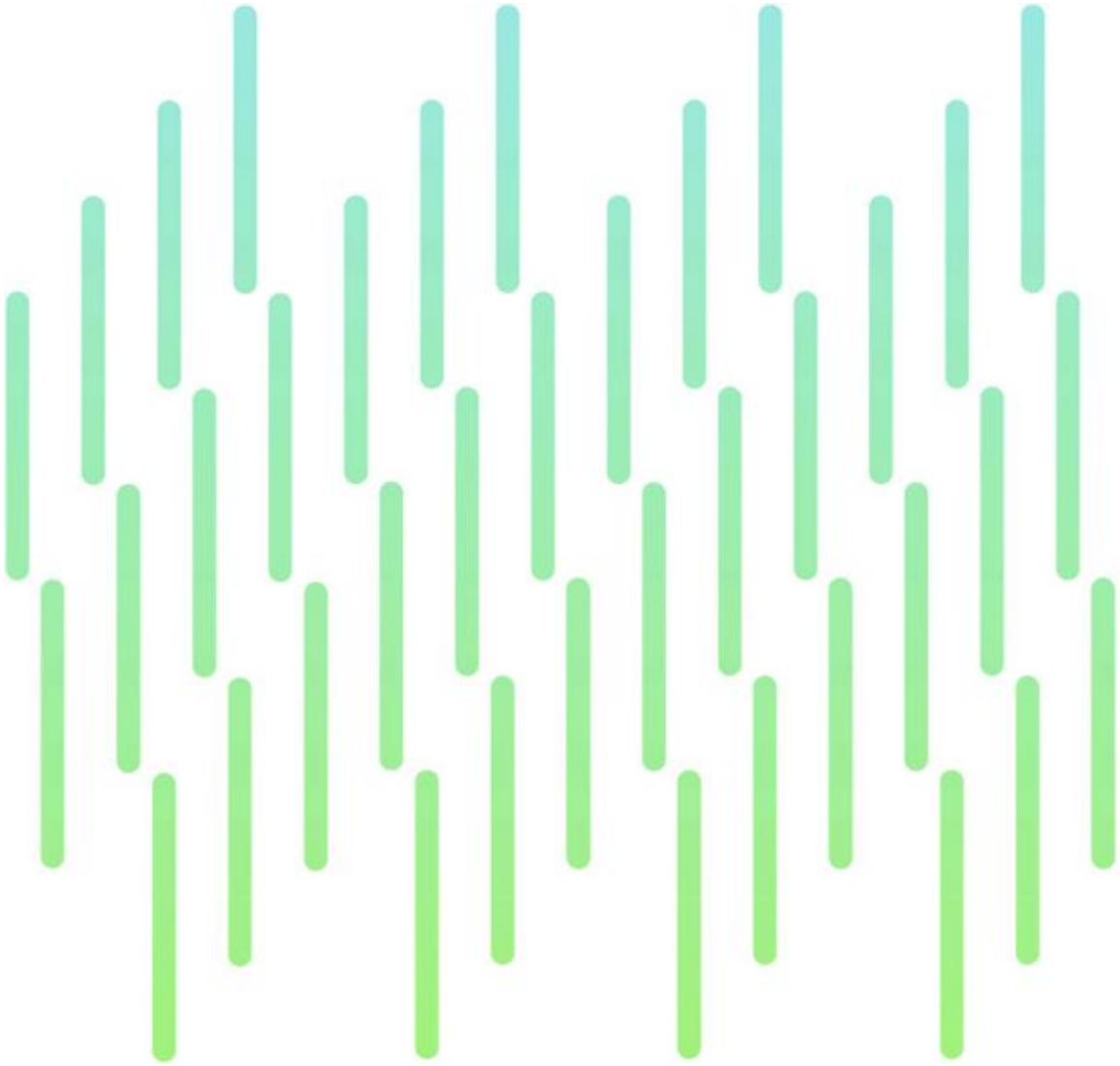
Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Council of Governors Meeting
22 May 2025

Agenda and papers



Feedback from Governors visits to In-Patient wards 20th March (Judi, Hann, Logie)

Gordon Smith

- Led by Matron (Jan) and also met Chief Nurse
- Staff feel they have very good working environment
- marked by respect and inclusive culture.
- Three-month in-house training programme attracts and ensures staff retention.
- Very good ongoing relation with senior management (they specifically mentioned the Chairman, Group CEO, Chief Medical Officer and Chief Nurse Officer).
- Need of more space as working units and equipment are stationed all over the corridors.
- Ward staff conscious that improvements are required with documentation. Some staff are still more used to manual versus electronic filling out of daily reports.

Ruth Myles

- Led by Matron (Nats).
- Patients have doubled in the last few years but staff numbers have not increased. However overall sentiment is that there is good support to the staff.
- A plan is in action to resolve an issue with delays with pharmacy prescriptions.
- Also, a plan is being implemented to unburden nursing staff from duties that can be taken over by admin staff eg appointments.

Cheselden

- Led by matron Cardiovascular Thoracic (CVT - Karen) and also met Senior Nurse (Elaine).
- Concerns about number of beds and physical space.
- Lengths of stay vary from radiology patients to amputees (the latter around 4-6 weeks). Extremely busy ward due to feeding from various other hospitals.
- Many patients are recurring and appreciate knowing the ward staff.

Major Trauma

- Led by Matron Aoife.
- Recently refurbished with obvious signs of better light and wider space than most other wards, it feels like a state-ofthe-art one.
- The new space meant sacrificing 4 beds from before but the additional space between beds is helpful as easier to fit equipment.
- Ward only works with emergencies, ie non-elective. There was police presence, which is not unusual due to knife crime-related injuries.
- Prescriptions are managed via a new Omicell security dispenser requiring fingerprints to access. This is being trialled for wider use in the SG and is expected to be improved to synchronise automatically with patients' records.
- The ward looks after children as well as having an orthogeriatric team. While we were visiting, a large delegation came in. They were inspecting the ward for a possible inter-ministerial visit next week related to the knife amnesty initiative.

- The ward has been offering reiki (complementary healing) to in-patients.
- A multidisciplinary team meets every morning to discuss each of the in-patient's cases.

General Notes:

All feedback received during the visit is provided by senior staff guiding the visit. A suggestion was made to have the relevant NED's join the Governors' visits.

Emphasise the need for space across all wards and the need for specific maintenance jobs (eg door in Ruth Myles [?] was not functioning) to be carried out.

Visit to the Urgent and Emergency Care departments 9th April (Jackie, Logie, Afzal, Judi, Ashok, Jim B, Augustine)

1. At the ED, the satisfactory progression of patients from point of entry, treatment, and discharged is praiseworthy. We hope our observation would reflect in the users' expression of satisfaction with their use of our ED system.

2. The Electronic check-in system has improved users experience of the ED system. The old problem of patients waiting without anyone knowing they were waiting is no more the case. The use of the QR scan system also helps staff to monitor patients within the progression system.

3. But the problem of 'flow' is not the same when comes to patients brought in direct to the ED by Ambulance; especially with Mental Health patients. There is the need for closer working relationship between the Control Centre and the wards to improve the flow within the system.

4. The continued use of Corridor to treat patients now and again remains a problem and staff said they are doing their very best to minimise the consequences of this problem. This is a national problem but our ED should be supported all the ways possible to improve patients' safety by all means.

5. Waiting time through the ED is said to have improved and continue to improve. For example, waiting time for children is said to be about 1.5 hours; and this is good news for the children and their parents.

6.At the ADU staff are happy with the now improved staff turnover; but the problem of 'boarding' and 'space' still persists.

7. There was clear evidence thar the recent CQC report on our hospital is adversely affecting staff morale. The departments concerned should be supported to uplift their sprits to work harder to turn things around and; improve the short comings that led to the negative report.

8. There is also the urgent need to address the long cues at the Pharmacy; often more than 3 hours for patients to collect their prescribed medication following discharge.

Governor visit 6th May - Surgical and Site Services

Sarah Forester Jackie Parker John Hallmark Alfredo Bendicto (part)

Discussion with outreach team

Louise and Aoife band 7 and 6 nurses. Team of critical care specialists who attend adult patients, on wards and often in hospital estate perimeter etc, who may be deteriorating or who other clinical staff want a more specialist opinion about management. Assess and can provide suitable equipment etc They are also responders to Martha's rule contacts

24/7 two nurses one registrar and one consultant on call Referrals come from Drs and nurses but also estates porters etc if not on wards. Particular support for new staff eg junior doctors and often get nurse to nurse calls. Follow up patients they see and have a monitoring role. Occasionally calls seem not appropriate; use this as a teaching point for staff

Last year had 11,500 calls. Prevent deterioration in patients by early intervention so key safety input Cost effective in helping flow across the hospital and helping management of critical ill people on wards avoiding ICU (but also escalate as necessary). Also, key role in upskilling staff and teaching eg Have run simulations of crash exercises with ward teams.

Marthas rule now rolled out across the whole hospital (separate bleep) and they respond to calls including paediatrics for this. Matron of team ensures signage for Martha's rule is in places where patients and relatives can see, and we saw evidence of this on our visits to wards.

Current challenges – making business case for replacing staff who are leaving or going on maternity leave

What's it like to work at St Georges? Has feeling of a district general hospital despite being large and tertiary centre. Good relationships between team and all departments Interesting and challenging role with lots of variety Feel their skills are valued.

Grey Ward

Mixed surgical and trauma ward (urology, colorectal and some gynae) Currently Silver accreditation (Missed gold accreditation by a few points)

Matron Aoife – a buddle of energy and enthusiasm who had really good grasp on what the team needed to improve care and a plan to do it. Reflected on post covid period of staff change, inconsistent leadership and relearning the basics of care after period of firefighting. Especially true of staff trained and newly qualified during pandemic, so had been an emphasis on team building and basics of care eg falls prevention pressure are area care etc Ward looked organised and calm though busy. Mentioned importance of staff appraisals and CPD

Current challenges – lack of oxygen at each bed – having to make case for this. Also lack of electrical points at bedside meant not always enough sockets for equipment plus patients to charge phones etc

Staffing establishment balance between day and night shifts Had trialled different patterns and working with staff. Some suggestion that although changes had been agreed this had been blocked at Group level

Felt that she had good support from senior nursing – name checked Nicola Copeland

One patient said care and staff were excellent but admission had been difficult and had needed pressure from his GP. He was also aware of other patents having issues on discharge

Florence nightingale ward

ENT surgical ward and only ward in SWL consortium that managed tracheotomies and laryngectomies outside an ICU space

Currently Platinum accreditation

Show round by Camille Matron and Abena Nurse in Charge again very positive and impressive leaders of their service

Looked like a platinum ward; extremely tidy and all staff busy calm and very friendly. A real sense of purpose pride and teamwork – Wanted a photo with us which all staff were encouraged to be in

Due to nature or work many patients stay longer periods in recovery getting used to various devices including airway support, nasogastric feeding etc Good support from a range of therapists SALT OT Physio and clinical psychologists. Clinical nurse specialist follows up patients at home as well

Staffing stable with no vacancies

Main issues – because tertiary service, increasing number of people needing airway support and having the right physical space plus enough trained specialist nurses to ensure safe care as demand grows They had trained nursing staff in Trauma to do airway support but due to issues about who takes responsibility in medical teams (outside ENT) they were not able to practice

Four beds had no bedside oxygen supply

Discharge of people with airway and feeding support needs can be a challenge, especially with care homes. One example of a homeless man with a tracheotomy waiting housing. One patient had been in for 5 months but still had medical needs due to complexity of surgery and reconstruction

No issues with estates IT etc

Discharge lounge

Russell Manager of discharge lounge

Space with 8-10 beds plus chairs for people waiting discharge but need eg test results, transport pharmacy. Most nights there are people staying overnight

This unit comes under site services rather than any clinical directorate. Situated in Cavell ward and shares space, but separate from, the oncology unit where people attend for daily chemo etc

Obviously and important part of flow through the hospital but a slight feeling that it was out on a limb and that with further thought it could be developed more. Possibly due to not being part of a clear clinical structure.

Main issues for supporting quicker discharge – timeliness after ward rounds – eg discharge patients may not take priority for junior medical staff to do admin, write up prescriptions etc transport and pharmacy.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Agenda

Meeting in Public on Thursday, 22 May 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

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

2.0 Strategy					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
17:50	2.1	Group Chief Executive's Report	GCEO	Update	Report

3.0 Quality and Performance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18.00	3.1	CQC Well Led Inspection – Letter in advance of report	GCCAO	Update	Report
18:10	3.2	SGUH Operational Performance and Priorities	MD-SGUH	Discuss	Report
18.30	3.3	Maternity Services	GCNO	Update	Report

4.0 Finance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18:40	4.1	Finance Update	GCFO	Discuss	Report

5.0 People					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
18:55	5.1	2024 Staff Survey	GCPO	Update	Report

6.0 Governance					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19.05	6.1	Recommendations on governor vacancies	GCCAO	Approve	Report

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7.0 Membership Engagement					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:10	7.1	Membership Engagement Committee Update	Committee Chair	Discuss	Report
19:15	7.2	Governor ownership of membership engagement	Lead Governor	Discuss	Verbal

8.0 Items for Noting					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19.25	8.1	Fit and Proper Persons Compliance 204/25	GCCAO	Update	Report

9.0 Closing Items					
Time	**Item**	**Title**	**Presenter**	**Purpose**	**Format**
19:30	9.1	Any Other Business	All	Note	Verbal
	9.2	Council of Governors Calendar of Events	All	Note	Report
	9.3	Reflections on Meeting			

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 Chairman	Chairman
Sophia Agha	Associate Governor (Young Members)	SA
Nasir Akhtar	Public Governor, Merton	NA
Afzal Ashraf	Public Governor, Wandsworth	AAs
Alfredo Benedicto	Appointed Governor, Merton Healthwatch	AB1
Ashok Bhatt	Public Governor, Rest of England	AB2
James Bourlet	Public Governor, Rest of England	JB
Luisa Brown	Public Governor, Merton	LB
Pankaj Dave	Non-Executive Director	PD
Dympna Foran	Staff Governor, Nursing and Midwifery	DF
Sarah Forester	Appointed Governor, Healthwatch Wandsworth	SF
Judith Gasser	Appointed Governor, Wandsworth Council	JG
John Hallmark	Public Governor, Wandsworth	JH1
Chelliah Lohendran	Public Governor, Merton	CH
Hann Latuff	Public Governor, Merton	HL
Julian Ma	St George's University of London	MA
Khadir Meer	Associate Non-Executive Director	KM
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		
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
Peter Kane	Non-Executive Director	PK
Ralph Michell	Director of Strategy & Integration	DS&I
Andrew Murray	Non-Executive Director	AM
Michael Pantlin	Interim Group Deputy Chief Executive Officer	IGDCEO
Kate Slemeck	Managing Director - SGUH	MD-SGUH
Victoria Smith	Group Chief People Officer	GCPO
Barbara Mathieson	Governance Manager (Minutes)	BM
Apologies		
Natalie Armstrong	Non-Executive Director	NA
Arlene Wellman	Group Chief Nursing Officer	GCNO
Sandhya Drew	Public Governor, Rest of England	SD
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)
Wednesday, 12 March 2025, 17:30 19:15
Hyde Park Room, Lanesborough Wing, St George's Hospital

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

Feedback from Governor visits	Action
Feedback from visits to various parts of the site A number of Governor visits had taken place since the last meeting, and governors expressed thanks to the staff who had facilitated the visits and for taking time out of their schedules to talk to them about the care provided. The following points were raised and noted: • Maternity: Governors were pleased to visit maternity services given the current challenges facing the service, and were generally impressed with the visit. The only concern raised was that one of the birthing pools had not been working for some time and staff had said they would like this to be fixed. The MD-SGUH noted this and added, for context, that there were two other birthing pools available for use. • Cardiology: Governors had enjoyed the visit to Cardiology and were pleased to hear about the care provided by clinical teams. They had noted that there was a broken door lock on the Coronary Care Unit and staff had expressed concern about security. This had been reported through the estates team and was being addressed.	

1.0	OPENING ADMINISTRATION	Action
1.1	**Welcome and Apologies** The Chairman welcomed everyone to the meeting and noted the apologies as set out above.	
1.2	**Declarations of Interest** There were no new declarations of interest.	
1.3	**Minutes of the Public meeting held on 12 December 2024** The minutes of the meeting held on 12 December 2024 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising** The Council of Governors note that there were no open actions on the Action Log. As a matter arising, the Council noted that a recent media article had suggested that the Trust had a high level of complaints that had been referred to and considered by the Parliamentary and Health Service Ombudsman (PHSO). The Council enquired about the factors that had led to the high numbers. The GCNO explained that the numbers set out in the media article were inaccurate and the numbers reviewed by the PHSO were considerably lower than had been stated. The GCNO added that it was unclear how the journalist had arrived at the numbers included in the story but it appeared that data from a recent Board report may have been incorrected quoted. The GCNO agreed to provide the Council of Governors with the data on the number of complaints that had been made to the PHSO.	**GCNO**
2.0	**STRATEGY**	
2.1	**Group Chief Executive Officer's (GCEO) Report** The GCEO introduced the report and highlighted the following points: • In January 2025, the Government announced the outcome of its review of the New Hospitals Programme (NHP). The review had been commissioned by the Secretary of State for Health and Social Care "to provide a realistic and affordable timetable for delivery" of the programme. The Government has said	

	that it is committed to delivering all schemes that were previously part of the NHP. These will be delivered in three phases. From a Group perspective, the key part of the announcement was the delay in the construction of the Specialist Emergency Care Hospital (SECH) at Sutton, and the upgrade for Epsom and St Helier Hospitals, which has been allocated to the second wave, with construction scheduled to start between 2033 and 2035 and completion anticipated between 2037 and 2039. The direct implications of the announcement from a St George's perspective were in relation to the consolidation of Renal services on the Tooting Site, and the announcement had led to some uncertainty about the way forward. • Major changes had been announced regarding the future of NHS England. The existing Chair and Chief Executive, together with a number of Executive Directors, had announced that they would be leaving. Sir Jim Mackey had been announced as the incoming Chief Executive with a remit to radically reshape how NHS England and the Department of Health and Social Care worked together. The Chair invited comments and questions from Governors and the following issues were raised and noted in discussion: • In relation to the Renal Development Programme, AB1 asked what the decision on the NHP would mean for the new build as it was not clear which phase this would slot into. The GCEO explained that while the majority of the costs of the build were not dependent on the NHP, some of the funding was linked. Due to inflation the anticipated cost of the build had increased by around £40m. Given the Trust's capital position was extremely challenged, it was not possible to proceed at the current time. • On the Government's waiting lists announcement, JH asked whether the dramatic increase in the number of patient appointments come with additional staff and beds and whether there was room to accommodate these. The GCEO stated that there was no new money for hospitals, though GPs would receive some limited funding increases. The key for the Trust was to become more productive, reduce the number of follow-up appointments and address the high levels of DNA (did not attend) rates. If the number of follow-up appointments could be reduced, there would be capacity to book in additional patients. • AB1 noted the recent departure of the Group Deputy Chief Executive and enquired about the plans for covering this portfolio and who would take that decision. The Chairman clarified that the appointment was the responsibility of the Board and that a process for the appointment of a successor would shortly be reviewed by the Nominations and Remuneration Committee. The Council noted the GCEO report.	
2.2	**Strategy Update** Ralph Michell, Group Director of Strategy and Integration, introduced the report and explained that the external environment had changed significantly since the strategy was developed in 2022-23, including the election of a new government and the delays to the new hospital programme. In light of these changes, the Board was scheduled to review the strategy at its meeting in July. In the meantime, the Board continued to receive regular updates on its implementation. Work was progressing on the development of corporate enabling strategies, with the Quality and Safety Strategy, People Strategy and Green Plan already agree by the Board, and strategies on digital, research and innovation, and estates in development.	

