll-out of shared EPR across the Group. Rollout undertaken in May 2025 as planned. Post-Go Live optimisation to deliver the benefits of a shared domain ongoing.	COO-ESTH	May-25	Completed
1	Strategy: Develop Group Digital Strategy and agree at Group Board: Revised plan to bring digital strategy to the Group Board for approval in November 2025.	GCTO	Apr-25	Overdue
2	Structures: Complete external review of Group digital services and develop plans for addressing actions identified: Draft report received. Final report scheduled by end June 2025.	GCTO	Mar-25	Overdue
3	Integration: Integrate the two Trusts' ICT departments into a single Group-wide department. This will be informed through the external review. Timeline for integration to be considered by the Executive Collaboration Group in June 2025.	GCTO	Mar-25	Overdue
4	Governance: Refresh the gesh Digital Governance Group. A revised ToR was reviewed by the Group Executive Committee on 3 June 2025.	GCTO	Jun-25	On Track
5	Prioritisation (1): Develop plans to respond to the Group Board's agreement that digital should be prioritised as a key enabler of strategy delivery and organisational transformation. Include as part of this training and development of Executives as sponsors of digital.	GCTO	TBC	TBC
6	Prioritisation (2): Develop and agree a set of digital priorities for 2025/26, including a shared view of the plan and the necessary trade-offs. A revised plan is scheduled to be presented to the Digital Governance Group in June 2025.	GCTO	Jul-25	On Track
7	Resilience: Agree priorities with clinical and operational colleagues. Review and apply learning from current projects.	GCTO	Dec-25	On Track
8	Disaster recovery: Enhance visibility and further develop horizon scanning.	GCTO	Dec-25	On Track
9	Cybersecurity: Develop cybersecurity dashboard on SWL basis. SWL work on this has been delayed.	GCTO	Dec-24	Overdue
10	Artificial Intelligence: Develop a framework / approach for the deployment of AI across the Group with appropriate governance and controls as part of the digital strategy.	GCTO	Nov-25	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

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

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

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	03 July 2025
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	Jul-25	4	3	12	Reasonable
Target	Mar-26	4	2	8	Good

Change since last review

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	12	12	12	12								

	Key controls *What are we already doing to manage the risk?*
1	SGUH research strategy 2019-24 continues to provide a relevant interim guide pending the development of a Group research strategy
2	Delivery arms of research for ESTH and SGUH are now one Group-wide team, restructured through the integration of corporate services
3	Leadership of research across the Group established through a new gesh Group Director for Research and Innovation
4	Partnership with medical school as part of City St George's University of London well established
5	Gesh Group and City St George's are in collaboration on the University's restructure of the Joint Research Enterprise Service
3	Key role in London Clinical Research Network
4	Translational and Clinical Research Institute established and extended to ESTH
5	NIHR Clinical Research Facility designation – St George's
6	Research governance in place

	Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Quality Committee receives reporting on progress on research annually	Reasonable	Second - Management
2	Integration implemented and reported through to the Group Executive Committee and People Committee	Reasonable	Second - Management
3	Gesh Group Director of Research and Innovation appointed on June 2025	Reasonable	Second - Management
4	Regular meetings of Joint Strategic Board with the University	Reasonable	Second - Management
5	A formal contractual agreement is in development and is anticipated in Q3 2025/26	Reasonable	Second - Management
3	Leadership positions in the Clinical Research Network. Group CEO chairs the CRN Partnership Board	Reasonable	First - Operational
4	TACRI Steering Group reporting to SGUH PSQG currently	Reasonable	Second - Management
5	5-year designation from NIHR	Reasonable	Third - External
6	Reporting on research through to the JRES and Quality Cttee	Reasonable	Second - Management

7	Group-wide non-medical research leadership post established through corporate nursing restructure	7	Required wider Group-wide integration of non-medical research support team	Reasonable	Second - Management
8	Research portfolio in renal and commercial portfolio within renal and ophthalmology at ESTH	8	Reporting on research through to the 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	ESTH research strategy expired prior to the formation of the gesh Group meaning that it does not provide the same relevant guide as the SGUH strategy currently does
2	Further work is needed to align research priorities and strategic focus across the Group
3	Further work is needed to align research activities across the Group now that the delivery support is provided by a single Group team
4	Further work is needed to develop the strategic relationship with City St George's University
5	Not all major Group clinical activities are yet proportionately reflected in research activity
6	Research IT infrastructure needs strengthening
7	Secure additional NIHR core funding
8	Explore opportunities for collaborative research across the Group
9	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	Bring together the delivery arms of research for ESTH and SGUH on a Group-wide basis through the integration of corporate services	GCMO	Mar-25	Completed
2	Appoint a gesh Group Director of Research and Innovation	GCMO	Jun-25	Completed
3	Develop and secure Group board approval for Group-wide research and development strategy	GCMO	Nov-25	On Track
4	Develop a formal contractual agreement between the gesh Group and City St George's for the Joint Research and Enterprise Service	GCMO	Dec-25	On Track
5	Explore opportunities for building a wider relationship with City University through its merger with St George's University of London	GCMO	Apr-25	Off Track
6	Create more research capacity through job planning	GCMO	Jun-25	Off Track
7	Establish research data warehouse	GCMO	Dec-25	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

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

Related risks on Surrey Downs Integrated Care Board BAF

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

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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	27 June 2025
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	Jul-25	5	4	20	Limited
Target	Mar-26	5	3	15	Reasonable

Change since last review

⟺

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	OPEL escalation triggers updated and revised actions in place
2	Daily surge call in place with system partners to help manage capacity and to escalate delayed patients / discharges/repatriations
3	Boarding arrangements to depressurise ED with SOPs in place
4	Transfer of care functions in place to facilitate discharge
5	ED overcrowding mitigating actions in place to manage risks of corridor care
6	Validation of PTLs
8	Long length of stay MDT meetings in place (SGUH) Divisional check and challenge of LLoS and 14 day/complex review panel (ESTH)
9	Regular bed management meetings to help manage flow
11	QMH Surgical Treatment Centre in place to help reduce waiting times ERF plan at ESTH and use of QMH capacity
12	Mutual aid across SWL

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	OPEL triggers regularly used and associated actions activated	Good	Second - Management
2	Used regularly to escalate concerns. Integrated TOCs at SGUH and ESTH means constant updates and escalation. SGUH and ESTH boarding SOPs in place and "live"	Reasonable	Second - Management
3	ED performance reported to Site, Exec, Committees and Board	Reasonable	Second - Management
4	In place. Integrated TOC team established on site at SGUH.	Good	Second - Management
5	Actions to mitigate safety risks in ED due to overcrowding reviewed by the Quality Committees-in-Common	Reasonable	Second - Management
6	Decrease in number of patients waiting longer than 52 weeks	Good	Second - Management
8	Oversight of LoS by Site Leadership teams. Meetings in place and increased when needed.	Reasonable	Second - Management
9	Oversight of flow by Site Leadership teams	Reasonable	Second - Management
11	Activity reviewed by SGUH Site team (improved utilisation and theatre to ESTH). ESTH@QMH plan being mobilised	Good	Second - Management
12	Reviewed by Site and Executive teams. Managed via ICB.	Reasonable	Second - Management

13	Virtual wards established	13	Hospital@Home capacity used 100% in Wandsworth. Sutton virtual ward now being used at or near capacity	Reasonable	Second - Management
14	Electronic Patient Record system on a shared domain across the gesh Group is now implemented (from May 2025)	14	Oversight of the implementation of EPR through the EPR Programme Board and Infrastructure Committee	Reasonable	Second - Management

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

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

Emerging risks	Emerging opportunities
• Staff burnout, illness and disengagement • Moral injury to staff • Increasing violence and aggression directed at staff • ability to physically accommodate further excess demand in site footprint (ESTH)	• Focus on leftward shift announced by Govt and expected in NHS 10 Year Plan • Focus on Neighbourhood Health • Local place-based alliances

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Put in place enhanced arrangements and oversight of ED safety in the context of overcrowding and corridor care	Site MDs	Dec-24	Completed
2	Implementation of electronic patient record system across the Group on a shared domain with SGUH	GCEO and EPR SRO	May-25	Completed
3	Utilising the capacity of EPR to support improvements in care	Site MDs	May-26	On Track
2	Implementation of actions to respond to staff concerns in EDs	Site MDs	Sep-25	On Track
4	Collaboration with South West London & St George's Mental Health Trust and Surrey and Borders Partnership NHS FT in relation to patients with mental health issues attending EDs.	Site MDs	TBC	TBC
5	Strengthening of mutual aid across Group and SWL	MDs	TBC	TBC
6	Work programme to understand health inequalities impact of long waits	GCMO	Dec-25	On Track
7	Implementation of the Transforming Outpatients Strategic Initiative	GCMO	Mar-28	On Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

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

Related risks on Surrey Downs Integrated Care Board BAF

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

Strategic Risk	SR9	Improving patient safety and reducing avoidable harm

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

Current Risk Score: 20

Assurance: Limited

Strategic objective	Right Care, Right Place, Right Time
Last review date	26 June 2025
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	Jul-25	5	4	20	Limited
Target	Mar-26	5	3	20	Reasonable

Change since last review: ⟺

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*		Assurances on controls *How do we have assurance that the controls are working?*	*Control Strength*	*Line of defence*
1	Quality governance structures and processes established at Group and Site levels with processes mapped and documented	1	Internal reporting to Site, Executive, Committees, and Group Board	Reasonable	Second - Management
2	Development of an Integrated Maternity Improvement Plan	2	Plan coordinates all actions into a single plan, which is monitored through gesh Quality Group and Quality Committee	Reasonable	Second - Management
3	PSIRF framework has been fully implemented across the Group	3	Oversight of PSIs by Mortality Monitoring groups and regular reporting to gesh Quality group and Quality Committee	Reasonable	Second - Management
4	Safety data established as core part of Integrated Quality and Performance Report	4	Safety data reviewed regularly by Site, Executive Quality Committee and Group Board	Good	Second - Management
5	Established governance on quality impact assessments of cost improvement plans	5	QIAs process agreed and individual QIAs reviewed by Site and Executive, with Quality Committee oversight	Reasonable	Second - Management
6	Governance and reporting on learning from deaths established	6	Regular reporting to Quality Committee and Group Board	Good	Second - Management
7	Established clinical audit plan	7	Reporting on clinical audit plans to Site quality groups and to Quality Committee	Good	Second - Management
8	Establishment of Group-wide functions across Corporate Nursing and Corporate Medical directorates to provide support across gesh	8	Provision of integrated and standardised reporting to gesh Quality Group and Quality Committees	Reasonable	Second - Management
9	Established ward accreditation programme	9	Reporting on ward accreditation through IQPR	Reasonable	Second - Management
10	Group-wide infection prevention and control governance in place	10	Regular reporting on IPC to Executive, Quality Committee	Good	Second - Management

11	Influenza and Covid vaccination programme	11	External NHS England data on vaccination rates – compliance rates low but among the best compliance rates in London	Weak	Third - External
12	Commissioned external quality reviews by Royal Colleges and other national bodies	12	Tracking action plans developed in response to external reviews	Reasonable	Third - External
13	Implementation of a Shared Electronic Patient Record system across the gesh Group in May 2025	13	Oversight of EPR implementation and post-implementation through EPR Programme Board and Infrastructure Committee	Reasonable	Second - Management

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	Safety culture, including culture of psychological safety and raising concerns
3	Systematic learning from Never Events: Insufficient evidence that learning has been embedded
4	Visibility of Getting It Right First Time (GIRFT) findings, data and actions
5	Consistent delivery of fundamentals of care
6	ITU bed demand may exceed capacity at SGUH
7	Out-of-date clinical policies and inconsistency across Group
8	Quality of the Trusts' estates

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

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

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		**Executive Lead**	**Due date**	**Progress**
1	Commence implementation of Patient Safety Incident Response Framework across the Group in phases	GCMO/GCNO	Mar-24	Completed
2	Develop and secure Group Board approval of new Group quality and safety strategy	GCMO/GCNO	Jul-24	Completed
3	Commence reporting of concerns raised by staff through to the Quality Committee	GCCAO	Dec-24	Completed
4	Map the Quality Governance architecture across the Group to ensure clarity of structures, processes and flows	GCMO/GCNO	Apr-25	Completed
5	Implement strategic initiative on developing a shared electronic patient record across the Group	GCEO	May-25	Completed
6	Develop a Quality Governance Improvement Plan	GCMO/GCNO	Jul-25	On Track
7	Implement Maternity Improvement Plan	MD-SGUH	Nov-25	On Track
8	Develop and implement Group-wide approach for dissemination of learning on patient safety	GCMO/GCNO	Dec-25	On Track
6	Bring together and strengthen maternity governance arrangements together across the Group	GCNO	Mar-25	On Track
7	Implementation of Phase 1 Quality Governance Review actions in line with agreed timetable	GCMO/GCNO	Jul-25	On Track
8	Implement strategic initiative on developing a shared electronic patient record across the Group	GCEO	May-25	On Track
9	Implement strategic initiative on strengthening specialised services at SGUH	GCMO/GCNO	Mar-28	Off Track

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF	
Score	**Summary risk description**
16	Delivering Access to Care (NHS Constitutional Standards)
9	System Quality Oversight

Related risks on Surrey Downs Integrated Care Board BAF	
Score	**Summary risk description**
16	Capacity in our Urgent and Emergency Care Services
15	Operational challenges impacting the safe delivery of maternity care

Strategic Risk	SR10	Improving patient experience

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.*

Current Risk Score: 16

Assurance: Limited

Strategic objective	Right Care, Right Place, Right Time
Last review date	26 June 2025
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	Jul-25	4	4	16	Limited
Target	Mar-26	4	3	12	Good

Change since last review: ⇔

Risk Score	Mar-24	Jun-24	Sept-24	Dec-24	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	16	16	16	16								

Key controls *What are we already doing to manage the risk?*	
1	Patient involvement and experience groups established at each Trust
2	Complaints and PALS teams established on Group-wide basis
3	Data on key patient experience metrics gathered and tracked
4	Action plans in response to national patient experience surveys
5	Established focus on support for veterans
6	Patient stories to the Group Board
7	Implementation of a Shared Electronic Patient Record system across the gesh Group in May 2025

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
5	Veterans Covenant Healthcare Alliance accreditation for ESTH and SGUH	Good	Third - External
6	Patient story taken at each group Board meeting	Reasonable	Second - Management
7	Oversight of EPR implementation and post-implementation through EPR Programme Board and Infrastructure Committee	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 data collection relating to patients with protected characteristics
4	Improve complaints performance (quality of responses)
5	Recruitment of additional volunteers
6	Ensure audit compliance with Accessible Information Standard
7	Raise profile of patient engagement groups
8	Identify and disseminate good practice across teams on patient engagement

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

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

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

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

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

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

Strategic Risk	SR11	Tackling health inequalities

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.*

Current Risk Score: 12

Assurance: Reasonable

Strategic objective	Right Care, Right Place, Right Time
Last review date	03 July 2025
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	Jul-25	4	4	16	Reasonable
Target	Mar-26	4	3	12	Reasonable

Change since last review: ⟺

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	16	16	16	16								

Key controls *What are we already doing to manage the risk?*	
1	Group strategy identified health inequalities as key priority for Group
2	Group Health Inequalities Programme is aligned with recent national ICB Blueprint and NHSE Statement of information on health inequalities, and is aligning with priorities at Place in local Sector
3	Initial analysis of health inequalities in ED and outpatients across the Group completed
4	Health Inequalities plan in place with short term and longer term workstreams
5	A gesh Community of Practice is established with a programme of meetings and a repository of resources
6	Health Inequalities Steering Group established and meetings scheduled
7	SGH Charity funded Health Equity Lead (clinical, 2 PAs for 3 years) has been in place at SGUH since April 2025 and the ESTH Charity funding is confirmed for a similar post at ESTH (June 2025)
8	A new Group Head of Patient Inclusion has been appointed (June 2025) in the People Directorate to support the Public Sector Equality Duty and Health Inequalities Programme

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	Reasonable	Second - Management
5	Structured input into wider HR programme	Reasonable	Second - Management
6	Reporting arrangements on progress established through GESH Quality Group and Quality Committee	Reasonable	Second - Management
7	Inputs into wider HI Programme	Reasonable	Second - Management
8	Inputs into wider HI Programme	Reasonable	Second - Management

9	A “Data Democratisation” programme is underway to strengthen data sharing between the SWL ICB and the gesh Group	9	Analysis of data through HR Steering Group	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
2	Developing reporting on health inequalities (evidenced-based reporting on impact)
3	Review of patient involvement from health inequalities perspective
4	Reporting of patient health inequalities in our PSED report is not as clear as staff equality, diversity and inclusion

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

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

Related risks on BAF and Corporate Risk Register – SGUH

Trust	Datix ID	Score	Summary risk description
No risks related to health inequalities on the CRR.			

Related risks on BAF and Corporate Risk Register – ESTH

Trust	Datix ID	Score	Summary risk description
No risks related to health inequalities on the CRR.			

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
No health inequalities focused risks on the SWL ICB BAF	

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
No health inequalities focused risks on the SH ICB BAF	

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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	19 June 2025
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	Jul-25	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	Group People Strategy approved by the Group Board
2	Well developed staff support programmes in place across Group
3	Board level Wellbeing Guardian in place at both Trusts
4	gesh 100 leadership forum in place and well established
5	Established ESTH and SGUH leadership development programmes
6	Staff induction in place at both Trusts
7	Employee Relations Service Improvement Plan in place
8	Group-wide Continuous Improvement team established and in place
9	Established ESTH and SGUH Quality Improvement programmes
10	Agreed approach in place for analysing and responding to NHS Staff Survey findings, with ability to cut data to local level

Assurances on controls *How do we have assurance that the controls are working?*		*Control Strength*	*Line of defence*
1	Approved by the Group Board in May 2024, with monitoring of progress through the People Committees-in-Common	Good	Second - Management
2	Delivery of staff support is reviewed by People Committee which has taken good assurance on this	Good	Second - Management
3	Approved by the two Boards; Wellbeing Guardian is a member of People Committee	Good	Second - Management
4	Positive feedback from staff involved in gesh100 events.	Good	Second - Management
5	Outputs reviewed locally and by HR. Leadership particularly at middle management remains an area of challenge.	Weak	First - Operational
6	Programme of induction events monitored by HR	Reasonable	First - Operational
7	Ongoing operational challenges for ER functions at both Trusts particularly at SGUH e.g. timeliness of investigations	Weak	Second - Management
8	CI team established.	Reasonable	First - Operational
9	Outputs from QI reviewed at Site level	Weak	Second - Management
10	Increase in staff engagement demonstrated through 2024 NHS Staff Survey results at both Trusts	Good	Third - External

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 function particularly at SGUH
3	Quality of staff appraisals, and linking of appraisals and objectives to Group strategy at every level
4	Quality of the estates and digital infrastructure impacting on staff experience
5	Up-to-date and accessible HR policies refreshed on Group-wide basis
6	Group-wide approach to Continuous Improvement and capacity of staff to engage with CI
7	Staff awareness of Group strategy and vision for Continuous Improvement

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

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

Related risks on BAF and Corporate Risk Register – SGUH			
Trust	**Datix ID**	**Score**	**Summary risk description**
SGUH	CRR-2530	16	Appraisal rates
SGUH	CRR-2532	16	Employee relations

Related risks on BAF and Corporate Risk Register – ESTH			
Trust	**Datix ID**	**Score**	**Summary risk description**
ESTH	CRR-1929	16	Senior leadership capacity
ESTH	CRR-1934	16	Staff engagement
ESTH	CRR-1935	16	Appraisals
ESTH	CRR-150	16	Mandatory and Statutory Training
ESTH	CRR-2072	16	Payroll provision
ESTH	CRR-2071	20	People Directorate

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

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

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

Strategic Risk	SR13	Fostering an inclusive culture that celebrates diversity

Current Risk Score: 20

Assurance: Limited

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

Strategic objective	Empowered, Engaged Staff
Last review date	19 June 2025
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	Jul-25	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

Key controls *What are we already doing to manage the risk?*	
1	Group People Strategy approved by the Group Board
2	Site-based Culture Equity and Inclusion Boards and Group Culture Forum established
3	Workforce Race Equality Standard Action Plan developed
4	Workforce Disability Equality Standard Action Plan developed
5	Group-wide framework for raising concerns in place reflecting national guidance, with FTSU Guardians in place across the Group
6	Raising Concerns Oversight and Triangulation Group established
7	Staff networks in place at both Trusts, with Executive sponsorship refreshed
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	Approved by the Group Board in May 2024, with monitoring of progress through the People Committees-in-Common	Good	Second - Management
2	Updates reported through Site SLTs and Group Executive	Reasonable	Second - Management
3	Action Plan in place. Single Group-wide WRES plan in development.	Reasonable	Second - Management
4	Action Plan in place. Single Group-wide WRES plan in development.	Reasonable	Second - Management
5	Regular reporting of concerns raised through FTSU considered at People Committee and Group Board	Reasonable	Second - Management
6	Reporting of key issues from RCOTG to Group Executive and relevant Board Committees	Reasonable	Second - Management
7	Networks meet regularly and programme of Board engagement with network chairs. Executive sponsorship refreshed.	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	Plans for developing transforming the way we work as a critical enabler of the delivery of the strategy
2	Diversity of the two Boards and senior leadership
3	Differences in values between the two Trusts – need for alignment (e.g. WRES action plans)
4	Improving the timeliness of responding to concerns and disseminating learning from concerns
5	Reviewing approach to addressing bullying and harassment
6	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**
	• Board recruitment in 2025/26 • NHS Staff Survey Results 2024

Material actions to address gaps in controls and assurances *What are we going to do, by when, to further manage and mitigate the risk?*		Executive Lead	Due date	Progress
1	Develop and implement a two-year People strategy in support of the Group Strategy	GCPO	May-24	Completed
2	Develop and implement single Group-wide WRES and WDES action plans	GCPO	Oct-24	Completed
3	Develop Group-wide Raising Concerns policy in line with new national raising concerns policy	GCCAO	Jan-25	Completed
4	Clarify Executive sponsorship of staff networks and align networks arrangements across the Group	GCPO	Feb-25	Completed
5	EDI Action Plan approved by Group Board	GCPO	Feb-25	Completed
6	Establish Shadow Board to help promote greater diversity in the leadership community across gesh	GCPO	Sep-25	On Track
7	Developing an approach to culture and high performing teams as a 'critical enabler' to the Group strategy, including developing a 'gesh way' and bring proposals to the Board for approval	GCPO	Sep-25	On Track
8	Develop and implement a Group-wide talent management programme	GCPO	Feb-25	On Track
9	Undertake forthcoming Board recruitment with focus on diversity	GCEO/Chair	Jul-25	On Track
10	Develop plans for improvement of Trusts' positions in relation to the NHSE Violence Prevention and Reduction Standard (delayed from January to September 2025)	GCIFEO	Mar-25	Off Track
11	Develop a Group-wide Raising Concerns strategy in line with good practice from NGO building on SGUH FTSU strategy (Delayed from July to November 2025)	GCCAO	Mar-25	Off Track
12	Develop a set of aligned values across the Group	GCPO	Dec-25	Off Track

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

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

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

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

Strategic Risk	SR14	Developing tomorrow's workforce

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.*

Current Risk Score: 20

Assurance: Limited

Strategic objective	Empowered, Engaged Staff
Last review date	19 June 2025
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	Jul-25	4	5	20	Limited
Target	Mar-26	4	4	16	Reasonable

Change since last review

Risk Score	Mar-24	Jul-24	Jan-25	Jul-25	Nov-25	Jan-26	May-26	Jul-26	Nov-26	Jan-27	May-27	Jul-27
	20	20	20	20								

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

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

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

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

Emerging risks	Emerging opportunities
• Financial pressures	• Create a competitive advantage through a more engagement people experience • Use workforce analytics to make the most of our talent • Use of HR and technology to improve people experience • Engage easily with flexible talent • Relationship with City University

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

Related risks on BAF and Corporate Risk Register – SGUH

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

Related risks on BAF and Corporate Risk Register – ESTH

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

Related risks on SWL Integrated Care Board BAF

Score	Summary risk description
16	Workforce capacity wellbeing and availability

Related risks on Surrey Downs Integrated Care Board BAF

Score	Summary risk description
12	ICB Workforce Instability

Group Board

Meeting in Public on Thursday, 03 July 2025

Agenda Item	3.1	
Report Title	**Quality Committees Report to Group Board**	
Non-Executive Lead	Andrew Murray, Quality Committees Chair, ESTH and SGUH	
Report Author(s)	Andrew Murray, Quality Committees Chair, ESTH and SGUH	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Quality Committees at their meetings in May and June 2025 and the matters the Committees wish to bring to the attention of the Group Board. These include:

1. Draft Quality Accounts: The Committee reviewed the draft Quality Accounts for both SGUH and ESTH and recommended that both be submitted to the Trust Boards for approval.
2. Quality Impact Assessments and Cost Improvement Plans: The QIA report detailed the process undertaken during a Quality Impact Assessment, with the Committee discussing how to balance delivering quality care whilst managing financial pressures.
3. Quality Governance Phase 2: The Committee reviewed the quality governance improvement plan and requested that another iteration be presented to the July meeting which details the resource needed to deliver the plan, along with the timing of the actions. Once this information is provided the Committee will be able to deliver an assurance rating against the plan.
4. Group Board Assurance Framework: The Committee proposed to recommend to the Group Board a change in the assurance rating of Strategic Risk 11 from “limited” to “reasonable”.

Action required by Group Board

The Group Board is asked to note and discuss the issues escalated by the Quality Committees and the wider issues on which the Committees received assurance in May and June 2025.

Committee Assurance

Committee	Quality Committees
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Not Applicable - No Appendices	

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 Report
Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Quality Committees at its meetings in May and June 2025 and includes the matters the Committees specifically wish to bring to the attention of the Group Board.

2.0 Items considered by the Committees

2.1 At its meetings on 27 March 2025 and the 24 April 2025 the Committees considered the following items of business:

29 May 2025	26 June 2025 (Focus Session)
• Draft Quality Accounts • Quality Impact Assessments and Cost Improvement Plans • Group Key Issues Report • Integrated Maternity Improvement Plan • Maternity Leadership Proposal • Integrated Performance Report • Quality Insights Report • Health Inequalities and Population Health • Safeguarding Report • SGUH Vascular Surgery Hybrid Theatre Risk Management • SWL Pathology • Clinical Ethics Committee Annual Report	• Pressure Ulcers • AFPP Theatre Safety • Quality Governance Phase 2 • Group Board Assurance Framework

2.2 The Committee was quorate at the meetings in May and June 2025.

3.0 May 2025 - Key issues for escalation to the Group Board

3.1 <u>Group Key Issues Report and Never Events</u>

The Committees received the Key Issues Report, which included an update on the following:

Water Safety Risk – Neonatal Unit, St Helier. Legionella and Pseudomonas were detected in E Block, housing the Neonatal Unit. Immediate mitigations include point-of-care filters and

copper-silver ionisation. While no harm has occurred, this remains a critical infrastructure risk. Whilst remedial work is underway, more definitive options to address this risk are in development for consideration. Oversight is through Estates and the Infrastructure Committee.

VTE Risk Assessment Compliance – SGUH. VTE compliance remains significantly below national benchmarks. Despite previous action planning, improvement has been limited. VTE risk assessment will be incorporated into the Group-wide ward accreditation tool launching in July 2025. An urgent trajectory for improvement is in place and will be closely monitored.

3.1.2 A deep dive report into Never Events was presented to the Committees, this included a verbal update on a never event declared on 28th May 2025, in which botox was intended to be injected into a female patient's bladder muscle via a cystoscope, but was accidentally injected into the wall of the vagina. Once this mistake was identified, the patient was informed and consented to the treatment continuing. Fortunately, there was no harm to the patient.

3.1.3 The Committees requested that GCMO meet with divisional leads to undertake a review into all areas of activity across SGUH with the view to identify areas which require more robust safety netting in place to prevent never events from occurring. An update on the outcome of this initial meeting to be provided to the Committee.

3.1.4 Assurance level: Limited. The Committee agreed that given another never-event has been declared on the 28th May 2025, Committee members could only take limited assurance from the key issues report- particularly in relation to never events.

3.2 St George's Maternity Integrated Improvement Plan

3.2.1 The Committees received the report, which detailed the newly developed Integrated Maternity Improvement Plan that consolidates all internal and external actions, recommendations and requirements for the maternity service. A parallel plan for Epsom and St Helier University Hospitals (ESTH) is being developed and is expected to be ready for submission to the Committee in the upcoming months.

3.2.2 The Group Chair noted how maternity improvement has been a concern for the Group Board for some time, he requested that the key priorities and cross cutting themes, alongside the actions from the integrated action plan which are key in delivering these priorities are presented at the next Public Board meeting.

3.2.3 Assurance Level: Reasonable. The Committee agreed that considering the comprehensive action plan which has been developed, it could take reasonable assurance that there is now a coherent approach to maternity improvement.

3.3 SGUH Vascular Surgery Hybrid Theatre Risk Management

3.3.1 The Committees received the report, which advised that two incidents have occurred in the past year caused by hybrid theatre equipment failure that resulted in significant harm. There is a capital investment project in progress to replace the hybrid theatre equipment, but this project is experiencing delays in regulatory approvals from the new Building Safety Regulator.

3.3.2 The Committee noted this report and agreed it was important to escalate this risk to the Group Board.

4.0 May 2025 - Key issues on which the Committees received assurance

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

4.2 Draft Quality Accounts

4.2.1 The Committees reviewed the draft Quality Accounts for both SGUH and ESTH and recommended that both be submitted to the Trust Boards for approval.

4.3 Quality Impact Assessments and Cost Improvement Plans

4.3.1 The Committees received the report, noting that the Group-wide QIIA Panel now meets weekly to consider proposals. In 2024-25 Q3, 10 proposals were considered. In 2024-25 Q4, 18 proposals were considered and in the first half of 2025-26 Q1 11 proposals were considered.

4.3.2 The Committee acknowledged that a key concern relates to understanding how gesh can handle the financial pressures it is currently under, whilst ensuring patient quality and safety. It was agreed that whilst currently the focus has shifted to meeting the financial demands, sometimes to the detriment of delivering excellent quality care, patient safety must never be put at risk. GCMO shared that although the executives are spending more time discussing finance than they have done in recent years, the conversations around quality are better structured to ensure the discussion provides appropriate levels of assurance on this aspect.

4.3.3 Assurance rating: reasonable: The Committee agreed it could take reasonable assurance on the processes in place to undertake quality impact assessments and embed cost improvement plans.

4.4 SWL Pathology Quality Update

4.4.1 The Committees received the report, which detailed that SWLP continues to be accredited by UK Accreditation Service to the International Standard (ISO) 15189:2022 following annual assessments. SWLP is currently in a period of change, upgrading most of its analytical equipment and integrating its IT systems across all of South West London in the period of 2025-2026. During this period of change, there are several risks across Pathology due to implementing these changes and the disruption this causes, or the impact of delays to these changes taking place.

4.4.2 Assurance Level: Reasonable. The Committee agreed that they can take reasonable assurance from the SWL Pathology service update.

5.0 May 2025 - Reports for discussion

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

5.2 Group Integrated Quality and Performance Report

5.2.1 The Committees received the IQPR report, which detailed the following successes and challenges for SGUH and ESTH:

SGUH

Mortality: Current mortality rates at SGUH, measured by the Summary Hospital-level Mortality Indicator (SHMI), are below expected levels at 0.86. However, the upcoming inclusion of

Same Day Emergency Care (SDEC) data in the Emergency Care Data Set may have a negative impact on SHMI figures.

ESTH

Pressure Ulcers: A reduction of pressure ulcers by 33% compared to previous month. Across ESTH (both acute sites), six hospital acquired pressure ulcers in April 2025 were reported. Zero acquired pressure ulcers from respiratory medical devices this month compared to four acquired last month.

5.2.2 The Committee welcomed the report, noting that it was an effective and informative document.

5.3 Quality Insights Report

5.3.1 The Committee noted the report, which is used effectively as a problem sensing tool, as if a particular area has lots of red it can indicate a wider problem within the service which may need addressing. It was advised that this tool is still in development and there are plans for further metrics to be added going forward.

5.4 Health Inequalities and Population Health

5.4.1 The Committees received the report, which provided an update on the progress of the health inequalities initiative. Progress was made in 2024–25 toward addressing health inequalities, including the establishment of a Group-wide Steering Group, strengthened BI partnerships across South West London, and initiation of targeted data and service improvement initiatives.

5.4.2 The Committee Chair noted that limited progress was made on the work looking at both deprivation and other factors on the waiting list that would help us think differently about how to prioritise those patients, along with the work with frequent attenders in ED. The Chair requested that the concrete actions for this year are absolutely realistic in terms of resources and are priorities that the organisation wants to make real progress on.

5.5 Safeguarding Report

5.5.1 The Committees noted the report, noting that the governance processes have been agreed with Site Safeguarding Meetings and the establishment of a Group Safeguarding Committee. Steering Groups for Learning Disability and Mental Health will report to the Safeguarding Committee. Plans are in place to address the uptake of safeguarding adults training at level 3, with an improved and accessible offer. Safeguarding concerns have been identified relating to the management of pressure area care and safe discharge.

5.6 Clinical Ethics Committee Annual Report 24-25

5.6.1 The Committees welcomed the report, noting that a core objective for 2025-26 is to further develop the relationship with ESTH, working towards the gesh Group's preferred direction of travel, namely a single gesh Group Clinical Ethics Committee with equity of access and involvement between ESTH at SGUH, amending the CEC's ToRs as necessary.

5.6.2 The Committees approved the Clinical Ethics Committee Annual Report for 2024-25.

6.0 Quality Committees Focus Session - 26 June 2025

6.1 Pressure Ulcers

6.1.1 The Committees welcomed the report, which evaluated prevalence, improvement initiatives, training compliance, audit outcomes, and localised risk, with comparison to national and regional benchmarks where available. It also highlighted the following:

- ESTH reported zero Category 4 Hospital Acquired Pressure Ulcers (HAPU) for the second consecutive year.
- SGUH did not meet the ambition of zero incidence of Category 4 HAPUs

6.1.2 The Committees noted the performance against pressure ulcers is a quality priority for 2025/26 and so a focus will remain on this throughout the year. Should the organisation achieve and maintain a zero grade for pressure ulcers, it will no longer be a Quality Priority for the following year, but the performance will continue to be monitored in the Integrated Quality Performance Report.

6.1.3 Assurance rating:

ESTH: Substantive. Committee members felt that as ESTH has achieved zero category four pressure ulcers for 2 consecutive years, and is meeting its target for category 3, it is able to take substantive assurance on the pressure ulcer action plan.

SGUH: Limited. It was agreed that as there is still work required in order to hit the targets for pressure ulcers at SGUH, Committee members can only take limited assurance.

6.2 AFPP Theatres

6.2.1 The Committees received the report, which provided an update on progress against the Action Plan that arose from the invited AFPP Peer Review.

6.2.2 The Committees agreed to the proposal that going forward, it will receive an annual report on theatre safety, agreeing that this would be informative and improve the quality governance of this aspect.

6.3 Quality Governance Phase 2

6.3.1 The Committee received the report, which detailed the quality governance improvement action plan in response to the Phase Two review of quality governance carried out by Dr Herne in October 2024.

6.3.2 The Committees reviewed the quality governance improvement plan and requested that another iteration be presented to the July meeting which details the resource needed to deliver the plan, along with the timing of the actions. Once this information is provided the Committees will be able to deliver an assurance rating against the plan.

6.4 Group Board Assurance Framework

6.4.1 The Committees reviewed the strategic risks which relate to quality, as follows:

- SR7: Developing new treatments through innovation and research
- SR9: Improving patient safety and reducing avoidable harm

- SR10: Improving patient experience
- SR11: Tackling health inequalities

6.4.2 Committees members agreed the risk score and assurance ratings for Strategic Risks 7, 9, 10, noting that no changes to risk scores or assurance ratings were proposed at Q1 2025/26

6.4.3 Although it was proposed to lower the risk score of Strategic Risk 11 (Health Inequalities) from 16 to 12, Committees members agreed the risk score should remain the same at 16. The Committee members agreed to an increase in the assurance rating of this risk from “limited” to “reasonable”. This change in assurance rating will be recommended to the Group Board.

7.0 Recommendations

7.1 The Group Board is asked to note the issues escalated to by the Quality Committees to the Group Board and the wider issues on which the Committees received assurance in May and June 2025.

Group Board Meeting (Public)

Meeting on Thursday, 03 July 2025

Agenda Item	3.2	
Report Title	**Group Maternity Services Report**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer Richard Jennings, Group Medical Director Kate Slemeck, Managing Director – St George's	
Report Author(s)	**Integrated Improvement Plan** Natilla Henry, Group Chief Midwifery Officer Sijo Francis, Divisional Chair CWDT **Gesh Maternity Leadership Proposal** Arlene Wellman, Group Chief Nursing Officer Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance Guy Cochrane, Associate Director of Integration, Service Improvement and Strategy	
Previously considered by	Quality Committees	29 May 2025
Purpose	**For Assurance**	

Executive Summary

This paper presents the gesh Group Maternity Services Report for assurance and strategic oversight.

It focuses on two key documents discussed in depth at the Quality Committees in May 2025. Together, these represent a significant step forward in the Group's ambition to deliver safe, effective, and equitable maternity care across both Trusts.

1. **St George's Integrated Maternity Improvement Plan**

This single, unified plan replaces fragmented action lists with a coherent, accountable, and time-bound approach to maternity improvement. Each action is clearly owned and tracked, enabling the Board to see and evaluate the impact of change through improved safety governance, transparency, and maternity performance metrics.
The governance process for retiring completed actions ensures continued rigour, with sign-off via divisional and site governance, the GESH Quality Group, and final approval at QCiC.

A similar integrated plan is now in development for Epsom and St Helier Maternity Services.

2. **GESH Maternity Services Leadership Proposal**

This outlines the new leadership structure, including the introduction of a substantive Group Chief Midwifery Officer (GCMiO) role. This role will provide senior strategic leadership across both sites,

ensuring that there is strong alignment with the Site Directors of Midwifery, promoting collaborative, system-focused leadership across the Group, with a focus on quality, safety, and workforce sustainability.

What This Means for the Board:

Together, these developments signal a more unified, transparent, and strategically led approach to maternity services. They provide the Board with clear lines of assurance, improved oversight of improvement delivery, and a robust leadership model capable of driving sustained and measurable progress in maternity safety and quality across the Group.

Action required by Group Board

The Board is asked to:

a. Receive for assurance the St George's Integrated Maternity Improvement Plan and endorse the approach to delivering a coherent, accountable, and outcomes-focused programme of improvement. The Board is also asked to note the strengthened governance arrangements in place to monitor progress and formally sign off completed actions through established divisional and Group quality structures.
b. Receive for assurance the GESH Maternity Services Leadership Proposal, including the introduction of the Group Chief Midwifery Officer role, and support the strategic intent to strengthen collaborative leadership, alignment across sites, and improved visibility of maternity governance at Group level.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
READING ROOM	**St George's Maternity Integrated Improvement Plan**
Appendix 1	**St George's Integrated Maternity Improvement Plan**
Appendix 2	**gesh Maternity Services Leadership Proposal**

Implications

Group Strategic Objectives

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

Risks

1- **St George's Integrated Maternity Improvement Plan:** Addressed in the plan.
2- **Transitional Uncertainty in Leadership Implementation**

There is a strategic risk that the implementation of the GESH Maternity Services Leadership Proposal may generate transitional uncertainty, particularly where existing leadership roles are being redefined, realigned, or expanded across the Group. This may impact staff confidence, clarity of accountability, and operational cohesion during the early stages of implementation.

