Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors Meeting
17 July 2025

Agenda and papers

Summary of scheduled Outpatients Visit - 10th of June 2025 – Provided by Luisa Brown

Governors attending
John Hallmark
Luisa Brown,
Sarah Forester
Huon Snelgrove
Shuille Syeda

On the 10th of June 2025, members of the Council of Governors were warmly welcomed to St George's Hospital for a scheduled visit of the Outpatient Departments. The visit was both insightful and uplifting, showcasing exemplary care environments and operational excellence across multiple specialties. Of particular note, **five departments had achieved Gold standard recognition**, with **one department awarded Platinum**, reflecting outstanding dedication, quality, and service delivery by the staff.

Overview of Visits and Key Findings

Phlebotomy Department

- **Impressions:** Bright, welcoming, clean environment with updated décor.
- **Service Innovation:** Introduction of a new **Phlebotomy Booking System** (launched 18th December 2023), which sees **approx. 220 service users daily**.
- **Impact:** Reduced wait times, smoother patient flow, and high user satisfaction (validated by FFT feedback).
- **Flexibility:** Emergency slots available for urgent needs; observed compassionate care during visit (Governor assisted a distressed patient).
- **Challenges:** Current IT system limitations prevent service usernames from displaying on waiting room screens, requiring staff to call out names—raising concerns about mispronunciation and reduced patient empowerment.

ENT Outpatients
Achievements: Gold standard care.

- **Environment:** Clean, bright, well-maintained, with ample seating.
- **Operations:** Nurse-led clinics available; clinics generally run to time with clear communication to patients if delays occur.
- **Strengths:** Stable staffing, high retention, and a sense of professional value and respect across the team.
- **Challenges:** Ongoing IT and system issues which staff expressed as a primary concern for operational efficiency.

Paediatric Outpatients – Dragon Centre

- **Environment:** Child-friendly with engaging artwork and a calming atmosphere.
- **Services:** Includes a paediatric phlebotomy area; options for sensory-sensitive children to be seen in Dragon Jungle Ward.
- **Care Quality:** High continuity of care with consultants familiar with their caseloads, ensuring trust and reassurance.
- **Strengths:** Thoughtful transition planning for patients moving into adult services; excellent staff engagement and morale.

Rheumatology Outpatients

- **Status:** Gold standard award recipient.
- **Capacity:** Currently operating with 6 beds; expressed a need for 10 to meet growing demand.
- **Space limitations** in clinical rooms raising concerns over confidentiality and workflow.
- **Notable backlog of cases** due to inadequate physical capacity.
- **Feedback:** Patients highly complementary of both reception and clinical teams.

Fracture Clinic

- **Recognition:** Gold standard.
- **Operations:** Efficient clinic flow with active consultant oversight, aiding decision-making and case continuity.
- **Observations:** Consultant often balances theatre and clinic responsibilities.
- **Environment:** Clean, open, well-organized, with good communication around waiting times.

Neurology Outpatients – Atkinson Morley Wing

- **Award Status: Platinum Award**, reflecting consistent excellence, following **three consecutive years at Gold level**.
- **Environment:** Housed in a **modern, purpose-built facility**, the neurology outpatient department offers **spacious clinical rooms** and a practical layout that enhances patient flow and staff workflow.
- The department includes capacity for **patients arriving via stretcher or trolley**, ensuring accessibility for those with complex needs.

• **A calming mural featuring trees** adds to the welcoming and therapeutic atmosphere.
• **Patient Demographic:**
A highly diverse patient base is served, including those with:
• **Multiple Sclerosis (MS)**
• **Parkinson's Disease**
• **Epilepsy**
• **Chronic Pain**
• **Muscular Dystrophy**, among others.

- **Operational Insights:** Clinics may occasionally experience delays, but staff proactively communicate using **mobile whiteboards** to keep patients informed about wait times—demonstrating excellent real-time responsiveness and transparency.
- **The department operates as a centre of excellence**, attracting patients from across the UK, which is a testament to the quality and reputation of care provided.

Team & Morale:

• Staff are **highly engaged**, experienced, and committed to their roles.
• Long-term retention suggests a culture of **staff empowerment, appreciation, and respect**.
• The **Sister in charge reports no concerns**, reflecting a well-managed and confident unit.

Minor Recommendation:

• Although the department holds a **prestigious Platinum Award**, it is currently displayed in a **small room near the reception**. I recommended during the visit that this recognition be **more prominently displayed** to celebrate the team's achievements and inspire continued excellence.

Final Reflections

The outpatient departments at **St George's Hospital** reflect a commendable commitment to high-quality care, operational effectiveness, and patient-centred service. The environments are welcoming and well-maintained, with several areas showcasing creative and thoughtful design that enhances user experience.

Common strengths observed across departments include:
• **High standards of cleanliness and aesthetics**
• **Strong clinical leadership and staff retention**
• **Innovative booking systems improving access and reducing delays**
• **Effective communication with service users**
• **Consistent delivery of timely and respectful care**

Where challenges were raised—such as **IT system limitations** in some areas, or **space constraints** in Rheumatology—they were paired with clear staff insight and constructive suggestions for improvement.

Themes and Observations:

• **Staff Retention & Morale:** A consistent theme across all departments was long-serving staff who feel empowered, valued, and committed to their roles.
• **Patient Experience:** High levels of satisfaction were observed and reported in FFT results and through direct interactions with patients.
• **Operational Excellence:** Most clinics are running efficiently with minimal delays, bolstered by good scheduling systems and proactive communication.
• **Challenges Noted:**
• **IT and System Limitations** (notably in ENT).
• **Space Constraints** (especially in Rheumatology).
• **Display Systems** could be improved to aid patient autonomy and reduce staff burden. (In phlebotomy)

Recommendations & Considerations

1. **Explore IT Upgrades:** Address system issues to enable patient name displays and improve overall clinic workflow efficiency.
2. **Capacity Planning:** Consider feasibility assessments for Rheumatology space expansion to meet patient demand and improve confidentiality.
3. **Continued Recognition:** Acknowledge and celebrate the high standards achieved (especially the Platinum and Gold departments) to reinforce positive culture.
4. **Replicate Successes:** Consider applying the effective strategies from the new phlebotomy booking system to other departments.

Conclusion

The visit provided a valuable window into the excellent standards upheld across outpatient departments at St George’s Hospital. The dedication of the staff and the quality of environments presented were exceptional, and the continual drive for improvement was evident.

I would like to **extend my sincere appreciation** to all departments visited, and in particular to **Doreen and Mel**, for their time, openness, and enthusiasm during the tour. The collective efforts of all staff in achieving and maintaining Gold and Platinum standards are not only evident but deeply commendable.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on Thursday, 17 July 2025, 17:30 – 19:30

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

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

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

2.0 Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
17:50	2.1	Group Chief Executive's Report	MD-SGUH	Update	Report
18:05	2.2	Strategy Update and Corporate Priorities	tbc	Update	Report

3.0 Quality and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18.25	3.1	SGUH Operational Performance and Priorities - Queen Mary's Theatres - Birthing Centre, St George's	MD-SGUH	Update	Report
18.45	3.2	Maternity Services	GCNO/GCMO	Update	Report

4.0 Finance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18:55	4.1	Finance Update	Committee Chair	Discuss	Report

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5.0 Governance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:10	5.1	Annual Report from External Auditor on Annual Accounts	tbc	Approve	Report
19:20	5.2	Proposal to develop a governor dashboard	GDDCA	Discuss	Report

6.0 Membership Engagement					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:30	6.1	Membership Engagement Committee Update	Committee Chair	Discuss	Report

7.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:40	7.1	Any Other Business	All	Note	Verbal
	7.2	Council of Governors Calendar of Events	All	Note	Report
	7.3	Reflections on Meeting			

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

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chair	Chair
Sophia Agha	Associate Governor (Young Members)	SA
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Ashok Bhat	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Hann Latuff	Public Governor, Merton	HL
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Abul Siddiky	Staff Governor, Medical and Dental	AS
Huon Snelgrove	Staff Governor, Non-Clinical	HS
Claire Sunderland Hay	Associate Non-Executive Director	CSH
Shuile Syeda	Appointed Governor, Merton Council	SS
Ataul Qadir Tahir	Public Governor, Wandsworth	AQT
In Attendance		
Ann Beasley	Non-Executive Director, Vice Chair	AB
Pankaj Davé	Non-Executive Director	PD
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
Richard Jennings	Group Chief Medical Officer	GCMO
Yin Jones	Non-Executive Director	YJ
Peter Kane	Non-Executive Director	PK
Khadir Meer	Associate Non-Executive Director	KM
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Arlene Wellman	Group Chief Nursing Officer	GCNO
Barbara Mathieson	Governance Manager (Minutes)	BM
Apologies		
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Natalie Armstrong	Non-Executive Director	NA
Sandhya Drew	Public Governor, Rest of England	SD
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Chelliah Lohendran	Public Governor, Merton	CH
Julian Ma	St George's University of London	MA
Ralph Michell	Director of Strategy & Integration	DS&I
Andrew Murray	Non-Executive Director	AM
Michael Pantlin	Interim Group Deputy Chief Executive Officer	IGDCEO
Jackie Parker		

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Georgina Sims	Appointed Governor, Kingston University	GS

St George's University Hospitals NHS Foundation Trust

Minutes of the Meeting of the Council of Governors (In Public)
Thursday, 22 May 2025, 17:30 to 19.50 :10
Hyde Park Room, Lanesborough Wing, St George's Hospital

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Mark Lowcock	Trust Chairman	Chairman
Sophia Agha	Associate Governor (Young Members)	SA
Afzal Ashraf	Public Governor, Wandsworth	AA
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhat	Public Governor, Rest of England	AB2
Luisa Brown	Public Governor, Merton	LB
James Bourlet	Public Governor, Rest of England	JB
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH
Chelliah Lohendran	Public Governor, Merton	CH
Hann Latuff	Public Governor, Merton	HL
Augustine Odiadi	Public Governor, Wandsworth	AO
Jackie Parker	Public Governor, Wandsworth	JP
Huon Snelgrove	Staff Governor – Non Clinical	HS
ShulieSyeda	Appointed Governor Merton Council	SS
In Attendance		
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director, Vice Chair	AB
Elizabeth Dawson	Group Deputy Director of Corporate Affairs and Head of Corporate Governance	GDDCA
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones	Group Chief Corporate Affairs Officer	GCCAO
Yin Jones	Non-Executive Director	YJ
Barbara Mathieson	Corporate Governance Manager	CCG
Andrew Murray	Non-Executive Director	AM
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Claire Sunderland Hay	Associate Non- Executive Director	CSH
Apologies		
Nasir Akhtar	Public Governor, Merton	
Natalie Armstrong	Non-Executive Director	
Sandhya Drew	Public Governor, Rest of England	
Peter Kane	Non-Executive Director	
Pankaj Dave	Non-Executive Director	
Julian Ma	Appointed Governor, St Georges University of London	
Ralph Michell	Group Director of Transformation	
Abul Siddiky	Staff Governor, Medical and Dental	
Georgina Sims	Appointed Governor, Kingston University	
Ataul Qadir Tahir	Public Governor, Wandsworth	
Arlene Wellman	Group Chief Nursing Officer	

Feedback from Governor visits	Action
Feedback from visits to various parts of the SGUH site	

Governors had undertaken a number of visits across the SGUH site since the last meeting, and they expressed thanks to the staff who had facilitated them and for taking time out of their schedules to talk to them about the care provided. The Chairman invited Governors to raise any further points. The following points were raised and noted during discussion: General points: • Governors were pleased to see evidence of Martha's law being introduced • Amazing nursing leadership was being demonstrated • Staff overall were felt to be impressive – this needed to continue • Staff shared frustration at having to routinely produce complex business cases in order to replace "regular staff requirements" • Continuing issues relating to Mental Health patients having to be seen and cared for in the Emergency Department Discharge Lounge: • It did not feel that the Discharge Lounge was as well developed as it could be – especially given its importance for flow through the hospital • Issues shared about communicating with the rest of the trust as some staff mentioned a disconnect. Pharmacy: • Staff had reported an issue with delays with TTO (To take home) prescriptions, which has a knock on effect on the operational side. Governors queried whether it would be worth exploring from the patient / operational perspective including collection from local pharmacies • Points raised from Governor visits: • The Governors asked how the information shared from ward and service visits was used and commented that where an issue of concern was raised. • MD–SGUH confirmed that the information from both Governor and Board visits was very helpful. In respect of the Discharge Lounge, it was confirmed that it had recently been moved and more effort need to be made to encourage its use. It was confirmed that the team report to the site team, but work was needed to ensure that they felt more included. The MD-SGUH also confirmed that she would take the feedback away and would see what improvements could be made. • Similarly, the GCMO confirmed that he would share the feedback with the Pharmacy Team. They receive many views on improvements. It was noted that it was a big unit with several specialist services operating from it.	**MD–SGUH** **GCMO**

1.0	OPENING ADMINISTRATION	Action
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting, including the new members and noted the apologies as set out above. Shulie Syeda was congratulated on becoming Deputy Mayor for the London Borough of Merton.	
1.2	**Declarations of Interest** There were no new declarations of interest.	

1.3	**Minutes of the Public meeting held on 12 March 2025** The minutes of the meeting held on 12 March 2025 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors reviewed the action log and matters arising: **COG 12.3.25/1- Matters Arising - Data on the complaints have been made to the PHSO to be shared with governors** The GCCAO shared the briefing on behalf the GCNO. Details were shared with the Council of Governors on how the trust manages and assures responses to investigations by the Parliamentary and Health Service Ombudsman (PHSO). The key points were that: • All enquiries and investigations were overseen by the central Patient Experience and Complaints Team, in conjunction with the Group Compliance team with input from divisional clinical and operational leads. • Between April 2023 and April 2025, SGUH managed 20 PHSO cases, with 3 upheld or partially upheld. • A total of 69 enquiries were received across the Group between 2018 and 2023, of which 44 proceeded to investigation. • Reporting on these cases was aligned with trust governance processes to ensure transparency and continuous improvement in patient care. These arrangements provide assurance that SGUH handles PHSO cases with rigour and uses them as a driver for learning and improvement. It was agreed that the action could be closed. **COG 12.3.25/2 - SGUH Operational Performance - Never Events** Date for Part Two PSRIF Training to be confirmed. Training was now arranged for 24 June 2025 Action to be to be closed.	
2.0	**STRATEGY**	
2.1	**Group Chief Executive Officer's (GCEO) Report** The Chairman invited comments and questions from Governors on the GCEO report. The following issues were raised and noted in discussion: • HL asked about the recent migration of maternity records to a new system and whether it was known that there were likely to issues and how concerned was the trust. The MD-SGUH confirmed that this related to the move of SGUH maternity records from a legacy system to the Electronic Patient Record – Cerner. This was separate to the large scale move at ESTH of Patient Records which had begun on the 9 May 2025. For the maternity records there had been some issues and work was ongoing with IT to try and resolve/ mitigate the concerns. Some of the issues related to staff getting used to the new ways of work, with GCMO reassured Council that all records were still available but those prior to the move to Cerner where still in paper form which was not ideal • It was confirmed that the ESTH move to EPR – on Cerner was largely going well. • A question was raised as to whether it was likely the reconfiguration of Renal Services across the Group would proceed, including the proposed build of a new Renal Services facility on the SGUH site. It was confirmed that all parties very much wished the project to continue to move forward. At present there was a £20m funding gap which would need to be covered, to proceed with the	

	current building plans. Work was being to see if the costs for areas of the project could be reduced so that it could be delivered within the available funding envelope. **The Council of Governors noted the GCEO report.**	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**CQC Well Led Inspection – Letter in Advance of Report** The GCCAO shared with the Council of Governors the initial feedback letter which had been received from the CQC following their Well Led Inspection which took place between 25 and 27 February 2025. The Trust was yet to receive the report of the inspection but had received a letter dated 11 March 2025 which shared some initial high-level feedback. The information shared with the meeting set out the initial written feedback from the CQC, mapped against the Trust's internal readiness assessment, and set out some key actions being taken both in response to the CQC's initial feedback and to improve further the Trust's position in relation to the Well Led framework. It was however stressed, that the full inspection report would provide greater detail than the CQC's initial feedback letter, and the views presented could yet evolve as they prepared its final report. A full action plan to respond findings would be developed following the receipt of the final report. The action plan would be presented to the Group Board for approval. Implementation of actions will be monitored on an ongoing basis by the Group Executive Committee with biannual updates to the Group Board and Council of Governors. The full final CQC report would be shared with the Council of Governors once received. It was confirmed that once the draft report was received from the CQC the Trust would have 10 days to respond in terms of addressing any areas of factual accuracy. The following points were raised during discussion: • Overall, the letter from the CQC was thought to be a fair reflection of the position of the Trust at the current time. The proposed actions had not been developed in isolation but sat along the various strategies which had been, or were in the process of being, created for SGUH the group. • The GCPO confirmed that she had various discussions with the inspection teams and the CQC were satisfied that the trust had good leadership development plans and that consistent efforts would be made to ensure continuous improvement. • A governor raised the point that the need for clarity between site and group had been raised in other reports including the first CQC Maternity Inspection report. In response to this point the GCEO stressed that it would take time to develop the culture of working together successfully between the two organisations and clarify the roles for Sites and the Group. The recently developed Group Accountability Framework was helping but needed to be socialised with the Divisions. A Governor also asked what was being done to try and improve staff morale within the maternity team. The MD-SGUH confirmed that this had been quite challenging but that a lot of work was being undertaken to try and raise morale. It was important that staff felt involved in making decisions regarding the service and that they were given the opportunity to engage in a range of ways. Leadership within the team needed to be strong and this was felt to have improved recently. There were also several staff wellbeing initiatives being undertaken.	**GCCAO**

	AM who is the Maternity Safety Champion, confirmed that he also felt that progress was being made in this area. This had been demonstrated in the recent walkabout he had undertaken where he had taken the opportunity to speak to matrons and a range of staff on an individual basis. It was also important to recognise the role of appraisals and where necessary performance management to maintain positive staff morale. **The Council of Governors noted the feedback from the CQC dated 11 March 2025 following their Well-Led inspection in February 2025.**	
3.2	**SGUH Operational Performance and Priorities** The MD-SGUH shared the following key points regarding Operational Performance at SGUH: • Cancer performance trajectories continued to be met in February 2025: 28-Day Faster Diagnosis Standard (86.5%), 31 Day Standard (96.1%) and 62-Day Treatment Standard (81%). • Value weighted activity as a percentage of total Out Patients activity continues to exceed target, achieving 50.3% (above the national ask of 49%). • Performance against the 4-hour standard continues to exceed the national requirement, with a performance of 83.6% through March 2025. Although the 12hr wait metric remained static. **Challenges outlined included:** • Patient Initiated Follow Ups (PIFU) rates are below the target of 5%, although continuing to see month-on-month increase. • Further increase in the number of long waiting patients on a referral to treatment pathway, with 75 patients waiting more than 65 weeks and 1,084 patients above 52 weeks, driven mainly by Neurosurgery and Bariatric Surgery. The trust was participating in the National Sprint programme to support full validation of the wait list and was working with the ICB to ensure the Trust was commissioned appropriately to provide the services • A high proportion of beds continued to be occupied by patients who do not meet the criteria to reside with delays impacted by interface process with social and Residential / nursing home care arrangements and subsequently there had been an increase in the average number of inpatients with a length of stay of over 21 days increase. Overall, it was noted that operational performance was doing relatively well t, particularly given the difficult financial position. The trust was undertaking additional work around referrals and triage and supporting increased advice and guidance for local GPs in order to reduce waiting lists. Other work included ensuring that there that there was consistency in outpatient clinics such as the number of patients seen, benchmarking of activity across London and reducing the number of patients brought back for follow up appointments. The following points were raised by the Governors: • Governors highlighted that on some occasions there was a considerable wait for any information to be received as to when a patient may receive an appointment. It was confirmed that partial booking should be in place and that patients should be informed as to when they are likely to receive an appointment date i.e. an appointment date will be issued in approximately X period • Questions was raised as to why there was an increase in the number of patients waiting over a year for an appointment. It was confirmed that the growth in demand continued to out strip capacity. • Questions were raised as to how local trusts and the wider system could work together to come up with more initiatives which would help with increased demand.	

	In response to the last point the GCEO confirmed that as part of the new 10 year plan for the NHS initiatives would include activities which should aim to help overall activity. Consideration needed to be given to undertaking different activity early in a pathway which would reduce the need for further follow up activity and to prevent unnecessary acute admissions. However, it was agreed that early interventions needed to be system wide. **The Council of Governors noted that SGUH Operational Performance update.**	
3.3	**Maternity Services** The GCMO presented the maternity services update on behalf of the GCNO, confirming that they were working closely together on strengthening the service following the outcomes of the reviews which had taken place over the past two years. It was confirmed that regular updates on maternity services were shared at the Group Board. In presenting the paper, the GCMO opened by saying that he undertook to ensure, with the GCNO, that future papers for Governors would l be written in a more consciously user-friendly way for a non-specialist readership, with technical terminology and abbreviations clearly explained. A number of Governors noted the challenges involved for the reader in picking up key points from the paper and agreed that this change would be very welcome. The Chairman asked, at the end of the discussion, for this commitment to be fed back, with thanks, to the report authors. **The GCMO highlighted the following points from the report.** • There had been some concerns that rates of post-partum haemorrhage were high. Consideration of the impact of the trust being a specialist centre for placenta accreta which held a high risk of serious haemorrhage, and whether this was adversely affecting results, had been undertaken. However, this had shown that taking this into account, the rates were higher than would be expected. • A maternal death had very sadly taken place at the trust early in March 2025. This would be subject to an external review which would take some time to deliver its outcomes, therefore an internal investigation had also been put in place. Initial findings related to concerns with identifying and escalating concerns relating to a deteriorating patient, and the impact of pre-existing health condition. • 9 of the 10 CNST requirements for the maternity financial rebate for 2024 had been met. There had been once missed opportunity regarding timely reporting to a national system. The trust had appealed against the ruling but this had not been successful. • The MD-SGUH updated the meeting on the progress of developing the Integrated Maternity Plan. This brought together the recommendations from the various reviews. There was also work being undertaken on ensuring actions were embedded. **The Council of Governors noted the Maternity Services update.**	
4.0	**Finance**	
4.1	**Finance Update** The GCFO presented the Finance update which confirmed that year end position for the 2024/25 and the plans for 2025/26, and noting the following key points :	

- 2024/25 financial targets were delivered in line with plan. This was against a background of significant financial pressures.
- The forecast until month 11 was to miss the target, but further support was received from NHSE and SWL in order to support delivery.
- The 2024/25 financial position was now subject to External Audit Review by Grant Thornton. That work has started and to date no material issues or concerns have been raised.
- The plan for 2025/26 was highlighted as being extremely challenging.
- While a balanced plan has been submitted to NHSE, for SWL overall and SGUH specifically, the delivery of this plan should be seen as being at extremely high risk. Work was being done across SGUH and the group to identify actions to minimise the risk.

Cost Improvement Plan (CIP)

- In order for the trust to reach its control total for the year it would need to find £95m of savings (7% of turnover). To date there were commitments to finding CIPs equating to £82m leaving a gap of £13m still to be found, with a focus on recurrent rather than one off savings £16m of the schemes had been fully approved and through the Quality Impact Assessment (QIA) process.
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- Governors noted that it would be huge challenge to achieve the required level of savings over the year.
- Following a question from the Governors it was confirmed that all CIPs undergo a QIA process before being fully approved. This takes place at local, site and group level. At the Group level these meetings were chaired by the GCMO and the GCNO. CIPs on occasions were not approved and the GCMO confirmed that often more information was requested.
- Whilst safety would never be compromised there may be the need to reduce the quality of some services to meet the financial constraints being placed on the trust.

Staffing

- A Governor asked if it was possible to influence the price paid for bank and agency staff. It was confirmed that work was often undertaken on standardising costs for these types of staff. Some progress was being made on local trusts working together to have standard rate cards.
- Also discussed were the number of staff within the trust and the fact that the aim was to reduce the overall number of wte roles (whole time equivalent) as opposed to the actual number of staff being employed. Currently there were approximately 10k posts – with 9k substantive staff, 1k bank and 600 agency staff, with a need to reduce agency use by around 50%.
- Reduction in headcount was being achieved in several ways including fewer bank shifts being available. The turnover rate was running at 10% which equated to around 900 posts. Careful consideration was being given as to if, and how, these staff would be replaced.
- Redundancy could not be ruled out but the aim would be to redeploy staff to other roles.

Other points

- There had been national guidance relating to the increase in corporate costs to comparable levels that there had been in 2018/19, and reducing this increase by.
- With the recent changes to the ICB it was still to be agreed what would be happening with some of the services that they delivered. This may have a financial impact on local trusts.
- Standard provision for pay rises had been included with the financial plan for 2025/26

	• Following a question from the Governors it was confirmed that there was concern relating to cash for the trust for the forthcoming year and extremely careful advanced planning would be needed. • Over the whole of the trust there was a need to be able to reduce the additional financial pressures e.g being able to reduce the number of beds – due to reducing the number of patients with no criteria to reside. Currently SGUH was caring for 150 patients within this category. **The Council of Governors noted the Finance update.**	
5.0	**PEOPLE**	

5.1	**2024 Staff Survey**
	
	The GCPO shared highlights from the results of the 2024 Staff Survey with the meeting. The following key points were highlighted:
	
	• The 2024 Staff Survey at SGUH benchmarked staff experience against national averages, guiding cultural enhancements aligned with People Promise themes.
	• The survey achieved a 47% response rate (4,765 staff, up 9% from 2023).
	• The results are largely positive, with 31 scores improving and 68 stable, ranking St George's 10th most improved trust nationally.
	• Significant gains were seen in all People Promise themes, Staff Engagement, and Morale, earning NHSE recognition.
	• Key strengths demonstrated from the results included:
	  ○ Significant improvements in staff engagement, morale, and multiple People Promise elements versus 2023.
	  ○ Compassionate and Inclusive' score (7.11) was strong, near the benchmark (7.21).
	  ○ 'Compassionate culture' (7.17) exceeded the benchmark (7.05);
	  ○ 89.33% of staff felt their role was meaningful.
	• Areas for improvement (vs. benchmark):
	  ○ Overall, Morale (5.75): Below benchmark (5.93), linked to intentions to leave and work pressure.
	  ○ Recognition & Reward (5.81): Below benchmark (5.92); pay satisfaction at 28.74%.
	  ○ Flexibility (5.92): Below benchmark (6.24); satisfaction with flexible options at 51.03%.
	  ○ Safety & Health (5.98): Slightly below benchmark (6.09); higher burnout indicated.
	  ○ Compassionate & Inclusive Sub-themes: 'Diversity and Equality' (7.72) and 'Compassionate Leadership' (6.82) were below benchmarks.
	  ○ Fairness in career progression perception was low (49.44%).
	