	In relation to the People Strategy, SD asked whether consideration had been given to using membership engagement to engage with the staff. The GDSI replied that consideration not specifically been given to this in terms of engaging with staff as 'members', but there had been considerable direct engagement with staff in the development of the strategy. In relation to the reference in the papers to the Board having agreed a number of "Board to Ward priorities", JP asked what these referred to. The GDSI explained that these were the priorities set out on page 6 of the slides under the CARE acrostic: working with other teams to reduce delays in patient journeys through our services; living within our means by innovating, working more efficiently and cutting costs; keeping our patients safe, including those waiting for our care; and making our team a great and inclusive one to work in". The GDSI added that the Board received regular updates against these priorities through the year through six-monthly reports on strategy implementation as well as through the reporting of performance in Integrated Quality & Performance Report (IQPR) which had been aligned to the CARE objectives. These priorities were not only overseen at Board level, but were increasingly being cascaded through the organisation so that both clinical and non-clinical teams could develop their own local priorities that supported the wider CARE objectives. SF asked about the recommissioning of community services in Merton and Wandsworth, noting that this had been delayed, and queried whether there was anything that could be done to help progress this. The GCEO commented that provider alliances were being set up in Wandsworth and Merton and the Trust was actively engaged in discussions about the future of community services in these boroughs. JH asked whether the strategy was set in stone or whether it could be changed given the fact that the operating environment had changed. The GDSI explained that there was scope to update the strategy and that the Board planned to review the strategy at its meeting in July to consider whether any changes were needed. The Council noted the report.	
3.0	**QUALITY AND PERFORMANCE**	
3.1	**SGUH Operational Performance** The MD-SGUH introduced the report and highlighted the following: • Cancer performance standard trajectories had been met in January. • First and procedure outpatient (OP) attendances as a percentage of total OP attendances continued to exceed target, achieving 51.8% (above the national ask of 49%). • The Trust had significantly reduced the number of patients waiting for more than six weeks for a diagnostic test. • Performance against the 4-hour Emergency Standard continued to exceed national ask, achieving 78.3% through January 2025 and was within the top quartile in London. Nonetheless, the early part of the year had proved to be challenging in the ED, with the Trust providing corridor care as a result of pressures on capacity. • SDEC (Same Day Emergency Care) activity continued to increase, demonstrating a sustained step change in improvement and helping to ease pressure on the Emergency Department. • One of the more challenged areas is referral to treatment (RTT), where there continued to be challenges with 52-week waits. Action plans had been developed to address this.	

	The Chairman thanked the MD-SGUH and invited comments and questions from Governors. The following points were raised and noted in discussion: • In response to a question about 52-week waits, the MD-SGUH explained some of the challenges and the steps the Trust was taking to bring the waiting list down. The Trust was reviewed the way in which patients were booked for appointments. Work was being undertaken to validate the waiting list. For example, some patients had had their procedure elsewhere or might no longer need the procedure, and the Trust was ensuring that the waiting list was accurate. Further actions were needed and this was an area of significant national focus. However, it was also important to recognise that there was no additional funding to bring down waiting lists, so the challenge was to work more efficiently, and work smarter, with the available resources. • In response to a question about patients who did not meet the "criteria to reside", the MD-SGUH explained that the Trust had good data on this through the St George's Line, which enabled the Trust to see where delays were happening. Discharge planning needed to be activated much earlier in the process. The major challenge, however, was the availability of social care support and the lack of this resulted in patients who were medically fit for discharge remaining in hospital longer than they needed to. Resolving this required ongoing work with the Trust's local authority partners and other stakeholders. However, the Trust also needed to reflect on its own processes to ensure these were not delaying how long patients remained in hospital. • In relation to a question about digital first and artificial intelligence, the MD-SGUH explained that AI had huge potential to transform how the hospital worked but that thew Trust was in the early stages of exploring its potential. There was a piece of work going on to explore ambient AI as a means of supporting clinicians to capture details of conversations with patients, update patient notes, and issue patient letters. This was in its early stages. In relation to digital transition more generally, the GCMO added that maternity had recently gone digital, with health records for maternity patients now available via iClip. When fully bedded-down this would be a major step forward in terms of safety and governance. There had also been some significant progress with the use of the patient portal as a digital mechanism for patients to be able to see their own outpatient appointments and the Trust was making major savings in the number of letters being sent to patients in hard copy. The Council of Governors noted the report.	
3.2	**Never Events** The GCMO introduced the report which provided an overview of the steps being taken to respond to and learn from recent Never Events. St. George's had recorded 17 Never Events over a two year period between January 2023 and January 2025. The two main categories of Never Events were 'retained foreign objects' and 'wrong site surgery'. The GCMO explained that there was evidence of improvement over the two years, especially in relation to retained guidewires and wrong site anaesthetic blocks, and in Never Events in a theatre setting. However, the risk of wrong site skin legion surgery remained an area of focus. The report presented to the Council had previously been considered by the Quality Committee, which had felt able to raise its level of assurance from "limited" to "reasonable". The GCMO added that while clear progress had been made, there remained a major focus on ensuring that learning from Never Events was embedded and that the required safeguards were operating effectively, and the Trust remained committed to ensuring that it was actively	

	minimising the chances of Never Events occurring. Andrew Murray, Non-Executive Director and Chair of the Board's Quality Committee, added that the Committee had sought assurance that the Trust understood the problem and was confident that the measures that were being put in place were being tracked and were effective. He explained that the report had gone some way towards providing that assurance. The Chairman invited comments and questions from Governors and the following points were raised and noted in discussion: • In response to a question from governors about how confident the Trust was that the improvements that had been made were sustainable, the GCMO stated that the Trust could be fairly confident about this, that mitigations had been put in place that were working, and the frequency of Never Events had fallen. However, it was impossible to rule out future Never Events and it was essential to maintain ongoing vigilance, supported by effective systems of quality governance. • AB1 commented that there had been significant investment in the implementation of the new Patient Safety Incident Response Framework (PSIRF) and queried whether the positive effects of this investment were evident. He asked to what degree the PSIRF approach had influenced the improving position on Never Events. He added that the governors had received excellent training on PSIRF in November 2024 which provided a very good understanding of that framework and how it had been deployed, but requested a follow-up training session for governors on how the implementation of PSIRF was delivering the desired results. The GCMO explained that one of the key features of PSIRF was that it reminded people that when care goes wrong, it was often the result of wider system issues. The value of PSIRF was in bringing a greater focus on these systems issues, as well as a focus on learning and a culture of improvement rather than a culture of blame. The GCNO added that a second PSIRF training session for governors would be set up and would be delivered by the Corporate Nursing team. • In response to a question about independent investigations, the GCMO explained that there were some cases where it was mandatory to undertake independent investigations. One example of this was certain types of obstetric events including maternal deaths and perinatal deaths which were mandatory for external investigation. • In relation to a question about safety management systems and whether the Trust was confident it was picking up all near misses, the GCMO explained that near misses were picked up but that it was impossible to give assurance that all such cases were identified. Identifying near misses was dependent on staff reporting such incidents and this related to the culture, including developing a culture of psychological safety to raise concerns. The Chairman thanked the GCMO for his clear explanation to the Council of the position on Never Events, and acknowledged the work of the Quality Committee on this issue. The Council of Governors received and noted the report.	**GCNO / Corporate Governance**
4.0	**Finance**	

4.1	**Finance Update** The GCFO provided a brief overview of the Trust's current financial position as well as work being undertaken to plan for 2025/26. The current year had been extremely challenging, and the year ahead appeared to be even more so. At month 10, the Trust was reporting a position £9.8m adverse to its financial plan for the year. The issues driving the position were unchanged, which included operational pressures and the demands of meeting Cost Improvement Plan (CIP) targets. The Trust was forecasting that it would be £13m adverse to plan by the end of the year. For 2025/26, there was an expectation from NHS England that Trusts and wider systems would remain within their control totals. The proportion of the control total given to South West London Integrated Care System that was for St George's to deliver was a deficit of £40m in 2025/26. Before any mitigating action, the Trust was projecting a deficit for 2025/26 of £156m. CIPs of around £90m were required to deliver the target set by NHSE. The financial plan was being developed and would need to be submitted later in the month. The Chairman invited comments and questions from Governors and the following issues were raised and noted in discussion: • AS asked about the areas of the Trust that would need to deliver the greatest savings and whether they were aware of the scale of the savings required. The GCFO explained that the plan was still being developed and identifying how and where savings could be made was an ongoing piece of work. One of the measures the Trust was using to help identify where savings might be made was the Getting It Right First Time (GIRFT) and Model Hospital data, which enabled the Trust to compare its productivity and efficiency with other similar trusts. NHSE was also using this data in challenging Trusts to go further in delivering savings. • SD asked about how patient care would be protected and maintained, and what steps were being taken to reduce corporate costs including costs associated with engaging expensive contractors and interim staff. The GCFO explained that the Trust was not currently engaging management consultants. It also had a big focus on reducing temporary staffing costs. At all stages of the development of the plan, consideration was being given to how best to protect the frontline delivery of care, and making savings in corporate areas was part of this. However, savings from corporate areas alone would not be sufficient to meet the scale of the ask. So services would need to review how they worked, improve their productivity, and in some cases focus on safety rather than service improvements. • NA asked whether the Trust sent patients to private hospitals to get the waiting list down and whether there was scope to make savings in this respect. The GCFO explained that the Trust did not typically do this, but it was an option for GPs. The Chairman commented that Governors may find it helpful to have a training session on finance, given the level of financial challenge that was expected over the next year. Finance would be built into the training session for new Governors which was scheduled for early May, and a follow-up focused training session on finance would also be arranged in the following months.	**GCFO/ Corp Gov**
7.0	**Closing Items**	
7.1	**Any Other Business** On behalf of the Council of Governors, the Lead Governor, Alfredo Benedicto, expressed Governors' thanks and appreciation for the Chairman, Gillian Norton, whose term of office would end on 31 March. Alfredo reflected on the many qualities Gillian had brought to the Board, and how the Trust was in a much improved position now compared with April 2017 when the Chairman had started in post. Alfredo	

	thanked Gillian for her commitment to the Trust and to working in partnership with Governors, and presented the Chairman with a gift on behalf of the Council. The Chairman thanked Alfredo for his kind words and all Governors for the gift. She added that it had been a privilege to serve as Chairman for the past eight years.	
7.2	**Council of Governors Calendar of Events** The Chairman noted that a calendar of meetings of the Council, Board and other key events were being developed and would be circulated to Governors and would be presented with the papers for each future meeting.	
7.3	**Reflections on the meeting** The Chairman invited Governors to offer reflections on the meeting. It was noted that bringing fewer agenda items had enabled more in depth discussions, which had been helpful. It was also noted that the discussions had been open, candid and there had been a good level of challenge with helpful responses from Board members.	

Date of next Meeting

22 May 2025 5.30pm – 8.30pm Hyde Park Room

Council of Governors - Public - 22 May 2025

St George's University Hospitals NHS Foundation Trust

Action Log

Action Ref	Section	Action	Due	Lead	Commentary	Status
COG 12.3.25/1	Matters Arising	Data on the complaints have been made to the PHSO to be shared with governors	22/05/2025	GCNO	15/3/25 The GCNO confirmed that she will provide a summary with the data rather than share on its on. To be confimed	To be confirmed
COG 12 3 25/2	SGUH Operational Performance - Never Events	PSIRF training part 2	Jun-25	GCNO/Corporate Governance	Date being finalised for mid June.	
COG 12.3.25/3	Finance Update	Training session to be provided on finance pressures	01/06/2025	GCFO	8/5/25 Fisrt part of finance session delivered as part of the new governors induction session.. A follow up session is currently being planned	

Council of Governors

Meeting on Thursday, 22 May 2025

Agenda Item	**Action Log**	
Report Title	**PHSO -Update for St George's Hospital**	
Executive Lead(s)	Arlene Wellman, Group Chief Nursing Officer	
Report Author(s)	Stephanie Sweeney, Group Director of Nursing for Quality and Safety Governance Alison Benincasa, Group Director of Compliance	
Previously considered by	Choose an item.	Click or tap to enter a date.
Purpose	**For Assurance**	

Executive Summary

This briefing outlines how St George's University Hospitals NHS Foundation Trust manages and assures responses to investigations by the Parliamentary and Health Service Ombudsman (PHSO). All enquiries and investigations are 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, St George's 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 is aligned with Trust governance processes to ensure transparency and continuous improvement in patient care.

These arrangements provide assurance that St George's handles PHSO cases with rigour and uses them as a driver for learning and improvement.

Action required by Council of Governors

The Council is asked:

1. Note the update

Committee Assurance

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

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☒ Right care, right place, right time	
☐ Affordable Services, fit for the future			☐ Empowered, engaged staff	
Risks				
There is a risk that the Divisions will not have sufficient resources to deliver the required improvement actions.				
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				
NHS organisations, including St George's, are legally required to cooperate with PHSO investigations. This includes timely provision of records, statements, and evidence, as well as implementation of recommendations or remedies.				
Equality, diversity, and inclusion implications				
None identified				
Environmental sustainability implications				
No significant environmental sustainability implications have been identified.				

Overview of PHSO Process at St George's

1.0 Introduction

This paper provides assurance to the Council of Governors regarding how St George's University Hospitals NHS Foundation Trust manages communications and investigations from the Parliamentary and Health Service Ombudsman (PHSO), and how this process is monitored and governed.

The **Parliamentary Health Ombudsman** plays a crucial role in addressing patient complaints related to healthcare services, particularly when individuals feel that their concerns have not been adequately resolved through normal channels within healthcare systems. The role of the ombudsman in handling patient complaints typically includes:

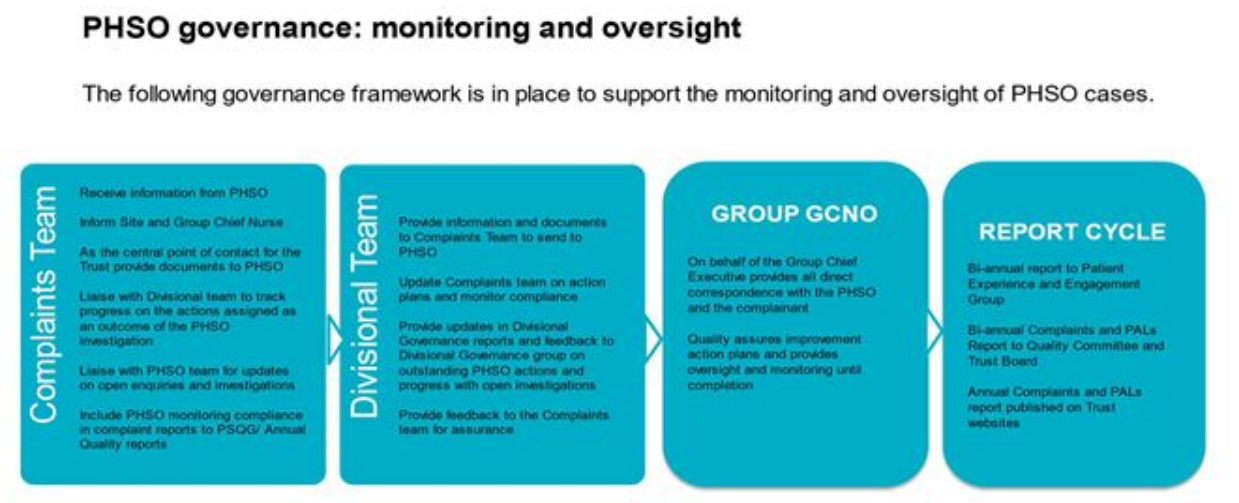
1. **Independent Investigation**: The Ombudsman investigates complaints from patients about healthcare providers, government health agencies, or public health services. These investigations are usually independent, meaning the Ombudsman does not have direct ties to the healthcare system and can objectively assess the situation.
2. **Ensuring Accountability**: The Parliamentary Health Ombudsman helps hold healthcare providers and government health authorities accountable for their actions. If the Ombudsman finds that patients' rights were violated, the service was substandard, or there was misconduct, they can recommend corrective actions or improvements.
3. **Providing Recommendations**: After investigating a complaint, the Ombudsman can offer recommendations for improvements in the healthcare service, practices, or policies. This can include suggesting ways to prevent similar issues from arising in the future or recommending changes in how healthcare services are delivered.
4. **Mediation and Resolution**: The Ombudsman can often act as a mediator between patients and healthcare providers, working to resolve disputes without the need for formal legal action. This can help expedite solutions and offer more satisfactory outcomes for both parties.
5. **Advocacy for Patient Rights**: The role often involves advocating for patient rights, ensuring that individuals are treated fairly and that their voices are heard within the healthcare system.
6. **Reporting and Transparency**: The Ombudsman may publish annual or special reports highlighting trends in patient complaints, systemic issues, and recommendations for reforms. This transparency helps inform the public and policymakers about the state of healthcare services and any areas needing attention.