In addition, there is a further risk of delay in recruiting to the substantive Group Chief Midwifery Officer (GCMiO) role, which may limit the pace at which unified leadership and Group-wide strategic alignment can be fully embedded.

These risks will be mitigated through proactive and transparent communication, visible executive sponsorship, and consistent staff engagement. An interim leadership model and regular progress updates to the Quality Group and QCIC will support continuity, assurance, and momentum during the transition.

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

Improved maternity quality and strengthened governance arrangements across the Group will help reduce the risk of non-compliance with the Maternity Incentive Scheme (MIS) and Clinical Negligence Scheme for Trusts (CNST) standards, thereby protecting access to financial incentives and avoiding potential penalties.

To successfully recruit and retain a high-calibre Group Chief Midwifery Officer (GCMiO), there may be a requirement to review and potentially increase the banding of the role as currently advertised, This would represent a strategic investment in senior maternity leadership, aligned to the scale, complexity, and ambition of the Group model.

Any additional costs associated with banding or transition will be balanced against the anticipated long-term benefits, including improved outcomes, workforce stability, regulatory assurance, and eligibility for CNST rebate funding.

Legal and / or Regulatory implications

This work supports the Group's compliance with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, in particular:

Regulation 12: Safe care and treatment

Regulation 17: Good governance

Regulation 18: Staffing

It also aligns with requirements under the CQC Registration Regulations, ensuring that the Group meets expectations for safe, effective, responsive and well-led maternity services.

In addition, delivery of this improvement plan and leadership model supports ongoing compliance with the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme, particularly in relation to safety action requirements and Board-level oversight of maternity performance.

Failure to deliver against these regulatory standards could expose the Group to increased scrutiny and reputational risk; therefore, ongoing governance and leadership development are essential to provide robust assurance and sustained compliance.

Equality, diversity and inclusion implications

SGUH Maternity Improvement Plan : EDI implications are included in the plan. **Maternity Leadership:** Efforts to harmonise leadership or governance structures across sites may unintentionally overlook local cultural and demographic needs, particularly as local communities differ in population makeup and health inequalities. This could result in a reduction in service responsiveness or staff alignment with improvement goals. If the appointment process for the Group Chief Midwifery Officer (GCMiO) and other leadership roles does not explicitly consider EDI, there is a risk of underrepresentation of minoritised or marginalised groups in senior leadership. Mitigations include working with the maternity voices partnerships to co-produce culturally competent, inclusive care models, ensuring that EDI impact assessments are conducted for key leadership appointments and changes to governance embedding diverse representation in the recruitment panel and stakeholder engagement processes for appointment to the GCMidO role.
Environmental sustainability implications
No issues to consider.

Group Maternity Services Report

Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This paper provides the Board with assurance on two key developments in Group maternity services, both aimed at strengthening quality, governance, and leadership across St George's and Epsom and St Helier (ESTH)

1.2 **St George's Maternity Integrated Improvement Plan**
The report presents a unified and accountable approach to maternity improvement at St George's, consolidating all existing action plans into a single, coherent framework. The integrated plan clearly defines priorities, ownership, deadlines, and cross-cutting themes (see Appendix 1, slides 4 and 5).

Through strengthened governance and enhanced visibility of delivery, the Board will be able to track impact via improvements in maternity safety, governance oversight, and key performance indicators. The full plan is available in the Reading Room for reference.

Completed actions will be stepped down through local and Group governance structures, with final approval via the Quality Committees-in-Common (QCIC).

1.3 An equivalent integrated plan is currently in development for ESTH.

1.4 **GESH Maternity Services Leadership Proposal**

This section outlines the new maternity leadership structure across the Group, including the establishment of a substantive Group Chief Midwifery Officer (GCMiO) role. It details how this new role aligns with existing Directors of Midwifery and supports collaborative, cross-site leadership to drive improvements in safety, workforce development, and service transformation.
(See Appendix 2.)

2.0 Background and context

2.1 **St George's Maternity Integrated Improvement Plan.** St George's Maternity Service has developed an Integrated Maternity Improvement Plan that consolidates all internal and external actions, recommendations and requirements for the maternity service. A parallel plan for Epsom and St Helier University Hospitals (ESTH) is being developed and is expected to be ready for submission to Quality Committee-in-Common in July 2025.

The integrated improvement plan brings together all relevant activity arising from:

- **Regulatory and statutory oversight**, including but not limited to, CQC inspections, NHS Resolution (CNST), Maternity and Neonatal Safety Investigations (MNSI)

- **Professional reviews**, such as Royal College of Obstetricians and Gynaecologists, National Maternity Perinatal Audit (NMPA) and other external peer reviews
- **Local mechanisms**, including Board Level Safety Champions walkarounds, incident investigations, patient feedback, and internal audit
- **National and System-level initiatives**, such as the Maternity Safety Support Programme (MSSP)

The full plan is available for review in the READING ROOM. It is structured to ensure clarity, ownership and traceability of actions across multiple levels of oversight and accountability, including directorate, divisional and site level, through to executive committee, board and external stakeholders. **A thematic analysis of the actions has been conducted since the plan's review at Quality Committee in Common in May 2025. The thematic analysis captures cross cutting themes and key priorities. Hyperlinks have been added to the plan to facilitate easy view of this across any in-progress actions.**

This will be a live document with a formal process for adding further action plans. The plan has a clear governance framework for stepping down elements that are delivered, embedded and stepped back to business-as-usual oversight. This governance framework involves the Directorate, Division, Site Leadership Team, gesh Quality Group and ultimately the Quality Committee in Common.

Given the size and complexity of the plan, **the agreed priorities, high impact actions, key risks and mitigations have been described in the paper at Appendix 1,** along with the cross-cutting themes that will underpin sustained improvement.

2.2 gesh Maternity Services Leadership Proposal. In response to regulatory scrutiny, most notably the CQC inspections of both SGUH (rated *Inadequate*, March 2023) and ESTH (rated *Requires Improvement*, August 2023), the Group commissioned an Independent Maternity Governance Review led by a NHSE Improvement Director. This review identified fragmented leadership, variation in practice, and inconsistent implementation of improvement plans

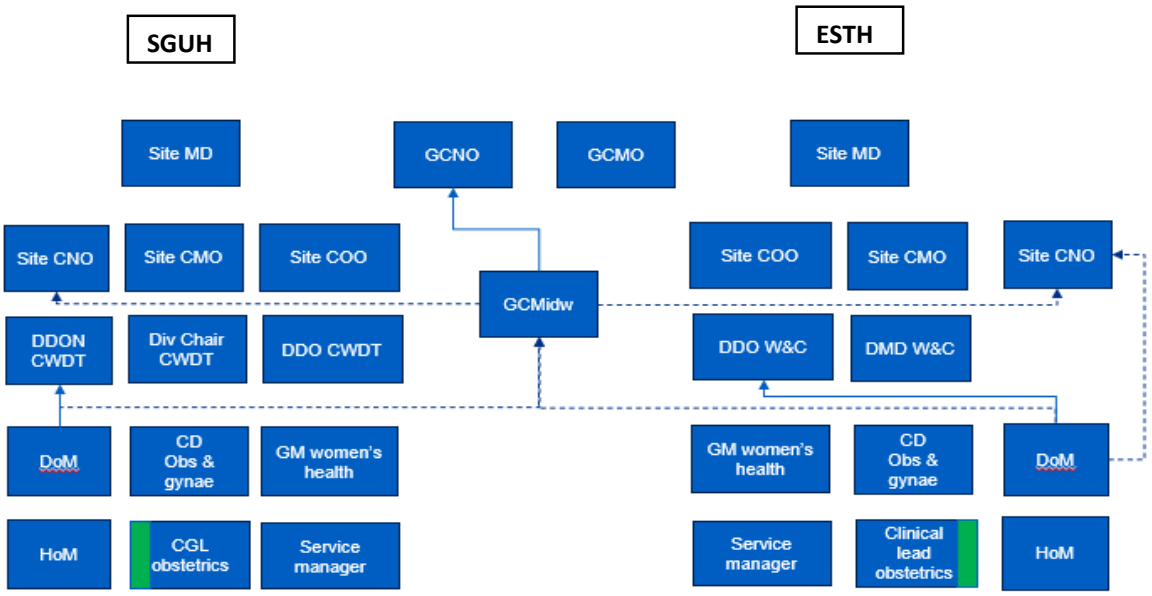
Informed by these findings and recognising that progress against the maternity improvement programme has not met expectations, the Executive team has committed to strengthening joint working arrangements across the Group. These changes are designed to enhance governance, improve leadership accountability, and deliver consistent, high-quality care in maternity and neonatal services.

The detail on the proposed changes, including the full leadership structure and governance model, is provided in **Appendix 2 GESH Maternity Leadership PowerPoint Presentation**. This includes a visual representation of the agreed leadership structure outlining how the new Group Chief Midwifery Officer role links with retained Directors of Midwifery and supports joint working across Sites.

The Key Developments and Proposals are:

2.2.1. Substantive Introduction of a Group Chief Midwifery Officer (GCMiO). The Group has created a new, substantive **Group Chief Midwifery Officer** post to provide professional and strategic leadership across both sites. This is an addition to the current maternity leadership structure, which retains **Directors of Midwifery (DoMs)** at each Trust. The GCMiO will report to the Group Chief Nursing Officer, with dotted lines to Site CNOs, and will work in close collaboration with local DoMs to ensure consistent standards, development opportunities, and aligned strategic priorities across GESH.

Table 1: New Leadership Structure across group



2.2.2 **Strengthened Obstetrics Leadership.** This will be delivered through the existing **Clinical Director for Obstetrics and Gynaecology (SGUH)** and the **Divisional Medical Director for Women's and Children's (ESTH)**. These leaders are mandated to lead group-wide obstetrics development. Additional Programmed Activities (PAs) have been allocated to support the time needed for planning and delivery. This approach maintains local continuity while embedding cross-site strategic responsibility.

2.2.3 **Creation of a Clinical Strategy and Standards Group (CSSG)**. To strengthen oversight and streamline governance, a new monthly **Clinical Strategy and Standards Group (CSSG)** will replace the current bi-monthly Maternity & Neonatal SLT meeting. This group will:

- Oversee the development of a **shared GESH Perinatal Strategy**
- Standardise clinical practice and reduce unwarranted variation
- Lead responses to **CQC inspections** and external review recommendations
- Support review and shared learning from **patient safety incidents (PSIIs)**
- Align digital systems and optimise use of the **EPR and clinical tools**

The CSSG will be chaired by the Group Chief Nursing Officer and include representation from obstetric, midwifery, neonatal, nursing, operational, and finance leadership teams from both Sites and commenced in June 2025.

2.2.4 **System-Level Collaboration and Endorsement.** The proposed structure has been discussed with the Integrated Care Board (ICB) and the Maternity Safety Support Programme (MSSP), both of whom are actively supporting the Group's improvement efforts. The changes are aligned with system-wide goals for maternity transformation, equity, and safety, and have been welcomed as a coherent and pragmatic model for delivering sustained improvement across both sites.

2.2.5 **Governance Streamlining and Impact.** The Clinical Strategy and Standards Group (CSSG) will replace the existing Group bi-monthly Maternity and Neonatal to eliminate duplication, free up leadership time, and focus on higher-value strategic discussion. The role of the CSSG complements existing forums like the Maternity Triangulation Meeting, which will continue to review insights from staff feedback, Employee relations cases, FTSU, complaints, and legal processes.

This restructuring of maternity services leadership reflects a shift from siloed governance to an integrated, strategic leadership model, creating the conditions for improved patient outcomes, enhanced staff experience, and better preparedness for future inspections and regulatory engagement.

These proposals have been developed collaboratively and have been **formally approved by** the **Group Chief Executive Officer, Group Chief Nursing Officer, Group Chief Medical Director**, and the **Managing Directors of both ESTH and SGUH**.

3.0 Recommendations

3.1 The Board is asked to:

a. Receive for assurance the St George's Integrated Maternity Improvement Plan and endorse the approach to delivering a coherent, accountable, and outcomes-focused programme of improvement. The Board is also asked to note the strengthened governance arrangements in place to monitor progress and formally sign off completed actions through established divisional and Group quality structures.

b. Receive for assurance the GESH Maternity Services Leadership Proposal, including the introduction of the Group Chief Midwifery Officer role, and support the strategic intent to strengthen collaborative leadership, alignment across sites, and improved visibility of maternity governance at Group level.

gesh

NHS
St George's University Hospitals
NHS Foundation Trust

Appendix 1

Integrated Maternity Improvement Plan - SGUH

Group Board

3 July 2025

Integrated Maternity Improvement Plan

gesh

NHS
St George's University Hospitals
NHS Foundation Trust

Overview

St George's maternity service has received a number of improvement directions via statutory and advisory bodies, internal reviews, national and system level initiatives and commissioned reports, resulting in a number of action plans. These have been consolidated into an Integrated Maternity Improvement Plan.

The plan is structured to ensure clarity and traceability of actions across multiple levels of oversight and accountability. It looks to establish processes that will become integral to the service's internal assurance and governance processes, enabling critical oversight from divisional and site leadership.

Given the size and complexity of the overall plan, the agreed priorities, high impact actions, key risks and mitigations are described, along with the cross-cutting themes that will underpin sustained improvement.

There is a need to continue strengthening the current ward to board governance framework that enables the delivery of this plan in a way that provides adequate assurance of continuous improvement.

Vision

To deliver a safe, responsive, and continuously improving maternity service underpinned by clear governance, aligned and embedded climate for improvement , and a culture of accountability, compassion, and learning. Through the Integrated Maternity Improvement Plan, we aim to build a service that meets the highest regulatory, professional, and user expectations—ensuring better outcomes, improved experiences for families, and confident, empowered staff.

What are the top 3 requirements that will achieve the vision?

1	Dedicated and sustained improvement built on a foundation of strong leadership and culture : Secure organisational development, transformation, and clinical leadership support to maintain momentum and continuity across all improvement domains
2	Robust governance and accountability framework: Embedded routine oversight at directorate, divisional, site, executive and Board levels to ensure visibility, timely escalation of risks, and assurance that improvements are sustained.
3	Integrated and dynamic improvement infrastructure: Maintaining a single, unified plan that triangulates and consolidates learning and actions across external reviews, internal feedback, and system initiatives. Built in feedback loops, audits, and real-time monitoring to adapt the plan in response to new challenges or evidence.
What is your ask of the group to progress?	**Endorse the vision and strategic direction** Confirm agreement with the vision of delivering a unified, transparent, and sustainable improvement programme within maternity services. The board's views on how best to provide visibility and assurance of these required improvements would be welcomed.

What are the top 3 risks that could prevent us from getting there?

1. The number of actions, and the overlap between some of them, creates a potential risk that key actions are not sufficiently prioritised unless strong governance, accountability and senior oversight is in place to maintain clarity. MITIGATIONS: clear ownership, strengthened governance and accountability framework

2. Sustaining capacity to deliver improvement within workforce, operational and financial constraints. MITIGATIONS: prioritisation, early escalation via maternity oversight group

3. Sustainability of behaviour change and change fatigue : long-term adherence may be undermined by workforce turnover, competing priorities, the need for further development of staff, and the ability to maintain morale within the clinical and operational teams. MITIGATIONS: build into assurance mechanisms

Benefits:

There are several benefits of an integrated improvement plan:

- **Improved visibility and alignment** across multiple assurance and improvement activities
- **Strengthened governance** and a single point of reference for monitoring progress and identifying risks or delays
- **Enhanced accountability**, with clarity of roles, responsibilities and purpose enabling the directorate and Trust leadership to take timely and targeted action
- **Supports Board-level assurance**, including triangulation of themes and evidence of impact
- **Facilitates the embedding of improvements** through integrated tracking of outcomes and sustainability measures

Cross Cutting Themes

A number of cross cutting themes have been identified through review of existing actions.

- **Culture:** Recognition that there is a need to address the broader culture within maternity. A number of feedback mechanisms indicate that although there has been improvement in siloed working, more needs to be done, both within maternity, and in the way maternity services interact with the wider trust. Medical engagement, as part of the maternity multidiscliplinary approach to driving improvements, needs strengthening.

- **Leadership:** The gesh leadership model has been approved but there is a need for developmental work with the maternity quadrumvirate, to enable leaders to drive change with a better understanding of the relationship between leadership, safety improvement and safety culture, enabling a psychologically safe, collaborative and supportive workplace.

- **Governance:** Fragmented governance pathways exist and there is a need to establish and agree a clear infrastructure that aligns with objectives, expectations, risks and reporting requirements. A maternity mapping exercise has taken place to agree a governance and accountability framework. Key aspects include clearly defined roles, responsibilities and accountabilities, and clarity on what information will be reviewed, where, by whom, and to what purpose. There exist a number of mechanisms for auditing, monitoring and oversight of elements of the action plan and ongoing work will streamline and strengthen this to ensure sustained improvement.

- **Assurance:** Flowing from improvements in governance will be the provision of credible information that demonstrates learning and change. This assurance information will be regularly reviewed to ensure the service remains safe, responsive, caring and effective and will contribute to a culture of continuous improvement. This includes effective use of the existing evidence assurance panel and alignment of maternity with existing established trust processes, including audit.

Key priorities and areas of highest impact

Given the volume of actions to complete, the following key priorities have been selected based on recurring themes identified in local incident investigations, national reviews (e.g., MNSI, MBRRACE-UK), regulatory feedback (CQC), and national safety initiatives (e.g., Maternity Incentive Scheme, NHS Resolution). These areas represent known risks where focused improvement is expected to yield measurable safety and quality gains, with a trickle-down impact on wider action areas.

1. **Triage –** consistent findings from local incidents, PSII investigations by the Maternity Neonatal Safety Improvement Programme (MNSI), and CQC inspection show variation in triage practice, risk assessment, and timely obstetric reviews and escalation.
2. **Fetal monitoring / CTG training –** ongoing issues identified in incident reviews, trainee feedback, CQC reports (2023 & 2024), and national audits point to gaps in interpretation and timely response and escalation to abnormal CTGs**.**
3. **Senior obstetric oversight** – incidents e.g., recent maternal death, have highlighted inadequate senior review and clinical oversight during high-risk periods. This is supported by findings from MNSI, Board safety walkarounds, and NHS Resolution Early Notification cases.
4. **Staffing and rota management** – midwifery fill rate is challenging, leading to gaps in the roster and safe staffing on some shifts. Medical cover, particularly out of hours, is challenging regarding provision of cover for all clinical areas due to the breadth of clinical services.
5. **Training compliance** – compliance with mandatory training is below trust target for some staff groups and role specific training e.g., PROMPT is also below expected target, particularly for medical staff.
6. **Perinatal Mortality Review Tool (PMRT)** – National requirement (MBRRACE-UK, Maternity Incentive Scheme) requires for timely, thorough, and family-engaged reviews that are MDT in composition and include external representation. SGUH did not meet CNST Year 6 safety action 1 due to late reporting of cases to MBRRACE, highlighting the need for improved oversight and governance.

Providing assurance and evidence of embedding

A consistent, embedded assurance process will be used across all key priorities and will be:

Multi-layered – drawing from real-time clinical data, staff feedback, audit, and outcomes.

Inclusive – all maternity staff will be expected to understand their role in delivering and evidencing safe, high-quality care.

Standardised – using agreed metrics, tools, and templates for consistency (e.g., audit tools, incident analysis, training compliance dashboards).

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Progress summary against actions

Integrated plan - Action Areas	Number closed	% Closed	Number open	% Open
Baby Falls	19	95%	1	5%
Transitional Care	14	100%	0	0%
SA3 Avoidable term admissions	8	89%	1	11%
MBRRACE 2020	9	100%	0	0%
MBRRACE 2021	29	97%	1	3%
Early notification scheme	5	71%	2	29%
MIS Year 6 actions	3	75%	1	25%
MIS Year 7 Actions	0	#DIV/0!	0	#DIV/0!
CQC Must dos 2023 inspection	14	67%	7	33%
CQC Immediate actions Jan 25	31	91%	3	9%
MSSP Actions	5	50%	5	50%
Safety Champions Actions	4	50%	4	50%
Total	141	85%	25	15%

This is a new action, updates will be provided during the MIS year

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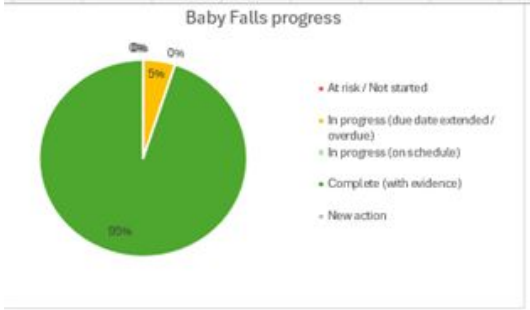
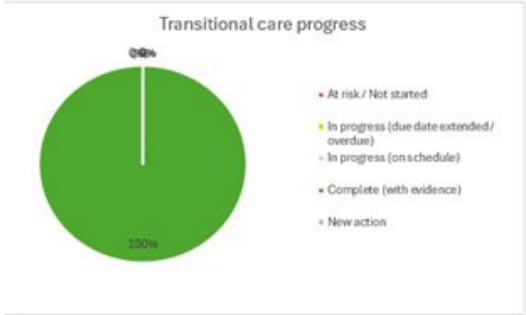
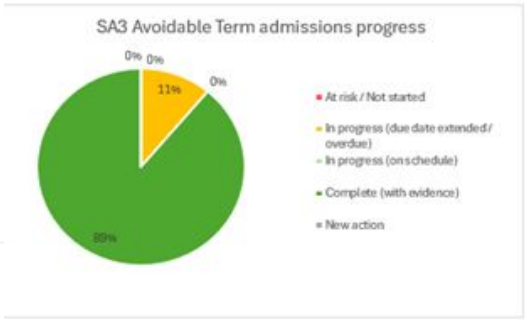
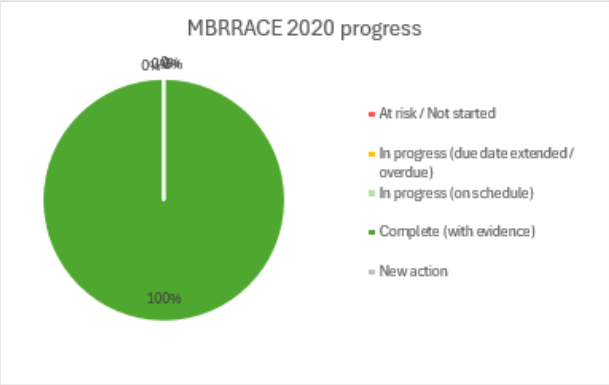
Progress charts

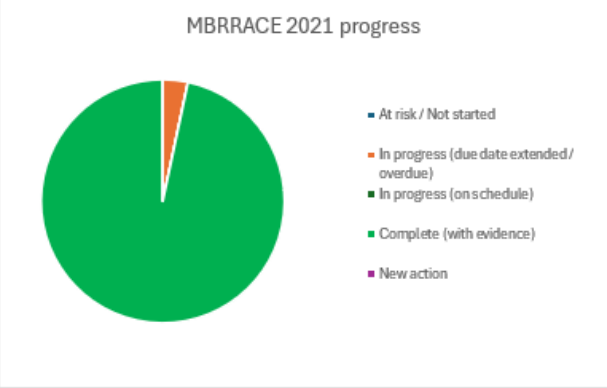


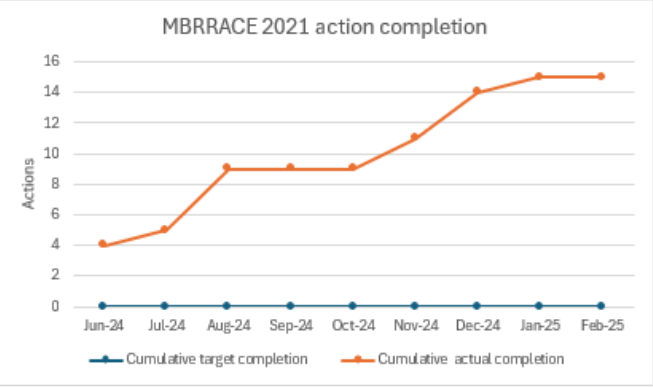




Progress charts







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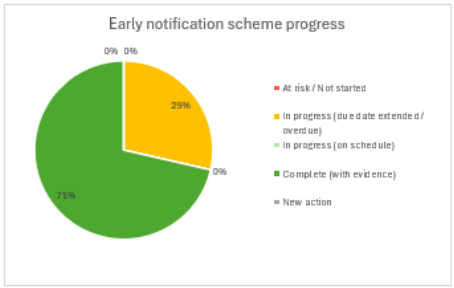
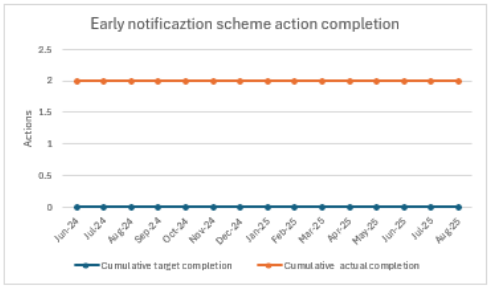
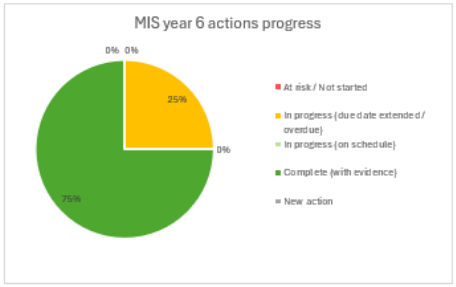
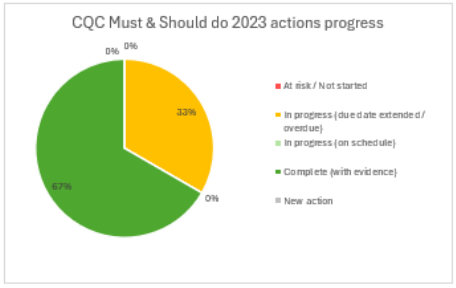
Progress charts

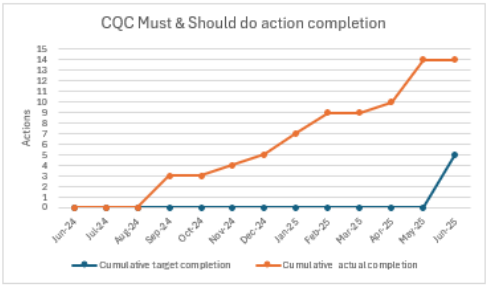




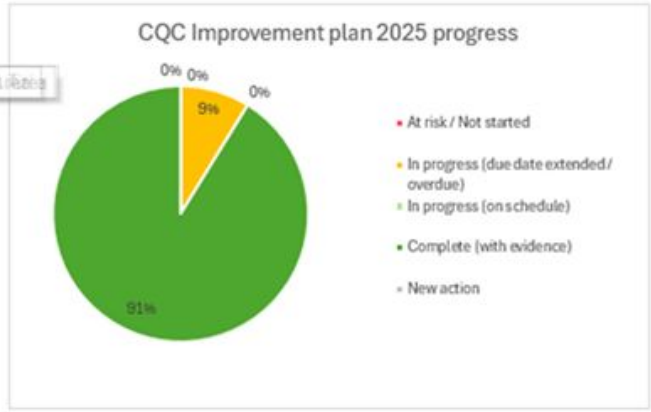
missing action completion dates







No action target completion dates



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Risks and Mitigations

Risks	Mitigation
The number of actions, and the overlap between some of them, creates a potential risk that key actions are not sufficiently prioritised unless strong governance, accountability and senior oversight is in place to maintain clarity.	Clear overall ownership of the plan, including of actions, timelines and RAG-rated progress Strengthened governance and accountability framework allowing responsiveness to key areas of risk across all levels of the organisation
Sustaining capacity to deliver improvement within current workforce, financial and operational constraints	Prioritisation based on risk, impact and regulatory requirements. Early escalation of resource gaps and/or actions at risk through the maternity oversight group
Sustainability of behaviour change and change fatigue : long-term adherence may be undermined by workforce turnover, competing priorities, the need for further development of staff, and the ability to maintain morale within the clinical and operational teams.	Build into assurance mechanisms, including evidence of cultural and behavioural change, audit and real-time metrics
Risk of duplication or misalignment between action plans	Clarity of roles and responsibilities Regular triangulation through strengthened governance and accountability framework

Oversight of the plan will be managed by:

- Review of progress against the key quality and safety indicators at the monthly Divisional Governance Meeting
- Integrated performance and quality reporting as part of the Divisional Quality and Safety reports to the Site Patient Safety and Quality Group
- Detailed oversight of key areas of risk through established site governance, including Mortality Monitoring Group
- Escalation of key risks, barriers and achievements to the Site Leadership Team via the Maternity Oversight Group.
- Quarterly updates of progress, interdependencies, key risks and externally mandated requirements to gesh Quality Group, Quality Committee in Common and Trust Board, through the maternity board report.

This structure, along with an evidence assurance panel that reviews the quality of assurance evidence, ensures actions are not only delivered but embedded, with mechanisms in place for ongoing monitoring, including audits, staff feedback and user experience.

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Thank you.

For any other information, please see:

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University Hospitals and Health Group

Appendix 2

Maternity Leadership- gesh

Group Board
3 July 2025

To support maternity improvement efforts – it was agreed that joint working arrangements should be implemented

Context:
Following the CQC inspection of St George's maternity unit from 22 March 2023 to 23 March 2023, and their visit to ESTH's maternity unit in August 2023 with an outcome Inadequate for SGH and Required improvement for ESTH.

An in-depth governance review has been undertaken by the external Improvement Director who was seconded working closely with the GCNO and GCMO. The Group appointed an Interim new role of Group Chief Midwifery Officer (GCMiO) on 19 February 2024.

The findings of the external review were submitted to the Trust leadership teams in April 2024 and the board has accepted the recommendations.

In parallel, an improvement programme has been put in place. However, progress against this programme has not been as rapid as desired. In response, the executive have committed to strengthening joint working arrangements across gesh – giving greater time for leads to consider and influence strategy and planning – whilst also creating clearer lines of accountability to the executive team.

Maternity joint working arrangements

The executive have committed to developing the following joint working arrangements:

1. Restructuring the maternity leadership across the group – retaining the Director of Midwifery roles at each Trust – with the GCMiO taking more responsibility for Quality and strategic leadership.
2. Developing group obstetrics leadership – allocating additional PAs to obstetric leads in each Trust and mandating these individuals lead the development of joint working arrangements across the Group.

3. Establishing a Clinical Strategy and Standards Group (CSSG) – to oversee joint strategy development and implementation of shared standards and plans

This deck outlines the proposals for these three initiatives


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University Hospitals and Health Group
Maternity Leadership: Structure
www.stgeorges.nhs.uk

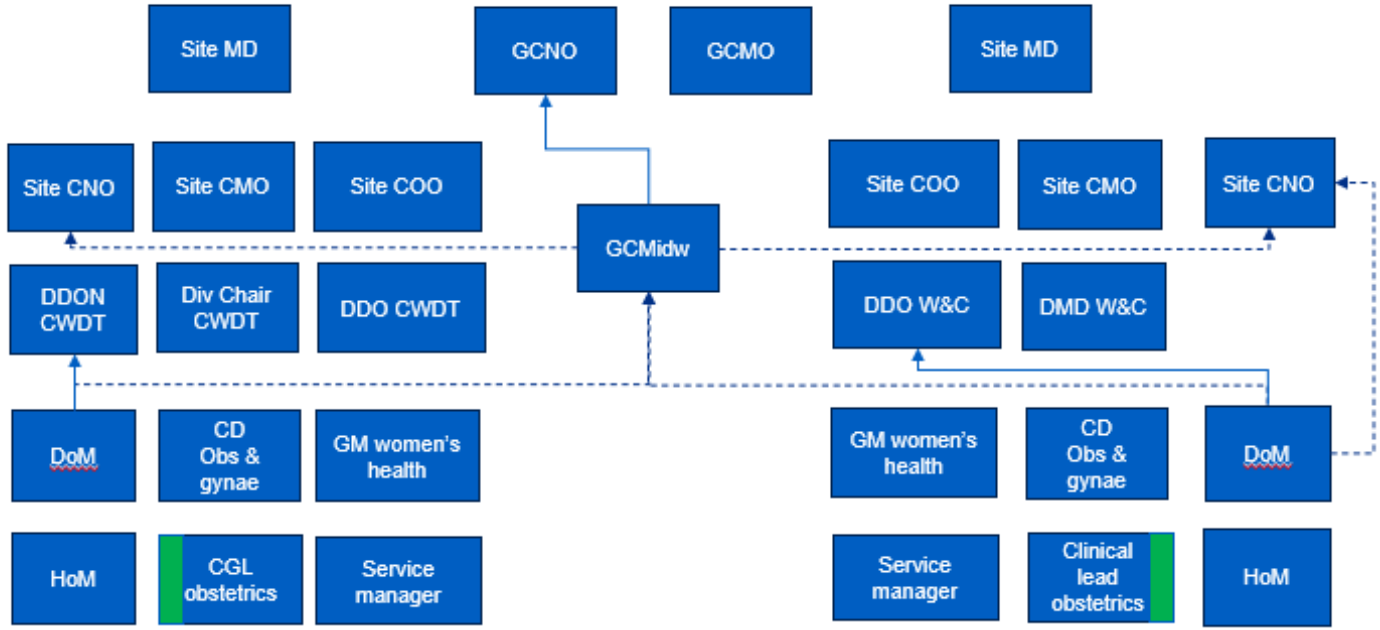
The Agreed Leadership Structure

The Maternity Leadership structure is being redesigned to strengthen collaboration and alignment between ESTH and SGUH.

One of the key changes is the introduction of a formal reporting line from the **Group Chief Midwifery Officer (GCMiO)** to the **Group Chief Nursing Officer**, with dotted-line accountability to the **Site Chief Nursing Officers**.

The model retains **Directors of Midwifery** at each site and sets out a structure that enables strategic oversight from the Group level, while maintaining strong operational leadership locally.

To support integrated working in Obstetrics, additional Programmed Activities (PAs) have been allocated to medical leads at site level.
The proposed structure is outlined in more detail in the annex opposite.

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University Hospitals and Health Group
Obstetrics leadership
www.stgeorges.nhs.uk

Obstetrics Leadership Across GESH to Be Delivered by the Divisional Medical Director at ESTH and the Clinical Director at SGH

- The Group Chief Medical Officer and Site Chief Medical Officers explored several models to enhance joint working across GESH.
- Options included the creation of shared leadership posts with cross-site responsibility. However, following detailed discussion, it was agreed that the most effective approach—given existing relationships and operational dynamics—was to invest additional Programmed Activities (PAs) in current clinical leaders.
- These individuals were formally tasked with developing and embedding joint working arrangements in Obstetrics across the Group

For Obstetrics, it was agreed that leadership responsibility for developing joint working arrangements would remain with current site-based leads. Specifically:

•At **St George's**, the Clinical Director for Obstetrics and Gynaecology will lead this work, supported by the allocation of an additional Programmed Activity (PA).

•At **ESTH**, the Divisional Medical Director for Women's and Children's will assume this responsibility, with no additional PAs required—reflecting the capacity available within the division for clinical leadership.

It was also recognised that other specialties may require bespoke approaches to cross-site collaboration, and as such, this model is not intended to serve as a universal template for all services across GESH.


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University Hospitals and Health Group
Clinical Strategy and Standards Group (CSSG)
www.stgeorges.nhs.uk

To strengthen oversight and decision-making it was agreed to establish a clinical strategy and standards group(CSSG)

Terms of reference for perinatal Clinical Strategy and Standards Group informed partly by CQC inspections of maternity, and our management response

Purpose: To develop shared clinical strategy and reduce unwarranted variation across gesh in perinatal services.
Regularity: Monthly

Membership:

- Group Chief Nursing Officer (chair)
- Group Chief Midwifery Officer
- Site Chief Nursing Officer
- Divisional Medical Director W&C, ESTH
- Divisional Chair, CWDT, SGH
- Clinical Director Women's, SGUH
- Director of Midwifery ESTH and SGH
- Clinical Lead for Obstetrics (ESTH)
- Care Group Lead for Obstetrics (SGH)
- Matron, NNU, SGUH
- Consultant Paediatrician, NNU, ESTH
- Neonatal Care Group Lead, SGUH
- Director of Nursing, NNU, ESTH
- Divisional Director of Operations/Deputy Divisional Director of Operations, Women's and Children's, ESTH
- Divisional Director of Operations/Deputy Divisional director of operations, CWDT, SGH
- Finance and Business Partner, ESTH
- Head of Finance, SGH
- Strategy and Planning Manager
- PMO lead
- Project administrator / business manager

Responsibilities:

- Oversee development of a gesh perinatal strategy – ensuring that this is consistent with existing programmes of work and national recommendations
- Oversee response to gesh Maternity CQC reviews and recommendations, including delivery of the improvement plans
- Ensure that strategies and plans are focused on delivering high-quality, sustainable perinatal services across gesh
- Identify opportunities to resolve unwarranted variation in outcomes and adopt a single set of clinical standards across gesh
- Identify opportunities to deliver financial savings through adoption of best practice, rationalisation of resources and implementing innovative and efficient practices.
- To review PSIIs – and ensure learning is shared across gesh
- To support alignment of clinical systems and digital tools – driving productivity and efficiency. This should include optimisation and standardisation of EPR use

Note:
This forum will not discuss operational issues, which will remain the responsibility of site divisional teams

Two GESH-Wide Governance Meetings Already Exist with Similar Remits

The following meetings are currently in place to support maternity and neonatal governance, strategy, and operational delivery across GESH. These forums provide oversight of key priorities including governance challenges, staff and stakeholder feedback, and opportunities for continuous improvement. **Quarterly Staff Engagement meetings** with Maternity Safety Champions also take place, offering an open platform for staff to raise questions and share concerns. These engagement sessions are out of scope for this review but remain a valued mechanism for staff voice.

Bi-Monthly Maternity & Neonatal SLT Meeting

Purpose: Offers an opportunity for site leadership teams to discuss more specific governance related issues and challenges and to share best practices across the sites.