	Overall, the outcomes for the 2024 staff survey were felt to be positive, particularly in terms of engagement with the improved response rate. However, the GCPO acknowledged that there were still several areas where it would be good to see an improvement and therefore the trust should not be complacent. For these areas Corporate and Local Action Plans were needed. It should also be acknowledged that 2025/26 was expected to be a very difficult year for the NHS with a number of challenges including considerable financial pressure expected. The trust therefore would need to work hard to ensure that staff remained engaged.
	
	YJ, the Group People Committee Chair, confirmed that several “People” related deep dives would be undertaken and would be presented to their meetings over the course of the year. People Business Partners would be working closely with the Divisions to ensure that improvements were made in the areas highlighted within the Staff Survey.	

	Council acknowledged the overall improvements in the Staff Survey outcomes. Questions were raised relating to how staff within different areas of the trust and with protected characteristics responded. The GCPO confirmed that this more detailed review was yet to be but agreed that this would be an important area to consider. Also noted, was the importance of staff being involved in continuous improvement work, shared governance and empowering individuals to take ownership of making change. In respect of inclusion there were some active networks which staff could become involved in alongside several local engagement champions. A Shadow Board was in the being developed and the trust was trying to involve a range of different staff in several initiatives which would benefit local environments. **The Council of Governors noted the summary of the Staff Survey results from 2024.**	
6.0	**GOVERNANCE**	
6.1	**Recommendations on Governor Vacancies** The GCCAO outlined the proposals to fill the various Governor vacancies, noting the following points: • That over the past few months two elected governors (one public governor (Rest of England) and one staff governor (Allied Health Professionals and Other Clinical and Technical) had stood down. • The seat for Southwest Lambeth had not received any nominations in the past two elections and remained vacant. As set out in the report a review of the options for filling these seats has been completed, considering information from previous elections such as turnout and votes for the candidates, the cost of running the election process and the elections already required later this year. The Governors asked about the membership figures for Southwest Lambeth (currently 539) and whether patients from the area were likely to use SGUH or another local hospital. It was confirmed that the constituency had the smallest number of members within the trust but that the local population should be considered significant as they did make use of the services. Therefore, it was important that it was represented within the Council of Governor and it would be a priority for promoting membership and engagement. **The Council agreed:** • **that the next highest place candidate from the previous election be invited to fill the vacancy left by Marie Grant (Rest of England) until the original term of office ends in January 2027.** • **the election for the Staff Governor (Allied Health Professionals and Other Clinical and Technical) to replace Atif Mian should take place during the scheduled elections due to take place in the autumn of 2025, Quarter 3 2025/26** • **that a further attempt to fill the vacant South West Lambeth seat should take place through the forthcoming elections in Q3 2025/26.**	
7.0	**MEMBERSHIP ENGAGEMENT**	
7.1	**Membership and Engagement Committee Update** JP, Chair of the Governor Membership and Engagement Committee shared a summary of recent activity. This included:	

	• A f meeting of the Committee had taken place and the activity on the 2025/26 Member Engagement Strategy reviewed/This included several actions which it was planned to deliver within the year • Several activities were planned, including delivering a talk for members. • A meet the Governors session was planned for 29 May 2025 at SGUH. **The Council noted the update from the Governors Membership and Engagement Committee.**	
7.2	**Governor ownership of Membership and Engagement** The Lead Governor reminded Governors that one of their main roles was to support the trust by representing the interest of its members. It was only able to do this if it engaged with the membership and this was the responsibility of all Governors. Several opportunities existed to engage with members of the trust and to encourage membership. This included: • Meet your Governor • Annual Members Meetings • Visits around the Trust and within their constituencies It was confirmed that leaflets encouraging the public to become members, and explaining the role of governors, were beginning updated. Guidance on what Governors should say to engage with members of the public and to encourage membership would be also be reissued. Governors stressed the importance of being able to offer a benefit to the public membership for example a regular membership newsletter. To date only one had been issued. The GCCAO confirmed that the intention was to restart issuing regular newsletters to all stakeholders. It was expected that the first would be issued in early June 2025.	
8.0	**Items for Noting**	
8.1	**Fit and Proper Persons Compliance 2024/25** The GCCAO presented the report which provided assurance to the Council of Governors that all Non-Executive Directors (NEDs) remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework (FPPT) for England published in August 2023. It was confirmed that all the NED at St George's University Hospitals NHS Foundation Trust (SGUH) had successfully undergone all the required checks under the Fit and Proper Persons Test Framework in 2024/25 and the Trust would make the required submission to NHS England ahead of the 30 June 2025 deadline. Two NEDs and one Interim NED at SGUH left the organisation in 2024/25. The required Board Member References had been completed for these departing Board members in line with the requirements of the Framework. Two new NEDs and one Associate NED joined SGUH in year and all relevant FPPT checks were completed. **The Council noted that the Fit and Proper Persons Test had been conducted for the period 2024/25 and that all NEDs satisfy the requirements of the Test.**	
9.0	**Closing Items**	

9.1	**Any Other Business** There was no further business.	
9.2	**Council of Governors Calendar of Events** The Council received and noted the forward plan for meetings and events.	
9.3	**Reflections on the meeting** The Chairman asked for reflections on the meeting. Members of the Council of Governors acknowledged that the timing of the meeting had over run but that there had been the opportunity to have detailed and useful discussions.	

Date of next Meeting

17 July 2025 5.30pm – 8.30pm Hyde Park Room

Council of Governors - Public - 17 July 2025

St George's University Hospitals NHS Foundation Trust

Action Log

Action Ref	Section	Action	Due	Lead	Commentary	Status
COG 12 3 25/2	SGUH Operational Performance - Never Events	PSIRF training part 2	Jun-25	GCNO/Corporate Governance	Part 2 PSIRF training completed on 24th June -	PROPOSED FOR CLOSURE
COG 12.3.25/3	Finance Update	Training session to be provided on finance pressures	25/09/2025	GCFO	8/5/25 First part of finance session delivered as part of the new governors induction session.. A follow up session is currently being planned for early autumn.	NOT YET DUE
COG.22.5.25/2	Points raised from governor visits	MD–SGUH confirmed that in respect of the Discharge Lounge, it was confirmed that it had recently been moved and more effort need to be made to encourage its use. It was confirmed that the team report to the site team, but work was needed to ensure that they felt more included. The MD-SGUH also confirmed that she would take the feedback away and would see what improvements could be made. GCMO confirmed that he would share the feedback with the Pharmacy Team. They receive many views on improvements. It was noted that it was a big unit with several specialist services operating from it.		MD-SGUH/GCMO	Feedback shared with reelevant teams.	PROPOSED FOR CLOSURE

Council of Governors

Meeting in Public on Thursday, 17 July 2025

Agenda Item	2.1	
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 Council of Governors on strategic and operational activity across the Trust and the sector.

Action required by Council of Governors

The Council 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

Council of Governors, 17 July 2025

1.0 Purpose of paper

1.1 This report provides the Council of Governors with an update from the Group Chief Executive Officer on strategic and operational activity across the Trust and the wider NHS landscape.

2.0 National Context and Updates

NHS 10 Year Plan

2.1 The Government published the NHS 10 Year Plan on 3 July 2025. 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 As expected, the Government has set out the 'three shifts' that 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 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.

There is more information on how the Plan could impact on our strategy later in the agenda for this meeting.

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.

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 June 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.

3.0 Our Trust and 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. 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 Group 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, 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.

CQC 'well led' inspection at St George's

3.3 As the Council 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 St George's University Hospitals and Epsom and St Helier 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 celebrate the diversity, strength and voices of our LGBTQ+ communities, and reaffirmed our commitment to inclusion and equality. We proudly raised the Pride flag at our sites 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 Council is asked to note the report.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 17 July 2025

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

Executive Summary

The Board agreed a five-year strategy for the Group in 2023. The strategy describes how we intend to achieve our vision for 2028, through:

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

Given the significant changes in the external environment since then, including the launch of the NHS 10 Year Plan, 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.

This report covers:

- The outcome of the Strategy Stocktake;
- Our developing plan for 25/26 including a proposed transformation portfolio; and
- Immediate next steps

Action required by Council of Governors

The Council of Governors is asked to:

1. Note the update

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

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

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University Hospitals and Health Group

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Group Strategy update

Council Of Governors

Ralph Michell
gesh Chief Transformation Officer

Report Authors:

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

17 July 2025

Introduction

The Board agreed a five-year strategy for the Group in 2023. The strategy describes how we intend to achieve our vision for 2028, through:

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

Given the significant changes in the external environment since then, including the launch of the NHS 10 Year Plan, 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, and considered how the Group's strategic positioning, partnerships and plan might need to change. At the June Board, the Board received proposals for an updated transformation portfolio (previously strategic initiatives) aligned to the 10 Year Plan.

The outcome of the stocktake was that whilst we have made progress against some of our strategic ambitions, we have further to go on others. We concluded that our strategic direction remains broadly fit for purpose, but that we should reprioritise our transformation portfolio to better align with the ambitions set out in the 10-Year Plan. We are also working closely with South West London Integrated Care Board as it develops the wider strategy for the region, ensuring alignment and a coordinated approach across the system.

Council of Governors is asked to note the update

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Changing environment for gesh

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

Since the 2024 general election, major structural and policy changes have reshaped the NHS. The NHS 10-Year Plan, published on 3 July, sets out a long-term vision for transforming the delivery of health and care. The plan is centred around three major shifts: a greater focus on prevention, increased use of digital technologies, and moving more services into community settings rather than hospitals. These shifts are underpinned by changes to the operating and funding model. This includes:

- Reintroduction of earned autonomy for Foundation Trusts, with restored freedoms (e.g., capital-raising, surplus reinvestment) starting this year;
- By 2035, all NHS providers are expected to become FTs with reformed governance and population health focus;
- From 2026/27, FTs will receive 3-year revenue and 4-year capital settlements;
- FTs must achieve 2% year-on-year productivity gains over the next 3 years. Surplus generation by 2029–30 is expected;
- Transitioning from block contracts to outcome-based tariff, with bonuses and withheld payments for quality

The NHS 10-Year Plan was published on the same day the Board met. The Board will be reconvening shortly to consider the Plan in more detail and reflect on its implications for our strategy and delivery.

At the same time, our financial position remains 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.

Finally, over the next several months, SWL will embark on a system-wideprocess 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'.

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Stocktake summary

While we have made some progress on our goals, there is still further to go.

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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.

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University Hospitals and Health Group

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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University Hospitals and Health Group

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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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University Hospitals and Health Group

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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. Progress is being reported to the People Committee Common by the group Chief People Officer. This reporting is expected to happen at least three times a year.
Digital	Work has commenced, led by the Chief Transformation Officer and interim Chief Digital Information Officer. Aiming for board development session review in October and then approval in Autumn 2025.
Environmental sustainability / 'Green Plan'	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 on the Group Estates Strategy has been delayed to 2026/27 due to resource constraints.

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Strategic Initiatives Update

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Initiative / Programme	Update
Building Your Future Hospitals (BYFH)	• All major risks have materialised and as of 1 April 2025, the programme team and external advisors stood down. Cost impairment confirmed via FIC and auditors. • Ongoing efforts are focused on progressing SECH enablers, such as the Epsom multi-storey car park project which is now progressing after Board approval on 1 May. • Active engagement in SWL's development of a new ten-year plan will be critical to shaping future strategy.
Collaboration across GESH	• Structural integration of corporate services is now complete for corporate affairs, communications, Deputy CEO office, corporate nursing and corporate medicine. The senior leadership of the HR department has now been integrated, with integration of the rest of the department underway. Integration of the estates & facilities department has begun. • Similarly, the design for initial phase 1 integration of digital services have been approved and in progress. Integration of the finance department is expected to conclude in 25/26. • There has been positive progress in mobilising Clinical Strategy Standards Groups (CSSGs) focused on delivering collaboration across clinical services, including in surgery, anaesthetics, renal, paediatrics, and pharmacy. • Corporate teams are taking action to enable integration/collaboration across the Group, including aligning policies and reviewing opportunities for integrating our corporate digital software suite.
Collaboration across Southwest London hospitals (Acute Provider Collaborative)	• All trusts have now agreed a restart of the PACS programme. Work is now underway with Optum to agree future programme including gateways. • SWLEOC 25/26 business plan presented at the June APC collaborative board including a review of 24/25 performance and an outline of support required from partners in the upcoming year to maximise productivity. • Ongoing work on a range of collaborative projects in elective care (e.g. launch of SWL ENT single point of referral in April and development of clinical questionnaires via the patient portal through clinical networks), including to procure a joint ambient AI solution.
Collaboration with Local Partners (Place)	• All three workstreams are progressing well and the shift toward provider-led care creates a key leadership opportunity for gesh, especially in Neighbourhood Health. • Wandsworth Provider Alliance memorandum of understanding has been signed by all partners and is now embedding; Merton Alliance is undertaking organisational development activities to formalise its structure and approach. • Communities of Practice for frailty and length of stay have been established; priorities, key performance indicators and delivery plans are being developed to support site and Group objectives. • Focused work underway to support delivery of Urgent Community Response, Virtual Wards, integrated neighbourhood multidisciplinary teams, and length of stay reduction across the Group.

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

Strategic Initiatives Update

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Initiative / Programme	Update
Strengthening our Specialist Services	• System-led commissioning of specialised services commenced on 1 April 2025, gesh working closely with ICBs and SLOSS to manage the transition and mitigate risks. • Financial review identified challenges in children's services and prioritised a strategy review for neurosciences that took place in June. • Delivery plans progressing, including a neurosurgery leadership group, major trauma roadmap, and children's services tertiary options appraisal development • Active contribution to the SLOSS sustainability review to inform strategies for sub-scale services. • Governance arrangements and risk oversight under review, aligned to the CARE strategy stock take.
High Performing Teams & Leaders	• Engaged with Deputy chief nurse to launch High Performing Wards (HPW) programme. • Cohort 3 in SGH Leading improvement & cohort 7 ESTH Improvement practitioner programmes complete, joint celebration event held 25th June. • Communication plan underway to support to assist in engagement & awareness of HPT. • Co-designing our long-term 5-year capability development plan for gesh has begun. • In response to our strategy stock-take, governance arrangements are being refreshed, and a new HPT oversight group is being established.
Culture, diversity and inclusion	• The Group Violence Prevention and Reduction Policy is in final draft, progressing to the Policy Review Group (PRG) for approval. • Police liaison has been established across gesh, with regular meetings now in place to support this collaboration. • High Impact EDI Action Plan has been approved by Board – moving into implementation phase • Engagement due to take place to define gesh values and behaviours (Q1 25 onwards)
Shared electronic patient records across gesh	• New EPR went live on 9 May – with intensive work now underway to ensure stabilisation, management of emergent issues • The BAU model for Digital, IT, BI, Training, and Operations is to be agreed and the benefits workstream is also being reviewed and refreshed to support long-term strategic planning. • With limited time to set up a full BAU structure by the end of May and given the risks of exiting the final gateway, a 12-week interim setup was put in place.
Transforming Outpatients	• Programme progressing well across four focus areas, with strong engagement at both site and Group level. • Ongoing collaboration with the SWL APC to draft a gesh-led business case and specifications for ambient voice technology; procurement and market appraisal activities underway. Deployment expected to reduce admin workload and deliver financial benefits. • Automation of outpatient coding live in two SG specialties. Further rollout to other specialties planned following launch of EPR at ESTH. Business case is currently being drafted. • SGUH recognised by NHSE as exemplar for PIFU use; digital clinical questionnaires live in Neurology Headache and Urology; pilots of appointment self-management underway. Framework developed for alignment with ESTH rollout; inclusive communications campaign launched, including well-attended portal roadshows. • Ongoing engagement to facilitate site integration and a focus on Follow Up reduction.

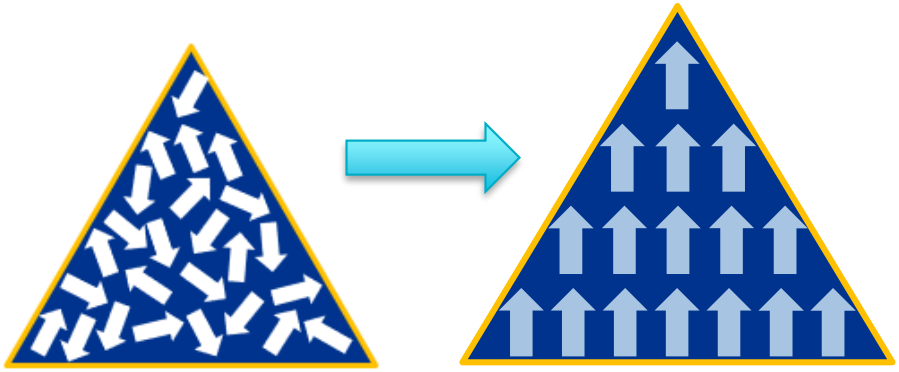
2025/26 – a year of transition

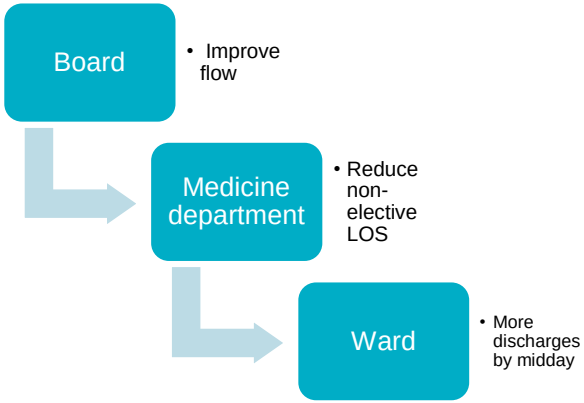
Given that the external environment continues to change rapidly (with the NHS ten year plan and South West London plan being developed), and the Board's desire to develop its strategic approach with partners rather than unilaterally, it is proposed that we treat 2025/26 as a year of transition:

- 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**.

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 nine 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. Following the publication of the NHS 10-Year Plan, we expect to develop a medium-term delivery plan to translate its ambitions into reality. We are using our existing transformation portfolio as a foundation and are now building it out in more detail to align with the priorities set out in the Plan.

As well as alignment to the NHS 10 Year Plan, 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

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

Recommendation

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St George's Council of Governors is asked to:

- Note the update

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St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 17 July 2025

Agenda Item	3.1	
Report Title	**SGUH Operational Performance**	
Executive Lead(s)	Kate Slemeck, Managing Director - SGUH	
Report Author(s)	Ed Nkrumah, Group Director of Performance & PMO	
Previously considered by	Finance & Performance Committee Quality Committee	
Purpose	**For Noting**	

Executive Summary

This report provides an overview of key operational performance measures and improvement actions at St George's Hospitals (SGUH), based on the latest available data. It highlights both the successes achieved during the month and the challenges affecting performance, which are listed below and summarised in the executive summaries.

The metrics and targets covered in this report are aligned with gesh strategic priorities relating to CARE, and with national priorities outlined in the following documents:

- NHS Priorities and Operational Planning Guidance
- NHS System Oversight Framework
- NHS Constitution and National Standard Contract

Data is presented using statistical process control, with benchmarking information included where available. The data quality status of each metric is also noted in the report.

The format and content of this report will continue to evolve in 2025/26 to reflect the Trusts' annual plans and any new guidance — such as the Performance Assessment Framework, which replaces the NHS System Oversight Framework.

Action required by Council of Governors

The Council of Governors is asked to:

1. Note the report.

Appendices

Appendix No.	Appendix Name
Appendix 1	N/A

St George's University Hospitals
NHS Foundation Trust

Implications

Group Strategic Objectives

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

Risks

Regulated activities

CQC Theme

☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

Environmental sustainability implications

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

SGUH Operational Performance Report

May 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 10 Jul 2025 | Contact: gesh.performance@stgeorges.nhs.uk

Executive Summary
Operational Performance

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.

Operational Performance
Overview Dashboard

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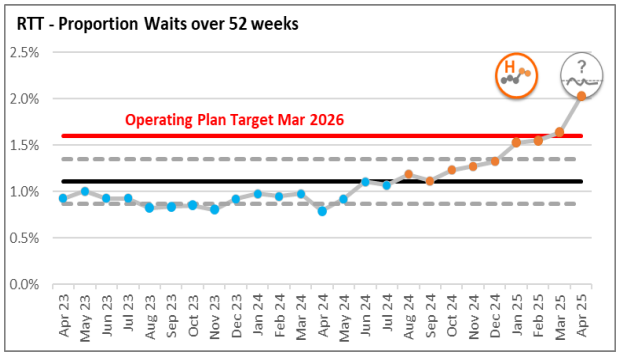
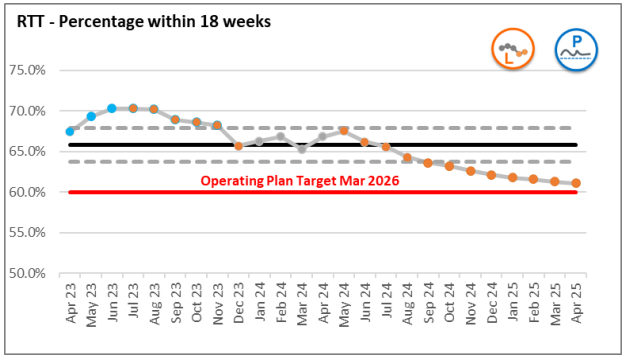
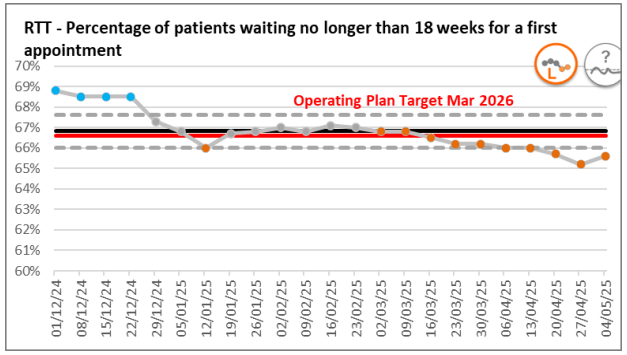
	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
RTT - Proportion Waits over 52 weeks	Apr 25	1.64%	2.03%	1.60%			2nd Quartile
RTT - Percentage within 18 weeks	Apr 25	61.3%	61.1%	60.0%			2nd Quartile
RTT - Percentage of patients waiting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

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)



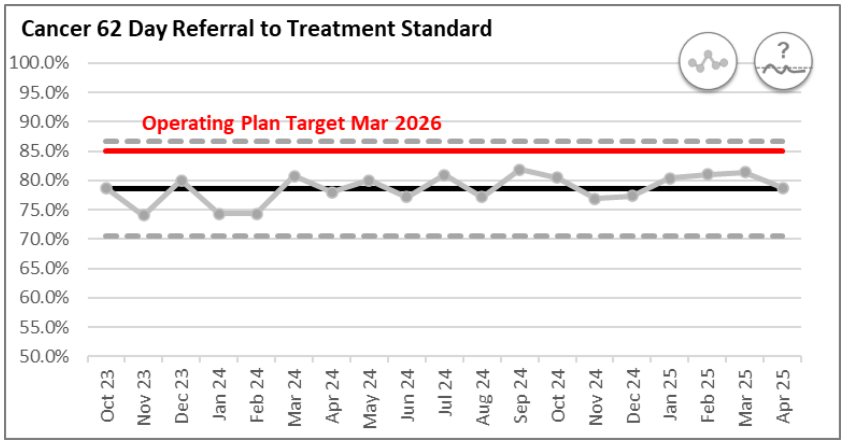




Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH % waits over 52 weeks – increasing trend % within 18 weeks – decreasing trend % wait for first attendance – below plan	At the end of April 2025; • Proportion of 52 week 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 | 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

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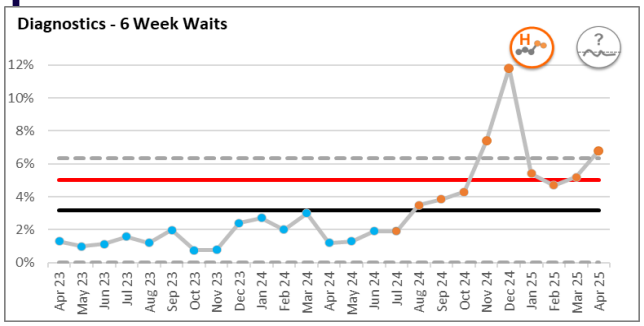
Operational Performance

Exception Report | SGUH Diagnostic Performance

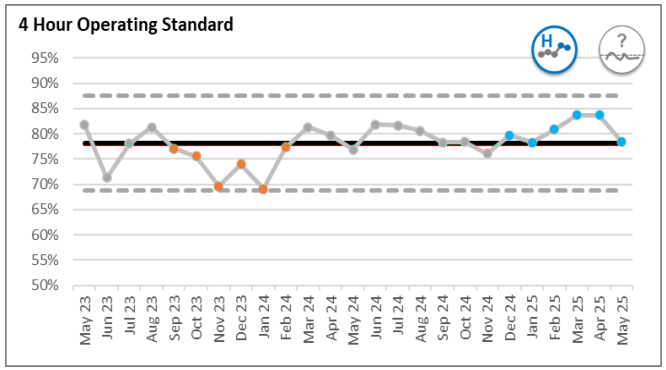


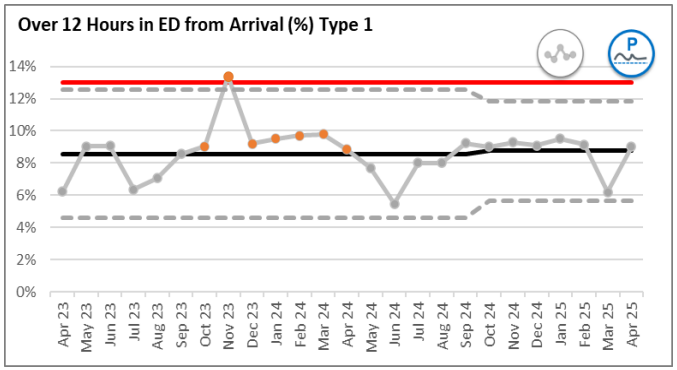
Modality	6Wk Breaches	6Wk Performance
Gastroscopy	282	43.7%
Cardiology - echocardiography	147	10.0%
Colonoscopy	134	40.0%
Flexi Sigmoidoscopy	70	47.0%
Computed Tomography	66	8.7%
Non-obstetric ultrasound	19	0.4%
Cystoscopy	12	20.7%
Urodynamics - pressures & flows	10	52.6%
Magnetic Resonance Imaging	9	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%