Overall, the **Parliamentary Health Ombudsman** serves as a safeguard for patients, providing an external, impartial avenue for addressing grievances and improving healthcare quality and accountability.

2.0 PHSO Governance: Monitoring and Oversight St George's Hospital

Oversight of PHSO Cases at St George's Hospital

At St George's University Hospitals NHS Foundation Trust, the governance of Parliamentary and Health Service Ombudsman (PHSO) cases is managed through a coordinated Group-wide framework designed to ensure consistency, oversight, and timely resolution. The process is overseen by the Group Chief Nursing Officer (GCNO), in partnership with the Complaints Team, Divisional governance leads, and executive colleagues.



1. Complaints Team (Trust-Wide Coordination)

The Complaints Team acts as the central point of contact for all PHSO enquiries and investigations. Upon receipt of a case from the PHSO, the team notifies the Site leadership and the Group Chief Nurse. They gather and submit all required documentation, liaise with the Divisional teams to track progress against actions arising from investigations, and ensure real-time updates are available on open and ongoing cases. This team also interfaces directly with the PHSO for updates and ensures compliance is reflected in Patient Safety and Quality Group (PSQG) reports and the Annual Quality Report.

2. Divisional Team (Operational Action and Reporting)

Divisional teams at St George's are responsible for delivering the actions arising from PHSO recommendations. They provide the Complaints Team with necessary documentation and regular progress updates. They also report on open cases and outstanding actions through Divisional Governance meetings and feed into Group assurance processes. This creates a closed-loop system whereby site-level operational work is tracked and escalated as needed for assurance.

3. Group Chief Nursing Officer (Strategic Oversight and Assurance)

The GCNO, acting on behalf of the Group Chief Executive, leads all formal correspondence with the PHSO and the complainant for upheld cases. The GCNO also provides strategic oversight, quality assuring all action plans and maintaining monitoring until each case is fully resolved. This role ensures that outcomes are not only implemented but also contribute to broader learning across the organisation.

4. Governance and Reporting Cycle

To support transparency and accountability, PHSO case activity is formally reported through the following channels:

- **Bi-annual reports** to the Group Patient Experience and Engagement Group
- **Bi-annual updates** to the Quality Committee and Trust Board via the Complaints and PALs report
- **Annual reporting** through the public Complaints and PALs report, which is published on the Trust websites

3.0 Activity Update (April 2025) for St George's Hospital

From April 2023 to April 2025, St George's Hospital has had **20 PHSO cases**, broken down as follows:

- **Ongoing investigations:** 11
- **Closed, not upheld:** 6
- **Upheld or partially upheld:** 3

Across GESH (Group-wide) in the 2024/25 year to date:

- **St George's:** 9 cases
- **ESTH:** 8 cases

From 2018 to 2023, there were 69 PHSO enquiries to GESH, with 44 investigations. The figures presented in the recent media article appear to have conflated enquiry and investigation data and reflect the total numbers for the Group- not St George's data alone.

4.0 Conclusion

The Trust has robust systems in place to manage, monitor, and respond to PHSO cases. Learning from upheld cases is embedded into quality improvement processes. The oversight mechanisms provide assurance that the Trust takes these investigations seriously and uses them to improve patient experience and service quality.

Council of Governors

Meeting in Public on Thursday, 22 May 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 on strategic and operational activity across the trust. Specifically, this includes updates on:

- The national context and impact at Group and Trust level
- Staff news and engagement
- Next steps

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, 01 May 2025

1.0 Purpose of paper

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

2.0 National Context and Updates

Abolition of NHS England and cuts to Integrated Care Boards

2.1 Governors would have seen that the Government has announced that NHS England will be abolished, with some functions absorbed into the Department of Health and Social Care. The Government also announced cuts to Integrated Care Boards of 50%.

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

2.3 A new model ICB blueprint was published earlier this month which sets out the role ICBs will play in the future as strategic commissioners and in realising the ambitions that will be set out in the 10 Year Health Plan. The document sets out areas where ICBs will continue to have a significant role, and potentially enhance their role, such as in relation to population health management, health inequalities, commissioning neighbourhood health, commissioning end-to-end pathways, and core payer functions. It also sets out areas where ICBs would retain but may need to adapt, as well as areas which may transfer from ICBs to provider trusts, including local workforce development, green plan and sustainability, estates and infrastructure strategy, digital leadership, and pathway and service development. We are currently reviewing the potential implications of the new blueprint for the Trust, and wider Group.

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

New Permanent Secretary at the Department of Health and Social Care

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

Supreme Court ruling on women's rights

2.6 The Supreme Court has recently ruled that the legal definition of a woman should be based on biological sex and is binary. We know that many of our staff, patients and visitors will be concerned by this ruling and how it will impact them. We are waiting for guidance from NHS England and will review our policies in line with their recommendations. In the meantime, we continue to help our teams care for all people with dignity and respect.

3.0 Our Group

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

3.1 As the Council of Governors is aware, the Care Quality Commission (CQC) undertook a planned "well led" inspection at St George's between 25 and 27 February 2025. The inspection followed previous CQC service inspections of maternity, Emergency Department and Theatres at St George's and Queen Mary's Hospitals in recent months. On 11 March 2025, we received a letter from the CQC providing high-level feedback from the visit, which is the subject of a later agenda item. We hope to receive the full inspection report in the coming weeks, and will develop an action plan in response to its findings.

Renal development programme on pause

3.2 Earlier this year, the government announced that our Building Your Future Hospitals (BYFH) programme has been delayed. Our Renal Development Programme at St George's was part of the BYFH programme and was expected to receive funding that is currently unavailable. As we have been unable to secure funding to progress with the Renal Development Programme this year, we will now need to pause the programme. While this takes place, there will be no impact for patients receiving kidney care at St George's who will continue to receive excellent treatment from our specialist doctors and nurses.

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

Introducing our new, transformative electronic patient record system

3.4 As part of the launch of the new electronic patient record system at ESTH, the current iClip system at St George's has been updated. iClipPro brings all patient information – from medical history to results of investigations and medications prescribed – together in one place across all our hospitals. This means clinicians will have more information at their fingertips and represents a significant, innovative and exciting gesh Group development, both for our patients and our staff. There have been many challenges to get us to this point but my thanks to all the teams who have been involved in the successful launch on 9 May 2025. This is a real step forward in supporting the two Trusts to work together effectively in caring for our patients – using one system for over 17,000 staff across multiple sites will help to ensure better joined up care for our patients, streamline administrative tasks and minimise duplication.

NHS Staff Survey Results 2024

3.5 I firmly believe that happy staff makes for happy patients, and the annual NHS Staff Survey provides a crucial insight into how our staff feel about working at St George's. The survey results are a substantive item on the agenda, so I will not dwell on the details but I did want to emphasise just how important the survey is and how much I appreciate the honesty of staff, having read

every comment. I am delighted that we have seen significant increases in the number of staff at St George's completing the survey this year compared with the previous year – in fact, St George's is the 10th most improved acute Trust in the country, with all scores relating to the People promise on the rise, which is real progress. Staff have also been candid about where we need to do better. Action plans developed at a local level will help drive changes that will make this a great place to work, while at a Trust and Group level we're focusing on improving leadership, promoting fairer career development, improving retention and fostering inclusion.

Communicating change with our staff

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

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

Home secretary visit to St George's

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

4.0 Appointments, Events and Our Staff

Changes to the Executive team

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

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

In his new interim role, Ralph will lead on strategy and transformation, performance and project management and continuous improvement.

Celebrating and valuing our staff

4.3 On 12 May, we marked International Nurses Day with a fantastic programme of events and celebrations under the theme, “out nurses, our future: caring for nurses strengthens economies”. The celebrations provided a wonderful opportunity for nurses across our site to come together, recognise the outstanding contributions of our nursing teams, and enjoy some well deserved fun and appreciation.

4.4 The previous week, on 5 May, we also marked International Day of the Midwife, which highlighted the vital role our midwives play in providing sexual, reproductive, maternal, newborn and adolescent health services. To mark the occasion at St George’s, midwifery colleagues gathered for a special bake-off and awards, supported by our wonderful St George’s Hospital Charity.

5.0 Recommendations

5.1 The Council is asked to note the report.

SGUH Council of Governors

Meeting in Public on Thursday, 22 May 2025

Agenda Item	3.1	
Report Title	**CQC Well Led Inspection (St George's)**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	Group Board	01 May 2025
Purpose	**For Review**	

Executive Summary

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

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

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

Action required by Council of Governors

The Council is asked to:

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

Appendices

Appendix No.	Appendix Name
Appendix 1	CQC Well Led feedback letter dated 11 March 2025

Appendix 2	Summary of actions in response to initial CQC feedback

Implications

Group Strategic Objectives

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

Risks

As set out in paper.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

N/A

Legal and / or Regulatory implications

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

Equality, diversity and inclusion implications

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

Environmental sustainability implications

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

CQC Well Led Inspection (St George's)

Council of Governors, 22 May 2025

1.0 Purpose of paper

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

2.0 Background

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

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

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

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

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

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

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

3.0 Initial feedback from the CQC

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

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

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

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

- noted the commitment regarding and progress in relation to environmental sustainability.

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

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

4.0 Actions following the inspection

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

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

5.0 Recommendations

5.1 The Council is asked to:

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

Care Quality Commission
Citygate
Gallowgate
Newcastle Upon Tyne
NE1 4PA

Telephone: 03000 616161
Fax: 03000 616171

www.cqc.org.uk

Sent via email

Our reference: AP8254

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

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

Date:11 March 2025

CQC Reference Number: AP8254

Dear Jacqueline Totterdell,

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

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

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

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

An overview of our feedback

The feedback to you is:

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

Shared Direction and Culture

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

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

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

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

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

Learning, improvement and innovation

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

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

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

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

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

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

Telephone: 03000 616161

Write to: CQC

Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

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

Yours sincerely

Antoinette Smith

Deputy Director of Operations

c.c. Chair of Trust

Name of NHS England representative

CQC regional communications manager

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

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

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

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
	policy and Regulation 5 and were managed to a high standard.	• Concerns were identified regarding the bandwidth of individual roles and associated accountability, suggesting potential challenges in allocating sufficient time for effective oversight. • We identified further work was required to develop robust succession planning. • We saw evidence of talent management opportunities but this was not reflective across the whole Trust.	• Develop set of shared values across the Group. • Implement our vision for High Performing Teams. • Fully establish the gesh Culture Forum as a driver of culture change across the Group.
Freedom to Speak Up	• We found evidence the organisation worked hard to foster a positive culture. • The Freedom to Speak Up framework and approach had been updated and was well-integrated within the service, resulting in a notable increase in individuals raising concerns.	• While the increased utilisation of Freedom to Speak Up processes suggests a positive cultural trend, we were made aware that some people still do not feel that their voices are being heard or that it is safe to raise concerns.	• Refresh the SGUH FTSU vision and strategy 2020-2024 and establish this on a Group-wide basis. A new Group-wide FTSU policy was approved by the Group board in January 2025. • Strengthen mechanisms for disseminating learning from speaking up inc. introducing regular communications to staff showcasing how the organisation has responded to concerns. • Develop and launch protocol for risk assessing and investigating allegations of detriment, in line with new NGO guidance.

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

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
			• Develop and publish new guidance for responding to concerns as part of wider manager's toolkit. • Development and use of the Insights Report to target support and interventions to teams that may be struggling and / or require support.
Workforce Equality, Diversity and Inclusion		• Senior leaders acknowledged that while they valued diversity in the workforce, there was still more to be done to ensure an inclusive culture. • The Board's composition did not adequately reflect the demographics of both staff, and the communities served. • The Trust had introduced initiatives and leadership programmes to support diversity and inclusion, however we were not assured that these initiatives and others were being measured or monitored for effectiveness in line with the EDI strategy.	• Implementation of the EDI Action Plan approved by the Group Board in February 2025. • Implementation of the Diversifying our Leadership plans, including introducing the Shadow Board initiative. • Focus on improving the diversity of the Board through upcoming Executive and Non-Executive appointments processes. • Launching the Talent Strategy to staff.
Governance, Management and Sustainability	• We found that there were many areas where there were effective structures, processes and systems of accountability	• However, we found that the governance systems needed to be reviewed to support the delivery of the strategy and	• Embed the Group Accountability Framework approved by the Board in February 2025.

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

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
	to support the delivery of care. For example, the use of an accountability framework and the divisional incident review groups.	consistent delivery of quality of care across all services. • This includes ensuring that roles and responsibilities are clear at group and site level. • Our review of documentation demonstrated that Duty of Candour communications and complaints were not always conducted in line with policy and in some instances we felt that the Trust lacked transparency.	• Embed the Group Risk Management Framework as approved by the Group board in March 2025. • Implement actions from the Phase 1 and Phase 2 Quality Governance Reviews. • Review issues identified by the CQC in relation to Duty of Candour and complaints.
Partnerships and Communities	• The Trust understood their duty to work in partnership with others to deliver services that work seamlessly for people. • The Trust demonstrated a commitment to collaborative working through system-wide meetings and showcased successful examples of cross-site working in areas such as pathology, renal, and pharmacy services. The Trust had a positive relationship with a local university and was		• Development, agreement and implementation of Group roadmap • Confirm Alliance governance structures

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

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
	working collaboratively to develop new accredited courses and clinical and nursing roles.		
Learning, Improvement and Innovation	• Leaders we spoke with were focused on continuous learning, innovation and improvement across the organisation and the local system. • The Trust research function was well established and was constantly exploring ways to involve investigators in research opportunities. Leaders told us this was challenging and sometimes there was not enough capacity to support creativity and innovation, however, there was a willingness from people to get involved. • The organisation's ward accreditation programme is well established and embedded.	• Some staff told us that [the ward accreditation programme] could benefit from introducing an external peer review process.	• Delivery of High Performing Teams strategic initiative. • Embedding of use of CARE boards throughout Group as a tool for Continuous Improvement. • Refresh Ward Accreditation Scheme.

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

Well Led Quality Statement	CQC initial feedback (Areas of positive feedback)	CQC initial feedback (Areas identified for improvement)	High level next steps and actions
Environmental Sustainability	• Our interviews with senior leaders demonstrated that those responsible for environmental sustainability recognise the negative impact of the Trust's activities on the environment. • The Trust has a Green Plan in place and is identifying actions to make a positive contribution in reducing any negative impacts and supporting people to do the same.	• The Trust's operational effectiveness is significantly impacted by the state of its estate, evidenced by a substantial backlog of repair work. • While a £100 million capital programme [sic] is allocated to address essential hospital needs, including safe water, fire safety, and asbestos remediation. However, during our assessment, we noted a limited clinical input into this programme. This raises concerns about whether the prioritisation of these works fully aligns with the immediate and long-term clinical needs of patients.	• Embed the green plan governance structures and processes and gesh Steering Group meetings. • Develop a KPI scorecard for environmental sustainability. • Start delivering clinical engagement workshops within the next 6 months and conclude within 12 months. • Initiate and deliver identified decarbonisation projects.

St George's University Hospitals
NHS Foundation Trust

Council of Governors

Meeting in Public on Thursday, 22 May 2025

Agenda Item	3.2	
Report Title	**SGUH Operational Performance**	
Executive Lead(s)	Group Deputy CEO	
Report Author(s)	Group Director of Performance & PMO	
Previously considered by	N/A	
Purpose	**For Noting**	

Executive Summary

This report provides an overview of 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				

gesh

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

SGUH Operational Performance Report

March 2025

Outstanding Care, Together: Our strategy 2023 to 2028

Publication Date: 15 May 2025 | Contact: gesh.performance@stgeorges.nhs.uk

Executive Summary
Operational Performance

St George's Hospital

Successes

- St George's cancer performance trajectories continued to be met in February 2025: 28-Day Faster Diagnosis Standard (86.5%), 31 Day Standard (96.1%) and 62-Day Treatment Standard (81%).
- Value weighted activity as a percentage of total OP activity continues to exceed target, achieving 50.3% (above the national ask of 49%).
- Diagnostic Performance improved driven by an increase in imaging activity, returning to compliance against the 5% target with 95.3% of patients waiting less than 6 weeks for their diagnostic performance at the end of February.
- Performance against the 4-hour standard continues to exceed the national requirement, with a performance of 83.6% through March 2025.

Challenges

- Patient Initiated Follow Ups (PIFU) rates are below the target of 5%, although continuing to see month-on-month increase. General Cardiology, ICC and Neurology to go live through April 2025, then full roll-out planned to all other specialities.
- Further increase in the number of long waiting patients on a referral to treatment pathway, with 75 patients waiting more than 65 weeks and 1,084 patients above 52 weeks, driven mainly by Neurosurgery and Bariatric Surgery. As of 31st March 2025, 48 patients had appointments scheduled beyond March 2025. The Trust is participating in the national Sprint programme to support full validation of the wait list and is working with the ICB to ensure we are commissioned appropriately to provide services.
- BADs performance has improved however an outlier against peers. Extensive work has been completed within Breast to identify what the challenges are and a number of actions are now in place which will be shared with all specialties and we expect performance to improve over the coming months.
- A high proportion of beds continue to be occupied by patients who do not meet the criteria to reside with delays impacted by interface process with social and Residential / nursing home care arrangements and subsequently we have seen the average number of inpatients with a length of stay of over 21 days increase.