Members
- Co-chaired by gesh GCNO & DIPC and gesh GCMiO
- Consultant Obstetrician, Care Group Lead for Obstetrics, SGUH
- Director of Midwifery, SGUH
- Divisional Medical Director, W&C, ESTH
- Matron, Antenatal Care & Community, SGUH
- Interim Governance Lead Midwife, SGUH
- Head of Midwifery & Gynae Nursing, ESTH
- Director of Midwifery, SGUH
- Clinical Governance Lead, NNU, SGUH
- Director of Nursing, NNU, ESTH
- Neonatal Care Group Lead, SGUH
- Clinical Director for Gynaecology & Obstetrics, SGUH
- Head of Nursing, CWDT, SGUH
- Lead Midwife, Clinical Governance & Assurance, ESTH
- Site Chief Nurse, SGUH
- Group Chief Nursing Officer and DIPC
- Matron, NNU, SGUH
- Consultant Paediatrician, NNU, ESTH
- Business Manager (GCNO)

Bi-Monthly Maternity & Neonatal Triangulation Meeting

Purpose: To discuss emerging issues with reference to feedback from Maternity Safety Champions, staff feedback, claims, coroners enquires/inquest, CQC inquires, PHSO/complaints/PALS, Employee Relations and FTSU.

Members
- Chaired by gesh GCNO & DIPC
- gesh Director of Compliance
- Head of Employee Relations, SGUH & ESTH
- Head of Midwifery, ESTH
- Head of Nursing for Quality and Safety Governance
- gesh Chief Midwifery Officer (GCMiO)
- Head of Nursing, Neonatal, SGUH
- Interim Maternity Governance Midwife, SGUH
- gesh Head of Legal Services
- Clinical Director for Women's, SGUH
- Non-Executive Director and Maternity Safety Champion
- FTSU Guardian, SGUH
- Consultant & Neonatal Safety Champion, ESTH
- gesh GCNO Business Manager
- Legal Services, ESTH
- Director of Midwifery, SGUH
- MSSP Maternity Advisor
- Lead Midwife, Clinical Governance & Assurance, EST

CSSG Will Replace the Two Existing GESH-Wide Governance Meetings from June 2025

Proposed Change: Replace the Bi-Monthly Maternity & Neonatal SLT Meeting with a Clinical Strategy & Standards Group, which meets monthly. The rationale for this change is as follows:

- **Increased time allocation:** The meeting would shift to becoming a monthly forum. This will allow for regular meetings to identify where the improvement programmes are off track and to facilitate rapid agreement on corrective actions. The increased time allocation will also allow for the development of a strategy that requires oversight, and ownership from the maternity, obstetrics and neonatal teams in both Trusts.

- **Overlapping Purpose**: The SLT meeting currently focuses on governance issues, sharing best practices, and challenges across sites. These objectives align with the CSSG's remit to develop shared strategies, reduce variation, and improve outcomes.

- **Streamlined Governance**: Combining the SLT into the CSSG eliminates redundancy while providing a sharper focus on clinical strategy. By introducing a structured agenda within the CSSG, key topics like governance, leadership challenges, and variation reduction can be addressed more effectively.

- **Optimised Use of Leadership Time**: Replacing the SLT ensures leadership teams spend their time in high-value discussions focused on strategic improvements rather than duplicative governance conversations.

- **Improved Outcomes Through Standardisation**: The CSSG can provide a more robust forum to align clinical systems, processes, and practices across sites. This drives consistency, reduces variation, and accelerates the adoption of best practices.

Group Board

Meeting on Thursday, 03 July 2025

Agenda Item	4.1	
Report Title	**Report from Finance and Performance Committee**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Ann Beasley, Committee Chair	
Previously considered by	n/a	-
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Finance and Performance Committee at its meetings in May and June 2025 and sets out the matters the Committee wishes to bring to the attention of the Board.

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

Action required by Group Board

The Board is asked to:

a) Approved updated terms of reference (appended to this paper, updated just for name change)
b) Note the paper

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Terms of Reference 2025/26
Appendix 2	[Add name or delete if not required]
Appendix 3	[Add name or delete if not required]

Implications

Group Strategic Objectives

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

Risks

[Set out summary of risk and state link to Board Assurance Framework]

CQC Theme

☐ Safe	☒ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

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

Financial implications

n/a

Legal and / or Regulatory implications

n/a

Equality, diversity and inclusion implications

n/a

Environmental sustainability implications

n/a

Finance and Performance Committee Report
Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Finance and Performance Committee at its meetings in 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 30th May and 27th June 2025, the Committee considered the following items of business:

30th May 2025	27th June 2025
PUBLIC MEETING • Finance Performance M1 • CIP update M1 • Costing/SLR • Business Planning 2025/26 • Productivity update • Terms of Reference 2025/26 • SWL Pathology update	**PUBLIC MEETING** • GCFO briefing • Financial Recovery Board update • Finance Performance M2* • CIP Update M2 • Cash update • Controls • BAF SR4 update • Productivity update • Business cases • IQPR • BAF SR8 update • QIA update

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

2.2 The Committee was quorate for both meetings.

3.0 Analysis

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

a) Financial Performance at M2- SGH and ESTH remain on plan at M2 despite risks in both financial positions. SGH has brought forward non recurrent benefits of £2.0m to date which will need to be made up in future months to deliver the plan. ESTH has more material risk on income delivery should ERF be clawed back by commissioners, because of downtime caused by the EPR go live.

b) CIP performance – Whilst progress is good in moving schemes to fully developed, there remains material risk that CIP targets will not be fully identified in the financial year.

c) Cash actions - The GCFO outlined some of the actions required to ensure the finance department maintains good cash management, as the external environment will make this far more challenging in 2025/26.

d) Operational Performance- The Committee reflected on good progress in many areas of Operational performance, as well as conducting detailed discussions on areas for improvement.

4.0 Sources of Assurance

4.1

a) Financial Performance M2
Both trusts have reported on plan at month 2. To do this some additional non-recurrent benefit has been added to SGH (£2.0m) to help support that position. This brings forward other planned benefits and means the challenge for later in the year increases. The plan position for month 2 is not as challenging as later in the year in terms of the level of CIPs required. Failure to identify and deliver CIPs in month 3 will make remaining on plan very difficult to sustain.

b) FRB/CIP discussion

Committee members focussed on CIP progress for 2025/26 where progress whilst better than at the same time in previous years, was slower than was needed to fully deliver the plan. The Committee noted the strategy to improve the level of fully developed schemes.

c) Business Cases

Committee members noted the update provided on business cases.

d) Productivity update

The SGH DFS updated on the latest productivity information noting an expectation for further clarity on how various metrics are calculated at the centre.

e) Cash 2025/26

The GCFO noted the key parameters for cash management in 2025/26, the interplay between delivery of recurrent cash releasing CIP savings and sufficient cash availability, and how the finance department would best begin to manage any risk.

f) Controls

The committee welcomed the update to the ICB on the control environment at each organisation.

g) Costing

In May the committee approved the submission of the assurance statements and noted the content of the report.

h) IQPR

Operational colleagues updated on some of the key challenges in delivering elective and non-elective targets as we begin the new financial year. Whilst there was strong

performance against benchmarks in many areas, the Committee asked for more assurance on benefits realisation on the EPR go live.

i) QIA

Committee members welcome the assurance outlined from the paper on the QIA process.

j) Terms of reference

The Committee signed off the new Terms of Reference for 2025/26 which updated for the change of name (only).

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

a) SWL Pathology report

The Committee noted the update from SWLP

5.0 Implications

5.1 The Committee approved the proposed BAF operational-related risk SR 8 – Reducing Waiting Times and recommended no changes to the score of '20' and limited assurance. It recommended targets for the year end of '15' and Reasonable assurance.

5.2 The Committee approved the proposed BAF finance risk SR4 - Achieving financial sustainability and recommended no changes to the score of '25' and limited assurance. It recommended targets for the year end of '20' and Reasonable assurance.

6.0 Recommendations

6.1 The Group Board is asked make decisions as requested above and to note the issues escalated to the Board and the wider issues on which the Committee received assurance in May and June 2025.

Finance and Performance Committee

Terms of Reference

1. Name

The Committee shall be known as the “Finance and Performance 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 and Risk 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 and Performance 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 and Performance Committee, acting as part of a Group-wide Finance and Performance 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 and Performance 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 and Performance Committee Terms of Reference
Version	0.4
Executive Sponsor	Group Chief Finance Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Committee approval	
Date of Trust Board approval	
Date for next review	July 2026

Group Board

Meeting on Thursday, 03 July 2025

Agenda Item	4.2	
Report Title	**Finance Performance & Assurance (PUBLIC MEETING)**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	GCFO	
Previously considered by	Finance and Performance Committees	27 June 2025
Purpose	**For Noting**	

Executive Summary

Month 2: Both trusts have reported on plan at month 2. In order to do this some additional non-recurrent benefit has been added to SGH (£2.0m) to help support that position. This brings forward other planned benefits and mean the challenge for later in the year increases. The plan position for month 2 is not as challenging as later in the year in terms of the level of CIPs required. Failure to identify and deliver CIPs in month 3 will make remaining on plan very difficult to sustain.

SWL reported on plan at month 2, other London systems are still off plan at month 2. Detailed reasons have not been made available as of yet, but the key issue for other systems seems to be the delivery of CIPs.

CIPs. Overall, on plan at month 2, although this is the month with a low level of planned CIP delivery. SGH has utilised more non-recurrent actions to achieve this position given lower than planned levels of recurrent CIPs. This will cause pressure later.

Workforce. ESTH slightly ahead of plan (9 WTE) supported by a favourable position on budgets offset by a delay in the TUPE of staff to SGH. SGH is 45 WTE adverse to plan, driven by lower levels of CIPs than the value expressed in the plan. The underlying level of adverse variance at SGH is higher than the 45 noted given the favourable impact of the delayed TUPE from ESTH.

The Board is asked to note that while the position is on plan the underlying position remains highly challenging, and looking at coming months our ability to remain on plan will be impossible to maintain unless more CIPs are identified.

Action required by Group Board

The Board is asked to note this paper.

Committee Assurance

Committee	Finance and Performance Committees

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

Appendices	
Appendix No.	**Appendix Name**
Attachment 1	

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

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

Trust Board (Public):
7th July 2025
25/26 M02 Financial Performance

GCFO, SGH Site CFO, ESTH Site CFO

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University Hospitals and Health Group

Introduction from GCFO

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Key messages

- Month 2: **Both trusts have reported on plan at month 2**. In order to do this some additional non-recurrent benefit has been added to SGH (£2.0m) to help support that position. This brings forward other planned benefits and mean the challenge for later in the year increases. The plan position for month 2 is not as challenging as later in the year in terms of the level of CIPs required. Failure to identify and deliver CIPs in month 3 will make remaining on plan very difficult to sustain.
- **SWL reported on plan at month 2, other London systems are still off plan at month 2**. Detailed reasons have not been made available as of yet, but the key issue for other systems seems to be the delivery of CIPs.
- CIPs. **Overall, on plan at month 2**, although this is the month with a low level of planned CIP delivery. SGH has utilised more non-recurrent actions to achieve this position given lower than planned levels of recurrent CIPs. This will cause pressure later.
- Workforce. **ESTH slightly ahead of plan (9 WTE)** supported by a favourable position on budgets offset by a delay in the TUPE of staff to SGH. **SGH is 45 WTE adverse** to plan, driven by lower levels of CIPs than the value expressed in the plan. The underlying level of adverse variance at SGH is higher than the 45 noted given the favourable impact of the delayed TUPE from ESTH.
- The Board is asked to note that while the position is on plan the underlying position remains highly challenging, and looking at coming months our ability to remain on plan will be impossible to maintain unless more CIPs are identified.

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University Hospitals and Health Group

Group M02 position

GESH

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	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• **In May both Trusts are reporting being on plan.**	• The month 2 plan has been met but the CIP ask increases markedly in future months	• Continued focus on the development and delivery of CIPs through site management meetings. • Controlling costs in line with budgets must be maintained.
Workforce costs and WTE plan	• Pay expenditure is £0.4m favourable at ESTH. • WTE at ESTH is 11 WTE favourable with agency staff being 27 WTE better than plan offset by bank and substantive which are both 9 WTE adverse. • WTE at SGH is adverse to plan by 45 due to CIP shortfall of 30 and seasonality of 32, offset by a 25 favourable on TUPE.	• Control of pay remains crucial. • Plans for future CIPs still required. Pressure on SGH position greater. • Favourable variances provide an opportunity to review.	• Continued focus on the identification and delivery of CIPs. Review areas favourable to plan to identify if these can be maintained. • Review and challenge areas adverse to plan to identify is the issue can be mitigated.
CIP delivery	• ESTH is on plan and has delivered £4.0m of CIP in May. Recurrent schemes were £156k ahead of plan which meant that £134k less of non recurrent finance actions were required in month. • SGH has delivered the £6.0m plan at M2 although this includes £2.0m of b/f NR delivery from future months.	• The CIP target has been met in month however the CIP requirement increases in each month over the year.	• Continued focus on CIPs identification and delivery within the Trust. • Work actively with SWL groups to identify other opportunities and system wide actions, including estates, medical staffing and agency.

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Site summary I&E

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	Head line I&E YTD	Key issues	Key actions
ESTH Acute	• £0.2m adverse to plan • On plan on CIP	• Adverse position to plan driven by shortfall on other operating income (mainly a profile issue) partially mitigated by non-pay underspends • Pay is on £0.4m favourable • Acute financial challenge accelerates as CIP is phased later in the year.	• Continued focus on CIP development, delivery and cost control on expenditure budgets.
ESTH IC	• On plan YTD • On plan on CIP	• Overall on plan in month with Pay £0.2m adverse offset by £0.2m favourable income.	• Ongoing review of CIP plans in progress and actions to move to fully developed and delivery
SGH Acute	• £0.1m adverse YTD	• Adverse income and pay offset by non-pay	• Acute financial challenge accelerates as CIP is phased later in the year. • Continued focus on CIP development, delivery and cost control on expenditure budgets.
Corporate (group)	• £0.5m favourable YTD	• SGH favourable by £0.1m • ESTH favourable by £0.4m • CIP targets will increase in coming months.	• Progress Corporate CIP development through Corporate Recovery focussing on benchmarking opportunity and integration savings.

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ESH - Summary Reported Position

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Performance	M02 Reporting Plan £'m	Actual £'m	Variance £'m	FOT Reporting Plan £'m	Actual £'m	Variance £'m
Income	119.7	119.5	0.3 A	727.6	727.6	-
Pay	-85.0	-84.7	-0.4 F	-487.9	-487.9	-
Non-Pay	-38.5	-38.6	0.1 A	-212.3	-212.3	-
Non Operating items	-4.7	-4.7	-0.0 F	-33.2	-33.2	-
Performance Target	**-8.5**	**-8.5**	**-0.0 F**	**-5.7**	**-5.7**	**0.0 A**

CIP	Plan £'m	Actual £'m	Variance £'m	Plan £'m	Actual £'m	Variance £'m
Recurrent Efficiencies	3.4	3.6	-0.2 F	47.1	51.8	-4.7 F
Non Recurrent Efficiencies	0.5	0.4	0.1 A	20.5	15.9	4.7 A
Total	**3.9**	**4.0**	**-0.0 F**	**67.6**	**67.6**	**0.0 A**

Efficiency Progress	Pay £'m	Non Pay £'m	Income £'m	Total £'m
Fully Developed	13.7	11.8	2.1	27.5 A
Plans in Progress	4.3	2.0	0.1	6.4 A
Opportunity	14.8	16.7	2.1	33.7 A
Unidentifed	0.0	0.0	0.0	-
Total	**32.8**	**30.5**	**4.3**	**67.6 A**

Workforce	Plan WTE	Actual WTE	Variance WTE
Substantive	6,381	6,391	-10.0 A
Bank	951	960	-9.0 A
Agency	136	107	29.0 F
Total	**7,468**	**7,458**	**10.0 F**

Key Metrics		Plan	Actual	Variance
Bed Numbers	**No**	**621**	**629**	**-8**
Capital	**£'m**	**2.4**	**4.0**	**-1.6 A**
Cash	**£'m**	**36.0**	**41.8**	**5.8 F**
BPPC	**%**	**95%**	**94.30%**	**0.70%**

- The Trust is on plan at the end of May with a deficit of £8.5m.
- Whilst there are risks, the Trust forecasts in the monthly NHSE return that its plan will be delivered at year end and mitigations identified and delivered.
- The Trust has delivered its CIP plan to date however the CIP ask increases in future months. £33.7m CIP remains as opportunity.
- The Trust is 10 WTE favourable to its workforce plan due to agency WTE.
- Capital is ahead of plan as spend on the EPR project has been brought forward.
- Cash is £5.8m better than plan due to timing of pay award and phasing of the income cash payments.
- G&A bed plan 621 average beds M2 compared to 616 plan. Driver is DTAs within SDEC and HUB reported as escalation beds – work with system ongoing to agree consistent reporting
- BPCC is slightly behind plan but on an improving trajectory – see balance sheet slides and cash paper.

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University Hospitals and Health Group

SGH - Summary Reported Position

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Performance		Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Income		212,281	211,725	-556	1,274,342	1,274,342	0
Total Pay		-137,008	-137,885	-877	-784,425	-784,425	0
Non-Pay		-81,682	-80,317	1,365	-469,203	-469,203	0
Non Operating Items		-3,483	-3,415	68	-20,714	-20,714	0
Performance Target		**-9,892**	**-9,892**	**0**	**0**	**0**	**0**

CIP		Plan £'000s	Actual £'000s	Variance £'000s	Plan £'000s	Forecast £'000s	Variance £'000s
Recurrent Efficiencies		4,823	1,891	-2,932	74,300	74,300	0
Non-Recurrent Efficiencies		1,175	4,107	2,932	21,000	21,000	0
Total		**5,998**	**5,998**	**0**	**95,300**	**95,300**	**0**

Efficiency Progress	Pay £'000s	Non Pay £'000s	Income £'000s	Total £'000s
Fully Developed	7,486	12,562	3,588	23,636
Plans in Progress	6,864	2,803	1,452	11,119
Opportunity	32,068	22,538	938	55,545
Unidentified		5,000		5,000
Total	**46,419**	**42,903**	**5,978**	**95,300**

Workforce		Plan WTE	Actual WTE	Variance WTE	Closing plan WTE
Substantive		9,922	10,026	-104	9,691
Bank		787	749	38	739
Agency		109	88	21	58
Total		**10,818**	**10,863**	**-45**	**10,488**

Key Metrics		Plan	Actual	Variance
Bed Numbers	**No**	**821**	**821**	**0**
Cash	**£m**	**79,004**	**77,889**	**-1,115**
Capital Spend	**£m**	**9,052**	**7,395**	**-1,657**
BPPC volume non NHS	**%**	**95.00%**	**90.08%**	**-4.92%**

Summary

The following slide summarises the key information given in the monitoring return submission for M2.

The detail of each of these metrics is included in the following slides.

- The Trust is on plan at M2 and forecasting this as well.
- CIP is on plan primarily being delivered non-recurrently.
- WTE is adverse by 45 owing to CIP shortfall
- Cash is slightly adverse to plan by £1.1m
- Capital is underspent by £1.7m
- BPPC is lower than the 95% target

Group Board

Meeting on Thursday, 03 July 2025

Agenda Item	4.3	
Report Title	**Group IQPR**	
Executive Lead(s)	Michael Pantlin, Group Deputy Chief Executive Officer	
Report Author(s)	Michael Pantlin, Ed Nkrumah	
Previously considered by	Finance and Performance Committees	27 June 2025
Purpose	**For Review**	

Executive Summary

This report provides an overview of the key operational and quality performance information, and improvement actions across St George's Hospitals (SGUH), Epsom and St Helier Hospitals (ESTH), and Integrated Care (IC) sites, based on the latest available data.

The executive summaries in the report highlight successes achieved throughout the month and challenges affecting performance for each Trust.

Meanwhile, the overall picture provided illustrates the challenge to improve access to safe care for patients and reduce costs considerably. Whilst historical attendances to A&E appear relatively flat, challenges are presented by the need to ensure patients are directed and/or discharged to the right care settings and capacity is managed accordingly.

In elective care, validation of the waiting list is helping improve data quality but this can also mean performance appears to deteriorate – such has been the case at St Georges, which remains within the set plan for RTT but with little headroom. Outpatients is one area where opportunities to improve capacity and reduce cost are being pursued – including improving Patient Initiated Follow Up rates (PIFU) and reducing Did Not Attend rates (DNA).

Amongst the sea of data, it helps to bring forward excellent performance otherwise overlooked by exception reporting. Addressing complaints in a timely way is important to patients and are valuable learning exercises for the Trusts. Responding fully to complaints within 35 days is at 94% at SGH and 86% at ESTH – both above target for a process which requires co-ordination across many clinical and support staff.

Technology is also worth highlighting, as ESTH continues the stabilisation of its new Electronic Patient Record (EPR). Ultimately, utilising the capability of an EPR will enable many improvements in care and the example of improving VTE risk assessments post-stabilisation is provided in the report as a priority. A new EPR is a huge change-over for staff and, as a shared system with SGH, this affects many across the whole of gesh. Staff have adapted to the changes admirably and the leadership and responsiveness of the programme team are also worthy of recognition.

Keeping with our people, we continue to see high retention of staff but challenges with sickness absence. A focus on sickness prevention is underway as part of a wide range of measures to improve attendance and the benefits this has for care and team morale.

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

This report format and content will continue to evolve in 2025/26, to reflect the annual plans of the Trusts and as new guidance emerges – such as the Performance Assessment Framework.

Please note that the implementation of iClip Pro at ESTH in May 2025 has temporarily affected data reporting for some KPIs. Work is underway to resolve these issues and, in the meantime, the narrative has been revised to reflect the current issues and actions being taken.

Action required by Group Board

The Board is asked to note this paper.

Committee Assurance

Committee	Finance Committee and Performance Committee
	Quality Committee
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name
Appendix 1	

Implications

Group Strategic Objectives

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

Risks

Failure to meet the financial control target as set by NHSE

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

Failure to meet statutory financial duties
Legal and / or Regulatory implications
N/A
Equality, diversity and inclusion implications
N/A
Environmental sustainability implications
N/A

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NHS
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University Hospitals and Health Group

Group Integrated Quality & Performance Report

May 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 20 June 2025 | Contact: gesh.performance@stgeorges.nhs.uk

gesh CARE Board
Board to Ward Improvement Priorities for 2025/26

C Collaboration & Partnership	A Affordable healthcare, fit for the future	R Right care, right place, right time	E Empowered, engaged staff
Work with other teams to reduce delays in patient journeys through our services	Live within our means: innovating, working more efficiently and cutting costs	Keep our patients safe – including those waiting for our care	Make our team a great and inclusive one to work in
Reduce average Non-Elective LOS: SGUH – 9.9 days – normal variation below mean ESTH - 11.5 days – normal variation above mean	**Deliver Financial Plan (month 2):** **Variance to plan** ESTH £0.0m (on plan) SGUH £0.0m (on plan) **Assurance on plan deliverability** ESTH Very challenging SGUH Very challenging	**Achieve Mortality Ratios (SMHI) of 1 or less:** SGUH – 0.87 (below expected) upcoming SDEC reporting likely to adversely impact reported performance ESTH - 1.13 (above expected) (*partly attributable to coding changes*)	**Reduce Staff Turnover Rates <13%** SGUH – 10.0% Achieving Target ESTH - 9.44% Achieving Target
Reduce demand at front door (A&E Attenders): SGUH – 426 per day (2024/25 average 417) ESTH - 436 per day (2024/25 average 434)	**Implied Productivity (YTD activity growth vs. cost growth) January 2025:** ESTH 3.6% positive SGUH -0.5% negative	**Improve VTE Risk Assessment Rates to 95% to national ambition**: SGUH – 64.7% (below target) ESTH - 78% (below target)* **April performance reported due to data quality issues following implementation of new EPR.*	**Reduce staff sickness absence rates** SGUH - 3.8% vs. target of 3.2% ESTH – 4.8% vs. target of 3.8% Sutton – 6.2% vs. target of 3.8% Surrey Downs – 4.3% vs target of 3.8%
	Deliver CIP Target YTD Month 2 - SGUH £6.0m reported to date in line with plan. Includes £2.0m of NR to support - ESTH £4.0m identified to date in line with plan	**Maintain ED (Type 1) 12-hour waits at or below the previous year's level:** SGUH – 9% vs. baseline (24/25) of 8.8% ESTH - 12.9% vs. baseline (24/25) of 12.4%	
	Cash - Current balance (M2) • ESTH £41.6m (£5.6m favourable) • SGUH £ 78m (£1m adverse) **Cash stress expected (based on current cashflows)** • ESTH Early Q3 • SGUH Early Q3	**Improve in RTT 18 –Weeks Performance by 5%:** SGUH –61.1% (March 26 Target of 60%) ESTH - 65.1% (March 26 Target 65.4%)	
		Deliver 78% 4-hr A&E Performance by March 26: SGUH –78.4% Exceeding Target ESTH - 66.8% Below Target (un-validated)	

Executive Summary
Safe, High-Quality Care

St George's Hospital

Successes

- **Mortality:** Current mortality rates at SGUH, as measured by the Summary Hospital-level Mortality Indicator (SHMI), are better than expected at 0.86. However, the forthcoming inclusion of Same Day Emergency Care (SDEC) data in the Emergency Care Data Set may negatively affect SHMI figures. This potential impact will be closely monitored following the reporting change.
- **Complaints:** SGUH consistently achieves its goal of providing full responses to complaints within 35 working days with performance in May at 94%, exceeding the target of 85%.
- **Infection Control:** There have been no MRSA bacteraemias year to date.

Challenges

- **Patient Safety Incident Investigations (PSII):** Two PSIIs were declared at SGUH in May 2025: a retained foreign object (Jelonet gauze) found following bilateral temporomandibular joint endoscopy in Oral & Maxillofacial (SNCT Division), which also qualifies as a Never Event; and a treatment/procedure delay in ENT Outpatients (SNCT Division).
- **Pressure Ulcers:** Seven category 3 pressure ulcers were reported in May 2025, none of which were related to medical devices. There was one category 4 medical device-related pressure ulcer, caused by an endotracheal tube in an adult intensive care unit. All incidents will be investigated and an action plan implemented.
- **Falls Prevention and Management:** In May 2025, there were three moderate harm falls and two high harm falls. Of the high harm falls, one occurred in the emergency department and the other on a senior health ward; both resulted in fractured hips, and both patients are recovering. Of the three moderate harm incidents, one occurred in the emergency department and two on medical wards; all patients are recovering. All incidents have been or will be investigated using the SWARM approach, with themes shared across divisions. A Trust-wide action plan is in place.
- **VTE:** In May 2025, VTE risk assessment compliance within 14 hours of admission was 63.6% against the national ambition of 95%. A VTE improvement plan is in place.
- **Infection Control:** There was a cluster of Trust-acquired C. difficile cases on Richmond (AMU). The cases are not linked by time or location, although two share the same strain type. The ward is under enhanced Infection Prevention and Control surveillance, and investigations are ongoing. Seven cases have been reported year to date.

Epsom & St Helier

Successes

- **Pressure Ulcers**: There were no hospital-acquired category 3 or above pressure ulcers in May 2025.

Challenges

- **Never Events:** One Never Event was reported at ESTH in May 2025 relating to wrong site surgery.
- **Patient Safety Incident Investigations (PSII):** One new Patient Safety Incident Investigation (PSII) was declared at ESTH in May 2025 which also qualified as a Never Event.
- **Complaints:** In May 2025, 98% of complaints were acknowledged within three working days, falling short of the 100% target. Measures are being implemented to drive continued improvement.
- **Falls Prevention and Management:** In May 2025, two falls resulting in moderate harm and one fall resulting in severe harm were reported. All incidents occurred on Senior Health wards, with one moderate harm fall and the severe harm fall taking place on ward B5. The severe harm fall resulted in a fractured neck of femur. All patients are recovering from their injuries, and investigations are underway.
- **VTE:** The Trust's VTE performance declined in May 2025, primarily due to challenges with completing risk assessments in iClip Pro post–go-live and issues with data reporting. Remedial actions have been initiated to resolve these problems as a matter of urgency.
- **Mortality:** Current mortality rates at ESTH, as measured by the Summary Hospital-level Mortality Indicator (SHMI), remain above the expected level at 1.13, though the most recent month has fallen below the lower confidence limit showing a positive decrease. This continues to be closely monitored and reviewed.
- **Infection Control:** A cluster of Trust-acquired C. difficile cases was identified on AMU (EGH). The cases are not linked by time or location and have different strain types, therefore this does not constitute an outbreak. However, an incident meeting was held to identify any learning or gaps in practice. Due to the increased risk associated with patient boarding on the ward, environmental contamination cannot be ruled out. The IPC team is developing specific guidance related to corridor care and boarding. There have been 11 C. difficile incidents year to date.

Executive Summary

Operational Performance & Productivity

St George's Hospital

Successes

- Cancer Faster Diagnosis Standard performance trajectory of 82% was achieved in May 2025.
- The number of outpatient first attendances and procedures, as a proportion of all outpatient attendances, continues to exceed the national target of 49%, with performance at 52% in May 2025.
- Performance against the 4-hour emergency department standard continues to be achieved with a performance of 78.3% in May 2025.
- The number of Super Stranded patients (those with a length of stay greater than 21 days) has continued to decline steadily over the past eight weeks and remains on track for further reduction.
- Capped theatre utilisation reached 83% in May 2025, reflecting a continued positive trend and placing SGUH within the top-performing quartile among Trusts in England.

Challenges

- The proportion of patients on a Referral to Treatment pathway waiting 52 weeks or longer increased to 2%, driven by an overall reduction in the waiting list following the Validation Sprint programme. At specialty level, Neurosurgery, Gynaecology, General Surgery, and Bariatric services have the highest number of long waits, each with ongoing action plans.
- Diagnostic waits performance has declined, with longer wait times in Endoscopy. Actions include a new validation strategy and approval to open an extra room four days a week. Further increases are expected due to ongoing technical issues resulting in cancellations and poor image quality from the 3T MRI scanner affecting Cardiac MRI services.
- Cancer 62-day referral to treatment standard fell below trajectory driven by limited access to theatre for Lung cases, and limited access to one stop Hysto/ Scan
- Current DNA rates of 10% is above peer average 8.3%. The Outpatient Transformation Board has been established with a dedicated workstream focused on reducing DNA rates where priority actions will be agreed and progress will be monitored.

Epsom & St Helier

Successes

- Theatre utilisation remains in the top quartile nationally, although there was a slight decrease dropping from over 80% in March 2025 to 79.24% in April 2025.
- Cancer performance standards were achieved in April 2025: 28-day Faster Diagnosis standard (84.0%), 31-day standard (99%), and 62-day standard (85.5%).
- 5.3% Patient Initiated Follow Ups (PIFU) rate achieved in April 2025.
- Waits for first appointment under 18 weeks met the trajectory of 81.3%, with a performance of 82.0%.
- ESTH length of stay reduced by 0.4 days in the month of April 2025 from a reported 12.0 in March 2025 to 11.6 in April 2025. There was a further reduction informed by initial headline data following cutover albeit by 0.1 day with a reported 11.5 days for the month of May 2025.

Challenges

- The move to iCLip Pro has taken a lot of resource, with teams learning new processes and a six week activity reduction plan needed to manage the transition safely. This has resulted in an impact to both elective and non-elective performance and metrics.
- Emergency department waiting times remain a challenge in April 2025 with 4-hour performance reported at 73.9%. Operationally for May this remains a challenge along with the teams transitioning to Cerner
- Mental health patients continue to experience prolonged delays in the emergency department prior to transfer to an inpatient mental health bed.
- Delays in cancer pathways are increasing due to extended waits for external diagnostics, including a 3–4 week wait for EUS, which has been raised as a concern in the network group. Lung cancer diagnosis delays are increasing due to rising referrals for Navigational Bronchoscopy at Royal Brompton. To manage demand, referrals are triaged by a multidisciplinary team, and RMP has formed a network group to explore expanding access to this procedure. Recently, there have been delays in PET scan appointments provided by Royal Marsden Hospital. To boost capacity, a Siemens Vision X PET scanner was installed in Sutton and a mobile unit added at Chelsea. A new consultant joining in July is expected to reduce delays.
- Reduced capacity during the Go-Live period is impacting patient pathways. Resources are being prioritised for cancer care to minimise delays, but overall cancer performance in May is likely to be affected. The cancer team are regularly validating patients to ensure comprehensive diagnostic and treatment plans.
- 52-week waits did not achieve the ambition of being below 1.37% in April 2025, with a performance of 1.7%. The specialties with the highest volumes of patients waiting more than 52 weeks were Dermatology (266), Gastroenterology (103) and Trauma & Orthopaedics (89).
- Reducing 65-week waits to 0 continues to be challenging with a total of 56 in April 2025. The specialties with the highest volumes were Gynaecology (11), Gastroenterology (8), and General Surgery (8). However, plans are in place across the specialities to regularly review and monitor progress.

Executive Summary

Integrated Care

Sutton Health & Care (SHC)

Successes

- 2-Hour UCR Service performance continues to exceed target (KPI 70%) achieving 79.6% in May 2025 with increased referrals.
- Virtual Ward occupancy rates continue to see an upward trend with 100% occupancy rate through May 2025 (KPI Target of 85%) .
- MAST compliance remained high in May at 91.8%.

Challenges

- The children's therapy waiting list remains a challenge although there are positive signs this may be reducing, due to national changes to the ECHNA process (education, care and health needs assessment). While there has been a reduction in the number of 52-week breaches overall (71 at the end of May compared to 93 in April 2025) , SALT and dietetic services remain under significant pressure.
- Increase in agency usage rate from 1.7% to 2.8% in May (special school nursing)

Surrey Downs Health & Care(SDHC)

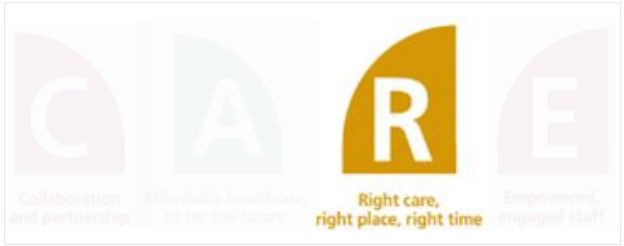
Successes

- Service consistently achieves the 2 –hour Urgent Community Response (UCR) target with a performance of 81.5% in May 2025 against a national target of 70%, while managing high levels of referrals.
- Reduction in waiting list size and no patients waiting over 52 weeks for specialist services .
- MAST compliance continues to exceed target of 85% reporting a compliance of 93.34% through May 2025.

Challenges

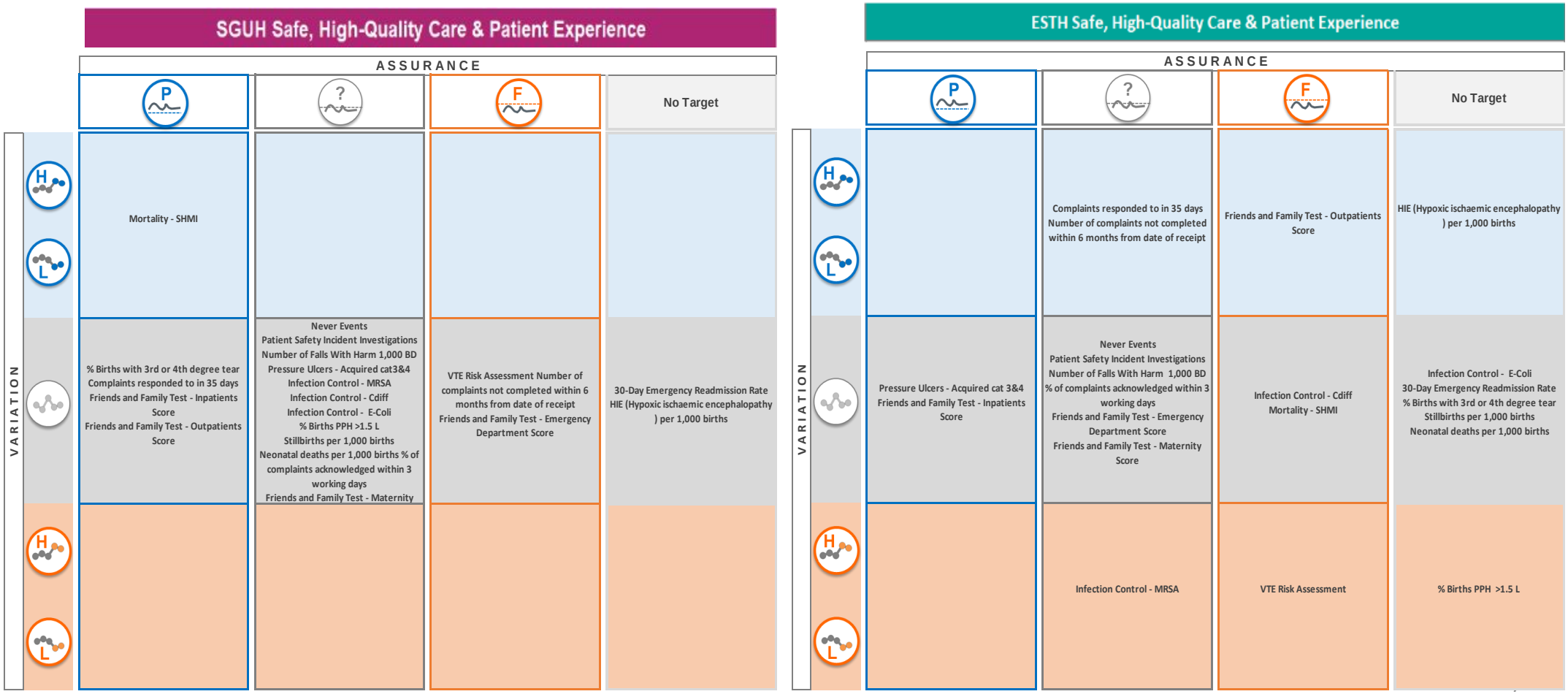
- Similar pressure ulcer category 3&4 incidents in the reporting month as in previous month. On-going review of incidents and mitigations as appropriate are in place.
- Increased sickness rate increased to 4.3% remaining above the target of 3.8%.
- Non-Medical Appraisal rate increased from 77.6% in April to 88.77% however slightly below 90% target.