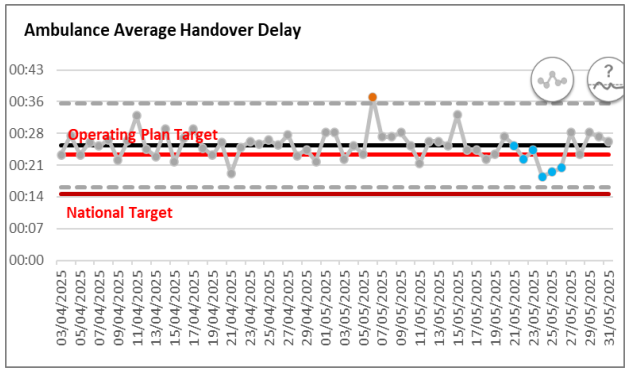
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH	Increase in number of patients waiting for more than 6 weeks for a diagnostic test reporting 6.8% in April 2025 **Endoscopy** **Increase in demand** • Staffing constraints 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 | 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

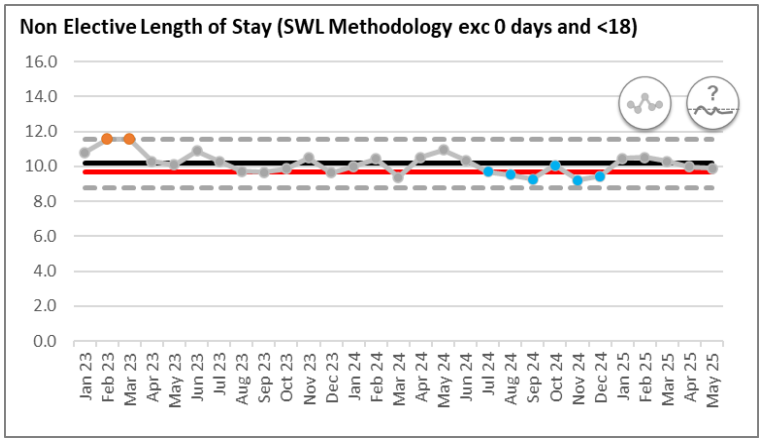
Operational Productivity

Overview Dashboard

	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	National Benchmark
Implied Productivity Growth	Jan 25	3.6%	3.6%	-	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
Theatre Utilisation (Capped)	May 25	81.9%	83.1%	85.0%			Top Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Feb 25	79.1%	80.6%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	May 25	1.9%	2.0%	5.0%			Lowest Quartile
Outpatients Missed Appointments (DNA Rate)	May 25	9.5%	10.1%	8.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	May 25	51.8%	52.2%	49.0%			2nd Quartile

Operational Productivity

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

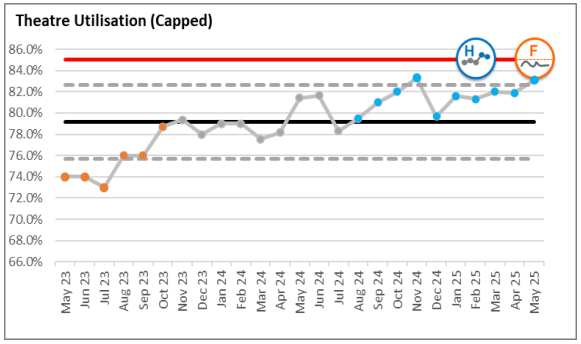


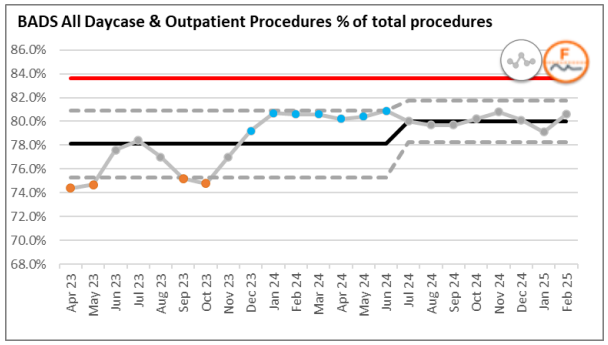
Metric	Reporting Month	Productivity Opportunity vs Target
NEL Length of Stay.	May-25	TBC

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





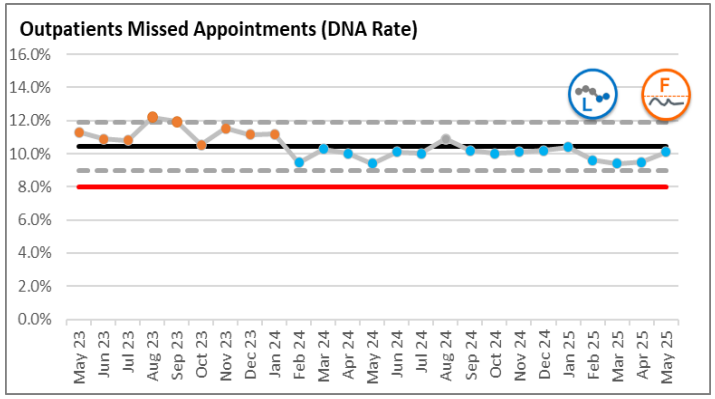
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	May-25	78 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Feb-25	370 cases opportunity to move to OP (3 month period)

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

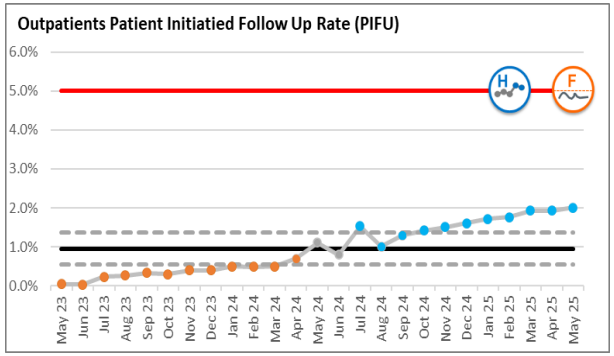
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

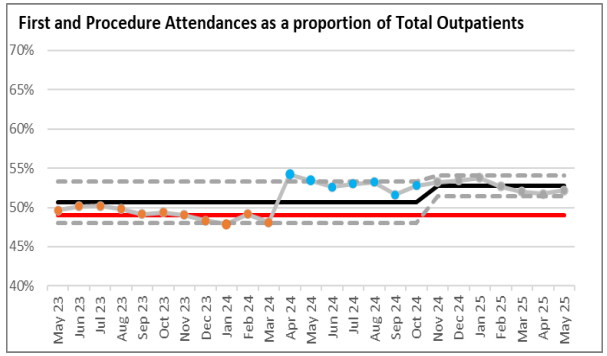
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality

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

gesh

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

Appendices

13

Statistical Process Control (SPC)

Interpreting Charts and Icons

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

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

Metric Technical Definitions and Data Sources

Metric	Definition	Strategy Drivers	Data Source
Cancer 28 Day Faster Diagnosis Standard	The proportion of patients that received a diagnosis (or confirmation of no cancer) within 28 days of referral received date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 31 Day Decision to Treat Standard	The proportion of patients beginning their treatment within 31 days of deciding to treat their cancer. Applies to anyone who has been diagnosed with cancer, including people who have cancer which has returned.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Cancer 62 Day Standard	The proportion of patients beginning cancer treatment that do so within 62 days of referral received date. This applies to by a GP for suspected cancer, following an abnormal cancer screening result, or by a consultant who suspects cancer following other investigations (also known as 'upgrades')	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Referral to Treatment Waiting Times	Monitors the waiting time between when the hospital or service receives your referral letter, or when you book your first appointment through the NHS e-Referral Service for a routine or non-urgent consultant led referral to treatment date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Diagnostic Waits > 6 Weeks	Percentage of patients waiting for more than 6 weeks (42 days) for one of the 15 diagnostic tests from referral / request date.	NHS Oversight Framework, Constitution, and Priorities & Operational Planning Guidance	NHS England
Venous thromboembolism VTE Risk Assessment	Percentage of patients aged 16 and over admitted in the month who have been risk assessed for VTE on admission to hospital using the criteria in a National VTE Risk Assessment Tool.	NHS Standard Contract & Constitutional Standard	Local Data
Capped Theatre Utilisation Rate	The capped utilisation of an individual theatre list is calculated by taking the total needle to skin time of all patients within the planned session time and dividing it by the session planned time	NHS Priorities & Operational Planning Guidance	Model Hospital
Non Elective Length of Stay	Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).		
PIFU Rate	Numerator: The number of episodes moved or discharged to a Patient Initiated Follow Up (PIFU) pathway. Denominator: Total outpatient activity	NHS Priorities & Operational Planning Guidance	Model Hospital
DNA Rates	Numerator: Outpatient missed outpatient appointments (DNAs) Denominator: Total outpatient appointments	Group and System Priority	Model Hospital
Advice and Guidance Rates	Utilisation of Specialised Advice. It is calculated based on the number of 'Processed Specialist Advice Requests' and is presented as a rate per Outpatient First Attendances.	Group, System and National Priority	NHS England Model Hospital
Never Events	Never Events are serious incidents that are entirely preventable	National Framework for Reporting and Learning from Serious Incidents	Local Data
Patient Safety Incidents Investigated	Any unintended or unexpected incident which could have, or did, lead to harm for one or more patient's receiving healthcare	National Framework for Reporting and Learning from Serious Incidents	Local Data
Falls	Number of unexpected events in which a person comes to the ground or other lower level with or without loss of consciousness	gesh Priority - Fundamentals of Care	Local Data
Pressure Ulcers	Number of patients with pressure ulcer (Category/Stage 3 & 4) in the Trust over a specific period of time.	gash Priority - Fundamentals of Care/ National Patient Safety Incidents	Local Data
SHMI	Rolling 12 months ratio between the actual number of patients who die following hospitalisation at a trust and the number that would be expected to die on the basis of average England figures, given the characteristics of the patients treated there.	NHS Oversight Framework	NHS Digital
FFT scores	Proportion of patients surveyed that state that the service they received was 'Very Good' or 'Good'.	NHS – National Priority	NHS Digital

Glossary of Terms

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

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

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

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

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

Council of Governors

Meeting on Thursday, 17 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	Group Board	3 July 20205
	Quality Committee-in-Common	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-Common (QCiC) 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 the Council of Governors

The Council is asked to:

a. Receive for update the St George's Integrated Maternity Improvement Plan.
b. Note the strengthened governance arrangements in place to monitor progress and formally sign off completed actions through established divisional and Group quality structures.
c. Receive for update the GESH Maternity Services Leadership Proposal, including the introduction of the Group Chief Midwifery Officer role, and note the strategic intent to strengthen collaborative leadership, alignment across sites, and improved visibility of maternity governance at Group level.

Committee Assurance

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

Appendices

Appendix No.	Appendix Name
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

Council of Governors, 17 July 2025

1.0 Purpose of paper

1.1 This paper provides 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

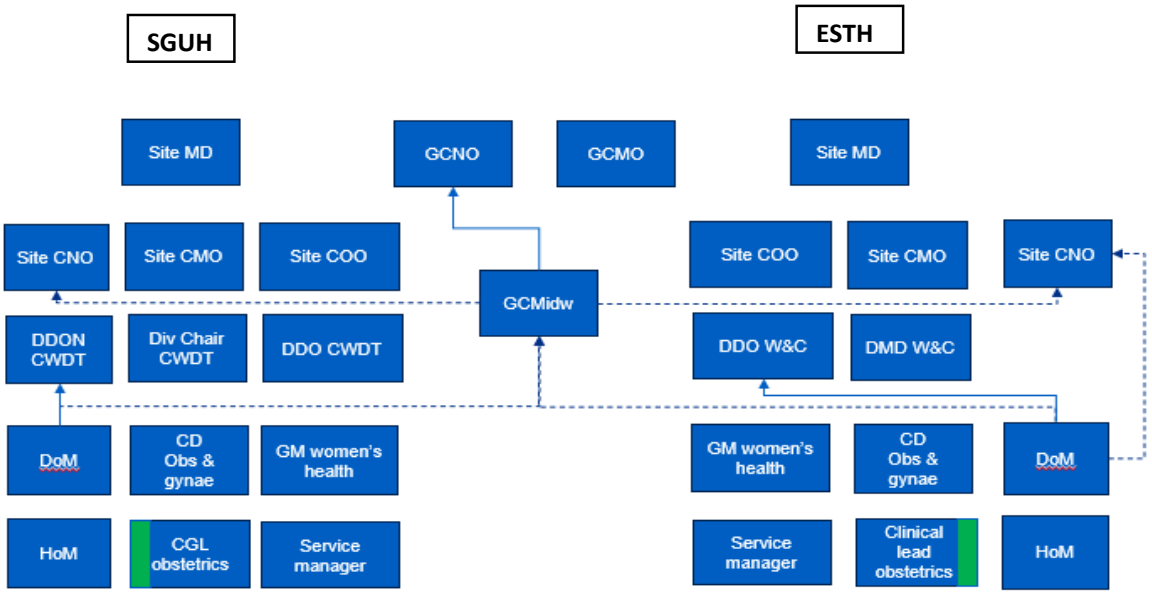
Informed by these findings and recognising that progress against the maternity improvement programme has not met expectations, the Executive team has committed to strengthening joint working arrangements across the Group. These changes are designed to enhance governance, improve leadership accountability, 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 Council of Governors is asked to:

a. Receive for update the St George's Integrated Maternity Improvement Plan.
b. Note the strengthened governance arrangements in place to monitor progress and formally sign off completed actions through established divisional and Group quality structures.
c. Receive for update the GESH Maternity Services Leadership Proposal, including the introduction of the Group Chief Midwifery Officer role, and note the strategic intent to strengthen collaborative leadership, alignment across sites, and improved visibility of maternity governance at Group level.

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Appendix 1

Integrated Maternity Improvement Plan - SGUH

Council of Governors

17 July 2025

Integrated Maternity Improvement Plan

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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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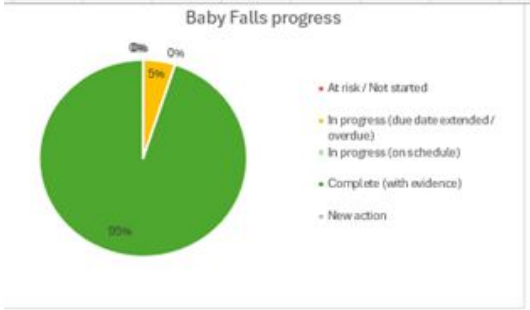
Progress summary against actions

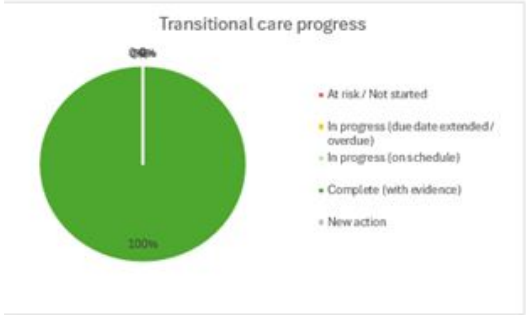
Integrated plan - Action Areas	Number closed	% Closed	Number open	% Open
Baby Falls	19	95%	1	5%
Transitional Care	14	100%	0	0%
SA3 Avoidable term admissions	8	89%	1	11%
MBRRACE 2020	9	100%	0	0%
MBRRACE 2021	29	97%	1	3%
Early notification scheme	5	71%	2	29%
MIS Year 6 actions	3	75%	1	25%
MIS Year 7 Actions	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%

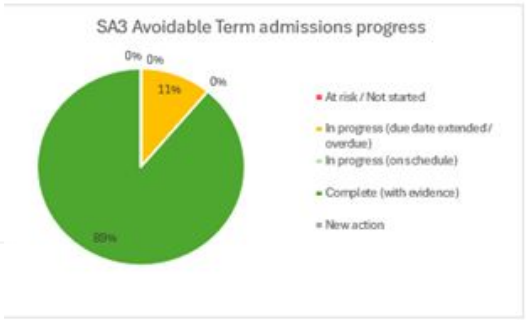
This is a new action, updates will be provided during the MIS year

6

Progress charts







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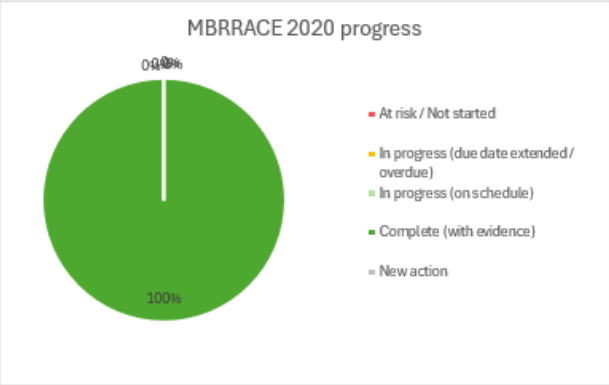
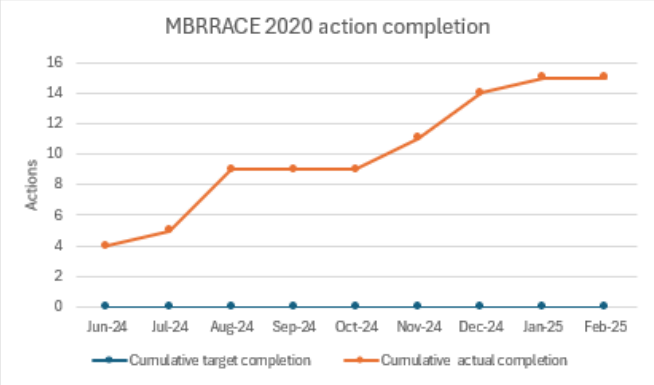
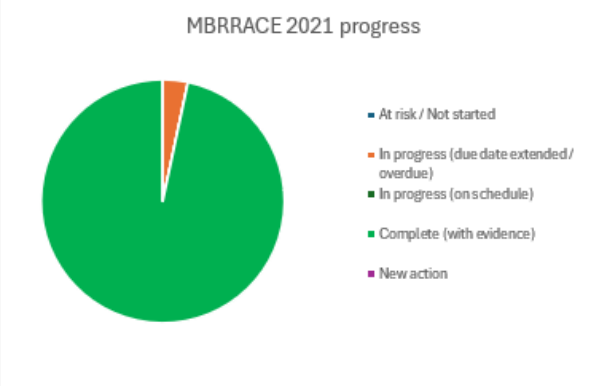
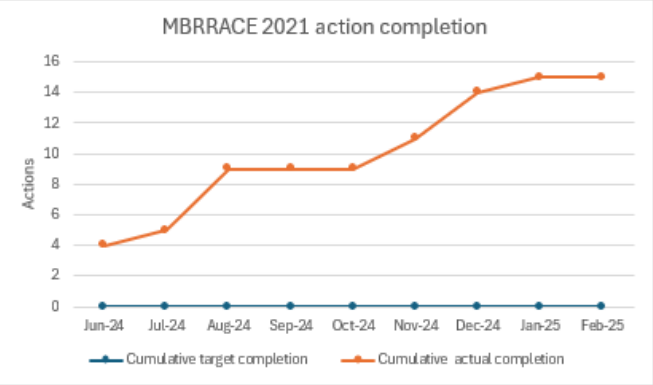
Progress charts









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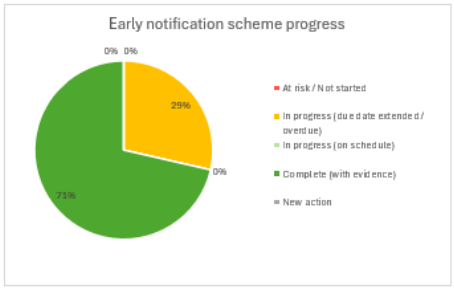
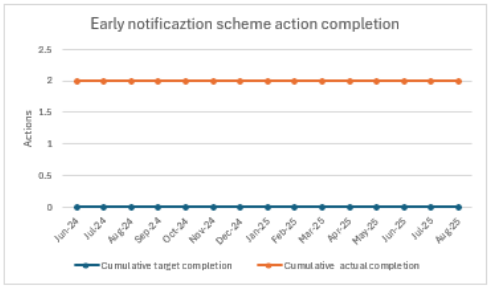
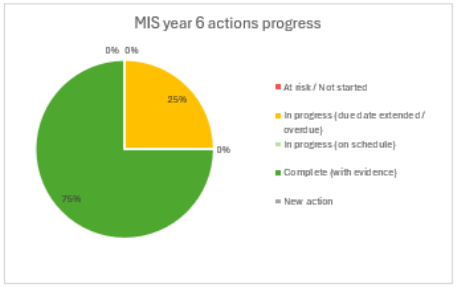
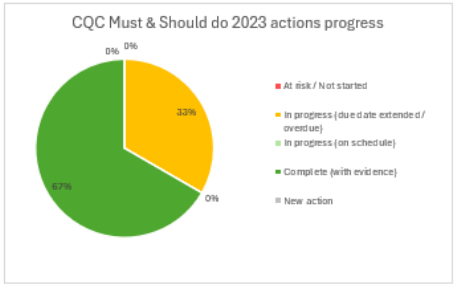
Progress charts

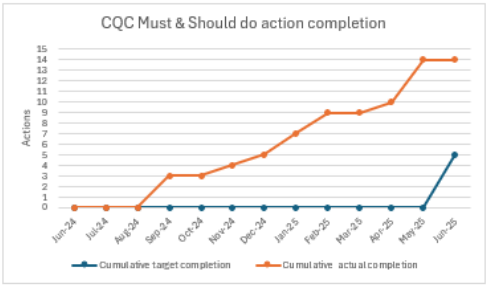




missing action completion dates







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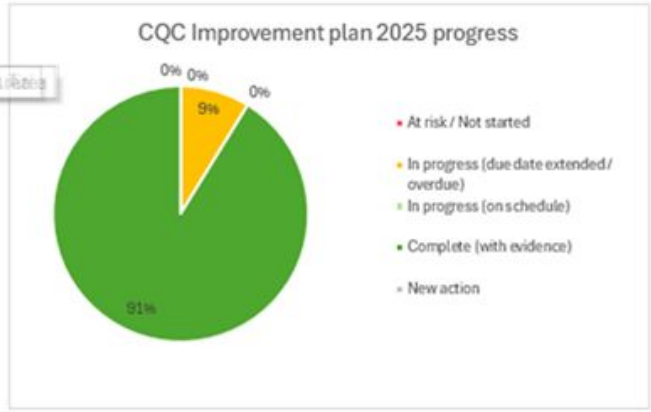

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Risks and Mitigations

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:

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

Appendix 2

Maternity Leadership- gesh

Council of Governors
17 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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Maternity Leadership: Structure
www.stgeorges.nhs.uk

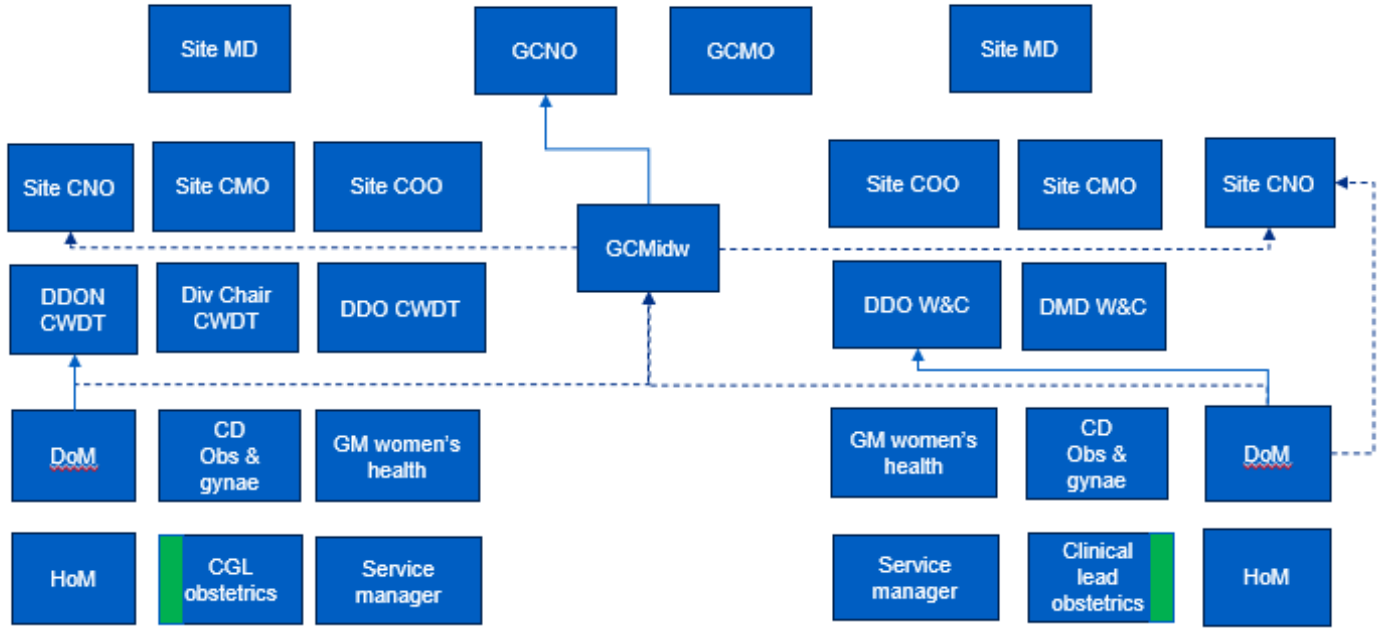
The Agreed Leadership Structure

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
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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.

Council of Governors

Meeting on Thursday, 17 July 2025

Agenda Item	4.1	
Report Title	**Finance Update**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Andrew Grimshaw, GCFO	
Previously considered by	Group Board	Click or tap to enter a date.
Purpose	**For Noting**	

Executive Summary

This paper updates the Council of Governors on the key issues discussed at the Trust Board on 3rd July

- Month 2 Financial position and forecast. The trust is currently on plan but needs to keep focused on need to provide assurance on delivery of the year end forecast. The Finance Committee has asked for further assurance on the forecast at its next meeting. The Board needs to be sighted on this issue.
- CIP delivery. While good progress is being made on developing and delivery CIPs we do not have assurance that the full value of plans can be delivered. The Finance Committee asked for assurance on how plans could be accelerated.
- Cash. Current cash forecast, based on a range of scenarios for CIP delivery look robust. However, material risks exist and if either trust were to move away from plan then cash would come under material stress very quickly. Especially if Q3 and Q4 Deficit Support Funding was withdrawn. It was reported at the Finance Committee NHSE are rejecting requests that are being made by other trusts for cash support.
- NHSE have indicated they will be launching a rapid review of 25/26 and then building medium term sustainability plans off this. Detailed information/guidance has yet to be received on this.

Action required by Choose an item.

The Council is asked to note this paper

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

Appendices	
Appendix No.	**Appendix Name**
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

Failure to deliver the 25/26 financial plan could result in regulatory intervention 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

Delivering financial balance is a statutory duty for NHS trusts.