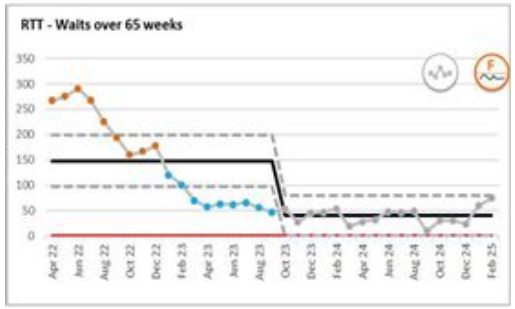
Operational Performance

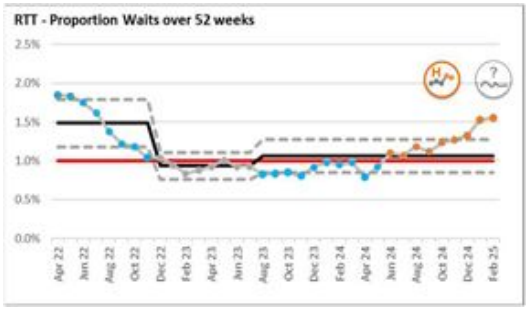
Overview Dashboard

	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	National Benchmark
RTT - Waits over 65 weeks	Feb 25	60	75	0		F	3rd Quartile
RTT - Waits over 52 weeks	Feb 25	1055	1084	129	H	F	3rd Quartile
RTT - Proportion Waits over 52 weeks	Feb 25	1.53%	1.55%	1.00%	H	?	2nd Quartile
RTT - Percentage within 18 weeks	Feb 25	61.8%	61.6%	67.6%	L	F	2nd Quartile
Cancer - 28 Day Faster Diagnosis Standard	Feb 25	80.2%	86.5%	77.0%	H	?	2nd Quartile
Cancer 31 Day Decision To Treat to Treatment Standard	Feb 25	93.9%	96.1%	96.0%		?	2nd Quartile
Cancer 62 Day Referral to Treatment Standard	Feb 25	80.4%	81.0%	70.0%		P	2nd Quartile
Diagnostics - 6 Week Waits	Feb 25	5.4%	4.7%	5.0%	H	?	2nd Quartile
4 Hour Operating Standard	Mar 25	80.9%	83.6%	78.0%		?	Top Quartile
Over 12 Hours in ED from Arrival (%)	Mar 25	9.1%	8.7%	8.8%		?	2nd Quartile
Ambulance handover Performance 30 - 60 minutes	Mar 25	157	63	-			
Ambulance handover Performance 60+ minutes	Mar 25	2	4	0	L	?	

Operational Performance

Exception Report | SGUH Referral to Treatment (RTT)

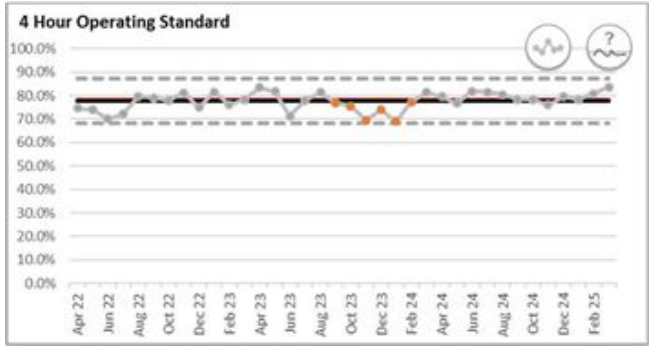


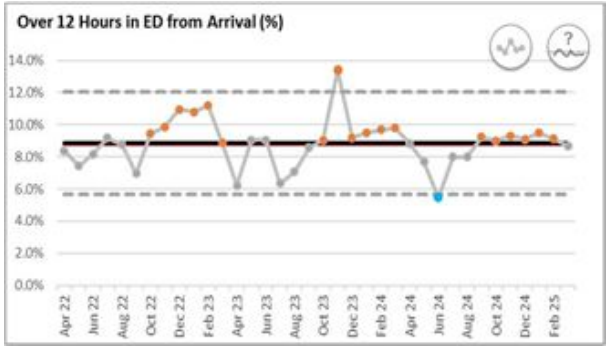


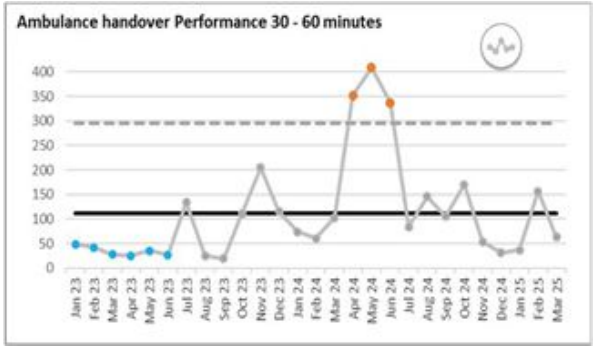
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 65 week waits behind plan 52 week waits behind plan	At the end of February 2025; • 65 week waits – Further increase with 75 open pathways over 65 weeks. Increase since December 2024 predominantly driven by within General Surgery, Vascular Surgery and Gynae. • 52 week waits –1,084 open pathways, impacted largely by on the non-admitted PTL and General Surgery on the admitted PTL. 52 weeks waits have increase by 43% over the past 12 months and currently is 1.55% of total PTL size. • Continued growth in overall PTL size. Over the past 12 months non-admitted PTL growth of 10.8% and admitted PTL 12.4%. • A high volume of out of area referrals have contributed to the long wait position. This is currently being addressed with ICBs	**Validation Sprint –** The Trust Is participating in the national *Sprint* programme to support full validation of the wait list and encourage an increase in timely clock stops. Reducing the overall PTL and removing duplicate pathways. **Demand Management:** Working with the ICB to ensure we are commissioned appropriately to provide services. **Revision of all Directories of Service DoS:** The Trust is focusing on ensuring that there is defined criteria for primary care to access services. Work has already begun in a number of specialties. **Theatre Productivity:** Focusing on late starts and early finishes as well as intercase down time and overall capped theatre utilisation	**June 2025** **Phased approach Completion June 2025** **Phased approach – completion June 2025** **March 2026**	sufficient for assurance

Operational Performance

Exception Report | SGUH A&E Waits and Ambulance Handovers







Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH 4 Hour Target met in March 2025 12 Hour waits Special cause variation of a CONCERNING nature	Four Hour Performance in March 2025 further improved with 83.6% of patients either admitted or discharged within four hours of their arrival. Performance remains in the top quartile nationally. Admitted performance improved through March 2025 however remains challenged. ED Capacity main driver for longer waits, with a high number of DTAs in the department which impacts waits over 12 hours The key drivers of operational pressures and delays are: • Volume of DTA's in department • Number of complex mental health patients spending >24hrs in department	• During March we had additional GP support out of hours, this included keeping UTC (funded b the ICB) open 24 hours on 11 occasions during the month, and direct booking into GP slots run by seldoc OOH. • Dedicated Treatment pod for faster delivery of IVs and dedicated investigation cubicle. • Maintaining in-and-out spaces to aid flow. • RAT rota fully established to redirect patients where appropriate. • Continue to work with 111 to optimise Urgent Treatment Centre (UTC) utilisation. • Further development of SDEC inclusion criteria, increase in surgical SDC capacity delivered with more planned. • Direct access to Paediatric clinics for UTC plastic patients. • Weekly meetings with London Ambulance Service (LAS) to resolve issues between both Trust and LAS. • Frailty Same Day Emergency Care (SDEC) pilot in progress. • Additional Emergency Practitioner on duty in peak hours to manage patients in the streaming queue. • Launch of Patient Check In has reduced average time in streaming queue from 28 mins to 8. • Long waiting patients in ED are continually monitored through their stay. Tests / diagnostics required for their onward treatment are requested while a ward-based bed is sought	TBC	sufficient for assurance From April 2025 only type 1 attendances will be counted to measure 12 hours waits

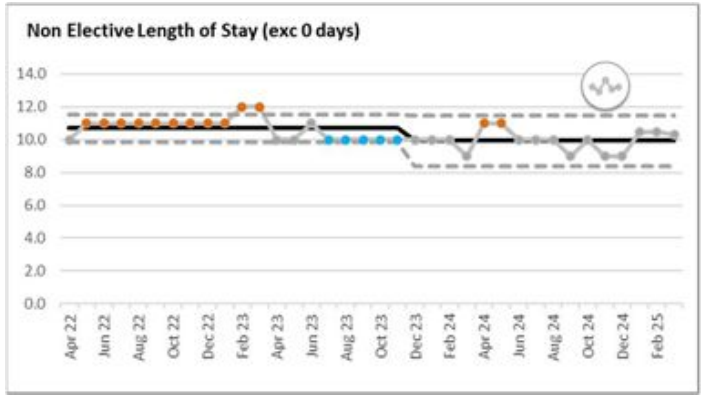
Operational Productivity

Overview Dashboard

	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	National Benchmark
Non Elective Length of Stay (exc 0 days)	Mar 25	10.5	10.3	-			N/A
Theatre Utilisation (Capped)	Mar 25	81.6%	81.6%	85.0%			2nd Quartile
BADS All Daycase & Outpatient Procedures % of total procedures	Dec 24	80.8%	80.1%	83.6%			Lowest Quartile
Outpatients Patient Initiatied Follow Up Rate (PIFU)	Mar 25	1.8%	1.9%	5.0%			Lowest Quartile
Outpatients Missed Appointments (DNA Rate)	Mar 25	9.2%	9.1%	8.0%			Lowest Quartile
First and Procedure Attendances as a proportion of Total Outpatients	Mar 25	52.7%	52.0%	49.0%			2nd Quartile

Operational Productivity

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



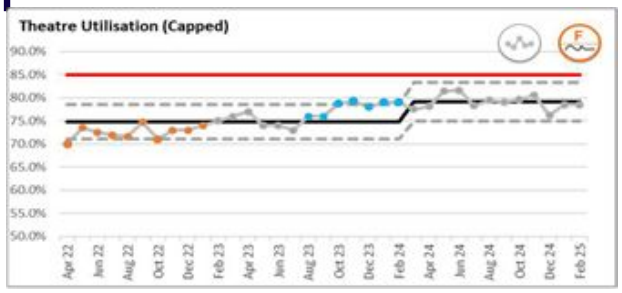
Metric	Reporting Month	Productivity Opportunity vs Target (annualised)
NEL Length of Stay.	Mar-25	116 Beds (approx.) to reduce by 1.5 days

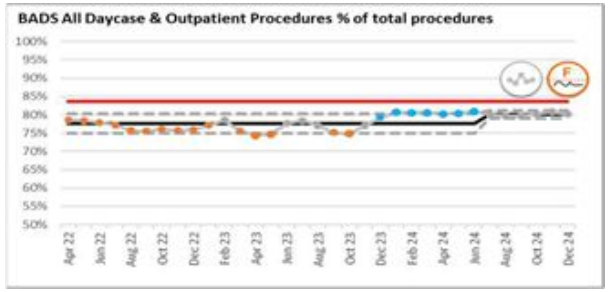
Adoption of SWL methodology for calculation of non-elective average LOS (i.e. Adult patients discharged from the hospital in month that had a method of admission of emergency, but excluding patients that did not have an overnight stay in hospital and excluding maternity, paediatric and A&E specialties).

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH NCTR LOS Los>21days: Consistently not meeting target, all showing performance below mean	• Non-Elective Length of Stay remains stable although slightly above the mean – on average in-patients staying for 10.3 days through March 2025 • Super Stranded patients >21 days has seen an upward trend however seeing normal variation approx. 173 patients per day • Number of patients not meeting criteria to reside- largest proportion of delays driven by 1. Hospital process – Awaiting therapy review of need for supported discharge – average 12 beds per day 2. Interface process – based social care service arrangements still underway (pathway 1 – average 9 beds per day 3. Interface process – Residential / nursing home care arrangements still underway (Pathway 3) – average 9 beds per day • 10% of discharges before 11am	• The Emergency floor and the Integrated Care Transfer Hub continue to review if Social Workers & CLCH partners can attend on site. • Transfer of Care team provided vital in-person support on the wards to facilitate discharge • Focussed sessions with ward teams to improve NCTR data capture, current performance 87% of patient have a CTR form completed • >21 day LoS meetings embedding lead by MedCard Deputy DDO. • LoS Triumvirate working on further actions to continue to drive down NEL LoS. • Improved usage of discharge lounge through March 2025 • Need to communicate with patients and visitors the importance of hand hygiene to help prevent the spread of IPC issues.	TBC	Sufficient for assurance

Operational Productivity

SGUH - Theatre Utilisation & Daycase Procedure Rates





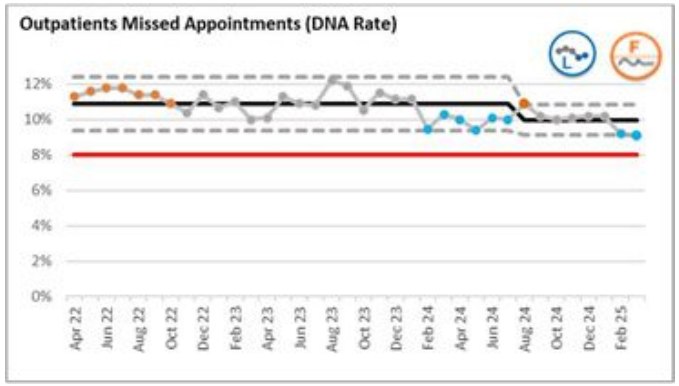
Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Capped Theatre Utilisation	Mar-25	342 cases (based on an average case time of 124 min) to hit top quartile
Day cases and outpatient procedures (BADS)	Dec-24	717 cases opportunity to move to IP to DC (3 month period) compared to peer

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH - Capped Theatre Utilisation 83%- IP 81%-DSU 69%- QMH	• Capped Theatre Utilisation: 81.6% across the month of March 2025. Most specialties have theatre utilisation above 80%. The surgical specialties with the lowest theatre utilisation were Dentistry (75%), Gynae (79%), Plastics (75%) and Neurosurgery (76%). [Week ending 23rd March utilisation improved to 85.0%]. • Total cases performed increased with average cases per session was 1.54 compared to 1.58 in February 2025. • 3% of total cases cancelled on the day including patient DNA.	• Adherence to 6-4-2 escalation processes being implemented to improve theatre capped utilisation and improve scheduling standards • Ongoing work with Business Intelligence colleagues to review theatre performance dashboards, aimed at improving reporting of cancellations and monitoring of DQ issues • Working to improve POA and comms process with patients to reduce DNAs and hospital initiated cancellations.		sufficient for assurance
SGUH: Improving trend, below top quartile peer	• December performance (80.1%) below peer upper quartile (86.8%) • Outpatient % of total procedures (inpatient, daycase and outpatient) above peer average positively at 41.4% (peer 32.3%) • Daycase % of total procedures (inpatient, daycase and outpatient) below peer average at 66.1% (peer 75.7%). Breast, ENT, Max Fax driving this in Model Hospital data • Discrepancy between the expected and actual overnight stays for elective cases due to coding and documentation errors. This discrepancy alters the true picture of BADS compliance. If this is due to data issue, we could improve compliance just by correcting data. • Due to the complexity of patients referred to SGUH Procedures normally coded as daycase can often be booked as an intended management of elective overnight which can under count actual DC).	• BADS compliance being discussed with all surgical specialities within theatre transformation to explore opportunity. "Right Procedure, Right Place" • Investigating whether intended management code is being used correctly (particular outlier). Test for change instigated in Breast where 50-68% believed to be incorrect were confirmed; Primary reason is the incorrect recording when adding patient to the wait list **Actions taken** include auditing data, identifying patterns, updating data retrospectively, w/c 10-Mar, no impact to revenue but will improve data accuracy, training, reports in place to monitor. **Next steps include** -Finalising the Trust-wide training -Update Job Aids for administrative and clinical staff -Engage and roll out to other services -Iclip technical update to 'Intended Management' to fix issue at source. Approved by CICG -retrospective audit and data correction across all services for Q4	TBC	Sufficient for assurance

Operational Productivity

SGUH - Missed Appointments (DNA Rate)

St George's



Metric	Reporting Month	Productivity Opportunity vs Top Quartile
Outpatients: DNA rates	Mar-25	1,375 appointments

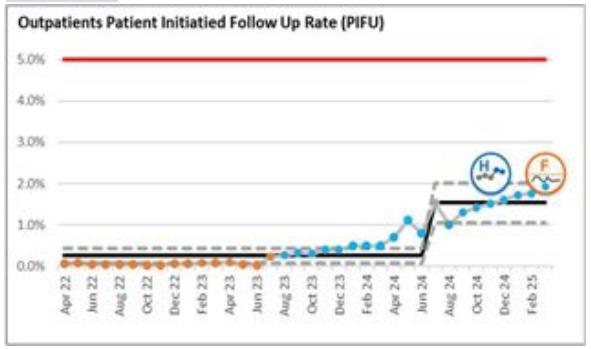
The methodology to calculate the opportunity to reduce the number of missed outpatient appointments is based on how your average missed outpatient appointments rate (from the last 6 months) compares to the national missed appointments profile for providers.