Quality & Safety



Safe, High-Quality Care & Patient Experience

Matrix Summary



Safe, High-Quality Care

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier Benchmark
Never Events	May 25	1	1	0			N/A	May 25	1	1	0			N/A
Patient Safety Incident Investigations	May 25	1	2	0			N/A	May 25	2	1	0			N/A
Number of Falls With Harm (Moderate and Above) per 1,000 bed days	May 25	0.29	0.20	0.12			N/A	May 25	0.05	0.15	0.03			N/A
Pressure Ulcers - Acquired category 3&4	May 25	7	8	7			N/A	May 25	0	0	7		P	N/A
Infection Control - Number of MRSA	May 25	0	0	0			3rd Quartile	May 25	1	1	0	H		3rd Quartile
Infection Control - Number of Cdiff - Hospital & Community	May 25	4	3	-			2nd Quartile	May 25	6	5	-		F	2nd Quartile
Infection Control - Number of E-Coli	May 25	11	15	-			1st Quartile	May 25	6	5	-			2nd Quartile
30-Day Emergency Readmission Rate	Apr 25	12.7%	13.3%	-			TBC	Mar 25	6.0%	5.0%	-			TBC
VTE Risk Assessment	May 25	62.7%	64.7%	95.0%		F	N/A	Apr 25	83.8%	78.0%	95.0%		F	N/A
Mortality - SHMI	Jan 25	0.86	0.87	1.00		P	Top Quartile	Jan 25	1.15	1.13	1.00		F	Lowest Quartile
% Births with 3rd or 4th degree tear	May 25	1.2%	1.8%	5.0%		P	3.0%	May 25	2.8%	1.9%	-			3.0%
% Births Post Partum Haemorrhage >1.5 L	May 25	3.8%	4.4%	4.0%			3.2%	May 25	3.1%	3.8%	-	H		3.2%
Stillbirths per 1,000 births	May 25	2.2	0.0	2.0			3.5	May 25	0.0	10.2	-			3.5
Neonatal deaths per 1,000 births	May 25	0.0	0.0	2.0			1.6	May 25	0.0	0.0	-			1.6
HIE (Hypoxic ischaemic encephalopathy) per 1,000 births	May 25	2.2	2.0	-			1.0	May 25	0.0	0.0	-			1.0

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

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

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

*Never Events are a subset of PSIIs

Safe, High-Quality Care

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Complaints responded to in 35 days	May 25	96.0%	94.0%	85.0%			N/A
Percentage of complaints acknowledged within three working days	May 25	96.9%	100.0%	100.0%			N/A
Number of complaints not completed within 6 months from date of receipt	May 25	1	1	0			N/A
Friends and Family Test - Inpatients Score	May 25	98.4%	97.5%	90.0%			Top Quartile
Friends and Family Test - Emergency Department Score	May 25	80.0%	80.9%	90.0%			2nd Quartile
Friends and Family Test - Outpatients Score	May 25	94.6%	94.7%	90.0%			3rd Quartile
Friends and Family Test - Maternity Score	May 25	83.8%	90.0%	90.0%			3rd Quartile

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 25	92.0%	86.0%	85.0%			N/A
May 25	100.0%	98.0%	100.0%			N/A
May 25	8	9	0			N/A
May 25	94.4%	100.0%	90.0%			3rd Quartile
May 25	64.7%	17.9%	90.0%			3rd Quartile
May 25	98.0%	95.0%	90.0%			2nd Quartile
May 25	96.9%	100.0%	90.0%			2nd Quartile

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Patient Safety Incidents Investigated	May 25	0	0	-		
Number of Falls	May 25	9	6	-		
Pressure Ulcers Category 3	May 25	3	2	-		
Pressure Ulcers Category 4	May 25	3	1	0		
Infection Control - Number of Cdiff	May 25	0	0	-		
Complaints	May 25	0	1	-		
Community FFT	Oct 24	98%	95%	90%		
Infection Control - Number of MRSA	May 25	0	0	0		
Infection Control - Number of Ecoli	May 25	0	0	-		

Surrey Downs

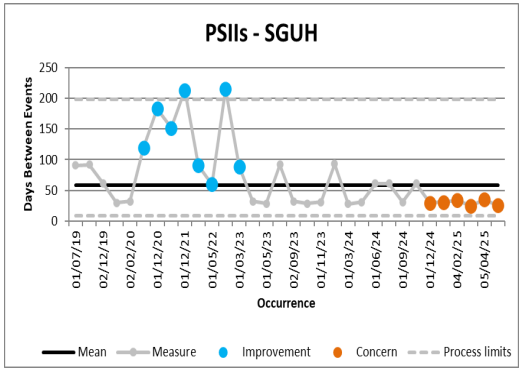
Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
May 25	0	0	-		
May 25	9	13	-		
May 25	6	8	0		
May 25	2	0	0		
May 25	0	0	-		
May 25	2	1	-		
Oct 24	98%	96%	90%		
May 25	0	0	-		
May 25	0	0			

- Community FFT is a subset of Epsom and St Heliers FFT data. The migration to a new system for FFT, has meant a split for Community is difficult. Under Review.
- IC (Dorking and Molesey Hospitals – community do not have set national trajectories for HCAIs although all cases are reviewed and investigated)

Safe, High-Quality Care

Incident Reporting- *[T-Charts used to measure Time(days) between incidents]*

St George's

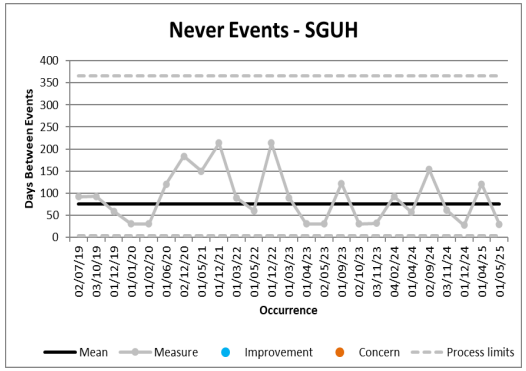


Summary & Actions

Two Patient Safety Incident Investigations (PSIIs) were declared at SGUH in May 2025.

- A retained foreign object (Jelonet gauze) was found after bilateral temporomandibular joint endoscopy in Oral & Maxillofacial (SNCT), qualifying as a Never Event.
- A treatment/procedure delay occurred in ENT Outpatients (SNCT).

There has been an immediate review by the theatre team of the process for using and accounting for this type of item.
A Standard Operating Procedure for managing this has been produced and is being communicated to the Maxillo-Facial theatres team, focusing on communication between surgeon and theatre team .



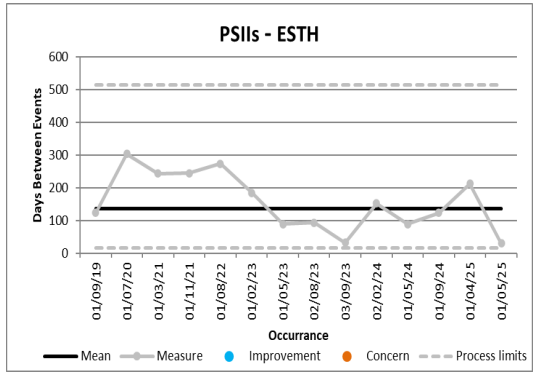
Summary & Actions

One Never Event was reported at SGUH in May 2025.

This incident related to retained foreign object (Jelonet gauze) post bilateral temporomandibular joint endoscopy in Oral & Maxillofacial (SNCT).

This incident will be investigated alongside the previous retained swab Never Event in cardiac surgery theatres (DW219305) to ensure that all the learning around accountable items can be brought together in a comprehensive Patient Safety Incident Investigation. It will also feed into the existing theatre safety improvement programme as part of the theatres protected teaching time.

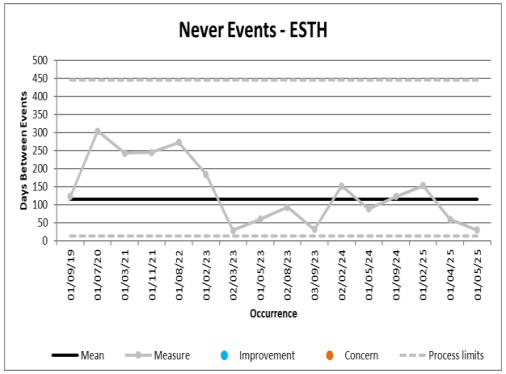
Epsom & St Helier



Summary & Actions

One new Patient Safety Incident Investigation (PSIIs) was declared at ESTH in May 2025. The locally agreed decision was for a SWARM to be undertaken as the initial learning response which is going to form part of a collective PSII incorporating the four recent NEs relating to invasive procedures.

To note: this patient safety event was 'declared' as a PSII (as per National requirements to the ICB.) This is the same incident described in the Never Event section. A Never Event safety learning workshop is to be held in June 2025 to review recent never events with key stakeholders (focus on key learning, areas for improvement and potential safety actions using the SEIPS framework.)



Summary & Actions

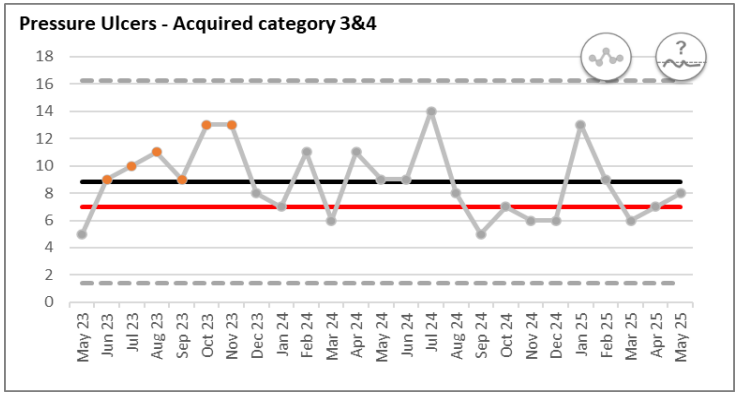
One Never Event was reported at ESTH in May 2025 relating to wrong site surgery.

A patient was consented for surgery by a Consultant for flexor tenotomies on the 2nd, 3rd and 4th toe on both feet. The consultant surgeon and the clinical fellow operated simultaneously on the two feet. On completion of surgery on the left 2nd, 3rd and 4th toes, the operator then started to incise the 5th toe (which was not consented for.) The scrub nurse noticed the error, spoke up and clarified what had been consented for.

10

Safe, High-Quality Care

Exception Report | SGUH Pressure Ulcers - Category 3 & 4



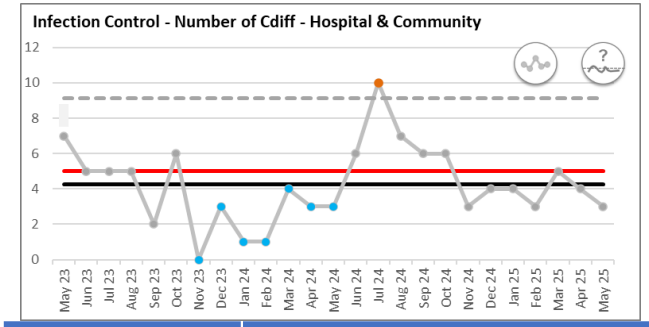
Indicator	Feb-25	Mar-25	Apr-25	May-25
Pressure Ulcers - Acquired Category 3	9	6	7	7
Pressure Ulcers - Acquired Category 4	0	0	0	1

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Pressure Ulcers Category 3 A total of 7 in May 2025 Pressure Ulcers Category 4 1 Category 4 incidents occurred in May 2025 Shows common cause variation with no significant change	• There was 1 category 4 medical device related pressure ulcer in May 2025, this was in an adult intensive care area and caused by an endo-tracheal tube. • There were seven category 3 pressure ulcers acquired in May 2025, this is the same as April 2025. • There were zero Category 3 medical device-related pressure ulcers reported in May 2025. • Category 2 pressure ulcers continue to show common cause variation • Inaccuracy in skin assessment documentation and completion of wound assessment and treatment charts continues to be an ongoing theme and may be contributing to the delayed identification and escalation of pressure ulcers at an earlier category (Category 1 or 2).	• The Dynamic Healthcare and Medical Physics teams will continue the gradual mattress replacement program, with completion expected by August 2025. • Trialling After Actions Reviews (AAR) - (new governance process in line with PSIRF). Working in conjunction with quality team across gesh on new PSIRF process. • A new continence product formulary and training programme has now been agreed and will launch at the end of June 2025 • Multiple pressure ulcer prevention projects underway across all adult critical care areas. Site CNO and tissue viability team continue to monitor. • The new nationally recommended pressure ulcer risk assessment Purpose –T (Pressure Ulcer Risk Primary or Secondary Evaluation Tool) Aiming for July 2025.	Targets under review for 2025/26 as part of quality priorities	Sufficient for assurance

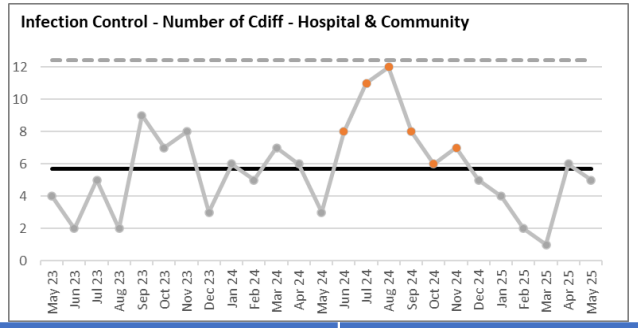
Safe, High-Quality Care

Exception Report | SGUH & ESTH - Infection Prevention and Control

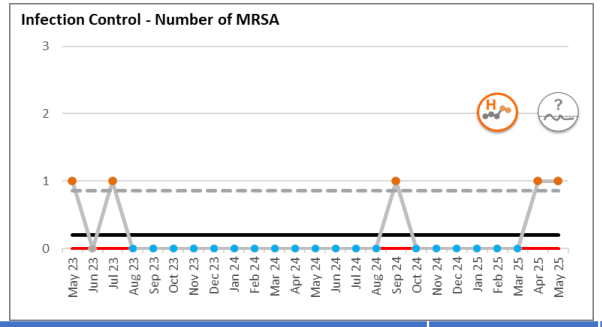
St George's



Epsom & St Helier



Epsom & St Helier

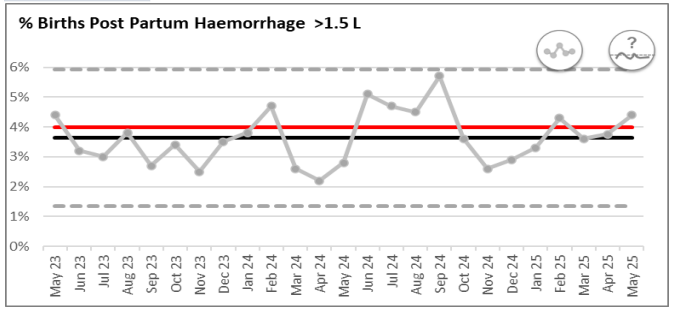


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH and ESTH : C.difficile Infections (CDI), and MRSA	**Healthcare Associated CDIs: NHSE are yet to publish the 2025/26 thresholds.** • **SGUH:** YTD 2025/26 7 cases. **ESTH**: YTD 2025/26 11 cases. **IC: YTD 2025/26** 0 **Healthcare Associated MRSA Bacteraemia:** • **SGUH:** YTD 0. **ESTH:** YTD 2 STH ITU patient - 49-year-old male with a background of alcohol-related liver disease and cirrhosis and diagnosed with Stevens-Johnson Syndrome/ Toxic Epidermal Necrolysis (SJS/TEN) with widespread epidermal detachment approx. 60-80% body surface. Results known after patient had died. MRSA was not on death certificate.	• **Both sites:** Continue with reviews and identify areas of focused training. UKHSA published a briefing paper in April showing a 33% increase in C diffs nationally. Awaiting new national recommendations to reduce increase in incidence. • **ESTH MRSA BSI:** Post infection review undertaken and it was deemed to be a likely a contaminant as MRSA not isolated from repeat blood cultures taken prior to antimicrobial therapy and the clinical picture was not consistent with a bacterial bloodstream infection. Baby was duly discharged.	C-diff October 2025 achieve downward trend. MRSA - Zero avoidable cases for 2025/2026	Sufficient for assurance
ESTH: C difficile Clusters	• There was a cluster of Trust-acquired C. difficile cases on Richmond (AMU). The cases are not linked by time or location, although two share the same strain type. The ward is under enhanced Infection Prevention and Control surveillance, and investigations are ongoing. Seven cases have been reported year to date.	• Draft new guidance for corridor care/boarding in relation to IPC. • Both sites have had C diff clusters on the admissions ward Richmond and SMU STH). Wards are on increased IPC surveillance and new IPC guidance on boarding/corridor to be published.	June 2025	Sufficient for assurance

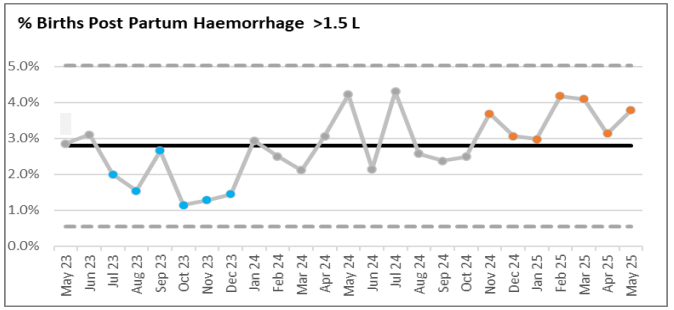
Safe, High-Quality Care

Exception Report | SGUH & ESTH | % of Births with Post Partum Haemorrhage >1.5

St George's



Epsom & St Helier

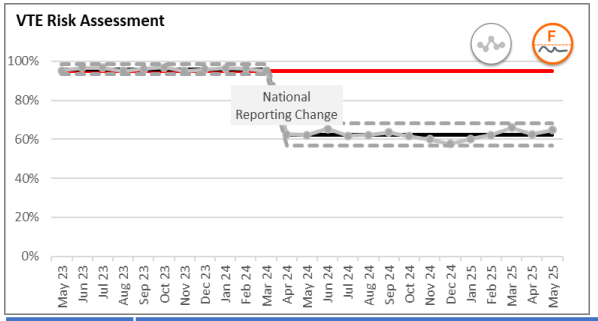


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH The percentage of births with Post Partum Haemorrhage >1.5L and shows common cause variation.	In February 2025, National Maternity and Perinatal Audit (NMPA) notified SGUH that they were flagging as a potential alarm-level outlier for postpartum haemorrhage >1.5L. (PPH) . In May 2025 percentage of Births Post Partum Haemorrhage >1.5L was 4.4% which is 0.4% above the local target at 4%, and against a peer average of **3.1%**.	The Trust has carefully analysed potential contributory clinical factors by undertaking a deep dive into PPH data for 2024, which has shown that in addition to factors such as being a placenta accreta spectrum referral centre, undertaking caesarean section for raised BMI (BMI 50), which are known causes for PPH, the data review shows the majority of PPH were associated with spontaneous vaginal delivery following induction of labour, and additionally following forceps delivery due to perineal trauma. The service continues with the improvement work in getting the PPH rates to or below the peer average of 3.1% SGUH received correspondence from NMPA on 12 June, advising that following review of the evidence submitted by SGUH in response to the alarm-level alert, SGUH will remain at alarm-level status in the NMPA report to be published July 2025. The Trust will address the actions associated with this outcome.	TBC – awaiting report from NMPA	Sufficient for assurance
ESTH Special cause variation of a concerning nature.	There is an increase in PPH over the past few months against our target set at 3%. An extensive retrospective audit over 5 years was carried out, which did not identify any major findings apart from the need to ensure PPH proformas are completed.	• The increase was discussed in the maternity risk meeting, with ongoing efforts to reduce and keep below 3%. • Focus is always on prevention, starting from the antenatal period. • Staff are reminded to risk assess at booking, improve Haemoglobin (Hb) with oral iron, and offer parenteral iron if Hb remains low at 34 weeks—an approach we have implemented promptly. • Aim is active management of 3rd stage and to offer tranexamic acid and carbetocin for operative births if no contraindications. • Above measures and reminders to our anaesthetists, Obstetrics and Gynaecology team.	September 2025	Sufficient for assurance

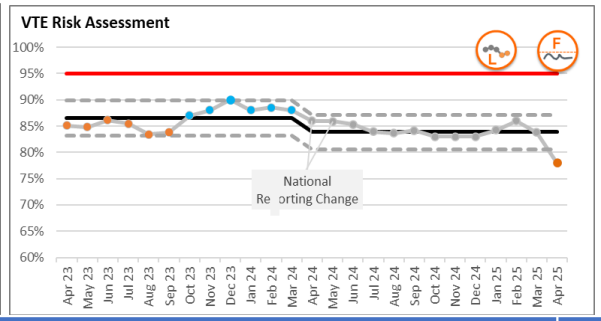
Safe, High-Quality Care

Exception Report | SGUH & ESTH VTE Risk Assessment

St George's



Epsom & St Helier

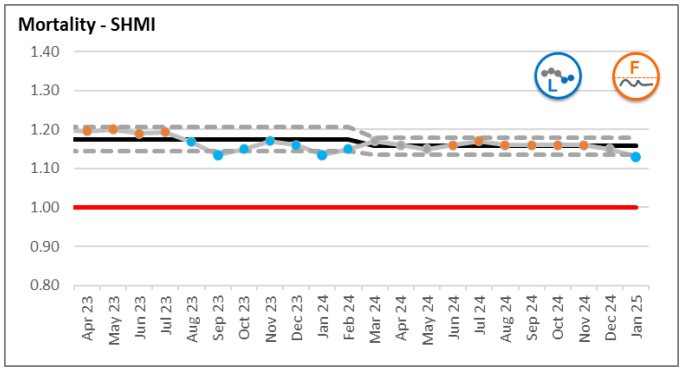


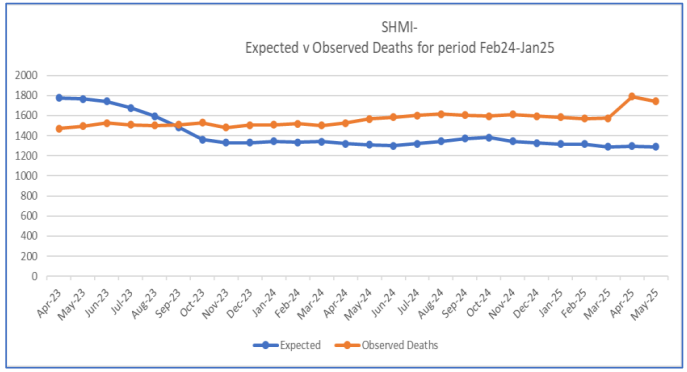
Site & Metric	Cause of variance/ non-compliance	Group Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH: VTE 63.6%. Not meeting target of 95%	• The national definition of this metric revised in April 2024 to reflect guidance recommending VTE assessment to be completed within 14 hours of admission or decision to admit, resulting in the significant decrease in performance. • VTE assessment alerts are not triggered in ED, causing delays in completion, Additionally, the alert system for other locations can be inappropriately bypassed. • The mandatory online training requirement (MAST) compliance target, applicable only to doctors and dentists, is currently not being met. Training is not currently mandated for the rest of the multidisciplinary team.	• The Site CMOs have programs at both acute trusts to improve VTE performance. • VTE champions form a multiprofessional group to boost assessment compliance, aiming for a 5% increase by October 2025, with further gains by December. • A joint workshop with thrombosis leads and VTE champions from both trusts will be held within 3 months to assess challenges and align assessments before iClip updates. • Shared digital VTE risk assessment tool, rules and controls to be developed to improve compliance but current change freeze. • Improve MAT (Medication Administration Tool) compliance and targeted support for underperforming areas • gesh VTE policy to be developed • At ESTH, iClip Pro now includes VTE reminders, and a similar engagement model will be introduced under the CMO's guidance, with a later timeline due to iClip implementation. A new consultant thrombosis lead will join ESTH in September 2025 to drive these actions.	Trajectories under review for 2025/26	Sufficient for assurance.

ESTH: VTE 78%. Not meeting target of 95%	• The ESTH risk assessment data for ESTH has been significantly impacted by iClip Pro go-live:
	  ○ iCM data for completed risk assessments pre go-live yet to be combined with iClip data
	  ○ Difficulty with locating the risk assessment initially post go-live within Maternity leading to the use of Badgernet - now rectified.
	  ○ Issues with data flow from iClip Pro to Power BI (reporting system) – under review by ESTH BI team
	  ○ Patient tracker boards including VTE risk assessment completion not easily found on iClip Pro; VTE nurses working with services to support with re-imbedding this
	  ○ Staff have taken some time to adjust to the system and navigate their way
	• Data quality issues include missing or incomplete coding on low-risk procedures
	• Lack of robust process to determine whether risk assessments took place at off-site locations.
			Trajectories under review for 2025/26	Not sufficient for assurance

Safe, High-Quality Care

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



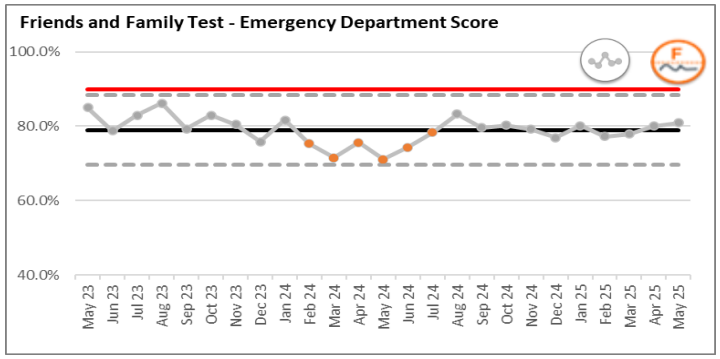


SHMI Source NHS Digital data based on rolling 12 months-Feb 2024 to Jan25 reported in May 2025. There were 205 more deaths than expected

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH SHMI: Special cause improving variation and consistently above expected rate	ESTH's mortality index is classified as 'higher than expected', but it shows a consistent trend with trend stabilised In 2020, ESTH reclassified Same Day Emergency Care (SDEC) activity as non-inpatient activity. This change reduced the total spell count used in the Summary Hospital-level Mortality Indicator (SHMI) model, leading to a decrease in the expected number of deaths, a trend that has been evident since then. Other Trusts were initially expected to adopt a similar reporting approach by July 2024. However, national data shows that by the end of September 2024, only 48 Trusts had submitted data, up from just 18 at the end of the previous year. As a result, NHSE has extended the deadline for Trusts to implement this reporting change to July 2025.	Comprehensive deep dives and thematic analyses of outlying areas have been conducted, covering electrolyte imbalances, UTIs, COPD, and pneumonia. The findings did not indicate any quality concerns. An in-depth review of themes from Structured Judgement Reviews (SJRs) has highlighted areas for improvement. Any identified care concerns are reported and thoroughly investigated Clinical leads in Sepsis and the Deteriorating patient have been appointed to support improvement work. Plans are underway for the recruitment of additional staff to ensure 24/7 Critical Care Outreach on both sites. Collaboration between clinicians and coders will be highly beneficial in improving record accuracy. The implementation of iClip Pro is expected to lead to improvement in coding as experienced in other Trusts. Several enhanced monitoring workstreams are in place, including mortality reviews and medical examiner scrutiny	Under review	sufficient for assurance

Safe, High-Quality Care

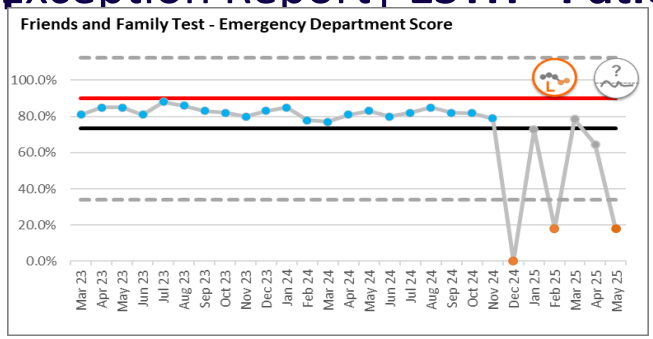
Exception Report| SGUH Emergency Department Patient Experience

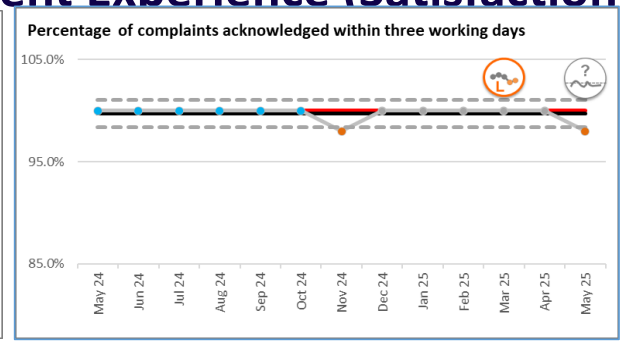


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH FFT ED Score	The ED FFT survey response rate continues to be well above the national average with 1,212 patients responding to the survey in May 2025. The number of patients that would recommend the department to friends and family was 81% for May 2025 - a slight increase compared on the previous month. It is line with latest national data, when comparing with the national average of 80%. During May 2025 , the number of ED attendances and patients waiting for a bed in the department remained high with the most consistent theme for negative responses being waiting times.	Actions for improving patient experience whilst waiting in ED include: 1. Review of patient feedback by each area with the relevant leads to identify areas where improvement is required - ongoing 2. Corridor care checklist and intentional rounding – ongoing 3. Standardised documentation template for use by RNs when looking after patients in the corridor – includes all elements of documentation to ensure all patients receive the same level of documentation and risk assessments. We are also offering all patients a comfort pack, consisting of eye masks and ear plugs - ongoing 4. Nurse In Charge (NIC) checklist on RATE – quality checklist to be completed by NIC at the start of each shift to identify safety checks completed within the department - ongoing 5. ED matron assurance checklist on RATE – completion for each area during Matron of the day rounds with focus on red crosses, enhanced care, safety checks, fire warden and quality/safety huddles - ongoing 6. Consultant Referral and Triage (RAT) rota ongoing. Rota amended so RAT shift is covered Mon-Fri 11:00-19:00 to give patients a more senior review sooner and redirect if necessary - ongoing 7. Patient Check-In (a digital check in tool) launched in January 2025 to make the checking in process more efficient 8. Same Day Emergency Care (SDEC) ongoing - 10 new clinical pathways for medical SDEC launched to redirect patients to medical service if more appropriate. Surgical SDEC launched beginning of June, to stream patients directly to Nye Bevan Unit clinic - ongoing	TBC	sufficient for assurance

Safe, High-Quality Care

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





Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH FFT ED Score Special cause variation of a CONCERNING nature Consistently failing target	The FFT contract at ESTH has concluded and transitioned to Gather, where the survey is accessible via posters, reaching a limited audience. IG approval is still awaited to send the survey to patients through text messaging, along with securing access to a text messaging service via procurement - pending IG approval External data reporting continues but is not directly comparable to previous months and shows some variations, particularly in services where surveys are conducted via text. Scores in ED for the month of May fell to 17.9% with 19 patients out of a total 23 responses saying the experience they received was Poor or Very Poor.	• Improve Response rates across both hospital sites • Analyse the themes and trends of patients who provide negative feedback. • Proposals to involve volunteers in the Emergency Department for feedback collection, including FFT, have been put forward; however, recruitment has not yielded results to date. • The Medical Division is committed to enhancing patient experience during periods of heightened emergency care demand by increasing staffing levels and optimizing patient flow to expand inpatient capacity.	Oct-2025	Not sufficient for assurance
ESTH Percentage of complaints acknowledged within 3 working days Performance has seen some fluctuation in recent months with the target not met in May 2025	The target was not met in May (98% against a target of 100%) however there remains a strong commitment to retain performance. The primary responsibility remains with the Complaints Team; however, enhanced engagement at the divisional level—most notably within the Women's &Children—has resulted in positive progress, which will facilitate the implementation of the gesh Group Policy changes relating to complaints management."	• Several initiatives within the complaints improvement work stream are currently in progress to support enhancements, these actions are ongoing and have been previously reported." • A review and re-allocation of current cases continues within the complaints team to support completion of complaints in the timescales established • The Women's &Children Division have initiated regular meetings with the Complaints Team to manage its backlog and assign investigation leads, resulting in a positive impact on the quality and timeliness of complaint responses."	Sept-2025	Not sufficient for assurance

Section 2.1:
Operational Performance

Section 2.1 Operational Performance

Matrix Summary

SGUH Operational Performance

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L		Cancer - 28 Day Faster Diagnosis Standard		
	Over 12 Hours in ED from Arrival (%) Type 1	RTT - Percentage of patients waiting for first attendance who have been waiting less than 18 weeks Cancer 62 Day Referral to Treatment Standard 4 Hour Operating Standard Ambulance average Handover Time (min)		
H / L	RTT - Percentage within 18 weeks	RTT - Proportion Waits over 52 weeks Diagnostics - 6 Week Waits		

ESTH Operational Performance

VARIATION	ASSURANCE: P	ASSURANCE: ?	ASSURANCE: F	No Target
H / L				
		RTT - Percentage of patients waiting for first attendance who have been waiting less than 18 weeks Cancer - 28 Day Faster Diagnosis Standard Cancer 62 Day Referral to Treatment Standard Over 12 Hours in ED from Arrival (%) Type 1 Ambulance average Handover Time (min)	RTT - Proportion Waits over 52 weeks Diagnostics - 6 Week Waits	
H / L		RTT - Percentage within 18 weeks 4 Hour Operating Standard		

Operational Performance

Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's 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
RTT - Proportion Waits over 52 weeks	Apr 25	1.64%	2.03%	1.60%			2nd Quartile	Apr 25	1.4%	1.7%	1.0%			2nd Quartile
RTT - Percentage within 18 weeks	Apr 25	61.3%	61.1%	60.0%			2nd Quartile	Apr 25	66.1%	65.1%	65.4%			2nd Quartile
RTT - Percentage of patients waiting for first attendance who have been waiting less than 18 weeks	Apr 25	66.8%	66.7%	66.6%			2nd Quartile	Apr 25	82.2%	82.0%	81.3%			2nd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Apr 25	84.8%	82.0%	82.7%			2nd Quartile	Apr 25	82.4%	84.0%	86.8%			Top Quartile
Cancer 62 Day Referral to Treatment Standard	Apr 25	81.4%	78.7%	85.0%			2nd Quartile	Apr 25	87.7%	85.5%	86.6%			2nd Quartile
Diagnostics - 6 Week Waits	Apr 25	5.2%	6.8%	5.0%			2nd Quartile	Apr 25	6.0%	9.1%	5.0%			2nd Quartile
4 Hour Operating Standard	May 25	83.7%	78.4%	78.0%			Top Quartile	May 25	73.9%	66.8%	78.0%			3rd Quartile
Over 12 Hours in ED from Arrival (%) Type 1	Apr 25	6.2%	9.0%	13.0%			2nd Quartile	Apr 25	12.9%	13.4%	13.5%			Lowest Quartile
Ambulance average Handover Time (min)	May 25	00:27:00	00:26:00	00:24:00			TBC	May 25	00:27:00	00:32:00	00:22:00			TBC

Targets based on Operating Plan end of year March 2026 position (trajectories in place)

Operational Performance

Overview Dashboard

Sutton Healthcare

KPI	Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance	Benchmark
Two hour UCR performance	May 25	86.9%	79.6%	70.0%			
Virtual ward - Bed Occupancy	May 25	89.0%	100.0%	85.0%			
Total Waiting List Size Adult	May 25	1983	1929	-			
Total Waiting List Size Adult >52wks	May 25	1	1	-			
Total Waiting List Size Children	May 25	1006	1042	-			
Total Waiting List Size Children >52wks	May 25	93	71	-			

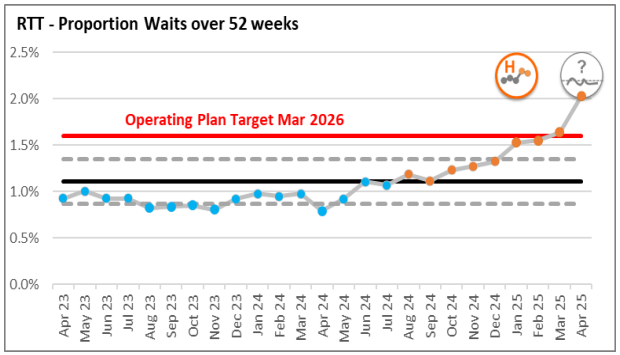
Surrey Downs

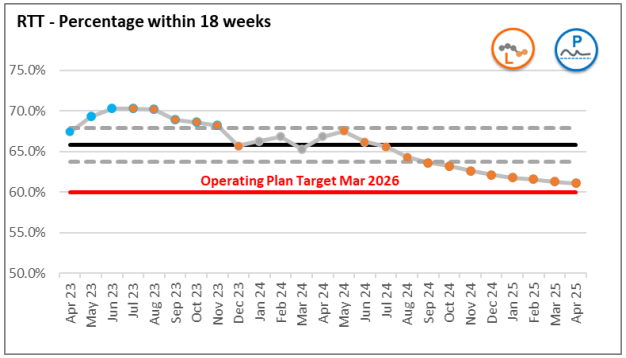
Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
May 25	85.8%	81.5%	70.0%		
May 25	79.3%	90.7%	80.0%		
May 25	6019	5859	-		
May 25	0	0	-		

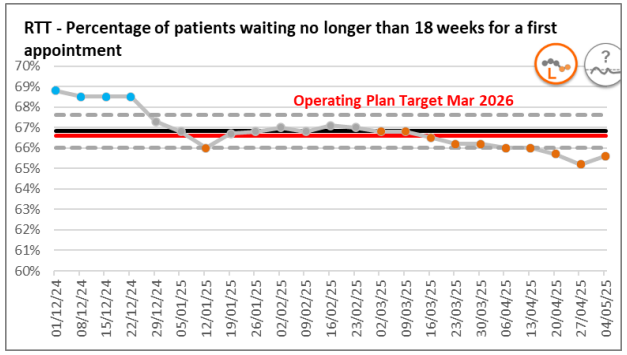
Watch metrics have been moved to Appendix Slide 42

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)



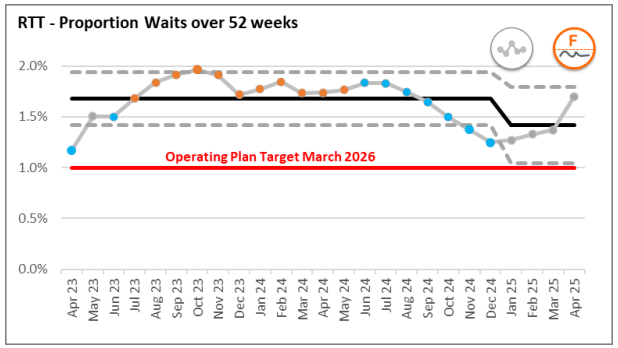


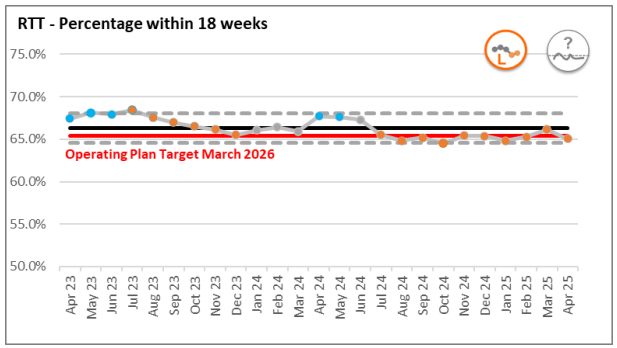


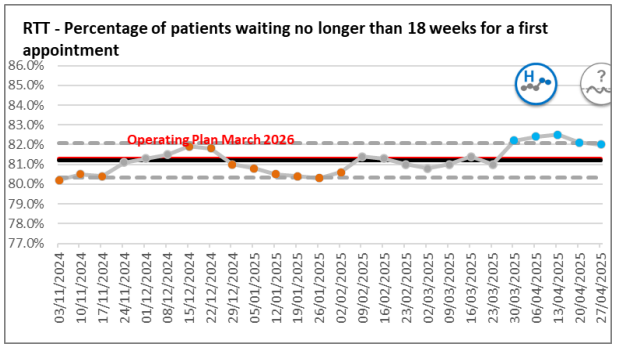
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – increasing trend % within 18 weeks – decreasing trend % wait for first attendance – below plan	At the end of April 2025; • Proportion of 52 week waits – Of the total PTL size, 2% of patients are waiting over 52 weeks (against a Mar 2026 target of 1.6% The Validation Sprint has reduced the denominator for % of 52 week waits. At specialty level Neurosurgery, Gynae, General Surgery and Bariatric have the highest number of long waits • A high volume of out of area referrals have contributed to the long wait position. This is currently being addressed with ICBs and NHSE • Percentage of patients below 18 weeks showing a consistent downward trend, however currently meeting our operational plan year end target of 60%.	**Validation Sprint June 2025–** The Trust remains on plan with targeted validation and is seeing an increase in the number of clock stops and pathway removals from the RTT PTL. **Neurosurgery: July 2025** • Capacity templates currently being reviewed to standardise slot times in line with national benchmarking and to balance outpatient and inpatient capacity to align with demand. • Issue identified with chronological booking of patients which has impacted wait times – currently being addressed • Weekly enhanced PTL meetings implemented **Gynae: July 2025** • Reviewing all Directory of Services alongside commissioning structures • Standardisation of clinic templates and appointment slot times • Weekly enhanced PTL meetings implemented **General Surgery: August 2025** • Revision of bariatric service pathway Pan London due to increase in unwarranted demand • Standardisation of clinic templates and appointment slot times • Review of procedures in “Right Procedure Right Place” GIRFT to maximise, theatres, daycase unit and outpatient minor op suites • Weekly enhanced PTL meetings implemented	25/26 trajectories expected to be achieved by March 2026	sufficient for assurance