Legal and / or Regulatory implications

[…]

Equality, diversity and inclusion implications

[…]

Environmental sustainability implications

[…]

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Council of Governors
17th July 2025
2025/26 Financial Performance & Assurance

GCFO & SGH Site CFO

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GCFO update (Private Board)

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- Month 2 financial position
  - On plan at month 2. Some support utilised at SGH to support this.
  - CIP delivery continues to improve, but the scale of the overall requirement remains very challenging.
  - The Finance Committee noted progress but sought assurance at future meetings on how the trust would remain on plan.
- I&E Forecast to year end
  - While we are making progress, the scale of the challenge continues to increase as the phasing of CIPs increases.
  - It was noted NHSE are increasing scrutiny on overall delivery of the plan.
  - The Finance Committee asked for assurance at the next meeting as to how the tension between delivering plan in month together with assurance on the forecast to year end.
- CIP delivery and forecast
  - Progress can be seen on the Tier2 projects, but the Finance Committee noted greater assurance is required on delivery.
  - The Finance Committee asked for assurance on how the identification and delivery of CIPs could be accelerated.
- Cash
  - Current cash forecast, based on a range of scenarios for CIP delivery look robust.
  - However, material risks exist and if the trust were to move away from plan then cash would come under material stress very quickly. Especially if Q3 and Q4 Deficit Support Funding was withdrawn.
  - It was reported at the Finance Committee NHSE are rejecting requests that are being made by other trusts for cash support.
- NHSE Planning review
  - NHSE have indicated they will be launching a rapid review of 25/26 and then building medium term sustainability plans off this.
  - Detailed information has yet to be received on this.

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Month 02 Financial Position

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Introduction from GCFO

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Key messages

- Month 2: **SGH hasreported 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. **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 a favourable impact of delayed TUPE from ESTH.
- The CoG 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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Group M02 position

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	Overview	What does this tell us?	What actions/mitigations are required?
Summary I&E	• **In May the Trust reported 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	• 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. • 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	• 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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SGH - Summary Reported Position

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

Plan £'000s	Forecast £'000s	Variance £'000s
1,274,342	1,274,342	0
-784,425	-784,425	0
-469,203	-469,203	0
-20,714	-20,714	0
0	**0**	**0**

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

Plan £'000s	Forecast £'000s	Variance £'000s
74,300	74,300	0
21,000	21,000	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
Substantive		9,922	10,026	-104
Bank		787	749	38
Agency		109	88	21
Total		**10,818**	**10,863**	**-45**

Closing plan WTE
9,691
739
58
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

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Key Risks: Income and Expenditure

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No	Risk £m	SGH	Mitigation
1	**Efficiency delivery** • The Trust currently has a 7% cost out efficiency assumption compared to delivery of c. 2% recurrent cost out 2425. • The % of fully developed and plans in progress is below 20% at both Trusts. There is a significant risk on delivery with the value of opportunity and the types of schemes identified – bed closures, significant WTE reductions (547 WTE at SGH)	0-50	Weekly Site Recovery Boards to progress CIP. Group Financial Recovery Board. Groupwide schemes and actions.
2	**Cost pressures not funded in plan** • Identified cost pressures have been reviewed and removed from the plan with actions identified to mitigate – further detail is in the appendices. In 2425 operational pressures were the key pressure to the risk in the financial position.	0-7	Review run rates within the position and review and mitigated adverse performance.
3	**Performance and finance** • The current assumption is that the delivery of the CIP challenge will not impact operational performance. As CIP are worked through from opportunity to fully developed there is a risk that there is some impact on operational performance. • The financial planning guidance is unclear at this stage with regard the correlation between performance and income earned. The plan currently assumes that there is no clawback of income in the plan if performance deteriorates.	0-5	Update assumptions with new guidance. Review CIP schemes for impact on operational performance and take to QIA panels for approval.
4	**Inflation** • Inflation has been set at national assumptions with no local pressures above national assumptions.	0-7	Monitor inflation pressures within contractual positions and contracts and present any adverse to assumptions.
5	**Redundancy costs** • The plan currently assumes no redundancy costs. With the WTE reduction plan there is a risk that redundancy costs will become a pressure.	0-3	Review risks to redundancy and work with SWL ICB and NHSE on process.
6	**Income** • Key Income risk relates to activity and ERF payments, Over-performance is on block and underperformance could be clawed back to create a risk even if the total activity is in line with expectations. Additional smaller alignment issue are also being worked through with associate ICB.	0-2	Continue to engage in dialogue with associate commissioners
7	**Specialised Commissioning** • Devolution of Specialised commission means that ICBs assume responsibility for delegated acute specialised services, with allocation methodologies not fully clear. ICBs taking over commissioning of specialised services face financial and operational challenges in managing high-cost, low-volume services.	0-5	Continue to engage in dialogue with associate commissioners on SpecComm risks and use NHSE support to ensure funding is passed through
	TOTAL	0-80	

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CIP delivery and forecast

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SGH M2 CIP delivery

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- M2 CIP delivered in line with plan including £2.0m NR brought forward.
- WTE reduction in M2 in at 75 WTE reduction, 30 adverse to plan.

Division	Annual	In-month M2			YTD M2		
	Target	Plan	Actual	Variance	Plan	Actual	Variance
CWDT	22,274	886	437	(449)	1,636	494	(1,141)
MEDCARD	20,448	813	469	(345)	1,502	718	(783)
SNTC	18,070	719	385	(333)	1,327	462	(865)
CLINICAL OPERATIONS	2,735	109	142	34	201	285	84
ESTATES	4,011	160	265	106	295	466	171
CORP	9,462	376	4	(373)	695	70	(624)
CENTRAL	18,300	187	1,027	840	345	1,503	1,158
Subtotal	95,300	3,250	2,730	(520)	6,000	3,999	(2,001)
Bring forward NR CIP		0	520	520		2,001	2,001
Total	95,300	3,250	3,250	0	6,000	6,000	0

NR/R	YTD Plan £'000	YTD Actual £'000	Variance £'000
Non-recurrent	1,175	4,109	2,934
Recurrent	4,823	1,891	(2,932)
Grand Total	**5,998**	**6,000**	**2**

PFR Category	YTD Plan £'000	YTD Actual £'000	Variance £'000
Income	359	487	128
Pay	3,675	1,722	(1,953)
Non Pay	1,964	1,790	(174)
SubTotal	**5,998**	**3,999**	**(1,999)**
b/f NR		2,001	2,001
Total	**5,998**	**6,000**	**2**

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Current phasing of CIP delivery SGH 25/26 - Trustwide

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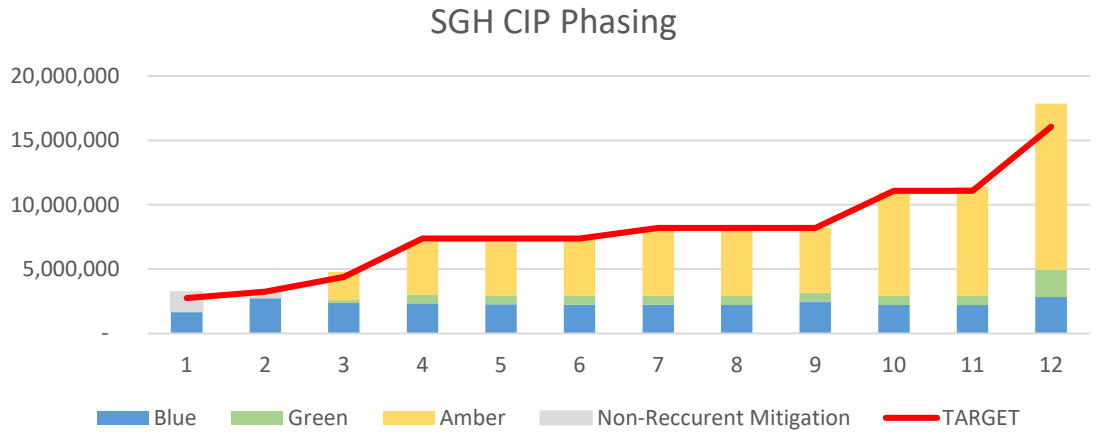
	M01 (£k)	M02 (£k)	M03 (£k)	M04 (£k)	M05 (£k)	M06 (£k)	M07 (£k)	M08 (£k)	M09 (£k)	M10 (£k)	M11 (£k)	M12 (£k)	Total
Fully developed	1,711	2,790	2,347	2,324	2,250	2,243	2,226	2,196	2,418	2,218	2,218	2,824	27,764
Plans in progress	-	-	228	696	695	711	713	713	745	723	739	2,108	8,071
Opportunity	-	-	2,197	4,054	4,143	4,527	5,125	5,050	5,025	7,996	8,436	12,929	59,481
Unidentified	-	-	-	-	-	-	-	-	-	-	-	-	-
Total	**1,711**	**2,790**	**4,772**	**7,075**	**7,087**	**7,481**	**8,063**	**7,958**	**8,187**	**10,936**	**11,393**	**17,861**	**95,300**



- The graph and table show the phasing of the 25/26 CIP plan, actuals and schemes in development and their RAG rating.

Blue =Fully developed
Green = Plans in progress
Amber = Opportunity
Red = Unidentified

Split of Fully Developed by Site

	M01 (£k)	M02 (£k)	M03 (£k)	M04 (£k)	M05 (£k)	M06 (£k)	M07 (£k)	M08 (£k)	M09 (£k)	M10 (£k)	M11 (£k)	M12 (£k)	Total
Fully developed	-	-	-	-	-	-	-	-	-	-	-	-	-
Acute	1,401	2,409	2,001	1,969	1,894	1,888	1,867	1,845	2,067	1,844	1,844	2,461	23,492
Corporate	311	381	346	355	355	355	359	350	350	373	373	362	4,272
Total	**1,711**	**2,790**	**2,347**	**2,324**	**2,250**	**2,243**	**2,226**	**2,196**	**2,418**	**2,218**	**2,218**	**2,824**	**27,764**

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Cashflow

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Introduction

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I&E Forecast	SGH £m
Run rate forecast	(59)
CIP to come	59
Other	-
Year end forecast	**0**
Plan	0
Variance from plan	**--**

Cashflow forecast	SGH £m
Opening balance 1st April 25	90
Current cash balance (M2)	78
Run rate forecast to year end (31st March 26)	(47)
Cash out (on run rate)	January
Cash forecast to 31st Mar 26 inc CIP at 80% cash releasing	26

- NHSE have indicated they will be placing greater emphasis on cash forecasting and expect a higher degree of cash reporting through to trust boards.
- As noted in last months Finance Committee the Provider Financial Return (PFR) has been amended to include greater emphasis on cash, together with early I&E forecasting to provide assurance on delivery. These can be used in combination by NHSE to test forecasts.
- The PFR now includes two elements that we expect NHSE to use to triangulate I&E run rates against cash forecasts.
- I&E run rates. The top table to the left summarises the I&E run rates. NHSE develop a forecast based on reported run rate and ask trusts to define how they will recover the balance back to plan. While simple this is effective in illustrating action that is still required to deliver the I&E plan. For both trusts this is currently broadly consistent with the phasing of CIP delivery.
- Cash forecast. The lower table summarises the run rate cash forecasting currently developed by the trust and used to help inform the reporting in the PFR. It should be noted to date NHSE has only requested trusts provide a cash forecast to month 6. We should expect this to be extended to the full year very shortly.
- The group should expect NHSE to triangulate these two positions to help develop a clearer understanding of how well trusts are delivering their agreed plans. The Finance Department will ensure that reporting on both is developed and used to test reported performance and provide assurance to the Finance Committee and Board..
- At month 2 cash positions are broadly consistent with agreed plans. The trusts reported a steady outflow of cash in the first two months as CIP plans are yet to have a material impact on payments. It should be noted, the step up in CIP delivery required in month 4 (and then again across Q4) means that any failure to ensure plans are in place to deliver those improvements will generate risk to both I&E and cashflow.
- The cash forecasts should be taken as reasonable at this time but requires further work. Steps are being taken over the coming months to improve them.
- It should be noted that the month end cash balance is not necessarily the cash low point in each month. This will be more clearly noted in future reports.
- The next page provides a summary of cash forecasting together with steps being taken to enhance cashflow forecasting and management.

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SGH I&E run rate and cash forecast

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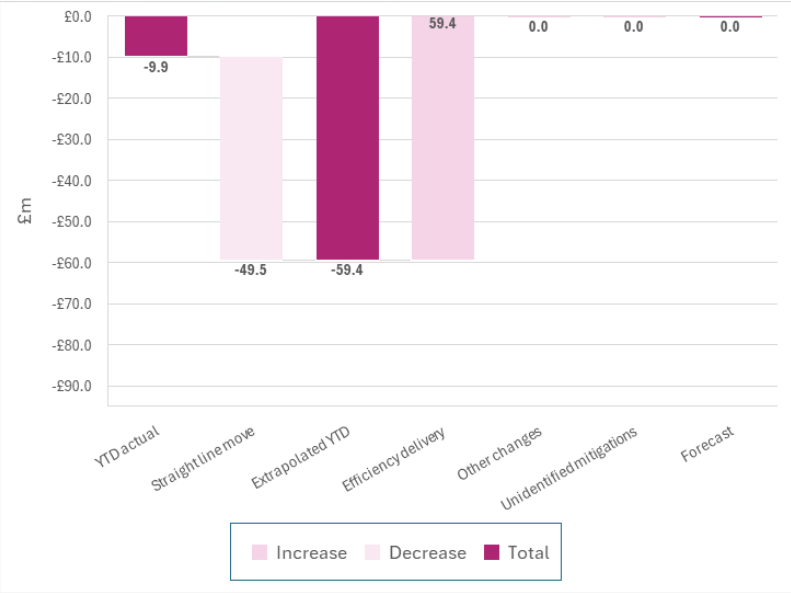

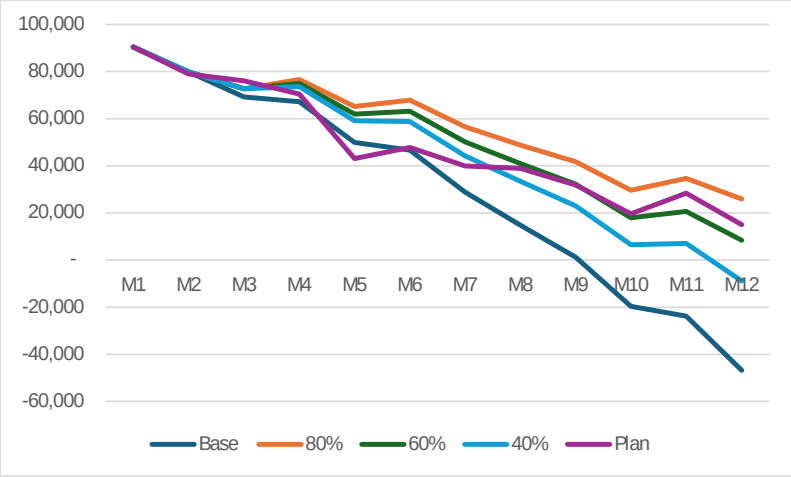

Top graph NHSE monthly I&E run rate forecast.

- This extrapolates the YTD deficit to a straight-line forecast position. For SGH this is £59.4m deficit compared to a planned breakeven.
- The main driver of how the Trust plans to deliver the movement from the £59.4m run rate deficit back to plan is the efficiency phasing in the plan, this phases £59.4m more CIP above the M2 YTD run rate in M3-12. The run rate return assumes this will deliver to meet the Trust plan position.
- The NHSE run rate bridge presents no unidentified mitigations at M2. In this scenario, cash risk would be mitigated in year.

Lower graph Cash flow forecasts (as at M2)

- This shows plan, current unmitigated run-rates and three scenarios based on current receipt and payment run rates. The key difference between the scenarios is expected level of "cash releasing" impact of the CIP programme. This is the key variable in the financial position but is also difficult to forecast at this time based on the current level of progress in the CIP plan.
- The trust has used the 80% CIP cash releasing option to inform the cash report to NHSE (to month 6 only).
- All scenarios show a material outflow of cash early in the year before CIPs begin to mitigate this. The current "cash run rate" position is shown for information to illustrate the impact of no CIPs. Across M1 and M2 SGH has seen a £12m outflow of cash.
- This demonstrates the "cash plan" included in the plan submission made to NHSE was broadly correct, with differences mainly in timing.
- Based on current forecasting SGH should expect to maintain a positive cashflows across 25/26 provided it can remain on plan and secure Deficit Support Funding (£10m per qtr)
- This forecast should be taken as indicative at this stage,.

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Other material risks to the cashflow

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	SGH £m	Comment	Mitigation
CIP delivery	£9-27m	Impact of 10-30% of target proving difficult to deliver.	Continued focus on CIP delivery
Deficit Support Funding	£10-20m	Failure to maintain on plan could see DSF withdrawn for Q3 (at month 5) and Q4 (month 8). For both trusts DSF is £10m per qtr	Ensure CIP delivery and/or limit expenditure to remain on plan.
Capital – CDEL without cash support	tbc	NHSE seem to be allocating capital expenditure limit (CDEL) allowances with no supporting cash. The expectation being cash is provided locally	Seek cash support, limit capital expenditure or manage from within the overall financial environment.
Issues outside of the plan	---	Any material eventuality that is not addressed within agreed plans; Nothing material identified as yet	Maintain focus on any potential issues and seek to mitigate.

- There are several key risks to the current cashflow forecast. The most material items are addressed in the table to the left.
- Continued focus is required on cashflows across 25/26 to ensure both trusts can maintain timely payments.

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NHSE planning refresh

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NHSE 25/26 medium term planning

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- The GCFO attended a national CFO meeting on 19th June. One area of note was the plan by NHSE to restart "medium-term planning" in July.
- This will have a two-stage approach
  - Phase 1 (July-Sept): Develop a robust, detailed and shared understanding of the base year 25/26.
  - Phase 2 (Oct – Dec): Develop 3 year integrated delivery plans that make the NHS more financial sustainable.
- This work is consistent with the publication of the 10 Year Plan and will be a material piece of work which will require considerable engagement on top of existing priorities.
- The following three slides were presented at the national CFO meeting. More detail has not yet been announced. More details will be provided once they are received.
- We should expect this to be a major area of focus.

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Effective medium-term planning will be a critical enabler for delivering our shared ambitions for the NHS

Planning over multiple years creates the opportunity to focus on **longer-term strategic changes** that support population health need, through service transformation, reconfiguration and adoption of new technology

The three-year revenue and four-year capital spending review provides the opportunity to pivot to a **mature, transparent and strategic approach** to medium term planning.

For us to be successful we:

- must get the **foundations of planning right** or we will be building our medium-term plans on sand
- need to develop plans based on a **coherent, consistent set of planning information and assumptions**

Medium term plans will be required for **each statutory body** linked to their specific roles and responsibilities in the context of an effective **system approach to addressing key opportunities and challenges**

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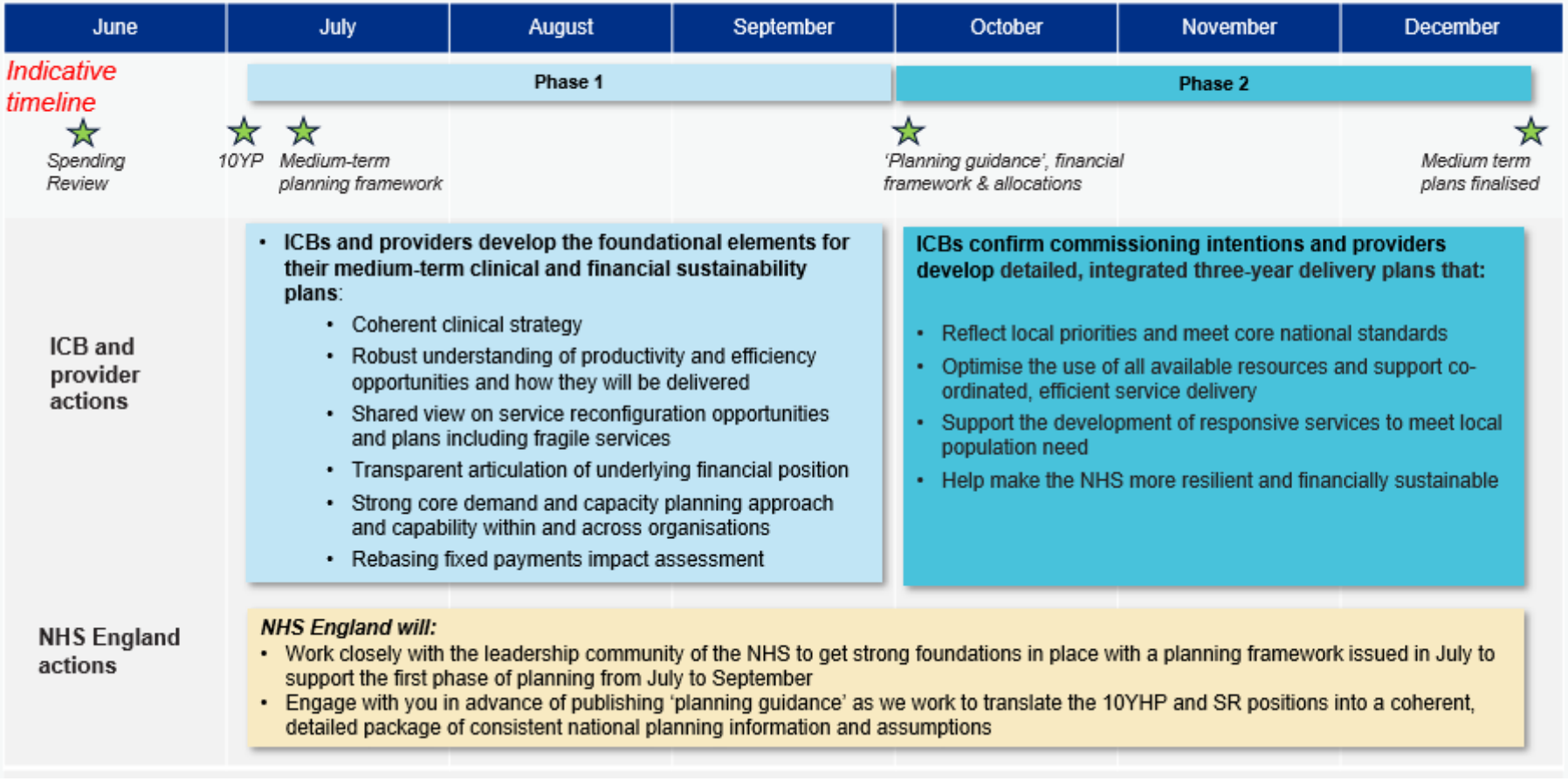
We will start immediately and work with you across through two phases



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Immediate financial aspects of phase 1 for you to urgently consider with your teams

Successful medium-term planning is contingent on a **robust, detailed, shared understanding** of the base year - 2025/26. During phase 1 we will work with you to understand:

- The **2025/26 underlying deficit**
  - Learning from the plan submission we have linked as many fields as possible with other parts of the monthly finance returns
  - We will **collect underlying at M3 for providers and M4 for ICBs**

- Assessment of **price x activity compared to acute block contract values** we will
  - Build on the **national impact assessment** shared early in 2025
  - Ask each provider and commissioner to **agree an assessment of difference** between activity x price and acute block contracts
  - We will **provide guidance and templates** to support a consistent approach

- How we might assess the **reasonableness** of block contract values for **mental health, community and ambulance services**

Council of Governors

Meeting on Thursday, 17 July 2025

Agenda Item	5.1	
Report Title	**SGUH External Audit Findings report**	
Executive Lead(s)	Andrew Grimshaw, Group Chief Finance Officer	
Report Author(s)	Grant Thornton	
Previously considered by	SGUH Audit and Risk Committee SGUH Board	18 June 2025 26 June 2025
Purpose	**For Assurance**	

Executive Summary

This report is the Audit Findings Report (AFR) from Grant Thornton (GT) into the 2024/25 Annual Accounts. The key items to note within the report are

- The financial statements give a true and fair view of the financial position.
- Some control risks noted within the SBS Oracle audit of their own system (page 19 and 20). We have noted these issues and will raise them with SBS. As noted in the report the trust has its own controls in place in these areas that compensate for these issues.
- Adjustments made during the audit are noted on page 31. GT do not consider these to be material.
- In the VFM arrangements the report notes a significant weakness in financial sustainability. This is addressed in detail in the VFM report.
- The audit fee of £300,650 is noted.
- The report makes no new recommendations.

The Trust Board reviewed and approved the accounts at an extraordinary meeting on 26th June to allow submission to NHSE by 30th June as required.

Action required by Council of Governors

The Council of Governors are asked to note the report.

Committee Assurance

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

Appendices	
Appendix No.	**Appendix Name**
Attachment 1	External Audit Report

Implications				
Group Strategic Objectives				
☒ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
Poor communication between the trusts and the auditors impedes the audit process.				
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				
Completion of the external audit could be impeded.				
Equality, diversity and inclusion implications				
Environmental sustainability implications				

Grant Thornton

Audit Findings for St George's University Hospitals NHS Foundation Trust

For the year ended 31 March 2025

June 2025

Grant Thornton

St George's University Hospitals NHS Foundation Trust
Bronte House
St George's Hospital
Blackshaw Road
London
SW17 0QT

Grant Thornton UK LLP
8 Finsbury Circus
London
EC2M 7EA
www.grantthornton.co.uk

18 June 2025

Dear Members of the Audit Committee

Audit Findings for St George's University Hospitals NHS Foundation Trust for the year ended 31 March 2025

This Audit Findings presents the observations arising from the audit that are significant to the responsibility of those charged with governance to oversee the financial reporting process and confirmation of auditor independence, as required by International Standard on Auditing (UK) 260. Its contents have been discussed with management.

As auditor we are responsible for performing the audit, in accordance with International Standards on Auditing (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance. The audit of the financial statements does not relieve management or those charged with governance of their responsibilities for the preparation of the financial statements.