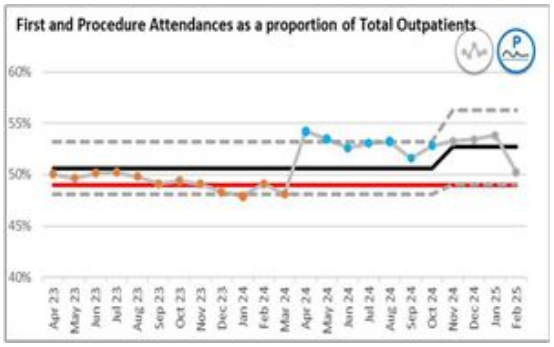
Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH Normal variation consistently not met target of 8%	Current DNA rates of 9.1% showing a further reduction compared against Peer average performance 8.6% . Highest proportion of DNA's within Physiotherapy, Dermatology, Rheumatology.	- Speciality-level data reviewed weekly with all operational leads in Elective Access Meetings and also monitored via CARE board by SLT weekly. - Reviewing Model Hospital data to view performance against peers and review opportunity to reduce DNAs - Working Group established to focus on Top 10 – First Meeting 12th March 2025 agreeing to trail some different strategies to reduce the DNA rate's; ○ **Cardiology** – A trial will be conducted to call patients with an upcoming appointment within the next six weeks who previously DNA'd to confirm their attendance. The impact of this approach will then be audited. ○ **Therapies** – A historic DNA audit will be conducted using Zesty for the past three weeks, as there were changes in the Call Centre's flow during this period. This will allow us to compare responses and assess whether the new flow has improved accessibility for callers. ○ **Respiratory** – A preventative DNA audit will be conducted using Zesty's two-way texting system over a one-month period. Patients will receive a text a week before their appointment, allowing them to respond cancel or reschedule if needed. The impact of this intervention on DNA rates will then be assessed.	TBC	sufficient for assurance

Operational Productivity

SGUH – Reduction in Outpatient Follow-Ups

St George's





Metric	Reporting Month	Productivity Opportunity vs Top Quartile
1st + Proc as a % of Total OP	Mar-25	*0 (exceeding target)*
PIFU Rates	Mar -25	*to be confirmed*

Site & Metric	Cause of variance/ non-compliance	Actions: Completed since last update, New, and Ongoing	Recovery Date	Data Quality
SGUH PIFU Rate: Consistently not meeting target, improving trend	In month performance for March 2025 continues to see a positive upward trend at 1.9%.	• All GIRFT specialties are now live with PIFU. Plans are in place to ensure more specialties are ready to go live - patient leaflets, clinician understand the process, and local SOP. • Of 22 services, we have officially gone live with 14 PIFU Pathways. Conversations are ongoing with General Managers in Spec Med for the remaining Spec Med specialities (Diab & Endo, Resp Med, Rheum, Lymphedema) with clinical pathways being discussed and finalised. Cardiology are aiming to go live with two pathways (General Cardiology and ICC) in April 2025 pushed back from March due to admin pressures. Neurology will be officially live with PIFU end of April 2025, staff training has taken place, patient leaflets being finalised and processes have been agreed, we should see a further increase in overall volume in the next couple of months. • We have contacted specialities who have begun to use PIFU but have not had discussions with us about patient leaflets and local processes. Also informing specialties around incorrect processes i.e. PIFU has been indicated on eCDOF but no order has been placed.	5% target for end of 25/26	sufficient for assurance

gesh

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

Appendices

11

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.

Watch List Metrics

Overview Dashboard

	St George's						
KPI	Latest month	Previous Month Measure	Latest Month Measure	Target	Variation	Assurance	Benchmark
Mixed Sex Accommodation Breaches	Mar 25	116	155	0			
Number of Complaints Received	Mar 25	69	71	-			
Number of re-opened complaints in month	Mar 25	1	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Received	Mar 25	0	1	-			
Parliamentary and Health Service Ombudsman (PHSO) Closed	Mar 25	0	1	-			
RTT - Total Size Incomplete Waiting List	Feb 25	69079	69734	64968			
On the Day Cancellations not re-booked within 28 days	Mar 25	5	4	-			
Outpatient Advice & Guidance Rate per 100 First OPA	Feb 25	19.6	20.4	16.0			
Emergency Department Attendances per day	Mar 25	409	430	-			
Mental health delays 4 Hour Breaches	Mar 25	125	108	-			
Length of stay > 21 days (super stranded)	Mar 25	161	173	117			
Overnight G&A beds occupancy - Adults	Mar 25	94.6%	94.0%	90.8%			
Number of patients not meeting criteria to reside (Daily Avg)	Mar 25	128	118	86			

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, 22 May 2025

Agenda Item	3.3
Report Title	**SGUH Maternity Services update**
Executive Lead(s)	Professor Arlene Wellman, Group Chief Nursing Officer and Director of Infection Prevention and Control
Report Author(s)	Natilla Henry, Group Chief Midwifery Officer
Previously considered by	Group Board 01 May 2025 Quality Committees in Common 24 April 2025
Purpose	**For Noting**

Executive Summary

Purpose

This report and the Perinatal Quality Surveillance Model (PQSM slide deck) provides an update on maternity services at St George's University Hospitals (SGUH). It outlines the Trust's progress on compliance with national standards, highlights risks, and presents key actions to address ongoing challenges and improve care quality.

Key risks and issues for noting:

- There was a maternal death on 03 March 2025, which has been reported to the CQC (as per the required process). This incident has been reviewed internally and the national Maternity & Newborn Safety Investigations (MNSI) service has accepted the case for investigation. The GCNO and GCMO provided a verbal update on immediate learning and safety improvements from our local investigation at the QCiC meeting on 24 April 2025.
- SGUH achieved full compliance with 9/10 safety standards for MIS Year 6. This was noted as low risk prior to the final submission, however, MBRRACE-UK have included additional cases into the numbers which has meant that the trust has been declared non-compliant with safety action 1. An appeal was submitted on the grounds that the additional cases were not part of the cohort of cases that should be included. The Trust has now received the outcome of the appeal, which was not upheld. SGUH is therefore not compliant with MIS Year 6 and will not receive a rebate of the 10% contribution made to the CNST fund for the MIS scheme.
- The National Maternity Perinatal Audit has flagged SGUH maternity services as a potential alarm-level outlier for postpartum haemorrhage in 2023. Some immediate safety improvement actions have already been taken, and work is ongoing to identify any further learning and safety improvements that may be required.
- The digital maternity transformation went live on 8 February 2025. Several challenges have arisen post-implementation as the system undergoes optimisation and mitigations are either in place or currently under development to address issues identified.
- Medical staffing training compliance has not achieved the 90% compliance target for this reporting period. The issue is with PROMPT training among consultants. The Clinical Director is aware and has a plan in place to recover the position.

Action required by Council of Governors
The Council of Governors is asked to: a) Note the maternity service updates and the key risks and points highlighted.

Appendices	
Appendix No.	**Maternity**
Appendix 1	SGUH Perinatal Quality Surveillance Model data (PQSM)

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☒ Right care, right place, right time	
☒ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
As set out in the report.				
CQC Theme				
☒ Safe	☒ Effective	☒ Caring	☒ Responsive	☒ Well Led
NHS system oversight framework				
☒ Quality of care, access and outcomes			☒ People	
☒ Preventing ill health and reducing inequalities			☒ Leadership and capability	
☒ Finance and use of resources			☒ Local strategic priorities	
Financial implications				
SGUH: Declared 9/10 compliance with the CNST Maternity and Perinatal Incentive Scheme Year 6 via the Board declaration form submitted to NHS Resolution on 3 March 2025. NHS Resolution has declared SGUH non-compliant with Year 6 of the scheme and will therefore not receive the 10% rebate of Trust Contribution.				
Legal and /or Regulatory implications				
Enforcement undertakings applicable to SGUH Compliance with the Health & Social care Act 2008 (Regulations 2014) and CQC Registration Regulations SGUH maternity received a section 29A Warning Notice. The Trust response includes the immediate safety actions undertaken together with a detailed action plan for further improvements.				
Equality, diversity and inclusion implications				
No issues to consider				
Environmental sustainability implications				
The lifts in the Lanesborough Wing are frequently out of service and poses a risk of delay in accessing prompt emergency care for pregnant women.				

SGUH Maternity Services Update

Council of Governors, 22 May 2025

1.0 Purpose of paper

1.1 This report and the Perinatal Quality Surveillance Model (PQSM slide deck) provides an update on maternity services at St George's University Hospitals (SGUH). It outlines the Trust's progress on compliance with national standards, highlights risks, and presents key actions to address ongoing challenges and improve care quality.

2.0 Content

2.1 The report data (PQSM slide deck) covers the position for January and February 2025, and includes.

Mandated monthly reporting requirements:

- The perinatal quality surveillance model (PQSM), (appendix 1)
- The maternity quality and safety dashboard trend data in relation to outcomes for birthing people and babies, (appendix 1, slide no.3)
- Perinatal mortality by exception (appendix 1)

Key updates include:

- Feedback from MIS Year 6 (CNST) for SGUH, section 4.2
- Maternity Safety Support Programme (MSSP), section 4.3
- Integrated Maternity Improvement Plan, section 4.4
- CQC MUST and SHOULD Do actions from the 2023 inspection, section 4.5.
- Risk register and key risks/emerging concerns – by exception section 3.1.2 (appendix 1, Slide 4).
- Maternal death, section 4.6.

3.0 Background and Overview

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

3.1.1 Outcomes

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

3.1.2 Risk register

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

- the first concerns the laser stack, which is beyond its intended lifespan and no longer covered by a manufacturer maintenance contract. A replacement stack was ordered and delivered on 10 April; however, data transfer from the old system and commissioning of the new stack are still pending. The replacement laser component remains outstanding due to challenges in sourcing a suitable device and the requirement for clinical trials prior

to adoption. In the meantime, a risk assessment has been completed to mitigate potential service disruption in the event of equipment failure.

- the second extreme risk relates to the service not meeting regulatory standards, following a CQC inspection in October 2024, which resulted in the issuing of a Section 29A notice. This risk was formally added to the risk register in February 2025 (see Appendix 1 slide 4)

3.1.3 MBRRACE-UK Perinatal Mortality Report 2023

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

3.1.4 Moderate and above harm cases

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

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

Notably, 21 of the incidents over the two-month period were related to PPH. A report of the high PPH rate was presented and discussed in detail at April's Quality Committee's in Common, including the factors that are contributing to the high rate and the actions being taken to improve.

3.1.5 Training Compliance

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

3.1.6 Midwifery fill rate

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

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

4.1 IClipPRO implementation

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

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

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

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

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

Until migration is completed, clinicians are being reminded to check and review patients' records on the legacy system at the point of care. The digital midwives also work closely with the clinical teams to ensure this is happening and to also troubleshoot issues that arise.

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

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

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

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

During the external verification of Safety Action 1, six deaths were found to have been reported to MBRRACE-UK late—one by 67 days. PMRT reviews cannot begin until a death is notified, which likely contributed to only 35% of reviews (25 in total) being started within the two-month requirement. Additionally, 14 reviews (50%) took longer than six months to publish. While mitigation measures are now in place, the Trust did not meet two verification standards and is therefore deemed non-compliant with Safety Action 1.

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

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

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

Note: The outcome of the appeal was received on the 12 May and was not upheld.

MIS Year 7 was published on 2 April 2025. SGUH is actively reviewing and disseminating the updated safety actions to the relevant teams.

4.3 Maternity Safety Support Programme (MSSP)

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

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

4.4 Integrated maternity improvement plan

The November 2024 Quality Committee Focus session was on maternity. The Committee requested that an integrated improvement plan for maternity was developed across GESH. Work on the plan was temporarily paused to allow the maternity team to prioritise the response to the Section 29A Warning notice and support the digital transformation programme (iClipPRO), which went live on 8 February 2025. Although the plan was originally scheduled for discussion at the April QCiC meeting, the draft SGUH plan was only finalised and shared on 4 April. This timing did not allow sufficient opportunity for review through the agreed governance process prior to submission to the Quality Committee.

Following a request from the SGUH Site Managing Director, it was agreed with the Committee Chair that the plan would be deferred to the May QCiC meeting to allow the governance process to be followed appropriately. Oversight and ownership of the plan has been confirmed to ensure clear accountability, traction, and measurable progress once implemented.

4.5 Care Quality Commission (CQC) Inspection 2023

Following the CQC inspections in 2023 SGUH had 15 MUST Do actions and 6 SHOULD Do actions. The following actions are outstanding as of 14 May 2025, all were previously presented to the Evidence Assurance Panel, however, further evidence was required to meet the level of assurance for sign off. These actions will be completed by the end of June 2025.

CQC Must Do	
MUST Do 2	The service must ensure that triage processes are safe, risk assessments are carried out, and women and birthing people have access to parity of service at any time of day or night.
MUST Do 5	The service must ensure that all staff groups complete mandatory training in a timely way.
MUST Do 7	The service must ensure medicines are stored safely and there are effective systems and processes in place to manage medicines safely, including regular reviews of risk assessments.
MUST Do 11	The service must ensure all staff are provided with annual developmental appraisals.
MUST Do 12	The service must ensure that adequate documentation takes place including but not limited to triage arrival times and assessments, perineal repair, consistent use of SBAR and MEOWS, sepsis risk assessments for babies, consistency and accuracy over several record-keeping systems

4.6 Maternal death 3 March 2025 – immediate actions

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

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

5.0 Implications

- **Financial:** As NHS Resolution has not upheld the appeal regarding Safety Action 1 – PMRT, the Trust will incur a financial loss equivalent to 10% of its contribution to the CNST Maternity Incentive Scheme
- **Regulatory:** The involvement of MNSI, MBRRACE, SWL ICB, NHSE Maternity Regional Team, and CQC means this case (maternal death) will be subject to multiple layers of external scrutiny. The outcomes may lead to further regulatory recommendations or enforcement actions, and the Trust will need to demonstrate robust, sustained improvements.

6.0 Recommendations

6.1 Council of Governors is asked to:

a) Note the maternity service updates and the key risks, issues and implications.

Council of Governors

Meeting on Thursday, 22 May 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	08 May 2025
Purpose	**For Noting**	

Executive Summary

This paper provides an update on the year end position for 24/25 together with the plan position for 25/26.

2024/25 financial targets were delivered in line with plan. This was against a background of significant financial pressures. As noted in previous meetings, 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 is 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 is extremely challenging. The paper provides a summary of the position together with some supporting information on the key issues driving the financial challenge and the actions being taken to deliver it.

While a balanced plan has been submitted to NHSE for SWL overall and SGH specifically, the delivery of this plan should be seen as being at extremely high risk.

The Group Executive and SGH Site Management team is working to identify actions to maximise delivery against this plan position. At this stage full delivery should be seen as being at risk.

Action required by Council of Governors

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**
Appendix 1	2025-26 Financial Plan Update

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				
[…]				

Outstanding care every time

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Council of Governors
Finance update

Andrew Grimshaw
Group Chief Finance Officer

GCFO & SGH Site CFO

Draft Year End 2024/25

The numbers included within this slide are best estimates of the Trust's financial position ahead of the final accounts' submission. These remain draft until final account are approved following the completion of the external audit in June.

I/E	Plan £m	Actual £m	Variance £m
Income	1,247.8	1,282.8	35.0
Expenditure	(1,152.1)	(1,287.1)	(35.0)
Surplus / (Deficit)	(4.3)	(4.3)	-

Income and Expenditure

- The Trust is reporting a deficit of £4.3m at year end, which is on plan.
- The plan includes £45.8m deficit funding from SW London ICB.

Capital	CDEL £m	Actual £m	Variance £m
Capital Spend	(47.2)	(47.2)	0.0

Capital Spend

- The Trust is reporting capital spend of £47.2m, in line with plan.

Cash	23/24 Closing Cash £m	24/25 Closing Cash £m	Movement £m
Cash Balance	48.5	80.4	31.9

Cash

- The Trust ended the year with a cash balance of £80.4m which is £31.9m higher than the opening balance for the year. The trust received PDC for capital in March that will be paid out in 25/26. In addition, large revenue receipts were received in later months to support the I&E forecast without cash outflows to offset.

Planning for 2025/26

- A Financial plan has been developed for the new financial year, starting 01st April 2025.
- NHSE has tasked all systems to deliver their respective financial “control totals”. For SWL the control total for 2025/26 is “balanced” inclusive of £104m “deficit support funding” (DSF).
- The start point for the plan for 2025/26 is
    - An initial Gross gap to balance of £145m
    - With DSF (£41m) and some further income from SWL (£10m) this is reduced to £95m.
    - Headline savings and efficiencies of £82m have been identified/ scoped for the trust. Further work is required to finalise these plans, and some are considered very challenging to deliver. This level of cost improvement is the highest ever targeted by SGH.
- This left a residual gap for SGH of £13m. This formed part of a wider SWL Gap of £63m.SWL flagged it structural issues and severe operation pressures meant delivering financial balance would be challenging. This plan position was submitted to NHSE at the end of March following Board review and approval.
- All savings proposed are subject to robust Quality Impact Assessment led by the GCMO and GCNO. This trust has been clear it will protect safety at all time, but in seeking to deliver this scale of financial improvement it will need to review quality standards in some areas. As an example, the Trust has not committed to delivering the 5% improvement in “Referral to Treatments “(RTT) time requested of all providers as part of planning.
- NHSE requested that SWL reconsider its plans and make every effort to secure financial balance for the year.
- The SWL ICB CEO met with the Chairs and CEOs from all trusts to review this position and agreed a range of additional actions to support delivery of financial balance. On the 8th May the Group Board approved the actions identified for SGH. These actions are seen as very high risk, with a proportion being the responsibility of SWL to lead delivery. This has been communicated to NHSE.
- A summary of the key movements across the development of the plan are summarised on the next page, with further explanation in the supporting pages.
- While a balanced plan has been submitted to NHSE for SWL overall and SGH specifically, the delivery of this plan should be seen as being at extremely high risk.
- The Group Executive and SGH Site Management team is working to identify actions to maximise delivery against this plan position. At this stage full delivery should be seen as being at risk.

Balancing the financial Plan for 25/26

Action	SGH	Comments
Gross gap to balance	145.0	• As per bridge
Deficit funding support	(41.0)	• From NHSE to support deficit position. Continuation of funding received in 24/25
Additional income from SWL	(10.0)	• SWL review of position and provision of additional support
CIP Plans to date	(82.0)	• CIPs identified up to last Finance Committee (April)
Gap to financial balance	**13.0**	
Offer of additional CIP delivery	(5.0)	• Further review of workforce growth • Service line review • Review of incremental service growth over recent years • Group consolidation
Income. Further adjustment from SWL	0.6	• Small reduction in income following further review by SWL.
Strategic actions	(8.6)	• Strategic actions to be led through SWL. Benefit will be felt within the trust
Total	**0.0**	
Residual surplus/(deficit)	0.0	

Supporting information

Finance plan: 2025/26
What are the key financial issues facing SGH?