Operational Performance

Exception Report | ESTH Referral to Treatment (RTT)





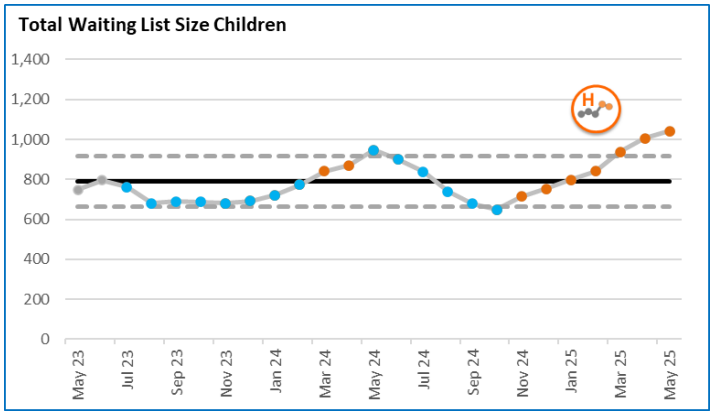


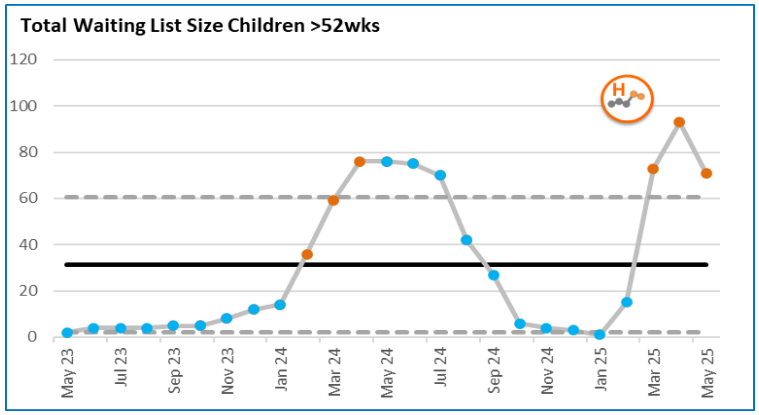
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Proportion waits over 52 weeks – above trajectory of 1.37% Percentage within 18 weeks – below monthly trajectory of 65.43% Percentage waits for first appointment under 18 weeks – meeting trajectory of 81.3%	• 52-week waits did not meet achieve the ambition of being below 1.37% in April 2025, with a performance of 1.7%. The specialties with the highest volumes of patients waiting more than 52 weeks were Dermatology (266), Gastroenterology (103) and Trauma & Orthopaedics (89). • 65-week waits continue to be above the ambition of zero, with a total of 56 patients waiting more than 65 weeks at the end of April 2025. The specialties with the highest volumes were Gynaecology (11), Gastroenterology (8), and General Surgery (8). • Dermatology is the most challenged specialty at ESTH, with several actions being taken to mitigate.	• Weekly long waiter updates continue to be provided to SWL ICS for assurance. • Recovery plans are in place and ongoing for the most challenged specialties. • **Gynaecology:** Patients waiting more than 52 weeks for treatment continue to decrease, with additional capacity being funded. No longer in the top three most challenged specialities. • **Medicine:** Mitigations include additional consultant support in dermatology, cardiology, and gastroenterology through to M03 FY25/26. Mutual aid from Croydon for lung function tests ended in February, with remaining patients booked for April and May. No continuation has been agreed, posing a risk to service and performance. Insourcing continues for Dermatology until M03 FY25/26, while Respiratory and Neurology insourcing ended in M02 FY25/26. The Virtual Lucy platform ceased on 31st March 2025, having discharged 620 dermatology patients (43% of those referred), positively impacting performance. • **Planned Care:** 65-week waits are closely monitored, though reduced tracking in General Surgery risks increasing the 52-week backlog. Endoscopy struggles with deep sedation list availability, and over 600 colorectal patients are overdue, with many still unbooked The iClip pro transition has been particularly challenging for Endoscopy which has a complicated workflow. The end of WLIs has further impacted Colorectal wait times. ENT outpatient capacity was reduced due to vacancies but resumed in February. The rollout of iClip Pro caused activity loss, with General Surgery most affected. The cessation of theatre lists at QMHR will impact on general surgery activity and work is underway to re-provide as much of the activity as possible.	25/26 trajectories expected to be achieved by March 2026	April 2025 data sufficient for assurance

Operational Performance

Exception Report | Community Services Waiting Times (Children)

Sutton Healthcare

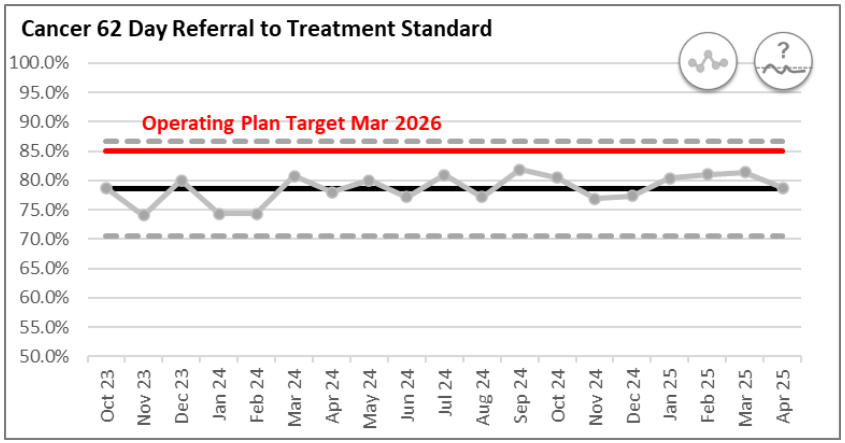




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Sutton has made positive strides in reducing overall waiting lists and median wait times. However, the Children's SALT Service has seen an increase in both waiting list size and 52-week breaches, driven by rising demand. This reflects a broader national trend in the growing need for NHS therapy services, which is recognised at both SWL and PLACE levels. EMIS recording issues affecting clock stops in Children's OT have impacted accuracy of reporting and contributed to the increase in long waits in March 2025. At the end of May 71 children were waiting more than 52 weeks across SALT and OT. Service transformation and fewer request for EHC Needs Assessment are helping to reduce these numbers month on month. SALT have the largest proportion of the long waiters; OT have sufficiently reduced their long waits. Dietetics and Physio wait times are more manageable.	• PLACE via Sutton Alliance in April 2025 agreed actions related to the external scrutiny of children's therapy to provide assurance of maximum efficiency, productivity alongside learning from best practice. Aim: improve the reduction in waiting times. An action was also taken to work alongside Cognus (LBS children's therapy service) to improve collaboration which would potentially further reduce wait times) • SWL ICB have noted the risk of waiting times within Suttons children's therapy service. • SHC Review of harms with Integrated Care CNO. Completed. No harm identified. • Education, Health and Care Plans (EHCP) targets remain on track.	TBC	Sufficient for assurance

Operational Performance

Exception Report | SGUH 62 Day Referral to Treatment Cancer Performance

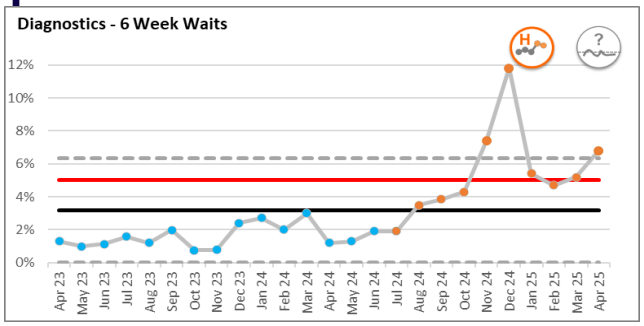


Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data25 Quality
SGUH 62 Day Normal variation below plan	• 62 Day Performance for April 78.7% below plan of 80.0%. Driven by; • Access to theatre for Lung (50%), H&N (71.9%) and Urology (81%). • Reduced capacity due to bank holiday and leave. • Gynae (56.3%) access to one stop Hysto/ Scan	The Trust has received £70K in summer operational resilience funding from RMP, allocated as follows: **£50K for Dermatology (Skin):** To support 100 consultant-led Minor Ops sessions. **£20K for Robotics:** To deliver 8–10 surgical cases across Thoracic, Urology, and Head & Neck. **Additional initiatives include:** **GI Pathway Group:** Developing a single-entry point for referrals, enhancing straight-to-test access, first-time-right diagnostics, and benign discharge processes to accelerate diagnostics and meet FDS standards. **Dermatology to Plastics:** Ongoing pathway mapping and analysis. **Navigational Bronchoscopy:** Under regional discussion. **Pre-assessment Improvements:** Aiming to deliver a PTL that will take the 7-day median delay from e-TCI to pre-assessment booking.	**Sep 2025**	Sufficient for assurance

25

Operational Performance

Exception Report | SGUH Diagnostic Performance

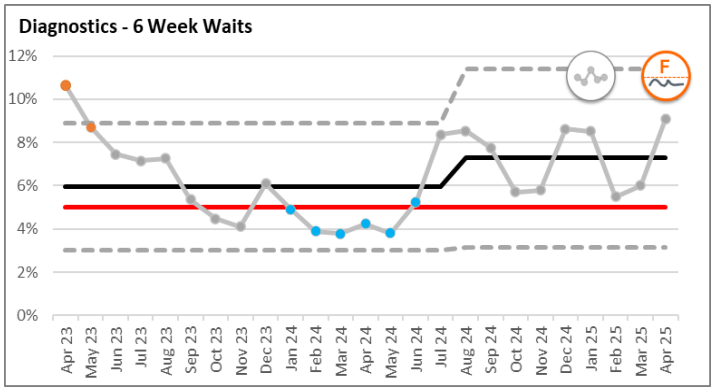


Modality	6Wk Breaches	6Wk Performance
Gastroscopy	282	43.7%
Cardiology - echocardiography	147	10.0%
Colonoscopy	134	40.0%
Flexi Sigmoidoscopy	70	47.0%
Computed Tomography	66	8.7%
Non-obstetric ultrasound	19	0.4%
Cystoscopy	12	20.7%
Urodynamics - pressures & flows	10	52.6%
Magnetic Resonance Imaging	9	0.5%
Respiratory physiology - sleep studies	6	1.7%
Cardiology - electrophysiology	1	100.0%
Audiology - Audiology Assessments	0	0.0%
DEXA Scan	0	0.0%
Neurophysiology - peripheral neurophysiology	0	0.0%

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH	Increase in number of patients waiting for more than 6 weeks for a diagnostic test reporting 6.8% in April 2025 **Endoscopy** **Increase in demand** • Staffing constraints impacting booking capacity • Bowel Cancer Screening • Increasing DNA Rates **Echo** • Stress Echo capacity – current 10 week wait • TTE Capacity – Currently 9 week wait due to increase in demand and urgent referrals **Urodynamics** An increase in waiting times was primarily driven by patients that 'Did Not Attend' (DNA), same-day cancellations, and the impact of bank holidays in April and May, resulting in a total loss of 36 appointment slots **Cardiac MRI** Technical issues and poor image quality from the 3T MRI scanner at continue to disrupt Cardiac MRI services leading to cancellations through June 2025 and reduced inpatient capacity.	**Endoscopy** • Optimize the referral process and maximizing efficiency. • Reminder calls - This proactive measure aims to decrease missed appointments. • Hybrid mail and SMS, improve patient communication, providing essential information and instructions. • Approval to open Room 6 for x4 days per week **Echo** • Core capacity is being optimized • Stress Echo – limited trained physiologists to carry out extra lists to reduce capacity. • Elective Services being used for ECHO sessions reducing. Capacity issue despite running 7-day lists • Physiologist now vetting / triaging all urgent requests for TTE and not for Stress Echo. **Urodynamics** • Full review of active and planned waiters to ensure accuracy of PTL • Currently we have two flow rate machines at QMH, however the older machine is very slow. Consultants at QMH to assess the feasibility of using both machines concurrently, running two additional lists per month • Rota under review to support SpR training in June 2025, enabling independent lists from July (pending fellow approval **Cardiac MRI** • Business case is currently under development, however there is no available capital funding to support procurement before the 2026/2027 financial year	TBC Sep 2025 (under review) Sep 2025 Under Review	Sufficient for assurance

Operational Performance

Exception Report | ESTH Diagnostic Performance

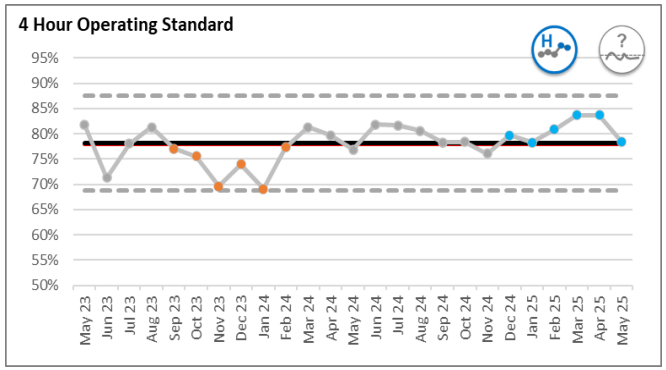


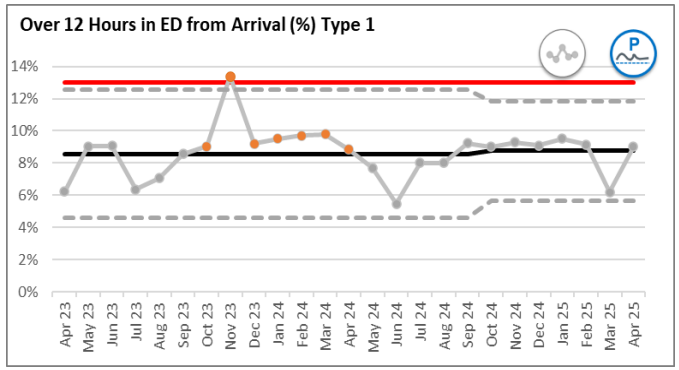
Modality	6Wk Breaches	6Wk Performance
Cardiology - echocardiography	282	25.5%
Non-obstetric ultrasound	221	3.2%
Audiology - Audiology Assessments	163	23.8%
Colonoscopy	136	27.4%
Gastroscopy	114	21.7%
Urodynamics - pressures & flows	92	63.9%
Cystoscopy	78	44.6%
Flexi sigmoidoscopy	36	24.5%
Computed Tomography	11	1.8%
Magnetic Resonance Imaging	9	0.7%
DEXA Scan	8	1.9%
Neurophysiology - peripheral neurophysiology	1	0.6%

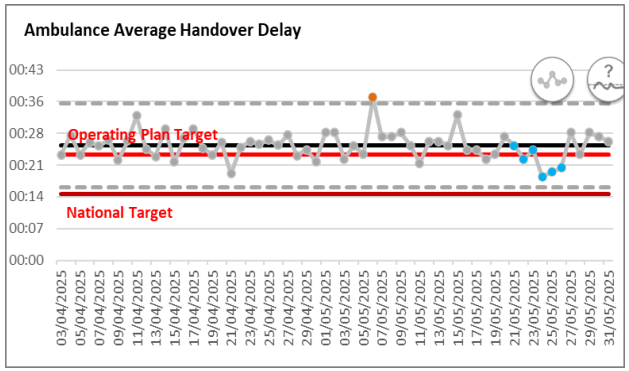
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 6Wk waits 9% not meeting national interim target of 5%	At the end of April 2025 there were 1151 patients waiting more than 6 weeks for their diagnostic (DM01). This is an increase on the previous month (March 2025) where there were 781. As a result, the performance for April 2025 deteriorated to 90.92%, from 93.99% in March 2025, which is still below the national interim target of 95%. The modalities with the highest volumes waiting >6 weeks at the end of April 2025 were Endoscopy (286), ECHO (282) & NOUS (221).	• **Endoscopy:** There are challenges around capacity for patients requiring deep sedation due to limited anaesthetic resources and workforce challenges. Saturday Waiting List Initiatives (WLI) additional sessions were on hold at present due to ongoing discussions around pay rates for nursing and medical staff. Significant challenges within the admin team have also contributed to the deteriorating position. Options paper being drafted to help support with activity loss during I clip pro awaiting approval for additional Saturday lists for a period of 12 weeks to help recover position and provide mitigation for lost activity during rollout of I clip pro. • **ECHOs:** The number of breaches at the end of April 2025 was 282, an increase from 179 in March 2025. Recruitment for the permanent band 7 was successful, employment checks currently ongoing. Although the 12-month fixed-term maternity cover was approved, we were unable to successfully recruit into it to date. Agency staff was approved to cover but a full-time locum hasn't been found yet, with only odd weeks being covered. This staff member has started mat leave on the 15th of May. Efforts are still ongoing to increase echo capacity, although WLI like mutual aid from Croydon has stopped at the beginning of February and ERF funding for 25/26 has reduced from 2wte B7 Physiologists to 1wte B7 physiologists. May is also expected to be significantly challenged due the iCLIP implementation and unforeseen staffing shortages due to bereavement and long-term sick leave. • **NOUS:** Number of NOUS breaches increased to 221 due to delays with booking patients early in the 6-week pathway because of reduced admin staff (sickness, vacancies, iClip training) which subsequently led to capacity challenges at the end of April. Further compounding this, there were 3 lists closed on 30th April due to clinical staff sickness.	March 2026	April 2025 data sufficient for assurance

Operational Performance

Exception Report| SGUH A&E Waits and Ambulance Handovers



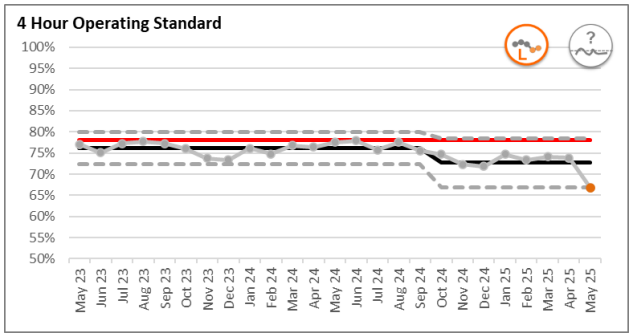


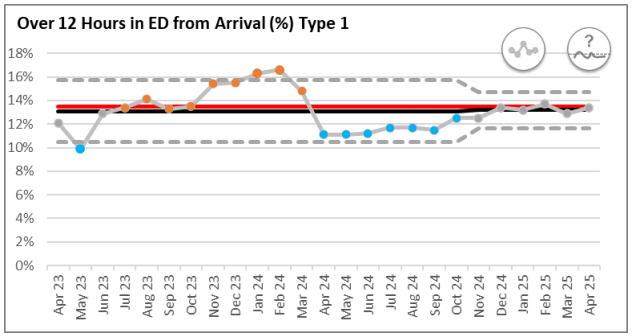


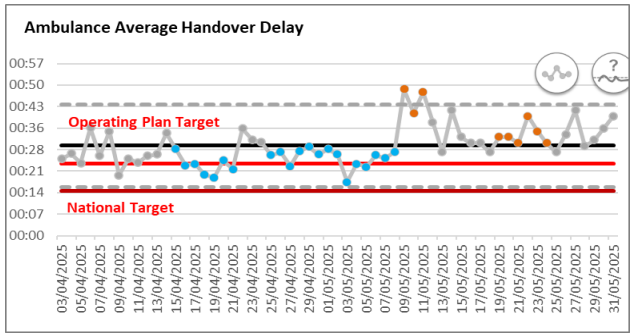
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in April 2025 12 Hour waits Type 1 – meeting plan Ambulance Handover – variable trend	Four Hour Performance continues to exceed national target, however has seen a decrease through May 2025. ED Capacity impacted by flow through the Trust main driver for longer waits, with a number of DTAs in the department which impacts waits over 12 hours. Historic submission of ECDS type's has been fixed which has previously shown over performance, hence submitted operating plan has a higher value which is more expected. In May 2025 the average handover time was 26 minutes which is meeting the UEC national target of 30 mins with the ambition to reduce to the 15 minutes target.	• Dedicated Treatment pod for faster delivery of IVs and dedicated investigation cubicle. • Maintaining in-and-out spaces to aid flow. • Continue to work with 111 to optimise Urgent Treatment Centre (UTC) utilisation. • Further development of SDEC inclusion criteria, increase in surgical SDC capacity delivered with more planned. • Direct access to Paediatric clinics for UTC plastic patients. • Weekly meetings with London Ambulance Service (LAS) to resolve issues between both Trust and LAS. • Planned Frailty Same Day Emergency Care (SDEC) Pilot June 2025 . • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Long waiting patients in ED are continually monitored through their stay. Tests / diagnostics required for their onward treatment are requested while a ward-based bed is sought • Pilot RAT consultant at ambulance triage to support timely handover and redirection • Review EP shift patterns / rota to allow additional streamer Mon-Wed • Working with pharmacy to launch Pharmacy First at front door • Review EPCH provision to ensure best use of resources • Reviewing medical rota to allow ACPs and PAs to support streaming	Performance currently being delivered	Sufficient for assurance 12 Hour - Not sufficient for assurance, underlying issues understood and ECDS data will be corrected LAS published data

Operational Performance

Exception Report | ESTH A&E Waits and Ambulance Handovers





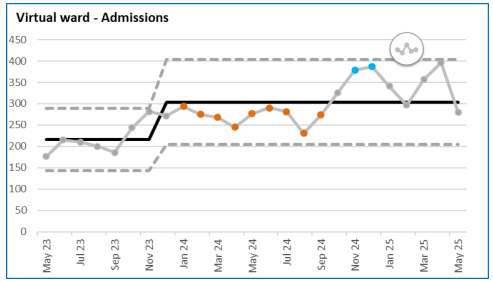


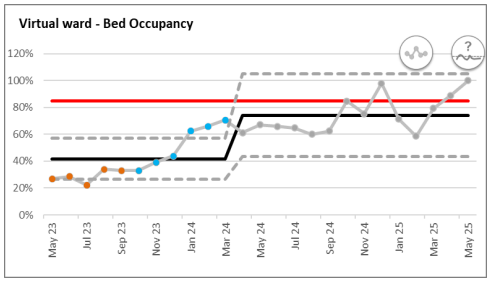
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH 4 Hr performance below trajectory of 75% ED Type 1 LOS>12 Hours - Meeting plan normal variation LAS Average Handover Time – Normal Variation not meeting plan	Emergency department wait times remained a challenge in May 2025, validated reporting for May remains pending. IClip Pro implementation had a significant impact on flow and ED processes in May as the teams got used to the new system and in how best to utilise it. The ED to SDEC pathway in particular has been time-consuming for the clinical teams to use. High numbers of mental health patients requiring admission to an inpatient bed with many of these patients waiting a significant period in the department prior to transfer.	• **The ESTH Urgent Care Transformation programme has been scoped and outlines an agreed set of priorities for 2025/26 to include:** • Criteria to Admit - Reduce avoidable hospital admissions utilising the Criteria to Admit decision support tool within emergency care pathways, improving patient outcomes and hospital capacity. • Frailty - To establish a 7- day acute frailty service in 2025/26, reducing avoidable admissions and improving outcomes for frail older patients through sustained resourcing and strengthened out-of-hospital referral pathways. • Front Door Processes - To implement best practice pathways across both emergency departments with a focus on ensuring robust processes to support admission avoidance, early senior clinical review, and appropriate streaming as an alternative to acute hospital care. **Revised KPI's are in draft to support UEC 2025/2026 Transformation programme and under progression with our BI team in line with ILCIP reporting capabilities.** A fix for the ED/SDEC workflow is now planned to go in to streamline the processes in June 2025 which should have a benefit on the processes and on the overall management of patients across the acute floor	TBC	April 2025 data sufficient for assurance

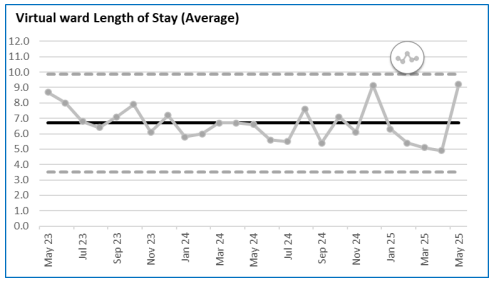
Operational Performance

Exception Report| **Integrated Care | Virtual Wards**

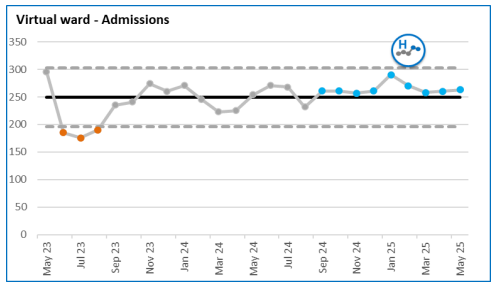
Sutton Healthcare

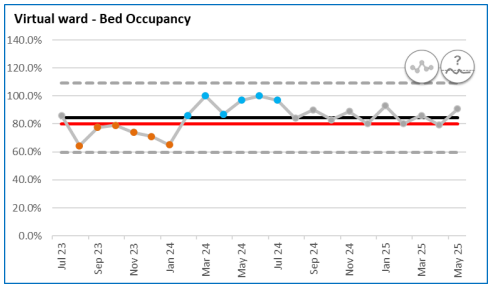


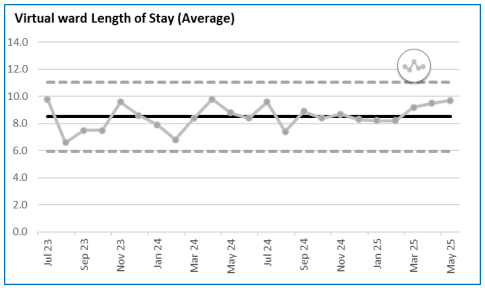




Surrey Downs







Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
Sutton Health & Care	Occupancy rate has risen above 85% target with admissions although falling continuing to show normal variation.	• LoS reduction programme with ESTH and Sutton Alliance is in progress to include virtual ward redevelopment. • Engagement work with relevant wards and clinicians continues.	Target met - monitoring	Sufficient for assurance
Surrey Downs Health & Care	Admissions to virtual ward remain above the mean with bed occupancy rate above 80%	• On-going development of enhanced care and new pathways in Virtual Wards.	N/A	Sufficient for assurance

Section 2.2:
Operational Productivity

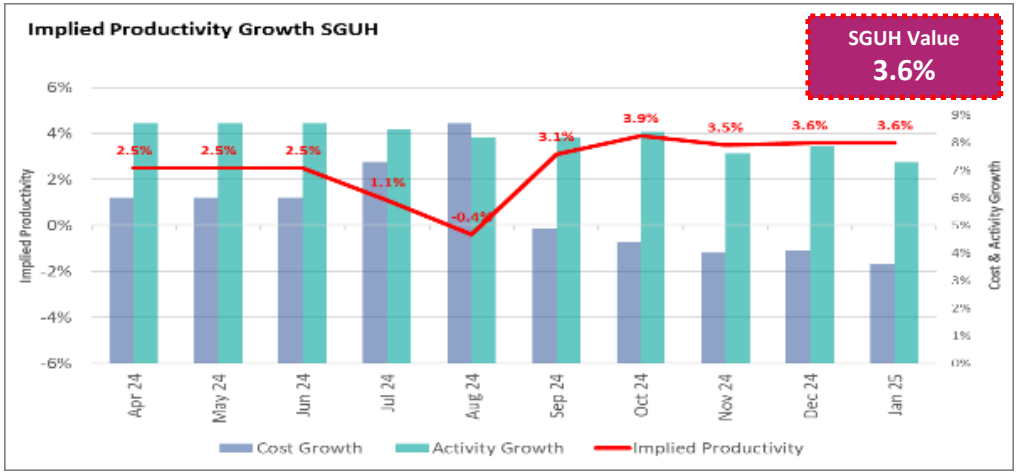
Operational Productivity

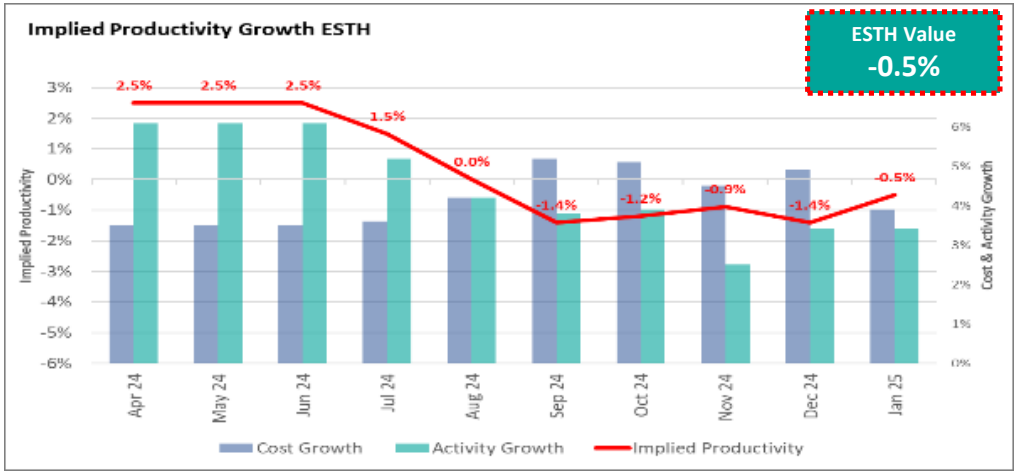
Overview Dashboard

KPI	St George's Latest month	St George's Previous Month Measure	St George's Latest Month Measure	St George's Target	St George's Variation	St George's Assurance	St George's National Benchmark	Epsom & St Helier Latest month	Epsom & St Helier Previous Month Measure	Epsom & St Helier Latest Month Measure	Epsom & St Helier Target	Epsom & St Helier Variation	Epsom & St Helier Assurance	Epsom & St Helier National Benchmark
Implied Productivity Growth	Jan 25	3.6%	3.6%	-	N/A	N/A	N/A	Jan 25	-1.4%	-0.5%	-	N/A	N/A	N/A
Non Elective Length of Stay (SWL Methodology exc 0 days and <18)	May 25	10.0	9.9	9.7			N/A	May 25	11.6	11.5	-		TBC	N/A
Theatre Utilisation (Capped)	May 25	81.9%	83.1%	85.0%			Top Quartile	Apr 25	81.9%	79.2%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Feb 25	79.1%	80.6%	83.6%			Lowest Quartile	Feb 25	79.1%	79.0%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	May 25	1.9%	2.0%	5.0%			Lowest Quartile	Apr 25	4.6%	5.3%	5.0%			Top Quartile
Outpatients Missed Appointments (DNA Rate)	May 25	9.5%	10.1%	8.0%			Lowest Quartile	Apr 25	6.4%	6.7%	6.0%			2nd Quartile
First and Procedure Attendances as a proportion of Total Outpatients	May 25	51.8%	52.2%	49.0%			2nd Quartile	May 25	46.0%	42.4%	49.0%			3rd Quartile

Operational Productivity
Model Hospital – New Implied Productivity compared to previous year

Implied productivity of acute and specialist trusts is calculated by comparing output growth (cost-weighted activity) to input growth (based on expenditure costs) against a baseline period. This measure examines year-to-date activity and costs compared to the same period in the previous financial year. The data is sourced from the Model Health System, which currently reports with a four-month lag. A negative value indicates decreased productivity, while a positive value indicates productivity growth. The target is a positive value.





Actions: Completed since last update, New, and Ongoing

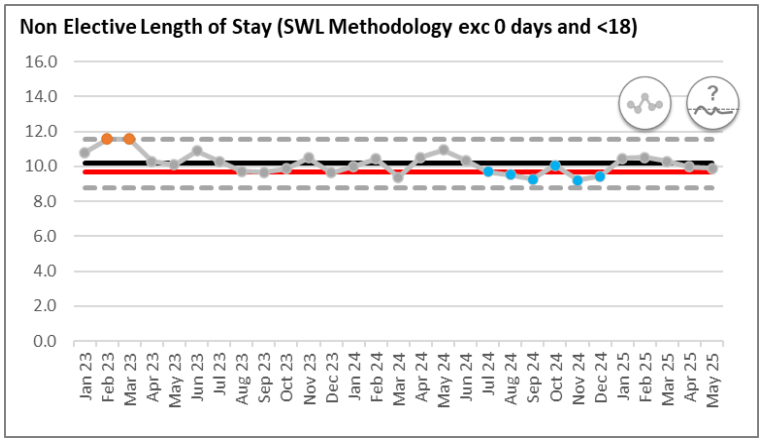
- New implied productivity shows a positive trend in recent months compared to 2023/24, largely driven by a reduction in cost growth between September 2024 and January 2025.
- Activity growth has been sustained throughout 2024/25, reflecting a notable increase compared to the previous year.
- National will be sharing more information to which will clarify the key drivers for reporting

Actions: Completed since last update, New, and Ongoing

- The *Implied Productivity* national metric shows a 0.5% decline in productivity in 2024/25 YTD Month 10 compared to same period the previous year (2023/24), driven by cost growth (operating expenditure) exceeding growth in *weighted* activity.
- Work in underway to replicate the national methodology locally in order to better understand the root cause, starting with *weighted* activity.
- Maternity services are being prioritised for the detailed activity vs cost analyses in light of the continuing trend of reduction in births.
- NHSE will be sharing more detailed information to help providers identify the key drivers behind the headline figures.

Operational Productivity

SGUH – Non-Elective Length of Stay (NEL LOS)

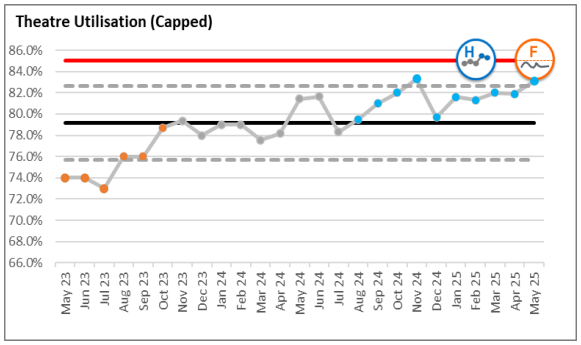


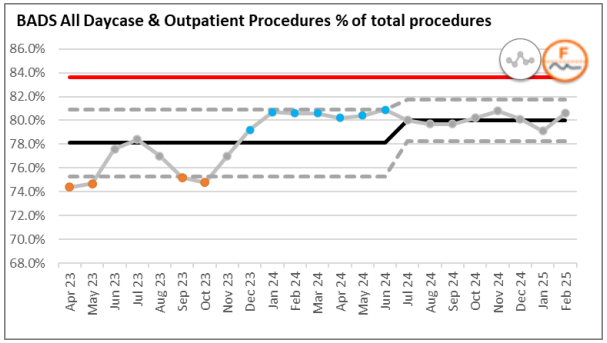
Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	May-25	TBC

Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties). The target is predicated on assumptions consistent with plans currently in place to facilitate the effective diversion of a proportion of short-stay admissions at the front door.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH LOS	• Through May 2025, on average in-patients stayed in a hospital bed for 9.9 days, which is below the mean for a consecutive month. • Super Stranded patients >21 days has continued to see a sustained reduction over the past eight weeks and remains on trajectory to decrease further • Largest number of NCTR patients are within pathway 0, which is an expected picture and the site is now achieving the national expectation of 80%, however the length of stay post NCTR for this cohort remains to high.	• >7 day LoS meetings embedding lead by all divisions with a 40+day panel established. • Divisions delivering the 10 divisional NEL LoS actions • Revised weekend plan to focus on discharge and criteria led discharges • Continued improvement in the use of the 24/7 discharge unit • Launch of described not prescribe model on 1st June 2025 delayed till 1st July to enable digital processes to be in place. • New full capacity protocol being drafted • Launch of Incident management system for site operations to ensure timely resolution to issues that prevent discharge or flow	Under review at LOS Working Group	Sufficient for assurance

Operational Productivity
SGUH - Theatre Utilisation & Daycase Procedure Rates





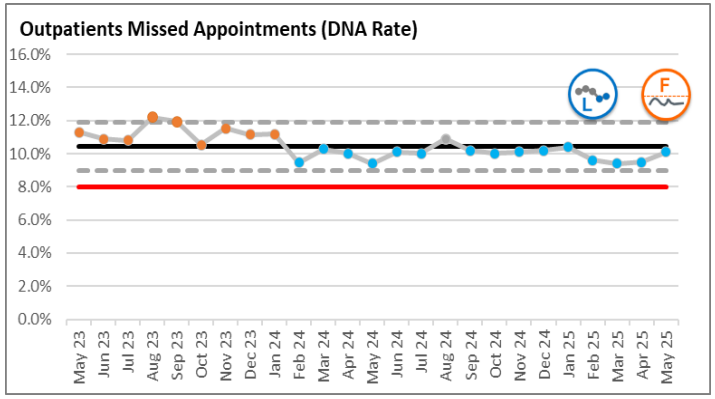
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	May-25	78 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Feb-25	370 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation 85% - IP 77% -DSU 71% - QMH	• Capped Theatre Utilisation: 83% across the month of May 2025 showing further improvement, particularly within IP where performance exceeded 85%. • A total of 34 cases cancelled on the day. Which is a reduction on the previous month. • Utilisation at 77% in DSU, with the main challenges being clinical on the day cancellations and cancellations during the 24-hour prior to surgery phone call which is reducing productivity.	• Adherence to a robust 6-4-2 escalation processes being implemented to improve theatre capped utilisation and improve scheduling standards, including the creation of a digitalised theatre scheduling tool to support with theatre productivity and meeting the production plan. • Implementation of the new OTDC cancellation policy has commenced but further work is required to align the Trust's and national cancellation reasons. An IT change is to be presented at the next CICG meeting for discussion. • Continued work is ongoing within the ePOA workstream which is being extended to Breast and ENT patient, following a successful pilot in Gynae. Full Cerner implementation will take place once the change freeze has been uplifted. • Ongoing QIA project within the Anaesthetic department to identify avoidable DSU clinical cancellations, working in collaboration with POA to optimise patients as early as possible.	TBC	sufficient for assurance
SGUH: Improving trend, below top quartile peer	• Further improvement seen with February performance at 80.6% against peer performance of 83.6% • Day case % of Inpatient procedures below peer average at 67% (peer 76.6%). Breast, ENT, Max Fax driving this in Model Hospital data assuming more can be moved to day case, work ongoing with each service through list planning to ensure procedures are moved from IP to DSU where appropriate. • Higher rate of inpatient procedures compared to peers - complexity of patients referred to SGUH with higher acuity resulting in higher number of IP beds required for DC procedures.	• BADS compliance being discussed with all surgical specialities within theatre transformation to explore opportunity. "Right Procedure, Right Place", through local theatre user groups. • Trust-wide training on the intended management code to improve data accuracy. • Ongoing work with services to change the operational process to better predict and classify day cases. • Update Job Aids for administrative and clinical staff • Engage and roll out to other services	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	May-25	1,274 appointments

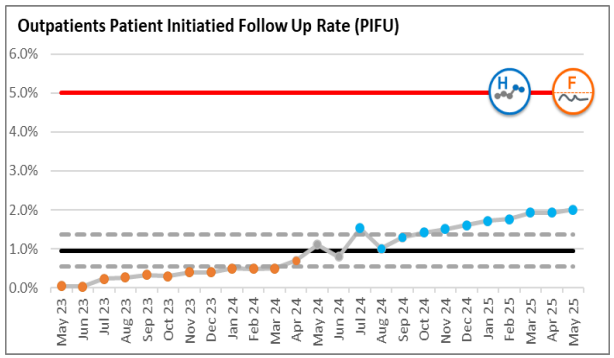
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

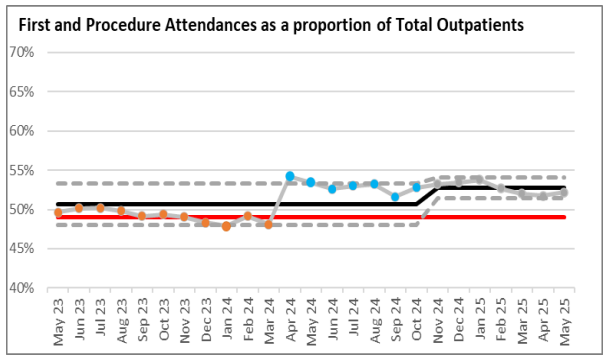
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

SGUH
Special cause variation of an IMPROVING nature however not meeting target of 8%
	Current DNA rates of 10% against a peer average performance 8.3% through May 2025.
	