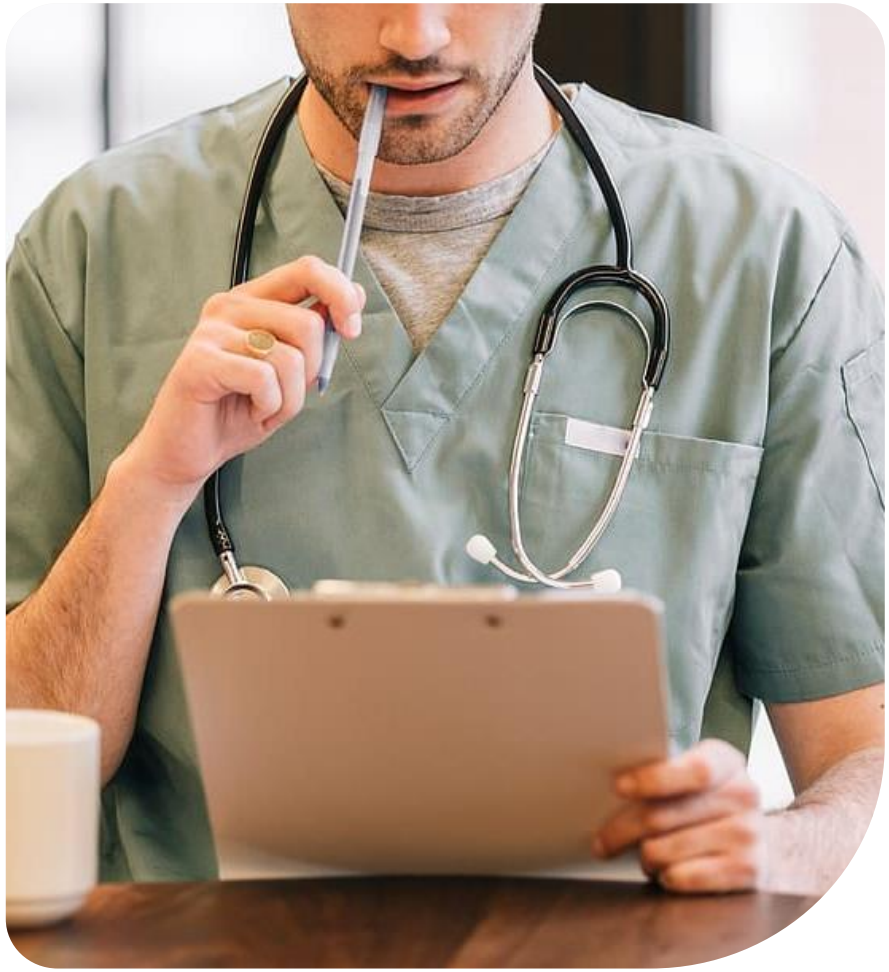
The contents of this report relate only to those matters which came to our attention during the conduct of our normal audit procedures which are designed for the purpose of expressing our opinion on the financial statements. Our audit is not designed to test all internal controls or identify all areas of control weakness. However, where, as part of our testing, we identify control weaknesses, we will report these to you. In consequence, our work cannot be relied upon to disclose all defalcations or other irregularities, or to include all possible improvements in internal control that a more extensive special examination might identify. This report has been prepared solely for your benefit and should not be quoted in whole or in part without our prior written consent. We do not accept any responsibility for any loss occasioned to any third party acting, or refraining from acting on the basis of the content of this report, as this report was not prepared for, nor intended for, any other purpose.

We encourage you to read our transparency report which sets out how the firm complies with the requirements of the Audit Firm Governance Code and the steps we have taken to manage risk, quality and internal control particularly through our Quality Management Approach. The report includes information on the firm's processes and practices for quality control, for ensuring independence and objectivity, for partner remuneration, our governance, our international network arrangements and our core values, amongst other things. This report is available at transparency-report-2023.pdf (grantthornton.co.uk).

We would like to take this opportunity to record our appreciation for the kind assistance provided by the finance team and other staff during our audit.

Paul Cuttle

Director
For Grant Thornton UK LLP



Contents

1 Headlines

Headlines

Summary of the key findings and other matters arising from the statutory audit of St George's University Hospital NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2025 for those charged with governance.

Financial statements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to report whether, in our opinion:

- The Trust's financial statements give a true and fair view of the financial position of the Trust and of its income and expenditure for the period;
- The Trust's financial statements, have been properly prepared in accordance with the Department of Health and Social Care (DHSC) group accounting manual 2024/25 (GAM); and
- The Trust's parts of the Remuneration Report and Staff Report to be audited, have been properly prepared in accordance with the NHS Foundation Trust Annual Reporting Manual 2024/25 (FT ARM).

We are also required to report whether other information published together with the audited financial statements in the Annual Report, is materially consistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated.

Our work is complete but subject to final internal quality review by Senior member of the Audit team. We have identified adjustment(s) to the financial statements which do not have impact on your reported deficit for the year. We have identified disclosure amendments detailed in in section 6 of this report. We have also raised recommendations for management as a result of our audit work. These are set out in Appendix B. Our follow up of recommendations from the prior year's audit are detailed in Appendix C.

There are no matters of which we are currently aware that would require modification of our audit opinion or material changes to the financial statements, subject to the following matters;

- Final review of certain areas by the Senior Audit team member;
- Receipt of management representation letter – See as an attached item separate to this report; and
- review of the final set of financial statements, including confirming the other information published together with the financial statements remains consistent post all audit adjustments.

We have concluded that the other information to be published with the financial statements, is consistent with our knowledge of your organisation and the financial statements we have audited.

Our anticipated audit report opinion will be unmodified.

Headlines

Summary of the key findings and other matters arising from the statutory audit of St George's University Hospital NHS Foundation Trust ('the Trust') and the preparation of the Trust's financial statements for the year ended 31 March 2025 for those charged with governance.

Value for Money (VFM) arrangements

Under the National Audit Office (NAO) Code of Audit Practice ('the Code'), we are required to consider whether the Trust has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources. Auditors are required to report in detail on the Trust's overall arrangements, and set out our key recommendations on any significant weaknesses in arrangements identified during the audit.

Auditors are required to report their commentary on the Trust's arrangements under the following specified criteria:

- Improving economy, efficiency and effectiveness;
- Financial sustainability; and
- Governance.

As part of planning our audit work, we considered whether there were any risks of significant weakness in the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources. We have identified risks of significant weakness and made key recommendation in relation to the Trust's Financial sustainability.

We have completed our work on Value for Money arrangements and our findings are set out in our Auditor's Annual Report which we will present to those charged with governance at the Audit Committee meeting on 18 June 2025.

Statutory duties

The National Health Service Act 2006 ('the Act') and the National Audit Office Code of Audit Practice also requires us to:

- report to you if we have applied any of the additional powers and duties ascribed to us under the Act; and
- to certify the closure of the audit.

We have not exercised any of our additional statutory powers or duties.

We cannot formally conclude the audit and issue an audit certificate for the Trust for the year ended 31 March 2025 in accordance with the requirements of the National Health Service Act and the National Audit Office Code of Audit Practice, until the National Audit Office has concluded their work in respect of consolidation returns for the year ended 31 March 2025.

We have been informed that NHSE is discussing the impact this could have on laying the accounts. Our present expectation is that revisions will be made to enable the accounts to be laid before Parliament in the instance the NAO have not concluded their work by this point.

2 Our approach to materiality

Our approach to materiality

As communicated in our Audit Plan dated 17 April 2025, we determined materiality at the planning stage as £21,800,000 based on 1.8% of Forecasted gross operating expenditure. On receipt of draft financial statements, we have reconsidered planning materiality based on the 2024/25 figures in the draft financial statements.

Our approach to determining materiality is set out here.

Materiality area	Amount (£)	Qualitative factors considered
Materiality for the financial statements	23,500,000	This is equivalent to approximately 1.8% of the operating expenses for the period ended 31 March 2025. This was revised following the receipt of the draft financial statements, incorporating the updated gross expenditure figure. Note in setting the balance we excluded one of expenditure relating to impairment of £11,581,000
Performance materiality for the financial statements	17,625,000	Performance materiality has been set at 75% of financial statements materiality. This reflects our risk-assessed knowledge of potential for errors occurring. Performance materiality is used for the purposes of assessing the risks of material misstatement and determining the nature, timing, and extent of further audit procedures. This is the amount we set at less than materiality for the financial statements as a whole, to reduce to an appropriately low level the probability that the aggregate of uncorrected and undetected misstatements exceeds materiality for the financial statements as a whole.
Reporting threshold	300,000	This is the reporting threshold for any errors identified as part of our work on the National Audit Office's Whole of Government Accounts (WGA) exercise. Note we have during the audit period received communication that this level could be increased to up to £1 million, given this was the level reported in the Audit plan we have determined to keep it at this level and to consider this new guidance in the subsequent years audit.
Materiality in respect of the auditable elements of the remuneration report (Senior officer pay only)	100,000	Due to the public interest in senior officer remuneration disclosures, we apply specific audit procedures to this work and set a lower materiality level for this area. We design our procedures to detect errors in specific accounts at a lower level of precision which we have determined to be applicable for senior officer remuneration disclosures. We evaluate errors in this disclosure for both quantitative and qualitative factors against this lower level of materiality. We apply heightened auditor focus on the completeness and clarity of disclosures in this area and will request amendments to be made if any errors exceed the threshold we have set or would alter the bandings reported for any individual

3 Overview of significant and other risks identified

Overview of significant and other audit risks identified

The below table summarises the significant and other risks discussed in more detail on the subsequent pages.

Significant risks are defined by ISAs (UK) as an identified risk of material misstatement for which the assessment of inherent risk is close to the upper end of the spectrum due to the degree to which risk factors affect the combination of the likelihood of a misstatement occurring and the magnitude of the potential misstatement if that misstatement occurs. A significant risk can be a significant risk due to error or due to fraud. For the purposes of the ISAs (UK), the auditor is concerned with fraud or suspected fraud that causes a material misstatement in the financial statements. Two types of intentional misstatements are relevant to the auditor – misstatements resulting from fraudulent financial reporting and misstatements resulting from misappropriation of assets. As part of our consideration of risks relating to fraudulent financial reporting, we consider the potential for override of controls or other inappropriate influence over the financial reporting process, such as efforts by management to manage income/expenditure/accruals in order to influence the Trust's year end performance.

Other risks are, in the auditor's judgment, those where the risk of material misstatement is lower than that for a significant risk, but they are nonetheless an area of focus for our audit.

Risk title	Risk level	Change in risk since Audit Plan	Fraud risk	Level of judgement or estimation uncertainty	Findings
Risk 1 – Management override of controls	Significant	↔	✓	Medium	●
Risk 2 – Fraud in revenue recognition (Patient Care Activities)	Significant	↔	✓	Medium	●
Risk 3 – Fraud in revenue recognition (Other operating income)	Significant	↔	✓	Medium	●
Risk 4 – Fraud in expenditure recognition	Significant	↔	✓	Medium	●
Risk 5 – Revaluation of land and buildings	Significant	↔	✗	High	●
Risk 6 – Asset under construction and impairment	Other	↔	✗	Medium	●

Key

↑ Assessed risk increase since Audit Plan

↔ Assessed risk consistent with Audit Plan

↓ Assessed risk decrease since Audit Plan

● No adjustment or change in disclosure required

● Non-material adjustment or change in disclosure required

● Material adjustment or change in disclosure required

Overview of significant risks identified – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Risk 1 - Management override of controls Under ISA (UK) 240 there is a non-rebuttable presumed risk that the risk of management override of controls is present in all entities. We have therefore identified management override of controls, in particular journals, management estimates and of transactions outside the course of business as a significant risk of material misstatement.	To address this risk, we: • Evaluated the design effectiveness of management controls over journals; • Analysed the journals listings and determine the criteria for selecting high risk unusual journals; • Tested unusual journals recorded during the year and after the draft accounts stage for appropriateness and corroboration; • Gained an understanding of the accounting estimates and critical judgement applied by management and considered their reasonableness with regard to corroborative evidence; and • Evaluated the rationale for any changes in accounting policies, estimates or significant unusual transactions.	Our audit work is complete. We have not identified any material issues in respect of this risk.
Risk 2 - Fraud in revenue recognition (Patient Care Activities) Under ISA (UK) 240, we have considered the rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. The agreement of a control total at Trust and ICS level may create an incentive for revenue to be manipulated in order to achieve budgeted financial performance. Trusts face significant external pressure to restrain budget overspends, if any, and Trust is under financial pressure to deliver its 24/25 control total, and we determined that any incentives or opportunities of risk of fraud in revenue recognition would relate to revenue being overstated. The majority of the Trust's revenue is received from ICBs and NHS England for the provision of patient care services. We have identified and completed a risk assessment of all material revenue streams. We have not rebutted the risk for all streams within patient care income. We have assessed these revenue streams as being at greater risk of being manipulated and as such we have identified a significant risk of fraud for the following revenue streams. • Income from commissioners under API contracts – variable • High-cost drugs • Other clinical income	To address this risk, we: • Evaluated the Trust's accounting policy for recognition of income from patient care activities for appropriateness and compliance with the DHSC Group Accounting Manual (GAM) 2024-25; • Updated our understanding of the system for accounting for income from patient care and evaluated the design and implementation of relevant controls; • Using the DHSC mismatch report, we investigated unmatched revenue and receivables balance, corroborating your unmatched balances to supporting evidence; • Agreed, on a sample basis, income from patient care activity transactions recorded in the year to contracts/agreements or other supporting evidence such correspondence from Department of Health/NHSE or Commissioners; • We carried out testing on a sample basis of invoices issued in the period prior to and following 31 March 2025 to determine whether income was recognized in the correct accounting period, in accordance with the amounts billed to the corresponding parties. • Agreed any additional funding due at the year end to the confirmation received from NHSI and agreed that this was appropriately recorded. • Evaluated the Trust's estimates and the judgments made by management in order to arrive at the total income from contract variations recorded in the financial statements.	Our audit work is complete. We have not identified any material issues in respect of this risk.

Overview of significant risks identified – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Risk 3 - Fraud in revenue recognition (Other operating income) Under ISA (UK) 240, we have considered the rebuttable presumed risk that revenue may be misstated due to the improper recognition of revenue. The agreement of a control total at Trust and ICS level may create an incentive for revenue to be manipulated in order to achieve budgeted financial performance. Trusts face significant external pressure to restrain budget overspends, if any, and Trust is under financial pressure to deliver its 24/25 control total, and we determined that any incentives or opportunities of risk of fraud in revenue recognition would relate to revenue being overstated. Other operating income consists of various revenue streams. We have evaluated the risk of fraud in revenue recognition for each of these streams as follows: • Education and training • Non-patient care services provided to other organizations There's a higher fraud risk due to the pressure to achieve breakeven or report a surplus, despite the lack of incentives to meet the control total in FY25. This pressure correlate with presumed risk of overstatement of revenue (non-blocked income related activities)	To address this risk, we: • Evaluated the Trust's accounting policy for recognition of income from other operating income for appropriateness and compliance with the DHSC Group Accounting Manual (GAM) 2024-25; • Updated our understanding of the system for accounting for other operating income and evaluated the design of associated controls; • Used the DHSC mismatch report to investigate unmatched revenue and receivables balances over the NAO £300k threshold, corroborating the unmatched balances with supporting evidence; • Agreed on a sample basis for income and year-end receivable/income accruals from non-patient care revenues to invoices and cash payments or other supporting evidence; • Carried out testing on a sample basis of invoices issued in the period before and after 31 March 2025 to determine whether income was recognized in the correct accounting period, in accordance with the amounts billed to the corresponding parties; and • Agreed any additional funding due at year-end to the confirmation received from NHSI and confirmed that this was appropriately recorded.	Our audit work is complete. We have not identified any material issues in respect of this risk.

Overview of significant risks identified – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Risk 4- Fraud in expenditure recognition As most public bodies are net spending bodies, then the risk of material misstatement due to fraud related to expenditure recognition may be greater than the risk of fraud related to revenue recognition. Conversely, in prior years auditors have encountered examples of NHS bodies over-accruing to reach a predetermined outturn position due to changes in funding arrangements and to arrangements made across system partnership regions. Given the financial pressures experienced by the Trust to meet its agreed budget, we consider there is a risk of fraud in expenditure recognition, namely Management could inappropriately: • Exclude or defer recognition of 24/25 expenditure to 25/26 • Capitalise expenditure which is in fact revenue related.	To address the risk we: • Evaluated your accounting policy for recognition of expenditure for appropriateness and compliance with the DHSC Group Accounting Manual 2024/25; • Understood and assessed the Trust's process for recording expenditure accruals and deferrals, along with any relevant controls; • Our journals testing focused on manual journals that impacted the control total by decreasing expenditure. We assessed whether there was an appropriate basis for posting these journals and whether the amounts were supported by appropriate evidence; • sample tested expenditure invoices around yearend to determine whether the expenditure was recognised in the correct accounting period and accruals were complete; • Inspected invoices recorded and payments made after the end of the financial year to assess whether they had been included in the correct accounting period; and • Tested a sample of expenditure and capital additions recorded in 24/25, corroborating these to evidence that the transactions had been classified appropriately.	Our audit work is complete. We have not identified any material issues in respect of this risk.
Risk 5 - Revaluation of land and buildings The Trust revalue its Land and buildings on an annual basis to ensure that the carrying value is not materially different from the current value at the financial statement date. This valuation represents a significant estimate by management in the financial statements. Management have engaged the services of a valuer to estimate the current value as at 31 March 2025. The valuation of land and buildings is a key accounting estimates which is sensitive to changes in assumptions and market conditions We therefore identified the valuation of land and building, particularly revaluations and impairment, as a significant assessed risk of material misstatement, and a key audit matter.	To address the risk we: • Evaluated management's processes and assumptions for the calculation of the estimate, the instructions issued to valuation experts, and the scope of their work; • Evaluated the competence, capabilities, and objectivity of the valuation expert; • Wrote to the valuer to confirm the basis on which the valuation was carried out; • Challenged the information and assumptions used by the valuer to assess completeness and consistency with our understanding, the valuer's report, and the assumptions that underpin the valuation; • Engaged our own valuer to assess the instructions to the Trust's valuer, the Trust's valuer's report, and the assumptions that underpin the valuation; • Tested revaluations made during the year to see if they had been input correctly into the asset register; and • Evaluated the assumptions made by management for assets not revalued during the year and how management has satisfied themselves that these are not materially different from current value at year-end.	Our audit work is complete. We have not identified any material issues in respect of this risk.

Overview of other risks identified – financial statements

Risks identified in our Audit Plan	Audit procedures performed	Key observations
Risk 6 – Asset under construction and impairment The Trust has a significant balance of Assets under Construction, which poses a potential risk of impairment that could have a material impact on the financial statements. This concern arises because the Trust is engaged in multiple projects, and any major changes in scope or the cancellation of these projects could lead to an impairment event as outlined in IAS 36.	To address the risk we: • Reviewed the Trust's Assets under Construction balance by undertaking detailed testing of a sample of key projects; • Examined each item to verify if there was evidence that the project was still ongoing and therefore still under construction; and • Assessed each project for impairment events as outlined in IAS 36 to ensure that there were no such instances present at the Trust that could lead to the impairment of the respective projects.	Our audit work is complete. We have not identified any material issues in respect of this risk.

4 Other findings

Other findings – significant matters

	Issue	Commentary
1	Significant events or transactions that occurred during the year	None identified
2	Business conditions affecting the Trust, and business plans and strategies that may affect the risks of material misstatement	None identified
3	Concerns about management's consultations with other accountants on accounting or auditing matters	None identified
4	Significant matters on which there was disagreement with management, except for initial differences of opinion because of incomplete facts or preliminary information that are later resolved by the auditor obtaining additional relevant facts or information	None identified
5	Adjustments identified as having been made to meet the system position (any concerns we have identified with a Trust making adjustments to meet an agreed system target).	None identified
6	Other matters that are significant to the oversight of the financial reporting process	None identified
7	Prior year adjustments identified	We noted several prior period adjustments disclosed in Section 6 – Audit Adjustments, which primarily relate to classification issues. These adjustments do not affect the overall reported totals.

Other findings – accounting policies

Accounting area	Summary of policy	Comments	Assessment
Revenue recognition	The Trust recognises revenue under IFRS 15, based on satisfaction of performance obligations in contracts with customers, primarily NHS commissioners. Income is recognised over time or at a point in time, depending on the service. NHS income is earned through aligned payment and incentive contracts, with fixed and variable elements. Additional income sources include CQUIN, BPT, education and training, research, and the NHS Injury Cost Recovery Scheme. Revenue is adjusted for penalties, contract challenges, and expected credit losses. Deferred income and contract assets/liabilities are recognised where applicable. The Trust ensures compliance through regular review of contract terms and performance.	We have not found any issues.	
Expenditure recognition	Expenditure on goods and services is recognised when, and to the extent that they have been received, and is measured at the fair value of those goods and services. Expenditure is recognised in operating expenses except where it results in the creation of a non-current asset such as property, plant and equipment	We have not found any issues.	
Valuation of Property, plant and equipment	The Trust capitalises PPE when it is used for service delivery or administration, expected to last over a year, and costs at least £5,000 (or collectively meets criteria). Assets are initially measured at cost and subsequently at current value, with specialised assets valued using depreciated replacement cost. Depreciation is applied over useful lives, except for land and assets held for sale. Revaluation gains/losses are recognised in reserves or expenses. Impairments are charged to expenses, with reversals treated accordingly. Subsequent expenditure is capitalised if it enhances service potential. Assets are de-recognised when sold, scrapped, or demolished.	We have not found any issues.	

Assessment:
- Marginal accounting policy which could potentially be open to challenge by regulators
- Accounting policy appropriate but scope for improved disclosure
- Accounting policy appropriate and disclosures sufficient

Other findings – key judgements and estimates

This section provides commentary on key estimates and judgements in line with the enhanced requirements for auditors.

Key judgement or estimate	Summary of management's approach	Auditor commentary	Assessment
Land and building valuations - £342.83m	Land and buildings comprises £306.57m specialised assets such as the Trust's hospitals, which are required to be valued at depreciated replacement cost (DRC) at year end, on a modern equivalent asset basis. Management have determined the amount of space and location required for ongoing service delivery in the light of their current and projected service needs and have instructed the valuer accordingly. The remainder of land and buildings are not specialised in nature and are required to be valued in existing use (EUV) at year end. The Trust engaged an external valuer Newmark, previously know as Gerald Eve, to complete the valuation of properties as at 31 March 2025.	We have: • deepened our risk assessment procedures performed including understanding processes and controls around the identification and determination of estimates. This included understanding methods, assumptions and data used; • discussed management's determination of accounting estimates with those charged with governance, for example, qualitative considerations, the development and validation of models, data integrity and the selection of inputs; • considered the competence, capabilities and objectivity of the valuation expert used by the Trust. We have not identified any concerns; • considered the data and assumptions used by management to derive the accounting estimate. We have not noted any issues with the completeness and accuracy of this underlying information; • considered the appropriateness of the MEA assumptions used, in particular we have confirmed that none have changed since the prior year; • confirmed that there have been no changes to the valuation method this year; and • assessed the reasonableness of the disclosures related to accounting estimates.	We consider management's process is appropriate and key assumptions are neither optimistic or cautious

Other findings – information technology

This section provides an overview of results from our assessment of information technology (IT) environment and controls which included identifying risks from the use of IT related to business process controls relevant to the financial audit. This includes an overall IT general control (ITGC) rating per IT system and details of the ratings assigned to individual control areas.

			ITGC control area rating			
IT application	Level of assessment performed	Overall ITGC rating	Security management	Technology acquisition, development and maintenance	Technology infrastructure	Related significant risks/other risks
SBS - Oracle	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	● (See below)
Electronic staff records	ITGC assessment (design and implementation effectiveness only)	●	●	●	●	●

Please note the red rating for SBS Oracle reflects a qualified service auditor report on this system. It is worth noting the Trust is not involved in this audit and relies on the SBS Oracle controls being in place. However, it is important to note for the Trust so they can consider the impact of this qualified service auditor report within their own control framework. We have undertaken our own work and are satisfied that this issue does not create a risk of material misstatement in the Trust's financial statements. For more detail please see the next slide.

Assessment

- ● Significant deficiencies identified in IT controls relevant to the audit of financial statements
- ● Non-significant deficiencies identified in IT controls relevant to the audit of financial statements/significant deficiencies identified but with sufficient mitigation of relevant risk
- ● IT controls relevant to the audit of financial statements judged to be effective at the level of testing in scope
- ● Not in scope for testing

Other findings

Matter	Commentary	Auditor view
Service Auditor Reports Under ISA 315R, auditors are required to understand and assess relevant internal controls of the systems relevant to the preparation of financial statements. This includes systems provided by service organisations. An independent auditor produces a service auditor report to provide management with assurance over the internal control environment of the system they use and as external auditors we review these service auditor reports when undertaking our work. The following systems used by Trust are provided by service organisations. The data from these systems are relevant to preparation of financial statements of Trust. • NHS Shared Business Services Limited's Finance and Accounting Service (SBS) • The Electronic Staff Record Programme (ESR)	**NHS Shared Business Service Limited: Finance and Accounting Services** The audit team reviewed the ISAE 3402 Audit Type II service auditor report, which assesses the design and operating effectiveness of the controls of finance and accounting systems, Oracle provided by NHS Shared Business Service Limited for period 1 April 2024 to 31 March 2025 A qualified opinion was given by the service auditor due to the following: Control Objective 3 – Controls exist to provide reasonable assurance that new supplier master data and changes to supplier master data are approved by appropriate individuals. A deviation was noted in testing that 1 out of 25 samples that there were no validation checks performed prior to change to bank details. Control Objective 8 – Controls exist to provide reasonable assurance that Sales Ledger transactions processed by NHS SBS are authorised by appropriate client user on the approved user hierarchy. Deviations were noted that for 2 of 40 samples, NHS SBS accounts receivable team did not check the authorisation was appropriate to client user's credit memo limit prior to processing. Control Objective 19 – Controls exist to provide reasonable assurance that there is segregation of duties for System Administration on FMIS. For the period 01 April 2024 to 31 October 2024, deviations were noted wherein 1 of 19 users was a generic user account, 1 of 19 users was an SBS client employee and 17 other users had access to the FMIS system user setup. As per our assessment, the findings noted by the service auditor are not relevant to ITGC control testing in scope for this IT application and we have therefore not performed further procedures. **NHS Business Services Authority and IBM UK Limited: The Electronic Staff Record Programme** The audit team have reviewed the ISAE 3000 Audit Type II service auditor report which assesses the design and operating effectiveness of controls of the ESR system provided by NHS Business Services Authority for period 1 April 2024 to 31 March 2025. This report noted no significant findings and concluded an unmodified opinion. We reviewed this report as part of our risk assessment.	**NHS Shared Business Service Limited: Finance and Accounting Services** We have considered the control findings identified and do not consider them significant enough to have an impact on our audit opinion. The qualifications are relevant to controls operating at the third party and not the Trust. We are satisfied that that the Trust has appropriate compensating controls in these areas to mitigate against any increased area of risk. **NHS Business Services Authority and IBM UK Limited: The Electronic Staff Record Programme** Assurance has been gained over the design and implementation over the controls at the service organisation. No control findings were identified and there is therefore no impact on our audit opinion.

5 Communication requirements and other responsibilities

Communication requirements

Issue	Commentary
Matters in relation to fraud	We have previously discussed the risk of fraud with the Audit Committee. We have not been made aware of any other incidents in the period and no other issues have been identified during the course of our audit procedure.
Matters in relation to related parties	We are not aware of any related parties or related party transactions which have not been disclosed
Matters in relation to laws and regulations	You have not made us aware of any significant incidences of non-compliance with relevant laws and regulations, and we have not identified any incidences from our audit work.
Written representations	A letter of representation has been requested from the Trust which is included as separate item in the Audit and Risk Committee papers.
Accounting practices	We have evaluated the appropriateness of the Trust's accounting policies, accounting estimates and financial statement disclosures. A number of minor amendments were made to the accounting policies to enhance the transparency of the disclosures within the Accounts, which are documented in the audit adjustments section of this report.
Confirmation requests from third parties	We requested from management permission to send confirmation requests to number of third parties. This permission was granted, and the requests were sent and have been received as part of our final accounts work.
Disclosures	Our review found no material omissions in the financial statements. The other disclosure misstatements are detailed in the audit adjustments section of this report.
Audit evidence and explanations	All information and explanations requested from management was provided.
Significant difficulties	None to report.