Pressures in current year

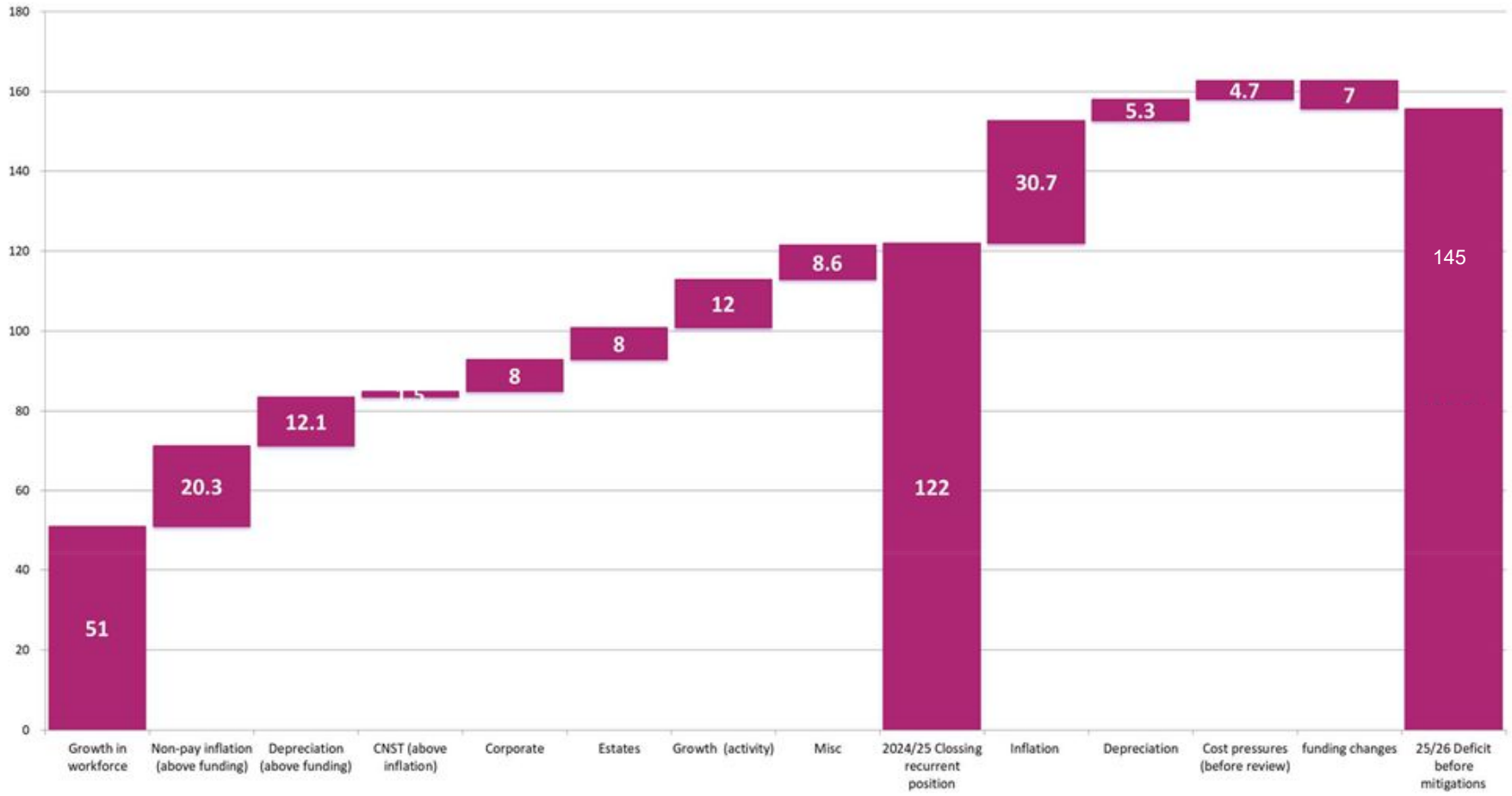
- Underlying deficit.
  - Exited “Financial Special Measures” just before Covid. Deficit circa £40m.
  - Covid. Cost growth and reduced productivity.
- Operational pressures.
  - Productivity.
  - High demand
  - Flow through the hospital.
  - Inflation.
- Scale of Cost Improvement (CIP) ask.
- Non-recurrent funds supporting position.

Planning for 25/26

- We haven’t agreed a plan with NHSE yet.
- Looks very challenging.
- Similar challenges across whole of SWL.
- Looking at what we can do within SGH, with Epsom St Helier and across SWL

Drivers of the deficit

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



24/25 underlying deficit

- Some further explanation for the items included on the drivers of deficit bridge on the previous page.
- Some further work required to validate.

Heading	£m	Explanation
Growth in workforce	51	Calculated through price and volume variance analysis to differentiate growth from on-boarding and adjusting for inflation. The next two slides seek to map how factors within pay are driving the current underlying deficit
Non-pay inflation	20	Excess inflationary costs above funding based on comparison of actual cost growth to various cost inflation metrics. Hospital cost price indexation has been seen to increase 33% across the period far in excess of the 13% in NHS non-pay inflation received via the tariff
Depreciation	12.1	High levels of capital investment has resulted in costs in excess of inflation. DN: NEED TO VALIDATE AGAINST DEPRECIAITON FUNDING
CNST	1.5	Actual growth above inflation funding in the tariff. Tariff inflation is based on the average national increase, with actual cost change at trust level being informed by individual assessment by NHE Resolution.
Corporate costs	8	ESTIMATED: Based on corporate benchmarking. Further validation to be confirmed. Included as NHSE will expect to see this.
Estates	8	Being validated.
Growth	12	Unfunded growth where blocked, and disparity between price and income where income is variable. Being validated.
Misc	8.6	Balancing item
Total	122	

2025/26 Financial Plan: Key deliverables

		Gross deficit inc deficit support (exc def supp)	Deficit submitted	CIP needed to balance	CIP identified to date
SGH	March FinCom	£95m	£13m	£95m	£82m
	April FinCom	**£95m**	**£13m**	**£95m**	**£82m**

- The trust is in receipt of “Deficit Support Funding” worth £41m in recognisiton of the challenge in achieving balance.
- To reach Our control total we need to find £95m of savings (7% of turnover).
- To date committed to finding £82m, leaving a gap of £13m.

- SWL system has a gap pf £63m overall.
- NHSE is requesting the system to move to balance.

Development of CIPs

SGH £m	Fully developed	Plans in progress	Opportunity	Grand total
Pay	5,926	5,507	35,077	45,511
Non-pay	7,519	3,911	15,800	27,230
Income	2,662	1,276	4,046	7984
Total	16,107	10,694	54,924	81,725

- The tables to left indicate the progress in developing CIPs to 25th April. This moves forward the position reported to the Finance Committee on the 25th April.
- SGH has developed £16.1m of the target to fully developed, a total of 1.4% of turnover.
- Work is continuing to develop CIPs.
- The following slide summarises the programmatic approach being adopted to help support this.

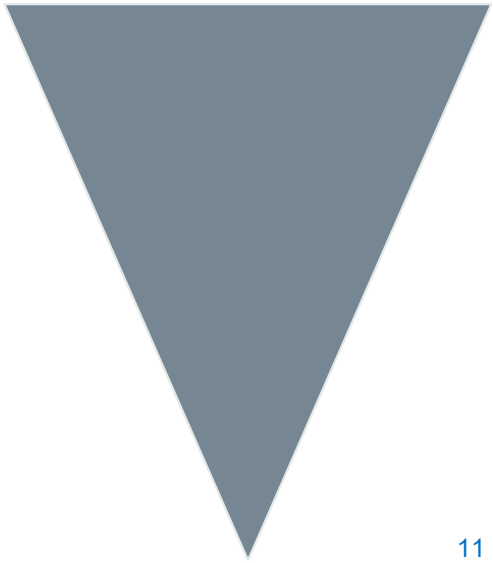
Financial recovery – programmatic approach

Following discussion at GEC and site recovery meetings, we propose the following shape to our financial recovery plan, with all CIP schemes fitting into the matrix below – and with implications for where FRB spends its time. The aim is:

- to secure full visibility to the savings programme - from transactional CIP to transformative and strategic developments - for various purposes from a single source of truth (for each site, IC and corporate)
- to be clear on the ownership of programmes and their interdependencies, using the accountability framework as a guide
- to enable speedy decision making across the group, where this is required
- to help prioritise the resources and support of enabling functions
- to give clear and effective assurance to the F&P Committee and Board on financial recovery
- to review the meetings & groups necessary, with a view to exercising the accountability framework

Programmes	Service config.	Elective	OP	Digital	UEC	Workforce productivity	Corporate	Non-Pay	Income
Strategic - coming together as Group/ system	E.g. reviewing maternity/paediatric services. Best done together across the Group/system.								
Transformation – site-led, Group-enabled	E.g. bed closures, or outpatient transformation. Needs to be delivered by sites, but there are Group enablers (such as a common access policy / digital enablers for OP transformation) or interdependencies between individual sites, and the scale/complexity/risk of the programmes justifies greater visibility across the Group.								
BAU CIP – local schemes	E.g. ESTH reporting radiographers case to reduce medicare/bank spend. Group needs proportionate visibility on delivery in the round via regular CIP reporting, but sites need to be free to 'get on'.								

Where FRB should spend its time



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Cash

High Level Forecast £m	SGH
Monthly net cash outflow from M1 (current run rate)	11
Closing cash balance 31 Mar 2025	75
Capital Creditors at year end 31 Mar 2025	18
Risk cash will be distressed:	
Excluding deficit support	Mid Q2
Including £41.6m 2526 deficit support	Mid Q3
Identified fully developed and plans in progress CIP delivered	Early Q4
All CIPs delivered – as per submission	**Not in 2526**

- Cash will be a key areas of concern for both trusts across 25/26 given the level of risk associated with delivering cips as outlined in the current financial plans.
- Failure to deliver a cash impact from cips will cause stress to the cash position, and if significant could cause distress.
- Stress is defined as short term issues for managing effective payments, with distress being a more fundamental mismatch between receipts and payments creating the need for support to manage timely payments.
- While there is not a standard process for obtaining revenue cash support in 25/26 trusts can expect NHSE to provide support to ensure payments can be maintained. However, if a trust has to seek that support the challenge is likely to be considerable.
- NHSE has indicated they expect trusts to enhance cash reporting through to Boards as part of regular financial reporting across 25/26. Cash reporting has already been a regular part of the financial reporting framework in place to the Finance Committee, with reference through to the Board.

Council of Governors

Meeting on Thursday, 22 May 2025

Agenda Item	5.1	
Report Title	2024 Staff Survey Council of Governors Update	
Executive Lead(s)	Victoria Smith, Group Chief People Officer	
Report Author(s)	Tairu Drameh, Head of Culture and Staff Engagement	
Previously considered by	n/a	Click or tap to enter a date.
Purpose	**For Review**	

Executive Summary

The 2024 Staff Survey (Oct-Nov 2024) at St George's Hospital benchmarks 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). 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:

- Significant improvements in staff engagement, morale, and multiple People Promise elements versus 2023.
- 'Compassionate and Inclusive' score (7.11) is strong, near the benchmark (7.21).
- 'Compassionate culture' (7.17) exceeds the benchmark (7.05); 89.33% of staff feel their role is 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) are below benchmarks. Fairness in career progression perception is low (49.44%).

Corporate actions & next steps: Our action plan will address these areas by:

1. Improving leadership development.
2. Enhancing staff health, wellbeing, and safety.
3. Strengthening culture, diversity, and inclusion programs.
4. Boosting training and career development.
5. Implementing NHS retention interventions.

Support for teams includes hypothesis-driven analysis, tailored action plans, manager workshops, working groups, and engaging infographics.

This report concludes that the 2024 survey shows positive progress but highlights areas needing attention, particularly morale, recognition, flexibility, and aspects of inclusive leadership. Planned actions aim to foster a more supportive and engaging environment.

Action required by Council

The Council is asked to:

a. Note the report's key findings and corporate response

Committee Assurance	
Committee	Council of Governors
Level of Assurance	Not Applicable

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

Implications

Group Strategic Objectives

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

Risks

[…]

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

[…]

Legal and / or Regulatory implications

[…]

Equality, diversity and inclusion implications

[…]

Environmental sustainability implications

[…]

2024 Staff Survey Council of Governors Update
Council of Governors, 22 March 2025

1.0 Purpose of paper

1.1 To inform the council of governors of the key findings from the 2024 Staff Survey, highlight areas of progress and concern regarding staff experience, and outline the corporate actions to address these findings and enhance our workplace culture.

2.0 Background

2.1 The annual Staff Survey is a critical tool for St George's Hospital to understand and improve the experience of its staff. It provides valuable data on various aspects of the work environment, benchmarked against national averages for Acute and Acute Community Trusts.

2.2 The survey results are integral to shaping a supportive, engaging, and inclusive workplace, aligning with the core commitments of the People Promise themes. Insights gained from the survey directly inform strategic initiatives and targeted actions aimed at enhancing staff well-being, professional growth, and overall satisfaction, which are crucial for delivering high-quality patient care and meeting the ambitions of our Care and People Strategies.

2.3 The staff survey took place between 7 October to 29 November 2024.

3.0 Key issues for consideration

3.1 Staff morale (5.75) is below the national average (5.93), linked to intentions to leave and work pressure. Burnout levels are also higher than average.

3.2 Scores for recognition/reward (5.81) and flexible working (5.92) are below benchmarks, with specific dissatisfaction regarding pay (28.74% satisfied) and flexible work options (51.03% satisfied).

3.3 Compassionate & Inclusive Culture while overall strong, specific areas like 'Diversity and Equality' (7.72), 'Compassionate Leadership' (6.82), and particularly 'Fairness in career progression' (49.44% perceive fairness) are below national averages and require attention.

4.0 Sources of assurance

4.1 Aligns with the CARE Strategy, People Strategy, NHSE People Promise, Long Term Plan and EDI Improvement Plan.

4.2 Board and Board Committees oversight

4.3 Executives oversight.

5.0 Implications

5.1 Prioritise staff retention & well-being to address below-benchmark morale, burnout, and work pressure to retain staff and ensure service quality.

5.2 Continue to strengthen Inclusive Leadership to foster a compassionate, inclusive culture and ensure fair career progression.

5.3 Continue to update and enhance recognition, and flexible working options to meet staff needs.

5.4 Commit to continuous improvement through embedded data-driven decision-making and staff engagement to achieve sustained enhancements in staff experience.

5.5 Resource people-focused initiatives by allocating necessary resources to planned actions for leadership, well-being, EDI, staff engagement and retention.

6.0 Recommendations

6.1 The Council is asked to:

a. Note this report's key findings.
b. Acknowledge the progress being made towards meeting the people promise goals.

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2024 Staff Survey Council of Governors Update

Tairu Drameh, Head of Culture and Staff Engagement
May 2025

Introduction

The staff survey scores at St George's Hospital are benchmarked against the national average across Acute and Acute Community Trusts, providing valuable insights into how the organisation compares to peers in key areas of staff experience. This benchmarking helps identify strengths and areas for improvement, ensuring that efforts to enhance workplace culture align with best practices across the sector.

The **People Promise themes** are vital in shaping a supportive and engaging work environment. These themes reflect the core commitments to staff well-being, professional growth, and fostering a culture where employees feel valued and heard.

Among these themes, **Compassionate and Inclusive** stands out as particularly crucial. Leaders who demonstrate empathy and inclusivity create psychologically safe workplaces where staff feel supported, respected, and motivated.

The staff survey took place between 7 October to 29 November 2024. The survey was carried out by Picker, who was also commissioned by 58 other acute and acute community organisations.

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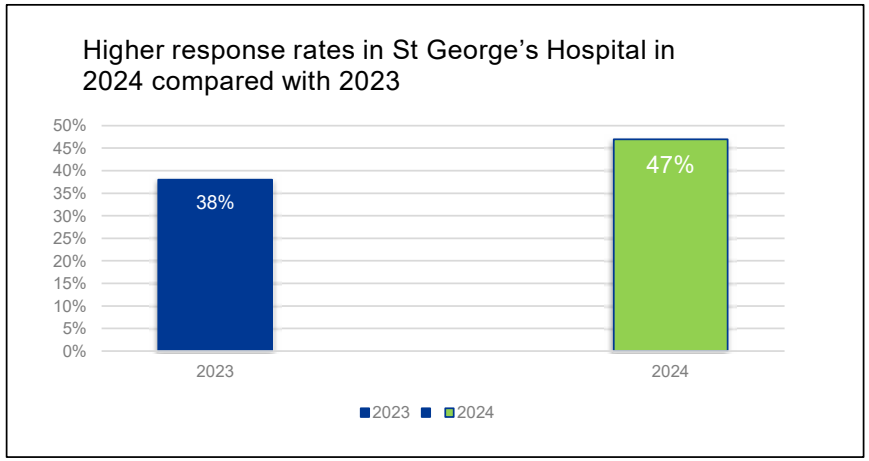
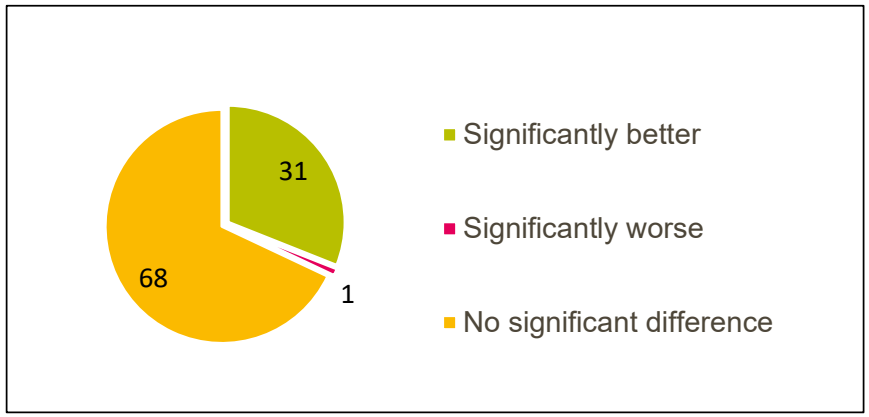
Response rate and scores improvements

In 2024, a total of 4,765 staff members across the Trust participated in the annual staff survey, reflecting a 47% response rate and 9% improvement from 2023.

Our survey results show overall positive trends, with most areas showing either improvement or stability compared to the previous year. Compared with the national average, St George's scores were lower in some areas, but greater improvements were seen in our organisation than in other Trusts overall. We are ranked number 10 most improved trust across acute and acute community trusts.

With 31 scores showing improvement and 68 questions remaining stable and only 1 score declining, this shows us that our efforts to improve certain aspects of our staff experience are paying off, yet there are still opportunities to sustain and further enhance our support to our staff.