	Highest proportion of DNA's within Physiotherapy, Dermatology, Rheumatology.
	
	10.2% DNA rate for first appointments
		- Speciality-level data reviewed weekly with all operational leads in Elective Access Meetings
		- Reviewing Model Hospital data to view performance against peers and review opportunity to reduce DNAs
		- Working Group established to focus on Top 10 –agreeing to trail some different strategies to reduce the DNA rate's which are listed below.
		  - **Cardiology** – A trial is underway to contact patients with upcoming appointments within the next six weeks who previously did not attend (DNA) to confirm their attendance. The effectiveness of this approach will then be shared and evaluated
		  - **Therapies** – A historic DNA audit has been conducted using Zesty. Results are being analysed and will be shared in the coming weeks.
		  - **Respiratory** – A preventative DNA audit will be carried out using Zesty's two-way texting system over a one-month period. Patients will receive a text message a week before their appointment, enabling them to cancel or reschedule if necessary. The effectiveness of this intervention on DNA rates will then be evaluated.
		- New Outpatient Transformation Board has been established with a dedicated workstream focused on reducing DNA rates. Priority actions will be agreed and progress will be monitored through the group.
			Under review at Outpatient Transformation Board	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups



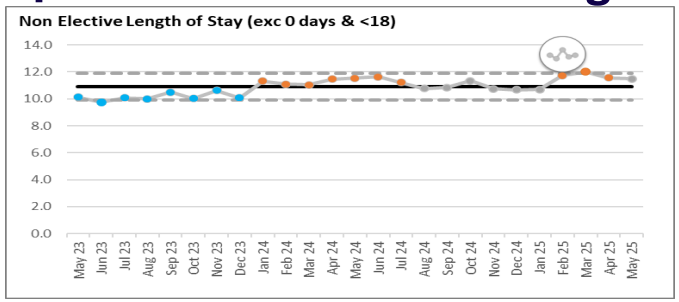


Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Apr-25	*0 (exceeding target)*
PIFU Rates	May -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend	In month performance for May 2025 continues to see a positive upward trend at 2%, however a significant increase is required across the year to achieve 5%.	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure more specialties are ready to go live - patient leaflets, clinician understand the process, and local SOP. • Of 22 services, we have officially gone live with 14 PIFU Pathways. Cardiology and Neurology were scheduled to go live last month (April 2025); however, due to operational pressures in both services, this did not occur. This issue will be addressed in the clinical leads meeting this month to raise awareness and establish a firm Go Live date. We are also coordinating with the Clinical Leads in Specialist Medicine to confirm processes and pathways for the remaining services. • We have contacted specialities who have begun to use PIFU but have not had discussions with us about patient leaflets and local processes. Also informing specialties around incorrect processes i.e. PIFU has been indicated on eCDOF but no order has been placed. • The opportunity to increase PIFU activity is based on PIFU Utilisation rate (over the last 3 months). Provider level utilisation rates are compared to the 85th percentile across all providers. Where the Provider rate is higher than the 85th percentile, no opportunity has been identified. Where your utilisation rate is less than the 85th percentile, the opportunity to increase PIFU activity is based on your current outpatient activity increasing to this level i.e. Opportunity = (Outpatient appointments for the most recent 3 months x 85th percentile) - current PIFU activity over the most recent 3 months. Cardiology, Dermatology and Neurology, Physio, T&O are high volumes specialties where the opportunities are the greatest.	5% target for end of 25/26	sufficient for assurance

Operational Productivity

ESTH – Non Elective Length of Stay



Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).

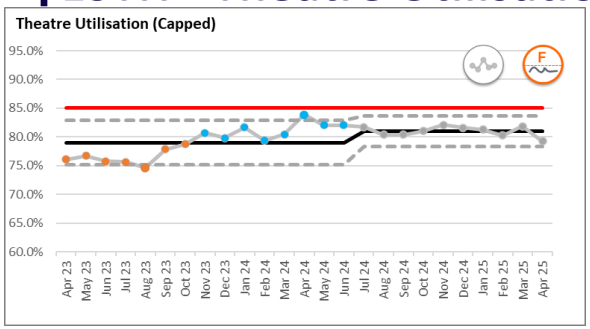
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	May-25	TBC

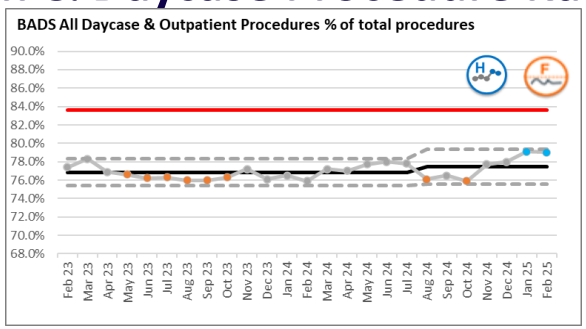
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH LOS Normal Variation	• ESTH LOS reduced by 0.1 days in the month of May to 11.5 from a reported 12.0 in March 2025 and 11.6 in April 2025. This number is headline and pre validated post ICLIP cutover. • The number of medically optimised patients on both hospital sites remain a challenge with many patients requiring complex discharge planning to support discharge . • A high number of patients continue to await a complex pathway 3 placement or onward inpatient neuro-therapy provider. A significant cohort of our medically fit patients are requiring on-going acute therapy prior to discharge.	**The ESTH Urgent Care Transformation programme has been scoped and outlines an agreed set of priorities for 2025/26 to include:** • Board Rounds/Ward Rounds - Improve patient flow and reduce non-elective length of stay by standardising ward processes and accelerating discharge pathways through structured board rounds and improvement huddles. • Therapies - To improve patient flow and service delivery by optimising the productivity and deployment of the therapies workforce, ensuring timely, efficient, and needs-based care through targeted workforce and process improvement. • Bed Reduction Plans - To agree and implement a redesign of the internal bed base across both hospital sites optimising the estate footprint and allocated staffing resource to ensure improved efficiency and a reduction in overall capacity requirements. • Acute Medicine Workforce - To agree and implement a review of the acute medicine workforce to ensure the best use of available resources whilst supporting timely and effective care for patients. • Operational Flow Management - To improve operational flow management across both hospital sites through the review and implementation of robust daily systems and processes to support improved patient flow, escalation, and governance. Revised KPI's are in draft to support UEC 2025/2026 Transformation programme and under progression with our BI team in line with ILCIP reporting capabilities. Daily reports in place identifying those patients who are medically fit for discharge have paused. We are working with teams to ensure identification and automated alerts via ICLIP to continue sharing with internal and external stakeholders, including our therapy teams. Ongoing reporting will include early notification of CTR compliance at Site/ Division and ward level. Weekly led reviews for those patients holding a 0-14 day LOS continue in line with Trust/ Site OPEL 3 reporting. This is addition to the Complex Discharge this has been complemented this month by a review of all patients with a LOS of 1-14 days in collaboration with the virtual wards and supporting pathways and forms Trust BAU. Revised KPI's are in draft to support UEC 2025/2026 Transformation programme and under progression with our BI team in line with ILCIP reporting capabilities.	TBC	April 2025 data sufficient for assurance

Length of stay activity for Epsom and St Helier includes activity for two community wards located in the acute hospital setting.

Operational Productivity

ESTH - Theatre Utilisation & Daycase Procedure Rates



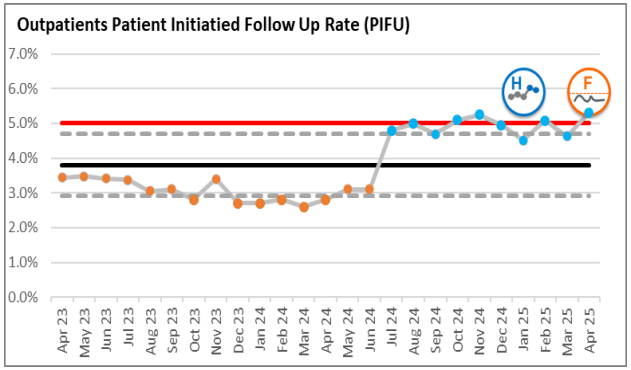


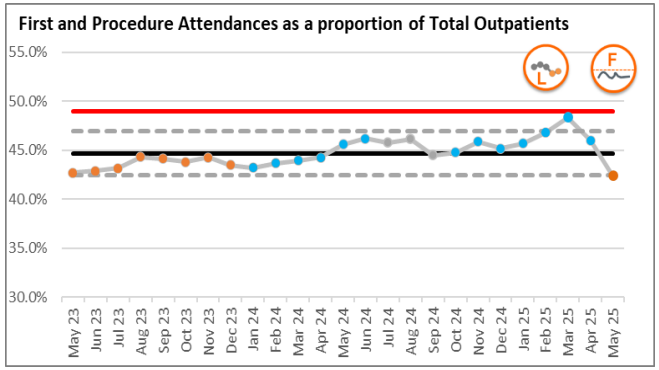
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Apr-25	217 cases (based on an average case time of 63 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Feb-25	485 cases opportunity to move to OP (3 month period)

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Theatre Utilisation Special cause improving variation and failing target (85%) BADS performanc e Not meeting target, Improving trend	Theatre utilisation has seen a slight decrease, dropping from over 80% to **79.24%**. This marginal decline is primarily attributed to an increase in **On The Day Cancellations**, which have risen to **8.93%**. . **Late Starts** remain under the 30 minute target at 19mins, and our **underruns** at 29 minutes. On The Day Cancellations have increased to **8.93%** in April. The leading cause continues to be patients deemed **unfit for surgery**, accounting for the majority of cancellations this month. In addition to clinical fitness, **No Theatre Time**, was the second leading reason for OTDC.	**Perioperative Care pathway and processes:** • Following the success of the initial pilot, the Group are working through plans to roll out the initiative to ENT and T&O at Epsom, in April. This will support a growing pool of 'green' patients, who can be declared *'fit'* on the same day they are listed for surgery. • **Day Case Rates (BADs):** Model Hospital data for BADs quarter ending Dec 24 is **77.9%** overall for ESTH**.** ESTH **excluding EOC** is **89.1%**. Improvements have been ongoing with the commenced EOC process changes for recording hips/knee procedures. • We have met with EOC colleagues and agreed that they will validate their day case activity daily to ensure that when ESTH data is submitted to model hospital the correct day case position for EOC is included going forward. • The estimated position for March is **84.2%** overall for ESTH and **93.8% excluding EOC**. • We are reviewing High Volume Low Complexity procedures against GIRFT with a view to increasing day case rate for certain procedures (Lap Chole and Hernias). **On The Day Cancellations:** • 'Patient unfit' continues to be the top cancellation reason for both *'Patient' & 'Clinical'* Cancellations . • We are setting up a Theatre List Planning Task and Finish Group to ensure robust processes are in place to support efficient scheduling of lists. • **Specialty Deep Dives:** • We are working with specialties who are consistently underperforming against 85% utilisation to understand the challenges and implement changes to support improved utilisation. • **Staring on Time:** • A Task and Finish Group has been set up to support lists starting on time in line with the opening of the new consenting space at Epsom.	March 2026	April 2025 data sufficient for assurance

Operational Productivity

ESTH – Reduction in Outpatient Follow-Ups

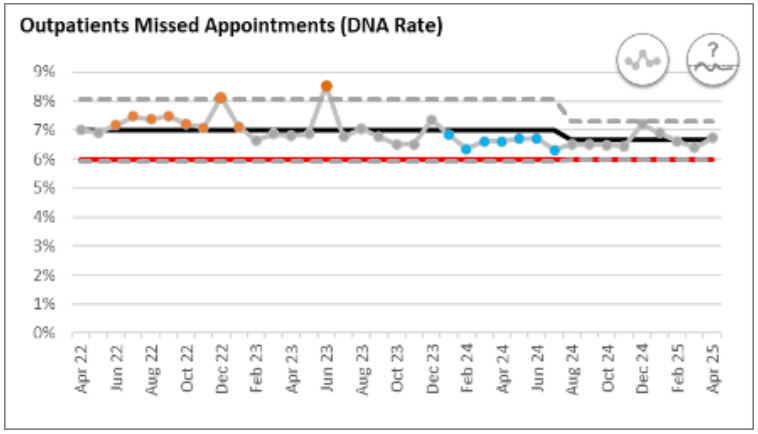




Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
Outpatients: [1st + Proc] as a % of Total OP	May-25	£600k
Outpatients: PIFU Rates	Mar -25	*Not quantified to avoid double-counting with New: FU Ratio opportunity*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
PIFU – normal variation First & Procedure attendances – below target	PIFU rate has returned to over 5% in April, reaching 5.3%. **Need to:** Reduce follow-up activity Reduce DNA Rates Increase PIFU Rates	**PIFU -** Monthly reviews of PIFU rates at specialty level are carried out by Transformation; teams with growth in their PIFU rates are celebrated and those with reductions are asked if there are any obstacles they are facing and if they require any support. PIFU data at clinician level has been shared with Renal and Medicine specialties in May and will be shared in June with other specialty teams to identify best practice at subspecialty level. This will be used to understand and share this learning to expand best practice, alongside sourcing learning from peers where their PIFU rate is higher. This subspecialty review will also seek to identify where colleagues are struggling or reluctant to use PIFU to better understand obstacles to using PIFU with an aim to mitigate and support staff to overcome these obstacles. **Follow Up Reduction:** Work continues to encourage outpatient teams to question the value of follow ups as they are used currently. Teams are working on ensuring follow ups of limited clinical value are reduced. Strategic data packs have been created to help teams identify opportunities and have been shared with the Medicine DMT, Renal, and the Planned Care Tri. An example of the work is the dedicated workshop to redesign the internal Urogynaecolgy pathway at ESTH that took place on 22 May with the subspecialty team engaged in proactively embracing this opportunity to improve the pathway. From this an updated shorter pathway has been proposed.	March 2026	May 2025 not sufficient for assurance due to large volumes of unoutcomed and uncoded activity

Operational Productivity
ESTH Missed Appointments (DNA Rate)



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Apr-25	684 Appointments

The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
ESTH Normal variation, no significant change Failing target of 6%	During the iClip Go live period, text reminders failed to run for a period of a week. This will have led to an increase in missed appointments which is expected to impact May 2025 performance.	Work to review patients who have DNA'd multiple times across multiple specialties has identified trends in patients from care homes and prisons and a report is now available highlighting patients who have DNA'd multiple times in a single specialty so that teams will be able to review where the access policy can be appropriately applied for these patients. Clinics with persistently high DNA rates in Gynaecology have been reviewed and a list of proposed clinics to test the impact of overbooking has been proposed to the service team for consideration.	March 2026	April 2025 data sufficient for assurance

Section 3 - Our People

Overview Dashboard | People Metrics

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Staff Sickness Absence rate	May 25	4.2%	3.8%	3.2%			2nd Quartile
Agency rates	May 25	101.9%	201.9%	-			
MAST	May 25	92.1%	92.1%	85.0%			Top Quartile
Vacancy Rate	May 25	4.4%	5.0%	10.0%			
Appraisal Rate Medical	May 25	85.6%	85.4%	90.0%			
Appraisal Rate Non Medical	May 25	80.0%	79.1%	90.0%			Top Quartile
Turnover	May 25	10.3%	10.0%	13.0%			4th Quartile
Percentage BAME staff band 6 and above	Apr 25	47.0%	47.0%	-			
Workforce WTE	May 25	10909	10863	10818			

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 25	4.6%	4.8%	3.8%			3rd Quartile
May 25	2.0%	1.7%	-			
May 25	86.5%	87.6%	85.0%			Top Quartile
May 25	11.7%	11.4%	10.0%			
May 25	93.5%	96.3%	90.0%			
May 25	72.5%	76.3%	90.0%			Top Quartile
May 25	10.2%	9.4%	12.0%			4th Quartile
May 25	41.1%	41.1%	-			
May 25	7508	7458	7468			

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Sickness Rate	May 25	6.1%	6.2%	3.8%		
Agency rates	May 25	1.7%	2.8%	-		
MAST	May 25	89.7%	91.8%	85.0%		
Vacancy Rate	May 25	11.0%	14.1%	10.0%		
Appraisal Rate Medical	May 25	100.0%	100.0%	90.0%		
Appraisal Rate Non Medical	May 25	70.2%	74.5%	90.0%		
Turnover (12-Month)	May 25	12.5%	16.7%	12.0%		
Percentage BAME staff band 6 and above	May 25	38.2%	38.3%	-		

Surrey Downs

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
May 25	3.9%	4.3%	3.8%		
May 25	3.5%	3.2%	-		
May 25	93.4%	93.3%	85.0%		
May 25	12.1%	13.5%	10.0%		
May 25	100.0%	100.0%	90.0%		
May 25	77.6%	88.8%	90.0%		
May 25	15.4%	18.5%	12.0%		
May 25	22.0%	22.0%	-		

gesh

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

Appendices

Appendix 1 Watch List Metrics

Overview Dashboard

St George's

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mixed Sex Accommodation Breaches	May 25	112	130	0			Highest Quartile
Number of Complaints Received	May 25	67	48	-			N/A
Number of re-opened complaints in month	May 25	2	3	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Received	May 25	0	0	-			N/A
Parliamentary and Health Service Ombudsman (PHSO) Closed	May 25	1	1	-			N/A
RTT - Total Size Incomplete Waiting List	Apr 25	70596	69860	70531			Quartile 3
Cancer 31 Day Decision To Treat to Treatment Standard	Apr 25	97.1%	96.6%	96.0%			Quartile 2
On the Day Cancellations not re-booked within 28 days	Apr 25	4	5	0			Quartile 2
Outpatient Advice & Guidance Rate per 100 First OPA	Mar 25	23.8	23.6	16.0			Quartile 2
Emergency Department Attendances per day	May 25	417	426	-			N/A
Mental health delays 4 Hour Breaches	May 25	84	165	-			N/A
Length of stay > 21 days (super stranded)	May 25	160	161	-			Quartile 4
Overnight G&A beds occupancy - Adults	May 25	97.3%	95.6%	96.0%			Quartile 3
Number of patients not meeting criteria to reside (Daily Avg)	May 25	123	119	-			Quartile 1

Epsom & St Helier

Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
May 25	47	44	0			Highest Quartile
May 25	61	45	-			N/A
May 25	2	1	-			N/A
May 25	1	4	-			N/A
May 25	1	0	-			N/A
Apr 25	49557	49751	50386			Quartile 3
Apr 25	100.0%	99.0%	96.0%			Top Quartile
May 25	0	3	0			Top Quartile
Mar 25	54.6	56.6	16.0			Top Quartile
May 25	436	436	-			N/A
Apr 25	233	227	-			N/A
Apr 25	172	152	-			Quartile 4
Apr 25	88.0%	88.3%	96.0%			Quartile 2
Apr 25	221	195	-			Quartile 3

Sutton Healthcare

KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance
Two hour UCR referrals received	May 25	360	460	-		
Virtual ward - Admissions	May 25	369	280	-		
Virtual ward Length of Stay (Average)	May 25	4.9	9.2	-		
Discharge to Assess- Pathway 0-3 Delays (Median Days)	May 25	6	4	-		

Surrey Downs

Latest month	Previous month measure	Latest month measure	Target	Variation	Assurance
May 25	549	477	-		
May 25	260	263	-		
May 25	9.5	9.7	-		
May 25	2	2	-		

Appendix 2

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 3

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 (RTT)	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
Non Elective Length of Stay	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).	NHS Priorities & Operational Planning Guidance	
Length of Stay>21 Days (Stranded patients)	based on NHSI Sitrep data. The guidance / methodology includes non-elective and elective patients as per operational planning technical guidance. Most of these patients will be non-elective, but to understand the overall impact it is important to include the number of elective patients.	NHS Priorities & Operational Planning Guidance	NHSI
Ambulance Average Handover Times	Data definition numerator: Total time in seconds of patient handover or transfer to a cohort that took place from the time of hospital arrival to handover time at ED and non ED sites. NB: This does not exclude the first 30 mins. Data definition denominator: This is a count of all arrivals at ED and non-ED sites over the period.	NHS Priorities & Operational Planning Guidance	
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
Never Events	Serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level	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
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gesh Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital
Implied Activity	Inclusions: Outpatients, outpatient procedures, elective (IP & DC), Non elective, A&E Methodology: Activity weighted by national average costs by HRG and POD so that e.g. overnight elective activity is more highly weighted than A&E attendances Cost: total operating expenditure, excluding impairments, includes PDC dividends, adjusted for inflation Compares YTD position with same YTD from previous year Updated monthly and shown on Model Hospital under Productivity & Efficiency section Published productivity metrics not broken down by POD or specialty	Performance Assessment Framework	SUS & national cost collection (for weighting) Provider Finance Return

Appendix 5
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 (Public)

Meeting on Thursday, 03 July 2025

Agenda Item	5.1	
Report Title	**People Committees Report to Group Board**	
Non-Executive Lead	Yin Jones, People Committees Chair	
Report Author(s)	Yin Jones, People Committees Chair	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the People Committees at its meeting in April 2025 and the matters the Committees wish to bring to the attention of the Group Board. The key issues the Committees wish to highlight to the Board are:

- Group Chief People Officer (GCPO) Report: The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) about national pay awards, ongoing job evaluation challenges (particularly Band 2 to 3 and new nurse profiles), progress on leadership and management standards, and national workforce controls.
- Board Assurance Framework (BAF): People Risks: The Committees noted that there were no proposed changes to the risk scores or assurance ratings for the strategic people risks (Staff Experience, Culture & D&I, Tomorrow's Workforce). This was due to the significant foundational work being undertaken and the desire to see the impact of these initiatives before adjusting scores. The upcoming refresh of the Group strategy and BAF, as well as anticipated CQC feedback, would inform future adjustments. The Committee commended the risk scores and assurance ratings for submission to the Group Board in July 2025.
- Workforce KPI Performance Report
  The Committee reviewed the regular monthly update on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. For May 2025, the total workforce was approximately 18,500 WTE, with substantive staff levels stable and positive reductions in bank and agency.

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 2025.

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

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

Implications

Group Strategic Objectives

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

Risks

The Committee reviewed People risks (SR12,13 and 14) at this meeting.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

As set out in paper.

Legal and / or Regulatory implications

N/A

Equality, diversity and inclusion implications

As set out in paper.

Environmental sustainability implications

N/A

People Committees Report
Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the People Committees at its meeting in June 2025 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 in June 2025, the Committees considered the following items of business:

19 June 2025

- Group Chief People Officer Report
- Medical Revalidation Responsible Officer Report Q4
- Guardian of Safe Working (GoSW) Q4 Report
- Area of Focus: Flexible Working
- Area of Focus: Temporary Staffing
- Freedom to Speak Up Report; Q3/Q4 and Annual Report
- Equality, Diversity and Inclusion (EDI) Action Plan Update
- Workforce KPI Performance Report
- Group Board Assurance Framework (BAF) – People Risks

2.2 As in 2024/25, the Committees, chaired by Yin Jones, is meeting every two months as agreed by the Group Board. An informal meeting between the Chair and GCPO takes place between Committee meetings.

3.0 Key issues for escalation to the Group Board

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

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

The Committees received a comprehensive verbal update from the Group Chief People Officer (GCPO) about national pay awards, ongoing job evaluation challenges (particularly Band 2 to 3 and new nurse profiles), progress on leadership and management standards, and national workforce controls.

The Committees discussed the financial recovery efforts within gesh ("Blue for Quarter 2"), proactive engagement with the ICB regarding potential workforce reductions, and the ongoing integration of the People function (Phase 2 completed, Phase 3 rollout from September).

Challenges with staff-side relationships, particularly concerning Band 2 to 3 implementation and Soft FM terms and conditions, were highlighted, with anticipated industrial action by United Voices of the World. Delays in the Shadow Board procurement process were also noted.

b) Board Assurance Framework (BAF): People Risks

The Committees noted that there were no proposed changes to the risk scores or assurance ratings for the strategic people risks (Staff Experience, Culture & EDI, Tomorrow's Workforce). This was due to the significant foundational work being undertaken and the desire to see the impact of these initiatives before adjusting scores. The upcoming refresh of the Group strategy and BAF, as well as anticipated CQC feedback, would inform future adjustments. The Committees commended the risk scores and assurance ratings for submission to the Group Board in July 2025.

4.0 Key Issues on which the Committees received assurance

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

a) Workforce KPI Performance Report

The Committees discussed the updates on vacancy rates, turnover, sickness absence, core skills compliance and appraisal compliance. For May 2025, the total workforce was approximately 18,500 WTE, with substantive staff levels stable and positive reductions in bank and agency. The group's vacancy rate improved to 7.6% (SGUH at 5%, ESTH at 11.4%). Sickness absence was reduced to 4.2% and the appraisal rates were just under 80%. Mandatory training compliance was around 90%. While turnover was reducing, key drivers for leaving included end of fixed-term contracts, relocation, and emerging themes like work-life balance, pay, and reward. Work was ongoing to align workforce reporting methodologies across the trusts.

b) Medical Revalidation & Appraisal Report

Both ESTH and SGUH demonstrated stable and high appraisal completion rates (approx. 95% at ESTH, >90% at SGUH for major divisions). Focus remained on locally employed doctors and, for St George's, bank doctors, who historically find the process more challenging. Cross-group appraisals are utilised in special circumstances. Discussions also addressed the importance of effective mentoring, particularly for newly qualified consultants.

c) Guardian of Safe Working (SGUH) Q4

The Committees noted that the Exception Reporting had increased, which was seen as positive, reflecting a culture where resident doctors felt able to report overworking. Concerns about immediate safety often related to patient load and staffing levels, particularly in acute and general medicine. The potential impact of new national requirements to automatically pay for approved overtime based on exception reporting was raised as a concern regarding staff well-being versus financial incentives.

d) Freedom to Speak Up Report Q3/Q4 and Annual Report

The Committees received the annual Freedom to Speak Up report, noting positive improvements in process standardisation and staff confidence in raising concerns. While the process itself offered reasonable assurance, the Committees assessed the overall staff experience and outcome resolution as having limited assurance, with ongoing work required to ensure timely resolution of complex cases and to embed a culture where concerns are effectively addressed at local levels. Further updates on the impact and learning from concerns will be provided. The Committees highlighted the need for continued focus on meaningful change and the impact of processes.

5.0 Other issues considered by the Committees

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

a) Area of Focus: Flexible Working

The Committees welcomed the launch of the Flexible Working Policy and the robust plans for its implementation and monitoring. The new policy is aiming to streamline processes and better meet staff requests. The initiative focuses on communicating the wide variety of flexible options available and empowering managers to embrace flexibility for improved staff retention, engagement, and well-being. Challenges include inconsistent policy application and potential managerial resistance, which will be mitigated through training and communications. Success will be measured through bespoke surveys and monitoring appeals.

b) Area of Focus: Temporary Staffing

The Committees noted the overview and emphasised that meeting national targets for reductions in agency and bank staff was crucial for financial recovery, but also a need to balance cost reduction with ensuring a safe environment for patients. The temporary staffing operations across the group were being streamlined, with integration efforts expected over the next 3-6 months. The goal was to move towards a more standardised and streamlined approach, leading to a more cost-effective service.

c) Equality, Diversity and Inclusion (EDI) Action Plan Update

The Committees noted that the EDI Action Plan was progressing well, though some actions were at risk of delay. Variances in flexible working opportunities and speak-up confidence across different staff backgrounds and grades were highlighted as ongoing EDI challenges that required targeted intervention.

6.0 Recommendations

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

Group Board

Meeting in Public on Thursday, 03 July 2025

Agenda Item	5.2	
Report Title	**gesh Freedom to Speak Up Report 2024/25**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Karyn Richards-Wright, Group Freedom to Speak Up Guardian	
Previously considered by	People Committees-in-Common Group Executive Committee Raising Concerns Oversight and Triangulation Group	19 June 2025 3 June 2025 15 May 2025
Purpose	**For Assurance**	

Executive Summary

This report provides a thematic analysis of concerns raised with the Freedom to Speak Up (FTSU) Guardians across the gesh group in 2024/25. It sets out the key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues. It is good practice for the FTSU report to be presented to the Board biannually.

St George's:

- A total of 143 concerns were raised with the FTSU Guardian.
- The staff groups which raised the highest number of concerns were: Administrative and Clerical staff (59 concerns – 41.25%; and Nursing and Midwifery staff (37 concerns – 25.87%).
- In terms of concerns raised across the Divisions:
  - 47 concerns (32.86%) were raised from Children's Women's Diagnostics and Therapies (CWDT), the largest Division,
  - 45 concerns (31.46%) were raised from MedCard;
  - 15 concerns (10.48%) were raised from Corporate Division;
  - 11 concerns (7.69%) were raised from SNCT Division
  - 9 (6.29%) concerns were raised from Estates and Facilities;
  - 4 concerns (2.79) were raised from SWL Pathology;
  - 2 concerns (1.39%) were raised from Research
  - 9 (6.29%) unknown divisions
- There were a total of 2 anonymous concerns (1.39%) raised to the FTSU Guardian.
- The main types of concern raised were: staff wellbeing and safety (65); bullying and harassment (57); systems & processes (42); and patient safety concerns (22).
- A total 94.1% of workers at SGUH have undertaken the Speak Up training to date.

Epsom and St Helier

- A total of 161 cases were raised with the FTSU Guardian over the same period.
- The staff groups which have raised the highest number of concerns were: Nursing and Midwifery (55 concerns – 34.16%); and Administrative and Clerical staff (42 concerns – 26.08%).
- In terms of concerns raised across the Divisions:

- 39 concerns (24.22%) were raised by staff within Medicine
- 26 concerns (16.4%) were raised by staff within Women's and Children's
- 17 concerns (10.55%) were raised by staff in Estates & Facilities
- 11 concerns each (6.83%) in Cancer & clinical services and Corporate
- 10 concerns in patient services (6.21%)

- Surrey Downs Health and Care (SDHC) and Sutton Health and Care (SHC) together saw 17 concerns (10.55%) raised.
- 14 concerns (8.97%) were raised by staff within Estates and Facilities
- 10 concerns (6.41%) were raised by staff within Corporate, Finance & Human Resources teams
- 60 staff at ESTH have completed the training. At present, the Speak Up training at ESTH is not mandatory.

Following the formation of the Group FTSU team, we have adopted the new national Freedom to Speak Up Policy as one off the first Group-wide policies, in line with national guidelines from NHS England. We have also developed a standardised process, within the team, for triaging concerns raised to the FTSU service to help ensure consistency is maintained in the way in which concerns are dealt with and escalated. This includes clarity on how the service escalated immediate patient safety concerns and its process for undertaking an early state assessment of the risk of concern raisers encountering detriment. in line with guidance from the National Guardian's Office, our triage process also sets out our process for checking in with concern raisers 6 and 12 months after raising a concern.

The Guardian is meeting with HR Business Partner's (HRBP's) regularly to progress concerns, the new Raising Concerns Oversight and Triangulation Group is assisting with further identifying and addressing barriers to timely resolution.

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

Action required by Group Board

The Group Board is asked to:

a. Note the number of concerns reported to the FTSU Guardians in 2024/25 for both SGUH and ESTH and the staff groups reporting.
b. Note the themes emerging from FTSU cases in this period.
c. Note the recommendations of the Group FTSU Guardian as set out in section 7 of the report
d. Note the priorities of the new Group FTSU service in the coming months which includes developing a new gesh FTSU vision and strategy.

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

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	
Appendix 2	

Implications

Group Strategic Objectives

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

Risks

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

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no specific financial implications relating to this report.

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

There are no specific environmental sustainability implications of this report.

Group Freedom to Speak Up Report, 2024/25
Group Board, 3 July 2025

1.0 Purpose

1.1 This report provides the Group Board with a thematic analysis of concerns raised with the Freedom to Speak Up Guardians across the Group during 2024/25. The report sets out key themes and trends in the number, type and origin of concerns and highlights cross cutting and emerging issues.

2.0 Background

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

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

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

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

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

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

1. We will support our staff to feel confident about speaking up

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

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

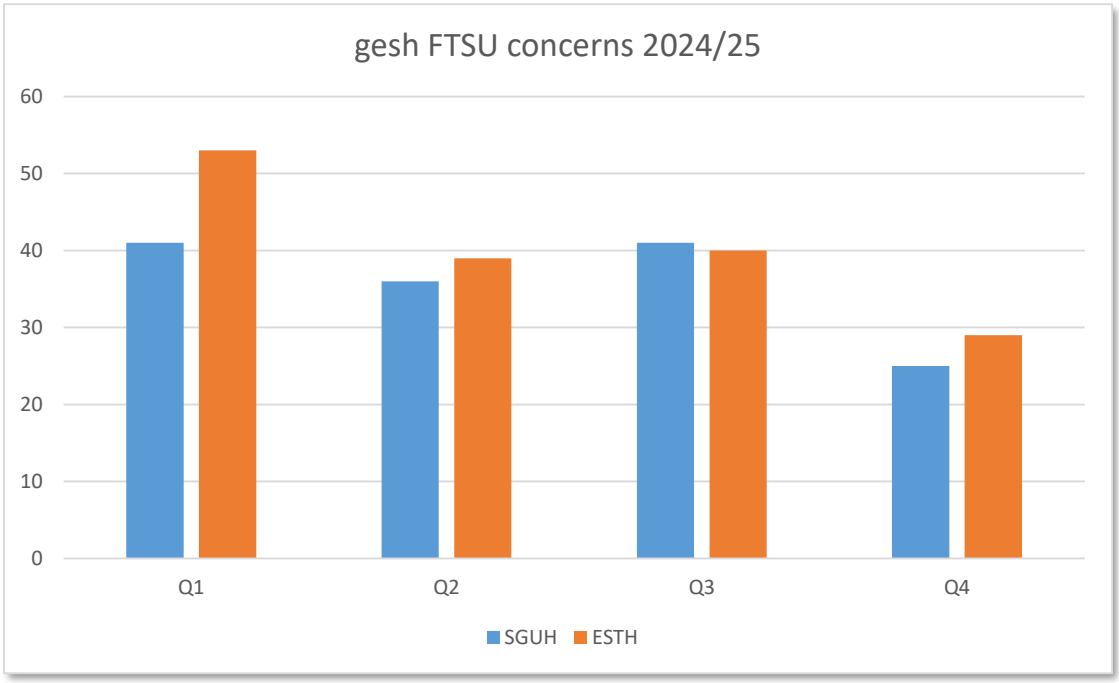
3.0 Current SGUH and ESTH FTSU activity and themes

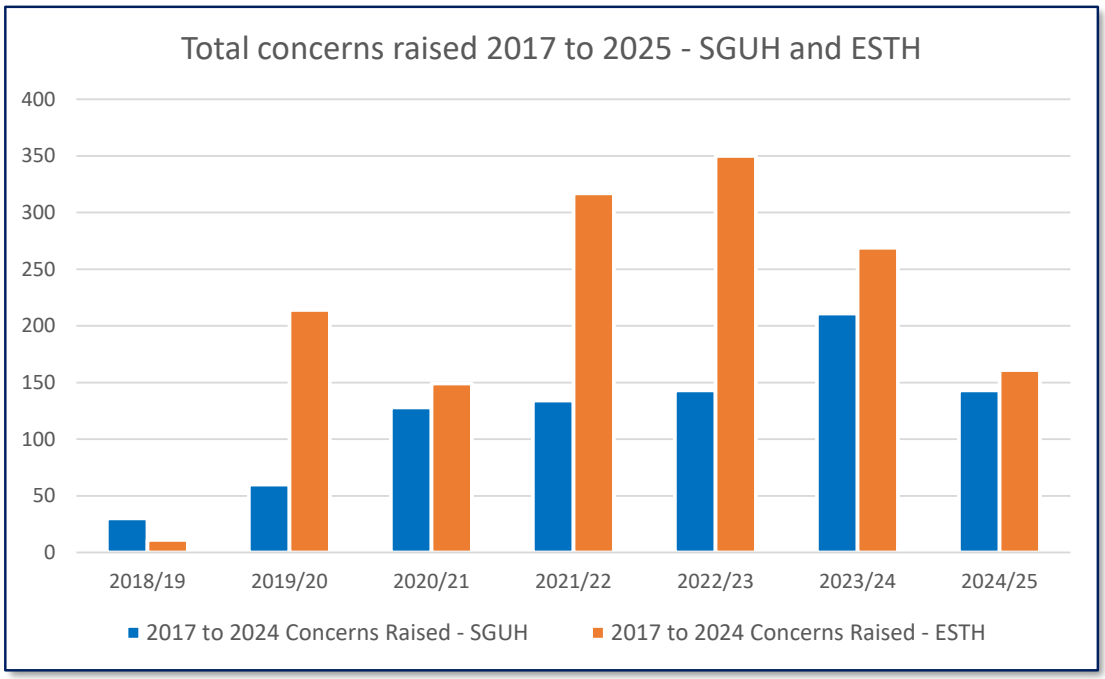
(a) Total number of concerns raised via Freedom to Speak Up in 2024/25

3.1 Between 1 April 2024 and 31 March 2025, a total of 304 concerns were raised with the FTSU Service across the gesh Group. SGUH staff raised a total of 143 concerns (46.88%), and ESTH staff raised a total of 161 concerns (52.78%).