Other responsibilities

Issue	Commentary
Going concern	In performing our work on going concern, we have had reference to Statement of Recommended Practice – Practice Note 10: Audit of financial statements of public sector bodies in the United Kingdom (Revised 2024). The Financial Reporting Council recognises that for particular sectors, it may be necessary to clarify how auditing standards are applied to an entity in a manner that is relevant and provides useful information to the users of financial statements in that sector. Practice Note 10 provides that clarification for audits of public sector bodies. Practice Note 10 sets out the following key principles for the consideration of going concern for public sector entities: • the use of the going concern basis of accounting is not a matter of significant focus of the auditor's time and resources because the applicable financial reporting frameworks envisage that the going concern basis for accounting will apply where the entity's services will continue to be delivered by the public sector. In such cases, a material uncertainty related to going concern is unlikely to exist, and so a straightforward and standardised approach for the consideration of going concern will often be appropriate for public sector entities • for many public sector entities, the financial sustainability of the reporting entity and the services it provides is more likely to be of significant public interest than the application of the going concern basis of accounting. Our consideration of the Trust's financial sustainability is addressed by our value for money work, which is covered elsewhere in this report. Practice Note 10 states that if the financial reporting framework provides for the adoption of the going concern basis of accounting on the basis of the anticipated continuation of the provision of a service in the future, the auditor applies the continued provision of service approach set out in Practice Note 10. The financial reporting framework adopted by the Trust meets this criteria, and so we have applied the continued provision of service approach. In doing so, we have considered and evaluated: • the nature of the Trust and the environment in which it operates • the Trust's financial reporting framework • the Trust's system of internal control for identifying events or conditions relevant to going concern • management's going concern assessment. On the basis of this work, we have obtained sufficient appropriate audit evidence to enable us to conclude that: • a material uncertainty related to going concern has not been identified; and • management's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Other responsibilities

Issue	Commentary
Other information	We are required to give an opinion on whether the other information published together with the audited financial statements (including the Annual Report), is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. Our work in this area is complete, pending internal quality review. we identified several errors that required correction to ensure compliance with reporting requirements and consistency across disclosures. The issues noted included: ▪ Incorrect salary figures reported for certain individuals ▪ Inaccuracies in the pensions table, including missing or outdated information ▪ Calculation errors affecting reported totals and individual disclosures ▪ Formatting inconsistencies, which impacted the clarity and presentation of the report
Auditable elements of Remuneration Report and Staff Report	We are required to give an opinion on whether the parts of the Remuneration Report and Staff Report subject to audit have been prepared properly in accordance with the requirements of the Act, directed by the Secretary of State with the consent of the Treasury. We have audited the elements of the Remuneration Report and Staff Report, including the Fair Pay Multiple Disclosures, have been properly prepared in accordance with the FT ARM, as required by the code, and have no matters to report. We propose to issue an unqualified opinion on this.
Licence conditions	There is no enforcement action against the Trust, and we are not aware of any licence condition breaches.
Referral to the regulator	Under Schedule 10 paragraph 6 of the National Health Service Act 2006, auditors can report to the relevant regulatory body if they have reason to believe that the audited body is: • About to make, or has made, a decision which would involve unlawful expenditure; and/or • About to take, or has taken, a course of action which, if pursued to its conclusion, would be unlawful and likely to cause a loss or deficiency. We did not make any referral to the regulator

Other responsibilities under the Code

Issue	Commentary
Matters on which we report by exception	We are required to report on a number of matters by exception in a number of areas: • the Annual Governance Statement does not comply with guidance issued by NHS England or is misleading or inconsistent with the information of which we are aware from our audit; • the information in the annual report is materially inconsistent with the information in the audited financial statements or is apparently materially incorrect based on, or is materially inconsistent with, our knowledge of the Trust acquired in the course of performing our audit, or otherwise misleading; • if we have applied any of our statutory powers or duties; or • where we are not satisfied in respect of arrangements to secure value for money and have reported significant weaknesses. We have nothing to report on these matters.
Review of accounts consolidation schedules and specified procedures on behalf of the group auditor	We are required to give a separate audit opinion on the Trust accounts consolidation schedules and to carry out specified procedures (on behalf of the NAO) on these schedules under group audit instructions. In the group audit instructions, the Trust was selected as a sampled component. Our work in this area is not yet completed. To date, we have nothing to report on these matters
Certification of the closure of the audit	We cannot formally conclude the audit and issue an audit certificate for St George's University Hospital NHS Foundation Trust for the year ended 31 March 2025 in accordance with the requirements of the NHS Act 2006 and the code of Audit practice until we have completed the work necessary in relation with the Trust's consolidation schedule, and we have received confirmation from the National Audit Office that the audit of the NHS group consolidation is complete for the year ended 31 March 2025. We are satisfied that this work does not have material effect on the financial statement for the year ended 31 March 2025.

6 Audit adjustments

Audit adjustments

We are required to report all non-trivial misstatements to those charged with governance, whether or not the accounts have been adjusted by management.

Impact of adjusted misstatements

All adjusted misstatements are set out in detail below, along with the impact on the key statements.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on net deficit £'000
Accrued income - Misclassification As part of the audit procedures, it was noted that an amount of £5.34 million had been incorrectly offset within Accrued Liabilities as at the reporting date. Upon further review, it was determined that this amount pertains to income that had been earned but not yet received and therefore should have been appropriately classified under Accrued Income. Management has agreed to amend the financial statements to reflect the correct classification.	-	Dr Accrued Income – £5,344 Cr Accrued liabilities – (£5,344)	-
Overall impact	-	-	-

Misclassification and disclosure changes

The table below provides details of misclassification and disclosure changes identified during the audit which have been made in the final set of financial statements.

Disclosure	Misclassification or change identified	Adjusted?
Note 1.2 – Going concern	The narrative per draft accounts explained that there were factors mentioned which represent material uncertainties that may cast significant doubt about the Trust's ability to continue as a going concern. However, this is not representative of the Trust's actual condition as confirmed with management, who has agreed to amend the wordings and take out references to material uncertainties.	✓
Note 1.27 - Critical judgements in applying accounting policies	In our review of the accounting policies, we understand that Note 1.27 relates to judgements not involving estimates, although the narrative added refers to a judgement on the valuation of land. We have proposed for this to be disclosed instead within the PPE note as the current disclosure does not include any critical judgements made in applying the accounting policy in line with IAS 1. Management agreed and made this amendment to the financial statements.	✓
Other Accounting policies	We have identified a number of accounting policies that are either not material or not applicable to the Trust this year. We also note that the accounting policy for allowance on impairment did not have sufficient detail to explain how transactions with different parties have been considered, including inter-DHSC bodies. Management has agreed to make the appropriate amendments.	✓
Note 2 – Operating Segments	During our review of Note 2 in the financial statements, we identified that the income allocation for Integrated Care Boards (ICBs) should be 40% rather than the 50% stated, and the income from NHS England (NHSEs) should be 40% instead of 32%. Management has agreed to update the accounts accordingly.	✓

Audit adjustments (continued)

Misclassification and disclosure changes (continued)

Disclosure	Misclassification or change identified	Adjusted?
Note 3.1 – Income from patient care activities (By nature)	During the review of the financial statement - Prior period adjustments were identified in Note 3.1 due to misclassifications within the accounts. The reclassifications are summarised as follows: • Income from commissioners under API contracts – variable element: Increased by £188.3 million • Income from commissioners under API contracts – fixed element: Decreased by £127.9 million • High-cost drugs income from commissioners: Increased by £36.7 million • Other NHS clinical income: Decreased by £0.6 million • Other clinical income: Decreased by £96.5 million These adjustments result in a net nil impact on total reported income but were necessary to ensure appropriate classification and disclosure in line with financial reporting requirements. Management agreed to update the accounts.	✓
Note 3.1 – Income from patient care activities (By nature)	During our review of income disclosures, we noted that the Trust's application of the API – Variable Income component in the template accounts was incomplete. The template guidance requires this line item to include not only Elective Recovery Funding (ERF) but also other variable elements such as outpatient procedures with NHSPS unit prices, first outpatient attendances, and wider variable activity element. However, the Trust had initially included only the ERF element. As a result, an adjustment was made to reclassify income related to Nuclear Medicine and Imaging from the fixed to the variable component. The following reclassifications were made: • 2024/25: Fixed component decreased by £17.9 million, variable component increased by the same amount • 2023/24: Fixed component decreased by £15.8 million, variable component increased by the same amount These adjustments have a net nil impact on total income but were necessary to ensure compliance with the prescribed reporting format and to improve the accuracy of income categorisation Management has agreed to amend the disclosure	✓
Note 5.1 – Additional information on contract revenue (IFRS 15) recognised in the period	During the review of the financial statements, a disclosure misstatement was identified in Note 5.1 – Additional Information on Contract Revenues Recognised in the Period. While the impact of the disclosure misstatement was not considered material, the following adjustments were identified to enhance the accuracy and completeness of the disclosures: • Income from services designated as commissioner requested services was originally disclosed as £1,156,231 and has been revised to £1,149,877. The prior year (PY) figure has also been adjusted from £1,061,500 to £1,057,310. • Income from services not designated as commissioner requested services was originally disclosed as £172,366 and has been corrected to £178,293, with the PY figure amended from £162,221 to £168,111. Although prior period changes were not required due to their immaterial nature, management has opted to amend the notes to the financial statements to ensure transparency and consistency in reporting	✓

Audit adjustments (continued)

Misclassification and disclosure changes (continued)

Disclosure	Misclassification or change identified	Adjusted?
Note 6.3 – Limitation on auditor's liability	We noted that the Trust had not correctly stated the limitation on auditor's liability within Note 6.3 of the financial statements. The correct amount should be £2 million. Management has agreed to amend the note accordingly	✓
Note 12 - Other gains / (losses)	The Trust has disclosed a disposal of old plant and equipment amounting to £2.9m. However, the disposal of transport equipment has been included in this disclosure. Management has amended the financial statements to separately disclose transport equipment.	✓
Note 21.1 – Trade and other payables	Management has identified a mapping error within Note 21.1., which has led to a reclassification of £6.2m from 'Other payables' to ' Accruals'. This has no impact on total payables.	✓
Note 23.1 – Borrowings & Note 17.5 – Maturity analysis of future lease payments	During our review of the financial statements, we identified mathematical inaccuracies in the allocation of lease liabilities between current and non-current portions. These inaccuracies have a consequential impact on the classification of borrowings and the maturity analysis of financial liabilities. We have brought this to the attention of management and management agreed to amend the note. The impact on the balance sheet is a reclassification from current to non-current borrowings amounting to £3.854m. With regards to the maturity analysis, this has no impact on the total net lease liabilities, and only impacts the classification between the categories.	✓
Note 30 – Related parties	The are 4 entities which have been disclosed as related parties where it was not clear how they met the definition of a related party under IAS 24. Upon our review of the relationship with the first two, we note that these are not related parties in line with IAS 24, and have proposed to management to disclose this fact and explain why they continue to be disclosed. The last two were disclosed in error and have been taken out. Management has agreed to make the appropriate amendments. We further note a disclosure made about instances where key management services have been provided by another entity but as the total transactions are nil for both the current and prior year, management has also agreed to remove these. Lastly, we have proposed for management to specifically disclose all other NHS bodies that the Trust has transactions with over a certain threshold. Management has now added all related parties with whom they have transactions with over £1m.	✓
Remuneration report including the pensions table (Annual report)	In our review of the remuneration report, the following adjustments have been raised: • The salary banding of Mr Pankaj Dave was not disclosed correctly in the draft annual report. This has been adjusted within the 0-5 salary banding. • Professor Natalie Armstrong, Professor Jennifer Hingham, and Philippa Tostevin had nil salaries disclosed. A disclosure has been added to explain why this is the case. • Mark Bagnall who is a non-voting executive director was not initially disclosed in the remuneration report. He has now been included and a narrative has been added in as well to explain that he is not disclosed within the pensions table as he has opted out of it. • There were no pensions-related benefits disclosed for Ms Jacqueline Todderdell and Mr Andrew Grimshaw for both the current year and the prior year. Management has agreed to add in a disclosure to explain that this is due to the valuation of their pensions resulting in a net reduction, and as such, should be reported as zero in line with FT ARM 2.52.	✓

Audit adjustments (continued)

Misclassification and disclosure changes (continued)

Disclosure	Misclassification or change identified	Adjusted?
Remuneration report including the pensions table (Annual report) (cont.)	In our review of the remuneration report, the following adjustments have been raised: • Angela Paradise did not have any pension-related benefits disclosed. Management has agreed to add in a narrative to explain that she has opted out of the pension scheme. • Where applicable, a footnote should be added underneath the table specifying the element of the individual's remuneration from the entity that relates to their clinical role. This has been added now for Dr. Richard Jennings in relation to the Clinical Excellence Award. • In the Pensions entitlement table, Mr Paul Da Gama has been disclosed as one of the executive directors but was not included in the remunerations table nor was he disclosed as an officer during the year. Management has confirmed that he will be excluded from the Pensions table.	✓
Other information (Annual report)	In our review of the rest of the annual report, the following points below were noted: • The 'About us' section explains that the Trust is part of a group with Epsom and St Helier called the GESH Group. Management has agreed to explain that they use the term "group" regarding GESH, and does not mean a "group" in the context of group consolidation. • In the percentage changes in remuneration of highest paid director and average employee 2024/25 within the Fair Pay Disclosures, we note that the percentage calculations were made based on the whole numbers rather than the rounded numbers disclosed in the accounts. This also did not include the prior year comparatives in line with FT ARM 2.92. Management has agreed to add in a disclosure to explain the rounding, and add in the prior year figures. • The gender table within the Staff Report had nil balances per draft annual report. This has now been updated by management. • The employee expenses table did not reflect the same split in relation to 'pension costs - employer contribution to NHS pension scheme' and 'employer contributions paid by NHSE on provider's behalf' to reconcile with the PFR submission. This has now been amended by management to reflect this correctly. • In the pay ratio table notes, the midpoint of banded remuneration of the highest paid director was incorrectly disclosed as £215k as this should be £217.5k (midpoint of band £215k - £220k). This has now been amended by management. • Table 3 within the Fair Pay disclosures show the Whole Time Equivalent number as 10,647 while shown as 10,653 per supporting workings and in the Average number of employees table. This has now been amended by management. • The Staff exit packages table shows three compulsory redundancies and three other departures agreed, while the supporting workings provided and PFR submissions show one compulsory redundancy and five other redundancies. These have been amended by management to reflect the latter.	✓
Throughout	As part of our audit procedures, we performed a reconciliation between the PFR and the draft financial statements. During this review, we identified certain inconsistencies, including hidden rows within the cash flow statement and discrepancies in the related parties note. These issues may impact the transparency and completeness of the financial disclosures. Management was agreed to amend the notes accordingly	✓
Minor Presentational points	We identified a significant number of minor presentational issues within the financial statements. These included incorrect year references, missing or hidden lines from the template accounts, and inconsistencies in the sequencing of note numbers. All identified issues were raised with management and have since been amended.	✓

Audit adjustments

Impact of unadjusted misstatements

The table below provides details of adjustments identified during the audit which have not been made within the final set of financial statements. The Audit Committee is required to approve management's proposed treatment of all items recorded within the table below.

Detail	Statement of Comprehensive Income £000	Statement of Financial Position £000	Impact on net deficit £000	Reason for not adjusting
We identified a number of balances in our prepayments testing that sat in both prepayments and trade payables. Our view is that balances pertaining to prepayments should be cash payments made prior to the year end, for the next financial year. Additionally, we are of the same view that Trade payable should only include balances relating to 2024-25 closing liabilities. We have noted in this table the factual misstatement which was identified by reviewing all the transactions above 50k in the prepayments listing. And then we extrapolated the error rate across the remainder of the population.	Nil	**Factual error** Dr Trade Payables £5,644 Cr Prepayments (£5,644) **Extrapolated error** Dr Trade payables £488 Cr Prepayment (£488)	Nil	Not material
We noted an overstatement in aged debtors due to income relating to the 2025/26 financial year being billed and recognised in 2024/25. The amount was recorded as a receivable with a corresponding payable, despite relating to a future period. There is no impact on the Statement of Comprehensive income	Nil	Dr Payables £4,152 Cr Receivables (£4,152)	Nil	Not material
We note a misstatement of £1.968m within accruals opening balances, which relates to previous year 22-23 and 23-24. This relates to accruals made on the basis of purchase orders, where the goods nor the invoices have been received, hence, were not valid accruals in both 2022/23 and 2023-24. These have now been correctly reversed in 2024-25. Hence, the opening 2024-25 accruals is overstated £1.968m, although correctly stated as at 2024-25 year-end.	Nil	Opening balances: Dr Accruals £1,968 Cr I&E Reserve (£1,968)	Nil	Not material
Overall impact	**Nil**	**Nil**	**Nil**	

Impact of unadjusted misstatements in the prior year

The table below provides details of misstatements identified during the prior year audit which were not adjusted within the final set of financial statements, for the reason of being immaterial for the 2023/24 financial statements. We have considered each of these and the impact on opening balances and whether these would still impact the closing balances for 2024/25 (the majority "unwind" within the 2024/25 period where they relate specifically to a cut off issue at the 31 March 2024. We are satisfied that considered alongside the unadjusted misstatements on page 31 that we are satisfied none of these could have a material impact on the 2024/25 financial statements and do not require adjustment.

Detail	Statement of Comprehensive Income £'000	Statement of Financial Position £'000	Impact on net surplus £'000
Bad Debt Provision During our prior year audit, we identified that the Trust had not recognised a bad debt provision for receivables due from St George's University of London, on the basis that management did not consider there to be a risk of non-payment. Based on our assessment, had the Trust applied its general debtor provision policy, a credit loss allowance of £215,654 would have been recognised. Additionally, we noted that the Trust applied a 17% bad debt provision rate to the NHS Injury Cost Recovery Scheme debtor balance. However, in accordance with the Group Accounting Manual (GAM), the required provision rate was 23.07%. Applying the correct rate would have resulted in a credit loss allowance of £932,255.	Dr Expenditure - £1,148	Cr Receivables – (£1,148)	£1,148
Impairment on Intangible Asset We tested the existence and impairment of intangible assets, During this testing it become clear that there were some long aged assets for internally generated information Technology from before 2017 and software licence before 2021. This included Cerner, iclip and E-Prescribing assets which on review are not being used by the Trust anymore and therefore should no longer be included as intangible assets and should be impaired.	Dr Impairment Expenditure - £2,080	Cr Intangible Assets – (£2,080)	£2,080
Understatement of Prepayments In our testing of prepayments, we identified error in relation to deferred income which had been incorrectly credited to prepayments. Our assessment of the extent of the error on extrapolation is that it would be a maximum of £464k which is below our performance materiality and therefore this is being reported as an unadjusted misstatement.	Nil	Dr Prepayment - £464 Cr Deferred income – (£464)	Nil
Overstatement of Accrued Receivables We identified Pharmacy related accrued income (receivables) recorded in the year end balance which related to January 2023 accruals which should be reversed out as the accrual had crystallised as paid income in the year. This would result in overstatement of income and receivables.	Dr Income - £2,527	Cr Accrued Receivables (£2,527)	£2,527

Impact of unadjusted misstatements in the prior year (continued)

Detail	Statement of Comprehensive Income £'000	Statement of Changes in Equity £'000	Statement of Financial Position £'000	Impact on net surplus £'000
Understatement of Expenditure We identified a factual error on a sample item of expenditure amounting to £693k understatement of expenditure for energy expenses. We tested the amount recognised in the accounts against the latest billing/credit note information available at the time the Trust finalised the accounts. Although the Trust were of the view that billing from this supplier has been inaccurate through the year and the meter readings could present more accurate information. We understand that the latest billing information is the only data practically available for making this accrual and this is what we carry out our audit testing against.	Dr Expenditure - £693	Nil	Cr Accruals – (£693)	£693
Overstatement of Expenditure In our testing previous year, we identified an invoice which related to the previous financial year; however, it was received in the current financial year. This expenditure had not been accrued into the prior period as would be expected. The item of expenditure in error was £154k. As it was impractical to fully isolate and identify the extent of other similar amounts, we extrapolated this error in our sample to reach a view as to the maximum extent of the error and gain assurance that this would not be material. The extrapolation came to £4.4m, well below our materiality of £17m hence giving assurance that the error within out representative sample would not be material. We would not request the Trust adjust the accounts based on an extrapolation.	Cr Expenditure – (£4,411)	Dr Income and Expenditure reserve - £4,411	Nil	(£4,411)
Understatement of Expenditure During our sample testing a variance was noted between the Apprenticeship levy recognised in the accounts against the NHS SBS Report due to incorrect posting of journals. This had led to an understatement of the expense being reported in the financial statement.	Dr Employee Benefits - £494	Nil	Cr Other taxes payable – (£494)	£494
Overall impact	**£2,533**	**Nil**	**(£2,533)**	**£2,533**

7 Value for Money arrangements

Value for Money arrangements

Approach to Value for Money work for the year ended 31 March 2025

The National Audit Office issued its latest Value for Money guidance to auditors in November 2024. The Code requires auditors to consider whether a body has put in place proper arrangements to secure economy, efficiency and effectiveness in its use of resources.

In undertaking our work, we are required to have regard to three specified reporting criteria. These are as set out below.

Improving economy, efficiency and effectiveness

How the body uses information about its costs and performance to improve the way it manages and delivers its services.

Financial sustainability

How the body plans and manages its resources to ensure it can continue to deliver its services.

Governance

How the body ensures that it makes informed decisions and properly manages its risks.

In undertaking this work we have identified a significant weakness in the Trust's Financial sustainability with one key recommendations. Our Auditor's Annual Report will be reported to the Audit Committee on 18 June 2025 with the Audit Finding Report.

8 Independence considerations

Independence considerations

As part of our assessment of our independence we note the following matters:

Matter	Conclusion
Relationships with Grant Thornton	We are not aware of any relationships between Grant Thornton and the Trust that may reasonably be thought to bear on our integrity, independence and objectivity.
Employment of Grant Thornton staff	We are not aware of any former Grant Thornton partners or staff being employed, or holding discussions in respect of employment, by the Trust as a director or in a senior management role covering financial, accounting or control related areas.
Business relationships	We have not identified any business relationships between Grant Thornton and the Trust.
Contingent fees in relation to non-audit services	No contingent fee arrangements are in place for non-audit services provided.
Gifts and hospitality	We have not identified any gifts or hospitality provided to, or received from, a member of the Trust's management or staff.

We confirm that there are no significant facts or matters that impact on our independence as auditors that we are required or wish to draw to your attention and consider that an objective reasonable and informed third party would take the same view. The firm and each covered person (and network firms) have complied with the Financial Reporting Council's Ethical Standard and confirm that we are independent and are able to express an objective opinion on the financial statements.

Following this consideration, we can confirm that we are independent and are able to express an objective opinion on the financial statements. In making the above judgement, we have also been mindful of the quantum of non-audit fees compared to audit fees disclosed in the financial statements and estimated for the current year.

We have made enquiries of all Grant Thornton UK LLP teams providing services to the Trust.

Fees and non-audit services

We confirm below our final fee charged for the audit and confirm there were no fees for the provision of non-audit services.

Audit fees	
Audit of Trust's financial statements 2024-2025 per the Audit plan	£300,650
Total	£300,650

The above fees are exclusive of VAT.

This covers all services provided by us and our network to the Trust, its directors and senior management and its affiliates, that may reasonably be thought to bear on our integrity, objectivity or independence.

9 Appendices

A. Communication of audit matters with those charged with governance

Our communication plan	Audit Plan	Audit Findings
Respective responsibilities of auditor and management/those charged with governance	●	
Overview of the planned scope and timing of the audit, form, timing and expected general content of communications including significant risks	●	
Confirmation of independence and objectivity	●	●
A statement that we have complied with relevant ethical requirements regarding independence. Relationships and other matters which might be thought to bear on independence. Details of non-audit work performed by Grant Thornton UK LLP and network firms, together with fees charged. Details of safeguards applied to threats to independence	●	●
Significant matters in relation to going concern	●	●
Views about the qualitative aspects of the Group's accounting and financial reporting practices including accounting policies, accounting estimates and financial statement disclosures		●
Significant findings from the audit		●
Significant matters and issue arising during the audit and written representations that have been sought		●
Significant difficulties encountered during the audit		●
Significant deficiencies in internal control identified during the audit		●
Significant matters arising in connection with related parties		●
Identification or suspicion of fraud involving management and/or which results in material misstatement of the financial statements		●
Non-compliance with laws and regulations		●
Unadjusted misstatements and material disclosure omissions		●
Expected modifications to the auditor's report, or emphasis of matter		●

ISA (UK) 260, as well as other ISAs (UK), prescribe matters which we are required to communicate with those charged with governance, and which we set out in the table here.

This document, the Audit Findings, outlines those key issues, findings and other matters arising from the audit, which we consider should be communicated in writing rather than orally, together with an explanation as to how these have been resolved.

Respective responsibilities

As auditor we are responsible for performing the audit in accordance with ISAs (UK), which is directed towards forming and expressing an opinion on the financial statements that have been prepared by management with the oversight of those charged with governance.

The audit of the financial statements does not relieve management or those charged with governance of their responsibilities.

Distribution of this Audit Findings report

Whilst we seek to ensure our audit findings are distributed to those individuals charged with governance, as a minimum a requirement exists for our findings to be distributed to all the company directors and those members of senior management with significant operational and strategic responsibilities. We are grateful for your specific consideration and onward distribution of our report, to those charged with governance.

B. Action plan

We set out here our recommendations for the Trust which we have identified as a result of issues identified during our audit. The matters reported here are limited to those deficiencies that we have identified during the course of our audit and that we have concluded are of sufficient importance to merit being reported to you in accordance with auditing standards.