Overall Performance - People Promise Elements & Themes (2024)

The improvement seen in 2024 has resulted in a 0.1 point increase in our people promise, staff engagement and morale indicators. We can see in Table 1, that significant improvements have been made in most areas of our people promise themes. Our improvements have resulted in a certificate of recognition for our achievement from NHSE.

Table 1: High-level overview of our performance across the seven People Promise elements and two key themes.

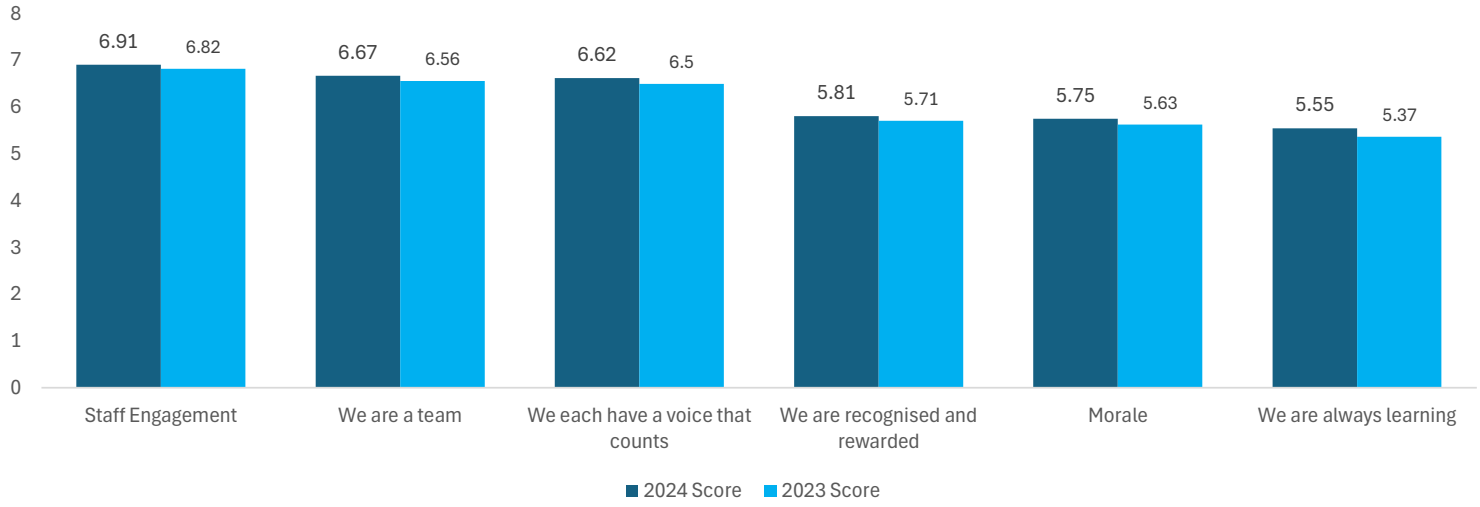
People Promise Element / Theme	Trust (2024)	Trust (2023)	Benchmark Average (2024)	Change from 2023
Promise 1: We are compassionate and inclusive	7.11	7.04	7.21	Not significant
Promise 2: We are recognised and rewarded	5.81	5.71	5.92	Significantly higher
Promise 3: We each have a voice that counts	6.62	6.50	6.67	Significantly higher
Promise 4: We are safe and healthy	5.98	5.94	6.09	Not significant
Promise 5: We are always learning	5.55	5.37	5.64	Significantly higher
Promise 6: We work flexibly	5.92	5.83	6.24	Not significant
Promise 7: We are a team	6.67	6.56	6.74	Significantly higher
Staff Engagement	6.91	6.82	6.84	Significantly higher
Morale	5.75	5.63	5.93	Significantly higher

(Scores 0-10, higher is better. Statistically significant changes from 2023 are noted)

Key Strengths

We have several key strengths to highlight, most notably, as chart 1, shows, we've seen statistically significant improvements across multiple people promise elements and both key themes (staff engagement and morale) when comparing 2024 to 2023. Although not a significant improvement, Compassionate and Inclusive remains a relatively strong area with a score of 7.11, close to the benchmark average of 7.21

Chart 1: Statistically significant improvements in several key areas (2023 vs 2024)



(Scores 0-10, higher is better

Areas for Improvement

While we celebrate our improvements, the survey also clearly indicates areas needing attention. Table 2, summarises some key areas requiring improvement. Despite a significant increase, overall 'Morale' at 5.75 is still below the benchmark average. This is linked to staff 'thinking about leaving' and perceptions of 'work pressure'. Similarly, 'We are recognised and rewarded', 'We work flexibly', and 'We are safe and healthy', including the 'Burnout' sub-score, present opportunities for focused improvement.

Table 2: Areas requiring improvement

Area	Trust Score/Detail	Benchmark Average	Concern
Overall Morale	5.75	5.93	Below average despite improvement.
Sub: Thinking about leaving	5.66 (lower is worse)	6.04	Indicates more staff considering leaving.
Sub: Work pressure	5.26	5.36	Perceptions of work pressure below average.
We are recognised & rewarded	5.81	5.92	Below average despite improvement.
Q4c: Satisfaction with pay	28.74% satisfied	31.14%	Lower satisfaction with pay.
We work flexibly	5.92	6.24	Below average.
Q4d: Flexible working opps.	51.03% satisfied	56.43%	Lower satisfaction with flexible work options.
We are safe and healthy	5.98	6.09	Slightly below average.
Sub: Burnout	4.94 (higher is better)	5.01	Indicates higher burnout than average.

Deep Dive: We are Compassionate and Inclusive (Overall Score: 7.11)

A key strength is our 'Compassionate Culture' score of 7.17, above the average, and 89.33% of staff feel their role makes a difference. However, 'Diversity and Equality' and 'Compassionate Leadership' score are below average. For instance, only 49.44% believe the organisation acts fairly regarding career progression, below the average of 56.02%. The initiatives within our corporate actions provides us with opportunities to mitigate these stated experiences.

Table 3: Our compassionate and inclusive scores

Sub-score	Trust Score	Benchmark Average
Compassionate Culture	7.17	7.05
Compassionate Leadership	6.82	6.98
Diversity and Equality	7.72	8.08
Inclusion	6.72	6.81
Key Points:		
Role makes a difference	89.33% agree	88.00%
Fair career progression?	49.44% yes	56.02%

Corporate Actions

Our proposed corporate action plan is designed to address the key improvements and challenges identified in our staff survey, aligning with our overarching people strategy and exemplar people promise programme. By focusing on the following areas, we aim to create a more supportive, inclusive, and development-focused environment for all staff at gesh.

- **Improve line management and leadership**

Implementing comprehensive leadership development programmes will foster compassionate and inclusive management practices. This aligns with our people strategy to enhance line management and leadership. By establishing a multiprofessional group-wide leadership development framework, including the senior leadership programme, compassionate and inclusive leadership programme, and management fundamentals, we aim to build strong, empathetic leaders who can effectively support their teams.

- **Keeping our staff healthy and safe**

Launching initiatives to promote health and wellbeing across the organisation is crucial. By implementing Health and Wellbeing standards, promoting Health and Wellbeing Champions training, and tackling violence and aggression against staff, we ensure a safe and supportive workplace. This will lead to improved staff morale, reduced absenteeism, and a healthier work environment.

- **Deliver our culture and diversity & inclusion programme**

Implementing the High Impact Action EDI Plan framework will ensure a fair and inclusive workplace with consistency across gesh. By focusing on training availability, improving awareness and understanding of LGBTQ+ issues, enhancing ER processes for minority groups, and promoting inclusive practices for career development, we aim to create a diverse and equitable environment. This will enhance staff engagement, satisfaction, and retention.

- **Improve training and career development**

Implementing talent management initiatives, including positive action programmes, career conversations, and enhanced recruitment processes, will support staff development and retention. By investing in our employees' growth, we aim to build a skilled and motivated workforce, ready to meet future challenges and opportunities.

- **Deliver the NHS exemplar Intervention on retention**

In 2024, GESH signed up to the NHS People Promise and became an exemplar organisation, joining a mix of acute, community, and mental health providers. NHS England is working with us through a dedicated resource to deliver interventions that will improve staff retention. This commitment underscores our dedication to creating a supportive and engaging work environment, ultimately leading to higher retention rates and a more stable workforce

Supporting teams with next steps

In our continuous effort to enhance the effectiveness and impact of our staff survey reporting and action planning, we are excited to introduce a new approach that focuses on efficiency, engagement, and actionable insights. In previous years, we produced detailed PowerPoint reports at both the division and care group levels. While comprehensive, this method was resource-intensive and limited our ability to provide enhanced support to HR Business Partners (HRBPs) divisions and teams. To address these challenges and better support our teams, we are proposing the following changes:

- **Hypothesis-driven analysis**

HRBPs will conduct hypothesis-driven analysis at the division level, with support from the Organizational Development (OD) team. This approach will allow for more targeted and meaningful insights.

- **Action plan development**

Divisions will create or amend their action plans based on the analysis and share them with their respective teams. This ensures that action plans are relevant and tailored to the specific needs of each division.

- **Manager support workshops**

We will schedule workshops to help managers interpret their results. These sessions will provide managers with the tools and knowledge they need to effectively address the survey findings.

- **Working Groups**

Site-level and divisional working groups will be established to support the delivery of the divisional action plans. These groups will foster collaboration and ensure that action plans are implemented effectively.

- **Engaging Infographics**

To communicate the survey results in an engaging and accessible way, we will create simple infographics. These infographics will highlight strengths and areas for improvement, aligned with our People Promise. They are designed to support local huddles and facilitate engagement with all team members.

By adopting this new approach, we aim to streamline our processes, enhance support for HRBPs and divisions, The shared ownership of this approach will ultimately drive more effective and impactful action planning. We believe this will lead to better outcomes for our teams and the group as a whole.

Council of Governors

Meeting on Thursday, 22 May 2025

Agenda Item	6.1	
Report Title	**Vacancies on the Council of Governors**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Elizabeth Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	n/a	-
Purpose	**For Approval / Decision**	

Executive Summary

Over the past few months two elected governors (one public governor, one staff governor) have stood down leaving their seats vacant. The seat for South West Lambeth is vacant having not received any nominations in the past two elections. The South West London Integrated Care Board (ICB) appointed position has also been vacant for some time.

A review of the options for filling these seats has been completed taking into account 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.

Action required by Council of Governors

The Council is asked to:

a. Agree that the next highest place candidate(s) be invited to fill the vacancy left by Marie Grant (Rest of England) until the original term of office ends in January 2027.
b. Agree the election for the Staff Governor (Allied Health Professionals and Other Clinical and Technical) to replace Atif Mian take place during the scheduled elections in the autumn.
c. Note that a further attempt to fill the vacant South West Lambeth seat will take place through the forthcoming elections in Q3.
d. Note the update on the South West London ICB vacancy.

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

Implications				
Group Strategic Objectives				
☐ Collaboration & Partnerships			☐ Right care, right place, right time	
☐ Affordable Services, fit for the future			☒ Empowered, engaged staff	
Risks				
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				
Other than the cost of the elections in Q3 there are no financial implications.				
Legal and / or Regulatory implications				
Our obligations as set out in the Constitution would be met through these proposals.				
Equality, diversity and inclusion implications				
Through our governor elections we aim to have a diverse and inclusive Council, representative of our community.				
Environmental sustainability implications				
n/a				

Vacancies on the Council of Governors

Council of Governors, 22 May 2025

1.0 Purpose of paper

1.1 This paper sets out the options to fill the vacancies on the Council left by the departures of Marie Grant (Rest of England) and by Atif Mian (Staff). It also reports on the long standing vacancies in South West Lambeth and the South West London ICB appointed governor.

2.0 Background

2.1 In December 2023 – January 2024, elections were held for the vacant Staff Governor positions with Atif Mian being successful in the (Allied Health Professionals and Other Clinical and Technical) seat. Atif has taken the decision to stand down from Council due to pressures of work and this is formally recorded from the date of this meeting.

2.2 In December 2024 – January 2025 elections were held for 2 vacant roles in the Rest of England Constituency. These roles became vacant due to the departures of James Giles and Padraig Belton who left mid term. Four candidates stood in the election.

Marie Grant, along with Ashok Bhat, was successful. At the end of March, Marie informed us that due to a health issue she would need to stand down.

2.3 The Trust's Constitution sets out the number of governors who make up the Council and the constituencies from which they are drawn. It also sets out the process for governor elections and the options open to the Council of Governors should a vacancy arise outside of the normal term of office:

> *4.1.2. where the vacancy arises amongst the elected governors, the Council of Governors shall be at liberty either:*
>
> *4.1.2.1. to call an election within four (4) months to fill the seat for the remainder of the term of office of the governor who is being replaced (unless they are in the last year of their term of office, in which case the seat may be left vacant until the next election due in respect of that seat is held); or*
>
> *4.1.2.2. to invite the next highest polling candidate for that seat at the most recent election, who is willing to take office, to fill the seat until the next election due in respect of that seat is held, at which time the seat will fall vacant and be subject to election for any unexpired period of the term of office of the governor who is being replaced.*

2.4 Efforts to recruit a South West Lambeth governor in the 2024/25 elections were unsuccessful, as they had been in the 2024 elections. The South West London ICB has not made an appointment to the Council since Sangeeta Patel stood down from the Council in 2023.

2.5 This means that there are the following vacancies on the Council:

- 1 governor elected from South West Lambeth
- 1 governor elected from Rest of England

- 1 governor elected from Staff (Allied Health Professionals and Other Clinical and Technical)
- 1 governor appointed from the South West London ICB

2.6 The Trust is required to appoint an independent Returning Officer to run and oversee elections to the Council of Governors. Governor elections have previously been run by Civica, an independent organisation. The cost for the 2024/25 elections was c.£14,000 with a turnout of 6.4% for Merton and 3.5% for Rest of England. The South West Lambeth election did not proceed as no nominations were received.

3.0 Proposals

3.1 **Rest of England**
Four candidates stood in the election receiving 89, 78, 66 and 48 votes respectively, the two highest polling of which were elected to the Council. As set out in 2.3 above, the Trust Constitution provides that if a vacancy occurs during a term of office the next highest polling candidate can be invited to fill the seat for the remainder of that term of office – which would be until 31 January 2027. Two other candidates stood in the election and we recommend that the third placed candidate be approached to fill the vacancy, and – if the third placed candidate does not wish to join the Council – the fourth placed candidate.

Consideration was given to including this vacancy within the election process later this year but given the previous election was relatively recent and there is not a significant difference between the votes received by candidates we believe there is sufficient mandate to move to fill this seat now.

3.2 **Staff (Allied Health Professionals and Other Clinical and Technical)**
In the 2024 election only 2 candidates stood with Atif Mian receiving 233 votes compared to the runner up with 36 votes. Whilst it would be preferable to have the post filled, given that we are now 17 months on from the original election and the significant gap between the two candidates, we believe that the second placed candidate would not have enough of a mandate and should not therefore be invited to take the vacant post.

With elections due later this year, we propose making use of provision 4.1.2.1 of the Constitution and including this seat in the elections in Q3.

To encourage a greater number of candidates in those elections, and to maintain engagement with this constituency we propose that we promote attendance as observers to the public part of the Council of Governors meetings throughout the rest of the year. This would be in addition to the usual steps taken to promote the elections.

3.3 **South West Lambeth**
Having only sought to fill this role 5 months ago, and having also been unsuccessful in 2023/24, it is proposed that we incorporate this vacancy into the elections that will take place later this year. We hope that this will give time for the membership engagement strategy to have had an impact and increase both member numbers and generate nominations. Targeted engagement with members in South West Lambeth will also be required and the Membership Engagement Committee will support this. This term will be until January 2027, due to the phasing of terms of office set out in our Constitution.

3.4 South West London ICB

The Trust and the Lead Governor are in contact with the ICB regarding this vacancy which we are keen to fill as SWL ICB is one of our key partners. However, it should be recognised that due to upcoming changes to ICBs this appointment may not be a priority for them.

4.0 Timeline

4.1 In recent years the elections have taken place in late Q3 into early Q4. We propose bringing this forward with the process to be fully completed with Q3. There are three main reasons for doing this:

- Maximise the time for promoting the vacancies amongst our members including at the September AMM and Meet Your Governor events.
- New Governor induction will be able to take place both before and much earlier in a governors term of office. This will support governors to be as effective in their roles as soon as possible in their term of office.
- On this occasion we will also be able to include the Staff (Allied Health Professionals and Other Clinical and Technical) seat as this will be within the 4 months set out in 4.1.2.1 for the notice of an election to be issued.

The notice of election would be issued in w/c 15 September with results available in December. The exact timings will be agreed with Civica.

5.0 Recommendations

5.1 The Council is asked to:

a. Agree that the next highest place candidate(s) be invited to fill the vacancy left by Marie Grant (Rest of England).
b. Agree the election for the Staff Governor (Allied Health Professionals and Other Clinical and Technical) to replace Atif Mian take place during the scheduled elections in Q3.
c. Note that a further attempt to fill the vacant South West Lambeth seat will take place through the forthcoming elections in Q3.
d. Note the update on the South West London ICB vacancy.

Report of the Membership Engagement Committee

Progress on Member Engagement Strategy
22 May 2025

Agenda Item	7.1	
Report Title	**Report from Membership Engagement Committee**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Jackie Parker, Meeting Chair Liz Dawson, Group Deputy Director of Corporate Affairs	
Previously considered by	n/a	-
Purpose	**For Review**	

Executive Summary

The Committee met on 24 April 2025 and recorded their thanks to Sandhya Drew, former Chair. The Committee recommend that Jackie Parker be appointed as her successor.

The Committee are also encouraging more governors to join the group – Augustine Odiadi observed in April and it is recommended that he be appointed as a member. Other governors will be observing in due course.

The 1-year Member Engagement Strategy was agreed by Council in September 2024. Whilst behind schedule 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.

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. A number of new member sign-ups were received in the days following the AMM. The website pages have also been refreshed, although further work is needed. We have also appointed our first Associate Governor (Young Members).

Areas where we are yet to make the progress we would have liked are the Member Talks or specific outreach sessions but the latter is beginning to move forward with contact made with a number of groups. Whilst the Corporate Governance team can provide support, such as through the Member newsletter, face to face engagement has to be carried out by governors - some governors have made been quite active but we would like to see all governors participating.