3.2 58% of the total number of concerns in 2024/25 were resolved through advice and signposting. Of this, 65.52% were closed within 30 days and 34.48% were open longer than 30 days for ongoing advice and support. Approximately 11 concerns are being formally investigated through an HR process. A total of 141 cases have been managed and closed through escalation through the line management route with FTSU support and there are currently 94 open cases as at June 2025 being managed between FTSU and line management.

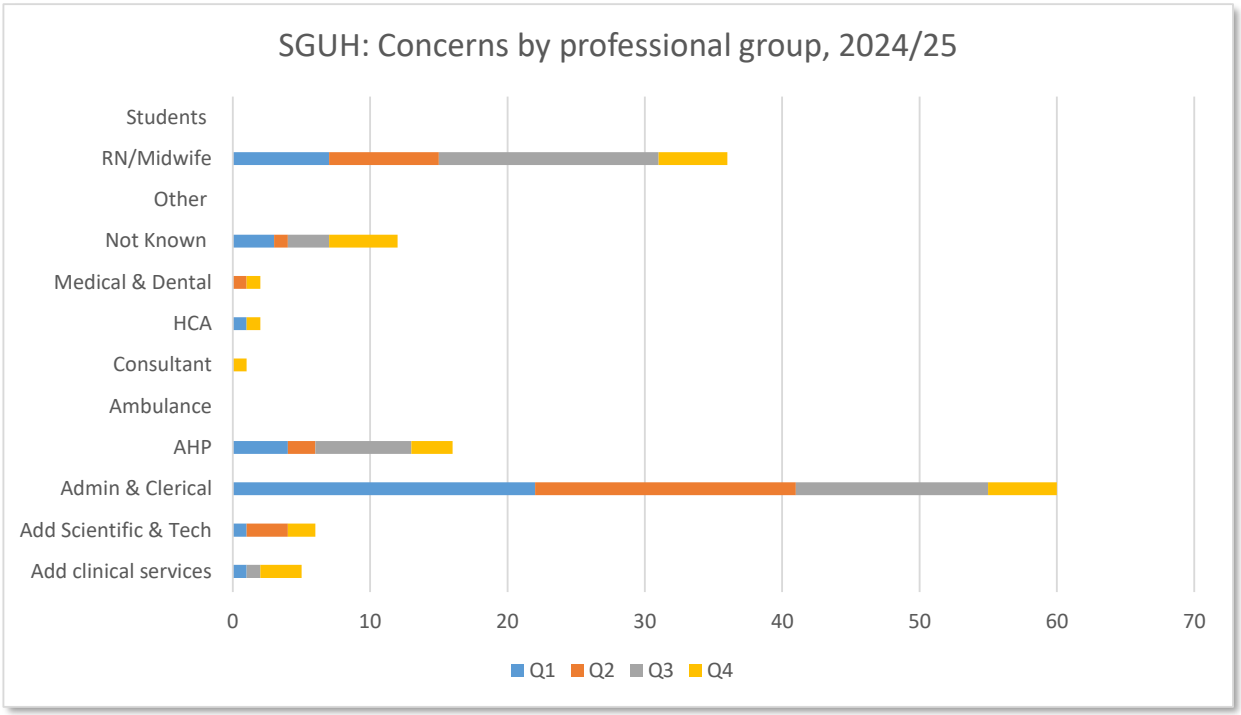
3.3 As reported previously (June 2024), there were differences historically in the way in which FTSU concerns were recorded at SGUH and ESTH. The 2024/25 data shows a 36.45% decrease in concerns compared with 480 concerns raised via FTSU in the preceding year. A common approach to the recording of concerns was adopted from the start of Q4 2023/24 in line with the National Guardian's Office (NGO) guidance, which resulted in a 23% reduction in the number of FTSU concerns at ESTH in 2023/24, recording of fewer concerns in Q4 at ESTH. The gesh FTSU team now have an aligned reporting process relating to concerns raised and as such moving forward this more consistent process will give a clearer picture for reporting purposes. As such, the reduction in concerns raised is not a surprise. SGUH concerns have remained quite consistent over recent years, apart from in 2023/24 when there was a spike in concerns totalling 211, though there was also an increase in collective concerns during this period.





(b) <u>Concerns raised by staff group in Q1 & Q2 2024/25 (SGUH)</u>

3.3 The following charts show the concerns raised via FTSU by staff groups at SGUH, during 2024/25

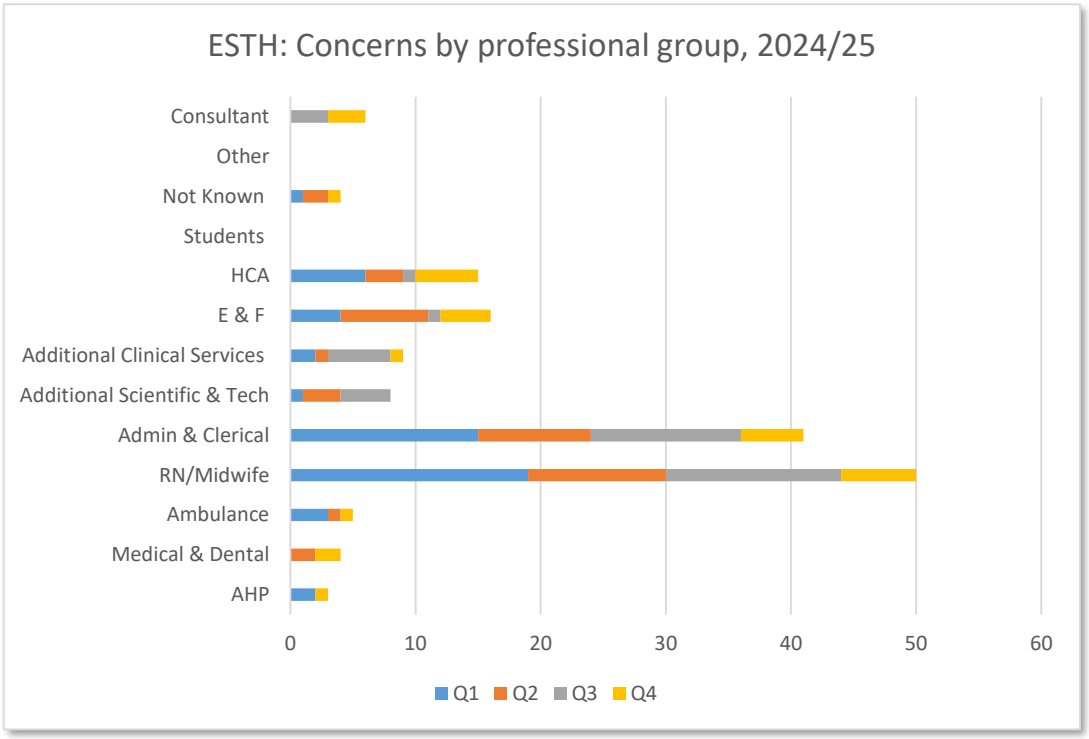


3.4 Staff groups at SGUH who have raised concerns with the FTSU Guardian over 2024/25

- **Administrative and Clerical staff** are the staff group which raised the highest number of concerns to the FTSU Guardian over the year. A total of 59 concerns (41.25%) were raised by this staff group.
- **Nursing and Midwifery** staff raised the second highest number of concerns with a total of 37 concerns being raised (25.87%)
- **Allied Health Professionals** raised a total of 16 concerns (11.18%),
- **Unknown staff groups** had 11 (7.69%) concerns raised whereby staff did not wish to say what their occupation was.
- **Additional scientific & technical staff** raised 6 concerns (4.19%)
- **Additional clinical services** raised 5 concerns (3.49%)
- **Anonymous** 3 concerns (2.09%)
- **Healthcare Assistants** 2 concerns (1.39%)
- **Medical & Dental** 2 concerns (1.39%)
- **Consultants** raised 1 concern(0.69%)
- **Estates** & Facilities raised 1 concern (0.69%)

(c) Concerns raised by staff group (ESTH)

3.5 The following chart show the concerns raised via FTSU by various staff groups at ESTH:

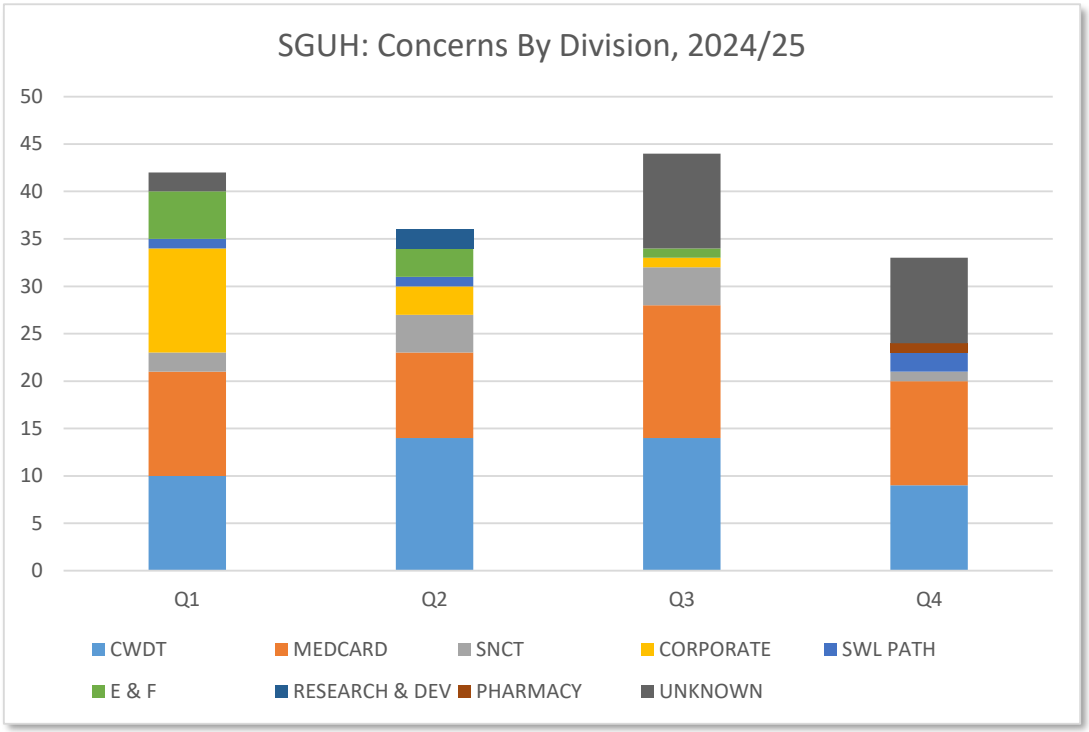


3.6 Staff groups which have raised concerns with the FTSU Guardian at ESTH over the past year shows that:

- **Nursing & Midwifery** are the staff group which raised the highest number of concerns totalling 50 (31.05%)
- **Administrative and Clerical** staff raised the second highest number of concerns totalling 41 (25.46%)
- **Estates, Facilities & Ancillary** staff raised a total of 16 concerns and HCA's both raised 15 concerns each (9.31%)
- **Additional Clinical Services** staff raised 9 concerns (5.59%)
- **Additional Scientific and Technical staff** raised a total of 8 concerns (4.96%).
- **Consultants** totalled 6 concerns (3.72%)
- **Ambulance staff** raised 5 concerns (3.10%)
- **Medical and dental** staff raised and unknown professions totalled 4 each (2.48%)
- **Unknown staff groups** 4 (2.48%)
- **AHP's** raised 3 (1.86%) concerns

(d) <u>Concerns raised by Divisions 2024/25 (SGUH)</u>

3.7 The following chart shows the number of concerns raised by Division during 2024/25

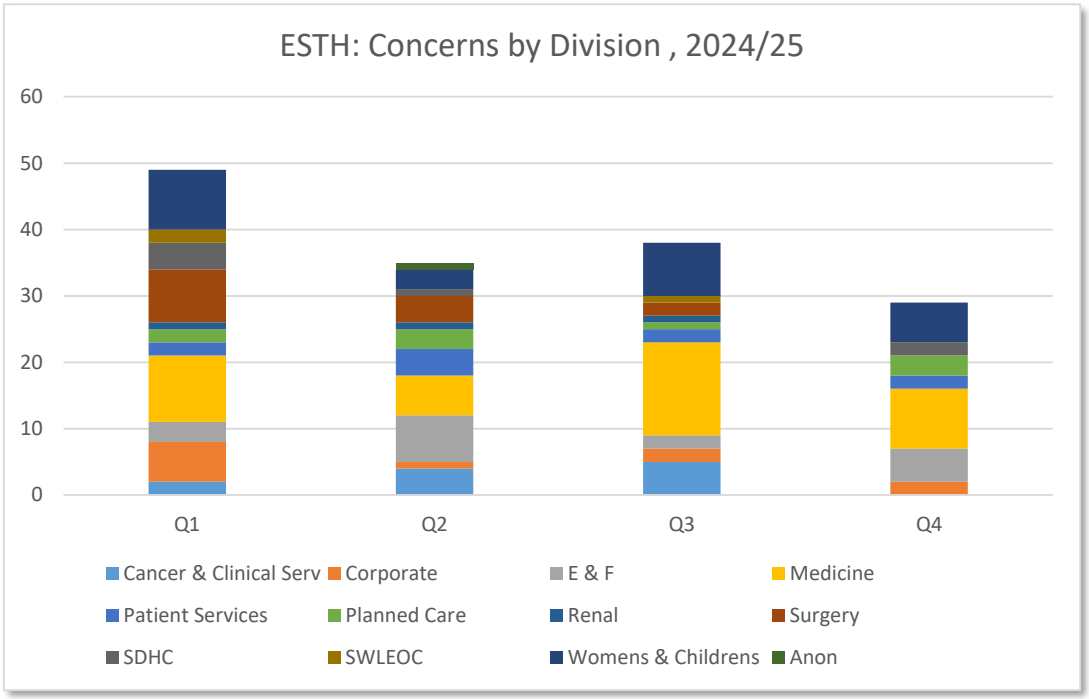


3.8 An analysis of the concerns raised by Division with the FTSU Guardian at SGUH shows that:

- Staff from the **Children's, Women's Diagnostics and Therapies (CWDT) Division (the largest division)** raised a total of 47 concerns out of a total of 143 (32.86%) of total SGUH concerns.
- **Medicine and Cardiovascular Division** staff raised the second highest number of concerns with 45 concerns raised, (31.46%). – *The Guardian would like to draw attention to Specialist Medicine whereby numerous concerns have been raised in relation to behaviours and culture which are being investigated. Work is required to improve the culture within this department.*
- **Corporate Division** accounted for 15 concerns (10.48%).
- E**states and Facilities** accounted for 9 concerns (6.29%).
- Staff from **Surgery, Neurosciences, Cancer, and Theatres (SNCT)** 11 concerns, (7.69%)
- **SWL Pathology** accounted for 4 concerns (2.79%).
- Staff from **Research and Development** raised 2 concerns (1.39%).
- There were 9 concerns in which the division was **unknown** (6.29%).

(e) Concerns raised by Division (ESTH)

3.9 The following chart shows the number of concerns raised by Division at ESTH over the past 2 quarters:



3.10 An analysis of concerns raised by directorate at ESTH shows that:

- **Medicine Directorate** staff raised the most concerns, a total of 39 concerns (24.22%). *The Guardian would like to draw attention to the Emergency Department where numerous concerns have been raised by both clinical and administration staff. Some of these concerns are now being dealt with through grievances. Work is required to improve the culture within this department.*
- **Women's and Children's Directorate** staff raised the second highest number of concerns, with 26 out of a total of 161 concerns (16.14%).
- **Estates & Facilities** had 17 concerns raised (10.55%).
- **Surgery Division** staff raised a total of 14 concerns, (8.69%).
- For the **Corporate & Cancer Divisions** each Division had 11 concerns raised each (6.83%)
- Staff from **Patient Services & Sutton Health and Care** each had 10 concerns each (6.21%).
- Staff from **Planned Care** raised 9 concerns (5.59%)
- Staff from **Surrey Downs Health and Care** a total of 7 concerns (4.34%)

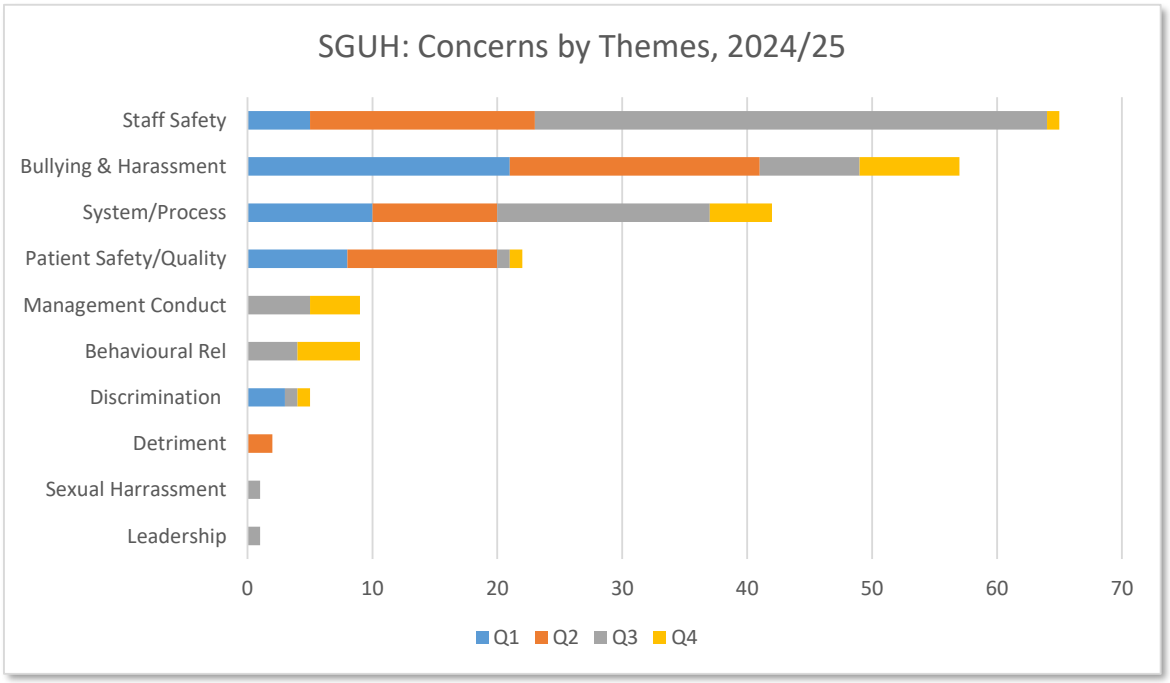
- Staff from **Renal** and **SWLEOC** raised 3 concerns each (1.86%)
- There was 1 anonymous concern (0.62%)

(f) <u>Themes in concerns raised with the Group FTSU Guardians in 2024/25 to date</u>

3.11 As well as analysing concerns raised by staff group and division, we also look at the types of concern being raised and the themes within these. Across the Group, the key themes in the concerns raised via FTSU in 2024/25 are:

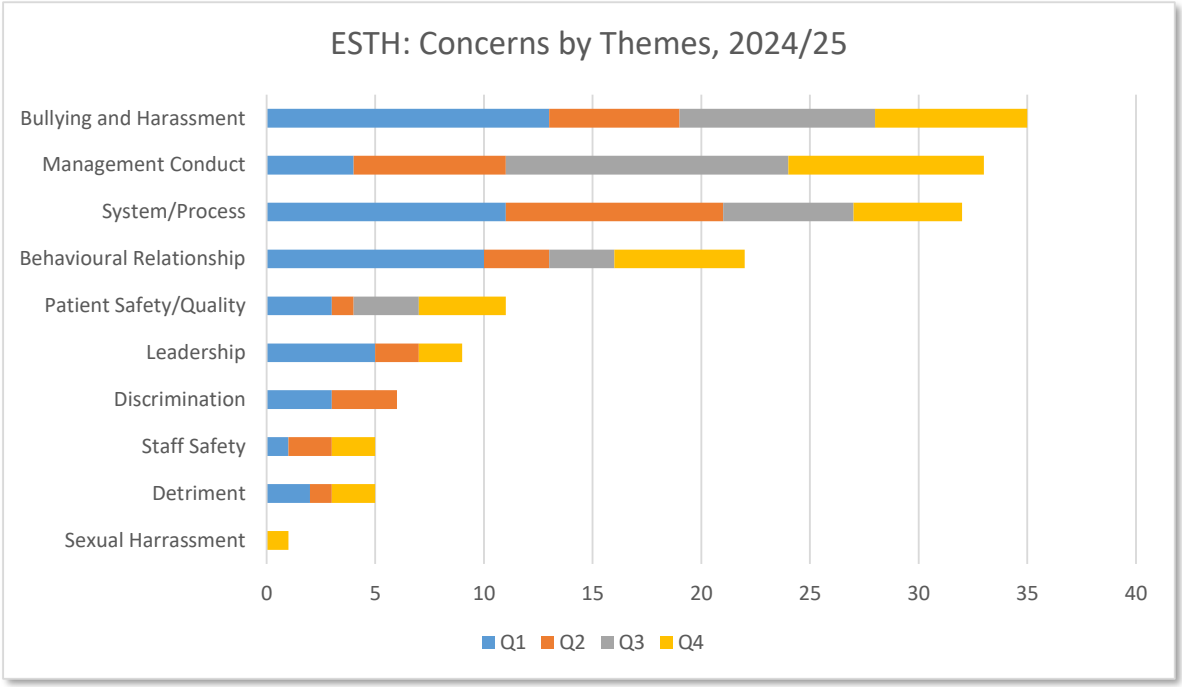
- Behavioural Relationship
- Bullying and harassment
- Discrimination
- Leadership
- Management conduct
- Patient safety/Quality
- Sexual Harassment
- System/Process
- Staff Safety
- Detriment

3.12 The charts below illustrate the themes of concerns raised during 2024/25:



(a) Often, concerns raised to FTSU contain more than one theme. In relation to the themes of the 143 concerns raised, concerns around staff wellbeing and safety (65 - mostly linked to B & H) bullying and harassment (57) were the main themes of all concerns raised to FTSU. System & Processes had 42 concerns raised with an increase in concerns relating to recruitment.

(b) In relation to the themes of the 161 concerns raised across the year ESTH, bullying and harassment (35) was the highest theme, Management conduct (33), system/process (32).



4.0 Timely resolution of concerns

4.1 This still remains an issue however the Guardian has seen an improvement following the inception of the Raising Concerns Oversight and Triangulation Group and subsequently following on from this group additional divisional meetings commenced. There are still concerns being raised to the Guardian by workers who have raised grievances at STUG and ESTH and feel that the timescales are extremely long for resolution. However, the Guardian does liaise regularly with HR throughout gesh which is working well to try and ascertain reasons for delays and any barriers. The Guardian would however recommend regular feedback to staff raising grievances which would minimise the anxiety and further escalation to FTSU.

4.2 The Guardian is able to resolve a large number of concerns informally through signposting to the appropriate route for handling the issue (e.g. a relevant HR process) or through raising the issue with the relevant team to enable prompt action to be taken to address the concern raised. The Guardian continues to work closely with HR colleagues, Staff Support, Organisational Development and is also a trust mediator so is also able to facilitate resolution of concerns through transparent conversations and negotiation.

4.3 The Guardian continues to have concerns relating to the link between concerns being raised and staff going on sick leave citing work related stress and the effect that long-standing cases have on staff wellbeing and productivity. The extensive tine taken to resolve cases has an impact on the wellbeing on staff and financial impact on the organisation.

4.4 The Guardian continues to recommend the organisation urgently review processes and

training of workers responsible for investigations surrounding timely resolution of concerns. The Guardian is pleased to note that further sessions for staff to train to become investigating Officers has recently been advertised and hopes that this will help with identifying suitable investigating officers which does seem to be a barrier at present for internal investigations.

4.5 The Guardian recommends the organisation pay particular attention to the issues and themes being raised by workers who are raising concerns through the Guardian, particularly those themes relating to trust processes not being followed which are on the increase, concerns pertaining to recruitment practices especially for acting up positions across gesh continue to rise together with concerns relating to partners/families working together and reporting to each other. The Guardian notes that a policy is underway regarding working relationships.

5.0 Learning from concerns

5.1 We continue to promote a culture that supports speaking up as a route to organisational learning not blame. We do this by working with leaders and line managers to support learning focused responses and proactively challenging responses that do not address any necessary learning opportunities.

5.2 Individual cases are reviewed within the FTSU service to identify areas of organisational learning and this is shared with teams and departments.

5.3 We are currently developing a communications approach for sharing learning from FTSU cases across the organisation in a structured and anonymised way, both to disseminate learning and help to build the confidence of staff in speaking up. The plan is for this to go live during Q2 2025/26.

6.0 Speak Up, Listen Up, Follow Up Training

6.1 In late 2021 at SGUH, the Trust incorporated training on raising concerns into its MAST Training programme, meaning it is now a mandatory training module for all staff. It is important that all workers are given protected time to complete the required training to ensure that workers are aware of how to raise concerns and that managers are aware and confident in applying their responsibilities to concerns raised with them. Following a national directive that all organisations should offer all workers regular mandatory training on how to speak up safely, how to respond to concerns and how to learn and reflect from these concerns. All 3 parts of the required training have now been released.

6.2 As 2 May 2025, 94.1% of staff at SGUH have completed their FTSU training. The FTSU Guardians regularly send reminders through communications and at all training, network meetings, nursing preceptorship training days, wards, and departments team training days. At ESTH, the training is not mandatory and data on current take-up of the optional training in speaking up is not available. However, as 2 May 2025 only 60 members of staff had completed the training at ESTH. While training alone will not be sufficient to equip staff and managers in raising and responding to concerns, low training levels mean concerns, and particularly complex concerns, are not always being appropriately addressed, with one of the issues being understanding of Freedom to Speak Up. The Guardian recommends that the training is made mandatory at ESTH in line with current arrangements at SGUH. In the meantime however, the FTSU team will be running sessions online and in person to cover the requirements of the training sessions however again, this is voluntary.

MAST Topic Organisation Compliance - Freedom To Speak Up

Date Run: 14/5/2025

200 Children and Women's Diagnostic and Therapy Services Division		Amt. Completions	Required Training	Compliant (%)
	Total:	3269	3383	97%
200 Corporate Division		Amt. Completions	Required Training	Compliant (%)
	Total:	900	1115	81%
200 Estates and Facilities Division		Amt. Completions	Required Training	Compliant (%)
	Total:	353	357	99%
200 Medicine and Cardiovascular Division		Amt. Completions	Required Training	Compliant (%)
	Total:	2396	2517	95%
200 Research & Development Division		Amt. Completions	Required Training	Compliant (%)
	Total:	93	100	93%
200 Surgery & Neurosciences Division		Amt. Completions	Required Training	Compliant (%)
	Total:	2128	2261	94%
200 SWL Pathology Division		Amt. Completions	Required Training	Compliant (%)
	Total:	639	653	98%

		Amt. Completions	Required Training	Compliant (%)
Organisation Total:		9778	10388	94.1%

7.0 Resources within the FTSU Service

7.1 The gesh FTSU service has now been in place for a year. During this time, one deputy guardian has left the service and as such we have one vacancy. We now have 1 lead guardian and 2 deputy guardians however, will be in the coming months looking at the structure of the service and what is required in relation to staffing to ensure high visibility and engagement with the organisation and various sites.

7.2 As a new Group-wide service, the team has focused on standardising and strengthening its own internal processes to ensure these are robust and provide timely, impartial and confidential support to concern raisers . We have developed a FTSU team triage process which sets out clear and consistent processes for the team to follow in receiving, acknowledging, logging, escalating and resolving concerns, as well as in how concern raisers are kept updated. This process also contains provisions for undertaking an initial assessment of the risk of the concern raiser encountering detriment for speaking up, and a process for checking in with concern raisers after six and 12 months following resolution of their concerns.

8.0 Priorities for FTSU Service Going Forward

8.1 In terms of the priorities of the Group FTSU Service into 2025/26, we are focused on:

a) **Increase confidence of managers responding to FTSU concerns:** Working with our L & D team to educate managers and support increased confidence and awareness of managers in responding to concerns raised by their staff is a key area where the Trusts need to focus. To assist with this, we are developing a Toolkit/guide to support managers, which will include advice, sources of support, and practical guides and worked examples.

b) **Implementing recommendations from the recent internal audit and Board reflection tool completed on 6 June 2024:** Recent reviews by both Trusts' internal auditors reached findings of "reasonable assurance" on the controls in place in relation to FTSU at both

Trusts. No urgent recommendations were made, but the audits were helpful in highlighting certain control areas where further strengthening of our processes can be made. Furthermore, the completion of the Board reflection tool has assisted in clarity regarding ongoing priorities and this will help inform the development of a new strategy and plan for raising concerns across the Group.

c) **Group FTSU Vision and Strategy:** Having a group Vision and Strategy further assists in clarity of the function. The current SGUH vision and strategy remains broadly fit for purpose 4 years on from approval by the Board, but would benefit from a refresh. ESTH has not historically had a Board approved FTSU vision and strategy place. As such, a Group FTSU Vision and Strategy is being developed, with an ambition to agree and launch this in mid to late 2025.

9.0 Recommendations

9.1 The Group Board is asked to:

a) Note the number of concerns reported to the FTSU Guardians in 2024/25 for both SGUH and ESTH and the staff groups reporting and identified areas requiring support pertaining to culture and behaviours.
b) Note the themes emerging from FTSU cases in this period.
c) Note the recommendations of the Group FTSU Guardian as set out in section 3 of the report.
d) Note the priorities of the new Group FTSU service in the coming months.

Group Board Meeting (Public)

Meeting on Thursday, 03 July 2025

Agenda Item	6.1	
Report Title	**Infrastructure Committees Report to Group Board**	
Non-Executive Lead	Ann Beasley, Infrastructure Committees Chair	
Report Author(s)	Ann Beasley, Chair of Infrastructure Committees	
Previously considered by	n/a	
Purpose	**For Assurance**	

Executive Summary

This report sets out the key issues considered by the Infrastructure Committees at their meetings on 23 May 2025 (Estates & Facilities focus) and 13 June 2025 (IT focus). The key issues the Committees wished to highlight to the Board are:

1. **Group Chief Officer - Facilities, Infrastructure & Environment (GCOFIE) Update**
   The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer which included updates about the Capital Programme and St Helier's fire safety. The Capital Programme had had a slow start this year due to reliance on unapproved NHS England funds. St Helier had not yet received the London Fire Brigade (LFB) Enforcement Notice (EN). NHSE's view was that LFB were considering how to approach fire compliance in NHS hospitals and that St Helier would receive an update in due course.
2. **Digital Strategy Development**
   The Committees received an update on the Digital Strategy development and suggested enhancing the "Opportunities" section of the SWOT analysis to reflect the organisation's increasing lead role in SW London and the recent appointment of Martin Ellis as the interim Group Digital Information Officer. The Committees also emphasised the importance of alignment with the overarching Group strategy and engaging group-wide clinical leadership in the development of the Digital Strategy.
3. **EPR Programme update**
   The Committees welcomed the news about the successful EPR go-live in May 2025 and the transition to the stabilisation phase. The provider Oracle provided positive feedback, calling it their best supported go-live, and data migration which achieved 99.9% success. The team was working on resolving issues, including EDS deck workflows, and focusing on reporting. The ambition was for the programme team to transition to the IT team by 1st September 2025.
4. **Board Assurance Framework (BAF) - IT and Estate Risks**
   The Committees reviewed the IT and Estate strategic risks and noted that no changes were proposed to headline risk scores or assurance ratings for SR5 (Estates) and SR6 (Digital Technology) for Q1 2025/26. The Committees agreed to approve the current risk levels and assurance ratings and recommend them to the Board.

5. **Green Plan Refresh**
The Committees reviewed the refreshed Green Plan and noted that the final draft was produced following consideration and approval from both SLTs and GEC. The Committees also approved the refreshed Green Plan and recommended it to the Board for approval, noting the need for financial support and continued management focus for its realisation.

Action required by Infrastructure Committees

The Group Board is asked to note the issues escalated by Infrastructure Committees to the Group Board and the wider issues on which the Committees received assurance in May and June 2025.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
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

See section 5.1 - Digital Risk Management Update

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

Set out in the paper.

Legal and / or Regulatory implications

Set out in the paper.

Equality, diversity and inclusion implications

N/A

Environmental sustainability implications

Set out in the paper. See section 3.5

Infrastructure Committees Report
Group Board, 03 July 2025

1.0 Purpose of paper

1.1 This report sets out the key issues considered by the Infrastructure Committees' meetings on 23 May 2025 and 13 June 2025 and includes 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 23 May 2025 and 13 June 2025, the Committees considered the following items of business:

May 2025 (Estates & Facilities focus)	June 2025 (IT focus)
• Group Chief Officer - Facilities, Infrastructure & Environment Update • Group Green Plan Update • Capital Programme Update • SGUH Estate and Facilities Update • ESTH Estate and Facilities Update • SGUH Community Estate • Deep Dive - Electrical maintenance • EPR Update	• Digital Leadership Update • Digital Strategy Development • Digital Delivery Update • Digital Risk Management Update • EPR Programme update • Board Assurance Framework (BAF) - Estate and IT Risks • Green Plan Refresh (for approval by the Committees before July Board meeting)

2.2 The Committee was quorate for both meetings.

3.0 Key issues for escalation to the Group Board

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

3.1 **Group Chief Officer - Facilities, Infrastructure & Environment Update**

The Committees received a written update from the Group Chief Officer - Infrastructure, Facilities and Environment Officer (GCOFIE) on the following key developments:

- The Capital Programme had had a slow start this year due to reliance on unapproved NHS England funds. Only 4 of 43 submitted schemes had been approved. However, funding was received for water hygiene and fire safety at Epsom and St Helier.
- St Helier had not yet received the London Fire Brigade (LFB) Enforcement Notice (EN). NHSE's view was that LFB were considering how to approach fire compliance in all NHS hospitals and that St Helier would receive an update in due course.

The Committees noted the update and suggested explicitly stating the assumptions underlying the recommended level of assurance, especially regarding backlog maintenance, to clarify understanding and aid independent review.

3.2 **Digital Strategy Development**

The Committees received an update about the Digital Strategy development and suggested enhancing the "Opportunities" section of the SWOT analysis to reflect the organisation's increasing lead role in SW London and the recent appointment of Martin Ellis as the interim Group Digital Information Officer.

The Committees also emphasised the importance of aligning the Digital Strategy with the overarching Group strategy and engaging group-wide clinical leadership in its development.

3.3 **EPR Programme update**

The Committees welcomed the news about the successful EPR go-live in May 2025 and the transition to the stabilisation phase. The provider Oracle also provided positive feedback, calling it their best supported go-live, and data migration which achieved 99.9% success.

The EPR team was working on resolving issues and focusing on reporting. The ambition was for the programme team to transition to the IT team by 1st September 2025. A formal lessons learned session will be undertaken in the next few months.

3.4 **Board Assurance Framework (BAF) - IT and Estate Risks**

The Committees reviewed the IT and Estate risks and noted that no changes were proposed to headline risk scores or assurance ratings for strategic risks SR5 (Estates) and SR6 (Digital Technology) for Q1 2025/26.

The Committees agreed to approve the current risk levels and assurance ratings and recommend them to the Board but questioned the realism of achieving the "reasonable assurance" target for estates by year-end, considering constrained resources.

3.5 **Green Plan Refresh**

The Committees reviewed the refreshed Green Plan and noted that the final draft was produced following consideration and approval from both SLTs and GEC. The Committees approved the refreshed Green Plan and recommended it to the Board for approval, noting the need for financial support and continued management focus for its realisation.

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4.0 Key Issues on which the Committees received assurance

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

4.2 **St. George's Community Estate**

The Committees noted the report about St. George's Community Estate and agreed with the recommended (reasonable) level of assurance. The Committees also requested that a report about Queen Mary's PFI be brought back at a later date.

4.3 **St George's Estates and Facilities Assurance Update**

The Committees welcomed the news that there had been significant improvement in the achievement of the Planned Preventative Maintenance programmes and improved reactive maintenance response times but inquired about the reasons for a low level of achievement for new works. DGCOFIE explained this was due to restrictions on any new works unless for Infection Control or Health and Safety reasons and the lack of infrastructure capital.

4.4 **Epsom & St Helier Estates and Facilities Assurance Update**

The Committees noted that short term Estates and Housekeeping actions to mitigate the fire safety risks identified on Frank Deas Ward and B2 Accommodation Block had been completed and that further invasive Building and Estates work remained necessary if these areas were to remain operational.

The Committees also noted a paper setting out progress on water safety issues affecting St Helier E Block and that further work was being led by the executive, noting the significant challenges with the estate and potential disruption to clinical services that may become necessary to resolve these issues.

5.0 Other issues considered by the Committees

5.1 **Digital Leadership**

The Committees noted that, as of 1 June 2025, the executive leadership for digital services had moved to the Group Chief Transformation Officer (GCTO) with the GCFO remaining SIRO and SRO for the PACS programme.

The executive had seen the first draft of the external review of the Group's digital services led by Matt Lawrence. Further work was needed to complete the review, particularly to review the spend and contract alignment opportunities, and the executive had asked that this work be concluded by July 2025.

5.2 **Deep Dive - Electrical Maintenance**

The Committees noted the report on electrical maintenance which evaluated the effectiveness, compliance, and reliability of current practices conducted by both the in-house Estates team and specialist contractors. The report identified improvement opportunities and levels of adherence to statutory and regulatory standards in relation to hospitals' electrical systems. The Committees noted the report and supported UPS (uninterruptible power supply) installation in operating theatres.

5.3 **Digital Delivery Update**

The Committees welcomed the update which reported significant changes in digital governance aimed at improving engagement with operational teams. Concern was expressed about the delays with integrating the IT service desk and requested that an update on the financial implications and priorities be presented to the next IT focused meeting of the committee.

6.0 Recommendations

6.1 The Group Board is asked to note the issues escalated by the Committees to the Group Board and the wider issues on which the Committees received assurance in May and June 2025.

Group Board Meeting (Public)

Meeting on Thursday, 01 May 2025

Agenda Item	6.2	
Report Title	**gesh Group Green Plan Refresh**	
Executive Lead(s)	Mark Bagnall, Group Chief Infastructure, Facilities and Environment Officer	
Report Author(s)	Mark Bagnall, Jenni Doman, Sam Hall	
Previously considered by	Infrastructure Committees	13 June 2025
Purpose	**For Approval / Decision**	

Executive Summary

Board to approve the 'Refreshed' gesh Group Green Plan.