Assessment	Issue and risk	Recommendations
Medium	**Unsigned Contract Variation** We noted that Contract Variation Form 03, relating to the updated South West London ICB contract value, had not yet been signed at the time of our review. We understand that this variation is currently progressing through internal governance processes.	Management should ensure that all contract variations and agreements with commissioners are formally documented and signed in a timely manner. Having signed contracts in place is essential to formalise agreements, reduce the risk of disputes, and support accurate financial reporting. **Management response** We acknowledge that Contract Variation CV03, which reflects the updated South West London ICB contract value, had not been signed at the time of the audit. However, we would like to confirm that the terms of this variation have already been formally agreed between the Trust and SWLICB. The signing of the document is now a procedural formality and is currently progressing through SWLICB's internal governance processes. Given the ICB contract is a 3-year agreement, there is no prescribed in-year deadline by which contract variations must be signed. The Trust's Contracts Team remains in regular contact with the ICB to ensure the document is finalised and signed as soon as possible. Based on our latest discussions, we expect the final signed version to be received within the next two weeks. We are confident that the agreement already in place mitigates any risk of dispute or financial misstatement.
Medium	**Completeness of Income** In our testing of completeness of income, specifically invoices raised, we note that one sample amounting to £48.6k with Oxleas NHS Foundation Trust where the transaction relates to 2023/24 but was not accrued for as the Trust wasn't aware of this income, and the Service Level Agreement for both 2023/24 and 2024/25 was finalised in 2024/25. However, as this relates to 2023/24, should have been accrued for based on service performed.	We recommend that the finance team implement additional review procedures, including proactive engagement with service departments, to identify any income-generating activities that may not yet be formally documented but relate to the reporting period. This will help ensure all relevant income is appropriately accrued and reported. **Management response** The department's management will ensure the management accountants will work closely with relevant budget holders in the monthly budget reviews to ensure that services received are billed/accrued in the financial year they have been carried out.

Key

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

B. Action plan (continued)

Assessment	Issue and risk	Recommendations
Medium	**Long standing Accrual** During our review of the Accrued Liabilities balance, we identified the opening balance of accruals totalling £1,967k, relating to financial years 2022/23 and 2023/24. These balances included long-standing accruals for which neither invoices had been received nor goods or services delivered. Despite this, the accruals were carried forward for more than two years and only reversed in the current financial year (2024/25).	We recommend that management strengthen controls around the review of accruals, particularly those carried forward across multiple reporting periods. A formal process should be implemented to regularly assess the validity of outstanding accruals, supported by appropriate documentation, to ensure timely reversal of those no longer required. **Management response** The department's management will implement a quarterly balance sheet review with colleagues in each division to ensure historic accruals are identified and plans made to resolve on a timely basis.
Medium	**Overstatement of Receivables and Payables** We have noted a number of unadjusted misstatements identified in line with receivables and deferred income, as well as prepayments and payables. Our view is that if the receivables and payables can only be recognised when the service has been provided. On the other hand, prepayments and deferrals should only be recognised when a payment has been made/received, as this is the reason for recognising the asset (for prepayments) and liabilities (for deferred income)The key reason for failing the samples is that there is no real asset/liability under the accounting principles. The trust has overstated the assets and liabilities, although has nil impact overall.	We recommend that management to implement procedures that reconciles the amount recorded as receivables at year-end and to check whether the income/receivable pertains to the current financial year or the next financial year **Management response** The department's management will implement a quarterly balance sheet review with colleagues in each division to ensure correct balance sheet codes are used in journals posted.

Key

- High – Significant effect on control system and financial statements
- Medium – Effect on control system and financial statements
- Low – Best practice for control systems and financial statements

C. Follow up of prior year recommendations

We identified the following issues in the audit of St George's University Hospital NHS Foundation Trust's 2023/24 financial statements, which resulted in 5 recommendations being reported in our 2023/24 Audit Findings Report.

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
✓	**Deferred income monitoring** To maintain a deferred income schedule to keep a track of the individual items awarded to the Foundation Trust and movement over the years.	Management has confirmed a tracker of deferred income will be maintained to assist with tracing in the future.
✓	**Retention of audit trail documentation for employee changes** In our audit testing it was observed that no leaver form/email documentation was retained for 8 leavers in our sample. Our understanding is that for starters and leavers that in addition to the change request on the portal, that the Trust would also complete Starter/leaver forms and issue a letter/email for the termination, which we would expect would be retained as an audit trail.	Management has confirmed this has been put into place as part of the HR team structures and processes.
✓	**Fully depreciated Assets** We have identified there are several assets that are fully depreciated within the Trust Fixed asset register (FAR) representing a Gross Book Value £13.3m. Although these assets have no impact on the statement of financial statement, the gross cost and depreciation could overstate the PPE note. Our view is that there should be a regular review of the FAR should be regularly reviewed for assets which are fully depreciated and no longer in use by the Trust so that the FAR and PPE note accurately state the asset in use by the Trust.	Management has confirmed that they are following a phased approach to dispose of these assets within the current fiscal year, consistent with the approach taken in previous years.

Assessment

✓ Action completed

X Not yet addressed

C. Follow up of prior year recommendations

Assessment	Issue and risk previously communicated	Update on actions taken to address the issue
✓	**Segregation of duty Conflicts within Oracle SBS** We have identified a deficiency in the IT General Control for finance system relating to the assignment of administrative rights to individuals within the finance team, administrative access to Oracle SBS has been granted to a combination of users who have non-IT responsibilities and are part of the finance function. The combination of non-IT responsibilities with the ability to set up new users is considered a segregation of duties conflict. We noted that five finance teams users had these permissions in the system.	Management has confirmed, that similar to the comments shared for the prior year audit findings report, like many NHS Trusts the current arrangements will continue in 2024/25 as it is not realistic in a small team that finance team staff would only have administrative rights. Mitigating controls are in place including requirements for separate review and approval of all journal entries.
✓	**Impairment Review for intangible assets** From the review of intangible assets register and inquiry from the management we identified assets amounting to £2m which are no longer in use by the Trust and are still recognised as having a valuation in the accounts	Management has confirmed that they have adopted a pragmatic approach by impairing intangible assets from the prior year in the current financial year consistent with the precedent set in previous years.

Assessment

✓ Action completed

X Not yet addressed

D. Our team and communications

Grant Thornton core team

Paul Cuttle
Engagement Lead/
Key Audit Partner

- Key contact for senior management and Audit Committee
- Overall quality assurance

Andy Conlan
Audit Senior Manager

- Key contact for senior management and Audit Committee
- Overall quality assurance

Zargham Malik
Audit Manager

- Audit planning
- Resource management
- Performance management reporting

Sabrina Hisham
Assistant Manager

- On-site audit team management
- Day-to-day point of contact
- Audit fieldwork

	Service delivery	Audit reporting	Audit progress	Technical support
Formal communications	• Annual client service review	• The Audit Plan • The Audit Findings • Auditor's Annual Report • Progress and Sector Update Reports	• Audit planning meetings • Audit clearance meetings • Communication of issues log	• Technical updates
Informal communications	• Open channel for discussion		• Communication of audit issues as they arise	• Notification of up-coming issues

As part of our overall service delivery, we may utilise colleagues who are based overseas, primarily in India and the Philippines. Those colleagues work on a fully integrated basis with our team members based in the UK and receive the same training and professional development programmes as our UK based team. They work as part of the engagement team, reporting directly to the Audit Senior and Manager and will interact with you in the same was as our UK based team albeit on a remote basis. Our overseas team members use a remote working platform which is based in the UK. The remote working platform (or Virtual Desktop Interface) does not allow the user to move files from the remote platform to their local desktop meaning all audit related data is retained within the UK.

E. Audit opinion

Our anticipated audit report opinion will be unmodified

Independent auditor's report to the Council of Governors of St George's University Hospitals NHS Foundation Trust

Report on the audit of the financial statements

Opinion on financial statements

We have audited the financial statements of St George's University Hospitals NHS Foundation Trust (the 'Trust') for the year ended 31 March 2025, which comprise the Statement of Comprehensive Income, the Statement of Financial Position, the Statement of Changes in Taxpayers Equity, the Statement of Cash Flows and notes to the financial statements, including material accounting policy information. The financial reporting framework that has been applied in their preparation is applicable law and international accounting standards in conformity with the requirements of the Accounts Directions issued under Schedule 7 of the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25.

In our opinion, the financial statements:

- give a true and fair view of the financial position of the Trust as at 31 March 2025 and its expenditure and income for the year then ended; and
- have been properly prepared in accordance with international accounting standards as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25; and
- have been prepared in accordance with the requirements of the National Health Service Act 2006.

Basis for opinion

We conducted our audit in accordance with International Standards on Auditing (UK) (ISAs (UK)) and applicable law, as required by the Code of Audit Practice (2024) ("the Code of Audit Practice") approved by the Comptroller and Auditor General. Our responsibilities under those standards are further described in the 'Auditor's responsibilities for the audit of the financial statements' section of our report. We are independent of the Trust in accordance with the ethical requirements that are relevant to our audit of the financial statements in the UK, including the FRC's Ethical Standard, and we have fulfilled our other ethical responsibilities in accordance with these requirements. We believe that the audit evidence we have obtained is sufficient and appropriate to provide a basis for our opinion.

Conclusions relating to going concern

We are responsible for concluding on the appropriateness of the Accounting Officer's use of the going concern basis of accounting and, based on the audit evidence obtained, whether a material uncertainty exists related to events or conditions that may cast significant doubt on the Trust's ability to continue as a going concern. If we conclude that a material uncertainty exists, we are required to draw attention in our report to the related disclosures in the financial statements or, if such disclosures are inadequate, to modify the auditor's opinion. Our conclusions are based on the audit evidence obtained up to the date of our report. However, future events or conditions may cause the Trust to cease to continue as a going concern.

In our evaluation of the Accounting Officer's conclusions, and in accordance with the expectation set out within the Department of Health and Social Care Group Accounting Manual 2024-25 that the Trust's financial statements shall be prepared on a going concern basis, we considered the inherent risks associated with the continuation of services provided by the Trust. In doing so we had regard to the guidance provided in Practice Note 10 Audit of financial statements and regularity of public sector bodies in the United Kingdom (Revised 2024) on the application of ISA (UK) 570 Going Concern to public sector entities. We assessed the reasonableness of the basis of preparation used by the Trust and the Trust's disclosures over the going concern period.

In auditing the financial statements, we have concluded that the Accounting Officer's use of the going concern basis of accounting in the preparation of the financial statements is appropriate.

Based on the work we have performed, we have not identified any material uncertainties relating to events or conditions that, individually or collectively, may cast significant doubt on the Trust's ability to continue as a going concern for a period of at least twelve months from when the financial statements are authorised for issue.

Our responsibilities and the responsibilities of the Accounting Officer with respect to going concern are described in the relevant sections of this report.

Other information

The other information comprises the information included in the annual report, accounts and quality report, other than the financial statements and our auditor's report thereon. The Accounting Officer is responsible for the other information contained within the annual report, accounts and quality report. Our opinion on the financial statements does not cover the other information and, except to the extent otherwise explicitly stated in our report, we do not express any form of assurance conclusion thereon.

Our responsibility is to read the other information and, in doing so, consider whether the other information is materially inconsistent with the financial statements or our knowledge obtained in the audit or otherwise appears to be materially misstated. If we identify such material inconsistencies or apparent material misstatements, we are required to determine whether there is a material misstatement in the financial statements themselves. If, based on the work we have performed, we conclude that there is a material misstatement of this other information, we are required to report that fact.

We have nothing to report in this regard.

Other information we are required to report on by exception under the Code of Audit Practice

Under the Code of Audit Practice published by the National Audit Office in November 2024 on behalf of the Comptroller and Auditor General (the Code of Audit Practice) we are required to consider whether the Annual Governance Statement does not comply with the disclosure requirements set out in the NHS Foundation Trust Annual Reporting Manual 2024/25 or is misleading or inconsistent with the information of which we are aware from our audit. We are not required to consider whether the Annual Governance Statement addresses all risks and controls or that risks are satisfactorily addressed by internal controls.

We have nothing to report in this regard.

Opinion on other matters required by the Code of Audit Practice

In our opinion:

- the parts of the Remuneration Report and the Staff Report to be audited have been properly prepared in accordance with the requirements of the NHS Foundation Trust Annual Reporting Manual 2024/25; and
- based on the work undertaken in the course of the audit of the financial statements, the other information published together with the financial statements in the annual report for the financial year for which the financial statements are prepared is consistent with the financial statements.

Matters on which we are required to report by exception

Under the Code of Audit Practice, we are required to report to you if:

- we issue a report in the public interest under Schedule 10 (3) of the National Health Service Act 2006 in the course of, or at the conclusion of the audit; or
- we refer a matter to the regulator under Schedule 10 (6) of the National Health Service Act 2006 because we have reason to believe that the Trust, or an officer of the Trust, is about to make, or has made, a decision which involves or would involve the incurring of unlawful expenditure, or is about to take, or has begun to take a course of action which, if followed to its conclusion, would be unlawful and likely to cause a loss or deficiency.

We have nothing to report in respect of the above matters.

Responsibilities of the Accounting Officer

As explained more fully in the Statement of the Chief Executive's responsibilities as the accounting officer, the Chief Executive, as Accounting Officer, is responsible for the preparation of the financial statements in the form and on the basis set out in the Accounts Directions included in the NHS Foundation Trust Annual Reporting Manual 2024/25, for being satisfied that they give a true and fair view, and for such internal control as the Accounting Officer determines is necessary to enable the preparation of financial statements that are free from material misstatement, whether due to fraud or error.

In preparing the financial statements, the Accounting Officer is responsible for assessing the Trust's ability to continue as a going concern, disclosing, as applicable, matters related to going concern and using the going concern basis of accounting unless the Accounting Officer has been informed by the relevant national body of the intention to dissolve the Trust without the transfer of its services to another public sector entity.

E. Audit opinion (continued)

Auditor's responsibilities for the audit of the financial statements

Our objectives are to obtain reasonable assurance about whether the financial statements as a whole are free from material misstatement, whether due to fraud or error, and to issue an auditor's report that includes our opinion. Reasonable assurance is a high level of assurance, but is not a guarantee that an audit conducted in accordance with ISAs (UK) will always detect a material misstatement when it exists.

Misstatements can arise from fraud or error and are considered material if, individually or in the aggregate, they could reasonably be expected to influence the economic decisions of users taken on the basis of these financial statements.

Irregularities, including fraud, are instances of non-compliance with laws and regulations. The extent to which our procedures are capable of detecting irregularities, including fraud is detailed below:

- We obtained an understanding of the legal and regulatory frameworks that are applicable to the Trust and determined that the most significant which are directly relevant to specific assertions in the financial statements are those related to the reporting frameworks (international accounting standards and the National Health Service Act 2006, as interpreted and adapted by the Department of Health and Social Care Group Accounting Manual 2024-25).
- We enquired of management and the audit and risk committee, concerning the Trust's policies and procedures relating to:
  - the identification, evaluation and compliance with laws and regulations;
  - the detection and response to the risks of fraud; and
  - the establishment of internal controls to mitigate risks related to fraud or non-compliance with laws and regulations.
- We enquired of management, internal audit and the audit and risk committee, whether they were aware of any instances of non-compliance with laws and regulations or whether they had any knowledge of actual, suspected or alleged fraud.
- We assessed the susceptibility of the Trust's financial statements to material misstatement, including how fraud might occur, evaluating management's incentives and opportunities for manipulation of the financial statements. This included the evaluation of the risk of management override of controls, fraudulent revenue and expenditure recognition. We determined that the principal risks were in relation to:
  - Journal entries which met a range of criteria defined as part of our risk assessment;
  - Revenue recognition for material streams of patient care income and other operating revenues; and
  - Fraudulent expenditure recognition to meet externally set targets.
- Our audit procedures involved:
  - evaluation of the design effectiveness of controls that management has in place to prevent and detect fraud;
  - journal entry testing, with a focus on journals meeting a range of criteria defined as part of our risk assessment;
  - challenging the Trust's estimates and the judgements in order to arrive at the total income from contract variations recorded in the financial statements and other manual accruals/deferrals of healthcare income and other revenues;
  - challenging and evaluating assumptions and judgements made by management in its recognition of expenditure accruals at year-end; and
  - assessing the extent of compliance with the relevant laws and regulations as part of our procedures on the related financial statement item.
- These audit procedures were designed to provide reasonable assurance that the financial statements were free from fraud or error. The risk of not detecting a material misstatement due to fraud is higher than the risk of not detecting one resulting from error and detecting irregularities that result from fraud is inherently more difficult than detecting those that result from error, as fraud may involve collusion, deliberate concealment, forgery or intentional misrepresentations. Also, the further removed non-compliance with laws and regulations is from events and transactions reflected in the financial statements, the less likely we would become aware of it.
- We communicated relevant laws and regulations and potential fraud risks to all engagement team members, including the potential for fraud in revenue and expenditure recognition and the significant accounting estimates related to land and building valuations. We remained alert to any indications of non-compliance with laws and regulations, including fraud, throughout the audit.
- The engagement partner's assessment of the appropriateness of the collective competence and capabilities of the engagement team included consideration of the engagement team's:
  - understanding of, and practical experience with audit engagements of a similar nature and complexity through appropriate training and participation
  - knowledge of the health sector and economy in which the Trust operates
  - understanding of the legal and regulatory requirements specific to the Trust including:
    - the provisions of the applicable legislation
    - NHS England's rules and related guidance
    - the applicable statutory provisions.
- In assessing the potential risks of material misstatement, we obtained an understanding of:
  - The Trust's operations, including the nature of its income and expenditure and its services and of its objectives and strategies to understand the classes of transactions, account balances, expected financial statement disclosures and business risks that may result in risks of material misstatement.
  - The Trust's control environment, including the policies and procedures implemented by the Trust to ensure compliance with the requirements of the financial reporting framework.

A further description of our responsibilities for the audit of the financial statements is located on the Financial Reporting Council's website at: www.frc.org.uk/auditorsresponsibilities. This description forms part of our auditor's report.

Report on other legal and regulatory requirements – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Matter on which we are required to report by exception – the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

Under the Code of Audit Practice, we are required to report to you if, in our opinion, we have not been able to satisfy ourselves that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources for the year ended 31 March 2025.

We have nothing to report in respect of the above matter, except on 18 June 2025 we identified a significant weakness in how the Trust plans and manages its resources to ensure it can continue to deliver its services. This was in relation to:

- the Trust's failure during 2024/25 to develop plans for required efficiency savings for 2025/26 which are intrinsic to addressing its underlying deficit and to maintain financial sustainability; and
- the Trust's failure to develop a credible medium term financial plan.

We recommended the Trust should:

- in conjunction with system partners, as part of the development of the system clinical strategy, develop service plans and initiatives that improve the short and medium term underlying financial position of the Trust;
- look to maximise recurrent cost saving opportunities in 2025/26 and quickly progress the development of savings to minimise risk.

Responsibilities of the Accounting Officer

The Chief Executive, as Accounting Officer, is responsible for putting in place proper arrangements for securing economy, efficiency and effectiveness in the use of the Trust's resources.

Auditor's responsibilities for the review of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources

We are required under paragraph 1 of Schedule 10 of the National Health Service Act 2006 to be satisfied that the Trust has made proper arrangements for securing economy, efficiency and effectiveness in its use of resources. We are not required to consider, nor have we considered, whether all aspects of the Trust's arrangements for securing economy, efficiency and effectiveness in its use of resources are operating effectively.

We have undertaken our review in accordance with the Code of Audit Practice, having regard to the guidance issued by the Comptroller and Auditor General in November 2024. This guidance sets out the arrangements that fall within the scope of 'proper arrangements'. When reporting on these arrangements, the Code of Audit Practice requires auditors to structure their commentary on arrangements under three specified reporting criteria:

- Financial sustainability: how the Trust plans and manages its resources to ensure it can continue to deliver its services;
- Governance: how the Trust ensures that it makes informed decisions and properly manages its risks; and

E. Audit opinion (continued)

- Improving economy, efficiency and effectiveness: how the Trust uses information about its costs and performance to improve the way it manages and delivers its services.

We have documented our understanding of the arrangements the Trust has in place for each of these three specified reporting criteria, gathering sufficient evidence to support our risk assessment and commentary in our Auditor's Annual Report. In undertaking our work, we have considered whether there is evidence to suggest that there are significant weaknesses in arrangements.

Report on other legal and regulatory requirements – Delay in certification of completion of the audit

We cannot formally conclude the audit and issue an audit certificate for East Sussex Healthcare NHS Trust for the year ended 31 March 2025 in accordance with the requirements of the Local Audit and Accountability Act 2014 and the Code of Audit Practice until the National Audit Office has concluded their work in respect of WGA for the year ended 31 March 2025. We are satisfied that this work does not have a material effect on the financial statements for the year ended 31 March 2025.

Use of our report

This report is made solely to the Council of Governors of the Trust, as a body, in accordance with Schedule 10 of the National Health Service Act 2006. Our audit work has been undertaken so that we might state to the Trust's Council of Governors those matters we are required to state to them in an auditor's report and for no other purpose. To the fullest extent permitted by law, we do not accept or assume responsibility to anyone other than the Trust and the Trust's Council of Governors as a body, for our audit work, for this report, or for the opinions we have formed.

[Signature**]**

John Paul Cuttle, Key Audit Partner
for and on behalf of Grant Thornton UK LLP, Local Auditor

London
** June 2025

Council of Governors

Meeting on Thursday, 17 July 2025

Agenda Item	5.2	
Report Title	**Council of Governors Data Dashboard**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs & Head of Corporate Governance	
Previously considered by	n/a	
Purpose	**For Review**	

Executive Summary

One of the main duties of the Council of Governors is to hold the non-executive directors individually and collectively to account for the performance of the board of directors. They also have a duty to represent the views of members.

To fulfil these aspects of their role appropriately, the Council needs to be provided with the right information, presented in a way that is as accessible as possible. The main source of information for Governors should be the papers that are submitted to Council meetings.

Governors have fed back that meeting packs can be too dense and suggested that a governor dashboard could be considered, summarising key information. An example of what this might include was shared at a recent NHS Providers Governor Conference by another NHS Foundation Trust (Appendix A).

To explore how such a dashboard could be developed and introduced at St George's it is proposed that the following actions are taken forward:

1. An information/training session is held for all governors to share and discuss how the IQPR (Integrated Quality and Performance Report) is produced, how that data is used to identify areas of focus and the key metrics that inform the Board discussions.
2. Informed by 1. above, a small task and finish group of 3-4 governors, Liz Dawson, and a member of the Performance Team be established to develop a prototype Governor Dashboard for consideration at the December meeting of Council.

Action required by Council of Governors

The Council is asked to:

a. Confirm their support for an information session on the IQPR.
b. Nominate 3-4 governors to join a task and finish group on the development of a governor dashboard.
c. Note that the prototype of the dashboard will be on the December agenda of the Council.

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Gloucestershire Health and Care NHS Foundation Trust Governor Dashboard

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships		☐ Right care, right place, right time		
☐ Affordable Services, fit for the future		☐ Empowered, engaged staff		
Risks				
Without robust, easily accessible data, the Council of Governors may be limited in their ability to fulfil their roles.				
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				
Information provided to the Council of Governors needs to accessible.				
Environmental sustainability implications				
n/a				

Proposal to Develop a Governor Dashboard
Council of Governors, 17 July 2025

1.0 Purpose of paper

1.1 This paper sets out the proposal to develop a Governor Dashboard.

2.0 Background

2.1 As the quality, breadth and depth of data produced by the Trust has evolved so has the information available to Governors. With the aim of finding the right balance of information there have been a variety of iterations of the reports and data that are included in the papers submitted to the Council of Governors over the past few years. This has included, amongst other things:

- presentations on a small number of areas and a 'Questions to the NEDs' item
- provision of full reports from each Board Committee
- reporting at each meeting on an area of concern eg: maternity services
- annual reports on key areas such as patient complaints

Some of these have been retained in the agenda that is currently in use but others, such as full reports from each committee were not retained as they provided too much detail, increased the length of the papers and repeated information already available to governors.

2.2 To support them in their role, Governors are also able to access other sources of information beyond those provided to meetings of Council, such as both Public and Private Board papers, observing Board and Committee meetings and taking part in the Governor visits programme. There are also regular informal meetings between Governors and NEDs providing a further avenue for discussion and information gathering.

2.3 As with all Board and Committee meeting cycles, some agendas are longer than others. The most recent Council papers have been c120 pages long (including agenda, minutes, action logs etc) but have been as long as 250-300 when there have been items such as the CQC report on maternity services. These longer agenda, whilst containing useful information, can become unwieldy for volunteer governors with limited time to prepare. This has, on occasion, been exacerbated when papers are unavoidably delayed in being issued.

2.4 At the recent NHS Provider Governor Conference, Gloucestershire Health and Care NHS Foundation Trust gave a presentation on their development of a Governor Dashboard. This contains key information identified by their governors as providing the data key to them and their role – with it noted that it continues to evolve. This has raised the question of whether a similar document could be developed at St George's.

3.0 Development of a Governor Dashboard

3.1 The challenge when preparing reports for the Council of Governors, or any Board/Committee, is to provide sufficient information to allow the forum to conduct its business effectively in a level of detail that is appropriate which does not prevent the group from focusing on the core data or inadvertently taking them beyond their remit which can bring a lack of clarity over roles and responsibilities. Governors have given feedback on the amount of data that is shared both at Council and at Committee and Board meetings. Whilst the latter two fora are outside the remit of governors, the reflections on the accessibility of information is one that is shared by those groups. As part of our continuous improvement work the quality and quantity of reports is an area of focus.

3.2 The production of reports, whilst an important can take considerable capacity. Wherever possible and appropriate, reports are therefore used across a variety of groups – for example, the IQPR[i] is used by Group Executive, Trust leadership, the Quality and Safety Group, the Group Board and its committees and, in a condensed version, the Council of Governors. Not only does this make the best use of limited capacity and resources it ensures that there is a single source of the truth. The production of the IQPR is done manually and is therefore labour intensive. A new governor dashboard would need to draw from the same data that is already collected rather than require different information both to manage staff capacity and to maintain the premise of their being a single source of the truth.

3.3 IQPR Information Session: To inform the development of a dashboard, and to support governors more widely in their role, it is proposed that an information session on the IQPR and how it is used across the Trust be held in September. As well as being useful training and development for governors, this session would assist in identifying which metrics in the IQPR may be of most value to the Council. The IQPR would not be the sole source of information for a dashboard and a small number of other reporting may need to be drawn on.

3.4 Task and Finish Group It is proposed that a Task and Finish Group be established to develop a prototype dashboard for consideration by Council in December. This timeline takes into account the summer break, capacity within the relevant teams and the likelihood that several iterations will need to be worked through, whilst still bringing sufficient pace to the project.

The membership of the Task and Finish Group would include:

- 3-4 governors
- Liz Dawson (GDDCA & Head of Corporate Governance)
- A member of the Performance Team (reporting into Ed Nkrumah, Director of Performance and PMO)

The governors on the group would be ablet to seek the views of other members of the Council outside of the meetings but by keeping the group small it will remain agile and able to work at pace. It is anticipated that the group will meet via Teams on 3 occasions during the autumn with business also conducted via email.

Following the development of a dashboard, the forward planner and agenda for Council meetings would also be reviewed to avoid duplication of reporting.

6.0 Recommendations

6.1 The Council is asked to:

a. Confirm their support for an information session on the IQPR in September
b. Nominate 3-4 governors to join a task and finish group to develop a prototype governor dashboard.
c. Note that the prototype dashboard will be discussed at the December meeting of the Council.

[i] It should be noted that the IQPR has to be produced manually from a variety of data sources, so any subset of this data would also need to be produced manually.