Committee Assurance	
Committee	Not Applicable
Level of Assurance	Not Applicable

Appendices	
Appendix No.	**Appendix Name**
Appendix 1	Membership One Year Strategy 2024-2025 Update

Action required by Council

The Council is asked to:

a. Confirm Jackie Parker as Chair of the Committee
b. Confirm Augustine Odiadi as a member of the Committee
c. Provide feedback on the progress on the strategy
d. Nominate a governor to be the link with the Patient Equality, Diversity and Inclusivity workstream
e. Ask all elected governors to identify and/or participate in at least one member engagement activity before the July Council meeting.

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Progress Report on the Member Engagement Strategy

1.0 Purpose of paper

1.1 To update the Council of Governors on progress on the one-year engagement strategy that was approved by the Council in September 2024.

2.0 Background

A refreshed and revitalised Membership Engagement Committee recommended an ambitious, yet achievable, 1 year strategy to Council in September, which was approved.

The strategy is set out around three key objectives:

- **Objective 1: Improve the quality of two-way engagement with members**
- **Objective 2: Ensure our membership is representative of the communities we serve – with a focus on engaging with younger members**
- **Objective 3: Maintain and where possible increase our membership, perhaps with a focus on increasing numbers in SW Lambeth**

3.0 Progress Update

3.1 **Objective 1: Improve the quality of two-way engagement with members**

There has been some progress on this objective. Constituency specific email addresses have been set up and promoted via the newsletter and the website but there has been very limited traffic.

Whilst the member newsletter 'Connected' has been relaunched, the aim of monthly issues, which was ambitious, has not yet been achieved. The aim had been to 'piggyback' on the Trust newsletter that was due to be reinstated but the date for this was pushed back. We are drawing up a schedule of items that could be included in future issues of 'Connected' around key themes, together with some news stories from the website, whilst avoiding too much repetition.

Whilst we have been delayed in the design and issuing of a member survey, originally scheduled for autumn 2025, this can still be completed within the lifespan of this strategy. Its findings can be built on when drafting the 2025-2028 Strategy which is to be launched at the Annual Members Meeting in September.

Pre-Christmas Meet Your Governor Events were cancelled due to lack of governor availability. New dates were set but unfortunately the event as QMH was cancelled again for the same reason. The event will take place at St George's on 30 May 2025 with 10 governors participating. It is being promoted via an email to all members and posters around the site.

We have connected with the Patient Partnership Engagement Group (PPEG) lead, Wendy Doyle. John Hallmark is a member of PPEG and Afzal Ashraf has now been linked with the Armed Forces Community. Alfredo Benedicto has formally become the link with the Carers Group and Jackie Parker the Accessibility Group. We have also been invited to provide a link

to the Patient Equality, Diversity and Inclusivity workstream, and we would like a governor to volunteer for this.

The St George's charity has also suggested a governor presence on their regular stands in the reception area. This is being followed up by Alfredo Benedicto with discussions to also include other areas for collaboration.

3.2 Objective 2: Ensure our membership is representative of the communities we serve – with a focus on engaging with younger members

The first step to achieving this objective was the appointment of an Associate Governor (Young Members). The process took place in December 2024, with Sophia Agha confirmed in post by the Council in March. Once Sophia has completed her induction we will be exploring in detail some of the excellent ideas she shared at her interview.

We have also made contact with the Merton Youth Council and South Thames College and will be actively pursuing a response over the coming months. We have yet to progress an event with City St George's, University of London and may have missed the window this year due to exam season. A stand at Freshers Week in the autumn may be more realistic.

3.3 Objective 3: Maintain and where possible increase our membership, perhaps with a focus on increasing numbers in SW Lambeth

The 'Bring a Friend' element showed promise – with a high turnout for the September AMM. We would like to encourage Governor attendance, and to 'Bring a Friend' at hospital events such as the recent Diwali celebrations or the numerous Christmas celebrations that took place. The dates are shared in the Governor Briefing and to allow for diary management we will incorporate these (as far as possible) in the annual calendar that has been shared.

South West Lambeth remains unrepresented by a Governor. Efforts were made, including promoting via local facebook and social media groups, to attract candidates in the recent governor elections but this did not bear fruit. Identifying groups with whom we can connect with in this constituency is a priority over the coming weeks.

4.0 Next steps

We believe that the majority of the Strategy is achievable and through this we hope to see an increase in members by September 2025. Over the next few months some of our key priorities, with the support of Corporate Governance, are:

- Designing and issuing the member survey
- Making contact with more local groups for governors to link to, particularly in SW Lambeth
- Seeking support from our colleagues in Comms on the running of at least one Member talk before September 2025
- Promoting and supporting the 'Meet Your Governor' Events
- Working with Comms on refreshed, low budget but high impact, information flyers for governors to distribute
- Researching and working with staff governors on bespoke engagement materials
- Begin drafting elements of the 2025-28 strategy

5.0 Action

The Council is asked to:

a. Confirm Jackie Parker as Chair of the Committee
b. Confirm Augustine Odiadi as a member of the Committee
c. Provide feedback on the progress on the strategy
d. Nominate a governor to be the link with the Patient Equality, Diversity and Inclusivity workstream
e. Ask all elected governors to identify and/or participate in at least one member engagement activity before the July Council meeting.

Council of Governors

Meeting in Public on Thursday, 22 May 2025

Agenda Item	8.1	
Report Title	**Fit and Proper Persons Test Annual Compliance Report 2024/25**	
Executive Lead(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Report Author(s)	Stephen Jones, Group Chief Corporate Affairs Officer	
Previously considered by	-	-
Purpose	**For Assurance**	

Executive Summary

This paper provides assurance to the Council of Governors that all Non-Executive Directors remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework (FPPT) for England published in August 2023.

All Non-Executive Directors at St George's University Hospitals NHS Foundation Trust (SGUH) have successfully undergone all of the required checks under the Fit and Proper Persons Test Framework in 2024/25 and the Trust will make the required submission to NHS England ahead of the 30 June 2025 deadline.

Two Non-Executive Directors and one Interim Non-Executive Director at SGUH left the organisation in 2024/25. The required Board Member References have been completed for these departing Board members in line with the requirements of the Framework.

Two new Non-Executive Directors and one Associate Non-Executive Director joined SGUH and all relevant FPPT checks were completed.

Action required by Group Board

The Council is asked to note that the Fit and Proper Persons Test has been conducted for the period 2024/25 and that all Non-Executive Directors satisfy the requirements of the Test.

Committee Assurance	
Committee	N/A
Level of Assurance	Not Applicable

Appendices

Appendix No.	Appendix Name

Appendix 1	FPPT Checks Annual Compliance 2024/25

Implications

Group Strategic Objectives

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

Risks

If we do not implement fully the FPPT Framework and apply it consistently, there is a risk that directors could be appointed to the boards who do not meet the required standards for appointment. This could potentially impact on patient safety and / or organisational performance and would likely trigger external regulatory intervention.

CQC Theme

☐ Safe	☐ Effective	☐ Caring	☐ Responsive	☒ Well Led

NHS system oversight framework

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

Financial implications

There are no financial implications.

Legal and / or Regulatory implications

Full implementation of the Fit and Proper Persons Test is a requirement under Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the 2023 Fit and Proper Persons Test Framework for board members.

Equality, diversity and inclusion implications

There are no specific EDI implications associated with the fulfilment of the FPPT requirements.

Environmental sustainability implications

There are no specific environmental or sustainability implications associated with the FPPT requirements.

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Fit and Proper Persons Test Annual Compliance Report 2024/25
Council of Governors, 22 May 2025

1.0 Purpose of paper

1.1 The purpose of this paper is to provide assurance to the Council that all Non-Executive Directors at the Trust remain fit and proper for their roles in line with Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and the Fit and Proper Persons Test Framework for England published in August 2023.

2.0 Background

2.1 In 2014, the Government introduced a 'fit and proper person' requirement which applies to directors and those performing the functions of, or functions equivalent or similar to the functions of, a director in all NHS organisations registered with the Care Quality Commission (CQC), which includes all provider licence holders and other NHS organisations to which licence conditions apply. These 'fit and proper person' requirements were introduced via Regulation 5 of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. Regulation 5 recognises that individuals who have authority in NHS organisations that deliver care are responsible for the overall quality and safety of that care. The Regulation 5 requirements are that:

a) The individual is of good character (whether the individual has been convicted of an offence; whether the individual has been erased, removed or struck off a register maintained by a regulator of health and social care professionals).
b) The individual has the qualifications, competence, skills and experiences that are necessary for the relevant office or position or the work for which they are employed.
c) The individual is able by reason of their health of properly performing tasks that are intrinsic to the office or position for which they are appointed or to the work for which they are employed.
d) The individual has not been responsible for, contributed to or facilitated any serious misconduct or mismanagement (whether lawful or not) while carrying out a regulated activity or providing a service elsewhere which, if provided in England, would be a regulated activity.
e) None of the grounds of unfitness specified in the Regulation apply to the individual (undischarged bankrupt, subject of a bankruptcy restriction, insolvent, included in the children's or adults' barred lists for safeguarding, or prohibited from holding relevant office).

2.2 In 2018, Tom Kark KC was asked by the Government to lead a review of the scope, operation and purpose of the Fit and Proper Person Test (FPPT) as it applies under the 2014 Regulations. The Kark Review was tasked with determining whether the fit and proper person test was working in its existing form and how it might be adapted to ensure better leadership and management and prevent the employment of directors who are incompetent, misbehave or mismanage. It included looking at how effective the FPPT was "*in preventing unsuitable staff from being redeployed or re-employed in the NHS, clinical commissioning groups, and independent healthcare and adult social care sectors*". Published in 2019, the Review highlighted areas it considered needing improvement to strengthen the existing regime, including seven recommendations to Government. These included proposing that: all directors meet specific standards of competence to sit on the board of any health-providing

organisation; a central database of directors be established to hold relevant information about qualifications and history; a mandatory reference be required for each director; the test be applied to commissioners and arms length bodies.

2.3 In August 2023, NHS England published a new *Fit and Proper Persons Test Framework for board members* in response to the Kark Review, and grounded in the requirements of the 2014 Regulations. In publishing the new Framework, NHS England explained that it would "*support the implementation of the recommendations of the Kark Review*", "*promote the effectiveness of the underlying legal requirements*", and "*introduce a means of retaining information relating to testing the requirements of the FPPT for individual directors, a set a standard competences for all board directors, a new way of completing references with additional content whenever a director leave an NHS board, and extension of the application to some other organisations, including NHS England and the CQC*". The new Framework became effective on 30 September 2023, with certain provisions (such as the introduction of mandatory new Board member references and using a new Leadership Competency Framework in all new board member recruitment) being introduced immediately and other elements (such as requirements around the storing of information on the Electronic Staff Record) being introduced in a phased way ahead of full implementation of the Framework by 31 March 2024.

2.4 Under the new Framework, full Fit and Proper Person Test assessments must be undertaken:

- For all new appointments to board member roles, whether permanent or temporary, where greater than six weeks (including promotions, temporary appointments and secondments, acting-up arrangements.
- Where an individual board member changes role within their current organisation (e.g. if an existing board member moves into a new board role that requires a different skill set).
- Annually, for all existing board members, that is, within a 12-month period of the date of the previous FPPT assessment to review any changes over the previous 12 months.

2.5 As part of the Framework, there is a requirement for NHS organisations to formally capture FPPT information, and wider information to support recruitment referencing and ongoing development of board members, and entering this onto board members' ESR record.

2.6 For departing board members, the employing organisation is required to complete a Board Member Reference in all circumstances, including retirement, which is retained in that individual's FPPT files in the event that it is requested for new board appointments at another NHS organisation.

2.7 In terms of assurance and oversight, the Framework sets out that:

- As part of Well-Led Reviews, the CQC will consider the quality of processes and controls supporting FPPT, the quality of individual FPPT assessments, board member references, and the retention of relevant data.
- NHS England has oversight through receipt of an annual FPPT submission by NHS organisations.
- Every three years, NHS organisations are expected to undertake an internal audit to assess the processes, controls and compliance supporting the FPPT assessments.
- Annually, an update should be taken to a meeting in of the Board in public to confirm that the requirements for the FPPT have been satisfied.

2.8 The Group Board agreed a new Group-wide policy on the Fit and Proper Persons Test at its meeting in January 2025, and this incorporates the requirements of the national FPPT framework published in August 2023.

3.0 Fit and Proper Persons Test: Summary of Checks Undertaken

3.1 The following checks are undertaken as part of the FPPT assessment for all Board members at St George's University Hospitals NHS Foundation Trust (SGUH):

FPPT Checks for new starters	Annual FPPT Checks
Identity Check inc. Right to Work in the UK	FPPT Self Declaration
Disclosure and Barring Service Check	Check of Professional Registration (if applicable)
Check of educational qualifications	Check of Insolvency Register
References covering the past 6 years	Check of Disqualified Directors Register
Check of Professional Registration (if applicable)	Check of Charity Commission Register for Removed Trustees
Check of Insolvency Register	Check of Employment Tribunals Register
Check of Disqualified Directors Register	Media Check
Check of Charity Commission Register for Removed Trustees	Social Media Check
Check of Employment Tribunals Register	
Media Check	
Social Media Check	
FPPT Self Declaration	
Occupational Health Check	

3.2 In addition to the Disclosure and Barring Service (DBS) checks for new starters, DBS checks were also undertaken for any director that had a DBS more than three years old. In line with our new Fit and Proper Persons policy, agreed by the Board in January 2025, all Board members will have a DBS check at least every three years.

3.3 Board Member References were also completed for all board members who left the Board during 2024/25.

4.0 Fit and Proper Persons Test: Outcome and Compliance 2024/25

4.1 During February and March 2024/25, under the supervision of the Group Chairman, who is accountable for FPPT under the Framework, all existing Board members underwent the annual FPPT assessment as outlined above for 2024/25:

- All Board members completed Annual FPPT Self Assessment Forms. These forms have been reviewed and are all satisfactory.
- The further annual check set out above were undertaken by an independent background checks company contracted by South West London Recruitment Hub.

These have been completed for all Board members and no issues have been identified that affect the fit and proper status of any member of either Trust Board.

- In addition, the SGUH Senior Independent Director reviewed the FPPT compliance of the Group Chairman for 2024/25.

4.2 Appendix 1 sets out the completion of the tests for the Non-Executive Directors for 2024/25.

4.3 Following the completion of the FPPT checks and review of this report by the Group Board, the annual compliance submission is made to NHS England in line with the requirements of the Framework, ahead of the deadline of 30 June 2025.

Departing Board members, 2024/25

4.4 Under the FPPT Framework, the employing NHS organisation is required to complete a Board Member Reference for any departing Board member using the prescribed reference template. Board Member References are completed by the Chairman for all Non-Executive Directors departing the organisation, and by the Chief Executive for all Executive Directors. Board Member References have been completed for all departing board members including the following Non-Executive Directors.

Board member	Role	Date left	Board Member Reference Completed
Jenny Higham	Non-Executive Director	31 August 2024	Y
Philippa Tostevin	Interim Non-Executive Director	31 December 2024	Y
Tim Wright	Non-Executive Director	31 January 2025	Y

New Board members, 2024/25

4.5 During 2024/25, the following Non-Executive Directors joined SGUH:

Board member	Role	Date joined	FPPT completed
Philippa Tostevin	Interim Non-Executive Director	4 September 2024 (Left 31 December 2024)	Y
Claire Sunderland Hay	Associate Non-Executive Director	18 October 2024	Y
Natalie Armstrong	Non-Executive Director	1 January 2025	Y

Conclusion

4.7 All Non-Executive Directors at St George's University Hospitals NHS Trust satisfy the requirements of the Fit and Proper Persons Test required under the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 and meet the requirements of NHS England's Fit and Proper Persons Test Framework for board members 2023.

5.0 Recommendations

5.1 The Council is asked to note that the Fit and Proper Persons Test has been conducted for the period 2024/25 and that all Non-Executive Directors satisfy the requirements of the Test.

St George's University Hospitals NHS Foundation Trust - Fit and Proper Persons Test Annual Compliance 2024/25														
Last Name	First Name	Job Role	Qualifications Check	Occupational Health Check	References Check	Open/Upheld Disciplinary Case	Open/Upheld Grievance Case	Social Media Date Checked	Not Disqualified as a Charitable Trustee	Not Disqualified from Directors Register	No Employment Tribunal Judgements	DBS Requirements	Not Found on Insolvency Register	Prof Reg Check	Self-Declaration
Norton	Gillian	Chair	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Armstrong	Natalie	Non-Executive Director (from 1 January 2025)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Beasley	Ann	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Davé	Pankaj	Non-Executive Director (from 1 February 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Jones	Chiew Yin	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Kane	Peter	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Murray	Andrew	Non-Executive Director	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	Completed
Sunderland Hay	Claire	Associate Non-Executive Director (from 18 October 2024)	Completed	Completed	Completed	None	None	Completed	Completed	Completed	Completed	Completed	Confirmed	N/A	Completed
Tostevin	Phillipa	Interim Non-Executive Director (until 31 December 2024)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed
Wright	Timothy	Non-Executive Director (until 31 January 2025)	Completed	Completed	Completed	None	None	Completed	Confirmed	Confirmed	Confirmed	Confirmed	Confirmed	N/A	Completed

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
	TBA	New Governors Induction – Part 2	TBA	TBA
	TBA	PSIRF part 2 Training	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 - Outpatients	11:00 – 13:00	Outpatients
	8 July	(Provisional) Governor/NED pre-meet	14:00 – 15:30	TBA
	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
	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

St George's University Hospitals NHS Foundation Trust

Board, Committees and Council of Governors Calendar 2025/26

Month	Date	Meeting	Time	Location / Format
September	5 September	Group Board Meeting (Public and Private)	09:15 – 15:30	St Helier Hospital, Whitehall Lecture Theatre
	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

St George's University Hospitals NHS Foundation Trust

Board, Committees and Council of Governors Calendar 2025/26

Month	Date	Meeting	Time	Location / Format
	19 December	Finance Committees-in-Common	09:00 – 13:00	MS Teams
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