- NHSE requires each trust and ICB completes a Green Plan Refresh by 31st July. A final draft is attached following consideration/approval from by both SLT's and GEC.

Action required by Group Board

The Board is asked to:

a. Approve the gesh Group Green Plan

Committee Assurance	
Committee	Infrastructure Committees
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	Gesh Group Green Plan Refresh

Implications

Group Strategic Objectives

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

Risks

Key risk is against our ability to adapt to and deliver effective responses to the Climate Change and Biodiversity Emergency

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

The detailed plans will address this in full

Legal and / or Regulatory implications

- The NHS embedded the national Net Zero targets into legislation through the Health and Care Act 2022. The Act requires commissioners and providers of NHS services to address the environmental & net zero emissions targets.
- The NHS has produced statutory guidance 'Delivering a Net Zero NHS' requiring a Green Plan.
- We are required to produce a Green Plan in line with the ICB. Every NHS trust & ICB now has a Green Plan.
- CQC have included Environmental Sustainability under the "Well-led" key question.
- NHSE requires each trust and ICB to complete a Green Plan Refresh by 31st July.

Equality, diversity and inclusion implications

Impacts all staff, visitors, patients, students and volunteers

Environmental sustainability implications

Principal support mechanism for improving sustainability in gesh

Meeting Strategic objectives for the gesh Group Green Plan Strategy

gesh Group Green Plan Refresh

Group Board, 03 July 2025

1.0 Purpose of paper

1.1 To bring the gesh Green Plan for approval in order to fulfil the NHS requirement for a Green Plan Refresh

2.0 Background

2.1 Update to the existing Green Plan as required by Greener NHS following their guidance documents

3.0 [Key issues for consideration]

3.1 Key updates are noted in the plan and highlighted

4.0 Sources of assurance

4.1 Approved at both ESH / SGH SLT & GEC, PMO and Strategy involvement, wide consultation undertaken with delivery teams.

5.0 Implications

5.1 The plan sets out the strategic approach to managing sustainability and 'green' issues at gesh. It covers all of the elements of the NHS guidance documents for the area including the Net Zero targets and other national strategic priorities for sustainability. Financial implications are addressed within the document, it is recognised that we are operating within financial constraints and that we will strive to access external funding opportunities. The plan discharges our legal duty to develop this strategy document and ensure it's implementation. The key risk to the organisation is through adaptation to and resilience in response to climate change and biodiversity loss. The plan has implications for all stakeholders and will seek to improve the quality of care we provide. The plan is the principal document ensuring that we identify and achieve our environmental sustainability goals.

6.0 Recommendations

6.1 The Board is asked to:

a. Approve the gesh Group Green Plan Refresh

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Background - Green Plan Refresh

- This document is our final draft of the refreshed gesh group Green Plan.
- Amendments made during the consultation are noted in the Notes section below each slide and highlighted.
- The document has been approved by each site Senior Leadership Team, the Group Executive Committee as well as being sent out for consultation with wider staff and operational groups.
- In 2020, the NHS became the world's first health system to commit to reaching net zero emissions. The Delivering a Net Zero National Health Service report set out the scale of ambition. The Health and Care Act 2022 reinforced this commitment, placing new duties on integrated care boards (ICBs), NHS trusts and foundation trusts to consider statutory emissions and environmental targets in their decisions.
- Trusts and ICBs are expected to meet these duties through the delivery of board-approved green plans. In 2021, NHS England asked systems and trusts to develop green plans spanning 3 years (2022/23 to 2024/25). These plans now need to be refreshed in line with updated statutory green plan guidance by 31 July 2025.

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Green Plan

Healthy planet, healthy people

Our strategy for 2025-2028

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Contents

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Foreword

We're all part of this big wonderful life system we call the planet. It's our home, we belong here. We know that our planetary ecosystem provides the basis for human health. You could say the ecosystem is our life support system. We simply cannot have healthy people without a healthy ecosystem. And we know that climate change and biodiversity loss will have profound impacts on the health of the population we serve, as well as our ability to deliver those services. We also recognise that we are part of the problem, burning fossil fuels and using scarce resources in the day-to-day delivery of healthcare. So, we must change.

This plan sets out how we will change. We are committed to achieving environmental sustainability and in the process improving our performance on the three key areas of Care, Cost and Carbon. Our vision is that by 2028 we will have integrated sustainability into everything we do. I encourage you to be part of this change and support the Green Plan.

Jaqueline Totterdell
Group Chief Executive Officer

We will be guided towards our vision by the following principles:

- The ecological principle – ecosystems are the basis of our health and wealth; ecosystems are our life support systems and the foundation of our economics too.
- The prevention of pollution principle – we have a responsibility to prevent pollution of and damage to our ecosystems as that damages the health of the people we aim to care for.
- The polluter pays principle – if we cause the pollution, we should be responsible for the costs of cleaning it up
- The hierarchy approach – we will seek to prioritise prevention, then reduction, reuse and recycling of: waste, materials, energy and water
- The principles of a circular economy – mirroring the natural cyclical processes of ecosystems and maximising reuse and recycling of materials
- Supporting regenerative processes – seeking to support ecological regeneration and the natural ability of life to heal
- The principle of nonmaleficence – the obligation of a physician, as the ancient Greek physician Hippocrates said, "to do good or to do no harm". We recognise that damaging the environment damages the health of our staff, patients and wider population, we have a responsibility to prevent harm and support health. That is the essence of our role and this Green Plan.

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Executive Summary

This strategy is an enabling strategy for our overarching CARE Strategy and vision of 'Delivering outstanding care, together' it sets out:

- How we intend to meet the legal and policy requirements around sustainability including Net Zero Carbon
- Our own strategic objectives and targets
- Our governance arrangements for how we will manage, monitor and continually improve our performance

Our vision is that we will integrate Net Zero Carbon into everything we do.

Environmental sustainability and Net Zero Carbon present significant challenges and we have set out objectives for our four domains:

- For **Clinical Transformation** we will enable our clinical staff to make sustainable improvements to their workplaces bring in best practice and innovation.
- For **Leadership and Workforce,** we will ensure the Group leadership teams are actively engaged in the Green Plan, supporting its delivery and championing its vision and aims. Our staff across the Group will be supported and enabled to make change through a program of training and communications.
- For **Estates and Facilities**, our buildings and operations will move away from fossil fuel to electricity from renewable sources. We will promote low emissions and active travel to staff, offer healthy sustainable food, maintain flourishing grounds, minimize our waste, construct energy efficient new buildings, move to an electric fleet, and ensure we're adapting to climate change.
- For **Procurement,** We will support and promote sustainability, social value as well as circular economy principles within our procurement activity. We will seek environmentally friendly suppliers who can demonstrate a commitment to achieving Net Zero Carbon and we will apply best practice i.e. buying products from sustainable sources that can be reused, repaired and recycled, and avoiding single use products.

Mark Bagnall
Group Chief Facilities, Infrastructure & Environmental Officer
Board Lead for the Green Plan

Green Plan

Where are we now?

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The Green Plan is a key part of Our Care Strategy

The Green Plan is one of six enabling strategies that run throughout the organization enabling 'Outstanding Care, Together' to be achieved.

The CARE strategy states:

"We will have reduced our carbon footprint, and be on our way to net zero by 2040"

"Becoming an increasingly sustainable group of hospitals is a growing priority due to the climate emergency and the link between environment and health."

Green Plan

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The wider context

National Ambition

Net Zero Carbon by 2050

In June 2019 the UK government adopted the legally binding target of achieving Net Zero Carbon by 2050. Enacted through the Climate Change Act of 2008, this enables the UK to achieve its nationally determined contributions and help the international community to achieve the Paris Agreement 2015 target of limiting global warming to 2°C by the year 2100, with an aspiration of 1.5°C.

The NHS Vision

Net Zero Carbon by 2040

The NHS Vision: ***To deliver the world's first net zero health service and respond to climate change, improving health now and for future generations.***

In October 2020, the NHS became the world's first health service to commit to reaching Net Zero Carbon recognising that climate change has direct consequences for patients, the public, and the NHS as a whole. In July 2022, the NHS embedded the net zero requirement into legislation, through the Health and Care Act 2022. This places a duty on NHS England, and all trusts, foundation trusts, and integrated care boards to contribute towards emissions reduction and environmental targets.

The Act requires commissioners and providers of NHS services specifically to address the net zero emissions targets. Trusts and integrated care boards (ICBs) will meet this new duty through the delivery of their localised Green Plans, and every Trust and ICB in the country is also required to have a board-level lead.

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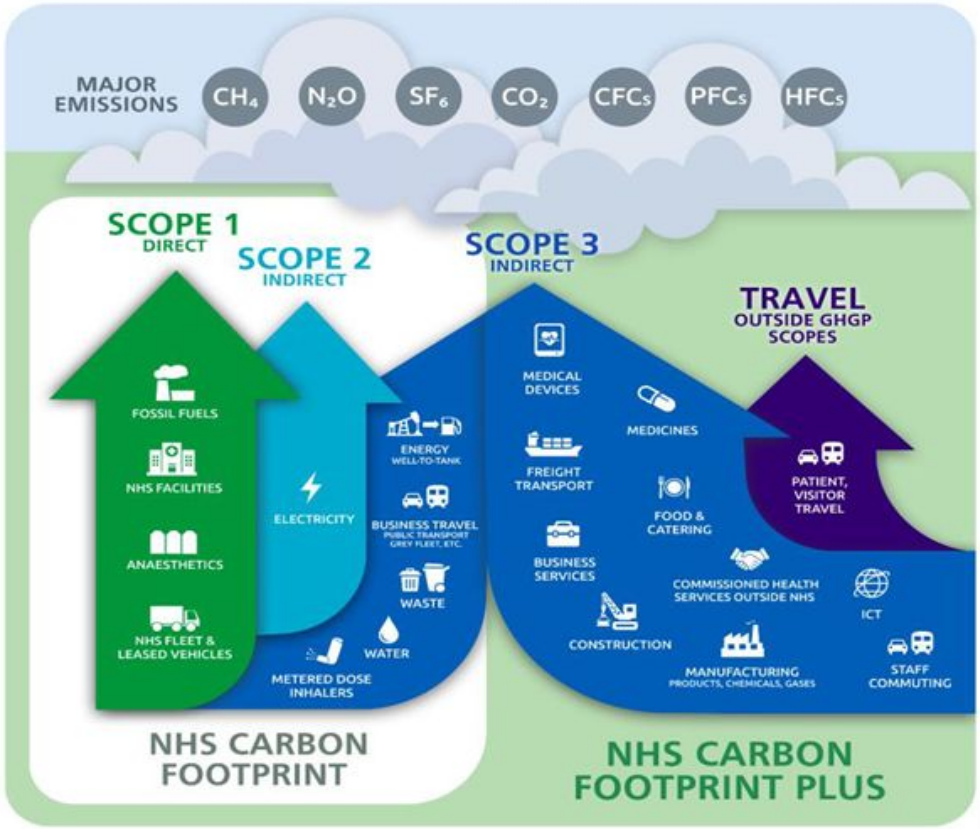
The NHS Net Zero targets



- For the emissions we **control directly** we will reach net zero by 2040, with an ambition to reach an 80% reduction by 2028 to 2032 (the NHS Carbon Footprint).
- For the emissions we can **influence** we will reach net zero by 2045, with an ambition to reach an 80% reduction by 2036 to 2039 (the NHS Carbon Footprint Plus).
- Against the **2019/20** emissions footprint:
  - Carbon Footprint reducing emissions by at least **47% by 2028-2032**;
  - Carbon Footprint Plus reducing emissions by at least **73% by 2036-2038**.

Green Plan

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Where are we now?

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Work to improve sustainability has been underway for some time through the St George's Green Plan agreed by Board in July 2021, and the Epsom & St Helier Green Plan agreed at Board in June 2023. Some excellent progress has also already been made at both St George's and Epsom & St Helier, including most recently:

- ✓ A successful bid application for over £3.14m from Greener NHS to install LED lighting across the group potentially saving over £1m per year and over 1000 tonnes of carbon.
- ✓ A successful bid applications for £468k from Great British Energy to install solar photovoltaic panels at St George's Hospital. We should be able to generate over £60k of electricity and save 60 tonnes of carbon each year.

St George's (SGUH)

- ✓ An Estates Decarbonisation Strategy document has been produced, giving a pathway to Net Zero
- ✓ We have developed the UK's first SMART theatres, reducing energy use and improving patient flow and outcomes
- ✓ We have ended the use of highly polluting anaesthetic gases, moved to low carbon methods of administering anaesthetics, decommissioned our Nitrous Oxide manifold and installed Nitrous Oxide cracking technology
- ✓ A programme of work has been implemented encouraging active travel e.g. Cycle to work events held, Dr Bike (free bike repair workshops for staff), Cycle to Work Scheme, and offering only ULEZ compliant and electric lease cars

Epsom & St Helier (ESTH)

- ✓ A Heat Decarbonisation Plan document has been produced by an external contractor through the Low Carbon Skills Fund, giving a pathway to Net Zero for our estates.
- ✓ A programme of work implemented encouraging active travel e.g. Staff travel survey, Travel Plan, Cycle to work events held, Dr Bike (free bike repair workshops for staff), Cycle to Work Scheme, and offering only ULEZ compliant & EV lease cars
- ✓ Low carbon patient menus have been implemented
- ✓ Tree planting scheme in place
- ✓ Grant received for walking aid return scheme

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Financial sustainability

Financial sustainability

Delivery of this green plan will also support financial sustainability longer term for gesh by:

- Reducing costs due to improved efficiency and lower energy demand.
- Future proofing the Trust against energy price shocks and by minimising the risk of emergency expenditure from climate issues such as flooding and heat waves
- Reducing the risk associated with supply chain partners by choosing those tackling their own carbon emissions and environmental impacts
- Delivering benefits of the circular economy by building sustainability into new contracts e.g. reusable, remanufactured, recyclable and low impact equipment and supplies that can save costs in the long run
- Improving the performance of clinical service delivery through efficiency savings, better use of staff time, and through reduced use of materials, transportation, and energy
- Acting as an anchor organisation communicating the co-benefits of environmental sustainability (e.g. active travel) thus improving health of patients and reducing the strain on services

To ensure delivery of commitments and funding to support this Green Plan we will investigate and explore external funding opportunities, alternative finance options, and innovative mechanisms designed to keep costs of change low. An indicative outline of the financial benefits of delivering this Green Plan is in development.

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Key challenges

Finance

In a financially challenging environment, internal and external funding needs to be accessed for longer term sustainability initiatives e.g. electric vehicle pool cars and charging points, and for developing and delivering investment grade proposals for estates heat decarbonisation. Improving levels of front-end investment to deliver longer term financial efficiencies and carbon reduction will be needed

Capacity and capability

Building capacity and capability around "green" issues. Understanding needs to be developed across gesh that achieving sustainability is a requirement for the whole organisation not just estates and facilities

Accountability

Given that sustainability has many factors, setting up robust Group oversight whilst also having site-based action plans, and real ownership of actions within all sustainability workstreams is a challenge. We will develop robust reporting assurance across the group.

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Opportunities

Scale and spread

The benefits of Group level collaboration provide a real opportunity to scale and spread what is working well at each site and to share sustainability resources e.g. training, education and awareness raising materials

Building a reputation for sustainability

Delivering the gesh Green Plan will improve the reputation and standing of the organisation as a centre of sustainability excellence. gesh has already led the way with nationally significant projects such as SMART theatres and the maternity departments Central Destruction Unit.

Improved outcomes and efficiency

Using a continuous improvement approach to deliver the Group Green Plan will lead to efficiency savings, better clinical services and improved outcomes for patients

Working Collaboratively

Learning from and sharing best practice with our PFI partners, local community partners the South-West London ICB, the local authorities Wandsworth, Merton and Sutton, the Greener NHS team and the NHS Estates team.

Green Plan

What do we want to achieve?

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Our vision: we will integrate Net Zero Carbon into everything we do

Clinical Transformation

Outstanding care will be provided across the Group in an environmentally sustainable manner
We will have integrated environmental sustainability into our clinical quality improvement processes
Where care can be provided more sustainably using digital technology we will default to this

Leadership & Workforce

The Group leadership teams will be actively engaged in the Green Plan, supporting its delivery and championing its vision and aims.
Our staff across the Group will be supported and enabled to make positive changes to their workplaces, operations and systems to promote sustainability

Estates & Facilities

We will produce minimal waste and be meeting national waste targets
Our current and new infrastructure will be sustainable, and resilient to the impacts of a changing climate
Patients, staff and the public will benefit from flourishing grounds and healthy sustainable food
We will transition to an electric fleet, generating minimal harmful air pollution
We will enable and encourage all staff, patients and visitors to use low emission travel

Procurement

We will support and promote sustainability, social value as well as circular economy principles within our procurement activity.
We will seek environmentally friendly suppliers who can demonstrate a commitment to achieving Net Zero Carbon and we will apply best practice i.e. buying products from sustainable sources that can be reused, repaired and recycled, and avoiding single use products.

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Domains

Green Plan

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Clinical Transformation

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Where are we now?

Clinical transformation is key to achieving sustainability, and this area covers optimising prescribing, substituting high carbon products for low-carbon alternatives, and making improvements in service delivery and waste processes. Additionally, development of more sustainable clinical models of care will also help to prevent unnecessary journeys through improved preventative medicine and enhanced digital care. So far, the following progress has been made:

- We have decommissioned use of desflurane across gesh, moved to TIVA pumps and oral anaesthetics, significantly reducing the clinical carbon footprint
- St George's have closed 3 of the 4 nitrous manifolds in 2024, and ESTH are planning to close the nitrous oxide manifolds in 2025
- Clinicians have been involved in the SMART theatres project and in implementing the Intercollegiate Green Theatre Checklist
- We have started the roll out of the clinical engagement workshops aimed at implementing a sustainable quality improvement process for all clinical departments

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Clinical transformation

What do we want to achieve?	How will we get there?
Sustainable models of care - we will deliver improvements in the three key areas of Care, Cost and Carbon. We will take a whole systems approach to the way care is delivered. Our approach will embed consideration of sustainability into any existing or new clinical model/ service change.	We will **support our clinical and operational teams to consider sustainability in their delivery of care through a Quality Improvement process** by: • Developing Sustainable Quality Improvement process and a programme of communication/ engagement for all clinical departments • We will help them to learn from our own successes, the professional bodies and national best practice. • Ensuring sustainability is embedded as a requirement for consideration in any future service change • Supporting programmes of work to avoid clinically unnecessary interventions and the procurement of sustainable products and equipment • Maximising digital delivery of care e.g. outpatient follow up activity • Seeking to deliver patient care in community-based settings closer to people's homes • Promoting preventative healthcare and lifestyle changes that support sustainability e.g. active travel, healthy diets.
Medicines - our clinical teams will be supported to optimise prescribing for example, by reducing the use of inhalers, nitrous oxide, and anaesthetic gases. We will have low levels of drug waste and will have minimised our emissions from medicines.	We will **implement plans to optimise sustainability in pharmacy.** This will include: • Manifold closures to reduce wastage (leaks) • Introduction of N_2O cracking for patient-controlled delivery • Promotion of Sevoflurane as the preferred anaesthetic gas • Moving to TIVA for anaesthetics • Increase of dry powder inhaler prescriptions and reducing/ recycling Metered Dose Inhalers • Developing a programme of awareness raising for staff • Minimising drug waste and over prescription

Green Plan

Leadership & Workforce

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

Where are we now?

This domain covers the essential role leadership and the workforce in general plays in delivering the aims of the Green Plan. Good progress has been made to date with the following success:

- We have held Trust level steering group meetings with the managing directors for both sites.
- We have a governance structure agreed at the group level.
- We have active working groups for each of the workstreams and key projects
- We have active staff led groups for Theatres, ED and ICU
- We have an active group Green Champions Group with representatives from throughout the organisation
- We have specialist groups like the Bicycle User Group

Green Plan

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

Leadership & Workforce

What do we want to achieve?	How will we get there?
Leadership The Group leadership teams will be actively engaged in the Green Plan, supporting its delivery and championing its vision and aims.	We will **implement the governance structures and performance reporting** for the group including: • Integrating the Green Plan Steering Group into existing leadership meetings • Ensuring the workstream areas have a nominated lead and support group • Developing a performance report including a dashboard of indicators • Fully integrate sustainability and Net Zero Carbon into financial decision making at all levels • Ensure capital investment is allocated to deliver longer term efficiencies and Net Zero Carbon
Workforce Our staff across the Group will be supported and enabled to make positive changes to their workplaces, operations and systems to promote sustainability	We will **develop and deliver a staff training, awareness and communications program** ensuring that • All staff have the opportunity to access a Group programme of sustainability training and education from Board level down, this will be role specific and key to increase education and raise awareness in clinical and corporate teams • Staff are enabled and empowered to take personal responsibility for integrating sustainability into everything they do and will support this with SusQi. • The Green Plan Team is in place to enable ongoing delivery of the Green Plan • Working with the Group Communications team to share sustainability messaging • Working with HR to include the Green Plan objectives into job descriptions • Working with the Wellbeing and Health and Safety teams to align sustainability messages and promote the importance for workforce wellbeing

Green Plan

Estates & Facilities

Where are we now?

This domain covers all functions which are responsibilities of Estates and Facilities including: waste, energy, capital projects, landscape & biodiversity, adaptation, food & nutrition, and travel & transport. The Green Plan Team is embedded in Estates & Facilities. Estates & Facilities is therefore at the heart of Group action on sustainability and has made some great Progress already:

- St George's have developed the SMART Theatres project saving £393,900 in energy costs and 254,484 kgC02e reduction every year
- We are replacing the fleet cars with Electric Vehicles (EVs)
- Both St George's and Epsom & St Helier have diverted all of their waste from landfill
- Our capital projects, the new Intensive Care Unit is targeting a Building Research Establishment Environmental Assessment Method (BREEAM) rating of "Excellent". The Renal and the Specialist Emergency Care Hospital in Sutton are now on pause but have both targeted "Outstanding".
- Our estates strategy is being informed by the Green Plan and Decarbonisation Strategies for St George's and Epsom & St Helier
- We have an abundant and varied set of gardens that provide a healing resource for staff, visitors and patients across gesh
- We have low carbon patient and canteen menus in place, digital ordering for the patient menu, and have moved to reusable cutlery and crockery and waste food recycling in the canteens across gesh
- We have ensured all Trust Vehicles (owned and leased) are ULEZ compliant across gesh
- Also across gesh only Low Emissions Vehicles (LEV) and Zero Emissions Vehicles (ZEV) vehicles available to staff through Trust lease scheme
- An inter-site shuttle bus is available to staff and public at ESTH, and ESTH has a travel plan currently awaiting approval
- A digital parking system was introduced in April 2024 at ESTH saving the equivalent of 350 trees per year compared with the scratch card system
- Cycle to work schemes are in place for staff with active cycling groups at both Trusts and the Cycle2Work scheme is available for staff across the group (includes electric bikes) and DASH cycle hire scheme is also available for staff at St George's
- "Dr Bike" free bike repair is available across both Trusts

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

Estates and Facilities

What do we want to achieve?	How will we get there?
Energy - we will be delivering key elements of our roadmap to 80% carbon reduction by 2028-32 and net zero carbon by 2040 and have moved a significant portion of the estate from gas to electric heating. Significant upgrades will have been made to more efficient fabric, low energy lighting, and smart metering. We will have minimised our local air pollution emissions and delivered energy efficiency work.	To do this we will **deliver our Estates Decarbonisation Strategies for each site.** This will include: • Mapping the pathway to move from gas to all electric heating and cooling • Improving the efficiency of our building fabric, lighting, and HVAC systems • Applying for funding for further decarbonisation support to replace equipment coming to the end of its life through upcoming phases of the Public Sector Decarbonisation Scheme (PSDS) and Low Carbon Skills Fund (LCSF) • A review the requirements for connection to the local electrical Distribution Network Operator, • Developing the on-site renewables capacity, electrical capacity and battery storage • Promoting energy efficient behaviours and efficient use of our buildings
Capital projects - our new buildings and refurbishments (Intensive care unit, Renal, SECH) will all meet the NHS Net Zero Building Standard (NZBS) requirements and target the BREEAM ratings of "Outstanding" and "Excellent", demonstrating sustainable construction and minimising embodied carbon, as well as reducing their operational energy demand.	We will **achieve key standards in the delivery of all new capital projects (e.g. BREAAM and NZBS).** We will: • Ensure ongoing delivery in line with the requirements of the Net Zero Building Standard • Integrate the requirements of BREEAM/ NZBS into business as usual and achieve them where appropriate

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NHS
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Estates and Facilities

What do we want to achieve?	How will we get there?
Waste - our waste volumes going to incineration will be low, and we will have improved segregation and recycling rates. In particular we will be achieving the targets for reducing the carbon footprint of our waste to Net Zero and implementing the requirements of the Clinical Waste Strategy 20/20/60	To do this we will **deliver national Clinical Waste targets**, ensure that the waste targets are embedded in relevant contracts, minimise waste production, improve segregation and recycling, aiming for net zero carbon from waste
Adaptation - our approach to adapting to climate change will be well defined, with clear protocols and risk assessments across the Group to respond to heat waves, cold weather, floods and other aspects of climate change and their impact on clinical services.	We will **develop and implement a group Climate Adaptation Plan** for responding to the changing climate**.** This will assess the vulnerability of the existing group estate against a list of key climate scenarios. We will develop a group wide climate risk assessment with consideration of longer-term potential issues and the impact on clinical services e.g. flooding and overheating
Landscape and biodiversity - we will be recognised as a leader in this area, with a robust landscape & biodiversity management plan in place across all current and future group sites. We will work in partnership with our patients, staff and communities to enhance our biodiversity and connection to it.	We will **develop and implement a group Landscape & Biodiversity Management Plan.** This will include a review of open spaces across all current and future sites to prioritise the maintenance and development of landscape and biodiversity. We will identify opportunities to engage with staff, public and local communities to support ongoing promotion and development of biodiversity and wellbeing

Green Plan

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

Estates and Facilities

What do we want to achieve?	How will we get there?
Food and nutrition - our delivery of food and nutrition across gesh will ensure minimal food waste, organic certification of products, delivery of low carbon menus, local sourcing and reduced food miles, and enhanced nutritional content.	We will **integrate sustainability into the delivery of food and nutrition** by identifying further opportunities for improvement in food waste reduction, improved purchasing and provision of 'sustainable' food e.g. organic certification, low carbon, locally sourced, and minimal waste
Transport The Group will be well along its roadmap of transition to an electric fleet with pooled community cars and couriers, shuttle buses, and an electric Patient Transport fleet generating minimal harmful air pollution	We will **transition to low carbon transport and an electric fleet.** This will entail: • Reviewing requirements and opportunities for infrastructure/ investment and funding for electric vehicle charge points • Develop new vehicles leases for pooled/ community/ courier vehicles • The Non-Emergency Patient Transport Service vehicle provider to offer a proposal for charging infrastructure and transition to an all-electric fleet
Travel Our staff across the Group will be able to work flexibly as appropriate and supported to choose sustainable methods of transport for their commute, with high levels of staff using active travel	A key focus will be to **promote active travel for staff, patients and the public:** • We will prioritise promoting the health and cost benefits to staff of active travel as well as the reduction in air pollution • A travel survey will be carried out annually and actions determined from staff feedback • Criteria for staff parking across the Group will be reviewed and aligned • An investment programme to be determined for staff cycling facilities • A programme of awareness raising will be developed for staff to include information on public transport/ active travel and air quality awareness • We will continue to work to develop air quality monitoring and communication

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Procurement

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

Where are we now?

The NHS supply chain accounts for approximately 62% of total carbon emissions and is a clear priority area for our Green Plan. We can use our purchasing power and decision-making processes to reduce carbon embedded in our supply chains. For example, reducing the use of clinical and non-clinical single-use plastic items, reusing or reprocessing equipment (such as walking aids) and considering lower carbon alternative supplies, such as reusable equipment.

To date progress includes:

- All relevant procurements include at least 10% of the evaluation weighting on criteria assessing social value and sustainability, with these themes embedded across the contract lifecycle within supplier KPIs as part of the ongoing contract management process.
- From April 2024, a full Carbon Reduction Plan is required for procurements of over £5m p.a. and a Net Zero Commitment is required for procurements of under £5m p.a. that are above the PA23 threshold
- Developing a sustainable procurement working group and updating procurement processes across the Group
- Encouraging suppliers to go beyond minimum requirements and engage with the Evergreen Sustainable Supplier Assessment

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

Supply chain and procurement

What do we want to achieve?

Supply chain and procurement - we will be an ethical and sustainable procurer of goods and services, with clear requirements for all our suppliers to outline their own sustainability plans and pathway to net zero. We will implement the principles of a circular economy prioritising products that can be reused and recycled. Greatly reducing single use plastics, substituting high carbon products with low-carbon alternatives and procuring products from sustainable sources.

How will we get there?

We **will build sustainability requirements into procurement processes and contracts using evaluation weightings, KPIs and ongoing contract management** and:

- Review procurement spend to identify high carbon products and contracts and develop a plan to tackle these as a priority
- Ensure social value/ sustainability has 10% weighting for all relevant tender contract scoring
- Make sure KPIs for sustainability are built into all new relevant contracts
- The procurement team will engage with all suppliers on net zero requirements

We will **review goods and services purchased against relevant sustainability criteria** develop and promote a programme to ensure we procure products that are reusable, repairable, recyclable, have a low embodied carbon footprint and are from sustainable sources. We will remove any unnecessary single use plastics from supply chain by 2028.

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Enablers

Quality and Digital Strategies

- This Green Plan will support delivery of the Quality Strategy, specifically the priority domain of "sustainably resourced".
- We will implement the principles of ISO14001 to ensure the consistency and rigour in developing appropriate management systems
- The Digital Strategy will align with the Green Plan in terms of leveraging the benefits of digital innovation e.g. use of patient apps to encourage patient access and communications

Partnership approach

- We will work closely with other stakeholders who utilise our estate or where we lease estate, particularly with City St George's University to ensure we are delivering against our sustainability vision in a collaborative manner
- We will also work closely with colleagues at SWL ICB, the NHS Estates Sustainability team and national Greener NHS team to deliver our plan

How do we get there?

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St George's, Epsom and St Helier
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Implementation approach

Implement-ation

- The Green Plan Team will manage implementation of the Green Plan and coordinate an annual review of the plan and update it as required.
- We will develop a road map of the high-level milestones for achieving the strategy phased over the four years of delivery and review progress annually
- We will develop annual action plans for each year of the strategy which will contain the detailed actions required to step gesh towards delivering key strategic objectives in each of the four domains
- Work to define the financial cost/ benefit analysis of actions will be a key part of implementation planning to ensure financial benefits are derived through implementation

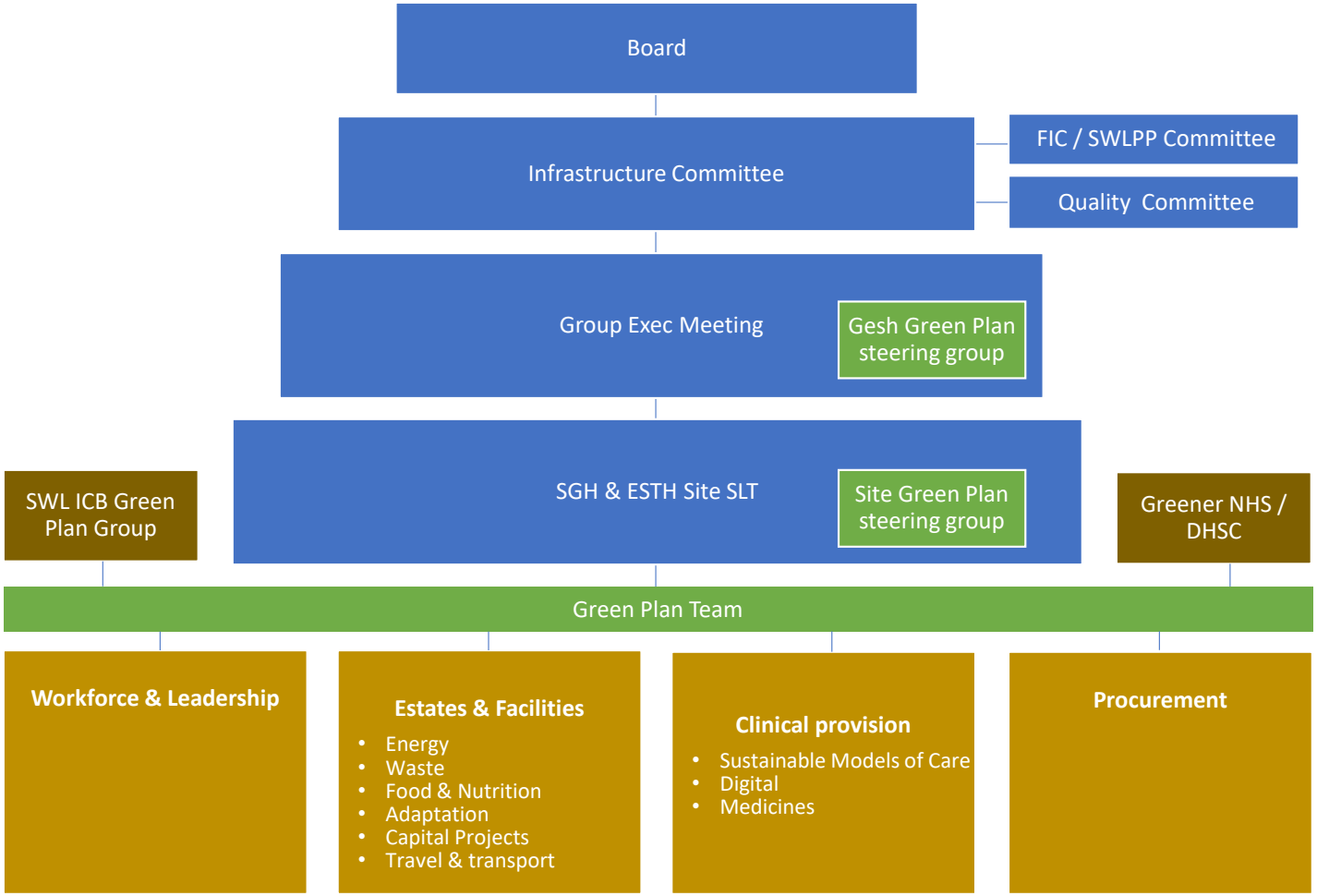
Evaluating impact

- A scorecard/ dashboard will be developed with key metrics to track progress and report on progress including:
  - Carbon emissions & energy use
  - Waste management
  - Travel and transport emissions
  - Sustainable procurement
  - Clinical transformation
  - Cost savings
  - Improvements in care

Green Plan

Green Plan Governance

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



The Board receives papers from each committee

The Infrastructure Committee receives the Green Plan Progress Report from GEM considers and approves recommendations.

The GEM acts as the gesh Green Plan Steering Group, receives the Green Plan Progress Report from SLT considers and approves recommendations at the group level.

The Site SLT acts as the site Green Plan Steering Group considers and approves the Green Plan Progress Report. Recommendations for improving performance and management are agreed.

The Green Plan Team facilitate the development, implementation and achievement of the Green Plan and create the Green Plan Progress Report. Reporting to wider NHS groups & SWL ICB as required.

The Domain/Workstream leads report progress to the Green Plan Team. Existing governance meetings used where possible e.g. Site E&F division meetings, clinical division meetings, SWL Procurement Partnership governance meetings.

Green Plan

Glossary of terms

Glossary

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

BREEAM	Building Research Establishment Environmental Assessment Method
DHSC	Department of Health and Social Care
EV	Electric Vehicle
ICB (SWL)	Integrated Care Board (South-West London)
KPI	Key Performance Indicator
LCSF	Low Carbon Skills Fund
LEV	Low Emissions Vehicle
NOx	Nitrous Oxide
NZBS	Net Zero Building Standards
NZC	Net Zero Carbon
PA23	Procurement Act 2023
PSDS	Public Sector Decarbonisation Scheme
SECH	Specialist Emergency Care Hospital
SMART	Intelligent design
SWLPP	South-West London Procurement Partnership
TIVA	Total intravenous anaesthesia
ULEZ	Ultra Low Emission Zone
ZEV	Zero Emissions Vehicle

Appendices

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

Appendix 1: Consultation

We've consulted with our stakeholders on the key themes and detail of this gesh Group Green Plan here's what they said.

Consultation

All staff	Staff responded to the Executive Question Time survey question "To what extent to you agree with this statement: I feel able to make green changes in my area" 1= not at all, 10 = completely with an Average of 4.725 (out of 161 respondents). We have developed all staff training and a program of Sustainable Quality Improvement as a result of this to engage staff where they work and to empower them to make positive changes.
Executive Team	Executive training on the Green Plan was held on the 5th December. We had positive feedback from the training with the Chairman and CEO convening a leadership action meeting in support of the Green Plan.
Green Champions	We have consulted with our Green Champions groups and integrated feedback into this plan.
Travel Survey	We have noted the views of staff, patients and visitors in developing our objectives and plans in this area.
Clinical Divisions & Departments	We have run a series of engagement presentations for clinical directorates and departments as well as consulted with existing clinical action groups. The feedback is that there is good support for the Green Plan aims but more could be done to engage clinical teams via quality improvement initiatives. We've made this the priority supported using a Sustainable Quality Improvement model.

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Appendix 2: Equalities & health inequalities

The solutions to the problem of sustainability needs to include the principals of equality and justice. Only global economic and social systems that prioritises the health of the planets ecosystems and a fair distribution of wealth will ultimately prove to be sustainable. We will strive to promote equality and reduce health inequalities as part of the Green Plan in line with the Public Sector Equality Duty. We will reach out to groups with protected characteristics to engage them in areas where they may be underrepresented.

Health inequalities

Action	Impact	Groups impacted	How is the Green Plan helping?
Increasing active travel and use of public transport	Reduces air pollution, improves population fitness, reduces obesity, improves mental health	Those with disabilities or mobility impairments Staff working nights Local community Staff, Patients, Visitors	Working with TfL to extend bus routes where possible Carrying out regular travel surveys to understand needs of our stakeholders to develop a Sustainable Travel Plan. Supporting active travel with facilities, advice and support (e.g. Dr Bike, DASH cycle hire and cycle to work scheme).
Access to green spaces	Helps to cool urban areas, improves air pollution, reduces stress, improves physical and mental health	Patients Visitors Staff Local community	Maintaining the grounds and gardens as a resource for all. Applying for charitable funds to develop new green spaces
Improved energy efficiency	Improves air quality, saves money, reduces carbon emissions and climate change	Patient Visitors Staff Local community	Installing solar panels, LED lighting and developing feasibility studies for future funding applications reduces the impacts of air pollution and climate change for everyone.
Increase in plant-based diets	Helps to tackle obesity, improves physical and mental health, improves food security	Patients Visitors Staff	Increasing plant-based options in our restaurants and on patient menus promotes a healthy diet for all.