Where can we gain further assurance – Committee Feedback summaries, NEDs, triangulation with public Board papers

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Core Facts – 2023/24

2023/24	2023/24	BUDGET
388,082	**1,022,366**	**£298.6**
REFERRALS	CONTACTS	MILLION

2023/24	2023/24	RATED
6,084	**3,179**	GOOD
COLLEAGUES	PUBLIC MEMBERS	BY THE CQC

GHC Long term Overview

Quality – Care Quality Commission Grading (2022 inspection) – Good

Staff Views – recommend GHC as a place to work (2024 national survey) – 71.5% *(2023 - 73.3% / 2022 - 69.2% /*

Staff Views – recommend GHC as a place to receive treatment (2024 national survey) – 76.3% *(2023 – 76.7% / 2*

Finance – Annual Financial Statements – unqualified external audit opinion received on 2023/24 accounts

Public Membership Statistics – at 12 March 2025

Constituency	
Cheltenham	518
Cotswolds	252
Forest of Dean	312
Gloucester	717
Stroud	521
Tewkesbury	351
Greater England & Wales	554
Total	3225

Ethnicity	
White British	2793
Mixed	57
Black/Black British	69
Asian/Asian British	99
White Other	99
Chinese/Other	6
Not Stated	95
Any Other	7
Total	3225

Disability in Gloucestershire	
Percentage disabled as of Census 2011	0.5%
Public membership	455 of 2669 members (20%)

Age Profile	
11-16	4
17-19	17
20-44	999
45-64	1078
65-74	503
75+	386
Did not disclose	238

Gender	
Male	1003
Female	2113
Transgender	4
Prefer not to say	105
Not Stated	0

Preferred Contact	
Email	2885
Post	340

	New Members	Removed
February 2025	6	8
January 2025	10	15
December 2024	13	7
November 2024	8	1
October 2024	12	7

working together | always improving | respectful and kind | making a difference

NHS
Gloucestershire Health and Care
NHS Foundation Trust

Indicators 2024/25 (at 31 January 2025)

Quality *(Data found in monthly Quality Dashboard Reports to Trust Board)*

Patients Friends and Family Feedback (Target – 95%) *(FFT analysis by team can be seen on page 8)*

Current Month Performance	Previous Report	Previous year Outturn/monthly comparison
January 2025 – 94% (2471)	November 2024 – 93% (2195) September 2024 - 94% (1960) July 2024 – 93% (2274) May 2024 – 93% (3093) March 2024 – 93% (2390)	2021/22 Outturn – 94% (16,581) 2022/23 Outturn – 94% (20,256) **2023/24 Outturn – 94% (30,519)**

Number of Complaints

The new NHS Complaints Standards, introduced from 1 August 2023, are designed to ensure that the right structures and systems are in place to capture and act on feedback, provide timely resolutions and deliver better patient and carer (and staff) experience. Data reporting has changed in a number of areas – for example, feedback is now either an "enquiry" (other contact) or a complaint. "Concerns" are no longer reported and therefore will no longer be included within this report.

Current Month Performance	Previous Report	Previous ye
January 2025 – 19 complaints / 183 enquiries	November 2024 – 13 Complaints / 157 enquiries September 2024 - 13 Complaints / 149 enquiries July 2024 – 9 Complaints / 149 enquiries May 2024 – 9 complaints / 172 enquiries March 2024 – 12 Complaints / 113 enquiries	2021/22 Outtu 2022/23 Outtu **2023/24 Outtu** * This includes concern before

Data now includes ALL complaints (closer look complaint / early resolution complaint). A directorate breakdown of all complaints and en
on Page 7.

Number of Open Complaints

Current Month Performance	Previous Report	Previous y
January 2025 - 63	November 2024 - 29 September 2024 - 30 July 2024 - 29 May 2024 - 21 March 2024 - 27	*N/A*

Includes ALL complaints (closer look complaint / early resolution complaint). This data now includes feedback that may previously have
analysis of timeframes and response times for open complaints is included in monthly Quality Dashboard reports.

Number of Compliments

Current Month Performance	Previous Report	Previous y
January 2025 - 183	November 2024 - 182 September 2024 - 173 July 2024 – 203 May 2024 - 241 March 2024 - 138	2021/22 Ou 2022/23 Ou **2023/24 Ou**

Finance *(Data found in monthly Finance Reports to Trust Board)*

Financial Performance better than or in line with plan? – YES/NO

Workforce *(Data included in Workforce KPIs report received at GPTW Committee and Performance Dashboard received at Trust Board)*

Staff Sickness (Threshold – 4%)

Current Month Performance	Previous Report	Previous year Outturn/monthly comparison
January 2025 – 5.64%	November 2024 – 5.25% September 2024 – 5.17% July 2024 – 4.96% May 2024 – 4.27% March 2024 – 4.62%	**N/A**

Mandatory Training completion (Target – 90%)

Current Month Performance	Previous Report	Previous year Outturn/monthly comparison
January 2025 – 94.3%	November 2024 – 96.2% September 2024 – 95.6% July 2024 – 95.5% May 2024 – 95.7% March 2024 – 94.1%	2021/22 Outturn – 90.3% cumulative 2022/23 Outturn – 92.4% cumulative **2023/24 Outturn - TBC**

Staff with Completed Personal Development Reviews (Appraisals) (excluding bank staff) (Target – 90%)

Current Month Performance	Previous Report	Previous year Outturn/monthly comparison
January 2025 – 87%	November 2024 – 91% September 2024 – 87% July 2024 – 87% May 2024 – 87% March 2024 – 86%	2021/22 Outturn – 67.7% 2022/23 Outturn – 85% **2023/24 Outturn - TBC**

Turnover Rate

Whilst the linear trendline for the monthly turnover rates demonstrates a stable turnover rate, the 12 monthly rate shows a declining line suggesting that the trusts workforce is becoming more stable.

Current Month Performance	Previous Report	Previous year Outturn/monthly comparison
January 2025 – 10.81%	November 2024 – 11.19% September 2024 – 11.48% July 2024 – 11.20% May 2024 – 11.70% March 2024 – 12.27%	**N/A**

Data extracted from key performance reports received at our Board Committees

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Breakdown of Complaints and Enquiries (January 2025)

This table shows all reported Patient Carer Experience Team (PCET) data received this month by type and directorate. It is important to note that this is a snapshot and does not consider directorate size/footfall/caseloads/acuity of patients.

Directorate	Complaint			Enquiry	Compliment
MH/LD urgent care and inpatient	0	Early resolution:	0	24	18
		Closer look:	0		
PH urgent care and inpatient	1	Early resolution:	1	14	47
		Closer look:	0		
CYPS	1	Early resolution:	1	30	11
		Closer look:	0		
PH/MH/LD Community	2	Early resolution:	2	43	73
		Closer look:	0		
Countywide	1	Early resolution:	0	27	32
		Closer look:	1		
IUCS	14	Early resolution:	14	0	1
		Closer look:	0		
Other	0	Early resolution:	0	45	1
		Closer look:	0		
Totals	19	Early resolution:	18	183	183
		Closer look:	1		

Examples of complaints (as reported) for each directorate:

- PH UC/IP: Patient unhappy as his injury was misdiagnosed at Stroud Minor Injuries.
- CYPS: Mother of patient wishing to raise a complaint concerning the proposed care plan for the patient - escalated from enquiry.
- Community: Patient unhappy with her recent meeting with her care coordinator.
- Countywide: Father of patient unhappy that the patient is growing out of his wheelchair which is broken and needs repair.

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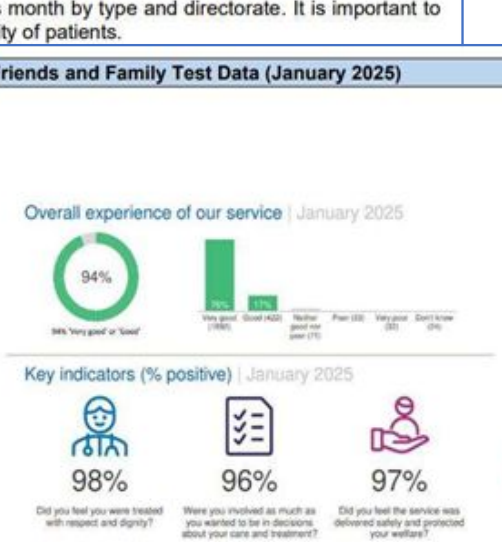
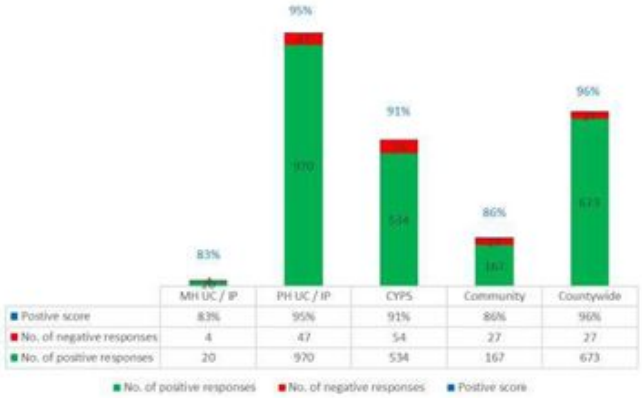
Friends and Family Test Data (January 2025)





The overall positive experience rating is 94% which is line with recent data. We are continuing to work with services where responses are low to promote a variety of survey methods, such as iPads, QR codes and paper where this is appropriate.

Governors can request specific areas of focus to be added to the Dashboard, e.g. analysis of Complaints and compliments, and average length of stay.

Board and Board Committee Activity

Trust Board

The next Trust Board meeting will be held on **Thursday 27th March 2025** at 10.00 – 1.00pm at Trust HQ, Edward Jenner Court. All Governors are invited to attend our Board meetings to observe. The papers for this meeting will be made available from Friday 21st March and notification will be sent out to Governors at that time. These papers will include the full minutes from our previous Board meeting held in January 2025, and Governors are encouraged to read these to keep up to date with Board discussion, developments and focus areas.

Board Committees

Summary reports setting out the key items of business discussed at our Board Commi
meeting. Since our last Council of Governors meeting in January, the following Comm

- Audit & Assurance Committee (6 February 2025)
- Great Place to Work Committee (25 February 2025)
- Resources Committee (26 February 2025)
- Quality Committee (4 March 2025)
- Charitable Funds Committee (12 March 2025)

The key agenda items received, discussed, and noted at these meetings are included
are invited to ask questions on any items of interest picked up from the agenda items

Gloucestershire Health and Care
NHS Foundation Trust

Audit & Assurance Committee (6 February) ***Chair: Bilal Lala***	**Great Place to Work Committee (25 February)** ***Chair: Sumita Hutchison***
Internal Audit – BDO - Progress Report New Data Security & Protection Toolkit & Audit Approach BDO Internal Audit Reports: • Procurement & Contract Management • Performance Appraisals • Directorate Governance Audit Action Plan • Internal Audit Plan 2025/26 External Audit – KPMG - Progress Report & External Audit Plan 2025 Counter Fraud, Bribery & Corruption Progress Report & orkplan 2025/26 Finance Compliance Report Cyber Security Assurance Report Risk Review Annual Review of Committee Effectiveness & TOR Sub Group Summary Reports: • Health & Safety & Security Management Group • Risk Management Group • Information Governance Group • BEME Management Group Internal Audit Evaluation 2024 Appointment of External Auditors	National Workforce Policy Update Staff Story: Reasonable Adjustments for Colleagues with a Disability Volunteer Strategy & Update Performance Report - Workforce KPIs Staff Engagement Update: • Staff Survey (embargoed 2024 Results) & Friends & Family Test Report • Gender, Ethnicity & Disability Pay Gap Report • Diversity Network Update Risk Register Report Board Assurance Framework Review of Committee Terms of Reference Summary Report of Management Groups Meetings: • Workforce Management Group • Joint Negotiating & Consultative Forum BDO Internal Audit Report – Performance Appraisals
Resources Committee (26 February) ***Chair: Jason Makepeace***	**Quality Committee (4 March)** ***Chair: Jan Marriott***
Finance Report – Month 10 System Finance Position & Deficit Risk Share Update – Month 10 Performance Report – Month 10 Budget Setting – 2025/26 update Business Planning Report – Quarter 3 Service Development Report – Month 10 Cyber Security Assurance Report ICS Cyber Security Strategy Annual Operating Plan update Risk Reporting – Quarter 3 Committee Effectiveness & Terms of Reference Review Summary Reports of Management Groups: • Digital Group • Capital Management Group • Business Intelligence Management Group • Strategic Oversight Group • Community Mental Health Transformation	Quality Dashboard Report (including): • Guardian of Safe Working (Q3) • NED Quality Visits (Q3) • Patient Safety Data • Safeguarding • Learning from Deaths (Q3) • Closed Culture Report Rapid Tranquilisation - Benchmarking Crisis Services Briefing Clinical Issues Report Berkeley House Update Sexual Safety Update Quarter 3 Risk Report Quality Assurance Group Summary Report Quality Strategy 2021-2026 – Bi-Annual Update Report Psychological Services Strategic Framework Review of Quality Committee Terms of Reference Medical Education Annual Report

Provides the opportunity for Governors to question and challenge the NEDs on items received – seeking assurance

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Council of Governors

Meeting in Public on Thursday, 17 July 2025

Agenda Item	6.1	
Report Title	**Report from the Membership Engagement Committee**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Jackie Parker/ Anna Missir	
Previously considered by	n/a	-
Purpose	**For Noting**	

Executive Summary

The Council of Governors is asked to note the matters considered by the Membership and Engagement Committee at its meeting on 24 June 2025.

Committee Assurance

Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name

Implications

Group Strategic Objectives

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

Risks

N/a

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☐ Well Led

NHS system oversight framework

☐ Quality of care, access and outcomes
☐ People
☐ Preventing ill health and reducing inequalities
☐ Leadership and capability

☐ Finance and use of resources	☐ Local strategic priorities
Financial implications	
N/a	
Legal and / or Regulatory implications	
N/A	
Equality, diversity and inclusion implications	
As set out in paper.	
Environmental sustainability implications	
N/A	

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Report from the Membership and Engagement Committee

Council of Governors, 17 July 2025

1.0 Purpose of paper

1.1 This report sets out the key matters considered by the reconstituted Membership and Engagement Committee at its meeting on 24 June 2025

2.0 Progress Report

2.1 The Committee met on 24 June 2025 recording Jackie Parker as the newly appointed chair.

The Committee encouraged more governors to join the group – Augustine Odiadi joined as an observer at the April meeting and as a member at its June meeting. At the June meeting Luisa Brown was welcomed as an observer with a view to becoming a member. It is hoped that other governors will be observing in due course.

The 1-year Membership Engagement Strategy was agreed by Council in September 2024. Whilst behind schedule in some areas, progress is being made and with the involvement of governors, the Committee believe that we will still be able to deliver the majority of the actions, however it was recommended that the survey be pushed back further giving way to other objectives being completed within the timeframe.

A key success has been the increase in numbers at the Annual Members Meeting – linked to the 'Bring A Friend' element, which was led by governors, and direct emails to members. Work has already begun on the advertisement of this year's Annual Members Meeting and a save the date was to be included in the Members Newsletter 'Connected' which is set to be released at the end of June. This action has now been completed.

On 30th May a very successful Meet your Governor took place in the reception area of the Grosvenor Wing in St Georges Hospital. 39 new members were signed up on the day with additional sign ups following the event. Two more events are planned before the end of the calendar year.

The Membership page on the website has been refreshed and advertisements for the SW Lambeth membership recruitment has been added. This is an ongoing process.

2.2 The Committee received a report from the Governors and Membership Engagement Officer (GMEO) that set out the age breakdown within each constituency. Also contained in the report was the ward areas for SW Lambeth as seen below:

Streatham Hill SW2	Clapham Town SW3	Clapham Common SW12	St Leonards SW16	Streatham South SW16	Streatham Hill West & Thornton SW12

The report displayed that overall quantity of membership was over what was required (minimum membership levels established in the Trust's Constitution), was healthy and was socially representative. The Committee noted that (1) There is under representation of 16–25-year-olds across all constituencies; (2) SW Lambeth was 39 members above the minimum membership level and currently had no Governor.

2.3 Youth Engagement

During June a meeting was held with Jackie Parker, Sophia Agha and the GMEO to discuss progressing the youth engagement strategy. Sophia updated the committee on items discussed:

- Career fairs: Featuring healthcare professionals and career advice.
- Volunteer days: Opportunities to directly participate in Trust projects
- Health awareness campaigns: Educational sessions on topics relevant to youth.
- Guest lectures or workshops hosted by Trust clinical/non-clinical professionals.
- Social media youth ambassadors
- St George's medical students' hackathon-style competition with them, pitching a solution to a problem that the hospital faces.
- Buddying with the junior doctors and university med students.
- Work experience school students
- Create youth governor email.
- Patient engagement – Under 25s
- Freshers Governors stall (Sept/Oct).

The Committee agreed with the ideas and suggested contact with Communications Team, Patient Partnership Experience Group, St Georges Hospital Charity and Human Resources (regarding work experience). It was also agreed that Connected issue 2 would contain a welcome slot for the new Associate Governor (Young Members). This action has been completed.

2.4 BAME Merton Under representation

A discussion took place around BAME under representation specifically in the Merton area. JP mentioned this had been mentioned in a previous meeting and wanted to hear from the Merton Governors on their thoughts about this or what support they might need. The following ideas were raised:

- Community events and trying to recruit people.
- Liaise with EDI team Joseph Pavett Downer, (EDI Lead)
- Advertise in Newsletter to recruit.

Chelliah Lohendran and Luisa Brown advised that they belonged to WhatsApp focus groups and were actively involved in BAME representation.

2.5 Staff Governor Roles

At a previous meeting of the Committee, it was decided that the Staff Governor role required defining and prior to this meeting example of Staff Governor roles from two different hospitals were provided for comment.

A discussion took place around the differences between Governor roles and in particular Staff governors and their members interaction. What kind of issues would a Staff governor be contacted for – an example was given saying if the role is not defined members may think that their governor would be able to deal with a bullying issue when its should be routed through Human Resources.

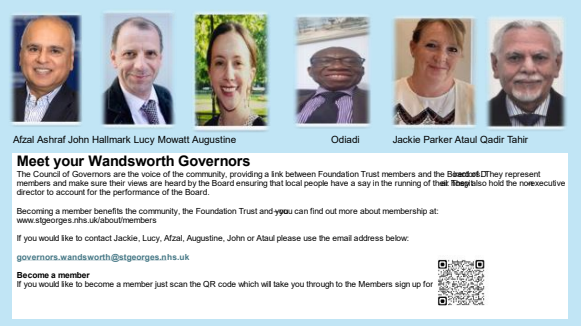
The following was also raised and agreed:

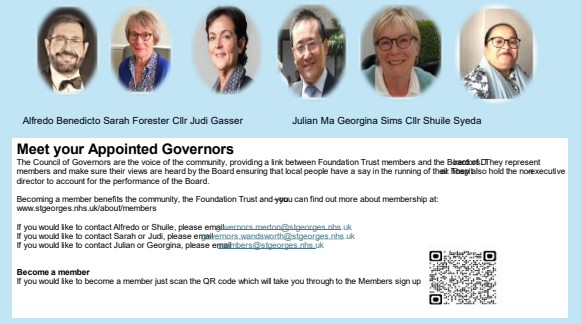
- Advertise role of staff governor intranet/website ‘hello we are here’ feature.
- Monthly walk arounds
- Staff governors to meet and discuss their role and include Atif Mian to get an idea of what issues he faced.

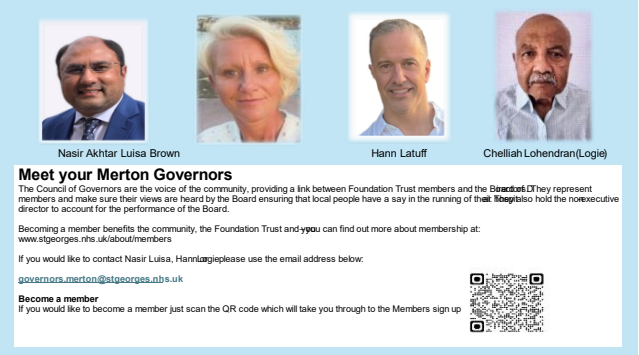
September sees the start of the recruitment process for electing a replacement for one of the staff governors so would be an opportunity to advertise on the intranet about the role.

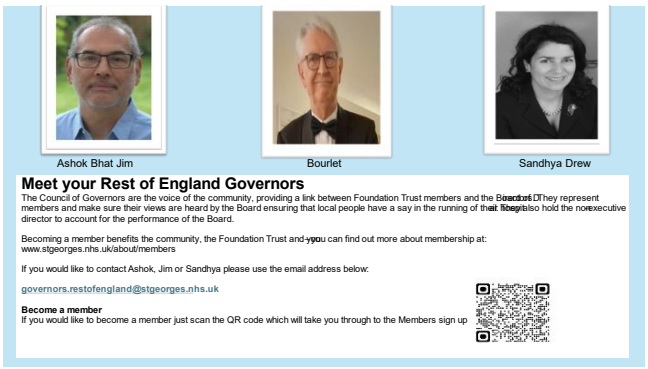
2.6 Constituency Posters/Leaflets

The constituency leaflets were provided for review to the Committee. It was agreed that the leaflets be printed out ready for governors’ collection. Individual leaflets have also been provided and are ready for collection.









3.0 Recommendations

3.1 The Council of Governors is asked to note the update on the matters considered by MEC at its June meeting and to consider the action points/recommendations

Board, Committees and Council of Governors Calendar 2025/26

St George's University Hospitals NHS Foundation Trust

Month	Date	Meeting	Time	Location / Format
May	1 May	Group Board Meeting (Public and Private)	08:30 - 16:00	QMH, Sheen and Richmond Rooms, Roehampton, SW15 5PN
	6 May	Governors Scheduled Visits – Surgical and Sites Services	14:30 – 16:30	Surgical and Site Services
	8 May	New Governors Induction	13:00 – 15:00	MS Teams
	22 May	Council of Governors Meeting	17:30 – 20:30	Hyde Park Room, St Georges Hospital
	30 May	Meet Your Governor – St Georges	09:30 – 16:30	Grosvenor Wing reception area St Georges
	30 May	Finance Committees-in-Common	09:00 – 13:00	MS Teams
June	10 June	Governors Scheduled Visits - Outpatient	10:00 – 12:00	Outpatients St Georges Hospital
	13 June	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	TBA	Membership Engagement Committee	TBA	TBA
	19 June	People Committees-in-Common	09:00 – 12:00	MS Teams
	26 June	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 June	Finance Committees-in-Common	09:00 – 13:00	MS Teams
July	3 July	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference Room 1
	8 July	Governors Visits – Diagnostics - Postponed	11:00 – 13:00	Outpatients
	8 July	Governor/NED pre-meet	14:00 – 15:30	MS Teams and Blackshaw Annex room 1.013
	17 July	Council of Governors Meeting	17:30 – 20:30	Hyde Park Room, St Georges Hospital
	24 July	People Committees-in-Common	09:00 – 12:00	MS Teams
	25 July	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	29 July	New Governor Induction part 2	13:00-14:30	MS Teams
	31 July	Quality Committees-in-Common	11:00 – 13:00	MS Teams
August	1 August	Finance Committees-in-Common	09:00 – 13:00	MS Teams
	21 August	Governors' visits – Senior Health	11:00 – 13:00	Senior Health
	22 August	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	TBA	Membership Engagement Committee	TBA	TBA
	28 August	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	29 August	Finance Committees-in-Common	09:00 – 13:00	MS Teams
September	5 September	Group Board Meeting (Public and Private)	09:15 – 15:30	St Helier Hospital, Whitehall Lecture Theatre

St George's University Hospitals NHS Foundation Trust

Board, Committees and Council of Governors Calendar 2025/26

Month	Date	Meeting	Time	Location / Format
	11 September	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	16 September	Governors Visits - Support Services	14:30-16:30	Support Services
	18 September	People Committees-in-Common	09:00 – 12:00	MS Teams
	19 September	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	24 September	Council of Governors Meeting	13:15–16:15	Hyde Park room, St Georges Hospital
	24 September	Annual Members Meeting	TBC	TBC
	25 September	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	26 September	Finance Committees-in-Common	09:00 – 13:00	MS Teams
October	1 October	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	14 October	Governor Visits – Renal Services	14:30 - 16:30	Renal Services
	23 October	People Committees-in-Common	09:00 – 12:30	MS Teams
	24 October	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	30 October	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	31 October	Finance Committees-in-Common	09:00 – 13:00	MS Teams
November	5 November	Governor Visits - TBA	TBA	TBA
	6 November	Group Board Meeting (Public and Private)	09:15 – 15:30	Hyde Park Room, St George's Hospital
	TBA	Membership Engagement Committee	TBA	TBA
	20 November	People Committees-in-Common	09:00 – 12:30	MS Teams
	21 November	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	27 November	Quality Committees-in-Common	11:00 – 13:00	MS Teams
	28 November	Finance Committees-in-Common	09:00 – 13:00	MS Teams
December	1 December	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	4 December	Group Board Meeting (Public and Private)	09:15 – 15:30	QMH, Sheen and Richmond Rooms
	5 December	Governor Visits - TBA	TBA	TBA
	10 December	Council of Governors Meeting	14:00-17:00	Hyde Park Room, St Georges Hospital
	11 December	People Committees-in-Common	09:00 – 12:30	MS Teams
	12 December	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	18 December	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	19 December	Finance Committees-in-Common	09:00 – 13:00	MS Teams

St George's University Hospitals NHS Foundation Trust

Board, Committees and Council of Governors Calendar 2025/26

Month	Date	Meeting	Time	Location / Format
January	8 January	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	19 January	Governor Visits - TBA	TBA	TBA
	22 January	People Committees-in-Common	09:00 – 12:30	MS Teams
	23 January	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	29 January	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	30 January	Finance Committees-in-Common	09:00 – 13:00	MS Teams
February	4 February	Governor Visits - TBA	TBA	TBA
	5 February	Group Board Meeting (Public and Private)	09:15 – 15:30	Epsom General Hospital, Conference room 1
	TBA	Membership Engagement Committee	TBA	TBA
	19 February	People Committees-in-Common	09:00 – 12:30	MS Teams
	20 February	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	26 February	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 February	Finance Committees-in-Common	09:00 – 13:00	MS Teams
March	4 March	Governor Visits - TBA	TBA	TBA
	5 March	Group Board Meeting (Public and Private)	09:15 – 15:30	Hyde Park Room, St Georges Hospital
	16 March	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	19 March	People Committees-in-Common	09:00 – 12:30	MS Teams
	20 March	Infrastructure Committees-in-Common	11:30 -13:30	MS Teams
	25 March	Council of Governors Meeting	17:30-20:30	Hyde Park Room, St Georges Hospital
	26 March	Quality Committees-in-Common	09:00 – 12:30	MS Teams
	27 March	Finance Committees-in-Common	09:00 – 13:00	MS Teams